King's Research Portal

*DOI:*
10.1016/j.midw.2021.103050

*Document Version*
Peer reviewed version

Link to publication record in King's Research Portal

*Citation for published version (APA):*
Arias, T., Rayment-Jones, H., Greaves, B., McArdle, J., & Walker, S. (2021). Cultivating awareness of sexual and gender diversity in a midwifery curriculum. *MIDWIFERY*, *101*(103050), [103050]. https://doi.org/10.1016/j.midw.2021.103050

**Citing this paper**
Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

**General rights**
Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

•Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
•You may not further distribute the material or use it for any profit-making activity or commercial gain
•You may freely distribute the URL identifying the publication in the Research Portal

**Take down policy**
If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 26. Oct. 2023

Elsevier Editorial System(tm) for Midwifery

Manuscript Draft Manuscript Number: YMIDW-D-20-00544

Title: Cultivating awareness of Sexual and Gender Diversity in a Midwifery Curriculum

Article Type: Original Research

Keywords: Midwifery education; sexual,gender diversity Corresponding Author: Ms. Teresa Arias, MSc Corresponding Author's Institution: King's College London

First Author: Teresa Arias, MSc Order of Authors: Teresa Arias, MSc; hannah Rayment -Jones, RM, MSc, PGCE, FHEA; Bethan Greaves, RM BA BSc; Jessamyne McArdle, RM BSc BA; shawn walker, RM PhD

Abstract:

Abstract Objective: To explore the perspectives of student midwives, midwifery educationalists and midwifery clinicians from and connected to one University in order to identify strategies to enhance awareness of sexual and gender diversity in a pre- registration midwifery curriculum.

Design: A mixed method study including an online survey and a series of focus groups Setting: One University in London Participants:47 survey respondents and 16 focus group participants

Findings: Two Inductive themes were developed from the data analysis: Practising Open Mindedness and Cultivating Openness and four sub themes; Making Assumptions, Developing self awareness, Challenge and Discomfort and Safe spaces. Participants proposed learning strategies that they thought would facilitate cultivating openness and open mindedness

AUTHOR VERSION

# Cultivating awareness of Sexual and Gender Diversity in a Midwifery Curriculum


## Abstract

Objective: To explore the perspectives of student midwives, midwifery educationalists and midwifery clinicians from and connected to one University in order to identify strategies to enhance awareness of sexual and gender diversity in a pre- registration midwifery curriculum.

Design: A mixed method study including an online survey and a series of focus groups

Setting: One University in London

Participants:47 survey respondents and 16 focus group participants

Findings: Two Inductive themes were developed from the data analysis: Practising Open Mindedness and Cultivating Openness and four sub themes; Making Assumptions, Developing self- awareness, Challenge and Discomfort and Safe spaces. Participants proposed learning strategies that they thought would facilitate cultivating openness and open mindedness.


AUTHOR VERSION

## Introduction

Existing evidence shows that health is generally worse for Lesbian, Gay, Bisexual, Transgender, Queer /Questioning (LGBTQ+) people than for the rest of the population and that sexual orientation or gender identity can have a significant impact on physical, mental and sexual wellbeing (NIESR 2016).The numbers of LGBTQ+ people in the United Kingdom (UK) having babies is unknown but data extracted from the fertility clinics (HFEA 2019) indicate that lesbian couples are one of the fastest growing groups to access fertility treatment and maternity care, increasing by up to 20% each year in the last decade (Darwin & Greenfield 2019). The numbers of birthing people who identify as male (transmen) or non-binary are presently not known however referrals to Gender Clinics in the UK are rising and therefore it is logical to consider that childbearing transmen may also be on the rise (Riggs et al 2016).

In the UK, healthcare providers have a legal obligation under the Equality Act 2010 to provide services that treat LGBTQ+ people without discrimination. The Unhealthy Attitude report commissioned by Stonewall (Summerville 2015) highlighted, however, that LGBTQ+ people continue to face barriers to accessing care with 1 in 8 people experiencing unequal treatment by healthcare professionals (HPs) and almost 1 in 4 having witnessed discriminatory remarks against LGBTQ+ people by HPs.

The limited literature on perinatal experiences of LGBTQ+ people inform us that though many HPs will endeavor to be kind and respectful (Hammond 2014), common challenges relating to communication can be detrimental to the person's experience. HP's embarrassment or anxiety related to using the correct terminology (Hoffkling et al 2017) can result in LGBTQ+ people feeling responsible, not only for the HPs comfort (Spidsberg 2007) but for educating them ( Xavier 2007). Lesbian women and transmen have reported experiencing inappropriate and intrusive questioning (Macdonald et al 2016; Spidsberg & Sorlie 2011; Dahl et al 2012). Additionally, lesbian women have expressed uncertainty as to whether poor experience of midwifery care, for example, not receiving enough breastfeeding support or not having their perineum inspected for signs of infection, have been related to their sexuality or other factors (Lee et al 2011).

Same sex couples experiences of HPs have ranged from subtle homophobia (Dahl et al 2012) to marginalization and invisibility as a result of HPs assumptions of heterosexuality (Walker et al 2017, Hayman 2013). In addition, studies suggest that pregnant and birthing transmen may experience feelings of loneliness, exclusion, isolation during childbearing and gender dysphoria(Light et al 2014; MacDonald *et al* 2016; Obedin-Maliver and Makadon, 2016).

