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Summarizing the Experiences of Individuals Who Have Obesity or Larger Bodies Seeking Fertility Care: A Scoping Review

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ABSTRACT

Females who have larger bodies or obesity may be at an increased risk for experiencing infertility. Problematically, both weight or body size and infertility are stigmatized, harming quality of care. We conducted a scoping review to understand the lived experiences of patients who may be subjected to intersecting stigmas of weight and infertility in healthcare. Searches included six databases (Medline, Embase, CINAHL, PsycInfo, Scopus, and Proquest Theses and Dissertations). Data were narratively summarized. With a team of interest holders, including lived experience experts, we identified future directions for research, clinical practice, and policy. Searches yielded 2724 articles, and 13 were included. Four themes were derived: 1. Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone; 2. Restricted access to fertility care; 3. Lack of weight management support; and 4. Self-blame. Directions forward for research include ensuring missing perspectives are studied (i.e., partners, gender diverse individuals, and healthcare professionals), examining the impact of stigma on behavioral responses (e.g., weight loss attempts), and comparing the use of body mass index versus other comprehensive measures of excess adiposity on fertility outcomes. Shared decision-making tools to guide patient-centered discussions about fertility and body weight are needed.

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1 | Introduction

Infertility is defined as the inability to achieve pregnancy after regular, unprotected sexual intercourse for 12 consecutive months in those aged 34 or younger, or for 6 consecutive months in individuals aged 35 or older [1]. Infertility affects approximately 17% of adults globally, although notably these estimates are based on heterosexual couples only [1–3]. Individuals who have obesity, defined as excess or abnormal adipose tissue that impairs health [4], are at an increased risk for experiencing infertility due to several potential physiological factors [5, 6]. Excess adipose tissue in females can result in anovulation, mainly due to polycystic ovarian syndrome (PCOS), but can also reduce fertility among ovulatory females, likely related to hormone dysregulation, insulin-related disorders, reduced progesterone levels, and increased inflammatory markers [5–7]. Moreover, females who have obesity are susceptible to menstrual cycle irregularity (with or without PCOS) and endometriosis, which can reduce the likelihood of successful conception and implantation [6]. In males, obesity is associated with issues such as insulin resistance, oxidative stress, inflammation, reduced sex hormone-binding globulin, and higher peripheral conversion of androgens to estrogen, which collectively can reduce free testosterone levels and sperm quality and motility [8]. Females with obesity are more likely to experience infertility than males, with most complications being related to ovulation disorders [6]. Furthermore, epidemiological evidence has shown that females who have a body mass index (BMI) $\geq 30.0\,kg/m^2$ are twice as likely to have reproduction-related complications (e.g., less successful fertility treatments; perinatal complications such as gestational diabetes and pre-eclampsia) than females with a BMI of 18.5–29.9 kg/m^2 [6]. Accordingly, several preconception and obesity guidelines suggest weight loss as a primary treatment goal for females who have obesity and are seeking fertility-related care (e.g., assisted reproductive technologies; ART) [6, 9–12]. Of note, when referring to obesity, this is defined as a chronic disease characterized by excess and/or dysfunctional adiposity, whereas when speaking to BMI or in instances where it is not about the function of adiposity on health, the preferred description is larger body or terminology as used by authors/participants [4].

There are inconsistencies in the literature regarding the effectiveness of preconception weight loss and successful fertility treatment [13]. Previous research has shown that weight loss may improve chances of natural conception; however, it is not always associated with increasing success rates of ART, nor is there an association between preconception weight loss and live birth rates [14–18]. Notably, there is also evidence highlighting that engaging in healthful behaviors, such as physical activity and nutrition, can result in improved fertility outcomes irrespective of weight loss or decrease in BMI [17]. Furthermore, there is a lack of research and knowledge on the amount of weight loss associated with improved fertility and pregnancy outcomes, as well as on the appropriate timeline over which such changes may occur safely [19, 20]. Females with larger bodies or obesity who are advised that weight loss may improve fertility and pregnancy outcomes report receiving vague recommendations and limited support [19–21]. Weight loss attempts without sufficient support may result in using ineffective and risky methods, such as extreme dieting or "yo-yo" dieting, which have further long-term consequences such as poor cardiometabolic outcomes, type 2 diabetes, body dissatisfaction, stress, and disordered eating [22–24]. Females of reproductive age who have obesity describe that they have received weight loss-related advice or comments nearly their entire adult life [25]. Therefore, when being advised that weight reduction may improve fertility outcomes, it is likely that they have already engaged in previous ineffective weight loss attempts [26].

Both infertility [27–29] and obesity [13, 25] are highly stigmatized. Disease or health conditions that are stigmatized are socially perceived as caused by the individual's autonomous decisions, and/or the condition itself or its symptoms deviate from what would be considered "normal" human functioning or appearance [30]. Infertility stigma, in particular, is described as contradicting what is considered "normal bodily functioning," as conception and pregnancy are viewed as natural human functions and a role specifically for women to eventually fulfill [31, 32]. In fact, individuals identifying as women who have infertility have described their bodies as "useless" [31]. Experiencing infertility-related stigma has been associated with poor psychosocial outcomes, such as stress, hopelessness, and marital conflicts [27, 31, 32].

Weight stigma is defined as negative misconceptions and stereotypes associated with people with larger bodies or higher weight, for example, assumptions that higher weight or obesity is caused by a person choosing to engage in unhealthy behaviors like poor dietary habits and sedentary behavior [33, 34]. Of note, although physiologically there is a relationship between obesity and infertility as discussed above, several studies have relied solely on BMI as a measure of obesity, which is indicative of only body size instead of a clinical assessment and diagnosis that determines if and how adiposity was impairing their health [33]. However, associations have been found between higher BMI or larger bodies and infertility [1], and accordingly, individuals with obesity and/or larger bodies may be at risk for infertility and weight stigma. In fact, recent studies have revealed that females who have obesity or larger bodies face stigma throughout the prenatal and postnatal periods, coming from several sources such as healthcare providers, the media, and their interpersonal networks [35, 36]. Healthcare, in particular, has been identified as a critical source of weight stigma during the perinatal period, resulting in barriers to care such as avoiding open discussions regarding patient concerns and instead directing all conversations to weight [26]. In fact, it was estimated that 1 in 5 pregnant individuals report experiencing weight stigma in a clinical setting, with greater frequency reported by those who have larger bodies, and this likely translates to the preconception period as well [26]. This is problematic, as weight stigma in the perinatal period has been associated with prenatal and postpartum depression [37].

