Weight Stigma in Healthcare in Aotearoa: Pacific Women's Voice

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Elti Sannyasi
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Abstract

This thesis is an exploratory study of the phenomenon of weight stigma in healthcare settings towards larger Pacific women living in Aotearoa New Zealand. It explores their experiences of weight stigma, how these experiences have impacted their health and wellbeing, shaped their views on health and self, and their perspectives on how healthcare should be delivered to prevent weight stigma. Weight stigma has become an area of increasing interest within the health and scientific community. Research indicate that weight stigma has significant physiological and psychological impacts on health, yet our health system continues to prioritise weight-centric measures and responses to health. As there are numerous ways in which the health system does not adequately serve larger bodied Pacific peoples, this research seeks to examine how weight stigma compounds their poor healthcare experiences. Young Pacific women are not immune to society's fixation on body weight. There are myriad social, health and cultural forces which increase preoccupation with weight, body size, body image and health. However, to date, no research has explored Pacific women's experiences of weight stigma in healthcare contexts.

Guided by the methodological framework of Talanoa, the study involved individual talanoa with 10 Pacific women (aged 28-65) throughout Aotearoa who reported experiences of weight stigma in healthcare settings. Phenomenology, the Fonua model (a Tongan health framework), and Talanoa epistemology provided the theoretical lens, ensuring a holistic and culturally grounded analysis. The talanoa were conducted in person or via Zoom™, then were recorded, transcribed verbatim and analysed using reflexive thematic analysis. The themes were presented as

composite narratives representing shared experiences, an approach that aligns with the Talanoa methodology.

Three overarching themes were generated: (1) experiences and impacts of dismissal and weight stigma in healthcare on health, (2) healthcare for Pacific women transcends clinical spaces extending into interpersonal relationships, self-worth, cultural identity, spirituality, social and economic domains and (3) underlying interpersonal and systemic biases must be addressed to provide equitable healthcare. Pacific women recommended a paradigm shift away from weight-centric care towards culturally safe, patient-centred and weight-inclusive practice. This includes review of aspects of the health system which reinforces structural barriers to health such as BMI (Body Mass Index) used as an individual measure of health and health professional biases alongside cultural humility training which addresses implicit and explicit weight and ethnic bias, that values Pacific knowledge and the creation of safe health environments.

In summary, this thesis is believed to be the first documentation of Pacific women's experiences of weight stigma in healthcare in Aotearoa. By centering their voices, it importantly exposes the multifaceted harms of weight stigma and underscores the urgent need for systemic change to achieve equitable and culturally grounded healthcare for Pacific women.

Dedication and Acknowledgements

Dedication

This thesis is dedicated to all the Pacific women out there who are made to worry about their bodies. May you thrive and exist peacefully in your body, in every way, shape or form.

'Courage is the bridge between fear and wisdom'

To the Pacific women who participated in this study; You have been courageous in telling your story, your fears, your vulnerabilities, you have shared these with us so generously and allowed wisdom to be generated and shared. Your hearts are most definitely as big as your bodies, and we are blessed by your existence.

To my grandparents, Leaupepe Poliko Ape, Auafaifetalaiga Ape, and Sivaletchumy Appanah. Thank you for the gift of family, education, and Faith.

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'Where there is love, nothing is too much trouble, and there is always time" – 'Abdu'l-Bahá, Baha'i Writings

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To the Health Research Council for supporting me and my research, I am so grateful to be a recipient.

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Glossary

Word	Definition
Fat	Used as neutral descriptor for larger-bodied women, reclaimed by fat activists (Kost et al., 2024)
Talanoa	Refers specifically to the methodology process, and epistemology of inclusive, participatory, and transparent dialogue (Vaioleti, 2006).
talanoa	Refers to the method of data collection. For example, each singular data collection interaction
Fonua	Tongan model of health, refers to people and the land and their healthy relationship (Tu'itahi, 2022)
Teu le Vā	To nurture the [relational] space between (Anae, 2016)
Big Back	Colloquial term used to imply that someone is fat
Lapo'a	Samoan word for fat
Magava	Samoan word for stomach
Aiga	Samoan word for family
Faka'apa'apa	A value/concept from the Talanoa methodology outlining respectful, humble, and considerate interactions (Vaioleti, 2006)
'Ofa Fe'unga	A value/concept from the Talanoa methodology which outlines showing appropriate compassion, empathy, aroha, love for the context (Vaioleti, 2006)
Mateuteu	A value/concept from the Talanoa methodology which highlights well-prepared, hardworking, culturally versed, professional, responsive engagement (Vaioleti, 2006)
Anga Lelei	A value/concept from the Talanoa methodology highlighting tolerant, generous, kind, helpful, calm, dignified engagement (Vaioleti, 2006)

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Chapter 1 — Introduction

1.1 Chapter overview

This chapter starts with an introduction to Pacific peoples in Aotearoa New Zealand (Aotearoa) with a specific focus on Pacific women, the concept of weight stigma and provides justification for this thesis. This is followed by the aims, objectives, theoretical underpinning of this thesis and positionality of the thesis author. It will also outline the structure of this thesis and student researcher's contributions.

1.2 Introduction

Pacific peoples comprise 8.9% of Aotearoa's total population (Stats NZ, 2018) . Their ancestral ties extend from many different islands, most commonly Samoa, Tonga, Cook Islands, Niue, Fiji, and Tokelau (StatsNZ, 2024). Pacific peoples exist as distinct cultural groups with similar values, practices and societal contributions to Aotearoa. This population is forecast to increase to comprise 11.2% of the total population by 2043 which marks its fast growing nature (Ministry of Health, 2025). While well-known in Aotearoa for their vibrancy, cultural pride and community-mindedness, Pacific Peoples are also known to have high prevalence of higher body weights and carry an inequitable burden of non-communicable diseases (Ministry of Health, 2024). The health disparities for Pacific peoples are well-documented (Wright & Hornblow, 2008) and often deficit-framed (Blakely & Dew, 2004) with an emphasis on individual responsibility for health, disregarding social inequity, environments and other determinants such as family and cultural community responsibility as

delineated by the Social Ecological model of health (Cassel, 2010). Multiple factors across the various levels of society intersect to contribute to the persisting health inequities. In addition to this, weight stigma has the potential to exacerbate and compound these negative health outcomes through stigma-induced stress and weight bias causing differential quality and access to treatment (Hebl & Xu, 2001; Puhl et al., 2009). Evidence identifies links between perceived racial discrimination and weight gain or metabolic abnormalities which increase likelihood of morbidity and mortality and increase subsequent health disparities (Puhl & Heuer, 2010).

Within existing Aotearoa-specific literature, there exists a gap in knowledge about the weight stigma that Pacific peoples experience in healthcare settings as it is an emerging field alongside low rates of Pacific peoples recruitment and participation in research (Enright et al., 2025). The research in other ethnic populations that does exist predominantly takes on a weight-centric approach, evaluating barriers to weight loss interventions, advice received from healthcare practitioners (HCP) or barriers that HCP face when broaching the subject of weight loss (Doolan-Noble et al., 2019). This is an issue as current research suggests that an excessive focus on weight loss can exacerbate stigma (Cohen et al., 2005).

It is important to note that this thesis is not about any possible implications of weight on health, rather, it is an exploration of the implications of weight stigma on health. This clarification is important for framing the lens through which this thesis is read. Weight stigma is defined as negative stereotypes, attitudes and discriminatory behaviours towards others based on weight, shape or size of their body (Dovidio et al., 2018). It persists in all environments as a more common and accepted area of discrimination targeted at those with higher body weights (Puhl & Heuer, 2010).

Weight bias refers to the individual negative views and attitudes that a person holds about others due to their weight (Puhl & Brownell, 2001). It signifies an underlying prejudice that leads to weight stigma when acted upon. It is seen as synonymous with ‘fatphobia’, ‘sizeism’ and ‘weightism’ and can be implicit or explicit (Phelan et al., 2015a). The focus of this study is weight stigma and its manifestations in healthcare and subsequent impacts on Pacific women, rather than the individual and systemic biases held within healthcare. Women may be more susceptible to rapid acculturation to the thin ideal, particularly those who experience sudden immersion in Western culture, hence the gendered focus of this study (Brewis & McGarvey, 2000; Chamorro & Flores-Ortiz, 2000; Davis & Katzman, 1999; Raphael & Lacey, 1992).

Weight stigma persists in different forms: enacted, anticipated, and internalised (Dovidio et al., 2018). Enacted weight stigma, defined through modes of discrimination such as teasing, bullying, social rejection and prejudice, has a significant adverse effect on health, particularly mental (Pearl & Puhl, 2016). Anticipated weight stigma stems from previous experience of enacted stigma and involves anticipation of weight-based discrimination in social environments (Hunger et al., 2020). For example, a larger-bodied person avoiding spaces like restaurants and gyms because they anticipate stares or judgment for taking up more space. Internalised weight stigma refers to the internal shame and expectation of discrimination that prevents an individual from seeking help (O'Donoghue et al., 2021b; Ryan et al., 2024). These forms of weight stigma can contribute to reduced motivation for physical activity and beneficial lifestyle behaviours and an increase in disordered eating behaviours (Major et al., 2014). Overall, weight stigma has a negative effect on the health of people with higher body weights through the

mechanisms of reduced motivation and feelings of efficacy towards health promoting behaviours, stress-induced pathophysiology, heightened cortisol markers, above recommended blood glucose levels, maladaptive eating patterns, weight cycling, poorer mental health outcomes and more whilst impacting the body through over-activation of stress systems, emotional dysregulation, and greater allostatic load (Himmelstein et al., 2017; Hunger et al., 2020; Sutin et al., 2014; Tsenkova et al., 2011). Weight stigmatisation reinforces unhealthy lifestyle behaviours that contribute to poor health and poses a significant barrier to health improvement (Brownell et al., 2005; Hunger et al., 2020; Puhl & Heuer, 2010). Health advice for higher weight persons presenting in healthcare often solely consists of weight loss interventions regardless of the presenting complaint (O'Donoghue et al., 2021b; Packer, 1990; Roberts et al., 2021). Studies have shown that long term weight loss can be difficult to sustain (Aphramor, 2010; Grodstein et al., 1996; Mann et al., 2007) and the benefits of doing so are uncertain. In some studies, weight loss of greater than 15% in overweight men and women was not found to be associated with reduced mortality rates (Ingram & Mussolino, 2010; Sørensen, 2003) while in others it was associated with increased risk of all-cause mortality (Booth et al., 2014; Simonsen et al., 2008).

Negative attitudes about people with higher weights have been well documented within the healthcare system (McClure et al., 2011; Vartanian, 2010). Physicians and dietitians are less likely to intervene for overweight patients, assume non-compliance or low adherence, provide substandard healthcare, and provide a generic weight loss intervention which fails to address social and economic determinants of health or investigate other underlying sources of illness or weight gain (Buxton & Snethen, 2013; Puhl & Heuer, 2010; Roy et al., 2023; Thomas et al., 2008). A meta-

ethnographic review of eight peer-reviewed journal articles concerning barriers to weight management in general practice in Aotearoa reported patients feeling social embarrassment, breaches of dignity and unmet healthcare needs and clinicians feeling ill-equipped to provide non-stigmatising weight management care (Norman et al., 2022). A qualitative descriptive study conducted in Aotearoa found that larger women tend to be disfavoured in places of health that they are supposed to attend due to weight stigma and discrimination. This includes locations such as first point-of-care health services, screening opportunities, and physical activity (Russell & Carryer, 2013). The sociocultural and clinical consequences of weight stigma have been found to be relevant to experiences in healthcare settings as they persist as significant barriers to access and trust in the healthcare system, particularly for already disenfranchised populations (Doolan-Noble et al., 2019).

Although the existing research conveys knowledge and gaps around weight stigma in healthcare settings, there is a striking lack of Pacific representation within the evidence-base. Pacific peoples experience well-documented health inequities, yet their perspective on weight stigma remains invisible. This is particularly concerning given that weight stigma can influence quality of care, trust and engagement (Alberga et al., 2019; O'Donoghue et al., 2021a). Without their unique voices and experiences, the current literature does not reflect the current realities or systemic influences which shape Pacific peoples experience of health. It suggests a lack of commitment to equitable health outcomes and does little to remove barriers to accessing quality healthcare for Pacific people. Documentation of weight stigma and its manifestations will enable greater understanding of how it can impact Pacific people’s perception of their own health and signify areas of improvement within the healthcare system. Understanding what the experience and impact of weight stigma

is for Pacific people in Aotearoa will provide important context for equitable healthcare, culturally appropriate HCP training and understanding possible wider determinants that impact Pacific health and wellbeing. Similarly, a greater understanding of weight-stigmatising experiences in healthcare can assist in providing evidence for a paradigm shift towards the importance of weight inclusivity in healthcare alongside tailored lifestyle interventions which extend beyond a prescription of weight loss and may be of more benefit to those with higher body weights, not only Pacific peoples. Failure to identify and address the impact of weight stigma will result in persisting inequitable health outcomes for Pacific people and increased barriers to access of healthcare.

1.3 Aim

To explore and document the lived experience of weight stigma for Pacific women aged 18 years and over when interacting with New Zealand health system, and identify their recommendations for reducing weight stigma in healthcare settings.

1.4 Objectives

a) To develop an in-depth understanding of Pacific women's lived experience of weight stigma in the various settings in which Pacific women receive healthcare
b) To explore how these encounters with weight stigma have impacted on Pacific women and their perceptions of health and wellbeing
c) To gather recommendations from Pacific women for reducing weight stigma in healthcare settings

1.5 Theoretical Underpinning and Positionality

This study is guided by phenomenological theory, Talanoa as epistemology and Intersectionality. Both seek to understand the lived experience of individuals from their own perspectives and explores how they make sense of the phenomenon of weight stigma. Talanoa as epistemology is used as a guide to co-create knowledge which prioritises Pacific ways of knowing and understanding the world, particularly the holistic exploration of experiences. The theory of intersectionality is also used to understand the complexity of identity, lived experience and the influence of dynamics of power and privilege which can construct minority positions in Western societies.

My status as a young Samoan/Indian woman, raised in Aotearoa in a multi-ethnic family, my familiarity with basic Samoan practices and language and intimate knowledge of Pacific community dynamics facilitated efforts to engage and build rapport with the Pacific women engaging in this study and provided insider perspective. My Nutrition and Dietetic studies have fostered a weight-inclusive approach to health and wellbeing which contributed to my desire to undertake this project and disseminate learnings because I recognise and am personally familiar with the influence and harms of the ‘thin ideal’ and society’s fixation on weight and body image.

1.6 Structure of Thesis

This thesis begins with an introductory chapter which outlines the background and context of Pacific peoples and the relevance of weight stigma and concludes with the

aims, objectives and hypothesis of this study. A glossary has also been provided for reference throughout the thesis.

Chapter two provides an in-depth exploration of the study population, Pacific peoples. It explores the key values, knowledge and practices of this population and their attitudes towards body size and health and a review of the relevant literature through the lens of the Fonua model of health to understand what current knowledge says about weight stigma and the experience and impact on Pacific peoples' wellbeing.

Chapter three explores and critiques the body of literature related to weight stigma in general populations around the world, within Aotearoa, and specific to Pacific populations.

Chapter four includes a manuscript of the study detailing the methodology, key themes, analysis and discussion of findings of this study, including the strengths and limitations.

Chapter five presents the conclusion and implications of the study findings and provide recommendations for future research in this area. It ends with two creative pieces which reinforce the themes of the study.

1.7 Researcher Contributions

Researcher	Contribution to Thesis
Elti Sannyasi MSc (Nutrition & Dietetics) Student – Massey University	Primary author of thesis Contributed to initial development and cultural oversight in early stages of the study

	Talanoa guide developer Ethics application Recruitment for study Interviewer Data analysis Development of themes and composite narratives Writing of the thesis
Dr Maria Casale Lead Researcher and Co-Supervisor Lecturer School of Sport, Exercise and Nutrition – Massey University	Conceptualised the study Ethics application Provided guidance and feedback on whole of thesis and study
Professor Lisa Te Morenga Co-Supervisor Professor of Māori Health and Nutrition – Massey University	Provided guidance and feedback on whole of thesis and study
Dr Sara Styles Co-Supervisor Lecturer in Department of Human Nutrition – University of Otago	Provided guidance and feedback on whole of thesis and study
Dr Edmond Fehoko Co-Supervisor and Cultural Advisor Senior Lecturer in Department of Human Nutrition – University of Otago	Provided guidance and feedback on whole of thesis and study Cultural support and supervision
Audrey Whitley Research Assistant	Recruitment Transcription & Coding

Chapter 2 — Pacific Peoples in Aotearoa NZ

2.1 Chapter Overview

This chapter will provide an overview of the Pacific population in Aotearoa. It will explore the context behind the diverse nations that are categorised as Pacific, capture and identify core Pacific values and attitudes toward body size in relation to health, outline the health challenges they face, and emphasise the need for more research for and by Pacific peoples to address the inequities and gaps in health service delivery in Aotearoa.

Pacific peoples comprise 8.9% of Aotearoa's total population (Ministry of Health, 2025). The term Pacific people is used in this study as an umbrella term for people from Oceania who migrated to live in Aotearoa or other countries. This term is most used in Aotearoa due to its multicultural population and often implies homogeneity however as Anae (2001) states *"Pacific Islanders exist only in New Zealand: I am called Pacific Islander only when I arrive at Auckland airport. Elsewhere I am Samoan" (p.128).* Oceania, in a colonially defined sense, is comprised of Micronesia, Melanesia and Polynesia and the distinct countries that reside in these regions (Makereti & Etherington, 2024). It should be noted that while these 17 countries are collectively described in Aotearoa as Pacific peoples, they are all incredibly diverse and distinct countries, cultures, languages and peoples (Hau'ofa, 1994; Makereti & Etherington, 2024). In addition to this, nearly 40% of the Pacific population identify with more than one ethnic group (Ministry of Health, 2025; Winter-Smith et al., 2023). One in three Pacific peoples under the age of 15 also identify as Māori, indicating a multifaceted lived experience for those with both Pacific and Māori heritage (Ministry of Health, 2025). This is important as aggregation of these distinct ethnic peoples

under one umbrella can lead to masking of the diversity of experiences, health care support needs and realities (Winter-Smith et al., 2023).

