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Associations between maternal physical activity in early and late pregnancy and offspring birth size: remote federated individual level meta-analysis from eight cohort studies

Running head: Pregnancy physical activity and birth size outcomes

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Abstract

Objective. Evidence on the impact of leisure time physical activity (LTPA) in pregnancy on birth size is inconsistent. We aimed to examine the association between LTPA during early and late pregnancy and newborn anthropometric outcomes.

Design. Individual level meta-analysis, which reduces heterogeneity across studies.

Setting. A consortium of eight population-based studies (seven European and one US) comprising 72,694 participants.

Methods. Generalised linear models with consistent inclusion of confounders (gestational age, sex, parity, maternal age, education, ethnicity, BMI, smoking and alcohol intake) were used to test associations between self-reported LTPA at either early (8-18 weeks gestation) or late pregnancy (30+ weeks) and the outcomes. Results were pooled using random effects meta-analyses.

Main outcome measures. Birth weight, Large-for-gestational age (LGA), macrosomia, small-for-gestational age (SGA), %body fat and ponderal index at birth.

Results. Late, but not early, gestation maternal moderate-to-vigorous physical activity (MVPA), vigorous activity and LTPA energy expenditure were modestly inversely associated with BW, LGA, macrosomia and ponderal index, without heterogeneity (all: I-square=0%). For each extra hour/week of MVPA, RR for LGA and macrosomia were 0.97 (95% CI: 0.96, 0.98) and 0.96 (95%CI: 0.94, 0.98) respectively. Associations were only modestly reduced after additional adjustments for maternal BMI and gestational diabetes. No measure of LTPA was associated with risk for SGA.

Conclusions. Physical activity in late, but not early, pregnancy is consistently associated with modestly lower risk of LGA and macrosomia, but not SGA.

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Key words: Pregnancy, physical activity, birth weight, macrosomia, LGA, SGA

Tweetable abstract: In an individual participant meta-analysis, late pregnancy moderate to vigorous physical activity modestly reduced birth size outcomes

Abbreviations

ALSPAC, Avon Longitudinal Study of Parents and Children

ABCD, Amsterdam Born Children and their Development study

BMI, body mass index

DNBC, Danish National Birth Cohort

GECKO, Groningen Expert Center for Kids with Obesity

HSS, Healthy Start Study

LGA, large-for-gestational age

LTPA, leisure time physical activity

MET, metabolic equivalent of energy expenditure

MVPA, moderate-vigorous physical activity

REPRO-PL, Polish Mother and Child Cohort

SGA, small-for-gestational age

SWS, Southampton Women' Survey

VPA, vigorous physical activity

Introduction

The prevalence of childhood obesity has increased worldwide over the last three decades¹. Babies born large-for-gestational age (LGA), or with macrosomia (birth weight (BW) above 4000 or 4500 g), have higher risks of obesity and raised metabolic disease markers in childhood compared to babies with appropriate BW^{2,3}. Physical activity during pregnancy is recommended to enhance the health of the mother-to-be⁴, but has also been explored as a potential intervention to lower the risk for LGA and macrosomia⁵⁻¹⁰. Physical activity might be especially appealing if it reduced high BW without increasing the risk of small-for-gestational age (SGA) babies. Physical activity during pregnancy might reduce fetal growth by increasing insulin sensitivity and by modulating glucose regulation^{11, 12}. Physical activity might also regulate fetoplacental growth by altering the rate of oxygen and nutrient supplies¹³.

Recent systematic reviews of randomised controlled trials on the effect of maternal exercise on birth outcomes reported modest BW reductions (10-30 grams)^{14, 15}. However, they report wide variation in the types of interventions studied, in terms of form, intensity and volume of exercise. Systematic

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reviews of observational studies on the association between maternal physical activity during pregnancy with birth size ^{16, 17} reported conflicting results; some studies report an inverse association ^{5-10,18, 19}, some a positive association ²⁰⁻²² and others no significant association ²³⁻²⁸. There is also some evidence that the timing of physical activity in pregnancy might be important ^{18, 29}. The heterogeneity between studies limits the ability to pool published results. One meta-analysis ¹⁷ reported that “high” physical activity levels were inversely associated with BW, but conversely “moderate” physical activity levels were positively associated with BW. The included studies had used different definitions of physical activity level and there was no standardization with regard to: the type and domains of activity, or the volume, intensity and timing. Most studies did not adjust for any confounder.

Here, we examined the association between leisure time physical activity (LTPA) during pregnancy and newborn anthropometric outcomes across a range of prospective cohort studies. Within a consortium created as part of the InterConnect project [30], we used a federated meta-analysis approach ³¹, which allows an individual participant-level meta-analysis to be performed remotely. Compared to a literature-based meta-analysis, this approach can reduce heterogeneity between studies by allowing harmonization of exposure and outcome variables, and by allowing the same models to be tested in each study.

Methods

InterConnect is an EU-FP7 funded project, which optimises the use of existing data by enabling cross-cohort analyses within consortia without pooling of individual-level data at a central location. For this research question, eight cohorts with data on physical activity in pregnancy and neonatal outcomes set up a server to allow remote federated analyses and joined the consortium. The collaborative group comprised the following prospective birth cohort studies: the Avon Longitudinal

Study of Parents and Children (ALSPAC, UK) ^{32, 33}, the Amsterdam Born Children and their Development study (ABCD, Netherlands) ³⁴, the Danish National Birth Cohort (DNBC, Denmark) ³⁵, the Groningen Expert Center for Kids with Obesity (GECKO)-Drenthe ³⁶ (Netherlands), the Healthy Start Study (HSS, USA) ¹⁸, the Polish Mother and Child Cohort (REPRO_PL, Poland) ³⁷, the ROLO study (Ireland) ³⁸, and the Southampton Women's Survey (SWS, UK) ³⁹. Characteristics of the participating studies are shown in Table S1. Each participating cohort obtained ethical approval from the corresponding local Ethic Committee (see details at the end). No PPI took place for these analyses.

