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Bachelorarbeit

Exploring Overweight and Obese Women's Desires and Expectations from Midwives Concerning Sexual and Reproductive Health: a Research Plan

Tag der Abgabe: 13.12.2024

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Studiengang: Hebammenwissenschaft B.Sc.

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Forward

Because of the size of the study proposed in this paper, this work will use the term woman and women in reference to cis-gender women only. Nevertheless, midwives count among their clientele people with diverse gender identities and presentations which are often neglected within the field of midwifery research. While this work focuses exclusively on cis-gendered women, I wish to stress the importance of future work which seeks to capture a more diverse array of pregnant, birthing, and postpartum people so that midwives can offer the best level of care for all their clientele.

This work focuses on women who are classified by their BMI as overweight or obese. I feel it is important to acknowledge that many people who fall within these definitions feel terms like overweight and obese are stigmatizing and have negative impact. As this paper specifically uses the BMI to identify participants, the terms overweight and obese will be used in accordance with their definitions as per the WHO.

A special thank you to my partner, my child, and my sister for their support and patience with me throughout my career change, studies, and work on this paper. I love you.

Abstract

Introduction: The scope of midwifery practice encompasses education and care in relation to sexual and reproductive health. With an ever-increasing population of overweight and obese child-bearing women, midwives are confronted with a population that has distinct needs and concerns regarding how they wish to receive care and counseling from a midwife about sexual and reproductive health. Despite this, heavier women face multiple challenges that could potentially serve as a roadblock to receiving adequate care in these subjects from a midwife. To better understand the encounters between women with elevated BMI and midwives concerning reproductive and sexual health, and improve current midwifery practice in the field, a study is proposed to ask: what do overweight and obese women desire and expect from midwives concerning sexual and reproductive health in the perinatal period, and; what has been their experience with midwives in this regard?

Method: A needs assessment survey with both quantitative and qualitative data collection is proposed. A questionnaire will be developed with the help of literature research and consultations from various interest groups to appropriately explore the subject. Women will be recruited from antenatal centers, midwifery and gynecological practices, obesity specialists, and other areas with connection to the subject population. They will be filtered with the help of online survey software to the following criteria: cis-gender women with a BMI of 25 kg/m^2 or greater, between the ages of 18 and 50, who have been or wish to become pregnant. Data will be collected and analyzed with the help of statistical software tools and thematic analysis techniques.

Expected Findings: It is possible women will bring up experiences of medical and societal weight stigma, the absence of quality sexual and reproductive health care and counseling, poor communication from midwives, and feelings of excessive shame leading to care avoidance.

Discussion: Rigorous steps will be taken during the development of the questionnaire and throughout the process of analysis to increase the validity of the findings. Limitations and bias, including volunteer bias and hostile attribution bias, are addressed and, when possible, solutions given to mitigate their influence.

Conclusion: This study plan seeks to emphasize the importance of studies like this one to improve upon midwifery practice for heavier women by elevating their voices to offer a more holistic, individualized approach to their care and counseling moving forward.

Table of Contents

Index of abbreviations

BMI	Body mass index
HCP	Health care professional
SRHOO	Sexual & Reproductive Health in Overweight and Obesity
UKE	University Medical Center, Hamburg, Eppendorf (*Universitätsklinikum Hamburg-Eppendorf)*
WC	Waist circumference

Tables

Figures

1 Introduction

The International Confederation of Midwifery considers sexual and reproductive health counseling a core competency of the midwife (*ICM Essential Competencies for Midwifery Practice*, 2024). Despite this, many midwives find it difficult to broach the subject of sexuality and reproductive health with their clients based on a lack of knowledge about and general discomfort around the subject (Azar et al., 2022; Harris et al., 2023; Percat & Elmerstig, 2017). These issues are further compounded during the care and counseling of overweight (BMI >25 kg/m^2) and obese (BMI >30 kg/m^2) women. Studies have shown the general stigmatization overweight and obese women are confronted with. Especially regarding their sexuality and reproductive health, overweight and obese women in modern society straddle the dichotomies of asexual and hypersexual with little room for nuance (Gailey, 2012; Najarian & Nee, 2023). Obese and overweight women note these stigmas in the medical field and report a poorer quality of care and more negative treatment during pregnancy and postpartum than those who are a normal weight (Mulherin et al., 2013a; Murray, 2004; Najarian & Nee, 2023). Midwives have been shown to be hyper-aware of these stigmas, leading them to avoid discussing weight during counseling (Christenson et al., 2018). Other research shows that during routine prenatal visits, overweight and obese women receive less counseling on lifestyle and less rapport building communication that fosters a compassionate and nonjudgemental relationship between the maternity-care provider and the pregnant person (Washington Cole et al., 2017). These findings highlight the lack of effective communication with overweight and obese women, especially regarding sexual and reproductive health, during pregnancy and the postpartum period.

Sexual health is a cornerstone of the overall health and wellbeing of adults. With nearly half the European population considered overweight or obese (WHO European Regional Obesity Report, 2022), an understanding of the sexual and reproductive health of overweight and obese people is essential. Being overweight or obese has been shown to have a negative impact on the sexual satisfaction and reproductive health of individuals while pregnancy and the postpartum period can have a similar negative impact (Grussu et al., 2021a; Sahu & Pajai, 2023). It is therefore imperative that midwives are aware of the struggles overweight and obese women face and are prepared to adapt to offer overweight and obese women a model of care tailored to their unique needs and wishes. Thus far, no research has been conducted to gain the perspectives of overweight and obese women regarding the care and counseling they received or wished to receive about sexual and reproductive health. This bachelor's thesis therefore propose a research plan to explore the following questions:

1. What do overweight and obese women desire and expect from midwives concerning sexual and reproductive health in the perinatal period?
2. What has been their experience with midwives in this regard?