To add to the layers of complexity when it comes to cultural identity, a total of 66% of Pacific peoples living in Aotearoa were born in Aotearoa with the remainder being born overseas. This is significant as there are cultural nuances and values which exist within Pacific diaspora which may differ from those born and raised in their native country, particularly when thinking about acculturation to the thin ideal. Aotearoa-born Pacific peoples are a relatively young demographic, with a median age of 25 years (Stats NZ, 2018). As a younger population, internalised and experienced weight stigma in adolescents can lead to harmful outcomes such as struggles with mental health and self-esteem and greater engagement in risk behaviours such as substance use, violence and sexual activities (Farhat, 2015; Roberts et al., 2021). This research is timely for us to understand and document the lived experiences of weight stigma in healthcare to improve health equity and quality of healthcare for a population that is projected to increase to 11% in Aotearoa in the coming two decades (Ministry of Health, 2025). Pacific peoples are also marked by an inequitable burden of poor health outcomes and treatment compared to non-Pacific populations (Naepi, 2021; Ryan, 2019). Addressing inequity in healthcare for Pacific peoples is a priority for Aotearoa as equitable healthcare is a human right for all populations (Pouono, 2024).

2.2 Pacific Health Status In Aotearoa

Health status is strongly shaped by the quality of healthcare access, income levels, education, cultural and social environments and housing. For Pacific peoples, challenging socio-economic circumstances, higher exposure to health risks, barriers

to using health services and shifting demographic patterns all contribute to poorer health outcomes (Jowitt, 2024; Tukuitonga & Finau, 1997). It is evident that the health system is failing Pacific people in Aotearoa as they experience the same system as non-Pacific people but reap significantly poorer outcomes in comparison.

To fully grasp the extent of the health inequity Pacific peoples face, the following data provides key contextual information:

- The life expectancy gap for Pacific women is 5 years and Pacific men is 6 years less than European/Other people (Health New Zealand, 2024a)
- 83% of Pacific adults describe their overall health as excellent, very good or good compared to 88% in non-Pacific, non-Māori (Health New Zealand, 2024a)
- Almost 40% of Pacific households are overcrowded compared to 4.5% in European/Other households (Stats NZ, 2020)
- Around 42% of the Pacific population lives in the 10% most deprived areas of the country (Jowitt, 2024)
- Pacific people are 1.2 times more likely to live with heart disease. Pacific women are 2.4 times more likely to experience heart failure compared to non-Pacific women in NZ (Heart Foundation, 2018)
- HbA1c is significantly higher among Pacific people compared to Māori and New Zealand European populations (Jowitt, 2024)
- Pacific populations had the highest estimated age-standardised diabetes prevalence in 2024 with about 137 cases per 1000 people (Health New Zealand, 2024c)

- Pacific peoples make up 4.9% of the Health New Zealand workforce indicating that they are relatively underrepresented in the healthcare sector (Health New Zealand, 2025)

2.3 Pacific People And Experiences In Healthcare In Aotearoa

Pacific peoples in Aotearoa often face significant barriers in accessing equitable healthcare. These barriers include cultural and language differences, institutional racism, difficulty navigating the health system, economic hardship and a lack of culturally appropriate services (Ludeke et al., 2012; Neville et al., 2022; Southwick et al., 2012). Many Pacific individuals report feeling misunderstood or disrespected in healthcare settings through negative assumptions and comments about lifestyle and diet alongside a lack of transparency about health processes, and vague/broad health advice given (Brown, 2018; Marsters, 2025). Subsequently, reduced trust and engagement with the system persist as consequences of this (Brown, 2018; Fa'alogo-Lilo & Cartwright, 2021). Additionally, structural inequities and limited availability of Pacific health professionals contribute to ongoing disparities (Ape-Esera et al., 2009; Brown, 2018).

2.4 Pacific Health And Cultural Values

To understand why Pacific health inequities persist and the most effective and acceptable approaches to addressing them, it is important to understand Pacific values and how they may differ from Western values. In a literature review conducted by Teariki and Leau (2024), five principles (holistic systems, family, spirituality, connection to the natural world, and the vā) were identified that were foundational to Pacific worldviews. They have been linked with the Fonua

throughout this chapter to demonstrate how foundational they are to Pacific health (Futter-Puati & Maua-Hodges, 2019; Pulotu-Endemann, 2001; Tu'itahi, 2010; Tuisano, 2021).

It is important to understand Pacific worldviews to create better service delivery for Pacific peoples as the Pacific view of health and wellbeing differs significantly from a Western view. The foundational Pacific principles revolve around reciprocity, holism, connection, physical and spiritual relationships, whereas a Eurocentric lens tends to view health as an individual responsibility, resolved through hard work and discipline (Teariki & Leau, 2024). The Fonua model, which is referred to throughout the study explores five dimensions (Spiritual, Mental, Physical, Community and Environmental) and five levels (Individual, Family, Local, National, and Global) (Tu'itahi, 2022). Many Pacific health and research models acknowledge the interconnectedness of these aspects of wellbeing, with their own distinct cultural traditions, mythology and knowledge (Naepi, 2019; Pulotu-Endemann, 2001; Teariki & Leau, 2024).

2.5 Pacific Health And Ecological Systems

Holism is a fundamental principle of Pacific worldviews. Throughout the various Polynesian, Melanesian, and Micronesian health models developed to support Pacific health aspirations, the fale, the outrigger canoe, the garland, and the octopus are used to represent structures, images, nature and cultural practices that demonstrate a holistic worldview (Naepi, 2019; Pulotu-Endemann, 2001; Tu'itahi, 2022). The visual representation of these models demonstrates the interconnectedness of each aspect of the lives of Pacific peoples; should one aspect become weakened, the well-being of the whole is affected. Holistic systems refer to more than physical human concepts including the connections and intricate

relationships between time, people, nature, space and the intangible (Pouono, 2024; Teariki & Leau, 2024). Pacific peoples have always had close relationships with the natural world. This relationship combined with their spiritual worldview determined their own systems of knowledge and practice to harness and care for the land that cares for them. Pacific academic and writer Epeli Hau'ofa emphasises the natural affinity of Pacific people towards the sea, developing great skills and living coherently with the natural environment. He uses this phenomenon to also remind Pacific people of their rich history of exploration, navigation, cultivation and socio-political networking to refute the prevailing Western view that Oceania is tiny, isolated, reliant on external aid and deficient in resources (Hau'ofa, 1994). This connection to the natural world fosters a profound respect for nature as a living entity, emphasising stewardship, sustainability and reciprocity (Tu'itahi et al., 2021). Pacific peoples traditionally view themselves as caretakers of the environment, with their own traditional knowledge guiding their health and wellbeing practices (Teariki & Leau, 2024; Tu'itahi, 2022). Ecological systems relate to Pacific health because colonisation, migration and assimilation have disconnected Pacific and Māori peoples from the land and holistic ways of living (Cram et al., 2019). Healthcare privileges Western biomedical models and, even when indigenous practices are acknowledged, there is little recognition of structural barriers such as loss of cultural knowledge, limited practitioners, and lack of supportive policy that restrict these populations access to these approaches (Cram et al., 2019; Marsters, 2025; Wilson et al., 2021).

2.6 Pacific Health And Family

Family exists as a cornerstone of identity, culture and social structure. It extends beyond the nuclear unit to include extended relatives and community for Pacific peoples (Teariki & Leau, 2024). It embodies a collective lifestyle, further demonstrating the holism and interconnectedness of Pacific lives. Within Pacific families, the individual is rarely exalted to a significant level, they willingly and humbly submit to the needs of the collective. Multigenerational households are common for Pacific families with crucial intergenerational exchanges of knowledge and service (Hau'ofa, 1994; Saunders, 2023). (Fa'alogo-Lilo & Cartwright, 2021) outline how a lack of understanding about the collectivist culture of Pacific peoples is a barrier to accessing healthcare as family involvement and relational models are not built into to the processes and systems operating.

2.7 Pacific Health And Spiritual Health

Spirituality refers to the innate connection with ancestors, mythologies, God, religion, church, land and relationships (Teariki & Leau, 2024). It is deeply intertwined with daily life, cultural practices, and the natural environment (Tu'itahi, 2022). Many Pacific cultures believe that a person is not just a manifestation of the physical, social and emotional aspects, but also a spiritual being, imbued with purpose, capacity for service to humanity and connected to each other and the natural environment (Pouono, 2024; Tu'itahi, 2022). It is within this spiritual worldview that their approach to health is determined. Health becomes the vehicle through which service can be carried out for the community and family can be looked after (Talemaitoga, 2011). Spirituality is central to the Pacific worldview and influences how Pacific peoples approach challenges, view health, maintain resilience, prioritise and make key decisions in life (Tu'itahi et al., 2021).

2.8 Pacific Health And The Vā

The vā refers to the relational space between entities, things and people. It relates to the notion of connection rather than separation, that between all things, there is space to relate, to create and to connect. The vā promotes harmony, respect, and balance within the individual, family, community and natural environments. It shapes Pacific values and practices, guiding how people interact, resolve conflicts and uphold communal obligations (Saunders, 2023). Within Samoan culture, the concept of "*teu le vā*" refers to the act of valuing, nurturing and restoring the vā and treating relational spaces as sacred. Within healthcare settings, the vā exists between patients and health professionals; the quality of the relationship between patient and provider affects trust, communication and willingness to seek care. This process of cultivating the vā is mostly driven by the healthcare professional or researcher (Anae, 2016).

2.9 Pacific Views On Body Size

To add context to the reasoning behind this study, it is important to understand the existing perception of body size in Pacific communities as body image and size has predominantly been researched in young White female populations (Boutté et al., 2025). An assumption exists that the findings of these studies are normative and can be extrapolated to inform guiding theories and akin to views about body image in other populations (Boutté et al., 2025). As with Black populations, Pacific women continue to be under-represented in body image research and their views often "othered" or disregarded (Nemani & Thorpe, 2023). Pacific peoples have traditionally had neutral or positive views on larger body sizes (Brewis et al., 1998; Hardin et al.,

2018; Metcalf et al., 2000). There is a widely cited assumption that Pacific peoples have a traditional preference for large body sizes, but this perception may reflect a misunderstanding of Pacific health research. Pacific people did not traditionally focus on body size as a measure of health but rather a vehicle for service to their family and community (Hardin et al., 2018). The literature posits that Pacific peoples frame their views about their larger bodies according to two determinants: their physical service to church and family and the collective spirit of hospitality and community (Hardin et al., 2018; Pouono, 2024). Teevale (2011) found that Pacific youth and their parents preferred average sized bodies rather than very large ones, although she notes that inconsistent definitions of body size in research may have led to misinterpretation. For Pacific women, larger bodies are culturally associated with serving family, community, and protecting the land as they demonstrated strength, nourishment, and being able to meet the physical and social demands of caring for a family (Braginsky et al., 2016; Craig et al., 1996; Gillon 2024; Pollock, 1995; Pouono, 2024; Teevale, 2011). One study found that Pacific people in Hawaii and Australia had larger body mass, but higher body satisfaction compared to Asian and European populations (Latner et al., 2011). Globalisation and Western thin ideals are gradually eroding these views, with weight-centric interventions (weight loss competitions, emphasis on body shape and BMI, eat less, move more campaigns) often causing unintended harm (Brewis & McGarvey, 2000; Hardin et al., 2018). Pacific adolescents increasingly experience body dissatisfaction while resisting the thin ideal (Craig et al., 1999; Frayon et al., 2021; Nemani & Thorpe, 2023) creating a dichotomy of healthy/unhealthy and thin/fat ideals (Williams et al., 2004). Recent research shows that young, athletic Māori and Pacific women face discrimination and body shaming from family, friends, coaches or community members, but some

attempt to reclaim body acceptance through their cultural identity indicating a move towards rejection of negative stereotypes about body size in some younger Pacific generations (Nemani & Thorpe, 2023). While some young Pacific women embrace body acceptance, weight stigma and negative stereotyping continue to impact experiences in school, sport and healthcare (Nemani & Thorpe, 2023). Addressing and eliminating weight stigma is essential to support their body acceptance without prejudice and prevent the harms of weight stigma from impacting young Pacific women.

Chapter 3 — Literature Review

3.1 Chapter Overview

Given the context presented in the previous chapter, it is important to understand why and how Pacific peoples' experiences with weight stigma when seeking medical care contribute to poorer health outcomes. Pacific peoples' bodies are routinely politicised and subject to constant criticism and discrimination (Loto et al., 2006). Weight stigma and bias are often present in the health sector under the guise of 'healthcare'. Given the inequity Pacific people face within the Aotearoa health system, an in-depth exploration of weight stigma in healthcare and its subsequent impact on Pacific people is essential to understand what gaps exist and how our research can contribute to equity in the healthcare space. The following chapter will provide a brief introduction to the Fonua model of health and its relevance to this study, an explanation of the language used and justification within the study. It will present an in-depth review of what the current knowledge of weight stigma and bias in healthcare is, and its impact on Pacific peoples. It will explore the current breadth of literature globally and locally on the topic of weight stigma through the lens of a Pacific worldview, using the Fonua model as the framework for analysing and categorising the literature.

Figure 1.

Literature review search strategy

Date searched: December 2024 – April 2025

Search Criteria:

PACIFIC (Pasifika OR Pasifica OR "Pacific Island*" OR Samoa* OR Tonga* OR Niue* OR Cook Island* OR Fiji* Or "Pacific People*" OR "Oceania*") AND (weight* OR BMI or "Body mass index*" OR obes* OR overweight OR underweight OR "healthy weight" OR "Body norm*") AND (stigma* or prejudice* or attitude* or discriminat* OR bias* OR view* OR perception* OR experience* OR qualitative*)

WEIGHT (weight OR overweight OR obese OR obesity OR fat OR fatness OR anti-fat OR heavy OR heaviness OR "body mass index" OR bmi OR antifat OR "over weight" or "body weight")

BIAS trust OR attitude OR attitudes OR belief OR beliefs OR phobic OR phobia OR stigma OR stigmas OR stigmatization OR stigmatizing OR stigmatize OR stigmatizes OR stigmatise OR stigmatises OR stigmatised OR stigmatisation OR shame OR shaming OR shamed OR discriminate OR discriminating OR discrimination OR bias OR biases OR biased OR stereotype OR stereotypes OR stereotyping OR stereotyped OR prejudice OR prejudiced OR prejudices OR tease OR teasing OR teased OR bully OR bulling OR bullied OR harass OR harassment OR harassing OR victim OR victimization OR victimisation OR ostracize OR ostracise OR ostracizing OR ostracizes OR ostracized OR ostracising OR ostracised OR ostracises

Filters: Limited to past 10 years, English language,

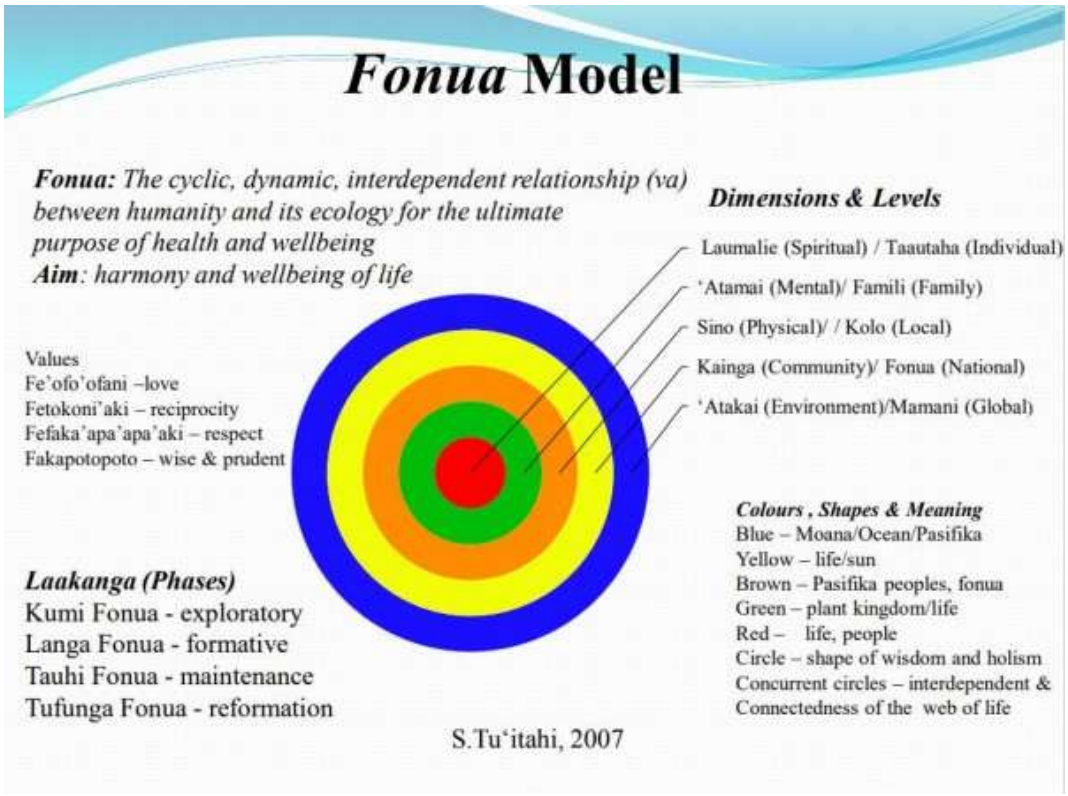
Electronic databases: Google Scholar, Scopus, Pubmed, Discover

3.2 Fonua Model

The Fonua model (Figure 2) is a pan-Pacific/Tongan model of health, designed to reflect the diversity of values, culture and health beliefs that Pacific peoples hold (Tu'itahi, 2007). It delineates the interdependent and complementary dimensions of life from a Tongan worldview and provides phases through which we can holistically address health issues (Tu'itahi, 2022). Through concurrent circles, we see that the dimensions interact simultaneously to influence health at all social levels: individual, family, local, national and global (Tu'itahi, 2022).

Figure 2.

The Fonua Model



Note: Fonua: A Pacific model. Reprinted from *Hauora Newsletter* (April 2007 edition) by S.Tu'itahi, 2007, Health Promotion Forum.

