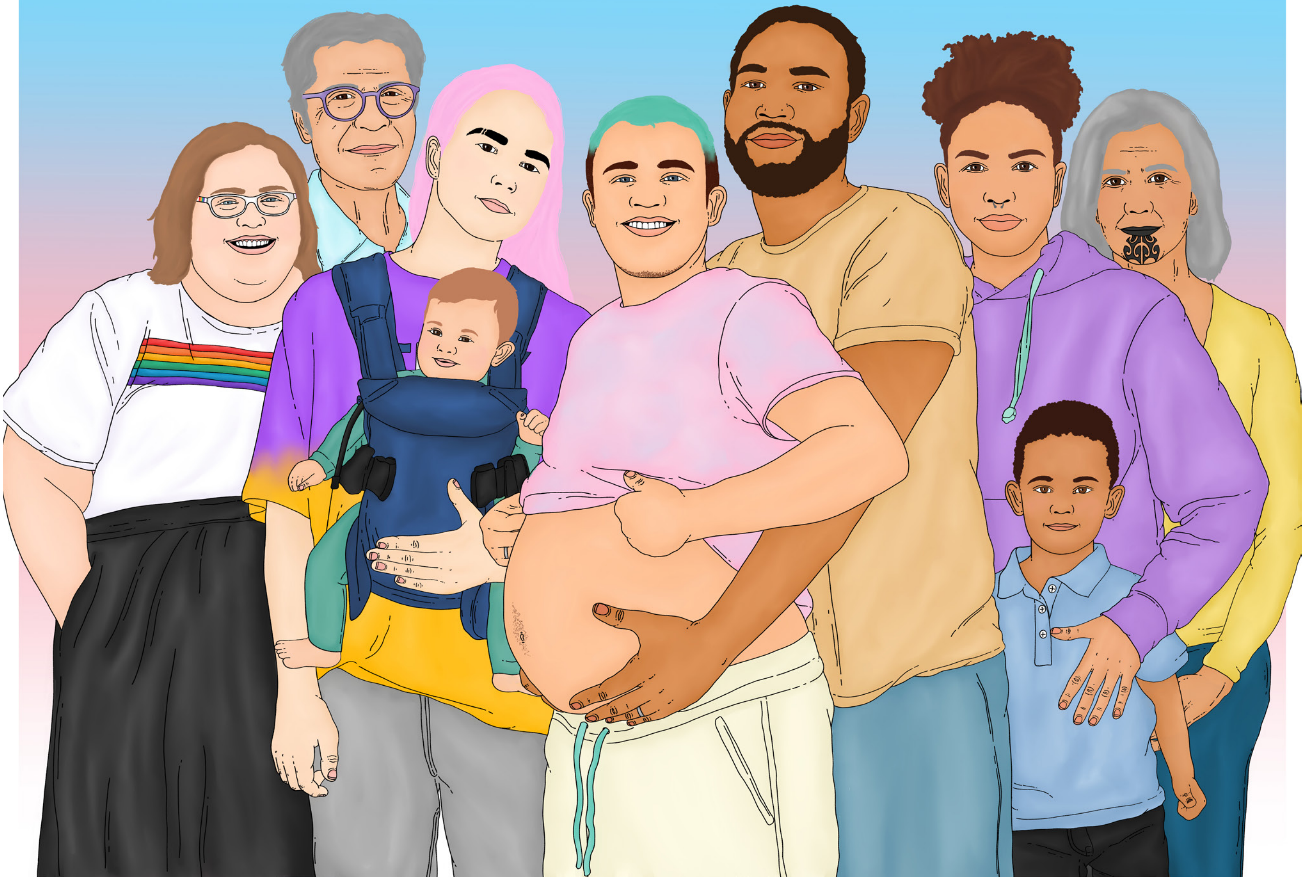

Warming the whare for trans people and whānau in perinatal care

Final deliverable report for the project:
Understanding the need for trans, non-binary and
takatāpui inclusive perinatal care (HRC 20/1498)

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Funder acknowledgement

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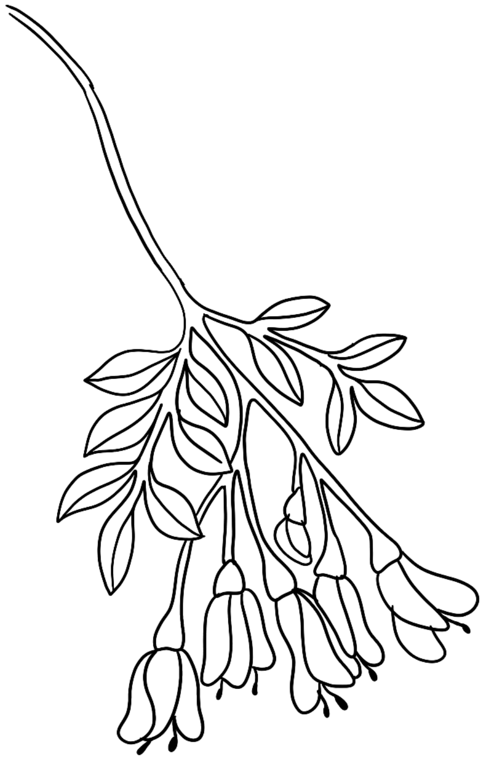

Tāku hei piripiri, tāku hei mokimoki, tāku hei tāwhiri, tāku kati taramea

My pendant of scented fern, my pendant of fragrant fern,
my pendant of scented gum, my sachet of sweet-scented speargrass

Form of endearment sung to small child

He Kupu Aumihi | Acknowledgements

Special acknowledgement to our project's takatāpui parent advisor, Scout Barbour-Evans, and to Ahi Wi-Hongi, Gender Minorities Aotearoa for your guidance and input throughout this research project. This project would not have been possible without you both, or the following people and organisations:

Rainbow-community organisations and champions:

- Tīwhanawhana Trust
- Intersex Aotearoa
- Professional Association of Transgender Health Aotearoa (PATHA)
- Trans Health Research Network

Clinical and professional organisations:

- Te Kāreti o ngā Kaiwhakawhanau ki Aotearoa: New Zealand College of Midwives (NZCOM)
- Royal Australia New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Ngā Maia Māori Midwives Aotearoa
- Pasifika Midwives Aotearoa
- Physiotherapy New Zealand
- Perinatal Society New Zealand
- Royal New Zealand College of General Practitioners (RNZCGP)

Community organisations:

- Women's Health Action Trust
- Perinatal Anxiety and Depression Aotearoa
- Parents Centre Aotearoa
- EMPWR

And the following individuals:

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- Huriana Kopeke-Te Aho for your stunning artwork
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- Health professionals who piloted our survey
- Gianna Leoni for te reo translations
- Support staff at Otago Polytechnic|Te Pūkenga and Te Herenga Waka|Victoria University of Wellington
- The many other organisations and individuals who have supported our project

Finally, but most importantly, we also thank everyone who took part in both phases of our project: to the trans people and whānau and to our workforce survey respondents. Thank you for your trust and taking the time to share your experiences with us.

This report is dedicated to Lou Kelly (1995-2023)

The contribution you have made to rainbow-inclusive perinatal care in Aotearoa is nothing short of mahi rangatira. Throughout our lives, binary gender norms and roles are forced on us in ways that are both endless and subtle. It feels uncomfortable – at times impossible – to untangle ourselves from the web they create around us. Thank you, Lou, for weaving together this pattern of care and compassion that we can don anytime our world unravels. Knit 1 purl 2.

May your legacy be forever held in the pages of this report and beyond.

Nāu te rourou, nāku te rourou, ka ora ai te iwi

Kaimahi at Women's Health Action Trust

Foreword

Tēnā koutou katoa
Ko Taranaki te papatūwhenua
Kei te noho au kei Ōtepoti ināianei i raro
i te maru o Ngai Tahu.
Ko Whakapunake te maunga
Ko Te Wairoa-hōpūpū-hōnengenenge-
matangi-rau te awa
Ko Ngāti Kahungunu rāua ko Ngāti Porou nga iwi
Ko Takitimu te waka
Ko Kahungunu te tangata
Ko Scout ahau
Tēnā koutou, tēnā koutou, tēnā koutou katoa.

Ko te pae tawhiti. Whaia kia tata, ko te pae tata. Whakamaua kia tīnā. E aku hoamahi, tēnā koutou. Nei aku mihi mutunga kore i te mahi me te ako. Whaihoki, ngā mihi nui ki a koutou i te aroha me te āwhina. My gratitude abounds for my hoamahi on the Trans Pregnancy Care Project. I am forever going to be grateful for what I have learned and how it will inform my career going forwards. Our mahi was not without its difficulties or delays. We lost people in the sector who we love dearly – including the pou rangatira of queer midwifery, Lou Kelly, and our mahi paused several times to allow us to feel those losses with our whole being. Between these losses, and an ongoing pandemic, the mamae was challenging at times.

I will also forever be grateful for the gift of experience given to us by the whānau interviewees and the perinatal care workers who filled out our survey – your words and stories will positively benefit so many. Change is made with all hands, thank you for bringing your whole selves to our narrative. And most of all, I am so grateful for the further questions this piece of research has brought to the surface. We hope that this research will serve as a roadmap for decades, encouraging the perinatal system to push further, look under more stones, and keep sparking change well into the future.

I didn't even need to think about the question before I accepted George's invitation to be a parent advisor for this research. It was the fastest yes, I've ever given! My kōtiro was 2 years old, and I'd not long completed an undergraduate project writing about my own "trans pregnancy." Memories of my brilliant midwife were forefront in my mind, and I was adamant that more people needed to have access to positive experiences like mine. After all, what is reproductive justice without choice and mana?

As the project has progressed, I have thought a lot about the intersections and differences between my being as takatāpui, versus the name we have given this research – transgender. As it is, I identify less and less as trans these days. The term serves its purpose, but my takatāpuitanga sits at the centre of my being. The kōrero we had during this project led to a lot of self-reflection for me, which I am also very grateful for. It was a phenomenal privilege advising on this project alongside the brilliant, Rangatira pounamu Dr Elizabeth Kerekere – and we brought our entire, glorious takatāpui and Māori selves into every discussion and mātauranga we gifted. This can be seen in the weaving of our position statement on "whānau".

It was a stunning Spring morning at Orokonui for one of our project hui, there was a little chill but nothing that prevented us from letting the birdsong in through the conference room doors. The whiteboard was commandeered from my kōtiro and word by word, concept by concept, we drafted the position statement that we hope will inform the rest of our research in this sector from now. I will leave you, readers, to find our statement as you read on.

This piece of research stands out from the crowd because of this determination from the researchers to honour Te Tiriti o Waitangi with their whole hearts, not simply on paper. It is easy in the colonial setting of academia to rattle off tikanga Māori as a tick-box exercise, but this project made a choice instead to live it.

Being part of the Trans Pregnancy Care Project was an utter privilege, and none of us are finished with this kaupapa. I'm a systems person myself – I hope for myself that I continue in this vein as my academic career continues, within the rest of the health policy sector. And I hope that this sparks that same inspiration and fight for our readers. I orea te tuatara ka patu ki waho, change will be achieved if we continue to seek the solutions we need.

Scout Barbour-Evans, Trans Pregnancy
Care Project Parent Advisor

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Language used in this report

In this report, we use the term *trans* as an inclusive shorthand for *transgender*, *non-binary and other gender diverse identities including takatāpui who are gender diverse (see below)*, referring to people whose gender differs from their gender assigned at birth. *Non-binary* is an umbrella term describing people whose gender is outside of the binary of woman / man, whose gender is fluid, or who do not have a gender. *Takatāpui* is a traditional Māori term that encompasses Māori of diverse sexualities, genders and sex characteristics. Like in many Indigenous cultures, gender and sexuality fluidity and diversity was an integral part of precolonial Māori societies. The binary norms around gender and sexuality, and the definition of a nuclear heterosexual family, were imposed in Aotearoa through European colonisation, resulting in the repression of gender fluidity in Te Ao Māori. In recent decades, however, takatāpui identities are being reclaimed thanks to the work of Māori activists and scholars (e.g., Aspin & Hutchings, 2007; Kerekere, 2017). We recognise the limitations of using an umbrella term such as *trans*: the ways that gender diverse people know and describe their gender are non-exhaustive, are culturally specific, can change over time, and depend on how individuals choose to determine their gender. Additionally, some trans, non-binary, and takatāpui people who are gender diverse wish to not label their gender. However, for practical reasons including brevity and the readability of this report we have elected to use *trans* as an umbrella term in this report.

Intersex describes people born with variations in sex characteristics (VSC), such as gonads, chromosomes, and hormones. As being Intersex is different from being trans, Intersex people can be cisgender or trans.

Cisgender is an adjective that means not trans. Cisgender people identify more or less with the gender assigned to them at birth.

We use the term *whānau* throughout this report to describe the people involved in perinatal care that trans people determine for themselves. This has resonance with current discussion occurring within the midwifery profession as the New Zealand Midwifery Council develops a proposed new Scope of Practice that recognises the whanau as the recipient of midwifery care (Te Tatau o te Whare Kahu Midwifery Council, 2022). This discussion is as yet unresolved but serves to contextualise some of our thinking. Our use of whānau is intended to indicate that experiences of perinatal care impact the wellbeing of all whānau members, not just the gestational parent.

We use the term *perinatal* in its broadest sense to include the periods of preconception, conception, pregnancy, and the postnatal period (up to six weeks). We use this in place of 'maternity' as that is a gendered term that many trans and non-binary people do not find affirming. We include experiences of accessing healthcare related to assisting fertility and conception within our project's scope, as a considerable proportion of trans people access assisted reproductive technologies as part of their whānau-building journeys.

The frameworks of *cultural safety* (DeSouza, 2008) and *cultural humility* (Fisher-Borne et al., 2015) are used in this report rather than *cultural competency* (Curtis et al., 2019). The frameworks of cultural safety and cultural humility were developed by Indigenous and other health scholars of colour to address racial, colonial, and other structural injustices in healthcare. The challenge of working towards cultural safety and cultural humility asks health providers and health organisations to engage with an on-going process of reflection on their own culture and their place within systems of privilege and power. The emphasis is on self-knowing and unlearning privilege rather than prioritising becoming "competent" in the culture of others (DeSouza, 2008). The effectiveness of providers and organisations in providing culturally safe and humble care, as defined by minority communities themselves, is measured through progress in achieving health equity (Curtis et al, 2019).

