

Description

We Aren't Over The Rainbow Yet: A Research Review Examining LGBTQ+ Families' Experiences In Perinatal Care Services

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Summary

Increasing numbers of LGBTQ+ people in the UK are choosing to become biological parents,[1] but reproductive and perinatal services are based within a cisheteronormative framework.[2,3] In this article, Mari Greenfield explores the small amount of research conducted with LGBTQ+ parents which shows that cisheteronormative policies and practices negatively impact the experiences of LGBTQ+ people at every stage of their journey to parenthood, from conception, through pregnancy and birth, and into the postnatal period.

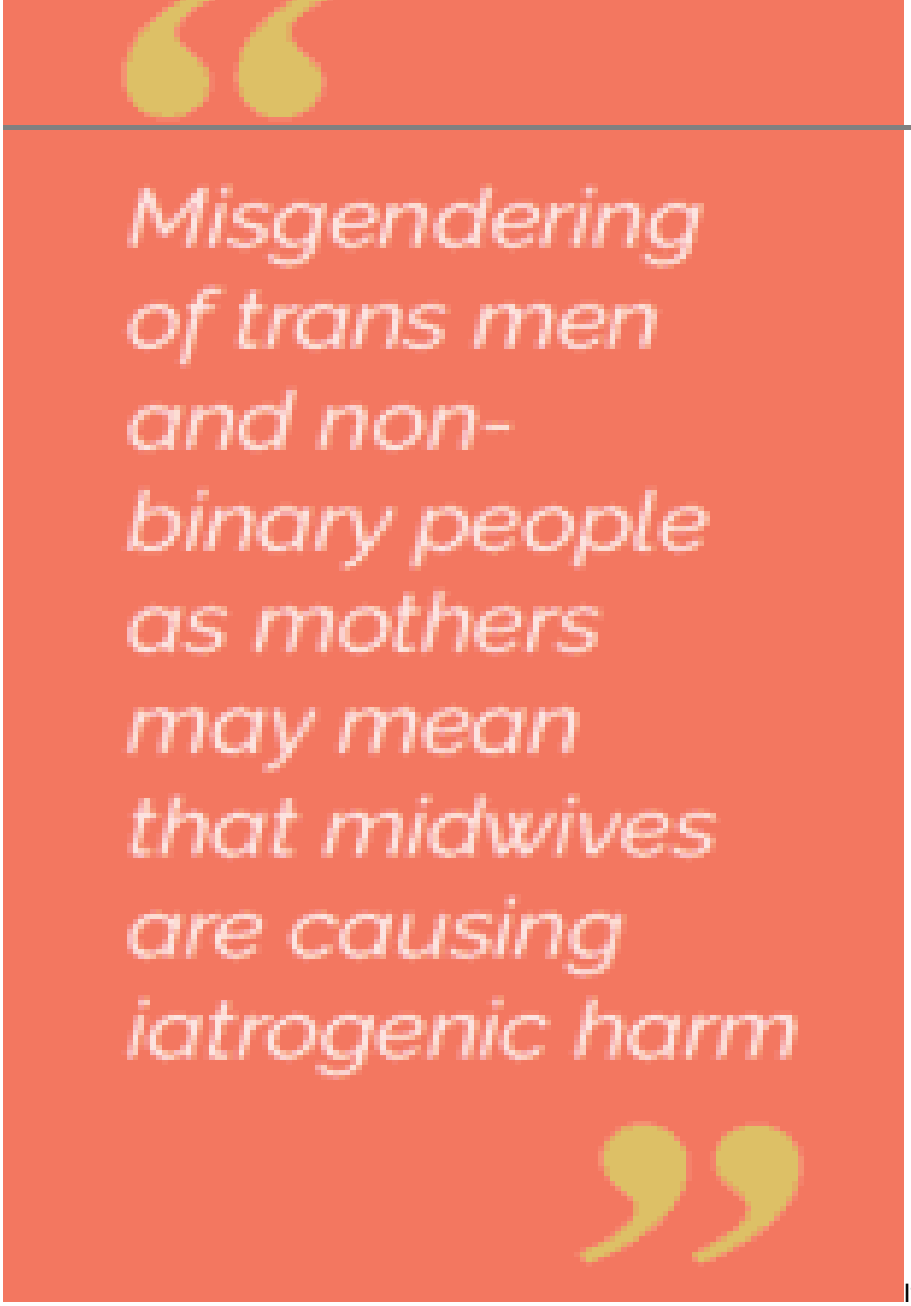
Problem or exploitation

We do not know what proportion of LGBTQ+ people choose to conceive at home, either with a partner or a known donor, but we do know that many choose to use a fertility clinic. The majority of those who do so are women in a same-sex relationship, but gay men working with surrogates are an increasing population too.[1]

