Fat Mothers' Experiences of Reproductive Healthcare, Justice, and Maternal Identity Development: A Qualitative Evidence Synthesis

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts

in

Psychology

At Massey University, Albany,
New Zealand

Abbie May Smith

2023

Abstract

Fat people often face stigmatising experiences in reproductive healthcare; yet, much of the current scholarship is influenced by biomedical framings of fatness as problematic and does not attend to the reproductive rights of fat people. The aim of this research was to bolster the current scholarship about fat peoples' experiences in reproductive healthcare. Using a Qualitative Evidence Synthesis approach and the Reproductive Justice framework, I thematically synthesised twenty-three primary qualitative studies related to fat peoples' experiences of reproductive healthcare and their interaction with medical professionals. Findings indicate that interactions with medical professionals have an impact of the maternal identity development of fat people. In addition, compounding forms of intersectional difference impact upon fat peoples' ability to access their desired reproductive healthcare experiences. Some participant enacted a range of resistance strategies in order to access their reproductive rights, and experience a positive maternal transition. Other participants were disempowered by their reproductive healthcare experiences and their maternal transition was not a positive experience. The findings have implications for future research and for medical processionals providing reproductive healthcare to fat people.

Key words: Fat, Reproductive Healthcare, Maternal Identity, Reproductive Justice, Qualitative Evidence Synthesis

Acknowledgments

A huge debt of gratitude goes to my supervisor Dr. Andrea LaMarre. I could not have done this without you. You have such a warm, compassionate presence and I'm so grateful to have had your guidance throughout this process. Your supervision made me feel encouraged and challenged as a learner but also supported as a human being. It was your postgraduate Critical Health Psychology paper that gave me the confidence to believe I could write a thesis, and in a full circle moment, here we are with the completed project. Thank you so very much.

Dr. Cat Pausé was a co-supervisor for this thesis. Her work was formative in this project's inception, and foundational in what the research became. I wish I was able to have known you longer, and learned more from you, Cat, but I'm grateful that your words, work, and legacy that remain with us. Thank you.

I also want to thank my wonderful friends who stories sparked my curiosity about maternal healthcare interactions. It is a joy to watch you be such wonderful mums and I delight in being your baby's aunty.

Mum, Dad, and Paddy – This whole going back to school thing would have been impossible without the three of you. Your years of love and support have kept me safe and secure, allowing me to pursue postgraduate study without worry or constraint. I love you all so much, and I am lucky to have you all in my corner. Thank you for being there, always.

Table of Contents

Abstract ..... **ii**

Acknowledgments ..... **iii**

Table of Contents ..... **iv**

List of Figures ..... **vi**

List of Tables ..... **vii**

Chapter 1: Introduction, Terms, Definitions, and Reflexivity **1**

Mother 2

Fat 2

Medical Professional 3

My Positionality 3

Chapter 2: Literature Review **5**

Reproductive Justice Framework 6

Medicalisation of Pregnancy and Biomedical Discourse 9

Fat stigma 12

Becoming a Mother: Maternal Identity Development 14

Fat Fertility, Pregnancy and Motherhood 18

Chapter 2 Summary 21

Chapter 3: Methodology and QES Protocol **22**

Background to Synthesis 22

Objective of Synthesis 24

Ontology, Epistemology, Theory, and Methodology 25

Reproductive Justice as a Critical and Theoretical Lens *25*

Relativism *26*

Social Constructionism *27*

Interpretive Syntheses *29*

Thematic Synthesis *31*

Synthesis Methods 33

Criteria for Considering Studies for this Review *33*

Sampling *43*

Assessing Methodological Limitations of Included Studies *43*

Approach to Synthesising Data 44

Choice of Synthesis Methods *44*

Thematic Synthesis *44*

Assessment of Confidence in the Review Findings *47*

Chapter 3 Summary 48

Chapter 4: Findings **49**

Description of Included Papers 50

Theme One: Navigating Fat Fertility, Pregnancy, and Birth 51
Constructing and Caring for Fat Maternal Bodies *51*
Negative Experiences of Medicalised Reproductive Healthcare *62*
The Impact of Medical Interventions and Surveillance on Accessing Desired Care *70*

Summary of Navigating Fat Fertility, Pregnancy, and Birth 81

Theme Two: Mothering and Maternal Identity 81
Interembodiment, Child-centrism, and Self-Management *82*
Distress During the Postpartum Period *85*
Personalising Motherhood *86*

Summary of Mothering and Maternal Identity 88

Theme Three: Intersectionality, and Material and Social Constraints 89

Summary of Intersectionality, Material, and Social Conditions 93

Theme Four: What Participants Want 94

Summary of What Participants Want 97

Chapter 4 Summary 97

Chapter 5: Discussion and Limitations 99

Discussion 99
Medical Professionals Impact Upon Fat Peoples Maternal Identity Development *99*
Intersectional Factors that Impact Upon the Reproductive Healthcare Experiences of Fat People *102*
What Participants Want in Future Reproductive Healthcare Interactions *104*

Limitations 105

Conclusion 107

References 109

Appendices 119

Appendix A: Search Terms for Systematic Database Search 119

Appendix B: Article Screening Inclusion and Exclusion Criteria 120

Appendix C: Abbreviated Search Terms for the Supplementary Search 121

Appendix D: Characteristics of Studies Included in the QES 122

Appendix E: Critical Appraisal Skills Programme Outcome (CASP) 126

Appendix F: RETREAT Framework for QES Methodology Selection 133

List of Figures

Figure 1. *Visual Representation of the Literature Review*…….6

Figure 2. *PRISMA diagram of QES Systematic Search and Screening Process*…… 42

List of Tables

Table 1 *PerSPE(C)TiF Research Question Development Tool*……..35

Table 2 *Included Studies and Corresponding Identification Number for Synthesis*……..49

Chapter 1: Introduction, Terms, Definitions, and Reflexivity

Being a fat person who is seeking fertility and perinatal healthcare can be fraught with shame and reproductive injustice. Biomedical discourses saturate many societies' understandings about conception, pregnancy and birth, particularly in western societies, impacting how fat people feel about their fertility, their pregnancies, and their birthing experiences. Scholarship on this topic has been building in recent years, with a number of qualitative studies exploring fat pregnant people's experiences of fatphobia, shaming and stigmatisation by medical professionals throughout fertility treatment and perinatal healthcare interactions.

In this research, I aimed to 'take stock' of relevant primary qualitative research by using the findings from a number of studies to inform an enhanced and potentially deeper understanding of the phenomena. Employing a qualitative evidence synthesis (QES) approach, I systematically selected, reviewed, integrated, and interpreted the results of primary research in this area. I summarised the current research while also answering the question: what impact do interactions with medical professionals have on the maternal identity development of fat people?

The purpose of this study was to develop an enhanced understanding of this phenomenon through a reproductive justice lens, while also supporting fat activism goals that are evident in much of the current scholarship. It is possible that this QES may have implications for the ways in which fat people who are seeking fertility and perinatal healthcare are treated by medical professionals, and subsequently offer suggestions that could both improve health outcomes and support parental confidence through policy and protocol changes.

Mother

I acknowledge from the outset that people of different genders are able to become pregnant and give birth, and also that not all those who are mothers will have given birth to their children. The majority of studies included in my QES are from the perspective of cisgender women, in particular women who identify as mothers and are the gestational parents of their children. I did not wish to exclude the perspectives of participants in some studies who had pregnancy, birthing and/or parenting experience and who did not identify as women or mothers. Their experiences with medical professionals are equally valid and, in working with a reproductive justice framework, important in promoting everyone's human right to parent (or not), in safe and healthy environments (Ross & Solinger, 2017). I have included their experiences within the analysis, but took care to not interpret their experiences in relation to discussions about maternal identity development specifically.

Fat

The first time I read the word 'fat' in academic writing, I was shocked that what I perceived to be such a negative word was being used so unapologetically. This initial reaction is precisely the thought pattern that fat activism and scholarship are working to disrupt; using the word "fat" is "neutral" yet "descriptive", and is a way in which people can take back their bodies, reducing shame and stigma (Brown & Herndon, 2020, p. 140). Honouring this perspective, I used the word fat in this QES to describe a bodily experience, but acknowledge that not everyone who is fat wishes to be labelled in this way (Brown & Herndon, 2020). In supporting fat activism with this QES I am attempting to counteract the biomedical language that is used in medical settings, such as "obese" and "obesity", as these automatically position fatness as problematic and unhealthy (Lupton, 2018). It was necessary to use the terms "obese" and "obesity" in the systematic search of this QES, as "fat" alone yielded too

few results. While the inclusion of biomedical language was not ideal, it did offer an opportunity to engage with a range of literature, from biomedically based studies, as well as critical obesity studies, and fat studies. This approach ultimately became a strength of the QES because in order to support my arguments for reproductive justice and fat activism within reproductive healthcare interactions, I needed to understand biomedical perspectives as well.

Medical Professional

I use the term medical professional to cover the spectrum of possible healthcare workers whom fat people will come into contact with when they are trying to conceive or are seeking healthcare in the perinatal period (pregnancy through to one year post-birth). This spectrum includes, but is not limited to, doctors, obstetricians, nurses, midwives, and radiographers.

My Positionality

I am a straight-sized, childless, cis-gendered woman. So why is this research important to me? I have just reached my 30s and over the past few years an increasing number of my peers have been navigating pregnancy for the first time. I have lived in Europe for six years, and over the past four years, two of my close friends have sought antenatal healthcare in Europe. I must note here that these friends are thin, and straight-sized. They shared with me that they had been weighed at every obstetrician appointment and sanctioned for gaining 'too much' weight during pregnancy. Advice ranged from limiting carbohydrate intake to the first meal of the day, to avoiding carbohydrates altogether to prevent subsequent weight gain.

These experiences of my friends lead me to wonder what my experience would be like if I were to seek pregnancy related healthcare in Europe also. While straight-sized, I am

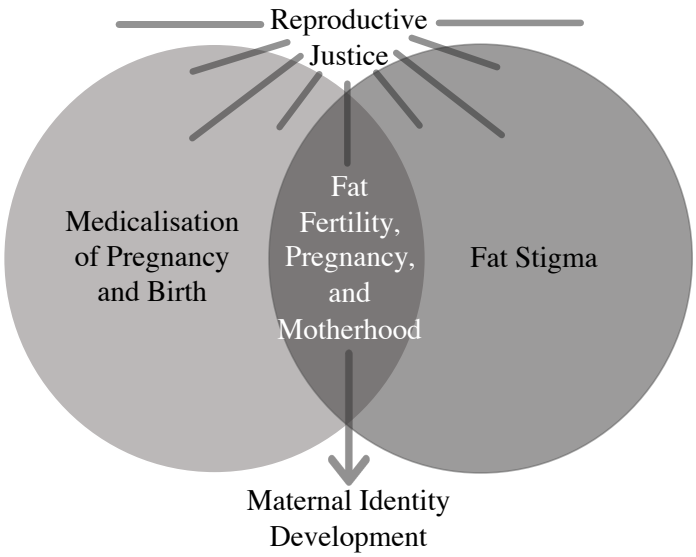
considered overweight with regards to the body mass index (BMI) scale. Would my body be sanctioned more than those of my friends when in medical settings, and how are people bigger than me treated by medical professionals when seeking reproductive healthcare? I wondered if this medical conduct was typical of maternity care in Europe, and also if it happened in Aotearoa New Zealand. I explored this topic some more during a postgraduate paper in 2020, finding the work of Cat Pausé and George Parker particularly powerful. Since then, I knew it was something that I would like to investigate thoroughly in the form of a Master's thesis.

Chapter 2: Literature Review

The purpose of this research was to synthesise data from a number of studies to explore the experiences of fat people's interactions with medical professionals, with the aim of finding out from the data, what impact these interactions had on maternity identity development. In order to review and conceptualise the current research on fat people's experiences in fertility and perinatal healthcare, it is important to provide some context to the systemic and underlying factors that shape those experiences. I will first introduce the concept of reproductive justice, as it is both the guiding theoretical framework for this thesis and it is the lens through which I view the relevant scholarship. I will then introduce the medicalisation and surrounding biomedical discourse of pregnancy and birth. Next, I summarise fat stigma, and provide some background regarding the establishment of a maternal identity as this is a key research question. The combination of these factors lays the foundation for better understanding the current research surrounding the experiences that fat people have when accessing fertility and perinatal healthcare which is briefly covered in the final section of this literature review. Typically a critical review of the current research would dominate the literature review section, but as several of the studies in the literature review are also in the QES itself, it is necessary to withhold much of the analysis for the actual synthesis. I have also provided a figure (Figure 1) to illustrate how the different aspects of this literature review fit together, as well as situating the origin of the main research question: what impacts do interactions with medical professionals have on the maternal identity development of fat people?

Figure 1

Visual Representation of the Literature Review



Reproductive Justice Framework

Reproductive justice (RJ) is the central theoretical framework of this thesis. RJ is a social justice movement created by African American women and has three fundamental tenets - "the human right to not have a child, the human right to have a child, and the human right to parent children in safe and healthy environments" (Ross & Solinger, 2017, p. 117). With these three tenets in mind, it is clear that RJ does not merely advocate for reproductive rights and freedom of choice; it is also concerned for the equity of outcomes in, across and beyond immediate reproductive experiences, extending its advocacy into parenthood (Ross & Solinger, 2017). It is intimately connected to social justice through the understanding that reproduction, along with food, water and housing, is a human right that should be afforded to every human being (Ross & Solinger, 2017). RJ is also a framework that critically examines the ways in which social and political power relations are tied to reproductive activities, and how these power relations permit and deny access to reproductive outcomes, and who is benefited or disadvantaged by them (Ross & Solinger, 2017). As such, RJ was born out of an

amalgamation between social justice and reproductive rights, and in response to Black feminist critiques that white feminism tends to assume that reproductive issues affected all peoples in the same way (Morison, 2021; Ross & Solinger, 2017), because historically and presently they do not. For example, contraceptive options, such as intrauterine devices or implants, can been seen as liberating for some people, because they enable people to personally manage their fertility as they see fit (Morison, 2021). However, these same pharmaceutical technologies can be oppressive for others if they are used coercively for purposes such as population control (Morison, 2021).

The inequity of outcomes associated with the contraception paradox that Morison (2021) highlights above also brings up Crenshaw's (1989) concept of intersectionality, initially coined to illustrate the ways in which Black women are doubly discriminated against, based on both race and sex in employment. In the years following Crenshaw's initial introduction of intersectionality, many academics and activists have applied intersectionality to describe the ways in which other marginalised groups of people deal with compounding forms of discrimination. This discrimination includes intersections of racism, classism, transphobia and homophobia, which affect marginalised peoples' life experiences and outcomes, including reproductive healthcare outcomes, in vastly different ways (Carastathis, 2016). One such example of intersectionality in reproductive healthcare outcomes is the shocking racial disparity in pregnancy-related mortality rates. In the United States (US), "Black, American Indian, and Alaska Native (AI/AN) women are two to three times more likely to die from pregnancy-related causes than white women" (Centers for Disease Control and Prevention (CDC), 2019, para.1). Data collected from 2006-2016 in Aotearoa New Zealand shows that there were more deaths among Māori and Pasifika mothers reported than other ethnicities, and "Māori women are overrepresented in the maternal suicides" (Perinatal

and Maternal Mortality Review Committee, 2018, p. 141). Using a RJ framework is important for illustrating these intersections of compounding inequality. Examples of inequities such as these maternal mortality statistics across different cultures and countries are not a coincidence, but are a consequence of serious systemic injustice within maternity care and society in general.

SisterSong (n.d) argue for the need to address reproductive oppression in all its forms in order to achieve justice for everyone. With this view in mind, I engaged with the RJ framework for this thesis and applied it to the analysis of fat people's reproductive experiences with medical professionals. Throughout US history, in which colonisation, slavery and industrial immigration are embedded, African American, Indigenous and women of colour were viewed by the in-power colonisers as unfit reproducers, as evidenced by sterilisation programmes that targeted these groups (Morison, 2021; Ross & Solinger, 2017). More recently, and in a similar vein, fat people are also deemed unfit reproducers, and experience a number of negative and coercive reproductive healthcare experiences in relation to fertility as well as pregnancy and birth (Bombak et al., 2016; LaMarre et al., 2020; McPhail et al., 2016). These brief examples demonstrate the historic and ongoing importance of the 'right to have a child' tenet that RJ promotes. These examples also demonstrate the kind of discrimination that the RJ framework helps to challenge. The framework provides a foundation through which to critically assess how wider institutions, policies, laws, and practices position certain groups of people to be 'othered' and therefore prevented from accessing the reproductive outcomes that they are entitled to as human beings (Ross & Solinger, 2017).

Ross & Solinger (2017) also chronicle the ways in which people manage their reproductive destinies despite the challenges or barriers that they face to accessing the care they desire, for example, accessing abortions when those options are not available legally. People taking matters into their own hands in relation to their reproductive health is a form of resistance, and supports the need for a social movement and framework like RJ that advocates for everyone's right to control their own reproductive outcomes in a safe and healthy way (Ross & Solinger, 2017).

Aside from using the RJ framework to support the analysis section of this thesis, it feels more pertinent than ever to keep supporting and promoting RJ as often as possible. During the course of writing this thesis, the Supreme Court in the US of overturned the historic *Roe v. Wade* ruling that protected people's right to access abortion. It is now illegal and criminal to seek, or aid in, an abortion across many states in the US. While Aotearoa New Zealand might be seen as more progressive than that, abortion was only officially decriminalised and made more accessible in 2020 with the Abortion Legalisation Act 2020. It is essential that when researching people's experiences of reproductive healthcare, we are also acknowledging and supporting their human right to parent (or not), in environments that are safe and healthy.

Medicalisation of Pregnancy and Biomedical Discourse

Historically, pregnancy and childbirth were expected, and even mystical, life events for women, and typically female family members or carers provided support to women throughout the process (Davison, 2020). The progression of medicalisation as the default model of pregnancy and birth care varies across countries, cultures and class systems, but stands as the dominant perspective today, particularly in western societies (Barker, 1998; Najmabadi et al., 2020; Shaw, 2013). Medicalisation occurs when non-medical bodily

functions become framed as medical problems that require treatment by a medical professional, and in the case of pregnancy, signs such as morning sickness become symptoms of illness that require treatment (Neiterman, 2013). In the US, it is estimated that less than five percent of women had contact with a doctor before the onset of labour during the first 20 years of the twentieth century (Barker, 1998), whereas in Iran, the medicalisation of pregnancy and birth has occurred only within the last 40 years (Najmabadi et al., 2020).

Until a recent resurgence of midwifery care, the medicalisation of pregnancy and birth has had the effect of side-lining more traditional and women-centred care providers, such as midwives and doulas (Davison, 2020). Men historically dominated the science-based medical profession (Davison, 2020). Some historians suggest that midwifery was deliberately marginalised by doctors, because midwives were a barrier to doctors having full control over pregnancy and birth (Shaw, 2013), with women being seen as unscientific and incapable of understanding the process (Davison, 2020). 'Modern' science understood that the human body operated like a machine, and therefore pregnancy and birth were mechanical processes that should be attended to by scientifically-minded male physicians, which in turn alienated women from the process (Davison, 2020; Marshall & Woollett, 2000). Not only was this side-lining of midwifery sexist, but it also exposed women and their bodies to increased surveillance and intervention during pregnancy and birth, in order to monitor and treat the 'illness', submitting to and transferring the control of their bodies to medical professionals (Neiterman, 2013). Medical interventions during pregnancy and birth can include foetal monitoring, ultrasound, induction, and caesarean section (Davison, 2020). Interventions are often promoted by medical professionals as a way to improve perinatal outcomes (faster, safer, less painful birth), but interventions such as induction can do more harm to mothers than good (Davison, 2020). Induction drugs often increase the intensity and duration of

contractions, leading to the need for analgesic drugs that can compromise the ability to feel contractions that are necessary for a vaginal birth, leading to the need for a caesarean section (Shaw, 2013).

Another by-product of the medicalisation of pregnancy and birth is the way in which people begin to associate this natural bodily function with risk (Rothman, 2014). Within a biomedical model of care, the assumption of risk and the anticipation of problems involved within a 'normal' pregnancy/birth are often exaggerated (Davison, 2020). Medical interventions can be helpful and lifesaving; however their impact may also, at times, be hard to differentiate from other advances that have taken place overtime, like better infection control and higher infant birth weight (Barker, 1998). An excellent example of conflating a medicalised pregnancy and birth with improved safety is the plight of northern Aboriginal communities in Canada during the 1950s (Shaw, 2013). The Canadian government at the time attributed the high death rate of infants in the community to the lack of medicalisation, when in reality the greater impact was the process of colonisation that saw these communities moved on to reservations, and away from their traditional resources and practices (Shaw, 2013). This colonising mentality continued into the 1980s when Canadian Aboriginal women were taken out of their communities and sent to give birth at hospitals in larger cities, away from their families and support networks, which was isolating and harmful to their wellbeing (Shaw, 2013). This example illustrates the need for culturally supportive environments during pregnancy and birth, particularly for Indigenous groups. For Māori women in Aotearoa New Zealand, "successful labour and delivery was linked to a conducive spiritual and physical environment" where birth practices respected and honoured the tapu, or sacred, nature of pregnancy and birth (Le Grice & Braun, 2016, p. 159). Pregnancy and birth are not just medical events but may also be spiritual and relational. Ensuring better pregnancy and birth

outcomes requires the holistic consideration of all aspects of a person's life and wellbeing, not only that of the biomedical view of health.

Midwives and doulas provide women-centred care, and are often seen as advocates for women during the pregnancy and birth process, supporting mothers to have the pregnancy and births that they desire. However, as mentioned earlier, maternal mortality rates for BIPOC folks are shocking, and highlight the systemic injustice within maternity healthcare. While midwives and doulas are seen as advocates for some women, this advocacy is not always without unintended consequences. Nash (2019) points out that by resolving and mitigating harm on behalf of Black women in maternal healthcare, a doula's advocacy work inadvertently supports the position that "Black maternal bodies" (p. 29) are something that are broken. These types of unintended consequences demonstrate how even a medical profession that is supposed to be women-centred is still impacted by and upholds patriarchal and racist medical framings of marginalised birthing bodies. The paradox between midwifery being helpful to some people, and unhelpful to others demonstrates how important it is to incorporate the RJ framework into research related to maternity and parenthood. Using the RJ framework helps to interrogate the highly political and intersecting realities in which pregnancy and birth exist, by highlighting systemic injustices, and may help to ensure moving forward that everyone gets the pregnancy and birth experiences they desire and are entitled to.

Fat stigma

Fat stigma is the negative stereotyping of fatness, ranging from people being repulsed by the visible fat body through to the imagined character deficiencies that fat people may have for allowing themselves to exist in a fat body (Lupton, 2018; Pausé, 2017). This

neoliberal emphasis on personal responsibility automatically associates fat people with unfavourable attributes such as laziness or lack of self-discipline, ultimately 'othering' fat people and positioning them as immoral and burdensome to those who are 'healthy' (Friedman et al., 2020; Lupton, 2018; Pausé, 2017). As with the medicalisation of pregnancy, the biomedical discourse surrounding fatness and the resulting stigma (particularly in western/global north societies) can be traced back to the way in which biomedical discourse constructs obesity as inherently unhealthy and dangerous (Brown & Herndon, 2020; Lupton, 2018). Biomedical understandings of excess body weight or obesity suggest that the greater the excess body fat that a person has, the more likely they are to develop heart disease, stroke, diabetes, and even cancer (World Health Organization (WHO), 2021). Interestingly though, other studies identify evidence of negative health effects, including psychological and social wellbeing, that are associated with being on the receiving end of fat stigma (Manokaran et al., 2021; Nath, 2019; Sutin et al., 2015). In a recent study, Keirns et al. (2022) observed that there was a positive association between internalised weight stigma, and visceral adipose tissue (VAT) for the women in their study, though this association was not observed for the men. VAT itself is a risk factor for cardiovascular issues and diabetes (Keirns et al., 2022) demonstrating that fat stigma is not only unhelpful and unproductive, but also harmful to fat people's health and wellbeing. Other studies related to the consequences of fat stigma suggest that fat people may delay or entirely avoid healthcare interactions if they anticipate negative or stigmatising experiences with their providers (Lee & Pausé, 2016; Pausé, 2017). The counterproductive nature of fat stigma demonstrates the necessity of supporting the work of fat activism and scholarship when researching the experiences of fat people (Manokaran et al., 2021).

Becoming a Mother: Maternal Identity Development

The experience of becoming a mother is a profound process of change for some people. I again acknowledge people of different genders are able to become pregnant and not all who have babies will identify as mothers. However, here I will be focusing specifically on experiences in relation to becoming a mother, as the relevant research is almost exclusively related to the experiences of people who identify as women.

Becoming a mother for many people is not only a physical process, but also an identity-altering process. The construction of this new identity may begin during pregnancy, with people fantasising about motherhood and future children (Hollway, 2016; Raphael-Leff, 2001), followed by a negotiation of who a person is during pregnancy and after birth, in relation to their independence, body, sexuality and employment (Laney et al., 2015; Mercer, 2004). This negotiation highlights how people, in particular women in western countries, may experience pressure to manage and maintain a public life (paid work, education), as well as a private life (raising children, marriage, domestic labour) simultaneously (Johnson, 2014).

Some of the most prominent conceptualisations of maternal identity development came from Rubin (1984) and later Mercer (1995), both of whom have a background in nursing. Initially Rubin (1984) observed women who were receiving perinatal care, and outlined the progression through four core tasks that contributed to their maternal identity development. These tasks were; keeping herself and the baby safe throughout pregnancy and birth; making sure herself and the baby would be socially accepted; "binding-in to the child" or forming attachments with them during pregnancy; and finally, the surrendering or giving of herself to the exhausting process of pregnancy, childbirth and beyond (Rubin, 1984, p. 62). Mercer (1995) built on these understandings, but instead framed maternal identity as maternal

role attainment, and more heavily leaned into cognitive development as the basis for this process (Parratt & Fahy, 2011). The stages of maternal role attainment are "the anticipatory stage" where a person imagines themselves as a mother, followed by "the formal/role-taking stage" where the actuality of becoming a mother becomes more salient through interactions with medical professionals (Mercer, 1995, p. 14). Next is "the informal/role-making stage" where the person situates the maternal role in relation to previous experiences and their desires for the future (Mercer, 1995, p. 14). Finally, "the personal role/identity stage" is attained when the mother reconciles the new maternal role alongside wider aspects of her identity (Mercer, 1995, p. 14).

These early conceptualisations of maternal identity development are foundational but antiquated and reflective of the time in which they were developed (Parratt & Fahy, 2011). Both Rubin and Mercer used logico-empiricism for their research which values observational data collection over valuing the lived experiences of participants from their own perspective (Parratt & Fahy, 2011). Interestingly, Parratt and Fahy (2011) also point out that these theories of maternal identity and maternal role attainment, rather than more recent theories that tend to be more mother-centred, were the basis for theoretical understandings of motherhood within well-regarded midwifery textbooks. This critique of Parratt & Fahy's validates the need for research to focus more on the lived experiences of people from their own perspective in relation to their maternal identities, as opposed to evaluating people against a pre-determined set of milestones that result in becoming a mother. It is interesting to consider how midwives who were trained with an understanding of these antiquated theories may have integrated them into their care practices, and how doing so may have impacted upon people accessing their care.