We included all live-born singleton full-term births and excluded mothers with pre-eclampsia and those with missing information for any of the covariates. The percentage of participants with any missing values across cohorts ranged between 10.2% and 34% for early pregnancy analyses and between 12.7% and 43.5% for late pregnancy analyses. Funding for this study was received from the European Union Seventh Framework Programme (FP7/2007-2013) under grant agreement n° 602068. Core Outcome Set (COS) and patient involvement (PPI) are not relevant to this study hence are not described here.

Physical activity during pregnancy

All studies assessed physical activity during pregnancy by questionnaire. HSS and SWS used interviewer-administered questionnaires, DNBC used a computer-assisted telephone interview and the other studies used self-administered questionnaires. Table S2 details the questions in each cohort. We harmonized self-reported data on LTPA during early pregnancy across seven cohorts and LTPA during late pregnancy across five cohorts. The median gestational age at which mothers replied to questionnaires was 8-18 weeks for early pregnancy and 30 weeks to one day post-delivery for late pregnancy. LTPA was chosen as it is the domain most amenable to intervention and therefore more relevant for public health recommendations; it was also the most commonly

assessed domain across the eight studies. Intensity of reported activities was expressed in metabolic equivalent of energy expenditure (MET) values according to the Compendium of Physical Activity ⁴⁰.

Four exposure variables were harmonized: (i) duration of LTPA (hours/week) which included any reported leisure time activity; (ii) duration of moderate-vigorous LTPA (MVPA) (hours/week) including activities with intensity ≥ 3 MET; (iii) duration of vigorous LTPA (VPA) (hours/week) including activities with intensity ≥ 6 MET; (iv) energy expenditure of LTPA (Met-hours/week) calculated by multiplying duration of LTPA by MET values. Three studies recorded categorical response formats for duration of LTPA (ALSPAC, GECKO and SWS. These were converted into numerical values, where relevant using the mid-point of the stated range (e.g. '>7 hours/week' was converted to 7 hours/week; '2-6' to 4; <1 to 0.5; 'never' to 0).

Outcomes

The following outcome variables were harmonized across all studies based on objective measurements in all studies: BW (g), macrosomia (defined as BW >4000 g), LGA (BW for gestational age >90th percentile according to the INTERGROWTH-21st Project ⁴¹ and SGA (BW for gestational age <10th percentile according to INTERGROWTH-21st). Ponderal Index, a measure of leanness (corpulence) [weight/length³, kg/m³] at birth was harmonized for six cohorts. Percent (%) body fat at birth was available for three cohorts. Of these, one (HSS) assessed newborn body fat using air displacement plethysmography (PEAPOD), while skinfold thickness measurements were available in HSS, SWS and in a subset of ROLO (N=219). Triceps and subscapular skinfolds were used to estimate % body fat using the algorithm reported by Slaughter ⁴²: % body fat = $1.21 * (\text{Triceps Skinfold} + \text{Subscapular Skinfold}) - 0.008 * (\text{Triceps Skinfold} + \text{Subscapular Skinfold})^2 - 1.7$.

Potential modifiers

The following potential modifying variables were harmonized across the studies: infant sex, maternal obesity (BMI: ≤ 20 kg/m², >20 -30 kg/m², >30 kg/m²), maternal ethnicity (white, black, other) and gestational diabetes mellitus (GDM; yes, no). Maternal weight was objectively measured in five cohorts and self-reported in three cohorts at varying times in early pregnancy up to week 18 of gestation. We applied a uniform correction factor to weights measured later than 12 weeks gestation derived by weight gain curves based on repeated maternal weight measures in the ALSPAC study. There was wide variation in definitions of ethnicity across cohorts; the 'other ethnicity' category includes a variety of Asian, Hispanic and other ethnic groups. GDM was defined using biochemical data at weeks 24-28 in HSS and ROLO, and by a combination of medical records and self-reports in the other studies.

Potential confounders and other covariates

Potential confounders were not harmonized because in federated analysis models, involving random-effects meta-analysis of the arising study-specific estimates, this would not impact the summary effect estimates and P-values. However, confounder variables were reasonably comparable across studies. Smoking in pregnancy was a dichotomous variable (yes/no) in all studies except DNBC, which determined the number of cigarettes/week. Alcohol intake was considered as: units of alcohol/week in ALSPAC, DNBC and SWS; glasses/week in ABCD; and as categorical variables in GECKO (none, <1 glass/week, 1-6 glasses/week, 7+ glasses/week), HSS (none, once per month or less, twice per month or more), REPRO_PL (yes/no) and ROLO (yes/no). Educational attainment was considered as a categorical variable in most cohorts (range 2- 6 levels) except ABCD, which recorded 'years of education after elementary school'. Parity (number of previous live births) was self-

reported in all studies and maternal age at delivery was calculated from mother's date of birth and delivery date.

Statistical analyses

All analyses were conducted using R within the DataSHIELD federated meta-analysis library⁴³. In this process, individual participant data from contributing studies are held securely on servers at each study location³⁰. Analytical commands are sent from a computer within the network, which requests each local server to undertake an analysis locally and return non-identifiable summary statistics. The result of this process is mathematically equivalent to an individual participant meta-analysis with the advantage that data remain within the governance structure of each single cohort study³⁰.

