Experiences of Pregnancy and Birthing for Trans and Non-Binary People in the UK

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July, 2023

Research submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), Royal Holloway, University of London.

Acknowledgements

First and foremost, I want to sincerely thank the 12 participants who took part in this study. I am beyond grateful for your deep generosity in sharing your time and experience, and feel honoured to have heard your stories, insights and reflections. This research has pushed me more than ever to keep working for change and liberation for trans people.

I want to thank my supervisors, A.J., Helen, Nuno and Jay, for their generous support. I have been learning, thinking and growing consistently throughout this project as a result of your guidance. I have been consistently challenged to think differently, more broadly, harder and deeper, and I feel so incredibly lucky to have received your insight. Your kindness and thoughtful feedback has shaped this piece of work immeasurably, and you have helped me to see how exciting and inspiring research can be.

To my family; mum, dad, Eja and mamma, thank you always for being beside me and for your unwavering support. A special thank you to my nanna, who would have been proud to see this. To George: I will be forever grateful for your words of encouragement, words of affirmation, being a proofreading whirlwind, and generally helping me to keep life on track whilst this piece of research took over. I am so fortunate and thankful to have you by my side. Finally, thanks to Pickles, my little pup, who has been a ray of sunshine and (literally) glued to my side throughout this process. I don’t thank her for barking during my interviews, though.

Contents

Lay Summary

Overview

This project is made up of two parts:

1) A research study (empirical paper)

2) A review paper (systematic review)

Language

- ‘Trans’: Someone whose gender feels different than the gender they were told to be at birth
- Non-binary: Lots of genders that are different than ‘man’ and ‘woman’. These genders can be outside of, in between, or a combination of identities. Some non-binary people also identify as trans
- ‘Cisgender (cis): is the word to describe someone whose gender feels the same as the gender they were told to be at birth
- Perinatal care: Care received during pregnancy and birth, and for one year after birth

Part 1: Research Study

Background

More trans and non-binary people are becoming pregnant and having babies, but they have worse experiences of perinatal care than cis women. They are more likely to become physically or mentally unwell through pregnancy and birth, and are less likely to use perinatal care. Lots of trans and non-binary people don’t use any care at all during the perinatal period.

Aim:

To understand trans and non-binary peoples’ experiences of perinatal care, and why they are less likely to use care during the perinatal period.

What did I do?

I interviewed 12 trans or non-binary people who were currently pregnant or had given birth in the last five years. I recorded the interviews, then typed them word-for-word so I could find similarities between different trans and non-binary peoples' experiences. This process is called 'Thematic Analysis'.

What was found?

I created two themes to describe these experiences:

- '**Navigating assumptions of womanhood'**

  This means that when trans and non-binary people go to perinatal services, people expect or assume them to be a woman

  This can make some people feel invisible, but for others, it feels like too many people can see them

  This is hard for trans people, as they want the people who are caring for them to understand who they are

  It also makes it harder for them to use services because computer systems and documents usually do not have options for trans or non-binary people

- **'Empowered autonomy: Personal narratives of choice, control and safety'**

  This theme talks about how trans and non-binary people make choices about their care, and how in control they feel about what happens to them

  Sometimes, the right choice is not available for trans and non-binary people in perinatal care, and this can make them feel more out of control or unsafe

  As services don't have a good understanding of trans and non-binary people and their needs, they might need to explain who they are and what they need

This can be hard, especially for people with health problems, mental health problems, and disabilities

Sometimes, using services and having to explain your needs can be too hard, and trans and non-binary people might try to use perinatal care less

Conclusion

There are many things that make it hard to use perinatal services for trans and non-binary people. Trans and non-binary people might try to avoid care if it feels too hard, too unsafe, or they feel too out of control. Because of this, it is important for perinatal services to:

- Use words that trans and non-binary people choose when talking about their bodies or their gender. This is different for everyone
- Ask trans and non-binary people if they need some extra support to feel safe and talk about their needs
- Make sure that documents and computer systems work for trans people
- This means staff in perinatal services need more support to understand trans and non-binary people and help them to feel safe

What happens next?

I want perinatal services to understand this research so they can support trans and non-binary people better. I also want to make this research available to researchers, healthcare, and other organisations, so that more people can understand it.

Part 2: Systematic Review

Background

Lots of LGBT+ people want to become pregnant and give birth to children. There are some legal issues that have made it hard for LGBT+ people to have babies, but these things are starting to change. When laws change, systems and peoples' attitudes can be slower to change. This means that LGBT+ can have worse outcomes in perinatal care than non-LGBT+ people.

Aim:

This study aimed understand what research tells us about LGBT+ peoples' experiences of perinatal care.

What did I do?

This type of study is called a systematic review. It is called this because it searches all the available data to find studies that answer the aim, then reviews them together to see what current research says about the topic. I searched for studies using many different words that can mean 'LGBT+ people', 'perinatal', and 'care and support'. As I wanted to understand peoples' experiences, I looked for research using words as data, called qualitative research.

Through the search, 3021 research studies were found. Thirteen of these were looking at all the right topics and answered the question. I brought data from all of these papers together and found shared themes between them.

What was found?

I created two themes to describe the shared experiences between LGBT+ birthing people:

- **'A prejudiced system'**

  This means that perinatal services are not set up for people who are not cis or heterosexual

LGBT+ people sometimes feel that they are treated differently or badly because of their identity

- **‘Feeling seen and heard’**

  LGBT+ people want to feel like services understand them and their families

- **‘Control and empowerment’**

  LGBT+ people often feel nervous or scared in perinatal care

  This means they feel like they need to take responsibility for their own care

  LGBT+ people gave lots of examples of when care made them feel in control and safe

Conclusion

Lots of things can make it hard for LGBT+ people to use and feel safe in perinatal care and they sometimes feel nervous or afraid to use perinatal care. The review gave some ideas to help LGBT+ people feel better supported.

Paper 1: Experiences of Pregnancy and Birthing for Trans and Non-Binary People in the UK

Abstract

The limited amount of research on pregnancy and birthing for trans people indicates that perinatal care is a challenging environment for these communities, and that there are many barriers to access. Recent research in the UK has found that trans people are less likely to seek care during the perinatal period than cis women, with around 30% forgoing care entirely throughout the perinatal period. In addition, trans people have worse experiences and outcomes when they do access perinatal care. This study aimed to 1) Develop a better understanding of how trans people experience perinatal care and, 2) Understand why trans people may be less likely to access perinatal care. Semi-structured interviews were completed with 12 trans birthing people and analysed using thematic analysis. The data was captured in two overarching themes: 1) ‘Navigating assumptions of womanhood’ and 2) ‘Empowered autonomy: Personal narratives of choice, control and safety’. The results support existing research about the inaccessibility of perinatal care for trans people, and adds richness and nuance to narratives around how challenging the experience of accessing care can be. A series of recommendations for clinical practice and future research are made.

Key words: Trans, non-binary, perinatal care, experiences, thematic analysis

Glossary of Terms

Biological-essentialism: The belief that characteristics and behaviours are determined by biology

Birthing person: A person who is pregnant or has previously given birth

Chest / Breast / Infant feeding: The act of feeding a child milk from a person's chest

Cisgender (cis): When an individual is aligned with the gender they were assigned at birth

Capacity for pregnancy: Individuals who are biologically capable of pregnancy

Gender dysphoria: Psychological distress experienced due to an incongruence between one's gender identity and their gender. Can also be caused by the perception or behaviour of others

Freebirth: To give birth without medical supervision, including births that happen before medical supervision can arrive

Gender modality: How an individual's gender stands in relation to their assigned gender at birth

Gender-affirming hormone therapies: Administration of hormones to support alignment with gender identity

Gestational parenthood: The act of becoming a parent through carrying and birthing a child

Global Majority: People who are Black, Asian, Brown, dual-heritage, indigenous to the global south, and/or have been racialised as 'ethnic minorities', and form the majority of the global population (Campbell-Stevens, 2020)

Intersectionality: The overlapping of marginalised identities and interconnected systems of oppression, including race, gender and disability (Crenshaw, 1989)

Non-binary: An umbrella term capturing definitions of gender that fall outside of the male-female binary, including conceptualisations that are specific to a community or cultures (Vincent & Manzano, 2017)

Perinatal care: Healthcare surrounding pregnancy, including pre, post-natal, and support during birth

Perinatal period: The time spanning pregnancy, birth and up to one year post-birth

Repronormativity: The assumption and expectation that all humans have the desire to reproduce

Transgender (Trans): Modality describing an individual whose gender identity differs from that assigned at birth

Transmasculine: Trans modalities in which the individual aligns with masculinity in some way

A Note on Language

It is essential to recognise the role of language in speaking to the experiences of trans communities, and acknowledge the nuance, complexity, and care with which terminology is crafted to convey experience. I have selected terms with the aim of treading the fine balance between clarity in writing and accurate reflection of identity.

I use ‘birthing person’ to stand against biological-essentialist and repronormative narratives, reflecting that not all cisgender women are birthing people, for example, some do not have the capacity or desire for pregnancy; and not all birthing people are cisgender women.

When discussing gender, this study aligns with Ashley's (2021) proposal of the term 'gender modality', to describe how an individual's gender identity is positioned in relation to their gender assigned at birth. This description captures both cis and trans modalities, and is inclusive of people who do and do not claim cis/trans modality as an aspect of their gender identity. For example, a trans man and a cis man share the gender identity of ‘man’ but have differing gender modalities in ‘cis and ‘trans’ respectively. Trans as a modality concept also captures non-binary people, insofar as nonbinary people do not identify with their assigned gender. Modality also speaks to the gender experiences of intersex people, who often do not fit into a strict cis/trans dichotomy. This also allows reflection on gender as a culturally constructed phenomenon: the dominant Western narrative does not reflect experiences of gender in all cultures and societies. The broadness of gender modality allows for inclusion of multiple identities, but also welcomes elaboration.

The modality of ‘trans’ will be used to describe anyone whose gender identity differs from that assigned at birth, including all trans and non-binary identities. Where appropriate, I will name specific identities, including when referring to study participants, and where associated relevant literature has focused on specific groups.

Introduction

Context: Being Trans in the UK

To contextualize trans birthing peoples’ experiences, it is imperative to consider the historical context and current climate for trans people living in the UK. Of UK adults, 0.5% (262,000) are trans, of which 48,000 are trans men, 48,000 are trans women, 30,000 are non-binary, and 18,000 are a different gender identity (Office for National Statistics [ONS], 2022). This is likely to be a conservative estimate, and other sources approximate that there are between 200,000 and 500,000 trans people in the UK (Government Equalities Office, 2018). At present there is no way to estimate the number of trans people with capacity for pregnancy, as it is unclear from the above data how many non-binary people would be included.

There are a few key pieces of legislation that purport to protect the rights of trans people. The Equality Act 2010, states trans people should be protected from discrimination in the workplace and in wider society. The Equality and Human Rights Commission Statutory Code of Practice (2011) states trans people should be treated in accordance with the gender identity in which they present, but makes an omission under ‘exceptional circumstances’. The process of obtaining a Gender Recognition Certificate (GRC), an important part of social and legal transition for many trans people, is governed by the Gender Recognition Act 2004. A GRC is required to align one’s gender on legal documents such as birth, marriage, and civil partnership certificates. There is presently no legal recognition of gender offered to non-binary people, nor for those under the age of 18.

To receive a GRC or access gender-affirming care, including hormones and surgery, trans people are required to provide evidence of a diagnosis of 'gender dysphoria', as defined by the DSM V (American Psychiatric Association, 2022) from an approved medical practitioner, namely psychiatrists and psychologists. Many trans people view the involvement of psychiatry in applications for gender recognition negatively and feel the process should be reformed (Hines, 2013). As such, the depathologising of trans identities has been central to trans activism for many years (Hines, 2020). Assessment for gender dysphoria can be accessed under the UK's publicly funded National Health Service's (NHS) Gender Identity Clinics (GICs), where conservative estimates of wait times for access an initial appointment currently stand at four years (GIC, 2022). Alternatively, trans people can pay private clinics for assessment. Private healthcare providers, and therefore health insurance covering access are not the norm in the UK, meaning this option is costly and inaccessible to most. Extended wait times for gender-affirming care can have a profound effect on wellbeing (Wright et al., 2021) and it is for this reason in part that trans people have poorer mental health outcomes (Bailey et al., 2014). Eighty-four per cent of trans people have thought about ending their life, and 48% of those have made a suicide attempt (McNeil et al, 2012).

These huge mental health disparities for trans people can be explained by minority stress theory (Brooks, 1981), which posits that marginalised groups are subject to cumulative stressors, owing to both discrimination and internalised stigma. In turn these lead to poorer physical and mental health outcomes for these groups comparatively. This model was initially developed to explain healthcare disparities in LGBT+ populations, but more recently it has been applied specifically to trans people (Hendricks & Testa, 2012). Research indicates that minority stress theory may explain elevated rates of mental health difficulties (Dolezal et al., 2023) amongst trans populations. Misgendering can also contribute to psychological distress and depression-related symptoms (McLemore, 2018), as can structural discrimination, such as lack of access to facilities, legal support, and healthcare (Lefevor et al., 2019).

Structural discrimination is increasingly evident in the UK. There is an overwhelming sense amongst the trans community that the UK is not safe for them, with the majority having experienced transphobic victimisation, and many feeling at risk of further victimisation in the future (Ellis, Bailey & McNeil, 2016). These feelings are compounded by a series of wider systemic factors. For example, the government has continually overturned legislation designed to support trans people, including the Scottish parliament's Gender Recognition Reform Bill (2022; House of Commons Library, 2023), and the exclusion of trans people from a ban on identity-related change efforts commonly known as 'conversion therapy' for wider LGB+ people (House of Commons, 2021).

Alongside this lack of tangible legal protection, there has been a significant rise in anti-trans feminist rhetoric in the last five years led by groups of 'gender-critical feminists' (Thurlow, 2022), who believe that trans existence is a threat to cis women's rights. This hostile rhetoric is fuelled by the media, with attention increasing dramatically in line with the rise of gender critical feminism. Daily Mail coverage of trans issues has increased by 1800% since 2013, centring inaccurate and harmful portrayals of trans people that delegitimise and ridicule the trans community (Leveson & Leveson, 2012).

Amongst this hostility, trans people have experienced a measurable rise in physical violence. The number of reported hate crimes against trans people has increased by 56% from 2021 to 2022, and by 1300% in the past ten years (Home Office, 2022). Trans people of the Global Majority are disproportionately impacted by violence (Fitzgerald, 2017) and may also experience intraracial violence within their own communities due to their gender modality (Meyer, 2012).

Trans people experience significant inequities in access to general healthcare (Whitehead, 2017), with 7% having been denied treatment due to their identity (Bachmann & Gooch, 2018). When they do access care, trans people report negative experiences, including 41% feeling that healthcare staff do not understand their needs, and 24% fearing discrimination from healthcare providers (Bachmann &

Gooch, 2018). These factors, in combination with the wider socio-political issues outlined above, lead many trans people to exhibit a mistrust of healthcare systems and professionals (Pearce, 2018).

Trans Pregnancy and Parenthood: Global Research

Research suggests that trans people desire parenthood at the same rate as cis individuals (Moravek, 2019). Among transmasculine people, 39% desire parenthood (Defreyene et al., 2020), with 9.3% intending upon gestational parenthood (Stark et al., 2019). There are currently no studies measuring pregnancy intentions amongst non-binary people, but it is known that their most common path to conception is through gestation (Tornello et al., 2019). Of the US trans population, 12% have been pregnant (Moseson et al., 2021), and pregnancy rates among trans youth (Veale et al. 2016), and trends in research participation (LGBT Foundation, 2022; Love, 2022), indicate that the population of trans birthing people is increasing.

A considerable portion of the transmasculine and non-binary population access the gender-affirming hormone testosterone. For many years, it was maintained that use of testosterone may impact fertility and reproductive function (The World Professional Association for Transgender Health [WPATH], 2022), with one publication stating that testosterone use would render individuals infertile (Blustin, 2005). These narratives led to misplaced beliefs that trans people could not become pregnant after former hormone use, or that it would negatively impact the health of the baby. This has since been disproven, and when testosterone is stopped at the appropriate time, there are many documented cases of healthy pregnancy and birth in trans people (Obedin-Maliver & Makadon, 2016; de-Castro-Peraza et al., 2019), with research indicating no resulting differences in perinatal complications (Light et al., 2014).

It is important to note that 16.4% of trans people mistakenly believe using testosterone acts as a contraceptive, and 5.5% were led to believe this by healthcare providers (Light et al., 2018). Individuals can and have become pregnant whilst actively using testosterone (Hahn et al., 2019; Hoffkling et al., 2017), with research indicating that one-third of pregnancies in trans men were accidental (Light et al., 2014). However, active use of testosterone whilst pregnant is harmful for the foetus, and therefore it is essential that individuals cease testosterone treatment when pregnant, or trying to become pregnant (Green & Riddington, 2020). Overall, there is still a paucity of research into testosterone's impact, meaning an overall fecundity rate for trans men cannot be calculated (Moravek et al., 2020).

At present, Australia is the only country that gathers data on the number of trans people in perinatal care (Pearce, 2019). As rates of pregnancy increase among trans people, it is inevitable that these communities present more frequently in perinatal settings. When navigating perinatal healthcare, trans birthing people face a myriad of unique challenges. For some, the experience of pregnancy, birthing (Light et al., 2014) and chestfeeding (MacDonald et al., 2016) can induce or exacerbate gender dysphoria, and positive psychological outcomes are dependent on trans people experiencing healthcare during pregnancy that is inclusive and affirmative of their identity (Obedin-Maliver & Makadon, 2016; Makadon et al., 2008). However, research conducted in the US (Light et al., 2014) and Sweden (Falck et al., 2020) indicates that healthcare providers have low levels of awareness about the unique needs of the trans people, and feel underconfident in supporting them (Johansson et al., 2020). Trans men (MacLean, 2021) and non-binary people (Fischer, 2020) feel isolated and invisible in birthing contexts, and may conceal their identity (Lowik, 2022) or avoid seeking support due to lacking availability of gender-affirming care (MacLean, 2021).

This lack of consideration and understanding translates into care outcomes. Despite increasing numbers of trans birthing people, they are more likely to encounter discrimination and improper treatment when accessing perinatal care

(Gedzyk-Nieman & McMillian-Bohler, 2022), and are more likely to experience traumatic birth (Greenfield & Darwin, 2020). These inequities could be linked to several socio-political factors. Trans people have historically been delegitimised in their reproductive capacities through practices of eugenics (Lowik, 2018). Although forced sterilisation of trans people was not enshrined in law in the UK, the surgical removal of reproductive organs is encouraged on medical grounds, despite little clinical evidence (Toze, 2018). Trans people fall under what Love (2022) defines as "deviant reproduction", one which society views as undesirable or unfit. This is reflected in the long-held medico-legal denial of trans pregnancy (Toze, 2018).

As a result, trans peoples' ability to navigate perinatal healthcare systems is largely dependent on their ability to advocate for themselves (White, 2018), an additional unpaid, invisible labour. Self-advocacy is more challenging for those who are multiply marginalised (Norris & Borneskog, 2022), and it is known that trans people are more likely to face mental health issues (McNeil et al., 2012), unemployment (Davidson, 2016) and trauma (Mizock & Lewis, 2008). Additionally, there is an increasing recognition that trans people are more likely to be neurodiverse. Recent research suggests trans individuals have higher rates of both diagnosis and self-reported traits, and it is estimated that trans people are three to six times more likely to be autistic (Warrier et al., 2020). Autistic people experience a range of barriers when accessing healthcare, including challenges communicating needs (Mali-Soni et al., 2022). In combination, these factors mean that trans people as a population are exponentially disadvantaged in perinatal care, and the most marginalised are likely to be the most severely impacted.

Trans Pregnancy in the UK

Regarding the general climate for trans people in the UK, there have been several instances of trans pregnancy and birth which have been reported and sensationalised by the media. Sensationalism of trans pregnancy by the media contributes to the view of trans birthing people as ‘other’, focusing more on the novelty and exotification of male pregnancy than the human experience, and strengthens the exclusive cis-heteronormative notions around pregnancy and birthing (Pearce & White, 2019). The labelling of the ‘first pregnant man’ in both 2012 and 2017 erases the existence of countless trans men who have given birth before this (Toze, 2018), and the complete lack of acknowledgement of non-binary birthing people is noteworthy, indicating that these identities may be seen as invalid or unimportant (Fiani & Han, 2020).

While the media sensationalises the existence of trans birthing people, legislative processes erase them entirely, as there is a complete absence of national guidance provided to NHS services. A policy review indicated that whilst there are no formal barriers to trans pregnancy in the UK, there is no consideration for trans people in policy (White, 2018). One such example is that a trans person who gives birth will be registered as the child's mother, regardless of their gender identity or possession of a GRC (McConnell and YY v. Registrar General, 2020). Brighton and Sussex (BSUH) NHS trust has developed its own local guidance and has a specific gender inclusion arm to support trans and non-binary service within its perinatal care service (Green & Riddington, 2020). However, this trust is responding to a local need, rather than following national guidance, from which local guidance would usually be derived. The complete absence of national guidance indicates a lack of awareness or acknowledgement of trans birthing people’s needs on a national scale.

A limited range of research exists exploring the experiences and needs of trans birthing people in the UK context. There are several studies linked to one international sample, with a subset of participants from the UK. An exploration of the embodied experiences of pregnancy (White et al., 2021) examined the complex social narratives around the trans pregnant body, and how being observed as pregnant can be challenging to navigate. Research examining the experiences of conception (Riggs, Pfeffer et al., 2020) and pregnancy loss (Riggs, Pearce et al., 2020) found a need for targeted services, and greater consideration of trans people in routine healthcare environments.

In response to the absence of studies exploring the outcomes and experiences of trans people in the UK, the LGBT Foundation (2022) conducted a mixed methods study on the experiences of 121 trans birthing people in the UK with a rich, racially diverse sample, of which 32% were from the Global Majority. Findings were compared to a survey of cis birthing women by the Care Quality Commission (CQC, 2022). Thirty per cent of the trans sample did not access any medical care through the duration of their pregnancy, with this figure rising to 46% for people of the Global Majority. Regarding cis women forgoing care, the closest comparison is that 2.4% of cis women gave birth at home, or before they could arrive at their birthing place (ONS, 2020). Of the trans participants who did not access care, around half desired the presence of a midwife during the birth but felt unable, and 80% did not feel confident in accessing perinatal care. This suggests that mistrust or fear influences decisions around access.

Regarding care received during the perinatal period, more than half of the sample felt they were not spoken to in a way that respected their gender. More than 50% felt that their decisions around feeding were not respected by midwives, compared with only 15% of cis women. Additionally, trans birthing people were twice as likely than cis women to report receiving insufficient information on infant feeding. Overall, this suggests trans people have poorer outcomes and worse experiences of perinatal care.

Four trans birthing people, two of which were of the Global Majority, were purposively sampled to participate in a follow-up qualitative interview focused on their individual experiences of perinatal care. All four interviewees reported concealing their gender in order to feel safe, and as an attempt to improve their care, despite this leading to gender dysphoria. Participants of the Global Majority were subject to both racism and transphobia, and identified that navigating this intersection made it more challenging for healthcare providers to understand their experience, leading them to feel dehumanised. Previous research with cis people also speaks to these experiences of medical racism, in that people of the Global Majority are less likely to receive adequate pain relief in healthcare settings (Hoffman et al., 2016) and are five times more likely to die during childbirth (Knight et al., 2009). The interviewed participants identified that trans people of the Global Majority cannot feel safe unless services address both transphobia and racism. As highlighted in the LGBT Foundation's (2022) paper, NHS perinatal services are not prepared to serve the trans birthing community, and additional research, guidance (Roosevelt et al., 2021), and ultimately, reform of perinatal care is necessary to meet their needs (Kukura, 2022).

In light of the literature reviewed above, it is essential that a clearer understanding is developed of trans people's experiences around accessing perinatal care in the UK context. As such, this study had two primary aims: The first was to understand how trans birthing people experience NHS perinatal care and other perinatal services in the UK. The second was to develop an understanding of why trans birthing people may be less likely to access perinatal care than cis women. To answer these questions, the study employed Braun and Clarke's Thematic Analysis (2006; 2021b) to analyse interviews with trans birthing people. This research can support in the theoretical understanding of trans peoples' experiences, which can guide services in clinical practice and inform policy and future research to better support the trans birthing population in their access to perinatal care.

Methods

Participants

Inclusion and Exclusion Criteria

The study invited the experiences of self-identified trans birthing people, inclusive of all trans and non-binary identities, who were currently pregnant or had given birth in the last five years. This timeframe was selected so that participants' experiences were temporally situated in the current sociopolitical climate. The last five years in the UK have seen a rise in visibility and discourse around trans people (Folan, 2023; Leveson & Leveson, 2012), and trans reproductive rights, since the release of a documentary about UK father Freddie McConnell's birth story (Cornwell & Finlay, 2019) and legal fight to be named father on his child's birth certificate (McConnell and YY v. Registrar General, 2020). The study invited participants who had or had not accessed NHS care during the perinatal period. People of all languages were invited, with the offer of an interpreter if required. Participants were unable to take part if they were outside of the UK at the time of pregnancy or birth, or if they were under 16 years of age, due to differences in capacity to consent under NHS procedure (NHS, 2022).

Participant Characteristics

All participants (n=12) were white British, and all had accessed NHS care during both pregnancy and birth. As identified through the diversity wheel, the sample was rich and diverse in other ways, including those with disabilities, mental health difficulties, trans partners, urban and rural locations and varied relationship structures, including single parents and polyamorous people. These self-identified characteristics were used to inform some specific questions in the interviews, and is therefore captured in participants' narratives, so is explored in the analysis. A full breakdown of core demographic characteristics can be found in Table 1. Participant ages (mean = 33, median = 33) are included as a range, and birth dates are rounded up or down to protect anonymity.