A more recent and critical understanding of maternal identity focuses on a 'maternal transition' and frames 'becoming a mother' as an experience, rather than an institution or set of sequential steps that people advance through during their pregnancies and beyond (Johnson, 2014). I chose to use Johnson's 'maternal transition' as a theoretical framing for maternal identity development because Johnson takes care to consider the political nature of pregnancy and birth, and understands that the experiences of pregnant and birthing people may differ vastly based on their geographic location. This attention to the difference between the global north and south resonated closely with this project because it brings into account the aforementioned concepts of intersectionality, as well as the paradoxes highlighted by the RJ framework. Johnson (2014) also discusses Adrienne Rich's (1995) concept of 'giving birth to one's self', in which the experiences of pregnancy and childbirth can be either self-actualising for a mother, or an act of self-replacement, depending on myriad of social, political and economic factors. A self-actualising experience can be the site of identity creation and affirmation, but Johnson (2014) notes that this view is based on the premise that the mother has the ability to make choices around her experience in terms of care providers and birth location. In contrast, self-replacement is more institutional (patriarchal), and suggests that a woman's entire purpose in life is to get pregnant and give birth for the good or advancement of society (Johnson, 2014). Birth as self-replacement is reflective of "patriarchal expectations, and create rigid social scripts for mothers", and validates a mothers identity only in relation to successfully birthing a child (Johnson, 2014, p. 90).

While mothers today (depending on their locality) commonly have the ability to make choices about their pregnancy and birth experiences in relation to healthcare, these patriarchal expectations still linger in the form of medicalisation and biomedical discourse surrounding pregnancy and birth (Johnson, 2014). Johnson (2014) also writes extensively about

medicalisation in relation to maternal identity. Maternal identity is inherently attached to reproductive healthcare as it is a common means by which someone can potentially or does (or does not) become a mother. Healthcare is a construct (medicalisation, biomedical discourse) in and of itself that can be rejected and negotiated by a person through their own process of establishing a maternal identity (Johnson, 2014). This negotiation of reproductive healthcare in relation to maternal identity formation is also aligned with RJ's acknowledgement of the way in which people often demonstrate resistance if their reproductive rights and desires are not being met because "control over, or acquiescence with the unpredictable, 'natural' process of birth is socially constructed, identity generating and reveals complex patterns of inequality" (Johnson, 2014, p. 25).

Johnson (2014, p. 10) also highlights that identity is typically "ascriptive", giving the example of Blackness being not just a physical trait, but also a socially constructed unit of meaning, just as "mother" and "maternal" are visible and yet socially constructed. The process of ascribing meaning to particular identities highlights social discourses that are available in relation to identity development. As it relates to this thesis, the identity of a fat mother is both hyper-visual, and comes with a whole host of discourses that such as the 'good mother' discourse, that need to be negotiated. I note here that I also adopt a social constructionist view of identity development, and therefore maternal identity development. I will discuss social constructionism more thoroughly in the methodology section of this thesis, and continue the discussion of fat reproduction and motherhood in the next section.

Finally, another consequence of the medicalisation of pregnancy and birth in relation to maternal wellbeing and identity development is child-centrism, as a by-product of the biomedical discourse and medicalisation surrounding pregnancy or the prioritisation of a

foetus/child's needs above those of the gestational parent (Lupton, 2012). Much like the conceptualisation of self-replacement (Johnson, 2014), Raphael-Leff (1991) highlights that a mother's womb is essentially a receptacle for the child's presumed potential in society. To be a 'good mother' and 'reproductive citizen' mothers should prioritise the child over her own wants and needs (Baker et al., 2005; Lupton, 2012). This tendency to focus on children in pregnancy and birth, as opposed to the mother, also highlights how important RJ is for ensuring that the needs of mothers are also met as a fundamental social right.

Fat Fertility, Pregnancy and Motherhood

So what happens to maternal identity development when people whose 'mother becoming' bodies are deemed unfit, unsafe or undesirable for motherhood? Here I briefly outline the current literature on fat people's experiences of reproductive and maternity healthcare, but note that the majority of the discussion is reserved for the QES, itself as several of the studies mentioned here are included in the synthesis.

In the midst of an 'obesity epidemic', current biomedical research suggests that fat pregnant people, and the in utero environment their bodies create, may be responsible for birth complications, childhood health issues, and may in future, negatively impact the economy (McPhail et al., 2016; Parker, 2014; Parker & Pausé, 2019; Warin et al., 2012). In conjunction with the over-medicalisation of pregnancy and birth, this biomedical discourse problematises fat pregnant bodies and, within neoliberal and western cultures, holds the mother accountable for potentially negative outcomes such as pregnancy and birth complications, miscarriage, and/or childhood obesity and diabetes (Parker & Pausé, 2018b; Warin et al., 2012). This biomedical construction is not only reproduced during interactions with medical professionals, but also socially and in the media (Budds, 2021; Marshall &

Woollett, 2000; Nippert et al., 2021; Warin et al., 2012). Fat pregnancy is therefore an interaction between fat stigma and highly medicalised understandings of pregnancy and birth, activities that on their own carry great risk, but when combined are framed as catastrophic. The material result of this discourse for fat pregnant women can be summarised as reproductive injustice and the production of maternal guilt and shame (Parker & Pausé, 2019).

Owing to the medicalisation of pregnancy and biomedical discourses outlining what constitutes a healthy pregnancy, fat mothers may be engaged in experiences that do not support their right to access their desired reproductive healthcare. Weight may be used by medical professionals as a reason for not providing services that mothers' desired and deserved, or ones that other straight-sized mothers may have access to (LaMarre et al., 2020; McPhail et al., 2016; Parker & Pausé, 2019). Medical and reproductive procedures may be dictated by doctors, rather than decisions being made in consultation with mothers (LaMarre et al., 2020; McPhail et al., 2016). Maternal healthcare is embedded in biomedical discourses and are oppressive to, and interfering of, a women's reproductive choices during fat pregnancy (Dickman, 2022; Lee, 2020).

Some studies, however, have also highlighted the ways in which fat pregnant people resist the 'risk' label or instances of coercion that they may encounter in their interactions with medical professionals. For example, some mothers use eating 'poorly' as an act of defiance (Atkinson & McNamara, 2017), while others minimised the 'risk' their bodies posed to their unborn child by measuring the risk of fat pregnancy against other frowned-upon behaviours such as drinking or smoking while pregnant (Bombak et al., 2016). In order to resist coercion during medical interaction, some fat pregnant people practised strong self-

advocacy, in order to access the care they desired (LaMarre et al., 2020). Pregnancy and birth are framed as 'risky' on their own; however, when this risk is combined with the threat posed by the 'obesity epidemic', fat mothers stand little chance of enjoying a 'normal' or de-medicalised pregnancy and birth, because their bodily condition exists across two plains of risk.

Despite employing methods of resistance, negative maternal care interactions are a common experience for fat people, and often produce feelings of shame and guilt for fat mothers by highlighting how they are in opposition of what a medically 'healthy' pregnancy looks like (Furber & McGowan, 2011; LaMarre et al., 2020; Parker & Pausé, 2018a; Ward & McPhail, 2019). Feelings of shame and guilt are so powerful that some mothers in Parker and Pausé's (2018b) study engaged in acts of self-discipline in an attempt to resolve the 'harm' or reduce the risk that their bodies had inflicted on their babies:

> The pre-emptive biopolitics of "obesity"… also leaves pregnant people to embark on motherhood in a deeply negative affective space as a "failed fat mom," leading us to ask what this means for how our participants go on to form relationships with their born children and to forge their identities as parents. We wonder about the health effects (physical, spiritual, and mental) for mothers and their children wrought by embarking on such a profound life transition so deeply dispossessed. (Parker & Pausé, 2018b, p. 131)

This wondering from Parker and Pausé is a key catalyst for this thesis. While invaluable for RJ, and in many cases the progression of fat activism, the current literature regarding fat people's experiences of fertility treatment, pregnancy and birth-related healthcare tends to focus on analysing themes and discourses that construct fat pregnancy, and the mothers body through various medical and social interactions, highlighting the institutional and social

power relations at play. As Parker and Pausé (2018b) ask, what impact do interactions with medical professionals have on the maternal identity development of fat people?

There is, to my knowledge, no previous QES of fat mothers' experiences of fertility and perinatal care interactions and the affects these experiences have on the development of a maternal identity. There are several adjacent systematic reviews that are concerned with exploring interventions for weight management before and during pregnancy (Hill et al., 2013; Huberty et al., 2017; Johnson et al., 2013), or obese women's experiences and perceptions of fertility and pregnancy (Dadouch et al., 2020; Relph et al., 2020; Saw et al., 2021; Westerman & Kuhnt, 2022). Additionally Furber et al. (2013) attempted to complete a Cochrane systematic review on 'Antenatal interventions for reducing weight in obese women for improving pregnancy outcome', but were unable to identify suitable studies for inclusion in the review. While these reviews do include some of the same studies that are analysed in the present QES, the framing and purpose of these previous systematic reviews were not concerned with maternal identity development, nor did they employ the use of the RJ framework, or support the goals of fat activism.

Chapter 2 Summary

This chapter has provided orientating and reflexive statements that defined key concepts that undergird this thesis as a whole. Introducing RJ and its critical framework provides a theoretical thread that weaves together the concepts of fat stigma, medicalisation of birth and pregnancy and maternal identity, before briefly highlighting the current literature on fat fertility, pregnancy and motherhood.

Chapter 3: Methodology and QES Protocol

Background to Synthesis

Initially, I had set out to complete a narrative analysis of the experience of becoming a fat mother. My research questions included:

- How do self-identified fat women story and make sense of their experience of becoming a mother?
- How do fat women construct their maternal identities through their stories?
- How have these experiences impacted upon the mothers relationship with her child?
- Do their stories of maternal identity construction have a resolution?

After the passing of my co-supervisor, Dr. Cat Pausé, a fat activist and scholar, it felt inappropriate to proceed with a project like this without her guidance. My co-supervisor, Dr. Andrea LaMarre, suggested a qualitative synthesis or systematic review as a way to continue with the focus of the original project, while also acknowledging our positionality as straight-sized people. Accordingly, I settled on completing a qualitative evidence synthesis.

A QES is a type of systematic review that offers a methodical and rigorous way to collate and synthesise primary qualitative studies, in order to answer research questions about a particular phenomenon (Noyes et al., 2018). Additionally, QES is often used in tandem with efficacy reviews to explore health interventions (Flemming & Noyes, 2021; Harris et al., 2018). While this QES is not exploring an intervention per se, it is clear that pregnancy and birth are largely medicalised and involve at least some form of intervention, fat people may be subjected to medical interventions/procedures without cause (Bombak et al., 2016; LaMarre et al., 2020). It is also clear that the feelings of stigma and shame fat people experience in reproductive healthcare are common and potentially impact on their overall

wellbeing (Parker & Pausé, 2018b). An assumption of QES is that a whole is greater than the sum of its parts (Flemming & Noyes, 2021), and so this research may help to bolster the depth of evidence in the primary studies, while supporting RJ and the goals of fat activism. From an ethical perspective, taking a QES approach felt most appropriate because I was able to conduct research on this topic in a way that aligned with my desire to support fat activism, without claiming a positionality that is not my own. Manokaran et al. (2021) make several suggestions for ally social science researchers who wish to study fatness. Allies should reaffirm the self-determination of fat people, involve the fat community in research, be self-reflective and accountable, and not pathologize fat people (Manokaran et al., 2021). A QES does not require institutional ethics board review and it does not involve collecting primary data. However, ethical considerations are still important in approaching and engaging with the studies. I was guided by a fat ethic as suggested by Manokaran et al. (2021). This approach, in addition to my attunement to RJ as a theoretical framework, informed how I orientated toward the work and reflected on my own positionality, while continuing to respect the dignity of the participants across the primary studies.

In order to ensure that the results of QES's are robust, the Cochrane Qualitative & Implementation Methods Group has been working on guidelines and tools to assist researchers in completing a methodical project. As a novice researcher, I referred to the Cochrane Effective Practice and Organisation of Care Group's protocol and review template to guide the planning of this review (Glenton et al., 2022). The following section is not a traditional QES protocol as would be prescribed by the Cochrane Group. Rather, it is combination of both the aforementioned protocol template, guidance from the Cochrane Qualitative and Implementation Methods Group literature, and an outline of my epistemological and theoretical considerations to satisfy the requirements of a Master's

thesis. This combination of protocol and literature also helps to demonstrate my decision-making processes more transparently.

Navigating fertility, pregnancy, and birth, as a fat person in an increasingly medicalised world is complex, and sometimes harmful (Parker, 2017). Scholarship in this area positions some medical professionals as contributors to negative reproductive experiences, and research grounded in fat studies asks what these interactions might mean for maternal identity, and general wellbeing of fat mothers (Friedman, 2021; Parker, 2017; Parker & Pausé, 2018b). In the following section, I will outline the synthesis objective before introducing my epistemological and theoretical assumptions in relation to this QES. I will then discuss QES methods, including a description of the systematic search and rationale for study screening and selection. Finally I will explain my application of thematic synthesis for the analysis process.

Objective of Synthesis

The primary objective of this QES was to synthesise evidence from primary qualitative studies of fat people's experiences of reproductive healthcare interactions. The main research question guiding this synthesis was: What impact do interactions with medical professionals have on the maternal identity development of fat people? It is common in QES that additional research questions will arise throughout the process of study selection and analysis (Flemming & Noyes, 2021). It became clear as the analysis progressed in this QES, and certainly from using the RJ framework, that additional research questions included: How do participants navigate fat fertility, pregnancy and birth? What intersectional factors impact upon their experiences? And perhaps most importantly, what do fat mothers and parents want in future healthcare interactions for themselves and others?

Ontology, Epistemology, Theory, and Methodology

Considering the epistemological assumptions embedded in any qualitative research is a challenging process. What I found particularly challenging in carrying out a QES was the layering of interpretation involved. I needed to describe and assert my epistemological assumptions while actively interpreting the interpretations of primary authors, based on their interpretations of what their participants have shared. Suri (2014) suggests that the first phase of synthesis should be identifying an appropriate epistemology for synthesis while also reflecting on how one's own political, epistemological and theoretical assumptions interact with the synthesis process should be the first phase of synthesis. Accordingly, I will reiterate here the importance of RJ as the critical lens through which I am interpreting the data in the primary studies. I will then locate my ontological and epistemological assumptions in relation to the nature of reality, how humans may come to know about this reality, and how reality is constructed as it pertains to healthcare interactions and maternal identity. Finally I will discuss the thematic synthesis method, its origins and underpinnings, and why I chose it for analysis.

Reproductive Justice as a Critical and Theoretical Lens

A key focus of this QES is how RJ is implicated in the experiences of fat people who are accessing reproductive healthcare, and the ways in which medical professionals may or may not support their reproductive rights. To reiterate, the core tenets of RJ are the right to have, or not have children, and the right to raise those children in safe and healthy environments, combined with a critical view of institutional and systemic factors that might violate these rights (Ross & Solinger, 2017). In order to incorporate that framework into this QES, I considered how each theme that I developed during the analysis process related back to the participants' reproductive rights in relation to the main tenets of RJ. For example, I

considered: whether or not, and how, medical professionals were a barrier to or facilitator of the primary studies' participants' rights as parents or parents to be; what other contextual or political factors impacted upon or mediated their experiences; and how participants may or may not have practised resistance.

Relativism

O'Reilly and Kiyimba (2015) argue that making explicit the researcher's ontological positioning is a critical first step when carrying out research. Ontology refers to the conceptualisation of reality, namely if and how reality exists in relation to people's multiple and diverse social realities (O'Reilly & Kiyimba, 2015). Clarifying the ontological positioning of a researcher is vital, as their understanding of reality has implications for the epistemological assumptions of the research project (how knowledge can be accessed) (Al-Ababneh, 2020; Carter & Little, 2007; Crotty, 2020; O'Reilly & Kiyimba, 2015). Moreover, those epistemological assumptions inform and provide justification for the subsequent methodology, as well as the validity and rigor of the results, owing to this inherently reflexive practice (Al-Ababneh, 2020; Carter & Little, 2007; Crotty, 2020; O'Reilly & Kiyimba, 2015). With the importance of ontology highlighted, my ontological positioning then is that of relativism. Relativism assumes that there is no reality outside of the socially constructed ones that we as human beings create through our interactions, and the meanings we apply to these interactions (Braun & Clarke, 2022; O'Reilly & Kiyimba, 2015). Even if an external reality did exist, as is suggested by a realist ontological positioning, relativists point out that there is no transparent access to this reality, only representations of reality that are mediated by our experiences and interactions (Braun & Clarke, 2022; O'Reilly & Kiyimba, 2015). One of the most common critiques of relativism is its value/moral-neutrality, or position that considers all value/moral systems to be equal (Braun & Clarke, 2022; Parker, 1998). This

moral and political ambivalence is considered to be a strength by some relativists because it "offers an ever available lever of resistance" with the potential for liberation, not bound to the discovery of 'objective' truths (Edwards et al., 1995, p. 39).

Relativism's potential for resistance is pertinent for this QES, particularly in relation to the use of the RJ framework. Using that framework, I considered how some perceived or asserted realities come to dominate. For example, a relativist may be critical of the ways in which the institution of obstetric medicine is patriarchal in nature (Davison, 2020; Shaw, 2013) and therefore in service of realities and truths that supports gender power imbalance, and the subjugation of intersecting positionalities such as race (Ross & Solinger, 2017). I also do not consider all prospective realities to be morally equal, because morality is socially constructed and "therefore, moral judgements ('a' is good, 'a' is right) receive truth-values only relative to some historically defined system of standards" (Niiniluoto, 1999, p. 227).

Social Constructionism

Relativism's alignment with social constructionism (SC) is important for this study because it is the epistemological standpoint through which I understand the production of knowledge and 'reality'. An anti-essentialist view, SC prioritises explaining the way people describe and make sense of themselves and the world (Burr, 2003; Cerulo, 1997; Gergen, 1985). SC is also interested in contesting taken-for-granted knowledge by locating its production within historical and social interactions, and identifying what "social, moral, political, and economic institutions" both reproduce and benefit from this knowledge (Gergen, 1985, pp. 267-268). For this QES, I argue that the interactions participants from the primary studies had with their medical professionals were mediated by the medicalised constructions of pregnancy and birth in the present day, which then contributed to the construction of their maternal identities. Importantly, a SC epistemology also aligns with RJ

in highlighting intersectional differences in terms of identity, specifically where the social and cultural constructions of women, and consequently mothers, are inherently White (Ross & Solinger, 2017). RJ also critically considers access to parenthood that is achieved through reproductive technologies such as surrogacy, egg and sperm donation, and in vitro fertilisation (IVF), as these are often accompanied by high financial costs and reserved for those who can afford them (Ross & Solinger, 2017).

SC is also concerned with how language is implicated in peoples meaning-making processes, and how language plays an active role in the construction of people's knowledge and understandings through discourses (Braun & Clarke, 2022). While discourse and discourse analysis were not the focus of this review, I would be remiss if I did not acknowledge them briefly. Several of the primary studies in this QES were focused on discourse, language and discursive practices, all of which are inextricably linked to SC (Johnson, 2014; Lupton, 2012; Parker & Pausé, 2018b). From a Foucauldian perspective, discourses and, by proxy, language are historically and culturally bound knowledge and power systems that inform the construction of objects and the positioning of subjects (Gergen, 1994; Holstein & Gubrium, 2012). This Foucauldian perspective also highlights organisations and the professionals within them (such as prisons, academia, government, and hospitals) develop specific language to legitimise their purposes and views of the world, leading to the legitimisation of their actions, and subsequent buy-in from people who interact with those organisations (Gergen, 1994). Biomedical discourses around fatness, pregnancy and birth that are present in medical organisations, intersect with 'good mother' and 'good citizen' discourses, ultimately constructing and positioning fat mothers as unfit, lazy, and immoral, leading some mothers to buy into and believe this judgment of themselves (Parker & Pausé, 2019).

Interpretive Syntheses

Typically research synthesis scholars suggest that honouring the epistemological and methodological positioning of the primary studies by using a complementary synthesis approach is important for mitigating the risk of misinterpretation (Booth et al., 2016; Major & Savin-Baden, 2011). For example, if the primary studies were ethnographic studies, then meta-ethnography is a complementary synthesis approach. While a complementary synthesis approach would create a very rigorous and methodologically consistent review, it limits the opportunity to include a variety of studies and voices, and reduces the scope of the review. Finfgeld-Connett (2014) argues:

> First, reviewers are urged to remember that combining findings from different epistemological perspectives represents a form of triangulation and enhances validity…Second, qualitative findings, regardless of their epistemological origins, constitute evidence-based results that have the potential to add to qualitative systematic reviews. Ignoring selected findings solely due to their epistemological origins seems entirely contrary to the goal of knowledge development and theory generation, especially when the meaning and context of the original findings are preserved. (pp. 348-349)

In line with Finfgeld-Connett (2014) arguments, the primary studies I included in this QES come from a variety of methodologies, from thematic and discursive analyses, phenomenological analyses, and even an autoethnographic study (Appendix D). Jones (2004) also points out that many researchers do not make explicit within journal articles their rationale for a particular methodology; thus, if syntheses were to exclude particular articles based on lack of methodological information, relevant studies could be missed, and unsuitable ones could be included. This was a notable issue during the screening and

inclusion process for this QES. Even though some authors did make their epistemological assumptions explicit, others did not. Thus I was only able to infer where the studies were positioned epistemologically based on their chosen methodology, and locate them across a spectrum of how they framed fat fertility, pregnancy and birth (biomedical, critical obesity, or fat studies) (Appendix D). While I cannot ensure epistemological or methodological congruence across all studies included in this QES (outside of the fact that they are all qualitative studies), each study does centre its participants' experiences and understandings as the focal point.

Suri (2014) has noted the potential restrictions that primary study congruence might have on systemic reviews, and developed the methodologically inclusive research synthesis (MIRS) framework that aims to provide flexibility in synthesis methodologies. Systematic reviews can orientate to either postpositivist, interpretive, participatory, or critical paradigms, whereas interpretive-orientated synthesis constructs more holistic and rich understandings about phenomena through the subjective experiences of the participants (Suri, 2014). Interpretive syntheses include meta-ethnography, meta-analysis of qualitative research, meta-synthesis, framework synthesis, and thematic synthesis (Suri, 2014). Suri (2014) suggests that what connects these slightly different interpretive synthesis styles is the common understanding that the world is socially constructed in relation to how people make sense of events, with the intention of fostering understanding in a world of subjective difference. In the process of trying to attend to subjective differences across participants and primary studies as a whole, interpretive synthesists also have to acknowledge that their own interpretations are not value-free, but inextricably linked to their own constructions and meaning-making processes (Suri, 2014).

Thematic Synthesis

Thematic synthesis (TS) is a relatively new method for synthesising qualitative research, and draws on a number of elements from primary research methods, including those of grounded theory, meta-ethnography, and thematic analysis (TA) (Barnett-Page & Thomas, 2009; Cruzes & Dybå, 2011; Thomas & Harden, 2008). TS is concerned with identifying consistent themes across primary qualitative research, and then abstracting higher, more analytical themes in order to answer questions about health interventions and effectiveness (Barnett-Page & Thomas, 2009; Cruzes & Dybå, 2011; Thomas & Harden, 2008). TS's alignment with grounded theory and meta-ethnography is based on the way in which the developing themes are combined, compared and contrasted throughout the synthesis process (Cruzes & Dybå, 2011), while its alignment with TA is linked to how synthesists applying the principles of TA for systematic reviews (Thomas & Harden, 2008).

TA is useful for informing TS because it is methodologically flexible and can be used with a range of qualitative research methods (Thomas & Harden, 2008). Importantly for the epistemological underpinnings of this QES, Cruzes and Dybå (2011) argue that TA can align with constructionist methods, but its interpretive power is limited if it is not used in conjunction with a theoretical framework. This limitation is also noted in TS, where results are at risk of being more descriptive than analytical (Flemming & Noyes, 2021). The potential for producing surface-level analysis with TS reinforced the importance of incorporating the RJ framework into this QES in order to develop rich interpretations of the primary studies.

During the analysis process, I noticed that some of the studies felt mismatched, or that there was a discrepancy between what the authors were trying to achieve and how they

delivered their findings. These studies were using qualitative methods, but the articles contained some elements that appeared to be more quantitative in nature, such as including a breakdown of participants' BMIs, or noting how many participants did/did not exceed the recommended gestational weight gain (GWG). Some of these 'mismatched' studies also used biomedical language and perpetuated more negative ideas about fat pregnancy. I raised this 'noticing' with my supervisor, and she suggested that I read about 'big Q' and 'small q' qualitative research as popularised by Braun and Clarke (2022) in relation to their style of reflexive TA. The 'big Q/small q' distinction describes this 'mismatch' perfectly, where "Big Q qualitative uses qualitative tools and techniques within a qualitative paradigm. Small q qualitative uses these techniques within a quantitative paradigm" (Braun & Clarke, 2022, p. 7). Several elements of reflexive TA align well with the overall orientation of this TS style QES. Firstly reflexive TA encourages the use of Big Q qualitative epistemology to explore meaning within context, without the expectation of finding an objective truth (Braun & Clarke, 2022), which aligns closely with my relativist, social constructionism positioning. Secondly, reflexive TA holds that the researchers cannot isolate themselves from the research, nor the participants, as the research is a sense-making exercise (Braun & Clarke, 2022). A researchers inability to isolate themselves from their research resonated with me while carrying out this TS. I could not be totally objective during the synthesis process, as I bought my own understandings and positionality into my interpretations of the primary researchers interpretations. Finally, at the heart of reflexive TA is the reflexivity itself and writing from a first person perspective for research quality and rigour (Braun & Clarke, 2022). Given these similarities with TS, it was essential for me to be as reflexive as possible throughout the research process, by being upfront about my positionality, acknowledging areas of potential bias, and continually noting my thought processes throughout this QES.

As mentioned, TS is the most suitable analysis approach in terms of time constraints, my abilities as a novice researcher, its flexibility as a synthesis method, and its overall coherence with my own ontological and epistemological assumption, despite its potential limitations (Flemming & Noyes, 2021). I attempted to mitigate the potential limitations of this method, including the risk of surface-level description (versus analysis), through the use of the RJ framework, particularly during the analytical theme development stage of the synthesis. Using the RJ framework provides a filter through which I could extract deeper and more critical themes from the coding and descriptive theme processes.

Synthesis Methods

Criteria for Considering Studies for this Review

As with any research project, it is important to develop a research question for QES to guide the process and determine the parameters of the review (Flemming & Noyes, 2021). Table 1 below outlines the research question, using the PerSPE(C)TiF question formulation structure (Booth et al., 2019; Flemming & Noyes, 2021). The PerSPE(C)TiF question formulation structure was chosen for this QES because, unlike other commonly used QES questions structures (such as SPIDER or PICO), it includes the considerations of context and time/timing (Booth et al., 2019). QES are mostly used to systematically explore a particular health intervention. Booth et al. (2019, p. 1) suggest using the PerSPE(C)TiF question formulation when exploring interventions from a "systems perspective" to encompass organisational culture within a review. I argue that this idea of 'organisational culture' is akin to the commonness of the fat stigma that is evident in healthcare interactions (Pausé, 2017). This expansion of QES question structuring is important to this QES in particular, because healthcare interactions in relation to fat fertility and perinatal care are not limited to a single

time and space, but rather may span multiple environments and interactions across an extended period of time, all with potentially political (RJ) implications.

Table 1

PerSPE(C)TiF Research Question Development Tool

PerSPE(C)TiF Term	**Scoping Review Definition**
Perspective	From the perspective of fat people who are seeking or receiving fertility or perinatal healthcare from medical professionals.
Setting	Studies will reflect experiences of reproductive healthcare in such places as fertility clinics, doctors' clinics, midwife appointments, hospitals, radiography clinics.
Phenomenon/Problem	What are fat mothers' experiences with medical professionals during fertility and perinatal care interactions, and what impacts do these interactions with medical professionals have on the maternal identity development of fat people?
Environment	Within an environment of widely medicalised pregnancy and birth and political tensions surrounding reproductive justice issues.
(C) Compare	Optional comparison not applicable.
Time/timing	Included studies will have participants who have sought fertility assistance to become pregnant, through to one year postpartum (perinatal period).
Findings	In relation to fat mothers' experiences and interactions with their relevant medical professionals and how those experiences impact upon their maternal identity development. Relevant to strengthening existing research and supports reproductive justice and fat activism goals.

