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Taking up the challenge of trans and non-binary inclusion in midwifery education: Reflections from educators in Aotearoa and Ontario Canada

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ABSTRACT

Perinatal services are being challenged to acknowledge that not all pregnant and birthing people are women and to ensure the design and delivery of services that are inclusive of, and deliver equitable outcomes for, trans, non-binary, and other gender diverse people. This is posing unique challenges for midwifery with its women-centred philosophy and professional frameworks. This paper presents the critical reflections of midwifery educators located in two midwifery programmes in Aotearoa[1] and Ontario Canada, who are engaged in taking up the challenge of trans and non-binary inclusion in their local contexts. The need to progress trans and non-binary inclusion in midwifery education to secure the human rights of gender diverse people to safe midwifery care and equitable perinatal outcomes is affirmed. We respond to an existing lack of research or guidance on how to progress trans and non-binary inclusion in midwifery education. We offer our insights and reflections organised as four themes located within the frameworks of cultural humility and safety. These themes address midwifery leadership for inclusion, inclusive language, a broader holistic approach, and the importance of positioning this work intersectionally. We conclude by affirming the critical role of midwifery education/educators in taking up the challenge of trans and non-binary inclusion to ensure a future midwifery workforce skilled and supported in the provision of care to the growing gender diverse population.

"Systems do not maintain themselves; even our lack of intervention is an act of maintenance. Every structure in every society is upheld by the active and passive assistance of other human beings" (Taylor, 2021, p. 82).

Introduction

The challenge of transgender (trans) and non-binary inclusion in sexual and reproductive health care is gaining momentum globally with important implications for midwifery knowledge, practice and education (e.g. Derosa, 2021; MacLean, 2021). Trans and non-binary inclusion requires expansion in the design and delivery of gynaecology, fertility and perinatal services, recognising that not all users of these services are cisgender women (Hoffkling et al., 2017; MacLean, 2021). Trans and non-binary inclusion are premised on the human rights of all people to safe, inclusive and quality sexual and reproductive health care (World Professional Association for Transgender Health [WPATH], 2012). This inclusion is part of broader movements in nursing and midwifery towards culturally safe and humble care that have become foundations to practice and education in the past three decades (Aboriginal Nurses Association of Canada et al., 2009; Te Tatau o te Whare Kahu: Midwifery Council, 2021b). The frameworks of cultural safety and cultural humility were developed by indigenous and other health scholars of colour to address racial, colonial and other structural injustices in healthcare (DeSouza, 2008; Fisher-Borne et al., 2015; Ramsden, 2002; Tervalon and Murray-García, 1998). These frameworks place emphasis on diversity

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[1] Aotearoa is the Māori language name for New Zealand. In recognition of Aotearoa as the Indigenous land of tangata Māori (the Māori people) the title Aotearoa will be used throughout the article.

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amongst health service users, and the vital dynamics at play between socio-political structures that produce health inequity, and the relationships between carer and cared for within health care. The health care worker is positioned as an agent of social change, tasked with the ongoing process of reflection on, and unlearning of systems of privilege and power in health care interactions (DeSouza, 2008).

In this paper we explore the role of midwifery educators in progressing trans and non-binary inclusion as part of our broader commitment to social justice and equity in midwifery. We begin by exploring why trans and non-binary inclusion in midwifery education is an important contemporary challenge for addressing health inequities and human rights for trans and non-binary people. We then explore some of the barriers that may exist as midwifery is challenged to grapple with gender essentialism and open up spaces for gender diversity. As midwifery educators who are engaged with the process of trans and non-binary inclusion in our programmes we offer our insights and reflections for how we are continuing to meet this challenge. We conclude by affirming that this process of inclusion can, and must, be incorporated into midwifery education to ensure a future midwifery workforce skilled and supported in the provision of care to the growing gender diverse population.

Who we are and our process of holistic reflection

We are a diverse collective of midwifery educators and supportive scholars, both gender diverse and cisgender, Indigenous, Black and people of colour (IBPOC) and white, located primarily in two midwifery education programmes in Aotearoa and Ontario, Canada. This paper was developed from a series of critical reflective conversations between our two midwifery programmes along with supportive scholars in Te Herenga Waka **I ,** Victoria University of Wellington. Aotearoa and Ontario Canada hold similar models of midwifery care with foundations in midwifery autonomy, continuity of care and "women-centred" partnership. However, there are also key differences, particularly with the process of reconnecting modern midwifery to each country's respective Indigenous foundations and birthing practices, and our progress to embed frameworks of cultural safety and humility into care (Association of Ontario Midwives (2015); Association of Ontario Midwives, 2021; New Zealand College of Midwives, 2015). In Aotearoa our process of decolonisation in midwifery is underpinned by Te Tiriti o Waitangi (https://www.archives.govt.nz/discover-our-stories/the-treaty-of-waitangi). Te Tiriti (the treaty) is considered the founding document of Aotearoa and was an agreement between the British crown as colonisers and Māori, the Indigenous people of Aotearoa. Midwifery's journey to take up the challenge of trans and non-binary inclusion in Aotearoa is in its infancy and is much further progressed in Canada. Governing bodies and professional associations in Canada have made headway with acknowledging the needs and dignity of gender diverse people in consensus statements and this is reflected in midwifery education programmes (Association of Ontario Midwives (2015); College of Midwives Ontario, 2021; Canadian Association of Midwifery, 2015).

