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How experiences of weight stigma impact higher-weight women during their maternity care: A meta-ethnography

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ABSTRACT

Aim: The aim of this review was to explore the experiences of pregnant women and birthing people with higher weight bodies, to understand the extent to which weight stigma impacted their maternity care.

Methods: We performed a systematic search of seven databases (CINAHL plus, Medline, Social Sciences Full Text [SSFT], International Bibliography of Social Sciences [IBSS], PsychINFO, Maternity and Infant Care [MIC], NIHR Journals Library, EThOS) using the Setting, Perspective, Intervention, Comparison, Evaluation (SPICE) framework search strategy and pre-defined inclusion and exclusion criteria. Included studies underwent a critical appraisal and data richness assessment. We undertook thematic analysis after coding first- and second-order constructs and developed a synthesis from the themes.

Findings: Thirty-eight papers, including six doctoral theses and one book chapter, met the inclusion criteria. Five themes were identified through thematic analysis, and the synthesis demonstrated that women of a higher weight experience shame, harmful attitudes and preconceptions from healthcare professionals regularly and repeatedly while receiving maternity care. This can be alleviated by individualised supportive care from a healthcare professional.

Key conclusions: Negative interactions with maternity care professionals are central to the experience of weight stigma, leading to a sense of 'shame', with pervasive feelings of humiliation, judgement and blame. Current guidance does not acknowledge the stigmatising effects of weight related conversations, additional interventions and restrictions on women's birthplace choices. Adopting a shame-sensitive lens within a culturally safe approach to maternity care could transform support for women.

Introduction

Weight stigma involves negative attitudes or discrimination against individuals and adversely impacts their health and wellbeing (Puhl et al., 2020; Tomiyama et al., 2018). People may hold prejudicial beliefs about higher-weight individuals, including assumptions about laziness, reduced intelligence, lack of self-discipline, and diminished motivation, compared to those with a 'normal' weight (Puhl and Brownell, 2001; Teachman and Brownell, 2001; Puhl and Heuer, 2009). This leads to discrimination across various settings, including employment, healthcare and interpersonal relationships (Puhl and Heuer, 2009).

Weight stigma has been defined as:

Prejudice and discrimination due to weight or body size. It includes experiences of being stigmatised by others, internalised weight (self) stigma, and anticipated or expectation of stigma - all of which have been linked to negative health outcomes and potentially life-limiting disparities of experience. (Latner et al., 2022)

There are medical, scientific and societal concerns about the potential risks of higher maternal weight (defined as body mass index (BMI) $\geq$30 kg/m^2), both before and during pregnancy (Denison et al., 2019; Parker and Pausé, 2018). What is unique to pregnancy and birth is that fat shaming and blaming of mothers extends beyond the individual to encompass the health of their unborn babies and also the long-term health of their children (Parker, 2014; Ward and McPhail, 2019).

The public health focus on raised BMI has resulted in more risk assessments for pregnant women with a higher weight due to the increased

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risk of pregnancy-related complications and adverse outcomes (Denison et al., 2019; Relph and NMPA Project Team, 2021) although the evidence base for these risks is contested (Gibbins et al., 2023). The resulting risk assessment and high-risk pathways result in many women receiving additional interventions such as being weighed, scans, screening tests and obstetric appointments (Denison, 2018; NICE, 2010). The pregnancy pathway for a higher-weight woman can mean being offered fewer birth options and experiencing more birth interventions, such as an induction of labour or caesarean birth, which are associated with an increased likelihood of experiencing birth as distressing or traumatic (Anderson, 2017; APPG, 2024).

Current guidance in the UK (Denison, 2018; NICE, 2023) requires maternity health professionals to discuss potential risks and benefits as part of informed decision-making and individualised care. This is a complex but important element of care, and poor communication can enhance the potential for women of higher weight to experience anxiety and feel stigmatised (Heslehurst et al., 2015a; Hyer et al., 2023; Schmied et al., 2011).

Previous systematic reviews have collated evidence about higher-weight women's experiences of maternity care (Saw et al., 2021; Smith and Lavender, 2011) and a narrative review (Hill and Incollingo Rodriguez, 2020) and a scoping review (Nagpal et al., 2020) have had a focus on maternal weight stigma or bias.

To our knowledge, this is the only systematic review that focuses on higher-weight women's experiences of weight stigma during pregnancy and which takes a life-course approach so that the influence of pre-pregnancy experiences and cultural contexts became apparent and could be incorporated within our conceptual synthesis. Therefore, this review aimed to synthesise qualitative evidence about how higher-weight women experienced stigma during maternity care to understand how cultural contexts and experiences of stigma before pregnancy affected this and to identify potential solutions or areas for further research.

Service user involvement

The first author (JC) used social media to reach out to higher-weight women and birthing people who had received maternity care, and with their help, formed an advisory group (known as the 'Research Collective') to advise on and develop the direction of the research. The group discussed the review with JC and provided feedback on the trustworthiness of the findings. In a discussion about preferred terminology, the group advised that 'higher weight' was more acceptable than 'raised body mass index' or 'obesity', so we adopted this term for the study. The group was also involved in the subsequent empirical stage of the study.

Methodology and design

Meta-ethnography is a means of synthesising existing qualitative research evidence to build theoretical or conceptual understanding. It is particularly useful when, as in this case, there is already a significant amount of rich textual data available (France et al., 2019). It incorporates transparent stepwise analyses and synthesis, potentially producing conceptual advancement in understanding the phenomena of interest (Campbell et al., 2011). We followed the seven stages of meta-ethnography as described by Noblit and Hare (1988) (Box 1). We also incorporated recent developments in meta-ethnography (Campbell et al., 2011; Pound et al., 2005; Toye et al., 2013). We have adhered to eMERGe guidelines to ensure our review is comprehensively reported (France et al., 2019). See Supplementary document 1 for details of how we met the guidelines.

Phase 1 Starting the meta-ethnography

Following an initial scoping search, we devised a review protocol which was published on Prospero (20/05/2021) (registration number CRD42021254638).

Phase 2 Deciding what is relevant

We designed our searches to be as comprehensive as possible due to uncertainties about which studies may contain important insights and concepts related to stigma. We used the SPICE framework as a basis for our search strategy and eligibility criteria (Booth, 2004) (see Table 1). We sought advice from an information specialist and carried out a pilot search in CINAHL plus using a combination of MeSH headings and keywords.

Eligible sources included peer-reviewed articles, theses and book chapters reporting primary research conducted with higher-weight women (BMI $\geq$30 m/kg^2) who were using or had recently (within five years) used maternity services. The sources had to include findings about experiences of weight stigma during pregnancy. We did not set a date limit as this is a relatively recent area of maternity research. The final search was completed on 18 August 2023. We excluded papers that primarily reported on women's experiences of interventions such as

Table 1
SPICE framework (Booth, 2004)

S	P	I	C	E
Setting	Perspective	Intervention/ phenomenon of interest	(Comparison)	Evaluation
Maternity services	Pregnant or recently pregnant women of higher weight	Weight stigma in maternity care.	N/A	Qualitative reports of lived experiences and perceptions of women of higher weight.

Box 1
Noblit and Hare's (1988) seven phases of meta-ethnography

Getting started

Deciding what is relevant to the initial interest

Reading the studies

Determining how the studies are related

Translating the studies into one another

Synthesizing translations

Expressing the synthesis

weight management services during pregnancy. The search strategy, search terms, databases and search dates are provided in Supplementary document 2. The inclusion and exclusion criteria and rationale are in Supplementary document 3.