Note. Source: (Booth et al., 2019)

There is no best practice technique when it comes to performing systematic searches of the literature (Flemming & Noyes, 2021). One of the most popular however, is "building blocks", often used by researchers who are using the PICO question structure for their reviews (Booth, 2008, p. 314). The process of building blocks involves breaking the research question down into sections, creating lists of keywords that reflect each section, combing these sections and keywords using Boolean operators, and then adding in methodological information (Booth, 2008). Adapting the building blocks technique for this project, I derived the keywords from the PerSPE(C)TiF question formulation structure as described above in Table 1, and have outlined the specific keywords in Appendix A. I used Boolean operators 'OR' and 'AND' on each database to allow for multiple combinations of the search terms, in order to maximise the results of the searches.

I chose to narrow my search to published journal articles available in English only. I acknowledge that not including grey literature, published books, and studies in multiple languages risks missing important data and stories (particularly from a RJ perspective), but owing to the scope, time and financial constraints of a thesis project, I decided to limit my search accordingly.

Initially I identified eight databases as potential sources for finding appropriate qualitative primary studies for this QES. These were PSYCInfo, Scopus, Web of Science, EBSCOHost, Sociological Abstracts, Index New Zealand, PubMed, CINAHL, and Medline, and were all available to me through Massey University's library. In consultation with my supervisor and a Massey University subject librarian, the database selection was refined to include only PsychInfo, Scopus, Web of Science, CINAHL, and Medline. This selection of

databases is in line with current QES database selections (Booth, 2016) and accounts for how databases, such as PubMed and Medline, yield the same results.

The search of the five databases was carried out over the course of three days, from 30 June, 2022 to 2 July, 2022. A total of 1,528 articles were returned across the five databases. Searching for qualitative primary studies is difficult because, variously, they make up a small percentage of overall studies on the databases in comparison to quantitative studies, they may be improperly indexed, and their titles are not always descriptive (Booth, 2016). I searched each database individually to avoid search engine errors. As the systematic search progressed, I noted that a number of articles were showing up across several databases, which gave me confidence that my search strategy was capturing articles that reflected the research question.

Initially, I had set out to locate articles for the QES that reflected the experiences of fat mothers and their interactions with medical professionals during fertility and perinatal healthcare. However, these preliminary searches returned between zero and two results – not enough for a QES. I expanded the search terms to also include biomedical language such as 'obese' and 'obesity'. I also removed 'mother' because while this search term is significant to part of the research question, it is not the whole aim of the QES. This approach yielded hundreds of results across several databases, so I chose to alter the final search terms to reflect this change (Appendix A). While using biomedical search terms such as 'obese' and 'obesity' in a project that is focused on supporting fat activism felt counter intuitive, I believe it also highlighted several issues moving forward. Firstly, it reinforced that there is great opportunity for more research related to fat pregnancy experiences to be carried out with a critical view, such as the works of George Parker, Cat Pausé, Jade Le Grice, and Deborah

McPhail. Additionally, it highlighted that there is potentially a lack of research regarding how these medical interactions impact upon maternal identity development, which supports the need for more research in this area. Finally, at an operational level, a lack of results in the initial search may have been attributable to keyword and indexing decisions by both authors and databases (Booth, 2016). Owing to my previous readings of the research related to fat pregnancy and stigma in healthcare settings, there were several articles that I had expected to show up that did not; thus, I needed to perform a supplementary search. It is essential moving forward that databases expand their indexing to include more critical approaches, or that a wider range of journals themselves accept and publish more qualitative and critical research.

As the search of the databases was conducted, references for each study were downloaded into EndNote 20. I then exported the references from EndNote 20 into an Excel spreadsheet. The spreadsheet was set up to include the article reference information, titles, abstracts and publishing journal for each search result. I created a new tab for each database on the spreadsheet to keep a record of what results were returned from each data base. At the completion of the searches, there were 1,528 results returned across the five databases. A total of 213 duplicate studies and were removed in EndNote 20, leaving 1,315 articles to be screened. The remaining 1,315 article references were then imported into a new 'combined' tab on the spreadsheet so I could screen the articles altogether.

During the initial screening, I used the articles titles and abstracts to determine if the studies met the inclusion or exclusion criteria (Appendix B) or were related to the research question. I gave each article a 'YES' (24), 'MAYBE' (82) or 'NO' (1,209) designation based on this information. The main reasons for rejecting articles outright were: 1. the content of the title and abstract was unrelated to the research question; or 2. the study was not a primary

qualitative study. Articles were given a 'YES' or 'MAYBE' designation if they appeared to contain at least some of the elements of the research question, but I required more information in order to confirm that status.

I read the initial 24 'YES' articles in full, and determined that nine either did not meet the inclusion criteria or match the RQ criteria. Some were also rejected because they were concerned with people's experiences with weight management programmes and interventions during pregnancy. This focus on weight management is in conflict with the aim of supporting fat activism in this QES, as such interventions are inherently anti-fat, and therefore problematise fat pregnancy. In addition, the focus on weight management interventions also meant that the participants in those studies were not sharing their direct experiences with medical professionals per se, but rather focused on the their experience of the particular intervention or programme.

Ultimately, all but four of the 82 initial 'MAYBE' articles were rejected because, upon further investigation, either the data in the studies were not from the perspective of fat mothers, or the studies did not have enough information regarding the participants' interactions with medical professionals (only 1-2 examples or direct quotes from participants about their interactions with medical professionals). Similarly, many studies were also based on the experiences of a weight management intervention.

I noticed that some key articles that I thought would turn up in my database searches did not. I knew that these articles existed as I had read them at that point. For this reason, I searched topic specific journals as a supplementary search strategy (Booth, 2016). Qualitative primary studies that explored the experiences of fat pregnant people (such as ones in the

literature review above) were relatively few in number, owing to the relative recency of academic research related to fat peoples' experiences of reproductive healthcare. Even with the use of appropriate research strategies, the main databases did not capture those articles, likely due to keyword and indexing choices for these as critical studies. The topic-specific journals that I searched were *Fat Studies*, and *Feminism & Psychology*.

I searched *Fat Studies* and *Feminism & Psychology* on July 19, using an abbreviated version of the Boolean operator terms as outlined in Appendix C, and based on the content of each journal. It was necessary to reduce the search terms because the journal search engines were not equipped to manage a large number of search terms at once. The *Fat Studies* supplementary search returned 21 results of which three met the inclusion criteria, while the *Feminism & Psychology* search returned five results of which one met the inclusion criteria.

There were several occasions where the decision to include particular studies was initially unclear, so I will highlight my decisions and rationale here. Firstly, several studies used the same participant pool (see Parker & Pausé, 2018a, 2018b, 2019, and Bombak et al., 2016, McPhail et al., 2016), which may be considered an issue for QES as it may create duplicate data from the same participants across multiple studies. However, I chose to treat each article as a separate study for the purposes of this QES where the researchers either employed a different methodology or were asking different questions of the data. This alteration of methodology or research question is important, because different secondary interpretations of the same primary data will produce different third-order interpretations, so that each study provides unique insights about the phenomena.

Secondly, I deliberated over the inclusion in the QES of Shaw & Feheko (2022) and Sim et al. (2020) in the QES. Both articles were important as they discuss fertility treatment

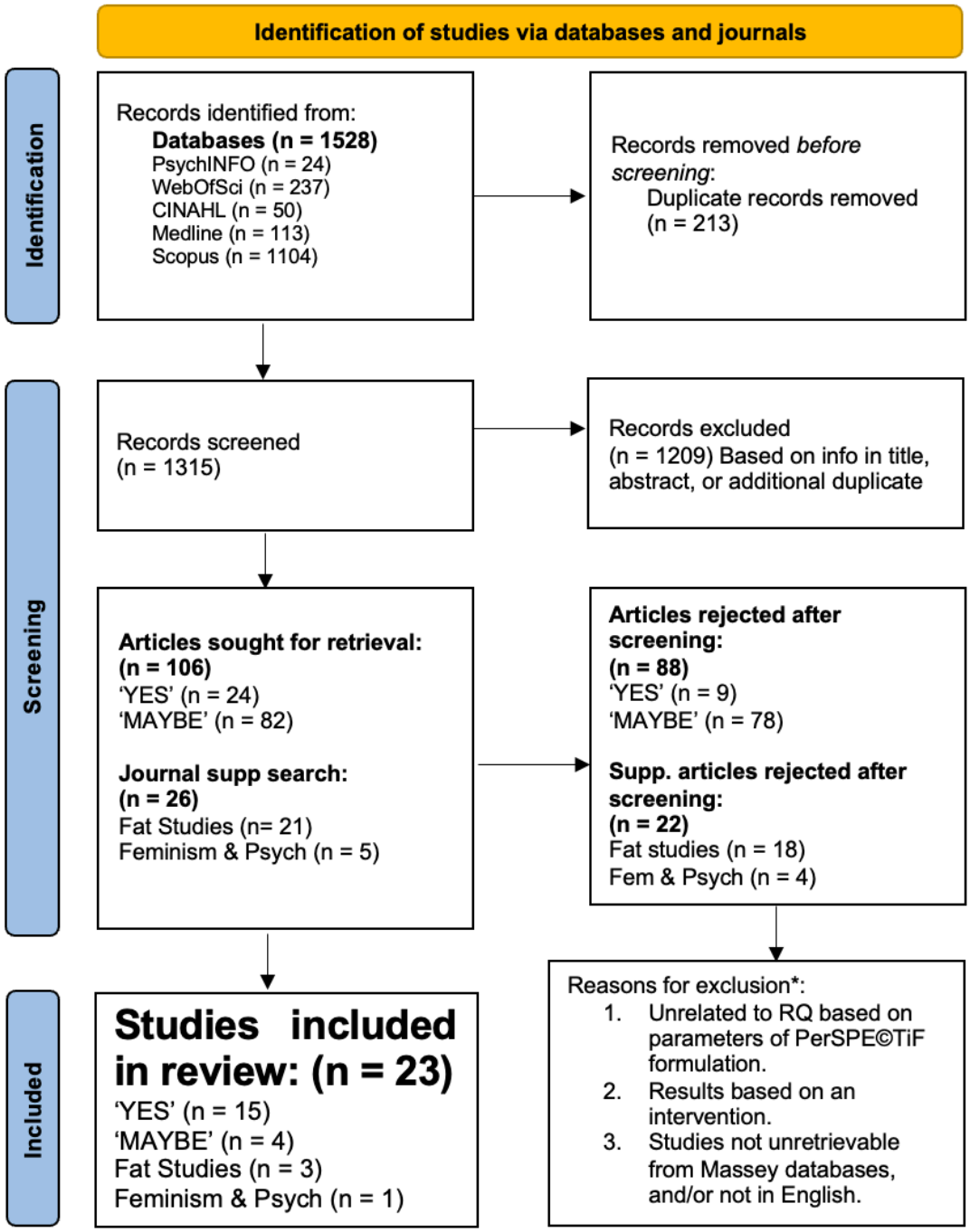
(Shaw & Feheko, 2022), and breastfeeding experiences (Sim et al., 2020) from the stand point of marginalised people. I questioned the inclusion of Shaw & Feheko (2022) because three out of the nine participants were not seeking fertility care at the time of the interview, but had done so in recent years. I questioned the inclusion of Sim et al. (2020) because there were only four clear examples of interactions with medical professionals across the article. Ultimately I decided to include both articles in the QES because they concentrated on areas of the mothering journey outside of pregnancy and birth. These articles also encompassed important stories and experiences relating to intersectionality which were valuable to discussing fat reproductive care experiences through a RJ framework.

Finally, Lee (2020) included a section in her autoethnographic study about mothering a toddler. This inclusion of Lee's experience beyond one year postpartum posed an issue because I had set the time limitations on the PerSPE(C)TiF question tool and search framework for up to one year postpartum. Because Lee's (2020) autoethnography was mainly centred around her fertility search, pregnancy, birth and immediate postpartum experience, I decided to include the study, but was careful not to include in the analysis the material on mothering a toddler, in order to maintain the parameters of the research question. It was important to include Lee's work because research grounded in fat studies was outnumbered by more biomedically-based studies in this QES. Including Lee's study was important for supporting fat activism and research, as well as supporting the "nothing about us, without us" stance of Manokaran et al. (2021, p. 544).

The database and supplementary searches along with subsequent screenings resulted in 23 final articles suitable for synthesis and interpretation. An outline of the systematic search and screening process is summarised in the PRISMA diagram below (Figure 2).

Figure 2

PRISMA Diagram of QES Systematic Search and Screening Process



Note. Source: (Page et al., 2021)

*The rationale for each screening decision is noted on an Excel spreadsheet.

*Some studies met more than one exclusion criteria.

Sampling

Purposeful sampling of primary studies is suggested for QES that focus on the interpretation of phenomena (Ames et al., 2019; Benoot et al., 2016; Suri, 2011). Given that a total of 23 studies met the inclusion criteria after a thorough screening process, it was unnecessary to sample the articles any further, so I used a comprehensive sampling strategy by default.

Assessing Methodological Limitations of Included Studies

A critical assessment of the primary data was completed using the Critical Appraisal Skills Programme (2018) CASP qualitative studies checklist (Appendix E). Using a critical appraisal tool in a QES is a common but somewhat contentious practice (Garside, 2014; Thomas & Harden, 2008) and examining studies for their methodological soundness lends itself to quantitative analysis practices. CASP is often used as a sampling tool to ensure that studies included in the review are methodologically sound, therefore making the results of the QES more 'reliable' (Garside, 2014; Long et al., 2020). However, it is difficult to gain full insight into a researcher's methodological decision-making process when researchers are typically confined to small word limits by journal publishers. It is understandable that qualitative researchers would sooner allocate more of their word count to data and discussion, as opposed to discussing their epistemological and methodological standpoints and rationales. Another obvious limitation of this particular CASP is that I was completing the appraisals without the assistance of a group of co-researchers, as is most common for a QES project. Even without co-researchers, I would argue that by conducting this QES from a relativist-social constructionist epistemology, and the subsequent assumption that there is no single truth that we can access outside of our socially constructed ones, inter-rater reliability with regards to apprising the studies is somewhat inappropriate. With these limitations in mind, I did not use the CASP tool for sampling purposes in this QES, but rather I used it to help me

to further engage with each of the primary studies as part of the "immersion" process (Cruzes & Dybå, 2011, p. 276). It was also a helpful exercise in the event that I carry out other research syntheses in the future.

Approach to Synthesising Data

Choice of Synthesis Methods

As outlined in the **Ontology, Epistemology, Theory, and Methodology** section of this review, I determined that an interpretive approach was most appropriate for this QES, and settled on using TS for the analysis. While I was confident in the decision to use TS, as a litmus test, I also used the RETREAT framework (Appendix F) that Cochrane suggest using to support the selection of the most appropriate methodology for a QES (Noyes et al., 2019).

Thematic Synthesis

I printed and read the final 23 studies in full to familiarise myself with the studies again. While reading, I manually highlighted and made notes in the margins about any themes or ideas that I began to develop, particularly in relation to the tenets of RJ. This process is called 'immersion', and it is an important step in thematic synthesis to ensure that the synthesist has a grasp on the scope of evidence before starting to extract the data (Cruzes & Dybå, 2011). I then imported the PDFs of each included study into NVivo20. For the analysis itself, I was guided by the thematic synthesis approach to analysis as outlined by Thomas and Harden (2008), working through their three stages of thematic synthesis, with supporting guidance from Cruzes and Dybå (2011). Stages one and two are focused on creating initial codes of the text and then developing more descriptive themes from the codes (Thomas & Harden, 2008). Stage three is where thematic synthesis really takes place and separates itself from primary research. Stage three is concerned with combining the stage two

themes into third order or analytical themes to produce new understandings of the phenomena (Thomas & Harden, 2008).

As Thomas and Harden (2008) suggest, the 'data' considered for analysis included any text in the primary studies that was labelled under the headings 'Findings' or 'Results'. That material included both direct quotes from the primary studies' participants, as well as the authors' comments and reflections. Including the authors' commentary within the findings and results sections was important because it aligns with the third order interpretative purpose of TS. For the purposes of coding the data, Thomas and Harden (2008) suggest free line-by-line coding of the text to ensure translation of concepts across the included studies. However, I opted for a more "segment of texts" approach to coding data that "involves identifying one or more passages in the text that exemplify the same theoretical or descriptive idea" (Cruzes & Dybå, 2011, p. 278). Owing to time constraints and working independently on this project, using a segment approach was helpful in trying to limit the volume of initial codes across the 23 studies, and having more contextual information in each code supported the development of descriptive themes in stage two. Even so, I still ended up with 659 initial codes across the 23 studies, so I feel confident that Thomas and Harden's (2008) translation of concepts across studies was attended too, while also accepting that this may be a result of being a beginner to research coding.

After the initial coding process was complete, I reviewed the codes and segments, rechecking their context as necessary. I then began to group codes together in NVivo20 that were related thematically, while also taking time to consider these codes through the lens of RJ. I created new codes or subthemes for these groupings that represented the meaning of the subtheme as a whole (Thomas & Harden, 2008). Developing descriptive themes is the start of

becoming further removed from the primary studies, where themes become more abstract and generalised (Cruzes & Dybå, 2011). Descriptive theme development does not happen sequentially; rather, there is a reiterative process of revisiting themes, renaming them, and even moving initial codes into a different descriptive group (Cruzes & Dybå, 2011). This process was perhaps the most time-consuming part of analysis for me. There were many instances where I had felt confident with an initial descriptive theme assignment; then, as I worked through subsequent initial codes on NVivo20, while reflecting on my research questions and the RJ framework, I realised that some codes needed to be moved to different or entirely new descriptive theme groupings.

Developing analytical themes is where a QES moves as far as possible away from the primary studies, where the synthesis occurs to answer the research questions or synthesis objectives (Cruzes & Dybå, 2011; Thomas & Harden, 2008). Earlier in this chapter I reflected on the initial challenge I had around understanding what it meant to reinterpret others' interpretations of yet someone else's experience. This stage of TS is exactly where that third-order interpretive process takes place, but its practice remains no less controversial due to the reliance on the synthesists perceptions and interpretations (Thomas & Harden, 2008). To mitigate this potential controversy and support the development of analytical themes, I continually used RJ as a reference point (Cruzes & Dybå, 2011). For example, when descriptive themes from stage two pertained to participants' interactions and experiences with reproductive healthcare professionals, I asked myself if these interactions were conducive to their reproductive rights; similarly, when considering maternal identity development, I asked myself if mothers were being supported or alienated in their parenting experiences. This practice of referring to a theoretical framework facilitated my

interpretations to remain internally coherent, and also produced more cohesive findings in relation to the research questions and objective of the synthesis (Cruzes & Dybå, 2011).

Assessment of Confidence in the Review Findings

Typically, a QES that is guided by the Cochrane Qualitative and Implementation Methods Group's work would include an **Assessment of Confidence in the Review Findings** (Noyes et al., 2018). Assessing the confidence of findings is considered important, particularly for reviews that are conducted to assess the effectiveness of health interventions so that policy makers can make informed decisions about the practicability of an intervention (Lewin et al., 2015). Cochrane Group recommend using a GRADE-CERQual approach which aims to assess "the methodological limitations of the qualitative studies contributing to a review finding, the relevance to the review question of the studies contributing to a review finding, the coherence of the review finding, and the adequacy of data supporting a review finding" (Lewin et al., 2015, p. 1; Noyes et al., 2018). Despite this recommendation of the Cochrane group, I chose not to complete a GRADE-CERQual for this QES. Firstly, this QES was not completed to assess the effectiveness of a health intervention. Secondly, the outcome of the above CASP checklist has an influence of the GRADE-CERQual assessment and as I completed it independently, and not for its intended purpose of sampling, the methodological limitations section of the GRADE-CERQual may be 'invalid'. Finally, this QES is a reflection of my interpretations of primary studies, as guided by a relativist-social constructionist epistemology. Trying to make claims about the validity or truth of my interpretive findings is at odds with relativist assumptions about the existence of multiple truths, and the social construction of knowledge creation.

Chapter 3 Summary

In this chapter I have provided a methodology section that attends to the structure and layout of a Cochrane inspired QES, as well as discussing the more abstract methodological considerations that ultimately supported my choice of a synthesis method. I first outlined the objective of the QES and then reiterated the tenets of the RJ framework to support the theoretical underpinning of this research. I then discussed my relativist-social constructionist positioning in relation to the nature and creation of reality and knowledge, followed by a discussion of how these informed my chosen interpretive synthesis approach. I then outlined what thematic synthesis is, why I chose it for the analysis, and how I applied its working stages to this QES. Despite GRADE-CERQual being a common aspect of Cochrane inspired QES's, I did not include a confidence of review finding assessment because the present QES is not synthesising studies that are concerned with interventions for the purposes of health efficacy reviews.

Chapter 4: Findings

In this chapter I describe the characteristics of the studies included in this QES, followed by a presentation of the findings. The findings of this QES are presented and organised into four over-arching themes: **Navigating Fat Fertility, Pregnancy and Birth, Mothering and Maternal Identity, Intersectionality, and Material, and Social Constraint**, and **What Participants Want**. Each theme and subtheme are supported by quotes from the participants and authors of the primary studies. While developing these themes, I reflected on the core tenets of RJ, as well as the implications of power relations and intersectionality that affected the course of reproductive healthcare experiences, and the subsequent development of maternal identity for the participants in the primary studies.

Table 2

Included Studies and Corresponding Identification Number for Synthesis

1	(Atkinson & McNamara, 2017)
2	(Bombak et al., 2016)
3	(Dejoy et al., 2016)
4	(Dieterich et al., 2022)
5	(Furber & McGowan, 2011)
6	(Hurst et al., 2021)
7	(Jarvie, 2017)
8	(Keely et al., 2011)
9	(Keenan & Stapleton, 2010)
10	(Knight-Agarwal et al., 2016)
11	(LaMarre et al., 2020)
12	(Lee, 2020)
13	(Lindhardt et al., 2013)
14	(McPhail et al., 2016)
15	(Mills et al., 2013)
16	(Nyman et al., 2010)
17	(Parker & Pausé, 2018a)
18	(Parker & Pausé, 2018b)
19	(Parker & Pausé, 2019)
20	(Shaw & Fehoko, 2022)
21	(Sim et al., 2020)
22	(Stengel et al., 2012)
23	(Thorbjornsdottir et al., 2020)

Description of Included Papers

As outlined in the PRISMA diagram above (Figure 2) a total of 1,528 articles were screened based on the PerSPE(C)TiF tool (Table 1), resulting in 23 articles being included in this QES. The characteristics of these 23 selected studies are presented in Appendix D. The studies have each been assigned a number to reduce the amount of in-text referencing for ease of reading. The number assignments and corresponding references can be found in both Table 2 and Appendix D.

The studies were published between the years 2010 and 2022. Most studies were from Aotearoa New Zealand (17, 18, 19, 20), the US (3, 4, 6, 22), and Canada (2, 11, 14, 21), each making up around 17.4 percent of the total studies. Studies from Australia (10, 12, 15), and England (5, 7, 9) each made up around 13.0 percent of total studies, while studies from the Republic of Ireland (1), Scotland (8), Denmark (13), and Sweden (16), and Norway (23) made up around 4.3 percent of the total studies each.

Every study in the sample employed the use of some variation of interview as their data collection method, with the exception of one autoethnographic study that used journaling (both written and audio-recorded), photography and critical essay writing as data collection methods (12). A semi-structured interview approach (1, 2, 3, 4, 5, 6, 8, 10, 11, 13, 14, 17, 18, 19, 21, 22, 23) was the most commonly described approach to interviewing; other interview approaches included in-depth narrative (7), longitudinal (9), phenomenological interview (16), in-depth (20), and a schedule facilitated interview (15).

The types of medical professional that the participants had interactions with included midwives, nurses, doctors (including obstetricians, paediatricians, gynaecologists,

anaesthesiologists, consultants, general practitioners, student doctors, endocrinologists, diabetes specialists, and fertility specialists), healthcare aides, ultrasound technicians or radiographers, lactation consultants, dieticians, and/or diabetes educators. At times, these types of medical professionals were referred to collectively in several studies as 'healthcare professionals' which made it difficult to ascertain the capacity in which the medical professional may have interacted with the participants in the primary studies. In addition, participants in the primary studies also referred to interactions they had with ancillary staff at hospitals and clinics such as receptionists or food service staff, but these staff members were not considered 'medical professionals'.

Theme One: Navigating Fat Fertility, Pregnancy, and Birth

This theme addresses the research question around fat people's experiences of reproductive healthcare, and their subsequent interactions with medical professionals. It is broken down into three subthemes: *Constructing and Caring for the Fat Maternal Body, Negative Experiences of Medicalised Reproductive Healthcare,* and *Medical Interventions, Surveillance, and Accessing Desired Care*.

Constructing and Caring for Fat Maternal Bodies

Body weight and image were ever-present for participants as they navigated fat fertility, pregnancy, and birth, from both a personal perspective and a reproductive healthcare perspective. Participants had to contend with how their fat maternal body contrasted with idealistic depictions of slim maternal bodies, and how their weight impacted upon the advice and care they received from medical professionals. The language used by medical professionals, and several of the primary study authors, reflected biomedical understandings of fat pregnancy and reinforced the idea that people who are fat are unfit to reproduce. In

response to being labelled unfit reproducers, participants engaged in a range of activities in an attempt to reduce the risk and manage the appearance of their fat pregnancy bodies.

Participants shared their ideas about what an ideal maternal body was and how it functioned. This ideal maternal body contrasted with the participants experiences of their own maternal bodies, and participants shared how they attempted to manage both the 'unideal' maternal body itself, and the medical interpretations of the fat maternal body. The research outlined in the literature review supports the idea that having a fat maternal body is unfavourable, a risk to children, society, and to the participants themselves. However, several participants stories also revealed constructions of what an ideal (or at least normalised) maternal body should look like (14, 21). As Sim et al. (2020) summarised:

> Throughout the interviews, participants' statements conceptualized an ideal physical maternal body as one that was youthful, clean of drugs (prescription or illegal), and without pre-existing health conditions. (p. 1740)

Breastfeeding was also identified as a marker of an ideal maternal body, as demonstrated by one participant's reflections in Sim et al. (2020):

> You breastfeed your child—that's why your body works, that's the way . . . mother nature works" and "I assume [breastfeeding's] just gonna work . . . that it'll be innate and instinctual and natural. (pp. 1740-1741)

Though fatness is not considered ideal, some participants acknowledged that pregnancy makes it permissible to have a big stomach (16), and physical symptoms of pregnancy such as decreased mobility are the same for most people, regardless of their starting weight (15).