To analyses data we used generalized linear models in each study. Each model was fitted in a federated manner using the iterative reweighted least squares process³¹. The primary models included MVPA duration as exposure and each outcome (BW, macrosomia, LGA, SGA, Ponderal index, %body fat) separately. Moderate to vigorous activity was chosen as the primary exposure because it has higher validity than lower intensity activities⁴⁴; also, the majority of existing guidelines recommended moderate intensity physical activity for pregnant women⁵. The adjusted models included each exposure separately (LTPA duration, MVPA duration, VPA duration, LTPA energy expenditure) with each outcome (BW, macrosomia, LGA, SGA, Ponderal index, %body fat), and were adjusted for gestational age (except for LGA and SGA), infant sex, parity, maternal age, smoking, alcohol, maternal education and ethnicity. Further models were additionally adjusted for maternal early pregnancy BMI. A schematic diagram of the analysis plan is shown in Figure S1. All covariates were chosen a priori based on literature evidence. To explore which covariate

contributed most to heterogeneity, we conducted further analyses by including each potential confounding variable one at a time. Physical activity is likely to exert its effect on birth size by altering maternal metabolic pathways such as glucose metabolism and there is evidence of its association with GDM (46). Therefore, GDM was added in a subsequent model to explore its possible mediating effect. We explored the possible modifying effect of infant sex, maternal obesity, maternal ethnicity and GDM by including interaction terms in the model. These potential effect modifiers were chosen a priori. The levels of physical activity and its effects on health differ across ethnic groups ⁴⁷. In pregnant women, both obesity and GDM might alter physiological characteristics that affect their ability to exercise ⁴⁸. All models were conducted separately for early and late pregnancy physical activity. Early pregnancy physical activity measures were available for ALSPAC, ABCDS, DNBC, HSS, REPRO-PL, ROLO and SWS. Late pregnancy physical activity measures were available for DNBC, GECKO, HSS, REPRO_PL and SWS. Regression analyses were conducted for each individual study, and then random-effects meta-analysis was used to combine the effect estimates. A random effects approach was chosen due to the reported heterogeneity between other published studies. Heterogeneity was assessed using the I^2 statistic.

Results

For early pregnancy physical activity analyses, 72,694 participants from seven studies were included (57,807 across six studies for ponderal index; 3,039 in three studies for % body fat). For late pregnancy analyses, the available sample was 58,820 from five studies (57,172 across four studies for ponderal index; 2,792 in two studies for % body fat). Maternal and infant characteristics are presented in Table 1. Mean BW ranged between 3356g and 4135g, and 3217g and 3963g for male and female infants, respectively. ROLO infants had the highest mean BW, and highest prevalence of macrosomia (51.8%) and LGA (61.7%), reflecting their inclusion of only secundigravid women whose first baby was macrocosmic. Among the other cohorts, macrosomia prevalence ranged between

5.6% in HSS and 21.7% in DNBC, and LGA between 8.7% in HSS and 30.2% in GECKO. SGA prevalence ranged between 0.8% in ROLO and 9.4% in HSS. Median ponderal index at birth ranged between 20.2 in REPRO_PL and 27.8 in SWS and % body fat was 10%, 11% and 16% in HSS, SWS and ROLO, respectively.

Reported levels of maternal LTPA during pregnancy varied across studies, with DNBC women having the lowest levels in both periods (64% of women reporting no LTPA). Among the other cohorts, median LTPA duration ranged from 2.0 – 6.5 hours/week for early pregnancy and 1-7 hours/week for late pregnancy. Median MVPA levels ranged from 0-4 hours/week for early pregnancy and 0-0.8 hours/week for late pregnancy. The proportion of women reporting any MVPA decreased from the early pregnancy in the four studies with data at both time points (DNBC: 34%, HSS: 72%, REPRO_PL: 20%, SWS: 84%) to late pregnancy (DNBC: 25%, HSS: 49%, REPRO_PL: 12%, SWS: 78%). The proportion of women reporting any VPA was low in most cohorts (range: 6.6-42.5%) and decreased in late pregnancy (range: 2.9-24.1%).

Physical activity associations in early pregnancy

Early pregnancy maternal LTPA was not associated with any measure of offspring birth size (Table 2, Table S3, Table S4). Heterogeneity across studies was high in unadjusted models ($I^2=79-86\%$ for BW, macrosomia and LGA, Table S1), but was substantially reduced after adjustments for potential confounders (0-54%, Table 2). In sensitivity models, with stepwise inclusion of covariates, ethnicity and maternal education contributed the most to (positive) confounding in some individual studies, with non-white ethnicity being associated with both lower BW and lower LTPA, and maternal education being associated with both higher BW and higher LTPA (not shown).

Late pregnancy maternal MVPA (Figures 1 and 2 and Table 2), VPA, and LTPA energy expenditure (Table 2, Table S3) were inversely associated with all birth size outcomes, except for % body fat and SGA, in adjusted models. For each +1 hour/week of MVPA, offspring BW was lower by 6.4 grams (95%CI: 9.1, 3.7; $p<0.001$) and ponderal index by 0.02 kg/m^3 (95%CI: 0.03, 0.00; $p=0.02$); the relative risks of macrosomia and LGA were lower by 4% (95%CI: 2, 6; $p<0.001$) and 3% (95%CI: 2, 4; $p<0.01$). No association was found for SGA (OR: 0.99, 95%CI: 0.98, 1.00) and % body fat (-0.01, 95%CI: -0.04, 0.02). VPA showed larger associations with BW (-22 grams per hour/week; 95%CI: -31.3, -12.7; $p<0.001$), ponderal index (-0.07 units; 95%CI: -0.13, -0.02; $p<0.01$), macrosomia and LGA (lower by 11%, 95%CI: 5, 16; $p<0.01$ and 11%, 95%CI: 5, 16 $p<0.001$, respectively) and no association with % body fat (-0.05; 95%CI: -0.17, -0.06) and SGA (OR: 1.01, 95%CI: 0.96, 1.16). The associations with late pregnancy LTPA were not mediated by GDM and persisted after further adjustment for early pregnancy maternal BMI (Table S5).

No interaction with ethnicity, infant sex, GDM or maternal obesity was found in either pregnancy period for LTPA and birth size (all p -values for interactions >0.05).

Discussion

Main findings

In this large cross-cohort analysis of up to 72,694 individuals, we found small but consistent inverse associations between maternal LTPA during late but not early pregnancy and offspring birth size. Each additional hour/week of MVPA in late pregnancy was associated with 6.4 g lower birth weight and 4% and 3% relative reductions in risk of macrosomia and LGA, respectively, without increasing the risk of SGA.