The Midwifery Education Program at Toronto Metropolitan University (TMU) is a 4-year programme leading to a Bachelor of Health Sciences in Midwifery, part of the Ontario Midwifery Education Consortium with McMaster University. The Te Kura Matatini ki Otago **I** Otago Polytechnic (OP) School of Midwifery provides a four-year undergraduate midwifery programme (delivered over three calendar years) leading to a Bachelor of Midwifery. OP also runs a postgraduate programme to Masters of Midwifery level. Midwifery educators across both programmes are acknowledging the need to adapt our programmes for the inclusion of gender diverse people but there is limited guidance for how this can be achieved.

Our critical reflective conversations were underpinned by Bass et al.'s (2017) model of holistic reflection for midwifery. The approach combines reflective techniques and critical theory with the goal of transforming oppressive structures and beliefs so that we may become the midwives we aspire to be. Midwives' engaging in the process of holistic reflection make connections between their own personal values and beliefs, and the social and political conditions of the wider health system that shape and position their practice. With its orientation to the relationship between self-awareness and social/system change, Bass et al's (2017) model is ideally suited to those midwives engaging in cultural safety/humility processes.The holistic reflective process moves those involved along a continuum of six phases starting with the process of coming into deep awareness of experience (phase 1: self-awareness; phase 2: description). The reflecting midwife/midwives then move to the exploration of experience through various critical lens and knowledge paradigms and undertake a critical analysis of how these external influences shaped experience (phase 3: reflecting; phase 4: knowing). In the final phases (phase 5: evaluation; phase 6: learning) the reflecting midwife/midwives arrive at transformative learnings whereby the context and facilitators of change can be articulated.

Participating educators were in contact prior to engaging in a formal reflective process about their activities to progress trans and non-binary inclusion in their respective programmes. It was through this contact and informal shared support that the idea for this manuscript was conceived. A process for engaging in a series of critical reflective conversations was negotiated between the educators from the two programmes with support from GP and EN. In the process we collaboratively identified the critical theoretical tools we would use to guide our reflection (Chadwick, 2018), how the conversations would be conducted, and how the insights from the reflective process would be captured and agreed on. Conversations were held over Zoom and facilitated by the lead author (GP) and a project facilitator (LK), who took detailed written notes. Conversations were recorded for later reflection but not transcribed. For ease of managing time-zones and capacity, conversations were held with educators from each programme separately. The common reflective insights across each conversation were mapped by GP, LK and SM and all educators were then given the opportunity to give their feedback with their further reflections and examples being incorporated. The lead author subsequently wrote up the reflective insights and again sought the educators' feedback and agreement with further revisions made.

The need for trans and non-binary inclusive midwifery care

Social norms surrounding gender identity and family building are changing. This is partly due to growing awareness of rights to fertility preservation and family building amongst trans and non-binary people and the continuing education of health professionals on issues related to trans health (Pezaro, 2019). Access to fertility preservation is now an accepted part of comprehensive gender affirmative healthcare pathways (WPATH, 2012). Consequently, trans and non-binary people are increasingly seeking to build families through the birth of children biologically related to them and are accessing fertility and perinatal services in greater numbers (e.g. Veale et al., 2019). Coupled with a trans health movement making gains in securing health care rights and services for trans and other gender diverse people (WPATH, 2012) the challenge is set for midwifery to meet both the clinical and cultural needs of this population.

Trans and non-binary people experience significant health disparities compared to the general population including higher rates

of mental distress; chronic illness; substance abuse; sexually transmitted infections; interpersonal violence; and income and housing insecurity (Reisner et al., 2016; Su et al., 2016; Veale et al., 2019). These health disparities result from the stress effects of daily lived experiences that are discriminatory and stigmatising for gender diverse people (e.g., Veale et al., 2019). An intersectional lens highlights how inequities experienced by gender diverse people are not shared equally but rather are compounded for gender diverse people who are also IBPOC and marginalised along other axes of difference (Farvid et al., 2021). For example, in Aotearoa, Māori people who are gender diverse are overrepresented in deaths by suicide (Tan et al., 2020). In the perinatal period existing health disparities can be compounded by the gendered norms and biases that surround reproduction and parenting, increasing vulnerability to perinatal distress, fear of childbirth, lack of trust in and engagement with services, unmet breast/chest feeding intentions, and adverse perinatal care outcomes (García-Acosta et al., 2019; Hoffkling et al., 2017; MacDonald et al., 2016; Malmquist et al., 2019; Singer et al., 2019).

The quality and safety of perinatal care provided to trans and non-binary people is pivotal in either exacerbating or alleviating health disparities (Veale et al., 2019). Existing research shows that perinatal care is currently insufficient for meeting the needs of trans and non-binary people (e.g. Roosevelt et al., 2021). Studies have identified transphobic and discriminatory behaviours by perinatal care providers (Hoffkling et al., 2017; Malmquist et al., 2019). This includes a general sense of being unwelcome; inappropriate and insensitive questions; intentional misgendering; and overt expressions of discomfort and dislike from perinatal care providers (Hoffkling et al., 2017; Malmquist et al., 2019). Alongside these overt expressions of transphobia, trans and non-binary people also navigate the everyday gendered assumptions and norms in perinatal care that erase their existence and have accumulative negative effects on their wellbeing (Hoffkling et al., 2017; Malmquist et al., 2019). This includes language use that erases gender diversity; physical spaces and design of labour units and wards that assume all users are cisgender women; data and information systems not designed to capture diverse gender identities; lack of involvement of trans and non-binary people in the design and evaluation of perinatal services; and a perinatal workforce that has limited opportunities for education in gender affirmative care (e.g. Ellis et al., 2015; Hoffkling et al., 2017).