More commonly, participants across the primary studies shared stories that constructed their own bodies in conflict with the 'ideal' maternal body, specifically in relation to the way the body looked, how complicated it was to care for, and how they felt about their bodies (2, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 23). Several participants shared disappointment that their bodies did not look 'traditionally' pregnant, if pregnant at all, and compared themselves to other pregnant people who had round baby bumps and little excess flesh (5, 12, 15, 19). Lee (12) highlighted how her body did not look visibly pregnancy as is expected in ideal images of pregnancy:

> Despite my weight gain, no one knew I was pregnant until about the eighth month, unless I told them. As a fat woman, I didn't develop that traditionally seen pregnant stomach silhouette. I still had a "double" stomach, it never became one big round shape... Some of the joy, in my case, of waiting for a new person, was dampened by this expectation I had of looking identifiably pregnant in the traditional sense (Lee, 2020, p. 6)

Many participants also had the 'high-risk' nature of their bodies reiterated to them, mainly through interactions with medical professionals (2, 3, 5, 14, 18, 19), but other participants were made aware outside of the context of healthcare at work or through media (7, 8). Louise (7) expressed concern about how people might have perceived her given a television programme she had seen:

> Well it come across to me that all people who have gestational diabetes are overweight…There were all these bigger women on there and it came across to me like you shouldn't be fat and having a baby because you've got the risk of diabetes…I had started telling people that I had got gestational diabetes and then I was thinkin', 'Oh my God', if they'd seen the programme then they would probably think I was like

> that…like eating crap and …then they'd sort of put me in the same sort of category as the people on that. (Jarvie, 2017, p. 83)

For some participants, having a fat pregnant body was embarrassing and not something they were proud of (15, 16, 19). It impacted upon their mental health in terms of stress and self-image (21,23).

While it may seem counter intuitive given the implication of participants weight in reproductive healthcare interactions, it was common for weight to not be discussed with some participants (1, 4, 6, 8, 9, 10, 12, 13, 14, 15, 22, 23). The lack of weight discussions was appreciated by some participants (1, 4, 23) because they had already worked hard on losing weight (1) or they felt that medical professionals prioritised other aspects of their care such as support with breastfeeding (4) or providing a holistic preview of birth (23). Two participants shared that their weight was not discussed during their initial interactions with medical professionals and were only made aware of an issue when they received news of a consultant or specialist appointment booking (8, 13) or the receptionist in the antenatal clinic highlighted their overweight/high-risk status (15). Other participants had expected that their weight would be discussed with them, but it ultimately was not (6, 9), with one participant anticipating that their weight would impact upon care options (6). When weight very clearly impacted upon care options, one medical professional was still unwilling to discuss it with the participant, as Lee (2020) related:

> The first obstetrician looked at me when I was seven weeks pregnant, and without examining me, discussing my medical history, or asking about my birth preferences, announced, "You'll be having a C-section." When I asked her if this was because of being fat, she said "You're obsessed with the fat issue, not me. I've been on every diet

> in the book, I can't talk." I never got an answer about why she pronounced that because I refused, in tears, to return to her. (p. 7)

Several participants in Keenan and Stapleton (2010) suspected that medical professionals avoided discussing weight because it was an uncomfortable topic (1, 8, 10). Another participant, Liz (1), suggested that participants were complicit in avoiding weight discussions as well, suggesting that both medical professionals and participants 'pussy footed' around the topic of weight. The suggestion that weight is uncomfortable to discuss was reiterated by participants across several studies who acknowledged that weight was a sensitive topic to discuss (1, 5, 9, 10, 15, 16, 23). There was also an acknowledgement that fat people are highly aware of their own body composition, and do not need to be informed about it by medical professionals about it (1, 23). Some participants suggested that conversations about weight might make people feel badly about themselves (1, 9, 23) but others acknowledged that they would rather have all the information about potential risks associated with being overweight and pregnant, provided the information was shared in a sensitive and truthful way (5, 15). One participant in Thorbjornsdottir et al. (2020) did not have the opportunity for a respectful discussion:

> One participant (i6), for example, experienced her weight as very private, and described an instance in which healthcare professionals discussed her weight in front of her partner—as though this was a subject she freely spoke about with her partner, which it was not. She experienced this as hurtful, and she felt shamed and humiliated; moreover, she found that the preconceptions and constant scrutiny experienced during this vulnerable period gave rise to feelings that had previously lain dormant. (p. 4)

Having such a strong emotional response to this experience reinforced that weight is a sensitive topic for people, and that such interactions can be profoundly negative. In one

case weight loss advice was so unhelpful to a participant that it led them to eat more (16).

Receiving advice that was confusing, vague, or contradictory was another common experience for participants across multiple studies (1, 6, 8, 9, 10, 11, 12, 13, 14, 15, 20, 21, 22). The most common way that contradictory advice was received was through different medical professionals providing different information about how much weight should be gained during pregnancy (6, 10, 12, 13, 22). For example, some participants were told to gain 15 pounds while others in the same study were told to gain between 0 and 20 pounds (6); in yet another study a midwife suggested a GWG of 7-9 kilograms, but the GP suggested 6 kilograms (13). Lee (12) gained 13 kilograms, which was within recommended guidelines, but was then told by an obstetrician in hindsight that it should have only been 5-9 kilograms. When accessing publicly funded IVF treatment for the first time, one participant, Malu, was told by a fertility specialist that she needed to have a certain BMI before treatment could commence, but Malu did not know what BMI was, or that it was a barrier to beginning treatment (20). As most publicly funded IVF pathways in Aotearoa New Zealand require a GP referral in the first instance, it is interesting to consider the possibility that a GP did not provide this information and advice to Malu around BMI requirements for IVF before making the referral. Other participants were told to lose or not gain weight but were given no further information from medical professionals about how to do so safely from both a dieting and exercise perspective (1, 9, 11, 15, 22) as Danielle (9) reflected:

> Everyone's very keen for you to lose weight but no one actually sort of says this is the best way for you to do it, or shall we monitor you, shall we help you and stuff (Keenan & Stapleton, 2010, p. 376).

Conflicting advice was also given in relation to breastfeeding where nurses gave differing advice about breastfeeding positions to participants, even after participants had adjusted positions to work with their bodies (13, 21)

To manage the shame of having a problematic maternal body and in many cases not receiving concrete information from medical professionals, participants shared stories of engaging in knowledge seeking (1, 5, 6, 8, 9, 10, 12, 22, 23) and/or the management of the fat pregnant body (2, 5, 10, 11, 12, 14, 15, 17, 18, 19, 20) in an attempt to access fertility treatment and mitigate their 'riskiness' (or at least try to understand it). The 'riskiness' here is associated with managing the body for pregnancy, or reducing the risk of complication for the participant.

Participants sought knowledge about weight management or GWG (1, 6, 10, 22), foetal development (5), gestational diabetes mellitus (GDM) (8), birth options (12), and medical risks associated with pregnancy and childbirth as a 'fat' person (8, 12, 23). The internet was the most common way that participants accessed this information. Some participants appreciated having the option of finding information online (1, 10, 21), but others found the results to be disheartening, scary, or anxiety provoking (8, 12, 19, 23).

Managing the fat pregnant body typically involved participants engaging in dieting and exercise in order to lose or maintain weight, or to have a 'healthy' pregnancy (10, 11, 12, 14, 15, 17, 18, 19, 20). Practices ranged from eating 'healthily' (10, 15, 18, 19) and exercising (15, 17, 18, 19) but when trying to access fertility treatment, one participant engaged in starvation dieting and over-exercising (14). Management practices were not limited to physical weight loss or being healthy. One participant in Dejoy et al. (2016) even

managed the heaviness of their clothing and personal care items, even though this had no actual impact on their body mass itself:

> There's a lot of stress during weighing. I'm very careful to wear my lightest clothes. I take off my shoes, even if they're the thinnest flip flops. I even think about how much gel I put in my hair because I'm so afraid of the problem of gaining too much weight. (p. 221)

Another participant also tried to manage their fat pregnant body by attempting to stimulate early labour by consuming castor oil to mitigate the risk of trying to birth an ever-growing baby (5). When the fruits of attempted weight loss and management were not realised physically, participants in Parker and Pausé (2019) experienced a decline in wellbeing, withdrawing socially, and having past eating disorders and self-medicating behaviours triggered.

Just as weight discussions impacted upon participants' views of their bodies, language regarding fatness in relation to fertility, pregnancy and birth varied across the primary studies, and appeared to have a tangible impact on the experiences of many of the participants (1, 2, 6, 7, 9, 15, 20). Participants and their bodies were labelled as 'obese', 'having obesity', 'overweight', 'fat', or 'having raised BMI' by some medical professionals and some authors. In some cases, this variation in language tended to reflect the authors orientation toward a more biomedical, or fat studies approach to research.

Participants described a variety of experiences in relation to how specific labels from medical professionals made them feel about themselves and their bodies. 'Obese' or 'obesity' language use was problematic for many participants, with participants describing it as insulting, awful, haunting, or stigmatising (1, 2, 6, 7). 'BMI' was less abrasive, but

participants commented that it was almost used as a euphemism or buffer to avoid the discomfort that the word 'obese' created, even though these terms are synonymous (1, 15). Conversely, participants in Shaw and Fehoko (2022) could not define BMI but knew it reflected an ideal standard of body and weight loss, and instead referred to themselves as overweight, obese, or morbidly obese. Hilary and Janna in Bombak et al. (2016) describe their experiences of language and the impact it had on them:

> Participants frequently described instances of feeling "wrong" and "disgusting" because of the language used by healthcare practitioners. Hillary, for example, was sent to a specialist because her family doctor suspected that PCOS was at the heart of her infertility. At her appointment, Hillary was told bluntly that her problem was not PCOS, but that she was "fat." She described this word usage as "upsetting." At the most extreme end of insensitive language usage, Janna was told by a physician that "if you don't get that weight off you now, you're going to be a menace to the government. (p. 98)

This insensitivity was not consistent across all studies, but the participants' accounts in Bombak et al. (2016) highlighted the negative connotation of with the word 'fat' that fat activists are trying to disrupt. In a demonstration of sensitivity, the midwives who helped Keenan and Stapleton (2010) with recruiting participants had an awareness that biomedical language such as overweight or obese might be unhelpful for people in their care. Instead, the midwives used "raised BMI" in antenatal settings (Keenan & Stapleton, 2010, p. 375), which may reflect the suspicions from participants that BMI is a neutralising euphemism (1, 15). The biomedical language used by medical professionals had tangible impacts on participants experiences of their own bodies and is a testament to the power of the institution of medicine to determine what is normal or healthy and what is problematic. Again, being positioned as

unhealthy, or in the case of reproductive care, unfit, has an impact upon fat people's right to access the reproductive healthcare and outcomes that they are entitled to.

The variation in language regarding the participants body composition tended to be a reflection the authors orientation toward more biomedical, or fat studies approaches to research. I noticed that this orientation also had an impact on the depth and criticality of these qualitative studies as well (1, 6, 8, 9, 10, 22), which relates back to the Big Q/small q variations of qualitative research as outlined by Braun and Clarke (2022). The clearest example of 'small q' qualitative research was from Hurst et al. (2021) who stated that their aim was to understand the weight bias and stigma that 'obese' women encounter in antenatal care interactions, but proceeded to include interview questions that asked participants about their understanding of how their weight could affect their health, pregnancy and child. This line of questioning explored participants understandings of the biomedical framing of their bodies and not their experiences of bias and stigma. Similarly, Knight-Agarwal et al. (2016) aimed to explore participants experiences of antenatal care, but proceeded to ask questions about their knowledge of weight risk, and appropriate GWG.

While exploring participants understanding of their bodily risk in line with their study aims, some participants in Keely et al. (2011) shared that their embodied experience was that of overall good health despite some previous medical events. Instead of focusing on the participants experience of being in good health, Keely et al. (2011, p. 365) boiled the participants lack of biomedical understanding down to "dissonance between actual state of health and obesity status". Keenan and Stapleton (2010) aimed to explore how biomedical discourse played out in participants interactions with medical professionals; while they critically reflected on their positionality, as is important in qualitative research, doing so was

ironically in relation to their assumed responsibility to inform the participants of the potential health risks associated with high BMI:

> Given the often inequitable nature of power relationships between the researcher and the researched (both interviewers are of average weight or 'normal' BMI), and in the context of a much broader, longitudinal project about food and transitions to motherhood, there were problems elucidating understandings of health risks associated with BMI status, about which participants were not aware. There are both ethical and recruitment/retention issues to consider here in potentially heightening women's anxieties by introducing understandings of elevated health risks. (p. 375)

As these examples suggest, several authors perpetuated biomedical discourse within their research, and subsequently reinforced ideas about fat reproductive bodies that position it as 'unfit' and 'risky'.

Participants' accounts of what the ideal maternal body is, and how they attempted to achieve it for themselves highlights that the appearance of having a traditional, slim pregnant body is often more important than physical health. A fat pregnant body implies the existence of health risks, and so participants had to manipulate their bodies in order to give the impression of a healthy pregnant body, even at the expense of actual wellbeing. Biomedical language was present in discussions about weight, and played an active role in constructing how participants viewed their bodies. Being constructed as an unfit reproducer, or confused about medical professionals' expectations of weight gain, and how weight might be implicated in care trajectories presents an issue for fat people accessing their reproductive rights. Within research as polarising as fat fertility and pregnancy, the opportunity for the development of critical and status-quo-disrupting research is lost when researchers employed a small q qualitative approach to research that perpetuated the use of biomedical language and

negative framings of fat pregnancy. Instead of having emancipatory potential for the participants and other fat people, small q research perpetuated the same biomedical and problematic framings of fat fertility, pregnancy, and birth, constraining fat people's ability to access the reproductive healthcare that they desire.

Negative Experiences of Medicalised Reproductive Healthcare

Negative interactions with medical professionals, and within reproductive healthcare in general, were prevalent experiences for many participants across the majority of primary studies. These negative interactions were not uniform experiences; they were related to a variety of experiences such as medical professionals making assumptions about participants health and behaviour based on their physical bodies, participants' inability to access the care they desired, and equipment and policy that were oppressive to participants. The experiences and interactions produced emotional responses from participants and led many participants to anticipate or avoid interactions with medical professionals for fear of it being a negative experience.

While not a negative experience per se, anticipating and avoiding negative interactions with medical professionals was both an experience and a tactic for participants. Anticipating negative interactions with medical professionals was common (1, 3, 4, 5, 6, 7, 9, 11, 12, 13, 15, 16, 19, 20), and often based on personal prior experience (3, 5, 6, 12, 20), the experiences of people close to a participant (9) or based on information they have read about anti-fat attitudes in healthcare (1,12). Participants anticipated that the interaction would be stigmatising (4, 7, 11) or humiliating (5, 16). This anticipation of negative interactions had led to the outright avoidance of reproductive healthcare for some participants (4, 7, 19, 20), or engaging in care but under a cloud of dread about the type of treatment they would receive

(1, 3, 5, 13). One participant in Dejoy et al. (2016) reflected on temporarily avoiding and anticipating a negative interaction:

> I didn't want to go see this doctor at all. After the second or third appointment where she kept on harping on, "You can't deliver this baby, you're too fat to deliver this baby, you need a repeat c-section," I just didn't want to go. It was upsetting enough that, you know, I didn't attempt to sabotage the appointments, but I would leave the house late, or I would drag my feet getting ready to leave the house because I didn't want to be subjected to another appointment. (p. 221)

Two participants from separate studies (15, 20) appeared to prioritise the potentially negative experience of the medical professional during interactions above their own. Participant Anita (15) shared that she was uncomfortable about her weight during labour but prioritised feeling sorry for the medical professional who had to perform vaginal examinations on her. Mona (20) anticipated shame or embarrassment coming from being given medical advice (that she had heard before) about changing health behaviours to conceive. As a result, Mona self-selected out of trying to access fertility treatments in order to not "waste" the medical professional's time, appearing to prioritise a potential inconvenience for the medical professional above her own desire to conceive:

> In discussing the reasons for their self-assessment, Mona commented that she did not want to waste the fertility specialist's time by getting advice she already knew she would hear about losing weight, stopping smoking, and limiting consumption of certain foods and beverages. Such advice was imparted by friends and internet research. By not hearing this advice from the fertility specialist, it appeared to spare Mona any shame or embarrassment she may have felt or experienced. (Shaw & Fehoko, 2022, p. 7)

Another type of negative interaction with medical professionals related to the way providers made assumptions about the participants' health and behaviour based on the way their body looked (2, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 16, 17, 20, 23). Participants shared that their fat bodies were interpreted by medical professionals as physical evidence of poor health behaviours and therefore health conditions they had such as infertility, polycystic ovarian syndrome (PCOS), GDM, instead of investigating their medical histories more thoroughly (2, 3, 6, 7, 11, 14, 20). For instance, participant Marjorie in McPhail et al. (2016) had:

> been referred to a fertility clinic after surviving cervical cancer. The cancer treatments had resulted in vaginal stenosis, a narrowing of the vagina, as well as irregular periods. Despite this, Marjorie was told from her very first consultation that her high BMI was the culprit: "The first, first thing was weight. And there was no conversation of vaginal stenosis, which was a big issue for me to get pregnant. I brought it up and it was like, just shut down, it was the weight. And I had said "But I had gotten pregnant twice." And it was back to the weight. … So they had said "We can't do anything for you until you lose thirty pounds. You've got till September". (pp. 107-108)

Participants also shared that they felt some interactions with medical professionals were accusatory or that the medical professional used their bodies as evidence of behaviour such as poor diet, or lack of exercise over listening to what the participants told them (3, 7, 12, 13, 16, 17). For instance, a participant in Dejoy et al. (2016) shared that:

> As [my doctor's] reading the food diary . . . which she then told me my husband needed to sign because she felt that I was lying and wasn't providing all of the food that I was eating because there was no way for me to remain at my size eating what I was eating. It

made me uncomfortable, not only as a fat person, but as a woman, to say that your husband needs to sign. (p. 220)

The authors explored how this participant's healthcare provider distrusted their reports to the extent that they had their husband sign off on their food diary. This illustrated the mistrust healthcare providers had for participants' accounts in the face of the 'evidence' they saw in participants' bodies.

While most assumptions about participants behaviours and health were in relation to infertility, PCOS or GDM, some participants also experienced medical professional making assumptions about their ability to breastfeed (13), ability to successfully carry a pregnancy and deliver a child, or their physical mobility (5, 23) as one participant described:

> She decided, from my BMI, that they were going to need an electric bed for me. So that they didn't have to manoeuvre me up and down the bed, and everything. And I didn't need any help moving myself around. I was up and about and I was off the morphine very quickly. They just presume. Without looking at you, they must have looked at just parts of your notes. Decision taken…I was taken to one side and it was put very nicely, without using the words 'you're very fat, and going to be too heavy for our nurses to lift, it would be better all round if we gave you this bed. Because you can manipulate yourself up and down. And my nurses won't have to struggle because we're not supposed to'. It's that assumption because you're overweight. I thought 'Yes. That's somebody stereotyping me'. (Furber & McGowan, 2011, p. 441)

When participants struggled to access desired care because of how their fat, 'risky' bodies were interpreted by medical professionals (2, 3, 6, 10, 11, 12, 14, 15, 16, 17, 20, 23) several issues ensued. These issues included being unable to access midwifery care (2, 3),

being refused fertility treatment until weight loss was achieved (2, 11), being refused a vaginal birth after caesarean (VBAC) (3) or being refused a homebirth (17). Issues of accessing desired care were not limited to the refusal of desired care but consequently created experiences where participants received types of care that they did not desire. For example, when participants were denied a vaginal birth, it could lead to a caesarean that they did not want (3), or when participants were denied midwifery care, it could lead to obstetric/high-risk care that they did not want (2, 3). One shocking example of the refusal of care was from a participant named Shelley (2, 14) who was in good health and wished to have a baby:

> I had had an IUD placed. And I wanted to have it out, and [my doctor] refused. She said that at my weight, it would be a disaster if I got pregnant. … So it was probably a year of me going and saying "I really want to take this out." And, her just saying 'Absolutely not'. (McPhail et al., 2016, p. 108)

Access issues were not limited to the outright refusal of care; but some participants also felt that medical professionals may have avoided providing care such as pap smears (2) or routine testing and examinations because of their weight (15). Anita (15) expressed concern that she did not receive the same routine care that a woman of 'normal weight' might have received.

Other participants expressed frustration that medical professionals added barriers to accessing desired care. For example, one participant was unable to begin the process of accessing publicly funded fertility treatment because their general practitioner would not give an outright diagnosis of infertility (23). Similarly, another participant suspected they would develop GDM and sought information from a doctor about how to manage it (10). The doctor refused to provide information until testing confirmed a GDM diagnosis, by which point the

participant had indeed developed GDM, but felt it could have been avoided if information was provided when they asked for it (10). Just as this participant had advocated for themself in seeking information, other participants had to advocate for themselves in the form of repeatedly having to ask for pain medication during and after labour (5,12). For Lee (2020), this pain relief was refused because drugs were not included in the pre-birth plan.

Interactions with medical professionals were not the only source of negative experience when navigating fat fertility, pregnancy, and birth for the participants in the studies. Closely related to issues of accessing desired care, 'oppressive things' represented non-human and non-physical 'things' that created or contributed to negative experiences with medical professionals, or inability to access desired care. These 'things' included equipment (3, 5, 7, 9, 11, 13, 15, 16, 19, 20, 21) and policy, protocol, and procedure (9, 11, 12, 14, 15, 23). Medical equipment such as blood pressure cuffs, hospital gowns, postpartum underwear, beds, sanitary paper and stirrups were all too small for many participants (3, 9, 13, 16) which was described as uncomfortable and embarrassing (13). Even being present in the physical building of a fertility clinic felt intimidating to some participants (20). Ultrasound machines were the most common piece of equipment that contributed to negative interactions and experiences (5, 7, 9, 13, 15, 19) as one participant recounted (13):

> I was there flat on my back and the ultrasound scanner had pushed and crushed my body from the outside and the inside to get a view of the baby but had to give up. She finally said that it was my fault she could not get a good view as I was too fat. (Lindhardt et al., 2013, p. 1103)

One participant mentioned that her postpartum breastfeeding pillow did not fit her body and impacted upon breastfeeding aspirations (21). This experience highlighted that it was not just hospital or medical equipment that ostracized fat people during pregnancy and birth, but it is

also mainstream consumer goods that reinforced messages about not having a 'standard' maternal body.

In addition to physical objects contributing to negative experiences, participants recognised that policy, protocol and procedure played a large role in dictating their care options (9, 11, 14, 15, 23). Alison (15) clarified that policy played a larger role in the determination of her care than the medical professionals:

> The people I see don't [choose to treat me differently], it's just the protocol that they've got to follow. (Mills et al., 2013, p. 316)

One participant shared that it was mandatory to meet the anaesthesiologist to determine if they were eligible for an epidural (11), while another shared that it was mandatory to get an epidural at their size, not because they needed one, but 'just in case' (23).

In several studies participants shared how negative interactions with medical professionals led to an emotional response from the participant. Unsurprisingly, weight was the consistent factor across participants negative interactions with medical professionals, which contributed to a broad range of negative emotions such as anxiety, fear, disappointment, shame, humiliation, guilt, devastation, stigmatisation, and alienation (1, 2, 3, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 19, 23). Not only did these interactions create negative emotions, but they also eroded any positive feelings or confidence that participants had prior to the interactions (13, 19), and contributed to bouts of comfort eating (7). Unfortunately for many participants, these emotions were not fleeting, but persisted after the interaction ended, throughout their pregnancies and beyond in some cases (1, 2, 3, 10, 12, 13, 19, 23). Nadine (19) reflected on the impact of a negative interaction with her midwife:

> When I met her [midwife] I was really happy but I could tell immediately on her face that she was not happy ... So she did the whole normal consultation and it wasn't until

> the end of the consultation that she said, ‘‘actually you’re very overweight, and I’ll take you, I’ll take you on as a case but when I get closer to the time, when you’re a bit further along I may have to assess the risk of you being a mother’’. And then she said, ‘‘and if the risk is too high for me I’m sorry, I can’t take you on, I’m going to have to give you to a specialist team’’. And that’s when I clicked, I’d never thought of my weight being a problem before, like I usually try to do things quite diligently, so when she said that, that automatically sparked fear, and then I was like in fear the whole way through my pregnancy. (Parker & Pausé, 2019, p. 258)

Several participants also described feeling dehumanised (2, 3, 11), and undeserving of quality care as a result of their negative interactions with medical professionals (2).

The overwhelming consensus from participants was that their fatness was always implicated in negative interactions with medical professionals and reproductive healthcare more widely. This focus on weight within negative interactions shows how medical professionals (guided by biomedical understanding of reproduction and the institution of medicine) positioned participants as unfit reproducers. At times, this positioning constrained the participants’ human right to have a child, and if the participant was pregnant, medical professionals did not contribute to a dignified start to parenthood. This subtheme also highlights how it is not just medical professionals themselves that impact upon participants reproductive rights, it is also medical equipment and policy that reinforced messages about fat people being unfit reproducers. These ‘oppressive things’ were reflective of the institutional power of medicine, denying access to desired care for participants.

The Impact of Medical Interventions and Surveillance on Accessing Desired Care

Participants across almost all studies experienced a variety of interventions or surveillance that were based on assumptions about their bodies and the risk their fatness posed. Interventions were numerous and sometimes painful and unnecessary. Surveillance was increased and care was escalated, sometimes without the participant consent, leading them to feel like they had no control over their reproductive care experiences.

Participants were often subjected to increased medical surveillance or monitoring throughout their reproductive care (1, 6, 7, 8, 9, 11, 12, 14). Most participants recognised that the increased monitoring and medical attention was due to their weight or BMI (2, 6, 8, 11, 14). However, some did not, but thought the increased monitoring was in relation to issues such as the zika virus or their age (6). Other participants had medical professionals attribute the extra surveillance to large babies or just pregnancy itself (9). The monitoring of, or testing for, GDM was also common form of increased surveillance and monitoring (1, 6, 7) with Hilary (1) describing the increased monitoring as medical professionals 'zooming in' on her weight after her GDM test. Similarly, Lee (2020) who already had type 2 diabetes was subjected to intense monitoring of her blood sugar levels and was prescribed medication before she was able to conceive. Lee was already attuned to the "hysteria" around diabetes and the medical professionals at the diabetes pregnancy clinic she attended reinforced this by stating "…that out of control blood sugar numbers can lead to miscarriage, large babies, and congenital issues", reinforcing messages about the fat, 'risky' body (Lee, 2020, p. 4). The assumption of GDM in fat pregnancy also led to automatic testing and over-concern from medical professionals about slightly raised blood sugar levels (7, 14).