1.1 Background

Research shows that overweight and obese women face unique challenges concerning sexuality and reproduction. These hurdles are in part the result of societal and medical stigmatization of heavier bodies, often referred to as “weight bias”, as well as preconceived beliefs about overweight and obese women’s sexuality. To begin with, overweight and obese people perceive more discrimination based on their weight in their daily lives than their average weight peers, with higher rates of bias noted among women (Brown et al., 2022; Spahlholz et al., 2016). Further, media depictions of heavier people perpetuate negative societal stereotypes with characteristics like slovenliness and laziness, and overweight or obese characters in television and film portrayed as less attractive and virtuous than their normal weight counterparts (Brown et al., 2022). These societal biases are further reflected in clinical settings. An implicit bias against overweight and obese people is seen among medical professionals (Lawrence et al., 2021) who associate people with elevated BMI with negative stereotypes including laziness, non-compliance, and low self-discipline (Foster et al., 2003). This results in higher rates of discrimination in medical settings among individuals with higher weight. In addition, evidence has shown physicians spend less time during appointments with overweight or obese patients (Hebl & Xu, 2001), are less likely to offer them health education (Phelan et al., 2015), and more often avoid screenings and other exams that they might otherwise perform on average weight patients (Telo et al., 2024). In obstetrics and maternity care, weight stigma is also not uncommon (Incollingo Rodriguez et al., 2020), with some overweight and obese women expressing a desire to give birth outside of hospital to avoid discrimination (Gibbins et al., 2023). Other studies have confirmed overweight and obese women’s avoidance of clinical settings, revealing that heavier women are less likely to seek medical care because of shame and fears of discrimination from health care professionals (Phelan et al., 2015). These findings should be alarming to obstetricians, midwives, and other birth workers, since high pre-pregnancy BMI is shown to have a significant correlation to various comorbidities during pregnancy (Smith & Lavender, 2011), and early intervention is essential to ensure the health of mother and baby. When heavier women either avoid health care professionals, cannot build a trusting relationship with them, or are neglected and stigmatized by those professionals, it would be unsurprising to find that their needs and concerns regarding sexual and reproductive health remain unaddressed throughout their care.

In addition to the character judgements and weight stigma heavier women face, the sexuality of overweight and obese women is also the subject of discrimination, assumptions, and prejudice. Najarian & Nee (2023) posit that prevailing social stereotypes portray the overweight or obese female body as unattractive and sexless, however niche communities which fetishize heavier women serve the opposite extreme and leave little room for a more nuanced perception of overweight or obese women's sexuality. Paired with weight bias from medical personnel which often results in less appointment time, rapport building, and counseling (Washington Cole et al., 2017), heavier women may not be receiving and may not feel comfortable asking for the advice or counseling they need or desire around sexuality and reproduction. Overweight and obese women have described feeling shame for their sexual desires within their overweight or obese bodies, emotions which correlate directly with negative self-worth influenced strongly by body size (Gailey, 2012). Additionally, heavier women face a plethora of psychological, physiological, and social factors relating to their weight that can influence their sexual and reproductive health. These range from hormonal imbalances, illnesses like depression and anxiety, relationship conflict, difficulty finding a partner, and negative body image (Chedraui & Nappi, 2024). These all have been shown to have impacts on different aspects of sex and reproduction.

The issue of sexuality is especially pertinent during the antenatal period for overweight and obese women. Sexual and reproductive health while trying to conceive, during pregnancy, and postpartum can change drastically for women and often, physical and psychological issues can evolve during an understandably difficult period in new parents' lives (Grussu et al., 2021b). At the same time, sexual dysfunction is significantly more prevalent among overweight and obese women (Chedraui & Nappi, 2024; Salari et al., 2023). This means that heavier women who are already at risk of sexual dysfunction when not pregnant, face a potentially higher risk of sexual dysfunction in the antenatal period than their average weight peers. Midwives play an integral role in promoting and upholding sexual and reproductive health. The intimate relationship and rapport that arises between midwife and client should ideally foster an environment where women feel comfortable bringing up any issues they have with sexuality and reproduction. Unfortunately, midwives sometimes find it difficult to bring up the topic of sex during counseling (Azar et al., 2022) and studies have further shown they forgo more in depth counseling with overweight and obese women for fear of using incorrect or offensive language and inadvertently marginalizing them further (Christenson et al., 2018). The quality-of-care midwives offer overweight and obese women specifically concerning their sexual and reproductive health is heretofore unexplored, but related literature suggests that it is an area that deserves closer examination. This proposed study seeks therefore to hear

directly from overweight and obese women what support they would like to or have received from midwives during the antenatal period to improve the quality-of-care midwives offer.

2 Method

2.1 Literature Survey

A survey of the available literature on the topic was conducted in the databanks PubMed and CINAHL using the PICO method (Table 1).

Table 1

PICO format used to explore the subject matter

	Population	**Intervention**	**Comparison**	**Outcome**
Keywords	Obese women, overweight women	Midwifery-led sexual and reproductive counseling	*not applicable*	Experiences, complaints, perceptions, desires

Note. Table is author's own

Deficiencies in the body of evidence became apparent almost immediately. The PubMed search revealed 10 articles, all of which were unrelated to the topic and the CINAHL search yielded no results. A study like the one proposed in this paper is therefore necessary to understand the subject at hand. Background information about this topic was informed by merging evidence from multiple studies across several different topics. Through the snowball method as outlined by Wohlin (2014), research was compiled into two main categories. Studies about the sexuality and reproductive health of obese women, including the role of weight stigma, form the foundation of this research. This foundation was then built on with further research on midwifery-led sexual and reproductive counseling as well as midwives' and birth-workers' perceptions of and experience working with overweight and obese clientele. While this background research enables speculation about what heavier women may desire or need concerning midwife-led counseling on sexuality and reproductive health, a lack of any information from the affected women themselves further stresses the necessity of a needs assessment like the one proposed here. Nevertheless, a working theory was developed which merged the research compiled to determine the most appropriate study design and to offer insight into what results such a study may yield.

