



**Karolinska  
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KAROLINSKA INSTITUTET  
Department of Women's and Children's Health  
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## Wanted: LGBTQ patients

Midwives' experiences and their prerequisites in the encounter with LGBTQ persons during care of pregnancy.

## Hbtq-patienter sökes

Barnmorskors erfarenheter och förutsättningar i mötet med HBTQ-personer vid vård under graviditet.

Master's Thesis in Sexual, Reproductive and Perinatal Health, 15 credits  
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## Abstract

**Aim** To explore midwives' experiences and their prerequisites in the encounter with LGBTQ people during care of pregnancy.

**Background** International, national and local professional recommendations address the needs of equal and culturally competent care. Issues concerning sexuality and LGBTQ can be considered side-lined in the education of Swedish healthcare professionals, resulting in insufficient competence and impede the understanding of the patients' rights and needs. LGBTQ people may experience barriers to care because of heteronormativity within reproductive healthcare and professionals' lack of knowledge. Few studies are conducted of midwives' experiences and views of the care given towards LGBTQ people during pregnancy.

**Method** A cross-sectional study, using a web survey with a quantitative, descriptive design. Midwives currently working in Sweden with care during pregnancy at midwifery units were invited to participate.

**Results** The demographics of the midwives showed a homogenous group, which in aspects of gender and age reflect on midwives in general. The midwives had limited experience of caring for LGBTQ people, especially in caring for LGBTQ families other than same-sex female couples. The level of comfort in caring for LGBTQ people differed between types of families. LGBTQ competence was in general not retrieved from their basic or continuous educations as nurses/midwives. The prenatal parental education was perceived as more suited for various types of families than the materials and written information. The midwives showed a general will to be inclusive but indicated that they need to develop additional competence and skills.

**Conclusions** Lack of knowledge and limited experience as well as heteronormative methods and materials are barriers to LGBTQ competent care in Sweden. The result indicates that the level of comfort and the care provided may depend on type of family within the LGBTQ spectra. The variation of answerers in satisfaction of care towards LGBTQ people and evaluation of methods and materials may indicate how equal care is depended on midwives' own interest and commitment or from independent efforts of employers.

**Keywords:** LGBTQ, pregnancy, experiences, competence, reproductive healthcare, midwife

## Sammanfattning

**Syfte** Att utforska barnmorskors erfarenhet och förutsättningar i mötet med hbtq-personer vid vård under graviditet.

**Bakgrund** Såväl internationella, nationella som lokala riktlinjer trycker på vikten av kulturell kompetens och jämlik vård. Vid utbildning av svensk sjukvårdspersonal kan frågor som rör sexualitet och hbtq anses åsidosatta, vilket leder till otillräcklig kompetens och försvårar förståelsen för hbtq-personers behov och rättigheter. Heteronormativitet i den reproduktiva vården och vårdpersonalens brist på kunskap utgör barriärer i mötet med blivande hbtq-föräldrar, vilket leder till otillräckligt stöd. Få studier är gjorda utifrån barnmorskans erfarenheter och perspektiv av vård under graviditet för hbtq-personer.

**Metod** En kvantitativ, deskriptiv tvärsnittsstudie utförd med hjälp av en webbenkät. Enkäten riktades till barnmorskor i Sverige som för nuvarande arbetar med vård under graviditet på barnmorskemottagning/inom mödrahälsovård.

**Resultat** De deltagande barnmorskorna i studien var en homogen grupp, där fördelningen av kön och ålder speglar barnmorskegruppen i stort. Barnmorskorna hade begränsad erfarenhet av hbtq-personer i sitt arbete, särskilt av att ta hand om andra hbtq-familjer än samkönade kvinnliga par. Hur bekväma barnmorskorna var i vården av blivande hbtq-föräldrar, skiljde sig åt mellan olika familjekonstellationer. Den hbtq-kompetens som barnmorskorna hade var generellt inte något de fått från sina sjuksköterske- eller barnmorskeutbildningar. Föräldrautbildningen ansågs vara mer anpassad för variationer av familjekonstellationer än det tillgängliga skriftliga informationsmaterialet riktat till föräldrar. Barnmorskorna visade en vilja att vara inkluderande men uttryckte även att de behöver ytterligare hbtq-kunskap och kompetensutveckling.

**Slutsatser** Såväl brist på kunskap och begränsad erfarenhet som heteronormativa arbetssätt och material utgör hinder för en inkluderande vård för hbtq-personer. Resultatet indikerar att det är skillnad på att vårda olika typer av familjekonstellationer inom hbtq-spektrat. Variationen i svaren angående hur nöjda barnmorskorna var med vården av hbtq-personer samt utvärderingen av hur inkluderande mottagningarnas arbetssätt och material är, signalerar att jämlik vård är beroende av barnmorskans individuella intresse och engagemang eller från den enskilda arbetsgivarens satsningar.

**Nyckelord:** Hbtq, graviditet, erfarenhet, kompetens, reproduktiv hälso- och sjukvård, barnmorskor

## Table of content

<b>INTRODUCTION .....</b>	<b>1</b>
<b>BACKGROUND .....</b>	<b>1</b>
LGBTQ.....	1
<i>LGBTQ history and legislation .....</i>	<i>1</i>
<i>Health of LGBTQ people .....</i>	<i>2</i>
<i>Heteronormativity and its consequences.....</i>	<i>2</i>
<i>Becoming parents as LGBTQ persons in Sweden.....</i>	<i>3</i>
<i>LGBTQ peoples' experiences of reproductive care.....</i>	<i>5</i>
LGBTQ COMPETENCE IN HEALTHCARE .....	7
Guidelines.....	7
Maternity care in Sweden.....	8
Education.....	8
Healthcare professionals' knowledge and attitudes.....	10
<b>PROBLEM DEFINITION.....</b>	<b>12</b>
<b>AIM .....</b>	<b>12</b>
<b>METHODS .....</b>	<b>12</b>
STUDY DESIGN .....	12
PARTICIPANTS .....	12
DATA COLLECTION.....	13
SURVEY CONSTRUCTION.....	13
DATA ANALYSIS.....	15
<b>ETHICAL CONSIDERATION.....</b>	<b>15</b>
<b>RESULTS.....</b>	<b>16</b>
PARTICIPANTS DEMOGRAPHICS .....	16
INDIVIDUAL EXPERIENCE AND COMPETENCE .....	16
MEANS AND METHODS .....	17
REQUESTED KNOWLEDGE AND COMPETENCE .....	18
<b>DISCUSSION.....</b>	<b>19</b>
DISCUSSION OF METHODS.....	19
<i>Choice of method .....</i>	<i>19</i>
<i>Study limitations .....</i>	<i>20</i>
DISCUSSION OF RESULTS.....	21
<i>Homogenic profession in a female dominated field.....</i>	<i>21</i>
<i>Professionals' lack of experience and patients' expectations .....</i>	<i>23</i>
<i>Welcoming the LGBTQ patient .....</i>	<i>25</i>
<b>CONCLUSION .....</b>	<b>26</b>
FURTHER RESEARCH AND IMPLICATIONS FOR HEALTHCARE .....	26
<b>REFERENCES .....</b>	<b>28</b>
<b>APPENDIX 1: GLOSSARY .....</b>	<b>33</b>
<b>APPENDIX 2: FLYER .....</b>	<b>37</b>
<b>APPENDIX 3: INFORMATION LETTER.....</b>	<b>38</b>
<b>APPENDIX 4: WEB SURVEY .....</b>	<b>40</b>
<b>APPENDIX 5: PARTICIPANT DEMOGRAPHICS .....</b>	<b>44</b>

## **Introduction**

The concept of family is today expanded and can be defined in many ways. An increasing number of LGBTQ persons (homosexual, bisexual, and transgender people and persons who defines themselves as queer) choose and have the opportunity to become parents (Bushe & Romero, 2017; Statistics Sweden [SCB], 2013). This requires the development of reproductive healthcare in order to provide good and equal care for all childbearing persons and their families. Research shows that heteronormativity in the health care system and among health care providers can create barriers to care. It concerns both the structures and content in health care programs and education as well as language, attitudes and knowledge on an individual level (Röndahl, 2009, 2011; Stewart & O'Reilly, 2017).

This study is the second part of a research project where in the first part the authors explored how LGBTQ people experience the encounter with reproductive health care in Sweden. Little is known how midwives experience the care given and what prerequisites they have to provide equal care. This study aims to provide additional knowledge of the profession's experience, in order to target future efforts towards a more inclusive care for LGBTQ people based on needs.

## **Background**

### **LGBTQ**

#### **LGBTQ history and legislation**

The rights and legislation for LGBTQ people differ in different parts of the world. Same-sex sexual acts are legal in 121 (63 %) of the United States, but illegal in 72 states (37 %). In 13 states (6 %) same-sex sexual acts can result in the death penalty (International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA], 2016). In Sweden homosexual relations were decriminalized in 1944, though until 1979 it was still classified as a mental illness. Same-sex couples were in 1995 allowed to register partnership and in 2009 the marriage law became gender-neutral. Discrimination based on sexual orientation was prohibited in 1999, and in 2009 the discrimination based on gender identity and expression was banned (Forum för levande historia, 2015). Since 1972 transgendered people are allowed to change their legal gender after reassignment surgery, but until 2013 sterilization was required to be able to get the surgery (Transformering, 2017). Transsexualism or 'gender dysphoria' is according to ICD-10 considered a mental disorder. Transvestism was declassified as a mental disorder in 2009 (Forum för levande historia, 2015; The Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights [RFSL], 2017b).

## **Health of LGBTQ people**

LGBTQ people experience numerous health disparities relative to the general population (National Board of Health and Welfare, 2016; Public Health Agency of Sweden, 2014; Public Health Agency of Sweden, 2015). In general, LGBTQ people estimate a lower state of health and have more health care visits per year. Simultaneously, they have lower confidence in health care and other social institutions (Public Health Agency of Sweden, 2014; Public Health Agency of Sweden, 2015).

LGBTQ people are more likely to suffer from mental illness such as anxiety disorders, depression or alcohol and drug addiction (National Board of Health and Welfare, 2016; The Swedish National Board for Youth Affairs, 2010). Compared to individuals in different-sex marriages there is an increased mortality rate due to suicide and HIV/AIDS among individuals in same-sex marriages (National Board of Health and Welfare, 2016). LGBTQ people have less social participation. They are limited in their everyday lives because of discrimination, violations, threats of violence and are more exposed to violence. Suicide thoughts and suicide attempts are more common in the LGBTQ group compared to heterosexual cis people (Public Health Agency of Sweden, 2014; Public Health Agency of Sweden, 2015; The Swedish National Board for Youth Affairs, 2010). In these aspects trans and queer people seem to be even more vulnerable (Macapagal, Bhatia, & Greene, 2016; Public Health Agency of Sweden, 2015; The Swedish National Board for Youth Affairs, 2010).

Although LGBTQ people are shown to have a greater need of healthcare, they tend to postpone or skip needed care due to fear of discrimination or because of negative healthcare experiences in the past (Macapagal et al., 2016; The Swedish National Board for Youth Affairs, 2010; World Health Organisation [WHO], 2015). Differences in access, use and treatment are seen between groups of sexual orientation and between cisgender, transgender and queer people. This means differences in health disparities as well as in presence of discrimination in healthcare situations or in treatment from healthcare professionals (Macapagal et al., 2016; Public Health Agency of Sweden, 2015; The Swedish National Board for Youth Affairs, 2010). In comparison to earlier studies, today it seems to be an overall improvement for LGBTQ people seeking health care. Although queer and trans people still face greater challenges and barriers to healthcare compared to lesbian, gay and bisexual cisgendered people (Macapagal et al., 2016).