Table 1:

Sample Characteristics

Pseudonym	**Gender**	**Pronouns**	**UK Region at time of birth**	**Pregnant or Postnatal (years postnatal)**	**Previous births**	**Age range**
Finn	Non-binary/ trans man	He/him	South West	Pregnant	None	30-34
Ricky	Trans man	He/him	South East	Pregnant	None	30-34
Billy	Non-binary	They/them	South East	Postnatal (<1 year)	None	Undisclosed
Hayden	Binary trans Man	He/him	North West	Postnatal (3 years)	None	25-29
Toni	Queer	They/them	South East	Postnatal (<1 year)	None	30-34
Kai	Non-binary/ Agender	They/them	East	Postnatal (<1 year)	None	30-34
Kip	Non-binary/ Genderqueer	They/them	South East	Postnatal (2 years)	None	35-40
Margot	Non-binary	They/them	South East	Postnatal (1 year)	None	30-34
River	Non-binary/ Genderfluid	They/them/she	North East	Postnatal (<1 year)	Three	30-34

Milo	Non-binary/ Genderfluid	They/them	South East	Postnatal (3 years)	None	35-40
Claude	Transmasc	They/he	South East	Postnatal (5 years)	One	40-44
Paris	Genderqueer	They/them	Wales	Postnatal (<1 year)	None	35-40

Recruitment

Participants were recruited through social media pages of LGBTQ+ and trans community organisations, and queer birthing pages. Two phases of recruitment were completed in December 2022 and February 2023. The second round aimed to recruit participants of the Global Majority. Advertisements (Appendix A) were shared by The Queer Birth Club, The Queer Parenting Partnership, UK Black Pride, Black Brown Rainbow and Gendered Intelligence. Adverts were also shared in several closed social media groups and Discord servers aimed at trans people and trans parents, with permission of the administrators. Some participants also requested to share materials within their personal networks, meaning a degree of snowball recruitment may have been involved.

Adverts included the lead researcher's email address for interested participants to contact. At this stage, participants were invited to share any accessibility requirements, so that communications and information could be provided in an alternative format if required. Participants were then emailed an information sheet (Appendix B) and invited to ask questions, and confirmed their interest in taking part by email.

Twenty-three participants contacted the researcher to express their interest in the study. Of these, ten did not follow up after receiving the information, and one got in touch after recruitment for the study had closed. All twelve remaining participants were eligible and consented to take part. Participants received £10 in Love2Shop vouchers to thank them for their emotional labour and time.

Sampling

Convenience sampling was utilised. Braun and Clarke (2021c) argue against the concept of data saturation as a method to determine sample size in advance of data collection. Instead, they encourage a pragmatic and reflective process, such as setting an upper and lower limit, with the final size determined by both practical constraints and richness of data. A lower limit of 10 participants and an upper limit of 20 was determined, which was felt to be appropriate due to the limited population size. When 10 participants had been recruited, the research team reviewed the sample and opted for a second round of recruitment aimed at diversifying the sample and recruiting participants from the Global Majority. Two additional participants came forward, and this was determined as an appropriate sample size due to the length of interviews and richness of the narratives. Additionally, this sample size is in line with recommendations for a doctoral project (Braun & Clarke, 2013).

Materials

An interview schedule (Appendix C) was developed by the research team, guided by the literature and the aims of the study. We were unable to involve an Expert by Experience (EbE) in this phase of the research due to limited budgets and procedural constraints, as the EbE was employed to support with the dissemination phase. Interviews began with a minimal set of demographic questions covering pronouns, gender, ethnicity, approximate UK region at time of pregnancy and birth, date of child’s birth or expected due date, and age. Interviews sought to explore five key facets of pregnancy and birth: participants’ story of conception and birth; their views of the perinatal healthcare system; feelings toward the system; experiences of the system and care they received; and whether, and if so how, the system needs to change.

The schedule underwent several iterations. An additional introductory question was added to the initial draft so that participants had an opportunity to begin the interview by sharing their journey to conception before asking questions about the system and their experiences of healthcare. This question does not address the research questions but was included to allow for rapport-building (Dempsey et al., 2016), and for participants to situate themselves in the experience. During the early interviews, the question order was adjusted slightly, in line with participant feedback and the the narrative flow of interviews. Individual interviews were chosen to gather data as they support generation of rich detailed accounts, which is necessary when little is known about a phenomenon (Gill et al., 2008). This was selected above group interviews, as the public nature can prevent exploration of individual experiences (DiCicco-Bloom & Crabtree, 2006).

A diversity wheel based on Burnham's (2018) GRACES was created in collaboration with artist, Flatboy (Figure 1). The GRACES are a way of exploring the layers of a person's social and personal identity, along the dimensions of visible-invisible, and voiced-unvoiced (Burnham, 2018). This was included to invite participants to share characteristics that felt salient in their narrative, rather than asking a long and largely redundant list of demographic questions. It also encouraged them to reflect on their positioning and consider how this might have played into their experience of pregnancy and birth. Furthermore, this invitation was an attempt to set the scene for an interview in which the researcher was not positioned as the expert and holder of power, but for a consensual relationship in

Figure 1

Diversity Wheel by artist Flatboy

which the participant had control over the personal information and experiences they chose to share (Turnhout et al., 2019). This information was used to shape the interviews, allowing the researcher to explore how specific identity characteristics impacted the participant's experiences, and as such is not reported here. Other materials included a consent form (Appendix D), debrief sheet (Appendix E), and a help and support sheet (Appendix F), all developed by the research team in accordance with the university's ethical and data handling guidelines.

Procedures

Interviews were completed between December 2022 and March 2023, and lasted between 39 and 125 minutes (mean = 77, median = 75). Participants were offered a video, telephone or in-person interview, but all opted to meet virtually. The interview process was outlined, and participants were invited to ask any questions. If they were content to proceed, they digitally signed the consent form (Appendix D). Participants were invited to schedule a break and were reminded that no questions were compulsory. To begin, participants were asked the demographic questions, then shown the diversity wheel and invited to share any characteristics they felt were important to their identity, story, or experiences of perinatal services. Interviews were audio-recorded and transcribed verbatim, then all potentially identifying details were removed. Once transcribed, audio files were deleted. All participants were offered the opportunity to read the study or hear about the outcomes.

Design

A cross-sectional, qualitative design was employed using Thematic Analysis (Braun & Clarke, 2006; Braun and Clarke, 2013), specifically, Reflexive Thematic Analysis (RTA; Braun and Clarke, 2019; 2021c). A qualitative approach was selected in accordance with the study's aims to develop understanding of how participants experienced perinatal care, and the meaning they ascribed to those experiences (Willig, 2019), rather than to quantify experiences in relation to specific hypotheses (Finlay, 2006). Perinatal care is innately relational in nature, and it is essential to understand the social and psychological processes at play in these environments (Willig, 2019).

RTA in particular was selected as it allows for the identification and analysis of themes in language-based data (Braun & Clarke, 2021a). This analytic approach specifically lends itself to the research aims: to develop an experiential understanding of participants' encounters with perinatal care, but also to examine their decision-making around care.

Interpretative Phenomenological Analysis (IPA; Smith et al., 2009), which aims to provide rich interpretations of individual experiences, was considered as an alternative. TA was deemed a better fit, as it allows for the development of a collective understanding of the community, rather than that of individuals. Creating meaning across TA also allows for an understanding of a specific experience across a wider social, cultural, and political context (Braun & Clarke 2021a). The social narrative is particularly important to this research, due to the current UK sociopolitical climate regarding trans people and their rights, and its interconnectedness with the way that trans people experience services. Additionally, the aim of this study was to inform practice; TA better lends itself to 'actionable outcomes' than IPA, meaning that it can be better translated into clinical implications (Sandelowski & Leeman, 2012).

Analysis

A qualitative analysis was carried out in accordance with Braun and Clarke's (2006) six phases, which consist of: 1) Familiarising with the data through transcription and noting of initial ideas. 2) Generating initial codes by identifying concepts explored within the dataset and collating relevant data. 3) Searching for themes by combining codes into groups of similar or connected ideas. 4) Reviewing themes to ensure they work across the data. 5) Defining and naming themes to tell the narrative, and refining the specifics of each. 6) Producing a report by writing up the findings of analysis using quotations, and considering how this analysis answers the research questions. The six steps are not carried out chronologically, rather they are a dynamic and flexible process, and the researcher moves back and forth between them. The reflexive element of RTA is captured in the acknowledgment of the researcher's active position in producing knowledge through their interpretations.

Several theoretical assumptions should be addressed when using TA, to justify how the conceptualisation of data addresses the research questions (Braun & Clarke, 2006; Byrne, 2022). Data was analysed from a constructionist standpoint to acknowledge that the relationship between language and experience is bidirectional, thus permitting acknowledgment that salience of a theme can indicate its importance in the analysis, rather than just recurrence (Braun & Clarke, 2012). Analysis was carried out from both an experiential and critical orientation. An experiential perspective was taken across the analysis to construct themes, but themes were examined using a critical orientation to interrogate how socially-constructed concepts around gender, birthing and parenthood influence how participants create meaning in these systems (Byrne, 2022), including how these meanings are situated within the wider sociopolitical context (Braun & Clarke, 2012). An inductive approach was used as the analysis was not constrained by pre-existing theoretical frameworks, or a codebook. Both semantic and latent coding were used, acknowledging surface-level meaning, but also allowing for interpretation. Latent coding acknowledges the active role of the researcher in constructing meaning, and considering meaning beyond what is immediately said. Analysis was completed using NVivo 13 (2020, R1), a qualitative analysis software.

Maintaining Quality

Braun & Clarke’s (2021a) guidance for ensuring quality was followed. This includes checking data for quality against the original recordings; ensuring coding is thorough and comprehensive; ensuring themes are distinct, and that each theme embodies a central organising concept; ensuring data is analysed rather than summarised; and ensuring analysis conveys a narrative about the data, that addresses the research question. The sample was also situated in participant demographics, as advised by Elliott and colleagues (1999).

Reflexivity

Reflexivity is essential in qualitative analysis, and it is important to name the positionality of the researcher. The researcher is a white British, trans non-binary, queer Trainee Clinical Psychologist. They have experience of accessing general, gender-affirming and mental health services as a trans person, through NHS and private care. They do not have any children, but they would eventually like to be a gestational parent. They engage regularly with social and community action, and are committed to the liberation of the trans community. The research team is primarily trans and includes the voices of those working in the fields of perinatal care, and researching LGBT+ health and reproductive justice. As such, all are invested in improving the experiences of the trans birthing population.

The researcher used a reflexive journal to reflect on the impact of the interviews, their own experiences, and consider how assumptions might be playing into the work (Nowell et al., 2017). Coding and themes were discussed at regular intervals with both field and academic supervisors. At several points, this supported in checking the lead researcher’s assumptions and considering how their position may be impacting interpretation. In these cases, coding or analysis was reverted a few steps and re-examined.

Ethical Considerations

The project received ethical approval form Royal Holloway, University of London’s REC. The ethics submission and approval can be found in the appendices (Appendix G & H). All data were anonymised, and participants digitally signed a consent form to indicate informed consent before the interview. Participants were also informed that they could withdraw at any point during the interview, and could withdraw their data up until May of 2023. Data was stored in accordance with the university’s guidelines, including storing data securely, storing consent forms separately from transcripts, and giving them a different file name.

Participants did not constitute a clinical population, but it is known that trans people are more likely to have mental health conditions (McNeil et al., 2012) and to have experienced trauma (Mizock & Lewis, 2008). Interviews covered potentially challenging topics, including possible traumatic birth and systemic oppression. Interviews were completed sensitively, and participants were invited to slowly situate themselves in the topic. Reactions were monitored in case it was necessary to stop the interview or skip a question. Participants were invited to schedule a break, and this was suggested if participants expressed that they found a topic emotionally challenging. Payment of participants is particularly important when working with marginalised groups, as they are often more hesitant to engage in research (Walter et al., 2013). Payment also enables the participation of those who may not be able to afford uncompensated labour (Gelinas et al., 2018).

At the end of the interview, participants were offered an opportunity to talk about their experience of the interview and ask questions. An optional follow-up call was offered, in case they wished to talk about the impact of the interview, and so the researcher could assist in signposting to some additional support. All participants received a debrief (Appendix E), and a help and support sheet (Appendix F) after the interview.

Findings

Through thematic analysis, two broad, overarching themes were constructed which ran through all participants' experiences of perinatal care. The first, '*Navigating assumptions of womanhood'*, was comprised of two subthemes: '*The embodied experience of pregnancy'* and *'In/visibility: 'Please understand who I am'.* The second overarching theme was: '*Empowered autonomy: Personal narratives of choice, control and safety'.* A table illustrating how many participants contributed to each theme can be found in Appendix I.

Navigating Assumptions of Womanhood

Through pregnancy and birth, trans people manoeuvre a range of societal norms and expectations which position pregnancy as synonymous with womanhood, motherhood and femininity: "It's just what the whole world sees as like, […] the most female thing you can possibly do is have a baby" (Paris, genderqueer, they/them). This cisnormative affixing of pregnancy to womanhood is echoed in all areas of perinatal care, and this dominant norm makes trans people feel as though they do not fit: "It just feels like you're intruding on a space […] Whenever I went on, like, the wards and things like that […] I didn't feel seen or like... It just felt... Unwelcoming" (Hayden, binary trans man, he/him). Being forced to negotiate these norms as an individual who looks and feels different to cis women can be jarring: "It was kind of shocking to me to be thrown into that system […] just like, all of the narratives around it, I found that just really confronting" (Kip, non-binary/genderqueer, they/them). Two subthemes were yielded around how trans birthing people experience and navigate this assumed womanhood.

The Embodied Experience of Pregnancy

Existing in a trans pregnant body elicits a range of emotions and responses, and presents a wide spectrum of experiences, from pregnancy as neutrally experienced, to a site of euphoria, to a site of distress or dysphoria. For many, pregnancy was regarded neutrally, not as something incongruent with their transness: "I felt comfortable in my identity, being pregnant." (Margot, non-binary, they/them). Participants often regarded pregnancy and birth as a biological capacity: "Why does pregnancy have to be like, a feminine thing? It just doesn't. It's a biological thing in my head, and it's something that I've always wanted to experience" (Paris, genderqueer, they/them). Birthing is something that their body is capable of, but is not intertwined with womanhood or femininity: "Isn't it amazing that like, loads of bodies can do this? Like, it doesn't matter what gender they are, like loads of bodies can grow other humans" (Billy, non-binary, they/them). Many participants described experiences of euphoria in relation to pregnancy: "From that moment I was just, like, absolutely loving life. Like, I was just so happy that I was pregnant […] just feeling like, really powerful and like, solid, and big" (Paris, genderqueer, they/them). This joy was also experienced in birth: "It was amazing, really. I just went very much kind of within myself. Like, it was a deep sort of kind of meditative, like, […] it is this incredible kind of like, intensity" (Claude, transmasc, they/he). There was also a sense of feeling empowered by their identity as a trans birthing person and parent, feeling connected to parenthood and birth-giving, but separate from womanhood:

> There were times when it felt quite powerful. Like, I remember this early spring, like during lockdown, I did a lot of gardening. We had a little patio and I carted, like, I bought a half tonne of Earth […] [baby] in the sling […] feeling like, strong, and hanging laundry, and feeling like a really strong sense of kinship with all of the people on this planet who have done that work, who have historically mostly been assigned female, but not feeling dysphoria around that […] I was able to kind of tease apart the Venn diagram of like birth givers from women (Milo, non-binary/genderfluid, they/them).

However, some did feel dysphoria in relation to pregnancy and there were many nuanced explorations of this. For a small number, elements of the bodily experience of pregnancy were dysphoric: “It was […] really hard […] like, my boobs getting bigger” (Paris, genderqueer, they/them). The nature of birthing, in which the body is visible to others, could also be challenging: “I've seen cis women that have been in birthing pools and […] they've got like, their chest out and I'm like, I couldn't cope with the idea of that, of having so many people around me and seeing that” (Hayden, binary trans man, he/him). Some felt detached from the concept of pregnancy:

> [Pregnancy] sort of drove me farther away from where I wanted to be […] Even with all the work that I did around like… 'The work that I did around disassociating!’ [laughs] […] but the kind of protection, I guess. I think it only exacerbated and cemented the incongruence between what I was meant to be, who everyone thought I was, and […] who I actually am (Claude, transmasc, they/he)

However, dysphoria was often not internally situated. Rather, it was induced by others’ interpretation of the trans pregnant body: “My dysphoria is very much at the level of how people treat me and not at the level of like, my own body” (Milo, non-binary/genderfluid, they/them). Being observed as pregnant often led strangers to assume that participants were women, which resulted in dysphoria: “It just made me feel like people weren't like, seeing me the way I was seeing me, because like, I couldn't understand why people were misgendering me” (Hayden, binary trans man, he/him). Incongruence between identity and how one is read by others due to their participation in pregnancy can affect a trans person’s entire experience:

> It was definitely a big note in my own experience with myself, and my social experience to be aware that everybody was reading me as a woman now that I was pregnant, and that it was much harder to code myself non-binary being pregnant, and having like, a bigger chest, and everyone seeing the bump and assuming 'Mummy' (Milo, non-binary or genderfluid, they/them)

In/Visibility: ‘Please understand who I am’

Trans people’s existence in perinatal settings challenges normative notions around pregnancy and birth. Participants described how this led to two contrasting outcomes; either feeling too visible or completely unseen. All described feeling invisiblised by the system to some degree: “Why is it not okay for us to get the, the support and stuff. Why not? Because what, because we don't exist to you?” (River, non-binary/genderfluid, they/them/she). Many participants described situations in which their erasure created barriers to access. When trying to arrange a booking appointment, one participant with a male marker on his NHS records was told: “Sorry I can't give you an appointment because you're a man, and the computer doesn't let us put a man into a pregnancy appointment” (Ricky, trans man, he/him). To resolve this, it was necessary for the service to change the marker to female for the duration of care. In this way, services were often not logistically prepared to provide care to trans birthing people:

> Because my name was male in the system, my bloods got sent off to the lab for testing, like, maternity bloods, and because it was male, they threw it away because they thought that it was sent by accident (Hayden, binary trans man, he/him)

Aside from a few services, paperwork and resources are heavily gendered and do not acknowledge the existence of trans patients: “I got a letter […] that referred to me as ‘her’ and I like, crossed it out and put 'them', before I put it in my file” (Toni, queer, they/them). In addition, only one participant was invited to share their pronouns or define their gender upon intake.

For those perceived as men, their physical presence in perinatal spaces often brought about a new visibility which left them feeling like “the odd one out” (Finn, non-binary/male, he/him). They suddenly felt visible in their transness, which could lead to unwanted attention:

> Me and my partner were at the reception desk talking to someone and they said something like, 'Good luck with the rest of your pregnancy,' […] and a couple of people, 'Oh, but isn't that… Isn't that two blokes? What's going on?' (Ricky, trans man, he/him)

Some participants experienced a sense of anxiety about being visible as trans, due to the anticipated reactions to their pregnancy: “I'm still like, a bit apprehensive […]

because I just don't know how people will react to it." (Ricky, trans man, he/him). Once determined to be a trans pregnant person, Finn's (non-binary/male, he/him) healthcare providers expressed an inappropriate curiosity in his identity, asking what his "old name" was, whether his stomach hair would disappear, and why he chose to carry over his partner. Participants shared not only their own experiences of treatment by healthcare providers, but also reflected on the commonality of this experience among their pregnant peers. Billy, for example, indicated that trans people are met with, "not like, fetishization, but like, over keenness […] about their transness […] people just wanting to work with them because they were trans, and it was like, an exciting patient to have" (Billy, non-binary, they/them).

Conversely, there was a sense that some trans people "fly under the radar" (Kai, genderfluid/non-binary, they/them). Whilst this sentiment could be felt by all genders, it seemed most salient among the non-binary participants, many of whom described being cis-assumed. This is likely the result of their having not accessed facets of gender-affirming, transition-related care. Despite some of their gender expressions being masculine and androgynous, they described nevertheless being read by others as cis: "I think like, in a lot of ways, I'm probably treated quite like a cis person because I'm not visibly trans" (Billy, non-binary, they/them). For some, this was experienced as frustrating and invalidating:

> My queerness is very erased in a lot of these institutional settings. Like, people assume that we're cis-het […] It's also really maddening that like, people see us and unless we're going to quite a lot of effort, people don't see our queerness (Milo, non-binary/genderfluid, they/them)

Others acknowledged the privileges that could come with being perceived as cis or heterosexual. Some participants' relationships were assumed to be heterosexual, based on their own gender expressions and sex assignments, in comparison to their partners: “Our relationship is not like, immediately flagged up to people as being a queer relationship, so that makes some things easier for us” (Kai, genderfluid/non-binary, they/them). There was a sense that not being “visibly trans” can be safer: “To cis people, I generally don't look trans to them, and so I didn't have any like, fears about being like, a visibly trans person in a waiting room” (Billy, non-binary, they/them).

The nuances in these participants’ experiences could play out in access to care. All three transmasculine participants who had taken gender-affirming hormones, and were more frequently interpreted as men, were assigned a continuity of care midwife, whilst only three of nine non-binary participants were given this. Interestingly, these non-binary participants could all have been identified as candidates for continuity of carer support based on other intersecting identities. Trans people not being anticipated by perinatal systems has very real consequences for access to care, and participants who had been erased by systems were left pleading to have their needs met: “I'm pregnant. I need an appointment the same as anyone else that's pregnant. Please give me an appointment. […] I just ended up crying and being like, 'You need to sort this out,'” (Ricky, trans man, he/him). Narratives conveyed a sense of desperation in requests to feel seen: “Please understand who I am, but also right, I've got to do this […] Please, understand who I am” (Margot, non-binary, they/them).

Empowered Autonomy: Personal Narratives of Choice, Control and Safety

The second theme captured how trans people experience autonomy and safety in relation to perinatal care. Many participants recounted a narrative of wrestling with control; a back and forth between feeling overlooked by the system and facing the many nuanced challenges that could come with advocating for their needs. They were often left to make constrained choices, making decisions that most reduced risk of harm, rather than holistically met their needs. There was an overwhelming sense that participants felt largely unsafe in perinatal services, and this in turn impacted their decisions around accessing care, and their experiences within it.

All participants expressed feeling disempowered by the perinatal system in some way, conveying a sense of enduring perinatal care, rather than feeling nurtured: “Just get through with the misgendering and stuff so that you can have your baby” (Billy, non-binary, they/them). Perceptions of safety within services were shaped early in care and compounded by several factors, including the pre-existing vulnerability that accompanies pregnancy: “You're automatically in quite a vulnerable position already like […] you’ve got your guard up” (Kip, non-binary/genderqueer, they/them). Mistrust could lead participants feeling a need to conceal their identity:

> I think I was a bit on edge because it felt. It felt a bit social worker-y and like, I was irrationally worried that somebody was gonna try and take my baby away […] it definitely wasn't a space where you could be like, 'So, this is my weird queer family’ (Kip, genderqueer/non-binary, they/them)

Many were met with a lack of understanding around their gender early in their pregnancy journey, aggravating existing mistrust or creating an apprehension about future encounters with care:

> It made me really anxious about then, like, what was the rest of my experience gonna be like? […] Is it gonna be like coming up against barriers every single step of the way? And is everyone gonna be this ignorant and talk to me the way that this person I talked to on the phone? (Ricky, trans man, he/him)

Participants expressed a sense that systems often do not understand nuances of gender identity: “What comes behind [language] is the medical and clinical side of that […] It's not just about pronouns. It's about what that person is feeling. It's about the physical needs of that person” (Margot, non-binary, they/them). Participants reported using a variety of terms to describe their anatomy and their roles as parents. Some felt comfortable with the terms breastfeeding, whilst others preferred chestfeeding. Some were ‘dad’, whilst others still felt a connection to the concept of motherhood. The majority of participants were not asked by healthcare professionals about gender at all, let alone given an opportunity to specify language preferences. Many participants noted that healthcare professionals seem to view gender-based needs an inconsequential preference, rather than something central in trans peoples’ experience:

> [Being misgendered] seems like such a little thing to cis people. […] I know what it feels like when someone misgenders me and I know how much of a distraction that could be, so I was like, really, really worried that like, somebody would do it while I was giving birth and then I'd like not feel safe, or I'd like disassociate (Hayden, binary trans man, he/him)

Healthcare professionals underestimated how central gender was to participants’ experiences in order to feel respected in their identity and have their needs around gender honoured:

> I don't think any of the Midwives really grasped […] for me, like, being non-binary informed like, every choice I made when I was pregnant. Like, choice not to go to the alternate class or to have a home birth, or to like, wait until the

> crap midwife had finished her shift and stuff, and I think there was never really any understanding that it could have an impact beyond like, my comfort levels? (Kai, genderfluid/non-binary, they/them)

For some, the impact on their care was noted in the immediate moment:

> It was an extra thing I had to think about and that I maybe had to like, compensate for it in ways. Like, I would go in with the list of questions […] and like I recorded all of my appointments […] There was more of a chance of me like missing a sentence if it had the wrong pronoun in it […] because I was busy like, fixing that in my head or like, almost reminding myself that someone was referring to me (Toni, queer, they/them)

For others, the impact was more latent: “I had a lot of like flashbacks to the birth and […] the misgendering was kind of part of that” (Kai, genderfluid/non-binary, they/them). This same participant expressed that if they were to give birth again, enduring the system as a genderfluid person was a greater cause for anxiety than birthing itself.

When a person's gender-related needs were overlooked, there was a significant emotional impact, and the compound effects led to mounting anxiety about accessing care: “As it went on, and as the kind of negative interactions increased, then I'd get more anxious, […] kind of on a rolling system basically, for like, what was gonna happen next” (Kai, genderfluid/non-binary, they/them). When asked about the impact of misgendering, Billy (non-binary, they/them) noted: “I can't be completely open with you. I have to censor myself. I'm not going to be able to fully trust you, and so actually I'm not gonna be able to access the care that I need at all.” The majority of participants shared experiences of how precious moments in their pregnancy and birth were stained by healthcare professional’s mistakes, marking them forever: “Being called a mum […] while I was holding my child for the first time. […] It's a big moment in your life and she did kind of ruin it, […] it's part of my memory of that” (Kai, genderfluid/non-binary, they/them).