2.2 Centering the Affected

"It is necessary to individualise care for obese pregnant women, which involves taking time to give the women an opportunity to tell their own story." (Nyman et al., 2010, p. 424)

The purpose of this proposed research is to center the experiences of overweight and obese women in order help midwives improve counseling on sexual and reproductive health to the subset's specific needs. To obtain this goal, two research questions have been posed: What do overweight and obese women desire and expect from midwives concerning sexual and reproductive health in the perinatal period, and; what has been their experience with midwives in this regard? Research focusing on the point of view of heavier women is lacking in all areas, and sexual and reproductive health is no exception. As such, the research question inquires specifically about the experiences of overweight and obese women regarding their lived experiences with and desires for counseling and care on the topic of reproductive and sexual health. This is in contrast with other studies which ask health care professionals (HCP) for their experiences in the counseling and care of overweight and obese women. Because this topic has yet to be explored, the experiences, wishes, needs, and concerns of the affected group themselves are imperative to offer more effective, needs-based, patient-oriented care and help midwives avoid making choices about the care of affected individuals founded on assumptions. Based on this, the research question above was posed and can be seen as an important starting point for further research in the field as well as a guidepost to aid midwives in modifying their practices to fill the needs and desires of clients with raised BMI.

2.3 Study Design

The author proposes a comprehensive healthcare needs assessment to answer the research question. A needs assessment can be understood as a tool used to determine the unmet healthcare needs, priorities, and desires of a certain population in order to improve that population's health and encourage more equity within healthcare settings (Tobi, 2016). This method was deemed the most appropriate based on the exploratory nature of this study as well as the convenience an online survey offers to data from several participants simultaneously. Such a survey enables researchers to explore the questions stated above by asking participants questions informed by the literature while also giving women the possibility to go into depth about experiences they have had as well as needs and expectations they have in the context of the research. The plan for this assessment is based around the German healthcare system and approaches midwifery work within this context. This research plan could, however, be used in other healthcare systems with only minor modifications.

2.3.1 Defining the Community

The population this study seeks to survey is defined as: cis-gender women, between 18 and 50 years of age, with a BMI over 25 kg/m^2, who have been or wish to become pregnant in Germany. Participants for this research would include cisgender women who have been previously pregnant as well as cisgender women who have not been previously pregnant but who wish to discuss subjects such as conception and/or pregnancy with a midwife. Although these women may not have had contact with a midwife previously, it is within the scope of midwifery to offer family planning counseling (*Definition of Midwifery*, n.d.). As conceiving can be more difficult for women with a BMI over 25 kg/m^2 (Langley-Evans et al., 2022), the information these participants offer will be relevant to midwives to improve their practice and quality of care for overweight and obese individuals in such circumstances. The data compiled for analyses should initially be confined to cisgender women with an understanding that transgender men and non-binary people face unique issues around the topics of body weight, sexuality, reproductive health, and stigma that necessitate studies more specifically tailored those intersections.

2.3.2 Developing a Questionnaire

A questionnaire will be developed with targeted questions to most effectively question the population. This questionnaire will use the Needs and Concerns Questionnaire developed by the University Medical Center Hamburg's (UKE) Junior Research Center for Sexual and Reproductive Health in Overweight and Obesity (SRHOO). This screener was developed to discern the needs and concerns overweight and obese people express regarding their sexual and reproductive healthcare and counseling by a much broader range of HCP. To develop a survey with relevant and thoughtful questions for this population, the scientists involved in SRHOO conducted further discussions with interest groups *Adipositashilfe Deutschland e.V.* and *Motherhood e.V*. Paired with literature research on the topic, a screener of closed and open-ended questions was created. These questions determine demographic information for sex and gender identity, age, height, weight, relationship status, partners' age, height and weight, number of children, employment, and education background. Participants are prompted to rate their general physical and mental health and then more specifically their sexual health. These questions are specific to the sex of the individual and include self-reported estimations of sexual function and sexual distress. Open-ended questions concerning participants experiences with sexual and reproductive health counseling from HCPs, their needs and desires concerning the subject, and any factors that might contribute to avoidance of care and counseling on the subject complete the questionnaire.

Figure 1

Excerpted Questions from the SRHOO Needs & Concerns Questionnaire

1. Have you ever spoken to a doctor/midwife/other practitioner about any of the following topics?

- Sexual problems in the partnership
- Sexual problems in connection with body weight
- Sexual practices
- Contraception
- (Unfulfilled) desire to have children
- Body weight and health when trying to conceive, during pregnancy, in the postpartum period, and while breastfeeding
- Dealing with and providing information on breastfeeding (for women during or after pregnancy)
- other problems in the partnership
- none of the topics mentioned

What were your experiences of this encounter?

2. What other topics relating to sexuality would you like to discuss or clarify with a doctor/midwife or psychologist? What counseling and/or treatment services for sexual and reproductive health would you like?

3. Are there any concerns or other causes up to the present which have kept you from seeking help or counseling for your sexual or reproductive health?

Note. Questions selected from the SRHOO Needs & Concerns Questionnaire. These questions were translated from the German language to English by the author. Original text can be found in the Appendix.

Figure 1 contains selected questions from the SRHOO survey. Targeted, multiple choice questions such as question one serve to collect quantitative data on themes that are relevant to the research subject while related, open ended follow up questions leave room for participants to answer in long form. This format is suited to the research questions which endeavor to hear directly from overweight and obese women. It gives participants the opportunity to do into depth about experiences and themes they deem important. It further allows them to touch on subjects and topics of which researchers may not be aware or not have considered.

Questions targeted to midwifery work will complete the survey. Supplemental to the interviews already carried out by SRHOO with advocacy groups, it is recommended that midwife advocacy groups and societies such as the *Deutsche Hebammenverband* (DHV) and the *Deutsche Gesellschaft für Hebammenwissenschaften* (DGHWi) also be interviewed

for their input when developing further questions. Proposed questions should be informed by keywords and thematic groupings, as outlined in Table 2.

Table 2

Examples of Possible Survey Questions

Keywords and themes	*Targeted Questions*
Midwife-led sexual counseling	Has a midwife ever spoken to you about your sexual and/or reproductive health? Did you feel like those encounters were sufficient and helpful?
Care Avoidance, Shame, Embarrassment, Comfort	Have you ever brought up your sexual health to a midwife? Do you feel comfortable speaking about your sexual health with a midwife? Why or why not?
Needs of the client	What subjects do you wish your midwife spoke to you about regarding your sexual and reproductive health?
Weight stigma	Have you ever felt that your body size influenced the counseling your midwife offered you?

Note. Table is author's own.