The increases in surveillance and monitoring also had the implication of care escalation for participants, with many sharing experiences of their care escalating in intensity due to their weight, without much regard for their personal preferences or the presence of increased risk (3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 23). The escalation of care also ties in closely with medical professionals making assumptions about participants bodies, because often the assumptions about health status led to participants being automatically determined as high risk and care being escalated accordingly in a standardised fashion. Participants felt that medical professionals treated them like objects (23) with almost mechanical certainty that complications would develop (3, 15). Alison (15) described this automatization as like:

> Being put in a 'bucket', 'you're overweight "beepbom" you're in this bucket. It's sort of like they have a bucket for different people and you don't feel like you're in a bucket you just feel like you're a person. (Mills et al., 2013, p. 316)

Others described their care being escalated, from their preferred midwifery care to specialist or consultant care, often without their knowledge or consent (8, 13). Care was also escalated through an automatic progression of interventions, from epidural to caesarean section (5, 11, 12). Cheryl (11) reflected on her conversation with an anaesthesiologist who was correct in his predictions of her intervention progression:

> So…he looked at me and said well, I'm going to tell you this because it's true. If you get an epidural you are going to have a C section. He goes I guarantee it because of your weight [. . .] And I, because I was so anti C section, I was like I felt like he had shot me, I was like – cause at the time I was really on the fence about epidurals. I really didn't want to get one. I didn't. I really - I'd read a lot about them. I was like no, no, no, no, no [. . .] And it also made me feel extremely fat shamed. It's like well you're fat you're going to get an epidural and a C section, I call it now, except

> he was right. I mean as judgmental as he was and all that, it was true. He could have said it in a way different way, but it was true. And yeah, it's like it's true because it's almost as if the minute you get that epidural you're on this downward spiral to the O.R. Like you just - it's automatic. (LaMarre et al., 2020, p. 350)

Closely linked to the automation and escalation of care was a tendency for participants to be coerced into or passive recipients of intervention. Participants shared experiences of medical coercion, where their care trajectory was based on their perceived risk, or instances of passivity where they simply gave up any control in determining their own care outcomes (3, 6, 9, 12, 16, 18, 19, 23). Some participants felt forced into, or accepted interventions because they were worried about the potential risks to themselves or their child or were concerned they would not receive adequate care from medical professionals, if they did not consent (3, 6, 9, 16, 19, 23). Participants in Dejoy et al. (2016) reported:

> That they felt coerced into giving birth via caesarean: "I was not preeclamptic; I wasn't diabetic; I wasn't having any additional problems; I had no complications. I was just fat while pregnant and therefore needed a c-section". (p. 220)

Other participants became passive or disengaged in decision making processes around their care because they did not feel like they had a say (6, 9, 16, 18, 23). Passivity was particularly clear in Katrina's (9) account where she described how "they" (the medical professionals) decided she would be having an induction because her child was too big for her planned natural delivery. Perceived or potential risk was the underlying factor in both coercion and passivity. Risk was used to encourage participants to accept intervention, or it was framed as something to be avoided through medical intervention. Ange, a participant in Parker and Pausé (2018b):

> Described her passivity in relation to the development of her birth plan, the control of which she had ceded to the hospital to mitigate the risks of her fatness: I was worried about my weight, and I still am, because I don't want to be a fat mum. And I remember my midwife was asking me about my birth plan and I said well, you know, the hospital's got my birth plan, it doesn't matter what I want, and that's tough. (p. 129)

A further consequence of automatisation and medical coercion based on assumption of risk was that some participants received interventions that were entirely unnecessary, and served no medical purpose in avoiding risk, or improving fertility or health outcomes (3, 5, 6, 11, 17, 23). Unnecessary interventions ranged from dietary counselling, GDM testing, sleep apnoea testing, genetic testing, blood work, frequent ultrasounds, caesarean section, and epidural catheter insertion (3, 5, 6, 11, 17, 23). Some participants only recognised that interventions or testing were unnecessary in hindsight when the outcomes of their assumed risk never eventuated. For example, several participants agreed to extra ultrasounds (5, 17). One participant elected to have caesarean based on the ultrasounds estimation of foetal size, only to learn after the birth that the measurements were inaccurate (5). Similarly some participants in Thorbjornsdottir et al. (2020, p. 6) who had to get an epidural catheter inserted based on hospital protocol reported that it "was removed postpartum without ever being used."

A less common but no less concerning experience for participants was being treated roughly during interventions and screenings (13, 15, 19), sometimes experiencing pain during ultrasounds (6) and examinations (16). Zoe in Parker and Pausé (2019, p. 259) shared her experience of being taken for an emergency caesarean:

> I felt like they were gruffer with me, like they were punishing me for being big. It's like you're automatically given a label ''larger, difficult, this is just going to be a big hassle'', yeah I think it's definitely there. (p. 259)

The assumed bodily risk associated with fat fertility, pregnancy and birth was used to explain, encourage and enforce increased medical surveillance and interventions for fat people, regardless of actual risk or necessity. Increases in medical intervention and surveillance reiterates medical assumptions about the danger of fat bodies and interfered with participants ability to access the reproductive care that they desired.

Having a problematic maternal body and trying to navigate reproductive healthcare settings with a fat 'risky' body left participants with only two ways to access their desired care. These were personally practising resistance or having supportive and empowering interactions with medical professionals. Defying negative framings of fat pregnant bodies through positive birthing outcomes was one tangible way that participants could practise resistance, albeit in hindsight. Several participants shared stories of uncomplicated births that did not require intervention and resulted in a healthy baby (3, 16, 17). Lisa in Parker and Pausé (2018a) shared a particularly satisfying account of resistance through a positive birth experience:

> I got my own back anyway (laughs), that's kinda what I thought afterwards, like "ha ha ha, tell me I can't do it". You know because the hospital was saying it was going to be so difficult and a caesarean, and the hospital midwives were there, and the obstetrician was on his way and it was just like all of a sudden it was over and she [midwife] was still filling out the paperwork and I was on the toilet going "he's here", "hello?". (p. 7)

Having had a positive birthing experience also provided reassurances to participants that their bodies were not as problematic and risky as medical professionals had predicted, giving them confidence to advocate for themselves in future reproductive care interactions, and also supported positive feelings about their maternal identity (17).

In the context of normalised biomedical discourse and over-medicalisation of fat reproductive care, many participants demonstrated resistance to, or challenges to these more mainstream understandings when reflecting on their experiences (1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 14, 15, 17, 19, 20, 21). Several participants reflected on 'acts of rebellion' as a form of resistance. Resistance included eating foods that were not recommended or 'allowed' during pregnancy (1, 10). One participant (Judith) shared that she had acquaintances who resisted a GDM diagnosis by making themselves sick before their GDM test, "defrauding the system" and preventing the test from going ahead (Jarvie, 2017, p. 82). Participants also raised several questions during their interviews that demonstrated their challenging of biomedical discourse and the over-medicalisation of their fat pregnancies. Some questioned the assumed link between fatness and GDM (7), fatness, endometriosis, and fertility (11), or how weight is implicated in pregnancy complications generally (8). Others questioned the catastrophising of their BMI (6) or slightly raised blood sugars (14). Finally, participants resisted the idea that their bodies were a risk to their children (2, 7, 14*)* with Gerry asking "like how much control do I really have over the outcome of a foetus?" (McPhail et al., 2016, p. 109).

While some participants felt passive in decision-making processes or coerced into particular care they did not necessarily want, others demonstrated self-advocacy during their interactions with medical professionals to ensure that they had the type of reproductive care experiences they desired (3, 4, 6, 7, 9, 11, 12, 13, 16, 17, 23). For some participants self-

advocacy involved changing medical professionals until they found one that was supportive and provided answers to their questions (11, 12, 13). Other participants used medical literature and the internet to argue for different treatment (3), or had medical professionals agree in principle to desired care, based on evidence participants researched and presented (23). Self-advocacy was not always a straightforward or easy process. Several participants found it exhausting to have to advocate for themselves repeatedly (11, 23) as Rachel from LaMarre et al. (2020) reflected:

> For me, the biggest part is to make sure that I always question people, always have a good enough answer why things are being done and continue to challenge why. That's what I would do differently the next time around. And to make sure that I was satisfied with the answer and was really clear about it and to not give up either. I think there's a point of exhaustion that happens and not to feel bad about it because there's only so much you can handle, right? I think having an advocate on the side would have been helpful too. So, my partner was there and did his job. But I think having a third party to be really strong and involved would have helped out a lot more too. (p. 353)

In line with Rachel's suggestions, participants in other studies also shared that they took partners to their appointments to make sure they were supported (16), and to help gain answers to any questions that they might have (13). Some participants were able to advocate for themselves through sheer confidence and were not afraid to initiate conversations with medical professionals about their weight or to ask for information directly (4, 6, 9).

When advocacy was not enough, several participants demonstrated resistance to 'risky' mother discourse and the discomfort it brought them through what Bombak et al. (2016, p. 99) introduced as a "toehold on respectability", and also through reassurance

seeking (1, 2, 7, 12, 17). The concept of ‘toeholds’ is best demonstrated by Dorothy in Bombak et al. (2016):

> I just want it on record that I'm not a racist, cause I'm not a racist. But I saw all kinds of other moms coming in who were high-risk. And [nurses were] taking reports from women, where the questions are 'How much have you had to drink today? You understand you shouldn't be drinking, right?' And they were getting like great bedside manner, like, just like a not biased, like 'I'm just here to do my job.' kind of thing. How come I couldn't have that? The interviewer (Author B) noted in her fieldnotes that by using the phrase “I'm not a racist,” Dorothy was flagging the fact that she was speaking of a racialized group of women, who given the geographical context of the story were clearly Indigenous. Thus, Dorothy resisted obesity mother-blame and demanded better, more compassionate care through deploying what Fellows and Razack (1998) have called a “toehold on respectability”. That is, the member of one marginalized group becomes more respectable - and in this case, becomes a “good mother” - on the backs of another marginalized group. (p. 99)

Dorothy (2) was not the only participant to use this resistance strategy to manage the discomfort of being categorised as a bad, fat mother. Other participants highlighted the fatter, smoking, drug-taking, and poorly eating mothers that they had seen (1, 2, 7, 17), and even described the “revolting”, “obese” stranger smoking a pipe on the street (Parker & Pausé, 2018a, p. 5). Participants also used their observations of others to identify exceptions to the biomedical discourse ‘rules’ (such as fat people are more likely to develop GDM and have large babies), by stating that they had seen thin women attending the same diabetes clinics as them (7), or that skinny acquaintances also had big babies (9). When violations of ‘health’ and biomedical discourse were not visible to participants as points of comparison, they sought reassurance from others that they were not alone in their experience as a fat pregnant

person. One participant asked their midwife if there were bigger people at the antenatal clinic and was reassured when the midwife said yes (1), while another found comfort in images of other fat pregnant bodies on a blog (12).

When self-advocacy and 'toehold' did not work, several participants resorted to providing justifications for their fat pregnant bodies, and gave reasons for certain outcomes as a way to resist the negative constructions of their bodies (10, 11, 15, 17). Most commonly, participants would situate their fat pregnant body against the historical context of it having been bigger their whole lives (10, 11, 15), while others had to acknowledge their fatness before being able to offer their healthfulness as resistance. As Parker and Pausé (2018a) surmise:

> The "heaviness" of the construction of pregnancy fatness as a problem meant their fatness could not be completely disregarded. Rather, participants created discursive spaces for resistance by first admitting to their fatness as an undesirable state but asserting their health and fitness in spite of it. (p. 5)

Another participant resisted negative assumptions about the ability of their birthing body by making clear that the caesarean they had was due not to their body, but due to the positioning of their baby (11).

When participants were unable to access their desired care on their own, it was a welcomed experience to have supportive and empowering interactions with medical professionals. Amongst the negative, scary, confusing, and stigmatising experiences that participants shared, there were also instances of interactions with medical professionals that were supportive and empowering (1, 3, 4, 7, 8, 9, 12, 14, 15, 16, 20, 21, 22, 23). Two participants who had harmful experiences with medical professionals shared subsequent

supportive experiences with different medical professionals (9, 14). The most obvious example of supportive interactions and empowering experiences was Shelley (McPhail et al., 2016) who as mentioned previously, had been repeatedly denied an IUD removal by her GP:

> So I called Planned Parenthood one day. I went there, to get it out. And I was crying. I went into that appointment thinking that I was going to have another doctor tell me that I shouldn't do it and I must be crazy. …And she realized I was crying and she said "You know, are you okay?" And I said "Well, you know, I'm just, I want to have a baby." And I was lying down, and I figured "Maybe she can't tell that I'm four hundred pounds." And she came up by me, and she said "Of course you want to have a baby. What's wrong?" And I said "Well, my doctor wouldn't take this out." She said "Okay. What am I missing?" I said "What do you mean?" She said "Well, what's your health, like, high blood pressure?" I said "No." "How's your blood sugar?" I said "Pristine."… And she said "Do you smoke?" I said "No." And she was like, "Of course, you've got every right in the world to want this." And she was rubbing my arm and that made me cry harder. And she took it out. (p. 108)

This prioritisation of other health indicators in place of solely focusing on weight and BMI was a common form of supportive interactions for other participants also (1, 4, 8). Even when weight was discussed, it was kept to a minimum and done in a compassionate, judgement-free way (3, 4, 15).

In light of breastfeeding being constructed as a task of the ideal maternal body, participants who struggled with breastfeeding felt validated by medical professionals who prioritised their wellbeing over the perceived necessity of breastfeeding, by supporting them to feed or supplement with formula (12, 21). Having supportive medical professionals involved in reproductive healthcare also helped to manage anxieties about pregnancy and

birth and allowed some participants to look to the future without stress, and to plan for such things as learning to breastfeed (4).

Empowering interactions occurred when medical professionals fostered a sense of trust with the participants, respecting them as human beings with agency, and involving them in their own care (12, 16, 23). Lee (2020) describes her positive interactions with her obstetrician:

> This obstetrician was indeed wonderful, and encouraged my questions throughout pregnancy. She suggested I could weigh myself each fortnight in the hospital before my appointment and let her know if there was a big jump in weight, so she could check for any medical issues related to that. Her trust in me, and the fact that she listened to my concerns, was probably the single biggest positive aspect to her treatment for me. (p. 6) (Lee, 2020, p. 6)

In response to negative reproductive healthcare interactions, participants deployed a ranged of resistance strategies to manage the discomfort of being a positioned as a 'risky' fat person, and to access their desired care. When desired care could not be accessed independently, participants appreciated supportive and empowering interactions with medical professionals. Practising resistance and having empowering interactions with medical professionals demonstrated that participants have ways and means of accessing their desired care with or without the influence of medical professionals, though this should not be the case. Authors discussed how systemic changes would need to occur in reproductive healthcare, and society more widely (2, 11, 14, 19, 20), to de-problematise fatness and thus remove the need for fat people to such fierce advocates for themselves.

Summary of Navigating Fat Fertility, Pregnancy, and Birth

In the theme of **Navigating Fat Fertility, Pregnancy, and Birth** I have synthesised data from the primary studies regarding participants experiences of navigating reproductive healthcare during the fertility, pregnancy and birth stages, and demonstrated how their reproductive rights were supported or constrained during their experiences. Using participant and author quotes, I described who and what is had an impact on determining whether participants have positive or negative care experiences, and demonstrated how the primary authors own biases or positionings may actually perpetuate negative framings of fat pregnant and birthing people. I also summarised how participants frame themselves as fat reproductive people, highlighting how some enact resistance strategies to access desired care, and frame themselves in a positive way prior to embarking on their parenting journeys. Practising resistance also demonstrated how participants attempted to manage their reproductive destines, with or without the support of medical professionals.

Theme Two: Mothering and Maternal Identity

The theme of **Mothering and Maternal Identity** encompasses participants experiences in relation to the research question: what do interactions with medical professionals have on the maternal identity development of fat mothers? This theme mostly reflected on postpartum experiences, but as maternal identity may begin to form during pregnancy and even prior, there were instances of participants maternal identity being constructed before even giving birth. The subthemes are *Interembodiment, Child-centrism and Self-Management, Distress During the Postpartum Period*, and *Personalising Motherhood*. These subthemes include how engagement in reproductive healthcare impacts upon the boundary between mother and child, postpartum distress, and how mothers make space for themselves as fat mothers in a largely fatphobic world. Again, I have taken care not to include the experiences of people

who have not identified themselves or been identified by authors as actual or potential mothers.

Interembodiment, Child-centrism, and Self-Management

This subtheme highlighted the way in which foetal/child wellbeing is the focal point of participants fertility, pregnancy, and birth care experiences, related to the development of their maternal identities (1, 2, 5, 7, 9, 10, 12, 14, 15, 16, 18, 19, 21). Lupton (2013) describes 'interembodiment' as a conceptualisation of how individual bodies, such as the bodies of a gestational parent and a foetus, exist in relation to each other. However Lupton argues elsewhere (Lupton, 2012) that a westernised understanding of reproduction has split this relational existence, and prioritises the foetus over the gestational parent (child-centrism). Using Lupton's work, Parker and Pausé (2019) highlight that 'interembodiment' may be the basis for the development of a maternal identity, requiring mothers to prioritise their child in the womb and beyond in order to be a good mother.

Owing to the biomedical 'riskiness' of their bodies, and as a consequence of interembodiment responsibilities, fat mothers experienced medical professional interactions during pregnancy where their wellbeing and desires were largely ignored, and their weight was highlighted as dangerous to their unborn child (1, 2, 5, 9, 12, 14, 15, 16, 18). To mitigate this riskiness, mothers engaged in a variety of self-management practices from pre-conception onward, in attempts to demonstrate good mothering and ensure their babies' safety (5, 15, 18, 19). Self-management included monitoring GWG, eating healthily, exercising, taking supplements, avoiding chemical exposure, and refusing pain relief during birth (10, 15, 18, 19). Parker and Pausé (2018b) reflected on how engaging in self-management is used as way to demonstrated mothers' commitment to their child:

> The force of the negative affect experienced by our participants led them to engage in regimes of self-governance in an attempt to salvage their maternal identities, and their babies, from the "ruins" of their fat pregnant bodies. This temporally urgent task to save their babies from their threatened future and in doing so constitute themselves as good mothers was undertaken at any cost to themselves. (p. 129)

Despite the separation of mother and child at birth, interembodiment and child-centrism continued into the postpartum period, and participants noticed a total prioritisation of the child during healthcare interactions, and next to no support postpartum for themselves (1, 5). Postpartum healthcare interactions centred around baby's weight gain (or lack of) and became a physical manifestation of good mothering.

There appeared to be contradictory interpretations of infant weight gain across studies. Sometimes, an infant's weight gain was a point of pride and maternal achievement for participants (9), while for other participants, big babies were seen as stigmatising (7), while Lee (2020) reflected on how fat children can be evidence of neglect in medical settings. Lee (2020) and a participant in Keenan and Stapleton (2010) described how medical professionals had recommended that their babies go on a diet. Conversely, mothers who struggle with breastfeeding and whose babies that were 'underweight' were also seen as neglectful (21). Reflecting on the work of (Murphy, 1999), Keenan & Stapleton (2010) suggested that:

> It is the labelling of a baby as a 'skinny' or 'slim' then, which signals a greater cause for concern amongst mothers in this study, who were required to do 'identity work' to avoid being interpreted or positioned as deviant bad mothers. (p. 380)

As mentioned earlier, many participants had their pregnancies highly monitored and experienced increased interventions, testing and surveillance. Through ultrasounds and blood tests, the maternal body is measurable, quantifiable and can be evaluated to ensure the foetus' safety. Interestingly a participant in Sim et al. (2020) had concerns about their breast milk quality and asked a medical professional if they could lab test a sample to ensure that the right nutrients were available in the milk for the baby. Milk testing was not an option and so the mother was left to measure their mothering success through the baby's growth.

Riddled with guilt, and feeling selfish, mothers questioned if they should have become pregnant at all, lost weight first, or if they should have more children in future (5, 14, 18, 19). McPhail et al. (2016) reflected on the delegitimization of participants' motherhood:

> The need to negotiate with moralities and expectations surrounding what a 'good mother' should weigh permeated almost all interviews and was perhaps the most greatly experienced consequence of the 'risky' label—the consequence of being labelled a "bad (potential) mother". (pp. 108-109)

When fat bodies were 'unmanageable' during pre-conception and pregnancy, the pressure to 'bounce back' after birth became a significant task and source of stress during the postpartum period (7, 10, 15, 16). In reference to their participants being positioned on a continuum of intention to lose weight, Mills et al. (2013) reflected on two of their participants plans:

> Towards the end of the continuum were women who felt they had no choice; they had to do something about losing weight, and this was expressed as they talked about their plans and strategies to achieve this. Gwen for example planned to change her diet '...as soon as the baby's born'. While Denise had learnt from experience, that weight 'starts to

> sneak on' after the baby is born, so her plans included setting 'a routine early this time... I've already started. . . really trying to focus on what my plans are going to be post [birth]'. (p. 314)

Jarvie (2017) and Knight-Agarwal et al. (2016) suggested that overweight and obese people should be offered support with weight loss in the postpartum period. None of the participants in Jarvie (2017) offered this support despite it being a National Institute for Health and Care Excellence (NICE) recommendation in the UK. While the suggestion of weight management support problematises postpartum fatness, it also reinforced other participants experiences of being pushed aside after childbirth, when medical professionals continue to favour of the child's health and wellbeing over national standards of care to postpartum mothers.

Distress During the Postpartum Period

As breastfeeding is used as a marker of good mothering and an ideal maternal body, mothers across several studies felt pressure to breastfeed. This pressure was anxiety-inducing and stressful, particularly in the face of already negative, reductive framings of their bodies (12, 13, 21). The pressure to breastfeed and prove maternal bodily function, along with having unmet expectations about their birth experience, resulted in emotional and mental distress for some participants (9, 12). Lee (2020) described her experience with postpartum distress after not having met her personal expectation of her breastfeeding:

> Reflecting on this now, I realize the breastfeeding schedule the hospital had me on contributed to the unrealistic and high expectations I had of myself. These expectations were directly related to what I wanted my fat body to be able to do. I thought, "Just because I'm fat, doesn't mean I'm unfit." My body can achieve a natural childbirth. But an induction is not a natural process. In fact, my fatness led to a sense of wanting to

> prove myself able in labor, of setting too-high expectations, of then seeing myself as a failure, which in turn contributed to postnatal depression. (p. 9)

The effects of fat shaming and negative experiences during pregnancy were not resolved as soon as a baby was born. Instead, the shame morphed into a range of distress that impacted upon motherhood as Parker and Pausé (2019) reflected:

> This negative state of being endured beyond birth, impacting on participants' emerging parenting identities and practices with ongoing health consequences for themselves and their children. Participants described a range of ways in which their sense of having failed as mothers before they had even held their babies in their arms carried into their parenting experiences, resulting in postnatal depression and anxiety, health-care avoidance, and concern about their own and their children's weight. (p. 263)

Personalising Motherhood

Just as participants had demonstrated resistance toward their medicalised, risky, and fat pregnancies, *Personalising Motherhood* is reflective of the way in which participants across studies attempted to reconstruct ideas of 'good' mothering in a way that created space for their frowned-upon fat bodies, and defended their right to be mothers (4, 17, 19, 20, 21). Successfully giving birth (17), having high self-confidence (4), and rejecting the link between fatness and bad mothering (14, 19), all helped participants resist the notion that they were bad, fat mothers. Samantha in McPhail et al. (2016) reflected:

> Some people will never understand what it's like to be bigger. And, they won't understand what it's like to be bigger and to be pregnant. Like, you're the same as everyone else. You just have a few more things to consider, you know? I don't consider myself a bad mother because I got pregnant when I was bigger. I don't consider myself

to be a bad pregnant person because I was bigger." The discourse of "obese" women as "bad (potential) mothers" was therefore soundly rejected by most participants, even at the same time they often had little or no control over its consequences. (p. 109)

Once again, breastfeeding became a central feature in participants stories of mothering. When breastfeeding is seen as a necessary function of the maternal body, it becomes an important ability to have, particularly when fat mothers' bodies are already problematised because of their size and weight. One mother was unencumbered by weight stigma in relation to their breastfeeding goals because it was something they wanted to do, and nothing could stop them seeking support to do so (4). Others who tried breastfeeding but were unsuccessful shifted to a 'fed is best' philosophy, focusing on how they could meet their babies feeding needs within their particular circumstances, and not letting the initial disappointment of not being able to breastfeed upset them:

> Infant feeding practices thus manifested as a relation of power; participants demonstrated agency by resisting the dominant discourse signifying breastfeeding practice as a maternal good and reshaping breastfeeding practice for their context. In negotiating their infant feeding decisions, participants described the important role that health professionals played; their expertise was valued for supporting them in navigating new parenthood and affirming their experiences as capable mothers and the decisions that they made regarding infant feeding and health-related practices. This was particularly important in the early days and weeks postpartum, which is a critical timeframe for establishing a breastfeeding relationship. (Sim et al., 2020, p. 1743)

Two participants bought up alternative forms of mothering that are not typical of westernised constructions of motherhood (20, 21). To avoid having to engage in the self-

management of preparing the body for fertility treatment, Awhina considered the option of becoming a mother through whāngai, where her sister would provide the egg and gestate a baby that Awhina would then raise as her own (Shaw & Fehoko, 2022). Conversely, a participant in Sim et al. (2020, p. 1742) resisted the westernised constructions of motherhood by not wanting to mother the child that she gestated, positioning herself as "a biological mother, but not a primary caregiver". These less 'traditional' pathways to or away from motherhood may demonstrate a more self-actualising experience where participants were able to have more control over their reproductive destinies.

Summary of Mothering and Maternal Identity

Mothering and Maternal Identity summarised the way in which medical professionals perpetuated biomedical understandings of foetal risk during pregnancy and throughout the postpartum period, bringing into question the participants right to parent, and therefore impacting upon their maternal identity development. Interembodiment, and the subsequent child-centrism that accompanied it, make the foetus/child the focal point of pregnancy and motherhood, leaving the mothers deprioritised or ignored by medical professionals. It was distressing for participants and harmful to their maternal identities when they did not meet the idealised standard of maternal body. Despite experiences being generally negative, some participants were able to share stories that demonstrated resistance to biomedical understandings and normative ideas about what a 'good' mother and maternal body looked like. This resistance helped them to establish a more self-actualised maternal identity.

Theme Three: Intersectionality, and Material and Social Constraints

This theme highlights the intersectional and ecological constraints that impact upon the reproductive healthcare and/or mothering experiences of many participants across the primary studies. While being fat and pregnant itself is a point of intersectional difference, removed from normative ideas about the ideal maternal body and mothering, there were other factors such as culture and ethnicity, social factors, gender identification, sexual orientation, and material constraints, that added additional layers of difference. Here I highlighted findings that demonstrated additional intersectional constraints that many participants had to contend with while navigating fat fertility, pregnancy, birth, and parenthood.

Any points of cultural difference that are removed from dominant, White ideals of reproduction and parenting become very apparent to participants who come from non-White cultural backgrounds (9, 11, 15, 20). Several participants experienced reproductive care that was not accommodating of their Indigenous traditions or sensitivities regarding reproduction (11, 20). For one participant, Rachel, accessing mainstream maternity care as a fat Indigenous woman was negative, embarrassing, and culturally unsafe because medical professionals lacked cultural competence to accommodate her desired care (11). Drawing on Gailey (2014), LaMarre et al. (2020, p. 351) describe Rachel's intersectional experience as 'hyper(in)visibility', with her body being highly visible, while her cultural identity is ignored in the context of a highly medicalised birth. Similarly, participants in Shaw and Fehoko (2022) struggled to access publicly funded fertility treatment in Aotearoa New Zealand owing to their physiological difference and the cultural acceptability of assisted reproduction. Firstly, it is accepted that Pasifika people have higher bone and muscle mass than their Pākehā counterparts, meaning that the BMI cut-off for publicly funded fertility treatment is discriminatory (20). Secondly, discussing reproduction and sex organs may be culturally

inappropriate for some Indigenous people, or there simply is not the language or terminology to address assisted reproduction in any language other than English (20). Another participant who is Asian struggled to balance her family's idea of what a healthy baby should be fed to gain weight (fried semolina and sugar) and look like (plump) against her own understandings of what is considered appropriate and healthy eating given her own experience with diabetes (9).

Participants also shared how close social relationships and society more widely impacted upon their pregnancy and parenting experiences. Participants had to contend with negative constructions of themselves and their reproductive capabilities from strangers, family, friends, and the media (4, 5, 7, 9, 10, 12, 15, 18). The people involved in these interactions made assumptions about the participants eating and lifestyle habits, and outwardly expressed their predictions about changes in the participants bodies, their parenting abilities, and the size of the baby (5, 7, 8):

> Women were perturbed that they might be judged as irresponsible, deficient mothers if their baby was too large. Three women reported receiving disparaging comments from friends/family/work colleagues imputing responsibility for a big...Andrea was shocked to be told by a work colleague, 'You could have a 15 pounder!'. (Jarvie, 2017, p. 83)

Participants also expressed frustration about the stereotypes and negative representations of fat pregnant people in society and media (10, 15, 18). For Lee (2020), her high level of education and privileged positionality served as a defence against negative stereotyping of fat pregnant people:

> I had been treated with respect by the third obstetrician, and by the endocrinologist, although she made classist remarks several times, which reminded me, I am a fat white cis-gendered middle-class educated woman, albeit with working-class family roots. I

> have no doubt that I received better care from her at times because I was educated, and I have a PhD. She therefore believed what I said and could relate to me. (p. 7)

Social support was also highlighted as an important factor for breastfeeding, but some participants struggled to access this support (4, 21). For some, their family members distaste for breastfeeding (4) or a lack of family help in general (21) was a deterrent to breastfeeding. For one participant, the COVID-19 pandemic presented a barrier to accessing in-person breastfeeding support socially and from healthcare providers (4).