In addition to needs around gender, many participants shared experiences of how their physical needs in relation to perinatal care were also overlooked. Three participants had significant challenges around feeding and reported feeling hugely under supported in managing this. One participant described difficulties for which they sought support from a range of NHS and non-NHS services. Their concerns were dismissed, and it was later found that their baby had a tongue tie: “I did end up having quite a traumatic experience with breastfeeding and I felt really unsupported” (Milo, non-binary/genderfluid, they/them). Due to previous experiences of being invalidated and sent away without support for feeding difficulties, another participant was hesitant to access support during their second pregnancy.

Many participants opted to endure care despite psychological discomfort, for the safety of their baby: “I think I just knew in my heart of hearts that [not accessing care] wasn't the best decision for my baby, you know, to make sure he was safe. […] I needed to really kind of like, put my own view of the hospital aside” (River, non-binary/genderfluid, they/them/she). There was often a sense of anxiety about the idea of accessing care due to concerns about their safety, and some opted to distance themselves from medicalised birth:

> A lot of mainstream birth is very hospital and doctor driven and like, you're gonna end up with an induction, you're gonna end up with like forceps, or ventouse, or C-section because they just like, they're not interested in giving you space to do what your body needs to actually have a like, unmedicalized birth experience” (Milo, non-binary/genderfluid, they/them).

Many responded to anxiety by attempting to exert control over their situation, to reduce risk of harm. Significant decisions were made around care as a result, and many participants decided to limit their contact with perinatal services based on fear of their care requests being overlooked: “Medical intervention, […] It just felt so untenable like, to be in that situation, and I feel so lucky that […] I didn't have to be in that situation as a trans person” (Claude, transmasc, they/he). Desire for a homebirth was common, with some reporting that this decision was made in order to create a safer environment than could be anticipated within a hospital or clinic: “I just wanted a homebirth because I was really worried about being in an environment where I didn't feel safe” (Kip, non-binary/genderqueer, they/them). Others felt that a homebirth would permit more control over who could access them during birth, for example, by increasing the likelihood of having “met everyone beforehand” (Milo, non-binary/genderfluid, they/them). Several participants expressed that homebirth allowed them to create distance from the perinatal system: “It was exactly what I needed, and away from any kind of medical intervention […] I felt very clear about wanting to be at home and […] to have a very small amount of people there” (Claude, transmasc, they/he). One participant chose to undergo a voluntary caesarean section, partly due to anxiety about pain, but partly as an attempt to exert control over their birthing experience: “One of the things that has played into my decision, probably, for why I want an elective C-section is because of the unpredictability of like, not knowing who I'd end up with” (Ricky, trans man, he/him).

For a chance to receive gender-affirming perinatal care, trans birthing people reported being required to advocate for their needs around care preferences and gender, for example, gendered language for themselves, their body parts, and their parenting role: “I'm constantly having to fight for my identity to be heard” (River, non-binary/genderfluid, they/them/she). Advocacy came in many forms and covered topics of identity, language, birthing environment, and physical needs around birthing. Some participants advocated for themselves verbally, or by using their birth plan. Others had a support system, and some hired a doula to support in advocacy. A small number had healthcare professionals who chose to support them through advocacy: “Anytime I've had those extra appointments, [my midwife] calls ahead and explains the situation” (Ricky, trans man, he/him).

However, some participants felt unable to advocate for their needs with regards to gender. For example, one participant was not yet out as trans, and therefore would be required to acquiesce to the idea of being read and interacted with as though they were a cis woman. As a result, they limited their contact with perinatal care services as much as possible:

> I have to pretend to be this like, woman […] I would have just ended up performing. […] I know how to do it because I've been doing for so long, so I understand what you need from me and what your expectations are and that's… For me, I think was a layer too much whilst also like carrying a kid (Claude, transmasc, they/he)

A range of nuanced factors at the levels of both individual identity and the perinatal system played into participants’ ability to advocate. Many expressed a sentiment of ‘choosing their battles’ in which they had a range of personal, situational and identity factors to advocate for during the perinatal period, and gender came lower down the list of importance. For example, some participants placed their babies’ health at the highest importance: “My initial worry is, ‘Is my baby OK?’ So, in that moment I don't feel like I can go, 'So, you know, this is who I am.'” (Margot, non-binary, they/them). One participant expressed that it felt more essential to them that their partner, a trans woman, was gendered correctly than themself. Another, who was a surrogate birthing person, expressed that the needs of the baby’s parents felt more important: “[I] abandoned [gender] almost, […] because I had this bigger fight […] I could cope with getting like, misgendered if it meant that everybody was in the room” (Toni, queer, they/them).

Some participants experienced marginalization based on other axes of their identities alongside gender modality, which they reported played a role in their ability to advocate for themselves in perinatal care spaces. For example, several participants were disabled, neurodiverse, had mental health conditions, or chronic health issues; additional layers that can contribute to fears and trauma around hospitals, and reduce capacity and energy: “I ended up being misgendered quite a lot because I just didn't have the spoons[1] or the energy to tell them (River, non-binary/genderfluid, they/them/she). One participant noted that neurodiversity “makes it harder to […] make changes, and […] ask people to change things” (Paris, genderqueer, they/them). Some participants had preexisting trauma in relation to medical environments: “I have quite a lot of kind of like, doctor traumas in the background” (Kip, non-binary/genderqueer, they/them). It was noted that this existing mistrust made them even more apprehensive about disclosure of their gender identity, and the trickle-down effect of intersectional marginalisation made it harder to access care:

> As soon as you get labelled with trauma […] it makes it difficult for people to listen, and you get gaslit quite a lot. I mean, I've had it used against me, especially in my maternity care […] They actually used my EUPD [Emotionally Unstable Personality Disorder] diagnosis against me and told me that I was just being over emotional when they were telling me that I was

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[1] ‘Spoon Theory, coined by Christine Miserandino is a way of explaining the limited capacity with regards to energy that comes as a result of disabilities or chronic illnesses

> having feeding issues with my eldest (River, non-binary/genderfluid, they/them/she).

Participants also identified several systemic issues within the perinatal healthcare system that made it challenging for them to advocate. Many expressed a desire for continuity of care, noting the constant introduction of novel characters in their care means they are required to express their needs repeatedly. Participants found self-advocacy especially difficult due to the intrinsic power imbalance between themselves as patient their and care provider: “When you're so dependent on someone like, there's a real like power dynamic there” (Kai, genderfluid, they/them). This was demonstrated in a scene painted by one participant when a midwife arrived at their homebirth:

> I had, like, everything on the floor, like I'd been labouring on the floor, so I had […] everything that I might need to grab and she just knocked everything over when she was walking around the room. […] The first thing that she said to me, like, in the middle of a contraction was that if I hadn't given birth in the next 12 hours, I'd have to go to hospital (Toni, queer, they/them)

There was a sense of feeling unable to challenge authority: “Effectively, they are the expert and there is that […] authority thing […] and so how when they when they are the professional, how do you challenge what they're saying?” (Margot, non-binary, they/them). This notion seemed to be compounded by an anxiety that advocating may leave participants vulnerable to bias, or that they may be perceived as burdensome, resulting in poorer care: “It's coming out to services and you don't know whether they're gonna have bias against you […] and it's really scary because you don't actually know who's gonna be transphobic” (River, non-binary/genderfluid, they/them/she).

Although all participants experienced difficulties, there were also many examples of positive practice in which healthcare professionals created trusted relationships with participants. Continuity of carer was associated with increased advocacy from healthcare professionals, and a greater sense of security. One participant was cared for by a trust that had an explicit gender-inclusion arm, focussed on understanding and advocating for service users of all genders. Although not without challenges, their experience was improved by input from the service, which helped to circumvent the need for advocacy or explanation of their identity, and freed up mental capacity for birthing safely:

> For me, being able to focus on that, and not have to worry about the understanding of who I am, and the language that comes around that, and the needs that I might have in relation to that... Yeah, I think that made all the difference to it being a calm, if you will, kind of birthing […] I could then focus on, effectively, […] advocating for my physiology and the baby, and not my identity, because that bits covered. Everyone understands who I am and what my needs might be (Margot, non-binary, they/them)

Some participants accessed non-NHS care which was specifically tailored to support queer and trans parents. When asked about how this was experienced in relation to NHS care, Kip described it as:

> Just worlds apart […] It's that thing of like […] how good do you have to be, or like how much do you have to have your defences up? […] You just knew from the absolute outset, like […] you just didn't have to […] have the

> defences up at all, whereas like, there wasn't an there wasn't an NHS interaction where I wasn't like, braced, or masking […] or like, trying to make sure that things would be okay (Kip, non-binary/genderqueer, they/them).

Discussion

The primary aim of this study was to develop a richer understanding of how trans people experience perinatal care in the UK. Following recent research that revealed trans people are significantly more likely not to access any care during the perinatal period, and have poorer outcomes than cis women (LGBT Foundation, 2022), it also sought to develop an understanding of trans peoples' decision-making around accessing perinatal care, and the factors that might be contributing to trans people abstaining from medical support throughout pregnancy and birth. It considered specifically how the UK perinatal context is experienced by trans pregnant people, which is unique in its design and delivery as a midwifery-led, public health model of care. This research adds thickness to narratives found by the ITEMS report (LGBT Foundation, 2022), and in welcoming the experiences of all trans people in one study, responds to requests for more detailed understandings of the shared and distinct experiences of different gender identities in birthing spaces (Greenfield & Darwin, 2020). In answering these research questions through analysis of interview data from 12 participants, two overarching themes were constructed: '*Navigating assumptions of womanhood'* and '*Empowered autonomy: Personal narratives of choice, control and safety*.'

Participants' experiences of perinatal care were largely demarcated by their trans modality. Upon entering services, trans people were met with a woman-centred system, and they do not fit this mould. Previous research found that trans people (Fischer, 2020; MacLean, 2021) are made to feel invisible in perinatal settings. This sentiment is echoed in the present study, with all participants describing experiences connected to invisibility, and expressing a desire to see themselves reflected in perinatal care. Bias is reflected in the design of the entire perinatal care process, rendering systems unprepared to welcome trans people into care. Multiple participants experienced what has formerly been coined ‘administrative violence,’ through which bureaucratic barriers enact violence upon marginalised people (Spade, 2015). Participants described difficulties accessing care, whereby administrative staff and computer systems denied them access to support. They were required to explain their identities multiple times to new professionals, to even be given an appointment.

Previous research noted that administrative staff, often the first point of contact for patients, can be the most harmful for trans people (Freeman, 2018). This is perhaps owing to the ways in which administrative staff are undervalued in healthcare (Tosanloo et al., 2019), and therefore often do not receive the same degree of training and support as clinical staff. These initial encounters with services fostered feelings of anxiety and mistrust. Computer systems used by healthcare services are designed by human engineers with their own biases, writing algorithms that overlook trans people entirely. The notion that anyone who is not a woman might need to access perinatal services was not coded into the possible options.

Participants also frequently had their physical support needs overlooked, making them feel disempowered. Several participants had difficulties with feeding and were made to feel invalidated and unsupported by healthcare professionals. One participant’s baby had an undiagnosed tongue tie, which can cause feeding difficulties and discomfort for the parent (NHS Choices, 2020). They were not offered a feeding assessment, and even after sharing their concerns, the tongue tie was not identified. This led to a prolonged experience of pain, distress, and ultimately trauma. For cis birthing women, under-diagnosis of tongue tie is associated with dismissal of concerns about feeding, and their expressions of pain being overlooked (Kendall-

Tackett, 2017). Treatment of pain is shaped by “multiple and intersecting forms of systemic violence and discrimination” (Wallace et al., 2021, p.9), and those belonging to a marginalised group, including being trans, are more likely to be dismissed in relation to pain (Craig et al., 2020), reducing their likelihood of adequate treatment. The LGBT Foundation (2022) hypothesised that healthcare providers may be more likely to attribute trans peoples’ feeding difficulties to dysphoria or their status as a trans person, rather than a physical issue such as a tongue tie. As such, trans birthing people may be less likely to receive adequate support around infant feeding difficulties, as supported by the narratives captured in this study.

Further to the physical effects of gender modality on birthing experience, this research contributes an additional nuanced understanding of the emotional journey through pregnancy and birth for trans people, addressing aspects such as dysphoria. Previous research has explored the role of dysphoria in pregnancy for all genders (Charter et al., 2018; Fischer, 2020; Macdonald et al., 2020), and the present study supports the notion that there are many heterogenous narratives around embodied experiences of pregnancy. These range from dysphoria, through ambivalence, all the way to joy (MacDonald et al., 2020; Fischer, 2020), opposing previous research that positions pregnancy as “at odds” with the being trans (Charter et al., 2018). Participants construed two clearly distinct narratives around dysphoria. One concerned bodily dysphoria as relating to physicality, and the other concerned social dysphoria as relating to the way they are perceived and treated by others (Goldbach et al., 2023; Lowik et al., 2023). A few experienced dysphoria in relation to their bodies, but all experienced social dysphoria in perinatal settings. Conversations around gender and language preferences were largely neglected, meaning clinicians frequently used the wrong language when speaking with service users. Even when participants had advocated for their needs around language, clinicians were often unable to use their specified language, blaming novelty, age, and situational pressures for their misuse of terms. Participants described the significant impact of social dysphoria, including one patient experiencing flashbacks to being misgendered, and others noting a reduction in their capacity to absorb information in appointments. It is possible that healthcare professionals assume dysphoria is situated within individuals, at a bodily level; rather than as something that can also be socially situated and elicited by interactions with others (Davy & Toze, 2018). If so, they may underestimate their ability for harm in their interactions with trans people.

There were notable distinctions between the experiences of transmasculine and non-binary people. For trans participants who were cis-assumed in accordance with their gender identities, for example, trans men who were read by others as cis men, their very existence as a patient in perinatal care means they are outed in their identity. Being outed as trans is common in healthcare environments, and it can have significant psychological impacts, including leading trans people to disengage from care (Freeman, 2018) and creating potential for victimisation (Perry & Dyck, 2014). On the other hand, non-binary people tended to 'fly under the radar' and were more likely to be overlooked (Lowik, 2022). This manifested in very evident ways. All trans men participants using hormone therapy were assigned a continuity of care midwife, whilst only three of nine non-binary participants were provided this. Continuity of carer allows birthing people to develop secure and trusting relationships with their healthcare professional and is known to significantly improve outcomes for birthing people, reducing likelihood of miscarriage, birth complications and improving experiences of birth (NHS England, 2017). Continuity of carer is recommended for all pregnant people, but due to service limits, is only routinely offered to vulnerable groups. However, this study indicates that trans people are not routinely offered this option.

There are several potential reasons for this difference in care. Previous research has shown that cis men are generally more likely to have their concerns and needs taken seriously compared with cis women in healthcare settings. They are more likely to receive pain relief (Hoffmann & Tarzian, 2001) and are less likely to have health concerns downplayed or dismissed (Samulowitz et al., 2018). Non-binary identities are often viewed as less valid than so-called “binary” trans identities (Fiani & Han, 2020), and as such, the concept of a trans man is more culturally and clinically tangible, in that all people understand and know someone of the identity ‘man’ (Vincent, 2016). Therefore, although perceived proximity to manhood is more highly visible, which is often undesirable, it may permit understanding of identity, and therefore access to care. Although being a binary-identified trans person did not completely inoculate them from harm, the findings from this project suggest that non-binary and binary-identified people did report different experiences of perinatal care. However, these differences did not necessarily equate to more positive or tolerable experiences overall when compared to non-binary people.

These experiences of having physical, emotional and identity-based needs overlooked leads to a deep sense of feeling misunderstood by perinatal services, and this extends beyond feeling unseen. There was a pervasive feeling that systems *will not* anticipate and incorporate trans people as part of their care, no matter how hard trans folks try to express their needs. Participants were frequently left feeling choiceless, with requests for gender-affirming care explicitly rejected. They were required to reassert and explain their identities to a multitude of providers, only for this to be later forgotten or ignored. There were many examples of trans people begging to receive care, pleading to be seen and understood, and to have their needs met; amounting to a sense of the system and the people within it dehumanising trans people.

There has been much research about the dehumanisation of cis women in childbirth, owing to systemic undervaluing of women’s lives as a whole (Jewkes & Penn-Kekane, 2015). As such, it is unsurprising that trans people report similar dehumanisation during the perinatal period. Trans people face significant challenges in navigating perinatal care, and are at increased risk of a range of factors that are known to make childbirth more challenging: Trauma (including traumatic associations with hospitals) Mizock & Lewis, 2008), pre-existing trauma around childbirth (Greenfield & Darwin, 2020), increased likelihood of disability (Smith-Johnson, 2022), chronic illness (Witten, 2014), and mental health conditions (McNeil et al., 2012).

All of the above characteristics were captured across participants in this study, and they identified how these factors impacted their experiences at many levels. One especially salient point was the ways in which these factors make it particularly challenging for participants to advocate for themselves. Due to a lack of understanding, legislation and guidance supporting and protecting them, care outcomes for trans birthing people are, at least in part, dependent on the ability to effectively advocate for oneself (White, 2018). All participants were required to advocate, or arrange advocacy on their behalf, with regards to both physical and gender-based care. Even participants with less intersecting marginalised identities describe the cumulative toll of advocacy on their emotions and energy. This supports previous research that for those at the intersections and facing multiple struggles, the additional burden of advocating on top of limited energy, fear of the system, and the knowledge that they would still possibly be overlooked, sometimes became unbearable (Lowik, 2022). When systems did not adequately support participants, and they were unable to advocate for themselves, there were several possible outcomes: Choosing not to advocate, which perpetuates feelings of invalidation, or participants finding ways not to need to advocate, by distancing themselves from or limiting access to care.

This invites the question of why trans people may be less likely to access care than their cis counterparts. In this study, all participants accessed care, so it is important to note that the voices of those who avoided care entirely are not captured.

As such, these suggestions are hypothesised based on the experiences of the sample, within which there were birthing people who had anxieties about accessing perinatal care and/or aimed to create distance from perinatal services for the following reasons: existing medical trauma related to past experiences of care, fears about being misgendered or having their identity invalidated, and previous poor experiences of perinatal care. In part, trans people may feel discouraged from accessing perinatal healthcare services due to the disparaging history of violent healthcare policy around trans birthing. Across the world, trans people are delegitimised in their reproductive capacities through practices of eugenics, with many governments forcing trans people to trade their fertility in exchange for legal gender recognition (Lowik, 2018). Repronormativity can be seen in state-sanctioned law and policy designed to prevent non-cis, heterosexual people from reproducing (Weissman, 2017). Although forced sterilisation of trans people was not enshrined in law in the UK, the surgical removal of reproductive organs is encouraged on medical grounds, despite little clinical evidence (Toze, 2018). Trans people fall under what Love (2022) defines as “deviant reproduction”, one which society deems as undesirable. As such, trans people have been actively denied their rights with regard to pregnancy and birth, and the historical conceptualisation of pregnancy as female has played a role in enacting discrimination against trans birthing people (Karaian, 2013). This is reflected in the lack of UK policy, and the NHS woman-centred model of care, which consequently oppresses trans birthing people (Pezaro et al., 2023).

The UK’s perinatal system is unique, in that care is midwife-led, within a public health service. The core principles of the UK’s midwifery care model are informed consent and autonomy, placing patients at the heart of decisions around their care (Leap, 2000). The model, rooted in feminism, was introduced as a response to the increasing medicalisation of birth (Davison, 2021). Despite these attempts to centre birthing people, several groups have highly inequitable perinatal outcomes under the UK's model of care. For example, people of the Global Majority are more likely than white people to die during childbirth (MBRRACE, 2023), and are more likely to receive general anaesthetic during caesarean, increasing likelihood of complications; but less likely to receive analgesia for pain during delivery (Bamber et al., 2023). In combination with the findings of this study and the LGBT+ foundations (2022), this indicates that the midwifery care in the UK has work to do in supporting marginalised groups, and those who are multiply marginalised experience even worse outcomes.

In addition, midwifery is a highly gendered profession, in that it is almost exclusively performed by women, reflecting the fact that the majority of service users are women. As such, midwifery is in itself a marginalised profession, and this may be reflected in midwives inability to see themselves as the perpetuators of harm or violence. In a system that is highly gendered toward cis women, the presence of trans people disrupts the norms, and participants in this study felt like intruders in perinatal contexts. They described feeling largely invisible, lacking in autonomy and choiceless; the antonyms to the central tenets of the UK's model of midwifery care.

Strengths and Limitations

Some limitations of the sampling method were noted. Convenience sampling was used, which can limit generalisability of findings, as the sample may represent a particular subset of the population (Sedgwick, 2013), such as those who are particularly interested in, or vocal about the experiences and rights of trans birthing people. Social media was used to advertise the study through LGBT+ charities and pages centred on pregnancy, birth, and parenthood. It is arguable that these pages are more likely to be used by individuals accessing care, which may explain the absence of trans people who did not access care's voices. The study has geographical range, but certainly had more participants from south-eastern England. There is a higher concentration of trans people in these areas (ONS, 2022), which may account for this difference, but might also mean healthcare providers are differently versed in trans healthcare compared with more rural and northern areas.

The sample has no racial diversity, with only white British participants. An attempt was made to address racial bias in the sample by completing a second round of recruitment through organisations that work with Global Majority trans folks, but no additional participants came forward before the deadline. There are many barriers to people of the Global Majority participating in research, including mistrust of healthcare systems and systemic discrimination in healthcare settings (Scharff et al., 2010). Given that trans birthing people of the Global Majority are the most likely not to access care (LGBT Foundation, 2022), there may be an additional layer of hesitation or mistrust. It is also possible that my own identity as a white person may have influenced the willingness of people of the Global Majority to come forward. The LGBT Foundation (2022) employed specific consultation to engage in outreach and include this population, but this was not in the scope of this project. However, the fact that trans birthing people of the Global Majority did not opt to, or perhaps feel safe coming forward, may say something in itself about fears around disclosure and safety in this population. It is also possible that the social media pages selected for recruitment may not be accessed by Global Majority folks, meaning that the research did not reach them at all. People of the Global Majority may lack belief that research is going to support their communities (George et al., 2014), which suggests that more time and effort from researchers is required to understand cultural nuances in communities' desires, and a commitment to providing this.

One way the study could have addressed this would have been for the entire research project to be co-produced with trans birthing people, which may have benefitted the study more generally in many ways. Unfortunately, this was prevented by budget constraints, requiring consultants and researchers from the community to work unpaid, which would be unethical. Co-production aims to create mutual, reciprocal and equal relationships between researchers and stakeholders by addressing unequal power dynamics, implicating more actionable and sustainable change for communities (Turnhout et al., 2019) and addressing experiential gaps in knowledge (Pettican et al., 2023).

There are several unique strengths to this piece of research, for example my position as a trans person within a primarily trans supervisory team. It is important to take the perspective of the community being researched, and my belonging to this community meant this was an intuitive process, facilitated by shared experience and empathy. Many participants fed back that they enjoyed the interviews and found them to be useful tools on which to reflect and process their experiences, and suggesting they did not feel a significant power imbalance. I will reflect on my positionality as a researcher further in Paper III.

This piece of research was, to my knowledge, the first qualitative study on trans pregnancy inviting the experiences of all gender identities rather than researching with trans men or non-binary people individually. It adds novel, nuanced perspectives around the experiences of trans birthing people in perinatal environments; particularly around dysphoria and access to care. It also adds to the literature on how medical settings, and perinatal environments particularly, are experienced by multiply marginalised folks. The research was rich in many perspectives, including variety in gender modality, disability, mental health, surrogacy and single parents.

The study was carried out in accordance with Braun and Clarke's (2021b) strategies for maintaining quality in TA, including checking transcripts against recordings for accuracy and ensuring reflexivity, for example, through keeping a journal and engaging in regular reflection with the supervisory team. The analysis was completed over a long period of time with a break in the process, allowing for development of analytic insight and reflection. Themes were reviewed and explored at several points in the process, with supervisors based both in the perinatal field and in academia. This allowed for a range of perspectives and expertise to shape the data analysis process. Much time, thought, and energy went into the construction of themes, thinking about their organisation and ensuring codes related to the same central concepts.

Implications

This research makes a unique contribution to the literature by developing an understanding of how trans people experience perinatal care and makes steps to explore why this population may be less likely to access care during pregnancy and birth than cis birthing women. The findings highlight several ways in which UK perinatal services can better support and welcome trans people, adding weight to all recommendations made by the ITEMS report (LGBT+ Foundation, 2022). The following points highlight and expand upon some of these recommendations in relation to the findings.

Services should strive to create environments and resources which welcome trans folks into services, making visible their commitment. This can be reflected in language, images, naming of services, and physical facilities, such as the availability of gender-neutral toilets and information (James-Abra et al., 2015). However, as one participant pointed out, visibility of trans people is only one piece of the puzzle. If this is not backed up by inclusive and supportive action, it is redundant. Whilst visibility is important, participants cannot develop trusting relationships with services unless practices and attitudes toward trans people are changed. This includes healthcare professionals facilitating discussions around language, including pronouns, bodily anatomy, and gender modality (Green & Riddington, 2020). It is also essential to explore how participants hope their child will refer to them, as many participants noted that they are not mothers.