I have chosen this model as a guide and framework as it provides grounding for an emerging young Pacific researcher, collaborating with Pacific women, working within a Western academic setting. Using a Pacific model of health helps to maintain a Pacific lens and ensure that this project is of benefit to Pacific peoples, while also empowering and amplifying their worldview. It would be a disservice to research this population without acknowledging or embedding their values and aspirations within every fibre of this project. The model highlights a holistic view of health and context, drawing attention to the many forces shaping this population's health and experience of weight stigma which may be overlooked in existing literature (Nabobo-Baba, 2004; Naepi, 2019).

3.3 Language

The language we use plays a crucial role in shaping societal attitudes, healthcare practices, and individual experiences, often reflecting deeper biases and cultural narratives about body size and health. Throughout this study, there are different terms that I use to describe different phenomenon, characteristics, and attitudes that I will clarify here. The word "fat" has been used in many spaces as a negative descriptor or insult against larger bodied people. "Fat" is commonly used as an insult or negative word with connotations of being bad, immoral, and unworthy of respect or decency based on a physical characteristic of a body (Meadows & Daníelsdóttir, 2016). However, there has been a recent movement of reclamation of the word 'fat' by fat activists and larger persons as a neutral descriptor (Kost et al., 2024). I acknowledge that this is a journey that not everyone is on, and there is no singular term that is fit for all. Within Pacific communities, there is limited research around the preferred terminology; however, based on my experience, I have chosen to use the

term ‘larger bodied’ alongside participant preference throughout the study and talanoa. The word ‘fat’ is used in a neutral and descriptive manner, interchangeably with ‘larger-bodied people’ and ‘higher weight’ to demonstrate the diversity of language accepted, preferred and used.

I have also chosen to reject the word ‘obesity’ or any of its derivatives in this thesis, as this term pathologises weight, labelling all people over a certain BMI or weight as unhealthy, regardless of actual wellbeing and promoting a dehumanising view of fat people (Brown et al., 2022; Lee & Pausé, 2016). The use of BMI as the main criterion for defining obesity is an oversimplified and inaccurate metric for measuring individual health status, especially for Pacific people for whom BMI does not accurately represent lean muscle mass, % body fat mass and distribution and genetic and environmental considerations because it is based on the data of predominantly European populations (Rush et al., 2007; Swinburn et al., 1996; Swinburn et al., 1999) and calls into question the validity of the term ‘obesity’ to adequately describe the health status of a larger individual (Kost et al., 2024; Vakamacawai et al., 2024). I also adopt a strengths-based approach and aim to challenge and undermine deficit-focused language to shift the pervasive and dichotomous view of fatness, especially when exploring the lived experience of Pacific peoples who are a constant target of deficit language. Language is used consciously and conscientiously as a strategy to reduce weight stigma and bias.

3.4 Weight Stigma

Weight stigma is defined as the social devaluation and denigration of individuals based on their weight, shape or size (Dovidio et al., 2018; Tomiyama, 2014). It is a

driver of prejudice, negative stereotyping, and discrimination towards individuals of higher weights. Weight stigma exists in enacted, anticipated, and internalised forms whereby the individual is affected by discrimination in social settings, feels anticipation of future trauma or internalised shame and fear of seeking help (Puhl & Heuer, 2010). There is evidence that weight stigma exists in a variety of settings: family, health care, education, workplaces, media and interpersonal relationships (Puhl & Heuer, 2010; Sabin et al., 2012; Tomiyama, 2014).

Stigma is described as a social process whereby society labels certain characteristics as undesirable, less valuable, or abnormal, resulting in a so-called “spoiled identity” (Goffman, 2009). Weight is an example of a stigmatised characteristic, alongside race, disability, and sexual orientation. Historically, in societies such as American Samoa, Puerto Rico, and Tanzania, larger bodies were not considered problematic but were instead associated with prosperity, practicality, service, generosity, fertility, prestige, and beauty (Brewis et al., 2011; Strings, 2019). However, with the rise of the transatlantic slave trade, increased globalisation, and the growing influence of Western ideals, body norms shifted, leading to the emergence and spread of the "thin ideal". This ideal, which first gained traction in the late 19th to early 20th century, perpetuates the notion that thinness equates to health, morality, and self-discipline (Strings, 2019).

Over time, the stigmatisation of fatness has extended into cultures where larger bodies had previously been neutrally viewed or celebrated, highlighting how weight stigma is deeply rooted in colonialism, classism and systemic racism (Brewis et al., 2011; Strings, 2019; Vandael, 2021). This gradual development of weight stigma reveals how power and oppression have shaped our understanding of bodies,

health, and worth. This shift signals a critical issue: healthcare systems that internalise and reproduce these racist and oppressive ideals cannot deliver equitable health outcomes.

Weight stigma first began to appear in academic research in the 1980s and 1990s, where larger bodied people were the subject of negative stereotypes and bias, particularly in employment, education, and healthcare settings (Maddox & Liederman, 1969; Rodin et al., 1989). Although it was not yet defined as "weight stigma", these early studies laid the groundwork for recognising it as a serious issue. Puhl and Brownell (2001) published a pivotal review on weight bias, emphasising the discrimination faced by fat individuals across multiple domains. Since then, a growing body of literature has explored the detrimental impact of weight stigma on both health and wellbeing. Research has increasingly shown that weight stigma is not only a social justice issue but also one with serious health consequences, contributing to delayed care, psychological harm, and worsened health outcomes (Wu & Berry, 2018).

Pacific women in Aotearoa face significant and persistent health inequities. Their average life expectancy is 79.2 years, notably lower than the 84.7 years observed for European and other non-Māori ethnic groups (Health New Zealand, 2024b). This disparity is compounded by structural factors such as unequal access to healthcare, limited educational opportunities, lower wages, and broader socioeconomic disadvantage. A 2002 cross-sectional study of Pacific adults in Auckland found that approximately 74% of Pacific women were categorised as “overweight” according to BMI classifications, and Pacific adults overall were more than 11 times as likely to

have a higher bodyweight than their European counterparts (Sundborn et al., 2010). While BMI is a flawed and reductionist metric that fails to capture the diversity of healthy bodies and other markers of health such as HbA1c levels, blood lipid levels and blood pressure (Mishra & Floegel-Shetty, 2023), it is still religiously used in health systems and has reinforced perceptions of Pacific adults as inherently unhealthy. This perception has serious consequences. Larger-bodied people, especially women, are routinely subjected to weight stigma in healthcare settings, where providers may overlook genuine medical concerns, offer lower quality care, or prematurely prescribe weight loss as a one-size-fits-all solution (Alberga et al., 2019). For Pacific women, who already experience systemic inequities, the added burden of weight stigma may serve to further entrench disparities. It remains unclear whether weight stigma compounds existing disadvantages and if it contributes to the already unequal health outcomes Pacific women face. Despite these urgent questions, there is a striking lack of research specifically examining how weight stigma affects Pacific women's experiences in the healthcare system. This gap is critical. Understanding how weight stigma operates at the intersection of gender, ethnicity, and body size for Pacific women is essential for addressing inequities, improving health outcomes, and developing culturally safe, non-stigmatising models of care. Given the higher baseline weights commonly observed in Pacific populations, it is vital to recognise the increased susceptibility to weight-based discrimination, and to centre Pacific women's voices in strategies to reform healthcare practice.

3.5 Definition Of Weight Bias

A growing body of research highlights the pervasive impact of weight bias within healthcare settings. Studies have shown that healthcare providers, including dietetic and medical students and physiotherapists, often hold both explicit and implicit biases against people with higher body weights (Flint, 2021; Phelan et al., 2014). These biases can lead to poorer patient–provider communication, misdiagnoses, and the inappropriate attribution of unrelated symptoms to weight (Sabin et al., 2012). Patients experiencing weight stigma report delaying or avoiding medical care altogether due to previous negative interactions, reinforcing barriers to timely and effective treatment (Phelan et al., 2015a).Despite efforts to reduce bias through educational interventions, these are often limited in scope, short term, and not embedded within institutional change (Talumaa et al., 2022). Most existing studies focus on general populations and lack attention to how weight stigma intersects with other axes of marginalisation such as race, disability, gender, and socioeconomic status.

Weight bias has been identified across multiple layers of the health system, yet critical evaluation of the existing literature reveals methodological and contextual limitations. Sabin et al. (2012) used Implicit Association Tests to show implicit weight bias among doctors. However, while useful in identifying subconscious attitudes, IATs are limited in predicting actual clinical behaviour. Similarly, studies by Roy et al. (2023), Ryan et al. (2024) and Puhl et al. (2009) demonstrate weight bias among dietitians, physicians, and nurses, although much of their evidence is drawn from self-reported data that is prone to social desirability bias (Grimm, 2010). Russell and Carryer (2013) provide a New Zealand specific perspective yet focus primarily on General Practitioner attitudes rather than the lived impacts on patients. Research by Phelan et al. (2014) and Puhl et al. (2014) documents the early development of bias

in medical and dietetic students, but these findings largely derive from U.S.-based cohorts, limiting their relevance to culturally distinct Pacific or Māori populations in Aotearoa. More robust experimental work by Hebl and Xu (2001) demonstrated that physicians had negative attitudes towards and spent less time with higher weight patients but ordered more tests, identifying real consequences of bias. Less time with HCP implies less attention, less individualised interventions and ordering more tests reduces patient-physician contact time to conduct a thorough assessment and build trust and rapport (Hebl & Xu, 2001). These limitations highlight the need for more contextually grounded, longitudinal, and intersectional research that examines how weight bias interacts with ethnicity and systemic inequities in healthcare delivery. It could also be inferred that the attitudes and biases of health professionals take precedence over the lived experience of fat individuals, considering the breadth of literature available about the former.

To critically analyse the literature and identify gaps relevant to Pacific peoples, the Fonua model is used here as a culturally grounded lens to explore how weight stigma affects both the general population and Pacific peoples.

3.6 Sino (Physical)

3.6.1 General Attitudes Towards Fat People

General societal attitudes toward individuals in larger bodies are shaped by complex sociocultural factors. In Western societies such as the United States, where individualism is a dominant ideology, body size is often perceived as a personal responsibility/failing. This framing reinforces weight bias, with fatness commonly associated with laziness, lack of discipline, poor willpower, and low moral character

(Crandall & Martínez, 1996; Gillon 2024; Gordon, 2020). These attitudes are perpetuated by media representations that use deficit-based language and alarmist narratives surrounding the added “burden” on healthcare settings (McClure et al., 2011). Such portrayals contribute to public perceptions that marginalise fat individuals and legitimise discriminatory behaviours.

While there is a growing body of literature examining weight stigma in global contexts, limited research has explored how these attitudes manifest in NZ, particularly toward Pacific peoples. Pacific communities are frequently subject to negative public discourse, often linked to dominant health narratives that mirror those imposed on Indigenous populations. Loto et al. (2006) highlight how media representations of Pacific peoples in New Zealand tend to reinforce stereotypes of deficiency and burden, although this analysis focuses on print media in the early 2000’s primarily which does not fully capture how digital media now influences public attitudes. Similarly, Warbrick et al. (2019) argue that Indigenous individuals are often depicted as incapable of self care, requiring paternalistic support from health systems; a narrative that reinforces racial hierarchies and cultural deficit ideologies. This points to a significant gap in the literature regarding how weight stigma intersects with cultural identity and systemic bias in the New Zealand context and how media exacerbates this.

3.6.2 Health Impacts And Weight Stigma

There is growing evidence that weight stigma functions as a physiological stressor, contributing to measurable harm across several bodily systems (Wu & Berry, 2018). Exposure to stigmatising situations has been associated with increased blood

pressure, cortisol, HbA1c, and inflammation markers such as C-reactive protein (Himmelstein et al., 2017; Hunger et al., 2015; Major et al., 2014; Sutin et al., 2014; Tsenkova et al., 2011). These studies suggest that chronic exposure to stigma activates stress pathways that may contribute to long term disease risk. Exposure to stigmatising situations triggers the hypothalamic–pituitary–adrenal (HPA) axis, resulting in elevated cortisol level, a mechanism supported by experimental evidence showing acute cortisol spikes following weight-based discrimination (Major et al., 2014; Schvey et al., 2014). Chronic activation of this stress response can lead to insulin resistance, abdominal fat accumulation, and immune suppression, increasing the risk for metabolic disorders. Simultaneously, ongoing stigma contributes to allostatic load, raising systemic inflammation as indicated by elevated C-reactive protein (Himmelstein et al., 2017; Hunger et al., 2015). Studies have also found that individuals reporting weight discrimination show higher HbA1c levels, suggesting impaired glycaemic control independent of body mass index (Sutin et al., 2014; Tsenkova et al., 2011). In addition, weight stigma has been associated with acute increases in blood pressure and heightened cardiovascular reactivity which, if sustained, can contribute to hypertension and cardiac risk (Major et al., 2014; Schvey et al., 2014). Additionally, many medications are dosed based on trials conducted on average-weight individuals, which may lead to under- or overdosing in those whose body size falls outside this narrow standard (Erstad, 2017). These physiological responses are often compounded by behavioural consequences of stigma, such as reduced physical activity, disordered eating, and healthcare avoidance, all of which exacerbate existing health risks (Major et al., 2014). Collectively, this evidence highlights that weight stigma is not merely a social issue but a physiological stressor with measurable effects on health. Most of these findings

are derived from cross-sectional data in the U.S., often among White, Black, and Latina participants, with limited exploration of how intersecting social identities shape these outcomes. Screening uptake for preventable cancers (which is already low for Pacific peoples), such as breast, bowel, and cervical, has also been shown to be lower among higher weight individuals, possibly due to anticipated or past healthcare discrimination (Lee & Pausé, 2016; Russell & Carryer, 2013). Despite the high prevalence of larger body sizes and health inequities among Pacific peoples in Aotearoa New Zealand, there is a lack of research investigating the physiological impact of weight stigma within this group. This gap limits our understanding of how stigma may be compounding existing structural inequities and underscores the need for culturally specific, physiologically informed research.

3.6.3 Weight Stigma And Weight Gain

Maladaptive eating behaviours have been consistently linked to experiences of weight stigma functioning as both a psychological and physiological response to chronic stress (Puhl et al., 2015; Vartanian & Porter, 2016). While the association is well documented, the evidence base is not without limitations. For example, Eisenberg et al. (2012) reported that internalised weight bias predicted short-term binge eating in a longitudinal sample, but the study focused on young adults in the U.S., limiting its generalisability to other age groups or cultural contexts. Experimental studies have shown that weight stigma exposure can result in increased food consumption, restrictive eating, and disordered patterns of eating (Durso et al., 2012; Major et al., 2014; Tomiyama et al., 2013; Vartanian & Porter, 2016). Experiences with weight stigma in people's everyday lives can negatively impact their eating habits via the hypothalamic-pituitary-adrenocortical (HPA) axis

which can be activated in stigmatising situations causing chronically elevated cortisol levels and reduced perceived dietary control among overweight women (Major et al., 2014). However, these studies were conducted in controlled settings or report cross-sectional data, and do not fully capture the complexity of real life stigma experiences. Despite methodological constraints, the consistency across findings strengthens the argument that weight stigma undermines self-regulation and coping, with potentially cyclical effects on health.

Given that Pacific dietary practices are frequently scrutinised in public discourse as high-carb, high-fat with large portion sizes (Loto et al., 2006), it is crucial to consider how weight stigma may contribute to disordered eating, rather than viewing eating behaviours as solely cultural or behavioural choices. Additionally, ethnic minority groups are less likely to seek or receive support for eating disorders due to stigma, cultural inaccessibility, or misdiagnosis (Chowbey et al., 2012; Sinha & Warfa, 2013). This highlights an urgent gap: the potential link between weight stigma and disordered eating in Pacific populations is not only under-researched, but may be actively and literally overlooked. As theorised by Hunger et al. (2015) and supported by Tomiyama (2014) and Brewis (2014), weight stigma can contribute to a self-reinforcing cycle, whereby psychological stress, impaired self-regulation, and healthcare avoidance may lead to further weight gain. Bacon and Aphramor (2011) critique dominant health paradigms that emphasise weight loss at any cost and underscores how weight focused approaches can inadvertently entrench the very outcomes they aim to prevent.

3.7 ‘Atamai (Mental)

Weight stigma is consistently associated with poor mental health outcomes, particularly as body weight increases (Emmer et al., 2020; Hunger et al., 2015). While these associations are well established, much of the evidence is based on cross-sectional or self-reported data, limiting causal interpretations. Studies have linked weight stigma to low self-esteem, social withdrawal, disordered eating, anxiety, and depressive symptoms mediated by internalised weight stigma through the mechanisms of increased psychological stress, the association of value with body size, maladaptive eating behaviours as a coping strategy and anticipation of weight-based judgement (Lacey et al., 2020; Major et al., 2014; O'Brien et al., 2016; Pearl & Puhl, 2016; Wott & Carels, 2010). However, many of these studies focus on predominantly European or Hispanic samples, leaving their applicability to other cultural groups in question. (McGarrity et al., 2024) adds nuance by showing that weight stigma persists even after weight loss interventions such as bariatric surgery, while qualitative research in NZ highlights the compounding effect of stigma in clinical encounters with Māori women, where mental health concerns were dismissed as weight-related (Gillon 2024). These findings are highly relevant to Pacific peoples, who experience higher average body weights, intersecting health inequities and are often dismissed when it comes to eating disorders. Yet, no current studies have explored how weight stigma affects the mental health of Pacific populations.

3.7.1 Deference To Health Professionals

A core value of Pacific peoples is respect and deference to elders and health professionals. Fa’alogo-Lilo and Cartwright (2021) reported an inclination with Pacific peoples, particularly elders, attending mental health services to display deference

and acquiescence to interventions suggested by health professionals out of high respect and trust for their title, fear of judgement or lack of knowledge. Although these characteristics are not displayed by all Pacific peoples, it is reasonable to suggest that it occurs in all health settings. Further, the reluctance to question or critique health advice could be a factor that increases susceptibility to weight-stigmatising experiences leading to poorer health outcomes. Olivia Rowe (2022) adds important context from a nationally representative New Zealand sample, finding that individuals with higher weight reported lower trust in doctors. This phenomenon makes it possible that Pacific people are more likely to internalise weight stigma and increase susceptibility to health harms.