## **Heteronormativity and its consequences**

The term heteronormativity can be explained as the system of norms which influences our understanding and perception of gender and sexuality. The hetero-norm is based on the notion that there are only two genders, woman and man. Men are expected to act masculine and women to act feminine as each other's opposites and are expected to desire each other. This is expressed through

body language and verbal communication as well as with other attributes such as the choice of clothes or hairstyles. All people in society are by default assumed to have heterosexual preferences until proven otherwise. Non-heterosexual orientations are in contrast considered deviant. People who do not identify as heterosexual become invisible and vulnerable to discrimination in society. When acting outside the hetero-norm, there is a risk of punishment such as exclusion, silence and violence (Ambjörnson, 2006; RFSL, 2015; Rosenberg, 2002; The Swedish National Board for Youth Affairs, 2010).

The heteronormativity in society also leads to a series of consequences for LGBTQ people in healthcare settings and creates barriers to care. Assuming that patients and significant others are heterosexual and cisgendered individuals, can be offensive and proof of neglect, which affects the communication and leads to lack of confidence. It could also mean that important and crucial aspects are lost when asking the wrong questions, which in turn may lead to incorrect judgement. Nursing staffs fear of behaving incorrectly, can be interpreted as signs of insecurity, thereby impeding further communication and confidence in care (Röndahl, Innala, & Carlsson, 2006). Transgender patients may experience how healthcare professionals tend to focus on their gender identity rather than their physical and psychological symptoms (Swedish Association of Local Authorities and Regions [SKL], 2013).

Transgender and queer patients are more likely to be denied service or equal treatment and are more often subject of verbal harassment or disrespect due to their LGBTQ identity compared to cisgender lesbian, gay and bisexual patients (Macapagal et al., 2016). To be the partner of a homosexual patient can be perceived as even more difficult facing heteronormative assumptions from healthcare staff. Resulting in feelings of not being accepted as a “true” relative or in exclusion and neglect (Röndahl et al., 2006).

## **Becoming parents as LGBTQ persons in Sweden**

### ***Preconditions for LGBTQ people becoming parents***

When planning a family as LGBTQ-parents, certain information and regulations are needed to be taken into account. It concerns both practical information about options available and how to conceive, as well as which rules and legislations that apply in each family constellation and choice of method. Since 2005 same-sex female couples have access to assisted reproduction with donated sperm within public health care. The demand of sterilization before undergoing gender confirmation medical treatment was abolished in 2013, making assisted reproduction available for trans men within public health care. Since 2016 assisted reproduction to single women/persons with uterus is allowed. This requires that the person in fact lives alone, is not married or has a registered partner.

One who desires to form a family with one or more than one person outside of a couple relationship, does not have access to assisted reproduction in Sweden (RFSL, 2018b).

The Swedish laws affects the choice and approach to parenthood. In Sweden one can only have two legal parents. The child has a right to gain information about its genetic heritage. Surrogacy is not permitted. The fetus should be genetically connected to one parent and the person who gives birth automatically becomes the child's mother. Joint adoption acquires the couple to be married (Parental Code, 1949:381).

### ***Legislation based on heterosexual conditions***

Though the legislation can be considered based on heterosexual conditions. For instance, when a different-sex couple undergo assisted reproduction, the one who carries the child can receive donated oocytes combined with the semen from the partner. In a same-sex lesbian couple only the oocytes from the carrying woman can be used combined with donated semen. However, her partner is not allowed to donate her oocytes because this is not considered as genetic linkage. Many LGBTQ people still choose to go abroad for assisted reproduction. The reasons for doing so are several, such as: a wish for anonymous donors of gametes, to use the partners oocytes or use donors of both oocytes and semen, due to the long wait for treatment within public health care or because of the age-limits in Sweden (RFSL, 2018b).

Again, inequalities in legislation between different-sex and same-sex couples are evident. In different-sex couples, regardless of marital status, who conceive at fertility clinics abroad, the man automatically is regarded as the father provided that he gave his consent to the treatment. This does not apply to same-sex couples, where the non-birthing parent needs to go through a process of second parent adoption to acquire legal right to parenthood after the child is born. The couple also has to be married (Parental Code, 1949:381). Almost all adoptions by same-sex couples are related adoptions. Although, since 2003, same-sex married couples have the legal right to joint adoption, this is rarely practiced. Only one known national adoption has been mediated. Foreign adoptions are often mediated through Swedish adoption agencies, but each country determines which requirements are imposed on the person or persons who adopts. As today, only one same-sex couple have had their adoption application approved, being accepted as adoptive parents in Colombia (RFSL, 2018a).

While writing this an update of the regulations concerning assisted reproduction is proposed from the Swedish government. The amendment includes, among others, that the requirement for genetic linkage between the child and a parent will be abolished. Certain rules will apply to people who become parents after changing their legal gender, which means that a person who has changed its



gender to male and gives birth will be considered a father. The regulations for assisted reproduction abroad will be equal for same-sex couples and different-sex couples. The process of determining paternity for the genetic father after surrogacy arrangements abroad will be made easier. The law concerning surrogacy will remain unaltered (Swedish Government Offices, 2018).

### **LGBTQ peoples' experiences of reproductive care**

As in other healthcare settings the hetero-norm also has consequences for the expecting parents within the reproductive field. Research on LGBTQ peoples' experiences of reproductive healthcare suggest that they may not be fully supported because of healthcare providers' lack of knowledge and heteronormative attitudes and practices (Dahl, Fylkesnes, Sørli, & Malterud, 2013; Ellis, Wojnar, & Pettinato, 2015; Klein et al., 2018; Larsson & Dykes, 2009; McManus, Hunter, & Renn, 2006; Wells & Lang, 2016). The majority of research is from a lesbian perspective, only a few focus on the experience of transgender parents. The gay men's experience of reproductive care seems understudied and those conducted focus on the men's means to become parents and views of gay parenthood/fatherhood (Norton, Hudson, & Culley, 2013).

Midwives' lack of knowledge concerning lesbian lifestyle can result in irrelevant questions, which can be perceived as rude, invading of their privacy or as pure noisiness. Lesbian women take on an educational role in the encounter, which in some cases feel acceptable. Though, this also cause feelings of responsibility, enabling equal care for themselves or other lesbian couples ahead (Dahl et al., 2013). Healthcare providers' lack of knowledge and the fear of judgemental treatment may drive lesbian, bisexual and queer women to seek information outside of the healthcare system, via peers on social media or through friends, when trying to conceive. Due to insufficient medical accuracy, these exchanges can lead to misinformation, which may negatively affect lesbian, bisexual, and queer women's fertility outcomes and overall health (Ruppel, Karpman, Delk, & Merryman, 2017).

Transgendered people describe a sense of loneliness through the entire process of becoming a parent, a feeling of being completely alone in the situation. This being reinforced due to lack of knowledge in healthcare and the additional difficulty to find correct information by themselves (Ellis et al., 2015). Fear of homophobia and prejudice is shown to have an effect on lesbian couples' choice of birthplace. For some, this result in having their baby at home or making deliberate choices of which hospital to use, described as lesbian-friendly (Dahl et al., 2013).

The heteronormative concept of the nuclear family is expressed in various ways. For instance, using careless language when referring to a co-mother as 'he' or father (Dahl et al., 2013), or when a pregnant transsexual man wrongly is being assigned with a female pronoun or termed 'mother'

(Ellis et al., 2015; Klein et al., 2018). The use of stereotypical and conservative documentation forms within reproductive care and fertility clinics, not reflecting on LGBTQ clients, makes non-heterosexual relations (Dahl et al., 2013; Klein et al., 2018; Larsson & Dykes, 2009) and variations of gender identities invisible. Additionally there is often a lack of visual representation of LGBTQ people or diverse family constellations in health care settings and accompanying materials (Klein et al., 2018).

Heteronormative assumptions and materials disables midwives in asking the right questions, thus failing to gain correct and proper information. This may result in incorrect advice about sexual health issues or methods of conception (Dahl et al., 2013; Klein et al., 2018). Same-sex mothers and co-mothers expresses being most offended during the prenatal parent classes. For example, when midwives divides classes in separate mother and father groups, the non-birthing co-mother being left wondering what group to join (Larsson & Dykes, 2009; Wells & Lang, 2016). Heteronormative use of language in prenatal parent classes creates barriers and hinders LGBTQ people in preparing for parenthood (Ellis et al., 2015; Klein et al., 2018; Larsson & Dykes, 2009; Wells & Lang, 2016).

Sexual orientation is invisible until proven otherwise by the women themselves. The patients are left with the recurrent burden of explaining and concealment, which is described as strenuous. 'Concealment' becomes central and can be perceived as a potential risk. Some choose not to disclose their sexual identity out of fear of prejudice, to be considered as a lesser parent or being denied care. Others cope by taking control over the situation by choosing the right and appropriate time for disclosure (Dahl et al., 2013).

Healthcare professionals signaling an inclusive and open attitude provides confidence and trust, making the encounters a positive experience for LGBTQ people (Dahl et al., 2013; Klein et al., 2018; Larsson & Dykes, 2009). This can be mediated by staff using gender inclusive language. Medical forms and documentation with inclusive options and clinics displaying LGBTQ friendly materials with visual diversity, eases LGBTQ peoples' experiences in the clinical setting (Bushe & Romero, 2017; Klein et al., 2018).

The need to be treated as any other family is important. At the same time, providers recognition of LGBTQ parents' special situation and specific needs is appreciated. It is important to recognize and include the partner as an equal parent and that they are seen as a legitimate family. Informational and supportive services directed toward LGBTQ parents may be important facilitators of care. Providers who are welltrained and experienced in LGBTQ sexual health needs, that is possesses LGBTQ competence, is desired (Dahl et al., 2013; Klein et al., 2018; Larsson & Dykes, 2009).

## **LGBTQ competence in healthcare**

### **Guidelines**

The International Code of Ethics for midwives according to International Confederation of Midwives (ICM) should act as a guideline in the realms of education, practice and research of the midwife. The emphasis is on women's health, but the midwife should also offer care and participate in health promotion for all childbearing families, regardless of cultural background. Midwives are also expected to develop their skills and integrate these throughout their professional lives. The code “seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect and trust, and the dignity of all members of society” (ICM, 2014).

The World Health Organization (WHO) also emphasizes the importance of healthcare professionals having a respectful approach and a non-judgemental attitude towards their patients. They argue that increased awareness of issues such as sexual orientation and gender identity is required.

Furthermore, they conclude that training is needed to ensure that good and competent care is given to patients in the field of sexual health. Likewise, employees must be prepared, provided support and appropriate conditions, as well as given opportunity to develop and maintain their skills (WHO, 2015).

In 2013 The Swedish Association of Local Authorities and Regions (SKL) created a national platform to promote equal care. They state that health is not equally distributed among the population, and therefore, that the same healthcare for everybody is not the same as equal healthcare. Efforts should instead be adapted to peoples' differing conditions and needs. According to the standard program for care during pregnancy applicable in Stockholm (Stockholm County Council [SLL], 2018), all care should be offered equally regardless of sex, gender identity, and sexual orientation, and tailored to the patient's needs. Furthermore, family support should be organized equitably with regards to the diversity of cultural background as well as differing family concepts.

In Sweden, a well known and established way to promote and work towards LGBTQ friendly environments is a certification program by the Swedish Federation of Lesbian, Gay, Bisexual, Transgender and Queer rights (RFSL). RFSL as an independent actor, provides education and support to enable workplaces and organizations to be more inclusive. The goal is to increase staffs' level of knowledge and to initiate a development for a more inclusive work environment. The educational period stretches over five months and requires all employees to participate (RFSL, 2016).