A recent A UK based survey of medical students (166) highlighted that 85% reported a lack of LGBTQ+ related education (Parameshwaren et al 2017). International studies have explored health curricula content (Lim et al 2015; Sequeira et al 2012; Obedin- Maliver et al 2011) and evaluation of learning after LGBTQ+ specific education (Vance et al 2017; Grosz et al 2017). Improvement in knowledge have been noted by HPs in these studies however most have not included the participation of midwives.

AUTHOR VERSION

The lack of HPs preparedness to provide safe, sensitive and knowledgeable health care has resulted in recommendations to include LGBTQ+ health related issues within a health curriculum (Wilton & Kaufmann 2011; McCann & Brown 2018). Stonewall has identified training needs for health professionals with specific recommendations for Royal Colleges and Nursing and Midwifery Council (NMC) to revisit: '*curricula, standards and training to ensure that teaching and ongoing compulsory training includes …providing LGBT inclusive care including specific information on trans inclusive care*' (Bachmann & Gooch 2018 pg 15) The new standards for pre-registration midwifery education (NMC 2019) make no specific recommendations for inclusion of LGBTQ specific perinatal education.

Midwifery education has a role in preparing students to meet the diverse needs of the population that they serve. The lack of evidence related to LGBTQ+ perinatal care and limited guidance for UK midwifery educations motivated the research team to embark on primary research.

Based on the principles of curriculum co-design, this study aimed to sensitively explore the perspectives of student midwives, midwifery educationalists and midwifery clinicians from and connected to a London University in order to identify strategies to enhance awareness of sexual and gender diversity in a pre- registration midwifery curriculum in a sensitive and culturally appropriate way.

## Methods

The COREQ criteria has been utilised to present the study team, design, analysis and findings. The research team was composed of one PhD midwife (SW- PI), a Senior Teaching Fellow HEA (TA), an NIHR Doctoral student and midwife (HR-J) and three midwifery students one from each year group of the BSc Midwifery programme (JM,BG & EC). Midwifery student researchers were included with the aim of enhancing their understanding of the research process.

The research was led by an experienced researcher (SW) with previous experience of focus group research and qualitative enquiry. Given the varied levels of experience within the team, we created an on-going training and support plan to enable each team member to participate in all aspects of the research. Ethical approval for this study was granted by the authors' university's research ethics committee.

To commence, the team needed to understand the experiences of the students and any identified gaps in learning to provide sensitive and respectful care to LGBTQ+ people. Baseline demographic data including age group, year of study, gender identification and experiences of caring for LGBTQ+ people were collected in the form of an online survey. This was placed, for easy access, on a University online platform for its familiarity to the students and its capability to preserve anonymity. The online platform provided detailed information about the survey. All students (250) were able to see the information and participation was interpreted as consent. A total of 47 students participated. The survey asked a mixture of closed ended questions and free text questions related to their experiences of providing care for LGBTQ+ people and participants were asked to identify education that would improve their midwifery care for this community.

AUTHOR VERSION

Focus groups (FGs) were chosen as the second data collecting strategy. FGs can generate considerable amounts of data in a short period of time, participant contribution can be loosely guided and clarified when needed, data can be used to inform the next focus group. Pragmatic reasons also meant FGs were a good but appropriate option as this study was not funded and this form of data collection is relatively inexpensive.

The team needed to attract student midwives, midwives and Faculty staff therefore purposive sampling was utilised. Posters publicising the FGs with researcher's contact details were placed around the common teaching areas and emails were sent via the Faculty administrative hub introducing the study and inviting all students to participate in the first and subsequent focus groups. Posters were sent to Heads of Midwifery (HOM) and consultant midwives (CMs) to display in the clinical areas in order to attract midwives from the link Trusts. Finally, faculty staff were invited to participate in a separate focus group via email. One clinician came forward to participate but was unable to attend on the day.

Three focus groups were held between May-July 2018 with approximately four to seven participants in each FG. These groups were facilitated by two members of the research team but these changed each time to share the experience. The focus group relies heavily on assisted discussion to produce results therefore the moderation of the discussion is important as the quality of the discussion relies on the skill of the moderator (Wilbeck et al 2007). The sharing of moderation may have impacted on quality of discussion however a benefit was that each group had a FG moderator from the target population and this may have put participants at their ease.

FG participants were provided with a detailed participant information form and a signed consent form confirmed their willingness to participate. Participants were given two weeks from the FG participation in which to withdraw. This time limit was set as the methodology was iterative meaning that the data was built on in the subsequent focus group. The groups took place in University rooms for ease of access and lasted between 60 -90 minutes. The groups were audio recorded and promptly transcribed and field notes were taken. This data was stored on a secured shared drive only accessible to the research team. FG participants were anonymised on transcription.

An online reflexive journal was used to register thoughts on transcriptions and monthly research team meetings were set up to on analysis. These strategies were initiated in an attempt to enhance rigour in the research process (Tobin & Begley 2004)

Comparisons have been made between FGs and Problem Based Learning (PBL) groups (Wilbeck et al 2007). PBL typically uses scenarios to motivate the participants to work out what the problem/question is resulting in an identification of learning needs. As the focus of the study was to identify learning needs to cultivate sexual and gender diversity awareness, the team was interested not just in the content of discussions but also what the participants were 'trying to learn'. Complex open- ended stimulus material, in keeping with PBL, was used to encourage interaction and collaborative learning and the questions generated from the FGs were built on in the next FG.