Strengths and limitations

A major strength of our approach was the planned individual level analysis across several cohort studies. Compared to the inconsistent findings of published literature-based systematic reviews, heterogeneity between study estimates was substantially reduced by consistent confounding adjustment and by harmonisation of exposures and outcomes. The remote federated analysis approach avoided the need to physically pool individual-level data, and hence substantially reduced the governance burdens and associated time delays, and avoided barriers due to limitations of consent and research ethics permissions. Another strength is that we were able to analyse the differential association of timing and intensity of physical activity in pregnancy with offspring birth size outcomes.

However, there were some limitations in our approach. Physical activity was self-reported in all included studies and only a few of the questionnaires were validated. Physical activity questionnaires are susceptible to measurement error related to both recall and social desirability⁵⁵. with validity estimated between 0.25-0.4⁵⁵. However, they are able to rank individuals according to activity levels⁵⁶. Furthermore, validity is higher among women than men and for vigorous intensity compared to lighter intensity activities⁴⁴. It remains a challenge to identify thresholds of physical activity in terms of health benefits. Contributing studies used different questionnaires with varying ways of assessing LTPA, which made harmonisation challenging. For example, some listed specific activities (e.g. 'swimming', 'walking') while others asked only about categories of activities (i.e. 'moderate', 'vigorous'), which included some activities outside of leisure time. Intensity information was not available in all questionnaires, which meant assumptions had to be made when assigning MET values. Differences in average LTPA levels across the studies might therefore reflect differences in methods, or real population differences. The timing of questionnaire administration differed across studies, particularly for early pregnancy LTPA. Unfortunately, data were unavailable on clinical outcomes associated with LGA and macrosomia, such as shoulder dystocia, 3rd or 4th degree

laceration, nor on pregnancies not resulting in live birth. Future analyses including such outcomes would be highly informative. Our use of international INTERGROWTH-21st Project data to define LGA and SGA led to unequal numbers for those outcomes and limited the statistical power to detect a possible association between VPA and SGA. Although we adjusted for many confounding factors, residual confounding cannot be ruled out. Limited geographical and ethnic diversity limited the power to detect modifying factors. One participating study (DNBC) was substantially larger than the other studies and accounted for more than 70% of the sample size in the analyses. Whilst the dominance of this study in driving results should be acknowledged, it is noteworthy that in adjusted models heterogeneity was reduced from >70% to 0% in most analyses, thus highlighting the consistency across studies and the generalisability of results.

Interpretations

The direction of our associations is consistent with some previous individual studies^{5-10,18,19}, however other studies reported null²³⁻²⁸ or even directionally opposite results²⁰⁻²². A recent meta-analysis¹⁷ reported that a “moderate” level of physical activity was positively associated with BW, while a “high” level of physical activity was inversely associated with BW. However, those results were based on a mixture of adjusted and unadjusted models, and their reported meta-analysis of only the adjusted models showed null associations for both moderate and high levels of physical activity. Furthermore, in that meta-analysis, there was substantial heterogeneity with I^2 values >80%. We demonstrate here that more consistent adjustment for confounding reduced heterogeneity between individual study estimates from I^2 >70% to 0% in several analyses. Furthermore, adjustment for ethnicity and maternal education avoided spurious positive associations between early pregnancy physical activity and birth size. We harmonized the intensity of activities by assigning the same MET values for similar reported activities across studies. Although the diverse nature of the questionnaires used in the individual studies made harmonisation

challenging, MVPA was less heterogeneous than other activity variables, particularly in late pregnancy; this may be because our harmonized MVPA variable was more robust to underlying methodological differences across studies.

The timing of PA associations with LTPA during late, but not early, pregnancy is also consistent with some reported studies^{18, 29, 49}. Clapp et al⁴⁹ reported inverse associations with newborn adiposity or BW only for late pregnancy physical activity. Hopkins and Cutfield²⁹ conjectured that high volume exercise only in the first half of pregnancy increased BW, but if performed throughout pregnancy or only in the second half of pregnancy it reduced BW. They suggested that the timing of physical activity caused different fetoplacental adaptations.

Regarding intensity of LTPA, we found that late pregnancy MVPA, VPA and energy expenditure, but not duration of LTPA, were inversely associated with offspring birth size. Some previous studies have assessed the impact of physical activity intensity on offspring birth size, with some findings consistent with ours^{21, 22, 49}, but others reported null results^{27, 50-52}. Different adjustment factors and different definitions, timing and categories of physical activities might lead to inconsistent findings between studies. Although the proportion of women reporting any VPA was small, our results suggest that changes in birth size outcomes are dependent on the intensity of LTPA, with larger effects observed with higher intensity. It is possible that LTPA intensity needs to reach a certain threshold before it has an effect on nutrient supply to the fetus. Alternatively, higher intensity recreational activities may be easier to recall and less prone to measurement error⁴⁴.

Our observed associations remained significant after adjustment for maternal BMI, possibly suggesting that the effect of physical activity on birth size is only partially mediated by maternal weight, however we did not have measures of late pregnancy maternal weight gain and BMI. Independent of maternal weight, physical activity increases maternal insulin sensitivity^{12, 53}, reduces maternal glucose and, hence, might reduce glucose transfer to the fetus⁵⁴. These metabolic changes are more marked at higher intensities and volumes of exercise and in late pregnancy^{11, 29}.

Conclusion

In conclusion, LTPA energy expenditure, MVPA and VPA during late, but not early, pregnancy had a small but significant and consistent inverse association with offspring birth size. Larger effects were observed with higher intensity of physical activity. Compared to the inconsistent findings of reviews of published reports, this remote federated individual level analysis substantially reduced heterogeneity between individual studies by allowing consistent adjustment for confounding and careful harmonisation of exposures and outcomes.

Ethical approvals

Avon Longitudinal Study of Parents and Children (ALSPAC): Ethical approval for the study was obtained from ALSPAC Ethics and Law Committee and the Local Research Ethics Committees

Amsterdam Born Children and their Development study (ABCD): Approval of the study was obtained from the Central Committee on Research Involving Human Subjects in The Netherlands, the medical ethics review committees of the participating hospitals and the Registration Committee of the Municipality of Amsterdam.