Glossary of Kupu Māori used in this report*

hongona	unions, connection, relationship
kaupapa	project, matter for discussion, plan, topic
kaimahi	worker or employee
kupu	(noun) a word, saying, vocabulary (verb) to speak
mahi	work
māmā	mother
mana	prestige, influence, status, spiritual power of atua – inherited at birth from divine sources
manākitanga	kindness, hospitality, upholding another's mana
Māori	Indigenous person of Aotearoa/New Zealand, normal, usual, natural
mātauranga Māori	Māori knowledge, wisdom, understanding, education
mauri	material symbol of a life principle, special nature of someone/thing
pānui	(noun) newsletter or announcement
pēpi	baby or infant
takatāpui	traditionally 'close friend of the same gender' – contemporarily reclaimed as encompassing Māori of diverse sexualities, genders and sex characteristics.
tane	man, male, husband
Tangata Whenua	Indigenous people of Aotearoa NZ ('people of the land'), local people
taonga	something prized, a treasure
tapu	sacred, restricted, set apart, prohibited, under protection
Te Tiriti o Waitangi	The Treaty of Waitangi
Te Ao Māori	the Māori world(view), perspective
Te Reo Māori	Māori language, dialect, tongue, speech
tikanga	correct procedure, custom, method, practice
tipua	shapeshifter, spiritual being who could change form. Mana Tipua – authority held by trans, Intersex and non-binary people (Kerekere, 2023)
wahine/wāhine	woman, female, wife
wairua	spirit or quintessence of a person that exists beyond death. Some believe wairua extends to all animate and inanimate things
whakapapa	to lie flat or describe layers in proper order – often in the context of relating family genealogy
whakawhanaungatanga	the process of establishing relationships
whanau/whānau	family group, extended family, in contemporary Aotearoa also may include friends who may have no kinship ties to other members
whare	house or dwelling

*definitions are from Moorfield, J. (2011). Te Aka Māori-English, English-Māori Dictionary. Pearson.

We acknowledge that the English meanings presented here are unlikely to fully convey exactly what the Māori word means to Māori because context and location provide more nuanced associations with the words used.

Executive Summary

Understanding the need for trans, non-binary and takatāpui inclusive perinatal care (HRC 20/1498) (Trans Pregnancy Care Project) was undertaken in response to the 2020 Maternity Services Research Request for Proposals through a joint initiative between Health Research Council NZ and Mānatu Hauora|Ministry of Health. The joint initiative sought to fund projects to directly inform the development of policy and practice for Aotearoa New Zealand's maternity service to achieve equitable outcomes and support a quality improvement culture. As a population, trans, non-binary and takatāpui people who are gender diverse (trans) people experience significant health disparities compared to the general population, which can either be compounded or alleviated by the quality, safety, and cultural responsiveness of health services. Prior to this study little was known about how trans people experience perinatal care in the context of Aotearoa New Zealand's unique perinatal service model. International research suggested a lack of perinatal system readiness to provide inclusive care and deliver equitable outcomes for trans people and whānau.

This study has addressed this knowledge gap in two phases seeking to understand what constitutes quality, safe and culturally responsive perinatal care services for trans people and to assess the readiness of the perinatal workforce to provide equitable care to trans people and whānau. Phase one of the study involved qualitative semi-structured interviews with 20 trans whānau (29 participants in total including gestational and non-gestational parents) who were on their whanau building journey from trying to conceive through to the early years of parenting. Participants described their engagement with perinatal services and their reflections on what constitutes trans affirming and inclusive perinatal care. These narratives from our phase one participants were integral – along with extensive consultation with Tangata Whenua, health professional organisations and community trans advocacy groups - to informing the design of phase two of the project: an anonymous online nationwide survey of perinatal healthcare providers. The survey findings provide an encouraging glimpse of an appetite for change within the practice of perinatal care providers but acknowledge the current limitations of poor resourcing and lack of education opportunities to support progress towards to a more equitable and inclusive perinatal care service.

The key themes from analysis of our participants' narratives (phase one) are followed by insights from the health practitioner survey about readiness for providing trans inclusive care (phase two). We conclude with recommendations for practice, relevant at both individual practitioner and system-wide levels.

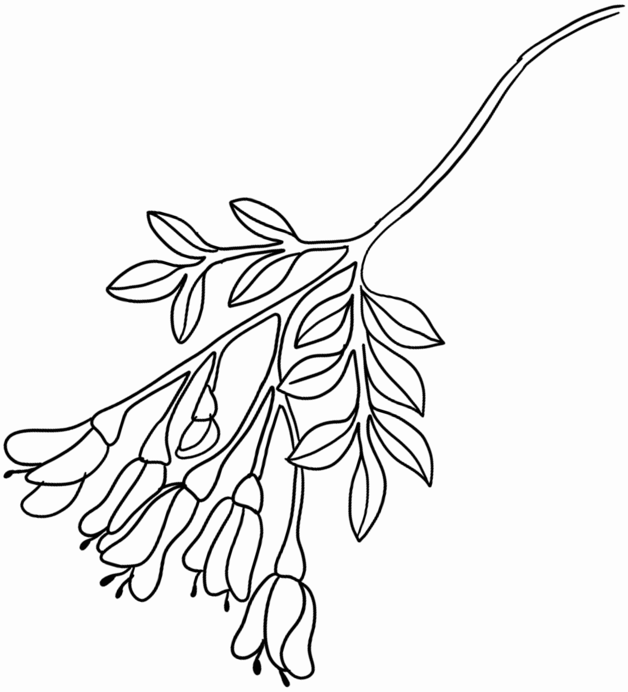
Key findings: Phase One

Theme One. "It's amazing how low the bar is we've set": Low expectations of care

- Participants commonly entered perinatal care with low expectations that they would receive care that was affirming and inclusive of trans people and whānau
- Low expectations were informed by previous negative experiences of healthcare and awareness of the gendered assumptions surrounding pregnancy and reproduction.
- Having low expectations often meant that participants anticipated and feared that perinatal care would not be a safe or inclusive space for them or their whānau.

Theme Two. "Look at this cool, strong man giving birth": Creating a bubble of trans affirming and inclusive care

- Participants were proactive in seeking out an LMC who would provide trans affirming and inclusive care, or least one who was open to learning.
- Securing care from a supportive LMC was described as a protective bubble providing some but not total protection from negative and harmful experiences in the wider perinatal system (see also Theme 3).
- Participants feared their LMC not being available, and many described inconsistent care beyond their LMC, especially when receiving hospital-based care.



Theme Three. "This odd not fitting in feeling": Systemic and interactional cisnormativity in perinatal care

- Participants described encountering pervasive binary gender norms that made them feel out of place or excluded from perinatal care settings.
- These binary gender norms were evident both structurally in perinatal care (e.g., in the physical environments of services) and in participants' interactions with care providers beyond their LMC bubble, particularly when participants were hospital inpatients.
- The impacts of not feeling seen or able to be oneself in services included losing trust, questioning quality of care or being worried about future care, disengaging from care, loss of joy, and not disclosing their gender.

Theme Four. "Being a witness in the room of how somebody's being treated": Advocating for trans affirming and inclusive care

- Participants advocated for themselves and their whānau using a range of strategies when their care was not experienced as affirming and inclusive
- Self-advocacy was experienced by many participants as a mental/emotional labour that adds layers of stress and exhaustion to the perinatal period.
- Participants expressed relief and gratitude when their LMC or another trusted provider advocated on their behalf for inclusive and affirming care provision, and addressed overt discrimination, particularly when they were hospital inpatients.

Theme Five. "I want to engage, it brings me joy, I feel seen": The characteristics of affirming and inclusive care for trans people and whānau

- Many participants described aspects of perinatal care that was safe, welcoming, affirming and inclusive for them and their whānau and/or could imagine what this kind of care would mean for them.
- Providers who deliver this care demonstrate common characteristics. They are 'knowledgeable about and aware of gender diversity' and they are 'self -reflective and culturally humble when working with trans people and whānau'.
- Participants described or imagined how safe, welcoming, affirming and inclusive care improves perinatal care experiences, engagement, and outcomes for trans people and whānau.

Key findings: Phase Two

Demographic characteristics of respondents

Responses to the perinatal health workforce survey from 476 individuals were analysed. Respondents included midwives (67%), doctors (19%) and other health professionals (14%). Demographics such as ethnicity, age and gender largely aligned with midwifery and medical workforce data, although the sample may reflect a respondent bias towards those who have an interest in this area of clinical practice.

Current practices in workplaces in relation to inclusive practice

Approximately half of the 476 respondents identified access to gender-neutral bathrooms, having clinical documents with space to record details for more than one support person and having a gender-neutral name for their practice. However, few identified clinical documents and policies as being trans inclusive, and less than 20% were working toward more inclusive practices. Of note, free text responses identified a vast range of initiatives that individuals were putting in place.

The majority of respondents did not ask clients/patients about their pronouns or the words they used to describe their body parts but if patients/clients shared their pronouns and words for body parts the majority of clinicians used these. Free text comments identified a willingness to learn, a need for leadership and support, but the impact of workplace stress leaving little capacity for "anything extra". About a third had started conversations in their workplace to make their practice more inclusive, including sharing education resources. Text responses identified that small community-based practices were easier environments in which to introduce change, and that despite staff willingness there were more barriers to change in large institutions.

Respondents' education experiences and preferences

Approximately 350 people responded to the questions about education related to inclusion. Of these, most perinatal health practitioners had not received any education specific to working with trans and non-binary, Intersex or takatāpui people during either their undergraduate / pre-registration (61%) or postgraduate/ post-registration (59%) education.

Of those who had received some education:

- At undergraduate (pre-registration) level, more people recalled receiving education about people with variations of sex characteristics (29%) than about trans and non-binary people (19%) or takatāpui people (10%).
- At postgraduate (post-registration) level, more people recalled learning about working with trans and non-binary people (36%) than about people with variations in sex characteristics (30%) or takatāpui people (23%).
- When asked about a wide range of topics relating to gender, sexuality and sex characteristic diversity respondents might have learned about during both their pre-and post-registration education, fewer than 20% of respondents recalled receiving education about any of the individual topics, with the exception of post-registration clinicians learning about terminology (24%).
- Of the 365 respondents who answered this question, 81% would be interested in attending or enrolling in education about trans, non-binary, Intersex and takatāpui inclusion if it was made available. Their preferred mode for receiving this education was divided evenly between having both online and face-to-face options available, online-only, and face-to-face only.

Knowledge, beliefs and clinical preparedness of the perinatal workforce

The survey results identified current knowledge and knowledge gaps in relation to meeting trans people's perinatal care needs. Knowledge gaps included core concepts about gender and sexuality diversity, referral pathways for gender affirming care, and access to resources for trans people and their whānau, particularly resources to support Māori and Pasifika people. Generally, respondents indicated beliefs that were supportive of improving and providing quality care for trans, non-binary, Intersex and takatāpui people. However, they indicated that their ability to do so was limited due to poor knowledge as to what constitutes best practice in this area and lack of resources and education opportunities for their professional development.

Recommendations

Our findings provide evidence to inform *Warming the Whare*, a guideline and recommendations for practice. We have been offered Kerekere's (2017; 2023) ***Te Whare Takatāpui*** framework to provide context for our guideline and recommendations. In this executive summary we provide only key concepts. To understand the context, we refer you to the full explication of the framework. In summary, the framework comprises six values, which we have aligned with specific practice recommendations to be applied at both individual practitioner and systems levels. The six values are Whakapapa (genealogy), Wairua (spirituality), Mauri (life spark), Mana (authority/self-determination), Tapu (sacredness) and Tikanga (rules and protocols), each representing a different part of a wharenui (ancestral meeting house). When these values are accounted for, the Whare can shelter and nurture all people with diverse genders, sexualities, and sex characteristics and their whānau.

Whakapapa

- Be aware that the journey into perinatal care may have been challenging for trans people and whānau.
- Engage in critical self-reflection about norms related to gender, sexuality and family forms in perinatal care.
- Create opportunities within services for trans people to self-determine their gender, words used to describe their bodies, and who is part of their whānau.
- Evaluate the preparedness of your workplace or practice to provide affirming and inclusive care to trans people and whānau in the future.

Wairua

- Understand the positive impacts of affirming and inclusive perinatal care on the health and wellbeing of trans people and whānau.
- Ensure services are welcoming and accessible for trans people and whānau.
- Respect and reflect the words people use to describe their gender, pronouns, different parts of their bodies, their babies' sex/gender, and who is part of their whānau.
- Anticipate whānau diversity in your practice or service.

Mauri

- Include visual representations of trans people and whānau and other signs of inclusion where possible in your services.
- Understand that trans people self-determine and express their gender differently and there are many ways of being trans.
- Consider that trans people have intersecting identities that may be equally important to recognise.

Mana

- Advocate for trans people and whānau to safely navigate their journeys through perinatal care.
- Provide opportunities for trans people and whānau to help inform the delivery of perinatal services to ensure services meet their needs.
- Build your own knowledge and awareness about trans inclusion.
- Identify and support practitioners in your service/practice who can champion trans inclusive care.

Tapu

- Provide trauma-informed care.
- Avoid assuming how trans people's bodies work, and only seek information about people's bodies when it is clinically relevant and with informed consent.
- Audit your service/practice for trans inclusion especially in large services with multi-disciplinary teams.
- Practice relationship-centred and continuity of care.

Tikanga

- Provide leadership for trans inclusion at all levels.
- Develop trans-inclusive policies and consensus statements, make the workforce aware of these, and ensure they understand how to implement them.
- Mandate pre- and post-registration education on trans inclusion for the perinatal workforce.
- Identify opportunities to use gender-inclusive language in your own practice and services.
- Take a 'walkthrough' of your service or practice, imagining how this space would be experienced by a trans person and whānau.

Conclusion

The Trans Pregnancy Care Project has been undertaken in response to growing calls both globally and in Aotearoa to improve healthcare access and delivery for trans people as a fundamental part of achieving health equity. There are unique considerations for health services such a gynaecology and reproductive health services that have historically assumed that users of care are cisgender women to ensure system and workforce readiness to provide trans affirming and inclusive care. Collectively, findings from both phases of our study highlight both the challenges that trans people and whānau can face in these services and strategies that all perinatal services and professions can implement to better serve trans people and whānau.

