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Weight Stigma in Gynecological Care Among Cisgender Women

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ABSTRACT

Objective: Healthcare is one of the primary contexts in which people experience weight stigma (social devaluation due to body weight), especially in gynecological care, where people's bodies are exposed. Thus, people may feel especially vulnerable to negative evaluations from healthcare providers due to their weight, given the physical exposure which accompanies a breast exam, abdominal palpitations, and a pap-smear or cervical exam. The existing literature examining weight stigma in obstetrics and gynecology has focused almost exclusively on pregnant or postpartum women. The only research on weight stigma during routine gynecological care is based on qualitative studies with small samples.

Methods: Participants ($N = 1087$; cisgender women) were sampled on Qualtrics, and quotas were set to reflect the most recent US census. The women reported their experiences with gynecological care and then were asked to qualitatively describe what they most recently encountered.

Results: Overall, 14% of the women in this sample had experienced weight stigma in reproductive or gynecological care at least once, and about 5% of this sample reported that this occurred frequently. Participants with higher body weights (≥ 30 kg/m^2) were more likely to report frequent weight stigma in gynecological care. A few participants reported more serious experiences, such as misdiagnosis, environmental or systemic weight stigma, and provider reluctance to perform a pelvic exam.

Conclusions: Women experience weight stigma in routine gynecological care, and future research should continue investigating the effects of these experiences.

1 | Introduction

Much effort in public health has gone toward widely increasing gynecological screenings; the subsequent increases in screening have improved uterine, cervical, and ovarian cancer outcomes [1]. However, disparities in these outcomes exist and have linked discrimination (e.g., racism) to increased incidence of breast cancer and decreased cancer screening for breast, cervical, and ovarian cancer [2]. Less work has investigated weight stigma (devaluation and poor treatment due to weight) in gynecological care, even though it may be especially relevant due to gynecological care's inherently exposing and potentially humiliating nature, especially for those with high body weight [3]. Routine gynecological care for a healthy adult includes a conversation about medical history including weight and sexual activity, a breast exam, abdominal palpitations (these typically occur as part of the pelvic exam), and a pap-smear or cervical exam. While patients usually wear a hospital gown, a significant portion of one's body is exposed [4]. Research has shown that more than half of women are nervous before gynecological

exams, and just over 40% report being embarrassed about having to take off their clothing [5]. Thus, weight stigma in gynecological care may be an important deterrent to preventive healthcare including vital screenings for cancer among those with high body weight.

Much of the research on patient experiences of weight stigma in gynecological and reproductive care has focused specifically on pregnant and post-partum people and primarily on reproductive care [6–8]. Indeed, obstetricians are cited as one of the most common sources of weight stigma among pregnant or postpartum women; about 33% of pregnant or postpartum women who have experienced weight stigma in healthcare reported that they've experienced weight stigma from their obstetrician [8]. Patients also report that their obstetricians and gynecologists make assumptions about their reproductive and sexual health because of their weight, including perceived extreme risk of complications in pregnancy, even for otherwise uneventful, healthy pregnancies resulting in a healthy child [3, 8, 9]. Additionally, among pregnant women, weight stigma contributes to overall (not OBGYN-specific) healthcare avoidance [10]. However, less work has regarded weight stigma in routine gynecological care. Routine gynecological care is vital because it includes screenings for breast cancer and ovarian cancer as well as other gynecological cancers [4]. Additionally, these appointments help women plan for pregnancy, discuss and implement birth control, and protect themselves from sexually transmitted diseases [4].

Qualitative work suggests that cisgender women with higher BMIs (body mass index in kg/m^2) are likely to delay pap screenings [11]. In fact, 52% of these participants cited their weight as a substantial barrier to their gynecological healthcare [11]. Early research on the topic suggested that women with higher body weights have more issues with cervical cancer because gynecologists more often forego pap screening on women with higher weights than on other women [12]. Women report noticing that gynecologists are hesitant to perform pelvic exams because of their weight [3]. This mixed-methods study aims to use a census-matched sample and mixed-methods approach to explore: (1) the frequency at which women are experiencing different forms of weight stigma in routine gynecological care, and (2) qualitatively what is happening when this occurs.

2 | Methods

Inclusion criteria for this study were: (1) being a cisgender woman, (2) being over the age of 18 years old, and (3) currently residing in the United States. 1114 Participants were recruited using Qualtrics paneling in 2022, based on budgetary restraints, and quotas were set for a sample reflecting the US census (For sample quotas see Supplementary Material). Of those originally recruited, 27 participants were then excluded for missing an item necessary for these analyses. BMI was close to the average BMI in the United States, at slightly overweight, M = 28.1, SD = 7.6 [13]. For other demographic information, see Table 1. The IRB at Kent State University approved this study (Protocol #85).

TABLE 1 | Demographic Information across samples.