## **Maternity care in Sweden**

Sweden's first maternity clinic was established in Malmö in 1915. The main purpose of the clinic was to detect signs of preeclampsia. In the 1930's, when the state subsidy was introduced, maternity care became free of charge and more established. For decades the main focus of the maternity care was somatic, but in the 1950's a social perspective was incorporated into the care. To get an idea of the women's situation, concerning social- and economic status, home visits were recommended. In 1978 prenatal parental education became mandatory, and the focus shifted from the woman to the whole family. During the 1980's the number of screenings were expanded and the care became increasingly individualized. Some ten years later, some of the maternity units changed name to midwifery unit, which was more true to their function. Sexual and reproductive care not involving pregnant people are also part of the tasks and the unit is mainly staffed by midwives (The Swedish Society of Obstetrics and Gynecology [SFOG], 2016).

In present day the role of the midwifery unit is to facilitate sexual and reproductive health for the entire population/all citizens. Swedish midwives are independently responsible for the health care and parental support during normal, uncomplicated pregnancies. Physicians are consulted when medical issues occur and during complicated pregnancies. In Sweden there are 35 midwifery unit chief physicians and 41 coordinative midwives, cooperating in developing guidelines and further education for midwives and physicians. The guidelines concerning care during pregnancy are based on recommendations and reports published by SFOG, as well as from international research and from documents of the Swedish National Board of Health and Welfare. Each county creates its own guidelines, hence there is no nationwide shared documents (SFOG, 2016).

## **Education**

Internationally, healthcare professionals lack competence regarding the situation and well being of transgender people, since this perspective is often left out of curriculum, guidelines and practical training (WHO, 2015). In a systematic review including examining education and skill level, a majority of the studies showed that healthcare providers did not receive sufficient and required training or continuous education concerning LGBTQ issues (Stewart & O'Reilly, 2017). Showing varying knowledge of LGB culture and what special needs LGB patients may have or risks they may face, the Nurse Practitioners in an american qualitative study confirmed that LGB health was not something that was taught in their formal education, clinical training or continuing education (Dorsen & Van Devanter, 2016).

In a Swedish study conducted by Røndahl (2011), nursing and medical students, defining themselves as members of the LGBTQ community, were interviewed with the purpose of

determining their experiences of LGBTQ perspective within their respective educations. They reported a lack of LGBTQ perspective both within the theoretical and practical aspects of the education. They emphasized the importance of making sure a LGBTQ perspective was included in all subjects. Furthermore, the students reasoned about the responsibility of integrating a LGBTQ perspective in the curriculum and noted that the main responsibility rested with the program coordinators and the university, though they also concluded that everyone bears a personal responsibility. Finally, a shared experience among the students was having to educate their own tutors.

The Public Health Agency of Sweden (2017) examined to what extent HIV-prevention, as well as sexual and reproductive health and rights were incorporated in the education of health care professionals, such as nurses, midwives and physicians. They found that these fields rarely were included in the curriculum of, and the job description associated with, said educations. Even though the medical doctor program and the midwifery science program were better at implementing LGBTQ issues, they still lacked any mentions of concepts such as heteronormativity in the relevant documentation and LGBTQ only occurred seldomly. While knowledge of these issues were taught throughout the course of the educational programs, the fact that they were absent from the relevant documentation, meant that they were sidelined, as curriculums and job descriptions reflect learning outcomes and professional identity. That in turn might lead to insufficient competence and impede the understanding of the patients rights and needs.

The Clinical midwife's field of expertise includes reproductive, perinatal and sexual health. The Swedish midwifery science program extends over one and a half year and aims to prepare the student to assess and handle complex situations, issues, and phenomena, based on the needs of both individuals and groups (*The Higher Education Ordinance*, SFS 1993:100). The national and local policy documents underlying the midwifery exam are 'The Higher Education Ordinance', 'The Swedish Higher Education Act' and the examination requirements of each respective academy. These documents do not detail the content of each curriculum and may therefore vary between differing academies (SFS 1993:100; *The Swedish Higher Education Act*, SFS 1992:1434). The Council of Education within the Swedish Midwife Association (Personal communication, 25 Januari 2018) asserts that it is not possible to determine when LGBTQ was introduced as a subject in the midwifery education, since no thorough review of curriculums and study guides has been conducted in the past.

LGBTQ lectures has been a part of the midwifery science program at Karolinska Institutet with reoccurring LGBTQ lectures since 2009 (Personal communication, 25 January 2018, L-Andreasson-

Hedman, Midwife Mama Mia Söder). The Council of Education within the Swedish Midwife Association provides various examples of education regarding LGBTQ within the midwifery science program. One such example is the University of Dalarna, where currently there is a course taught, in which parts of the examination is centered around discussions regarding LGBTQ-perspectives, for example 'women's sexual and reproductive health related to LGBTQ from a biopsychosocial perspective'. In Lund, LGBTQ as a subject has been a part of the midwifery science program for several years, but it was not until 2016 that it was formally submitted to the curriculum (Personal communication, 25 January 2018).

### **Healthcare professionals' knowledge and attitudes**

As well as in previous studies of patients' experiences, healthcare professionals with LGBTQ identities relates to the experience of having to "come out" over and over again, in their workplace and in their everyday life. The stereotypical good and caring nurse/midwife opposes the image and prejudice of the lesbian woman, resulting in homosexual women not displaying their way of life (Mander & Page, 2012). In Kantrowitz, Ellis and McFarlane's (2014) study female-to-male transgender midwives expressed feelings of isolation and loneliness in the profession. The process of determining their gender can lead to discomfort for patients as well as for midwives. Being perceived as women provided more acceptance as a midwife. One participant had been compelled by educators and clinical preceptors not reveal his true gender identity.

Patients' experiences indicate a prevalence of negative attitudes and fear of discrimination. In an integrative review, the knowledge, beliefs and attitudes of nurses and midwives of the LGBTQ patients were examined. Queerphobia was revealed to be primary theme, and took the form of offensive language, ridicule and assumptions based upon the sexuality of the patient. Healthcare professionals related colleagues espousing condescending views regarding LGBTQ patients and one in five reported having experienced colleagues make disparaging remarks about transsexual patients. Furthermore, one in six would not challenge colleagues making such remarks to or about LGBTQ patients (Stewart & O'Reilly, 2017).

Simultaneously, healthcare professionals are described as being open and inclusive in their attitudes. Midwives relate their outspoken ambition to develop their communicative skills and their effort to accommodate the patient/couple in regards to language use and documentation. Several studies show that healthcare professionals stand up for their LGBTQ patients, by minimizing stigma, advocating the inclusion of the partner in same-sex relationships and thereby improving patient care. At the same time, some midwives find it awkward to talk about sexuality and gender identity with their patients. A fear of expressing the "wrong" sentiment and/or to offend, sometimes

lead to uncertainty and a strained dialogue with the patient. Moral and/or religious reasons for condemnation of LGBTQ patients are rare, but they do exist. Among nurses, less than 10 % stated that they were able to meet the need of care of LGBTQ patients and 21 % felt uncomfortable caring for trans people (Stewart & O'Reilly, 2017).

Dorsen and Van Devanter's (2016) study showed the ambivalence that health care providers can feel in caring for LGB patients. Although the Nurse Practitioners overall had a positive attitude towards caring for sexual minority groups and felt a professional obligation to care for all, it could mean a conflict between their own personal values, such as religious or cultural beliefs about homosexuality. This could result in developing strategies in order to maintain their professionalism, resulting in not asking about sexuality/sexual orientation or overly focusing on sexual risk behaviours. Caring for LGB patients was expressed as being culturally competent, being able to care for diverse group of patients. 'Treating everyone the same' was a philosophy used in an effort not to discriminate. 'Good care' of LGB patients was synonymously as treating them the same as heterosexuals, questioning whether LGB patient may have special needs.

Spidsberg and Sørli (2012) also concluded that neutral care can be a sign of ambivalence rather than acceptance in the care of lesbian women and their partners. The midwives expressed the importance of being balanced in the encounter, hoping to express a genuine interest in their patients with the fear of instead being perceived as nosy. To preserve the patients integrity was of great importance for the midwives and they described how they used their professional instinct deciding when and what to ask. Caring for a lesbian couple can evoke feelings of uneasiness but was mainly described as unproblematic.

A danish study (de la Fuente Fonnest, Søndergaard, Fonnest, & Vedsted-Jacobsen, 2000) explored the attitudes of health care providers within the obstetrical and gynecological field. Nurses, midwives and doctors participated. It showed a discrepancy between the recommendations of the Ethical Council of Denmark and the attitudes among health care providers. Regarding access to artificial reproduction, a majority was against providing the service to single women (63 %) and lesbians (64 %). There was also negative attitudes towards adoption by homosexuals were a majority (74 %) opposed. Religion was shown to have a strong impact on the health care professionals attitudes. In the matter of adoption a direct association correlated to the degree of religious belief, were strongly religious people expressed more negative attitudes.

There is a lack of research about Swedish midwives' knowledge of LGBTQ people. In grey literature from Hedman (2013), midwives at midwifery units were tested on their knowledge of LGBT issues. The participants were also given the opportunity to describe, in their own words,

what they lacked in order to provide good care to LGBT people. A majority of the participants showed accurate knowledge of LGBT. Still they expressed a need for more education and competence. Similarly, they requested training in how to be inclusive, such as use of language, as well as a deeper understanding about the living situation of LGBT people. Finally, the participants saw a need for more specific information such as juridical aspects, how to conceive through insemination and assisted reproduction.

## **Problem definition**

Healthcare professionals, including midwives might be conflicted in caring for LGBTQ people with a range of both positive and negative attitudes. Feelings of insecurity and lack of knowledge may affect the encounter, resulting in misjudgements or inadequate care. Little research in Sweden is directed towards LGBTQ issues within midwifery units aimed towards midwives. It would be of interest to explore how midwives themselves perceive the care given and the prerequisites they have in the care of LGBTQ people. How do they value their own achievement and capability in the encounter with LGBTQ people? Is there something they lack or need to provide equal care? Hopefully this current study may serve as a source of inspiration to further research and of value in the planning and implementation of efforts for a more inclusive reproductive healthcare.

## **Aim**

To explore midwives experiences and their prerequisite in the encounter with LGBTQ persons during care of pregnancy.

## **Methods**

### **Study design**

This cross-sectional study was conducted using a web survey with a quantitative, descriptive design.

### **Participants**

Midwives currently working in Sweden with care during pregnancy at midwifery units were invited to participate. The participants were to work full time, part time or by the hour. Exclusion criterias were midwives merely working in other sections of health care or women's health, for example within birthing/delivering care or postnatal care. We wanted to study the current conditions, why



midwives who had not been working with care during pregnancy at midwifery units for the past year were excluded. This could be due to sick leave, parental leave, retirement, end of/or other employment. The study is limited to Swedish conditions and therefore midwives working outside of Sweden were excluded.

### **Data collection**

There are approximately 560 maternity care/midwifery units in Sweden. The number of employed midwives per unit differ from the smallest with one midwife to up to 35 midwives in the largest unit. In total there are 41 coordinative midwives (Inera, 2017).

The supervisor of this study helped administer information about the study via email to the coordinative midwives nationwide in Sweden. The email contained a flyer with short information about the purpose of the current study and a link to the web survey (Appendix 2). Also attached in the email was a letter of information, with further information and background to the study and project. In the letter was also a link to the webb survey (Appendix 3). Information about consent to participate was written in both the flyer and the information letter. It stated that the midwife approves participation by answering the questionnaire and that one could cancel the participation at any time in which case a non-completed survey not gets included in the results.