Stigma hinders care and health behaviors, so its mitigation is crucial to improving patient outcomes; to develop effective strategies, understanding the lived experience is a necessary first step [30, 33, 38]. Previous studies have documented experiences of individuals with larger bodies or obesity in fertility care settings, but a review to synthesize findings with a focus on understanding stigma has not been conducted. The purpose of this scoping review was to summarize the lived experience of females navigating healthcare environments who have both obesity or

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larger bodies and infertility. Additionally, we sought to identify and summarize studies that have evaluated the perspectives of healthcare professionals who provide fertility care to females who have obesity. Scoping review methods are recommended as an initial exercise to map current knowledge on a novel subject and identify gaps or future directions [39]. Findings from this review may help inform prospective research that can conceptualize the intersecting stigma of infertility and obesity or larger bodies and evaluate health and behavioral implications.

2 | Methods

The Preferred Reporting Items for Systematic Review and Meta-Analysis extension for Scoping Review (PRISMA-ScR) was used to guide this scoping review, and the checklist for reporting of all items is included in Supplementary Table 1 [40, 41]. The protocol for this scoping review was registered a priori on Open Science Framework (https://doi.org/10.17605/OSF.IO/TVXKC). This study is being conducted in accordance with the involvement of patients and the public in research [42], and their involvement has been summarized in Supplementary Table 2 with the Guidance for Reporting Involvement of Patients and the Public 2 (GRIPPP2) short form tool [43]. The research question this scoping review aimed to answer was: What are the experiences of individuals who have larger bodies or obesity and infertility seeking fertility care and of clinicians providing care?

2.1 | Identification of Studies

An information specialist (LD) developed database-specific search strategies for the following keywords: Obesity AND Fertility AND Experience (Supplementary Table 3). An information specialist supports the research team with library and database expertise; this includes identifying appropriate databases based on the research questions, developing the search terms and modifying them accordingly for each database, and running the searches. We recognize that, although there is a clinical definition of obesity [4], BMI has most often been used as a measure of body size and is associated with fertility [6]. Additionally, individuals with larger bodies are susceptible to weight stigma in healthcare settings [33]. Therefore, the search strategy developed for the term "obesity" incorporates diverse descriptors for body size that may have been used in the literature (e.g., BMI, fat, larger bodies). The following databases were searched by the information specialist on July 17th, 2024: Medline, Embase, CINAHL, PsycInfo, Scopus, and Proquest Theses and Dissertations. Database searches were also supplemented with screening references of all included articles and citations using Google Scholar. Retrieved articles were transferred to Covidence online software [44], and duplicate studies were removed. First, all titles and abstracts were screened by two independent reviewers (BJH, HR). Next, the same reviewers independently screened full-text articles. At either stage, if there were any discrepancies, they were discussed between the two reviewers, and if a decision could not be made, a third reviewer was available for consultation (TSN). Selection criteria were primary studies, participants were assigned female at birth, had obesity or larger bodies, and were undergoing or recalling experiences of fertility care or experiences of healthcare professionals who provide fertility care to females who have obesity. Studies that included perspectives of partners (who may or may not also be receiving fertility treatments) were also included if conducted in conjunction with the female who has obesity or a larger body seeking fertility treatment. We included qualitative and cross-sectional study designs given the objective was to summarize experience. No date or language restrictions were employed.

2.2 | Data Extraction

Data were extracted onto a standardized Excel spreadsheet from each study by one reviewer and checked in full by a second reviewer (BJH and HR, respectively). The following study characteristics were extracted: year published, country, study or recruitment period, registry or data source if applicable, study design, inclusion criteria, exclusion criteria, primary aims/objectives, recruitment method, data collection and analysis method, and how obesity or body size was defined or characterized. Participant information that was extracted included sample size, average age, average BMI or range, other body size or anthropometric measures, and whether the population pool includes patients, partners, or healthcare professionals. For patient and partner populations, we also extracted the months postpartum if applicable, relationship status and couple composition, gender, type of fertility treatment being received, and any comorbidities. For healthcare professional populations, we extracted type of provider(s). We also extracted the main findings for each study as reported by authors, and any relevant participant quotes from qualitative studies.

2.3 | Data Synthesis

As per the Arksey and O'Malley framework [45] and Tricco et al. [46], scoping review synthesis guidelines, data were narratively summarized. Three reviewers (BJH, HR, TSN) independently assessed the main findings reported by the authors, including themes in qualitative studies and participant quotes, and established codes that represent examples of experiences related to having obesity or larger bodies and receiving or providing fertility care. Codes were reviewed, and through discussion, overarching themes that summarize the data were established. The developed themes were reviewed by a panel of key interest holders (co-author list), including individuals with lived experience of obesity and receiving any kind of fertility treatment or care, researchers in maternal health and obesity or weight stigma, clinicians who provide fertility care, and relevant patient-centered knowledge translation organizations. Lived experience experts were identified through networks such as Obesity Canada and internally among collaborators. Feedback was sought for clarity of themes, and refinements were made to improve the overall presentation of findings. Additionally, once themes were confirmed, each interest holder was tasked with providing suggestions for future directions based on their specific perspective and area of expertise, which were then summarized in the discussion. All interest holders were involved with the development and approval of the review protocol and provided meaningful and substantial input to the rationale, interpretation of themes, and discussion of future directions. While the list of perspectives

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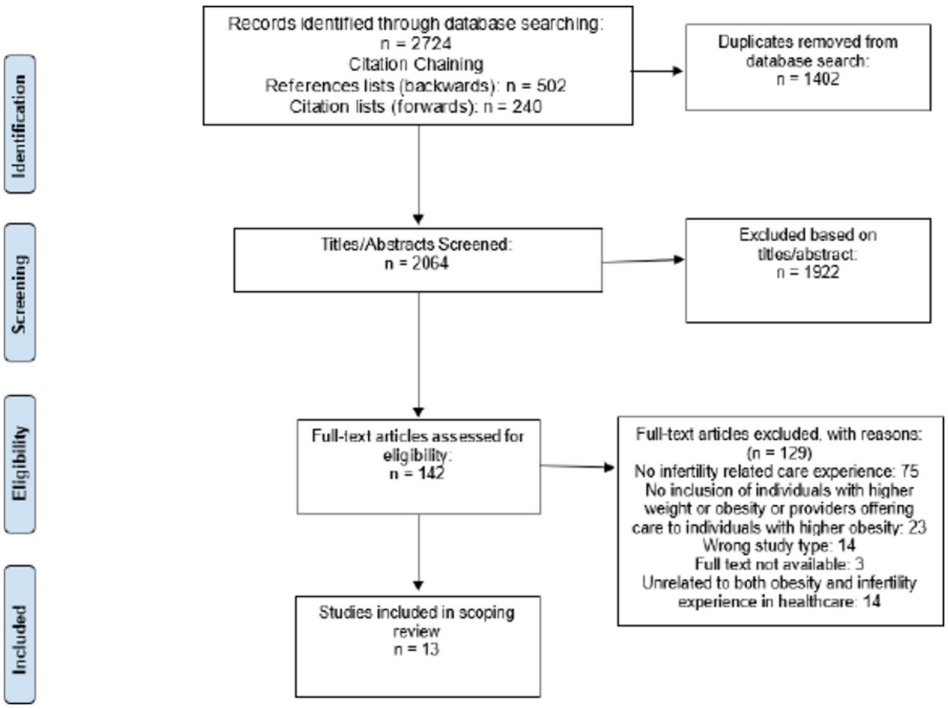