	Full sample (N = 1087)		Qualitative sample (N = 69)	
	M	***SD***	***M***	***SD***
Age	46.68	16.84	41.87	15.58
BMI	28.12	7.60	30.62	9.36
	N	***%***	***N***	***%***
Race/Ethnicity				
Asian	63	5.8	2	2.9
Black	164	15.1	11	15.9
Hispanic/Latino	177	16.3	10	14.5
White	617	56.8	43	62.3
Multiracial or not listed	66	6.1	3	4.3
Income				
< 29,999	244	22.4	16	23.1
30 k–59,999	257	23.7	20	28.9
60 k–99,999	261	24.0	14	20.2
100 k–149,999	228	21.0	11	15.9
> 150,000	97	8.9	8	11.6
Education				
High school or less	231	23.5	16	23.1
Some college	280	25.8	18	26.1
Associate's degree	151	13.9	10	14.5
Bachelor's degree	276	25.4	12	17.4
Master's degree	120	11.0	11	15.9
Doctoral or professional degree	29	2.7	2	2.9
BMI category				
< 18.5	42	3.9	7	10.1
18.5–24.9	399	36.7	14	20.3
25–29.9	290	26.7	16	23.2
> 30	356	32.8	32	46.4

Abbreviation: BMI = body mass index in kg/m^2.

2.1 | Measures

Measures, quantitative data, and syntax can be found on OSF (https://osf.io/e4xwj/). Participants were asked about weight stigma in gynecological care, based on previous work on the topic [3, 6, 9, 11, 14]. Participants were first asked, "How often have you felt discriminated against because of your weight while receiving reproductive care such as an annual pap smear or care related to prescription birth control?" In another portion of the survey, participants had been provided examples of weight stigma/discrimination in health care. Then, participants were asked, "If this has happened, please explain what happened" on the same page with an open-ended response box for participants to freely respond.

Then, they were asked if their healthcare provider (due to their weight): (1) "discouraged you from considering parenthood or pregnancy," (2) "made assumptions about your reproductive

health or sexual activity," and (3) "were reluctant to perform a pelvic exam." Items were rated from (1) *This happens nearly every time I seek out this kind of care* to (5) *This has never happened to me.* Then, items were reverse coded so that higher values are associated with greater frequency of stigmatizing experiences, $\alpha = 0.86$.

2.2 | Data Analysis

Data were analyzed using IBM SPSS version 29.0. Reported results are descriptive in nature (frequencies, mean, SD). Frequencies were analyzed from the quantitative data collected from the full sample to assess frequency from all participants. Additionally, frequencies by BMI category were calculated. Qualitative responses were collected only from those who reported weight stigma in gynecological care, and frequencies of such instances were analyzed. Qualitative responses that were irrelevant to the question were removed before further analysis (e.g., keyboard smash). Thematic analysis was used to identify themes within the data [15]. The second author and a research assistant read through the responses and created themes. Two raters coded all responses accordingly. Inter-rater reliability on responses were determined using Cohen's weighted kappa (denoted κ; [16]). Themes with $\kappa < 0.4$ were evaluated and discussed by the authors and all were determined to be too ambiguous for reporting (e.g., whether 'overt' stigma had occurred). Most themes showed substantial agreement (75% $\kappa \geq 0.61$) but values ranged from 0.41 to 1.00. Members of the research team discussed disagreements and decided on unanimous coding.

3 | Results

Fourteen percent of respondents ($N = 153$) had experienced at least some weight discrimination in gynecological care (for frequencies, see Table 2). Eighteen percent ($N = 64$) of those with BMI > 30 kg/m^2 reported at least one instance of weight stigma in gynecological care. However, a greater number of participants with BMI ≥ 30 kg/m^2 versus the overall sample (8.4% vs. 4.8%) reported that weight stigma in gynecological care happens "a lot" or "nearly every time." Eleven percent of women reported that their healthcare provider made assumptions about their reproductive health or sexual activity because of their weight ($N = 120$), and 3.5% experienced this often. Similar numbers of participants with BMI ≥ 30 kg/m^2 reported this form of weight stigma (11.8%).

About 12.6% ($N = 137$) of all participants reported being discouraged from considering parenthood or pregnancy by a healthcare provider because of their weight, and 3.1% experienced this often. Similarly, 12.6% of those with BMI ≥ 30 kg/m^2 reported this happening at least once. Fewer participants (7.6%; $N = 83$) reported that their healthcare provider seemed reluctant to perform a pelvic exam due to their weight. Three percent of participants reported this as frequent. Similar to the overall sample, about 7.6% of those with BMI ≥ 30 kg/m^2 reported that their provider seemed reluctant to perform a pelvic exam. For information about demographic predictors of weight stigma in gynecological care, see Supporting Information S1: Table S1.

TABLE 2 | Frequencies of stigmatizing experiences in reproductive care.