As our findings show, some providers and services are already implementing these initiatives, primarily led by Lead Maternity Carers who champion affirming and inclusive community-based care. Improvements are needed to ensure that trans people and whānau can anticipate care that is consistently affirming and inclusive when they engage in all types of perinatal care beyond their lead provider, particularly when they receive hospital-based care. Historically, the perinatal workforce has not been adequately prepared to provide trans affirming and inclusive care but most providers are willing and open to engaging in education to support trans affirming and inclusive practice***. 'Warming the Whare: A Te Whare Takatāpui informed guideline and recommendations for trans inclusive perinatal care'*** provides guidance and recommendations to promote both system and individual provider level changes to ensure all trans people and whānau can thrive in perinatal care. This framework should be implemented holistically, noting that each of the six values presented in the framework are interwoven.

Introduction

As a population, trans, non-binary and takatāpui (trans) people experience significant health disparities compared to the general population, which can either be compounded or alleviated by the quality, safety and cultural responsiveness of health services. In the past decade, notable efforts have been made to improve trans people's access to and experiences within healthcare settings as part of the move towards depathologising gender diversity (Coleman et al., 2022). In Aotearoa, this includes the development of guidelines for gender-affirming healthcare based on Tā Mason Durie's Te Whare Tapa Whā (Ministry of Health, 2017; Oliphant et al., 2018) and recent Government investment into gender-affirming healthcare in primary care (New Zealand Government, 2022).

One area of health care that remains overlooked in relation to trans inclusivity in Aotearoa is perinatal care services. Many trans and non-binary people seek to create families and whānau in diverse ways, including through the birth of their own children (Stolk et al., 2023). *Counting Ourselves*, a national study conducted in 2018 of trans and non-binary people's health found that almost one in five participants (19%) 'definitely wanted' a child or more children, and this rate was higher for Māori (32%). Out of participants who were assigned female at birth, 4% had been pregnant since identifying as trans or non-binary and 1% were unsure if they had been (Veale et al., 2019). The narratives of reproduction and family-building told by trans people continue to inform health and public understandings of trans pregnancy (e.g., Finlay, 2019). It is likely that more trans people and their whānau will access fertility, pregnancy and birth care as they realise their reproductive rights. It is imperative that the perinatal care workforce and systems in Aotearoa are equipped with the knowledge and resources to ensure safety for, and proactively meet, the needs of trans people and their whānau throughout their pregnancies.

Providing policy direction and educating health professionals to provide clinically and culturally safe care to trans and non-binary people is a key strategy in transforming the experience of health services for them and their whānau. There is currently no research on trans people's experience of perinatal services in Aotearoa nor on the knowledge and beliefs of the Aotearoa perinatal workforce in providing care to trans people and whanau. As a result of this we undertook *Understanding the need for trans, non-binary and takatāpui inclusive perinatal care (HRC 20/1498) (Trans Pregnancy Care Project)*to generate evidence. The aim was to inform perinatal healthcare provision for trans people and whānau in Aotearoa's unique model of midwifery-led perinatal care.

Upholding Mana Motuhake for Māori and trans communities in perinatal healthcare

The articles of Te Tiriti o Waitangi were the stars which guided every stage of this project. The research team is in firm agreement that our perinatal sector still has some way to go to uphold the principles of Te Tiriti o Waitangi. We acknowledge the disparities of care forced upon Māori communities that are underpinned by colonisation and racism. Our team is comprised of a diverse mix of voices – Māori, takatāpui, transgender and non-binary, Pākehā, queer, cisgender and heterosexual identities alike. The mātauranga Māori included in this report are taonga gifted to this project by Dr Elizabeth Kerekere who is the kaitiaki of this mātauranga. No voice held supremacy in team hui, but appropriate weight was given to the lived trans, Māori and takatāpui experiences. After all, we abide by the principle of "nothing about us without us".

We intend for this research to enhance and solidify the mahi being done within the perinatal and other health sectors to uphold Te Tiriti o Waitangi and improve equity and outcomes for Māori and all people. The road is long, and the obstacles are many – but progress is made through collective action and solidarity.

Review of existing literature

Research to date indicates that the quality and safety of health care provided to trans people is critical in either exacerbating or alleviating health disparities for this population group. Trans people experience unique interpersonal and structural barriers that prevent them from accessing culturally and medically competent health care (Kcomt, 2019). These barriers stem from overt stigma and discrimination from health care providers along with gendered norms and assumptions in health care that render invisible and/or pathologise trans people and their health and healthcare needs (Dean, et al., 2016; Falck et al., 2021; Meyer & Frost, 2013; Norris & Borneskog, 2022). This can result in trans people avoiding accessing health care services. For example, just over a third (36%) of *Counting Ourselves* participants reported avoiding seeing a doctor because they were worried about disrespect or mistreatment, including 20% reporting this in the 12 months prior to the survey data being collected in 2018 (Veale et al., 2019). The compounding effects of avoiding care can lead to poorer health outcomes (Knutson et al., 2016; Seelman et al., 2017; Stevens, 2013). On the contrary, some research has found associations between trans-inclusive healthcare providers and positive mental and physical health outcomes and health-seeking behaviours (Christian et al., 2018; Treharne et al., 2022).

Emerging research on trans people's experiences of perinatal services highlight mixed experiences of care (Hoffkling et al., 2017). The practices of affirming and inclusive care providers identified in existing literature include consistently using gender-inclusive language (Berger et al., 2015), gendering trans people correctly (Light et al., 2014) and normalising trans pregnancy (Riggs et al., 2020; Hoffkling et al., 2017). While some participants have reported positive experiences with individual care providers, aspects of perinatal care services are more frequently perceived and experienced as unsafe and non-affirming of trans people (Charter et al., 2018; Ellis et al., 2015; Falck et al., 2021; Fischer, 2020; Hoffkling et al., 2017; Light et al., 2014; Riggs et al., 2020). Negative experiences in perinatal interactions include being asked inappropriate or insensitive questions about one's gender, and some providers' discomfort with providing care to trans people (Hoffkling et al., 2017). Other studies have identified more subtle yet pervasive microaggressions in perinatal care, such as the inconsistent use of pronouns and constant use of gendered language that conflates gender and sex (Falck et al., 2021; Fischer, 2020).

Unexamined norms about gender in perinatal care at a systemic level can also impact on trans people's experience of care (Kirczenow Macdonald et al., 2020). These norms are evident in the continued use of signage with gendered assumptions; physical spaces and design of perinatal services and wards that assume the users are women; data and information systems not designed to capture gender diversity; lack of Rainbow cultural safety education for maternity providers; and a lack of perinatal research about trans, non-binary and takatāpui reproductive health and healthcare needs (Ellis et al., 2015; Hoffkling et al., 2017; Veale et al., 2019).

Trans people's adverse experiences of perinatal care have been found to lead to exclusion and isolation from perinatal care settings (Falck et al., 2021; Charter et al., 2018; Greenfield & Darwin, 2020) and may increase vulnerability to poorer wellbeing outcomes associated with perinatal distress (Charter et al., 2018; Greenfield & Darwin, 2020; Malmquist et al., 2019). While not all trans people experience heightened gender dysphoria throughout pregnancy, the gender-related distress or dysphoria that some experience (which might result from ceasing testosterone usage or the physical changes of pregnancy) can compound existing mental health challenges (Berger et al., 2015; Brandt et al., 2019; Greenfield & Darwin, 2021; Light et al., 2014; Malmquist et al., 2020; Patel & Sweeney, 2021).

The barriers identified in literature on trans people's experiences of pregnancy and associated healthcare affirm the need for perinatal services to attend to the clinical and cultural needs of trans people and their whānau (Grundy-Bowers & Read, 2019; Keuroghlian et al., 2017; Kukura, 2022; McCann & Brown, 2018; Mitchell et al., 2018; Roosevelt et al., 2021). The importance of this has also been outlined as a global priority in addressing health inequities for Rainbow communities in international position statements (e.g., International Confederation of Midwives, 2017). Despite addressing these inequities being stated as a priority, there is currently inconsistency across individual providers' knowledge, attitudes and beliefs on providing affirming and inclusive care for Rainbow communities (Arias et al., 2021; Echezona-Johnson, 2017; Stewart & O'Reilly, 2017) and trans people specifically (e.g., Brown et al., 2021; Johansson et al., 2020). This variability has been attributed to cis- and heteronormative cultures in care settings, and the historic lack of education in health curricula on Rainbow communities' health needs (See Stewart & O'Reilly, 2017). International literature highlights current initiatives to fill gaps within health education and professional development (Chu et al., 2023; Effland et al., 2020; Kattari et al., 2020; Light & Obedin-Maliver, 2019), although more research is needed to evaluate the long-term impacts of these initiatives.

Existing literature on trans pregnancy and perinatal care mostly consists of smaller (<10 participants) qualitative or case studies that have elicited the views of trans people assigned female at birth about their experiences of pregnancy and perinatal care (Charter et al., 2018; Ellis et al., 2015; Hoffkling et al., 2017; Kerppola et al., 2019). Other literature canvases the views of perinatal professionals' knowledge and beliefs about providing care to trans and non-binary people (Hahn et al., 2019; Johansson et al., 2020; Pezaro et al., 2023; Stewart & O'Reilly, 2017). No identified studies have collected the perspectives of both trans people and perinatal professionals' perspectives on trans-inclusive care and analysed these perspectives in conversation with each other. There is also no published research on the experiences of trans people in Aotearoa's unique perinatal services nor of the experiences of takatāpui pregnant people and whānau.

Perinatal services are delivered within Aotearoa in a model that differs from other high resource countries. When a person becomes pregnant they register with a Lead Maternity Carer (LMC) who is typically a midwife but may be a private obstetrician or general practitioner with additional obstetric qualifications. In partnership with the pregnant person and their whanau, this LMC coordinates their perinatal care, including referral to other primary, secondary or tertiary services as necessary if complexity develops during the pregnancy. Even if ongoing secondary/tertiary care is required, it is usual for the LMC to remain involved as a known and trusted caregiver throughout the pregnancy and postnatal period until about six weeks following the baby's birth.

The extant international literature related to education around trans pregnancy consists of commentaries by perinatal health researchers and clinicians on the need for perinatal services to start addressing the clinical and cultural needs of this growing population of birthing people (e.g., Moseson et al., 2020; Parker, et al., 2023; Pezaro, 2019). While existing research identifies the need for health professional education to meet the clinical and cultural needs of trans and non-binary people (Stewart & O'Reilly, 2017; Johansson et al., 2020), this research has not elaborated the essential components of this education for the perinatal workforce. Apart from a few studies on lactation among transfeminine people (e.g., Ellis & Dalke, 2019; Walls et al., 2019), the perinatal care experiences of transfeminine and non-binary people assigned male at birth, as well as trans non-gestational partners, remain under-researched.

Research aims

Our study set out to:

1. Identify key themes about what constitutes quality, safe and culturally responsive perinatal services for trans, non-binary, and takatāpui people and whānau
2. Assess the knowledge and attitudes of the perinatal healthcare workforce in the provision of services to trans, non-binary, and takatāpui people and whānau
3. Provide evidence that supports the development of a quality improvement culture, including policy recommendations and targeted education interventions to improve equitable access to and delivery of maternity services to trans, non-binary and takatāpui pregnant people and whānau.

Phase One methods

Phase One of the Trans Pregnancy Care Project received Ethics approval from Te Herenga Waka – Victoria University of Wellington's Human Ethics Committee in October 2021 (#0000029879).

Study design: A whānau-centred approach

As a research team, we developed the following statement to guide our project and the values underpinning our commitment to Te Tiriti o Waitangi and whānau-centred research:

> *This project honours rangatiratanga of whakapapa by centering the mana and voices of trans, non-binary, takatāpui and Intersex whānau. We hold space for whānau to self-determine their identities and bodies and to decide who to include in sharing their experiences of perinatal care with us.*

At an operational level this meant we provided opportunities for participants to tell us who was part of their perinatal care journey. We welcomed non-gestational parents, as well as support people and other whānau members, to take part in the interviews if they chose to. This meant that some interviews involved non-gestational parents, including transfeminine, non-binary and cisgender partners or lovers. Some participants chose to have individual interviews. Others contacted us wanting to share their experiences about fertility treatment. In response we expanded our scope to include fertility/conception experiences, in recognition that conception can be more complex for some trans people and that trans people conceive in diverse ways. In our analysis, we paid attention to the unique experiences and dynamics that exist for both pregnant people and non-gestational parents. We further centered the experiences of trans whānau in the perinatal healthcare workforce survey by using their experiences to inform the questions we asked in the survey.

Data collection

Phase One of the project received ethics approval from the Victoria University of Wellington Human Ethics Committee in October 2021 (#0000029879). We used purposive convenience sampling methods to invite trans, non-binary, takatāpui and Intersex people to take part in semi-structured interviews on their experiences of perinatal care in Aotearoa. Prospective participants were recruited through social media posts on the project's public Facebook page and Instagram account, trans and Intersex Facebook groups and pages, through the Professional Association of Transgender Health Association's (PATHA) email listserv for professionals working in transgender healthcare in Aotearoa, and via word of mouth. Participant recruitment documents and the interview guide were developed in consultation with the project's parent advisor and through stakeholder consultation with Gender Minorities Aotearoa (GMA).

People were invited to participate if they were aged 18 years or older; self-identified as transgender, non-binary, Intersex or takatāpui and gender diverse; and had accessed fertility, pregnancy or birth care within the past five years in Aotearoa. Our definition of 'accessing services' was intentionally kept broad, acknowledging that trans people create families and whānau in diverse ways that can involve several people accessing services alongside the pregnant person. This meant that trans non-gestational parents, who accessed services in this role, were welcome to participate, and people were invited to bring whānau or support people along.

In total, 27 whānau initiated contact or expressed interest in participating. Of the 27, seven did not respond after a follow-up email. Twenty whānau agreed to take part in an interview. As nine of the interviews were held with two people, this resulted in 29 participants in total. Of these 20 interviews, 19 were conducted by George Parker, a non-binary Pākehā health researcher, registered midwife, and parent, and one interview was conducted by Alex Ker, a transmasculine Pākehā research assistant. Of all interviews, 15 were held over Zoom and five were held face-to-face, four in the participant's home, and one in a public space. Each whānau was sent a $30 gift voucher as acknowledgement of their participation.

See Table 1 in Appendix 1 for detailed participant demographics.

