Midwifery 119 (2023) 103621

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Creating change with families: Reflections and recommendations for the care of gender diverse and LGBTQIA+ individuals and their families throughout pregnancy and birth

Matilda Copeland[a], Julie Tucker[a], Annette Briley[a,b,*]

[a] Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, SA 5112, Australia
[b] Caring Futures Institute, Flinders University, Bedford Park, SA 5042, Australia

ARTICLE INFO

Article history:
Received 13 September 2022
Revised 16 November 2022
Accepted 18 January 2023

Keywords:
Gender diverse
Lgbtqia+
Non-binary
Transgender
Pregnancy
Birth

ABSTRACT

Objective: To derive a deeper understanding of transgender and non-binary people's experience of pregnancy and birth, and ways to modify practice to provide inclusive care.
Design: Case study reports describe the experiences of two transgender and non-binary people who received pregnancy and birth care through a Midwifery Group Practice program.
Setting: A tertiary hospital in metropolitan South Australia with approximately 3800 births per annum.
Methods: Qualitative methodology, utilising open-ended, semi-structured, face-to-face interviews were undertaken postnatally. Interviews were audio recorded and transcribed verbatim to analyse and identify themes.
Findings: Both clients feared being misgendered within pregnancy care services. They appreciated the constancy of the Midwifery Group Practice midwife, which meant they did not have to repeat their history to multiple health care providers. They appreciated their pronouns being documented on case notes and welcomed staff attempts to use their preferred terms. Both felt the pregnancy care environment was focussed on cisgender females and found this alienating. They appreciated the midwife's suggestion that the cot card for their baby did not have to be pink or blue. They both suggested staff use more gender-neutral language, and resources, when providing pregnancy care.
Key conclusion: Staff attempted to support these parents, and this was appreciated by them, but the continuity provided by the Midwifery Group Practice model was highly valued by both, regardless of risk status. It was identified that further education for staff was required to facilitate provision of more inclusive care.
Implications for practice: The case studies identified a need for greater awareness and education for staff regarding care provision for transgender and non-binary people. Simple adjustments had a big impact. Further research is needed to identify how best to meet the needs of gender-diverse people and address the educational needs of staff.

Introduction

There is growing evidence within the literature around gender identity, expression, diversity, and dysphoria, yet many people's understanding of these terms remains limited. An individual's sex is usually assigned at birth, based on external genitalia. Gender identity refers to the alignment between an individual's internal self and assigned gender (Shine SA 2022) (Table 1). It is estimated that, globally, 2% of people do not match their assigned sex (www.statista.com, 2021). Transgender is a broad term used to describe those who do not identify with their assigned sex. Gender dysmorphia refers to the degree of distress caused by the discrepancies between gender identity and assigned sex (Knudson et al., 2010), and is not experienced by all transgender people (Coleman et al., 2012).

International studies have identified the need for equity in access and the delivery of healthcare for lesbian, gay, bisexual, trans and intersex individuals, yet there remain stark disparities between care provision for these people, and those afforded to cis-

Abbreviations: MGP, (Midwifery Group Practice); LGBTQIA+, (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, +); NALHN, (Northern Adelaide Local Health Network); PTSD, (post-traumatic stress disorder); POTS, (postural orthostatic tachycardia syndrome); GDM, (Gestational diabetes mellitus); IUGR, (Intra-uterine growth restriction).

* Corresponding author.
E-mail address: annette.briley@flinders.edu.au (A. Briley).

https://doi.org/10.1016/j.midw.2023.103621

Table 1
Gender and Sexual Diversity Terms (Shine SA 2022).

Gender diversity terms	
Cisgender	Describes a person who identifies with the gender that is presumed of them at birth (for example, someone who is presumed female at birth and identifies as a woman).
Cisnormative	The presumption that being cisgender is the norm and thus anyone who falls outside of this category is abnormal and awarded less privileges.
Transgender or trans	Describes a person whose gender identity differs from the gender they were presumed at birth (for example, someone who was presumed male at birth and identifies as a woman). Nonbinary people can be included in this label if it feels right for the individual. Some nonbinary people do not identify as trans and that's okay too!
Nonbinary	an umbrella term representing those whose gender identity is neither a man nor a woman but rather somewhere in-between; fluid or fixed, or off the gender spectrum all together (see, for example agender).
Body diversity terms	
Intersex	Anyone born with variations in their physical sex characteristics meaning they don't neatly fit into the binary sex categories of male and female
Endosex	Not intersex, meaning aligning within the categories of male or female
Sexual diversity terms	
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual, + (the plus sign acknowledges the diversity of the rainbow community and the ever-expanding identity terms within it).
Queer	a term that can be used to broadly describe their sexual and/or gender identity as a way of sharing that identity without sharing a specific label. Some people may be harmed by this term due to it's historical use in a negative way. **Note: How people who are gender and/or sexually diverse identify is very personal and varies between individuals. The above definitions and descriptions are a guide only and it's respectful and best practice to check with a person and reflect the language they use.**