2.4 Data Collection

The questionnaire and study proposal will be submitted for review to the local ethics committee at UKE. Pending approval, the questionnaire will be uploaded to an online survey tool such as "Qualtrics XM" or "Unipark". Such tools significantly streamline the process of data collection, and their accessibility can easily expand the range of participants. They automatically collect results and store data on secure servers. The introductory page of the survey will include information about the purpose of the study, estimated time to completion, and data protection. Participants must agree to the terms and conditions of the study on an informed consent form before beginning. Data will be anonymized.

2.4.1 Recruitment

QR-codes will be generated for the online survey and printed on business card size flyers with the contact information for the study director and given to a small, select group of midwifery practices, freelance midwives, maternity wards, gynecological practices, and practices specializing in weight management and obesity. This will allow researchers to seek out women who have been or will be in the care of a midwife. As this research is exploratory and relies heavily on qualitative data to discern themes in depth, the recruitment pool should be limited to avoid overwhelming the dataset unnecessarily. Using the online

survey tool, participants will be automatically filtered to determine their eligibility for the study based on age, sex, gender, BMI, and reproductive wishes. Data collection should cease at twenty participants with an expectation that the homogeneity of the population will result in saturation before twenty (Hennink & Kaiser, 2022).

2.4.2 Bias Control

This research is intended to be exploratory and, while results will be helpful to improve midwives understanding of the healthcare and counseling of the population concerned, care must be taken to control for certain biases. Potential pitfalls of this type of study are explored in depth in Chapter 4.

2.5 Analysis

This paper proposes a combination of both qualitative and quantitative data styles to gain initial perspective into the desires, expectations, and experiences from heavier women of midwives. As such, multiple techniques for data analysis are necessary to properly assess the results gathered. The quantitative data that will be obtained will be analyzed descriptively with a focus on frequencies with the help of statistics software. Qualitative data obtained from open-ended questions will be analyzed to thematically group specific answers and identify potential patterns in the narratives compiled as described by Braun and Clarke (2021). Table 3 illustrates this approach to reflexive thematic analysis in six phases.

Table 3

Phases of Thematic Analysis

Phase 1: Familiarity with Data	Immersion in the dataset by way of reading the data repetitively and making necessary notes about insights.
Phase 2: Coding	Identify relevant or meaningful parts of data to capture concepts in the data.
Phase 3: Formulate Initial Themes	Identify patterns or themes across the dataset.
Phase 4: Develop and Review Themes	Assess the initial themes in relation to the question. Revise if necessary.
Phase 5: Refining Themes	“Fine-tune” the theme analyses and write a synopsis of each.

Phased 6: Write Up	Final write up of the evidence as a research paper.

Note. Contents of this table is from (Braun & Clarke, 2021).

3 Expected Findings

Several expectations arise for this study. These will be discussed in the next section in detail and are grouped thematically. Nevertheless, it is extremely important to not overly rely on these expectations, which could in turn influence midwives to make assumptions about overweight and obese women's needs without first hearing from the population themselves. Such assumptions only serve to further contribute to the marginalization, medicalization, and stigmatization of heavier women while also robbing them of their autonomy in health care settings (Nagpal et al., 2024; Thorbjörnsdottir et al., 2020). It is for this reason that this work suggests a study like the one described here to help midwives better understand what overweight and obese women need, as described in their own voices. These themes should be used to help researchers to answer the research questions posed through understanding the myriad potential factors that heavier women experience which could have influence on midwifery practice, sexual and reproductive counseling, and health care encounters.

3.1 Sexual and Reproductive Health Counseling from the Midwife

The literature relating to sexual and reproductive health care and counseling from midwives shows that midwives have different approaches and levels of comfort toward sexual and reproductive health counseling and care. In their paper on sexual counseling in an antenatal clinic in Sweden, Percat and Elmerstig's (2017) interviews with midwives showed that they were highly sensitized to the importance of sexual counseling but felt uncomfortable in certain circumstances to offer it. Their reasons included assumptions that the women presenting in their clinic would not require any information, that cultural aspects made the topic difficult or uncomfortable to address, and that they were not sufficiently educated on the topics to offer their help in the field. Other studies have reinforced the notion that cultural attitudes toward sex tend to influence midwifery practice regarding sexual and reproductive counseling (Azar et al., 2022; Percat & Elmerstig, 2017). They show that midwives working in more sexually conservative cultures where sex is a taboo subject or midwives who personally have more conservative social values around sexuality tend to avoid the subject matter based on discomfort around the subject (Ege et al., 2008). This is exacerbated when midwives perceive their clientele as not sufficiently educated on sex and sexuality (Yılmaz, 2023). Further research suggests midwives and midwifery students feel insufficiently educated on the subject matter (Manninen et al., 2024) and therefore ill equipped to offer adequate counseling. It would therefore be unsurprising if participants in this study stated that they received little or ineffective counseling on sexual and reproductive health from a midwife, regardless of BMI. Body weight can further

influence the type of care heavier women receive and has the potential to exacerbate this issue.

3.1.1 Lack of training and fear of unintentional stigmatization

The issues midwives face concerning counseling on sexual and reproductive health care might be further compounded when offering sexual and reproductive counseling to heavier women. Christenson et al.'s (2018) qualitative survey of 17 Swedish midwives demonstrated that the midwives were aware of medical weight stigma and the internalized shame women with elevated weight experienced. They were concerned about bringing up the topic of weight during antenatal care for fear of potentially stigmatizing the women in their care further and causing them distress during pregnancy and postpartum. Because of this, they tended to avoid the topic of weight and thus any associations with its adverse health effects. This poses a significant problem as elevated BMI has been shown to negatively impact the sexual and reproductive health of individuals (Mahmood, 2023) and thus represents a potentially significant influence on the health and well-being of heavier women under the care of midwives. BMI is thus a source of possible sexual and reproductive dysfunctions that midwives might forgo communicating with their clients in a misdirected effort to avoid offending them. Moreover, midwives in Christenson et al.'s survey expressed a lack of training in communication skills when bringing up the topic of weight as a further reason for their reluctance to address the subject. A review of practices of HCPs in communicating about weight with heavier women during pregnancy further highlighted this avoidant behavior, with reluctance to address weight and discomfort at the subject presenting as prominent themes (Dieterich & Demirci, 2020).