AUTHOR VERSION

A structured approach was used to analyse the data. Thematic analysis using Braun and Clarke's approach (2006) and a description of the process follows.  Data analysis was led by JMc but all authors contributed in discussing and agreeing the themes. Phase 1 Familiarisation: SW, JMc and BG transcribed the recordings verbatim., SW and TA listened to all the audio recordings whilst reading transcriptions to note any inconsistencies. Phase 2: Initial coding: J Mc coded each line of the transcripts. Data was organised using NVivo 11 software Phase 3: Searching for themes: JMc, SW and TA reviewed each transcript and JMc & TA refined themes Phase 4: Reviewing the themes: JMc and TA mapped data to identify prevalence of themes. Theme names were drawn from the data. Phase 5. Defining and naming themes: thematic trees were devised for two major inductive themes and findings were written up as descriptive accounts with accompanying illustrative quotations. The description of themes incorporated minor themes.

## Findings

There were two themes and 4subthemes:

1)Practising Open mindedness with sub themes: Making Assumptions and Developing self-awareness

2) Cultivating openness with sub themes: Challenge and Discomfort and Safe spaces

AUTHOR VERSION

The survey and FG data highlighted that students had mixed experiences of providing LGBTQ+ midwifery care with some observing judgemental remarks by HPs which conveyed a lack of empathy. Survey participants were asked to identify gaps in their knowledge that could be enhanced to improve care for this community. Many expressed their lack of confidence in using the correct terminology so as not to offend however one comment communicated a strong response to this question:

*'I am a decent person and I know how to treat people with dignity and respect, regardless of their gender and sexual orientation, class, race, religion etc. I do not believe that I need to be re-educated on how to treat others in a humane way'* S1.

Throughout the research process, survey and FG respondents were at pains to acknowledge that the majority of the care they had witnessed came from 'a loving place'. Kindness and empathy are qualities expected of HPs however the subsequent FGs discussions challenged the idea that these qualities should be assumed or sufficient in providing LGBTQ+ people with appropriate, sensitive care.

## Practising Open mindedness

### Making assumptions

Empathy was identified as essential in providing sensitive care by Focus Group (FG1) participants and open- mindedness was identified as necessary to achieve this. FG participants viewed open-mindedness as an attitude that doesn't make assumptions and one that accepts difference:

*"I think maybe, a key thing that goes with open mindedness is to never assume". FG2 A. "Diversity, as a health care professional, is less about looking at people and making assumptions and more about asking the questions because that's the key"* FG1 C.

The fear of 'getting it wrong' frequently arose in the FGS and though consensus was reached about not making assumptions, people started to share their own stories:

*"I felt stupid that I had assumed that her partner wouldn't be a man. But yeah, I think by default you kind of do, and that's kind of the nature of being a minority*" FG1 A.

Participants agreed that there was a 'human' tendency to make assumptions and that judgements needed to be 'checked':

*"No but you can't help it! So it's like you judge, but then it's how you are going to..I think we have to be aware of our judgements to get to know ourselves really well"* FG2D. The cost on the individual of becoming aware of one's judgements was also expressed:

"*It's just really disorientating to have to kind of question your own assumptions all the time like.. isn't it? Like it's just a bit tiring sometimes*" FG1 B.

One participant FG2 A acknowledged that human error was common, offering her own story of making assumptions, however societal norms were posited as influential in creating expectations:

*"Yeah, because everybody's human – I'm married to a woman and I still presume other people are married to men, all the time, all the time. Because that's society, that's what it does to us, it's not a fault of anybody's."* FG2 B.

### Developing self- awareness

Participants were asked to reflect on how successful the midwifery programme had been in terms of enhancing self- awareness:

"*In clinical practice, students are encouraged to think 'Why are you doing this? Are you doing this because it is easier for you or are you doing this because it is the right thing for the family?"* FG3 C

The academic component of the curriculum however was considered almost too focused on midwifery:

"*I don't think the curriculum does this very well at all…I think it gives us phrases that can make us sound like we are self aware but I don't think it teaches us self-awareness very well' FG3 A.*

This participant suggested that for students to enhance their self-awareness, education needed to include a stronger emphasis on the wider societal and political landscape as a way of understanding the influences on personal behaviours in addition to the institutional norms.

The National Health Service (NHS) emerged as a continuing and logical 'backdrop' to discussions as most UK HPs are trained in this institution with student midwives spending

AUTHOR VERSION

50% education in NHS Trusts. There seemed to be a suggestion that the NHS deliberately cultivated an image of neutrality in order to respond to the diverse needs of the population. This was interpreted as a 'blank canvas' by FG2 members that did not convey any cultural allegiances or hold pre-existing judgements. Discussions provided interesting insights into how this image was interpreted into best practice:

"*When you care for someone who's pregnant, you're looking at them as an individual, regardless of who their partner is, how they got pregnant, what mental health issues they have, and then you tailor the care to meet them"* FG1 C.

Another equated neutrality to providing no difference in care: "*but ultimately when we're in practice, you have to accept everyone and care for everyone in the same way."* FG1 A.