Only two studies considered the intersectional implications of fat fertility and pregnancy for LGBTQ+ people (11,14). These studies importantly highlighted the tendency for medical professionals to prioritise weight as a risk factor over getting to know their patients and providing inclusive, safe care. Participants Megan (11) and Gerry (14) sought reproductive healthcare for the purposes of conceiving with donated sperm, but from the outset, their respective medical professionals made the assumption that they were struggling with infertility due to their weight. LaMarre et al. (2020) argued that:

> The spaces participants navigated at times showed their heteropatriarchal and colonizing roots. Participants' accounts reflected how even in spaces designed to be accessible and inclusive, vestiges of marginalization and a lack of understanding of gender nonnormativity persist. (p. 352)

This was not just the case for participant Megan and Gerry, but also for Luke, a White trans man, who noted that while there were 'gestures' of inclusive care such as trans affirming posters on the hospital walls, he still experienced problematic interactions with medical professionals (11).

Experiencing material deprivation as a fat pregnant person or parent was immensely complicated for participants (7, 11, 21). Most commonly, material constraints were financial in nature, but also included associated issues such as insecure, unsafe housing and food insecurity (7, 11, 21). For participants who were having their reproductive care medically managed (7, 11), or who were trying to practise good mothering postpartum (21) material constraints presented a huge intersectional challenge that impacted upon their ability to access their desired care (11), adhere to dietary and exercise recommendations (7), and feed their children (21).

Participants with GDM noted the financial strain of having to follow specific dietary and exercise recommendations. Eating healthy, going to the gym, or engaging in weight management programmes such as Weight Watchers was expensive, particularly when participants were already experiencing financial difficulty (7). Participants also noted that 'good' foods were more nourishing and expensive, while affordable, more accessible foods offered less nutritional value (7, 21). Nutrition was also implicated in some participants breastfeeding experiences (Sim et al., 2020):

> I don't eat . . . the way normal people eat . . . I didn't even think of factoring that into my ability to breastfeed." In later interviews, a participant described how both her body weight and food insecurity was influencing her breastmilk: I was worried about whether or not she was getting the proper nutrients and things like that . . . but I was also wondering, you know . . . if my being so overweight was actually causing the milk to be too fatty and not give her enough, essentially. (p. 1741)

The increased medical management of fat fertility and pregnancy added to material constraints as participants had to manage costs of travel to extra appointments with social and work obligations (7, 11) as Jarvie (2017) commented:

> Many participants emphasised the expenditure required to attend additional antenatal appointments due to obesity/diabetes. Women/families on benefits/low incomes struggled to meet transportation and hospital parking costs. Working women worried about employers not being favourable to time off. Some women paid for additional childcare to avoid being accompanied by young children to lengthy clinic appointments. (p. 82)

Having to attend additional hospital appointments while trying to manage the stresses of material constraints may be unhelpful people's wellbeing and may highlight how little some medical professionals considered the more holistic and contextual factors of their patients' lives when making treatment and care plans.

Summary of Intersectionality, Material, and Social Conditions

In addition to being fat and seeking reproductive healthcare, participants across thirteen of the primary studies were located at additional intersectional points of difference, or experienced material and social constraints, which impacted upon their ability to access their desired reproductive care. Existing at the centre of multiple positionalities such as fat and Indigenous, or fat and queer opened participants up to negative experiences where medical professionals made assumptions about their care based on their bodies, or their fertility and birth experiences were not culturally safe or appropriate. Lack of financial resources and familial support impacted upon participants ability to manage health conditions and achieve breastfeeding aspirations. Wider social acceptance of biomedical ideas about fat reproduction also created negative experiences for participants during interactions with

acquaintances and even strangers. These negative experiences were a direct violation of the participants right to parent in healthy and safe environments, and highlighted how compounding forms of oppression, or deprivation, amplify discrimination in reproductive healthcare.

Theme Four: What Participants Want

Across the primary studies, participants asserted their own ideas and recommendations for how medical professionals should treat them (and others) in future, by providing humanising care that is that accommodates differences and looks at the participants health in a holistic way. Participants also described how they wanted to have provisions for social support facilitated.

Instead of care being determined by assumptions about fat bodies, health and behaviours, participants suggested that medical professionals should take a holistic view of participants well-being (1, 7, 11, 16, 23). For most participants, a holistic view of their bodies meant not focusing on weight and fatness as the sole determinant of health and subsequent care options or interventions (7, 11, 16, 23). As Thorbjornsdottir et al. (2020) reflected:

> She [research participant] wished for healthcare personnel to see beyond the exterior of her body. To interact and communicate factually without prejudice and with respect to her, holistically, so that she too, could have a positive experience. (p. 4)

Other participants wanted their health to be considered equally important alongside the baby's (1), or for medical professionals to actually ask participants about the state of their general health or potential 'unhealthy' behaviours, rather than drawing conclusions based on their appearance (11).

Taking into consideration participants accounts of the sometimes confusing, avoidant, and generic advice and information given to them by medical professionals, participants across several studies made calls for advice and information to be clear and personalised (1, 6, 10, 13, 14, 15, 22, 23). Participants want accessible information regarding their care and potential risks delivered in a factual, non-judgmental way (1, 14, 23). Having information about potential risks helped some participants to feel accommodated (23), and like they had some autonomy over their care and experiences (14). Participants also wished that messaging and advice around their weight would be tailored to them (10, 13, 22) because several participants had received conflicting advice from different medical professionals (10, 13).

In light of negative reproductive healthcare experiences, participants across several studies made suggestions for how medical professionals should treat fat people in reproductive healthcare settings to ensure more positive experiences for everyone in future (11, 12, 14, 15, 21, 23). Overwhelmingly, participants described wanting medical professionals to be accepting of their bodies and who they are, while providing the same standard of care to participants as they would any other patient (11, 14, 15, 21, 23). As Kimberley (11) suggested:

> What I would say is . . . people who are overweight know it, they don't need to be placated. It doesn't need to be a three-ring circus. You need to be caring, wanting them to feel better for themselves, not necessarily because it's the norm. You need to be helping them, it's not your job to make them like everybody else. (LaMarre et al., 2020, p. 354)

This centring and acceptance of difference also extended to a participant's suggestion of how a medical professional's compassionate care can impact upon participants likelihood to engage in healthcare (12).

It is difficult enough to access desired reproductive healthcare as a fat person without the added challenges that intersectional points of difference present. Participants who existed at the multiple intersections of marginalisation made suggestions for how the care for themselves and others could be improved in future (11, 20). Considering gender identity, Scott (11) suggested that medical professionals should receive better training regarding the care of gender fluid people, as well as putting in place systems to support patient advocacy.

In terms of providing culturally competent care, participants in Shaw and Fehoko (2022) made a variety of suggestions. Those suggestions included, firstly, the revision of BMI requirements for Māori and Pasifika people to access fertility treatment. Secondly, participants suggested the development of culturally appropriate messaging, information and terminology regarding BMI and fertility treatment, in collaboration with community and church leaders, to create informational resources that discuss fertility and sex organs in an appropriate way (20). Rachel, in LaMarre et al. (2020), also suggested the need for medical professionals to be better educated about cultural ceremonies surrounding birth.

Several participants highlighted how social support could be better incorporated into care in both the pregnancy and immediate postpartum periods (2, 6, 7, 12). Some participants agreed that having antenatal care in a group setting could have been helpful (6) while others thought that food vouchers that were redeemable for fruit and vegetables only would be a good way to support people experiencing financial hardship to manage their GDM (7).

Interestingly, Cheryl in Bombak et al. (2016) highlighted that the high risk hospital ward she was in did not provide accommodations for her support person to stay with her. Cheryl's observation related to how Lee's (2020) midwife had to request permission for

Lee's husband to stay overnight in the hospital on a trundle bed after Lee was left extremely exhausted from breastfeeding, major surgery, and infection. Lee (2020) noted that partners were not encouraged to be in the hospital overnight. While Lee (2020) and Cheryl (2) did not expressly suggest that having a partner or support person sleep over in the hospital is something that all mothers want, or even something they wanted for themselves, Lee's struggles in the immediate postpartum period were evidence that hospitals and birthing facilities should have accommodations for social support, and facilitate support so that mothers do not have to manage everything on their own.

Summary of What Participants Want

Overwhelmingly participants wanted to be treated like human beings in their interactions with medical professionals. Humanising care means having medical professionals look at a participant holistically, beyond their weight, and then providing care that supports them to have reproductive healthcare experiences that are positive, encompassing their wants and needs. Participants wanted medical interactions and advice that accommodated their points of difference, while not having their care options restricted just because they were fat. By expressing their opinions and desires for reproductive healthcare, participants demonstrated advocacy for themselves and were highlighting how medical professionals and reproductive healthcare at large can support them in their right to parent in safe and health environments regardless of their weight, socioeconomic status, sexuality, gender identity or culture.

Chapter 4 Summary

In this chapter I have provided a summary of findings from the QES, through the thematic synthesis of data from the primary studies. Across four overarching themes I addressed participants experiences of fat fertility, pregnancy, birth, and motherhood, with

considerations of intersectional and material and social differences and constraints to highlight how fat people were supported (or not) in their reproductive right to have or not have children. I also summarised and thematically described participants suggestions for how they had hoped their reproductive healthcare was or could be in the future.

Chapter 5: Discussion and Limitations

In this QES, I systematically selected, reviewed, and thematically synthesized qualitative research about fat people's experiences of reproductive healthcare. With this QES and the application of the RJ framework as a critical lens, I interpreted the data from the primary studies to address the research questions: What impact do interactions with medical professionals have on the maternal identity development of fat people? What intersectional factors impact upon their experiences? And what do participants want from medical professionals in future reproductive healthcare interactions? Here I discuss the findings, limitations, and make suggestions for future research.

Discussion

Medical Professionals Impact Upon Fat Peoples Maternal Identity Development

Maternal identity development, or rather, 'maternal transition' as described by Johnson (2014) understands that becoming a mother is either self-actualising or self-replacing experience. A self-actualising, and positive identity developing experience, is possible, provided that the mother can have autonomy over her reproductive healthcare. On the other hand, giving birth for self-replacement, with limited autonomy in reproductive healthcare, perpetuates the oppressive and patriarchal institution of motherhood, and position fat mothers as bad mothers. A sense of morality is implied through the negative construction of being a fat mother, but through a relativist-SC understanding of identity, and the RJ framework, I believe that this QES works to disrupt the moralising, negative constructions of fat motherhood, and instead holds space for a variety of mothering experiences to be true. I argue that participants in the primary studies experienced both self-replacing and self-

actualising constructions of motherhood based on their experiences with medical professionals and the associated biomedical discourse that was present in their interactions.

Weight and fatness were inescapable for participants in their experiences of reproductive healthcare and during the fertility and perinatal periods more broadly. Regardless of whether a medical professional, acquaintance, or media was the messenger of biomedical discourse about fat pregnancy, the stigmatising message was clear to participants: their bodies were risky to their (potential) child. The maternal duties implied by interembodiment and the assumption of bodily risk in healthcare settings impacted upon many participants ability to access desired care, and have autonomy over reproductive care choices, such as accessing fertility treatment, or midwifery care instead of high-risk obstetric care. Through coercion or passive submission, many participants agreed to treatment and interventions that prioritised the foetus/child over themselves, which is exemplary of a self-replacing maternal transition. Parratt and Fahy (2011) point out that prioritising the baby is also reflective of the outdated 'transition to motherhood' theories of maternal identity development:

> The theory positions the midwife as knowing more about a woman's transition than the woman does herself. When midwives, consciously or unconsciously, use the transition to motherhood metanarrative to understand women's self-change during child-bearing, each woman's embodied and contextual experience becomes invisible. Likewise, her inner power and inner knowledge are over-ridden and silenced. The woman is thought of as a passive recipient of social forces and caregiver actions; in practice, this translates into caregivers surveilling and policing women's behaviours. Under this metanarrative, the most disadvantaged women in society are the ones who are likely to be the subject of caregiver reporting to child protection agencies. (p. 450)

These reflections again reinforced the importance of using a more critical understanding and theory of maternal identity development.

Conversely, some participants were able to access more self-actualising experiences of maternal identity development. This self-actualising experience was accessed in two main ways: 1) Medical professionals stopped catastrophising their fatness as a risk to the foetus/child and focused on a more holistic view of participants health, and 2) Participants advocated for their desired care and resisted biomedical constructions of their 'risky' maternal bodies. These self-actualising and self-replacing experiences of maternal transition also highlighted reproductive (in)justice where participants were either supported or undermined by medical professionals in their right to be a parent, and rejecting or negotiating the overmedicalisation is indicative of participants fighting for their reproductive destinies.

Notably, it was not just medical professionals who were responsible for negative experiences; participants also highlighted the 'oppressive things' such as equipment and policies. I borrowed the term "oppressive things" from Liao and Huebner (2021, p. 1) who argue that "material artifacts and spatial environment" should be included in the analysis of oppressive systems. Liao and Huebner (2021) use this in relation to racism, but I suggest that it could also be applied to analysing the oppressive potential of the institution of medicine, and therefore medical equipment and policy, especially when many participants in the primary studies had the same experience of feeling ostracized by hospital gowns and policy. This analysis of oppressive systems also extends to fat people accessing healthcare more generally as it is well established that fat people experience stigma and discrimination in healthcare regardless if it is reproductive or not (Pausé, 2017).

It is disturbing that at least two mothers reported having medical professionals recommended putting their babies on a diet. Lee (2020) reflected on her experience of this recommendation, referencing Bacon's (2010) *Health at Every Size: The Surprising Truth about Your Weight* book, in which readers are encouraged to share responsibility with their child about what they eat from as early as infancy in order to help them develop good habits and avoid obsessing about weight in future. It was disheartening to read these accounts of diet recommendations for babies and realising that the cycle of fat phobia and exposure to the normalisation of diet culture is beginning before a baby is even conscious of it.

Intersectional Factors that Impact Upon the Reproductive Healthcare Experiences of Fat People

When searching and screening for articles to include in this QES, it was frustrating that some studies claimed to be from the participants perspective, but were exploring weight management interventions during pregnancy, and asking participants what the barriers to their participation were. Studies about weight management in reproductive healthcare setting problematise fat pregnancy (Parker, 2017) and also communicates neoliberalist ideas about how personal responsibility is implicated in obesity (Lupton, 2018; Pausé, 2017). The focus on personal responsibility ignores that some health indicators such as BMI are discriminatory (Parker et al., 2020) and that many people do not have access to resources and social support that may influence their ability to afford nutritious food and participate in recreation for health (Lupton, 2018). A key aspect of RJ is its attention to intersectionality, illuminating the social and power relations at play in reproductive activities, and advocating for the equity of outcomes in reproductive healthcare (Ross & Solinger, 2017). On top of being fat, participants across multiple studies also had ethnic, sexuality and gender identity, as well as low socioeconomic status implicated in their care.

Though participants did not share experiences of overt obstetric violence such as state sanctioned sterilisation (as was mentioned in the literature review), the same ideas about fitness to reproduce that underlie the sterilisation programmes, was present in participants stories in a less severe and more covert ways. Most notably, the Māori and Pasifika participants in Shaw and Fehoko (2022) were denied access to publicly funded fertility treatment, because their naturally larger bodies did not meet the BMI requirements put in place by medical professionals. The intersectional implication of this is that their fatness and ethnicity were problematised by medical professionals and in turn, impeded on their right to have children. Normative ideas about sexuality and gender identity were also reproduced by medical professionals and left several participants having to advocate for themselves to access reproductive care. Heteronormative assumptions about what constitutes a parenting partnership, and cisnormative assumptions about who can gestate and give birth impacted upon LGBTQ+ participants ability to access to safe and affirming care, and ultimately served as a barrier to their right to parent.

Material constraints were also a point of compounding difference, most noticeable in the stories of the participants in Jarvie (2017) and Sim et al. (2020). Being fat and experiencing relative poverty (and all the subsequent issues that come with poverty), impacted directly on the participants right to parent (with one participant having their baby removed at the hospital by authorities), and to parent in safe and healthy environments (with participant Sherry having insecure, poor-quality housing, financial issues, and a partner who was wanted by police). Being fat is not necessarily unhealthy, being poor is not a crime, and yet these participants were having their reproductive rights violated because of these intersecting factors. As well as demonstrating the tangible impacts of institutional power,

these participants stories also highlighted how RJ is a human right, and in order to ensure this human right for everyone, issues such as poverty need to be addressed.

I argue that the interactions fat mothers have with their medical professionals are mediated by the medicalised constructions of pregnancy and birth of the present day, which then contributes to the construction of maternal identities for the participants. Importantly, a SC epistemology also aligns with RJ in highlighting intersectional differences in terms of identity, specifically where the social and cultural constructions of women, and consequently mothers, are inherently White (Ross & Solinger, 2017). RJ also critically considers access to parenthood that is achieved through reproductive technologies such as surrogacy, egg/sperm donation, or in vitro fertilisation (IVF), as these are often accompanied by high financial costs and reserved for those who can afford it (Ross & Solinger, 2017). Using the RJ framework highlighted how important is that intersectionality is addressed within research about reproductive healthcare. As SisterSong (n.d) posit, "Our society will not be free until the most vulnerable people are able to live self-determined lives without fear, discrimination or retaliation" (para. 4).

What Participants Want in Future Reproductive Healthcare Interactions

In line with Johnson's (2014) suggestion that autonomy in reproductive healthcare interactions is conducive to positive maternal identity development, as well as RJ's position that people will find ways to manage their reproductive destinies, it was important from both an identity construction and RJ perspective to dedicate space in this QES to synthesising participants own accounts of participants want. These desires and aspirations were very simple – to be treated like a human being, receive reproductive healthcare that views them as a whole person, and to not have their care restricted just because they are fat. By vocalising

what they want out of future interactions, participants across the primary studies were advocating for themselves, disrupting the status quo of reproductive healthcare, and enacting resistance to the negative, medical framings of their bodies. Ultimately their assertion of their wants for reproductive healthcare interactions helps to support their rights, and the rights of other fat people to parent (or not) in safe and healthy environments.

Limitations

This QES had several limitations surrounding the scope of a thesis project. As mentioned in Chapter 2, study inclusion parameters (such as English language, journal articles only) had to be set with respect to the time and financial constraints of a Master's thesis project. These parameters presented several limitations to the application of this QES. Firstly, the included studies were entirely from global north counties, which is suggestive of relative wealth, and access to modern standards of medical care for the participants. Aside from a handful of BIPOC participants, the sample of participants is largely White. The lack of BIPOC participants raises questions about how different the finding may have looked had there been more BIPOC voices. As highlighted in the literature review, discrimination and inequitable health outcome disproportionality affects BIPOC folks, and I argue that this QES may have demonstrated grater instances of BIPOC discrimination, had there been greater diversity across the participants. It was also difficult to determine if the lack of diversity was due to my own sampling choices (including studies only in English), or if it is reflective of a lack of qualitative research about the reproductive healthcare experiences of fat people more globally.

A second limitation of the search parameters was filtering for published journal articles only. I have missed some rich data from books and grey literature that may have

added to the breadth and depth of this QES. One book that comes to mind is Friedman et al.'s (2020) edited book *Thickening Fat: Fat Bodies, Intersectionality and Social Justice* that includes research from Deborah McPhail, George Parker, Cat Pausé, and Jade Le Grice and other researchers in the field.

Another potential limitation of this QES is the fact that I completed it independently. QES's are typically undertaken with a group of researchers, developing themes together, and providing checks and balances along the way. In the spirit of reflexivity, I want to make clear some of my potential bias that I reflected on as I carried out this QES. Owing to my friend's poor experiences with their obstetricians and having read about the negative experiences of fat people in maternity healthcare for several years now, I found myself assuming that most of the articles that I would find during the systematic search stages would be inherently negative. Viewing these studies through a reproductive framework also tended to highlight the negative experiences and systemic challenges more readily. As much as I would like to have had a tidy picture of 'fat pregnant person + mean medical professional = bad experiences and injustice' to write about, that simply was not the case. Instead, I learned that there were also pockets of positive and empowering experiences between fat people and medical professionals during reproductive healthcare experiences, and some strong examples of resistance that demonstrated people taking control of their reproductive destinies despite challenges.

Directions for Future Research

As mentioned in Chapter 2, the inclusion of biomedical terms such as 'obese' and 'obesity' as search terms was necessary in order to generate adequate search results for synthesis, but also somewhat counter intuitive in a study that is trying to support fat activism. A combination of the 'obesity epidemic' and the saturation of biomedical research that

blames fat mothers for a range of medical and social issues (McPhail et al., 2016; Parker, 2014; Parker & Pausé, 2019; Warin et al., 2012) leaves ample opportunity for the completion of fat studies based research on fat reproductive healthcare and motherhood (or parenthood) from the perspective of fat people themselves (Manokaran et al., 2021). In addition to more critical studies, and as mentioned in the limitations, I suggest that a concerted effort should be placed on completing research and recruiting participants that reflect a more diverse and intersectional picture of fat reproduction and parenthood.

As mentioned in Chapter 3, I had set out to complete a narrative analysis of fat people's experiences of maternal identity development in light of their experiences with medical professionals for this research project. Given the somewhat small and indirect accounts of maternal identity development across the primary studies in this QES, I believe that more critical research on the maternal identity development of fat people is warranted and necessary.

Conclusion

Interactions with medical professionals played a significant role in many fat peoples experiences of reproductive healthcare across the studies in this QES, restricting or facilitating access to their desired care, and indeed their reproductive right to have a child (or not) in a safe and healthy environment. The variety of medical interactions, in conjunction with intersectional points of difference, also constrained some participants ability to access their desired care. This combination of biomedical care and contextual factors also influenced how some participants were able to negotiate a self-actualising or self-replacing experience of maternal transition. Despite the challenges of engaging with a medicalised system of care that positions them as unfit reproducers, many participants were able to practise resistance in an attempt to break through those barriers, and determine their own reproductive destines.

Manokaran et al. (2021) put out the call for social science scholars, and in particular, psychologists to explore "the lived experience of fat individuals, and how the mind adopts, revises, and reinforces fat attitudes". Though not every participant in the QES identified as fat, (and some rejected the label entirely), and I have not adopted a Fat Studies epistemological approach to this QES, I hope that by centring the experiences of fat people in reproductive healthcare that I have been "part of the solution" for change in an appropriate way (Manokaran et al., 2021, p. 541).

References

Al-Ababneh, M. M. (2020). Linking Ontology, Epistemology And Research Methodology. *Science & Philosophy*, *8*(1), 75-91. https://doi.org/10.23756/sp.v8i1.500

Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: a worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, *19*(1), 1-9. https://doi.org/10.1186/s12874-019-0665-4

Atkinson, S., & McNamara, P. M. (2017). Unconscious collusion: An interpretative phenomenological analysis of the maternity care experiences of women with obesity (BMI≥30 kg/m²). *MIDWIFERY*, *49*, 54-64. https://doi.org/10.1016/j.midw.2016.12.008

Bacon, L. (2010). *Health at Every Size: The Surprising Truth about Your Weight*. BenBella Books. https://ezproxy.massey.ac.nz/login?url=https://ebookcentral.proquest.com/lib/massey/detail.action?docID=544573

Baker, S. R., Choi, P. Y. L., Henshaw, C. A., & Tree, J. (2005). 'I Felt as though I'd been in Jail': Women's Experiences of Maternity Care during Labour, Delivery and the Immediate Postpartum. *Feminism & Psychology*, *15*(3), 315-342. https://doi.org/10.1177/0959-353505054718

Barker, K. K. (1998). A ship upon a stormy sea: the medicalization of pregnancy. *Social science & medicine (1982)*, *47*(8), 1067-1076. https://doi.org/10.1016/s0277-9536(98)00155-5

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*(1). https://doi.org/10.1186/1471-2288-9-59

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC Medical Research Methodology*, *16*(1), 1-12. https://doi.org/10.1186/s12874-016-0114-6

Bombak, A. E., McPhail, D., & Ward, P. (2016). Reproducing stigma: Interpreting 'overweight' and 'obese' women's experiences of weight-based discrimination in reproductive healthcare. *Social Science & Medicine*, *166*, 94-101. https://doi.org/10.1016/j.socscimed.2016.08.015

Booth, A. (2008). Unpacking your literature search toolbox: on search styles and tactics. *Health Information and Libraries Journal*, *25*(4), 313-317. https://eds.p.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=1143b979-dc49-41c7-b452-7877abe68df1%40redis

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: a structured methodological review. *Systematic Reviews*, *5*, 74. https://doi.org/10.1186/s13643-016-0249-x

Booth, A., Noyes, J., Flemming, K., Gerhardus, A., Wahlster, P., van der Wilt, G. J., Mozygembz, K., Refolo, P., Sacchini, D., Tummers, M., & Rehfuess, E. (2016). *Guidance on Choosing Qualitative Evidence Synthesis Methods for use in Health Technology Assessments of Complex Interventions*. http://www.integrate-hta.eu/downloads/

Booth, A., Noyes, J., Flemming, K., Moore, G., Tunçalp, Ö., & Shakibazadeh, E. (2019). Formulating questions to explore complex interventions within qualitative evidence synthesis. *BMJ Global Health*, *4*, e001107. https://doi.org/10.1136/bmjgh-2018-001107

Braun, V., & Clarke, V. (2022). *Thematic Analysis: A Practical Guide*. SAGE Publications Ltd.

Brown, H., & Herndon, A. M. (2020). No Bad Fatties Allowed? Negotiating the Meaning and Power of the Mutable Body. In M. Friedman, C. Rice, & J. Rinaldi (Eds.), *Thickening Fat: Fat Bodies, Intersectionality and Social Justice* (pp. 139-149). Routledge. https://doi.org/https://doi-org.ezproxy.massey.ac.nz/10.4324/9780429507540

Budds, K. (2021). Fit to conceive? Representations of preconception health in the UK press. *Feminism & Psychology*, *31*(4), 463-482. https://doi.org/10.1177/0959353520972253

Burr, V. (2003). *Social Constructionism* (3rd ed.). Taylor & Francis Group. https://ezproxy.massey.ac.nz/login?url=https://ebookcentral.proquest.com/lib/massey/detail.action?docID=2011179

Carastathis, A. (2016). *Intersectionality : Origins, Contestations, Horizons*. University of Nebraska Press. https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=e000xww&AN=1355895&site=eds-live&scope=site&authtype=sso&custid=s3027306

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, *17*(10), 1316-1328-1328. https://doi.org/10.1177/1049732307306927

Centers for Disease Control and Prevention. (2019). *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html

Cerulo, K. A. (1997). Identity Construction: New Issues, New Directions. *Annual Review of Sociology*, *23*, 385-409. https://www-jstor-org.ezproxy.massey.ac.nz/stable/2952557

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989(1)*, 139-167.