Trans folks are significantly more likely to have experiences of trauma (Barr et al., 2022), traumatic birth, and perinatal mental health difficulties (Greenfield &

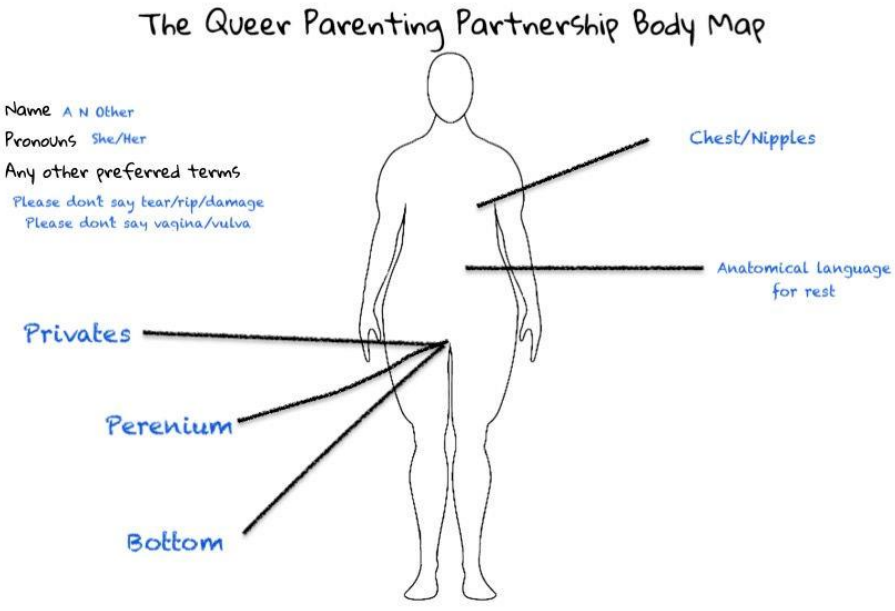
Darwin, 2020) which can be triggered by perinatal care (Gokhale et al., 2020; Sabola & Sheppard, 2022). To increase relational safety within services, it is essential that interactions are underpinned by trauma-informed principles. One example of a helpful exercise is a discussion around how participants name their anatomy, supplemented with a body map, a trauma-informed practice (Crawford, 2010; Green & Riddington, 2020). An example of a completed body map from the Queer Parenting Partnership (n.d.) can be seen in Figure 2.

Continuity of carer is a central tenet of trauma-informed care. As a vulnerable group, trans people should routinely be offered continuity of carer. In the present study, participants who were easily identifiable as trans received continuity of carer, however, those who 'flew under the radar' were only offered this if they belonged to another marginalised group. This further emphasises the importance of routine inquiry around gender modality. Notably, these practices are only valuable if healthcare professionals are able to use the correct language. Changes to language take time to integrate, and adapting may be challenging under a stretched system with high workloads. It may be important to offer healthcare staff opportunities to practice using gender-affirming language outside of interactions with trans service users.

It is essential that staff are supported by the system to provide better care, including opportunities for reflective practice and regular training, facilitated by, or in conjunction with experts by experience. Reflective practice could support staff to examine their personal responses to changes, and whether they feel resistance toward them. It also offers staff space to reflect on their own feelings and possible biases toward trans people and consider how this might influence their practice.

Figure 2

Example of a completed body map detailing terms that the person feels comfortable using to refer to their anatomy



The Queer Parenting Partnership Body Map

Name A N Other

Pronouns She/Her

Any other preferred terms

Please dont say tear/rip/damage

Please dont say vagina/vulva

Please annotate this body map with the words you feel most comfortable using.

Participants noted several examples of physical barriers in the system. Those with male markers on their NHS records were blocked from perinatal appointments in tech systems, and had their bloods discarded. This highlights that it is essential to train staff at all levels of the system, rather than just clinical staff. This includes those designing the tech used by the NHS, and the administrative staff, who are often the first person encountered when entering services, and the most likely to cause harm (Freeman, 2018).

All of the recommendations highlighted rely on identification of trans people, to prevent the need for advocacy. As participants are rarely asked about their gender, and there is no national requirement to collect this data, there is no clear record of trans people’s existence in perinatal care. In order to identify, support, and carry out accurate quantitative research with trans people, it is necessary to begin routinely asking about, and monitoring gender modality as part of intake.

In addition to recommendations made by the LGBT+ foundation, it may be useful to identity a number of midwives within each service as champions or leads, who have particular knowledge of supporting trans birthing people. Finally, it is important to note that the recommendations highlighted above would benefit all individuals accessing perinatal care, including cis women, intersex people, and the families of birthing people. Supporting the most marginalised within perinatal services can improve care for all, as trauma-informed care can benefit everyone by facilitating consent-based interactions and autonomy in care (Kuzma et al., 2020).

Future Research

Future qualitative research should explore the narratives of those missed in this study, including people of the Global Majority and those who opt not to access care. It will be particularly useful to complete qualitative research with both cis and trans people who decline aspects of clinical care, exploring similarities and differences in their experiences and motivations. This will allow for a better understanding of how systemic issues and personal factors influence decisions not to access care. It is also important to explore the personal views and experiences of perinatal healthcare staff working with trans birthing people, identifying the challenges and benefits this presents to them, and the barriers to providing better support to this community.

The majority of research in this area at present is qualitative, which is important for understanding experiences and contextualising them within the system. Further quantitative research is also essential to inform policy and service development, and eventually to evaluate change. This could include trialling the implementation of trauma-informed approaches, and training perinatal staff in trans-inclusive healthcare, then evaluating how these impact trans peoples' experiences of care. However, evaluation focussed on trans people is not possible without implementing routine monitoring in services, as accurate data around trans birthing people does not exist at present. Therefore, it is essential for services to begin routinely gathering data on birthing peoples' gender. In addition, research should continue to examine the experiences of those who feel unable to access perinatal care, to ensure their voices are not missed in this narrative. Participatory Action Research (PAR) may be particularly valuable, in which communities experiencing the issues being studied co-produce research and lead social change (Cornish et al., 2023). PAR supports in redressing power imbalance (Wimpenny, 2010), centring experiential understandings to answer research questions, and forming relationships between communities and academics (Frisby et al., 2009), something that is particularly important for marginalised people.

Conclusion

This study responds to recent requests for more research following findings of poorer perinatal outcomes for trans birthing people than cis women (LGBT Foundation, 2022; Greenfield & Darwin, 2020). It contributes novel and nuanced understandings of trans birthing peoples' experiences of perinatal care. Assumptions of womanhood leave trans people feeling unwelcome, erased, and create physical barriers to access. Their experiences of perinatal care are underscored by a sense of feeling unsafe, lacking in choice, and out of control, which increases fear around accessing perinatal care. As a result, trans people are frequently required to advocate, which is dependent on a range of factors, and more challenging for the most marginalised. When trans people are unable to advocate, or their expression of need goes unheard, they feel disillusioned and excluded by the system, increasing the likelihood of limiting their contact with care. Overall, this research highlights how poorly this vulnerable group is understood and supported by perinatal services. To support trans people to have autonomous and safe pregnancies and births, services need to better understand and respond to trans peoples' experiences, identities and needs.

Paper 2: A Systematic Review of LGBTQ+ People’s Experiences of Perinatal Care

Abstract

Recent years have seen many advances in law and policy regarding LGBT+ peoples' rights to gestational parenthood. However, healthcare systems are slow to adapt to this change, and LGBT+ people still face a myriad of challenges when accessing support during pregnancy and birth. This systematic review aimed to synthesise existing qualitative literature on European LGBT+ peoples' experiences of perinatal care in order to better understand how perinatal care feels for these communities, and how they can be better supported. Search terms to capture the concepts 'LGBT+', 'perinatal', and 'care and support' were developed, and searches were conducted across PubMed, Web of Science and PsychINFO databases. Thirteen qualitative papers matching the criteria were found, and a thematic analysis was conducted. Analysis yielded three themes: 1) 'A prejudiced system', 2) Feeling seen and heard, 3) 'Control and empowerment'. A range of experiential, clinical, and bureaucratic issues make the experience of perinatal care emotionally and practically challenging for LGBT+ people. Theoretical and practice implications are outlined, and recommendations for future research are made.

Key words: LGBT+, perinatal, care and support, systematic review, qualitative

Introduction

LGBTQQIP2SA Access to and Experiences of Healthcare

LGBTQQIP2SA[2] (hereon referred to as LGBT+) people are at an increased risk of various health conditions including cancer (National Cancer Institute, 2020), chronic pain (Alaa & Fiala, 2019), cardiovascular disease (Fredriksen-Goldsen et al., 2013) and accelerated cognitive decline (Correro & Nielson, 2020). Despite a need for sensitive and responsive healthcare, LGBT+ communities face unique challenges when navigating healthcare environments, including negotiation of disclosure to healthcare professionals depending on sense of safety, and feeling at risk of discrimination (Kamen et al., 2018). Increasing evidence suggests that a minority stress model, initially developed by Brooks (1981), but popularised by and often attributed to Meyer (1995), in which the discrimination and marginalisation faced by minoritized groups leads to poorer mental health outcomes, can explain the health disparities faced by LGBT+ individuals (Mongelli et al., 2019). This model posits that marginalised groups are continually exposed to “distal” and “proximal” stressors throughout their life. Distal stressors comprise discrimination and prejudice from others, and proximal stressors comprise internalised stigma owing to mistreatment, or anticipation of mistreatment. These induce acute stress responses, and over time, chronic exposure leads to poorer physical and mental health outcomes compared with non-marginalised counterparts.

Additional social determinants of health, such as structural stigma in the form of policy and law (Hatzenbuehler, 2016), education, and environment, may also drive these inequalities (Matthews et al., 2018). It is imperative to understand the experiences of LGBT+ people from an intersectional standpoint. These communities

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[2] The abbreviation LGBTQQIP2SA stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two-spirit and asexual, capturing a range of sexual and gender identities that are largely minoritized by modern society.

are more likely to exist as part of additional minoritized identities, relating to socioeconomic status or mental health difficulties (Fish, 2008). For example, multiply marginalised folks, such as LGBT+ people of the global majority, experience distress owing to both racism and sexism. As such, the resulting distress is also more severe (Balsam et al., 2011). These intersecting characteristics and the unique experiences that result impact access to, and treatment during care (Cyrus, 2017).

In navigating these many challenges, it is unsurprising that when entering healthcare settings, LGBT+ individuals feel at risk of discrimination and judgment, and experience healthcare professionals (HCPs) as lacking in understanding and knowledge of their unique needs (Henriquez & Ahmad, 2021). This lack of trust is compounded by the hetero- and cisnormative nature of healthcare environments (Smith & Turrell, 2017), through which patients are required to “continuously defend and justify their positions as parents” (Malmquist & Nelson, 2014). Experiences of discrimination in healthcare leads to a range of potentially harmful behaviours, including delaying or avoiding care, self-medicating and enduring health concerns, alongside developing a general mistrust of healthcare settings (Apodaca et al., 2022). As a result, LGBT+ individuals often feel as though they are ‘surviving’ healthcare systems (Colpitts & Gahagan, 2016).

Perinatal Healthcare for LGBT+ Individuals

In many European countries, there are still significant barriers to LGBT+ rights. For example, sterilisation is still a requirement for trans people to gain legal gender recognition in nine European countries (Lukas, 2022). This legislation is rooted in eugenics, under the guise that it centres children’s safety (Lowik, 2018). There have, however, also been many significant advances in European legislation and policy around LGBT+ people’s rights to gestational parenthood. For example, in 2013, Sweden lifted its sterilisation requirements for trans people (Payne & Erbenius, 2018), and UK LGBT+ couples were recently granted access to fertility treatment through public healthcare for the first time (NHS, 2023); a step towards more equitable access to gestational parenthood. Despite these gradual changes, there is often a sense of LGBT+ populations not being fully considered in perinatal settings. LGBT+ populations have poorer obstetric (Croll et al., 2022) and mental health outcomes (Ross et al., 2007; Greenfield & Darwin, 2020) than cis, heterosexual women.

As legislation and technology continue to advance, healthcare systems are increasingly likely to encounter LGBT+ individuals in perinatal spaces. The perinatal period is a time of vulnerability for cis heterosexual women, and LGBT+ individuals of all genders (Spidsberg, 2007). Alongside the issues outlined above and bearing in mind that LGBT+ individuals enter healthcare with an existing mistrust of services due to lived and anticipated experiences of homo/transphobia and poor understanding of their needs, perinatal settings present additional challenges for this community. Perinatal healthcare settings are especially gendered, as they are geared towards cis women and heterosexual couples. For some LGBT+ people in partnerships without the combined anatomy and physiology to become pregnant via sexual intercourse, fertility treatments will be one of the only pathways to parenthood (Downing, 2019).

In many parts of Europe, midwifery support is dominant in perinatal settings, and the majority of European countries have public healthcare. As such, access issues are very different in Europe compared with other parts of the world. This means that whilst access to perinatal healthcare is generally better in Europe, there is less opportunity to select the model of care. For example, doulas would not be funded, and there is less choice around the individual practitioners delivering care. In the UK, the National Healthcare Service (NHS) delivers care for the majority, and the model of perinatal care is centred on a ‘woman-led’ midwifery model. As such, LGBT+ individuals who are trans or non-binary may not fit well into this system, and cis/heteronormativity is also often received by lesbian and bisexual women uncomfortably.

Heteronormativity is seen and experienced by lesbian couples as embarrassing and exclusionary (Röndahl et al., 2009). Trans individuals found HCPs to be uninformed about their care needs, and did not feel they were treated with respect (Carlström & Gabrielsson, 2021). It is important to note that such experiences are not just met with a sense of unease or discomfort, rather, they have a long-lasting, damaging impact on LGBT+ patients. For example, employing normative practices when working with queer women 'further[s] the effects of structural marginalisation' (Searle et al., 2017), and that in order to empower this group, it is necessary to challenge and reconstruct traditional, dominant models of care. System-level inequalities for LGBT+ individuals lead to poorer mental health outcomes and exclusion from perinatal healthcare settings (Kirubarajan et al., 2022). Lesbian and bisexual women are more likely to experience complications during pregnancy and birth, including increased likelihood of miscarriage, stillbirth, low birth weight infants and preterm births (Everett et al., 2019). They experience pregnancy loss differently to heterosexual women due to added layers of complication, relating to their unique social and legal position (Black et al., 2014). These factors mean the required care and approach may be different than when working with heterosexual people.

In addition, LGBT+ people are more likely to have been exposed to trauma (Eckstrand & Potter, 2017), which can inform healthcare experiences and access (McKinnish et al., 2019). Trauma and health disparities both disproportionately impact LGBT+ people of the Global Majority (Singh, 2017). For example, a recent report by the LGBT Foundation (2022) found that trans and non-binary people have consistently worse experiences of perinatal care than cis women, and are made to feel disrespected and undignified. The report also discovered that 30% of the sample opted not to access any care throughout the perinatal period, suggesting there are significant barriers to access for the trans birthing population.

Current Review

As legislation advances, increasing numbers of LGBT+ individuals require perinatal care. However, services have largely not adapted. This has led to worse physical and mental health outcomes for LGBT+ patients, leaving them feeling excluded, at risk of discrimination and less likely to access care. Despite this, there exists a distinct lack of LGBT+ visibility in policy (Crowther et al., 2022, Greenfield, 2022), and there is a particular lack of understanding regarding how LGBT+ folks experience services (Darwin and Greenfield, 2019). Whilst the functions of minority stress may be similar outside of Europe, the dominant models and systems in perinatal healthcare are vastly different.

This systematic review aims to synthesise and critically examine existing qualitative literature pertaining to the experiences of European LGBT+ individuals' experiences of perinatal care. In turn, it aims to develop an understanding of how services can adapt practice to better meet the needs of this community. It will develop an understanding of the LGBT+ people as a whole, and explore the similarities and differences between how people with different identities experience care.

Method

Three categories of terms combined with Boolean operators (Table 2) were included the systematic search of PubMed, Web of Science and PsychINFO databases, completed in December of 2022. Searches were limited to exclude books and papers not written in English.

Table 2

Search Terms

Category	Terms
LGBTQQIP2SAA	LGBT* OR Lesbian* OR Gay OR Bisexual* OR Transgender* OR Trans-gender* OR Trans OR Trans gender* OR Transsexual* OR Trans-sexual* OR Trans sexual* OR Queer* OR Intersex* OR Pansexual* OR Pan sexual* OR Pan-sexual* OR Two-spirit* OR Twospirit* OR Two spirit* OR Homosexual* OR Androgyn* OR Asexual* OR Non-binary OR Non binary OR Nonbinary OR Gender non-conform* OR Gender non conform* OR Gender-non-conform* OR Gender fluid* OR Gender-fluid* OR Genderfluid* OR Gender divers* OR Gender-divers* OR Genderdivers* OR FTM OR Female to male OR Female-to-male OR Trans masc* OR Transmasc* OR Trans-masc* OR Same sex OR Same-sex
Perinatal	Pregnan* OR Pre-natal OR Prenatal OR Pre natal OR Perinatal OR Peri natal OR Peri-natal OR Postnatal OR Post-natal OR Post natal OR Antenatal OR Ante-natal OR Birthing OR Childbirth OR Matern* ORLabor* OR Labour* OR Gestation*
Care and support	Care* OR Support* OR Midwif* OR Doula* OR Assist*

Study Eligibility

Eligibility of studies for inclusion was decided based upon these criteria: (1) studies focussed on LGBTQ+ experiences of care during the perinatal period; (2) qualitative studies, or those with a qualitative component, when the qualitative data could be clearly identified; (3) were carried out in Europe, or included participants from Europe when the participants could be clearly separated from the rest of the sample. Exclusion criteria were: (1) papers not available in English; (2) quantitative designs; (3) sample did not include, identify, or focus on LGBTQ+ individuals; (4) studies not centred on experiences of perinatal care; (5) papers drawing from the same sample; and (5) books, chapters, reviews, conference presentations and opinion pieces. In this review, the perinatal period is one that includes from conception through to postnatal care. Therefore this review considers all pregnancy outcomes, including abortion, miscarriage, stillbirth and livebirth, as well as all postnatal support, such as infant feeding.

Study Selection

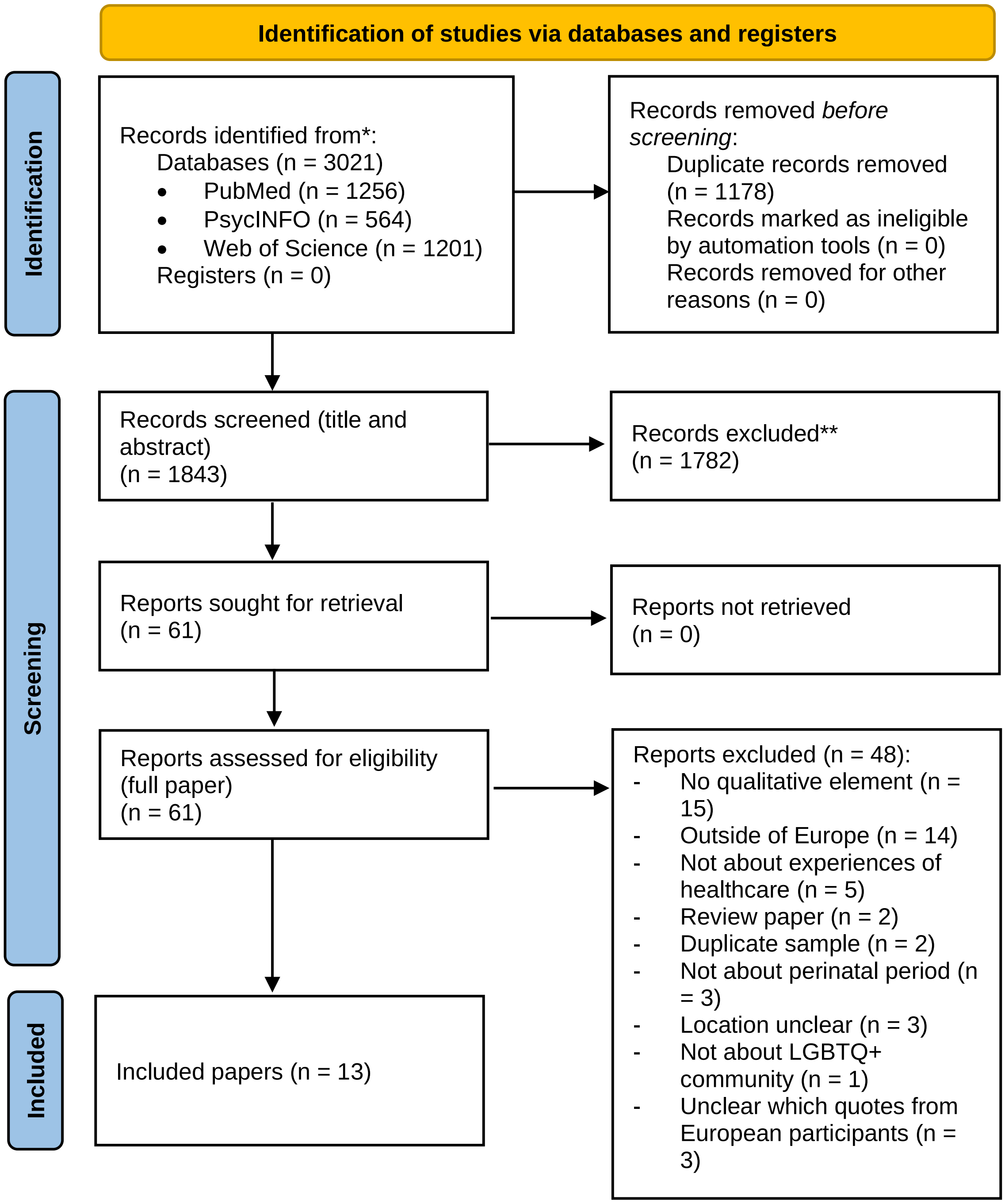
Papers were identified, screened, selected and assessed in accordance with PRISMA's (Preferred Reporting Items for Systematic Reviews and Meta-Analyses, Page et al., 2021) guidance. EndNote software was used to manage references and record decisions. The screening process, outlining numbers of papers at each stage, is outlined in Figure 3. Of the 1178 papers remaining after duplicate removal, 61 papers were retained after abstract screening. Of these, 15 met criteria for inclusion in the review. Three papers drew from the same sample and data (Malmquist et al., 2019; Malmquist & Nieminen, 2021; Malmquist et al., 2021), so the paper with most relevance to the review was retained (Malmquist et al., 2019) leaving 13 papers to be included.

Quality Control

At the title and abstract screening stage, 30 per cent of papers were independently reviewed by two additional members of the research team (10 and 20 per cent respectively), and agreement between reviewers was examined. Discrepancies between reviewers were discussed and agreement was reached. Full paper screening was completed by the lead researcher, and reviewed collaboratively amongst two additional researchers from the supervisory team.

Figure 3

PRISMA Flow Diagram



Quality Appraisal

The Critical Appraisal Skills Programme (CASP; 2018) qualitative checklist was employed to assess methodological quality of retained studies. Quality appraisal of qualitative studies is regarded an essential step in Cochrane guidance (Hannes et al., 2011), and the CASP tool was chosen due to its endorsement from Cochrane (Long et al., 2020). However, the viability of quality appraisal is contentious and its feasibility has been questioned (Carroll & Booth, 2014), and it should be noted that there is no clear guidance with regard to inclusion or exclusion of qualitative studies based on quality appraisal (Thomas & Harden, 2008).

The tool assesses qualitative methods in accordance with a set of ten criteria using a ‘yes’, ‘no’ or ‘unsure’ criteria. For mixed methods study, the checklist addressed only the qualitative elements of the study. Due to the lack of clarity in process and validity outlined above, the decision was taken to include studies regardless of the CASP outcome. However, ratings were used to guide reflection on methodological considerations, and examine the overall strengths and weaknesses of the included research.

Data Extraction

The following data was extracted from the papers: Target population, design (sampling method, type of data and methodology), reported participant characteristics, study aim, type of care concerned, reported themes and stated limitations (Table 3).

Data Synthesis

Methods for data synthesis were considered in line with Cochrane’s (Higgins et al., 2019) guidance on extraction of qualitative evidence. Briggs and Flemming (2007) define qualitative research as ‘studies in which qualitative methods were used to describe people’s experiences’. As such, direct participant quotes and authors’ paraphrased summaries of qualitative data were extracted. In this way, first order interpretations of data, in which authors stay close to the data and summarise, were considered appropriate to include. A degree of selectivity was employed: author’s interpretations; through which authors go beyond the data to make interpretations, extrapolations or comparisons of findings with previous research; were not included.

This method was selected to include as much data from the original studies as possible, whilst trying to avoid bias.

Once extracted, Thomas and Harden's (2008) method of thematic synthesis was employed to analyse data. This method denotes three steps of analysis: inductive coding of the extracted qualitative data, grouping codes into themes and generating analytical themes which go beyond the data to address the review question. Coding was completed in NVivo 13 (2020, R1), a software developed for qualitative analysis. The second and third phases were carried out by the lead researcher, then reviewed and agreed by the wider research team.

Findings

Quality Assessment

Methodological weaknesses were found in the majority of studies, particularly in researchers' justification of the design (n=10) and their exploration of positioning in relation to the study and participants (n=8). The majority presented thorough accounts of analysis (n=10) and all clearly stated findings. A table outlining ratings can be found in Appendix J.

Overall Study Characteristics

The included studies spanned a 21-year period (2001-2022) and originated from or included participants from four European countries: Sweden (n=6), Finland (n=1), United Kingdom (n=4) and Norway (n=1). One paper (Riggs et al., 2020) stated that the study included participants from the European Union (including the UK), Australia, United States and Canada including the UK, but did not specify from which countries participants were recruited.

A total of 287 participants, aged between 22 and 55 were recruited, with individual study sample sizes ranging from three to 68 participants. Studies used purposive (n=2), snowball (n=7), voluntary (n=5), convenience (n=3), and strategic opportunistic sampling (n=1). Some studies used several types of sampling. Data was gathered in the form of interviews (n=9; of which one included joint interviews with partners) and surveys with qualitative questions (n=2). Data was analysed using Thematic Analysis (n=6), Content Analysis (n=3), Adapted Gadamerian Hermeneutic Phenomenology (n=1), and Phenomenological Hermeneutical Analysis (n=1). Two papers did not specify their analytical methodology. Further details about each of the included papers can be found in Table 3.