3.7.2 Cultural Dissociation

Stigma in any form is detrimental to the formation of self-identity. Cultural identity is a complex and evolving concept that is demonstrably a protective factor for health and wellbeing (Pulotu-Endemann, 2001). However, the enforcement of Western concepts of health and the “thin ideal” can lead to dissociation from protective cultural values and cause distress for the Pacific diaspora in Aotearoa who are learning to navigate their own culture in a Western context. It is reasonable to speculate that coming from a community that is thriving, larger bodied, and collectively oriented juxtaposed with a dichotomous Western view where health is equal to skinny, and it is the individual’s responsibility to do all they can to embody this, may cause significant ideological and cultural disconnects for Pacific peoples in NZ and impacts on health (Brewis & McGarvey, 2000). Stigmatising norms are not always internalised and can be very context specific (Brewis, 2014; Brewis & McGarvey, 2000; Hebl & Heatherton, 1998; Teevale, 2011). Brewis and McGarvey (2000) found that the thin ideal was less

pronounced in environments where participants are the dominant ethnic group. Similarly, Hardin et al. (2018) explored body norms for Samoan and Nauruan women in their respective islands and describe how Samoan women found it hard to see their body size as unhealthy because they remembered the larger bodies of their ancestors and could not align their bodily experience with the messaging that big was unhealthy. However, over time, the constant messaging about body size as a risk factor has increased the moral value of thinness and shaped their body experience negatively both in the Pacific Islands and in NZ (Hardin et al., 2018). For Pacific peoples, experiences of stigma may be detrimental to mental health by diminishing the protective value of cultural identity through assimilation of Western body ideals, which are incongruent with their cultural reality.

3.7.3 Healthcare Avoidance

Healthcare access remains limited and unwelcoming for larger bodied people. Weight stigma in healthcare contributes to increased avoidance of healthcare settings as individuals seek to protect themselves from stigmatising experiences (Hunger et al., 2015). Healthcare avoidance can result from a range of factors, including disrespectful treatment, provider bias, internalised weight stigma, body-related shame, and lack of appropriately sized equipment such as blood pressure cuffs, chairs, and hospital gowns (Major et al., 2014; Puhl et al., 2009). Weight stigma in healthcare most commonly manifests through misdiagnosis, exclusive physical environment and equipment, disrespectful comments, and impractical health advice, particularly unsolicited weight loss recommendations, which are inappropriate at best and potentially harmful at worst (Buxton & Snethen, 2013; Drury & Louis, 2002; Gillon 2024; Russell & Carryer, 2013; Sabin et al., 2012;

Tomiyama et al., 2018). Weight stigma may compromise clinical judgement and influence treatment decisions, leading to stigmatising experiences which discourage larger bodied individuals from seeking care. This reinforces the misconception that higher body weight is inherently indicative of poor health and ignores the psychological and physiological issues for which patients initially seek help (O'Donoghue et al., 2021b).

3.8 Laumalie (Spiritual)

3.8.1 Impact Of Stigma On Spirituality

Spirituality is a fundamental dimension of health and identity for Pacific peoples, interwoven into holistic health models such as Fonofale (Pulotu-Endemann, 2001) and Te Whare Tapa Whā (Durie, 1985) where spiritual wellbeing is interconnected with physical, mental, and social domains and promotes increased self-esteem in Pacific populations (Ihara & and Vakalahi, 2011). Despite this, the impact of weight stigma on spiritual wellbeing remains largely unexplored. In the context of healthcare, repeated exposure to weight-based discrimination may challenge an individual's sense of worth, potentially disrupting spiritual wellbeing. For some, this disenfranchisement may lead to deeper reliance on faith as a protective resource, turning to God, prayer, or community-based spiritual practices when medical systems fail to offer culturally safe care (Ihara & and Vakalahi, 2011; Popkess-Vawter et al., 2005; Wilson et al., 2021). Without research that centres the lived experiences of Pacific peoples, the spiritual consequences of healthcare-based weight stigma, such as internalised unworthiness or disengagement from health-seeking, remain invisible. Given the centrality of spirituality to Pacific wellbeing,

exploring this intersection is essential to understanding the full scope of harm weight stigma may cause, and to shaping culturally grounded, holistic care responses.

3.8.2 The Role Of The Church

Church settings play a central role in the lives of many Pacific Island communities in NZ. They are frequently targeted for health promotion initiatives. Church-based weight loss programmes are common and show modest success in achieving weight reduction. More recently, they have shifted towards a holistic approach, incorporating physical activity, nutrition education, church policy changes, and peer support (Bell et al., 2001; Dewes et al., 2013; Simmons et al., 1998). These initiatives often operate within cultural contexts where traditional values and practices, such as food as a gift, financial giving to the church, and deference to church leadership, take precedence. While these programmes aim to improve health, their weight-centric framing can unintentionally reinforce implicit weight bias by equating health with thinness. This risks perpetuating stigma in spaces that are otherwise seen as culturally safe. Within the Fonua model, the church represents both spiritual and community domains, making it a powerful setting for promoting health, but also one where care must be taken to avoid replicating harmful, weight-focused narratives.

3.9 Kainga (Community)

3.9.1 Family Experiences

Weight stigma experienced in childhood or adolescence can have long-term effects that extend across generations. A longitudinal study found that parents exposed to weight-related talk in their youth were more likely to engage in similar behaviours

with their own children, contributing to harmful outcomes such as restrictive feeding, increased child weight, and poorer psychosocial wellbeing (Berge et al., 2025; Roberts et al., 2021). While no such studies have been conducted in Pacific populations, this intergenerational impact highlights another critical area for further research. A qualitative study in the US found that parental sources of weight stigma were most prevalent in childhood, particularly from maternal sources. These experiences were seen as having a long-term impact on the recipients in varying forms: internalised weight bias, disordered eating behaviours, depressive symptoms, psychosocial symptoms, and body dissatisfaction among others (B. J. Lawrence et al., 2022; Madowitz et al., 2012). Many Pacific families talk about weight openly and without the same level of shame seen in Western cultures (B. J. Lawrence et al., 2022). Terms and comments relating to weight are often conveyed in a blunt, innocuous but humorous way. Family and community are the initial domains in which attitudes and values towards weight are observed, reinforced and cultivated. Pacific peoples are well aware of their body size and popular misconceptions about their bodies (Hardin et al., 2018; Teevale, 2011). While Pacific peoples are not a monolith, their experience of weight stigma within a family setting manifests as humorous, affectionate banter touted as a cultural norm. It is rarely seen as malicious thin-centric commentary on weight, however, it can have an impact on self-esteem. Generational shifts among NZ-born Pacific peoples reflect a growing reluctance to accept weight-related humour, with many more likely to challenge or internalise it as harmful weight stigma, shaped in part by increased exposure to evolving social norms around body image and discrimination (Nemani & Thorpe, 2023). This requires further research to determine the true extent of the different cultural

experiences of weight stigma in Pacific family settings and the evolution of generational views on body size.

3.9.2 Intersectionality

Weight stigma is a phenomenon that intersects with the various social identities that shape an individual such as race, class, gender, sexuality, neurodivergence, and disability. Within the literature, it appears that weight stigma is equally present across racial groups, however, coping methods, internalisation and degree of impact differ (Himmelstein et al., 2017). One study suggests that black people may be buffered from the negative impacts of weight stigma and internalisation. This may be due to Black women holding fewer anti-fat views and experiencing lower rates of body dissatisfaction, indicating that cultural body norms can protect against weight stigma (Hebl & Heatherton, 1998; Himmelstein et al., 2017). Intersectionality may also play a role, as Black and Hispanic women face discrimination across multiple aspects of their social identity, potentially fostering greater resilience against different forms of discrimination (Reece, 2018). However, the concept of additive intersectionality complicates this finding, since Black people appear to fare better than non-Hispanic white individuals under weight stigma, which seems inconsistent with the theory. Importantly, this buffering effect does not negate the harm of stigma; rather it highlights the development of resilience, coping mechanisms and underlying inequities. In exploring the intersection of weight stigma and racism towards Māori in Aotearoa, some research suggests that approaches centred on weight loss have not resonated as strongly with Māori as they may overlook the culturally specific views of health, aspirations and compounding experiences of Indigenous peoples (Gillon 2024; Warbrick et al., 2019). Further research is needed to explore how weight

stigma is experienced at the intersection of gender, body size and Pacific identity in NZ as current evidence is largely centred on the experiences of European and North American populations. There is also a reliance on cross-sectional and self-reported data, which limits causal inference and long-term understanding.

Neurodivergent individuals often face compounded discrimination from both ableism and weight stigma, as sensory sensitivities, atypical eating behaviours and body awareness difficulties, which are common in conditions like autism and attention-deficit/hyperactivity disorder are frequently misunderstood by health professionals (Cobbaert et al., 2024). This can lead to delayed care, inappropriate treatment, harmful weight-centric advice and increased vulnerability to internalising stigma, contributing to poor mental health, disordered eating and healthcare avoidance (Cobbaert et al., 2024). Despite these intersecting risks, research on how weight stigma specifically affects ethnic and neurodivergent populations remains limited (Cobbaert et al., 2024).

3.10 ‘Atakai (Environmental)

3.10.1 Food Environment

Significant dietary changes have occurred for Pacific peoples, shaped by colonisation, urbanisation, and reliance on imported foods. Lameko (2020) and Pressler et al. (2022) describe a “nutrition transition” in Samoa and Tokelau, associated with increased energy intake and rising non-communicable diseases. While these studies highlight important trends, they largely present descriptive data and lack critical analysis of the structural forces at play. In NZ, Pacific peoples are disproportionately affected by poor food environments in low income areas,

contributing to calorie-rich diets and poorer health outcomes (Jowitt, 2024). Research on the “healthy migrant effect” suggests that migrants’ health declines over time due to poverty, limited access to healthcare, and adoption of Westernised diets (Antecol & Bedard, 2006; Jowitt, 2024). Although these findings focus on non-Pacific populations, they may be applicable to Pacific migrant populations (Antecol & Bedard, 2006; Fennelly, 2007). Despite the influence of structural factors on body size, much of the literature fails to connect these with weight stigma. This gap reinforces harmful narratives that frame higher weight as a personal failing. A critical, equity focused lens is needed to better understand how colonisation, food policy, and systemic inequity contribute to health outcomes for Pacific communities, challenging the stigmatising and individualistic assumptions that dominate current weight stigma discourse.

3.11 Summary of findings

This literature review has provided an extensive overview of the existing research on weight stigma and its experience and impact on Pacific women in NZ through the lens of the Fonua model of health. It highlights the key findings as they relate to the physical, mental, spiritual, community and environmental dimensions of health for Pacific people. The methodological approaches within the study of weight stigma have been varied but the evidence indicates that weight stigma is a pervasive driver of inequity in healthcare and has many significant impacts on the health of larger bodied people. For Pacific people, there remains a gap in knowledge regarding the impact of weight stigma on them in all domains of the Fonua Model but particularly within health care. To our knowledge, this study is the first of its kind to explore the

phenomenon of weight stigma in healthcare through the lens and voice of a Pacific women.

Chapter 4 — Research Study Manuscript: Weight Stigma in Healthcare in Aotearoa: Pacific Women's Voice

4.1 Chapter Overview

This chapter outlines the methodology and protocols, presents the key findings from the ten talanoa and discusses how they relate to the objectives and aims of this study in the form of a manuscript for publication.

4.2 Abstract

Pacific women's experiences of weight stigma in healthcare settings highlight longstanding harms that have been overlooked within both health services and research in Aotearoa New Zealand. Internationally, weight stigma has been shown to contribute to many adverse health outcomes ranging from impact on clinical markers of health risk to healthcare avoidance (Wu & Berry, 2018). Pacific women are likely to experience the compounded effects of weight stigma, racism and gender bias in healthcare, making their perspectives particularly important to understand for reducing health inequities (Himmelstein et al., 2017). This study aimed to explore their experiences of weight stigma in healthcare in Aotearoa, its impact on their health and wellbeing, and their recommendations for change.

Using the Talanoa research method (Vaioleti, 2006), this study shares the results of ten talanoa which were conducted with Pacific women aged 28–65 years who had experienced weight stigma in their interactions with health professionals. Talanoa were held face-to-face and guided by the principles of the Fonofale model to capture

the multifaceted impact of this phenomenon (Pulotu-Endemann, 2001). Interviews were audio-recorded, transcribed automatically via Zoom™, checked for accuracy, and then coded manually. Reflexive thematic analysis was used to identify key themes and composite narratives were used to convey findings generated from the talanoa (McElhinney & Kennedy, 2022).

Pacific women reported experiencing weight stigma to varying degrees over the course of their lives. Key themes generated were 1) experiences of dismissal and stigma in healthcare 2) healthcare for Pacific women transcends physical spaces and 3) underlying biases within systems need to be addressed to improve quality of care for Pacific women.

Pacific women's narratives highlight weight stigma as a structural and interpersonal issue, compounded by ethnicity and gender, that deeply undermines equitable healthcare and self-esteem. Healthcare in Aotearoa remains a weight-centric setting and the impact on Pacific women's health extends into all domains of health outlined by the Fonua model of health: spiritual, mental, physical, economic, cultural, and ecological (Tu'itahi, 2007, 2022). Suggested avenues to address included meaningful cultural safety and humility training for health professionals, recognising and addressing weight bias and its interconnections with culture and ethnicity and strive to more consistently and effectively implement a patient-centred approach to patient interactions. It is hoped that by highlighting the far-reaching impacts of weight stigma that health professionals and health systems can begin to reflect, interrogate and review the overreliance on weight as a health measure and demonisation of higher body weights. These findings call for a paradigm shift in the treatment of perceived higher body weights, particularly for Pacific women.

4.3 Introduction

A crucial part of addressing inequity in healthcare is understanding the experiences of those for whom the health system was not designed. in Aotearoa one such population, who experience a higher burden of health and gender inequity, is Pacific women. They experience a pay disparity—even for the highest paid Pacific women (Cochrane & Pacheco, 2022). They are likely to experience the compounded effects of racism and gender bias in healthcare, employment and media which has adverse impacts on health (Ryan, 2019). Given the prevalence of societal weight bias, Pacific women—who often have naturally larger body sizes—are likely to experience heightened levels of discrimination (Pearl, 2018). Despite polarising attention given to the health inequities and levels of discrimination Pacific people face in both the scientific, academic and wider community (Loto et al., 2006; Marsters, 2025), to the authors' knowledge no studies have explored weight stigma from the perspective of Pacific women in Aotearoa to date. Naepi (2021) states '*When we record these experiences of being stopped by walls, we make apparent what was previously invisible*' (p.1). It is with consciousness of some of the invisible realities and walls Pacific women face in society that this study explores their experiences and impacts of weight stigma in healthcare settings across Aotearoa.

Weight stigma (also known as fatphobia) refers to the negative stereotypes, attitudes, and discriminatory behaviours enacted towards others based on their weight, shape or body size (Dovidio et al., 2018). Across all settings, weight stigma is evident such as in health care, employment processes and workplaces, and in media reporting. It is seen by many as an acceptable form of discrimination because

of the moral superiority tied to ‘thinness’ and fuelled by weight-centric narratives of health (Pausé, 2017; Swami, 2013). This bias is readily perpetuated by health professionals who are trained to understand excess body weight as the most important risk factor for many health conditions, have less positive contacts with larger bodied patients, and are exposed to faculty biases in practicum (Phelan et al., 2015b). They also operate within a system that perpetuates these very biases (Hebl & Xu, 2001; Phelan et al., 2014; Puhl et al., 2009).

Understanding of the origins, manifestations and health impacts of weight stigma has grown considerably in the last decade, reframing excess weight from being an individual responsibility and a personal failing to seeing it as a complex, socio-ecological and intersectional state of the body which is influenced by genetic, behavioural, psychological and environmental factors (Bacon & Aphramor, 2011; Pausé, 2017). Existing literature reports a myriad health impacts of weight stigma on individuals physiologically such as raised c-reactive protein, blood pressure, cardiovascular reactivity and cortisol for larger persons through hyperactivation of stress pathways and allostatic load that can contribute to long-term disease risk (Wu & Berry, 2018). Mental and behavioural impacts of weight stigma are also well documented, including social isolation, increased risk of binge eating, healthcare avoidance and diminished self-worth (Emmer et al., 2020; Kost et al., 2024; Major et al., 2014). Studies demonstrate that these harms are compounded by experiences of ethnic and gender inequality (Himmelstein et al., 2017; Nolan & Eshleman, 2016). Weight stigma can be damaging to self- and cultural identity which are both protective factors for health (Pulotu-Endemann, 2001; Swami, 2013). It undermines and reshapes how an individual views themselves within their family, community and society (Swami, 2013). Despite the increasing body of literature exploring weight

stigma, it persists in healthcare settings. This exploratory study aims to make apparent the experiences weight stigma of Pacific women in Aotearoa healthcare settings, to give insight into the impacts of this lived experience and to document their suggested avenues for change to reduce this bias within healthcare.

4.4 Methodology

4.4.1 Overview

Ten Pacific women from around New Zealand participated in this study which adopted a qualitative, phenomenological and talanoa-based methodological framework. The sample consisted of self-identified larger bodied Pacific women aged from 28 to 65 years who attended one talanoa session lasting up to 90 minutes (Table 1). Each talanoa was held individually face-to-face, either in-person and on Zoom™ software to allow for genuine connection and deeper discussion about personal impacts. A study protocol was developed to ensure cultural protocols were adhered to and ensure consistency amongst talanoa (Appendix 1). Qualitative phenomenology was deemed appropriate for this study as it centres Pacific women's lived experience and focuses on detailed accounts of feelings, meanings and perceptions (Bevan, 2014).