Challenging gender essentialism in midwifery

Midwifery is reckoning with the ways in which trans and non-binary inclusion challenges our norms and assumptions about gender. Pregnancy and childbirth are profoundly gendered events in our society and are part of the dominant construct of womanhood (e.g. Graham and Rich, 2014). Midwifery is also a gendered profession (Te Tatau o te Whare Kahu: Midwifery Council, 2021a). The recovery of midwifery as an autonomous profession and the reassertion of birth as a normal life event were part of the women's liberation movement from the 1960s (e.g., Donley, 1986). Indeed, feminist activism and scholarship focused on women's rights to sexual and reproductive autonomy has underpinned midwifery's work to reclaim childbirth from medical control. It is therefore no surprise that midwifery has come to articulate itself and the work it does in gendered ways. Midwifery's relationship with women is a fundamental tenet of the profession's philosophy and professional frameworks (International Confederation of Midwives [ICM], 2017b). Yet midwifery philosophy is also committed to providing care that is flexible, creative, empowering and supportive (e.g. New Zealand College of Midwives [NZCOM], 2020), and to progressing the rights of lesbian, gay, bisexual, transgender, intersex[2] (LGBTI) people (ICM, 2017a).

Within midwifery, gender is commonly conceptualised in ways that conflate sex characteristics (e.g., having sex characteristics marked as female such as ovaries and a uterus) with the gender role, identity, or expression of "woman". In other words, it has been assumed that, because a person can be pregnant and give birth, they *are* a woman. While this alignment will be true for the majority of people in our care, it cannot be assumed. The sex/gender distinction helps us to understand that pregnant or birthing people may have a gender role, identity, and/or expression that does not align with their assigned sex or gender at birth and/or their body's capacity for pregnancy and birth. The conflation of sex and gender and the assumption that gender roles, identity and expression are universal, and are biologically determined by our sex can be understood as gender essentialist thinking (Pergadia, 2018). Gender essentialism doesn't account for people who are born with variations in sex characteristics, nor does it acknowledge genders that differ from the sex a person was assigned at birth (Skewes et al., 2018). Within midwifery, gender essentialism underpins the invisibility and denial of the fact that gender diverse people can and do carry and birth their babies. Gender essentialism also creates set and narrow meanings about reproductive bodies and birth that are unhelpful for midwifery more generally (Kurz et al., 2020). For example, gender essentialism has been critiqued for how it has underpinned popular discourse about natural birth in ways that have led to problematic constructions of "good," and "bad," mothers and births (Kurz et al., 2020).

Progress towards trans and non-binary inclusion is being made in midwifery. The ICM position statement acknowledges discrimination towards sexuality and gender minorities in pregnancy and birth care and affirms the right of all people to receive humanised and inclusive midwifery care (ICM, 2017a). In the United Kingdom, the midwife-led Gender Inclusive Perinatal Care Project (Brighton and Sussex University Hospital NHS Trust, 2020) has developed guidelines for gender inclusive language in perinatal care alongside a range of local initiatives for progressing gender inclusive perinatal care in their service. Position statements on trans and non-binary inclusion are being adopted by midwifery professional bodies in various countries. The Canadian Association of Midwifery (CAM) has taken a strongly inclusive stance with their 2015 position statement 'Trans inclusivity and human rights' (CAM, 2015). These position statements have enhanced the visibility of transgender and nonbinary people and signalled their belonging within birth and midwifery spaces.

Educating for trans and non-binary inclusion within midwifery

The importance of health provider education in the development of rainbow inclusive health services has been affirmed as a global priority for addressing health inequities for gender diverse and sexual minority people (Outright Action International, 2017). Education programmes for health professionals (pre and post registration) designed to cultivate core competencies in rainbow health are key in realising this priority (Keuroghlian et al., 2017; McCann and Brown, 2018). In relation to midwifery education, the ICM specifically recommends member associations advocate for the inclusion of gender and sexual minorities within the midwifery curriculum in their country (ICM, 2017a).

Despite the affirmed importance of health professional education as part of inclusive health services for gender diverse peo-

[2] Intersex is a general term used for a variety of situations in which a person is born with reproductive or sexual anatomy that doesn't fit the boxes of "female" or "male."

ple, research suggests that programmes are not currently meeting the educational needs of the health workforce (e.g. James and Colling Sylvester, 2018). We identified no published research on how midwifery education programmes have, or are, incorporating trans and non-binary inclusion into their curricula. Existing research related to nursing and medicine indicates education gaps around gender diverse people's health status and provision of competent care with a particular lack of attention to pregnancy and birth (James and Colling Sylvester, 2018; Tollemache et al., 2021). For example, in Tollemache et al.'s (2021) audit of 19 undergraduate medical education programmes in relation to rainbow healthcare content, the topic of maternity and childbirth was identified as the area that had the least planned content, the least delivered content, and the least understanding from medical students.

Progressing trans and non-binary inclusion in midwifery education

The intention of this project was to inspire action by offering a "road map" for other midwifery educators navigating trans and non-binary inclusion in their programmes. However, as Chadwick (2018) reminds us, just as with birth itself, when we try to position something so complex and ever changing into clockwork framings, we fail to do justice to the uncharted territory that this work takes us down. Rather than a road map per se, we have come to see these reflections with less precision and more as what we term "fleshy" resources (as per Chadwick, 2018. p.15) for other educators to lean against in their own unique process through trans and non-binary inclusion in their programmes. These "fleshy" resources are imperfect, unfinished, and in-process, but we hope they inspire and nurture fellow educators in the "sticky praxis of discomfort" (Chadwick, 2018) that is unlearning gender essentialism and opening spaces for trans and non-binary inclusion. The following four themes were identified collaboratively through our process of reflection: midwifery educators creating space; opening up language; holistic approaches; and feminist intersectionality.