gender individuals (Hyde et al., 2014). Notably, transgender people have reported negative experiences with healthcare practitioners in Australia (Strauss et al., 2017). White et al. (2015) identified health professionals' lack of knowledge was associated with suboptimal care for this population. The absence of formal education and training, and limited social awareness, has contributed to detracting from quality of care for these people (Shepherd et al., 2019). Somerville (2015) reported that 1 in 5 (21%) nurses and midwives did not have the knowledge and skills to provide care to transgender people. Furthermore, the author reported that only 11% of frontline nursing and midwifery staff have received ongoing training, as continuous professional development, and that the specific health needs of the LGBTQIA+ community are rarely part of undergraduate curricula in university training programs (Somerville, 2015).

In recent years, midwifery practice has expanded to include transgender and gender non-binary people, who have female reproductive organs and therefore can experience pregnancy, labour and birth (Obedin-Maliver and Makadon 2016).

One integrative review identified heteronormativity as predominant in health care settings, with language used by midwives and nurses as a key factor. In the perinatal care setting LGBTQIA+ patients are given little opportunity to disclose their sexual orientation or gender identity (Stewart and O'Reilly, 2017). Stewart et al. (2017) reported associations with homophobic, biphobic and transphobic attitudes and the actions of nurses, and provision of inequitable or discriminatory care to these clients. Whilst some nurses and midwives acknowledged that LGBTQIA+ patients should be treated the same as others, this was largely when considering sexual orientation as relevant to sexual health complaints (Stewart et al. 2017).

Inequities in women's health and pregnancy care services for those in sexual minority groups have been reported. Additionally, many lesbian couples state their sexual orientation, and acknowledgement of a same sex partner, is commonly ignored at all stages of the pregnancy and postnatal continuum, leading to feelings of vulnerability, invisibility, and awkwardness (Fish and Bewley 2010). This is of concern and negatively impacts on the delivery of person-centred care. Despite a paucity of data, pregnancy complications and outcomes for transgender parents have been reported as not dissimilar to cisgender people: preterm birth (10%), placental abruption (10%), anaemia (7%) and hypertension (12%) (Light et al., 2018).

When two gender diverse people attended for pregnancy care within a few weeks of each other a Northern Adelaide care provider felt care provision in a Midwifery Group Practice model, where continuity of midwifery care is delivered throughout the antenatal, intrapartum and postnatal periods by one or two known midwives, would provide high quality, consistent care. It would also enable the service, and health care professionals, to develop an understanding of the specific peripartum experiences and needs of transgender and non-binary people to improve practice to provide inclusive, optimal care in future.

Methods

Exploration of the regulatory requirements to undertake research within this area confirmed this should be undertaken as a Quality Improvement Project, with the aim of identifying gaps in care for this minority group and addressing these to improve pregnancy health and outcomes for gender diverse people. Departmental and Divisional approval was obtained for Quality Improvement Project QI 4960 from Northern Adelaide Local Health Network (NALHN). Approval for publication of the outcome was granted from Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC) reference number: 16,941.

The annual birth rate in a large metropolitan pregnancy care service l is approximately 3550 to 3837 births per year (2015 to 2021). There are six care pathways for pregnant persons, the Midwifery Group Practice (MGP) setting provides a continuity of care model with two known midwives providing client care, either as the primary carer, or as part of a multi-disciplinary pathway.

During the provision of antenatal care two families identifying as transgender and non-binary people, expressed a desire to share their stories to inform others, both health care professionals and those from sexual minority groups, regarding their experiences, in order to help develop services and improve care for different families. Members of the MGP and clinical academics worked together to investigate a methodology to undertake this research. Communication with other health care providers in the metropolitan area revealed no other services had delivered pregnancy care for transgender or non-binary families either currently or in the recent past

Table 2
Summary characteristics of the pregnancy journey for each case.