A week after publishing the survey, in order to reach a larger number of participants, a flyer and link to the survey was posted in social media (Facebook) in a closed group for midwives and student midwives.

### **Survey construction**

The survey was constructed using the program Survey & Report (version 4.2.3.3.5), licensed to Karolinska Institutet. The survey was constructed in two parts. The first part consisted of 14 demographic background questions such as age, years in the profession, sexual orientation and gender identification. The second part consisted of 11 questions concerning the midwife's experiences and perceived conditions to provide care to LGBTQ persons during pregnancy. The second part of the survey contained questions with scales of ordinal and nominal design. The majority of the questions had fixed-alternative, multiple choice answers (Polit & Beck, 2012).

The questions were inspired from the results and four themes which emerged from interviews in the previous qualitative study in this research project (see table 1); 1. Inadequacies and mistreatment in reproductive healthcare, 2. Consequences of heteronormativity, 3. Satisfaction with reproductive healthcare despite heteronormativity, 4. Wishing for LGBTQ competent reproductive healthcare (Garzón & Klittmark., 2017).

The first two themes concerned different heteronormative barriers in reproductive healthcare and the consequences for LGBTQ parents. From this result, questions were constructed to see how the midwives perceive the care given, for example how inclusive their prenatal parent classes or written information are. The third theme highlighted the participants' satisfaction with aspects of good care and LGBTQ competent care, including being satisfied despite lacking support. In the survey, one question emerged from this theme which instead regarded the midwives satisfaction in the care of LGBTQ people. The last theme described the participants' wishes for inclusive and LGBTQ competent care and what healthcare professionals can do to achieve LGBTQ competent care. It became clear that this theme was essential for this study and is incorporated in a majority of the questions. The last question had, besides multiple choice answers, a free text space enabling the participants to describe in their own words what they as midwives need to provide equal care.

**Table 1: Result Garzón & Klittmark, 2017**

<b>1. Inadequacies and mistreatment in reproductive healthcare</b>
Lack of knowledge regarding LGBTQ and pathways to parenthood Heteronormative assumptions Being excluded or questioned as LGBTQ Other forms of judgments and mistreatment
<b>2. Consequences of heteronormativity</b>
Worrying and negative expectations Struggling and coping with heteronormativity Seeking out LGBTQ competent healthcare
<b>3. Satisfaction with reproductive healthcare despite heteronormativity</b>
Satisfied with good care Satisfied with LGBTQ competent care Satisfied despite lacking support
<b>4. Wishing for LGBTQ competent reproductive healthcare</b>
Acquire LGBTQ competence Communicate LGBTQ competence Provide LGBTQ specific support

Two midwives working at midwifery units served as pilot for the 25-question survey. The introductory text was after their opinions altered, clarifying that little or no experience from working with LGBTQ patient is of no significance for their participation. Since this project consists of two parts, we also wanted the opinions of the two authors from the previous study. Two questions were cut based on their comments and one question was modified, resulting in a total of 23 questions (Appendix 4).

Shortly after the survey was published comments came in from a participant, criticising the content of the background questionnaire due to lack of anonymity. Working in smaller/urban regions makes postcode area revealing because of the small number of colleagues, especially since the question of

sexual orientation was also requested. Though the authors never intended to present results from specific postcodes or connect postcodes to sexual orientation/identity, the postcode question was altered to being voluntary.

### **Data analysis**

The statistical program SPSS, (Statistical Package for the Social Sciences) version 24 was used for the data analysis. The demographics of the participants are presented in text, mainly using percents to describe the distribution of the sample. A full description can be viewed in Appendix 5.

Descriptive analysis was created from the data and presented through graphs and text. Percents was mainly used but occasionally numbers. The free-text answers from the last question is presented in text including quotes from the participants.

### **Ethical consideration**

This project has been granted approval by the Regional Ethical Review Board in Stockholm (Dnr: 2017/1161-31). The study has been conducted in accordance with the Helsinki declaration which states ethical principles for medical research involving human subjects (World Medical Association [WMA], 2013). Another ethical consideration within this study was the maintenance of confidentiality. Participation was voluntary and the surveys were filled in anonymously. No answers from any individual can be traceable to a person's identity in the final text. The respondents were informed that by answering the survey they gave their consent to participation, but that they could end their participation at any time. We as authors and the supervisor of this study are the only people who have access to the material.

We thought an important aspect when research refers to a specific group, such as in this study LGBTQ people, is the risk of potentially stereotyping the members of the community. It is important for the authors and readers to keep in mind that LGBTQ people are more than their sexual- and gender orientation, having a wealth of other attributes. The intention of this project is to visualize aspects of care in the encounter with expecting non-heterosexual, trans- and queer parents. Though, in the strive to make the health care more equal, the fear is to further alienize the members of the community. We as authors found it important throughout the process to remind us of our own pre understanding and the fact that since we are not part of the community ourselves, this may reflect upon the construction of the study and interpretation of the result.

## Results

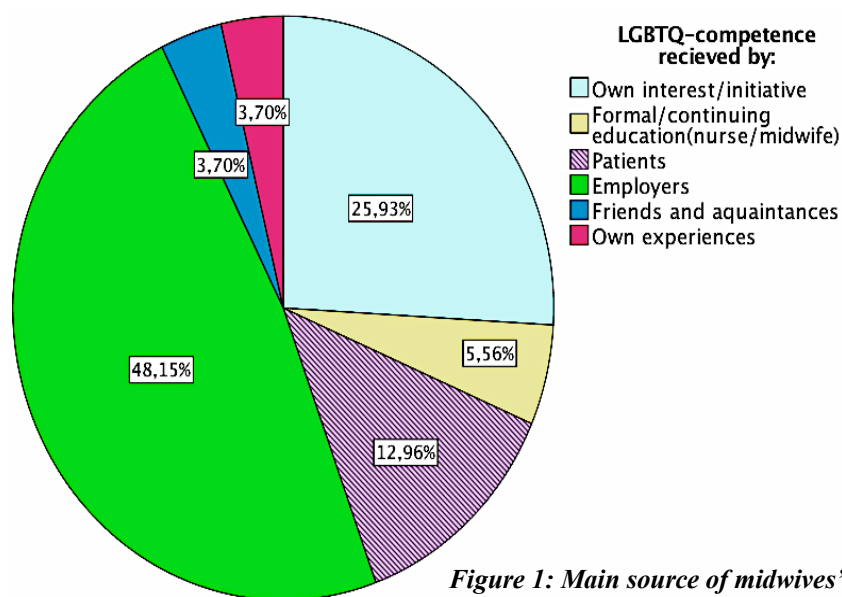
### Participants demographics

A total of 54 participants submitted the survey. 12 surveys were left uncompleted. All participants identified themselves as women, one with the experience of being a trans person. The vast majority identified as heterosexual (93 %) and were born and had lived in Sweden for a majority of their lives (94 %). Their mean age was 46 years (range 29-65). There was a spread in number of years in the profession, although most of the participants had worked several years as midwives; 22 % of the participants had <5 years in the profession, 39 % had 6-15 years in the profession and the remaining 39 % had >16 years in the profession. When asking for years at midwifery units/within maternity care, 46 % had <5 years experience, 37 % had 6-15 years of experience and remaining 17 % had >16 years of experience. In this small sample there was a variation of representatives from large cities (39 %), from medium sized towns (29 %) and from urban areas (32%). The classifications of swedish municipalities is taken from SKL (2016). Though, geographically there is only a few participants from the northern part of Sweden.

### Individual experience and competence

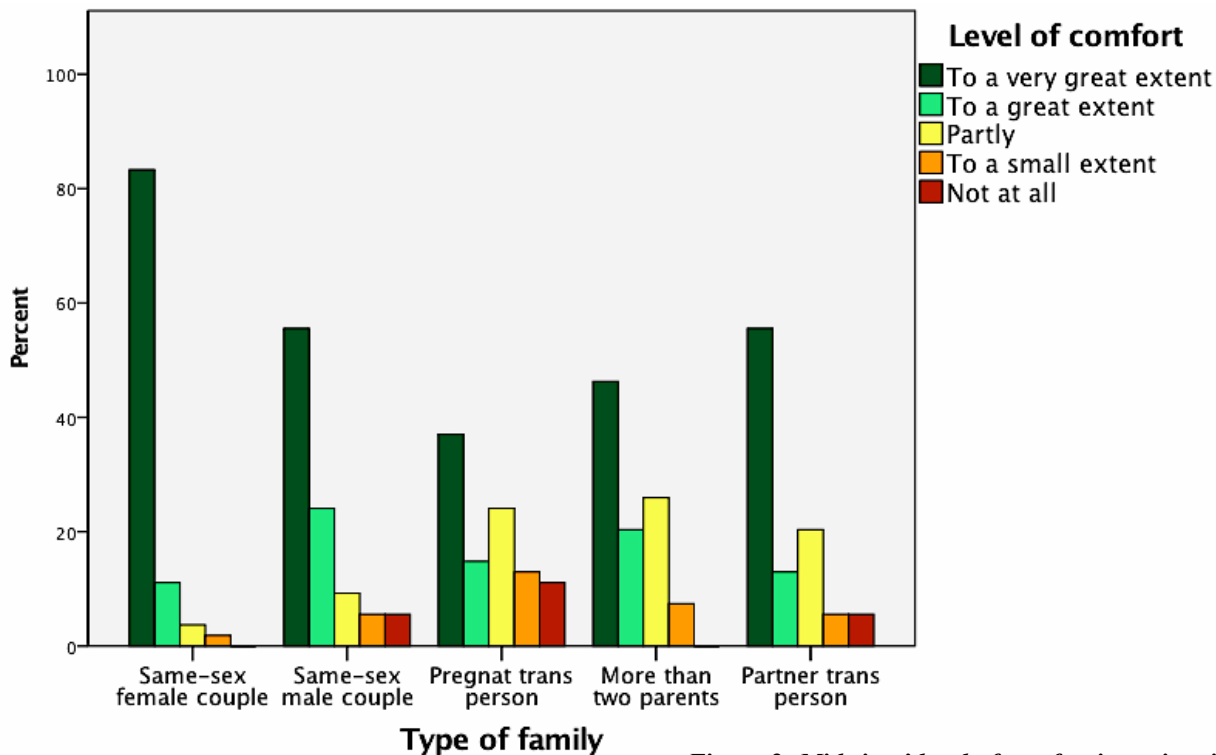
The majority of participants in this sample does not meet with expecting LGBTQ parents on regular basis. 70 % stated that this occurs occasionally each year, 6 % stated that they never encounter expecting LGBTQ parents in their work at the midwifery unit. 69 % stated that LGBTQ knowledge was not a part of their continuing education when becoming midwives, which is correlated to years in profession ( $p=0,01$ ).

LGBTQ competence is instead something they recieved elsewhere, mainly from employers' efforts or gaining knowledge out of own interest, reading or taking courses. Nearly 13 % had mainly received their LGBTQ competence from their patients (Figure 1).