Danish National Birth Cohort (DNBC, Denmark): Approved by the Committee on Biomedical Research Ethics. The cohort is approved under case number (KF) 01-471/94.

Groningen Expert Center for Kids with Obesity (GECKO)-Drenthe: This study was approved by the Medical Ethics Committee of the University Medical Center Groningen (UMCG).

Healthy Start Study (HSS): approved by the Colorado Multiple Institutional Review Board.

Polish Mother and Child Cohort (REPRO_PL): The study was approved by the Ethical Committee of the Nofer Institute of Occupational Medicine, Łódź, Poland (Decision No. 7/2007)

ROLO study: Approved by the Ethics Committee at the National Maternity Hospital, June 2006

Southampton Women's Survey (SWS): Approved by South Central - Hampshire B Research Ethics Committee

Conflict of interest

The authors declare that they have no conflict of interest. Completed disclosure of interest forms are available to view online as supporting information.

Contribution of authors

GD, KKO, SP contributed to planning the study. SP, KW, SB, AK, DOG, KKO coordinated harmonisation of all variables; TB and PS conducted the federated remote statistical analyses. SP, KKO, DOG, SB interpreted the results. SP wrote the article. SP, TB, SB, KW, NJW, GD, KKO, SRC, CG, KK, LKK, EOB, KP, KAS, MHZ, BW, CA, PRB, CC, EC, DD, WH, HMI, FM, SFO, TGV contributed to the analysis plan, the production of the paper, the harmonisation algorithms and the review of the manuscript.

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References

1. Ng M, Fleming T, Robinson M, Thomson B, Graetz N, Margono C et al: Global, regional, and national prevalence of overweight and obesity in children and adults during 1980-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2014; 384:766-81
2. Boney CM, Verma A, Tucker R, Vohr BR. Metabolic syndrome in childhood: association with birth weight, maternal obesity, and gestational diabetes mellitus. *Pediatrics*. 2005; 115(3):e290-6.
3. Gu s, An X, Fang L, Zhang X, Zhang C, Wang J et al. Risk factors and long-term health consequences of macrosomia: a prospective study in Jiangsu Province, China. *J Biomed Res*. 2012; 26(4):235–40.
4. Amercian College of Obstetricians and Gynaecolgist. Committee Opinion No. 650: Physical Activity and Exercise During Pregnancy and the Postpartum Period. *Obstet Gynecol*. 2015;126(6):e135-42.
5. Clapp J F 3rd, Capeless EL. Neonatal morphometrics after endurance exercise during pregnancy *Am J Obstet Gynecol*. 1990; 163(6 Pt 1):1805–11.
6. Morgan KL, Rahman MA, Hill RA Zhou SM, Bijnsma G, Khanom A.et al. Physical activity and excess weight in pregnancy have independent and unique effects on delivery and perinatal outcomes. *PLoS ONE*. 2014; 9(4):e94532
7. Juhl M, Olsen J, Andersen P K, Nøhr E A, Andersen A M. Physical exercise during pregnancy and fetal growth measures: a study within the Danish National Birth Cohort. *Am J Obstet Gynecol*. 2010; 202(1):63.e1–63.e8
8. Owe K M, Nystad W, Bø K. Association between regular exercise and excessive newborn birth weight. *Obstet Gynecol*. 2009; 114(4):770–6
9. Currie L M, Woolcott C G, Fell D B, Armson B A, Dodds L. The association between physical activity and maternal and neonatal outcomes: a prospective cohort. *Matern Child Health J*. 2014; 18(8):1823–30
10. Alderman BW, Zhao H, Holt VL, Watts DH, Beresford SA. Maternal physical activity in pregnancy and infant size for gestational age. *Ann Epidemiol*. 1998; 8 (8) 513-9
11. Clapp JF 3rd, Capeless EL. The changing glycemic response to exercise during pregnancy. *Am J Obstet Gynecol*. 1991; 165(6 Pt 1):1678Y83.
12. van Poppel MN, Oostdam N, Eekhoff ME, Wouters MG, van Mechelen W, Catalano PM. Longitudinal relationship of physical activity with insulin sensitivity in overweight and obese pregnant women. *J Clin Endocrinol Metab*. 2013; 98(7):2929-35.
13. Jackson MR, Gott P, Lye SJ, Ritchie JW, Clapp JF 3rd. The effects of maternal aerobic exercise on human placental development: placental volumetric composition and surface areas. *Placenta*. 1995; 16(2):179Y91.