FIGURE 1 | PRISMA flow diagram illustrating the study selection process, including identification, screening, eligibility, and inclusion of studies in this scoping review.

included was not intended to be completely representative of experiences or expertise related to obesity and infertility, this approach allowed us to systematically identify knowledge gaps and key future directions, which is an integral goal of scoping reviews. Similar approaches have been taken in other reviews to facilitate an inclusive way for data synthesis among teams and broaden perspectives when considering implications of findings to research, practice, and knowledge translation [47, 48]. In line with PRISMA-ScR guidelines, critical appraisal is not required [40, 41].

3 | Results

3.1 | Study Characteristics

A total of 2724 articles were retrieved with the initial search, and citation chaining yielded an additional 742 articles. After removal of duplicates and screening of titles/abstracts, 142 articles were reviewed in full, and 13 unique primary studies met the selection criteria for this scoping review (Figure 1). Among the included articles, 11 were qualitative [49–59], and two were cross-sectional [60, 61]. All presented the perspectives of female patients who had obesity or larger bodies and infertility and were seeking preconception/fertility care, while no studies were identified reporting from the perspectives of partners or healthcare providers. The sample size in the qualitative studies ranged from 14 to 249 participants, mostly identifying as female and women, and the two cross-sectional studies had 302 and 403 participants. A total of six countries were represented, including the United Kingdom, Canada, New Zealand, the United States, Australia, and Sweden. Seven studies used BMI as their main measure or description of obesity or body size, ranging from $\geq 30.0\,kg/m^2$ to $\geq 35.0\,kg/m^2$ [49, 55, 56, 58–61]. Two studies defined body size as "obesity" or "overweight," without specific BMI criteria being mentioned or another definition [53, 57]. Four studies described larger bodies as plus size or fat; three were from the same cohort, although unique data were analyzed in each published study [50–52, 54]. Several types of fertility treatments were either being received, had been tried, or were being counseled on, including IVF, intrauterine insemination, fertility medications, fertility sparing treatment, intracytoplasmic sperm injection, and ovulation induction. Table 1 includes a summary of study characteristics, and Supplementary Table 4 includes further details regarding study populations and methods.

3.2 | Themes Identified to Describe Healthcare Experiences

Four themes were derived to describe the healthcare experiences of females with infertility and obesity or larger bodies: 1. Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone; 2. Restricted access to fertility care; 3. Lack of weight management support; and 4. Self-blame. Table 2 summarizes the main objective and key findings of each study, and which of the four themes the study informs, along with any relevant participant quotes (from qualitative studies).

3.2.1 | Lack of Education/Information Provided to Patients on the Link Between Infertility and Obesity or Larger Bodies and Focusing on Weight Alone

Five studies described that participants were aware that obesity or having a larger body was related to challenges with fertility, but they did not understand why, and this was not effectively

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TABLE 1 | Study and participant characteristics of the included studies. This table summarizes key study details including study design, sample size, participant demographics, definitions or descriptions of obesity or body size, comorbidities, and types of fertility treatments received or discussed.

Author (year), country	Study design	Total sample size	Average age or age range (years)	Gender	How was obesity defined/described or body size defined/described?	Average BMI, BMI range	Comorbidities	Type(s) of fertility treatment being received or discussed
Basinger et al. (2023), United States of America	Qualitative	249	36.4	95.2% of participants identified as women 0.8% of participants identified as nonbinary 4% of participants did not provide their gender identity	Participants self-identified as plus-size or fat.	Not reported	Diabetes, gestational diabetes, high blood pressure, depression, anxiety	IVF, IUI
Basinger et al. (2024a), United States of America	Qualitative	69	37.4	All participants identified as women	Participants self-identified as plus-size or fat.	Not reported	Diabetes, hypertension, anxiety, stress, depression, gestational diabetes	IVF, IUI
Basinger et al. (2024b), United States of America	Qualitative	150	36.6	149 participants identified as women, and one identified as nonbinary	Participants self-identified as plus-size or fat.	Not reported	Gestational diabetes, high blood pressure, cardiovascular complications	Not specified
Bombak et al. (2016), Canada	Qualitative	24	28–57	All participants identified as women	Participants self-identified as having overweight or obesity; no specific BMI cut-offs were used.	Not reported	Diabetes, high blood pressure, smoking, anxiety	Not specified
Charnley et al. (2024), United Kingdom	Qualitative	18	29.6	Not reported	BMI $\geq 35.0\,kg/m^2$	$37.3\,kg/m^2$	Not reported	Not specified

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TABLE 1 | (Continued)

Author (year), country	Study design	Total sample size	Average age or age range (years)	Gender	How was obesity defined/described or body size defined/described?	Average BMI, BMI range	Comorbidities	Type(s) of fertility treatment being received or discussed
Kim et al. (2023), Canada	Qualitative	14	34	Not reported	BMI ≥ 35.0 kg/m^2	42.0 kg/m^2, 35.0 kg/m^2–64.0 kg/m^2	Endometrial cancer, diabetes, hypertension, obstructive sleep apnea	Fertility sparing treatment
Kim et al. (2024), United States of America	Cross-sectional	302	18–64	Not reported	BMI ≥ 30.0 kg/m^2	All BMI groups were included. 199 participants had a BMI ≥ 30.0 kg/m^2	Hypertension, prediabetes or diabetes, anxiety or depression	Fertility medications (Letrozole, Clomiphene citrate, Gonadotropin injections, Metformin, Inositol)
Kluge et al. (2023), Sweden	Qualitative	17	30–43	Not reported	BMI ≥ 30.0 kg/m^2 to ≥ 35.0 kg/m^2	BMI at time of participation in the intervention on average was 32.6 kg/m^2; this interview took place approximately 6 years later, and BMI was not measured at this time.	Gestational diabetes, hypertensive disorders of pregnancy	IVF
LaMarre et al. (2020), Canada	Qualitative	17	35	Not reported	Generally indicated participants were labeled as "overweight" or "obese"	Not reported	Diabetes, high blood pressure	IVF
McPhail et al. (2016), Canada	Qualitative	24	Not reported	22 identified as women and 2 identified as queer women	Self-identified as fat	Not reported	Cancer, cardiovascular disease, gestational diabetes	Not specified
Riggan et al. (2023), United States of America	Qualitative	40	33	All participants identified as women	BMI ≥ 35.0 kg/m^2	35 participants had a BMI < 40.0 kg/m^2. 24 participants had a BMI > 40.0 kg/m^2	None	IUI, IVF, oral medications, oocyte retrieval