Data analysis

Interviews were audio recorded and transcribed verbatim by an external transcriber who signed a confidentiality agreement prior to transcribing. AK, the research assistant, removed identifying details from the transcripts to ensure participants' confidentiality however we had ethics approval for participants who wished to retain their own name rather than use a pseudonym. Guided by trans epistemology (Streed et al., 2023) and indigenous research practices (Svalastog & Erikksen, 2010), our project parent advisor elected to participate in the research as a participant and retained use of their own name for transparency. However, their transcript was anonymised to the research team members who coded it. The interviewer was excluded from this process. Prior to beginning analysis, each participant was sent their de-identified interview transcript, which they were invited to provide feedback on. In total, seven responded with feedback on their transcript (such as adding thoughts or requesting to remove some details from the transcript). Transcripts were analysed using reflexive thematic analysis led by GP and AK (Braun & Clarke, 2019). First GP and AK performed complete coding on each transcript independently and met frequently to discuss the codes. Codes were then discussed in wider team hui to understand how our subjectivities as researchers influenced our interpretations of the data. GP, AK, SM and SB all coded the same part of a chosen transcript independently and then met to discuss their coding and rationale. AK manually grouped the data excerpts into a coding scheme, which was discussed in a wider team hui and used these groups to develop candidate themes and subthemes. Candidate themes were again discussed at wider team hui until consensus was reached on the central themes. EK confirmed the analysis of data from takatāpui participants and central themes were presented back to the project's parent advisor and Gender Minorities Aotearoa for discussion.

Phase One key findings

Interview participant demographics

Each participant described their gender in a range of ways, including trans man, non-binary, agender, takatāpui, genderfluid and genderqueer. The mean age of the 29 participants was 31 years. Participants described their ethnicity, allowing for more than one ethnicity, as Pākehā/NZ European (17); takatāpui (4); other European (8); missing (4). Participants were at various stages of their pregnancy and whānau-building journeys; 18 participants were gestational (or intending gestational) parents, and 11 were non-gestational parents.

Themes

Through our reflexive thematic analysis (Braun & Clarke, 2019), we identified five key themes across the experiences of trans people and whānau who took part in the interviews. Overall, these findings indicate that trans people and their whānau experience barriers to accessing perinatal care in the first place and go to great lengths to mitigate the non-inclusive care they anticipate. Many participants shared examples of both subtle and overt acts of exclusion throughout the parts of their care where they had little autonomy to self-determine their gender, their whānau and their health needs as trans and non-binary people. Importantly, participants valued care providers who were knowledgeable and aware, and who demonstrated self-reflection and cultural humility. Care providers who were advocates for inclusive care lightened the burden of self-advocacy for participants.

Theme One. "It's amazing how low the bar is we've set": Low expectations of care

Key points

- Participants commonly entered perinatal care with low expectations that they would receive care that was affirming and inclusive of trans people and whānau.
- Low expectations were informed by previous negative experiences of healthcare and awareness of the gendered assumptions surrounding pregnancy and reproduction.
- Having low expectations often meant that participants anticipated and feared that perinatal care would not be a safe or inclusive space for them or their whānau.

Many participants shared they had low expectations of perinatal care prior to entering services. Sarah, the cisgender partner of Olly, "expected to have a lot of unpleasant interactions with people" throughout their perinatal care due to Olly being a pregnant trans man. Olly (trans guy, gestational parent) described how these expectations were informed by prior experiences in healthcare settings, having had "a lot of experience of medical professionals who have no clue what to do with my gender and will make really harmful comments." Similarly, a few participants described how low expectations were a result of previous negative health experiences or internalising the idea that "a lot of [trans] people [don't] think they deserve good care" (Brodie, non-binary trans man, intending gestational parent). However, many participants attributed these low expectations to their awareness that healthcare systems in general are stretched and under-resourced, and therefore are not able to prioritise trans inclusion.

> *I don't tend to expect high quality [gender-affirming] care in a public health system. It's just not resourced to be able to provide that. But I can understand that it's the resourcing not the people, most of the time. Sometimes it's the people. (Scout, takatāpui, gestational parent)*

Others said that their expectations were based on perinatal care being a highly gendered area of health, one that had catching up to do in terms of recognising trans people in perinatal care:

> *I didn't approach [my pregnancy care] with any hope that it would actually help me whatsoever. I knew that it was just going to probably be an absolute, excuse my French, a shitshow […] Just because knowing the whole entire medical system and how gendered it is, how backwards it is at the moment. (Pete, trans man, gestational parent)*

Some participants described the anticipation of entering a service where they were likely to be misgendered if they did not advocate for themselves. As Jesse (non-binary, TTC gestational) said:

> *I think that overall I've had to go on the assumption that [healthcare is] not going to be affirming […] I'm going to have to educate people, I'm going to have to advocate for myself, and essentially there's going to be a level of picking my own battles, because you can't do that all the time. The idea of there being a system that is affirming for people like me and other trans people is, oh, it would bring me to tears to be honest.*

In contrast, Rex (non-binary, non-gestational parent) expected a much higher standard of inclusive care than what they experienced: "really blew mind […] like it's 2022, we live in an age where there's just so much happening and I can't understand why people aren't moving with the times or trying to educate themselves to be more accepting and to make spaces feel more safer for everyone".

When participants received care that was to some degree affirming and inclusive, most described being "surprised" or "lucky" to receive this type of care. Olly (trans man, gestational parent) commented that "I've been pleasantly surprised at how, you know, we still have to deal with a fair bit of shit, but way less than I expected". Rory (agender, gestational parent) reflected on why people may feel lucky when they receive affirming and inclusive care:

> *I think [low expectations] comes with just being a marginalised group, you just always kind of have that jadedness of, I know that it's not something that people are used to and so if they give me any, just even the tiniest little bit of consideration it's like they've done everything I could ever wish for. So, when they go more than just that little, tiny step, it feels huge, and I'm sure, and like I said that happens with any marginalised group but especially for gender diversity because right now it's such a divisive topic, it's either very, very divisive or people just don't talk about it.*

Participants also talked about valuing care providers, especially midwives, who made efforts to practice inclusively but perceived difficulties in seeking such a care provider when there was already a workforce shortage. Tyler (non-binary gestational parent), who found an inclusive midwife more easily than expected, said that "I didn't necessarily expect to be lucky enough to find someone who had any [trans and non-binary] expertise already, but that obviously made my decision-making and selecting the midwife really obvious".

Theme Two. "Look at this cool, strong man giving birth": Creating a bubble of trans affirming and inclusive care

Key points

- Participants were proactive in seeking out an LMC who would provide trans affirming and inclusive care, or least one who was open to learning.
- Securing care from a supportive LMC was described as a protective bubble providing some but not total protection from negative experiences in the wider perinatal system (see also Theme 3).
- Participants feared their LMC not being available, and many described inconsistent care beyond their LMC, especially when receiving hospital-based care.

Finding a supportive LMC

Entering care with low expectations of the perinatal system, participants described the priority they placed on trying to access care from a perinatal provider – usually an LMC midwife – who had some knowledge of or experience working with LGBTIQ+ takatāpui whānau and communities. Lor (non-binary, gestational parent) described finding an affirming and inclusive LMC midwife as "fundamental, absolutely fundamental" and like many participants was highly motivated in seeking such a provider. Similarly, Natalie, a gestational parent and cisgender partner of Flora, a trans woman, explained:

> *I definitely wanted someone who was LGBTQI, you know, inclusive. Part of me was also thinking of the delivery and things like that, I didn't want Flora to be 100% misgendered all the time, when I'm in labour I can't stick up for her, kind of situation, yeah, and I wanted, you know, obviously, Flora to feel comfortable in the environment as well.*

Participants sought supportive LMCs through various mechanisms including personal networks, Rainbow community groups on social media, referrals from other practitioners, and through the 'Find your midwife' website. Scout (takatāpui, gestational parent) reflected on their own motivation to find a supportive LMC: "I chose my midwife before I conceived [my child], and chose that based on a recommendation that I got from contacting someone that I knew who worked at Family Planning." Participants explained that they appreciated perinatal providers who were explicitly welcoming of LGBTIQ+ takatāpui whānau (such as stating so on their online profile), or who at least communicated subtle signs of inclusion such as the use of pronouns in their bio or email.

Proactive attempts to find an affirming and inclusive LMC were not always successful or possible. Some participants identified barriers in their search for a supportive LMC including the LMC midwife shortage (which was compounded for those who lived outside of main centres), and/or being less of a priority relative to other needs or challenges they were facing such as socio-economic deprivation, illness, or other chronic health challenges. When participants couldn't find a provider who was explicitly welcoming of or knowledgeable about gender diversity, they had a minimum expectation that the provider would be open to learning about and being responsive to what the participant and whānau needed to make their care experience safe and commonly took on the educator role for their LMC. As River (non-binary, gestational parent) explained:

> *I don't mind being the first, you know, non-binary person that the provider comes across but if I am the first I need to have some reassurance that their interaction with me will be influencing the interaction with others and de-gender the birthing space in general.*

Creating a “bubble” of care

Participants who were able to secure care from a supportive LMC said they valued the opportunity to receive continuity of care from this provider throughout their pregnancy and birth journey. This gave participants space to invest in building a relationship with their LMC where they could be open about who they were and feel seen and known. Olly (trans man, gestational parent) described the positive impact of his LMC midwife’s affirmations of his gender on his pregnancy experience: “I felt that she was going, ‘well look at this cool strong man giving birth’”. Where participants developed trust that they were understood and affirmed by their LMC, this provider was viewed as offering some degree of protection or insulation from the wider perinatal system which was commonly viewed as unwelcoming and unsafe for them and their whānau. Several participants used the metaphor of a bubble to describe that sense of protection offered by their LMC midwife: “as a bubble ay, like just a little bubble ... first six weeks in a little bubble and I think I always knew that it was going to close” (Lor, non-binary, gestation parent).

Difficulty beyond the “bubble”

Beyond this protective “bubble”, many participants feared contact with unknown perinatal care providers and the wider perinatal system. Avery (unspecified gender, non-gestational parent) for example, shared that “it was absolutely fine with [our LMC]. It was more problematic once we were in the hospital, and with the hospital midwives”. Participants commonly experienced gaps and inconsistencies in perinatal providers’ knowledge and understanding about trans-inclusive care beyond the LMC bubble (see also Theme 3). Jesse (non-binary, TTC gestational) reflected:

> *as soon as you’re out of that nice bubble, it’s a roll of the dice on whether that medical professional even knows who a trans person is or if sadly there’s that fear involved of maybe they do know who a trans person is and they’ve already got a preconceived notion and it’s not a favourable one.*

For some participants, the experience of inconsistency in care came from within their own LMC midwife or GP’s practice, when a practice partner stepped in to provide care. Olly described his experience of care from his LMC’s practice partner:

> *she just kept misgendering me, and ‘she-ing’ me, and calling me ‘mum’, or referring to mums in general and me in that, and it was just a real blow, and especially because I was like, fuck, if there is something going wrong you are not the person that I want, but I felt like I didn’t have a choice.*

Many participants described their motivation to try to minimise their contact with the perinatal system beyond their LMC midwife, for example by planning to birth at home, reducing postnatal stays to the minimum, and opting out of childbirth education classes (see Theme 4). However, this was not always possible, and many participants reflected that exposure to care providers and services beyond the LMC bubble was associated with feelings of stress and distress. Tyler (non-binary, gestational parent) was pregnant with twins and was reluctant about their decision to give birth in hospital due to clinical indications, even with the presence of their trusted LMC midwife:

> *But that was one of the reasons why I would have chosen a home birth if I was having one baby at once, to not have to deal with that and expecting that to happen especially at the birth with so many different nurses coming and going, and you know, just wondering who will actually be at the hospital birth besides my midwife and [name], my partner.*

Theme Three. "This odd not fitting in feeling": Systemic and interactional cisnormativity in perinatal care

Key points

- Participants described encountering pervasive binary gender norms that made them feel out of place or excluded from perinatal care settings.
- These binary gender norms were evident both structurally in perinatal care (e.g., in the physical environments of services) and in participants' interactions with care providers beyond their LMC bubble, particularly when participants were hospital inpatients.
- The impacts of not feeling seen or able to be oneself in services included losing trust, questioning quality of care or being worried about future care, disengaging from care, loss of joy, and not disclosing their gender.

Cisnormativity in perinatal care systems

For many participants, the lack of recognition of gender diversity in some perinatal care settings highlighted the diffuse assumptions that all people accessing perinatal care are cisgender, heterosexual, and in monogamous couple relationships. These assumptions were identified by participants in several structural aspects of perinatal care, rather than being attributed to individual care providers: in language, service names, and signage that assumed all service users are cisgender women, in enrolment forms, and in the design and organization of service physical environments such as only providing bathroom facilities for "women". Participants experienced these normative assumptions about the gender, body, and/or relationship of the people using perinatal care as leaving little or no "space" for their gender diversity to be recognised.

> *I was never asked what my gender identity was, at the most basic level there was no form to fill, like it was never on the form, there was nothing in there about pronouns, there was nothing in there about gender or sexuality, and there was no acknowledgement that there were queer people who might be in straight partnering relationships, there was just an assumption that if you were a woman who was not with, who was with someone who was a man, that you were just heterosexual, like its total erasure, that's the thing, like there was just nothing, so I don't really have anything to tell you aside from, there was nothing, no forms, no questions (Ellis, non-binary, gestational parent)*

As Ellis' quote suggests, the expectation that all pregnant people are cisgender women impacted on participants' sense of belonging in perinatal services. As Giuseppe (non-binary, pregnancy loss) described, the language around womanhood and motherhood "ma[d]e me feel really, like I didn't belong there, because I was really clear that I wasn't a mother". Scout shared a similar story:

> *The really gendered nature of it, even things like the posters that are up, it's all very woman-centric, and I can understand that and I didn't necessarily expect it to change, but I also don't feel at home or safe or at ease there, and, you know, with the combination of my mental health and my gender I decided that home birth was definitely the safest option" (Scout, takatāpui, gestational parent)*

Some participants described feeling they had to conform to a normative narrative or "script" about who perinatal care was for, which did not include trans people. The pervasiveness of this script meant that several participants did not feel comfortable or safe to disclose their gender to care providers, or they decided to "let things slide" (Rory, agender, gestational parent) by not sharing their gender, to get through perinatal care services. Nic (non-binary and genderqueer, intending gestational) shared that, throughout their fertility treatment, “it felt like the whole way through, the system isn’t set up for me, and I’m not legible to the system”. When Nic described presenting to the service in ways that made them more intelligible to care providers, they said they had “to tuck a part of myself away […] to minimise how much I can be hurt by the service and how disempowered I am by the service”.