Table 3

Summary of Studies

Reference	Target Population	Design (Sampling method, type of data & methodology)	Participant characteristics	Aim	Type of care	Reported themes	Stated limitations
Asklöv, Ekenger & Berterö (2021)	Swedish, assigned female at birth but assigned female at birth	Purposive & snowball sampling, email interview, Thematic Analysis	N = 9 Age range: 25-43 Gender: Men, transgender & transmasculine Race: Not reported	Understand experiences of transmasculine people's encounters with healthcare professionals (HCPs) in perinatal settings	Reproductive, perinatal & sexual healthcare	*1. 'Normalisation and confirmation':* When HCPs normalise gender identity, healthcare feels safer *2. 'Respect in an especially exposed situation'*: In situations which are already emotionally exposing, respectful encounters make the situation more manageable	Using social media for recruitment, sample size
Falck et al (2020)	Swedish, transmasculine	Purposive sampling, interview, Thematic Analysis	N = 12 Age range: Omitted for anonymity Genders: Men, trans men, transgender, gender fluid on the male spectrum, non-binary	Investigate how transmasculine people experience perinatal care	Gender clinics, prenatal care, obstetrics	1. '*Setting expectations: sterilization law in gender clinics':* Questioning gender identity at a time where legal gender recognition required sterility 2. *'Being excluded and ignored':* Feeling like outsiders in perinatal care 3. *'Trusting HCPs: Knowledge, integrity,*	Results cannot be generalised

			combined with man or trans man, exclusively non-binary Race: Omitted for anonymity			*responsiveness and continuity':* Trust in professionals depended on their ability to respect identity 4. *'Pregnancy as a contradiction':* HCPs treating masculinity and pregnancy as incompatible 5. *'Manoeuvring to ensure needs':* Taking responsibility for own needs due to mistrust of HCPs 6. *'Selective disclosure':* Not always choosing to disclose gender identity 7. *'Bridging knowledge and power gaps':* Educating HCPs to improve quality of care		
Juntereal & Spatz (2020)	American and British same-sex mothers	Voluntary and snowball sampling, quantitative questionnaire and interview, Content Analysis	N = 68, British N = 1 Age range: British participant aged 38 Genders: Cis Women Race: White (n=68), Black/African American	Explore lactation experience and support of birth mothers in same-sex relationships	Postnatal care	1. *'Committed to a year':* Planning to breastfeed for at least a year 2. *'Deciding how to do it':* Process of decision-making around who would carry and therefore feed 3. *'Sources of information':* Obtaining information on breastfeeding	-	Sampling method means that the sample may represent those who are more open about their experiences

			(n=2), Hispanic/ Latino (n=1). Race of British participant not reported			4. *‘Involvement of partner’:* Involving the non-birthing partner in the feeding experience 5. *‘Need for inclusive and educated care practitioners’:* Need for better support and understanding from healthcare providers	- Not all participants took part in the interview meaning the study may not be representative
Kerppola et al (2019)	Finnish LGBTQ, both birthing and non-birthing parents	Voluntary sampling, interview, Inductive Content Analysis	N = 22 Age range: Not reported Genders: Not reported Race: All participants were white	Understand what empowers LGBTQ parents in perinatal and child healthcare settings	Perinatal and child healthcare	The following were identified as empowering for parents: 1. *‘Recognition and acknowledgement’:* Being invited to share about their gender 2. *‘Cooperation and interaction’:* Being encouraged to seek knowledge and support 3. *‘Equitable care’:* Good quality and access to care, and feeling secure in it	Limited to participants with internet access so unlikely to capture parents who are more vulnerable and less visible
Larsson & Dykes (2009)	Swedish lesbian women, both birthing and non-birthing parents	Snowball sampling. Interview, Content Analysis	N = 18 Age range: 28-49 Genders: Cis women Race: Not reported	Explore views and experiences of lesbian women during pregnancy and birth	Care received during pregnancy and birth	1. *‘Recognition of sexual orientation’:* Importance of feeling accepted and included as homosexual parents 2. *‘Openness’:* Decision-making about how and when to share sexual orientation, and	Snowball sampling means that participants are vocal about the topic, meaning that women who are less open about

						sometimes choosing not to 3. *‘Relationships within the homosexual family’:* Approaches to conception and parenting structures 4. *‘Different encounters and attitudes within the healthcare system’:* Experiencing healthcare positively, but feeling it is set up for heterosexual parents	their sexuality may have been missed
Lee, Taylor & Raitt (2011)	British, primarily birthing parents, one non-birthing parent	Snowball sampling, interview, Adapted Gadamerian Hermeneutic Phenomenology	N = 8 Age range: Not reported Genders: Cis women Race: Not reported	Understand lesbian women’s experiences of perinatal care, particularly negative experiences	NHS perinatal care	1. *‘Health professional attitudes’:* Negative attitudes of HCPs, owing to both personality and views of LGBT individuals 2. *‘Organisational pressures’:* Negative experiences owing to lack of resources and organisational issues in the NHS 3. *‘Sexual orientation and physical care’:* Poor care owing to sexual orientation	- Sample size - Only individuals who had disclosed their sexual orientation
Malmquist (2022)	Swedish transgender men who started families with	Voluntary sampling, interview, Thematic Analysis	N = 3 Age range: 29 – 41	Understand transgender men’s experiences of having and		1. *‘Negotiating pregnancy, birth, and lactation’:* Gender experiences in pregnancy and birth,	Sample size and lack of participation from cisgender partners

	cisgender men		Genders: Transgender men Race: Not reported	raising children in this family structure, and understand how they experience gender in parenting		including gender dysphoria 2. *‘Negotiating maternity and femininity’:* Negative experience of being assumed as mothers, but appreciation at being granted access to women’s spaces 3. *‘Negotiating paternity and masculinity’:* Needing to protect their masculine identity, and being treated differently because they are perceived as caregiving fathers 4. *‘Negotiating equality’:* How being socialised as girls impacts expectations of caregiving, but appreciating the benefits of being in a same gender relationship	
Malmquist et al (2019)	Swedish lesbian, bisexual and transgender parents with fear of childbirth (FOC). Both birthing and non-birthing parents.	Voluntary sampling, interview, Thematic Analysis	N = 17 (9 individual, four couples) Age range: 25-42 Genders: Primarily lesbian and bisexual women, ‘a few’	Explore and describe thoughts and experiences of perinatal and reproductive healthcare in lesbian, bisexual and transgender people who	Perinatal and reproductive healthcare	1. *‘General fear of childbirth’:* What participant’s FOC is centtred around 2. *‘Minority stress – an added layer of vulnerability’:* Fears which relate to their gender identity or sexuality 3. *‘Hetero- and cisnormative treatment’:* Poor	Sample size limits transferability

			transgender and non-binary people Race: Not reported	have a fear of childbirth		treatment as a result of hetero and cisnormative addumptions and lack of knowledge 4. *‘Hypervigilance’:* Previous experiences of homo- or transphobic treatment make them afraid of experiencing the same 5. *‘Internalised homo/transphobia’:* Concealing identity and experiencing guilt and shame due to internalised beliefs	
Peel (2010)	British, American, Canadian and Australian lesbian and bisexual women	Strategic opportunistic sampling through online outlets, online survey with some open-ended questions, Thematic Analysis	N = 60, UK N = 26 Age range: 22-55 Genders: Cis women Race: 92% white, other races not reported	Explore lesbian and bisexual women’s experiences of miscarriage, stillbirth, and neonatal death	Fertility clinics, hospital, doctors office	1. *‘Processes and practices for conception’:* Routes to conception and degree of effort required compared with heterosexual couples 2. *‘Amplification of loss’:* The amount of tie and effort that goes into conception amplified loss 3. *‘Healthcare and heterosexism’:* Negative experiences including prejudice and heterosexim based on sexuality	Using a questionnaire over an interview meant there was no opportunity for specific exploration of the experiences
Riggs et al (2020)	Australian, American, British, Canadian	Convenience sampling, interview,	N = 16, European N = 8	Explore experiences of pregnancy loss amongst men,	Hospital and informal support	1. *‘Pregnancy losses count as children’:* Losses are still thought of as children	- Did not explore the impact of age on

	and European, transmasculine and non-binary people who had experienced a pregnancy loss	Thematic Analysis	Age range: 23-49 Genders: Men, transmasculine and non-binary people Race: Not reported, but participants of colour recruited	transmasculine and non-binary people	surrounding pregnancy loss	*2. ‘Minimising pregnancy loss’:* Losses not treated as children and viewing loss as a biological function *3. ‘Accounting for the causes of pregnancy loss’:* Normalising and explaining the reasons for loss *4. ‘Pregnancy loss as devastating’:* Challenging emotional impact of pregnancy loss *5. ‘Pregnancy loss as having positive meaning’:* Finding positivity in loss, such as hope that pregnancy is possible *6. ‘Fears arising from a pregnancy loss’:* Fears of pregnancy not being possible due to gender, and fears about being a pregnant trans person *7. 7. ‘Experiences of hospitals enacting inclusion’:* Choosing whether to access formal support, and experiences of support received *8. ‘Lack of understanding from family’:* Support, or lack of, from family	experiences of pregnancy loss - Did not explore the connections between conception, pregnancy, loss and use of hormones

						9. *'Lack of formal support offered':* Lack of support offered from hospital staff 10. *'Importance of friends, including those with lived experience':* Importance of informal support	
Röndahl, Bruhner & Lindhe (2009)	Swedish lesbian women	Voluntary and snowball sampling, interview, Qualitative analysis, no methodology specified	N = 10 Age range: 30-46 Genders: Cis women Race: Not reported	Report lesbian parents' experiences of perinatal care	Antenatal care, childbirth or postnatal care	1. *'Communication':* Experiences in response to coming out as lesbians 2. *'Parenthood education and forms':* Lack of understanding from providers. Heterosexual-centric information and approaches.	Snowball sampling means that the sample may not be representative of the whole population
Spidsberg (2007)	Norwegian lesbian couples, both birthing and non-birthing parents	Convenience and snowball sampling, interview (single or joint), Phenomen-ological Hermeneut-ical Analysis	N = 12 (6 couples) Age range: Not reported Genders: Cis women Race: Not reported	Describe the perinatal healthcare experiences of lesbian couples	Not reported	1. *'Being open':* A need to be open about sexuality, and things which facilitate or prevent this 2. *'Being exposed':* How different healthcare providers approach their sexuality 3. *'Being confirmed':* What makes for positive experiences of healthcare	- Sample fairly small and from a limited geographical area - Researcher taking an outsider perspective may have impacted how willing participants were to participarte

							- Did not address feminist and political aspects of the data
Wilton & Kaufmann (2001)	British lesbians, birthing parents	Convenience and snowball sampling, questionnaire with quantitative and qualitative components, descriptive qualitative study. Methodology not specified.	N = 50 Age range: Not reported, but all but one over the age of 30 Genders: Cis women Race: 45 white participants, no further information recorded	Explore lesbian's experiences of perinatal care	Perinatal care	1. *'Booking and disclosure':* Decision-making around whether to come out during booking appointment 2. *'Health professionals' response':* Responses to disclosure of sexuality 3. *'Information exchange':* Type of information requested after participants disclose 4. *'Non-disclosure':* Reasons for not disclosing sexuality 5. *'Antenatal classes':* Negative experiences due to heteronormativity 6. *'Labour and birth':* Choices around labour and experiences of care 7. *'Postnatal care':* Experiences of and satisfaction with postnatal care	Not stated

8. *‘Partners’:* Treatment and involvement of partners in the process
9. *‘Overall satisfaction’:* Overall satisfaction with care received
10. *‘Suggestions for improvement’*

Synthesis Findings

Through synthesis, three main themes and nine subthemes were identified. These are set out in Table 4, and in Appendix K a breakdown of individual paper contributions to each theme is outlined.

Table 4

Themes and Subthemes

Theme	Subthemes	Number of contributing papers
A prejudiced system		13
	Cis and heteronormative system failings	13
	Individual prejudice	8
Feeling seen and heard		12
	We exist	11
	Feeling understood as a family	7
Control and empowerment		12
	Fear, anxiety and hesitation	8
	Taking responsibility	9
	Empowered by care	8

Theme 1: A Prejudiced System

Perinatal healthcare settings are most often not designed with LGBT+ patients in mind. Participants experienced prejudice at all levels of the system, including from an organisational standpoint during patient-provider interactions.

Subtheme 1: Cis and Heteronormative System Failings

Perinatal healthcare systems are predicated on gendered norms, and as such, are not set up to meet the needs of people who are not cis and heterosexual. Patients observed “the way the health care system is divided into female and male, binary health care” (Asklöv et al., 2021, p.328, transmasculine). Documentation and records offered “only normative options for families, parents, and genders” (Kerppola et al., 2019, p.5), and participants often found that information systems failed to capture their existence in these spaces due to expectations that those accessing the service would be heterosexual, cis women. Falck and colleagues (2020) described a situation in which a trans participant could not be registered on the system. These seemingly small ‘snags’ within a system are not just inconvenient, but can have a significant negative impact on care and safety:

> In delivery they wanted to make a […] CTG [exam to record fetal heartbeats and uterine contractions] and it was not possible to see the curve on the computer because they were not able to enter my id number (Falck et al., 2020, p.47, transmasculine)

Alongside this was a general sense that perinatal healthcare finds masculinity and non-traditional womanhood to be incompatible with birthing. Falck and colleagues (2020) noted that assumptions surrounding pregnancy being synonymous with femaleness meant knowledge of trans health was reduced (Falck et al., 2020). This sense of hetero/cisnormativity that was seen across the system can also be observed in HCPs’ language and attitude when interacting with LGBT+ patients. The lack of adjustment and consideration led to mistrust of healthcare systems more widely:

> [Healthcare provider] emphasized the whole time that ‘here is where the father can go and get coffee’, and ‘the father can sit there’, even though we were two women couples and two woman-man couples sitting there […] So it didn’t feel very good, so we were very upset and got a lot of strange ideas about exactly how aware the staff was. And would we be respected when we got there? (Röndahl et al., 2009)

There was a frequent sense of being misunderstood, or that the system had not been prepared to work with LGBT+ people. One trans individual described a scenario in which urgent care was delayed due to a lack of knowledge from healthcare staff:

> When we went to the hospital reception [my friends said]; ‘Eh, our friend he’s pregnant. He’s having a baby, the baby’s coming’. And the hospital people were like, ‘He’s having a baby?’ […] So, it took a while for them to attend to me. By the time they [did] I was actually three centimeters open. [By then it] was already too late. It was the he pronoun, father [that confused them] (Falck et al., 2020, p.48, transmasculine)

As a result, patients were often required to educate their HCPs whilst receiving care:

> Part of it is good because she needed to learn, and she seemed open. But then there’s another part that gets mad because […] I’m not there to… educate their staff, so a part of me is sitting there wishing ‘please stop asking about that’ and find out why I’m having early contractions instead. Because in this situation, all we wanted was help… (Röndahl et al., 2009)

Patients found the continual need to educate HCPs “exhausting” (Asklöv et al., 2019, p.328), and desired continuity of care to circumvent this:

> Continuity of care is very important ... [the] midwives changed [with] every appointment and often I just let the ‘father’ and ‘husband’ comments go as I knew I would not be seeing them again so there was no point putting myself through an embarrassing situation (Wilton & Kaufmann, 2001, 209, lesbian).

Lack of consideration for LGBT+ patients led to, or affirmed existing mistrust. As such, even positive experiences did not alter overall beliefs and expectations about healthcare, because patients did not believe that change would be unified across the wider system (Falck et al., 2020).

Trans patients noted the impact of cisnormativity on their experience, including delaying or avoiding gender-affirming treatment in order to feel safe in perinatal settings:

> It was a very conscious decision [to refrain from changing legal gender]. If you pass as a woman, even if you are a very masculine woman it is easier for others, they do not have to get stressed […] Sometimes other things are more important than your gender identity (Riggs et al., 2020).

However, if they had not accessed any gender-affirming care prior to their pregnancy, their gender was disrespected or invalidated: “You are seen as less transgender. If I had gone through assessment and taken testo [testosterone] for a while and then wanted to have a child, I would probably have received completely different reactions” (Falck et al., 2020, p.48, transmasculine). Malmquist (2022) describedd how one trans patient was made to defend his decision to give birth after being questioned by a healthcare professional about how it aligned with his gender identity.

Subtheme 2: Individual Prejudice

Issues with care were evident at all levels of the system, and patients often recognised the role of wider systemic or organisational factors on their experience. However, many LGBT+ patients also experienced more direct forms of prejudice and violence from individual HCPs. These experiences seem to occur on a spectrum.

Some participants identified poor treatment such as “general unfriendliness and lack of eye contact” (Peel, 2010, p.725, identity not stated) or staff refusing to push a birthing person’s partner in their wheelchair (Wilton & Kaufmann, 2001). Others were left without support, with untreated infections, or HCPs refused to examine them (Lee et al., 2011). Some attributed mistreatment to “bad chemistry” (Röndahl et al., 2009), whilst others were left questioning whether their poor care is due to their identity (Lee et al., 2011). One participant described a negative experience, then queried the intention:

> The public nurse arrived at our house with her bicycle helmet on…barely looked at us at all, just kept looking at all the papers. I tried a bit of small talk…no response. She didn’t look at the baby until the visit was nearly over. Frankly, she was a bitch. But, whether this was her personality, or whether it had anything to do with us, I don’t know (Spidsberg, 2007, p.483, lesbian)

This illustrates the challenges participants faced when trying to make sense of their experiences of poor healthcare. For some participants, it felt easier to identify their experiences as the result of prejudice:

> An internal examination at nine months was so rough it made me bleed, and worse, was so painful and frightening I felt I had been assaulted. No other midwife has ever hurt me like she did, nor laughed at my questions or put me down as she did. She ignored my partner, turning her back to her during my antenatal appointments. Before appointments, when she saw us in the waiting room, she’d roll her eyes and point at us to the receptionist (Wilton & Kaufmann, 2001, p.209, lesbian)

Some patients were explicitly discriminated against, with HCPs refusing to treat them: “[The GP] stated outright that a woman should not consider childrearing unless married to a man; she was in fact quite rude” (Wilton & Kaufmann, 2001, 205, lesbian). Even after experiencing poor treatment, patients often found that HCPs would try to excuse their mistakes: “[The midwife] kept saying, ‘I will say the wrong thing and you have to correct me’ (Falck et al., 2020, p.47, transmasculine). In response to prejudice, patients reported feeling “Angry, sad, anxious and helpless, misunderstood and invalidated” (Falck et al., 2020, p.48). One woman noted that she felt “frightened each time I met another midwife that she would hurt me or my baby because she didn’t like lesbians” (Wilton & Kaufmann, 2001, p.209, lesbian).

Theme 2: Feeling Seen and Heard

Participants expressed the importance of feeling seen, heard, and understood in their identities as individuals and as members of family units, and the negative impact of being made to feel invisible.

Subtheme 1: We Exist

Many LGBT+ patients reported feeling like “outsiders” in perinatal contexts (Falck et al., 2020, p.46), as though there was not a place for them in this system. This could manifest as being made to feel very different to others, for example, being treated as a risk: “[They] placed [my] child on [the] concern list! Because of the nature of our relationship, i.e. lesbians.” (Wilton & Kaufmann, 2001, p.205, lesbian), or feeling as though their identity draws unnecessary attention:

> Being a lesbian is always a theme. It’s a theme at the health centre and it is a theme in the neighbourhood and it is a theme at work. I wish it didn’t have to be a theme, but I understand that it happens because you are different from others (Spidsberg, 2007, p.481, lesbian).

Contrastingly, some patients felt that this sense of difference can be enacted by being made to feel invisible. Lack of consideration and acknowledgment is noted: “The very first postnatal visit was conducted by a locum midwife and she didn’t talk to or even look at my partner” (Wilton & Kaufmann, 2001, p.208, lesbian). Others got a sense that this part of their identity is ignored entirely:

> I don’t know, some people have a way of approaching it by just ignoring it, pretending that it isn’t there. Everybody knows it’s there, but nobody dares to mention it. It’s like ‘The Emperor’s New Clothes’, everybody knows but nobody says anything. (Spidsberg, 2007, p.481, lesbian)

This treatment left patients feeling “offended, invisibilised and stressed” (Malmquist et al., 2019, p.6). Some respond by asserting their identity more clearly: “to demonstrate that we exist” (Spidsberg, 2007. P.480, lesbian), whilst for others, it felt like a relief to be treated “like a ‘normal’ pregnant mum to be” (Wilton & Kaufmann, 2001, p.205, lesbian) and found this to be supportive in the building of trust:

> Parents needed to be sure that being LGBTQ did not affect the way that they and their child were treated in either appointments or group meetings. They wanted to be a “normal” family and have access to the same services as everyone else (Kerppola et al., 2019, p.6)

Many examples of ways that HCPs support LGBT+ patients to feel seen and represented in perinatal spaces were offered by participants. This includes the importance of communicating with neutral or more encompassing language:

> She used words like ‘cisgender’, ‘cis male’ and ‘cis female’ which I find inclusive. When she talked about the ways the reproductive medicine clinic can help people to reproduce, she said, ‘the person with uterus/ovaries’, ‘the person who will carry the pregnancy’ and ‘person with penis/sperm’” (Asklöv, 2021, p.328, transmasculine).

Participants appreciated being given the opportunity to define themselves, without needing to initiate the conversation, for example, through ensuring that documentation offered an opportunity to share their identity (Kerppola et al., 2019). There was a sense that acknowledging, but not fixating on identity helped participants to feel safe and understood, such as simple comments that could be recognised as affirming of their identity (Wilton & Kaufmann, 2001). Others expressed a desire for community support, or to see other units who looked like them: ‘[We could have been supported] by letting us know if any other women were in the same situation as us. We felt very alienated.’” (Wilton & Kaufmann, 2001, p.209, lesbian)

Subtheme 2: Feeling Understood as a Family

For many LGBT+ people, family structures can differ significantly from that of a cis or heterosexual family, and can be very large (Larsson & Dykes, 2009). This might include the involvement of sperm donors, expansive relationship structures such as non-monogamy, or additional support systems, for example: “One respondent was particularly angry that […] her partner’s biological children had been excluded and ignored by health professionals” (Wilton & Kaufmann, 2001, p.208). Patients also noted that often, perinatal environments physically could not accommodate expansive family units: “If there are three or four parents and there are two chairs, then it's a pretty clear sign that you are not welcome, you don't belong there, or you are too much” (Kerppola et al., 2019, p. 5). HCPs often did not understand the family units that LGBT+ people can form, and the importance of being welcomed as a unit:

> You could only bring one person to the ultrasound examination. We tried very hard to persuade them to let us all come since our family constellation is a bit different, but no. It was as if the whole world would fall apart if one extra person came along (Larsson & Dykes, 2009, mother).

Across the articles, many birthing people noted the importance of the non-birthing partner being involved, treated respectfully, and as an equal. Some patients found HCPs to be “aggressive and excluding” toward their partners (Wilton & Kaufmann, 2001, p.207, lesbian). If HCPs actively included the non-birthing parent from the beginning, it supported the development of trusting relationships between provider and patient (Röndahl et al., 2009). This sense of acceptance could be expressed in many ways. One example is through the HCP’s manner: “I think eye contact has been important; they have always looked at us both” (Larsson & Dykes, 2009, p.685, mother). Others identified more purposeful inclusion of the partner:

> My main midwife would direct questions at my partner and ask how she was feeling, how she was coping […] and would say hello and goodbye to her. She was seen as being as much a part of the pregnancy as I was (Wilton & Kaufmann, 2001, p.208).

Theme 3: Control and Empowerment

This theme explores facets that shape LGBT+ patients feeling empowered in their care versus lacking in control.

Subtheme 1: Fear, Anxiety and Hesitation

Many participants entered perinatal care with an expectation of prejudice: “It isn’t certain that they are prejudiced; it’s just the way it is. And then I walk around, being a bit paranoid, I think” (Spidsberg, 2007, p.481, lesbian). For many, their expectation of perinatal care was shaped by previous negative experiences, leading to a general sense of mistrust of professionals and of perinatal settings. In turn, participants were lacking in trust toward healthcare staff and tended to be hypervigilant toward prejudice (Malmquist et al., 2019). One such example was the expectation for birthing parents to be women (Falck et al., 2020). When their experiences defied this narrative, it came as a surprise, as seen by this description of non-homophobic care as ‘a blessing’: “The doctors and nurses were great—no homophobia, no problem at all with us […] No questions or issues which was a huge blessing in those circumstances” (Peel, 2010, p.726).

Several factors were considered when exploring this expectation of poor care. For many, the time around pregnancy and birth is already a time of vulnerability. Navigating perinatal healthcare as an LGBT+ person adds an additional layer. Some require additional support around the legalities of LGBT+ parenthood (Kerppola et al., 2019), whilst others have anxieties about physical aspects of birthing, such as the navigating the effects of gender affirming care. One participant was anxious about genital pain and heightened risk of injury during labour due to the accessing gender-affirming hormone testosterone (Malmquist et al., 2019), or managing increases in gender dysphoria which can be brought about by pregnancy:

> Still, I was quite afraid about how much dysphoria I was going to feel. […] The fear of looking female, or feeling that my body would look very female, and that I’d feel a huge amount of self-hatred, as I did when I was younger, before the mastectomy and so on. […] But, so, the dysphoria was about, well, a lot

> about how my surroundings would see me, would they treat me like a, or “girl” me, or would I hear “she” again (Malmquist, 2022, p.374, binary transgender man)

A degree of confidence in navigating the system was required, but developing this knowledge takes time and energy, “leaving the vulnerable behind” (Falck et al., 2020, p.48). Participants noted they were accustomed to navigating hetero/cisnormativity, but the additional vulnerability and fear that comes with childbirth means that their identity added additional stress to an already challenging situation (Malmquist et al., 2019).