*Figure 1: Main source of midwives' LGBTQ competence*

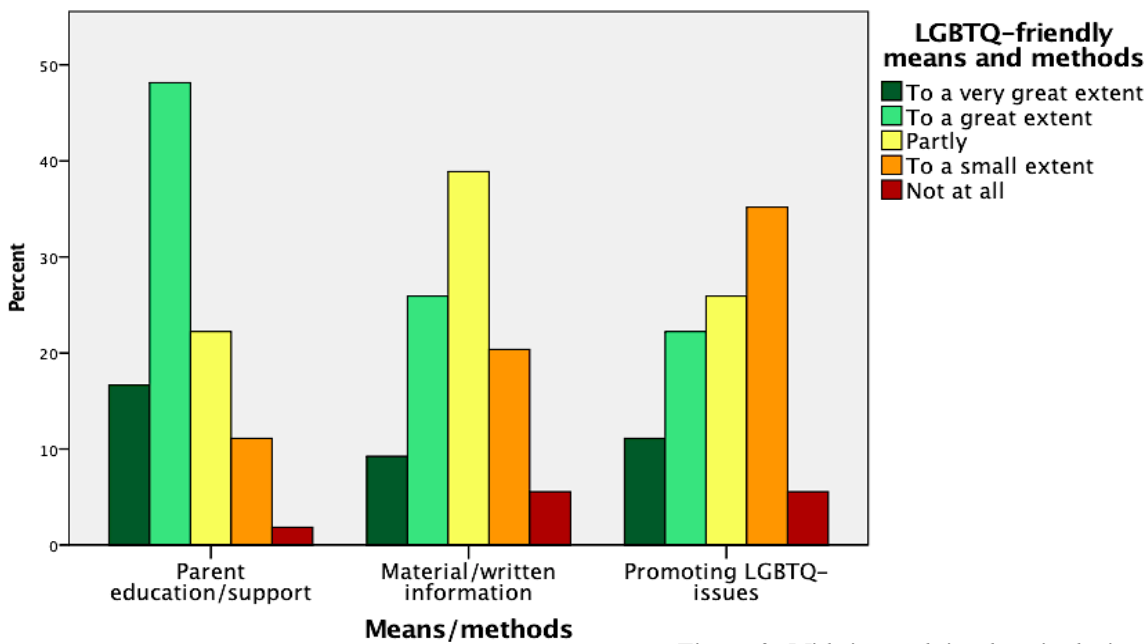
When asking for basic knowledge in the encounter with LGBTQ people, 57 % of the midwives valued that they had the knowledge required at a great extent or very great extent. When asking for specific knowledge related to pregnancy and specific needs of LGBTQ people 41 % valued that they had the knowledge required at a great extent or very great extent. The level of comfort differed between type of family, with highest level of comfort caring for same-sex female couples and lowest level of comfort caring for a pregnant transgender male (Figure 2).



*Figure 2: Midwives' level of comfort in caring, in relation to type of LGBTQ family*

## Means and methods

Overall the midwives were partly (30 %) or to a great extent satisfied (48 %) with the care offered to expecting LGBTQ parents. When valuing how well their materials and methods were suited to different types of families and parents, the midwives differed between the written information/materials given to parents and the prenatal parent education/support. They valued the prenatal parent education and support more suitable than the written information. There was a range in the result when asked about how active their unit is in promoting LGBTQ-issues (Figure 3).



*Figure 3: Midwives valuing how inclusive their prenatal parent education and brochures/written information are, as well as how active their unit is in promoting LGBTQ issues.*

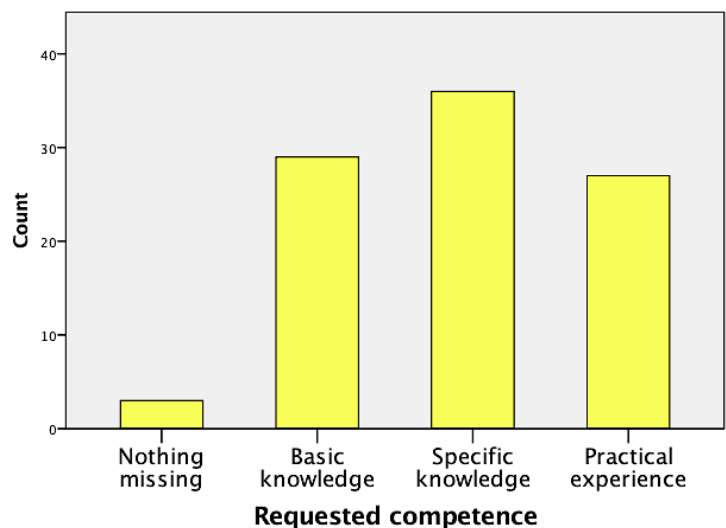
### Requested knowledge and competence

To be able to provide equal care, the participants generally expressed a need for additional knowledge and competence. Basic as well as specific knowledge and practical experience, such as more frequent encounters with LGBTQ patients, was desired (Figure 4).

Ten respondents used the free-text option.

In free-text the midwives expressed a limited experience of LGBTQ people during care of pregnancy, and how this may result in insecurity and fear of behaving incorrectly or offensive. Several answers indicate a particular lack of experience from trans persons and same-sex male couples. Simultaneously they showed a general will to be inclusive and to develop their skills and competence.

They also acknowledged that there is a risk of falling into heteronormativity. As one midwife put it:



*Figure 4: Requested LGBTQ competence from midwives in order to provide equal care*

*“I think most of the people working at my unit, including myself, try to be open-minded to various types of family constructions, but sometimes I think we get caught in heteronormative thinking. You may also be a bit “nervous” to say the wrong thing or make mistakes...”*

Another midwife pointed out the fact that they have not met that many LGBTQ people, and how this affects the quality of care: *“Mainly it could be that we have not met that many different types of partners and family constructions yet. We try to make everything fit for a partner/expecting parent no matter who that person is but it is not that common in healthcare yet.... In fact, the actual encounter is what is most important, that we really see the person we have in front of us, and the more people we meet, the better we become in the encounter”.*

Professional supervision and education was requested emphasizing the importance of developing the care to be more inclusive. One midwife asked for LGBTQ diploma at her unit, knowing that other units in her area were certified. The level of comfort in the care of LGBTQ people was also related to the attitudes and knowledge of their colleagues, fearing that their patients may be treated disrespectfully.

## **Discussion**

### **Discussion of methods**

#### **Choice of method**

The aim of the study was to explore midwives' experience and prerequisites in the encounter with LGBTQ persons during care of pregnancy in Sweden. By using a web survey it enables collecting information from a larger and geographically diverse sample in a short/limited period of time. It is cost effective and easy to distribute (Billhult & Gunnarsson, 2012; Polit & Beck, 2012).

The survey was constructed to be filled in anonymously, with the hope of a higher response rate. An anonymous questionnaire was chosen to increase the chance of participants answering truthfully, recognizing that LGBTQ issues can be a sensitive matter. Polit & Beck (2012) claims that anonymous questionnaires often result in a higher amount of socially unacceptable responses (responses that may place participant in unfavorable light) comparing with interviews. The absence of an interviewer also reduces interviewer bias. The ideal of an interviewer being neutral is difficult to achieve and interaction may affect responses.

Polit & Beck (2012) describes the importance of validity (testing that the instrument will provide what it aims to measure) in quantitative research and how to achieve this when designing a new research instrument. Content validity can be ensured by constructing the instrument based on first

hand knowledge, from literature reviews or from a qualitative inquiry on the subject. Our questionnaire was inspired from the result of the qualitative interview study by Garzón and Klittmark (2017), which also is the first part in this research project. Face-validity can be achieved by testing the instrument to people who are well acquainted to the subject (Gunnarsson & Billhult, 2012, Polit & Beck, 2012). This was sought by testing the survey on two midwives working at midwifery units and the two authors of the first part of this project before publication.

When exploring experiences and prerequisites by using a quantitative survey instrument, it is much more difficult to reach reliability compared with other sorts of quantitative instruments, for example measuring a blood pressure (Gunnarsson & Billhult, 2012).

### **Study limitations**

The study has its limitations due to the low response rate and can therefore mainly be considered a pilot. It would have been of interest to study the correlation between the outcome and the participants' demographics. For instance, one intention was to investigate geographical differences nationwide. Would the results differ in rural areas from urban areas? Where there differences in south and north of Sweden? Though, the small number of participants in this study, makes it hard to draw conclusions and trust the generalizability of the outcome, representing the majority of the midwife profession.

There is the question of selection and non-response bias. If there are differences between the characteristics of participants and those of people who did not answer (Polit & Beck, 2012). What made participants answer the survey and why did so many choose not to? The high non-response rate, particularly from the northern part of Sweden, can partly be explained by outdated contact information of the coordinative midwives. We also were informed by a midwife from a midwifery unit that some of the coordinative midwives in the Stockholm area recently ended their employments. This was discovered after the surveys final date. Another explanation may be that the number of mailings to employees are high with the risk of information becoming invisible or unnoticed. How does the loss reflect on the outcome? One possibility is that the respondents in this sample are more comfortable with and have a general interest in LGBTQ issues than those who did not participate. Other than the demographic data, there is no traceability, making the non-response rate difficult to analyze further. Twelve surveys were unsubscribed for unknown reasons.

By using a quantitative survey, the information obtained may be superficial compared with interviews and may not gain a deeper understanding of peoples' behaviour. Polit & Beck (2012) describes how much of the richness and complexity of respondents' experiences can be lost. We



therefore tried to complement the data by adding the open ended question, enabling respondents to fill in the gaps.

Concerning generalizability the sample in this study can be seen as homogenic, with all participants identifying as women, the vast majority identifying as cis and heterosexual. A vast majority had lived the majority of their lives in Sweden. Although, to some extent the sample is consistent with the demographics of midwives in Sweden. Among healthcare professionals, midwife is the most women dominated profession. In 2015, when looking at the proportion of women versus men working as midwives the percentage of men is close to zero (National Board of Health and Welfare 2018). The mean age of the participants is 46 years, compared with the mean age of midwives in Sweden which is 48 years (SCB, 2015). Although the response rate was low there were a variation of representatives from large cities, medium sized towns and urban areas. There was also a range in age and professional experience.

### **Discussion of results**

The demographics in the sample showed a homogenous group concerning gender and sexual orientation, which may affect the care toward a diverse group.

The result is in many aspects in accordance to research from a patient perspective. For instance the desire for more LGBTQ knowledge and competence and the inadequacies of promoting LGBTQ issues. Although the prenatal parent education stands out as deviant, indicating that the expectations of care may differ between midwives and expecting parents.

Though the midwives expressed an intention to provide equal care, this might depend on individual interest of midwives and/or efforts from employers.

### **Homogenic profession in a female dominated field**

Midwife is the most women dominated profession among healthcare professionals in Sweden. In 2016, 100 % of the graduated midwives were women (National Board of Health and Welfare 2018). All participants in this sample identified themselves as women. It is well known that midwives are used to caring for women and are trained and educated, not exclusively, but foremost about female anatomy and reproduction. The majority of a midwife's work-field mainly involves caring for women. Does the overrepresentation of women among staff as well as patients make it more challenging caring for people not identifying as women?

Similarly, Kantrowitz-Gordon et al. (2014) describe the midwife profession in the USA with a lack of ethnic and gender diversity. Men working as midwives is rare and their position in a female-dominated profession comes with questioning, exclusion and discrimination as well as with

privilege. Homogeneity within the profession was one of the findings of Mander and Page's (2012) study. There were differences between midwives and registered nurses recognizing the significance of sexual orientation. Nurses seemed to have the advantage due to a richer diversity among their patients as well as within the profession.

Ryan (2013) showed that because in society, there is a strong association between pregnancy and femininity, it may feel challenging for pregnant people with a masculine self-concept. Kantrowitz-Gordon et al. (2014) argues that supporting a diverse midwifery workforce both in education and professional practice, would help strengthen midwifery as it would respond to the challenges of a diverse population.

In free-text, several participants had considerations about the question concerning level of comfort in caring for LGBTQ people. This because the lack of experience, more specifically lack of encounters with trans persons and same-sex male couples. It was a deliberate choice not to include a non-experience alternative. One thesis is that lack of encounters may affect the level of comfort. As mentioned earlier, the majority of studies focuses on lesbian woman. In a nordic review of literature (Wells & Lang, 2016) the results indicate that despite organisational and personal challenges, lesbian parents generally have positive experiences from the child health field (prenatal, labour/birth, postnatal, child health centre) and are accepted by child health professionals (nurses, midwives, doctors).