4.4.2 Recruitment

A purposive and snowball sampling technique from the New Zealand Pacific population was used to recruit women. Snowball sampling refers to a process whereby initial study participants recruit future participants from their own networks. This approach is commonly used for hard-to-reach populations and relies on trust and interpersonal connections (Parker et al., 2019). Recruitment criteria included

participants who self-identify as female, larger-bodied, aged 18 or over, and had experienced weight stigma in healthcare settings in New Zealand. While previous qualitative studies defined inclusion criteria based on BMI (e.g. >25kg/m^2 or >30 kg/m^2), this study did not use BMI as an inclusion criterion in acknowledgement of the inadequacy of BMI as an individual measure of health (McAnulty & Scragg, 1996; Rush et al., 2007) and, to support an inclusive research approach that did not rely on BMI or other weight-based thresholds as women of all body sizes can be subjected to weight stigma. Participants were recruited through word-of-mouth via academic and health networks alongside poster advertisement on social media and in public libraries (Appendix 2). Potential participants completed a short screening survey to collect demographic information and ensure that inclusion criteria were met. Following this, participants were contacted via phone/text/email to arrange a time to meet. Five women requested Zoom™ talanoa due to family or time commitments or living outside of Auckland. For in-person talanoa, the venues chosen were public library meeting rooms, nearby parks or the woman's home and times were decided by the women according to their preferences.

4.4.3 Sample Size

The intention of this qualitative study is not to generate generalisable findings, but rather, purposive and exploratory. This study is conducted with the aim of generating insight and understanding the experiences of the women participating. Saturation relates to the researcher's judgement as to whether the data collection is generating new information or not (Hennink et al., 2019; Morse, 1991). Ten talanoa were conducted in total to generate a rich dataset. 'Information power' was used to determine whether the talanoa provided a sufficient basis for the proposed analysis.

Information power refers to the notion that studies can gain useful knowledge from a range of factors such as richness, relevance, and quality of participants and moves away from a pre-determined number of participants, in this way a sample size can be smaller if the information gathered is strong and specific (Braun et al., 2022; Malterud et al., 2016). The ten talanoa provided both richness of information and recurrence of themes in line with both saturation and information power.

4.4.4 Data Collection

Talanoa is a culturally appropriate method for engaging with Pacific women in a research setting. Vaioleti (2006) states *"if researching ethically is about respecting human dignity, then it is critical that the process is culturally appropriate for the participants*" (p.29). The use of talanoa ensured that women were engaged in an informal, reciprocal process of conversation which strengthened relationships in pursuit of knowledge and moved towards shared understanding (Vaioleti, 2006). The vā or relational space (Anae, 2016) was nurtured between researcher and women through open communication, use of humour and empathy, offering food and gift voucher, a clear vision of what their collaboration will entail and usage of data collected and the humble offering of the researcher's own stories to enable the women to feel comfortable to describe their own experience, feelings and meanings to impart how they make sense of the phenomenon of weight stigma (Vaioleti, 2006). The Pacific women involved were offered a $75 gift voucher for a store of their choice and food vouchers for food to eat during talanoa or share with family. The provision of food and gift voucher as a meaalofa (gift) emphasised the reciprocal spirit of generosity that characterised the talanoa. I recognise the unique epistemology of Pacific people, and the use of the Talanoa methodology allowed for

genuine contextual interactions that create more authentic sharing of knowledge (Farrelly & Nabobo-Baba, 2012; Naepi, 2019). This methodology was also used to relate the themes identified to Pacific values in the discussion (Vaioleti, 2006)

The talanoa guide was developed by the primary researcher, refined through community consultation with Pacific and Māori academics and health professionals, and used to guide the conversation (Appendix 3). The talanoa began with introductions and relationship building, leading into an exploration of any cultural views on body size or weight. The women were asked to describe their experiences with weight stigma in healthcare settings, explain any impacts it had on their health and wellbeing and to share any recommendations they thought could address weight stigma in health.

4.4.5 Data Analysis

Interviews were recorded and transcribed using Zoom™ software, checked for accuracy and coded manually. Iterative reflexive thematic analysis was completed using Braun and Clarke's 6 steps to thematic analysis (Braun & Clarke, 2021): 1) familiarisation with the data included participating fully in each talanoa followed by analysis of audio recordings before and during reading the talanoa transcripts; 2) open coding was conducted manually in Word documents with colour-coded quotations highlighted to ensure that the voices and key contributions of the women were captured; 3) all codes were categorised using a mind-mapping approach and quotes from the transcripts were collated into one document to enable initial theme generation to outline potential patterns of shared meaning and core concepts arising from the Talanoa; 4) the initial themes were reviewed and developed to capture the narrative of Pacific women's experiences and the impact of weight stigma in

healthcare settings through 3 key themes; 5) themes were then refined, defined and named appropriately with peer discussion; 6) the final analysis of the women's experiences were woven into three composite narratives which add to the body of knowledge surrounding weight stigma and Pacific women's lived experience.

4.4.6 Composite Narratives

Composite Narratives were chosen as an appropriate method to present the talanoa findings (McElhinney & Kennedy, 2022; Willis, 2019). It resonates with the oral traditions of Pacific peoples, while also allowing complex accounts to be presented in context, without reducing them into fragments (Willis, 2019). Each composite narrative explores an objective of the study: 1) experiences of weight stigma in healthcare settings; 2) impacts of weight stigma on aspects of health and wellbeing; 3) recommendations for reducing weight stigma in healthcare. Quotes were highlighted and chosen from talanoa transcripts and shared with the talanoa participants for consent to use. Composite narratives provide an accessible format for the dissemination of study findings for the Pacific and general populations. The three composite narratives each touch on an overarching concept and are based on commonalities from transcripts from all ten talanoa, woven together with the women's quotes to become a single story which protects anonymity but covers the breadth of the talanoa. As they are an amalgamation of experiences, specific medical diagnoses and details are kept intentionally vague. Within the discussion, four concepts from the Talanoa methodology *(*Faka'apa'apa, 'Ofa Fe'unga, Mateuteu, and Anga Lelei) to guide research engagement with Pacific communities are signposted below each theme and integrated into the discussion demonstrate where healthcare experiences diverge from Pacific values, provide insights into how

these experiences may be improved and ensure that the narratives conveyed are culturally relevant (Vaioleti, 2006).

4.4.7 Ethical Considerations

Prior to data collection, a robust consultation process was conducted with Pacific and Māori community leaders in health, academia and nutrition. The consultation ensured that the study design and talanoa guide were culturally safe, upheld the integrity of the study, ensured careful and conscious guardianship of the gift of knowledge of these women and that the findings are of benefit to Pacific peoples (Cochran et al., 2008; Naepi, 2019; Smith, 2021). Ethical approval from the Massey University Human Ethics Committee was granted on 25 March 2025 for 1 year. Reference Number: OM2 25/03. Participant Information Sheets (Appendix 4) and consent forms (Appendix 5) were explained before and during the talanoa and the right to withdraw was emphasised.

4.4.8 Reflexivity

A key tenet of Reflexive Thematic Analysis is researcher positionality. The researcher is seen as an active participant in knowledge production in the analytic process rather than a neutral observer (Braun & Clarke, 2021).The primary researcher's Pacific heritage and dietetic background inevitably influenced talanoa, interactions and interpretation of their accounts including preconceived notions of weight inclusivity and neutrality characterised and a desire to explore how the perception of being overweight/bigger bodied can influence Pacific health and wellbeing. Reflexive practice was central through ongoing journaling, post-talanoa debriefs, and peer discussions to critically analyse how personal beliefs about

health, weight and culture may be shaping the analytic decisions. It also manifested as acknowledgement that I do not exist within a larger body, however, there are aspects of weight stigma that I also shared with the women participating. Within theme development, latent meanings regarding power, stigma and structural determinants of health were produced through an iterative process which emphasised depth and richness over consensus coding. Coding and analysis were conducted independently by the author and then discussed reflexively with supervisors to enhance depth of interpretation. In the final analysis, the resulting themes are understood to be co-constructed through the interactions between participant-researcher talanoa, theoretical frameworks, and researcher reflexivity and delivered as composite narratives which increase accessibility and ensure anonymity.

4.5 Results

4.5.1 Introduction

This chapter outlines the demographic information, talanoa results, analysis and interpretation of results. The results of this study are presented here as composite narratives. Composite narratives enable greater accessibility to and resonance with the experiences and themes generated within this study (Willis, 2019). They also connect with the oratory nature of Pacific peoples. Each narrative is a composite of the shared themes across the ten talanoa with the Pacific women who gave voice and meaning to this study. Names have been changed and talanoa are de-identified for confidentiality reasons. The three composite narratives encompass the three objectives of this study 1) to understand how Pacific women experience weight

stigma in healthcare, 2) how these experiences shape their health and wellbeing, and 3) what changes they believe are needed to reduce weight stigma in healthcare settings. From the talanoa and composite narratives, three themes were generated which explore the experience and impact of dismissal and stigma, how healthcare for Pacific women transcends physical spaces, and underlying interpersonal and systemic biases must be addressed to provide equitable healthcare.

4.5.2 Talanoa Participant Demographics

Table 1.

Demographic characteristics

Participant	Age	Location	Place of Birth	Ethnicity
P1	29	Auckland	New Zealand	Niuean/Cook Islander
P2	62	Porirua	New Zealand	Samoan
P3	51	Christchurch	New Zealand	Samoan/Fijian/European
P4	28	Auckland	New Zealand	Niuean
P5	36	Auckland	Tonga	Tongan
P6	31	Auckland	New Zealand	Niuean
P7	29	Auckland	New Zealand	Samoan
P8	45	Auckland	New Zealand	Samoan/Māori
P9	29	Auckland	New Zealand	Samoan
P10	28	Auckland	New Zealand	Samoan

4.5.3 Composite Narrative 1 - Letau

Experiences and impact of dismissal and stigma in healthcare

Letau's narrative explores how Pacific women experienced weight stigma within healthcare settings. It shows how they were subject to unsolicited comments about weight in private and public settings, their presenting complaint was often overlooked due to higher body weight, use of fear tactics stemming from weight bias, and a lack

of tailored and culturally relevant care which included stereotypical assumptions about lifestyle and diet. This theme captures how weight stigma operates within healthcare settings, shaping (dis)engagement and (dis)trust in the health system.

This is the story of Letau. Letau is a Samoan name. It refers to being not connected or not belonging. This name is deeply personal – it belongs to a close family member, but it also reflects the experience of not being accepted as you are by the health system and the lack of connection created between HCP and patients.

Letau is a 28-year-old Pacific woman from Christchurch. She had been with the same GP for her entire life. During her teens, she experienced irregular periods and stomach issues. Concerned, she went to see her family GP. Instead of receiving a potential diagnosis or clear explanation, she was immediately told *'Oh the weight! It's the first thing that you should be addressing […] If you take care of your weight, everything else will be okay' (P2)*. She wasn't given any clear guidance on how to lose weight, or a referral to weight loss support, and no further tests or investigations were ordered.

At home, she tried to make changes. She cut down on foods to the point of starvation, exercised fanatically, and tried different diets. But when she returned to the GP, the only thing they seemed to care about was that her weight hadn't dropped enough. The GP said her eating was the problem, without recognising the stress, physical and mental health struggles Letau was also carrying. Letau recounted that

'Sometimes I would not eat, and that's not good for your body anyway, because your body needs that nourishment to be able to burn fat. You can't burn nothing with

nothing. So, I would suffer from a lot of body dysmorphia […] that was what consumed me' (P6).

"Because it's an invisible ailment that they can't see, they just look at how you present yourself and they go "Oh, that's because you're big" [...] it always comes back to food/lifestyle and it's like, okay [in a sarcastic tone]" (P8)

Whenever she visited her GP, it was the same message – her weight was the problem. Meanwhile her symptoms persisted. When she returned to her GP some years later, after a bit of an absence, she was shamed about her weight:

'I walked in, [the GP] was like "Whoa, you've gotten really big" […] and then in front of everyone, started asking me about what I was doing to lose it and that was […] in a social setting, because it's in the waiting room in front of a group of people' (P9).

Feeling embarrassed, she explained to her mum*, 'it made me not want to go doctors, because I just thought it was pointless' (P10). While I can acknowledge that, yes, you take one look at me and you think weight is the issue, that shouldn't be what I met with. I should be met with "what are your concerns today?" (P6)*. Over the years, this fixation on weight continued to characterise her GP visits. Whether she went in for a bad cold or a bruised ankle, the response was the same: just lose the weight and it will all be fine. Her diet was always questioned, often through sweeping assumptions about the kinds of foods she ate and her portion sizes. One day, the GP said: '"*I'm guessing you don't eat that healthy […] Oh, you need to stop having takeaways because that's what you guys mostly like*"'. Letau would subtly try to call this out without causing a scene – *"when you say you guys, what do you mean?"* And [they] said "*Oh, you know, your family I guess*." *I was just like, oh okay because*

my parents don't really like takeaways, so I don't eat it that much' (*P1).* Letau couldn't believe it, telling her sister, '*They just look at brown people sometimes and I think they're very quick to make judgments on their level of education or knowledge sometimes' (P3)*. Even worse, the GP was a vegan and told her that she should become a vegan too *"because, you know, lots of anti-inflammatory foods, leafy greens. Good for your blood. Good for this blah blah" (P6).* She thought to herself *"this is not what I came here for. I came here because I think I have this [health condition]. But you just think that I need to change my eating habits that aren't already bad." That was the last straw (P6).*

A routine developed that made Letau dread her appointments. She would wait anxiously in sterile waiting rooms for her name to be called, then be weighed in a corner of the reception. The consultation would turn into a lecture about her weight because her BMI was high, leaving no space to talk about her actual concerns, *'I feel like the thing that gets us Islanders the most is the BMI chart. That's really what gets us'* (P7). To Letau, these visits felt less like healthcare and more like constant reminders that her body was wrong. She often thought to herself during these encounters, *'I already know I'm big. I don't really need to be reminded, and what's hopping on the scales gonna do for the behaviours? It's probably gonna make me eat more if I see them' (P3).*

Eventually, Letau was diagnosed with Adenomyosis, Type 2 diabetes and Cardiomyopathy and was prescribed metformin straight away. The doctor said: *"Here's some Metformin. This is good for PCOS, because it helps with stabilising blood sugars and weight loss" (P6).* And that was all. The focus was on weight loss. And then she said *"and when you incorporate this with going vegan it will help.*

Okay?" (P6). The doctor's assumption that a vegan diet would be best irked her. She came from a large Pacific family, who cooked and ate dinner together every night. Going vegan was not realistic on their food budget either. The side effects of Metformin made her stop because she could not handle the diarrhoea and upset stomach when she had her parents to look after and work. Her GP did not have time to address the medication at her next appointment and so it became less of a priority to Letau. The GP referred her to a Dietitian who happened to be Pacific. Her experience was like *'an aunty just wanting to talk to you about how you need to make better life choices, but the advice was still the same [as the doctors and other health professionals]' (P9).* Still, she felt grateful compared to her friend Malia, who had seen a male dietitian that barely spoke to her, handed her a pamphlet, and offered advice that ignored Pacific foods altogether. She told Letau, *'He didn't have consideration for me, or care or passion about what he's doing… or even really want to help someone […] Maybe ask me what can you afford? I don't eat this food because he's giving me this Palagi food"' (P5).* Malia also felt judged and unheard in that consult, stating *'he was saying "if you don't follow this, five years from now, you're gonna be so sick" […] I felt I was invisible because I didn't have time to talk… so I didn't want to listen or be there' (P5).*

When Letau found out she was pregnant, her GP told her '*that because of [her] high BMI that [she] would have complications with [her] son and that wouldn't make it past 12 weeks'* (P7). Because of her weight problem, as the GP described it, she was offered an abortion as a first option. It felt so offensive and dismissive. Her GP knew about her fertility issues and how much she wanted a child. For a week, she considered abortion but, she refused, leaning into her spirituality, knowing in her heart that this baby was a gift from God.

Her pregnancy was difficult, with multiple hospital admissions. The fearmongering was a constant, and the message was always *“if only we could get the weight down” (P9)*:

‘I had gotten that experience from my midwife and then from every other health professional that I had met. It was almost like every appointment was a “oh, it's tricky, it's such a high-risk pregnancy” constantly reminding me that I shouldn't have gone through with it’ (P9).

She began praying more, leaving messages for her unborn baby, and developing safety strategies in case of death. Her baby was born premature but healthy. Still, Letau carried the sting of her GP’s words: *‘Everything following that always came down to that conversation we had. And even now I'm too scared to have another kid, because I don't want to go through that again’ (P7).*

After the birth, Letau decided she would not return to that GP. She sought out a new provider. This time, a Māori health service that she hoped would value her voice and cultural identity. At her first appointment, she was alone but determined to advocate for herself. Firmly, but with a shake in voice, she told the GP: ‘*I'm not here for you to give me a blanket solution. I'm here to actually get to the bottom of my concern.” (P6).* This time, the GP heard her, noticed her distress, and took time to reassure her. She listened, ordered the tests, and mapped out a clear plan. Letau left that appointment with a pathway forward and a sense of hope for better health for herself and her child.

4.5.4 Composite Narrative 2 - Loto

Healthcare transcends physical spaces

Loto's story highlights the impacts of experienced weight stigma on the Pacific women through the holistic lens of the Fonua model. Pacific women reported the experience of weight stigma impacting them across several domains of their lives. Her views of weight were shaped before interaction with the health system through social, cultural, and relational interactions and crafted narratives. These influenced the development of internalised weight stigma which shaped how she anticipated care, interpreted stigma and carried fear, self-preservation and hypervigilance into each appointment. The clinical experiences served to compound and intensify internalised weight stigma as it was tied to severe limitations in aspects of life such as social engagement, health and pain management, stresses of life, and increased mental load. This theme highlights that Pacific women's healthcare experiences are inseparable from the broader ecosystems of racism, societal body expectations and judgement, family experiences and cultural identity. Healthcare is not confined to physical health spaces such as the GP or hospital but is continuously operating and being shaped as Pacific women move throughout life.

Loto means heart or soul in Samoan. I chose this name because ultimately, when weight stigma occurs, the heart and soul are deeply affected. When combined with 'tele', it becomes 'loto tele' or 'courageous/strong'. This reflects both the negative impacts of weight stigma on Pacific woman alongside the huge amounts of courage and resilience and forbearance these women have displayed throughout their lives.

Loto is a 45-year-old Pacific woman living in Auckland, raising three teenagers on her own. Her relationship with healthcare and her weight has been shaped by many layers of experience in her family, her community, and in the wider world.