Existing vulnerabilities paired with anticipated or actual negative experiences led some participants to feel anxious or afraid of accessing perinatal care. In some cases, this can prevent LGBT+ patients from accessing care entirely, for example, Asklöv (2021) noted that a service being named a ‘women’s clinic’ made some participants too uncomfortable to go there. These fears could be rooted in their country’s legislation. For example, one participant noted the impact of Sweden’s recently lifted requirement for sterilisation of trans people:

> I fear that there will be someone there to forcibly castrate me, who forcibly sterilizes me when I have been put to sleep, when I cannot defend myself. And of course, I know that it is really irrational, but it is that year [in evaluation] when it was taken for granted that they could do it against my will (Falck et al., 2020, p.47, transmasculine)

Even when legislation such as sterilisation requirements are lifted, participants noted that HCPs may continue to harbour beliefs that trans people should not be birthing parents:

> Healthcare staff had told them that men should not give birth, and that people who do are not actually trans. […] When planning to have children, these experiences made Jonathan afraid of future contact with 'maternity' care and delivery wards (Malmquist et al., 2019, p.7).

Anxiety around care sometimes manifested as participants concealing their LGBT+ identity, or selectively disclosing depending on sense of safety due to anxieties about the impact it might have on their care (Larsson & Dykes, 2009). One participant talked about the way they assessed situations, to decide how safe it was for them to reveal their identity:

> I always started to get a feel for the terrain, maybe talked about something that does not concern me personally to see how it is received, like transgender care […] closing in on the topic in big circles […] to give me the option to back off and still get treated reasonably well if they cannot handle it (Falck et al., 2020, p.48, transmasculine)

Despite fear and anxiety, individuals often endure care regardless: "Birth giving is unescapable when you are in labour. In his worst-case scenario, he imagined how he would be trapped in an unfriendly, transphobic situation" (Malmquist et al., 2019, p.7).

Subtheme 2: Taking Responsibility

As a result of these experiences and emotional responses, many participants opted to, or felt a need to assume responsibility for their care in some way:

> I think you must, as a lesbian, be the one who gives the information, you have to accept any discomfort and get used to it if you are going to have children.

> Much of the responsibility lies with you (Larsson & Dykes, 2009, p.685, mother).

This took the form of parents educating themselves (Juntereal & Spatz, 2020), seeking specific healthcare providers who they perceived to understand their needs (Spidsberg, 2007), or changing hospitals as a result of poor treatment: “This respondent had since had two subsequent pregnancies, during which she travelled to a midwifery team on the other side of her borough – taking 45 minutes by bus with a double pushchair – to avoid this particular midwife” (Wilton & Kaufmann, 2001, p.209, lesbian).

Many participants felt obligated to educate HCPs to ensure better care for themselves and future LGBT+ parents: “It got really tiring, because all the time they placed the responsibility on me […] rather than seeing their own responsibility” (Falck et al., 2020, p.47, transmasculine).

Subtheme 3: Empowered by Care

To feel truly safe, many participants expressed a need to feel empowered in their care. Notably, this is not a desire unique to LGBT+ people, but as these populations are more likely to enter systems in a state of vulnerability and anxiety, it holds additional importance. A symbiotic relationship with HCPs was desired, in which services offer advice, but invite patients to take control over their own care: “[HCPs] are experts in their own field, but I know what is best for me and my child” (Kerppola et al., 2019, p.5, gender not recorded). Patients described affirming care as being received with “open arms” or feeling like “coming home” (Spidsberg, 2007, p.482, lesbian), and patients provided multiple examples of when they felt truly accepted by HCPs:

> The doctor who examined our baby before we left the hospital was nice and accommodating. He shook hands with both of us, and I enjoyed his comment before he left: ‘a perfect boy. Well done for country and people’. Perhaps this is what he usually says, but I think it was so cool that he said it to us, you know. To me it was a kind of acceptance, and that he thought it was a cool thing to do (Spidsberg, 2007, p.482, lesbian)

Participants also appreciated HCPs being aware of, and offering support with, the unique challenges that LGBT+ birthing people and families face, such as legal issues (Spidsberg, 2007). A sense that patients were being held in mind, and that HCPs actively wanted them to feel safe, was hugely appreciated: “The midwife who ran the antenatal classes was so supportive – she realised that we were lesbians, rang us the first night after the class to check that we felt welcome, always acknowledged my partner” (Wilton & Kaufmann, 2001, p.207, lesbian).

Discussion

This review aimed to synthesise and evaluate qualitative findings on European LGBT+ birthing people’s experiences of perinatal care. Thirteen studies from four countries were included, alongside one article that did not identify from which country its participants were sampled. Three themes were identified across the papers: ‘*A prejudiced system,’* ‘*Feeling seen and heard,’* and ‘*Control and empowerment.*’

Various reviews have been completed in this general domain before, including exploring LGBT+ healthcare inequities (Medina-Martinez et al., 2021) and perinatal mental health in lesbian (Ross, 2005), trans and non-binary birthing people (Greenfield & Darwin, 2020; McCracken et al., 2022). However, to my knowledge, there are no existing reviews specifically exploring how perinatal settings are experienced by LGBT+ patients, and within this, none focussed on qualitative literature.

In all the studies reviewed, participants felt a lack of control, which impacted their confidence in HCPs and how they interacted with services. These experiences are situated in a wider context of challenges and barriers in accessing healthcare for LGBT+ people. For example, negotiating disclosure of identity and feeling at risk of discrimination (Kamen et al., 2018), alongside experiences of actual discrimination and lack of understanding from HCPs (Henriquez & Ahmad, 2021). It is important to consider that after many experiences such as these, one may have pre-existing anxiety, hesitation or fear about accessing all facets of healthcare, including mistrust of professionals (Smith & Turell, 2017). Furthermore, LGBT+ people enter services with additional, preexisting vulnerabilities (Pellicane & Ciesla, 2022) and increased risk of mental and physical health problems (Eckstrand & Potter, 2017). They are also more likely to face barriers in accessing care (Trettin et al., 2006) and are less satisfied with their care than their heterosexual and cis counterparts (LGBT Foundation, 2022). Experiences as an LGBT+ birthing person are compounded by these pre-existing systemic factors, as set out by minority stress theory (Brooks, 1981), and birthing environments promote additional challenges.

Upon entering services, participants were met with barriers and normative assumptions at all levels of the system, including in policy, in healthcare environments, and in individuals. In all studies reviewed, participants report some degree of prejudice, ranging from subtle to more explicit. In some cases, patients were left doubting whether their experience constituted homo/transphobia. For example, they were unsure whether being asked inappropriate questions, or having to educate their providers due to a lack of knowledge constituted discrimination on the part of those providers. Experiences such as these are labelled in literature as microaggressions (Vaccaro & Koob, 2019), and are often unintentional or unconscious. However, repeatedly encountering this type of prejudice can have a significant impact on mental health (Nadal et al., 2016). In perinatal settings, microaggressions are experienced as a form of minority stress, and LGBT+ individuals are “effectively punished, dehumanized, and humiliated by the very people who have the power to provide or deny them health care” (Pezaro et al., 2022).

Additionally, many experienced more explicit forms of prejudice, in which they were refused care or treated with visible disdain by HCPs. For a group that is already disproportionately impacted by trauma, these prejudicial experiences can be retraumatising and have a range of negative impacts, as established by this review. These can include: mistrust of HCPs, feeling the need to conceal one’s LGBT+ identity, and even complete disengagement from services. The decision not to access care during the perinatal period is far more prevalent amongst cis lesbian and bisexual women than cis heterosexual women (Greenfield et al., 2021), and more prevalent again within trans communities (LGBT Foundation, 2022). Disengagement from medical care can lead to poor outcomes for both parent and baby (McKenzie et al., 2020). The choice to not to access care is often driven by patients finding perinatal care inaccessible or traumatic (Dahlen et al., 2011). That such a high number of LGBT+ individuals feel safer without input from services is an indicator of the ways in which perinatal care is failing theses populations.

Further to wider issues relating to healthcare access and experiences, there are many additional systemic factors specific to perinatal care which may exacerbate anxieties and fears. For some LGBT+ populations, this sense of mistrust may be rooted in European countries’ ties to eugenics (Lowik, 2018); in that sterilisation is still a requirement for legal gender recognition processes in nine European countries (Lukas, 2022). In Sweden, the requirement was lifted in 2013, however, systemic change including policy, procedures, HCP attitudes and patients’ trust toward healthcare environments takes time, and many patients' beliefs and experiences are shadowed by former legislation (Payne & Erbenius, 2018). This can explain the ongoing disparity between policy and lived experience, as found in this review.

Despite poor experiences and anxiety or hesitation around accessing services, LGBT+ birthing people are still required to navigate a perinatal healthcare system that was not created with them in mind. This review echoes previous research that found this community is often made to feel invisible and overlooked (Darwin & Greenfield, 2019). It is imperative that LGBT+ patients feel safe, secure and empowered by perinatal services. LGBT+ individuals entering perinatal spaces disrupt norms and assumptions, and as such, systems need to respond to this presence by disrupting “expectations of and relations within the very space(s) where birthing occurs” to “embody orientations that reside outside heteronormativity” (Goldberg et al., 2011).

Participants across the reviewed studies made recommendations for creating care in which they feel represented and empowered. Many participants referenced the importance of acknowledging and responding to the unique constellations of LGBT+ families. This includes equal and welcoming treatment of the partner and the creation of a physical space permitting different family dynamics. In addition, many participants desired an opportunity to express sexuality, gender, and associated needs both verbally and in documentation. For example, many participants did not see themselves reflected in IT systems, forms and in the physical environment. Whilst this is uncomfortable at best, it can also lead to delays in care and inappropriate data handling.

There remains a distinct lack of research regarding LGBT+ people in perinatal settings (Darwin & Greenfield, 2019; Roosevelt et al., 2021). Within this, even less literature acknowledges the intersections between LGBT+ identity and other characteristics, such as race and disability (Nadal et al., 2016). As such, what little is known, is known about predominantly (if not exclusively) white, able-bodied, wealthy people; despite our knowledge that there is an increased likelihood of LGBT+ people being multiply marginalised. This is reflected in the studies reviewed here, none of which explore the impact of other identity characteristics on the LGBT+ perinatal experience. The reasoning for this erasure of identity is unclear, indicating a lack of awareness or intention around understanding how intersecting identities can impact experience.

Methodological Considerations

Methodological appraisal using the CASP tool (2018) was utilised to guide assessment of methodological soundness. There was a distinct lack of reflection on positionality or identity of the researchers. In qualitative research, reflexivity and acknowledging one's position in relation to research and participants is deemed an essential quality assurance practice (Braun & Clarke, 2021; Nowell et al., 2017). This may have contributed to the limited reflection on diversity and intersectionality across the samples. The checklist also identified the lack of methodology justification from researchers. However, this was often followed by a thorough description of how the methodology was used. Some studies were methodologically poor, including failing to state aims or name the methodology used.

The included papers primarily used convenience and snowball sampling, meaning that data might not be reflective of the intended population. Some voices may be missed, for example, this data does not attend to those who might not feel safe or able to access perinatal care, despite knowing that this is more common in LGBT+ populations (Greenfield et al., 2021; LGBT Foundation, 2022).

An additional key limitation not considered under the tool is the lack of recording of participant demographics, including age and ethnicity. This is deemed an important part of quality assurance in qualitative research (Elliott, 1999) as it situates the sample in the population, allows for deeper understanding of how intersecting identities can impact experiences, and highlights which groups are missing from research. The motivation for omitting this information is unclear, but this means that there are layers of meaning missing from the interpretations.

Overall, the data collection methods and write up were rated highly, but the justification and narrative for the reader on method selection was lacking. This means that the data utilised in the review is largely rich and helpful in addressing research questions.

Strengths and Limitations

With regard to strengths, this review captures a range of identities across the LGBT+ birthing spectrum, including marginalised genders, in trans and non-binary people; and sexualities, in lesbian and bisexual women. It provides an up to date account of how LGBT+ people experience perinatal care, responding to gaps in the literature (Darwin and Greenfield, 2019). Synthesis found that overarching themes were identified across almost all papers included. This suggests shared experiences across different identities and European countries, indicating potential clinical utility of the findings. More than half of the studies were carried out in 2019 or more recently, indicating the data is largely relevant to the present cultural climate in Europe.

As for limitations, only a subsection of papers were reviewed by a second reviewer in the initial stages. However, two second reviewers were involved in the process, screening 10 and 20% of the papers respectively, and agreement was high.

Practical and Clinical Implications

This understanding of LGBT+ experiences of perinatal care can influence all levels of the system. It is essential that policy and guidance from healthcare institutions and governing bodies actively facilitate knowledge, inclusion and safety of LGBT+ patients. This requires training of staff to become culturally competent in supporting LGBT+ individuals (MacKinnon et al., 2019), including support to understand their paths to conception and challenges faced. It is also important that staff feel equipped to sensitively and appropriately engage in questioning of patients, without relying on them for education.

Even where there exists a desire to provide better services, HCPs are not supported in providing sensitive, appropriate care for LGBT+ birthing people. For example, perinatal healthcare staff recognise the cis/heteronormativity functioning in perinatal environments, and acknowledge transphobia amongst their colleagues (Pezaro et al., 2023). However, it is difficult to effect change in these systems for a variety of reasons, including underfunding and overloading public healthcare services such as the NHS, and individual entrenched attitudes toward LGBT+ people. These issues require significant reform at multiple levels of the system, from government and healthcare policy to individual training.

In addition, it is necessary for services to develop the physical infrastructure to welcome LGBT+ individuals and families, for example, having spaces that are equipped to accommodate non-normative family structures and creating documentation which actively includes LGBT+ people, inviting them to share their identities. LGBT+ individuals should co-produce, deliver and disseminate resources, services and trainings. Previous research with perinatal HCPs found that a short training session can support staff to develop their knowledge of LGBT+ individuals, reduce prejudice, and improve intended behaviour (Singer et al., 2019). However, it is unclear what would be the lasting impact of this type of intervention, and this also does not address the wider systemic issues at play.

In this way, as well as routine trainings, the approach of the wider healthcare system is required to shift. It is essential that HCPs understand the position from which LGBT+ individuals come when accessing services, in that they enter systems at a disadvantage, with existing vulnerabilities (Pellicane & Ciesla, 2022) and increased likelihood of exposure to trauma (Eckstrand & Potter, 2017). As such, a trauma-informed approach to care for LGBT+ individuals is necessary. Trauma-informed approaches centring LGBT+ individuals, anti-ableism and accessibility have been piloted in non-perinatal settings, and were found to have potential to avoid retraumatising and meet the needs of the community (Tam et al., 2022). It is suggested that trauma-informed care should foster empowerment, connection with community and affirm all facets of a person's identity (Levenson et al., 2021). A model that captures these domains would speak to all the issues experienced by participants in this review. Within this, it is also essential that HCPs are offered reflective spaces to make sense of their own misunderstandings, prejudices and assumptions about this community in a safe and contained way, without projecting onto LGBT+ individuals or seeking knowledge from them during a vulnerable time (Cole, 2000; Summers, 2017). To ensure that these ideas are enacted in services, it is essential for policy and law to address the issues, and for healthcare services' governing bodies and guidance to enshrine these principles as essential to the safety and wellbeing of LGBT+ individuals in perinatal care.

From a theoretical standpoint, this review can contribute to understandings of minority stress theory (Brooks, 1981; Meyer, 1995) for LGBT+ individuals; in perinatal healthcare, the additional layer of vulnerability has a significant impact on care experiences. This review can also contribute to understandings of how trauma can manifest in healthcare settings for the LGBT+ community, impacting access to and experiences of care (McKinnish et al., 2019). It contributes additional evidence that existing as part of minoritised groups impacts healthcare outcomes, and in addition, suggests that minority stress may be exacerbated in settings promoting vulnerability, such as perinatal services.

Future Research

More research is needed to explore how perinatal care for LGBT+ individuals is experienced by both patients and HCPs. Qualitative research is particularly useful for developing an understanding of organisational and cultural issues within services, and to inform service development (Sinuff et al., 2007), such as creating trainings, policies, and service models. This experiential insight also allows for the design of targeted quantitative studies, which can more accurately measure and reflect the experiences of the community (Trivedi & Chan, 2023). Regarding quantitative studies, there is currently a lack of research examining outcomes for LGBT+ birthing people compared with cis, heterosexual women. It is essential that studies of this nature acknowledge the existing inequities for LGBT+ individuals and consider outcomes from a minority stress theory standpoint.

More generally, research that sensitively and thoroughly explores the intersection of LGBT+ identity with other marginalised characteristics is also required, as there is currently a lack of nuance within perinatal research. More attention should be paid to recording characteristics, both within research and services. It is important for research to include questions specifically addressing participants' experiences of their unique and distinct identities. Once a clearer understanding of experiences, outcomes, and HCP knowledge and attitudes has been developed, targeted interventions, such as trauma-informed approaches, can be piloted. It is also important to understand how other identities, such as gay men, and trans women, experience perinatal spaces, for example as birthing partners, or when accessing spaces with a surrogate.

Conclusion

This review aimed to synthesise and review articles relating to European LGBT+ individuals' experiences of perinatal healthcare. It established that LGBT+ individuals enter perinatal care at a disadvantage due to marginalisation and minoritisation, which leads to minority stress and an existing mistrust of healthcare systems. Perinatal care is not designed with LGBT+ people in mind, making them feel isolated and invisible. In addition to this, they frequently experience prejudice from HCPs, ranging from microaggressions to explicit prejudice such as the denial of care. As a result, LGBT+ birthing people feel unsafe and are presented with a series of barriers to accessing perinatal care, which cis, heterosexual women are less likely to experience. The review highlights a series of clinical and theoretical implications, including contributions to minority stress theory, trauma-informed approaches, and recommendations for adjusting perinatal care to support LGBT+ people at all levels of the system

Paper 3: Integration, Impact and Dissemination

Integration, Impact and Dissemination

Integration

The two papers outlined here are both interlinked and distinct from one another. There are many distinct communities that make up ‘LGBT+ people’, each with unique and varied experiences and identities. Trans comes under the umbrella of LGBT+, in that all identities under the acronym are marginalised by society on the basis of sexuality or gender modality. Paper 1 and paper 2 both examine the LGBT+ population, only Paper 1 concerns a subset of the population. Paper 2 supported in a foundational understanding of the subject matter, creating a broad understanding of these populations, and how they experience perinatal care.

Associated themes were identified across the two papers, indicating shared struggles across LGBT+ communities in their access to perinatal care. Perinatal services are predicated on norms that do not reflect LGBT+ identities, and as such, LGBT+ people do not see themselves reflected there. Both LGBT+ people as a whole and within this, trans people specifically, encounter pervasive cis/heterosexual normativity and feel disempowered, lacking in autonomy, and ultimately unsafe as a result. In some way, there is a distinct feeling of invisibility, or erasure, for all, however, both papers saw the experiences of transmasculine folks were marked by their inability to conceal, whereas both lesbian, bisexual, and non-binary people can opt not to reveal their identity, which can be used to their advantage. Trans men were frequently blocked by administrative issues, which impacted their access to care.

Despite these united struggles, there were some distinct differences in the papers also. Paper 1 delved in more depth into the specific connotations of a trans identity, exploring the nuances of invisibility, notably, that trans people can be simultaneously too visible, and erased. It also explored the added dimension of embodied experiences of pregnancy and birth, considering the added layers of experience shaped by being perceived as trans. Although lesbian and bisexual couples in perinatal services are still a minority, there is more cultural awareness and less media sensationalism around their pregnancies and birth. Notably, the phenomenon of transness is regarded in UK popular culture as something novel, but transness is not new, as trans people have existed for eternity. However, recent public discourse means more trans folks are able to live authentically, and as such, are more likely to present to services as their full self. In this way, trans peoples' presentation in perinatal care is often a new venture for care providers, revealing staff's lack of education, leading to additional anxiety and more potential for prejudice than with lesbian and bisexual women.

The UK has seen a steep rise in anti-trans groups, contributing to a climate of fear for trans people. It is important to note that there is also a considerable degree of infighting across LGBT+ communities, in that some anti-trans groups are led specifically by lesbian women, who believe that the fight for trans liberation is impinging the rights of lesbian and bisexual women (Bindel, 2016; Stock, 2021; 2022). These two papers in combination acknowledge both distinct and shared experiences of trans, lesbian, and bisexual birthing people in perinatal care, and highlights a case for collective liberation. The fact that there is an overlap between research in the last 21 years and the current study covering the last five, indicates that very little has changed for these communities. It also highlights a need for continual renewing of these types of research, so that changes to their experiences can be tracked over time, and compared with corresponding changes to the sociopolitical climate.

Systematic Review Reflections

The review topic was selected to lay a foundation for paper 1, intending to shape an understanding of the wider contextual sphere with regards to LGBT+

perinatal healthcare, within which the UK system exists. The review was limited to studies carried out in Europe. I went back and forth on this issue, unsure whether to extend to a global search to create a richer narrative, however, the decision was made in order to hone in on the systemic issues faced by LGBT+ birthing people in Europe. European perinatal care is arguably different from other countries, such as America and Canada, where a considerable portion of research is carried out. The increased availability of public healthcare, and the dominance of midwifery in perinatal care means that the context is unique, and as such, it is important to develop a specific understanding of this. This was the first study of its kind to examine the European context specifically. Upon reflection, it may have been interesting to carry out a global review and include some comparative elements between the UK, Europe and other countries. However, European search returned a very high number of results, and as such, a review of this breadth would not have been feasible in the scope of this project.

Decisions around quality analysis were also challenging, as quality appraisal is mandated by Cochrane, but there is much debate around the utility and feasibility of quality appraisal for qualitative systematic reviews. Many papers complete quality analysis to meet necessary requirements for publication, but the outcomes do not impact retention or exclusion of studies (eg. Bohren et al., 2019; Munabi-Babigumira, 2017) due to a lack of clarity around appraisal processes and a lack of validity of measures (Carroll & Booth, 2015). Although quality appraisal for qualitative reviews is not robust enough to promote exclusion, it supported in guiding the strengths and limitations discussion. Additionally, noting the many methodological weaknesses informed the rigour of paper 2.

Empirical Paper Reflections

My primary reflections surround how much I deeply enjoyed this research. Hearing peoples' stories, and their rich reflection on their identity and position, was an honour. It was an exciting, and at times challenging process, to capture and convey these narratives in the themes. I noticed a sense of anxiety that I would not be doing my participants justice if I was unable to capture all of their stories. At times, the rich and complex data I was faced with felt overwhelming. I went back to the literature (Braun & Clarke, 2021) and reflected on this feeling, acknowledging how my own position as a trans person, who has experienced feeling overlooked and misunderstood, might be influencing this narrative.

To overcome this, I needed to settle into the Thematic Analysis methodology and embrace the iterative process. I relinquished to the uncertainty and relaxed into the idea that going back and forth, refining, pruning and sometimes completely overhauling themes was an essential part of the process. I took time away from the data and returned to it several times, and eventually began to feel more secure in my construction of themes. This process felt creative, rewarding, and highly enjoyable.

My personal interest in social justice and liberation psychology, and my work in community psychology settings with a focus on co-production, left me with many ideas about power in research. I noted my frustration at the lack of budget for true co-production, being permitted only one hour of paid time with an expert by experience. This can feel tokenistic, and is arguably consultation, rather than co-production. As such, it felt important to do everything in my power to address the power imbalance between myself as a researcher, and participants. This included inviting participants to choose the medium of the interview, the development of the diversity wheel for demographic collection, the gentle pace of the interview, through which participants were invited to co-construct both the schedule and direction

(Elwood & Martin, 2000), and my manner as an interviewer. Many participants reflected that they found the interview process enjoyable, and several reported that they found it helpful in processing their experiences. Overall, I have come away from this process feeling invigorated and renewed with ideas. I hope to continue working in this field.

Researcher Reflexivity

Thematic analysis denotes the essential role of reflexivity, noting that it is impossible to extricate oneself and views from the process of analysis, and instead to acknowledge the active role of the researcher in knowledge production (Braun & Clarke, 2006). I reflected on my positionality, in that I am part of the trans community, and have the intention to birth a child eventually. However, I am also an outsider, in that I am not *yet* a birthing person, which means I am exploring topics with which I have no experience. I had a good knowledge of the perinatal period through my own interest, and a good understanding of the perinatal system, as guided by my field supervisor. However, there were undoubtedly times where I relied on participants for explanation or clarification. It is arguable, however, that this process of curious enquiry can lead to richer data. Additionally, I considered my role as a researcher/clinician, acknowledging the potential for harm in both of these identities working with marginalised groups, as reflected by trans peoples' mistrust of healthcare systems (Bachmann & Gooch, 2018; Pearce, 2018) and marginalised groups' hesitation to be involved in research (Walter et al., 2013). As such, the safety of participants was my utmost priority, as reflected in procedure.

As a trans person, I experienced some difficulty untangling my own narratives from those of participants. I sometimes noticed preconceived ideas informing my interpretations, and managed this through supervision, personal reflection, and reflexive journalling (Nowell et al., 2017) in order to consider carefully my role in knowledge production through both interviews and analysis. This sometimes required starting over with a more conscious neutrality, making room for other interpretations and perspectives.

Overall, feel that my role as an 'insider-outsider' was a great strength. My position as a trans person facilitated trust and empathy, and as someone with lived experience of gender dysphoria, mental health difficulties, and access to both general and gender-affirming healthcare, I had a lived understanding of some parts of participants' narratives. I was careful not to not over assume the role of certain aspects of experience as salient, such as dysphoria.

Impact and Dissemination

Potential Beneficiaries

One participant requested to support with the research if possible, so I have worked alongside them in an EBE capacity to produce the plans for dissemination, and they were compensated for their time. There is potential to create impact in healthcare, at both service and policy levels, with grassroots and community organisations, and on trans birthing people themselves. It is also arguable that this research has conceivable benefit for cis birthing people.

Perinatal Care and the Wider Healthcare System

This research supports the recommendations made by the LGBT Foundation (2022). It backs up these findings with additional evidence, supporting them through experiential narratives. At present, there is a complete lack of national guidance on working with trans people in perinatal services. For local initiatives such as service adjustment and clinician training to come into place, national guidance will be required to inform these changes. In combination with the LGBT Foundation's (2022) paper, this study can support the development and implementation of these policies.