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14. Wiebe HW, Boulé NG, Chari R, Davenport MH. The effect of supervised prenatal exercise on fetal growth: a meta-analysis. *Obstet Gynecol.* 2015; 125(5):1185–94
 15. Sanabria-Martínez G, García-Hermoso A, Poyatos-León R, González-García A, Sánchez-López M, Martínez-Vizcaíno V. Effects of exercise-based interventions on neonatal outcomes: A metaanalysis of randomized controlled trials. *Am J Health Promot.* 2015; 30(4): 214-23
 16. Schlüssel MM, Souza EB, Reichenheim ME, Kac G. Physical activity during pregnancy and maternal-child health outcomes: a systematic literature review. *Cad Saude Publica.* 2008; 24 Suppl 4:s531-44.
 17. Bisson M, Lavoie-Guénette J, Tremblay A, Marc I. Physical activity volumes during pregnancy: A systematic review and meta-analysis of observational studies assessing the association with Infant's birth weight. *AJP Rep.* 2016; 6(2):e170-97.
 18. Harrod CS, Chasan-Taber L, Reynolds RM, Fingerlin TE, Glueck DH, Brinton JT et al. Physical activity in pregnancy and neonatal body composition: the Healthy Start study. *Obstet Gynecol.* 2014; 124 (2 Pt 1): 257-64
 19. Perkins CC, Pivarnik JM, Paneth N, Stein AD. Physical activity and fetal growth during pregnancy. *Obstet Gynecol.* 2007; 109 (1) 81-7
 20. Leiferman JA, Evenson KR. The effect of regular leisure physical activity on birth outcomes. *Matern Child Health J.* 2003; 7 (1) 59-64
 21. Nieuwenhuijsen MJ, Northstone K, Golding J, ALSPAC Study Team. Swimming and birth weight. *Epidemiology.* 2002; 13 (6) 725-8
 22. Hatch MC, Shu XO, McLean DE, Levin B, Begg M, Reuss L et al. Maternal exercise during pregnancy, physical fitness, and fetal growth. *Am J Epidemiol.* 1993; 137 (10) 1105-14
 23. Hegaard HK, Petersson K, Hedegaard M, Ottesen B, Dykes AK, Henriksen TB et al. Sports and leisure-time physical activity in pregnancy and birth weight: a population-based study. *Scand J Med Sci Sports.* 2010; 20 (1) e96-e102
 24. Duncombe D, Skouteris H, Wertheim EH, Kelly L, Fraser V, Paxton SJ. Vigorous exercise and birth outcomes in a sample of recreational exercisers: a prospective study across pregnancy. *Aust N Z J Obstet Gynaecol* 2006; 46 (4) 288-292
 25. Klebanoff MA, Shiono PH, Carey JC. The effect of physical activity during pregnancy on preterm delivery and birth weight. *Am J Obstet Gynecol.* 1990; 163 (5 Pt 1): 1450-6
 26. Magann EF, Evans SF, Weitz B, Newnham J. Antepartum, intrapartum, and neonatal significance of exercise on healthy, low-risk pregnant women. *Obstet Gynecol.* 2002; 99(3):466–72
 27. Jukic AM, Evenson KR, Daniels JL, Herring AH, Wilcox AJ, Hartmann KE. A prospective study of the association between vigorous physical activity during pregnancy and length of gestation and birthweight. *Matern Child Health J.* 2012; 16 (5) 1031-44

28. Voldner N, Frøslie KF, Bo K, Haakstad L, Hoff C, Godang K et al. Modifiable determinants of fetal macrosomia: role of lifestyle-related factors. *Acta Obstet Gynecol Scand*. 2008; 87 (4) 423-9
29. Hopkins SA, Cutfield WS. Exercise in pregnancy: weighing up the long-term impact on the next generation. *Exers Sport Sci Rev*. 2011;39(3):120–7
30. <http://www.interconnect-diabetes.eu/>, accessed on 03/07/2017
31. Jones EM, Sheehan NA, Masca N, Wallace SE, Murtagh MJ, Burton PR. DataSHIELD – shared individual-level analysis without sharing the data: a biostatistical perspective”, *Norsk Epidemiologi*. 2012; 21(2): 231-9
32. Boyd A, Golding J, Macleod J, Lawlor DA, Fraser A, Henderson J et al. Cohort profile: the 's09 eht fo nerdlihC'– the index offspring of the Avon longitudinal study of parents and children. *Int J Epidemiol*. 2013; 58:111–27
33. Fraser A, Macdonald-Wallis C, Tilling K, Boyd A, Golding J, Davey-Smith G et al. Cohort profile: the Avon Longitudinal Study of Parents and Children: ALSPAC mothers cohort. *Int J Epidemiol*. 2013; 42(1): 97-110
34. van Eijsden M, Vrijkotte TG, Gemke RJ, van der Wal MF. Cohort profile: the Amsterdam Born Children and their Development (ABCD) study. *Int J Epidemiol*. 2011; 40(5):1176-86
35. Olsen J, Melbye M, Olsen SF, Sørensen TI, Aaby P, Andersen AM et al. The Danish National Birth Cohort- its background, structure and aim. *Scand J Public Health*. 2001;29:300-7
36. L'Abée C, Sauer PJJ, Damen M, Rake JP, Cats H, Stolk RP. Cohort Profile: The GECKO Drenthe study; overweight programming during early childhood. *Int J Epidemiol*. 2008; 37: 486-9
37. Polanska K, Hanke W, Gromadzinska J, Llgocka D, Gulczynska E, Sobala W et al. Polish mother and child cohort study — defining the problem, the aim of the study and methodological assumptions. *International Journal of Occupational Medicine and Environmental Health*. 2009;22(4):383–91.
38. Walsh JM, McGowan CA., Mahony R, Foley ME, McAuliffe FM. Low glycaemic index diet in pregnancy to prevent macrosomia (ROLO study): randomised control trial. *British Medical Journal*. 2012; 345:e5605.
39. Inskip HM, Godfrey KM, Robinson SM, Law CM, Barker DJ, Cooper C. Cohort profile: the Southampton Women's Survey. *Int J Epidemiol*. 2006;35:42–8
40. Ainsworth BE, Haskell WL, Herrmann SD, Meckes N, Bassett DR, Tudor-Locke C, et al. Compendium of Physical Activities: A Second Update of Codes and MET Values. *Medicine and Science in Sports and Exercise*. 2011; 43(8):1575–81
41. <http://www.intergrowth21.org.uk/>, accessed on 03/07/2017