	Client 1	Client 2
Age	21	21
Parity at onset	Primiparous	Primiparous
Gender identity	trans/non-binary	agender/gender-fluid. Previously gender-fluid with sub-genders at various times (trans masculine, non-binary, demi-girl)
Pronouns	they/them	they/them (at time of interview. Pronouns were he/they during pregnancy)
Sexuality/partner(s)	Polyamorous, currently living/co-parenting with 1 partner (he/they pronouns)	polyamorous, currently single
Pregnancy care	**Antenatal:** Medically **uncomplicated** pregnancy, midwifery-led care (MGP) from 26 weeks gestation. Appointments at home, with one of two named midwives. **Birth**: Spontaneous onset of labour, waterbirth. **Postnatal:** Physically straightforward postnatal follow-up. **Perinatal Mental Health input during and after pregnancy.**	**Antenatal:** Medically **complicated** pregnancy, due to previous medical conditions. Also developed pregnancy complications. Obstetric-led care with MGP support **Birth**: Emergency caesarean at 35/40 gestation, due to severe IUGR and pre-eclampsia. **Postnatal:** Baby in special care nursery. **Perinatal Mental Health input during and after pregnancy**

(up to 5 years). Due to the small sample size and limited evidence in the literature, a case study was selected in order to maximise the impact. The transgender and non-binary people were provided with information about the case study review at least 12 weeks prior to consent and recruitment, this allowed participants time to consider participation and to have completed their pregnancy care episode. Written informed consent was obtained prior to the interviews, which occurred at five weeks and three months postnatal. All participants (gestational parents $n = 2$ and partner $n = 1$) stated they would prefer to be interviewed by a member of the care team, as they felt comfortable with those midwives, and could be open and honest in their company. This was another reason for the delay between completion of episode of care and interviews. It was felt that, with the passage of time, interviewees would not be compromised by being interviewed by a care provider. Participants knew they were free to withdraw at any time without giving a reason.

Individual open-ended, semi-structured interviews were undertaken by a midwife working in MGP (MC) in a place where the clients felt comfortable and at ease. The interviews were audio recorded to allow the researcher to become fully immersed in conversations. Audio recordings were transcribed verbatim to analyse findings and identify themes.

Interviews began with a general statement asking participants to describe their experiences, as a gender diverse person, of pregnancy and birth in the perinatal care setting. The open-ended style of interview encourages rapport and empathy through a conversational nature (Van Manen 1990). Audio recording the interviews allowed the researcher to participate fully in conversation, noting the realm of emotions and experiences.

Transcripts were reviewed and content analysis was used to identify emergent patterns by grouping words, content and themes. These were then analysed using thematic analysis to deduce meaning. Analyses were undertaken by MC, and checked for consistency by JT and AB.

Exploration and reflection of the text using thematic analysis identified four main themes: Anticipation of pregnancy care/communication from staff, education for staff, inclusive literature, and continuity of care (Table 3).

Cases

The two participants shared their experiences of multidisciplinary collaboration, with midwives pivotal to the care these families received (Table 2).

Client 1: A 21-year-old healthy person who identified as gender non-binary. Although polyamorous, throughout the pregnancy they resided with their one partner. This was their first pregnancy.

Client 1 was very anxious throughout the entire pregnancy, even though their pregnancy was clinically straightforward. They preferred antenatal visits at home rather than coming into the hospital clinic. They stated they were always overwhelmed and preferred their partner present at appointments in the familiar environment of their home. Preceding and throughout the pregnancy Client 1 had input from mental health teams due to their ongoing depression and anxiety.

Client 1 and their partner received practical support from their families, although neither felt their families understood their gender identities, and knew their families had different views around their pregnancy and imminent parenthood. Ultimately, they felt emotionally unsupported by their families.

Client 1 was overwhelmed by changes to their body caused by the pregnancy, experiencing significant gender dysphoria. Their experience of pregnancy symptoms troubled them and they required constant assurance throughout pregnancy that their symptoms were normal. Client 1 experienced nausea and vomiting in the first trimester, insomnia, and Braxton Hicks uterine tightenings from mid pregnancy until labour onset.