Cisnormativity in perinatal care interactions

Cisnormativity was also evident in some of the interactions that trans people and their whānau had with perinatal care providers. These typically occurred in hospital-based settings when there were fewer opportunities for people to self-determine gender, in contrast to community-based care with their LMC midwives and GPs. The most common experience across participants’ accounts was constantly being assumed to be a woman:

> *most people just assume […] I’ve had that happen to me at the hospital multiple times, when I was going in with pregnancy issues, when I’ve been told that I was not Pete, multiple times. (Pete, transmasculine, gestational parent)*

> *I selected to also have an obstetrician on board […] she’s very nice, but I do remember being misgendered, and I don’t think there was any necessarily, intake process that acknowledged gender diversity (Tyler, non-binary, gestational parent)*

As Tyler’s quote illustrated, participants often attributed being misgendered to structural barriers in services to self-determine one’s gender, rather than individual providers’ ill-intent. Participants also experienced more overt comments or questions that indicated cisnormativity, such aas being told they were in the wrong fertility service (Raven, non-binary, intending gestational). Olly (trans guy, gestational parent) described being asked an invasive question about how they had conceived, which made them feel like a “freak show”. Some participants described interactions with perinatal providers that were overtly discriminatory and transphobic. Before their emergency caesarean section, Rory was told by the surgeon about to perform their surgery that non-binary pronouns were invalid (Rory, agender, gestational parent).

Non-gestational parents valued being actively involved and included in their partner’s care; as Pax (non-binary, intending non-gestational) put it, “I need people to recognise me as the parent from the first go and not as an afterthought”. However, trans non-gestational parents supporting their pregnant partners spoke about how they were often assumed to be friends or a support person in perinatal care, which inadvertently excluded them from important moments in their pregnant partner’s perinatal care.

The cumulative impacts of cisnormativity

Participants’ accounts of cisnormativity suggest that the constant exposure to the norms that privileged cisgender, heterosexual and monogamous people had cumulative effects on their wellbeing over the course of their perinatal journey. These norms were evident both through the invisibility of gender diversity in care settings and more overtly in assumptions, comments and questions among some care providers. Frequent exposure to these norms in some cases led participants to losing trust and confidence in the care they received. These participants discussed being uncertain if they would be believed if they voiced concern about their pregnancy or care and questioned the quality of care and information they received.

> *it’s now kind of second guessing a lot of things like, you know, even down to little things of, when that nurse gave me my injection at night and I ended up getting a bruise later, [was that] because they did it wrong on purpose, or they just didn’t do it right or my skin just bruised because it bruised? (Rory, agender, gestational parent)*

> *[Not being acknowledged as a non-binary person] didn't give me a lot of trust in the care we were getting there. It definitely puts me into a more cynical space where I go, I don't know, I'm not safe to be my whole self here and because you haven't bothered to ask, I don't know that you're a particularly good health professional [...] I'll take everything you say with a grain of salt. (Lor, non-binary, gestational parent)*

For some participants, being misgendered made them "want to withdraw" (Tyler, non-binary, gestational parent) from the care they received or found being misgendered distracted them from their care. Being constantly aware of the gender norms in perinatal care settings was described as detracting from the enjoyment of pregnancy or focus on the pregnant person for several participants:

> *And I felt really sorry for my partner because [going through antenatal classes] was a beautiful moment for us to kind of go through this together, but a lot of it was kind of taken away from them, these kind of situations, and there was more focus on what, things that were happening rather than actually focusing on the great situation of my partner being pregnant (Rex, non-binary, non-gestational parent)*

> *the focus is on māmā in those spaces so the sense of erasure is kind of amplified by the fact that it doesn't feel right to kind of create focus around gender, when the purpose and the holding really, needs to be around māmās in that space (Banfhaídh, gender-diverse, non-gestational parent)*

For some participants, the anticipation of being misgendered or questioned because of one's gender, often informed by previous negative experiences or low expectations of care (see also Theme 1), led to avoiding perinatal care engagement where possible. For example, despite Scout (takatāpui, gestational parent) being ill with severe morning sickness, they "did everything I could to avoid [hospital-based care]" as it was not an affirming nor inclusive environment for them. Similarly, cisnormativity influenced participants' decisions about their birth care. Several participants discussed their preference to birth outside of hospital, in environments that were affirming and self-determined rather than risking exposure to unsafe and non-affirming perinatal care environments. It was important for participants to have a smooth birth, and being misgendered was seen to disrupt this process.

> *I wouldn't need my midwife to be overt about my personal identity but I would need them to be overt that whoever's coming into my birthing space needs to be an ally […] because if you're coming into my birthing space with very heterosexual cisgendered ideas, you're going to interrupt my birthing process (River, non-binary, gestational parent)*

> *part of our reason for choosing a home birth was like, I don't want to be going to hospital and having to be misgendered all the way through my birth, through this very vulnerable, exquisite moment, having to advocate, you know about all of the biases of the hospital system (Lor, non-binary, gestational parent)*

In a few cases, participants described the exclusion in perinatal care settings having longer-term impacts on their parenting identity, including feeling like an "inferior" parent due to not having carried the child, or like a "failure" as a trans parent. As Avery (unspecified gender, non-gestational parent) said, "I think the non, non-ideal start, you know, has put me on the back foot, and maybe put us on the back foot a little bit, so it'd be interesting to see how that flows". These experiences suggest the ways in which participants internalise cisnormative messages and the long-term impacts these can have beyond the postnatal period. As Rex (non-binary, non-gestational parent) reflected:

> *there were so many times, I said to my partner, like I honestly wish we were just in some sort of heterosexual straight relationship, because you, like you saw the joy that other people got, that they had and stuff and it was really, oh, I'm going to cry – and it was really hard.*

Theme Four. "Being a witness in the room of how somebody's being treated": Advocating for trans affirming and inclusive care

Key points

- Participants advocated for themselves and their whānau using a range of strategies when their care was not experienced as affirming and inclusive.
- Self-advocacy was experienced by many participants as mental/emotional labour that added layers of stress and exhaustion to the perinatal period.
- Participants expressed relief and gratitude when their LMC or another trusted provider advocated on their behalf for inclusive and affirming care provision, and addressed overt discrimination, particularly when they were hospital inpatients.

Advocating on behalf of self and whānau

All participants described their commitment to advocating for care that affirmed their gender and was inclusive of them and their whānau and did so using a range of strategies. Like their search for an LMC provider, many participants were proactive and motivated in their efforts at self and whānau advocacy as they navigated wider perinatal services. Self or whānau advocacy took on various forms, including proactively disclosing their gender to perinatal providers; repeatedly asking perinatal providers to use correct names, pronouns, parent titles (e.g., dad or parent rather than mum) and names for body parts (e.g., chest rather than breast); correcting misgendering when it occurred; and addressing discriminatory and negative attitudes from some providers. Raven described contacting their fertility doctor in advance of consultations to let them know their gender and what they needed for their care to be safe and affirming for them: "I sent them an email before the appointment, with a long list of like, look I have a lot of medical trauma, these are my pronouns, this is how I identify, my body doesn't work the same way."

Participants' efforts to be affirmed and included in perinatal care often had to be repeated when information about participants' gender and requested aspects of affirming care (such as correct pronouns) were not handed over from shift to shift nor captured in data systems. Jesse (non-binary, intending gestational) described this:

> *I think it does mean that you constantly have vigilance, constantly doing this extra sort of work of, you know, you walk into a clinic and you're not just there to advocate for yourself and your health problem, but also then educate, and you're a teacher and you're an advocate, and you're a policy maker.*

Despite the energy put into self and whānau advocacy, some efforts were not responded to. As Jesse went on to describe:

> *I did have to fill in a form and I made myself a little box of, you know, "please refer to me as 'Mx' and my pronouns are 'they, them'," and the person at reception went, "ah, thank you, we need to update our forms," and I said, "thank you so much, that would be great." The letter they sent out still said 'she'. They still sent it to 'Ms' Jesse.*

Some self and whānau advocacy efforts demonstrated participants' innovative strategies when they were hospital inpatients and dealing with multiple different perinatal providers over a longer period. Rory (agender, gestational parent) experienced complications with their pregnancy leading to a lengthy stay in the antenatal ward. Along with their partner, they tried to manage their constant misgendering in the following ways:

> *we eventually just made a sign that was, like, on my little night stand next to my bed that said, "this is my name and these are my pronouns." Name, they were usually fine with because that was on my file […] it was pronouns that were really, really difficult, and using inclusive language around kind of, pregnancy, because they are on the antenatal ward and it's just what they do all day every day […] [T]here were some people you had to remind over and over and over even having like a sign there and we tried everything we could.*

Some participants clearly expressed that, while they were motivated and resourceful in their advocacy for themselves and their whānau to be affirmed and included, this took mental and emotional labour that at times detracted from their perinatal experience. Rex (non-binary, non-gestational parent) reflected:

> *like it's supposed to be an amazing time, you're supposed to be focusing on whatever's happening but we're forever having to correct people or be like, "no this is my partner," like you know, this is, like "no, their name is Rex […] not a male," just like that forever having to advocate and rather than enjoying watching, you know, seeing your baby on a scan for the first time.*

Nic (non-binary, TTC gestational) described advocating for fertility care that met the needs of their whānau as challenging: "it feels like me and my loves are constantly like magpies, to try and get what we need, to try and make enough to get through, but that feels difficult." Several participants who attempted to disrupt their erasure through advocating for affirming and inclusive care assumed defensive or embattled positions such as being "always on guard" (Jesse, non-binary, intending gestational), on the "front foot" (Olly, trans man, gestational parent) or as in a "constantly defensive position" (Raven, non-binary, intending gestational) when asserting their needs.

Participants could not always spare the energy and stress associated with self-advocacy, especially during particularly intense and vulnerable parts of the perinatal journey such as childbirth. Rex (non-binary, non-gestational parent) went on to explain:

> *it was a long labour and I remember it just being really challenging […] it was all really, really high tense emotional time and just with the added having to still have those same conversations, I was, you know, I was just like, I can't just keep correcting people, like I'm just, I'm, like it was just like I can't do this anymore.*

On top of this exhaustion, some participants experienced additional layers of fear that "calling out" misgendering and/or negative or discriminatory behaviors by perinatal providers may have negative repercussions for them in terms of the quality of care they received. Rory (agender, gestational parent) reflected:

> *[Y]ou walk this really thin line of how much can I push back or just how much can I not? Because I do need to ultimately let you do what you need to do and is that going to affect my care. Like if something goes wrong, is it going wrong because [the health professional] has been careless because you've decided I don't matter anymore?*

Because self and whānau self-advocacy was emotionally taxing, participants said they didn't always feel they had "the spoons" to self-advocate. This was especially the case for participants who were also navigating other intersecting and compounding marginalities, such as participants who were takatāpui, young, disabled, and/or fat.

> *As a disabled person I don't have lots of energy levels in general, I think it's different kinds of labour, there's an emotional toll, and emotional labour side of it, but there's also real, there's a physical labour to it, you're spending extra time explaining to somebody, you're holding a lot of their emotions in that process, you're doing all of this extra work that a cis person wouldn't have to do (Jesse, non-binary, intending gestational)*

Yet to not self-advocate meant being complicit in their own erasure, which carried its own emotional tax. The constant dilemma participants faced about when to self-advocate and when to accept misgendering and/or negative attitudes was described by Olly (trans man, gestational parent):

> *I think it's easier sometimes to just put on some psychological armour and field the misperception than to have those uncomfortable conversations and try and educate people, and usually it gets worse, it's more uncomfortable, if people are not cool about it then it's way worse, so, than just "oh well this person scanning my tummy thinks I'm a woman", whatever.*

One strategy employed by several participants to manage this dilemma was to weigh up the amount of contact they were likely to have with the specific perinatal provider and to invest their advocacy efforts with those perinatal providers they were likely to see more frequently. As Olly's quote demonstrates, participants were less likely to self-advocate with providers such as sonographers or phlebotomists who they might not see again. However, this compounded participants' sense of erasure and being embattled. Rosa (cisgender woman, non-gestational parent and Pax's partner) described the constant weighing up of whether self-advocacy was worth the effort:

> *It's the level of interaction that you're going to have with them as well, right, so like [name], the doctor, totally, we kept on correcting her […] [b]ut it was worth the effort in that regard, right, but if you go in and like a receptionist or nurse that you're going to encounter once, the level of energy required to correct them and explain it versus somebody that you know that you're going to come across routinely.*

Being advocated for: The critical role of LMCs

Because self and whānau advocacy was experienced as constant and draining throughout the perinatal care journey, participants expressed relief and gratitude when their healthcare providers (usually their LMC) advocated on their behalf. Rory described how their LMC midwife's advocacy improved their resiliency: "it's just that that taking that piece off of my plate so I can do what I need to do, rather than just being spread super thin." Several participants used metaphors that evoked their LMC as a type of defense system, particularly during the intense time of giving birth. Rory (agender, gestational parent) reflected "[our LMC midwife] was just on it, from the beginning, she was so fantastic, a really good like, fierce defender of me too with all of the different medical personnel that I ended up encountering."