The NHS as neutral was not a concept that every participant agreed with. Faculty members in FG2 pondered over the role of midwifery education in socialising the student into a culture that assumes heterosexuality. The exasperation by one revealed the enormity of the task to counteract this heteronormative, cultural influence:

*"there's also this sort of other ether type influence that's coming from all sorts of other sources and some of them are quite subtle. A bit of media thrown in, a bit of the written guidance, a bit of the literature, the kind of absence of literature and research around these issues, the absence in the curriculum explicitly with very definite sort of words of diversity".* FG2 C

## Cultivating Openness

### Challenge and Discomfort

Faculty participants in FG 2 appeared to want to learn what their responsibilities might be in educating students to be open minded. The topic of sexual and gender diversity was perceived as a highly sensitive one. Student cohort sizes are large, approximately 100, and content is delivered in mainly lecture style. Debate ensued on the best approaches to exposing and challenging discriminatory views:

*'I think we need to be able to give people the.. to create a learning space where they can explore their own ideas… I think people should feel free to express an opinion but I think we do need to give the lead around equality and diversity and gender diversity and actually really kind of shape, how, 'this is the expectation of you…and if that means taking a lead and saying 'this is what's ok, this is what's not ok'. I don't think we can be neutral in the classroom, completely…I think we need to…yeah.. give the opportunity to broaden people's minds"* FG2 E.

A fellow faculty member conveyed discomfort about the role of 'challenger' as potentially 'shaming' the student. Setting expectations was offered as an alternative strategy that could feel safer for both students and the lecturer:

*"it's horrible to use the word ground rules – but getting the expectations clear at the beginning would help that, because you'd sort of be able to discuss more openly 'what will*

AUTHOR VERSION

*we do if…'… there wouldn't be this sense of 'oh my goodness'… I don't want to blame or shame"* FG2 C

The lack of familiarity and knowledge with particular aspects of sexual and gender diversity, such as correct terminology, concerned faculty participants as they felt pressure to 'know it all':

"*I'm really conscious of my age and that there's this whole set of language.. " FG2E*

*"People don't want to put their foot in it and feel embarrassed. S0 that's the thing, but how does one know?"* FG2D

Though faculty members showed their discomfort in not knowing, it was deemed important that they role modelled comfort in not knowing. It was not only an unrealistic expectation that they would hold all the knowledge, but students will be faced with situations of uncertainty and need to develop own strategies for this. Something which educators felt was not adequately addressed in the current curriculum:

"*And in terms of like learning about open-mindedness, one of the things that's also been coming out is how important it is for lecturers and teachers as facilitators to these discussions to be open-minded themselves to be open to learning new things, to be open to being able to say, 'I don't know' to model the type of comfort with uncertainty that we hope that students will be able to get".* FG 3 A.

Discomfort and vulnerability were commonly perceived as being an integral part of the process to gaining self- awareness and opening the mind. Participants were asked to recall if there had been an educational experience that had ever led to a change of mind. As they reflected, participants agreed that being presented with a different perspective could sometimes arouse feelings.

A final year student recalled an educational debate, from the previous year, about the right to choose elective caesarean section in which one person in the whole cohort spoke up in support of it:

"*it was an entire cohort against one person who'd wanted an elective section just for choice……it's something that I'm really ashamed of…I don't think we really listened to the reasoning behind why…".* The student explained that they had seen the person recently and apologised for '*ganging up on them ..the person was like.. 'it's really interesting cause I think I'm kind of actually more the other way' "* FG3 A.

The concepts of discomfort leading to a change of mind continued in another student's account. Recalling a video interview with a free birthing woman:

*"we were there to learn about midwifery and so like to… to hear something like where we were just not involved was like maybe a bit scary?....it was always in the back of my mind this kind of awareness that like people giving birth, you know ( laughs) like, irrelevant of the proximity to a midwife nearby …it was just like a build up and then to hear kind of, quite a lot of different views… hearing reactions.. I think I realised… like my mind was changed to the point whereby, it's just.. this is someone's choice' FG3 B.*



AUTHOR VERSION

These two participants described a period of 'percolation' as opinions were reformed and both alluded to the influence of the '*pack mentality*':

"*I think it's quite hard to have an opposing view if a whole class is thinking one thing.. you sort of go with that. It takes you to be out of the pack to consider what is happening'* FG3 A.

## Safe spaces

Challenge and discomfort though part of the process of learning, stimulated discussion on optimal learning spaces. There appeared to be consensus that students needed 'spaces' or opportunities where people could feel safe in expressing opinions. The concept of 'safe spaces' in various formations including destabilised classroom hierarchies, where the educators were participants in the learning and spaces for making mistakes were explored such as in Forum theatre where lecturers played parts in a clinical scenario and students could stop the action and advise on the communication or the care plan.

Participants made suggestions over the three FGs for learning strategies and content to cultivate awareness of sexual and gender diversity (Table 1). Specific information was deemed important in 'preparing' students to provide basic respectful clinical care to LGBTQ+ people however reflexive, preparatory work to enhance self-awareness was identified as essential.

An educational space that encourages love, open-mindedness and self-awareness was proposed by FG participants as one that allows people to be vulnerable, to make mistakes and to deal with those struggles in smaller groups where relationships could develop over time and give permission to form and reform opinions:

*"it's around kind of being vulnerable. And I do completely agree with you about needing to have different groups and sometimes with people that you don't speak to all the time, but I also think that you're more vulnerable around people that you know." FG3 A*

This space was also identified as important to safely admit a lack of knowledge on LGBTQ+ issues:

*" I think, it's also important to remember that it is ok to say 'I don't know' and stuff like that, because, you know, for a lot of people, unless you are personally interested in learning about this gender sexual diversity etc. Kind of, urm, in your own time, then it can sometimes maybe be the first time you've come across some of these things'"* FG3 B

## Discussion

HPs' attitudes and assumptions have been described by LGBTQ+ people as barriers to accessing fair and equitable healthcare (O'Neill et al. 2013; Pyne 2012, Lee et al. 2011). This may be especially true of maternity services where gender roles and behaviours within the family have historically been understood as binary inherently masculine or feminine and thus shaping social expectations and understandings of pregnancy, birth and parenting.