1. "It's time, it's time that everybody needs to be recognised in midwifery": Midwifery educators creating space for trans and non-binary inclusion.

In this first theme the vital role of midwifery educators as "culture setters" for trans and non-binary inclusion within their programmes and in wider perinatal professional spaces is emphasised. Our midwifery educators reflected on the personal work and leadership characteristics required to embed trans and non-binary inclusion as a cultural norm in their programmes. For our educators, engaging in their own process of cultural safety or humility in relation to cisgender privilege and gender essentialism was the first step in this process. Rather than learning someone else's culture with the goal of mastery, cultural humility tasks the learner with a lifelong commitment to self-evaluation and critique, combined with a desire to address power imbalances and the development of partnership with others (Fisher-Borne et al., 2015; Tervalon and Murray-García, 1998). Likewise cultural safety focuses on practitioners' self-understanding and an emphasis on the attitudes and values they bring to their practice (DeSouza, 2008).

One of our educators described this process of self-reflection as "doing their own work first." For some, leading trans and non-binary inclusion was a given, an obvious extension of their personal positioning in 'rainbow'[3] identities and communities. For these educators, trans and non-binary inclusion was a pressing equity issue, and inaction was viewed as harmful and indefensible. For others, trans and non-binary inclusion was initially perceived to conflict with their commitment to women's rights and women-centred midwifery care. For these educators their shift to embrace trans and non-binary inclusion required "challenging themselves" through reflection on gender essentialism, identifying the ways in which they experience cisprivilege, and a taking up of responsibility to be an ally to gender diverse people as a marginalised group. Our educators could identify catalyst or crisis moments where their commitment to this process was crystalised. For example, TMU educators described the actions of a Toronto news media reporter wanting to write sensationalist articles about their programme being "anti-women" as they made steps towards trans and non-binary inclusion. This was seen as mobilising rather than stalling their commitment to inclusion.

In addition to "doing their own work," our midwifery educators also reflected on what good leadership looked like as "culture setters" for trans and non-binary inclusion in their programmes and the wider profession. Over two decades ago, midwifery scholar Nicky Leap captured the essence of the ways in which midwives facilitate birth when she coined the phrase 'the less we do, the more we give' (Leap, 2000, p. 17). Leap was describing the ways in which midwives facilitate birthing spaces by minimising disturbance, direction, authority, and intervention and placing trust in, and shifting power towards, the childbearing person. This spirit of handing over power was a feature of our educators' embrace of trans and non-binary inclusion in their programmes. Our educators described harnessing champions for inclusivity – faculty, students, and trans and non-binary community leaders- and to some extent "getting out of the way" for the work to be done. The view of the educators was that the majority of midwifery students, especially younger students, were ready for trans and non-binary inclusion and indeed expected it from midwifery education. Our educators described how much they had to learn *from* their students and this issue provided opportunities for student leadership and innovation. The key role of midwifery educators in leading trans and non-binary inclusion in the wider midwifery profession and in the perinatal sector more broadly was emphasised. For example, educators in both settings described their advocacy for inclusive approaches in government and perinatal health service documents, and in perinatal workforce education packages such as emergency skills days, in professional organisations, and as members of interprofessional bodies.

2. "Changing our language is the first step of many": Opening up language as a pathway to inclusion.

The use of language that acknowledges diverse genders is central to the safety, visibility and inclusion of gender diverse people in midwifery care (Stroumsa and Wu, 2018). The use of inclusive language in midwifery education was identified by our educators as being the starting point to progressing trans and non-binary inclusion in their programmes. Inclusive language requires a conceptual shift in understanding that not all pregnant and birthing people are women and therefore committing to the use of non-gender specific words and phrases related to pregnancy, birthing, and midwifery care. Opening up language beyond gender specificity was seen by our educators as igniting a sometimes-uncomfortable process of reflection about gender essentialism in midwifery. As one of our educators described, "We had to address our reservations and

[3] A broad umbrella term that covers a diversity of sexual orientations, as well as gender and sex identities. This includes lesbian, gay, bisexual, transgender, intersex, queer, and Indigenous rainbow identities including two spirit and takatāpui. Two spirit is used in Canada by some Indigenous people who identify as having both a masculine and a feminine spirit to describe their sexual, gender and/or spiritual identity. https://lgbtqhealth.ca/community/two-spirit.php. Takatāpui is a traditional term meaning 'intimate companion of the same sex.' It has been reclaimed to embrace all Māori who identify with diverse genders, sexualities and sex characteristics such as whakawāhine, tangata ira tāne, lesbian, gay, bisexual, trans, intersex and queer. All of these and more are included within Rainbow communities. https://takatapui.nz/takatapui-part-of-the-whanau#part-of-the-whanau

lean into that discomfort." Our educators also acknowledged that changing language is hard and that there is not a "right way" but rather a multiplicity of approaches to progressively include trans and nonbinary people within midwifery education. They emphasised that having openness to learn from any mistakes they made was a key aspect of their reflective process.