This might manifest if participants use the open-ended follow up question in Figure 1, Question 1, "What were your experiences with this encounter?" to describe encounters with a midwife which felt impersonal or avoided mentioning the participants weight completely. This suggests certain factors that might make the HCP uncomfortable or less able to offer counseling that is individualized to the participants unique needs as an overweight or obese woman. Such inferences are exclusively speculatory, however, and present a limitation to the study. Further research into how midwives in Germany view their communication with heavier women is necessary to understand the complexity of the situation. The growing visibility of the systemic effects of weight stigma in health care suggest that awareness of weight stigma is no longer a foreign subject to German midwives. The study proposed in this work provides an opportunity to question overweight and obese women and use their experiences as an impetus for further research.

3.2 Weight Stigma

Gender has been shown to have a significant impact on sociocultural attitudes toward elevated body weight, with overweight and obese women more likely to be confronted by prejudicial and negative attitudes or bias towards individuals who are overweight or obese, known as weight stigma (Spahlholz et al., 2016). This weight stigma is in part heavily influenced by ideological prejudice which portrays “fatness” as a factor reliant wholly on will-power and self-control (Crandall & Schiffhauer, 1998). This is reproduced in media depictions which portray stereotypes of overweight people, and especially women, as slovenly, unattractive, lazy, and weak-willed (Mauri, 2022; Whyte, 2010). Further depictions emphasize an image of femininity that is overly preoccupied with appearance and concerned with weight gain (De Brún et al., 2013), implying that overweight or obese women are less feminine than their normal weight counterparts. Repeated exposure to media depictions can lead people to accept media portrayals as reality and therefore holds strong influence over societal attitudes toward heavier women (Grabe et al., 2008). Despite this, certain cultures and sub-cultures do not attach negative connotations to excess body weight and instead consider such women attractive or neutral (Krems & Neuberg, 2022; Pearce et al., 2014). This suggests prejudice toward heavier bodies is not innate. Nevertheless, these societal attitudes can bleed into medical practice. It has been observed that HCPs, including midwives, tend to hold negative beliefs toward heavier women if they themselves adhere to the belief that weight is a matter of self-control (Christenson et al., 2020; Foster et al., 2003). Further research confirms that weight stigma in the medical profession is pervasive and midwives are not immune to it (Christenson et al., 2020; Mulherin et al., 2013b; Nagpal et al., 2024). It is possible, then, that the results of this study reveal that many overweight and obese women have perceived weight stigma and potentially discrimination from a midwife in various way. In the following sections, potential manifestations of weight stigma, and especially how that weight stigma may manifest in conjunction with sexual and reproductive health, will be discussed.

3.2.1 Delayed care, inadequate education, and less time

Negative and judgmental views towards overweight and obese women have been shown to influence HCPs practice in handling heavier patients, with serious discrepancies arising when compared to HCPs care of normal weight individuals. These discrepancies include delaying care, not offering specific treatments or tests, and spending less time in appointments with heavier individuals. Especially alarming is, for example, the reluctance physicians have exhibited in offering routine cancer screenings to obese women(Brown et al., 2022). Further studies have shown that HCPs who hold negative views toward

overweight and obese patients devote less time to those patients than they would to normal weight patients (Phelan et al., 2015). Researchers of this study can infer this manifestation of weight stigma if participants suggest their encounters with midwives and other HCPs felt rushed, they felt they were not offered the same care as normal weight peers, or even experienced demeaning language or other overt discrimination from their provider. This is admittedly a limitation to the research as the lived experiences of participants cannot be substantiated without a control group to conclusively show that such incidences were the result of weight stigma and not other, unrelated factors.

3.2.2 Assumptions about the sexuality of heavier women

Weight stigma manifests particularly in connection to overweight and obese women's sexuality. Assumptions around heavier women's sexuality are not uncommon and media portrayals of overweight and obese women emphasize the stigma (Brown et al., 2022). These assumptions include the belief that overweight and obese women are less sexually active, either because of their own disinterest in sex, because they are not attractive enough for a sexual partner, or because physical limitations keep them from engaging in sexual activity (Najarian & Nee, 2023). It is possible that such societal assumptions can influence midwives who may dismiss or not even consider potential concerns that women have about their sexual and reproductive health. Harmful mainstream stereotypes portraying heavier women as nonsexual (Gailey, 2012) can also influence midwives to avoid talking about the subject completely. Because of this, it can be inferred that a study such as the one proposed in this work might show that overweight and obese women perceived weight stigma in such a way that assumptions about their sexual and reproductive health influenced time spent on and depth of counseling on sexual and reproductive health from a midwife. Further, the fetishization of heavier women in certain subcultures as being hypersexual and even "desperate" could make overweight and obese women reluctant to bring up sex and sexuality for fear of further stereotyping themselves (Hall, 2018). This could be concluded if participants explicitly mention such a fear.

3.2.3 Excessive focus on weight loss and physical fitness

Another aspect of weight stigma in health care settings is the phenomenon colloquially referred to as "fat broken arm syndrome". This is characterized by a tendency from HCPs to show little concern or downplay health concerns of overweight and obese women and instead focus in large part or completely on weight loss and physical fitness (Paine, 2021). This can overshadow the legitimate needs of heavier women regarding sexual and reproductive health and has the potential to completely overlook issues that may

not have any direct correlation to weight. Any issues become secondary to weight loss and lose any potential urgency they might otherwise be afforded in patients of average weight. It is reasonable to conjecture that this phenomenon might occur when overweight and obese women bring up sexual and reproductive health concerns during visits with HCPs. While elevated BMI has been shown to play a role in sexual and reproductive dysfunction, overly emphasizing weight and presenting weight loss as the only solution suggests that HCPs don't view the health and wellness of overweight and obese women through a holistic, individualized lens. Through this, heavier women's sexuality is delegitimized and their sexual satisfaction portrayed as an unimportant aspect of their general well-being. Participants may answer the question, "What are your wishes for such a conversation?"[1] by expressing a desire receive advice and counseling that isn't solely related to weight loss.