Critical Appraisal Skills Programme. (2018). *CASP Qualitative Studies Checklist*. https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Crotty, M. (2020). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Routledge, Taylor & Francis Group. http://ezproxy.massey.ac.nz/login?url=https://www.taylorfrancis.com/books/9781003115700

Cruzes, D., & Dybå, T. (2011). Recommended Steps for Thematic Synthesis in Software Engineering. *International Symposium on Empirical Software Engineering and Measurement 2011*, 275-284. https://doi.org/10.1109/ESEM.2011.36

Dadouch, R., Hall, C., Du Mont, J., & D'Souza, R. (2020). Obesity in Pregnancy - Patient-Reported Outcomes in Qualitative Research: A Systematic Review. *Journal of Obstetrics and Gynaecology Canada*, *42*(8), 1001-1011. https://doi.org/10.1016/j.jogc.2019.09.011

Davison, C. (2020). Feminism, midwifery and the medicalisation of birth. *British Journal of Midwifery*, *28*(12), 810-811. https://doi.org/10.12968/bjom.2020.28.12.810

Dejoy, S. B., Bittner, K., & Mandel, D. (2016). A Qualitative Study of the Maternity Care Experiences of Women with Obesity: "More than Just a Number on the Scale". *Journal of Midwifery and Women's Health*, *61*(2), 217-223. https://doi.org/10.1111/jmwh.12375

Dickman, M. C. (2022). Reproducing fatness and disability: Risk avoidance and the womb. *Fat Studies*, *11*(1), 57-69. https://doi.org/10.1080/21604851.2021.1906527

Dieterich, R., Chang, J., Danford, C., Scott, P. W., Wend, C., & Demirci, J. (2022). She "didn't see my weight; she saw me, a mom who needed help breastfeeding": Perceptions of perinatal weight stigma and its relationship with breastfeeding experiences. *Journal of Health Psychology*, *27*(5), 1027-1038, Article 1359105320988325. https://doi.org/10.1177/1359105320988325

Dykes, F., & Hall-Moran, V. (2009). *Infant and Young Child Feeding*. Wiley. https://books.google.co.nz/books?id=pMgyW3RcJMYC

Edwards, D., Ashmore, M., & Potter, J. (1995). Death and Furniture: the rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences*, *8*(2), 25-49. https://doi.org/10.1177/095269519500800202

Finfgeld-Connett, D. (2014). Use of content analysis to conduct knowledge-building and theory-generating qualitative systematic reviews. *Qualitative Research*, *14*(3), 341-352. https://doi.org/10.1177/1468794113481790

Flemming, K., & Noyes, J. (2021). Qualitative Evidence Synthesis: Where Are We at? *International Journal of Qualitative Methods*, *20*, 1-13. https://doi.org/10.1177/1609406921993276

Friedman, M. (2021). Pregnancy, Parenting and the Challenge of Fatness. In C. Pausé & S. Renee Taylor (Eds.), *The Routledge International Handbook of Fat Studies* (pp. 150-164). Routledge.

Friedman, M., Rice, C., & Rinaldi, J. (2020). *Thickening fat : fat bodies, intersectionality, and social justice*. Routledge. http://ezproxy.massey.ac.nz/login?url=https://www.taylorfrancis.com/books/9780429507540

Furber, C. M., & McGowan, L. (2011). A qualitative study of the experiences of women who are obese and pregnant in the UK. *MIDWIFERY*, *27*(4), 437-444. https://doi.org/10.1016/j.midw.2010.04.001

Furber, C. M., McGowan, L., Bower, P., Kontopantelis, E., Quenby, S., & Lavender, T. (2013). Antenatal interventions for reducing weight in obese women for improving pregnancy outcome. *Cochrane Database of Systematic Reviews*(1), 1-25. https://doi.org/10.1002/14651858.CD009334.pub2

Gailey, J. A. (2014). *The hyper(in)visible fat woman : weight and gender discourse in contemporary society* (1st ed.). Palgrave Macmillan. https://ezproxy.massey.ac.nz/login?url=https://ebookcentral.proquest.com/lib/massey/detail.action?docID=1882014

Garside, R. (2014). Should we appraise the quality of qualitative research reports for systematic reviews, and if so, how? *Innovation: The European Journal of Social Sciences*, *27*(1), 67-79. https://doi.org/10.1080/13511610.2013.777270

Gergen, K. J. (1985). The Social Constructionist Movement in Modern Psychology. *American Psychologist*, *40*(3), 266-275. https://doi.org/10.1037/0003-066X.40.3.266

Gergen, K. J. (1994). *Realities and Relationships: Soundings in Social Construction*. Harvard University Press.

Glenton, C., Bohren, M., Downe, S., Paulsen, E., & Lewin, S. (2022). *Effective Practice and Organisation of Care (EPOC): EPOC Qualitative Evidence Synthesis: Protocol and review template*. http://epoc.cochrane.org/epoc-specific-resources-review-authors

Harris, J. L., Booth, A., Cargo, M., Hannes, K., Harden, A., Flemming, K., Garside, R., Pantoja, T., Thomas, J., & Noyes, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 2: methods for question formulation, searching, and protocol development for qualitative evidence synthesis. *Journal of Clinical Epidemiology*, *97*, 39-48. https://doi.org/https://doi.org/10.1016/j.jclinepi.2017.10.023

Hill, B., Skouteris, H., & Fuller-Tyszkiewicz, M. (2013). Interventions designed to limit gestational weight gain: a systematic review of theory and meta-analysis of intervention components. *Obesity Reviews*, *14*(6), 435-450. https://doi.org/10.1111/obr.12022

Hollway, W. (2016). Feminism, psychology and becoming a mother. *Feminism & Psychology*, *26*(2), 137-152. https://doi.org/10.1177/0959353515625662

Holstein, J. A., & Gubrium, J. F. (2012). The Constructionist Analytics of Interpretive Practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (4th ed., pp.

253-289). SAGE Publications. https://books.google.co.nz/books?id=jRNzAwAAQBAJ

Huberty, J., Leiferman, J. A., Kruper, A. R., Jacobson, L. T., Waring, M. E., Matthews, J. L., Wischenka, D. M., Braxter, B., & Kornfield, S. L. (2017). Exploring the need for interventions to manage weight and stress during interconception. *Journal of Behavioral Medicine*, *40*(1), 145-158. https://doi.org/10.1007/s10865-016-9813-z

Hurst, D. J., Schmuhl, N. B., Voils, C. I., & Antony, K. M. (2021). Prenatal care experiences among pregnant women with obesity in Wisconsin, United States: a qualitative quality improvement assessment. *BMC Pregnancy and Childbirth*, *21*(1), Article 139. https://doi.org/10.1186/s12884-021-03629-4

Jarvie, R. (2017). Lived experiences of women with co-existing BMI >= 30 and Gestational Diabetes Mellitus. *MIDWIFERY*, *49*, 79-86. https://doi.org/10.1016/j.midw.2016.12.009

Johnson, C. (2014). *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. Routledge.

Johnson, M., Campbell, F., Messina, J., Preston, L., Buckley Woods, H., & Goyder, E. (2013). Weight management during pregnancy: A systematic review of qualitative evidence. *MIDWIFERY*, *29*(12), 1287-1296. https://doi.org/10.1016/j.midw.2012.11.016

Jones, M. L. (2004). Application of systematic review methods to qualitative research: practical issues. *Journal of Advanced Nursing*, *48*(3), 271-278. https://onlinelibrary-wiley-com.ezproxy.massey.ac.nz/doi/full/10.1111/j.1365-2648.2004.03196.x

Keely, A., Gunning, M., & Denison, F. (2011). Maternal obesity in pregnancy: Women's understanding of risks. *British Journal of Midwifery*, *19*(6), 364-369. https://web.p.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=1&sid=8625b4b0-060f-429e-899f-6bdfc61960eb%40redis

Keenan, J., & Stapleton, H. (2010). Bonny babies? Motherhood and nurturing in the age of obesity. *Health, Risk & Society*, *12*(4), 369-383. https://doi.org/10.1080/13698571003792926

Keirns, N. G., Keirns, B. H., Tsotsoros, C. E., Sciarrillo, C. M., Emerson, S. R., & Hawkins, M. A. W. (2022). Associations between internalized weight stigma and visceral adipose tissue status are observed in women but not men. *Stigma and Health*, *7*(2), 161-168. https://doi.org/10.1037/sah0000381

Knight-Agarwal, C. R., Williams, L. T., Davis, D., Davey, R., Shepherd, R., Downing, A., & Lawson, K. (2016). The perspectives of obese women receiving antenatal care: A qualitative study of women's experiences. *Women and Birth*, *29*(2), 189-195. https://doi.org/10.1016/j.wombi.2015.10.008

LaMarre, A., Rice, C., Cook, K., & Friedman, M. (2020). Fat Reproductive Justice: Navigating the Boundaries of Reproductive Health Care. *Journal of Social Issues*, *76*(2), 338-362. https://doi.org/10.1111/josi.12371

Laney, E. K., Hall, M. E. L., Anderson, T. L., & Willingham, M. M. (2015). Becoming a Mother: The Influence of Motherhood on Women's Identity Development. *Identity*, *15*(2), 126-145. https://doi.org/10.1080/15283488.2015.1023440

Le Grice, J. S., & Braun, V. (2016). Mātauranga māori and reproduction: Inscribing connections between the natural environment, kin and the body. *AlterNative*, *12*(2), 151-164. https://doi.org/10.20507/AlterNative.2016.12.2.4

Lee, J. (2020). "You will face discrimination": Fatness, motherhood, and the medical profession. *Fat Studies*, *9*(1), 1-16. https://doi.org/10.1080/21604851.2019.1595289

Lee, J. A., & Pausé, C. J. (2016). Stigma in Practice: Barriers to Health for Fat Women. *Front Psychol*, *7:2063*, 1-15. https://doi.org/10.3389/fpsyg.2016.02063

Lewin, S., Glenton, C., Munthe-Kaas, H., Carlsen, B., Colvin, C. J., Gülmezoglu, M., Noyes, J., Booth, A., Garside, R., & Rashidian, A. (2015). Using qualitative evidence in decision making for health and social interventions: an approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). *PLoS Medicine*, *12*(10), 1-18. https://doi.org/10.1371/journal.pmed.1001895

Liao, S.-Y., & Huebner, B. (2021). Oppressive Things. *Philosophy and Phenomenological Research*, *103*(1), 92-113. https://eds.p.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=6b675442-ae9e-48c6-b0d6-af1d600346b5%40redis

Lindhardt, C. L., Rubak, S., Mogensen, O., Lamont, R. F., & Joergensen, J. S. (2013). The experience of pregnant women with a body mass index > 30 kg/m(2) of their encounters with healthcare professionals. *Acta Obstetricia Et Gynecologica Scandinavica*, *92*(9), 1101-1107. https://doi.org/10.1111/aogs.12186

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Lupton, D. (2012). *Configuring Maternal, Preborn and Infant Embodiment* Sydney Health & Society Group Working Paper, Sydney. https://www.researchgate.net/publication/236111253_Configuring_Maternal_Preborn_and_Infant_Embodiment

Lupton, D. (2013). Infant embodiment and interembodiment: A review of sociocultural perspectives. *Childhood*, *20*(1), 37-50. https://doi.org/10.1177/0907568212447244

Lupton, D. (2018). *Fat* (2nd ed.). Routledge. https://doi.org/https://doi-org.ezproxy.massey.ac.nz/10.4324/9781351029025

Major, C. H., & Savin-Baden, M. (2011). Integration of qualitative evidence: Towards construction of academic knowledge in social science and professional fields. *Qualitative Research*, *11*(6), 645-663. https://doi.org/10.1177/1468794111413367

Manokaran, R., Pausé, C., Roßmöller, M., & Vilhjálmsdóttir, T. M. (2021). 'Nothing about us without us': Fat people speak. *Qualitative Research in Psychology*, *18*(4), 537-549. https://doi.org/10.1080/14780887.2020.1780355

Marshall, H., & Woollett, A. (2000). Fit to Reproduce? The Regulative Role of Pregnancy Texts. *Feminism & Psychology*, *10*(3), 351-366. https://doi.org/10.1177/0959353500010003005

McPhail, D., Bombak, A., Ward, P., & Allison, J. (2016). Wombs at risk, wombs as risk: Fat women's experiences of reproductive care. *Fat Studies*, *5*(2), 98-115. https://doi.org/10.1080/21604851.2016.1143754

Mercer, R. T. (1995). *Becoming a Mother: Research on Maternal Identity from Rubin to the Present*. Springer Publishing Company.

Mercer, R. T. (2004). Becoming a Mother Versus Maternal Role Attainment. *Journal of Nursing Scholarship*, *36*(3), 226-232. https://doi.org/10.1111/j.1547-5069.2004.04042.x

Mills, A., Schmied, V. A., & Dahlen, H. G. (2013). 'Get alongside us', women's experiences of being overweight and pregnant in Sydney, Australia. *Maternal and Child Nutrition*, *9*(3), 309-321. https://doi.org/10.1111/j.1740-8709.2011.00386.x

Morison, T. (2021). Reproductive justice: A radical framework for researching sexual and reproductive issues in psychology. *Social and Personality Psychology Compass*, *15*(6), 1-10. https://doi.org/10.1111/spc3.12605

Murphy, E. (1999). 'Breast is best': Infant feeding decisions and maternal deviance. *Sociology of Health and Illness*, *21*(2), 187-208-208. https://doi.org/10.1111/1467-9566.00149

Najmabadi, K. M., Tabatabaie, M. G., Vedadhir, A. A., & Mobarakabadi, S. S. (2020). The marginalisation of midwifery in medicalised pregnancy and childbirth: a qualitative study. *British Journal of Midwifery*, *28*(11), 768-776. https://doi.org/10.12968/bjom.2020.28.11.768

Nash, J. C. (2019). Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects. *Women's Studies Quarterly*, *47*(3), 29-50. https://doi.org/10.1353/wsq.2019.0054

Nath, R. (2019). The injustice of fat stigma. *Bioethics*, *33*(5), 577-590. https://doi.org/10.1111/bioe.12560

Neiterman, E. (2013). Sharing bodies: the impact of the biomedical model of pregnancy on women's embodied experiences of the transition to motherhood. *Healthcare policy = Politiques de sante*, *9*(Spec Issue), 112-125. https://eds.s.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=7452af07-7054-45fe-aa10-ad4b381f24bd%40redis

Niiniluoto, I. (1999). *Critical scientific realism*. Oxford University Press. https://doi.org/https://doi.org/10.1093/0199251614.001.0001

Nippert, K. E., Tomiyama, A. J., Smieszek, S. M., & Incollingo Rodriguez, A. C. (2021). The Media as a Source of Weight Stigma for Pregnant and Postpartum Women. *Obesity*, *29*(1), 226-232. https://doi.org/doi-org.ezproxy.massey.ac.nz/10.1002/oby.23032

Noyes, J., Booth, A., Cargo, M., Flemming, K., Harden, A., Harris, J., Garside, R., Hannes, K., Pantoja, T., & Thomas, J. (2019). Qualitative evidence. In *Cochrane Handbook for Systematic Reviews of Interventions* (pp. 525-545). https://doi.org/https://doi.org/10.1002/9781119536604.ch21

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology*, *97*, 49-58. https://doi.org/https://doi.org/10.1016/j.jclinepi.2017.06.020

Nyman, V. M. K., Prebensen, A. K., & Flensner, G. E. M. (2010). Obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth. *MIDWIFERY*, *26*(4), 424-429. https://doi.org/10.1016/j.midw.2008.10.008

O'Reilly, M., & Kiyimba, N. (2015). *Advanced Qualitative Research: A Guide to Using Theory*. Sage.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., . . . Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, *372*, 1-9. https://doi.org/10.1136/bmj.n71

Parker, G. (2014). Mothers at Large: Responsibilizing the Pregnant Self for the "Obesity Epidemic". *Fat Studies*, *3*(2), 101-118. https://doi.org/10.1080/21604851.2014.889491

Parker, G. (2017). Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care. *Women's Studies Journal*, *31*(1), 22-33. https://web.p.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=2&sid=1922316e-aaec-4b19-9823-a142f77fc52b%40redis

Parker, G., & Pausé, C. (2018a). "I'm Just a Woman Having a Baby": Negotiating and Resisting the Problematization of Pregnancy Fatness. *Frontiers in Sociology*, *3*, 1-10. https://doi.org/10.3389/fsoc.2018.00005

Parker, G., & Pausé, C. (2018b). Pregnant with possibility: Negotiating fat maternal subjectivity in the "War on Obesity". *Fat Studies*, *7*(2), 124-134. https://doi.org/10.1080/21604851.2017.1372990

Parker, G., & Pausé, C. (2019). Productive but not constructive: The work of shame in the affective governance of fat Pregnancy. *Feminism & Psychology*, *29*(2), 250-268. https://doi.org/10.1177/0959353519834053

Parker, G., Pausé, C., & Le Grice, J. (2020). "You're Just Another Friggin' Number to Add to the Problem" Constructing the Racialized (M)other in Contemporary Discourses of

Pregnancy Fatness. In M. Friedman, C. Rice, & J. Rinaldi (Eds.), *Thickening Fat : Fat Bodies, Intersectionality, and Social Justice* (1st ed., pp. 97-109). Routledge. https://doi.org/https://doi-org.ezproxy.massey.ac.nz/10.4324/9780429507540

Parker, I. (1998). *Social Constructionism, Discourse and Realism*. SAGE Publications Ltd. https://doi.org/https://dx.doi.org/10.4135/9781446217412

Parratt, J. A., & Fahy, K. M. (2011). A feminist critique of foundational nursing research and theory on transition to motherhood. *MIDWIFERY*, *27*(4), 445-451. https://doi.org/10.1016/j.midw.2010.02.012

Pausé, C. (2017). Borderline: The ethics of fat stigma in public health. *Journal of Law, Medicine and Ethics*, *45*(4), 510-517. https://doi.org/10.1177/1073110517750585

Perinatal and Maternal Mortality Review Committee. (2018). *Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality and morbidity 2016*. Wellington, New Zealand: Perinatal and Maternal Mortality Review Committee. Retrieved from https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/12th-PMMRC-report-final.pdf

Raphael-Leff, J. (1991). The Mother as Container: Placental Process and Inner Space. *Feminism & Psychology*, *1*(3), 393-408. https://doi.org/10.1177/0959353591013005

Raphael-Leff, J. (2001). *Pregnancy : The Inside Story* (Rev. ed.). Karnac. https://doi.org/https://doi.org/10.4324/9780429478482

Relph, S., Ong, M., Vieira, M. C., Pasupathy, D., & Sandall, J. (2020). Perceptions of risk and influences of choice in pregnant women with obesity. An evidence synthesis of qualitative research. *PLoS ONE*, *15*(1), 1-15. https://doi.org/10.1371/journal.pone.0227325

Rich, A. (1995). *Of Woman Born: Motherhood as Experience and Institution*. W.W. Norton and Company.

Ross, L., & Solinger, R. (2017). *Reproductive Justice: An Introduction*. University of California Press. https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=nlebk&AN=1477981&site=eds-live&scope=site&authtype=sso&custid=s3027306

Rothman, B. K. (2014). Pregnancy, birth and risk: an introduction. *Health, Risk & Society*, *16*(1), 1-6. https://doi.org/10.1080/13698575.2013.876191

Rubin, R. (1984). *Maternal Identity and the Maternal Experience*. Springer Publishing Company.

Saw, L., Aung, W., & Sweet, L. (2021). What are the experiences of women with obesity receiving antenatal maternity care? A scoping review of qualitative evidence. *Women and Birth*, *34*(5), 435-446. https://doi.org/10.1016/j.wombi.2020.09.014

Shaw, J. C. A. (2013). The medicalization of birth and midwifery as resistance. *Health care for women international*, *34*(6), 522-536. https://doi.org/10.1080/07399332.2012.736569

Shaw, R. M., & Fehoko, E. (2022). Epistemic injustice and Body Mass Index: Examining Māori and Pacific women's access to fertility treatment in Aotearoa New Zealand. *Fat Studies*, 1-15. https://doi.org/10.1080/21604851.2022.2063507

Sim, S. M., Kirk, S. F. L., & Aston, M. (2020). Mothering at the Intersection of Marginality: Exploring Breastfeeding Beliefs and Practices Among Women From Nova Scotia, Canada Who Identify as Overweight, Low Income, and Food Insecure. *Qualitative Health Research*, *30*(11), 1737-1748. https://doi.org/10.1177/1049732320921830

SisterSong. (n.d). *Reproductive Justice*. https://www.sistersong.net/reproductive-justice

Stengel, M. R., Kraschnewski, J. L., Hwang, S. W., Kjerulff, K. H., & Chuang, C. H. (2012). 'What my doctor didn't tell me': Examining health care provider advice to overweight and obese pregnant women on gestational weight gain and physical activity. *Women's Health Issues*, *22*(6), e535-e540. https://doi.org/10.1016/j.whi.2012.09.004

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75. https://doi.org/10.3316/QRJ1102063

Suri, H. (2014). *Towards Methodologically Inclusive Research Syntheses: Expanding possibilities*. Routledge. https://doi.org/https://doi-org.ezproxy.massey.ac.nz/10.4324/9780203383193

Sutin, A. R., Stephan, Y., & Terracciano, A. (2015). Weight Discrimination and Risk of Mortality. *Psychological Science*, *26*(11), 1803-1811. https://journals-sagepub-com.ezproxy.massey.ac.nz/doi/pdf/10.1177/0956797615601103

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 1-10. https://doi.org/10.1186/1471-2288-8-45

Thorbjornsdottir, K. E., Karlsen, I. E., Dahl, B., & Roseth, I. (2020). "Talk to me, not at me": obese women's experiences of birth and their encounter with birth attendants - a qualitative study. *International Journal of Qualitative Studies on Health and Well-Being*, *15*(1), 1-10. https://doi.org/10.1080/17482631.2020.1845286

Ward, P., & McPhail, D. (2019). Fat Shame and Blame in Reproductive Care: Implications for Ethical Health Care Interactions. *Women's Reproductive Health*, *6*(4), 225-241. https://doi.org/10.1080/23293691.2019.1653581

Warin, M., Zivkovic, T., Moore, V., & Davies, M. (2012). Mothers as smoking guns: Fetal overnutrition and the reproduction of obesity. *Feminism & Psychology*, *22*(3), 360-375. https://doi.org/10.1177/0959353512445359

Westerman, R., & Kuhnt, A. K. (2022). Metabolic risk factors and fertility disorders: A narrative review of the female perspective. *Reproductive Biomedicine & Society Online*, *14*, 66-74. https://doi.org/10.1016/j.rbms.2021.09.002

World Health Organization. (2021). *Obesity and overweight*. https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

Appendices

Appendix A: Search Terms for Systematic Database Search

fat or body fat or obese or obesity or overweight
pregnant or pregnancy or fertility or reproductive or reproduction or antenatal or prenatal or postnatal or perinatal
medical professional or health practitioner or obstetrician or healthcare or doctor or nurse or midwife or clinician
qualitative or qualitative study, qualitative research or interview or focus group or narratives or phenomenology or grounded theory or thematic analysis
experience or interaction or perspective

Appendix B: Article Screening Inclusion and Exclusion Criteria

Inclusion	**Rationale**
Primary qualitative research from the perspective of fat people related to their experiences of fertility and perinatal healthcare interactions with medical professionals.	This relates directly to the research question.
Full access, journal articles published in English.	I am monolingual, the scope, timeframe, and resources of a master's thesis are too small to allow for accurate translations of studies, or for the full and detailed reading of books and longer form academic writings.
Participants had engaged in reproductive healthcare including fertility treatment, or up to one-year postpartum.	Primarily interested in participants experiences in relation to maternal identity development as opposed to ongoing identity negotiations.
Exclusion	**Rationale**
Quantitative or mixed methods research, and literature reviews.	This is a QES concerned with participants experiences from qualitative primary studies.
Research from the perspective of medical professionals about fat pregnant people.	This perspective would be the antithesis of research question.
Studies that explore the experiences of a weight management programme or intervention.	Studies carried out in the context of a weight management intervention are not part of maternity care globally, and interventions do not necessarily require interactions with medical professionals. Additionally, they problematise fat pregnancy from the outset.
Articles that are not retrievable through Massey University database subscriptions.	Timeframe and potential resource issues involved with accessing articles that are not available through Massey.
Studies with limited to no data about participants interactions and experiences with their healthcare provider.	Studies with limited data on participant interactions with healthcare professionals will not contribute to synthesis meaningfully.

Appendix C: Abbreviated Search Terms for the Supplementary Search

Fat Studies:	Fat AND Pregnant OR Pregnancy OR Reproductive OR Reproduction.
Feminism & Psychology	Fat or obese or obesity or overweight AND pregnancy or pregnant or reproduction or reproductive.