The use of gender additive language, in which gender-neutral terms such as "birthing person," are used alongside gender specific terms such as "woman," (Brighton and Sussex University Hospital NHS Trust, 2020) was identified by our educators as one strategy for the shift towards inclusive language. OP educators reflected how the use of gender additive language helped to alleviate the concerns of those midwifery educators in their programme that opening up language beyond gender specificity might contribute to the invisibility of women. TMU educators were incorporating gender additive language into course outlines and teaching materials, and in spoken word in the classroom. TMU educators described how the use of gender additive language was a steppingstone in the shift to using gender inclusive[4][4] language in many aspects of their programme. Their shift to predominantly gender-inclusive language use occurred as educators gained confidence in how to expand their language, felt reassured that there were no tangible impacts on cis-women or the quality of midwifery education, and came to find the additive approach laborious. TMU educators noted that while official documents such as course outlines are now primarily gender inclusive, the use of case-based scenarios in clinical courses allows students to use pronouns and language as chosen by the people in the cases. The case-based approach provides opportunities for students to practice and be comfortable in the process of identifying and respecting differing preferences for gendered language amongst the people in their care. It also makes visible those who identify as cis-gendered women, as gender fluid or as trans male. Educators at OP identified the synergies between inclusive language for trans and non-binary inclusion and the Māori world view that places emphasis on the family (or whanau) rather than the individual (Te Tatau o te Whare Kahu: Midwifery Council, 2021c).

3. "There are feelings of resistance at the start of change - but that shouldn't stop you changing": A holistic approach to trans and non-binary inclusion.

The shift to inclusive language is a vital first step in making space for trans and non-binary people in midwifery, however our midwifery educators also reflected that language change perhaps receives more focus than it deserves in that it is not the only step towards inclusion. Goldhammer et al. (2018) observe that focusing on stopgap measures such as language change without addressing the underlying culture of an organisation risks maintaining the structural health inequities that gender diverse people face.

Educators across both programmes reflected how the process of trans and non-binary inclusion gained momentum once they moved past the notion that inclusiveness could be achieved through a tick-box approach. Rather it involved a multifaceted and holistic process of cultural change in their programmes, to which there is no tangible end point. This included use of pronouns in online signatures (including email and Zoom), biographies, and in classroom learning (Brown et al., 2020); the use of diverse representations of gender and family building in teaching scenarios, imagery, and assessments (Solotke et al., 2019); and the development of specialist modules on LGBTIQ+ inclusive midwifery care incorporated into undergraduate and postgraduate courses. At OP, educators had gone one step further and developed a full postgraduate course "Queering Midwifery" designed to educate midwives post-registration in safe and inclusive care for gender and sexual minorities. Our educators also described the steps taken to make their learning environments safe for gender diverse midwifery students including the provision of all-gender bathrooms on campus, altering student data systems, and the established of a rainbow liaison educator role.

However, actions by themselves, without a commitment to continue engaging with a process of cultural humility and safety, was viewed by our educators as insufficient for enabling lasting culture change. As we identified in the first theme, those educators who initially felt challenged by aspects of trans and non-binary inclusion such as language change, could identify the shifts that occurred when they engaged in a process of self-reflection and self-evaluation. Rather than a one-off endeavour, our educators described the need to continuously facilitate "brave and safe" (Arao and Clemens, 2013) spaces of reflection for themselves, their colleagues, and their students. These spaces allow for reflection on and exploration of assumptions, norms, and overlapping systems of privilege and oppression that privilege cisgender, white, heterosexual, able-bodied women in midwifery. They contribute to the erasure of and health inequities experienced by gender diverse people and other minorities**.** Within these spaces educators could navigate the error-making, discomfort, and unlearning that runs central to cultural humility and safety. At OP this involved an on-going series of facilitated staff workshops where sometimes difficult conversations and experiential learning were supported and encouraged.

Expanding the many facets of our programmes to be trans and non-binary inclusive allowed our midwifery educators to further consider which parts of midwifery education and care were failing gender diverse people and why. This consideration led to further learning around clinical aspects of trans and non-binary inclusive care such as fertility and family building, trauma aware care, and diverse infant feeding experiences. Engaging with these aspects of care was seen by our educators as deepening midwifery's commitment to culturally safe care for gender diverse people beyond simply signalling inclusion.

4. "We underestimate the transformational potential of midwifery education": Realising the potential of inclusion through feminist intersectionality.

In this final theme our midwifery educators reflected that the greatest shifts towards trans and non-binary inclusion in their programmes could be achieved through the building of alliances with other equity and social justice issues in midwifery, particularly work towards decolonisation and racial justice, and gender justice for ciswomen. Midwifery educators acknowledged some initial perceived tensions between work to progress trans and non-binary inclusion, when racial justice and decolonisation in midwifery is languishing, and when work to achieve gender justice for ciswomen was yet to be realised (e.g., Dawson et al. 2022)

However, our educators had come to view the various equity and social justice challenges facing midwifery as an opportunity to build trust, momentum, energy and relationships in the process of change. As one educator reflected "equity for others does not mean less equity for you, equity is not a pie". Our midwifery educators posed the challenge that we should not talk less about gender essentialism and cisprivilege, but should always be asking, "what else should we be talking about in midwifery? What else matters?". Intersectional feminism was identified by our educators as a key resource in the pathway out of seeing various equity and social justice issues in midwifery as in competition or conflict with each other. Intersectional feminism brings to light the interconnection between and interweaving of different forms of oppression rather than seeing these as competing or oppositional (Crenshaw, 1989).