42. Slaughter MH, Lohman TG, Boileau RA, Horswill CA, Stillman RJ, Van Loan MD et al. Skinfold equations for estimation of body fatness in children and youth. *Hum Biol* 1988; 60:709–723.
43. www.datashield.ac.uk, accessed on 03/07/2017
44. Durante R, Ainsworth BE. The recall of physical activity: using a cognitive model of the question-answering process. *Med Sci Sports Exerc.* 1996; 28: 1282-91
45. Evenson K.R., Barakat R., Brown W.J. Guidelines for physical activity during pregnancy: comparisons from around the world. *Am J Lifestyle Med.* 2014;8:102–21
46. Aune D, Sen A, Henriksen T, Saugstad OD, Tonstad S. Physical activity and the risk of gestational diabetes mellitus: a systematic review and dose-response meta-analysis of epidemiological studies. *Eur J Epidemiol.* 2016;31(10):967-97
47. Gill JM, Celis-Morales CA, Ghouri N. Physical activity, ethnicity and cardio-metabolic health: does one size fit all? *Atherosclerosis.* 2014; 232: 319–33
48. Konstantina D, Triantafyllou A, Grigoriadou I, Kintiraki E, Triantafyllou GE, Poullos P et al. Impairments in microvascular function and skeletal muscle oxygenation in women with gestational diabetes mellitus: links to cardiovascular disease risk factors. *Diabetologia.* 2017; 60 (1):192–201
49. Clapp JF, Kim H, Burciu B, Schmidt S, Petry K, Lopez B. Continuing regular exercise during pregnancy: Effect of exercise volume on fetoplacental growth. *Am J Obstet Gynaecol.* 2002; 186(1):142–7.
50. Mudd LM, Pivarnik J, Holzman CB, Paneth N, Pfeiffer K, Chung H. Leisure-time physical activity in pregnancy and the birth weight distribution: where is the effect? *J Phys Act Health.* 2012; 9 (8) 1168-77
51. Rose NC, Haddow JE, Palomaki GE, Knight GJ. Self-rated physical activity level during the second trimester and pregnancy outcome. *Obstet Gynecol.* 1991; 78 (6) 1078-80
52. Sternfeld B, Quesenberry Jr CP, Eskenazi B, Newman LA. Exercise during pregnancy and pregnancy outcome. *Med Sci Sports Exerc.* 1995; 27(5): 634-40
53. McMurray RG, Hackney AC, Guion WK, Katz VL. Metabolic and hormonal responses to low-impact aerobic dance during pregnancy. *Med Sci Sports Exerc.* 1996; 28(1):41–6.
54. Bonen A, Campagna P, Gilchrist L, Young DC, Beresford P. Substrate and endocrine responses during exercise at selected stages of pregnancy. *J Appl Physiol* 1992; 73:134–142.
55. Helmerhorst HJF, Bragen S, Warren J, Besson H, and Ekelund U. A systematic review of reliability and objective criterion-related validity of physical activity questionnaires. *Int J Behav Nutr Phys Act.* 2012; 9: 103

Wanner M, Probst-Hensch N, Kriemler S, Meier F, Autenrieth C, Martin BW. Validation of the long international physical activity questionnaire: Influence of age and language region. *Prev Med Rep.* 2016; 9(3):250-6

Figure captions

Figure 1. Forest plots for late pregnancy moderate to vigorous activity (hours/week) associated with birth weight and Ponderal Index. Associations were adjusted for gestational age, sex, parity, maternal age, smoking, alcohol, maternal education and ethnicity. N=58,820 except for Ponderal Index (N=57,172)

Figure 2. Forest plots for late pregnancy moderate to vigorous activity (hours/week) associated with relative risk of macrosomia and LGA (large for gestational age). Associations were adjusted for gestational age, sex, parity, maternal age, smoking, alcohol, maternal education and ethnicity. N=58,820

Figure S1. Schematic representation of the analysis plan

Table 1. Study population characteristics

	ALSPAC	ABCD	DNBC	GECKO	HSS	REPRO_P L	ROLO	SWS
N^a	9,058	6,464	53,671	1,335	1,054	982	617	1,902
Female, n (%)	4,428 (48.9)	3,244 (50.2)	26,371 (49.2)	638 (41.8)	509 (48.3)	487 (49.6)	309 (50.1)	916 (48.2)
Birth weight, g								
Male, mean (SD)	3,551 (479)	3,572 (491)	3,709 (503)	3,708 (505)	3,356 (432)	3,490 (440)	4,135 (481)	3,589 (480)
Female, mean (SD)	3,424 (447)	3,435 (456)	3,575 (481)	3,538 (490)	3,217 (420)	3,316 (432)	3,963 (423)	3,445 (458)
Macrosomia, n (%)	1,158 (12.7)	871 (13.4)	11,681 (21.7)	289 (21.6)	60 (5.6)	84 (8.5)	320 (51.8)	267 (14)
LGA, n (%)	1,888 (20.8)	1,222 (18.9)	15,052 (28)	405 (30.3)	121 (8.7)	183 (18.6)	381 (61.7)	369 (19.4)
SGA, n (%)	418 (4.6)	311 (4.8)	1,849 (3.4)	59 (6.4)	100 (9.4)	58 (5.9)	5 (0.8)	101 (5.3)
Ponderal Index^b, median (IQR)	26.2 (24.7- 27.8)		24.9 (23.5- 26.5)		26.9 (24.9- 29.2)	20.2 (18.9- 21.6)	27.1 (25.3- 29.3)	27.8 (26.3- 29.2)
% body fat^c, median (IQR)					10 (8-12)		16 (14- 18)	11 (10- 13)
Early pregnancy physical activity median (IQR)								
LTPA (h/w)	4.0 (0.5- 5.5)	2.0 (0.5- 4.3)	0.0 (0.0- 1.0)		3.0 (1.0- 5.8)	4.0 (0.0- 7.0)	1.7 (1.0- 2.3)	6.5 (3.2- 11.5)
MVPA (h/w)	4.0 (0.5- 5.0)	1.5 (0.0- 3.5)	0.0 (0.0- 1.0)		1.5 (0.0- 3.5)	0.0 (0.0- 0.0)	0.3 (0.0- 1.0)	1.2 (0.3- 3.0)
LTPA EE (Met-h/w)	15.2 (3.0- 25.2)	8.1 (1.7- 19.3)	0.0 (0.0- 6.0)		10.2 (3.1- 23.6)	16.5 (0.0- 33.0)	4.5 (2.0- 7.8)	17.5 (8.7- 32.1)
Women doing vigorous PA, n (%)	604 (6.6)	1876 (29)	4321 (8.0)		244 (23.1)	84 (8.5)	61 (9.8)	810 (42.5)
Late pregnancy physical activity median (IQR)								
LTPA (h/w)			0.0 (0.0- 1.0)	1.0 (1.0- 1.0)	2.0 (0.5- 3.6)	5.0 (0.0- 8.0)		7.0 (3.4- 12.0)
MVPA (h/w)			0.0 (0.0- 1.0)	0.3 (0.0- 1.0)	0.0 (0.0- 1.5)	0.0 (0.0- 0.0)		0.8 (0.1- 2.3)
Women doing vigorous PA, n (%)			1599 (2.9)		61 (5.7)	77 (8.3)		443 (24.1)