Although both MGP midwives introduced a dialogue around chest feeding, Client 1 showed no interest, due to their feelings of gender dysphoria around their chest. This also meant they did not want skin-to skin contact with their infant immediately following the birth.

Consistent advice and support were provided throughout the pregnancy by the MGP midwives allocated to the care of this family. Additionally, the midwives, with client consent, liaised as required with perinatal mental health services, a general practitioner and the Strong Start service.

Client 1 went into spontaneous labour at 39+6 gestation. They attended the hospital with their partner and were met by one of their MGP midwives. Labour duration was 4 h and resulted in a waterbirth, the couple were supported by the same midwife throughout their labour and birth. The baby was briefly admitted to the Special Care Nursery due to transient tachypnoea. The parents had always intended to formula feed their infant, who was slow to feed initially, but had regained birthweight by day 6 postnatally. Parents and the infant were transferred home on day 2. Postnatal support was provided by the same MGP midwives.

Client 1 struggled with pain and dysphoria when their milk came in on day 3. They stated they didn't feel an initial bond with their baby and didn't want skin-to-skin, but the non-gestational parent felt an immediate bond and was able to provide initial skin-to-skin. Client 1 felt more of a bond later, but found it difficult to cuddle their baby as their chest was very sore and anything in contact with it triggered dysphoria.

Table 3
Themes and sub-themes.

Main themes	Sub themes	Concerns	Process for change in Midwife care	Quotes
Anticipation of pregnancy care communication from staff	brace themselves-misgendered	Labels	corrected themselves when they got it wrong documented the correct pronouns on top of their case file	*"I thought I would get feminised a lot more and I thought that people would not address me being non-binary"* *"non-binary people can't have a baby".*
	Feeling Feminised	Anxiety Misunderstood	midwifery group practice model of care Respectful care	*"in the end I think that was a very different experience for me, but the anticipation I think was the hardest thing"*
Education for staff	Gaps in the system	No current university education on LBGTQIA+ care Inappropriate health professional questions/ enquiry and disrespect	Respectful care resulted in a positive client experience	*"I just learned to realise that even when other people aren't educated, it's always a chance to educate people"*
Gender inclusive literature		No current literature at hospital gender inclusive No visual representation of LBGTIQ Use of pink/blue cot cards	Sensitive enquiry by midwifes as to cot card colour reduces stress and anxiety	*"the resources and stuff about pregnancy? They all show pictures of cisgender females. We need to make some gender-neutral ones"* *"The pamphlets and the group names…it's 'mother'-orientated"*
Continuity of care			Group Practice, as it was acknowledged as best pathway to care	*"I didn't have my opinions and my morals shut down"* *"I wasn't put into a box" (stereotyped)* *"you guys [group practice] have been a lot more understanding ….to get me through the pregnancy"*

Client 2: A 21-year-old, also experiencing their first pregnancy, had a complex medical history including a previous pulmonary embolism, intercranial hypertension and postural orthostatic tachycardia syndrome (POTS). They also had an extensive psychiatric history with diagnoses of bipolar disorder, post-traumatic stress disorder (PTSD), autism and stress-induced psychosis. At the time of the pregnancy, Client 2 was using he/they pronouns, although when interviewed 3 months postnatally, they were consistently using they/them pronouns. They explained how they are gender-fluid, and their gender identity and pronouns they feel comfortable with change over time. At the beginning of the pregnancy, Client 2 was in a relationship with a transgender woman who was the other biological parent of the child. However, this relationship had ended by the time the baby was born, in part because Client 2 felt their partner was not supportive and that this lack of support could contribute to social services removing the child from their care.

Due to their complex history, Client 2 attended the Obstetric High-Risk clinic for all appointments with additional support from the Midwifery Group Practice. At 28 weeks Client 2 developed gestational diabetes (GDM) and was treated with insulin. During the antenatal period Client 2 was admitted to the hospital on multiple occasions. Working with the named midwives and the doctors, Client 2 devised a birth plan for induction of labour at 39 weeks. However, after they developed pre-eclampsia and IUGR (intra-uterine growth restriction), an alternative decision for emergency caesarean birth at 35 weeks was agreed.