Growing up with her grandparents, Loto was surrounded by stories that shaped how she understood health and healthcare. She would overhear conversations about upsetting hospital visits which lacked tailored support, dismissed their concerns, and gave "palagi"[1] advice. Her family experiences planted seeds of mistrust and fear. *'On [her] mom's side, both of [her] grandparents went in [for minor surgery] and they didn't come out' (P1).* Her father would say *'that he's healthy because he's skinny' (P1)* and if he dies, it is God's plan for him; he preferred to focus on making sure his family was fed and happy rather than worry about his health. These stories and attitudes left her fearful that seeking help might reveal a burdensome illness or repeat her grandparent's experiences.

Outside family, other influences compounded fears. Social media and news that portrayed Pacific people as too fat and Pacific diets as extremely unhealthy unsettled her. These narratives never matched her lived experience, but they left her anxious that doctors would see her only through this lens.

'…they don't see us as human beings. They see us as people who make poor decisions. These poor decisions didn't lead us here. It's the lack of understanding from other groups of people that put us into these boxes and make it almost impossible for us to get out of…' (P6).

[1] Palagi is the Sāmoan word for white person or foreigner

Her husband's constant consumption of videos about "ideal" bodies subtly reinforced messages about what she should look like. The movies she watched as a girl featured thin European women, while her world was filled with strong, hardworking Pacific women whose bodies looked bigger and different. The lack of representation, the constant body policing, and the racialised undertones all signaled to her that being Pacific, being a woman, and being fat placed her outside what was valued in society. Within her family, she observed contradictions. Some relatives framed larger bodies as their inheritance from ancestors *'when we have our weight around our manava[2], I always say it's because we're carrying our ancestors' (P2)* while others linked size negatively to migration and colonisation, '*there are a lot more bigger people in people's families now versus in the fifties or sixties, when my grandparents migrated here and that was very rare' (P6).* At home, jokes about "big backs"[3] or being "lapo'a[4]" were common. She found them humorous but also stinging*:*

"I'll just say the attitude towards it […] terms of being big, it's something to be mocked for but if you're too skinny, then you're sick' (P9). '*My son, they refer to him as lapo'a, like a big boy, or chubby or chunky and they laugh about it, but it's almost like […] that's being put on him as a "it's cute now, but not for later"' (P9).*

At church, eyes lingered on her plate, she would be called "fia palagi"[5] when she bought salad to the feast. At work, she overheard colleagues mocking celebrities' weight gain, but those women looked like her. Even in mundane settings like parent–teacher interviews, she encountered physical barriers, such as small chairs and

[2] Manava is the Sāmoan word for stomach
[3] Big back is a colloquial Gen Z term for fat or greedy person
[4] Lāpo'a is the Sāmoan term for fat/large/big
[5] Fia palagi is the Sāmoan term for someone who tries to act like a white person

cramped offices. These moments accumulated into a heavy burden of discontent with her body, fear of judgment, and fear of healthcare.

Against this backdrop, Loto finally went to her GP for chronic pain. Her fears were realised. She felt self-conscious trying to squeeze into such a small chair in the waiting room, hyperaware of the size and colour of those around her. She felt their eyes linger a little longer on her and imagined them thinking that her chair might break. Over the course of many appointments, she was referred from one specialist to another, shuttling herself between doctors, gynaecologists, specialists, carrying her own notes and research because she was constantly having to repeat what had been said in other appointments with health professionals: '*I guess they don't have time to explain things properly. Because they're so busy and so overwhelmed. But then, whose responsibility is it. It can't be ours' (P1).* She felt bad about wasting the health professional's time because she couldn't lose enough weight between appointments. She was given limited choices for treatment and when she was told surgery was not an option due to her weight, she deferred to the expertise of doctors. Her frustration deepened as she felt trapped in a vicious cycle.

The impact on her life was immense. Pain flare-ups prevented her from attending her children's prizegivings, family/social events, church gatherings, and exercise. When talking to her partner, Loto expressed that *"its actually slowing me down with our goals and plans that we want to put in place for our young family, too, you know and it's like, okay, I'm now living a life of avoidance' (P8).* Some family members questioned her pain tolerance, unable to understand its cause, persistence or severity. '*My family, they were like "you must be eating bad if you got it again"' (P1).* She experienced breakdowns in relationships, being unable to manage life with

chronic illness: '*It took a toll on the previous relationship that I was in*' (P8). Even her faith wavered as she questioned why she was burdened with this experience.

'That led me astray from religion [...] I couldn't understand – I'm a good person. I'm a good daughter. I'm a good granddaughter [...] and I'm being rewarded by having shit health and healthcare' (P6).

Frustrated with constantly broad, unhelpful weight loss advice, Loto researched her cultural foods, explored ancestral ways of living, and invested in private scans, consultants, and nutritionists. She spent money she didn't have to spare and countless hours navigating online sources of health information, rescheduled appointments, long waits, and travel while juggling her children and pain. Over time, she developed ways to cope with weight stigma and the constraints of healthcare. She researched ahead of appointments to maximise limited consultation time, sharing that she would *'plan ahead [...] and write everything down before I talked to doctors so they could just stick on topic' (P10*). She brought robes when hospital gowns wouldn't fit. She advocated for herself while also trying to be a "model patient" who was compliant, deferent and avoided the stereotype of being a "*difficult, loud brown woman*" (P8). To defuse tension and pre-empt weight stigma, she used humour. *'I always make things funny to make me feel better' (P4),* and with time, she learned that bringing up her own weight first would allow her to control her doctor's perception of her and her weight.

'I was trying to beat them to it because I didn't want them to tell me the reason why you're recovering slower is because of your weight [...] I just don't want to hear it from other people, especially if you don't look like me. How would you know that I'm progressing slower because of my weight?' (P4)

Yet the mental toll was immense. She would often think, *'Is there something more that I could do for them to take me seriously?' (P1).*

'I continuously get rejected and there's only so much I can take and so it can be quite frustrating where it's like […] What's the point? Why don't I just give up? You know prematurely sending me to have the eternal occupation of pushing daisies' (P8)

She developed body dysmorphia, cycled through fad diets, eight-week challenges, masked disordered eating, and spending time and money in pursuit of an onerous outcome: *'even when I'm doing something right, I'm still criticised for it because the way I look, they think I don't' (P9).* She became hypervigilant, conscious of weight stigma and racism and defensive of herself and her actions. She felt *'genuine frustration [...] not just in the lack of the […] culturally responsive care but just the systemic stigma […] that treats weight as a moral failing instead of a complex intersectional issue' (P8).* Her journey with healthcare was not just about pain or weight, it was about navigating biases, systems and societies that frequently failed to see her fully, leaving her to carry both the visible and invisible burdens of being a fatter Pacific woman in Aotearoa.

4.4.9 Composite Narrative 3 - Lupe

Underlying interpersonal and systemic biases need to be addressed to provide equitable healthcare

Lupe's narrative represents the recommendations from Pacific women to addressed weight stigma in healthcare through a vision of future care received by a young Pacific woman. Pacific women call attention to aspects of their healthcare that

embodied the intersection of weight, ethnicity and gender and the underlying biases that frame these aspects of identity through a deficit lens. The narrative reveals how stigma is produced or interrupted by the attitudes, assumptions and relational practices of HCP. According to Pacific women, these biases can be disrupted through Pacific representation, cultural humility and genuine, non-judgmental partnership. This narrative highlights that addressing bias is not only about avoiding weight stigma but intentionally adopting models of care that honour cultural worldviews and creating spaces where patients feel seen, safe, and valued. Her encounter redefines what equitable, non-stigmatising care could look like from a Pacific women's perspective.

Lupe is a Pacific pigeon. It is culturally important as one of the largest forest birds in the Pacific. It is known as the only one able to feed on and spread the large seeds of some of our most important rainforest trees. I chose this name because it represents the strength and capacity of these women to take these experiences, share them with me and disseminate the seeds of their learnings to grow trees and fruits which benefit future generations.

Lupe, a 24-year-old Pacific woman from Porirua, had recently completed her Applied Nutrition degree. Through her studies, she carefully considered the social determinants of health, cultural models of health, and the principles of cultural safety and humility. These frameworks emphasised the centrality of culture, family and environment in shaping wellbeing, alongside the recognition that food is deeply personal with multiple meanings. These insights reinforced the value of reflective practice and patient-centred approaches to care, lessons she intended to carry into her future professional role.

After graduation, Lupe became a patient when she experienced an acute episode of gallbladder inflammation. In the emergency department, Lupe arrived in extreme pain but was quietly reassured by the environment. The waiting room displayed vibrant images of Pacific families in diverse body sizes and appropriately sized seating, which further eased her anxiety, reflecting the importance of the physical space. Staff interactions reinforced this sense of belonging: the receptionist was warm, and the doctor greeted her with a cultural welcome after recognising her surname: *'That's why we say the language, the welcoming of anybody into those spaces is so important for them to feel valued, even if they don't quite value themselves' (P2).*

The consultation process was characterised by partnership. The doctor asked Lupe how she was feeling, listened to her account, and sought consent before ordering further investigations:

> *'He didn't make it about my weight but [asked] if I need to be healthier, what are some of the options I would look at? and I say "well, [that] would be my food, the time I eat, and what am I prepared to give up". He goes "that's a good start" (P2).*

The doctor's laughter in response to Lupe's nervous humour humanised the interaction, breaking down power imbalances and creating a sense of ease. When her pain persisted, the doctor validated her experience and reinforced that her pain was real and worthy of more attention. It gave her hope that young Pacific women in the future would access quality healthcare from the first presentation of the issue. Lupe's subsequent GP consultations extended these positive experiences. The GP

explained her condition in simple terms, situating diet as one possible factor while acknowledging that there are multiple causes. Lupe knew that not all of her friends and family had such positive healthcare experiences. It seemed that the way they approached fat people [...] was very black and white. Her sister often recalled being told *"You're this way, because you eat too much. Stop eating too much and get off the couch"* (P9) by a GP.

Lupe's GP resisted perpetuating a narrative of individual blame, a recurring frustration voiced by her family about their own healthcare providers. Lupe was invited to share her usual food practices, and her Pacific diet was received with respect and understanding. The GP even shared a funny story about being scared to try 'oka[6] for the first time, which not only reduced tension but reflected cultural humility.

Crucially, the GP went beyond the presenting complaint. When Lupe disclosed acne flare-ups, the doctor asked about stress and sleep, recognising the interplay of mental, emotional, and physical health. For Lupe, the opportunity to reflect on the pressures of being the eldest daughter in her family opened a space for holistic care. The GP's response was filled with empathy. He acknowledged that Pacific women were stalwarts of the family and often the last to put themselves first when she expressed that '*Pacific women are generally caregivers [...] We're used to looking after everybody. But when we're in a position like that [...] we can't be that person and maybe if more healthcare professionals knew that they would be more [...] softer' (P1).*

[6] Sāmoan raw fish dish

The handling of routine monitoring was also significant. The GP explained the purpose of tracking weight and blood pressure trends, then asked Lupe if she was comfortable with taking these measures. Her initial hesitation shifted to relief when she saw a large blood pressure cuff was available and the weigh-in would be private. These seemingly minor details such as choice, privacy, appropriately sized equipment were pivotal in shaping feelings of safety rather than stigma. Lupe left the consultation with a clearer understanding of her condition and confidence in her GP. At home, her partner was supportive of the advice and helped her implement changes for the family. He understood and reinforced that her weight did not determine her value and she was grateful for this reminder on her hardest days. She resolved to move her parents to this GP practice because of the quality of care. More importantly, she felt heard, affirmed, and respected:

'My feedback is not a complaint. It's more of a cry of hope. Yeah, that our health system, they would honour the voices, and listen more for those who are like me, who walk this path that are outside the norm, and that they embrace the models of care that reflect the richness of our diverse communities' (P8).

4.6 Discussion

To the best of our knowledge, this study is the first to qualitatively examine this phenomenon for Pacific women. Those in our study experienced weight stigma from a range of sources: cardiologists, nurses, dietitians, hospital doctors, physiotherapists, gynaecologists, surgeons with GPs being the most common source

of weight stigma in healthcare settings. Across the various health settings, women faced weight stigma in a variety of ways. Most commonly, unsolicited, critical comments about weight, weight loss recommendations in lieu of medical diagnosis, and negative assumptions about diet/lifestyle based solely on visual assessment and participants perceived this to have lasting negative impacts on their wellbeing. Pacific women reconfirm the existing research on weight stigma in healthcare settings (S. E. Lawrence et al., 2022; O'Donoghue et al., 2021a; Ryan et al., 2024); however, they also offer novel and key insights about the intersection of culture, ethnicity, gender and weight in Aotearoa. Findings were reported through composite narratives. Within these narratives, key themes developed through analysis were 1) experiences and impact of dismissal and stigma in healthcare 2) healthcare for Pacific women transcends physical spaces and 3) the desire for underlying biases in healthcare to be addressed.

4.6.1 Experiences And Impacts Of Dismissal And Stigma In Healthcare

Faka'apa'apa (respectful, humble, considerate)

Vaioleti (2006) states that with faka'apa'apa, researchers are encouraged to reflect on their manner towards participants, to dive deeper, to listen not simply hear, to foster credible exchanges which maintain and build trust and 'tauhi vaha'a/teu le vā' (Saunders, 2023). As recounted in Letau's narrative, and reported by others, Pacific women frequently face weight stigma in healthcare settings to varying degrees from unsolicited comments about weight, dismissive body language, poor communication, unsuitable physical equipment, use of fear tactics, excessive prescription of weight loss, medication-related weight gain, and dismissal of patient non-weight-based health concerns (Hebl & Xu, 2001; Lee & Pausé, 2016; Major et al., 2014;

O'Donoghue et al., 2021a; Phelan et al., 2015a; Ryan et al., 2024). Lack of a tailored approach, minimal health education and communication from HCP was a significant impediment to the perceived quality of healthcare received (Buxton & Snethen, 2013; Drury & Louis, 2002; Gillon 2024; Russell & Carryer, 2013; Sabin et al., 2012; Tomiyama et al., 2018). Few weight stigma studies have identified clinicians' knowledge gap regarding medication-related weight gain outside the context of anti-psychotic medications as a contributor to weight stigma through influences on clinical decision-making (Bianchi & Ricupero, 2020; Kohlstadt & Wharton, 2013). The experience of receiving inadequate healthcare from HCP reflected in Letau's story is consistent with research which indicates that healthcare professionals often hold implicit or explicit anti-fat attitudes that influence their clinical interventions, diagnostic reasoning, and patient interactions alongside a systemic normalisation of weight-based judgement within clinical culture (Phelan et al., 2014; Puhl et al., 2009; Sabin et al., 2012). The dismissal of Pacific women's concerns represents a breakdown of the relational and respectful relationships which are considered foundational to Pacific models of health (Teariki & Leau, 2024). The experience of feeling weight stigma can lead to healthcare avoidance was expressed in Letau and Loto's narrative. Our findings parallel those of a recent qualitative study in Ireland where experiences of weight stigma led to patients cancelling appointments and delaying seeking healthcare until their condition worsened (O'Donoghue et al., 2021a). Weight stigma increases healthcare avoidance in larger-bodied populations and makes quality care impossible by causing patients to disengage from the health system (Hunger et al., 2015; Puhl & Heuer, 2009). Within this study, Pacific women engaged in healthcare avoidance, finding their health appointments pointless, repetitive and expressing that they would delay their health appointments until

completely necessary, leading to delayed diagnosis and poorer continuity of care. Pacific women's accounts from this study mirror those of previous studies in relation to healthcare avoidance, however, they also add importance nuance as many expressed that they found their appointments repetitive, dismissive or unproductive. This indicates that their avoidance is a rational response to structural inefficiencies and lack of culturally safe care. Healthcare avoidance in this context becomes a form of self-protection, not simply non-compliance as is assumed by HCP.

Similarly, the fear tactics used by HCPs to motivate Pacific people to lose weight to solve their health problems can also lead to disengagement from the health system, as told in Letau's story. The message Pacific women received from some health professionals was that their weight equalled death with significant implications for their children and families. This had significant impacts on quality of life and health such as social isolation, decreased self-efficacy and self-esteem, poor body image, depression, alienation and death anxiety (Cullin & White, 2025; Douglas et al., 2021; Ryan et al., 2024). Use of fear tactics to induce weight loss disregards the complex societal and environmental conditions which shape health, placing blame solely on individuals and ultimately disempowering patients (Puhl & Heuer, 2010). Therefore, the use of fear and shame tactics to promote weight loss is proven to be ineffective at improving patient health as it can cause significant social, physiological and psychological stress (Cullin & White, 2025; Puhl & Heuer, 2010; Talumaa et al., 2022).

This study extends existing knowledge by showing how these biases intersect with cultural identity for Pacific women. Within this context, weight stigma becomes not

only a medical bias but a form of cultural invalidation that undermines trust and discourages help- or health-seeking (Major et al., 2014; Puhl et al., 2021). These encounters communicate to larger Pacific women that their bodies are incorrect and unwelcome in health spaces, eroding trust in healthcare and self-esteem (Puhl & Heuer, 2010). The resulting avoidance of healthcare reflects a self-protective response to repeated experiences of shame, dismissal and resignation (Puhl et al., 2021). For Pacific women, shaming language, fear-mongering, dismissal of their concerns, unclear communication and deep frustration at feeling unheard was a clear example of how the vā can be soiled with very harmful implications (Anae, 2010).