[4] Gender inclusive language refers to speaking and writing in a way that does not discriminate against a particular sex, social gender or gender identity, and does not perpetuate gender stereotypes, primarily through the use of gender neutral words and phrases e.g. parent instead of mother (United Nations, 2021)

From an intersectional feminist perspective, trans and non-binary inclusion must be understood in relation to, and alongside, other equity and social justice issues that impact on pregnant and birthing people including decolonisation and racial justice, gender justice, disability justice, and environmental justice. Intersectional feminism offers midwives a way through "issue overwhelm" by offering a lens through which to understand the connections between these issues and to strive towards a more just perinatal system for all pregnant and birthing people, their families, and communities. Intersectional feminism centres the voices of those experiencing overlapping and concurrent forms of oppression and challenges us to engage in dialogue to understand the depths of inequities and the relationship between them. This helps shift midwives from seeing transphobia and the erasure of gender diverse people as separate from gender injustices for cis-women and racial injustice, to an illumination of the connections between all movements for equity and social justice. Our task in midwifery then becomes to root out all forms of oppression and to work in solidarity across marginalised groups. In other words, intersectional feminism "serves as a framework through which to build inclusive, robust movements that work to solve overlapping forms of discrimination, simultaneously" (United Nations Women, 2020, para 13).

Intersectional ways of thinking were valued by our midwifery educators as a vital framework for guiding trans and non-binary inclusion in our programmes in ways that not only maintained, but more so actually enhanced, progress on racial and gender justice, and decolonisation. Educators in both programmes were engaged in incorporating intersectional feminist perspectives in their courses. Further, educators from diverse backgrounds can draw from their own lived experiences, and work in partnership with both marginalised and privileged students to help them identify how intersectional injustice may play out in their own lives. For tertiary learning institutions it is becoming increasingly necessary to diversify faculty to meet the diverse needs of students (Mercer-Mapstone and Bovill, 2020), and this need was reflected on by our educators as an important aspect of intersectional and culturally humble midwifery education.

Back to the future: concluding reflections

This paper presents the critical reflections of midwifery educators involved in facilitating the process of trans and non-binary inclusion within two midwifery education programmes in Aotearoa and Ontario, Canada. By applying Chadwick's ideas about the challenge of 'nailing down' inherent complexities within 'messy' and evolving ways of being, we have offered these reflections as "fleshy" resources (Chadwick, 2018 pp.15). As resources, we hope they might support further dialogue and action towards realising the human rights of gender diverse people to safe, inclusive, and equitable midwifery care. Inclusive health care has been affirmed as a critical step in addressing global health disparities for transgender, nonbinary, and other gender diverse people (Outright Action International, 2017). We assert that the time has come for midwifery education to play an active role in trans and non-binary inclusion as part of a broader commitment to equity and social justice in midwifery. However, we acknowledge that progressing trans and non-binary inclusion asks midwives to reckon with norms and assumptions about gender that have become embedded in our philosophy, professional frameworks, and day to day practices in clinical care and education. This is no small task when midwifery itself remains a profession that is marginalised in wider health care systems in many parts of the world that continue to privilege biomedically dominated pregnancy and birth care. We also acknowledge the many other equity and social justice issues in midwifery that equally and necessarily call for our attention.

There is currently a dearth of guidance available to midwifery educators to guide the process of trans and non-binary inclusion in our programmes and we have greatly valued and benefited from the opportunity for support and shared learning fostered through the relationship between our two programmes. When we began this project, we imagined collectivising our learning and reflections to offer a road map to other midwifery educators to help guide this work in other programmes. However, we have come to question the possibility for an arrival at a destination of trans and non-binary inclusion that might be suggested by the notion of a "road map". We take up the challenge offered by feminist geographers (Brown and Staeheli, 2003) who point to the ways in which the concept of "arrival" and the question "are we there yet?" diminish the purpose of justice-based feminism: to keep going, to stay inside the work, and to redefine our ways of knowing and being as the world around us changes.

What we have offered here instead is an insight into our ongoing process of cultural humility and safety in relation to gender diverse people, accepting that this is a process without end. We have identified the critical work that happens when we make spaces for the voices of marginalised people, and in self and shared reflection, evaluation and dialogue. These spaces of listening, talking, and learning/unlearning have enabled us to understand ourselves as midwives and educators within intersecting matrices of oppression and privilege as gender diverse and cisgender, IBPOC and white, heterosexual, and queer, able bodied and those disabled by communities that do not meet their particular needs. We have acknowledged the sometimes messy, uncomfortable, and fraught process of unlearning gender essentialism and addressing the operation of cis-privilege in midwifery education whilst affirming this work as vital to equity and justice for gender diverse people. We have offered up some of the conceptual tools and practical approaches that have and continue to support us in the process of trans and non-binary inclusion that we hope might also support others. We know that these tools and approaches are not definitive and that we are not the only midwifery educators involved in this process. We invite an expansion of dialogue in midwifery education, research, and practice as we work collectively towards a future midwifery workforce able to provide excellence in care to the growing gender diverse population.

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George Parker: Conceptualization, Writing – original draft, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Lou Kelly:** Conceptualization, Writing – original draft, Writing – review & editing, Project administration. **Suzanne Miller:** Conceptualization, Writing – original draft, Writing – review & editing, Project administration. **Vicki Van Wagner:** Conceptualization, Writing – original draft, Writing – review & editing. **Manavi Handa:** Writing – original draft, Writing – review & editing. **Sally Baddock:** Writing – original draft, Writing – review

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References

Arao, B., Clemens, K., Landreman, L., 2013. From safe spaces to brave spaces. In: The Art of Effective Facilitation, 1. Stylus Publishing, pp. 135–149.

Association of Ontario Midwives (2015). Gender inclusivity and human rights statement.

Bass, J., Fenwick, J., Sidebotham, M., 2017. Development of a model of holistic reflection to facilitate transformative learning in student midwives. Women Birth 30 (3), 227–235. doi:10.1016/J.WOMBI.2017.02.010.