LMC advocacy on behalf of trans people and whānau took multiple forms including trying to prevent misgendering through communication with other perinatal providers and in-patient services, "guarding" the birthing space, trying to connect participants with other Rainbow-inclusive providers such as childbirth educators and obstetricians, and actively addressing negative and harmful behaviors and interactions with other perinatal providers. Rory, for example, recalled the actions taken by their LMC midwife after the upsetting interaction with the surgeon just prior to their caesarean section:

> *My midwife came in shortly after [the incident with the surgeon] and I told her immediately what had happened and she […] submit[ted] a complaint for us, saw if there was any, that close to a surgery you can't really switch out the surgeon but she tried for us, and so it was more she just kind of was the buffer between me and the surgeon.*

Pete (transmasculine, gestational parent) described his LMC midwife's pre-emptive attempts to reduce misgendering and negative interactions when he was in hospital to have his baby, along with his obstetrician's advocacy, when Pete was misgendered anyway: "when I was going in to have [my child], she made sure that on my notes, saying that you had to call me by Pete and 'he, they' […] [The hospital staff] didn't manage it well but thankfully my obstetrician had a nice, lovely word with them." While many participants expressed relief and gratitude for their LMC's advocacy efforts some also acknowledged the additional labour this placed on providers who were already under strain, as Avery (unspecified gender, non-gestational parent) reflected:

> *so it's kind of the role of people around you to help be that advocate for you, and I do think that midwives fall into that category but like I said they are also very overworked, underpaid, under-appreciated as health providers, so I think that should be part of the job, I don't necessarily expect that, because they have so much going on already.*

Some participants also reflected that it was often LMCs and other perinatal providers who were LGBTQIA+ themselves who were most willing to step into an advocacy role of their behalf. Rex (non-binary, non-gestational parent) questioned where heterosexual and cisgender allies were in stepping up to advocate for queer and trans whānau in perinatal care:

> *it's sad that it's the same people having to advocate or try and push for it, but it's really hard to even find some good allies that push it or try and do the same thing, like it's yeah, it's people from within the community still fighting for other people in the community.*

Theme Five. "I want to engage, it brings me joy, I feel seen": The characteristics of affirming and inclusive care for trans people and whānau

Key points

- Many participants described aspects of perinatal care that were safe, welcoming, affirming and inclusive for them and their whānau and/or could imagine what this kind of care would mean for them.
- Providers who deliver this care demonstrate common characteristics. They are 'knowledgeable about and aware of gender diversity' and they are 'self -reflective and culturally humble when working with trans people and whānau'.
- Participants described or imagined how safe, welcoming, affirming and inclusive care improved perinatal care experiences, engagement, and outcomes for trans people and whānau.

Despite some of the challenges that engaging with perinatal care presented to trans people and whānau, participants offered reflections about the characteristics of the positive perinatal care they received (or wanted to receive) that was safe, welcoming, affirming and inclusive of trans people and whānau.

Common characteristics included providers who are *knowledgeable about and aware of gender diversity*; and providers who are *self-reflective and culturally humble when working with trans people and whānau* (Tervalon & Murray-Garcia, 1998).

Knowledge and awareness

Participants described a range of practices that perinatal providers did (or could do) that would constitute knowledgeable and aware care in relation to gender diversity. This included providers who actively signalled that they were aware and welcoming of gender diversity (see also Theme 2); providers who invited trans people and whānau to self-determine their gender and calmly and consistently reflected this; and providers who adapted their practice to be inclusive of trans people and whānau, such as through changing their language. Several participants stressed how uncomplicated baseline knowledge and awareness about gender diversity can be. As Brodie (non-binary trans man, intending gestational) reflected: "Well, I think [gender-affirming care is about] just people not making assumptions, largely."

Setting aside assumptions and inviting trans people and their whānau to self-determine what and who was important to them was described by participants as foundational to care that would be experienced as affirming and inclusive. This included inviting participants to self-determine their gender and pronouns, the words they used to describe parts of their body and how they wanted to be referred to as a parent, who their partners and significant other people were and how they were referred to, and how the sex/gender of their baby would be identified. Tyler (non-binary, gestational parent), for example, reflected:

> *[my LMC midwife] just affirmed back that they had that experience, and knew how to use that language, and also that I could feel welcome to correct them if there was ever any moment when I was feeling unaffirmed or like the language was binary, and yeah.*

Self-reflection and cultural humility

In addition to having providers with the knowledge and awareness to engage with gender diversity, participants valued providers who were self-reflective and culturally humble in their practice with trans people and whānau. Participants stressed that they didn't expect perinatal providers to be perfect. Being self-reflective and culturally humble involved providers taking responsibility for their own learning (and unlearning) and being committed to improving care for trans people and whānau; acknowledging mistakes, apologising and moving on; inviting feedback from participants and incorporating this into continually improving their practice. Lor (non-binary, gestational parent reflected: "I really trusted (LMC midwife's name), and (LMC midwife's name) like demonstrated that she could, if she got the pronouns wrong, that she could change quickly and apologise and it wasn't going to be a big deal". Most participants expressed their appreciation of providers who were willing and open to learning about gender diversity even when it was out of their sphere of experience. That said, participants highly valued care providers who were careful not to task trans people and whānau to educate them and who had done their work to be knowledgeable and aware in advance of or in between care encounters. As Olly (trans man, gestational parent) described:

> *[Our LMC midwife] just didn't really seem to bat an eyelid about it and I think that's what was so great, and on the whole it seemed like she either knew her shit, because, you know, some people just do, or she'd done her work, like she'd done her own work, to find out what she needed to do.*

Authenticity and respect were values participants associated with reflective and culturally humble perinatal care. Authenticity meant not just making signs or shows of affirmation and inclusion but meaningfully engaging in the process of inclusion, taking feedback from trans people and whānau on board and continually improving care. As Rory (agender, gestational parent) observed:

> *I think another big piece is kind of that authenticity and that drive to actually want to be inclusive, because again, seeing those signs everywhere that say 'hey, we're trying to do better, let us know if there is anything we need to do,' but then they would push back when you try.*

Similarly Rex (non-binary, non-gestational parent) emphasized that, while it was okay for providers to make mistakes such as misgendering someone, there needed to be a meaningful commitment to changing their practice: "if they make a mistake, own it, "hey look, I'm really sorry," but don't keep on doing it, like I'm not asking for a lot, I'm just asking for the real basic type of, you know, just be respectful."

Decreasing stress, increasing engagement, improving outcomes

Participants shared insights on how positive care experiences could improve the trust and engagement of trans people and whānau in perinatal care, which in turn could reduce stress, fear and exhaustion, leading to better outcomes for themselves and their whānau. As Nic (non-binary, intending gestational parent) described, "it makes such a huge difference being, feeling seen in all of you."

Participants described the possibilities of affirming care to increase one's ability and motivation to engage in perinatal care. Tyler (non-binary, gestational parent) described how feeling affirmed by their LMC made them "feel like I'm a part of the experience rather than kind of removed from it." Similarly, Giuseppe imagined the impacts of affirming pregnancy care: "I want to engage, it brings me joy, I feel seen...[h]aving this gender affirmative care is like, you don't need any of the boxes, and we're going to walk with you in whatever space that is."

Some participants described the positive impacts that being affirmed had, or would have had, on their mental health and wellbeing. For Rory (agender, gestational parent) affirming and inclusive care would have been "that one fewer thing to worry about, that would have been amazing." Some participants also described a connection between the wellbeing associated with safe and affirming care and physiological pregnancy and birth. As Annika (genderfluid, gestational parent) observed:

> *If you feel safe, you can be more relaxed […] a person does need to be very relaxed when they're birthing a human, like if someone feels unsafe, even not thinking about it, your body tightens up and your muscles clench, everything can be quite tense so it's important to be able to feel safe, and warm, and relaxed. And if you feel like you're constantly having to remind people who you are you can't take the time to relax.*

Beyond birth, other participants spoke of the longer-term benefits of an affirming and inclusive perinatal care experience. Lor (non-binary, gestational parent) for example, described their experience of affirming and inclusive LMC midwifery care as a resource that would continue to empower their whānau into the parenting years:

> *I feel like birth and pregnancy is one of those critical moments where if you provide great care you can really influence the outcomes for people as parents and further down the track […] maybe it's just when you have a stink experience, being able to go, it wasn't always like this, there was one time that we felt good, you know, and that has a long-term effect on the shape of your mental health and the number of resources you have to draw on because those resources are memories.*

Phase One discussion

We have described the challenges our participants encountered in perinatal care that compounded their experiences of vulnerability and stress throughout their pregnancy journey. Our findings also demonstrate that trans people and whānau do access affirming and inclusive perinatal care but currently this largely depends on individual LMCs who have taken self-responsibility for their own preparedness. However, this dedication to providing affirming and inclusive care for trans people is often not experienced in the wider, highly gendered perinatal system (particularly in hospital-based services), which were described by many participants as unsafe due to anticipated and actual experiences of being excluded from or misgendered in care interactions. Our findings highlight the unique impacts that widespread gendered assumptions about pregnant people and their whānau can have on trans people's trust and engagement in care and on their wellbeing.

Some of our findings in relation to participants' expectations of perinatal care not being affirming nor inclusive outside of their chosen LMCs, and taking on the responsibility of self-advocacy, are consistent with themes identified in Norris and Borneskog's (2022) review of 32 papers on trans and non-binary people's sexual and reproductive healthcare. They found that being fearful about healthcare encounters could lead to adverse health-seeking behaviours among trans people such as avoiding necessary care. The "onus" on trans people to self-advocate for inclusive and appropriate care, in response to low levels of healthcare provider knowledge, was also identified as a barrier to seeking care. Our findings support Norris and Borneskog's assertion that there are several "cisnormative blindspots" that need to be attended to in sexual and reproductive health settings. Minimising the adverse impacts of assuming all people are cisgender - and more specifically of the perception that pregnancy is exclusively compatible with womanhood - is a critical part of service design and provision.

This study also contributes novel findings to the existing literature on trans people's experiences of perinatal care. First, as most literature to date has largely focused on trans men and transmasculine people, our findings highlight the specific challenges that non-binary people experience to being recognised or "legible" as non-binary people in perinatal care. Some participants spoke about not being believed as non-binary people by care providers in various ways, suggesting that there may be low levels of understanding among healthcare providers about who non-binary people are, or a misperception that being non-binary 'looks' a certain way. Because common assumptions about trans people still tend to be based on binary framework of gender (Vipond, 2015), non-binary people may be required to do more self-advocacy for their identities and experiences to be understood. Importantly, the experiences of trans non-gestational parents is an under-researched area that we have identified warrants further research. Our initial findings suggest that cis-heteronormative ideas of whānau creation act as barriers to the full involvement and inclusion of trans non-gestational parents.

It is important to note that both the positive experiences and challenges that participants identified in our study and those identified in other similar studies cannot be attributed solely to either individual providers' practices or structural issues in perinatal care. Rather, these two layers of care provision must be considered in relation to one another, and both must be addressed. For example, if trans inclusion is proactively addressed at a structural level, through evaluating the inclusiveness of physical environments, including trans health in pre-registration education, and ensuring opportunities for professional development, this may contribute to creating cultures of inclusion that enable staff to be prepared to provide affirming and inclusive care.

Part of the broader challenges facing perinatal care

Trans people and whānau are not unique in being underserved by the perinatal healthcare system. It is well established that the perinatal system is underserving Māori and Pacific peoples along with ethnic communities, young people, people with disabilities, and people living in areas of higher deprivation (Dawson et al., 2022; PMMRC, 2022). Being in Aotearoa New Zealand, the perinatal sector is required to uphold the principles of Te Tiriti o Waitangi. We acknowledge at all steps of the perinatal journey that this bare minimum standard has not been achieved. As it is, wāhine Māori and their babies are at higher risk for mortality and morbidity during the perinatal period and as such the perinatal system is said to be failing Māori (Stevenson et al., 2020). A common thread in research that describes the experiences of communities underserved by perinatal care is the failure to provide base level safe and culturally responsive care when these whānau interact with the perinatal system.

Stevenson et al.'s (2020) Kaupapa Māori research, for example, interviewed 10 wāhine and their whānau who entered the perinatal system unexpectedly following the harm or loss of their baby. Wāhine and their whānau described their care as lacking tikanga manaakitanga – support, kindness and concern for their cultural practices and beliefs; tikanga rangatiratanga - the ability to have self-determination over what care was provided and how it was provided; and tikanga whakawhānaungatanga - the opportunity to develop meaningful relationships with providers and to collaborate in care that meets the needs of their whānau. In the absence of tikanga manaakitanga, tikanga rangatiratanga, and tikanga whakawhānaungatanga, wāhine and their whānau described being "denied the opportunity, and right, to be and openly thrive as Māori" (p. 68) in their care encounters, which diminished their mana and wairua, and led to feelings of powerlessness, isolation, alienation and feeling unconnected in their care (Stevenson et al., 2020).

There are some common threads between Stevenson et al.'s (2020) findings and those we have presented here. Participants and their whānau in our study also described lacking opportunities to be known and supported as *trans people* in broader perinatal care systems, frequently experienced care settings as unwelcoming and inflexible to meet their needs, and often lacked opportunities to self-determine their gender and other aspects of care that would be affirming and inclusive for them and their whānau. Care that was not culturally responsive to them as trans people, put whānau on the defensive, drained them mentally and emotionally through their self-advocacy efforts, and sometimes disengaged them from care altogether. The cumulative effect was to make perinatal care something that was endured and that led to a loss of wellbeing at a significant and often stressful time for whānau.

A base level of safe care for everyone

Because some of the drivers of systemic failures in perinatal care for underserved communities are shared, we argue that improving the cultural responsiveness of perinatal care to align with both Te Tiriti o Waitangi and Te Ao Māori - as proposed in frameworks such as Te Hā o Whānau (Stevenson et al., 2020) will also benefit trans people and whānau. We therefore explicitly position the needed improvements in perinatal care for trans people and whānau as part of the broader task to achieve equity for all communities who are currently underserved, which necessarily starts with addressing Te Tiriti o Waitangi breaches and improving the perinatal care system for Māori. The principles of self-determination and cultural humility highlighted by trans participants and their whānau in our study are congruous with, and add further compulsion to, work towards culturally responsive perinatal care for all.

Participants spoke of valuing care providers who demonstrated an openness and willingness to learn. Cultural humility involves lifelong commitment to self-reflection and self-critique by health professionals, and tasks them with identifying and addressing power imbalances in institutional settings (Tervalon & Murray-Garcia, 1998). Rather than placing expectations on healthcare providers to be experts on others, as is typical in cultural competency approaches (Curtis et al., 2019), the health professional is actively involved in understanding their own beliefs, cultural identities, and norms. Developing and enhancing the capacity of the perinatal workforce to work in culturally humble (and/or culturally safe) ways with diverse whānau means that perinatal providers can meet whānau with a spirit of *not knowing*, opening up spaces for whānau to self-determine who they are, who and what is important to them, and what kind of care will best meet their needs.