4.6.2 Healthcare For Pacific Women Transcends Physical Spaces

'Ofa Fe'unga (showing appropriate compassion, empathy, aroha, love for the context)

'Ofa Fe'unga relates to working with others, maintaining relationships characterised by integrity, love and empathy (Vaioleti, 2006). In their recollection of their experiences, Pacific women expressed the importance of relationships in both healthcare settings and familial and social settings. Loto's narrative highlights how Pacific women are impacted spiritually, culturally, mentally, economically and physically by their experiences of weight stigma. This is seen within the literature, however, not in such a Pacific-specific context (Hassan et al., 2024; O'Donoghue et al., 2021a; Puhl et al., 2021). Loto developed a range of coping mechanisms ranging from reliance on- or distance from spiritual/religious sources, maladaptive eating responses, excessive exercise practices, hypervigilance, healthcare avoidance, reliance on- or erosion of family support, exploring ancestral and indigenous ways of living, self-advocacy and self-acceptance (Tomiyama, 2014; Tomiyama et al., 2018;

Wu & Berry, 2018). Pacific women are influenced and adversely affected across multiple domains of wellbeing due to systemic weight stigma. These domains extend beyond physiological and psychological harm to deeply embodied and existential angst threatening and weaking foundational aspects of cultural and social identity (Brochu, 2020; Wu & Berry, 2018). Despite such negative experiences, Pacific women were deeply empathetic to health professionals and constraints of the health system. There was a notable mental tension where while some knew their weight was not a health issue nor a cause for discrimination, they viewed weight loss to be the best path to health (Puhl & Heuer, 2010). This learned weight stigma (commonly known as internalised weight stigma) persisted even with acknowledgement of enacted weight stigma (Puhl & Brownell, 2001). I have adapted the term ‘learned weight stigma’ as research has found that Pacific peoples typically held weight neutral or positive views on body size sizes (Brewis et al., 1998; Hardin et al., 2018; Metcalf et al., 2000). The usage here is adapted from Marsters (2025) who reframes ‘internalised racism’ as ‘learned inferiority’ to dissuade the blame and judgement that can be placed on individuals instead of peoples and systems enacting the racism and weight stigma (Marsters, 2025). Pacific women learn and experience weight stigma from a variety of sources such as cultural and familial interactions and practices which is compounded by weight stigma in healthcare. Despite this, Pacific women relied heavily on familial, spiritual and cultural relationships to support and sustain their wellbeing. Although networks can perpetuate weight bias (S. E. Lawrence et al., 2022), these same networks are also sources of support and resilience, emphasising that health is fostered through multiple dimensions and weight stigma persists across multiple domains (Blaisdell, 1996; Puhl et al., 2021). This finding is significant as it shifts and reinforces the notion of healthcare as

institution-based to being relationship- and community-based embodying protective Pacific cultural values. It emphasises the need for weight bias to be addressed at all levels of the Fonua model through education and reduction in weight-centric interventions and language.

4.6.3 Underlying Interpersonal And Systemic Biases Need To Be Addressed To Provide Equitable Healthcare

Mateuteu (well prepared, hardworking, culturally versed, professional, responsive) and Anga Lelei (tolerant, generous, kind, helpful, calm, dignified)

Vaioleti (2006) explains that 'a researcher must do his or her homework before involving participants' (p.30). In this same way, healthcare professionals must know themselves, their own cultural identity, and make efforts to understand that of their patients (Lekas et al., 2020). Pacific women expressed the need for a deeper implementation of cultural safety and competency training which intersects with weight stigma. Health professionals are still trained in a weight-centric system which provides a narrow view of health and leaves them ill-equipped to approach health from weight-neutral lens within the current system (Ministry of Health, 2017; Warbrick et al., 2019). While popular and tentatively associated with increased patient satisfaction (Govere & Govere, 2016), the effectiveness of cultural competency training is debatable (Curtis et al., 2019). Some implications of cultural competency such as potential driver of 'othering' and perpetuation of stereotypes, alongside a lack of consideration for intersectionality and organisation/systemic processes indicate that it can perpetuate harm against Pacific peoples (Curtis et al., 2019; Lekas et al., 2020; Marsters, 2025). It can be seen as a tokenistic approach particularly considering the structural racism that can arise from homogenised grouping of Pacific peoples (Lekas et al., 2020; Marsters, 2025). More appropriately,

Lekas et al. (2020) proposes ‘cultural humility’ which enacts a paradigm shift where self-reflective practice is emphasised, collaboration with- and appreciation for patients’ social identity, and deconstruction of power imbalances through connection and introspection of one’s own cultural identity and how this can relate or promote empathy to others. The development of cultural humility within healthcare will have significant contributions to dismantling racism and weight stigma through a reflexive recognition of bias and shift away from restrictive biomedical notions of health towards a more holistic approach. Cultural humility also facilitates a patient-centred approach as it is process- rather than content-oriented (Lekas et al., 2020).

With Anga Lelei, Vaioleti (2006) states that there are aspects of Pacific peoples world which can be unfamiliar or hard to understand. To foster understanding, researchers must learn to be observant, develop an understanding of the participant’s situation and create a safe space for participants to contribute safely and freely. Similar values and processes must occur within healthcare as well. Pacific women often felt unseen, not listened to and invalidated in their experiences. The lack of patient-centred care is consequential in the context of weight stigma, as clinical reasoning was often secondary to assumptions about body size and lifestyle (Puhl & Heuer, 2009; Talumaa et al., 2022). Weight-focused interactions contribute to patient disengagement, delayed diagnoses and poorer health outcomes (Tomiyama et al., 2018). Adopting a patient-centred approach can mitigate weight stigma through increased understanding of a patient’s social, cultural and medical context particularly for Pacific women, where relational and communal dimensions of health play a large role in shaping body perceptions and health priorities (Pulotu-Endemann, 2001; Tu’itahi, 2007). Ultimately, prioritising cultural humility and patient-centred care is a structural strategy and imperative for dismantling racism and weight

bias in health. There is deep systemic work required such as purposeful policy and reflexive revision of clinical training and procedural processes to address this issue (Talumaa et al., 2022)

Weight stigma cannot be properly interrogated without acknowledgement of its roots in racism, thus, Pacific women's experience of weight stigma is complex (Strings, 2019). The historical weight -neutrality or -inclusivity of Pacific cultures (Brewis et al., 1998; Hardin et al., 2018; Metcalf et al., 2000) indicates that weight stigma stems from historic and subsisting Western presumptions about ethnicity and gender and promotion of colonial beauty norms (Brewis et al., 2011; Strings, 2019; Vandael, 2021). It acts insidiously to legitimatise oppressive behaviour and systems against non-Western populations through racism and weight stigma at an interpersonal and systemic level (Strings, 2023). Within this study, Pacific women reported perceived differential treatment compared to those of other genders and ethnicities, including microaggressions (body language, dismissal of personhood or high levels of pain) (Miller et al., 2018; Olson et al., 2019), delays in receiving care or medication and false racialised assumptions (Marsters, 2025; Puhl & Heuer, 2009). Weight stigma intersected with racism in instances where assumptions were made about patient diet and lifestyle based on broad stereotypes and visual cues without in-depth assessment as explored in chapter 4.6.1 (Olivia Rowe, 2022; Seymour et al., 2018). For example, in Letau and Loto's narratives, the overt assumption that they eat unhealthily based on a lack of information and ethnic stereotypes emphasises how a lack of patient-centred assessment and underlying racial assumptions operates on face-value judgements, harming the vā between patient-provider interactions. Compounded experiences of weight stigma and racism justifiably lead to healthcare

avoidance (Mensinger et al., 2018; Puhl et al., 2021). Interestingly, in some of the talanoa, Pacific women were eager to be given concrete examples and guidance on how to lose weight despite experiences of weight stigma but found the advice lacking, suggesting the complex interplay between avoidance, deference and hope for meaningful support. In contrast, in the United States, a study found non-Hispanic Blacks were less likely to implement healthcare avoidance based on weight stigma and were more likely to want to engage in weight-related discussions with healthcare professionals (Lewis et al., 2016). The divergence in findings may reflect the differences in sociocultural histories, collective experiences of racialisation and development of adaptive strategies where familiarity with adversity may buffer against complete disengagement Reece (2018). These differences highlight how weight stigma is not uniformly experienced, even in seemingly similar marginalised communities, and is mediated by cultural context, experiences of racialisation and the presence of culturally safe care.

Pacific women questioned the use of BMI in their consults as a measure of health. The reliance on BMI is indicative of structural racism within healthcare whereby Pacific women are unfairly held to body mass standards which were not developed from a representative population and subsequently penalised for it through exclusion from life-preserving surgeries in lieu of medication and weight loss advice (Deurenberg et al., 1998; Rush et al., 2007; Strings, 2023; Swinburn et al., 1996; Swinburn et al., 1999). While BMI is a useful tool for monitoring population health, the over-reliance on BMI at the clinical level as a patient diagnostic and risk assessment tool is problematic given it promotes a narrow conceptualisation of health which is closely tied to body weight and is an inaccurate proxy for metabolic

and lifestyle markers of health (Mishra & Floegel-Shetty, 2023). The questioning of BMI which emerged frequently in talanoa and Letau's narrative reinforces that Pacific women have mostly experienced BMI at a clinical and patient level in lieu of better measures such as actual presence of disease, or pain. The health system in Aotearoa largely reflects Western systems which limits how cultural considerations and body diversity are recognised and prioritised, despite being known protective factors for health (Nemani & Thorpe, 2023; Pulotu-Endemann, 2001; Tu'itahi, 2022). It continues to prioritise Western ideals and falsely equates this with health. Deeper evaluation of the systemic manifestations of weight stigma and racism such as reliance on BMI is required to adequately address weight stigma within healthcare settings.

4.6.4 Strengths And Limitations

The findings of this study are situated within the framework of Fonua whereby Pacific women's contributions were explored from a holistic and culturally relevant lens (Tu'itahi, 2022; Vaioleti, 2006). To enhance the validity of the study, our methodology differed from prior studies as it prioritised and operated through a relational, strength-based and Pacific lens as opposed to a Western scientific method (Vaioleti, 2006). This included sufficient engagement time for each talanoa, member checking and peer-debriefing. To enhance the reliability of this study, detailed data recording was applied. This study extends the existing knowledge through the intersection of ethnicity, gender and weight stigma which has been explored in Māori, Arab and Black populations but not Pacific (Gillon 2024; Hassan et al., 2024; Hebl & Heatherton, 1998). The use of composite narrative within this study provides a novel

approach to qualitative research conducted with Pacific populations within the Master of Science of Nutrition and Dietetic field. They provide an accessible and impactful glimpse into the scope of harm caused by weight stigma which resonates with both health professionals and lay-persons at an emotional and practical level for dissemination. Importantly, this method of analysis and presentation of results clearly aligns and resonates with Pacific people for whom this research has been conducted. It conveys the breadth of the emotion, experience and impact which the Pacific women imparted and honours their unique ways of creating, making sense of and imparting knowledge. Further, the majority of previous studies investigated the impacts of weight stigma in the context of weight management (O'Donoghue et al., 2021b). A conscious decision was made to explore weight stigma without limiting criteria such as BMI or weight management to freely investigate the various manifestations of weight stigma towards individuals of a range of body sizes. Further, diverse representation in terms of age and ethnicity also strengthened the study.

Limitations of this study include use of a small, convenience, non-probability sample to ensure that talanoa were rich in insights and time and resource could be dedicated to cultivating the vā (relational space). Further, I acknowledge that the composite narratives are not generalisable nor reflective of the experiences of all Pacific women with healthcare in Aotearoa. In addition, this study also had a high proportion of Auckland-based women therefore, the results may differ in other major cities in Aotearoa. Volunteer bias may also play a role as participation in the study was voluntary. As noted, there has been no previous research into the experiences,

impacts and recommendations of Pacific women who have experienced weight stigma in healthcare in Aotearoa.

4.6.5 Manuscript Conclusion

Through talanoa, Pacific women have highlighted the challenges that thin, non-Pacific women may not face in healthcare in Aotearoa. Together, we have interrogated the ethnic inequity and weight stigmatising assumptions and practices underpinning the health system in Aotearoa and amplified an unheard voice. This study shows that Pacific women's experiences of weight stigma are shaped by both interpersonal bias and wider systemic forces that undermine culturally safe care. The use of the values of the Talanoa methodology to interpret the composite narratives highlights how stigma damages the vā, affecting wellbeing beyond the clinical encounter. While echoing international research, these findings also reveal a Pacific perspective where weight stigma intersects with racism, gender and cultural identity in ways not captured by mainstream health frameworks and the existing body of literature. Pacific women's insights point to clear pathways to change which move beyond weight-centric practice, strengthen cultural humility, and embed patient-centred care. Meaningful progress will require structural shifts in training, policy and models of care that will provide Pacific women with equitable and dignified healthcare.

Chapter 5 — Conclusions and Future Recommendations

The findings of this study qualitatively explore weight stigma and racism and subsequent impacts on health and strongly resonate with the existing body of literature. It situates Pacific women's lived experience within the framework of Fonua model and Talanoa methodology, within a holistic and culturally relevant lens. This methodology differed from prior studies as it was conducted through an exploratory, relational, strengths-based and Pacific lens as opposed to a solely Western scientific method. The findings support the current qualitative literature surrounding experiences and impacts of weight stigma within healthcare settings both within Aotearoa and internationally (Gillon 2024; Kost et al., 2024; Merrill & Grassley, 2008; Olivia Rowe, 2022) and calls to attention the racist and weight-stigmatising systems which underpin the health system in Aotearoa and how they subject compounded harm against underserved populations (Curtis et al., 2019; Marsters, 2025). Through the composite narratives, an accessible and impactful glimpse into the scope of the harm caused by weight stigma is highlighted. Pacific women are influenced and adversely affected across multiple domains of wellbeing due to systemic weight stigma. These domains extend beyond physiological and psychological harm and were deeply embodied and existential threatening and weakening foundational aspects of cultural and social identity. Furthermore, the majority of previous studies investigated the impacts of weight stigma in the context of seeking treatment for higher body weights and solving the issue of "obesity" (O'Donoghue et al., 2021b). This study made a conscious decision to explore weight stigma without limiting

criteria such as BMI or seeking weight loss advice to freely investigate the various manifestations of weight stigma towards individuals of a range of body sizes.

This study advances understanding of Pacific women's healthcare experiences of weight stigma in Aotearoa. It provides a foundation for future research centred on reducing weight stigma and improving health equity for Pacific populations in Aotearoa through research, practice and policy. Future studies could explore Pacific male experiences or Pacific families' experiences of weight stigma to understand intergenerational experiences and impacts of weight stigma and its role in health. It is clear that weight stigma has significant and lasting impacts on Pacific women's health and wellbeing and must be addressed, not solely for benefit of Pacific women but also for the progress of health equity in Aotearoa.

With their generous permission, I end this thesis with two poems (Figures 3 and 4), written by a Samoan and an Indo-Rotuman poet, to honour Pacific creatives and their ability to illustrate the pervasive nature of weight stigma and its impact in a powerful and poignant way.

Figure 3.
She goes to the hospital

It begins with the nurse measuring me – height and weight.
She leaves and returns, with a look on her face, and says
blah blah blah Body Mass Index
blah blah blah Do you know about food?
blah blah blah You big fat brown bitch

She doesn't actually say, You big fat brown bitch.
But she means, You big fat brown bitch.

She also means: You big fat brown lazy bitch.
You big fat brown stupid bitch.
And: You big fat brown worthless bitch.

I don't tell her that I know the Body Mass Index
was invented by a man named Adolphe,
a white man measuring white men's bodies – the measure
of the social ideal
inn 1830, boom time of racist science, genocide and colonisation.

I don't tell her that by the early 1900s the BMI became the rationale for eugenics, for the sterilisation of the disabled,
the autistic, the poor and the coloured.
I don't tell her this because I know she can never believe
what exits the mouth of a big fat brown bitch.

So, I draw myself up to my full Big Fat Brown Bitch height
and try to look sure of myself, but not too threatening
educated, but not too threatening
and calm, but not too threatening.

Note: From *Big Fat Brown Bitch* by T.Avia 2024. Te Herenga University Press, 2024.

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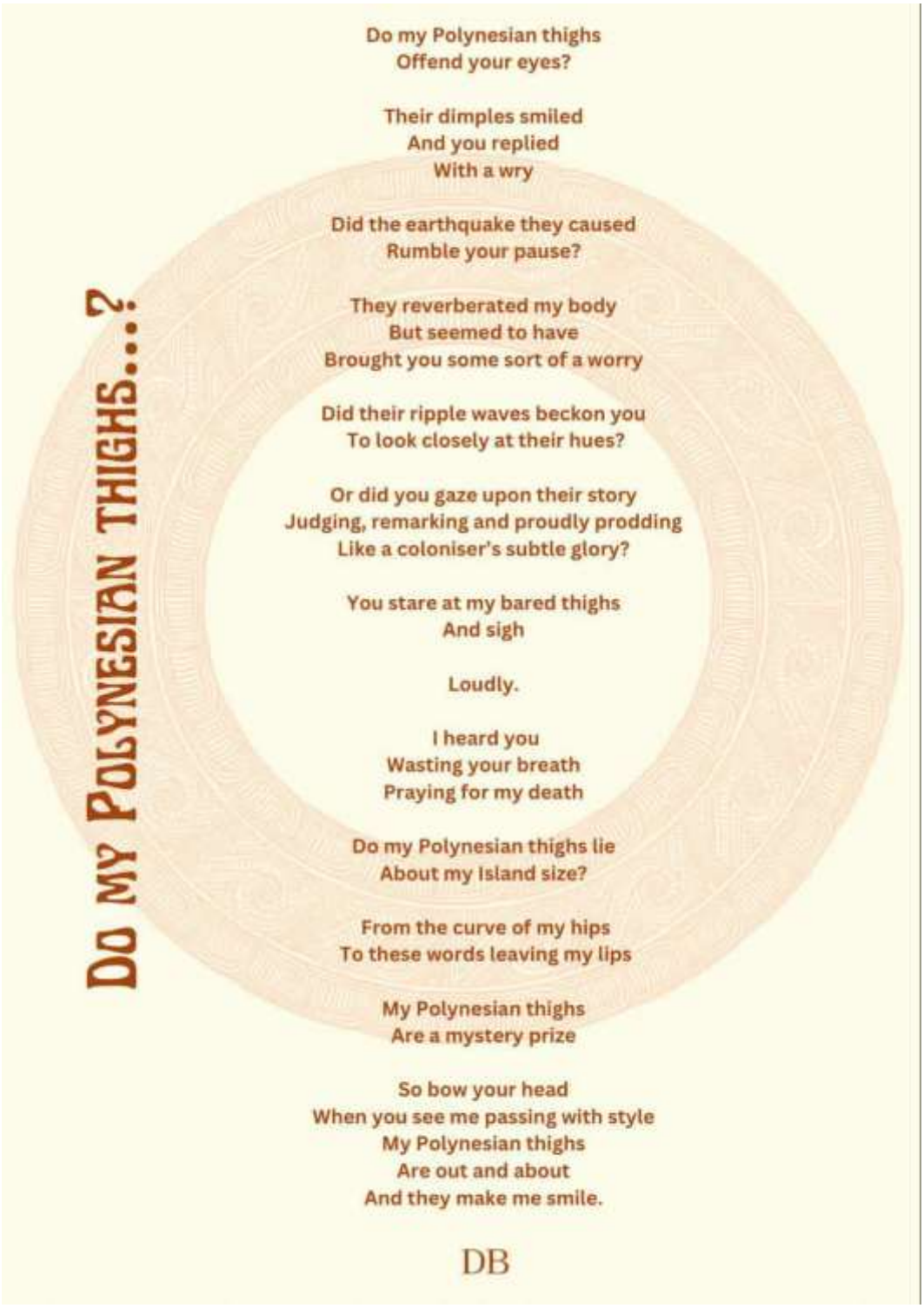
Figure 4.