The MGP midwife was present for the caesarean birth which was uncomplicated. Client 2 achieved 10 min of skin-to-skin with their baby before the infant was transferred to the special care nursery. The MGP midwife was able to ensure all theatre staff were aware of Client 2′s gender identity and pronouns prior to the caesarean section.

Client 2 was very keen to chest feed and express milk for the baby while they were in the Special Care Nursery and felt well supported by their known midwives and nursery staff to do this.

Results/discussion

The results and discussion of pertinent points are outlined below. These are presented interactively as they were discussed within the interviews.

Anticipation of pregnancy care/communication from staff

The opening interview question asked the clients to describe how they anticipated their gender identity affecting their experience of pregnancy care. Both clients anticipated being misgendered by hospital staff which they identified as a source of anxiety. Client 2 described having to brace themselves for being called 'she' and 'mum', which they found dysphoric. This client explained that because their pregnancy was medically complicated, it meant they needed multiple hospital appointments and admissions, therefore maximising the number of times they were called 'mum'. Although this client stated that the midwives in the ward often stumbled with their pronouns, they appreciated the fact the midwives tried to correct themselves when this occurred. They also liked that their chosen pronouns were documented prominently on their case file.

Client 1 anticipated similar issues and worried about being misgendered and feeling feminised. However, they stated having a primary midwife who identified as queer in the MGP model of care made their experience easier than expected. They felt well supported within this model of care as their midwives undertook antenatal appointments at home, which meant they weren't exposed to 'being feminised' in hospital or clinics. These feelings concur with the findings of McCann et al. (2021) who identified similar thoughts from LGBTQIA+ people feeling anxiety around healthcare providers misunderstanding their sexual orientation, and the need for midwifery policies and practices to reflect the distinct needs of this community. Similarly, in a Swedish study Malmquist et al. (2019) reported fear of prejudicial treatment in perinatal care services added to fear of childbirth in transgender

people, as well as lesbian and bisexual women (Malmquist et al., 2019).

Both clients reflected on specific staff members at the hospital who had provided individualised care by respecting their gender identities, which stood out to them at the time and remained clear in their memories. Client 1 and their partner recounted an experience of one paediatrician, who quickly took on the couple's choice to not refer to the baby with gendered pronouns. This change in clinical practice was appreciated and they acknowledged that the health professional was engaged and willing to learn from them.

One client suggested in order to help trans and non-binary people feel safe and supported, that health professionals ask all people for their pronouns when first meeting them, so it becomes second nature. The other client further suggested adding a section in the hand-held pregnancy record which stated each person's pronouns would be beneficial in delivering client centred care.

Education for staff

Findings from the case studies suggested that a broader knowledge of gender diversity would be helpful for pregnant people in the LGBTQIA+ community, and staff members alike indicated their lack of knowledge. This demonstrates the need for university and hospital training to include education on gender and sexual diversity.

Research regarding health workers' interactions with gender-diverse people has identified the need to educate staff to be able to adequately care for trans and non-binary people and treat them with respect. Besse et al. (2020) discuss the need for 'gender-affirming care, across sex-and-gender-specific health care systems and settings, especially as more people embrace gender diversity and fluidity in contemporary society'. They discuss how, despite the growing need for gender affirming care, there remains a paucity within the literature. Limited staff knowledge and occasional blatant transphobia or homophobia has resulted in LGBTQIA+ people having little trust in healthcare staff (Malmquist et al., 2019). This has a negative impact on the short-, medium- and long-term health and wellbeing of LGBTQIA+ people. In maternity services, and particularly for midwives, there is an opportunity to develop a relationship over time, that is mutually respectful and trusting, and this would improve, not only the pregnancy health, but the long-term health and wellbeing of the parents and the child.

In a study by Johansson et al. (2020), midwives reflected on their own lack of knowledge on how to care for transgender men during childbirth. They experienced confusion around how they assumed transgender men would feel about their own bodies, and although wanting to provide high quality care, their own lack of knowledge impeded this. 'Respect, dignity and humility were highlighted as important aspects of support'. It is therefore important that caring for these clients is embedded in both undergraduate education and ongoing professional development for midwives to empower them to provide optimal care for these clients. As new data emerge it will be important for midwives to keep up with the evidence and new developments to improve pregnancy outcomes and implications for the longer-term health of these parents and families.

Gender-inclusive literature

Both participants commented on the absence of gender inclusive literature available from the hospital (consumer pamphlets, posters).