Screening

Two reviewers screened each item 'blind' at title, abstract and full-text stages. Any differences in opinion between the first and second reviewer were discussed with the third researcher. Decisions about full-text inclusion were made by consensus, with discussions if there was any uncertainty. The rationale for exclusion was recorded (see Fig. 1, PRISMA diagram).

Appraisal of included papers

Whilst critical appraisal has been described as essential in qualitative evidence synthesis (Noyes et al., 2022), Noblit and Hare (1988) did not use appraisal in the original method. We opted to conduct appraisals using the Critical Appraisal Skills Programme (CASP, 2022), a tool for qualitative research, to gain insight into the reporting quality of the diverse sources we included. We assessed this by examining how comprehensively authors discussed and justified approaches to data collection, data analysis, reflexivity, rigour and the extent to which findings were supported by data. CASP is widely used in healthcare and aligns with the internationally recognised Cochrane Handbook's recommended appraisal domains for qualitative evidence (Noyes et al.,

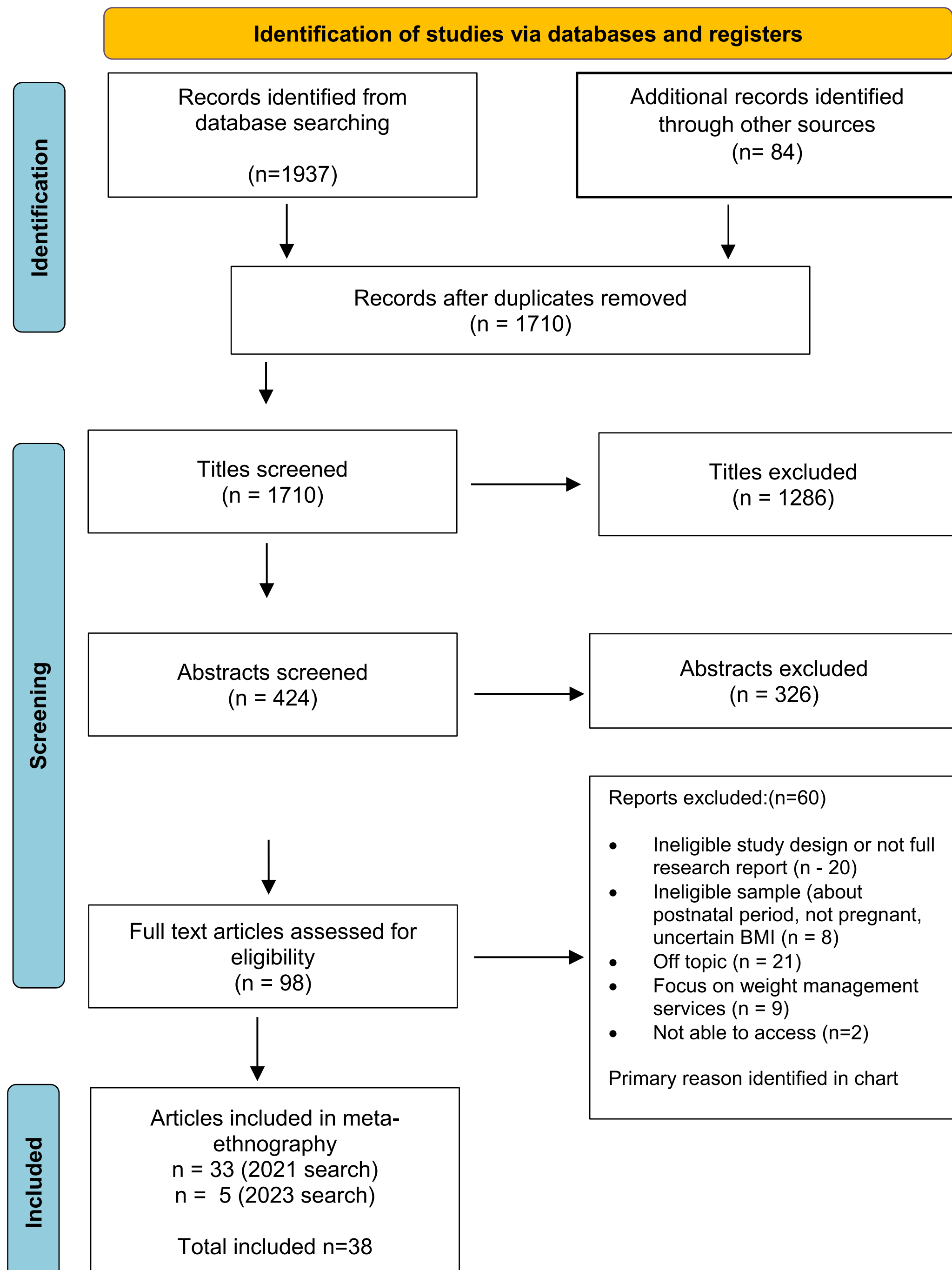

Fig. 1. PRISMA chart

2022).

There is some concern that quality assessment tools give priority to the reported methodological strengths and limitations of a paper rather than its novel findings or conceptual content (Long et al., 2020; Toye et al., 2013). To address this concern, we also completed a data richness assessment for included papers (Ames et al., 2019).

Phase 3: Reading the studies and extracting the data

The first author (JC) read the studies and extracted key study information (author, year and country, aims, sample, setting, data collection, study design/ methodology, data analysis and key findings), see Table 2. Content from the findings and discussions sections (specifically, verbatim quotes used in source papers and data interpretations by source study researchers) were then extracted into NVIVO 12 by JC, who created codes using first-order (participant quotes) and second-order (study author interpretations) constructs. The second and third authors reviewed extracted data, and the team discussed the analysis regularly, addressing questions and uncertainties that arose and collectively reaching decisions about the analytic process and the findings.

Phases 4 and 5: Determining how studies are related and translating studies

Meta-ethnography was designed specifically to take into account the unique research contexts in primary studies (France et al., 2019). First-order constructs (quotes) were analysed and synthesised along with their corresponding second-order constructs (source study author interpretations) as recommended by France et al. (2019).

JC then undertook a reflexive thematic analysis (Braun and Clarke, 2019) to develop sub-themes and drew concept maps to create higher-level themes (see Supplementary document 5). Although thematic analysis is not required within meta-ethnography, we used this to facilitate a consistent approach to the data set, which was detailed and extensive. Five sources from the second search (conducted in August 2023 to update the review) were added to this framework; data from added papers were mapped to existing themes and findings. During this stage, all three authors held regular meetings to discuss, review, 'sense-check' and agree on the sub-themes. JC then created a spreadsheet with all 38 papers and with candidate 'overarching' themes and read each study again, in chronological order, cross-checking themes identified within each paper.

Phase 6: Synthesising translations

The themes were then organised into a conceptual model or a 'line of argument synthesis' (Noblit and Hare, 1988); this is reported in the 'findings' section.