3.3 Shame and Internalized Weight Stigma

It is clear stigma plays a prominent role in attitudes toward weight. Women with elevated BMIs contend with weight stigma at higher rates than men not only in society at large but also in the medical field (Puhl et al., 2008). Combined with societal pressure around beauty standards and body size, overweight and obese women can develop deep feelings of shame around their weight and can internalize weight stigma themselves (Pearl & Puhl, 2016). Internalization of weight stigma is characterized by negative self-worth and self-blame regarding higher weight, as well as the acceptance of and agreement with negative stereotypes and devaluation of heavier bodies. This internalization often leads to poor mental health, including intense feelings of shame which are often exacerbated when people with elevated BMIs experience significant weight stigma from HCPs (Alegria Drury & Louis, 2002). Despite the evidence of internalized stigmatization, this presents a limitation. Potential internalized stigma could lead participants to express their belief that, for example, they have not experienced stigma from midwives or even that perhaps negative treatment they receive is justified and therefore not an issue they bring up. Unfortunately, this cannot be completely avoided, and researchers will not be able to conclusively discern if such internalized stigma plays a role in the answers participants give.

[1] This is a follow up question in response to the multiple-choice question: Did you ever desire a conversation with a doctor/midwife/other provider about any of the following subjects?

- Sexual problems in the partnership
- Sexual problems in connection with body weight
- Sexual practices
- Contraception
- (Unfulfilled) desire to have children
- Body weight and health when trying to conceive, during pregnancy, in the postpartum period, and while breastfeeding
- Dealing with and providing information on breastfeeding (for women during or after pregnancy)
- other problems in the partnership
- none of the topics mentioned

In spite of this, internalized stigma does offer one explanation for the phenomenon described in the following section and should be taken into account with the awareness that further research is needed.

3.3.1 Care avoidance

Participants of this study may explain that choose to forego seeking care because they fear of judgement or negative encounters. This is known as care avoidance, defined as the delay or abstention from the seeking of medical care. While care avoidance in the general population is influenced by multiple factors, Mensinger et. al (2018) found that among overweight and obese women, care avoidance was heavily linked to intense feelings of shame and internalized fat phobia. In other words, heavier women preferred to forgo medical encounters to avoid the psychological distress those encounters were linked to. The emotional toll of living in a society which devalues the worth of heavier bodies and views the sexuality of such women in harmful, negative extremes can lead overweight and obese women to avoid seeking care all together, but especially concerning sexual and reproductive health.

3.4 Diversity of experience based on BMI

The main interest of this study lies in determining the experiences of women who fall into the category of overweight or obese as defined by BMI and what they desire from sexual and reproductive health care from a midwife. It is, however, possible that these experiences will vary drastically depending upon where on the spectrum of overweight or obese they fall, thus leading to a perception bias. Visual detection of overweight and obesity as determined by BMI has been shown to be frequently underestimated, especially when the subject is closer to lower end of the overweight classification (Oldham & Robinson, 2017). Moreover studies have shown that up to 30% of individuals who are technically classified as overweight or obese do not view themselves as such (Gruszka et al., 2022; Robinson et al., 2020). It is within the realm of possibility that midwives' visual perceptions of technically overweight or obese women, and not the BMI of those women, influences their practice. Therefore, a woman with a BMI nearer to 25 kg/m^2 might describe more positive encounters than a woman with a BMI over 30 kg/m^2. The method for data collection proposed here allows researchers to compare the responses of women with a BMI under 30 kg/m^2 to those with a BMI over 30kg/m^2. A similar study, altered to ask for midwives' assessments of their practice with overweight and obese women, would be beneficial to achieve a broader understanding of the subject matter.

4 Discussion

4.1 Choice of Method

The use of a needs assessment survey to explore the research question enables researchers to hear from a selected sample of the described population. The survey method allows researchers to ask specific questions and open-ended answers make it possible to go into detail on topics and potentially touch on themes that researchers might have overlooked. The survey method also allows for a mix of both qualitative and quantitative data collection, enabling depth but also more concrete, measurable insights. Despite the limitations discussed in the previous chapter, this method is an important first step into a topic with almost no prior research. The data from this study can be used to inform further research into the subject with more a more targeted approach. Future research might use the same methods to question a broader population or a more specified population. It would be useful, for example, to expand this research to question midwives about their own experiences in relation to the subject, to question women of child-bearing age regardless of BMI, or to confine the population to members of the LGBTQIA community.

4.2 Study Validity

Despite the necessity of a study such as the one proposed here, there are several questions of validity that arise. The qualitative portion of the research proposed here is essential to understand psychosocial aspects of patient care, however qualitative research has been criticized for being difficult to test for validity and reliability. Nevertheless, qualitative research is necessary in the medical and care disciplines to understand and improve upon real world practice. The confidence practitioners have of qualitative research for it to be used in the development and improvement of practices is therefore determined by the ability of the researchers to demonstrate sufficient rigor.

Validity in the context of qualitative research relies on *appropriateness*. Leung (2015, p. 325) defines this appropriateness as “whether the research question is valid for the desired outcome, the choice of methodology is appropriate for answering the research question, the design is valid for the methodology, the sampling and data analysis is appropriate, and finally the results and conclusions are valid for the sample and context.” In the context of the study proposed here, Table 4 can be used as an aid to determine the appropriateness, and thus validity, of this study.

Table 4

Suggested measures to increase validity of the study

Tool	*Key Questions*	*Considerations*	*Measures Taken*
Research Question	Is the research question correct to test for desired outcome?	What is the goal of the research? Are the aims clearly defined?	Development of the research question followed the PICO approach and was further informed by literature research.
Methodology	Will this method give us data to answer the research question?	What does research seek to interpret? Does this method enable that?	A needs assessment survey was chosen as the best method because it allows the researchers to reach a greater number of individuals simultaneously. Open-ended questions in an online format enable researchers to immediately draw from rich data.
Design	Is the questionnaire valid and are the questions plausible?	How was the questionnaire written? Who was involved?	The questionnaire was written by experts in the field along with collaboration from interest groups for the proposed population.
Sampling	Are the participants the correct population to answer this question?	How are participants selected? Are these participants appropriate considering the research question? Transparency about recruitment and consideration of potential pitfalls?	Clear criteria were outlined for the selection of individuals for the sample. Each factor used for selection was justified.
Analysis	Is the analysis method rigorous? Does it appropriately assess the data collected?	Is the method for analysis sufficiently described? Are the findings clearly stated and described?	Thematic analysis has been suggested as the best method to analyze results. Thematic groupings here must be rigorous and clearly defined by the researcher.