Client 2 stated "*They all show pictures of cisgender females. We need to make some gender-neutral ones*".

Client 1 and their partner suggested the pamphlets could just say *'parent' instead of 'mother'*.

These findings concur with pregnancy services in the UK by Lai-Boyd and Lai-Boyd (2021). These authors identified 'The lack of visual representation in the NHS is both perplexing and outdated for an organisation that advertises itself as a service for everyone at any time. Leaflets, posters, websites – they are all lacking representation of LGBTQIA+ people'. Furthermore, Besse et al. (2020) stated 'obstetric and gynaecological spaces cater to cisgender women through their literature, brochures, décor, and restrooms', these authors comment on the impact of this for transgender people, making them feel 'uncomfortable and unwelcome before even meeting a provider' (Besse et al., 2020).

The information technology (IT) system used by the health service provider, for both these clients, prevented anyone being identified differently from their sex assigned at birth delineated by external genitalia (female, male, indeterminate or unknown). Both clients acknowledged this limitation could cause distress or anxiety when labels are printed on their case notes or ID band. An issue also addressed by Lai-Boyd and Lai-Boyd (2021), who noted: 'the rigidity of IT systems means that midwives are unable to perform simple tasks such as virtually admitting men onto a postnatal ward and a variety of similar issues'. Using birth-assigned sex as an identifier on case notes or ID bands may be unnecessary, as other forms of identification can be more useful, and removing a person's sex may help gender diverse client/patients feel more at ease and respected. Consideration should be given to support systems, such as IT, as simple adjustments could make a difference to these and other client groups.

Client 1 discussed the almost universal use of pink and blue cot cards for babies. Knowing they would be using gender neutral pronouns for their baby, the MGP midwife asked about their preferences and thoughts regarding their baby's cot card during an antenatal appointment. The MGP midwife suggested they could print out a different colour.

Client 1 reflected that the consideration this demonstrated from their midwife made them happy and relieved, as it was something they had been upset and stressed about, but hadn't mentioned. They also suggested that for families with intersex babies, gendered cot cards could cause unnecessary stress. In order to prevent embarrassment, or exposure of sexual orientation, parental preferences or neonatal problems, the introduction of gender-neutral cot cards could be an example of the impact of a minor adaptation to practice providing huge benefit.

Continuity of care

The Australian College of Midwives (2021) recognises midwifery continuity of care as the 'gold standard' for perinatal care www.midwives.org.au. Having a known midwife allows the client and their family to build a trusting relationship and allows the midwife to provide individualised targeted midwifery care according to individual clients' beliefs, values, needs and preferences. In complex cases midwives work together with other care providers as required, and advocate for their client's needs to establish the most rewarding outcome for the client. Both clients in this case study were fast-tracked into the Midwifery Group Practice. It was acknowledged that they would benefit from the continuity of care model and midwives who understood their gender identity and would communicate with other staff to ensure the client did not need to repeatedly explain their identity and needs. It was acknowledged that many staff would be not have experienced caring for gender non-binary people. Both clients were placed with a midwife who is themselves part of the LGBTQIA+ community and who could understand their issues, worries, whilst providing expert care and advocating appropriately for them.

The continuity allowed facilitation between other disciplines involved in the clients' care, where the known midwife ensured the clients' pronouns and identities were understood and respected. The MGP midwife worked with the Perinatal Mental Health nurse to ensure the use of Client 1′s correct name and pronouns and encouraged practicing getting used to using them. Prior to commencement of Client 2′s caesarean section, the obstetrician held a surgical 'team time out', to enable the midwife to explain how best to ensure the client felt safe and respected whilst in theatre.

Each client created a document with the midwife outlining their pronouns, roles, expectations, and preferences, which was placed in the case notes for other staff to refer to. Again, this was a relatively simple action, but had a positive impact on the clients and the multidisciplinary staff caring for them.