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TABLE 1 | (Continued)

Author (year), country	Study design	Total sample size	Average age or age range (years)	Gender	How was obesity defined/described or body size defined/described?	Average BMI, BMI range	Comorbidities	Type(s) of fertility treatment being received or discussed
Rodino et al. (2015), Australia	Cross-sectional	403	34.5	All participants identified as women	The definition of obesity that was used was "Obesity is broadly defined as accrued body fat that exceeds a clinically defined weight threshold." BMI cut-offs used were obese ≥ 30.0 kg/m^2 and morbid obesity ≥ 40.0 kg/m^2	52.0 kg/m^2	None	Ovulation induction, IUI, IVF, intracytoplasmic sperm injection
Shaw et al. (2023), New Zealand	Qualitative	39	20–45	All participants identified as women	BMI ≥ 32 kg/m^2	Not reported	None	IVF, IUI

Note: All studies included participants receiving fertility treatment or care, and none were from the perspective of healthcare providers.
Abbreviations: BMI = body mass index, IVF = in vitro fertilization, IUI = intrauterine insemination.

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TABLE 2 | Summary of included study aims and main findings. This table presents the objectives of each study, key findings, relevant participant quotes (where applicable), and the themes identified that describe healthcare experiences of individuals with obesity or larger bodies seeking fertility care.

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Basinger et al. (2023)	Individuals who identified as plus-sized or fat and had previously tried to conceive, had a diagnosis of infertility, or had been pregnant completed an online survey where they provided examples of memorable messages they had received about their bodies in the preconception or prenatal period. Content of messages was assessed via reflexive thematic analysis.	1. Memorable messages conveyed that "fat mothers are bad mothers," and several sources (e.g., friends, family) would suggest losing weight will improve chances of pregnancy. 2. Denied fertility care due to their body size and lack of compassion from healthcare providers 3. Constantly receiving messages that a lower weight would be better 4. Weight-inclusive messaging, when received, was empowering.	"I was told by my primary care physician when we were trying to have my second child that I was too overweight to conceive. I was 34 years old and at 290. I had already conceived one child 3 years previously at the same weight." "I was rejected from a fertility clinic based on my weight and was told it was unhealthy to have a baby at my size." Another provider told a participant that she "would never get pregnant if [she] stayed fat."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support T4: Self-blame
Basinger et al. (2024a)	Individuals who identified as plus-sized or fat and had a diagnosis of infertility provided examples of memorable messages they received from healthcare providers. Content of messages was assessed via reflexive thematic analysis.	1. Body size is the reason for infertility; providers made comments that assumed the main cause for infertility is weight without engaging in discussions about other potential health issues or medical histories. 2. Weight loss will lead to a successful pregnancy. 3. Denial of care until weight was lost	"One of the first things he said to me was that if I wanted the best results for IVF, I should lose weight ... He never really said why or how much. The fact that I was otherwise totally healthy—eat well, exercise regularly, etc.—was never taken into consideration." "She did not think fat women deserved to have children because they obviously did not care enough about their own bodies, let alone anyone else." "In my search for fertility doctors, several flatly turned me down because of my weight. One center told me their exam tables and other equipment would not support my weight." "I was rejected from a fertility clinic based on my weight and was told it was unhealthy to have a baby at my size. I was told I would not receive treatment until I lost something like 10% of my weight. I was also referred to a nutritionist."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Basinger et al. (2024b)	Individuals who identified as plus-sized or fat and had previously tried to conceive, had a diagnosis of infertility, or had been pregnant completed an online survey where they were asked to provide advice for other individuals in a similar situation. Content of messages was assessed via reflexive thematic analysis.	1. Intrapersonal advice included trusting your own body, focusing on your health and not your weight. 2. Communication-related advice included ignoring negative feedback that you cannot be pregnant but be prepared to hear it from several sources, and advocate for yourself in those situations, such as in healthcare settings if a provider is not compassionate. 3. Social support advice included finding an inclusive provider and even changing providers if necessary, seeking support from friends and family, and joining online communities	"Find respectful sources of information that are not fat phobic and do not buy into BMI. The process of trying to conceive and pregnancy (and I'm sure the others) are already full of worries, why add more worry?" "Also, advocate for yourself. Do not allow for anyone to reduce your experience to your body size/shape. Demand the best care and push for what you know you and your body needs." "On the infertility front, make sure your clinic has no weight requirement UP FRONT." "Surround yourself with people/social media accounts/podcasts that will counteract the fatphobic messages of our society and culture..."	T2: Weight restricts access to fertility care. T4: Self-blame
Bombak et al. (2016)	Women who self-identified as having overweight or obesity and had ever tried to conceive in the past, whether or not they did get pregnant and give birth, were eligible to participate in interviews with the overall aim to describe their experience of reproductive healthcare. Data were assessed thematically.	1. General experiences of weight stigma in healthcare settings included language used by healthcare providers which made patients feel "wrong," and refusal of care based on weight. 2. Felt mother-blame, described as being held responsible for any potential fertility or pregnancy complications 3. Resistance towards mother-blame, including pushing back against stereotypes and assumptions that they will have complicated pregnancies	"The intern was throwing statistics at me... [They told me that] because I'm overweight or obese, then I could have a child with birth defects. ... So, in addition to denying [women] treatment, and being kind of, rude about it, it's outright trying to put fear in them, saying 'Your baby's going to have a defect because you are fat."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T4: Self-blame