The majority of LGBTQ+ people who use fertility clinics do not actually have a fertility problem – instead they have a lack of access to gametes – but the majority of fertility clinic clients are heterosexual couples who have fertility problems.[4] This means that the services offered to LGBTQ+ people at fertility clinics may not always be appropriate. Some researchers have raised concerns that women in same-sex relationships may be exploited by fertility clinics, as they have a valuable commodity – fertile human eggs.[4]

Antenatal care

However they conceive, once pregnant, LGBTQ+ families face the cisheterosexism of perinatal services. This begins at the booking appointment, where the mother's and father's details are sought. Within the father's details, some questions are asked about potential genetic issues, and some about the social situation in which the child will be raised. Some NHS Trusts now ask for the mother and her partner's details, but this can result in inappropriate genetic questions being asked of a female partner who is not related to the child.[5]



It also misses out the non-biological father where gay male couples have conceived with a surrogate, and additional people who may be involved in child-raising in polyamorous families. For same-sex female couples where the gestational parent has conceived using the eggs of the non-gestational parent, the question of whose details should be recorded as ‘mother’ may also be complex. The misgendering of trans men and non-binary people as mothers may mean that midwives are causing iatrogenic harm to those they are supposed to be caring for.

These forms reflect the cisheteronormative basis of most perinatal policies and services, and in examining them we can see how over-simplified sex-based language can harm a range of LGBTQ+ parents. Assuming there is one (and only one) mother who will be pregnant, makes non-gestational mothers invisible, harms pregnant trans men and non-binary people, and gives surrogates responsibilities neither they nor the intended parents want. LGBTQ+ families literally do not fit into the boxes allowed by perinatal services.

Intrapartum care

The care received during the intrapartum period has been shown to have a significant effect on the birthing person and anyone else present, including partners, doulas and midwives. Poor care can cause birth trauma.[6] The negative
sorder and other clinically diagnosable
nd the breakdown of marital/partner

ficant number report receiving poor care
intrapartum care reported by LGBTQ+
uring labour, deliberately rough vaginal
g to offer help with breastfeeding.[2,7]



Recent evidence from my own research shows that LGB+ women were much more likely to consider freebirth[8] in response to the pandemic (making up 14% of those who considered freebirth compared to 4% of the total sample). Further data from the same survey (to be published imminently) shows that LGB+ women reported higher levels of postnatal anxiety.

There were not enough non-binary people and trans men in this research to provide comparative figures, but other research shows similar trends, with non-binary people and trans men being likely to choose to freebirth (30% of the sample freebirthed)[9] and also experiencing poorer perinatal mental health.[10]

It is important to say that choosing to freebirth can be a positive and empowering option, and it is essential that birthing people retain the right to make that choice; however, when the choice is made because care may not be respectful, appropriate, or safe, then these levels of freebirth are concerning.

Mental health

If LGBTQ+ people are experiencing greater levels of perinatal mental health difficulties, perinatal mental health services must meet their needs. Yet the current cisheteronormative focus on 'maternal' and 'paternal' mental health services means that some LGBTQ+ people are not provided with an appropriate service.[11]

In particular, it makes access difficult for non-gestational mothers, and it ignores the diverse ways in which LGBTQ+ families may be formed – for example where the roles of gestational and non-gestational parent may be different in



eady experienced birth as a non-gestational
:her mother.[11]

The lack of recognition of diversity in family form extends to other areas as well. Infant breast/ chestfeeding is assumed to be a dyadic relationship between a gestational parent and a baby(s). In LGBTQ+ families, there may be other options, and families may – for a variety of health, practical and choice-based reasons – decide that the non- gestational parent is going to be an additional or sole breast/ chestfeeder.[12]

For parents in the UK, there is no NHS support available in this situation, as the non-gestational parent is not an obstetric patient, nor do they fall under the scope of midwifery practice. As I have reported elsewhere, this has led to non-gestational mothers being denied the right to feed their baby whilst the baby is in hospital, and some have been told by midwives that they are not mothers, but instead are considered milk donors.[13]

Podcast

For more information about the issues raised in this article, listen to Pride in Birth – Mari's podcast all about LGBTQ+ birth research.

Conclusion

We have come a long way in recognising that LGBTQ+ people exist within perinatal services – both as clients and parents-to-be, and as midwives, doulas, researchers, health visitors and obstetricians, but there are still barriers which prevent LGBTQ+ expectant parents from receiving appropriate and safe care. Whilst individual midwives providing more culturally competent care will help, it will not remove the systemic barriers that services based on a cisheteronormative model of a family has created. Rather, we have to dismantle simplistic notions that family consists of a mother, a father and a baby and embrace diversity of family forms if we want to reach the place over the rainbow where LGBTQ+ people can receive equitable perinatal care. **TSM**

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