Understanding and mutual respect is paramount in the delivery of client centred continuity of care. Client 1 revealed knowing they were cared for by a staff member who was in the LGBTQIA+ community enhanced their journey lowered their anxiety levels and helped them feel more comfortable and respected. Whilst it may not be possible for a midwife from the LGBTQIA+ community to care for all gender diverse people, the importance of continuity of carer for both these clients, with very different birth outcomes, is apparent. Wellbeing SA report states that only 11.7% of birthing people in SA accessed continuity models in 2019 (Wellbeing SA 2021) Increasing support for these programs would mean that more people could receive the care they want and require, especially benefitting people in minority groups who may feel more vulnerable in a mainstream, heteronormative system. In many cases, pregnancy can be a person's first engagement with healthcare services as an adult, so it is important that a person feels safe, listened to and understood, as it could affect future decisions to seek care.

Conclusion

Whilst there are considerable limitations in this study, including the small number of participants and the provision of pregnancy care from one metropolitan health care provider, it does provide insights of the experiences for this vulnerable population. It also concurs with the findings of others internationally in terms of experiences and outcomes (Fish and Bewley 2010; Coleman et al., 2012; Malmquist et al., 2019; McCann et al., 2021). Due to the current limited numbers of non-binary and transgender people accessing pregnancy services it would not be possible to undertake rigorous investigations of model of care, for example. Despite this major limitation the experiences expressed demonstrate a need for adjustments to current standards of practice and training for health professionals providing birth and pregnancy care to gender diverse individuals and their families. There is insurmountable anxiety around being misgendered in health care, especially the perinatal setting, which has been identified previously and these data confirm.

Continuity of care models have been shown to advantageous to many groups irrespective of risk status (Sandall et al., 2016). Given the increased risks of pregnancy complications and psychological impact of pregnancy on transgender and non-binary people (Veale et al, 2016), inclusion of this group in continuity models would appear desirable for optimal outcomes. Continuity of care models reduced the need to retell clients' stories and facilitate individualised care. Staff need to be proactive in care and can learn from engagement encompassing the needs of people in the LGBTQIA+ community.

System-wide change might include IT systems that do not identify people with their assigned sex at birth. Given government classification of sex and gender has long included a third option for those who do not exclusively identify as either male or female, and also has capacity for amendment of previously recorded sex/gender (Australian Government, 2013) the current IT system used in health appears outdated.

Unconditional respect and acknowledgement of staff for individual client needs had long lasting positive memories of the health care system for these people. The introduction of health systems in which every person is asked what their pronouns are at the commencement of pregnancy care was identified as imperative to improving care. Simple changes included a gender-neutral cot card for people not wishing to share the birth-assigned sex of their baby, but introduction of these could increase diversity and avoid stigma for this group and others. The midwifery continuity of care was identified as an integral part for health outcomes for the clients within depth understanding of LGBTQIA+ persons identities and preferences could help ensure that other staff members were respectful and inclusive, negating the need for client explanation.

Further training and education is required for frontline staff and service providers to address some of the issues identified, both in terms of patient encounters but also in consideration of the pregnancy care environment. Lai-Boyd and Lai-Boyd (2021) and others have identified these issues in other countries and health care settings. It would appear, currently, that health care providers in many countries fail to meet he needs of this group within standard service provision.

This small study identifies a minority group that require further investigation, in terms of optimising care and pregnancy outcomes. Given the reported poorer health outcomes for transgender and non-binary individuals, and the public health role of midwives, engagement with and positive experiences of pregnancy care services has the potential to improve the short medium- and long-term health of these people and their children. The findings from this research provide a pathway for further research to explore the experiences and needs of gender diverse people accessing pregnancy care.

Ethical approval

This Quality Improvement Project was granted approval by North Adelaide Local Health Network (reference number QI 4960. Approval for publication of the outcome was granted from Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC) Reference number: 16,941.

Funding sources

This work was undertaken as a Quality Improvement project and received no funding.

Clinical trial registry

Not applicable.

Contribution of authors

Matilda Copeland: conceptualisation, data acquisition, formal analyses, prepared original draft. **Julie Tucker:** conceptualisation, formal analyses, methodology, project administration, supervision. Writing- review and editing. **Annette Briley:** conceptualisation, formal analyses, methodology, project administration, supervision, Writing- review and editing.

Declaration of Competing Interest

None declared.

Acknowledgements

The authors acknowledge the contribution of the families who allowed us to tell their stories. Thanks also to Dr Megan Cooper and Dr Alison Coppe for their support and assistance is reviewing final drafts.