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Charnley et al. (2024)	Participants with a BMI ≥ 35.0 kg/m^2 who had previously participated in the Fit for Birth study were interviewed to explore their experiences of lifestyle behavior change and navigating antenatal care with the goal of informing guidelines for obesity and pregnancy. Data were assessed by an inductive thematic analysis.	1. Antenatal care was described as inconsistent, including unclear BMI cut-offs for fertility care. 2. Additional maternity services specifically for women with an elevated BMI were desired. 3. Women felt constantly judged in healthcare environments due to their weight. 4. Previous history of weight cycling was prevalent and needed to be considered in their preconception and prenatal care.	"Oh no you cannot have IVF cos you are overweight. See I think that's wrong cos I do not think that should matter, it's down to whether you can carry a baby or not is not it. It's not down to being overweight I do not think, not being able to fall pregnant. We are all as good as each other whether we be skinny or whether we be fat." "I think the only thing is with the doctors and that. Because they put everything down to the weight part of you and sometimes it's not and you know it's not. you know like I went one week, and I was breathing bad and I had a chest infection and he was sort of looking at me as if to say 'it's cos you are overweight.'"	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support
Kim et al. (2023)	Females with a BMI ≥ 35.0 kg/m^2 diagnosed with endometrial cancer/atypical hyperplasia and undergoing fertility-sparing treatment were interviewed to understand their acceptability of bariatric surgery. Data were analyzed thematically using a mixed deductive and inductive approach.	1. Lack of knowledge on the complex interplay of obesity, cancer, and infertility 2. Struggled with sustaining weight loss in the past, but this did not increase acceptability of surgery; instead, they feared a surgical procedure for weight loss. 3. Desire for patient-oriented counseling on managing all of cancer, infertility, and obesity. 4. Appointments were dominated by feelings of fear, guilt, and frustration due to their condition. 5. Perceived weight stigma from healthcare providers	"Well, I mean every doctor I see the first thing out of their mouth is that you need to lose weight." "I felt lost, and it did affect me emotionally, physically, and mentally especially, just knowing that here's something I have, I do not have information on it, and the little information that I do have tells me that it's something that potentially can be dangerous or ruin my chances of even having a family one day." "I've had them [healthcare providers] look at me with disgust."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T4: Self-blame

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Kim et al. (2024)	A cross-sectional study surveyed individuals who had PCOS and had ever tried to be pregnant on their experiences with receiving PCOS and pre-pregnancy counseling ($n = 302$). Participants completed a series of demographic questions, including collection of BMI and healthcare satisfaction scales. They also indicated what topics they had been counseled about (e.g., weight loss, prenatal complications). Data were descriptively assessed, and associations with demographics were tested.	1. Less than half of the participants received counseling about PCOS before pregnancy, and of them, most indicated they were not satisfied. 2. Those who were on fertility medications were more likely to be counseled, whereas factors such as BMI were not associated. 3. Approximately 43% received weight management advice, of which most was about exercise and nutrition, and only 38% were satisfied with this counseling.	N/A	T3: Lack of weight management support
Kluge et al. (2023)	Women who had obesity (BMI $\geq 30.0\,kg/m^2$) who had previously participated in a randomized controlled trial with the goal of losing weight for IVF treatment were interviewed post-intervention to discuss their experience with the program and weight reduction. A thematic content analysis was performed to analyze data.	1. Pros of participating in the trial included feeling as though it was a "win-win," as they would get support for weight reduction and access to IVF treatment. 2. They had previous challenges with sustaining weight loss, and so they appreciated the trial offered ongoing support, including nurses and dietitians. 3. Some women lost weight, but IVF still did not work, and this made them feel lost. 4. Women wanted healthcare providers to know that they do not want to be judged by a "number" (BMI), and instead of denying care outright, they want an individual assessment on the potential success of IVF. 5. As a part of fertility counseling for IVF, women suggested they should be given weight management support as they had with the trial.	"What I would really have needed when everything was so up and down with the IVF was to establish routines, to think right. Because I got a really good start but it ended up as a flop...because I was left on my own immediately afterwards." "...I've always known that being over weight can make it more difficult to get pregnant. It's always been a worry. So...when the opportunity came to participate, I felt it was obvious, both for my own sake and to increase the chances of getting pregnant."	T2: Weight restricts access to fertility care T3: Lack of weight management support

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
LaMarre et al. (2020)	Individuals who were grouped as "overweight" or "obese" when receiving medical care were interviewed to broadly describe the reproductive care experiences they seek and have. Data were analyzed thematically.	1. Weight leads to assuming dysfunction; they described weight-stigmatizing encounters with healthcare providers that positioned them as individually responsible for their weight and therefore infertility and any potential future pregnancy complications. Any recommendations for weight loss were also individualistic and vague. 2. Limited access to fertility care or care described as less than ideal, presumably due to their weight. Their bodies were described as troublesome for healthcare. 3. Participants desired reform or change in healthcare, in particular wanting a healthcare environment that welcomes difference. They felt they constantly need to self-advocate for quality care.	"[The obstetrician] assumed that I would develop high blood pressure, never did. He assumed that I would develop preeclampsia, did not. I did get gestational diabetes, but it is what it is and that's a condition that can happen to anybody. And I ultimately did need a c-section but it was because of his position not because of my size." "I went into my first interactions with people in a defensive mode. I assumed that they would not accept me. So I would like there to be a more welcoming attitude that I should not have to go in with my fists up kind of thing."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support T4: Self-blame
McPhail et al. (2016)	Women who identified as fat and were either trying to conceive, pregnant, or postpartum were interviewed about their healthcare experiences. Data were assessed thematically.	1. In all stages of reproductive care, women were meant to feel as though they are always at risk of complications. 2. Women themselves felt they had "risky bodies" 3. Denial of care based on body size, which even led participants to seek unhealthy methods of weight loss	"The first, first thing was weight. And there was no conversation of vaginal stenosis, which was a big issue for me to get pregnant. I brought it up and it was like, just shut down, it was the weight. And I had said "But I had gotten pregnant twice." And it was back to the weight. ... So they had said "We cannot do anything for you until you lose thirty pounds. You've got till September." The first thing she said to me was "You know, you need to lose weight." That was the first thing she said to me. And I was like "Okay. You know, do not you generally end up gaining weight when you are pregnant? I do not know that I can [lose], but I'll try."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Riggan et al. (2023)	Females with a BMI ≥ 35.0 kg/m^2 being seen at a Reproductive, Endocrinology, and Infertility clinic participated in interviews to learn about their experience accessing fertility care and recommendations to improve communication of BMI guidelines. Using grounded theory, data were analyzed thematically.	1. BMI restrictions were described as discriminatory and confusing without medical reasoning. 2. Participants said there should be individual counseling instead of generic BMI cut-offs. 3. BMI restrictions cause pressure to lose weight and harm relationships. 4. Participants wanted proactive referrals to weight management 5. Lack of uniformity of BMI restrictions across clinics and providers 6. BMI is a restriction to fertility care, and this is yet another hurdle usually faced after a lifelong struggle with weight to date, thus another example of weight bias or discrimination.	"She [appointment staff] goes, 'Is it true your BMI is 54? (...) There's nothing we can do for you until you lose weight.' I said, 'Well, I wanna do a consultation.' She said, 'There's no point in scheduling a consultation until you lose weight.'" "I think just being more positive when it comes across to women about their BMI (...) Like, 'Oh, I see that your BMI is higher than what we provide for our services. Here are some resources that we'd really like you to entertain to help lower that BMI so we can help you pursue your dream for a family.'" "It's really frustrating now, too, because I know my BMI is important. I understand a healthy weight is important. I understand all of this. It's just frustrating because I will not have much time left (...) I wanna get pregnant and time's ticking and I need help." "People who are overweight, who are fat, we know we are fat. It's not something that society in any way lets us forget. When you are at the doctor, you are reminded of it all the time too even more, and we are on edge about it because we are so tired of being denied care because of it."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care. T3: Lack of weight management support