Brighton and Sussex NHS (BSUH) trust's local policy, developed based on the needs of the local community, could be updated and utilised for this purpose.

For the development of national guidance such as National Institute for Health and Care Excellence (NICE) guidelines, robust, rigorous evidence, such as clinical trials is required. I hope to move into a career in research with this as my interest. I hope to eventually conduct a control trial to evaluate the impact of gender-inclusive, trauma-informed perinatal care, with the intention of shaping a policy to guide services in supporting trans patients. This could include offering training and support for perinatal staff around trauma-informed care, offering reflective practice to support staff in making the changes, and changing systems including technology and documentation. The research will be co-produced and co-delivered with trans birthing people. It is possible that there will be resistance to these ideas due to the roots of midwifery, so pilot research demonstrating the utility of this research at one site, such as BSUH who are already implementing these ideas, will likely be necessary. Before this, I will disseminate the findings to midwifery services across the UK.

Trans People and Community Organisations

Trans birthing people may wish to know about the outcomes of the study, and to access available support and resources. Due to the known mistrust of healthcare services amongst trans people (Bachmann & Gooch, 2018; Pearce, 2018), it is essential to consider other ways of supporting the community to access care, support and knowledge. As part of the dissemination plan, I am working alongside the EBE to reach out to community organisations. We hope to facilitate sharing of these findings with grassroots, community organisations and peer-led support groups, who have direct contact with trans people and may be more trusted. We are currently scoping appropriate services for this task. The organisations *Gendered Intelligence* and *TransActual* specialise in trans research. I will also share these findings with them.

Academic Knowledge

To my knowledge, this is the largest qualitative study exploring specifically UK trans birthing people's experiences of perinatal care, responding to gaps in the literature and supporting existing research. It presents novel contributions to the literature around the experiences of UK trans birthing people, and adds nuance and complexity to existing understandings. I plan to publish this research and present at conferences and events for the trans community, alongside an EBE.

Throughout the process, I noticed many journal articles in this area utilise language that is outdated, deemed uncomfortable, and is potentially dysphoria-inducing for trans birthing people. When researching marginalised people, it is essential that the research community upholds responsibility in staying updated with appropriate and affirming language. If there is uncertainty or ambiguity, trans people should be consulted around language, and the decision-making process should be transparently documented to aid language development and understanding among researchers. It would be helpful to develop a research network to understand other research happening in this field, and to share best practice.

Cis and Heterosexual Birthing People

It is arguable that, although this research is specifically about the trans experience, the practice recommendations will benefit all birthing people. There is a plethora of literature demonstrating that birth trauma (Yildiz et al., 2017), overmedicalised, and institutionalised birth (Page & Newnham, 2020) are also common among cis birthing women. Trauma-informed approaches (Sperlich et al., 2017), including consent-based processes are known to improve care experiences for birthing women also. In protecting and tending to the needs of the most marginalised, we also empower everyone.

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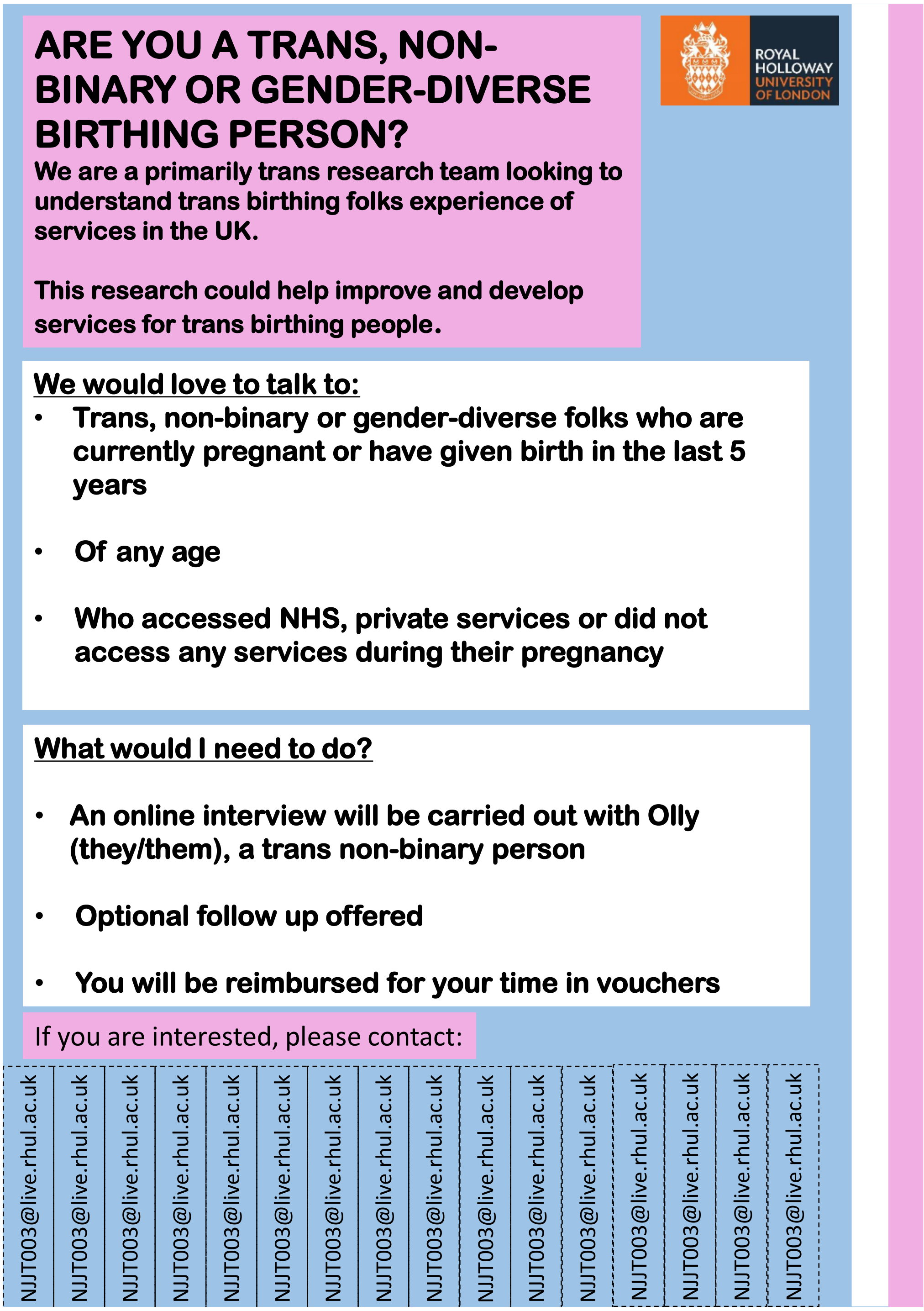
Appendices

Appendix A: Research Advertisement



ARE YOU A TRANS, NON-BINARY OR GENDER-DIVERSE BIRTHING PERSON?

We are a primarily trans research team looking to understand trans birthing folks experience of services in the UK.

This research could help improve and develop services for trans birthing people.

We would love to talk to:

- **Trans, non-binary or gender-diverse folks who are currently pregnant or have given birth in the last 5 years**
- **Of any age**
- **Who accessed NHS, private services or did not access any services during their pregnancy**

What would I need to do?

- **An online interview will be carried out with Olly (they/them), a trans non-binary person**
- **Optional follow up offered**
- **You will be reimbursed for your time in vouchers**

If you are interested, please contact:

NJT003@live.rhul.ac.uk
NJT003@live.rhul.ac.uk
NJT003@live.rhul.ac.uk
NJT003@live.rhul.ac.uk
NJT003@live.rhul.ac.uk
NJT003@live.rhul.ac.uk
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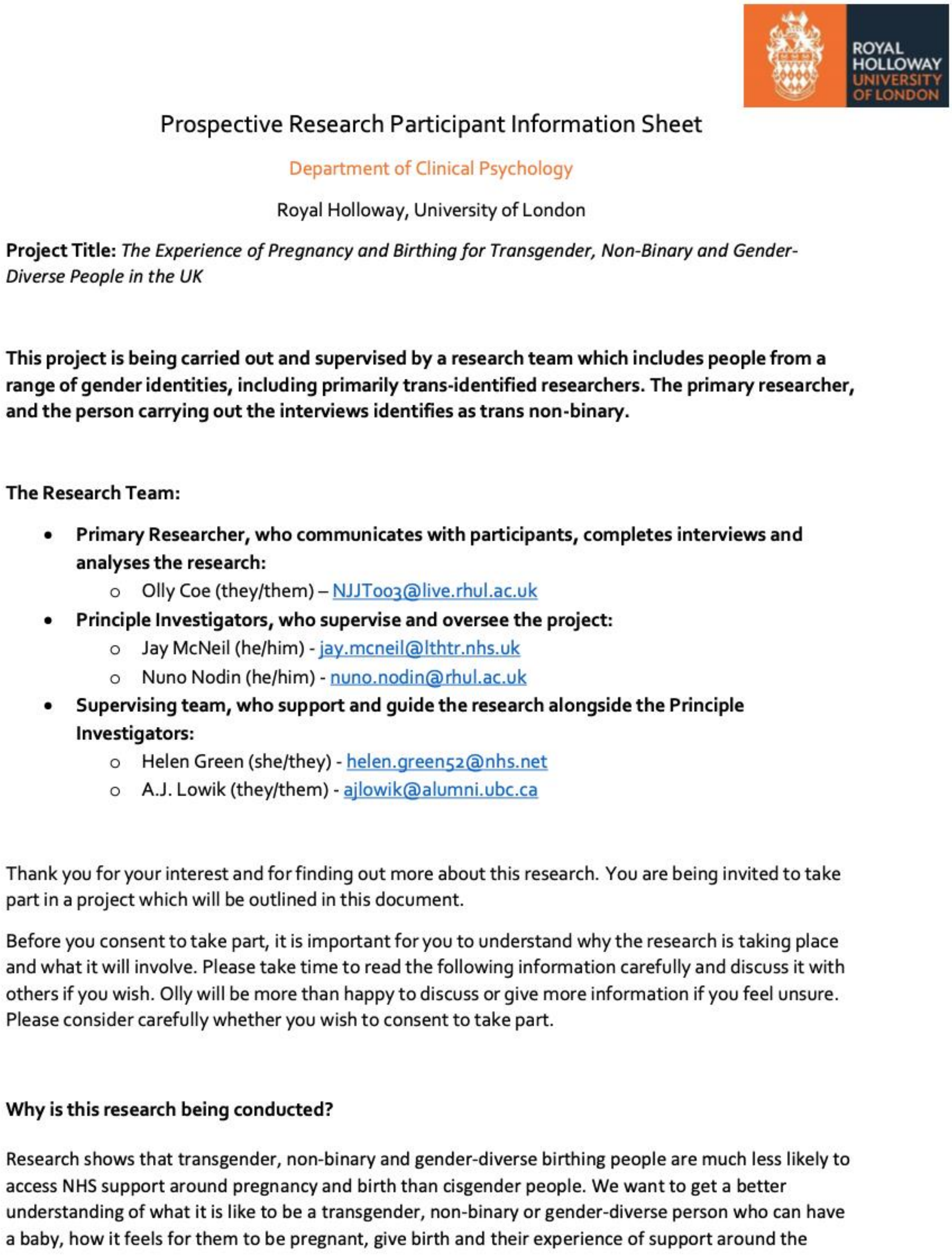
Appendix B: Participant Information Sheet



ROYAL HOLLOWAY UNIVERSITY OF LONDON

Prospective Research Participant Information Sheet

Department of Clinical Psychology

Royal Holloway, University of London

Project Title: *The Experience of Pregnancy and Birthing for Transgender, Non-Binary and Gender-Diverse People in the UK*

This project is being carried out and supervised by a research team which includes people from a range of gender identities, including primarily trans-identified researchers. The primary researcher, and the person carrying out the interviews identifies as trans non-binary.

The Research Team:

- **Primary Researcher, who communicates with participants, completes interviews and analyses the research:**
    - Olly Coe (they/them) – NJJT003@live.rhul.ac.uk
- **Principle Investigators, who supervise and oversee the project:**
    - Jay McNeil (he/him) - jay.mcneil@lthtr.nhs.uk
    - Nuno Nodin (he/him) - nuno.nodin@rhul.ac.uk
- **Supervising team, who support and guide the research alongside the Principle Investigators:**
    - Helen Green (she/they) - helen.green52@nhs.net
    - A.J. Lowik (they/them) - ajlowik@alumni.ubc.ca

Thank you for your interest and for finding out more about this research. You are being invited to take part in a project which will be outlined in this document.

Before you consent to take part, it is important for you to understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Olly will be more than happy to discuss or give more information if you feel unsure. Please consider carefully whether you wish to consent to take part.

Why is this research being conducted?

Research shows that transgender, non-binary and gender-diverse birthing people are much less likely to access NHS support around pregnancy and birth than cisgender people. We want to get a better understanding of what it is like to be a transgender, non-binary or gender-diverse person who can have a baby, how it feels for them to be pregnant, give birth and their experience of support around the pregnancy/birth. We also want to know what might make them more or less likely to ask for support from the NHS.

Why have I been invited to take part?

We would like to talk with anyone who identifies as transgender, non-binary and gender-diverse, who is currently pregnant or has given birth in the last 5 years. Unfortunately, you will be unable to take part in this study if you live outside of the UK or are under 18 years old, however, there are no other exclusion criteria, including language. Interpreters can be arranged.

Do I have to take part?

It is completely up to you to decide whether you wish to take part or not. You can withdraw from the study at any time without needing to give a reason and with no consequences, and you can withdraw your data until 26/05/2023 by contacting Olly, the primary researcher.

Please note that after this date, the research will be published and/or submitted as a thesis for assessment and withdrawing your data will no longer be possible.

What will my participation involve, what are the possible disadvantages and risks in taking part, and how might these be mitigated

Olly will contact you to arrange an interview date. At this point, we will have a conversation about any accessibility needs you might have to make the process as easy as possible. The interview will be carried out online. If you are unable to access a device connected to the internet, or with a reliable connection to the internet, we can arrange a telephone or in-person interview.

On the day of the interview, Olly will talk with you about the study, and you will have a chance to ask questions and discuss the process. If you are happy to proceed, we will ask you to sign a consent sheet to confirm you have understood and are content with the process. The interview will be conducted in a single session and will take a maximum of 1.5 hours. During the interview, we will discuss your experiences of pregnancy and birthing, and how you experienced the services you interacted with during this time. It is likely that we will be exploring potentially challenging topics around pregnancy, birth, mental health, and challenges within systems such as the NHS. Regular breaks will be offered throughout.

With your consent, we would like to audio record the interview. This is so we can analyse your interview alongside the others to identify any themes across all the participants. We will transcribe the interview verbatim and anonymise it by removing any identifying details such as names, dates and places.

After the interview, we will have a chance to talk about your experience and whether the interview brought up any challenging themes or emotions for you. You will be given a debrief sheet with some support phone numbers, websites and organisations. You will also be offered a 2-week follow up phone call with Olly to check in and assist you in finding additional support, should this be needed.

Are there any benefits in taking part?

Whilst there are no immediate benefits for participants, we hope this research can lead to benefits for the transgender community in healthcare settings in the future. We hope this study will inform future research and possibly help people working in the NHS to understand how it feels to ask for support as a transgender person who is pregnant or has had a baby.

Payments

You will be paid in retail vouchers for your participation and emotional labour.

What personal information will be collected and why is it relevant for the research?

The following information will be collected:

- Consent forms
- Audio recordings of interviews
- Anonymised transcripts of interviews

Identifiable data will be stored securely for two years after publication or submission. Other research data will be stored for up to five years after publication or submission. Only the researcher and research team will have access to the research data. Whilst it is not possible to anonymise data completely, to the best of our ability identifiable details including names, dates and places will be removed. A pseudonym (false name) will be selected for each participant. Although these details are removed, it is important to note that the narratives and individual experiences will remain. It is important to think carefully about whether you are comfortable with this, and how much you feel able to share based upon this.

We would like your permission to use this data in future studies, and to share this with other researchers (e.g. in online databases).

Once the data is analysed, we may recruit a transgender non-binary or gender-diverse birthing person to support in presenting and disseminating the research to the community.

How will the results of my participation be used? Will the research be published? Could I be identified from any publications or other research outputs?

This research will be used to produce a thesis for a Doctorate in Clinical Psychology (DClin) course which will be deposited in Pure, Royal Holloway's research information system, and/or with the British

Library to be made available via EThOS or Electronic Thesis Service. The findings from the research may also be written up for academic publications, conference presentations, reports commissioned by an external organisation, websites, videos etc.

To the best of our ability, we will remove all identifiable data, as detailed above. We would like your permission to use direct quotations but without identifying you in any research outputs.

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this study, please contact either the primary researcher, Olly, via njjt003@rhul.live.ac.uk, the principal investigators Jay McNeil via Jay.McNeil@LTHTR.nhs.uk or Nuno Nodin via nuno.nodin@rhul.ac.uk, or Royal Holloway's Research Ethics Committee via ethics@rhul.ac.uk. If you wish to make a formal complaint, please email integrity@rhul.ac.uk.

Ethical Approval

This study has received ethics approval from Royal Holloway, University of London's Research Ethics Committee, with the approval ID of 3375.

Safeguarding and when confidentiality may need to be breached

If we become concerned for your safety or the safety of someone else during the process of the interview, we may need to talk to someone about this. With your consent, we might contact a healthcare professional you trust, signpost, or support you in referring to a relevant organisation for additional help.

Data protection

This research commits to abide by the Data Protection Act (2018). For detailed information about what this means for research participants, please visit the Research Participant Privacy Notice: *https://intranet.royalholloway.ac.uk/research/documents/researchpdf/new-intranets/research-participant-privacy-notice.pdf*

General Data Protection Regulation Statement

Important General Data Protection Regulation information (GDPR). Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area'. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally-identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/ and if you wish to exercise your rights, please contact dataprotection@royalholloway.ac.uk

NB: You may retain this information sheet for reference and contact us with any queries.

Appendix C: Interview Schedule

To cover before interview:

- Any questions
- Consent form
- Breaks
- Accessibility
- Written notes

Pre-interview demographics:

- Pronouns*
- Gender*
- Age*
- Ethnicity*
- UK? Region? At present? At time of pregnancy if post? During previous pregnancies
- Pregnant, post-natal?
- First time pregnancy? If not, how many, and when?
- If post, how long ago?
- Show participants diversity wheel based on Burnham's (2018) Social GRACES. Allow them to identify any characteristics which resonate or feel important to them before beginning the interview.

Definitions:

- **Perinatal:** Surrounding pregnancy, eg. Pre, post-natal, and birthing
- **Conception:** How you became pregnant

Schedule for people who are currently pregnant:

1. What was your path to conception?
2. What is your birth plan?
3. Before we talk about your own experiences, what are your views of the current NHS care system for transgender and non-binary birthing people?
4. How do you feel your experiences of pregnancy are similar and different to that of a cisgender person?
5. Do you have any fears or anxieties about accessing perinatal care? Have those concerns affected your decisions about your conception, pregnancy or birth plan?

6. What care/support have you accessed so far throughout your pregnancy? This can include NHS, non-NHS healthcare, doulas, family, friends, community support, charities.
7. I'm now going to ask you about your experiences with the care received during your pregnancy. I'm wondering whether accessing NHS care - or not accessing care through the NHS - has impacted your experience?
8. Do you feel barriers currently exist for transgender and non-binary birthing people, compared with cisgender people? If so, what are those barriers?
9. If you could shape perinatal healthcare for transgender and non-binary birthing people, what would it look like?
    a. This might include suggestions based on your personal experience, such as things that you wish would be available to you, but that aren't; or, you can think about what your dream birthing experience might be as a trans/non-binary person - who's there, who's not there, what language is used, what does the space look like, etc.
10. *If the individual identified any characteristics on the diversity wheel:* Thinking about your current pregnancy, do you think the characteristics you identified earlier have made your experience any different than individuals who don't identify with those characteristics?
11. Thinking about your current pregnancy, I'm interested in hearing about memorable health care experiences. You can share experiences that were memorable because they are negative, experiences that were memorable because they were positive, or experiences that were neutral and felt surprisingly momentous.
12. Is there anything else you would like us to know about your experiences?
13. Anything else you feel we should be asking?
14. Follow up call?
15. Materials?
16. Hear about results?

Pre-interview demographics:

- Pronouns*
- Gender*
- Age*
- Ethnicity*
- UK? Region? At present? At time of pregnancy if post? During previous pregnancies
- Pregnant, post-natal?
- First time pregnancy? If not, how many, and when?
- If post, how long ago?
- Show participants diversity wheel based on Burnham's (2018) Social GRACES. Allow them to identify any characteristics which resonate or feel important to them before beginning the interview.

Schedule for people who have previously given birth:

1. What was your path to conception?
2. What is your birth story?
3. What care/support did you access throughout your pregnancy and during your birth? This can include NHS, non-NHS healthcare, doulas, family, friends, community support, charities.
4. Did you have any fears or anxieties about accessing perinatal care? Did those concerns affect your decisions about your conception, pregnancy or birth plan?
5. Did you ever consider accessing different or additional support? Why did you choose that option over the others?
6. I'm now going to ask you about your experiences with the care received during your pregnancy and birth.
   a. Review each type of support they accessed.
   b. I'm wondering whether accessing NHS care - or not accessing care through the NHS - impacted your experience?
7. How do you feel your experiences of pregnancy and birth are similar and different to that of a cisgender person?
8. Do you feel barriers currently exist for transgender and non-binary birthing people, compared with cisgender people? If so, what are those barriers?
9. If you could shape perinatal healthcare for transgender and non-binary birthing people, what would it look like?
   a. This might include suggestions based on your personal experience, such as things that you wish had been available to you, but that weren't; or, you can think about what your dream birthing experience might be as a trans/non-binary person - who's there, who's not there, what language is used, what does the space look like, etc.
   b. Dream birthing experience
10. *If the individual identified any characteristics on the diversity wheel:* Thinking about your most recent pregnancy, do you think the characteristics you identified earlier made your experience any different than individuals who don't identify with those characteristics?
11. Thinking about your most recent pregnancy, I'm interested in hearing about memorable health care experiences. You can share experiences that were memorable because they are negative and experiences that were memorable because they were positive, or experiences that were neutral and felt surprisingly momentous.
12. Is there anything else you would like us to know about your experiences?
13. Anything else you feel we should be asking?
14. Anything else you feel we should be asking?
15. Follow up call?
16. Materials?
17. Hear about results?

Appendix D: Participant Consent Form

Sample Research Participant Consent Form

Research Participant Consent Form

Name and email address of researcher: Olly Coe (they/them), njjt003@live.rhul.ac.uk

Name and email address of supervisors: Nuno Nodin (he/him), nuno.nodin@rhul,ac,uk and Jay McNeill (he/him), Jay.McNeil@LTHTR.nhs.uk

Research Participant - please read the following statements and indicate your response to each statement.

I confirm that I have read and understood the information sheet about this study	Yes/No
I agree to participate in this study	Yes/No
I have had the opportunity to ask questions about this study	Yes/No
I have received satisfactory answers to my questions about this study, if I had any	Yes/No/ n/a
I understand my participation in this study is voluntary	Yes/No
I understand that I am free to withdraw from the study/research project at any time up to 26/05/2023 without giving a reason and without detriment to myself. After this point data will be published or written up for the purposes of a thesis	Yes/No
I understand that my data will be stored securely for 5 years. After this date my data will be destroyed/permanently deleted	Yes/No
I agree to my interview being audio recorded and transcribed	Yes/No
I agree that my data can be written up for the purposes of a doctoral thesis, and possibly for publication as detailed in the information sheet	Yes/No
I agree to anonymised, direct quotations being used in the write up of this research	Yes/No
I understand that confidentiality may be breached in certain circumstances as detailed in the information sheet	Yes/No
I agree to my anonymized data being used in future research or publications	Yes/No

Participant signature………………………………………………….   Participant Name ………………………………………………….

Date …………………………

Please note that this Consent form will be stored separately from the responses you provide.

If you have any concerns about this research, please email ethics@rhul.ac.uk.

Appendix E: Debrief Sheet

Thank you so much for taking part in the interview today.

We know this interview may have covered some difficult topics and would like to thank you for your vulnerability in talking to us today. We have put together a sheet of support resources specific to trans folks, along with some more general mental health support contacts. Olly will contact you in two weeks time for a check-in phone call and to help you in accessing some support if needed.

We hope to get this research out to the transgender birthing community, healthcare services and other organisations. It is extremely important to us that this research is accessible to the trans community. If you are interested in supporting with this process, please let Olly know. We would love to have transgender birthing folks supporting in presenting the research or reviewing it for publication.

Please also let us know if you would like to read the research when it is completed, so we can ensure you receive a copy.

If you have any concerns or feedback about this research, you can contact Olly Coe at NJJT003@live.rhul.ac.uk or Nuno Nodin at Nuno.Nodin@rhul.ac.uk.

Thank you again for your time and openness.

Appendix F: Help and Support Sheet

Trans-Specific Support Resources- Click the blue text to visit websites

- Mindline Trans+: Confidential, emotional, mental health support line for people who identify as transgender, Agender, Gender Fluid Non-binary +. and their family members and friends. Mondays and Fridays from 20:00 – 00:00 on **0300 330 5468**
- LGBT+ Switchboard: Information and support helpline **01273 359042**
- CliniQ: Holistic service for all trans people, partners and friends covering sexual health, mental health and wellbeing. A trans-led team, who offer peer mentoring and counselling. For information or advice contact admin@cliniq.org.uk
- London Friend: Online support and counselling. Support can be accessed via their website
- Pink Therapy: Directory of therapists accredited to work with gender, sex and relationship diverse clients

General Mental Health Support

- Samaritans: 24/7, 365 days a year talking and crisis support helpline. Call 116 123
- SHOUT Text Crisis line: Text "SHOUT" to **85258** to contact the Shout Crisis Text Line, or text "YM" if you're under 19
- Samaritans safety planning resources
- Mind A-Z of support services for mental health conditions and other difficulties
- Mind advice on accessing crisis support

Appendix G: RHUL Self-certification Ethical Approval

Ethics Review Details

You have chosen to submit your project to the REC for review.	
Name:	Coe, Olly (2020)
Email:	NJJT003@live.rhul.ac.uk
Title of research project or grant:	The Experience of Pregnancy and Birthing for Transgender and Non-Binary People in the UK
Project type:	Royal Holloway postgraduate research project/grant
Department:	Psychology
Academic supervisor:	Nuno Nodin
Email address of Academic Supervisor:	nuno.nodin@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	
Start date:	01/06/2021
End date:	30/05/2023

Research question summary:

In this form, 'transgender' will be used as an umbrella term to refer to any individual whose gender differs from that which they were assigned at birth. This includes non-binary and other gender-diverse identities.