	N	%
Weight discrimination in reproductive care		
Never	934	85.9
Once	44	4.0
A few times	57	5.2
A lot	28	2.6
Nearly every time	24	2.2
Being discouraged from pregnancy		
Never	950	87.4
Once	60	5.5
A few times	43	4.0
A lot	23	2.1
Nearly every time	11	1.0
Assumptions about sexual activity		
Never	967	89.0
Once	45	4.1
A few times	37	3.4
A lot	24	2.2
Nearly every time	14	1.3
Reluctant to perform pelvic exam		
Never	1004	92.4
Once	23	2.1
A few times	28	2.6
A lot	19	1.7
Nearly every time	13	1.2

Of the 153 participants who had experienced weight stigma in gynecological care, 69 of them responded to the open-ended question with a relevant response about the stigmatization in reproductive care. When asked to describe their experiences with weight discrimination in reproductive care, 13.0% ($N = 9$) reported some form of environmental or systemic stigma, such as an improperly fitting speculum or being unable to receive treatment because of their weight. Ten percent ($N = 7$) of participants reported feeling unheard during their appointment because of their weight:

> They just wave off an issue I'm having by saying its only my weight causing the issue.

About 14.5% ($N = 10$) reported experiencing body shame in the context of reproductive healthcare, whether from experienced stigma or self-consciousness:

> Well, they are just mean to me and tell me I'm [obese] and it makes me feel low about myself. I'm trying hard to lose a few pounds.

Few participants (5.8%, $N = 4$) described being stigmatized or feeling ashamed due to being underweight during their appointment. A few participants reported low frequency but serious weight discrimination. Three participants reported being discouraged from pregnancy or parenthood by obstetricians.

> I was married [in my early 30s] and wanted to start a family right away. I went to [the obstetrician] and he told me I would have a problem because of my weight and age. I would be high risk. He did a test on my tubes and prescribed a low dose fertility pill. I got pregnant in one month and had a beautiful baby via C-section.

Two participants reported receiving a misdiagnosis due to their weight. Two participants also reported getting less time with their provider because of their weight, including an insufficient exam.

4 | Discussion

This study aimed to quantify the frequency at which weight stigmatizing experiences occur for cisgender women when they seek gynecological healthcare. Overall, weight stigma was commonly reported in the context of gynecological care, with 14% of participants reporting it had happened at least once. Additionally, qualitative responses echoed previous research; participants reported environmental and systemic weight stigma, misdiagnosis, assumptions about health, recommendations to lose weight regardless of the purpose of the appointment, and increased body shame when seeking gynecological and reproductive care, especially due to poor treatment by staff. Like those in previous research [3, 8], participants in this study reported having the risk of their weight emphasized when discussing pregnancy with their healthcare provider, despite having no complications throughout pregnancy. Future research should compare healthcare providers' perceptions of risk of weight compared to the actual risk of higher body weights in an array of contexts, including pregnancy.

It is notable that in this sample there were no substantial differences between those with higher body weights and lower body weights in frequency of different events. This may be due to healthcare avoidance (and thus, protection from stigmatizing experiences). However, more research is necessary to draw conclusions about these findings. It may be that, specifically in gynecological care, there is less of an association with actual BMI. Overall, each instance was infrequently reported (less than 15% of the sample reporting it had happened at least once). Thus, small differences between BMI categories may also be due to the distribution of responses and infrequency of events across the sample.

This study is strong in its large, census-matched sample of women and mixed-method approach, since it is appropriately powered and tailored to explore frequencies of experienced weight stigma in gynecological health care among this population. One limitation of this study is that only cisgender women were included. However, people of other gender identities are also vulnerable to weight stigma in gynecological and reproductive healthcare, so research on weight stigma in gynecological care should be extended to those with other gender identities. Additionally, a limitation of the qualitative portion of this study was that attrition was high (55%) from the quantitative screener to the qualitative response. Because of this, the qualitative data is unlikely to have captured all relevant experiences of the women in the overall sample who reported weight stigma in reproductive or gynecological care.

Because cervical cancer screening is incredibly important for early detection, lower cancer incidence, and lower mortality [1], further research should seek to understand the role of weight stigma on these outcomes through decreased screening. Research has already established racial discrimination as a reason for disparities in ovarian, uterine, and cervical cancer outcomes [17], so the same may occur for weight stigma, since weight stigma may be a contributing factor to cancer outcomes that are currently attributed to weight itself. Additionally, implications for access and adherence to birth control as well as STD risk should be investigated in relation to avoidance of gynecological care by those with higher body weights due to concerns about stigma.

Overall, it is important to continue to investigate how routine gynecological care may be an environment in which people experience increased body salience and body shame, which may leave them especially vulnerable to experiences of weight stigma. Beyond pregnancy and post-partum, women's experiences of weight stigma when receiving gynecological care, especially exams, should be a priority in research, where these everyday experiences have been largely under-studied.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

This study was not pre-registered. Quantitative data, materials, and code can be found on OSF (https://osf.io/e4xwj/).

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.