The opportunity to develop awareness of how experiences and beliefs have influenced attitudes in clinical practice was raised as an important factor in enhancing and cultivating sexual and gender diversity awareness. Reflecting and examining one's own assumptions,

AUTHOR VERSION

values and beliefs is the first step towards 'cultural competency' (Dorsen & Van Devanter 2016) This finding concurs with other studies that offer strategies to midwives providing care to LGBTQ+ people (Walker et al, 2016) and contributes to a wider conversation about self-awareness, and how 'attitudes, beliefs and preconceptions' influence quality of healthcare for LGBTQ+ people (McCann & Brown 2018, 8).

In our study, participants' descriptions of open-mindedness often spilled over from caring for LGBTQ+ people to caring for all of the perceived differences that a midwife might encounter in their practice. They saw the relevance of developing self-awareness and open mindedness to care of every individual. Though this can be viewed as positive, it mirrors a certain type of cultural competency training that groups together sexual orientation and gender under the general umbrella of diversity (Dorsen & Van Devanter 2016) which may result in the specific needs of this community not being acknowledged.

Cultural safety, builds on enhanced awareness. It requires the HP to reflect on their own unique cultural background in order to understand the impact and power of professional and personal dynamics on healthcare relationships (Phiri 2010). A health curriculum and its content should foster a critical consciousness of the self, others and the world in order to address health inequity (Muntinga et al 2015) and this cannot be done without helping the student to reflect on their own norms and values and the systemic issues that sustain differences in health outcomes (Muntinga et al 2015)

The educational strategies and moments that were recalled by students as contributing to their minds being 'opened' or 'changed' involved a degree of emotion or discomfort. Emotional engagement during educational encounters is recognised as being beneficial during the learning process and aligns with theories grounded in transformational learning (TL) (Hall & Mitchell 2017). Transformational learning has been defined as a strategy '*which involves a fundamental and irreversible shift in perspective'* (Heddy & Pugh 2015 cited by Hall & Mitchell 2017) involving a fundamental alteration in personality ( Boyd 2009) and scholars have agreed that, along with content acquisition, TL should be influencing students' perspectives (Boyd 2009). Though aspirational, these life changing learning events are difficult to achieve and Heddy & Pugh 2015 posit that a series of Transformational experiences that generate small scale transformation may be as effective.

Faculty focus group members hinted that there may be some discomfort or lack of readiness for teaching LGBTQ+ focused material due to lack of experience and knowledge as demonstrated in other existing research about healthcare for LGBTQ+ people (Carabez et al 2015; Lim et al 2015; McCann & Brown 2018). A collaborative approach to learning in healthcare creating specific content with LGBTQ+ students and parents may facilitate a 'deep reflective level of learning' (Clouston 2018, 1017). This type of learning makes demands on educators to be critically engaged and self-reflective, and to be open to dialogue with students (Moony & Nolan 2006).

Participants considered the learning strategies that could cultivate open mindedness. As in our focus group findings, the combination of didactic learning and interactive pedagogical approaches such as group discussion, videos, case studies have been proposed, in the

AUTHOR VERSION

literature, as more likely to result in attitudinal change ( Higgins et al 2019). Perspective taking from films and reading fiction enables people to see the world from the protagonist's lens. A variety of media and contact with the LGBTQ+ community, may have the biggest influence on reducing blatant and subtle prejudice (Cramwinckel et al 2018)

In each of the focus groups 'safe spaces' were remembered as educational spaces or occasions where alternative view points were presented. Participants recalled specific moments when they felt discomfort as a result of being challenged by these views and a variety of spaces were proposed as 'safe spaces'. They could be small, intimate groups for sharing opinions and listening to those of others, or they could be larger groups where students could let opinion formation happen around them.

As an educational strategy, creating multiple versions of and opportunities for 'safe spaces' contributes to a wider conversation about creating safe learning environments in healthcare education to engender the critical reflection and thinking that leads to compassion and caring values (Clouston 2018). Safe space pedagogy has, at times, been translated into avoidance of controversial issues in the classroom, jeopardising the opportunity to develop a critical approach (Flensner et al 2019; Barret 2010; Boostrom et al 1998). Providing expectations of safety may be counterproductive, therefore, to the development of critical thinking as discomfort and challenge are integral to the process of developing these intellectual skills (Barret 2010; Boostrom et al 1998). This poses a challenge for midwifery educators as the human rights of LGBTQ+ students need to be considered as alternative view points shared in the classroom may result in painful experiences. Educators can influence the safety of the educational space by demonstrating explicit allyship (see Glossary) and setting clear ground rules that include respectful communication. Educational technologies such as password protected blogs or online journals could allow midwifery students to explore their assumptions and biases with faculty members in private (Walker et al 2016, 738). Safety in the classroom cannot always be guaranteed (Bruggemann & Moddelmog 2002) and alternatives such as 'brave spaces' (Arao & Clemens 2013) and 'classroom of disagreement' (Iversen 2018) have been suggested to better convey the requirement of student and educationalist to be courageous and the expectation of disagreement.

AUTHOR VERSION

## Study limitations

A limitation of this study is that this small sample is aligned to one University. The absence of clinical midwives as participants is a significant limitation to this study as their perceptions and experiences of providing care for LGBTQ+ people may have provided valuable insights into the learning needs of this group. There is a lack of research into the midwife's perspective of caring for LGBTQ+ people (Spidsberg & Sorlie 2011) and their role in training student midwives means that any gaps in their education are likely to impact significantly on students.