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TABLE 2 | (Continued)

Author (year)	Brief study description and main objectives/aims	Summary of main findings	Relevant participant quotes	Themes informed
Rodino et al. (2015)	Individuals who were undergoing fertility treatment participated in a cross-sectional study and completed a series of questionnaires including: Demographics, International Physical Activity scale, Depression, Anxiety and Stress scale, Positive and Negative Affect Schedule, Fertility Problem Inventory, Rosenberg Self-Esteem Scale, Clinical Perfectionism Questionnaire and Eating Disorder Examination—Questionnaire. The main objective was to investigate psychological wellbeing amongst those undergoing fertility treatment and differences based on BMI.	1. There was no difference in psychological wellbeing based on BMI. 2. Shape concerns and low self-esteem were higher among those with an obese BMI than in the normal weight category. 3. There was an association with an obese BMI and body shape concern, low self-esteem, and binge eating. 4. Irrespective of BMI, there was higher than the national average reporting of engagement in physical activity.	N/A	T3: Lack of weight management support T4: Self-blame
Shaw et al. (2023)	Women with a BMI ≥ 32 kg/m^2 identifying with a Pacific and Māori background were interviewed to understand their experience of accessing fertility with an elevated BMI, which restricts publicly funded services. Data were analyzed thematically.	1. Felt that due to their BMI, they could not voice their concerns or desire for alternative treatment options. 2. Unwelcoming healthcare environment 3. Lack of information on fertility treatment options 4. Lack of information on obesity causing infertility and culturally sensitive messaging for weight management	"Imagine being told you that your BMI needs to be at a certain number, and you are like, 'what is a BMI?' I remember asking the specialist if there was any way around the BMI, because it was like another mountain to climb. The hardest mountain was making the initial contact, and then getting told about the BMI stuff was very hard to accept." "It is very confusing and frustrating, you know. All I want is a child, but when you cannot please both parties, I do not know what to do. Very frustrating, like I have some Aunties who are bigger than me in size and yet have a lot of kids naturally."	T1: Lack of education/information on the link between infertility and obesity provided to the patient and focusing on weight alone T2: Weight restricts access to fertility care.

Abbreviations: BMI = body mass index, IVF = in vitro fertilization, PCOS = polycystic ovarian syndrome, T = theme.

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explained to them by a healthcare professional [49, 50, 54–56]. For example, females who were denied access to publicly funded fertility clinics due to a high BMI identified lack of education as a major barrier [49]. This included not understanding the range of available fertility treatments or how weight or obesity might affect pregnancy success rates depending on the type of fertility procedure [49]. Participants commonly received messaging that preconception weight loss was necessary to improve pregnancy outcomes but were not given an explanation as to why [49, 50]. Further, women felt they could not ask questions because the environment itself was "not welcoming" and their healthcare provider perceived that, because of their current BMI or size, they should not be trying for pregnancy at this time [49]. Study participants were often told about their risk for several potential perinatal complications (e.g., miscarriage, developmental delays, congenital anomalies) or limited chance of ART success because of their body size, but no physiological explanations were given as to why this was the case [50, 54]. As a result, participants described BMI cut-offs for accessing fertility care without a specific rationale as "discriminatory," and that weight loss targets to achieve before care could even be offered as "offensive" [49, 55]. Kim et al. (2023) assessed the perspective on bariatric surgery among 14 women who had obesity, infertility, and cancer [56]. Participants reported not receiving counseling on their unique condition, and as a result, they expressed fear of weight management methods like bariatric surgery and worried that it would reduce their chances of pregnancy further [56].

Furthermore, five studies indicated that a common experience individuals had was weight being discussed in nearly every appointment or being associated with all concerns they may share with their healthcare provider [50, 52, 53, 57, 58]. Participants felt that any health issues brought up to their provider were "reduced to weight" and that their medical histories or other health conditions were rarely considered when discussing potential causes of infertility [52, 58]. Even in instances when participants emphasized that they were engaging in healthy behaviors or were inquiring about other unrelated health concerns (e.g., chest infection), their weight seems to always come up in their conversations [50, 58]. An example of a weight-stigmatizing encounter with healthcare providers mentioned was that individuals with larger bodies or obesity were made to feel "individually responsible" for their weight and therefore also responsible for why they were unable to conceive [57]. In response to this, participants shared coming to their appointments in "defense mode" and always prepared to have to deal with discussing their weight even if they did not want to or intend to [57].

3.2.2 | Restricted Access to High-Quality Fertility Care

In 10 studies, participants shared that weight, BMI, or body size appeared to be the main reason patients who have obesity or larger bodies and infertility could not access fertility treatments or felt as though they were denied quality care [50–55, 57–60]. Three studies had specific comments about the unfairness of BMI restrictions for IVF in particular [55, 59, 60]. Fertility care was described as "inconsistent" with vague recommendations on how much weight loss was needed to improve outcomes, and accordingly, women argued that there should be more of an assessment than just BMI to decide whether or not they were eligible for IVF [55, 59]. Restrictions based on BMI were "frustrating," and participants reported they were told even if they were to get pregnant, their body size would still put them at risk for perinatal complications (e.g., gestational diabetes). To participants, this felt "unfair" and "discriminatory," given that several other factors (e.g., family history of diabetes) could position women with smaller bodies at risk for the same complications, yet they would not be denied fertility treatment [55]. Kluge et al. (2023) interviewed 17 women who previously participated in a weight loss randomized controlled trial prior to IVF treatment and found that most agreed BMI limits are restricting, although some said if weight loss would certainly improve their chances of conception and pregnancy outcomes, then the BMI cut-offs should remain [59]. Several instances were reported across studies of participants being told by healthcare providers that they would not get pregnant until they reduced their weight [52, 53, 57], and even being denied discussing treatment options until they lost weight [53]. Basinger et al. (2024) aimed to summarize advice from women ($n = 150$) on having a larger body and navigating reproductive care services for other women who may be in similar situations; advice included seeking a provider who does not use weight or size as a criterion for fertility care and encouraging changing providers if necessary [51]. Furthermore, participants indicated that it may be compulsory to self-advocate for quality care, such as speaking up during appointments, when a healthcare professional is not compassionate or weight-inclusive. They also suggested finding networks such as friends, family, and online communities, with whom they could receive emotional support and build connections through shared experiences. Examples were shared by participants that the healthcare environment was "unwelcoming" to them for wanting a pregnancy at a higher weight and described their bodies as "troublesome" to the healthcare system [51].