Reflexivity

Reflexivity concerns the ways that researchers reflect on their influence on research processes and acknowledge how their background, roles, preconceptions and ways of selecting questions and choosing analytical approaches contribute to how research findings are constructed (Malterud, 2001). We discussed our positionality in relation to the topic before undertaking the review. JC is a midwife and doctoral student; she believed that weight stigma was adversely affecting women's experience of maternity care and reducing their choices and felt some guidelines could cause potential iatrogenic harm to higher-weight women due to increased interventions. MC is an anthropologist interested in the social and political factors affecting childbirth and in critical midwifery studies. By engaging with biosocial research concerning health and disease, she has included perspectives from critical medical anthropology and epidemiology in her work, linking the macro with the micro level. She believed that weight stigma was inextricably connected with neoliberal values and patriarchal understandings of women's bodies, contributing to increased discrimination, surveillance and mother-blaming in maternity care. KC is a researcher with a background in midwifery and risk social science. Having previously worked on an interventional study involving higher-weight pregnant women, she believed current maternity care approaches could exacerbate pre-existing healthcare stigma. During the review, we acknowledged these assumptions and worked to remain open to data which did not confirm our prior beliefs.

Findings: outcome of study selection

We conducted initial searches in June 2021. After removing duplicates, 1385 titles were screened; at the next stage, we screened 109 abstracts and then 70 full-text documents for eligibility. We checked references from included sources and citations on Google Scholar. Amongst 38 included sources (33 from the original search plus five additional studies from the updated search in August 2023) were six theses and one book chapter (see Fig. 1, PRISMA diagram).

Strengths and limitations of included papers

Most sources clearly reported methods, data analysis and findings and had a score of 3 or 4 out of 5 for data richness. Several had a limited discussion about researcher reflexivity; this was less common in papers by 'weight critical' scholars (Friedman et al., 2020; LaMarre et al., 2020; Lee, 2020; McCullough, 2013). For more

Summary of included sources/documents

Sources were published between 2010-2023. Seven used a phenomenological approach, two were autoethnographies, and the remainder used a variety of qualitative methodologies, including feminist, narrative and descriptive approaches. The most common form of data collection was by semi-structured interviews. The papers came from differing philosophical standpoints, and this was reflected in their findings. For instance, 'weight stigma' was a more prominent finding in studies by critical weight (or fat) studies scholars (Friedman et al., 2020; LaMarre et al., 2020; Lee, 2020; McCullough, 2013). Other authors from social sciences or healthcare professional backgrounds had a greater focus on weight, weight gain and clinical risk (Faucher and Mirabito, 2020; Keely et al., 2017; Kerrigan, 2019; Lingetun et al., 2017). Most papers were published in higher-income countries (UK n=14, USA n=6, Canada n=6, Denmark n=3, Sweden n=2, Norway n=1, Australia n=2, New Zealand n=2). Two papers reported research from middle-income countries, Iran and Turkey. We found no papers from low-income countries.

Phase 7 Expressing the synthesis

A meta-ethnography synthesis moves beyond developing new themes or concepts to theory development (France et al., 2019). Our synthesis of weight stigma during maternity care is summarised here:

Women of a higher weight experience shame, harmful attitudes and preconceptions from healthcare professionals regularly and repeatedly during maternity care. This is experienced either as interpersonal weight stigma or as internalised weight stigma, or both. This can be alleviated by individualised supportive care from a healthcare professional. At its best, such care can be transformative and lead to improved body image and feelings of empowerment. There are important intersections with weight stigma, which include culture, ethnicity and socio-economic status, which can both protect against and exacerbate stigma.

The analysis developed five themes (See Table 3), four of which were reciprocal translations (where the concepts described by different studies are judged to be similar in meaning) and one a refutational

Table 2
Data extraction from studies

Author, year and country	Aims	Sample, setting, data collection	Study design/ methodology, data analysis	Key findings
Arden et al., 2014 United Kingdom	To explore women's perspectives about the weight gain guidance using comments in posts on public parenting forums	Threads from three parenting forums	Qualitative Thematic analysis	Three main themes: Perceived control and responsibility; risk perception; confused messages.
Bombak et al., 2016 Canada	The experiences of self-identified overweight and obese women in reproductive healthcare.	Pregnant or postnatal women (n=18) Study (24 individuals) Community setting Semi- structured (SS) interviews	Poststructural feminist perspective Thematic analysis	Overt and covert experiences of stigma when accessing reproductive care founded in healthcare practitioners' focus on fetal risk and "mother-blame"
Chowdhry 2018 United Kingdom	How do larger women experience pregnancy, childbirth and maternal healthcare in the context of 'maternal obesity'?	Pregnant women with BMI ≥35k g/m^2 (n = 6) (also 5 obstetricians, 6 midwives and 2 anaesthetists) Maternity unit Longitudinal interviews (3)	Social constructionist Two-stage structural narrative	Complexity of maternity healthcare professional positionality in relation to the larger pregnant body. Larger women's highly stigmatised and visible bodies render them vulnerable to screening which also stigmatises the fetal body. The process serves to silence women becoming somewhat (in)visible.
Cunningham et al., 2018 United Kingdom	To explore the experiences of pregnant women with a raised BMI to investigate if their pregnancies were affected by their interactions with midwives and other health professionals	Pregnant women with BMI ≥30 kg/m2 (n = 11) Antenatal clinic SS interviews	Exploratory qualitative approach Thematic analysis	Three themes: 'feeling judged', 'knowledge gap' and 'doing your best'.
Dadouch 2023 Canada	To understand the communication challenges within obesity-in-pregnancy clinical encounters.	Women (n = 16) and HCPs (n=19) Obesity specialised antenatal clinic In-depth interviews by phone	Narrative Dialogic Narrative Analysis	Five narrative tensions around perceptions of obesity and health and the impact on communication between pregnant women and healthcare professionals.
DeJoy et al., 2016 USA	To explore the experiences of women with obesity in the maternity care system in the United States	Women BMI ≥30 kg/m^2 (self-reported) (n = 16) Online plus size communities SS interviews by phone	Descriptive phenomenology Giorgi's descriptive phenomenological method	Three themes: Personalised care, Depersonalised care, Setting the Tone
Dieterich et al. 2021 USA	To explore if and how postpartum individuals perceived weight stigma impacted their breastfeeding counselling, decisions and experience.	Pregnant women (n= 18) Purposive sampling characteristics (BMI, ethnicity, etc.) SS interviews by phone	Qualitative descriptive approach Content analysis	Three themes: "Size Doesn't Matter: They Looked Beyond the Scale,"; "My Self-Confidence and Desire to Breastfeed is More Important than Weight") "I Was on My Own"—Limited Social Support not Weight Stigma Influenced Breastfeeding.
Doughty 2019 United Kingdom	An exploration and interpretation of the experiences of obese mothers during childbearing and the perspectives of midwives who provided care.	Pregnant women with a BMI ≥30 kg/m^2 (n=2) Postnatal women with BMI ≥ 30kg/m2 (n=11) Birth centre and diet club/ community SS interviews	Interpretivist qualitative framework Thematic analysis	Three themes: 'The Reductionist Approach to Maternity Care'; The Lost Opportunities for Health Promotion' and 'The Experiences and Everyday Theories of Obesity'
Faucher and Mirabito 2020 USA	Women's perceptions and behaviours related to GWG, diet, and exercise were investigated along with their feedback about a proposed GWG intervention	Pregnant women with a BMI of 30 kg/m^2 or above Birth centre and health centre Three focus groups (n=17 women)	Qualitative Content Analysis (Graneheim et al)	Themes appeared in 4 content areas: perceptions of GWG, exercise in pregnancy, healthcare provider counselling, and feedback about the proposed intervention
Feltham 2022 United Kingdom	To consider pregnant women's experiences of their maternity care including choice, consent, and control with a BMI of 35 kg/m^2 or above	Pregnant women with a BMI of 35 kg/m^2 or above (n = 11) Community and antenatal clinic Interviews	Constructivist grounded theory study underpinned by poststructuralist feminist epistemology Constructive grounded theory methods (Charmaz)	Multiple factors influence women's perceptions of weight and care which impact on choice, consent and control, namely: social and cultural factors, maternity practices, maternity service provision and maternity policy.
Friedman et al., 2020 Canada	To explore weight stigma in reproductive care services in Canada	Women-identified and trans people (from a larger study) (n = 9) Community Open ended conversations	Feminist storytelling Narrative	Three major themes: On risk; on recognition of weight and other stigma; on reclamation of bodies.
Furber and McGowan 2011 United Kingdom	To explore the experiences related to obesity in women with BMI ≥35 kg/m2 during the childbearing process	Pregnant women with BMI ≥30 kg/m^2 (n=19) Specialist antenatal clinic SS interviews	Qualitative approach Framework analysis	Pregnant women who are obese are sensitive to their size. The interactions with health professionals and others that they encounter may increase distress.
Furness et al. 2011 United Kingdom	To explore women's experiences of managing weight in pregnancy and the perceptions of women, midwives and obstetricians of services to support obese pregnant women in managing their weight	Pregnant women ≥30 kg/m^2 (n=6) Midwives (n=7) Hospital and community SS focus groups	Exploratory qualitative study Thematic analysis	Two overarching themes were identified in the data: (1) Explanations for obesity and weight management and (2) Best care for overweight women
Heslehurst et al. 2015 United Kingdom	To explore obese pregnant women's experiences to better understand how to acceptable services	Pregnant women with BMI > 30 kg/m^2 (n=15)	Interpretive Thematic content analysis	Two overarching concepts – key issues for women, with themes of women's weight, women's facilities, women's experience