Participants in our study affirmed gender self-determination as fundamental to perinatal care that is safe, welcoming, affirming and inclusive for trans people and whānau. For our participants and their whānau this meant that both perinatal systems and individual providers would take responsibility for identifying and addressing cisnormativity wherever it is embedded, and hand power over to trans people and whānau to self-identify their gender and who makes up their whānau, the language they use to describe their bodies and their parenting roles, the ways in which their baby is gendered, along with any other aspect of care that affirmed them and their whānau as trans. Embedding the practice of cultural humility and the principle of gender self-determination in perinatal healthcare is likely to be beneficial for everyone by providing space for broader understandings for who whānau are and what they need. This will help “warm the Whare,” reconnecting underserved whānau to perinatal healthcare.

Raising knowledge and awareness

Our Phase One findings also present a wero (challenge) to ensure the perinatal workforce is being prepared with some knowledge and awareness about gender, sexuality, sex characteristics and relationship diversity so that all perinatal providers are safe for trans people and whānau to interact with. Many participants described care from their LMC midwives that was responsive and aware because these midwives took responsibility for their own learning about trans people’s health and perinatal care needs. At present the preparedness of these midwives for affirming and inclusive practice with trans people and whānau is often not reflected in the wider perinatal system or in the care provided by other perinatal providers, where care becomes inconsistent and often unsafe for trans people and their whānau. This creates a two-tiered system of perinatal care that is antithetical to Aotearoa’s integrated system.

Trans people and whānau value the ability to self-determine their lead perinatal care provider and are highly motivated to ensure that provider is safe for them and their whānau. Any reforms to the existing LMC midwifery model need to be cognisant that this model is currently working well for those trans people and whānau who have the personal resources to seek out an LMC that works for them, and/or who are in urban areas where they may have a choice of provider. Finding an LMC with whom trans people and whānau feel safe and comfortable is more challenging when they live outside urban areas and/or face compounded marginalities leading to competing priorities, such as housing and mental health. This emphasises the need for consistent care across the perinatal system whenever trans people and whānau interact with services, a need identified in other international studies on Rainbow people’s experiences of accessing perinatal care (e.g., Kerppola et al., 2020).

A mandate for improving perinatal care for trans people and whānau

Te Pae Tata, the Interim New Zealand Health Plan, commits to improving access to health services that work for Rainbow communities, including trans and non-binary people, recognising they have been underserved by the New Zealand health system (Te Whatu Ora|Te Aka Whai Ora, 2022, p. 16). This is part of a systemic commitment to transforming our health system so that it delivers health equity for those communities consistently underserved, also including Māori, Pacific people, tāngata whaikaha (disabled people), rural communities, those on low incomes, and ethnic communities. Crucially, takatāpui who are gender diverse, and trans people and whānau who are also part of other underserved communities may navigate intersecting and compounding barriers to accessing healthcare. These barriers include the impacts of colonisation and racism (Espiner et al., 2021) and ableism (Roguski et al., 2022), alongside hetero- and cisnormativity in health systems (Pihama, 2020).

Improving access to healthcare for trans and non-binary people, and Rainbow people more generally, has been identified as a global priority for addressing rainbow health inequities, including during the perinatal period (e.g., Green & Riddington, 2020).

The International Confederation of Midwives (2017) position statement 'Human Rights of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People' recognises that LGBTI people have been marginalised within pregnancy and birth care, disengaging them from care and putting their health at risk; the statement also affirms all people's "right to self-determination and their right to receive health care that is free from discrimination" (p. 1).

Phase One of this report has provided insight into the need to improve perinatal care for trans people and whānau and their perspectives on how this can be achieved. Phase two of this project offers insight on the current readiness of a broad sample of the perinatal workforce to meet this challenge and the education needed to support them. At the end of this report, we present 'Warming the Whare: A Te Whare Takatāpui informed guideline for trans inclusive perinatal care - which brings Phase One and Two insights together to provide guidance for the changes (both systemic and individual provider level) needed to ensure equity of access to and outcomes from perinatal care for trans people and whānau.

Strengths and limitations

One of the strengths of this phase of the project is that it fills an identified gap in existing literature about how trans people and whānau experience perinatal care in the context of Aotearoa's unique LMC integrated model of primary maternity care, and that it includes non-gestational parents and centres the whanau as the smallest unit of care. Another strength is that it is trans-centered, by being conducted by and for trans people. The experiences of trans people and whānau captured in Phase One were used to shape the survey questions in Phase Two. Additionally, trans team members - GP and AK – were responsible for recruitment, interviewing, and leading the analysis of Phase One data. This is consistent with a trans epistemology that centres trans people's capacity to claim and produce knowledge about the world as it is experienced by them (Radi, 2019). Our participants included a diversity of genders, experiences of gender affirmation and medical transition, family formations, ages, and geographical locations around the country, giving us some rich insight into trans family creation in Aotearoa. Our participants were also diverse in terms of other aspects of their lived experience, including being neurodivergent, disabled, and experiencing other forms of marginalisation, such as those related to their ethnicity, socio-economic status and chronic illness.

Phase One also has some limitations. As participants were relatively ethnically homogenous over-representing NZ European experience, we are limited in our ability to examine in depth the relationship between race and colonisation as they intersect with gender diversity in perinatal care. Additionally, none of our participants disclosed that they had innate variations in their sex characteristics, which means we were not able to explore Intersex people's experiences of perinatal care. We recognise this as an area that warrants further research. We note many participants described positive experiences with their LMCs. Because the recruitment flier was shared by LMCs who were aware of and actively supporting the project, we may have an overrepresentation of participants who had received affirming and inclusive LMC care.

Phase Two methods

Phase Two of the Trans Pregnancy Care Project received Ethics approval from Te Herenga Waka – Victoria University of Wellington's Human Ethics Committee in August 2022 (#0000029879). In this phase, we developed and carried out an online anonymous survey to assess the current knowledge, beliefs and clinical preparedness of health professionals in the perinatal workforce in Aotearoa New Zealand.

Survey design

The perinatal workforce survey was collaboratively designed with input from all research team members. SM wrote a first draft of the survey, on which SB, GP and AK gave iterations of feedback. We sent the first draft to our wider research team and our project's parent advisor Scout Barbour-Evans and integrated their feedback. We also sought and received feedback from Gender Minorities Aotearoa, Intersex Aotearoa (ITANZ), Te Kāreti o ngā Kaiwhakawhanau ki Aotearoa: New Zealand College of Midwives, and Dr Edward Hyde (an obstetrics and gynecology consultant).

Our survey was structured in four sections: demographic information; what is currently happening in respondents' community-based practices and institutional work settings; education and professional development on gender diversity; and individual knowledge and beliefs about gender and sexuality diversity. We considered the advantages and limitations of using validated scales to assess healthcare professionals' knowledge, beliefs and clinical preparedness for working with trans people. After assessing the existing validated scales, we found that most were either irrelevant to our research questions and research context, or they included harmful language and stereotypes about trans people that we did not want to reinforce through our survey. They also did not reflect any consideration of Indigenous perspectives, a strong focus within our own research.

We decided to develop new questions directly relevant to our research questions and aims, given the unique perinatal care model in Aotearoa and our intentions to develop an educative and strengths-based survey. The questions in the survey were largely informed by the priorities and issues that interview participants named in Phase One. To finalise the survey questions, each research team member individually ranked their perceived importance and relevance of each item in a matrix, and then removed the least ranked items from the scale.

Questions included a range of response types. Some required a yes/no response with options for *don't know* and *prefer not to say* as appropriate; others required a numeric or categorical response from a drop-down menu; while the majority of questions asked for responses on a Likert-type scale. These included five-point scales with options from *never to frequently* and from *never to always*, as well as questions that asked respondents to rate their agreement with statements using a five-point scale from *strongly agree* to *strongly disagree*. A number of questions provided the option for free-text responses in addition to the quantitative response.

Data collection

The final survey draft was loaded into Qualtrics and survey logic was used to create a survey flow that showed questions only relevant to participants based on their previous answers. The survey was translated into Te Reo Māori by kaimahi recommended by the Kaitohutohu Office (Māori research office at Te Kura Matatini ki Otago / Te Pūkenga) and participants could choose to take the survey in Te Reo Māori or English.

Before disseminating the survey, we asked eight colleagues, who had expertise in health but would not be eligible to take the survey, to test the survey for comprehension, timing, survey logic and general feedback. We then implemented this feedback where applicable.

People were eligible to participate if they were 18 years or older and were currently practising as a perinatal care provider in Aotearoa, defined in the survey as "provid[ing] care related to fertility, pregnancy, birth and the postpartum period (up to 6 weeks after birth) to people in Aotearoa NZ".

We sent an invitation to take the survey to various professional bodies, organisations, and individuals related to perinatal care in Aotearoa, as well as posting about the survey on our social media pages. Various professional organisations agreed to share the invitation to participate with their membership. These included Te Kāreti o ngā Kaiwhakawhanau ki Aotearoa: New Zealand College of Midwives (NZCOM); Royal Australian and New Zealand College of Obstetricians and Gynaecologists (through their newsletter *Pānui*); Perinatal Society of New Zealand; Physiotherapy New Zealand; Royal New Zealand College of General Practitioners; Ngā Maia - Māori Midwives Aotearoa; Pasifika Midwives Association. The invitation was also shared on social media by other supporting organisations including Women's Health Action Trust and Parents Centre.

Data analysis

Three respondents started the Te Reo version of the survey but two switched to the English version. The third person's data was removed during data cleaning due to no data added beyond the demographics. All analysis was therefore conducted from the English version.

Data was extracted from the Qualtrics platform after removal of duplicate entries. It was then anonymised by the Research Assistant who had signed a confidentiality agreement. Data was uploaded into IBM SPSS Statistics (Version 28.0.1.0) and cleaned by removing data from respondents who had not progressed past the demographic questions.

The remaining data set comprised 476 respondents. Data was analysed to produce descriptive statistics such as frequency tables and, as appropriate, means and standard deviations. The qualitative responses within the survey were summarised to present key content areas and illustrative comments were included in the findings.

Phase Two key findings

This section of our report presents the findings from the national online survey of perinatal health practitioners. It provides evidence from a large sample across our perinatal healthcare professions as to where the workforce in Aotearoa is currently at with respect to their experience, knowledge and clinical readiness to promote trans and non-binary, intersex and takatāpui inclusion in perinatal service delivery. We present here overall summaries of the data but please refer to additional data tables located within the appendices of the report where indicated.

Our findings are presented in four sections:

- the demographic characteristics of the respondents
- information about what is currently happening in workplaces in relation to inclusive practice
- information about respondents' education experiences and preferences
- information about the knowledge, beliefs and clinical preparedness of the perinatal workforce.

A note about missing data: there were some areas within the survey where missing responses accounted for up to 73% of the data. In some cases this high number of missing data was due to the question not being relevant for the respondent's workplace, so was not unexpected. We have reported missing data transparently in this report, and any instance where the analysis included only the responses that were collected (ie the missing data was excluded), this is also described transparently, such as in Section Four, where the number of responses (N) for each statement is presented for readers to assess the findings in relation to the response size to each item. Whole numbers are presented for means and all percentages are rounded.

Section One: Respondent demographics

A total of 476 individuals participated in the survey and the characteristics of respondents are presented in Tables 2 and 3 in Appendix 1.

The mean age of respondents was 44 years (SD = 12; range 18 – 74). Prioritised ethnicity indicated 11% identified as Māori, 64% identified as NZ European and 19% as other European. Pasifika, Chinese, Indian and other non-European accounted for the final 5%. While most (93%) identified as wahine/woman, 4% identified as tane/man and 2% as another gender.

Those who considered themselves to be trans or non-binary accounted for 2%, takatāpui for 1.5%, born with a variation in sex characteristics (VSC) as 0.2% and the balance of 94% identified they were not trans or non-binary. While 74% identified as heterosexual, others described themselves as being bisexual (8%), pansexual (4%), lesbian (4%), queer (3%) fluid (2%) and something else (1%). Less than1% chose a range of other descriptors.

When professions were collapsed into three groups, the majority were midwives (67%) with 19% identifying as doctors and 15% as other health professionals. Those who were registered in Aotearoa NZ had been so for a mean of 17 years (SD 10.99, range: 1 – 41). Most had completed their qualification in Aotearoa NZ (72.2%) with 16% in the UK, 3% in Australia and the balance in a range of other countries.

The mean time practicing in Aotearoa NZ was 15 years (SD 10, range: 1 -41) and respondents most commonly practiced in major urban settings (58%) with decreasing numbers in large (19%), medium (7%) and small (4%) settings and 8% practicing in rural settings.

Most respondents identified they never or rarely provided perinatal care to trans or non-binary people (76%) or to Intersex people (85%) but a small number occasionally or frequently provided perinatal care to trans or non-binary people (7%) or to Intersex people (7%).

Clinical settings where respondents worked were spread over five settings: community-based practices (46%), hospital wards or birthing suites (33%), hospital-based clinics (10%), other settings (6%) and care in clients' home only (4%).

Section Two: Inclusive practice in the workplace

Respondents were asked about activities that they were currently engaged in to be more inclusive of trans clients/patients and also to indicate if they were moving towards such inclusion or not.

The activities most frequently identified by respondents as already being in place related to the provision of gender-neutral bathrooms (54%), having clinical documents with space to record details for more than one support person (54%) and having a gender-neutral name for their practice (43%). Respondents less frequently identified having documents with space for recording gender or sex options other than 'male' and 'female' (37%) or for recording personal pronouns (31%).

Policies on gender inclusive employment practices and policies to support trans inclusion were cited by less than a quarter of respondents. Very few respondents reported that they were engaging in activities to be inclusive of trans and non-binary people, and over half said they were not even progressing towards this. The activity that respondents were least commonly engaging in was that of visibly displaying trans inclusive imagery or information materials in the waiting area or ward space (Table 4).