, 2009. Aboriginal Nurses Association of Canada, Canadian association of schools of nursing, & Canadian nurses association.

Brighton and Sussex University Hospital NHS Trust. (2020). Gender inclusive language in perinatal services: mission statement and rationale. https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Gender-inclusive-language-in-perinatal-services.pdf

Brown, C., Frohard-Dourlent, H., Wood, B.A., Saewyc, E., Eisenberg, M.E., Porta, C.M., 2020. "It makes such a difference": an examination of how LGBTQ youth talk about personal gender pronouns. J. Am. Assoc. Nurse. Pract. 32 (1), 70–80. doi:10.1097/JXX.0000000000000217.

Brown, M., Staeheli, L.A., 2003. "Are we there yet?" feminist political geographies. Gender Place Cult. 10 (3), 247–255. doi:10.1080/0966369032000114019.

Canadian Association of Midwifery. (2015). A statement on gender inclusivity & human rights. https://canadianmidwives.org/wp-content/uploads/2018/06/CAM_GenderHumanRights_PSRevisedV02FINAL_20180525.pdf

Chadwick, R., 2018. Bodies That Birth. Routledge doi:10.4324/9781315648910.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In University of Chicago Legal Forum (Vol. 1989, Issue 1). http://chicagounbound.uchicago.edu/uclfhttp://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

College of Midwives Ontario, 2021. Professional standards for midwives.

Dawson, P., Auvray, B., Jaye, C., Gauld, R., Hay-Smith, J., 2022. Social determinants and inequitable maternal and perinatal outcomes in Aotearoa New Zealand. Women's Health 18, 174550652210759. doi:10.1177/17455065221075913.

Derosa, A., 2021. Care considerations for pregnancy in transgender and nonbinary patients. Contemp. Obstetr. Gynaecol. 66 (6), 33–35.

DeSouza, R., 2008. Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. J. Res. Nurs. 13 (2), 125–135. doi:10.1177/1744987108088637.

Donley, J. (1986). Save the Midwife. New Women's Press.

Ellis, S.A., Wojnar, D.M., Pettinato, M., 2015. Conception, pregnancy, and birth experiences of male and gender variant gestational parents: it's how we could have a family. J. Midwifery Women's Health 60 (1), 62–69. doi:10.1111/jmwh.12213.

Farvid, P., Vance, T.A., Klein, S.L., Nikiforova, Y., Rubin, L.R., Lopez, F.G., 2021. The health and wellbeing of transgender and gender 'non-conforming' people of colour in the United States: a systematic literature search and review. J. Community Appl. Soc. Psychol. 31 (6), 703–731. doi:10.1002/casp.2555.

Fisher-Borne, M., Cain, J.M., Martin, S.L., 2015. From mastery to accountability: cultural humility as an alternative to cultural competence. Social Work Educ. 34 (2), 165–181. doi:10.1080/02615479.2014.977244.

García-Acosta, J.M., San Juan-Valdivia, R.M., Fernández-Martínez, A.D., Lorenzo-Rocha, N.D., Castro-Peraza, M.E., 2019. Trans* pregnancy and lactation: a literature review from a nursing perspective. Int. J. Environ. Res. Public Health 17 (1), 44. doi:10.3390/ijerph17010044.

Goldhammer, H., Malina, S., Keuroghlian, A.S., 2018. Communicating with patients who have nonbinary gender identities. Ann. Fam. Med. 16 (6), 559–562. doi:10.1370/afm.2321.

Graham, M., Rich, S., 2014. Representations of childless women in the Australian print media. Fem. Media Stud. 14 (3), 500–518. doi:10.1080/14680777.2012.737346.

Hoffkling, A., Obedin-Maliver, J., Sevelius, J., 2017. From erasure to opportunity: a qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. BMC Pregnancy Childbirth 17 (S2). doi:10.1186/s12884-017-1491-5.

International Confederation of Midwives. (2017a). Human rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) people. https://www.internationalmidwives.org/assets/files/statement-files/2018/04/eng-lgtbi.pdf

International Confederation of Midwives. (2017b). Partnership between women and midwives. https://www.internationalmidwives.org/assets/files/statement-files/2018/04/eng-partnership-between-women-and-midwives1.pdf

James, S., Colling Sylvester, H., 2018. Transgender health and its current omission from medical school curriculum: medical students' perspective. Adv. Med. Educ. Pract. 9, 607–609. doi:10.2147/AMEP.S176532.

Keuroghlian, A.S., Ard, K.L., Makadon, H.J., 2017. Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming health care environments. Sex Health 14 (1), 119. doi:10.1071/SH16145.

Kurz, E., Davis, D., Browne, J., 2020. Analysing constructions of childbirth in the media; moving possibilities for childbirth beyond gender essentialism. Women Birth 33 (4), 377–382. doi:10.1016/J.WOMBI.2019.06.014.

Leap, N. (2000). The less we do the more we give. In M. Kirkham (Ed.), The Midwife-Mother Relationship (1st ed., Vol. 1, pp. 1–18). Palgrave Macmillan.

MacDonald, T., Noel-Weiss, J., West, D., Walks, M., Biener, M., Kibbe, A., Myler, E., 2016. Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity: a qualitative study. BMC Pregnancy Childbirth 16 (1). doi:10.1186/s12884-016-0907-y.

MacLean, L.R.D., 2021. Preconception, pregnancy, birthing, and lactation needs of transgender men. Nurs. Women's Health 25 (2). doi:10.1016/j.nwh.2021.01.006, (N. Y).