(continued on next page)

Table 2 (*continued*)

Author, year and country	Aims	Sample, setting, data collection	Study design/ methodology, data analysis	Key findings
		Hospital Depth interviews		of negativity and women's priorities and desired outcomes
Hurst et al. 2021 USA	To identify ways to improve the quality of care for pregnant women with high BMIs receiving perinatal care	Women with BMI of >40 kg/m^2, who had given birth in past 3 years (n=30) Hospital records SS interviews by phone	Quality improvement Thematic analysis (and content analysis)	Most women felt at least somewhat dissatisfied with their current weight. They reported that general health, pregnancy, and the health of their baby were important reasons to maintain a healthy weight.
Lyekekpolar 2016 United Kingdom	To explore the experiences of overweight pregnant women in relation to their heightened medicalised antenatal care.	Pregnant women with BMI of >30 kg/m^2 (n=12) Hospital and community SS interviews	Social constructionist approach and Foucauldian interpretive lens Thematic analysis	Women's understanding of risk and risk perception, the power of science and how it constructs their maternal health and the power of obstetricians justifying medical interventions
Jarvie 2016 United Kingdom	To explore how having a big baby is problematised in lay discourses and how women defend themselves to maintain their identity as 'good mother's	Pregnant women with BMI of >30 kg/m^2 and type 2 diabetes or gestational diabetes (n=30) Diabetic antenatal clinic + UK pregnancy/parenting forums In-depth narrative interviews	Longitudinal qualitative Interpretive analysis	Having a high birthweight baby is seen as a source of stigma, with potential to jeopardise a woman's identity as a 'good mother'.
Jarvie 2017 United Kingdom	To explore the lived experiences of women with co-existing maternal obesity (BMI ≥ 30 kg/m^2) and Gestational diabetes mellitus during pregnancy and the post-birth period	Pregnant women with BMI of >30 kg/m^2 and gestational diabetes (n=27) Diabetic antenatal clinic In-depth narrative interviews	Longitudinal qualitative sociological design Thematic analysis	Social and economic stressors and stigma.
Jensen et al. 2022 Denmark	To explore the lived experiences of maternal obesity and women's motivation for participating in a postpartum lifestyle intervention	Pregnant women in 4th trimester, with a pre-pregnancy BMI 28 kg/m^2 (n=5) Gynaecological outpatients In-depth SS interviews	Exploratory qualitative approach Interpretative Phenomenological Analysis	An overall theme of ambivalence and sub-themes reflected contrasting feelings where the obese body was simultaneously an arena for aesthetic failure, functional success and moral dilemmas.
Keely 2017 United Kingdom	To explore the experiences, attitudes and health-related behaviours of pregnant women with a BMI > 40 kg/m2. To determine the impact, and attitudes of significant family members.	Pregnant women BMI ≥40 kg/m^2 (n = 11) Partners (n = 7) Antenatal clinic SS interviews x 2	Prospective serial interview study Thematic content analysis	6 themes: the complexities of weight histories and relationships with food; resisting risk together; resisting stigma together; pregnancy as a 'pause'; receiving dietary advice; postnatal intentions.
Keenan and Stapleton 2010 United Kingdom	Explores medicalisation (through BMI) and moralisation of large bodies in pregnancy as 'obese' and how this influences their access to healthcare and their understandings of their infants' bodies.	Pregnant women who with diabetes or who self-identified as 'very overweight' (BMI ≥30 kg/m^2) Antenatal clinic and snowballing Interviews	Longitudinal qualitative study Thematic – cross-sectional, categorical indexing (Mason 2002)	Interactions with maternity professionals in pregnancy: 'Nobody's mentioned my weight'; Birth choices and 'outcomes': 'You know why you had a big baby, don't you? Infant feeding and the 'bonny' baby
Kerrigan 2019 United Kingdom	To explore obese women's experiences and views of their preparation for labour as well as their experience of childbirth (part 3 of the thesis)	Women who been pregnant 6-8 weeks earlier with a BMI of ≥35 kg/m^2 (n = 8) Special clinics for obese pregnant women SS interviews	Qualitative Framework approach	Three themes: Embodiment of obesity; Being pregnant and overweight; Resource intensive maternity care Overarching theme: window of opportunity for short-term and potential longer-term change
Knight-Agarwal et al .2016 Australia	To investigate the perspectives of pregnant women with a body mass index (BMI) of ≥30 kg/m2 receiving antenatal care	Pregnant women with a BMI of ≥30 kg/m^2 (n=16) Antenatal clinic SS interviews	Qualitative Interpretative Phenomenological Analysis	Four major themes: obese as part of a long history of obesity; lack of knowledge of the key complications of obesity; conflicting, confusing and judgmental communication about weight and gestational weight gain; most women are motivated to eat well during pregnancy and want help to do so
Knox 2016 New Zealand	What are the experiences of ethnically diverse maternal women labelled as 'overweight' and 'obese'?	Women who experienced overweight or gestational weight gain in their previous pregnancy. Pregnant (n=14) and non-pregnant (n=2) (total n=16) Hospital and community Interviews	Post-intentional phenomenological design Whole-part-whole analysis	Women described care as being preoccupied with control and surveillance of maternal bodies. Women sought humanised and empathy-based care which reflected their cultural values, social contexts, and clinical needs.
LaMarre et al., 2020 Canada	To understand the kind of reproductive healthcare that people classified as "obese" receive	Women and trans people in larger bodies (obese) seeking fertility and/or pregnancy care (n=17) Community SS interviews	Qualitative Thematic analysis	Experiences of being surveilled and controlled in medical settings which negatively impacted their access to desired care. In order to receive the kinds of care they wanted, many participants had to become self-advocates
Lauridsen et al., 2018 Denmark	What did the women experience when they were invited to take part in an intervention project focusing on severely overweight pregnant women?	Women who had been pregnant 4-5 years previously with a BMI of ≥30 kg/m^2 (n=21) Hospital SS interviews	Qualitative Interpretive analysis	Women believed that during pregnancy an approach based on weight was acceptable. Some reported no negative experiences with HCPS whilst others reported prejudice and silence. Most women reported that the interventions