Note. This table was developed using information from (Coleman, 2022), (Leung, 2015), and (Critical Appraisel Skills Program, 2023).

The method illustrated above follows Morse et al.'s (2002) approach to validity and reliability in qualitative research by taking rigorous steps during the development of a study to verify and maintain validity instead of testing for those factors after the study's completion. This approach further emphasizes the researcher's preparedness to relinquish theories and ideas that they have previously held at all stages of the inquiry process if results contradict those notions. It thus enhances the trustworthiness, in this circumstance understood as methodological integrity by which the researcher conducts themselves, by relying on the

results obtained to answer the question posed by the means described in the methodology. This is in line with previous statements within this work to avoid overly relying on expectations or assumptions while conducting this study. The literature research which informs the *Expected Findings* described in Chapter 3 can offer researchers orientation during analysis, however researchers should not be overly reliant on these expectations and must be prepared to abandon any theories if research revels contradictions to those theories.

4.3 Limitations

In Chapter 3, possible outcomes were discussed with speculation about how such results might be inferred by researchers based on the answers participants give. Various limitations were also mentioned in connection to potential results. Because a study such as the one proposed here has thus far never been done, these limitations cannot be completely avoided. Even so, this study seeks to understand the *experiences* of overweight and obese women. Reports from the perspective of the participants may not always be verifiable in the context of this study but they help researchers to discern how overweight and obese women perceive the way they are treated within the context of this study as well as understand what participants feel are the most important issues concerning the subject. These accounts serve to give researchers more focused direction for future studies surrounding this subject.

4.4 Bias

It is important to acknowledge several instances of this research where potential biases may arise, although these biases may not be completely possible to avoid in all circumstances. Nevertheless, as this research is exploratory, future research can take greater care to control for any potential biases that are observed during the inquiry.

On the part of the researcher, confirmation bias poses the greatest threat to not only to the study's trustworthiness but also to this study's ability to achieve its stated goal with respect to the research question. Confirmation bias is defined as "the search for and use of information to support an individual's ideas, beliefs or hypotheses" (Spencer & Heneghan, 2018, para. 1). During thematic analysis of the narratives collected for this study, researcher's must examine the results wholly and be prepared to accept answers that do not align with their expectations.

The qualitative method chosen for this research is further at risk of volunteer or self-selection bias. This bias occurs in any research wherein the participants who volunteer to take part in this research differ from the true population the research seeks to investigate

(Brassey et al., 2017; *Self-Selection Bias*, n.d.). In this circumstance, the greatest threat comes from the likelihood that those prepared to take the time to fill out a questionnaire on their experiences, needs, and concerns do so because they have had exceptional experiences which they feel compelled to address. This can in turn lead to results which skew toward particularly negative experiences or extremely high need dictated by very poor care, thus resulting in findings which do not realistically represent the population. Further, volunteers for such a study might be more educated on and invested in the subject than non-volunteers. To mitigate the effects of this bias, measures should be taken to minimize participant refusal. This can include offering incentives, however ensuring anonymity and confidentiality, drawing participants from multiple sources, and being clear and concise about the nature of the research also help lessen the effects of volunteer bias.

The discrimination that overweight and obese women face daily further puts this research at risk of hostile attribution bias. This bias occurs when ambiguous behavior is interpreted as hostility, and can result when individuals who have experienced discrimination or persecution are more likely to assume negative intentions from interactions (Nikolopoulou, 2024). This could lead to heavier women interpreting otherwise neutral interactions with midwives as hostile and describing them as such. Without a second study with a control group, observations of interactions between midwives and overweight or obese women, or a similar study to this one which includes women of all weights, it will be difficult to determine the veracity of the experiences these women describe. Further, this study strives to give heavier women agency by telling their own stories. It is thus important to offer these women trust when interpreting their experiences.

4.5 BMI as indicator of adiposity

This study plan proposes the WHO definitions of overweight and obesity as determined by body-mass index (BMI) as a biomarker of the population it seeks to examine. Despite this, the BMI is an imperfect tool and other methods, such as waist circumference (WC) have been suggested as better alternatives. For example, Jannsen et al. (2004) found that WC and not BMI was a more reliable factor to determine comorbidity. The Women and Equalities Committee of the UK House of Commons proposed in a 2021 report that a new tool of measurement was needed, citing weight stigma and the adverse effects it has on the health of individuals as a leading factor. The report also considers HCPs ill-equipped to assess heavier women as individuals, thus overly relying on BMI as a measure of health and risk (Women and Equalities Committee, 2021). Although these criticisms are valid, BMI has thus far been the main tool used to determine overweight and obesity and is the measure nearly all research to this point has used to assess risk and BMI remains the

dominant tool of measurement in the patient-provider dynamic. It is therefore still the best measure for this study. Future studies might consider options such as self-assessed body size (i.e. women who self-identify as “fat”), waist circumference, or waist-hip-ratio.

5 Conclusion

There is a growing population of overweight and obese women in Germany with increases across all age brackets, including among women of child-bearing age (Schienkiewitz et al., 2022). The consequence of this is an increase in overweight and obese women in the care of midwives. Despite this, midwives feel ill-equipped to offer individualized, evidence-based care to heavier women, potentially resulting in medical neglect by way of avoidance of uncomfortable topics and dismissal of health concerns. The root of this reluctance appears for many midwives to lie in a lack of communication skills that convey empathy and respect while also recognizing the possible health risks related to elevated weight. Instead of exclusively relying on the opinions and experiences of HCPs, midwives and their clientele stand to benefit tremendously from the inclusion of the voices of those effected moving forward. Research has highlighted the importance that nurturing trusting, empathetic relationships between midwives and women in their care has on the effectiveness of exercising shared decision making. This research also suggests that participation in the development of maternity services by way of “creating the time and space to listen to women” is essential to promote participatory health care (O’Brien et al., 2021, p. 2). This is why this study endeavors to ask, what do overweight and obese women desire and expect from midwives concerning sexual and reproductive health in the perinatal period, and what has been their experience with midwives in this regard? The goal of this research is to use the answers from such a study to improve upon the work midwives do while simultaneously empowering a population that has heretofore been discriminated against.