LTPA EE (Met-h/w)			0.0 (0.0-3.0)	1.0 (0.0-4.0)	6.3 (1.5-11.9)	19.8 (0.0-33.0)		16.7 (8.5-31.1)
Maternal age (y), mean (SD)	28.5 (4.7)	30.9 (5.1)	30.1 (4.2)	30.8 (4.2)	28 (6.1)	29.0 (4.2)	32.2 (4.1)	30.6 (3.7)
Maternal BMI								
Mean (SD)	22.5 (4.3)	24.0 (4.1)	24.7 (4.1)	24.7 (4.7)	26.7 (6.0)	22.8 (3.6)	26.6 (4.8)	26 (4.8)
Overweight, n (%)	1,257 (13.8)	1,447 (22.3)	14,896 (27.7)	320 (24)	334 (31.6)	162 (16.4)	233 (37.7)	606 (32)
Obese, n (%)	586 (6.4)	527 (8.1)	5,546 (10.3)	169 (12.6)	225 (21.3)	39 (3.9)	114 (18.4)	323 (17)
GDM, n (%)	41 (0.4)	76 (1.1)	380 (10.7)	44 (3.2)	43 (4)	34 (3.4)	12 (2)	19 (1)
Ethnicity								
White	8,867 (98)	4,490 (69.4)	53,671 (100)	1,321 (99)	814 (76.5)	982 (100)	612 (97.5)	1,840 (96.8)
Black	77 (0.8)	486 (7.6)	0 (0)	0 (0)	162 (15.3)	0 (0)	2 (0.3)	10 (0.5)
Other	114 (1.2)	1,488 (23)	0 (0)	14 (1)	78 (7.2)	0 (0)	14 (2.2)	52 (2.7)

LGA= Large for gestational age; SGA= Small for gestational age; LTPA=Leisure-time physical activity; MVPA=moderate to vigorous leisure time physical activity; EE= energy expenditure; GDM= Gestational diabetes mellitus.

a. Sample size available for late pregnancy physical activity analyses were: DNBC=53,684, HSS=1,044, REPRO_PL=919, SWS=1,838

b. Sample size available for analyses of Ponderal index for early pregnancy analyses were: ALSPAC=7,118, DNBC=53,487, HSS=976, REPRO_PL=977, ROLO=523, SWS=1,844; for late pregnancy analyses: DNBC=53,500, HSS=968, REPRO_PL=915, SWS=1,789

c. Sample size available for analyses of %body fat for early pregnancy analyses were: HSS=988, ROLO=189, SWS=1,862; for late pregnancy analyses: HSS=987, SWS=1,805

Table 2. Associations between physical activity during pregnancy and offspring birth size

	BW (grams)	Macrosomia	LGA	Ponderal Index	SGA
Physical activity	<i>RR, 95% CI</i>	<i>RR, 95% CI</i>	<i>RR, 95% CI</i>	<i>Beta, 95% CI</i>	<i>Beta, 95% CI</i>
Early pregnancy	<i>I²</i>	<i>I²</i>	<i>I²</i>	<i>I²</i>	<i>I²</i>
LTPA (h/w)	-0.86 (-2.33, 0.61)	0.99 (0.98, 1.01)	0.99 (0.98, 1.00)	0.0 (-0.01, 0.01)	0.99 (0.98, 1.01)
	23%	51%	46%	0%	0%
MVPA (h/w)	-1.38 (-3.77, 1.01)	1.00 (0.98, 1.01)	1.00 (0.98, 1.01)	0.00 (-0.01, 0.01)	0.99 (0.98, 1.00)
	41%	52%	43%	0%	0%
VPA (h/w)	-1.38 (-3.77, 1.01)	1.00 (0.98, 1.01)	1.00 (0.98, 1.01)	0.00 (-0.05, 0.04)	0.99 (0.98, 1.00)
	41%	52%	43%	18%	0%
LTPAEE (met-h/w)	-0.14 (-0.58, 0.30)	1.00 (0.99, 1.00)	0.99 (0.99, 1.00)	0.00 (0.00, 0.00)	0.99 (0.99, 1.00)
	49%	53%	38%	0%	0%
Physical activity					
Late pregnancy					
LTPA (h/w)	-2.22 (-5.54, 1.0)	0.98 (0.96, 1.00)	0.98 (0.97, 0.99)	-0.01 (-0.02, 0.00)	0.99 (0.97, 1.01)
	64%	37%	0%	13%	0%
MVPA (h/w)	-6.43 (-9.12, -3.74)	0.96 (0.94, 0.98)	0.97 (0.96, 0.98)	-0.02 (-0.03, 0.00)	1.01 (0.97, 1.03)
	0%	0%	0%	0%	0%
VPA (h/w)	-22.0 (-31.3, -12.7)	0.89 (0.84, 0.95)	0.89 (0.84, 0.94)	-0.07 (-0.13, -0.02)	1.06 (0.96, 1.17)
	0%	0%	0%	0%	0%
LTPAEE (met-h/w)	-0.93 (-1.43, -0.42)	0.99 (0.99, 0.99)	0.99 (0.99, 0.99)	0.00 (-0.01, 0.00)	0.99 (0.99, 1.00)
	9%	0%	0%	0%	0%

Models are adjusted for gestational age, sex, parity, maternal age, smoking, alcohol, maternal education and ethnicity. LGA= Large for gestational age; SGA= Small for gestational age; LTPA=leisure time physical activity; MVPA=moderate to vigorous leisure time activity; EE=energy expenditure. VPA= vigorous leisure time activity. Statistically significant associations are highlighted in bold.