(*continued on next page*)

Table 2 (*continued*)

Author, year and country	Aims	Sample, setting, data collection	Study design/ methodology, data analysis	Key findings
				during their pregnancies did not lead to any lasting lifestyle change. The women disagreed over whether, in principle, pregnancy was a suitable time to be targeted
Lee 2020 USA	How can a fat woman have a voice during pregnancy and into motherhood?	A self-identified fat woman Community Journals, written and recorded	Autoethnography Analysis not stated	Stigmatising experiences throughout pregnancy and the postnatal period.
Lindhardt et al. 2013 Denmark	To examine the experience of women with a pre-pregnant BMI >30 kg/m2 in their encounters with healthcare professionals during pregnancy	Pregnant women with pre-pregnant BMI >30 kg/m^2 (n=16) Specialist antenatal clinic In-depth interviews	Phenomenological approach Giorgi's descriptive phenomenological method	Two main themes (1) an accusatorial response from healthcare professionals; and (2) a lack of advice and helpful information on how being obese and pregnant might affect the women's health and that of their child.
Lingetun et al. 2017 Sweden	To describe what pregnant women who present themselves as overweight or obese write about their pregnancy in their blogs.	Internet blogs written by women who self-identified as pregnant and overweight or obese (n=13) Internet Texts from blogs	Explorative qualitative design Thematic analysis	Three main themes were identified: pregnancy as an excuse, perspectives on the pregnant body and becoming a mother.
McCullough 2013 USA	The cultural significance of the construction and the reading of the fat maternal body as irresponsible or troubling	A woman who self-identifies as fat and pregnant	Autoethnography (a reflective and narrative account) Anthropological lens Analysis not stated	Stigmatising experiences during maternity care.
Mills et al., 2013 Australia	To explore the perceptions and experiences of overweight pregnant women attending two maternity units in Sydney, Australia	Pregnant and recently postnatal women with a BMI >30 kg/m^2 (n=14) Antenatal clinic Interviews	Qualitative descriptive method Thematic analysis	Four themes: 'being overweight and pregnant', 'being on a continuum of change', 'get alongside us' and 'wanting the same treatment as everyone else'.
Nagpal et al. 2021 Canada	Women's suggestions for how to reduce weight stigma in prenatal clinical settings	Pregnant women with BMI ≥35 kg/m^2 (n=9) Antenatal clinic SS interviews by phone	Qualitative descriptive method Content analysis	Experiences of weight stigma included poor communication, generalizations made about health and lifestyle behaviors, and focusing only on excess body weight during clinical appointments as the cause of negative health outcomes. Ways to reduce weight stigma were suggested.
Nagpal et al. 2022 Canada	To explore sources of weight stigma in physical activity-related contexts from the perspective of pregnant women living with obesity	Pregnant women with a BMI ≥35 kg/m^2 with co-morbidities (n=8) Prenatal appointment	Qualitative description approach Inductive content analysis	Two sources of weight stigma related to prenatal PA were identified: 1. Lack of visual representation; 2. Lack of individualized recommendations
Nyman et al., 2010 Sweden	To describe obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth	Postnatal women with BMI ≥30 kg/m^2 (n=10) Postnatal ward Interviews	Phenomenological approach Phenomenological analysis method (Karlsson 199)	The meaning of being both obese and pregnant is living with a constant awareness of the body, and its constant exposure to the close observation and scrutiny of others. Affirmative encounters alleviate discomfort and provide a sense of wellbeing
Parker et al. 2017 New Zealand	What it is like for fat maternal subjects to be on the receiving end of discourses and practices that problematise and govern their fatness.	Pregnant and postnatal women who identified as fat (n=27) Community and hospital SS interviews	Qualitative Thematic analysis	Three themes: 1) Weight matters; 2) Swept away; 3) Sticks and stones
Sercekus et al. 2021 Turkey	To reveal difficulties, coping and expectations of overweight/obese women during pregnancy	Pregnant women with BMI ≥25 kg/m2 (n=14) Antenatal clinic SS interviews	Descriptive phenomenological approach Content analysis	Three themes: 1) Difficulties experienced; 2) Coping; and 3) Expectations.
Shahbazzadegan 2019 Iran	To explain the pregnancy experience in women with a high body mass index	Pregnant women with BMI ≥30 kg/m^2 (n=10) Antenatal clinic SS interviews	Qualitative Interpretive phenomenological approach	Main theme: "Pregnancy concurrent with concern". Subthemes: sense of risk; lack of care facilities for mothers with high body mass index; obesity as a stigma; lack of specialised care.
Thorbjornsdottir et al. 2020 Norway	To explore the birth experiences of obese women in regard to their encounter with birth attendants	Women with BMI ≥30 kg/m2 who had had a baby in the previous 5 years (n=10) Facebook Interviews	Phenomenological approach Descriptive phenomenological method (Giorgi)	Four themes: The preconception and prejudice of being unhealthy and less able; being unique among all the other unique women; "Talk to me, not at me"—the importance of information and communication, and; feeling secure enough to be in the 'birthing bubble'.

translation (discordant findings, where these differences in findings cannot be explained by differences in the studies) (Garside et al., 2023). Themes were titled using the first and second person, to convey the language and emotions experienced by research participants in the included studies and are not direct quotes (Toye and Barker, 2020). The themes are second-order constructs; that is, they arise from how data within the papers have been interpreted by this research team. We present each theme with illustrative quotes (first-order constructs) in a separate table (see Supplementary document 6).

Table 3
Themes and sub- themes

Themes and sub- themes	Translation
I experience shame during maternity care.	Reciprocal
• Experiences of weight stigma prior to pregnancy • Feeling judged and blamed during maternity care • Internalised weight stigma	
I am harmed by your value judgements and preconceptions.	Reciprocal
• Maternity care was negatively affected by the experience of weight stigma • Experiences of microaggressions • Interventions and appointments	
I try to resist weight stigma	Reciprocal
I am nurtured and protected by your individualised care	Reciprocal
My culture protects me	Refutational

Theme 1. I experience shame during maternity care

The experience of shame was a finding consistent throughout nearly all the studies (n=37) and included feelings of guilt and humiliation as well as being judged and blamed. This finding was in relation to experiences of care both before and during maternity care. Shame is a powerful emotion and encompasses a wide range of adverse feelings, which include being judged negatively by others and a feeling of being worth less than others (Dolezal and Gibson, 2022).