## Recommendations

Although the results of this small exploratory study cannot be generalised, it offers valuable insights into how midwifery training could be enhanced to increase confidence in caring for childbearing LGBTQ+ people. FG participants acknowledged early on that the midwifery care

to LGBTQ+ often came from a position of love however this study supports the notion that love and kindness are not enough and that specific teaching and learning about the LGBTQ+ community is necessary. Further research should invite the participations of LGBTQ+ families and midwives in order to gain insight into their experiences and inform midwifery education.

## Conclusion

The numbers of LGBTQ+ people giving birth are increasing in the UK and there is a lack of evidence that guides optimal midwifery practice for this group. Significant health disparities exist, in part, due to previous experiences of insensitive and inappropriate care reducing the motivation to access healthcare. Learning that emerged from this research study contributes to literature on midwifery education and LGBTQ+ midwifery care however the key points are relevant to care for all families we encounter. The findings from this mixed method exploratory study propose that students need learning opportunities that develop self-awareness and open mindedness. The learning strategies proposed may help develop these qualities.

AUTHOR VERSION

Table 1. Educational content and learning strategies generated from focus group.

| LGBTQ+ specific Content | What are the optimal ways in which we can learn it? |
|---|---|
| LGBTQ+ maternity experience/research<br><br>LGBTQ+ Health issues and health disparities<br><br>Glossary of terms including gender pronouns<br><br>Assisted conception and reproductive rights<br><br>Infant feeding eg co mothers' and transmen's preparation to breastfeed or chestfeed<br><br>Exposing heteronormativity in<br><br>workplace practices/environment and heteronormative language in policy and guidance documents | • Storytelling<br>• Videos<br>• Forum Theatre<br>• Role play<br>• Outside speakers to tell their stories<br>• Debates and discussions: opportunity to listen to a different perspective<br>• Case studies where diversity is reflected eg same sex couple and their baby<br>• Blogs: private opportunities for students to confront own responses to sexual and gender diversity<br><br>• Images in teaching resources that reflect sexual and gender diversity to normalise and stimulate discussion<br><br>• Specific lectures about LGBTQ maternity care<br>• Small tutorial groups where students may feel able to reflect on own attitudes |

AUTHOR VERSION

## Table 2.Glossary of terms: Selected mainly from Stonewall's Glossary of terms https://www.stonewall.org.uk/help-advice/glossary-terms

| Term | Meaning |
|---|---|
| Allyship | Allyship is about building relationships of trust, consistency and accountability with marginalised individuals and/or groups of people though not a member of that group. This can be done by endeavouring to understand the struggle and using one's voice to support the person/group. (https://www.england.nhs.uk/about/equality/allyship/) Retrieved 15/02/21 |
| Bi | Bi is an umbrella term used to describe a romantic and/or sexual orientation towards more than one gender. |
| Cisgender | Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people. |
| Gay | Refers to a man who has a romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian |
| Gender | Often expressed in terms of masculinity and femininity, gender is largely culturally determined and is assumed from the sex assigned at birth |
| Gender Dysphoria | Used to describe when a person experiences discomfort or distress because there is a mismatch between their sex assigned at birth and their gender identity.<br>This is also the clinical diagnosis for someone who doesn't feel comfortable with the sex they were assigned at birth. |
| Gender Identity | A person's innate sense of their own gender, whether male, female or something else (see non-binary below), which may or may not correspond to the sex assigned at birth. |
| Gender Pronoun | Words we use to refer to people's gender in conversation - for example, 'he' or 'she'. Some people may prefer others to refer to them in gender neutral language and use pronouns such as they/their and ze/zir |
| Heteronormativity | Assumption of heterosexuality as the norm (Goldberg et al 2011) |
| Homophobia | The fear or dislike of someone, based on prejudice or negative attitudes, beliefs or views about lesbian, gay or bi people. Homophobic bullying may be targeted at people who are, or who are perceived to be, lesbian, gay or bi |
| LGBTQ+ | The acronym for lesbian, gay, bisexual, transgender, queer or questioning with plus including all other sexual orientation such as pan sexual, asexual and gender identities. |
| Non Binary | An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely. |

| | |
|---|---|
| Queer | Queer is a term used by those wanting to reject specific labels of romantic orientation, sexual orientation and/or gender identity. It can also be a way of rejecting the perceived norms of the LGBT community (racism, sizeism, ableism etc). Although some LGBT people view the word as a slur, it was reclaimed in the late 80s by the queer community who have embraced it |
| Sex | Assigned to a person on the basis of primary sex characteristics (genitalia) and reproductive functions. Sometimes the terms ‘sex’ and ‘gender’ are interchanged to mean ‘male’ or ‘female’ |
| Trans | An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.<br>Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender. |

AUTHOR VERSION

References

Arao, B., & Clemens, K. 2013. From safe spaces to brave spaces: A new way to frame dialogue around diversity and social justice. In L. M. Landreman (Ed.), The art of effective facilitation Stylus Publishing, LLC pp. 135-150.

Bachmann and Gooch 2018 LGBT in Britain Health Report https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf accessed July 15th 2020

Beagan BL; Fredericks E & Goldberg L 2012 Nurses' work with LGBTQ patients: "They're just like everybody else, so what's the difference?" Canadian Journal of Nursing research 44, 44-63.