Women in maternity care hold a degree of trust for midwives based on their assumed competence (Lewis et al., 2017). It should thus be understood that this trust is predicated by the expectation that midwives uphold the best interest of women and their children through competent, evidence-based care and shape their practice around that. This includes taking the initiative to improve upon or change maternity care if it doesn’t align with the needs of the community it purports to support. Sexual and reproductive healthcare is an important element of midwifery practice, and the effects of weight stigma threaten midwives’ ability to offer adequate care to heavier women. Previous neglect to hear from overweight and obese women on their experiences and needs on this subject represents a significant oversight that must be rectified. Not providing equal care to overweight and obese women based around lack of education, fear, or personal prejudice is overt neglect and a health threat (Ewing, 2019).

Elevated BMI is shown to have adverse effects on sexual satisfaction, with obesity shown to have influence on factors such as desire, lubrication, and the ability to orgasm (Esposito et al., 2007; Polland et al., 2019). Excess weight is further related to comorbidities which can influence reproductive health and the ability to conceive. Women with elevated BMIs should feel secure in seeking education and aid from their midwives. Because the working relationship between midwives and their clientele results in a unique intimacy built on trust, personalized care, and empowerment (Perriman et al., 2018), midwives are in a unique position to foster an environment free of judgement and shame, while also offering evidence-based counseling about sexual and reproductive health. Midwives have the responsibility to be sensitive to overweight and obese women's individual needs and ensure that heavier women in their care feel confident that they will receive the care and education they require while also feeling comfortable enough to pose difficult questions.

This study seeks to empower overweight and obese women by giving them the opportunity to voice their needs and describe the encounters they have had or wish to have with midwives. To hear these accounts directly from those affected serves to help overweight and obese women reclaim their autonomy and agency in sexuality and reproductive health and well-being. The necessity for such a study is increased through the need for midwives to update their practice to be more inclusive and understanding of heavier women while also still offering them quality care that is based around their specific needs. This is essential to promote sexual satisfaction as defined within the scope of midwifery practice.

Overweight and obese women face discrimination in nearly all aspects of their everyday life. The stigma that heavier women experience from HCPs is perhaps one of the most egregious forms of this discrimination as it promotes inequalities in the access overweight and obese women are offered and receive to obtain individualized, holistic healthcare. Further, women with elevated BMI have long been subjected to a medical system which dictates their needs *to* them instead of informing practice and recommendations by listening and holding room for conversations *with* them. Midwifery practice values practicing respectful communication and supporting women and other child-bearing people to make decisions about their care. The first steps to upholding these values requires listening to women describe their needs and shaping practice around those needs. Research which further examines the complexities of midwifery care of overweight and obese women are recommend for future studies.

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Appendix

Original German language text of questions from the Needs and Concerns questionnaire.

1. Hatten Sie oder haben Sie den Wunsch danach jemals mit einer Ärzt:in/Hebamme/weiteren Behandler:innen über eines der folgenden Themen zu sprechen?

- Sexuelle Probleme in der Partnerschaft
- Sexuelle Probleme im Zusammenhang mit Körpergewicht
- Sexuelle Praktiken
- Empfängnisverhütung
- (unerfüllter) Kinderwunsch
- Körpergewicht und Gesundheit bei Kinderwunsch, in der Schwangerschaft, im Wochenbett und in der Stillzeit
- Umgang und Aufklärung zum Thema Stillen (für Frauen in oder nach der Schwangerschaft)
- andere Probleme in der Partnerschaft
- keines der genannten Themen

Welche Wünsche hätten Sie an ein solches Gespräch?

2. Welche anderen Themen rund um Sexualität würden Sie gerne mit einer Ärzt:in/Hebamme oder Psycholog:in besprechen oder abklären? Welche Beratungs- und/oder Behandlungsangebote zur sexuellen und reproduktiven Gesundheit wünschen Sie sich?

3. Gibt es Sorgen oder andere Gründe, die Sie bisher davon abgehalten haben, Beratung oder Hilfe zu Ihrer Sexualität oder reproduktiven Gesundheit in Anspruch zu nehmen?

Eidesstattliche Erklärung

Hiermit versichere ich, Stephanie Christiano, [redacted] dass ich die vorliegende Bachelorarbeit mit dem Titel

Exploring Overweight and Obese Women's Desires and Expectations from Midwives Concerning Sexual and Reproductive Health: A Research Plan

selbstständig und ohne fremde Hilfe, insbesondere ohne entgeltliche Hilfe von Vermittlungs- und Beratungsdiensten sowie ohne die Anwendung von KI-Sprachmodellen wie z.B. ChatGPT, angefertigt und keine anderen als die von mir angegebenen Quellen und Hilfsmittel benutzt habe. Alle wörtlichen oder sinngemäßen Entlehnungen aus anderen Arbeiten sind an den betreffenden Stellen als solche kenntlich gemacht und im entsprechenden Verzeichnis aufgeführt, das gilt insbesondere auch für alle Informationen aus Internetquellen. Ich erkläre zudem, dass ich die an der Medizinischen Fakultät Hamburg geltende „Satzung zur Sicherung guter wissenschaftlicher Praxis und zur Vermeidung wissenschaftlichen Fehlverhaltens an der Universität Hamburg" in der jeweils gültigen Fassung eingehalten habe.

Des Weiteren versichere ich, dass ich die vorliegende Bachelorarbeit vorher nicht in dieser oder ähnlicher Form in einem anderen Prüfungsverfahren dieser oder einer anderen Fakultät bzw. Hochschule eingereicht habe.

Ich erkläre mich einverstanden, dass meine Bachelorarbeit zum Zweck der Plagiatsprüfung gespeichert und von meiner/-m Erst- und Zweitprüfenden mit einer gängigen Software zur Erkennung von Plagiaten überprüft werden kann.

Ich erkläre mich einverstanden, dass oben genannte Bachelorarbeit oder Teile davon von der Medizinischen Fakultät der Universität Hamburg oder von der HAW Hamburg veröffentlicht werden.

12.12.24 [redacted]

Datum, Unterschrift