References

Australian College of Midwives website, 2021, https://midwives.org.au/Web/Web/About-ACM/Who-we-are.aspx?hkey=2ac07796-f05c-4b5a-a171-a4bda83b9d56#:~:text=ACM%20believes%20all%20women%20should,evidence%20to%20prove%20this%20fact. Accessed 15th August 2022.

Australian Government, 2013. Australian Government Guidelines on the Recognition of Sex and Gender. Australian Government www.ag.gov.au/sites/default/files/2020-03/AustralianGovernmentGUidelinesontheRecognitionofSexandGender.pdf.

Besse, M., Lampe, N.M., Mann, E.S., 2020. Experiences with achieving pregnancy and giving birth among transgender men: a narrative literature review. Yale J. Biol. Med. 93 (4), 517–528.

Coleman, E., Brockting, W., Botzer, M., et al., 2012. Standards of care for the health of transsexual, transgender and non-gender conforming people, version 7. Int. J. Transgenderism 13 (4), 165–232.

Fish, J., Bewley, S., 2010. Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities. Health Soc. Care Commun. 18 (4), 355–362.

Hyde, Z., Doherty, M., Tilley, P.J.M., McCaul, K.A., Rooney, R., Jancey, J., 2014. The First Australian National Trans mental Health Study; Summary of Results. School of Public HealthCurtin University, Perth, WA.

Johansson, M., Wirén, A.A., Ssempasa, D., Wells, M., 2020. A qualitative study of midwives' challenges to support transmen during childbirth: a short report. Eur. J. Midwifery 4, 3.

Knudson, G., De Cuypere, G., Brockting, W., 2010. Recommendations for revision OD the DSM diagnoses of gender identity disorders: consensus statement of the world professional association for transgender health. Int. J. Transgenderism 12 (2), 115–118.

Lai-Boyd, B., Lai-Boyd, S., 2021. Pride in maternity, LGBTQIA+ maternity care. In: The Practising Midwife September, pp. 13–15.

Light, A., Wand, L.F., Zeymo, A., Gomez-Lobo, V., 2018. Family planning and contraception use in transgender men. Contraception 98, 266–269.

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

McCann, E., Brown, M., Hollins-Martin, C., Murray, K., McCormick, F., 2021. The views and experiences of LGBTQ+ people regarding midwifery care: a systematic review of the international evidence. Midwifery 103.

Obedin-Maliver, J., Makadon, H.J., 2016. Transgender men and pregnancy. Obstet. Med. 9, 4–8.

Sandall, J., Gates, S., Shennan, A., Devane, D., 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst. Rev. (4), CD004667.

Shepherd, A., Hanckel, B., Guise, A., 2019. Trans Health and the Risks of Inappropriate Curiosity. BMJ Opinion 9 Sep 2019 www.htpps://blogs.bmj.com/bmj/2019/09/09trans-health-and-the-risks-of- .

Shine SA, 2022. Gender and Sexual Diversity 101 – Information Sheet https://shinesa.org.au/media/2022/05/Gender-and-Sexual-Diversity-101-Information-Sheet.pdf.

Statista, 2021. Gender Identity Worldwide 2021, By Country. Statista www.statista.com/statistics/1269778/gender-identity-worldwide-country/.

Somerville, C., 2015. Unhealthy Attitudes: the Treatment of LGBT People Within Health and Social Care Services. Stonewall, London.

Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A., 2017. Trans pathways: the mental health experiences and care pathways of trans young people. Summary of Results. Telethon Kids Institute, Perth, WA.

Stewart, K., O'Reilly, P., 2017. Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: an integrative review. Nurse Educ Today 15, 67–77.

Van Manen, M., 1990. Researching the Lived Experience Human Science For an Action Sensitive Pedagogy. University of Western Ontario, USA.

Veale, J., Watson, R.J., Adjei, J., Saewyc, E., 2016. Prevalence of pregnancy involvement among Canadian transgender youth and its relation to mental health, sexual health and gender identity. Int. J. Transgender 17, 107–113.

Wellbeing SA, 2021. Supporting Your State of Wellbeing Pregnancy Outcomes. Wellbeing SA www.wellbeingsa.sa.gov.au/evidence-data/pregnancy-outcome-statistics.

White Hughto, J.M., Reisner, S.L., Pachankis, J.E., 2015. Transgender stigma and health: a critical view of stigma determinants, mechanisms and interventions. Soc. Sci. Med. 147, 222–231.