Boostrom R.1998. "Safe Spaces": reflections on an Educational Metaphor. Journal of Curriculum Studies 30(4) 397-408 https://doi.org/10.1080/002202798183549

Boyd, B. L. 2009. Using a case study to develop the transformational teaching theory. Journal of Leadership Education, 7(3), 50-59.

Bosse J., Nesteby J., Randall C .2015 Integrating sexual minority health issues into a health assessment class. Journal of Professional Nursing 3 (6) 498-507 DOI 10.1016/j.profnurs.2015.04.007

Brueggemann B J., & Moddelmog DA.2002. Coming-out pedagogy: Risking identity in language and literature classrooms. Pedagogy: Critical Approaches Teaching, Learning, Language, Composition, and Culture, 2(3), 311-335.

Carabez R., Pellegrini M., Mankovitz A., Eliason M., Ciano M., Scott. 2015 "Never in all my years…": Nurses' education about LGBT Health. Journal of Professional Nursing. 31 (4):323-9.

Braun, V. and Clarke, V. 2006 Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101. ISSN 1478-0887 Doi:10.1016/j.profnurs.2015.01.003

Clouston T 2018. Transforming learning: Teaching compassion and caring values in higher education. Journal of Further and Higher Education 42 (7)1015-1024. 10.1080/0309877X.2017.1332359 file

Cramwinckel F., Scheepers DT., van der Toorn J. 2018. Interventions to reduce blatant and subtle sexual orientation-

AUTHOR VERSION

and gender identity prejudice (SOGIP): Current knowledge and future directions. Social Issues and Policy review 12 (1): 183-217 https://doi.org/10.1111/sipr.12044

Dahl B., Fylkesnes AM.,Sorlie V., Malterud K 2013 Lesbian women's experiences with healthcare providers in the birthing context: A meta-ethnography Midwifery 29:674-681 doi: 10.1016/j.midw.2012.06.008

Darwin Z., Greenfield M. 2019. Mothers and others: The invisibility of LGBTQ people in reproductive and infant psychology. Journal of Reproductive and Infant Psychology. 37:4. 341343 DOI: 10.1080/02646838.2019.1649919

Dorsen C & Van Devanter N 2016 Open arms, conflicted hearts; nurse-practitioner's attitudes towards working with lesbian, gay and bisexual patients. Journal of Clinical Nursing 25, 3716-3727

Elliott MN; Kanouse DE;Burkhart Q; Abel GA; Lyratzopoulos G; Beckett MK; Schuster MA; Roland M 2015. Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey Journal of General Internal Medicine 2015 Jan; 30(1): 9–16. doi: 10.1007/s11606-014-2905-y accessed 16th July 2019

Flensner K., Von der Lippe M 2019. Being safe from what and safe for whom? A critical discussion of the conceptual metaphor of 'safe space' Intercultural Education. 30 (3) 275-288. DOI.org/10.1080/14675986.2019.1540102

Goldberg L., Harbin A., Campbell S. 2011. Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. Sexualities 14 (2) 173-192

Grosz AM., Gutierrez D., Lui A., Chang J., Cole-Kelly K., Ng H 2017. A student led introduction to lesbian, gay, bisexual and transgender health for first year medical students.Fam.Med.49 (1)52-56

Hall J., Mitchell M. 2017. Educating student midwives around dignity and respect. Women and Birth. 30:214-219. DOI.org/10.1016/j.wombi.2017.04.007

Hammond C. 2014. Exploring same sex couples' experiences of maternity care. British Journal of Midwifery 22 (7) 495-500

Hayman, B., Wilkes, L., Halcomb, E. J., & Jackson, D. 2013. Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. Contemporary Nurse, 44(1), 120–127. doi:10.5172/conu.2013.44.1.120 cannot upload

Heddy BC., Pugh KJ. 2015. Bigger is not always better: Should educators aim for big transformative learning events or small transformative experiences? Journal of Transformative Learning.3 (1) 52-58

HFEA 2019 Fertility treatment 2017: trends and figures . Human Fertilisation and Embryology Authority.

Higgins A., Downes C., Sheaf G., Bus E .,Connell S., Hafford-Letchfield T., Jurcek A., Pezzella A.,Rabelink I., Robotham G., Urek M., van de Vaart N., Keogh B. 2019. Pedagogical principles and methods underpinning education of health and social care practitioners on experiences and needs of older LGBT+people: Findings from a systematic review. Nurse Education in Practice. 40 102625. DOI:ORG/10.1016/j.nepr.2019.102625

Hoffkling A, Obedin-Maliver J, Sevelius J 2017 From erasure to opportunity: A qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. BMC Pregnancy & Childbirth 17(Suppl 2):332.

Hudson-Sharp N., Metcalf H.2016. 'Inequality among lesbian, gay bisexual and transgender groups in the UK .: A review of evidence NIESR

Iversen LL. 2019. From safe spaces to communities of disagreement. British Journal of Religious Education 41: 315-26

LEE E., TAYLOR J. & RAITT F. 2011 'It's not me, it's them': How lesbian women make sense of negative experiences of maternity care: a hermeneutic study. Journal of Advanced Nursing 67(5), 982–990. doi: 10.1111/j.1365-2648.2010.05548.x

Light AD., Obedin-Maliver J., Sevelius JM., Kerns JL. 2014 Transgender men who experienced pregnancy after female to male gender transitioning. Obstetrics & Gynecology. 124 (6) 1120-1127 doi: 10.1097/AOG.0000000000000540