Literature demonstrates that transgender birthing people experience unique challenges when navigating healthcare systems, and healthcare professionals are not well equipped to support them. The primary aim of this research is to develop an understanding of the experience of perinatal care in both NHS and non-NHS UK contexts for transgender birthing people. The study also aims to develop a better understanding of why this group is less likely to access medical support during and after pregnancy . We hope this study can contribute to an increased awareness of the experiences and needs of this group, creating opportunities for services to improve their support.

Research method summary:

Participants will be recruited via social media. Prior to commencing the interview, participants will be given an information sheet detailing the aims of the study, how their information will be recorded, used, and stored, and how the findings will be disseminated. If participants consent, they will sign a consent form. This will be done via 'PandaDoc', an online software through which electronic signatures can be gathered (https://www.pandadoc.com). PandaDoc is Health Insurance Portability and Accountability Act (HIPAA) compliant and GDPR certified. Participants will also be asked to indicate their consent verbally once the audio recording is commenced. Semi-structured interviews lasting 1 to 1.5 hours will be conducted virtually. Upon commencing the interview, participants will be given an “intersectionality wheel” based upon the social GRACES (Burnham, 2018) and invited to select characteristics they identify with to develop a better understanding of their context. Following the interview, all participants will be provided with a debrief sheet with a range of services participants can access if the interview brought up any challenging themes or emotions. Participants will also receive a two-week follow up phone call from the interviewer to review how they felt following the study and to offer support in seeking additional services should they need it. Interviews will be audio recorded using a recording device then transcribed verbatim. Identifying details will be removed and transcripts given a code to ensure participants are not identifiable. Information will be stored securely using the university's DropBox and backed up on the Y drive. Transcripts will be analysed qualitatively using Thematic Analysis (TA, Braun & Clarke, 2006, 2013). An Expert by Experience (EBE) will be recruited to review the interview schedule. A qualitative design, and TA in particular, has been selected to allow an experiential understanding of the subject matter. This is essential as the topic

Working with participants that are 'at risk'

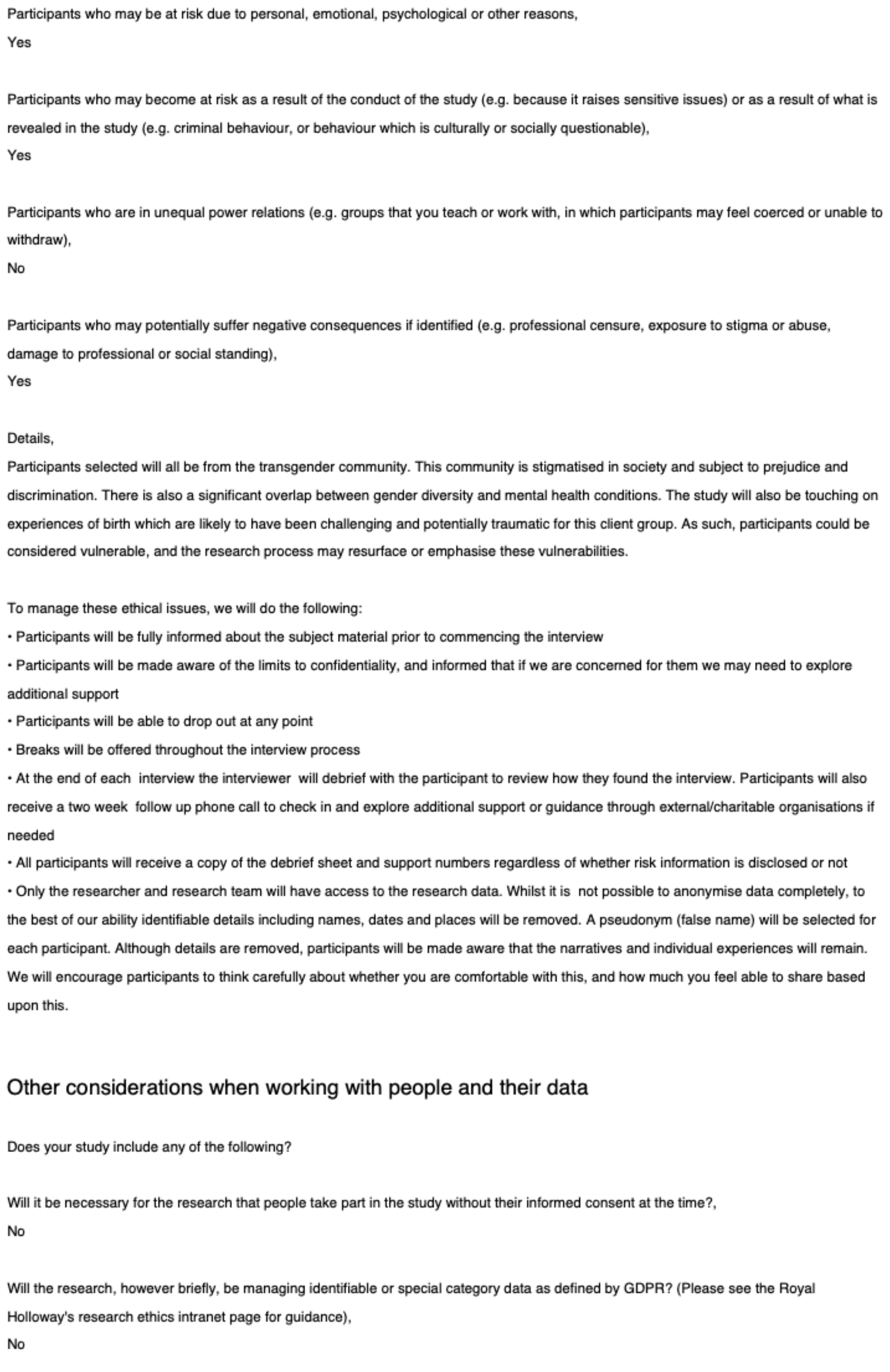
Will the research involve any of the following ‘at risk’ participants?

Children (under the age of 16),

No

Participants with cognitive or physical impairment that may render them unable to give informed consent,

No



Participants who may be at risk due to personal, emotional, psychological or other reasons,
Yes

Participants who may become at risk as a result of the conduct of the study (e.g. because it raises sensitive issues) or as a result of what is revealed in the study (e.g. criminal behaviour, or behaviour which is culturally or socially questionable),
Yes

Participants who are in unequal power relations (e.g. groups that you teach or work with, in which participants may feel coerced or unable to withdraw),
No

Participants who may potentially suffer negative consequences if identified (e.g. professional censure, exposure to stigma or abuse, damage to professional or social standing),
Yes

Details,
Participants selected will all be from the transgender community. This community is stigmatised in society and subject to prejudice and discrimination. There is also a significant overlap between gender diversity and mental health conditions. The study will also be touching on experiences of birth which are likely to have been challenging and potentially traumatic for this client group. As such, participants could be considered vulnerable, and the research process may resurface or emphasise these vulnerabilities.

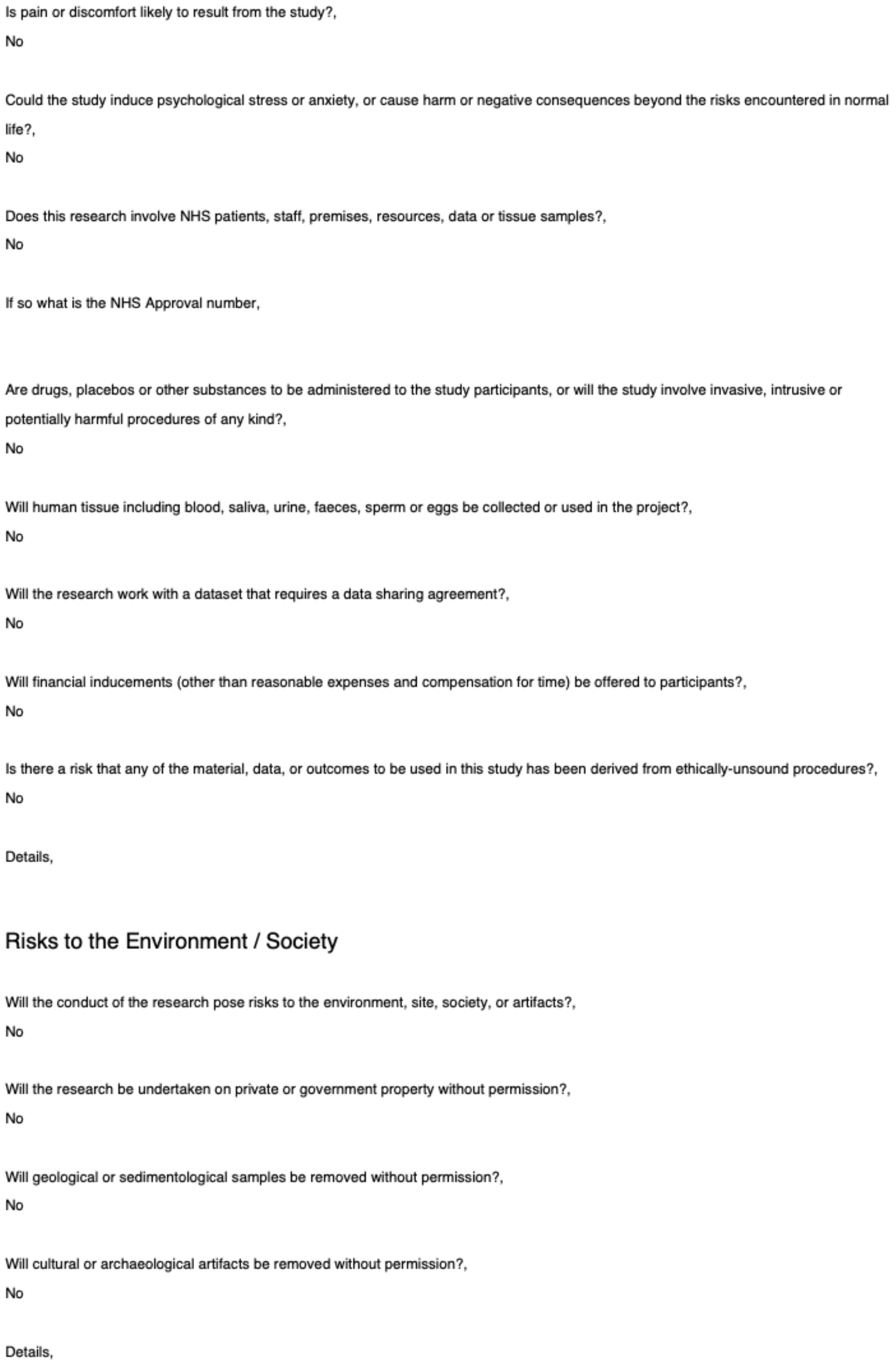
To manage these ethical issues, we will do the following:
- Participants will be fully informed about the subject material prior to commencing the interview
- Participants will be made aware of the limits to confidentiality, and informed that if we are concerned for them we may need to explore additional support
- Participants will be able to drop out at any point
- Breaks will be offered throughout the interview process
- At the end of each interview the interviewer will debrief with the participant to review how they found the interview. Participants will also receive a two week follow up phone call to check in and explore additional support or guidance through external/charitable organisations if needed
- All participants will receive a copy of the debrief sheet and support numbers regardless of whether risk information is disclosed or not
- Only the researcher and research team will have access to the research data. Whilst it is not possible to anonymise data completely, to the best of our ability identifiable details including names, dates and places will be removed. A pseudonym (false name) will be selected for each participant. Although details are removed, participants will be made aware that the narratives and individual experiences will remain. We will encourage participants to think carefully about whether you are comfortable with this, and how much you feel able to share based upon this.

Other considerations when working with people and their data

Does your study include any of the following?

Will it be necessary for the research that people take part in the study without their informed consent at the time?,
No

Will the research, however briefly, be managing identifiable or special category data as defined by GDPR? (Please see the Royal Holloway's research ethics intranet page for guidance),
No



Is pain or discomfort likely to result from the study?,

No

Could the study induce psychological stress or anxiety, or cause harm or negative consequences beyond the risks encountered in normal life?,

No

Does this research involve NHS patients, staff, premises, resources, data or tissue samples?,

No

If so what is the NHS Approval number,

Are drugs, placebos or other substances to be administered to the study participants, or will the study involve invasive, intrusive or potentially harmful procedures of any kind?,

No

Will human tissue including blood, saliva, urine, faeces, sperm or eggs be collected or used in the project?,

No

Will the research work with a dataset that requires a data sharing agreement?,

No

Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?,

No

Is there a risk that any of the material, data, or outcomes to be used in this study has been derived from ethically-unsound procedures?,

No

Details,

Risks to the Environment / Society

Will the conduct of the research pose risks to the environment, site, society, or artifacts?,

No

Will the research be undertaken on private or government property without permission?,

No

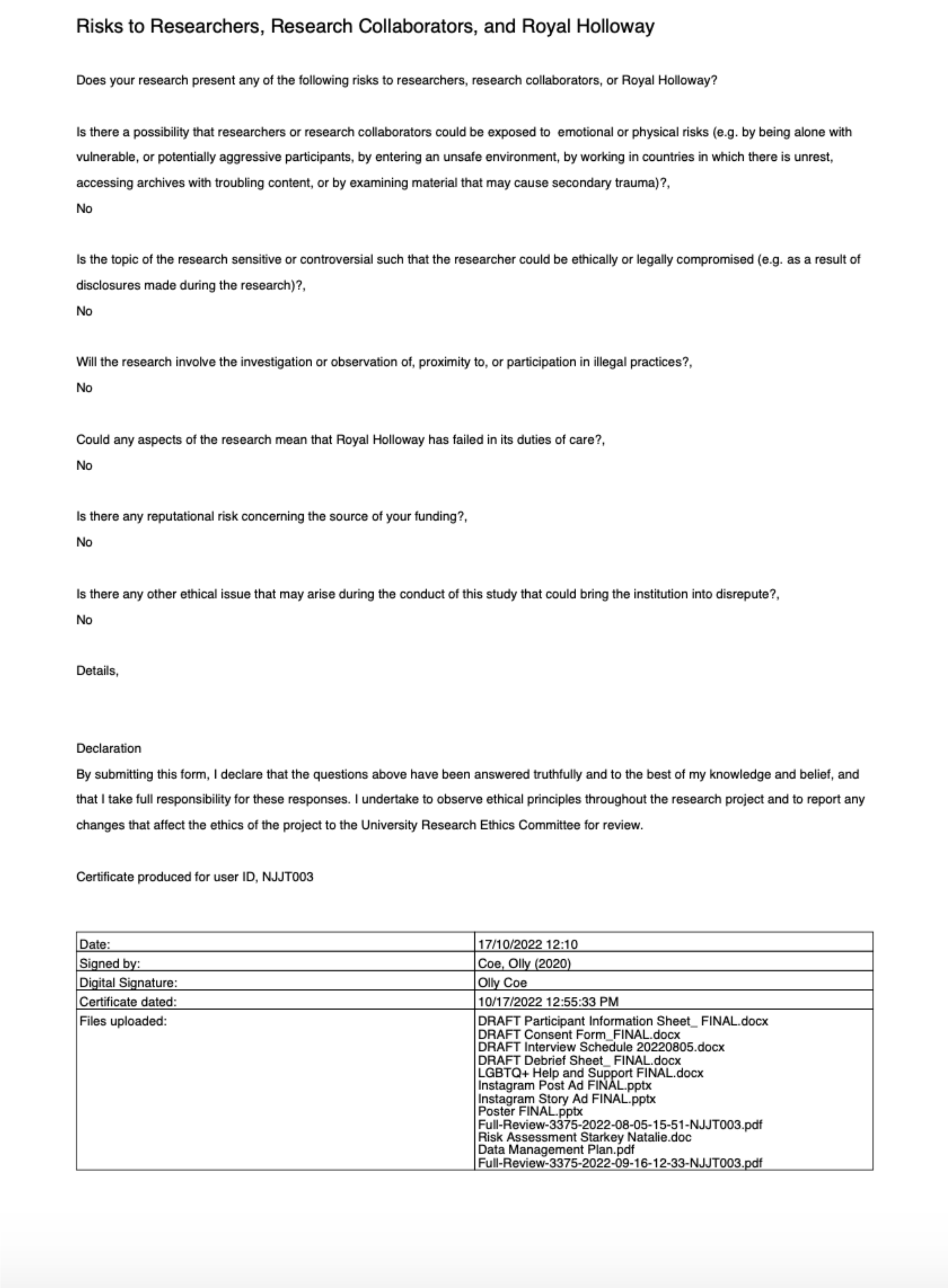
Will geological or sedimentological samples be removed without permission?,

No

Will cultural or archaeological artifacts be removed without permission?,

No

Details,



Risks to Researchers, Research Collaborators, and Royal Holloway

Does your research present any of the following risks to researchers, research collaborators, or Royal Holloway?

Is there a possibility that researchers or research collaborators could be exposed to emotional or physical risks (e.g. by being alone with vulnerable, or potentially aggressive participants, by entering an unsafe environment, by working in countries in which there is unrest, accessing archives with troubling content, or by examining material that may cause secondary trauma)?,
No

Is the topic of the research sensitive or controversial such that the researcher could be ethically or legally compromised (e.g. as a result of disclosures made during the research)?,
No

Will the research involve the investigation or observation of, proximity to, or participation in illegal practices?,
No

Could any aspects of the research mean that Royal Holloway has failed in its duties of care?,
No

Is there any reputational risk concerning the source of your funding?,
No

Is there any other ethical issue that may arise during the conduct of this study that could bring the institution into disrepute?,
No

Details,

Declaration
By submitting this form, I declare that the questions above have been answered truthfully and to the best of my knowledge and belief, and that I take full responsibility for these responses. I undertake to observe ethical principles throughout the research project and to report any changes that affect the ethics of the project to the University Research Ethics Committee for review.

Certificate produced for user ID, NJJT003

Date:	17/10/2022 12:10
Signed by:	Coe, Olly (2020)
Digital Signature:	Olly Coe
Certificate dated:	10/17/2022 12:55:33 PM
Files uploaded:	DRAFT Participant Information Sheet_ FINAL.docx DRAFT Consent Form_FINAL.docx DRAFT Interview Schedule 20220805.docx DRAFT Debrief Sheet_ FINAL.docx LGBTQ+ Help and Support FINAL.docx Instagram Post Ad FINAL.pptx Instagram Story Ad FINAL.pptx Poster FINAL.pptx Full-Review-3375-2022-08-05-15-51-NJJT003.pdf Risk Assessment Starkey Natalie.doc Data Management Plan.pdf Full-Review-3375-2022-09-16-12-33-NJJT003.pdf

Appendix H: Conditional Approval from Ethics Committee

Memorandum

To: Olly Coe
From: Jessica Kingston (on behalf of the Research Sub-committee)
Copy to: Nuno Nodin
Date: 7/1/22
Re: Main Research Project Proposal

The Research Sub-Committee has considered your Main Research Project Proposal and has decided to give you **conditional approval**.

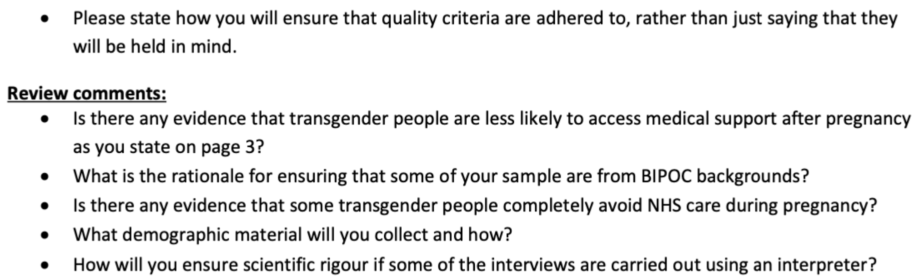
The following feedback is from me and from a second reviewer. In order to receive full approval, please consult with your supervisor/s and respond in writing to the following conditions by **4th February 2022.** The additional comments that are not conditions are points to which you and your supervisor/s should give serious consideration but do not need to respond to. **Please ensure that your feedback to each item is not more than 200 words with an overall limit of 1500 words for the whole reply. Please email your feedback to Michelle Watson (dclinpsy email).**

Please also provide a copy of your completed Systematic Review Checklist with your feedback. This can be found on Moodle in the Research section.

Chair Conditions:
- You need to submit a draft interview schedule and reference list

Chair comments
- It is the view of the research committee that you should do the transcription yourself as this is a key part of the process of qualitative analysis.
- The content of the interview, pregnancy or having given birth are not good reasons to pay participants. Please resubmit the resources form with a clear rationale for requesting payment for participants (examples are on moodle and info can be found in the handbook).

Reviewer Conditions:
- Please provide a reference list.
- How is your study different from LGBT Foundation (in publication)? (NB I am not sure what 'in publication' means).
- Please justify your sample size using a stronger rationale than convention.
- What is the size of the population that you are recruiting from? That is, is there any estimate of how many people in the UK would meet your inclusion criteria?
- Please provide an interview guide.
- Are you suggesting that an EbE and students are involved in independently analysing the data? That is, will there be transcripts that you are not analysing? If the answer is yes, this is not appropriate for a doctoral level study.
- In what way will you be carrying out deductive analysis?



- Please state how you will ensure that quality criteria are adhered to, rather than just saying that they will be held in mind.

Review comments:
- Is there any evidence that transgender people are less likely to access medical support after pregnancy as you state on page 3?
- What is the rationale for ensuring that some of your sample are from BIPOC backgrounds?
- Is there any evidence that some transgender people completely avoid NHS care during pregnancy?
- What demographic material will you collect and how?
- How will you ensure scientific rigour if some of the interviews are carried out using an interpreter?

Appendix I:Themes and subthemes with contributing participants

Table 5

Summary of participants contributing to themes and subthemes

Theme	**Navigating Asusmptions of Womanhood**		**Empowered autonomy: Personal narratives of choice, control and safety**
Subtheme	Embodied experiences of pregnancy and birth	In/visibility: Please see me for who I am	
Kip	✓	✓	✓
Paris	✓	✓	✓
Ricky	✓	✓	✓
River		✓	✓
Margot	✓	✓	✓
Claude	✓	✓	✓
Milo	✓	✓	✓
Finn	✓	✓	✓
Hayden	✓	✓	✓
Kai	✓	✓	✓
Billy	✓	✓	✓
Toni		✓	✓

Appendix J: Quality ratings using CASP (2018) checklist

Table 6

Quality ratings using CASP (2018) checklist

	CASP Criterion									
Included Studies	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher & participants been adequately considered?	Have ethical issues been taken into account?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Asklöv, Ekenger & Berterö (2021)	yes	yes	unclear	yes	yes	yes	yes	yes	yes	highly
Falck et al (2020)	yes	yes	yes	yes	yes	yes	yes	yes	yes	highly
Juntereal & Spatz (2020)	yes	yes	yes	yes	yes	no	unclear	no	yes	somewhat
Kerppola et al (2019)	yes	yes	unclear	yes	yes	no	yes	yes	yes	highly

Larsson & Dykes (2009)	yes	yes	unclear	no	yes	no	yes	yes	yes	highly
Lee, Taylor & Raitt (2011)	yes	yes	yes	no	yes	no	yes	yes	yes	highly
Malmquist (2022)	no	unclear	unclear	unclear	yes	no	yes	yes	yes	unclear
Malmquist et al (2019)	yes	yes	unclear	yes	yes	no	yes	yes	yes	highly
Peel (2010)	yes	yes	unclear	yes	yes	no	yes	yes	yes	highly
Riggs et al (2020)	yes	yes	yes	yes	yes	yes	yes	yes	yes	highly
Röndahl, Bruhner & Lindhe (2009)	yes	yes	no	no	yes	yes	yes	no	no	not very
Spidsberg (2007)	yes	yes	unclear	no	yes	yes	yes	yes	yes	highly
Wilton & Kaufmann (2001)	yes	yes	no	yes	unclear	no	unclear	no	yes	not very

Appendix K: Themes and subthemes with contributing papers

Table 5

Summary of papers contributing to themes and subthemes

Theme	**A prejudiced system**		**Feeling seen and heard**		**Control and Empowerment**		
Subtheme	Cis and heteronormative system failings	Individual prejudice	We exist	Feeling understood as a family	Fear, anxiety, and hesitation	Taking responsibility	Empowered by care
Asklöv, Ekenger & Berterö (2021)	✓	✓	✓			✓	✓
Falck et al (2020)	✓	✓	✓		✓	✓	✓
Juntereal & Spatz (2020)	✓		✓			✓	
Kerppola et al (2019)	✓		✓	✓	✓		✓
Larsson & Dykes (2009)	✓		✓	✓	✓	✓	✓
Lee, Taylor & Raitt (2011)	✓	✓	✓			✓	✓
Malmquist (2022)	✓		✓			✓	
Malmquist et al (2019)	✓	✓		✓	✓	✓	

Peel (2010)		✓	✓	✓	✓		
Riggs et al (2020)	✓			✓			
Röndahl, Bruhner & Lindhe (2009)	✓	✓	✓	✓	✓		✓
Spidsberg (2007)	✓	✓	✓		✓	✓	✓
Wilton & Kaufmann (2001)	✓	✓	✓	✓	✓	✓	✓