Malmquist, A., Jonsson, L., Wikström, J., Nieminen, K., 2019. Minority stress adds an additional layer to fear of childbirth in lesbian and bisexual women, and transgender people. Midwifery 79, 102551. doi:10.1016/J.MIDW.2019.102551.

McCann, E., Brown, M., 2018. The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: a systematic review. Nurse Educ. Today 64, 204–214. doi:10.1016/J.NEDT.2018.02.028.

Mercer-Mapstone, L., Bovill, C., 2020. Equity and diversity in institutional approaches to student–staff partnership schemes in higher education. Stud. Higher Educ. 45 (12), 2541–2557. doi:10.1080/03075079.2019.1620721.

New Zealand College of Midwives, 2015. Midwives Handbook For Practice, 5th ed. New Zealand College of Midwives.

New Zealand College of Midwives. (2020). Philosophy and code of ethics. https://www.midwife.org.nz/midwives/professional-practice/philosophy-and-code-of-ethics/

Outright Action International. (2017). Agenda 2030 for LGBTI health and wellbeing. https://outrightinternational.org/content/agenda-2030-lgbti-health-and-well-being

Pergadia, S., 2018. Geologies of sex and gender: excavating the materialism of Gayle Rubin and Judith Butler. Fem. Stud. 44 (1), 171–200.

Pezaro, S., 2019. 'They/them' in the birth room. Br. J. Midwifery 27 (11), 678–679. doi:10.12968/bjom.2019.27.11.678.

Ramsden, I.M. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu: a thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing. Victoria University of Wellington. https://www.croakey.org/wp-content/uploads/2017/08/RAMSDEN-I-Cultural-Safety_Full.pdf

Reisner, S.L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C.E., Max, R., Baral, S.D., 2016. Global health burden and needs of transgender populations: a review. Lancet N. Am. Ed. 388 (10042). doi:10.1016/S0140-6736(16)00684-X.

Roosevelt, L.K., Pietzmeier, S., Reed, R., 2021. Clinically and culturally competent care for transgender and nonbinary people. J. Perinat. Neonatal Nurs. 35 (2), 142–149. doi:10.1097/JPN.0000000000000560.

Singer, R.B., Crane, B., Lemay, E.P., Omary, S., 2019. Improving the knowledge, attitudes, and behavioral intentions of perinatal care providers toward childbearing individuals identifying as LGBTQ: a quasi-experimental study. J. Contin. Educ. Nurs. 50 (7). doi:10.3928/00220124-20190612-05.

Skewes, L., Fine, C., Haslam, N., 2018. Beyond Mars and Venus: the role of gender essentialism in support for gender inequality and backlash. PLoS One 13 (7), e0200921. doi:10.1371/journal.pone.0200921.

Solotke, M., Sitkin, N.A., Schwartz, M.L., Encandela, J.A., 2019. Twelve tips for incorporating and teaching sexual and gender minority health in medical school curricula. Med. Teach. 41 (2), 141–146. doi:10.1080/0142159X.2017.1407867.

Stroumsa, D., Wu, J.P., 2018. Welcoming transgender and nonbinary patients: expanding the language of "women's health. Am. J. Obstet. Gynecol. 219 (6). doi:10.1016/j.ajog.2018.09.018, 585.e1-585.e5.

Su, D., Irwin, J.A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D.A.R., Coleman, J.D., 2016. Mental health disparities within the LGBT population: a comparison between transgender and nontransgender individuals. Transgender Health 1 (1), 12–20. doi:10.1089/trgh.2015.0001.

Tan, K.K.H., Ellis, S.J., Schmidt, J.M., Byrne, J.L., Veale, J.F., 2020. Mental health inequities among transgender people in Aotearoa New Zealand: findings from the Counting Ourselves Survey. Int. J. Environ. Res. Public Health 17 (8). doi:10.3390/ijerph17082862.

Taylor, S.R., 2021. The Body is Not An Apology. Berret-Koehler Publishers.

Te Tatau o te Whare Kahu: Midwifery Council. (2021a). 2021 Midwifery Workforce Survey. https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Workforce%20surveys/Midwifery%20Workforce%20Survey%202021.pdf

Te Tatau o te Whare Kahu: Midwifery Council, 2021b. Statement on Cultural Competence For Midwives b.

Te Tatau o te Whare Kahu: Midwifery Council of New Zealand. (2021c). Whānauitanga o Te Mahi | Midwifery Scope of Practice. Draft Revised Scope of Practice.

Tervalon, M., Murray-García, J., 1998. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J. Health Care Poor Underserv. 9 (2), 117–125. doi:10.1353/hpu.2010.0233.

Tollemache, N., Shrewsbury, D., Llewellyn, C., 2021. Que(e)rying undergraduate medical curricula: a cross-sectional online survey of lesbian, gay, bisexual, transgender, and queer content inclusion in UK undergraduate medical education. BMC Med. Educ. 21 (1), 100. doi:10.1186/s12909-021-02532-y.

United Nations Women. (2020, July 1). Intersectional feminism: what it means and why it matters right now. United Nations Women: News and Events.

https://www.unwomen.org/en/news/stories/2020/6/explainer-intersectional-feminism-what-it-means-and-why-it-matters

Veale, J., Byrne, J., Tan, K.K.H., Sam, G., Ashe, Y., Nopera, T.M.L., & Bentham, R. (2019). Counting ourselves: the health and wellbeing of trans and non-binary people in Aotearoa New Zealand. https://researchcommons.waikato.ac.nz/handle/10289/12942.

World Professional Association for Transgender Health. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people 7th Edition. https://www.wpath.org/publications/soc