Lim F., Johnson M., Eliason M. 2015. A national survey of Faculty knowledge, experience and readiness for teaching lesbian, gay, bisexual and transgender health in Baccalaureate Nursing Programs. Nursing Education Perspectives. 36 (3)144-152 DOI 10.5480/14-1355

Macdonald T., Noel-Weiss J., West D., Walks M., Biener M., Kibbe A.,Myler E 2016. Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity: a qualitative study. BMC Pregnancy and Childbirth 16:106. DOI 10.1186/s 12884-016-0907-y

McCann E & Brown M 2018 The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programme: A systematic review. Nurse Education today 64 204-214 doi: 10.1016/j.nedt.2018.02.028

Mooney M., Nolan L 2006. A critique of Freire's perspective on critical social theory in nursing education. Nurse Education Today 26(3)240- DOI: 10.1016/j.nedt.2005.10.004

Muntinga ME., Krajenbrink., Peerdeman SM., Croiset G., Verdonk P . 2016. Towards diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation. Adv Health Sci Educ Theory Pract. 21 (3) :541-559 DOI:10.1007/s.10459-015-9650-9

NIESR. 2016. Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence National Institute of Economic and Social Research 1-164. Niesr.ac.uk/sites/default/files/publications/160719_REPORT_LGBT_evidence_review_NIESR_FINALPDF.pdf retrieved 20/5/20

NMC.2019. Part 3: Standards for Pre-registration Midwifery Programmes https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-for-pre-registration-midwifery-programmes.pdf accessed 20th Jul 2020

Obedin-Maliver J., Goldsmith ES.,Stewart L., White W.,Tran E.,Brenman S.,Wells M.,Fetterman DM.,Garcia G.,Lunn M.2011. Lesbian, Gay, Bisexual and Transgender-related content in an undergraduate medical education. JAMA 7;306(9):971-7. doi: 10.1001/jama.2011.1255.



AUTHOR VERSION

Obedin-Maliver & Makadon 2016 Transgender men and pregnancy Royal society of Medicine Press LTD 9 (1)4-8 DOI.org/10.1177/1753495X15612658

Parameshwaren V., Cockbain BC.,Hillyard M., Price JR. 2017. Is the lack of specific lesbian, gay , bisexual transgender and queer/questioning (LGBTQQ) health care education in medical school a cause for concern? Evidence from a survey of knowledge and practice among UK medical students. Journal Homosexuality 64 (3)

Phiri J.,Dietsch E., Bonner A. 2010 Cultural safety and its importance for Australian midwifery practice. Collegian 17 (3): 105-111. DOI:10.1016/j.colegn.2009.11.001

Pyne J 2012.Transforming Family: Trans Parents and their struggles, strategies and strengths. Torornto: LGBTQ Parenting Network, Sherbourne Health Centre.

Reisner SL; Poteat T; Keatley J; Cabral M; Mothopeng T; Dunham E;Holland CE; Max R; Baral SD Transgender health 3 Global health burden and needs of transgender populations: a reviewLancet 2016; 388: 412–36 http://dx.doi.org/10.1016/ S0140-6736(16)00684-X

Riggs DW, Power J, and von Doussa H (2016)Parenting and Australian trans and gender diverse people*: An exploratory study.Journal of Transgenderism*, 17(2): 59-65.

Sequeira, G. M., Chakraborti, C., & Panunti, B. A. (2012). Integrating Lesbian, Gay, Bisexual, and Transgender (LGBT) Content Into Undergraduate Medical School Curricula: A Qualitative Study. *The Ochsner journal*, *12*(4), 379–382.

Spidsberg BD 2008. Vulnerable and strong-Lesbian women encountering maternity care. Journal of Advanced Nursing 60 (5): 478-86 doi:10.1111/j.1365-2648.2007.04439.x

Spidsberg B.D. & SØRLIE V. 2012 An expression of love – midwives' experiences in the encounter with lesbian women and their partners. Journal of Advanced Nursing 68(4), 796–805. doi: 10.1111/j.1365-2648.2011.05780.x

Stewart K., O'Reilly P. 2017. Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An Integrative review. Nurse Education Today 53.67-77

Somerville C 2015 Unhealthy attitudes: The Treatment of LGBT People within health and social care services. Stonewall.

London
https://www.stonewall.org.uk/system/files/unhealthy attitudes.pdf accessed July 20th 2020

Tobin, G. A., Begley, C. M. 2004. Methodological rigour within a qualitative framework. Journal of Advanced Nursing, 48, 388-396. doi:10.1111/j.1365-2648.2004.03207.

Vance, S.R., Deutsch, M.B., Rosenthal, S.M., Buckelew, S.M., 2017. Enhancing Pediatric Trainees' and Students' Knowledge in Providing Care to Transgender Youth. Journal of Adolesccent Health 60(4), 425-430.

Walker K; Arbour M; Waryold J 2016. Educational strategies to help students provide respectful sexual and reproductive healthcare for lesbian, gay and bisexual and transgender persons Journal of Midwifery & Women's Health 61 737-743

Wilbeck V, Dahlgren M and Oberg G 2007 Learning in focus groups: An analytical dimension for enhancing focus group research. Qualitative Research 7(2):249-267

Wilton T., Kauffman T. 2001. Lesbian mothers' experiences of maternity care in the UK. Midwifery. 17 203-211. DOI 10.1054/midw.2001.0261

Xavier J., Honnold J. A., Bradford J.2007. The health, health-related needs, and lifecourse experiences of transgender Virginians. Richmond: Virginia Department of Health.

AUTHOR VERSION