LGBTQ people may share similar experiences, given their non-heterosexual and/or non-cis identities in a heteronormative society. Although, our result indicates that there is a distinction between caring for different types of LGBTQ families, were caring for childbearing trans people stood out as being the least comfortable encounter and lesbian couples the most comfortable. Since the demand of sterilization before undergoing gender confirmation medical treatment was abolished in 2013, transgender men's presence in reproductive care is historically a new phenomenon. The level of comfort can simply be seen a result due to lack of experience and number of encounters but also reflect on available research and knowledge. Even though the research field expands and healthcare professionals develop their skills, there still remains a gap in research and knowledge concerning gay men, bisexual, transgendered and queer people.

Klein et al. (2018) questions if the needs of lesbian women can be generalizable to all LGBTQIA (lesbian, gay, bisexual, transgender, queer, intersex and asexual) individuals and argues that combining them into one group may obscure the differences among them. Additional research is therefore needed on separate populations with focus on cisgender gay men, cisgender bisexual men and women, transgender individuals, and intersex and asexual individuals.

### **Professionals' lack of experience and patients' expectations**

The results in this study differ from research from a patient perspective concerning the prenatal parent education. A majority of the midwives (65 %) perceived their prenatal parent education and support as suitable for different types of families to a great or very great extent. However in Wells and Lang's (2016) review of nordic research, same-sex mothers and co-mothers felt the most offended during the prenatal parent classes, caused by heteronormativity in use of language and method. Forslund Frykedal, Rosander, Berlin and Barimani (2016) explored challenges midwives face in working with prenatal parent education classes. The midwives expressed challenges with managing diverse groups and parents' expectations. Despite the desire to involve all participants and adapt the content to the group, they found it difficult to satisfy everyone.

Participants in current study expressed the fear of falling into heteronormative thinking and a lack of confidence due to lack of experience and competence. The result of McCann and Brown's (2018) review of healthcare education and training programmes, showed that although attempts are made for a more LGBTQ friendly and inclusive care, the result may be varying due to staffs' attitudes and the maintenance of heteronormative practices and policies. Healthcare professionals should be supported not merely by adequate education, but also be able to explore their own beliefs and preconceptions. The discrepancy between patient experience and midwives' perceptions in current study may be explained by bias in the selection of participants, being midwives comfortable with LGBTQ issues. An other possibility may be a unawareness of the heteronormativity within the reproductive field.

The complexity of the profession of midwifery and the powerful influence midwives can have on the lives of patients and their families, is discussed in Halldorsdottir and Karlsdottir's (2011) study. The professionalism is based on five main focuses. Professional caring: cares for the patient within the professional domain; Competence: most important to ensure safety for mother and child; Wisdom: the interplay between knowledge and experience; the Interpersonal Competence: empowering communication and partnerships with the patient and a personal and professional development. These factors needs to be put together to ensure that the care given is optimal for each person. It is a complex mission to combine professional competence and caring into one whole. The midwife function as a personal guide, leading the family through the journey of the childbearing process, adapting to the needs of each family. The authors states the importance of evaluating own attitudes, communication skills and self-knowledge in addition to cognitive and practical competences.

In previous research healthcare students identifying as LGBTQ as well as LGBTQ patients, state how they need to educate and bring knowledge to those who in fact have the educational

responsibility (Garzon & Klittmark, 2017; Nama, MacPherson, Samson, & McMillan, 2017; Røndahl, 2011). The student/patient experience is confirmed by the 13 % of midwives in our study, who stated how they mainly received their LGBTQ competence from their patients. It seems likely to presume that the percentage who received some part of their knowledge from patients is higher. Patients describe the tutoring role as strenuous and carry feelings of responsibility (Dahl et al., 2013). Although we can not know if this inadequacy also is a concern for the midwives. When patients possess greater knowledge, the healthcare professionals may not be able to meet the needs and expectations of their patients.

Almost 26 % of the participants answered that they received their LGBTQ competence through their own initiative, based on their own interest. The problem with midwives educating themselves is that the care becomes dependant on the individual midwife rather than being standardized. Only a third of participants stated that LGBTQ knowledge was a part of their continuous education as midwives. However, it should be noted that the majority of the participants of our inquiry received their degree decades ago. The institutions of higher education that are exemplified in our background all have, to varying degrees, some elements of LGBTQ education as part of their midwifery science program. In most cases, LGBTQ competence is offered as a single course rather than included as a perspective of norm-criticism throughout the education.

It is difficult to reach a national consensus regarding what minimum level of LGBTQ competence should be taught in the midwifery science program, since the institutions of higher education each design the syllabus and training of their own program. When the Public Health Agency of Sweden (2017) reviewed all 13 midwifery science programs, they found only seven indicators of LGBTQ in the 121 syllabuses. Walker, Arbour and Waryold (2016) states that there are several ways to integrate these issues in education for healthcare professionals to provide respectful sexual and reproductive health care for the LGBTQ community. For example by traditional on-site classes, hybrid courses and online systems. The content could consist of terminology, identifying personal bias, use of case studies and determination of appropriate referrals.

Though it may be that the subject gets stymied due to time constraints and is left languishing in the shadow of more prioritized subjects such as obstetrics. In McCann and Brown's (2018) review the LGBTQ inclusion often appears as patchy and limited in health education and training. The authors address the need to integrate the LGBTQ perspective in curriculums, advocating a more consistent approach in the education of healthcare professionals.

## **Welcoming the LGBTQ patient**

Midwives showed a will to be inclusive, with the intention to provide good and equal care, regardless of type of family. One explaining how the actual encounter being what is most important. The results are consistent with Andréasson-Hedman's (2013) study, where the participants also expressed how they wanted to keep things simple, not complicating the encounter. This with the intention of treating all people the same, not making LGBTQ people feel different. The pregnant transgender men in Light, Obedin-Maliver, Sevelius and Kerns's (2014) study asked for compassion and respect and wanted to be treated as normal human beings with normal bodies. For the midwife, the challenge is to find a balance between the specific needs of the LGBTQ group and to normalize the expecting family. The result of neutral care, disregarding the significans of sexual orientation and gender identity, may instead be miscommunication and shortcomings in caring for expecting LGBTQ parents.

Bushe and Romero (2017) argues that creating trust and confidence for lesbian expecting parents can not solely depend on the single solid midwife. Even if the encounter with one healthcare professional was wonderful, this may be cluttered by negative experiences with other colleagues at the practice and may result in patients avoiding the unit in the future. A participant in our study exemplified this by stating not being comfortable with LGBTQ patients because of attitudes and the lack of knowledge of her colleges, fearing that patients may be treated disrespectfully. This demonstrates the importance of actively working with LGBTQ issues and promoting a norm-critical approach at each unit, not letting equality of care depend on the lottery of assigned caregiver.

First impression matter. An open and inclusive environment can be facilitated by LGBTQ families being visually represented in the units décor or with LGBTQ-friendly reading materials (Bushe & Romero, 2017; Klein et al., 2018). When midwives in our study valued the written material handed out to patients, they expressed that it could be more suited to different types of families and parents. Our result also showed that there was a variety in how active the midwives' units were in promoting LGBTQ issues. 33 % felt that the unit to a great extent or very great extent were active in promoting LGBTQ issues, 61 % answered partly or to a low extent active and 6 % answered that the unit was not active at all in promoting LGBTQ issues. Again, how LGBTQ friendly the reproductive health care is, may not be equal, instead depending on individual interest from midwives and/or efforts from employers.

LGBTQ patients express the need for services with a LGBTQ profile, with welltrained and experienced LGBTQ competent professionals (Dahl et al., 2013; Klein et al., 2018; Larsson & Dykes, 2009). These sevicees can and are provided in larger cities, such as the midwifery unit Mama Mia Söder in Stockholm (Barnmorskegruppen Mama Mia AB, 2018). Although, it may be difficult

to run specific units for LGBTQ parents in all rural areas, emphasizing the importance of being inclusive and welcoming to all expecting families. The LGBTQ certification program by RFSL was requested by one participant in free-text. In 2017 nine midwifery units in Sweden had certifications. This can be compared with approximately 40 certifications of youth guidance centres (RFSL, 2017a). The current price for the certification 125,000 kr for 25 employees. The certificate is valid for three years and then needs to be renewed (RFSL, 2016). Although, relying on a certification which is provided by an independent organization and being charged for, limits the accessibility, making LGBTQ issues depend on local commitments and/or economical priorities.

## **Conclusion**

Due to the scarce number of participants, this thesis can be considered a pilot. Lack of knowledge and experience (i.e patient encounters) as well as heteronormative methods and materials are barriers to LGBTQ competent care in Sweden. The result indicates that the care and level of comfort in the encounter with LGBTQ people depend on type of family within the LGBTQ spectra. The midwives showed a general will to be inclusive but indicated that they need to develop additional competence and skills. The variation of answers in satisfaction of care towards LGBTQ people and evaluation of means and materials may indicate how equal care is depended on midwives own interest and commitment or from independent efforts of employers.

## **Further research and implications for healthcare**

A larger sample would make it possible to compare the care nationwide and between regions. There might be a need to review the means and materials of care during pregnancy in our regions to ensure that professionals and patients have the same equal prerequisites in reproductive healthcare.

Although midwives have the responsibility to develop their competence and incorporate new knowledge throughout their career, equal care for LGBTQ people should not solely depend on each midwife's own interest and commitment. Sweden's municipalities and county councils, are currently working on nationwide guidelines and documents for midwifery units. This to ensure that reproductive healthcare, no matter where in Sweden it is provided, is equal and safe. This will also make it easier for midwives and gynecologists to gain information about specific groups of patients (Inera, 2017). Hopefully the LGBTQ perspective will be incorporated in these guidelines, creating conditions for equal and inclusive reproductive healthcare.

Specific knowledge concerning reproduction for LGBTQ people is needed. Additionally, to use the term heteronormativity and include a perspective of norm-criticism into curriculums, health care

documents and guidelines, could emphasize the significance of challenging society's norms concerning sexuality and reproduction.

Since there was a distinction in caring for different types of LGBTQ families it would be interesting to explore this further from a caregiver perspective. How is the level of comfort affected by attitudes, experience and knowledge? How does the healthcare system restrict access to care for certain people? In contrast to research from LGBTQ parents, the midwives valued the content of their prenatal parent education seemingly high. To examine the content of the prenatal parent classes and how they are conducted would be of value when targeting the efforts for a more inclusive care.

This study gives an insight to the midwives prerequisites in the encounter with LGBTQ people in the care during pregnancy. In addition, to get a deeper understanding of the midwives needs and thoughts, it would be of value to conduct a qualitative study. This to emphasize the complexity of caring and midwifery and associate patients expectations to midwives ability to provide care.

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## Appendix 1: Glossary

*Glossary borrowed with permission from RFSL, The Swedish Federation for LGBTQ Rights. Retrieved October 17, 2017, from: <https://www.rfsl.se/en/lgbtq-facts/lgbtq/glossary/>*

**Asexual** A person who may not experience sexual attraction or sexual lust or, during a period of their life, does not wish to engage sexually with other people. Asexual can be used as an umbrella term for people who identify with the term in different ways, such as *demisexual* – when a person only feels sexual attraction to another person after having established a deep emotional connection, or *autosexual* – when a person only wishes to have sex with themselves. There is considerable diversity among the asexual community with many people identifying with and using the term differently.

**Bisexual** A person who has a romantic and/or sexual attraction to another person regardless of their sex or gender identity.