1.1. Experiences of weight stigma prior to pregnancy

Women described having experienced weight stigma before pregnancy, often over many years. The stigma was related to attitudes and comments from family, friends and wider society (Dadouch et al., 2023; Furber and McGowan, 2011; Heslehurst et al., 2015b; Keely et al., 2017; Keenan and Stapleton, 2010; Lauridsen et al., 2018; Parker, 2017; Serçekuş et al., 2022) as well as during past healthcare experiences (Dadouch et al., 2023; DeJoy et al., 2016; Friedman et al., 2020; Heslehurst et al., 2015b; Hurst et al., 2021; Jensen et al., 2022; LaMarre et al., 2020; Parker, 2017). These experiences were distressing and upsetting, and in many cases, these stigmatising encounters had started in childhood or teenage years.

1.2. Feeling judged and blamed during maternity care

During maternity care, women had experienced feeling humiliated by healthcare professionals (Furber and McGowan, 2011; Nyman et al., 2010; Serçekuş et al., 2022) and judged (Dadouch et al., 2023; Feltham, 2022; Hurst et al., 2021; Mills et al., 2013; Nagpal et al., 2021) . Many women felt that healthcare professionals held stigmatising views, which associate higher weight with character flaws such as lacking intelligence and being lazy (Arden et al., 2014; McCullough, 2013).

The shame appeared to originate from a tacit belief that having a higher weight is "morally troubling" (McCullough, 2013, p. 224) and from what LaMarre defines as "the weight of assumed dysfunction" (2020, p. 15) where individuals were blamed for their weight and implicitly made responsible for any issues encountered in pregnancy. The judgement women felt about having diabetes in pregnancy (Jarvie, 2017) supported this idea of blame and culpability. Some felt guilt for simply being pregnant in a larger body and the risk this may pose to their pregnancy (Arden et al., 2014; Cunningham et al., 2018; Dadouch et al., 2023; Kerrigan, 2019; McCullough, 2013; Parker, 2017; Shahbazzadegan, 2019). There were also examples of 'mother blame', which was largely communicated through conversations about fetal risk during pregnancy, particularly during the ultrasound scan, and caused distress to women (Bombak et al., 2016; Chowdhry, 2018; Feltham, 2022; Furber and McGowan, 2011; Jarvie, 2017; Keely et al., 2017; Lee, 2020; McCullough, 2013; Parker, 2017). The projected size of a baby was a source of guilt, blame and stigma for some women (Jarvie 2016).

1.3. Internalised weight stigma

Internalised weight stigma occurs when someone absorbs negative social messages and stereotypes about higher-weight bodies (Durso and Latner, 2008). Study participants reported feelings of embarrassment, shame, distress, low self-esteem and discomfort (Cunningham et al., 2018; Doughty, 2019; Feltham, 2022; Furber and McGowan, 2011; Jensen et al., 2022; Lingetun et al., 2017; Mills et al., 2013; Nyman et al., 2010; Serçekuş et al., 2022; Thorbjörnsdottir et al., 2020). Some used strong negative language about their bodies, such as 'self-loathing' (Doughty, 2019; Furber and McGowan, 2011), 'ugly' (Serçekuş et al., 2022) or comparing themselves to large animals (Lingetun et al., 2017); some felt they did not look pregnant due to their body shape (Jensen et al., 2022; Lingetun et al., 2017; McCullough, 2013; Mills et al., 2013).

There were occasions when women were invited to reveal their bodies, for instance during aquanatal classes (Furber and McGowan, 2011), during intimate examinations (Mills et al., 2013) or to take a bath in front of a partner (Nyman et al., 2010). These could increase feelings of embarrassment, discomfort and dislike of their own bodies.

Theme 2. I am harmed by your value judgements and preconceptions

This theme concerns how healthcare professionals' attitudes and actions and the healthcare system in which they work affect women's experiences and perceptions of weight stigma. Women reported being labelled by default as 'high risk' by maternity healthcare professionals. This resulted in choices being reduced or denied and women feeling different or in a separate group from other pregnant women. Women also experienced microaggressions ranging from hurtful and stigmatising language to the lack of provision of appropriate equipment.

2.1. Maternity care was negatively affected by the experience of weight stigma

A well-documented issue, described in detail in many papers, was the negative effect that a woman's higher weight had on maternity care and choices. For many this constituted discrimination and made them feel 'othered' and stigmatised (Arden et al., 2014; Bombak et al., 2016; Chowdhry, 2018; Keenan and Stapleton, 2010; Kerrigan, 2019; Knox, 2021; LaMarre et al., 2020; Lingetun et al., 2017; Nyman et al., 2010; Parker, 2017; Thorbjörnsdottir et al., 2020).

This also prevented women from receiving care led by midwives (Bombak et al., 2016; DeJoy et al., 2016; LaMarre et al., 2020; Mills et al., 2013; Parker, 2017). For example, women mentioned not being 'allowed' to give birth in a midwife-led unit (Arden et al., 2014) and being refused a water birth (Feltham, 2022; Keely et al., 2017). The medicalisation of birth was experienced in further ways; some women perceived their healthcare providers were promoting epidural use due to their weight (Chowdhry, 2018; Furber and McGowan, 2011; LaMarre et al., 2020; Thorbjörnsdottir et al., 2020). Some healthcare professionals advised women to expect a caesarean section, rather than a vaginal birth, which women found disempowering and discriminatory (LaMarre et al., 2020; Lee, 2020; McCullough, 2013). Another study reported that women were refused a vaginal birth after caesarean (VBAC) due to their weight (DeJoy et al., 2016). The medicalisation of women's pregnancies and birth led some researchers to conclude that some women did not have a voice, were not able to speak up or were not listened to (Feltham, 2022; Kerrigan, 2019; Lee, 2020; Nyman et al., 2010; Parker, 2017; Thorbjörnsdottir et al., 2020).

Some women found that their healthcare professionals were

solely focused on the wellbeing of their unborn babies, rather than holistically on the mother and baby (Furber and McGowan, 2011; Nyman et al., 2010). Sometimes, scare tactics were used by healthcare professionals to explain the advice or recommendation given (Arden et al., 2014; Hurst et al., 2021; Jarvie, 2016), for instance, "… *we are just trying to avoid having a stillborn baby here* …" (Hurst et al., 2021, p. 8). Others felt that their healthcare focused on their weight to the exclusion of other health concerns (Hurst et al., 2021; McCullough, 2013; Nagpal et al., 2021).

2.2. Experiences of microaggressions

Microaggressions are "everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional *or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership*" (Sue, 2010, p. 3). These were apparent in the language health professionals used to describe women with a higher weight. Words such as 'obese' and 'obesity' were disliked by women as a rude and degrading expression of body size (Cunningham et al., 2018; Doughty, 2019; Hurst et al., 2021; Jarvie, 2017; Nagpal et al., 2021). Microaggressions include ambiguous communication, where individuals were left not quite understanding the meaning of the message, questioning their experience of reality and how to respond to it (Knox, 2021; McCullough, 2013).

Microaggressions can also be experienced as environmental snubs, which in the context of maternity care include the lack of suitable equipment or clothing for larger bodies. Examples included waiting room furniture, with arms on the chairs, hospital clothing, narrow beds, CTG monitoring and problems with the ultrasound scan (DeJoy et al., 2016; Keenan and Stapleton, 2010; Lindhardt et al., 2013; McCullough, 2013; Mills et al., 2013; Serçekuş et al., 2022; Shahbazzadegan, 2019). In her autoethnography, McCullough (2013) wrote about a nurse making obvious her displeasure about needing to find the appropriate blood pressure cuff for her arm.