Appendix D: Characteristics of Studies Included in the QES

Reference	Location	Participants	Objectives / RQ	Healthcare Interaction	Data Collection & Methodology	Stage of fertility or perinatal healthcare	Key findings
1. (Atkinson & McNamara, 2017).	Republic of Ireland.	15 participants, women with BMI ≥30kg/m² at first antenatal appointment.	To explore the lived experiences of women with BMI of ≥30kg/m² in maternity care, and to identify best practice for supporting similar women in future.	Midwife, nurse, doctor, healthcare professionals.	Semi structured interviews. IPA, double hermeneutics. Biomedical.	Pregnancy, birth, postpartum	"unconscious collusion" – weight not mentioned, just recorded. Unclear nutrition advice from HCP. Avoidance of communicating health messaging around obesity, "toehold". Rejection of word "obesity".
2. (Bombak et al., 2016).	Canada – 'Centreville' & 'East River'.	24 Participants, 18 from the larger city (Centreville). Overweight or obese. 3 participants did not experience reproductive care while overweight or obese but were still included.	To analyse participants experiences of obesity stigma in reproductive healthcare, attempting to disrupt it by bridging the gap between critical obesity scholarship and biomedical understandings of obese pregnancy and birth.	Doctor, nurse, healthcare aid, gynaecologist, intern, student doctors, obstetrician, anaesthesiologist.	Semi structured interviews. Theoretical analysis, drawing on poststructuralist feminism and Foucauldian theory. Bridging biomedical and critical obesity studies.	Fertility treatment, pregnancy and postpartum	Participants had both positive and negative experiences with medical professionals. Language relating to body size was of importance to participants. Examples of medical professionals refusing care. Experience of participants internalising mother blame/risk discourse which may be experienced as stigmatising, and some participants display resistance to these discourses.
3. (Dejoy et al., 2016).	USA, 13 states.	16 women with BMI ≥30kg/m². Pregnant and recently postpartum from online communities for plus sized pregnant women.	To explore obese women's experiences of the maternity care system in the United States.	Midwife, nurse, doctor, OBGYN.	In-depth, semi structured interview. Descriptive phenomenology, thematic analysis. Biomedical.	Pre-conception counselling, pregnancy, birth, postpartum	1/3 of participants had no negative experiences, while 2/3 had at least one negative encounter during maternity care. Negative experiences included stigmatisation and depersonalised care leading to instances of medical coercion. Interactions tainted the pregnancy experience.
4. (Dieterich et al., 2022).	Pittsburgh, PA, USA.	18 participants with pre-pregnancy BMI of ≥25kg/m², 1-2 months postpartum. (Sample from larger study).	To explore experiences and perspectives of overweight and obese participants who intended to breastfeed and if weight stigma impacted upon this intention.	Nurses, obstetricians, paediatricians, lactation consultants.	Semi structured interviews. Qualitative content analysis. Biomedical.	Pregnancy, postpartum (breastfeeding focused)	Some participants had positive interactions that were supportive and focused on other health indicators rather than weight. Confidence and intention to breastfeed superseded concern about stigma, but lack of social support was a barrier.
5. (Furber & McGowan, 2011).	England.	19 women with BMI of ≥35kg/m² during pregnancy.	To explore the experiences of obese women during pregnancy, birth and postnatal periods.	Midwife, nurse, obstetrician, sonographer.	Semi structured interviews. Framework analysis. Biomedical.	Pregnancy, birth, postnatal	Being obese and pregnant leads to humiliating experiences, and a high degree of medicalised care which can become distressing.
6. (Hurst et al., 2021).	Midwest, USA.	30 women with BMI of ≥40kg/m².	To understand that weight bias and stigma that obese women experiences in antenatal care interactions, and what their preferred language would be in relation to weight based discussions. Authors also sought feedback for group antenatal education.	Nurse, doctor, sonographer, anaesthesiologist, hospital staff (food service staff).	Semi-structured interviews. Thematic content analysis. Biomedical.	Pregnancy, birth, postpartum	Many participants had at least one negative encounter with a medical professional during their antenatal care despite experiences being generally positive over all. Participants reported instances of increased intervention/screening based on their weight and wanted medical pros to be more direct with discussions around this, or to

							consider their health more holistically, rather than focusing on their weight as a key indicator.
7. (Jarvie, 2017).	England.	27 women with BMI of ≥30kg/m² and GDM.	To explore the experiences of women with maternal obesity and gestational diabetes mellitus during pregnancy and postpartum period.	Midwife, sonographer, dietician, consultant, "healthcare professionals".	In-depth narrative interviews. Cross sectional thematic analysis. Biomedical.	Pregnancy, postpartum	Social and financial factors impacted upon participants ability to 'manage' obese pregnancy and GDM and they felt stigmatised by medical professionals and general public.
8. (Keely et al., 2011).	Edinburgh, Scotland.	8 women with BMI of ≥40kg/m² at first appointment.	To explore obese women's experiences of maternity care and their perceptions of the risk of maternal obesity.	Midwife, anaesthetist, "health professionals".	Open ended, semi structured interviews. Content analysis. Biomedical.	Pre-pregnancy, pregnancy	Maternity care was not negative, nor were participants offended by med pro comments, but participants did want more consistent information regarding potential risks of obese pregnancy.
9. (Keenan & Stapleton, 2010).	England.	60 women with pre-pregnancy BMI of 30-57kg/m².	To explore how biomedical discourse plays out in women interactions with medical professionals during the perinatal period.	Midwife, nurse, doctor, consultant.	Longitudinal and one-off interview. Cross sectional thematic analysis. Critical obesity scholarship.	Pregnancy, birth, postpartum	Some med pros did not mention weight to participants, others did not pathologize it during interactions. Participants frustrated that medical interventions were sprung on them after weight was seemingly not an issue prior.
10. (Knight-Agarwal et al., 2016).	Australia.	16 pregnant women with BMI of ≥30kg/m².	To explore the perspectives of women with BMI of ≥30kg/m² receiving maternity care.	Doctor, "health professionals", diabetes specialist, diabetes educator.	Semi-structured interviews. Interpretive Phenomenological Analysis (IPA). Biomedical.	Pregnancy, postpartum	Many participants had been overweight or obese for most of their lives, and lacked in depth understanding of potential health risks this may have for themselves and child. GWG advice was scarce or judgmental and confusing, but participants want help with and were motivated to eat healthily.
11. (LaMarre et al., 2020).	Ontario, Canada.	17 "overweight or obese while pregnant" participants.	To analyse the narratives of people who were labelled overweight or obese in relations to their fertility and pregnancy healthcare experiences.	Midwife, doctor, fertility doctor.	Semi-structured interviews. Thematic analysis from critical feminist perspective. Considers policy etc. Fat studies.	Fertility treatment, pregnancy, birth	Participants told stories of stigmatising experiences with med pros, self-governance, resistance, self-advocacy, and non-inclusive care experiences.
12. (Lee, 2020).	Melbourne, Australia.	1 participant.	To highlight the impact that medicalisation of fatness, pregnancy and early motherhood.	Midwife, doula, nurse, obstetrician, lactation consultant, friend who is a General Practitioner.	Journaling, photography, and critical essay writing. Autoethnography. Fat Studies	Pre-conception, pregnancy, birth, postpartum	Even with access to fat activist support and a history of fat acceptance to support a positive experience, Lee still experienced a myriad of negative experiences and emotions during pre-conception, birth and motherhood.
13. (Lindhardt et al., 2013).	Denmark.	16 women with pre-pregnancy BMI of ≥30kg/m².	To examine obese women's experiences with medical professionals during pregnancy.	Midwife, nurse, General	Semi-structured interview. Giorgi's phenomenology.	Pregnancy, birth, postpartum	Interactions with medical professionals were often stigmatising and shame inducing in nature. Simultaneously participants shared that there was

				Practitioner, obstetrician.	Biomedical.		a lack of information and advice provided to them by med pros.
14. (McPhail et al., 2016).	Canada – 'Centreville' & 'East River'.	24 Participants, 18 from the larger city (Centreville).	To explore the reproductive healthcare experiences of fat women who are seeking fertility, pregnancy and birthing care.	Midwife, General Practitioner, fertility specialist, obstetrician, endocrinologist.	Semi-structured interviews. Theoretical analysis drawing on poststructuralist feminism and Foucauldian theory. Critical obesity scholarship.	Fertility treatment, pregnancy	Med pros centred care interactions around foetal risk which positioned fat mothers as unfit reproducers. Participants shared experiences of being denied care such as contraceptive removal which is akin to eugenic practices.
15. (Mills et al., 2013).	Sydney, Australia.	14 women, BMI of ≥30kg/m² 3rd trimester or perinatal period.	To explore the maternity care experiences and perceptions of overweight pregnancy women.	Midwife, doctor, GP, sonographer/radiologist, "healthcare professional", receptionist.	Interview. Thematic analysis. Biomedical.	Preconception, pregnancy, birth, postpartum	Being overweight and pregnancy was uncomfortable and affected how women viewed themselves. They had varying levels of intention to do something about their weight and wanted supportive and equitable treatment from medical pros.
16. (Nyman et al., 2010).	Sweden.	10 women with BMI greater than 30kg/m².	To provide a description of obese women's interactions with medical professionals during pregnancy and birth.	Midwife, "caregivers".	Interview. Phenomenological psychological method (Karlsson). Biomedical.	Pregnancy, birth	Being obese and pregnant opened participants up increased awareness of themselves, as well as scrutiny of others, leading to negative emotions. Negative emotions were amplified by humiliating interactions with med pros, while affirming interactions had the opposite effect and supported wellbeing.
17. (Parker & Pausé, 2018a).	Aotearoa NZ.	27 self identifies fat women and new mothers.	To understand how women are oppressed by dominant discourses around fat pregnancy, and how they also negotiate and resist it.	Midwife, doctor.	In-depth semi-structured interview. Post structural discourse analysis. Fat studies.	Pregnancy, birth	Women were active participants in negotiating and resisting the problematic framing of their fat pregnancy, demonstrating the ways in which their successful experiences ran counter to the dominant discourses that initially projected poor outcomes for their babies.
18. (Parker & Pausé, 2018b).	Aotearoa NZ.	27 self identifies fat pregnant people.	To demonstrate how fat pregnant peoples wellbeing and maternal identity are implicated by the cross over between the biopolitics of fat pregnancy, and the care and concern they have for their unborn child.	Midwife.	Semi-structured interviews/caring conversations. Foucauldian inspired discursive thematic analysis. Fat Studies.	Pregnancy	The internalisation of biomedical discourses around fat pregnancy lead to participants feeling like they had failed at motherhood before their child was even born.
19. (Parker & Pausé, 2019).	Aotearoa NZ.	27 self identifies fat pregnant people.	To demonstrate how medical discourse problematises fat pregnancy leading to mothers feeling shamed into self-governing practices that are not improving health of mother or child.	Midwife, doctor, ultrasound tech/ radiographer.	Semi-structured, conversational style interview (with guide). Affective discursive analysis. Fat Studies.	Pregnancy, birth, postpartum	Shaming encounters lead to participants to self-govern, often leading to engagement in unhealthy behaviours in an attempt to protect their child from their 'dangerous' fat bodies.
20. (Shaw & Fehoko, 2022).	Aotearoa NZ.	9 Māori and Pasifika women with BMI ≥32kg/m².	To explore the experiences of Māori and Pasifika women whose BMI was a key barrier for their eligibility for publicly funded fertility treatments.	Fertility doctors and specialists, general practitioner.	In-depth zoom interviews. Thematic analysis with Epistemic injustice lens.	Fertility treatment	Most of the participants experienced some form of epistemic injustice. BMI was problematic for most participants typically because even with intentional weight loss, their genetic predispositions and cultural environment made

					Fat Studies.		BMI targets unreasonable. Fertility treatment language and office is Eurocentric.
21. (Sim et al., 2020).	Nova Scotia, Canada.	6-8 participants (2 drop out?), pre-pregnancy BMI of ≥27kg/m².	To explore the beliefs and practices around breastfeeding for women who are overweight and experience financial hardship and food insecurity.	Nurse, public health nurse, "healthcare professionals".	Semi-structured interview. Feminist post structural Discourse analysis. Biomedical, but critical.	Postpartum (breast feeding)	The good mother discourse was salient in the participants experiences of breastfeeding both in being best for the child and for confirming their role as mother. Being overweight and food insecure complicated breastfeeding and tension arose between what is the "right" way to feed a child, and what is actually possible for mothers.
22. (Stengel et al., 2012).	Pennsylvania, USA.	24 overweight or obese women (BMI).	To describe medical professionals advice regarding gestational weight gain during pregnancy, and how participants interpreted that advice.	Doctor, obstetrician.	Semi-structured interview. Grounded theory approach. Biomedical.	Pregnancy	Participants felt that doctors were not concerned about GWG, and received little information regarding recommended exercise during pregnancy. Participants are very keen to have information relayed to them by their doctors.
23. (Thorbjornsdottir et al., 2020).	Norway.	10 women with BMI of ≥30kg/m² at the beginning of pregnancy.	To explore obese women's experiences with their birth attendant.	Birth attendant, doctor, anaesthesiologist, "healthcare professional".	Semi-structured interview. Giorgi's phenomenology. Biomedical.	Pregnancy, birth.	Participants valued and benefitted from supportive and empowering interactions with birth attendants but were still met with instances of overmedicalisation and assumption of risk.

Appendix E: Critical Appraisal Skills Programme Outcome (CASP)

Key: ***Y – Yes*** ***N – No*** ***C/T – Cannot tell***	**Was there a clear statement of the aims of the research?**	**Is a qualitative methodology appropriate?**	**Was the research design appropriate to address the aims of the research?**	**Was the recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issue?**	**Has the relationship between researcher and participants been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings?**	**How valuable is the research?**	**Overall Assessment**
1. Atkinson & McNamara (2017).	Y – Aim reiterated and rationale provided.	Y – Interested in exploring and understanding lived experience.	Y – Use of IPA justified.	Y – Recruitment strategy explained, and brief mention of exclusions.	Y – Interview setting and procedure justified. Guide provided.	Y – Reflexivity process noted.	Y – Gained ethics approval, considered sensitive nature of participation and referral arrangements made.	Y – In-depth description of analysis. Full example of one super-ordinate theme. Ample data provided.	Y – Clear statement of findings, and thorough discussion.	Y – Discusses findings in relation to maternity care services and transferability.	No or very minor concerns.
2. Bombak et al. (2016).	Y – Aim stated and context was provided.	Y – Interested in participant experiences.	Y – Rationale provided for research design.	Y – Recruitment process explained and rationale provided for inclusion.	Y – Pseudonym of interview locations provided, data collection method stated.	N – Reflexive practice not noted in article.	Y – Gained ethics approval, participants self-selected into study, pseudonym created for cities in study.	Y – Analysis process described. Data presented to support findings.	Y – Findings clearly organised with in-depth discussion.	Y – Discusses findings in relation to current research and practice. Suggestions for future research.	Minor concerns.
3. Dejoy et al. (2016).	Y – Purpose stated and context was provided.	Y – Interested in exploring lived experience.	Y – Rationale provided for research design.	Y – Recruitment and sampling process explained. Non-participation explained.	Y – Interview setting and procedure justified. Guide provided. Saturation discussed.	C/T – Reflexive practice not noted in article. Only mentions “bracketing” to reduce bias.	Y – Gained ethics approval. Pseudonyms assigned for participants and self-selected into study.	Y – Analysis process described. Table of major and minor themes. Ample supporting quotes.	Y – Findings clearly organised. 3 analysts and respondent validation of themes.	Y – Discusses findings in relation to practice and future research.	Minor concerns.

4. Dieterich et al. (2022).	Y – Study objective and context provided.	Y – Interested in participant experiences.	Y – Rationale provided for research design.	Y – Purposeful sampling justified.	Y – Interview setting and procedure justified.	Y – Reflexive practices noted but not described in detail.	Y – Gained ethics approval. Reflexive journal kept.	Y – In-depth description of analysis process. Raw data available.	Y – Findings clearly organised with in-depth discussion.	Y – Suggestions for future research and acknowledges transferability limitations.	No or very minor concerns.
5. Furber & McGowen (2011).	Y – Aim/objective reiterated and context provided.	Y – Interested in participants experiences.	N – Justification not explicit but framework analysis supports focus on participant perspectives.	Y – Recruitment and inclusion/ Exclusion criteria explained.	Y – interview setting the procedure justified.	C/T – Reflexive practice not noted. Discussions during analysis to reduce bias.	Y – Gained ethics approval. Information provided on two occasions. Transcripts anonymised.	Y – Clear description of analysis process. Mentions minimising bias. Plenty supporting data.	Y – Findings clearly organised with in depth discussion. Two analysts.	Y – Suggestions made for practice and future research.	Minor concerns.
6. Hurst et al. (2021).	Y – Statement of aims and context provided.	Y – Interested in the experiences of participants.	N – Describes review board approval rather than rationale for content analysis.	Y – Recruitment and inclusion/ Exclusion criteria explained.	C/T – Interview guide and recording methods provided. Saturation discussed. Question aim/interview congruence	C/T - Reflexive practice not noted. Mentions limitations of having medical student as interviewer.	Y – Approval from institutional Review Board at Hospital. Participants assigned ID number.	Y – Clear description of analysis process. Sufficient data presented.	Y – Three analysts. Findings clearly organised and related to the three aims of the research.	Y – findings were expected to directly inform practice, and suggestions are made.	Minor to moderate concerns.
7. Jarvie (2017).	Y – Aim/objective reiterated and context provided.	Y – Interested in exploring lived experience.	Y – Rationale for research design provided.	Y – Recruitment and inclusion criteria explained. Provides reasons for participant drop out.	Y – interview guide provided and form of data collection noted.	C/T – Not explicit but mentions taking reflective fieldnotes.	Y – Approval from NHS research ethics committee. Pseudonyms provided. Informed consent sought repeatedly.	Y – In-depth description of analysis. Sufficient supporting data provided.	Y – Clear statement of findings discussed in relation to research question.	Y – Policy and practice suggestions made. Notes limitations in relation to representing wider population.	Minor concerns.

8. Keely et al. (2011).	Y - Statement of aims and context provided.	Y – Interested in the experiences of participants.	Y – Rationale for research design provided.	Y – Recruitment and inclusion/ exclusion criteria described. Provides reasons for participant drop out.	Y – Interview type, location, and type of data collection described.	N – Reflexive practice not noted in article.	Y – Gained ethics approval. Informed consent received.	C/T – Very brief description of analysis process provided.	C/T – Findings clearly organised in relation to research question, but no discussion of credibility.	Y –Suggestions for future research and practice made.	Minor to moderate concerns.
9. Keenan & Stapleton (2010).	Y – Goal of research and relevance clearly discussed.	Y – Interested in participants experiences.	C/T – Justification not explicit but cross sectional analysis supports focus on participant experiences over time.	Y – In depth discussion about participant selection and sampling.	C/T – Interview style, location, and recording method not noted in this article, but described in-depth in other publications.	C/T – Only notes average or normal BMI in relation to the participants.	C/T – only references ethics committee in relation to participant recruitment. Considers potential of study to increase participant anxiety of risks.	C/T – References analysis style but provides no description. Data sufficiently supports findings.	Y – Finding clearly organised and discussed in relation to research aims.	Y – Suggestions for future research. Critical of public health policies and interventions related to infant feeding and maternal self-management.	Minor to moderate: Moderate concerns at face value but, these are largely resolved by reading chapter 7 in Dykes and Hall-Moran (2009).
10. Knight-Agarwal et al. (2016)	Y – Research aim stated and relevance explained.	Y – Interested in participants perspectives and lived experiences.	Y – Explained why IPA is appropriate.	Y – Outlines recruitment strategy and eligibility criteria.	Y – Outlines interview location and procedure.	C/T – Mentions interviewers being trained to reduce bias.	Y – Gained ethics approval, participants expressed interested in study and gave signed consent. Anonymity ensured through use of identifying number.	Y – Analysis process described. Researchers triangulated themes, and used participants quotes to support code and themes generation.	Y – Clear statement of findings, and a thorough discussion of those findings in relation to other research.	Y – Suggestion that themes from study could be built upon for future empirical studies and later inform policy or practice.	No or very minor concerns.
11. LaMarre et al. (2020).	Y – Research objective and relevance clearly stated.	Y – Interested in participants experiences.	Y – In-depth discussion of research design.	Y – Recruitment strategy explained and barriers or limitations to recruitment discussed.	Y – Interview setting, data collections method, and outline of interview questions provided.	Y – Reflexive practices and positionality thoroughly discussed.	Y – Gained ethics approval from 4 ethics boards. Pseudonyms used.	Y – In-depth discussion of analysis process and theoretical underpinning.	Y – Findings clearly organised with ample supporting data. Reflexivity	Y – Reiterates participants suggestions in relation to suggestions for practice change.	No or very minor concerns.

									practiced throughout.		
12. Lee (2020)	Y - Research aim stated and relevance explained.	Y – Auto-ethnography is appropriate for narrating personal experience.	Y – In-depth discussion about methodology.	Y – In-depth reflection of personal experiences positions Lee and an expert on this topic.	Y – Outlines data collections methods appropriate to auto-ethnography.	Y – Reflexivity considered and thoroughly discussed.	N/A	Y – personal stories discussed in relation to wider cultural and political factors.	Y – Findings clearly organised with in-depth discussion.	Y – Suggests that fat studies scholars continue to share their own stories to inform medical practice.	No or very minor concerns.
13. Lindhardt et al. (2013).	Y – Research objectives and relevance explained.	Y – Interested in participants lived experiences.	Y – Methodology described and brief rationale provided.	Y – Recruitment method explained. Outlines inclusion criteria.	Y – Interview type and collection method noted. Rationale for interview guide. Opening question and data saturation noted.	C/T – Mentions reflection in relation to analysis process.	Y – Gained ethics approval and informed consent was provided. Participants assigned numerical identifier.	Y – Description of analysis process provided. Tables showing main themes with ample supporting data.	Y – Findings are clearly organised in relation to the research question. Mentions validation. More than one analyst.	Y – Suggestions for practice change provided. Notes limitation of homogenous participant group.	No or very minor concerns.
14. McPhail et al. (2016).	Y – Research aim and relevance explained.	Y – Interested in participants experiences.	Y – Rationale provided for research design.	Y – Recruitment methods explained and barriers or limitations to recruitment discussed.	Y – Clear description of data collections method, brief outline of interview questions.	C/T – Only notes that research encounters are where discourses are expressed and retold.	C/T – Ethics approval not explicit but larger studied was approved, pseudonym created for cities in study.	Y – Analysis process described. Ample data provided to support findings.	Y - Findings are clearly organised in relation to the research question. Multiple analysts.	Y – Suggests changes for practitioners and encourages further critical research. Notes limitation of small and homogenous participant group.	Minor concerns.

15. Mills et al. (2013).	Y – Research aim and relevance explained.	Y – Interested in participants experiences.	Y – Rationale provided for research design.	Y – Recruitment methods explained and barriers or limitations to recruitment discussed.	Y – Clear description of data collections method. Interview schedule provided.	N – Reflexive practice not noted in article.	Y – Gained ethics approval and written consent prior to interviews. Pseudonyms used.	Y – Analysis process described. Findings supported. Notes how contrasting findings.	Y - Discussed findings in relation to research questions. Multiple analysts.	Y – Suggestions for practice and policy. Notes that participants were not entirely representative of the wider population.	Minor concerns.
16. Nyman et al. (2010).	Y – Research objective and relevance explained.	Y – Interested in describing participants experiences.	Y – Rationale provided for research design.	Y – Recruitment method and inclusion/ exclusion criteria described.	Y – Participants chose interview location. Opening interview questions and data collections method described.	Y – Authors discussed personal attitudes toward obesity together prior to interviews.	Y – Gained ethics approval. "Standard ethical principles" followed. Pseudonyms used.	Y – Analysis process described in-depth with two accompanying examples. Sufficient data provided.	Y – Findings are clearly organised in relation to the research question. Multiple analysts. Describes vertical and horizontal consistency.	Y – Notes implications for practice and makes suggestions for future research.	No or very minor concerns.
17. Parker & Pausé (2018a).	Y – Research aim and relevance explained.	Y – Interested in exploring peoples discursive resistances.	Y – Rationale provided for research design.	Y – Understanding that findings are from a wider study, therefore recruitment not discussed in-depth.	Y – Clear description of interview style and rationale. Data saturation noted.	Y – Brief description of positionality and shared experiences of participants.	Y – Gained ethics approval and written informed consent. States research practice is grounded in care ethics.	Y – Analysis process discussed in-depth. Ample data to support findings.	Y - Findings are clearly organised in relation to the research question. Data saturation suggests generalisability and therefore validity.	Y – Findings discussed in relation to their potential to shift dominant understandings, and inform practice changes.	No or very minor concerns.

18. Parker & Pausé (2018b).	Y – Research aim and relevance explained.	Y – Interested in exploring participants experiences.	Y – Rationale provided for research design.	Y – Recruitment methods and inclusion criteria described.	Y – Interview location and style and structure described.	Y – Brief description of positionality and shared experiences of participants.	Y – Understanding that findings are from a wider study, therefore ethics approval and written informed consent were gained.	C/T – Analysis process noted and referenced but not described in-depth. Ample data to support findings.	Y – Key finding discussed at length in relation to research aim.	Y – Asks how findings impact upon participants futures.	No or very minor concerns.
19. Parker & Pausé (2019).	Y – Research aim and relevance explained.	Y – Interested in participants experiences.	Y – In-depth rationale provided for research design.	Y – Recruitment methods and inclusion criteria described.	Y – Interview location noted, and style and structure described in-depth.	Y – Brief description of positionality and shared experiences of participants.	Y – Gained ethics approval. Pseudonyms provided.	Y – Analysis process discussed in-depth. Ample data to support findings.	Y - Findings are clearly organised in relation to the research question.	Y – Considers findings in relation to systemic factors and makes suggestion of more compassionate care practices.	No or very minor concerns.
20. Shaw & Fehoko (2022).	Y – Focus of article and relevance explained.	Y – Interested in participants experiences and stories.	Y – In-depth rationale for research framing.	Y – Recruitment methods and inclusion criteria rationale described. Notes barriers to recruitment.	Y – Interview location and collection method noted, data from larger study.	C/T – Only notes that 2/3 interviewers share the same cultural identity as participants.	Y – Gained ethics approval. Notes preliminary conversations with participants for cultural safety, trust and confidentiality. Pseudonyms provided.	C/T – Reference provided for analysis process but not described. Ample data to support findings.	Y - Findings are clearly organised in relation to the research question. Respondent validation.	Y – Considers findings in relation to research questions and systemic factors. Suggestions for policy changes.	Minor concerns.
21. Sim et al. (2020).	Y – Objective and relevance clearly explained.	Y – Interested in participants experiences.	Y – In-depth discussion of research design.	Y – Recruitment method and inclusion criteria described.	Y – In-depth discussion of data collection and interview conduction.	Y – Notes that journaling and active interviewing supported reflexive practices and highlighted the effects of positionality.	Y – Gained ethics approval. Written informed consent. Participants not named or identified in any way.	Y – In-depth description of analysis process. Sufficient data to support findings. Reflexive practices noted.	Y – Findings clearly organised. Discussion of trustworthiness and credibility of findings. Data triangulation. Findings discussed in relation to research question.	Y – Considers findings in relation to research questions and systemic and material factors. Suggests focus on person centred care. Notes limitations.	No or very minor concerns.

22. Stengel et al. (2012).	Y – Aim and relevance clearly explained.	Y – Interested in participants experiences.	C/T – Described but not explicitly justified.	Y – Recruitment method and inclusion criteria described. Sampled from larger study.	Y – Data collection described. Interview questions provided. Saturation noted.	N – Reflexive practice not noted in article.	Y – Gained ethics approval, and verbal consent. Participants not named or identified in any way.	C/T – Analysis process referenced and briefly described. Sufficient data to support findings.	Y – Table of emergent themes provided. Findings were agreed upon by all investigators.	Y – Notes limitation of transferability due to sampling convenience method. Describes implications for practice.	Minor concerns.
23. Thorbjörnsdottir et al. (2020).	Y – Purpose and relevance clearly explained.	Y – Interested in participants experiences.	Y – Rationale provided for research design.	Y – Recruitment method and inclusion criteria described.	Y – Data collection and setting described. Opening question provided.	C/T – Bias's not made explicit but notes the use of bracketing and multiple analysts to address potential bias.	Y – Gained ethics approval and written informed consent. Participants assigned codes for anonymity.	Y – In-depth description of analysis process. Sufficient data to support findings.	Y – Results clearly organised. More than one analyst used. Results discussed in relation to research question.	Y – Notes implication for practice as well as strengths and limitations. Results considered in relation to other research and systemic factors.	No or very minor concerns.

Appendix F: RETREAT Framework for QES Methodology Selection

Review question: Concerned with the experiences of fat people who are seeking reproductive healthcare, and the interactions they have with medical professionals. Thematic synthesis is frequently used in QES that are interested in exploring the full spectrum of people's experiences and interaction with, and understanding of, healthcare (Flemming & Noyes, 2021).
Epistemology: As noted in the epistemology section of this thesis, TS is appropriate for analysis owing to its associations with TA and the inherent flexibility that TA provides (Thomas & Harden, 2008). In addition my own relativist standpoints supports the notion that there is no singular truth that can be known, and therefore having methodological incongruence across primary studies is acceptable (Braun & Clarke, 2022; O'Reilly & Kiyimba, 2015). In order to avoid generating descriptive themes from the analysis which is a common issue with TS, I will used a reproductive justice framework as a lens through which to interpret the synthesis findings (Flemming & Noyes, 2021). This is an appropriate framework to use as much of the scholarship in this area is critical in nature, and this thesis is intended to support reproductive justice for fat people.
Time frame: TS is an appropriate methodology as it is efficient for the time limitations of a master's thesis, and for my skill level as a novice researcher (Booth et al 2016). TS can also be completed in a shorter time frame than other QES approaches, it can utilise with 'thin' and 'thick' data from primary studies, and is prescriptive for first time researchers (Flemming & Noyes, 2021). All of this makes it a suitable approach to QES within the scope of a master's thesis. One downside of TS is that it can result in descriptive, rather than higher level or interpretative themes (Flemming & Noyes, 2021).

Resources: There are limited resources for the scope of the master's thesis QES. There is no research team or financial support. For example, sampling for primary studies that are in English to avoid the cost of professional translation services (Benoot et al 2016; Booth et al 2016).
Expertise: TS is an appropriate methodology of synthesis for novice researchers like myself as it is more prescriptive than other types. As a master's thesis, there is no ability to have a team, however, I have the support of my supervisor and have engaged with library staff also (Booth et al 2016).
Audience and purpose: The main audience of this QES is the markers of this thesis, however the thesis will be discoverable on Massey University's library database. The audience then is anyone who has access to this databased, such as students or researcher. Because TS was developed using aspects of a number of well-established research methodologies, it provides a robust basis for synthesising qualitative studies, and may inform research, policy or practice (Thomas & Harden, 2008).
Type of data: This QES considers both the verbatim quotes of participants, as well as the interpretations of the researchers as data for analysis in this QES as suggested by Thomas and Harden (2008). The rationale behind this decision is that QES is a type of meta synthesis, meaning that I have interpreted the interpretations of the primary studies to extract higher order meanings and synthesis based on the phenomena (Thomas & Harden, 2008).