**Cis Person** A person who identifies with the sex they were assigned at birth. *Cis* is latin for “on the same side”.

**Cisnormativity** The assumption that all people identify with the legal sex assigned to them at birth, and that people are expected to live according to the social codes that are associated with that sex. There is also the assertion that cisgender is the norm and being transgender is therefore abnormal or unnatural.

**Dyke** A person who commonly identifies as a woman and has a romantic and/or sexual attraction to other women. Dyke is often used synonymously with the word lesbian.

**Gay Man** A person who identifies as a man, and has a romantic and/or sexual attraction to other men.

**Gender Binary** The dominant social system and classification of all people based on their sex and gender into two distinct, oppositional and disconnected forms of male (masculine) and female (feminine). The gender binary classifies people into one of only two groups and assumes that the differences between the groups are greater than the differences between individuals within the groups. The gender binary permeates all of our social interactions and structures within society. (See also Queer)

**Gender Confirming/Affirming Treatment** Earlier referred to as “sex change” but this term is no longer considered appropriate. The range of medical and/or surgical treatments offered to transgender and gender-diverse people, including counselling, speech and language therapy, hair removal, hormone therapy, and surgeries. To access publicly funded gender-affirming treatment in Sweden, a person must first be assessed at one of the gender clinics. Within the healthcare system, the term *gender reassignment* treatment is commonly used. (See also Transsexual Person)

**Gender Dysphoria** A strong and persistent feeling of having been assigned the wrong gender. This feeling is often associated with a mental ill health and can lead to a reduced ability to function in everyday life. Hence, persons with gender dysphoria can seek gender affirming health care.

**Gender/Sex** In most contexts, the terms gender and sex are used interchangeably to systematically separate people into the different groups of men and women, however, gender/sex is much more complex.

- **Body** Is defined by internal and external genitalia, chromosomes and hormones, but there is a huge diversity of bodies among female, male, and intersex people.
- **Legal Gender/Sex** The sex/gender as stated in the Population Register, passports and identity documentation. In Sweden, the legal gender marker is recorded in the second last digit of a person’s identity number and all people are given one of two legal genders, based on their biological sex.

- **Gender Identity** A person's self-defined gender – the gender one identifies with (for example, woman, intergender, genderqueer, non-binary, man). A person's body and/or legal gender do not necessarily reflect a person's gender identity.
- **Gender Expression** The way in which a person expresses their gender identity through presentation, accessories or behaviour that are socially associated with gender, such as clothes, body language, and hairstyle.

**Gender-Neutral Pronouns** Gender-neutral pronouns, such as *zie* and *they*, are used primarily when a person does not identify as a man or woman, but rather as intergender, genderqueer or non-binary, for example. *Zie* or *they* can also be used when referring to a person whose gender identity is unknown. (*Zir*, *hir*, *hirs* and *they*, *their*, *theirs*)

**GenderQueer (GQ)** A person who self-identifies as between or beyond the gender categories of man/male and woman/female. Genderqueer can be used synonymously with intergender or non-binary.

**Heteronormativity** The system of norms that affect our understanding of gender and sexuality. According to heteronormativity, people are either a man/boy or woman/girl and nothing else. Women and girls are expected to be feminine, and boys and men are expected to be masculine, with everyone expected to be heterosexual. We are all impacted by these norms, whether we conform to them or not. If we do conform or “pass”, we are entitled to certain financial, political, and social privileges. To resist and take a stand against heteronormativity, not conforming or not “passing”, may result in different levels of punishment, from invisibility to violence. (See also Gender Binary)

**Heterosexual** A person who has a romantic and/or sexual attraction to people of another sex than their own.

**Homophobia** An ideology or attitude that is rooted in a strongly negative view of homosexuality or homosexual and bisexual people. Homophobia and transphobia usually overlap.

**Homosexual** A person who has a romantic and/or sexual attraction to other people of the same sex. This term is frequently used in Sweden to refer to gay and lesbian people.

**Intergender** A person who self-identifies as between or beyond the gender categories of man/male and woman/female. Intergender is often used synonymously with non-binary and genderqueer.

**Intersectionality** A perspective that is used to study how different power structures in society are interconnected, and how different identities emerge as a result of class, religion, gender, sexuality and age, depending on the individual person, community, and context.

**Intersex/Inter\*** Intersex is an umbrella term used for a variety of experiences in which a person is born with, or develops, a reproductive or sexual anatomy that does not fit the typical definitions of female or male. An intersex person may identify as female, male, or neither, and this has nothing to do with how they define their sexuality. *Inter* is Latin for between, and so intersex means between the sexes. A person who is not intersex is referred to as dyadic.

**Lesbian** A person who commonly identifies as a woman and has a romantic and/or sexual attraction to other women.

**LGBTQ** An umbrella term for lesbian, gay, bisexual, transgender and queer people. The L, G, and B refer to sexual orientation, who a person feels romantically or sexually attracted to, and the T refers to gender identity and expression. Q refers to queer in relation to sexual orientation, gender identity and expression, or relationships and sexual practice, but it also represents a critical view of existing norms (see Queer). The first time that the acronym, LGBT (hbt), was used in print in Sweden was in 2000 in RFSL's member magazine, *KomUt* – the purpose was to broaden terms such as gay and homosexual.

**Non-Binary** A person who self-identifies as between, beyond, with both, or neither of the gender categories of woman/man. Sometimes non-binary is used as an umbrella term for different gender identities that do not fit within the gender binary, such as intergender or genderqueer. Non-binary does not mean the same thing for everyone who identifies with it. For some, it means feeling both male and female; for others, they are between the two categories, while many non-binary people do not identify with any gender at all. Some people may wish to change their bodies with hormonal treatment and/or surgeries.

**Norm Critique** A pedagogical method with the purpose of contributing to increased social equality. The aim is to shift focus from individuals, who are seen as different, to analyzing social structures and questioning what is considered to be “normal”. When working with a norm-critical perspective, there are three steps to take into consideration:

- Highlighting and questioning norms
- Highlighting the privileges conferred on those who conform to the norm
- Reviewing one’s own position

**Pansexual** A person who experiences romantic and/or sexual attraction to any person regardless of their gender. The word *pan*, meaning all, suggests that there is a spectrum of sexes and genders rather than only two, as some feel is implied by the term bisexual.

**Polyamorous** A person who has sexual and/or emotional relationships with more than one person at a time.

**Pronoun** *She, he, zie, they* – how a person wants to be referred to when talked about by other people (for example, Zie is kind, I like hir). A person’s pronoun may or may not reflect their gender identity. If you are uncertain about a person’s pronoun, you can ask them in a respectful way. (“What is your pronoun?/What pronoun would you like me to use when I talk about you?”) Some people prefer to be referred to by their name, rather than a pronoun. *They* is often used when a person’s gender is unknown.

**Queer** A term based upon a critical view of ideas about what is considered normal or not regarding gender and sexuality, and how everyone is placed in specific categories resulting from a heterosexual and gender binarist perspective. In other words, a way of questioning dominant social ideas about how people should experience sexual, as well as other, relationships, how we should form families, express our gender, and so on.

There are also queer activists who organize to challenge existing norms and structures, and people who call themselves queer. For some, being queer is a way of defining their gender identity and/or sexual orientation, while for others it offers an identity where one does not have to define one’s sexual orientation and/or gender.

**Racialization** A process that legitimizes people from a privileged position to ascribe to others certain personal traits, experiences, opinions, cultural attributes, based on assumptions about their colour, ethnicity and/or religion, which leads to exclusion and inequality.

**Sexual Orientation** A term that describes a person’s identity regarding the focus of their romantic and/or sexual attraction. According to Swedish anti-discrimination legislation, there are three distinct sexual orientations – heterosexual, bisexual, and homosexual. In reality, many people identify with other terms when it comes to sexual orientation.

**Transgender/Trans\* Person** A person who does not identify with the sex assigned to them at birth. Transgender is an umbrella term with several different identities, as there are many different ways of being transgender. The term specifically refers to gender identity and gender expression, and has nothing to do with a person’s sexual orientation.

**Transphobia** An ideology or attitude that is rooted in a strongly negative view of transgender or gender-diverse people. Transphobia and homophobia usually overlap.

**Transsexual Person** Transsexual people have a gender identity that is inconsistent with their assigned sex and desire to permanently transition to the gender with which they identify, usually seeking medical treatment to align their body with their identified gender. Transsexualism/gender dysphoria is a medical diagnosis by which a person is assessed to undergo gender confirming/affirming treatment within the Swedish healthcare system. This process is usually referred to as *transition* and entails hormone treatment and surgery to change the body to become more “masculine” or “feminine”.

Gender identity is separate and distinct from a person’s sexual orientation – a transsexual person can be heterosexual, bisexual, pansexual, asexual or homosexual.

**Whiteness/White Privilege** The social construction of whiteness as an ideology tied to social, financial and political status. Whiteness has historically been constructed as the norm and the embodiment of dominant culture and ideologies. White privilege goes hand in hand with racism and racialization. It is a global phenomenon, stemming from colonialism and means that light skin is a symbol of status, also in countries where whites as an ethnic group are a small minority.



## Appendix 2: Flyer



**Karolinska  
Institutet**



### **Vill du vara med och förbättra vården för blivande hbtq-familjer?**

Vi söker deltagare till ett forskningsprojekt som syftar till att förbättra graviditets- och förlossningsvården för hbtq-personer som ska bli eller planerar att bli föräldrar.

Vi önskar ta del av barnmorskors erfarenheter och förutsättningar i mötet med hbtq-personer på barnmorskemottagning inom den reproduktiva vården. Liten eller ingen erfarenhet av patientgruppen är inget hinder för deltagande!

Du som är barnmorska och jobbar på barnmorskemottagning/inom mödrahälsovård inbjuds att delta. Din medverkan består av ett webbaserat frågeformulär. Studien genomförs av Karolinska Institutet i Stockholm och ingår som ett examensarbete på barnmorskeprogrammet. Projektet har Etiskt godkännande via Regionala Etikprövningsnämnden i Stockholm (Dnr: 2017/1161-31).

Genom att svara på enkäten, godkänner du ditt deltagande i studien. Medverkan är frivillig och du kan när som helst avbryta ditt deltagande, dina svar kommer då inte att användas eller registreras. Svaren kommer att behandlas konfidentiellt så att inte obehöriga kan ta del av dem. Enkäten besvaras anonymt och information om dig kan inte spåras tillbaka till dig i slutgiltig text. Karolinska Institutet ansvarar för hanteringen av all data och skyddas av personuppgiftslagen (PuL).

#### **För mer information, kontakta:**

Josefin Lager, leg. sjuksköterska, barnmorskestuderande,  
[josefin.lager@stud.ki.se](mailto:josefin.lager@stud.ki.se)

eller

Gabriella Carlö, leg. sjuksköterska, barnmorskestuderande,  
[gabriella.carlo@stud.ki.se](mailto:gabriella.carlo@stud.ki.se)

Ansvarig för forskningsprojektet:  
Leg. Barnmorska, Med Dr. Ewa Andersson  
Institutionen för kvinnor och barns hälsa  
[ewa.andersson@ki.se](mailto:ewa.andersson@ki.se)

## **Appendix 3: Information letter**

### ***Informationsbrev***

Detta brev innehåller information om den forskningsstudie som du visat intresse för. Studien kommer att undersöka barnmorskors erfarenheter och förutsättningar i mötet med hbtq-personer vid vård under graviditet. Denna studie är del av ett forskningsprojekt där även hbtq-personers upplevelser av stöd från graviditets- och förlossningsvården vid föräldrablivandet undersöktes hösten 2017.