2.3. Interventions and appointments

An area of potential harm was the 'routine' intervention of being weighed by a healthcare professional at the beginning of pregnancy. Many women disliked this aspect of their care as it brought to the fore feelings of failure, visibility and vulnerability. McCullough (2013) described being weighed as a "loaded ritual" (2013, p. 221) and explained that it made her body more visible as it was out of the "designated normal range". She turned her back to the scale to make it more bearable. One participant in Knox's study (2021) complied with being weighed but withdrew psychologically from the process. Women in DeJoy et al.'s (2016) study dreaded weight checks, expecting to be judged and "found wanting" (p 221). Lingetun (2017) described the anguish that being weighed caused, with feelings of worthlessness if the women could not follow the recommendations given to them by healthcare providers.

Women also experienced an additional burden due to the increased number of antenatal appointments and tests they were invited to take up (Chowdhry, 2018; Furness et al., 2011; Hurst et al., 2021; Jarvie, 2016; LaMarre et al., 2020). Some authors reported that women delayed or did not access care – or discussed not accessing care – due to a fear of judgement and stigmatising experiences (Cunningham et al., 2018; DeJoy et al., 2016; Jarvie, 2017; Parker, 2017).

Theme 3. – I try to resist weight stigma

This theme encompasses ways that women seek to resist and deflect weight stigma. It involves the advocacy work that women feel is necessary to receive good care. The burdens include anticipating weight stigma and needing to self-advocate to achieve good care.

Some researchers appeared to suggest that women fail to recognise their own 'ob*sity' as a condition and risk factor and that this demonstrates a lack of knowledge and self-reflection (Doughty, 2019; Keely et al., 2017; Lingetun et al., 2017). Women were also seen as being defensive in their interviews (Heslehurst et al., 2015b). We have re-positioned these concepts as mechanisms women use to resist the pervasive stigma they experience due to the limited agency they have as stigmatised individuals.

Women prepared for future anticipated stigmatising healthcare experiences by searching for their own evidence before their appointment (Arden et al., 2014; Hurst et al., 2021; Iyekekpolar, 2016; Lee, 2020; McCullough, 2013). Others expressed scepticism about the evidence that underpins the medicalisation of the high-risk pathway and sought to counter it (McCullough, 2013). Some proactively looked for healthcare professionals who did not exhibit stigmatising attitudes about higher weight (Hurst et al., 2021; Lee, 2020; McCullough, 2013). These three studies are from the USA where women can often choose their healthcare provider, rather than simply attend their local maternity service.

Women also resisted stigma through knowledge and experience of their own bodies, in terms of their own health and capabilities. This counteracted the 'high-risk' narrative they continually heard, including from healthcare professionals (Arden et al., 2014; Dadouch et al., 2023; Feltham, 2022; Iyekekpolar, 2016; Jarvie, 2017, 2016; Jensen et al., 2022; Keely et al., 2017; Knox, 2021; Lingetun et al., 2017; Parker, 2017). Women used the experience of friends and family members who either were of a higher weight and *did not* experience complications or were of a "healthy" weight and *did* experience complications to counterweight stigma (Arden et al., 2014; Jarvie, 2016; Keely et al., 2017).

These examples can be interpreted as showing that women employed different techniques to protect themselves from stigmatising experiences, reject unreasonable and unfair blame and responsibilisation. This "ubiquitous and enormous impact of thinking and strategising about weight" (Friedman et al., 2020, p. 6) added an extra burden to women's pregnancy experiences.

Theme 4. – I am nurtured and protected by your individualised care

Positive treatment from healthcare professionals could support and nurture women. Women often expressed how they feel invisible behind the visibility of their bodies (McCullough, 2013). Being treated as an individual was seen as highly valuable and desirable; this helped women to feel supported, respected and listened to (Dadouch et al., 2023; DeJoy et al., 2016; Feltham, 2022; Friedman et al., 2020; Hurst et al., 2021; Jensen et al., 2022; Knox, 2021; Lee, 2020; McCullough, 2013; Thorbjörnsdottir et al., 2020). This includes findings about women being seen as a whole person, rather than as "an object in the form of an obese body identical to other obese bodies" (Thorbjörnsdottir et al., 2020, p. 4).

A supportive, non-judgmental relationship with a healthcare professional enhanced women's wellbeing, relieved discomfort and provided security (Cunningham et al., 2018; Dadouch et al., 2023; DeJoy et al., 2016; Dieterich et al., 2021; Feltham, 2022; Furness et al., 2011; Jarvie, 2017; Knox, 2021; Mills et al., 2013; Nyman et al., 2010; Thorbjörnsdottir et al., 2020). One study found that most women felt that they had been treated like other pregnant women, but that they also received additional support due to their higher weight (Lauridsen et al., 2018).

Thorbjörndottir's et al. described how women who felt 'affirmation and praise' (2020, p. 6) from their midwife during their birth enabled them to flourish and be proud of their bodies. In the same way, one of the participants in Friedman et al.'s study (2020) experienced midwifery care that was de-stigmatising and enabled her to view her body as strong and powerful, rather than 'risky'. Nagpal et al. (2021) found that non-judgmental care enabled reassurance about women's abilities and capabilities, and Nyman et al. reported that women experienced feelings of joy when "being seen behind the fat" and treated like other women (2010, p. 427).

Continuity of care or having a familiar healthcare professional was enjoyed by some women who appreciated the support and rapport with their healthcare professionals (Doughty, 2019; Furness et al., 2011; Thorbjörnsdottir et al., 2020). Some studies reported that women really valued individualised care and if they did not receive this in the current pregnancy, they hoped this would be possible in a future pregnancy (Friedman et al., 2020; Nagpal et al., 2021).

Theme 5. – My culture protects me

This was the only refutational finding (meaning it did not fit with the overall line of argument about experiencing stigmatisation during pregnancy). For some, body image and weight were socially constructed as positive, in keeping with a supportive cultural context which viewed larger bodies as normal and as an asset. This was reported in two studies; one from the USA (Dieterich et al., 2021) with a high proportion of African American participants with high body confidence, and one from Australia (Mills et al., 2013) where women from Pacific Islands reported less dissatisfaction with their weight.

Discussion

This meta-ethnographic review explored the impact of weight stigma on higher-weight women during maternity care. The findings reflect the interplay between women and birthing people's lifelong experiences of preconceptions held by healthcare professionals, often reinforced by media representations of larger bodies, and how these engendered harm and feelings of shame during maternity care. They also give an insight into how feelings of shame can be resisted by women and prevented or eased by skilled and supportive healthcare professionals.

There has been an increasing interest in weight stigma in recent years, and additional reviews, including one within wider healthcare (Ryan et al., 2023) and another within maternity care (Hailu et al., 2024), published after our searches were completed, are consistent with our findings about stigmatising experiences. Whilst Hailu et al.'s mixed methods review focused exclusively on drivers of weight stigma during the perinatal timeframe and included data from healthcare providers, our review centred on women's experiences within a culturally contextualised life-course approach. This allowed us to trace the origins of stigma and show how women and birthing people anticipate judgement and humiliation in maternity care rather than congratulations or positive support during their pregnancies. In addition, we have identified 'shame' as the concept which brings together pervasive feelings of humiliation, being judged and blamed. We also articulate how some women resist weight stigma during their maternity care, which, to our knowledge, has not previously been reported in studies about maternity care of higher-weight women. A deeper understanding of the actions and beliefs of women about weight, diet and health may help improve communication and trust and reduce feelings of shame during maternity care.