3.2.3 | Lack of Weight Management Support

Although healthcare providers often link improved fertility outcomes or access to treatment with weight reduction, participants in 10 studies reported receiving limited support—such as vague guidance on weight management and unclear information about the amount of weight reduction/weight loss associated with improved chances of successful fertility treatment [49–51, 54, 55, 57–61]. Participants emphasized that nearly every person in their close network, from family and friends to healthcare providers, has suggested they should lose weight to improve their chances of pregnancy [51]. Clinical encounters for fertility care often began with questions about how much weight they had lost, without inquiring about the actual health behaviors they were trying to follow, or any other questions related to overall wellness [57]. Participants reported that they felt "pressure" to lose weight quickly [57], and two studies even shared examples of participants using unhealthy means of weight loss, such as extreme restrictive dieting [54, 60]. Participants were also concerned about their age and the amount of time it could take to reduce their weight [49, 55]. They wanted continuous support for weight management as a part of fertility care, such as referrals to allied health professionals (e.g., a nutritionist), and indicated that healthcare providers should acknowledge they have likely tried to lose weight in the past and therefore being given generic advice to reduce their BMI is not helpful [50, 60].

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3.2.4 | Self-Blame

Participants across six studies expressed feelings of guilt for not having lost weight before they wanted to conceive [51–53, 56, 57, 60]. Participants shared that there is a social perception that mothers who have larger bodies are "bad mothers" and are "choosing" to put their fetus at risk for complications during pregnancy [52, 53]. As a result, women described feeling fearful for even wanting to be pregnant while knowing the potential risks and blamed themselves for not successfully sustaining weight loss in the past [53, 55]. Moreover, participants highlighted that healthcare professionals often made them feel "individually responsible" should they conceive and have complications later on due to their pre-pregnancy weight. For example, Bombak et al. (2016) found that the language healthcare professionals used to discuss potential pregnancy risks made the individual feel like they themselves are "wrong" for wanting to be pregnant at their weight [53]. Advice from women who had larger bodies and infertility for other women who are going through the same experience included "trusting your own body" and embracing the beauty and strength of a larger body that is capable of having a pregnancy; women emphasized that the focus should be on one's health and not their weight [51].

4 | Discussion

This scoping review aimed to summarize lived experiences of individuals who have obesity or larger bodies and infertility in healthcare. The identified themes are similar to what has been reported in other populations (e.g., generally among adults, individuals undergoing obesity treatment, young adults/youth, perinatal contexts) in healthcare settings [26, 62, 63], and therefore, these findings further underscore the pervasiveness of weight stigma in healthcare environments and its negative impact on patient experiences. Table 3 summarizes this discussion by listing the directions forward that are described in more detail below for further research, clinical practice, and policy advocacy. Overall, there is limited understanding of the relationship between obesity (without relying on BMI only) and fertility outcomes, as well as missing perspectives that are essential to guide care (i.e., gender diverse individuals, partners, healthcare providers). It is necessary to advocate for more research and resources for advancing our knowledge in this area to offer equitable care, as well as resources to effectively explain obesity and fertility relationships to patients and guide shared-decision making.

Common examples of healthcare providers implicitly or explicitly making weight-stigmatizing remarks include centering all conversations around weight and offering generic weight loss advice to their patients who have obesity or larger bodies [62, 63]. This parallels the first theme identified in this review from the perspective of individuals who have obesity or larger bodies undergoing fertility care, where they expressed frustration around weight constantly being blamed for their infertility and limited information on why weight or obesity is physiologically affecting fertility outcomes. Moreover, themes two (restricted access to fertility care) and three (lack of weight management support) further emphasize that focusing solely on weight or BMI is a stigmatizing experience for patients in clinical settings, and they find generic weight loss advice unhelpful. The lack of support for weight management likely results in individuals independently trying to navigate weight loss, and as noted in this review, "failed" weight loss attempts or lack of weight loss heightens poor mental health outcomes and self-blame (theme four). Self-blame also increases the risk of internalization of stigma, and in the context of weight stigma, this has been shown

TABLE 3 | Summary of future directions recommended for research, clinical practice, and policy. This table outlines key recommendations derived from the findings of this scoping review and stakeholder input.

Research:	• Capture the perspectives of gender diverse individuals, partners, and healthcare professionals providing care to individuals who have obesity and infertility. • Evaluate in detail methods used to lose weight to improve fertility, length of time, and the impact on prenatal outcomes. • Test the effect of comprehensive and recently recommended measures of obesity, other than BMI and weight, on fertility outcomes.
Clinical practice:	• Develop patient education tools that can accessibly explain the association between obesity or higher weight and fertility. • Develop shared decision-making guidelines for healthcare professionals to use with their patients to facilitate discussions surrounding potential success of fertility treatment options, patient-centered weight management support, and reduce weight stigma or fear mongering.
Policy:	• Increase transparency that we currently lack research on the link between obesity and fertility, as most of our knowledge relies on measures of BMI or weight alone. • Educate public health officials and health systems from the perspective of patients with obesity undergoing fertility treatment who may also be harboring detrimental feelings of self-blame. • Urgent call for support for research that can assess the implications of obesity on fertility that go beyond BMI or weight alone, develop educational tools for patients, and establish referral pathways to allied health professionals to support weight management and mental health. • Integrate mental health resources into regular preconception care, especially for patients seeking fertility care who also have obesity, larger bodies or higher weight.

Abbreviations: BMI = body mass index.

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to worsen physical and mental health outcomes [33]. Poor preconception mental health has been associated with pregnancy complications and reduced success of ART [64, 65]; therefore, it may be plausible that weight stigma itself contributes to reduced fertility success, but no studies have tested this effect (e.g., mediating effect of weight stigma between obesity or body size and fertility outcomes).

Important to note, though, there were no studies that aimed to explore the perspective of healthcare professionals who provide fertility care to individuals who have obesity or larger bodies, and this is a critical gap. One article identified in our search, published in 2011, was excluded because it was a commentary. However, it did summarize practices among medical directors of U.S. infertility programs ($n = 43$), reporting that over 70% of respondents agreed that there should be BMI-based restrictions (between 30.0 kg/m^2 and 35.0 kg/m^2) for fertility treatments [66]. The majority (90%) said that they tell their patients to exercise and improve their diet, and receive counseling from a nutritionist to lose weight, with recommended weight loss amount ranging from at least 5%–10% or until they reach the clinic's BMI cut-off [66]. Current guidelines available to healthcare professionals do indeed recommend weight loss and BMI considerations for fertility care [6, 9, 10, 12]. Healthcare professionals are therefore challenged with having to balance patient desire for family planning while mitigating potential perinatal risks [12]. It is necessary to gather the perspective of healthcare professionals and learn directly from them what tools or resources may be helpful for improving patient interactions and quality of fertility and obesity care.