### ***Inbjudan***

Du som är barnmorska och jobbar på barnmorskemottagning/inom mödrahälsovård inbjuds till att delta i denna studie som syftar till att förbättra graviditets- och förlossningsvården för hbtq-familjer.

### ***Bakgrund***

Hbtq-personer har alltid skaffat barn, oavsett omgivningens lagstiftning och attityder. Idag skaffar allt fler hbtq-personer barn i Sverige. Det beror delvis på de förändringar i lagstiftning som skett de senaste 15 åren, som gett fler hbtq-personer juridiska och medicinska möjligheter att bilda familj. Förändrade familjemönster ställer nya krav på professionen inom mödrahälsovården.

Många hbtq-personers liv präglas fortfarande av heteronormativitet, homo-/transfobi och diskriminering, vilket även avspeglas i hälso- och sjukvården. Ett av graviditets- och förlossningsvårdens ansvarsområden är att stödja blivande föräldrar, och att verka för att främja hälsan hos alla barnalstrande familjer. Heteronormativitet inom vården kan tänkas påverka hbtq-personers möjligheter att få stöd i sitt föräldrablivande.

Ett ökande antal studier görs med fokus på hbtq-personer och deras erfarenheter av vård, även inom graviditets- och förlossningsvården. Merparten är ur ett samkönat lesbiskt perspektiv. Familjebegreppet är idag vidgat men fåtalet svenska studier har fokuserat på barnmorskans erfarenheter av att möta hbtq-personer i samband med vård under graviditet. Vi vill därför undersöka vilka förutsättningar som finns för god och jämlik reproduktiv vård i Sverige idag.

### ***Deltagande***

I det här forskningsprojektet kommer både hbtq-personer, personer som lever i hbtq-familjer, och barnmorskor att få delge sina upplevelser av att få/ge vård under graviditet och förlossning. Denna del av projektet består av ett webbaserat frågeformulär riktat till barnmorskor som jobbar med vård under graviditet på barnmorskemottagning/familjecentral/inom mödrahälsovården i Sverige.

### ***Frivilligt***

Det är frivilligt att delta i studien och du kan när som helst avbryta ditt deltagande utan närmare förklaring. Dina svar registreras ej vid ofullständigt ifylld enkät.

### ***Konfidentiellt***

Svaren kommer att behandlas konfidentiellt så att inte obehöriga kan ta del av dem. Enkäten besvaras anonymt och kan inte spåras tillbaka till dig i slutgiltig text. Karolinska Institutet ansvarar för hanteringen av all data och skyddas av personuppgiftslagen (PuL).

### ***Etiskt godkännande***

Projektet har etiskt godkännande via Regionala Etikprövningsnämnden i Stockholm.  
(Dnr: 2017/1161-31).

### ***Betydelse***

Studien kommer att ge värdefull kunskap om hur hbtq-personer och barnmorskor upplever mötet i vården runt graviditet och förlossning. Denna kunskap kan ligga till grund för planering av vårdens innehåll. Undersökningen kommer också att öka förståelsen för olika perspektiv på graviditet och barnafödande och ge underlag för vidare forskning.

Studien administreras av undertecknad vid Institutionen för Kvinnors och Barns hälsa vid Karolinska Institutet. Om du har frågor om studien är du välkommen att ringa, sms:a eller skicka e-post. Resultatet av studien kommer att presenteras i form av en vetenskaplig rapport.

Med vänliga hälsningar,

Ewa Andersson, leg Bm, Med Dr.  
Institutionen för Kvinnors och Barns hälsa  
Widerströmska huset  
Tomtebodavägen 18A, plan 8  
171 77 Stockholm  
Tel: 08-524 824 16  
Mobil 073-654 43 55  
E-post: [ewa.andersson@ki.se](mailto:ewa.andersson@ki.se)

Jag har tagit del av ovanstående text. Genom att svara på enkäten godkänner jag mitt deltagande i studien.

Länk till enkäten:

<https://survey.ki.se/Survey/9588>

## Appendix 4: Web survey



Denna enkät handlar om vilken erfarenhet och förutsättningar du som barnmorska har i mötet med HBTQ-personer vid vård under graviditet, inom mödrahälsövården.

*Liten eller ingen erfarenhet av patientgruppen är inget hinder för deltagande!*

Begreppsförklaring:

**Homosexuell:** En person som har förmågan att bli kär i och/eller attraherad av någon av samma kön.

**Bisexuell:** En person som har förmågan att bli kär i/eller attraherad av människor oavsett kön.

**Transperson:** En person som inte alls eller delvis inte identifierar sig med det kön en har fått tilldelat vid födseln. Att vara transperson kan också innebära att inte följa rådande normer för hur en person med ett visst juridiskt kön ska vara, förutsatt att personen själv identifierar sig som transperson. Begreppet rör könsidentitet och könsuttryck och har ingenting med sexuell läggning att göra.

**Queer:** Queer som identitet kan innebära en önskan att inte behöva definiera sitt kön eller sin sexuella läggning, medan en del använder queer som ett sätt att beskriva sin könsidentitet eller sin sexualitet.

(RFSL, 2018)

1. Senaste året har jag varit verksam inom mödrahälsövården i Sverige.

☐ Ja

☐ Nej det har jag inte. Ex p.g.a pension, sjukskrivning, föräldraledighet, tjänstledighet eller arbete utanför Sverige.

2. Hur gammal är du?

3. I vilket land är du född?

4. Hur länge har du bott i Sverige?

☐ <1 år

☐ 1-2 år

☐ 3-4

☐ 5-6

☐ >7 år

☐ Merparten av livet

5. Hur många år har du varit verksam som barnmorska?

☐ <2

☐ 2-5

☐ 6-10

☐ 11-15

☐ 16-20

☐ >20

6. Hur många år har du totalt jobbat på barnmorskemottagning/inom mödrahälsovård?

- ☐ <2  
☐ 2-5  
☐ 6-10  
☐ 11-15  
☐ 16-20  
☐ >20

7. Vilken är din sysselsättningsgrad på barnmorskemottagning/inom mödrahälsovård?

- ☐ Heltid  
☐ Deltid  
☐ Timanställd

8. Jobbar du även med annan verksamhet inom vården?

- ☐ NEJ  
☐ JA, Jag arbetar inom:

Kommentar

9. Ange postnummer för den mottagning där du är verksam

(Denna uppgift är frivillig)

10. Inglück HBTQ-undervisning i din barnmorskeutbildning?

- ☐ Ja  
☐ Nej

11. Vad har du för sexuell läggning?

- ☐ Homosexuell  
☐ Heterosexuell  
☐ Bisexuell  
☐ Inget av ovanstående  
☐ Vill ej uppge

12. Vilken könsidentitet har du?

- ☐ Kvinna  
☐ Man  
☐ Annat alternativ  
☐ Osäker  
☐ Vill ej svara

## 13. Har du erfarenhet av att vara transperson?

- ☐ Ja  
☐ Nej  
☐ Vet ej  
☐ Vill ej svara

## 14. Hur ofta möter du eller har kontakt med hbtq-personer som planerar eller väntar barn i ditt arbete på barnmorskemottagning?

- ☐ Aldrig  
☐ Enstaka tillfällen per år  
☐ Mindre än en gång per månad  
☐ Två till tre tillfällen per månad  
☐ Varje vecka  
☐ Dagligen

## 15. Jag känner mig bekväm med att vårda blivande föräldrar:

	I mycket hög grad	I hög grad	Delvis	I låg grad	Inte alls
I ett samkönat kvinnligt par	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ett samkönat manligt par	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
där den som bär barnet identifierar sig som man	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I en hbtq-familj där det finns fler än två planerade föräldrar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
där den gravidas partner identifierar sig som transperson	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 16. På min arbetsplats arbetar vi aktivt med hbtq-frågor (t ex utformning av lokaler, utbildningsmaterial, kompetensutveckling etc)

- ☐ I mycket hög grad  
☐ I hög grad  
☐ Delvis  
☐ I låg grad  
☐ Inte alls

## 17. Jag har nödvändig kunskap för att bemöta hbtq-personer (exempelvis definitioner och språkbruk)

- ☐ I mycket hög grad  
☐ I hög grad  
☐ Delvis  
☐ I låg grad  
☐ Ingen alls

## 18. Jag har de kunskaper som krävs om de specifika behov som hbtq-personer kan ha i samband med familjebildning

- ☐ I mycket hög grad  
☐ I hög grad  
☐ Delvis  
☐ I låg grad  
☐ Inte alls

19. Den hbtq-kompetens jag har inom reproduktiv vård, har jag i huvudsak fått genom:  
(Välj det alternativ som stämmer bäst in på dig)

- ☐ eget intresse, ex läst eller gått kurser på eget initiativ
- ☐ min grundutbildning(sjuksköterske-, barnmorskeutbildning)
- ☐ patienter som delat sina kunskaper och erfarenheter
- ☐ utbildning via arbetsgivare, ex internutbildning, kurser, temadagar etc.
- ☐ vänner och bekanta
- ☐ egna erfarenheter och upplevelser

20. Vår föräldrautbildning/vårt föräldrastöd är tillgänglig för olika typer av familjebildningar:

- ☐ I mycket hög grad
- ☐ I hög grad
- ☐ Delvis
- ☐ I låg grad
- ☐ Inte alls

21. Det informationsmaterial vi delar ut till blivande föräldrar riktar mot olika typer av familjebildningar:

- ☐ I mycket hög grad
- ☐ I hög grad
- ☐ Delvis
- ☐ I låg grad
- ☐ Inte alls

22. I vilken utsträckning är du nöjd med den vård din mottagning kan erbjuda hbtq-personer i samband med familjebildning?

- ☐ I mycket hög grad
- ☐ I hög grad
- ☐ Delvis
- ☐ I låg grad
- ☐ Inte alls

23. Studier har visat att hbtq-personer upplever att det finns brister inom den reproduktiva vården. Vad upplever du som barnmorska fattas för att kunna tillgodose jämlik vård? (Här kan du välja mer än ett svarsalternativ)

- ☐ Jag upplever inte att något saknas, vården är jämställd och ges på lika villkor.
- ☐ Grundläggande kunskap kring inkluderande språkbruk och bemötande av hbtq-personer.
- ☐ Fördjupad kunskap om reproduktion och hbtq-personers vägar till föräldraskap. Ex: konception och familjejuridik.
- ☐ Praktisk erfarenhet, fler patientmöten.
- ☐ Annat, beskriv med egna ord:

Kommentar

## Appendix 5: Participant demographics

<b>Participant Demographics</b>	<i>n</i>	%
<b>Age</b>		
29-39	16	30
40-49	21	39
50-59	13	24
60-65	4	7
<b>Country of birth</b>		
Sweden	51	94
Other European country	3	6
<b>Years living in Sweden</b>		
>7	3	6
Majority of life	51	94
<b>Residence</b>		
Large city	17	31
Medium sized town	13	24
Urban area	14	26
Did not answer	10	19
<b>Sexual identity</b>		
Bisexual	1	2
Heterosexual	50	93
Homosexual	2	3
Do not want to display	1	2
<b>Gender identity</b>		
Woman	54	100
<b>Experience of being trans</b>		
No	53	98
Yes	1	2
<b>Years working as midwife</b>		
<5	12	22
6-10	13	24
11-15	8	15
16-20	5	9
>20	16	30
<b>Years working at midwifery units</b>		
<2	7	13
2-5	18	33
6-10	12	22
11-15	8	15
>16	9	17
<b>Employment</b>		
Full time	34	63
Part time	19	35
By the hour	1	2
<b>Also working within other healthcare fields</b>		
No	39	72
Yes	15	28