Do My Polynesian Thighs...?



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Chapter 6 — References

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Chapter 7 — Appendices

Appendix 1. Study Protocol

Study Protocol

Recruitment

1. Potential participant expresses interest via QR code screening tool or email
    a. If via email, link to screening tool will be sent
2. If participant meets the screening criteria, participant information sheet and consent form will be sent to the participant for perusal
3. A follow up phone call will take place minimum 2 days after PIS is sent to answer questions and discuss time and venue to meet
    a. Will also clarify any dietary requirements and preferred voucher

Talanoa

1. Researchers will arrive 30 min before Talanoa to set up food, curate space and prepare selves
2. Greetings and relationship building
    a. Reminder of time for talanoa
    b. Would they like to have karakia?
    c. Would they like to eat and have a cuppa during the talanoa or afterwards?
3. Go through consent for talanoa and voice recording
4. Follow Talanoa guide
5. Save audiorecording to Sharepoint/Zoom drive
6. Give kai and vouchers depending on participant
7. Sign participant voucher sheet with voucher serial number

8. Farewells or kai and chat

Appendix 2. Study Recruitment Poster

Appendix 3. Talanoa Guide

Talanoa Guide

1. Welcome

Thank you for taking part in this study and for agreeing to be a part of this talanoa.

Whakawhanaungatanga/mihimihi

- *Offer to start with a tatalo or karakia to bless the space. Provide food and drink to be consumed either during or after the Talanoa, based on participant preference.*

2. Introductions

If samoan, do lāuga/pepeha explaining background, name, family, occupation etc.

If non-samoan, give a similar introduction in english.

Offer a chance for participants to do the same if they wish.

3. Acknowledgement

I exist in this type of body; I acknowledge that I am on this end of the body size spectrum. I'm here to share space with you, I've had some experience with this, but I have not had the same experiences that you have had. If there is anything you think that I'm not understanding, please let me know and tell me what is needed to understand.

4. Overview

For this research project, we are interested in the subject of weight stigma and bias in healthcare, especially how it affects you as a Pacific woman living in NZ. I am very interested in hearing your thoughts and experiences on this subject and understanding how we might be able to make a change in this area.

Short definition of weight stigma/bias if needed:

Weight stigma is defined as negative attitudes and beliefs towards others based on weight, shape or size of their body (Dovidio, Penner, L.A, Calabrese, S.K, & Pearl, R.L, 2018).

What is Weight Stigma?

Weight stigma and bias refer to negative attitudes, stereotypes, and judgments directed toward individuals based on their body weight or size. These attitudes can occur in various settings, including healthcare, workplaces, schools, and even within personal relationships. Understanding these concepts is important because they can have serious physical, emotional, and social consequences.

Weight stigma involves discrimination or stereotyping based on a person's weight. For example, someone might assume that a person in a larger body is lazy, unhealthy, or lacks self-control—even when these assumptions are untrue. This stigma is rooted in societal norms and media portrayals that idealize thinness and associate it with success, beauty, and health.

What is Weight Bias?

Weight bias refers to the beliefs and attitudes that fuel weight stigma. It includes the internalized thoughts or prejudices that individuals or groups hold about people with different body sizes. These biases can be implicit (unconscious) or explicit (conscious) and often influence how individuals are treated. **Healthcare = Healthcare professionals and environments** **Anyone you have encountered in your healthcare journey**

5. Consent for recording

Review Consent Form and Participant Information Sheet

If it is okay with you, I will be recording the interview as I won't be able to remember all that you say, and I want to be able to capture your experience as accurately as possible.

Give voucher and sign voucher confirmation list.

6. Structure

As discussed, the interview will take around 90 minutes but we can take as much time as you need. I will ask a few questions that we have come up with to guide us in our Talanoa based on what we currently know about weight bias and stigma. Please answer as honestly and openly as you can, you are most welcome to dive into a deeper discussion about what is shared too.

7. Talanoa

I am using the Talanoa method which is “a personal encounter where people story their issues, their realities and aspirations” (Vaioleti, 1999-2003). It allows more mo’oni (pure, real, authentic) information to be available for Pacific research than data derived from other research methods” (Vaioleti, 2006). This is a conversation for us to explore the themes of this research. The questions are just a guide to facilitate discussion between us.

8. Things to note:

- Anything that you have been subjected to is not your fault and we know very well that people are subjected to inappropriate and harmful comments, behaviours and policies (e.g transplant BMI cut-offs, denied surgery til they lose weight)
- There are no right or wrong answers. Everyone's experience and opinion are important. You are most welcome to agree or disagree with whatever is said. This is a safe space, and we would like to hear your personal perspective.
- I would also like you to feel comfortable sharing the positives and negatives of your experience. The more open and honest you can be, the richer the insights we can gather. I will also be my most open and honest self here with you.
- If you need to pause, or would not like to answer any question, that is okay. If you feel that you require some extra support after the interview, please let me know and I will share some resources that might be helpful.

9. Talanoa Question Guide

Topic	Potential probing questions
Opening/ Establishing rapport/ Whakawhānaungatanga	Tell me a bit about yourself and who you are - Family - Where you are from – born in NZ or overseas? - Background What does a typical day in your life look like? Do you have any hobbies or passions? Can you tell me a bit about your culture? - Any particular cultural views around weight and body size? - How do you feel about these? What is it like being a larger bodied Pacific woman? How would you like yourself to be addressed in these situations? - Fat, larger, bigger – terminology - what sits best with you?
Experiences of Weight stigma/bias Aim: To develop an	Tell me about any experiences you had with a healthcare professional that involved anything to do with your body size? - How does your doctor talk to you about your weight? - Have you ever been to the doctor with e.g heavy menstrual bleeding and they've told you just to lose weight?

in-depth understanding of Pacific women's lived experience of weight stigma in the various settings in which pacific women receive healthcare through talanoa	- Have you ever been to the doctor and felt they weren't listening because they were too focused on weight and how do you feel about that? - How many times have you gone to the doctor and weight has been brought up? - What stood out to you about this interaction? In the moment, how did you feel? - Spiritually - Mentally - Physically - Emotionally Did the HCP address the reason you went to see them in the first place? - Get context of why they were seeing the HCP – was it for something that actually required weight loss or not? What was the ethnicity and gender of the HCP that you experienced this from? If you feel comfortable to share Was there any concrete advice and recommendations from the HCP about how to address your weight? - In what ways were they helpful or not helpful?

	Was there anything about the physical environment (e.g equipment/furniture) in this clinic that you noticed was not inclusive of your body size? - Did it make you feel comfortable or uncomfortable? If you have children: have they been with their children where their child's weight becomes an issue that was not the reason you went? What is it like for you being a pacific person and also fat?
Impact of Weight stigma/bias Aim: To explore how these encounters with weight stigma have impacted on Pacific women and their perceptions	Can you please describe how you felt after that appointment with a HCP? How has this interaction impacted the way you view your health and wellbeing? How has your HCP attitudes and experiences shaped your healthcare decisions? How did it impact parts of your wellbeing? Use fonofale or te whare tapa wha - Spiritually - Mentally - Physically - Other aspects: culture, financially, environment, safety

of health and wellbeing	How has this experienced impacted your relationship with: - Your family? - Your children? - Your friends/community? - Other HCP you engage with? How do you think the HCP found the interaction? (Satisfying or unsatisfying… what kind of vibe did you get from them?) Do you think this kind of interaction is common for Pacific women engaging with HCP? Have any of your friends or family members shared their own experiences with you? When you had experiences that prevented you from using health services, how did you handle those experiences? Do you think your experiences would be different if you weren't fat, Pacific Islander or a woman? Why? What is important to you in healthcare? Treatment, environment, cultural safety, weight-wise?
Recommendations from	If you could tell your doctor one thing, what are you going to tell them?

Pacific women's voice Aim: To identify recommendations based on the voices of Pacific women for reducing weight stigma in these healthcare settings	Do you have any suggestions about how your experience could have been made more positive for you as a patient? For future generations of Pacific women or girls in your family coming through the health system, how could it be made more positive for you and them as Pacific woman? What would it look like if you were to see Pacific women (and Pacific people) having interactions with the healthcare system that were not characterized by weight stigma or bias? • What would the outcome of that be? Are there any obvious ways of eliminating weight stigma and bias in healthcare? What would you tell your HCP about you that would help them deliver quality care?
Extra prompts for Talanoa	The simplest, meaningful support would be… If there were no limitations on time, money, location etc, helpful support from HCP would look like…

10. Resources

- Share about resource if they feel like they need to talk more/dealing with difficult emotions

11. Conclusion

Thank you for sharing your thoughts and expertise with me. It is much appreciated. Fa'afetai tele lava mo le avanoa. Thank you for the opportunity to speak about this topic with you and be able to document this to support sustainable change in our healthcare system.

References:

Vaioleti, T. M. (2006). Talanoa research methodology: A developing position on Pacific research. *Waikato journal of education*, *12*.

Dovidio, J. F., Penner, L.A, Calabrese, S.K, & Pearl, R.L. (2018). Physical health disparities and stigma: Race, sexual orientation, and body weight. In J. &. Davidio, *The Oxford handbook of stigma, discrimination, and health* (pp. 29-51). Oxford University Press.

Appendix 4. Participant Information Sheet

Participant Information Sheet

Experiences of Weight Stigma and Bias in the Aotearoa Healthcare System

An exploratory qualitative study

Lead researcher: Dr Maria Casale

Main contact: Elti Sannyasi

Contact phone number: [redacted]

Contact email: E.Sannyasi@massey.ac.nz

You are invited to take part in a study investigating your experiences and the impact of weight stigma when receiving healthcare, and your suggestions for any changes. Whether you take part or not is your choice. If you want to take part now, but change your mind later, you can pull out of the study at any time. This information sheet will help you decide if you'd like to take part. It explains why we are doing this study, what your participant would involve, what the benefits and risks to you might be, and what will happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether you will take part in this study. Before you decide you may want to talk about the study with other people, such as whanau, friends, or Church members. This form is 5 pages. Please make sure you have read and understood all the pages

Voluntary Participation and Withdrawal from This Study

Participation in this study is completely voluntary. You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular questions

- Withdraw from the study at any time without providing a reason
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the study findings when it is concluded
- Withdrawing from the study, should you choose to, will not result in any disadvantage to you.

What is the purpose of the study?

It is common for healthcare professionals to focus on a person's weight when providing medical care. We are interested in finding out about Pacific women's experiences with this, what impact it has, and if they have any suggestions for how this could be changed or improved.

How is the study designed?

The study will involve approximately 10 Pacific women aged 18 and over, who have engaged with the healthcare system at least once for the past three years. Participant will complete an online form to check eligibility. If they wish to take part in the study, there will be one visit in which a Talanoa will take place to discuss their experiences, along with some shared kai, which will take approximately 1-2 hours.

Who can take part in the study?

Females aged 18 and over who identify as being Pacific Islander. Participants will complete a short screening questionnaire to ensure they meet inclusion criteria.

What will my participation in the study involve?

If you decide to take part in this study, after you have had time to read and consider the information in this information sheet, you will be asked to complete the screening questionnaire. This involves answering a few questions, and can be done at home either online, or over the phone, and will take approximately five minutes. Your answers to these questions will help us to see if you are eligible to take part in this study or not.

What are the possible risks of this study?

The researcher will be asking you questions about times when you may have experienced a negative reaction towards your weight in a healthcare setting. This may be upsetting or personal to some people, and it is important that you understand that you do not have to answer any questions or discuss something you are not comfortable with. The researcher will make every effort to make sure you feel comfortable and confident throughout the Talanoa, and we respect your decisions.

What are the possible benefits of this study?

This study is the first of its kind in Aotearoa New Zealand. You will contribute the first understanding that we have of how Pacific women experience and navigate healthcare when weight is a focus, and you will have an opportunity to explain how things could be done better. This will help to inform healthcare professionals about the most helpful and beneficial way that they can support Pacific women in healthcare settings.

What will I receive for taking part?

You will not incur any costs for taking part. You will be reimbursed $75 for your gift of your knowledge. Food will also be provided.

What will happen to my information and my thoughts and opinions that I share?

During this study the researchers will record information about you and your study participation. This includes the results of any study assessments. You cannot take part in this study if you do not consent to the collection of this information.

Identifiable Information:

Identifiable information is any data that could identify you (e.g. your name, date of birth, or address). The research staff may have access to your identifiable information to complete study assessments.

De-identified (Coded) Information

To make sure your personal information is kept confidential, information that identifies you will not be included in any report generated by the researcher. Instead, you will be identified by a code. The researcher will keep a list linking your code with your name, so that you can be identified by your coded data if needed.

The results of the study may be published or presented, but not in a form that would reasonably be expected to identify you.

Anonymised Information

The lead researcher may remove the code from your de-identified information – this is called ‘anonymisation’. This makes it very difficult (but not impossible) to identify the information that belongs to you. The researcher may share this anonymised information with other researchers on request for the purpose of accumulating data from individual studies. The anonymous/anonymised data is unable to be accessed, corrected, or withdrawn; and return of individual results will not be possible.

Future Research Using Your Information

If you agree, your fully anonymous/anonymised information may be used for future research related to weight stigma and bias. This is optional and you could still participate in the present study if you do not agree.

This future research may be conducted overseas. You will not be told when future research is undertaken using your information. Your information may be shared widely with other researchers. Your information may also be added to information from other studies, to form much larger sets of data.

You will not get reports or other information about any future research that is done using your information.

Your information may be used indefinitely for future research unless you withdraw your consent. However, it may be extremely difficult or impossible to access your information or withdraw consent for its use once your information has been shared for future research.

Security and Storage of Your Information

Your identifiable information is held at Massey University during the study. After the study it is transferred to a secure archiving site and stored for at least 10 years, then destroyed. Your coded information will be entered into electronic case report forms. Coded study information will be kept in secure, cloud-based storage indefinitely. All storage will comply with local and/or international data security guidelines.

The linked data in this study will be destroyed at the end of the study.

Risks

Although efforts will be made to protect your privacy, absolute confidentiality of your information cannot be guaranteed. Even with coded and anonymised information, there is no guarantee that you cannot be identified.

Rights to Access Your Information

You have the right to request access to your information held by the research team. You also have the right to request that any information you disagree with is corrected.

If you have any questions about the collection and use of information about you, you should ask researcher.

Rights to Withdraw Your Information

You may withdraw your consent for the collection and use of your information at any time, by informing the study researchers.

If you withdraw your consent, your study participation will end, and the study team will stop collecting information from you.

Information collected up until your withdrawal from the study will continue to be used and included in the study. This is to protect the quality of the study.

What happens after the study or if I change my mind?

You may withdraw from participation in the project without any disadvantage to yourself of any kind. You may request to withdraw your data from the project before (date tbc).

Can I find out the results of the study?

Yes, on the Consent form provided, you can circle YES to opt-in. We will share a summary of the research findings, a copy of the completed research and an opportunity to join an online meeting with the researchers to share and discuss findings.

Who is funding the study?

The study is funded by the Health Research Council with an Activation Grant (#24/1338).

Who has approved the study?

Approved by the Massey University Human Ethics Committee on 25 March 2025 for 1 year.

Reference Number: **OM2 25/03**

Who do I contact for more information or if I have any questions?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Dr Maria Casale, NZ Registered Dietitian, Lead Investigator, Massey University

Email: M.Casale@massey.ac.nz

Ms Elti Sannyasi, Researcher, Massey University

Mobile: [redacted]

Email: E.Sannyasi@massey.ac.nz

The other members of the research team are:

- Dr Edmond Fehoko, Senior Lecturer, University of Otago
- Professor Lisa Te Morenga, Ngāti Whātua Ōrākei, Te Uri o Hua, Ngāpuhi and Te Rarawa, Nutrition and Maori Health researcher, Massey University
- Dr Sara Styles, University of Otago

Appendix 5. Study Consent form

Weight Stigma and bias in healthcare in Aotearoa:

Pacific Patients' Voices

TE KUNENGA KI PŪREHUROA
MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

***Reference Number:* OM2 25/03**

13 May 2025

CONSENT FORM FOR PARTICIPANTS

I have read the Participant Information Sheet. I have been given sufficient time to consider whether or not to participate in this study and ask questions. I was offered support from the researcher to help me understand what the study involves. I am satisfied with the answers and know the nature of the research and why I have been invited to participate.

I know that:

1. My participation in this study is voluntary.

2. The time needed is up to 90 minutes to participate in this study.

3. I will receive a $75 gift voucher of my choice after completing the Talanoa.

4. My participation in this study is confidential and no material which could identify me personally will be used in any reports on this study.

5. I agree to be audio-recorded.

6. After participating in the data collection, I have up to two weeks if I want to withdraw from this study without giving a reason.

7. I understand that the Talanoa includes an open-questioning technique where the precise nature of the questions that will be asked have been determined in advance but will depend on the way in which the interview develops. If the line of questioning does develop in such a way that I feel hesitant or uncomfortable I can exercise my right to decline to answer any question(s).

8. I understand that data will be kept for seven years and separate from the Consent Forms, after which they will be destroyed, retained or returned to the participant based on their preference.

9. I understand that the research findings may be used in policy reports, journal articles, and other academic publications. The research findings may be presented at conferences, online media, radio, and podcasts. Every attempt will be made to ensure that I will not be identified.

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 25/03. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 2, email humanethics2@massey.ac.nz

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I wish to receive the summary of findings (please circle one) Yes / No

I wish to see the quotes from my transcript that will be used in the research (please circle one) Yes / No

After 7 years, I would like my data to be (please circle one) Returned to me /

Destroyed / Retained

If Yes: Send to this email address

Email address: _____

I agree to take part in this project

Name _____

Participant Signature _____ Date _____