In the absence of such support for healthcare professionals to offer weight management support presently, they may be giving generic weight loss advice, and this is a common weight-stigmatizing experience in clinical settings and is associated with patients experiencing self-blame and internalization of stigma [62]. Healthcare professionals have indicated wanting resources to improve weight-related discussions before, during, and after pregnancy, and tools have been developed and tested (e.g., 5 As for Healthy Pregnancy Weight Gain) [67]. However, it goes beyond discussing current weight management with patients, as it is also necessary to understand their previous experiences with weight loss attempts [4]. A systematic review that assessed the impact of weight loss before and between pregnancies noted that most studies provide the weight loss amount, but do not describe the weight management approach used or the duration of the weight management approach, both of which could impact perinatal outcomes [20]. Furthermore, as the availability of pharmacotherapy also increases (e.g., GLP-1), it is necessary to investigate how this could affect weight loss before pregnancy, fertility outcomes, and pre- and postnatal outcomes to best guide patients [4].

Based on the findings of this review and others that continue to emphasize healthcare environments as problematic for weight stigma, we suggest two approaches to equitably advance fertility-specific clinical practice: 1. Development of patient-centered and patient-facing tools to educate on the link between obesity and fertility and facilitate sensitive discussions and shared-decision making around weight management; 2. Development of a clinical decision-making tool or guideline to support clinicians with offering fertility treatment options and appropriate assessment of risks related to obesity.

There have, in fact, been a few resources designed and tested to explain infertility to patients, such as the "Tell Me Tool," which is a survey that patients complete to help clinicians understand their questions, priorities, and well-being surrounding fertility [68]. The clinician reviews the responses on the "Tell Me Tool" to help guide discussions with their patient about infertility and their options for treatment [66]. Similarly, there have been patient-centered tools developed to explain obesity as a chronic disease to patients and to facilitate sensitive patient-centered discussions surrounding weight management [67, 69]. Accordingly, we recommend the development and use of patient-centered educational tools to guide discussions that thoroughly and simply explain the relationship between infertility and obesity, and why weight management may improve chances of conception and pregnancy outcomes. Similarly, healthcare providers also need support to guide their clinical decision-making in a collaborative way with patients who have obesity or larger bodies and infertility that goes beyond relying solely on BMI. Ideally, such a tool can facilitate sensitive discussions surrounding potential treatment options, referral pathways prior to fertility treatment to help with weight management if necessary, and transparent conversations on chances of successful conception and pregnancy without fear mongering.

Despite these two recommendations, we also need to increase awareness and transparency that we currently do not have enough research on obesity and infertility to fully guide clinical decision-making, and therefore, there should also be an urgent call to action to fill this gap to improve patient care and experiences. Restrictive practices (e.g., BMI cut-offs for care) and guidelines implemented in the absence of patient-centered research on obesity and infertility may reduce access to timely fertility care. Additionally, both obesity and infertility are associated with poorer mental wellbeing [13]. Studies included in this review allude to further mental health complications and self-blame when patients have both obesity and infertility. Therefore, it may be necessary to advocate for integration of mental health resources into regular preconception care, especially for people seeking fertility care who also have larger bodies or obesity.

Aside from the perspective of healthcare providers, two additional populations we would like to highlight as "missing" and require further research are the following: experiential accounts from gender diverse individuals and partners. Across all included studies, most of the participants were female and women and were the individuals who would be undergoing fertility treatment and be the birthing parent. Although this perspective is indeed critical, fertility care has significant implications on relationships and associative stigma with partners who may or may not also be receiving treatments [70, 71]. Gender will also impact experiences of infertility and weight stigma [31, 72, 73]. Recent research in weight stigma has shown that individuals who identify with a minority gender group are more likely to have poor mental health outcomes such as disordered eating and depression [72]. Furthermore, fertility preservation among transgender individuals is becoming an increasingly viable option, yet there is still stigma associated with this decision [74].

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Along with transgender individuals, same-sex couples and other gender diverse individuals are frequently excluded from fertility services, policies, and research [3]. Therefore, to effectively understand weight and infertility stigma and develop inclusive mitigation strategies, purposeful research considering gender and relationships is needed.

4.1 | Strengths and Limitations

This is the first review, to our knowledge, that has aimed to summarize the literature on the simultaneous lived experience of having larger bodies or obesity and infertility in healthcare settings. A diverse panel of key interest holders, including individuals with lived experience of obesity and infertility, informed the interpretation of the themes and future directions. Having the lived experience perspective was critical to the interpretation of the themes and also informed language selection in the preparation of this manuscript to avoid contributing to weight-stigmatizing discourse. Given that this was a scoping review, however, study quality was not considered overall [41]. The pool of available studies to inform our knowledge on the topic is small. Moreover, all included studies were primarily focused on implications of weight stigma and not infertility stigma, and this is an important gap to consider in future research that may try to conceptualize the intersecting experience of both forms of health-related stigma. In lieu of these limitations, our discussion offers a guide for future research, and we also caution interpretation of these findings given the limited number of studies retrieved.

5 | Conclusion

Findings of this scoping review highlight that weight stigma is pervasive in fertility care and negatively impacts patient experiences. Patients who have obesity or larger bodies and infertility report receiving limited information on why their obesity or body size impacts fertility, and there is a lack of support for weight management. Additionally, BMI or weight-related cut-offs for fertility care are perceived as unfair. Participants describe feelings of self-blame for wanting to be pregnant at their current weight and find that weight becomes the focus of nearly every clinical interaction. These findings can help inform future directions for research, clinical practice, and policy to improve quality of patient care.

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Conflicts of Interest

X.R.S. has no conflicts of interest related to this study. As a research consultant, X.R.S. receives consulting fees from international non-profit and private organizations through Replica Communications and her consulting company in Sweden (K&X Ramos AB). S.N. has previously consulted with Eli Lilly Canada in her role as a weight stigma researcher. The authors declare no conflicts of interest related to this study.

Data Availability Statement

The data that supports the findings of this study are available in the supplementary material of this article.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist. **Table S2:** Guidance for reporting involvement of patients and the public (GRIPP2) short form. **Table S3:** Search strategy modified for each database. **Table S4:** Additional population characteristics in included studies.

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