Shame is a common and serious issue in healthcare but it is rarely discussed in either clinical situations or research investigations (Dolezal and Lyons, 2017), nor is it acknowledged in maternity guidance about weight and pregnancy. This review exposes how such advice can produce poor and negative experiences of care for women. By identifying microaggressions as specific harm that women experience due to their higher weight, this review adds to the scholarship on this topic (Munro, 2017). Indeed, the very act of being weighed during maternity care caused feelings of shame for some women, particularly as internalised body-related shame, which can lead to healthcare avoidance (Amy et al., 2006; Mensinger et al., 2018).

Feelings of shame and discomfort may be compounded when clinicians find discussions difficult due to lack of knowledge, confidence and professional support (Hyer et al., 2023). This is corroborated by reviews of pregnant women's experiences of maternity care, which point to how a lack of or inconsistent information about higher weight from healthcare professionals can lead to women feeling anxious or uneasy when they reflect on such conversations (Dieterich and Demirci, 2020; Saw et al., 2021). A separate study by Christenson et al. (2018) found that midwives avoid discussing excessive gestational weight gain due to concerns about eliciting worries, shame or feelings of guilt for women in their care, whilst an earlier study described discussion of weight and risk in pregnancy as a 'conversation stopper' (Smith et al., 2012, p. 3). Research on the cycle of weight stigma across the reproductive life phase highlighted the physical and psychological negative outcomes for women and their children, recommending interventions that address the over-medicalisation of higher-weight pregnancies and improved communication (Hailu et al., 2024b). Using a shame lens may help to bring focus on how maternity health professionals' actions and behaviours can adversely affect the experiences of pregnant women and enable development of practical ways to reduce this.

Feeling judged and blamed during pregnancy led to feelings of 'mother blame' for some women. Jackson and Mannix (2004) describe this as a sensation that occurs "from the very point of their infant's conception, and continues throughout the pregnancy and the child's life" (2004, p. 151). This may be heightened by increasing surveillance of the pregnant body and the 'womb environment' (Parker, 2014). Our review found that the ultrasound scan was a particular intervention that was experienced by some women. The 'Saving Babies Lives' Care Bundle (NHS England, 2023a), recommends increased scanning for women with a BMI of >35 kg/m^2 due to the unreliability of standard measuring with tape. It is possible that clinical care which has been implemented in the UK following the introduction of this care bundle may intensify feelings of mother blame. On the other hand, Feltham (2022) also found that women looked forward to these additional scans as a way to bond with their babies.

Maternity care-induced harm extended to limiting women's choices in selecting their birthplace. Some encountered restrictions on accessing the choice of a midwifery-led unit (MLU) due to their weight. However, evidence suggests that multiparous women with a BMI >35kg/m^2, without additional risk factors, have lower obstetric intervention rates and comparable infant outcomes compared to nulliparous women with a normal BMI (Hollowell et al., 2014). Recent UK intrapartum care guidelines (NICE, 2023) have eliminated a BMI cutoff for birthplace selection, advising women instead to consider the heightened risk of complications associated with having a higher BMI. However, the impact on women's actual choices and the extent of personalised care and assessment by clinicians require further investigation.

Our meta-ethnography found that individualised maternity care meant that women felt seen, safe and their experience of pregnancy care was enhanced. Personalised care in maternity care is a key priority in policies and maternity plans (NHS England, 2023b), yet despite the global ambition to provide this, many healthcare systems have not implemented it successfully (Santana et al., 2018). To receive personalised care, women often need to advocate for themselves to make their preferences heard, which not all women feel able to do. The intersection of a protective culture, where higher weight was viewed positively by the women themselves, was the only refutational finding, and one which suggested a different experience for some women. Brewis (2017) describes how, in countries where large and curvy bodies were once viewed positively, they are now increasingly judged negatively, "*seemingly as a core cultural norm*" (p. 2). The extent to which such cultural protection persists when women relocate to countries with more negative perceptions of body size is also unclear.

The impact of the intersection between higher weight and other stigmas, such as poverty or ethnic and/or minority background, also remains under-researched (Hill and Incollingo Rodriguez, 2020; Jarvie, 2016; Puhl et al., 2008). In common with other authors (Capper et al., 2023; McLachlan et al., 2022), we advocate for provision of culturally safe maternity care as a means of reducing the stigmatisation and prejudice experienced directly from maternity care providers.

Strengths and limitations

Our meta-ethnography was conducted using a detailed protocol, which was prospectively registered on Prospero (CRD42021254638). We incorporated relevant sociological theory on shame to inform our analysis, which led to new ways of understanding how weight stigma operates over the life course and elicits a range of responses from women and birthing people. We also conducted a novel assessment of data richness in the included studies, which allowed us to account for differences in approach, depth and perspectives between papers. Our Research Collective stakeholder group, who had lived experience of maternity care as higher-weight women, helped us to establish the authenticity of our interpretations. By adopting a life course approach to the review, we were able to shed light on the cumulative impact of weight stigma over time and how this impacted women and birthing people's expectations of how their bodies would be perceived during pregnancy and by maternity care professionals.

Limitations include the absence of studies from low-resource settings and few studies from middle-resource settings, reducing the transferability of our findings to these regions. Few papers examined intersectional aspects of weight stigma or explored whether more body-positive cultural perspectives persist or are sustained in current contexts, presenting clear gaps in knowledge about how to provide culturally sensitive and safe care.

In relation to practice, our review demonstrates the need to develop weight stigma-reducing interventions and implement shame-sensitive, culturally safe approaches within maternity care. Other forms of stigma in healthcare have been tackled through awareness-raising; in the US, weight bias is recognised as the fourth most common form of discrimination experienced by adults (Puhl et al., 2008), but other countries, including the UK, have not publicly addressed this issue in healthcare. Further research is needed into the impact of weight stigma in less well-resourced settings, including middle-income countries whose citizens recently experienced increases in average weight. More research is needed on the interactions between weight stigma and intersectional inequalities in general health and maternity care settings.

Conclusion

This meta-ethnography highlights the significant negative effects of weight stigma on pregnant women and birthing people, as well as the strategising women employ to try to resist this stigma. The effects of supportive, personalised care by healthcare professionals may give insight into how care might be improved. The experience of shame during maternity care by higher-weight women underscores the need for further research to explore ways to enhance care and provide the individualised support women need and hope for. Given the rising prevalence of higher weight and often intensely negative experiences of these women in maternity care, this issue is a priority in designing personalised maternity care. Reducing weight stigma necessitates a cultural shift involving the voices of those stigmatised and a reflection on implicit and explicit beliefs about shame, weight, health, and pregnancy. Adopting a shame-sensitive lens in maternity care, as proposed by Dolezal and Gibson (2022), could transform support for women, but it necessitates additional training, education, and support for midwives and healthcare professionals.

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CRediT authorship contribution statement

Jenny Cunningham: Writing – review & editing, Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Dr. Melania Calestani:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Conceptualization. **Dr. Kirstie Coxon:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. The author is an Editorial Board Member/Editor-in-Chief/Associate Editor/Guest Editor for this journal and was not involved in the editorial review or the decision to publish this article.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2024.104242.

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