Table 4. Progress on activities in the workplace to be inclusive of trans and non-binary people (percentages rounded)

Total respondents = 476

	Yes n (%)	Working toward n (%)	No n (%)	Missing n (%)
My online professional/practice profile specifically mentions that I welcome trans and non-binary people.	71 (15%)	81 (17%)	195 (41%)	129 (27%)
Some of the documents I use (e.g. enrolment or hospital admission forms) have space for recording gender or sex options other than 'male' and 'female'.	176 (37%)	66 (14%)	167 (35%)	67 (14%)
Some of the documents I use (e.g. enrolment or hospital admission forms) have space for recording personal pronouns.	145 (31%)	77 (16%)	191 (40%)	63 (13%)
Some of the documents I use (e.g. enrolment or hospital admission forms) have space for recording details of more than one support person.	255 (54%)	38 (8%)	115 (24%)	68 (14%)
My workplace's social media, website or marketing materials include reference to trans and non-binary people.	91 (19%)	82 (17%)	196 (41%)	107 (23%)
The waiting area or ward space in my workplace visibly displays trans- and non-binary-inclusive imagery or information materials (e.g. trans pride flags, posters with welcoming messages).	58 (12%)	65 (14%)	280 (59%)	73 (15%)
The name of my practice is gender-neutral (e.g. Birth Care, Peoples' Place).	204 (43%)	16 (3%)	155 (33%)	101 (21%)
The signage in my workplace is gender-neutral or gender-inclusive (e.g. service name signage for an antenatal clinic, waiting room signs).	156 (33%)	33 (7%)	194 (41%)	93 (20%)
My workplace has gender-neutral bathroom facilities.	256 (54%)	10 (2%)	146 (31%)	64 (13%)
My workplace has a policy on gender inclusive employment practices.	119 (25%)	65 (14%)	157 (33%)	135 (28%)
My workplace or practice has policies or guidelines to support trans and non-binary inclusion.	82 (17%)	90 (19%)	195 (41%)	109 (23%)
I have received formal feedback from my trans and non-binary clients/ patients about their care.	71 (15%)	17 (4%)	226 (48%)	162 (34%)

When asked about inclusion of the same activities for Intersex people and takatāpui people the results indicate considerably less progress on specific inclusion of these communities (see Tables 5 and 6 in Appendix 1).

Free-text responses associated with this question identified further inclusion activities such as use of pronouns on badges, email signatures, changing the service name from 'women's health' to 'obstetrics and gynaecology', changing forms to include space for pronouns, extra support people, terms parents would like to use for baby and parent identification, using gender neutral language when teaching, and avoiding making assumptions about gender/sexuality of parents. The tone of the comments generally indicated a willingness to be inclusive, and this is illustrated by the following respondent comments:

> *I check notes for information regarding preferred pronouns, as our LMC and community midwives are good at ensuring they've noted if someone is non-binary, trans or has a non-heterosexual partner, but generally don't ask directly if the person appears to have a fairly clear gender presentation. If I am unsure of someone's gender I will introduce myself with my pronouns to open up the opportunity for them to do likewise.*

> *Trying to change the toilets at hospital entrance to all gender toilets rather than female and male. Categorising the ward toilets to room number rather than male and female. Trying to attend the study days ... Possibly becoming part of a focus group to assist in policies and guidelines in this area.*

> *[...] As the mother of two trans children I have an interest in including all pregnant people in my care.*

Perspectives from two Māori respondents were illustrated by the following comments:

> *As a Māori midwife, we use the word IA often which incudes in our world non-binary intersex, hence why you may not have policies etc as we don't need it.*

> *[...] working with Māori we don't discriminate in this realm I believe, we live and work from a Te Ao Māori view.*

A minority of comments suggested all care was appropriately focused to individuals and as such suggested there was not the need for specific activities to be inclusive of gender diversity.

Use of inclusive language

Respondents were asked questions about how often they used clients'/patients' correct pronouns and language in relation to describing their own bodies. Responses were indicated on a five-point Likert scale ranging from *never* to *always* (Table 7). Most respondents (60-70%) reported that they "never" or "sometimes" shared their pronouns when introducing themselves; asked clients/patients about their pronouns; observed staff at the place they worked asking patients/clients to share their pronouns; or asked their clients/patients about the words they used to describe their body parts.

A minority (6 to 14%) responded to use of inclusive language with "mostly" or "always". The pattern was reversed when clients/patients provided pronouns or shared words they used to describe their body parts. Respondents were much more likely to use these pronouns (62% always) or words for body parts (48% always) when these had been shared with them.

Table 7. Use of inclusive language

Total respondents = 476

	Never n (%)	Sometimes n (%)	About half the time n (%)	Mostly n (%)	Always n (%)	Missing n (%)
When I introduce myself to clients/patients I share my pronouns	257 (54)	76 (16)	11 (2)	21 (4)	14 (3)	97 (20)
I ask clients/patients about their pronouns	155 (33)	162 (34)	14 (3)	25 (5)	24 (5)	96 (20)
Staff at the place I work ask for clients'/ patients' pronouns	163 (34)	133 (28)	8 (2)	18 (4)	11 (2)	143 (30)
I ask my clients/patients about the words they use to describe their body parts	152 (33)	138 (29)	16 (3)	37 (8)	30 (6)	103 (22)
I use a client's/patient's self-determined pronouns	36 (8)	23 (5)	2 (0.4)	45 (10)	249 (52)	121 (25)
I use the words that my clients/patients use to describe their body parts in my interactions with them	52 (11)	50 (11)	14 (3)	100 (21)	128 (27)	132 (28)

Respondent comments related to use of language included the following:

> *Asking if there is a name they prefer to use other than their 'legal' name. Checking what 'parental' name they and their partner(s)/other parent(s) (if one) want to use and if they are OK with me using them when talking with the baby. Asking how they want the baby referred to and other things important to them around gender.*

The questions also prompted some reflection on current behaviour.

> *Embarrassingly, I'm guided by what is handed over to me or what is documented by the LMC rather than asking myself.*

Other comments identified strategies for asking about pronouns:

> *During introductions I ask "what do you like to be called?" This offers a space for sharing pronouns or true names, while also being useful for getting to know patients who are unfamiliar with rainbow related kaupapa (sharing nicknames, preferred titles etc)*

Leadership from management was enabling of change:

> *We are all asked to put our pronouns in our email signature and I recently gave a talk on trans healthcare in O and G and what's available in the [region] and the importance of using pronouns in creation of safe space*

Other inclusive initiatives

A free-text question invited respondents to share anything else about what was happening in their work area around trans, non-binary, Intersex or takatāpui inclusion. A range of views from 107 respondents were expressed in this section. These included many strategies and actions as well as global comments about practitioners' willingness to embrace change if properly supported to do so. Some specifically mentioned a need for Manatū Hauora Ministry of Health/ professional groups to lead this change.

> *I thought that I was inclusive because I treat all my clients with respect and follow their lead and listen to what they need to say. I have realised that I need to be more forward in promoting the care I can provide to trans/nonbinary/intersex/ takataapui - replacing woman/women in written text with people is not enough.*

> *There's a lot of small thinking in our rural area around trans/NB acceptance. Not outwardly hostile but makes people a bit uncomfortable. Our new manager is outwardly supportive of LGBTQI+ so I am expecting this to influence workplace knowledge/tone.*

> *I'm honestly struggling with how to navigate making tangible changes without some systemic support from the ministry. I think the medical council or ministry coming out with a statement on inclusion and making it compulsory to begin active changes to improve this would go a long way in places like this where a lot of stigma and bias tend to take the front seat.*

There were a large number of comments about the need for support for 'LGBTIQ+/ Takatāpui education and suggestions it should be mandatory professional development.

This appetite for change was counterbalanced by respondent comments that expressed more gender-essentialist concepts such as "women give birth not men" or that we shouldn't "pander" to a minority by engaging in wholesale practice change. "Erasure" of women was a concern for several respondents, and older age, conservatism and religious views were mentioned several times as barriers to progress.

> *I have only just started here, but have been in active discussions … to get badges to include pronouns. We have met pushback […] for "religious reasons"*

Several comments identified workplace stress and being overwhelmed as contributing to gender inclusion strategies being a low priority for management.

> *Would like to think genuine client centred care is offered to all people regardless but acknowledge that ignorance around trans and non-binary issues is likely to be a significant barrier despite good intentions. Chronic staff shortages & burn out are no excuse but may be contributing to slow progress in this area*

> *I'm not saying that this isn't important because I know that it is & will become increasingly more so in the future. However, I believe it is worth noting that the "work place/ the system" is broken, care providers are burnt out & leaving the profession in droves, the service is barely holding on/non-existent in some areas…*

Workplace conversations

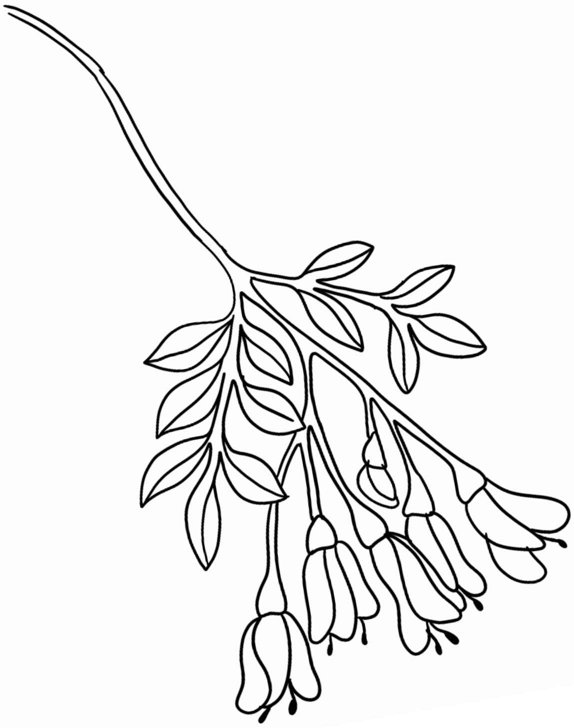
Respondents were asked about starting workplace conversations to make their practice or service more inclusive of trans people. Over a third (37%) reported that they had started these types of conversations about inclusivity of trans people and their whānau, or that their colleagues had initiated these conversations (22%). Responses were lower for conversations about inclusion of Intersex people and their whānau (21% personally started conversation, 16% colleagues started conversations) and for takatāpui people and their whānau (21% personal, 17% colleagues).

When invited to provide more information about these conversations, 136 respondents added comments.

They described that the conversations in their workplaces mostly centred around correct pronoun use, language change, and facility change, such as changing cot cards to be less binary, providing gender-inclusive bathroom facilities, naming spaces, and changing forms and online systems to be more inclusive. Despite these efforts, many faced challenges in bringing colleagues on board.

> *I am consistently bringing this up and trying to make it a more consistent approach across our whole team in terms of using pronouns and asking about language for body parts, using inclusive resources etc. It is hard because not everyone thinks it's important and we are all exhausted by the state of midwifery at the moment, so some of my colleagues just won't do anything extra like education unless they have to*

Other common comments were about sharing education resources, disseminating learnings from education sessions, or protecting trans people within non-inclusive environments. The presence of a trans person on the ward seemed to be a stimulus for conversation between staff members. One trans respondent felt strongly that not all trans people want the same things, but that education and practice recommendations tend to assume they do. Others spoke of seeking out others in their workplace who were ‘on board’ and working together for change.



Making changes in the work environment

When asked if they had tried to make changes in their work environment to be more inclusive, 36% identified that they had done so for trans people and their whānau, 15% for Intersex people and their whānau, and 17% for takatāpui people and their whānau. Over a third (39%) identified that they had not tried to make changes to be more inclusive of trans people.

When provided the opportunity to expand on these experiences, 119 respondents provided free-text comments. The responses centred mainly around easeful change or barriers to change.

Easeful change was described in small practices where all practice members were 'on board' with the kaupapa. Easy changes included use of pronouns and gender-neutral language – though some said this change took time and involved younger practitioners educating older ones. Bathroom reconfiguration to all-gender toilets was easy in some places. People discussed changing their online profiles to be more inclusive, revising website information and imagery to be inclusive, having their own pronouns on identification badges, and managers 'leading from the front and by example' as smoothing the path to change. Several comments noted that any education they had received had improved their confidence to have conversations with colleagues and clients.

> *The conversations went really well. Everyone's views were respected. The majority of midwives did not want the words or images of women/wāhine excluded but were very happy to include images of gender diverse whānau. This is despite none of us ever having looked after a hapū trans-man. So I thought that went well…*

Barriers to change included multiple comments clustered around the respondent's initiation of discussions about change measures. They identified ideas being well received and the need for change being acknowledged, but that things "move at snail's pace" or don't happen at all. Several respondents spoke of resistance at management level in large organisations, despite clinicians being willing and open to change. Nominating special interest groups or 'champions' in workplaces was seen as having the potential to speed up change but was sometimes met with resistance when this cost money. Workload pressures were cited as a reason this work could not be progressed.

> *I know there is anxiety about losing the term 'woman'. For me it's not about losing this term. Rather it is about adding language reflective of the people. Adding 'pregnant person' includes everyone, without losing the term 'woman'.*

> *Those outside the rainbow community often just can't understand the need for inclusivity.*

There were several comments that related to older practitioners' conservatism or resistance, with younger respondents reporting that they don't get 'taken seriously' or are mocked when they attempt to make change (for example, "*oh, we're on this bandwagon now, are we?*").

> *At times, I felt like other colleagues rolled their eyes at me, since I am known as 'the progressive one'. Particularly among the older midwives-there are many who don't take the younger/inclusive voice seriously.*

Section Three: Respondents' education experience, needs and preferences

Our survey identified that most perinatal health practitioners had not received any education specific to working with trans and non-binary, Intersex or takatāpui people during either their undergraduate / pre-registration (61%) or postgraduate/ post-registration (59%) education.

Of those who had received some education:

- At undergraduate (pre-registration) level, more people recalled receiving education about Intersex people (29%) than about trans and non-binary people (19%) or takatāpui people (10%).
- At postgraduate (post-registration) level, more people recalled learning about working with trans and non-binary people (36%) than about Intersex people (30%) or takatāpui people (23%).

Among those who have received any **pre-registration education** about gender and sexuality diversity, the topics they most often recalled learning about included variations in sex characteristics, information about babies who have an intersex variation at birth, and relationship diversity. Topics least often recalled were intersectionality relating to trans and non-binary people and mental health, family formation among trans and non-binary people, and GAHC (prescribing and use of hormones, referral pathways etc.) (See Table 8 below).

Among those who received education during the **post-registration** period, topics that they most often recalled learning about were terminology relating to trans and non-binary people, relationship diversity, gender-affirming health care (prescribing and use of hormones, referral pathways) and opportunities for self-reflection about one's own norms and values. Least often recalled were learning about the psychosocial impacts of the medicalisation of Intersex variations, takatāpui and other diverse genders/sexualities across cultures, and intersectionality relating to trans and non-binary people and mental health (Table 8).

Table 8. Topics respondents recalled receiving education about

Total respondents n=476

	Pre-registration n (%)	Post-registration n (%)
Terminology relating to trans and non-binary people	56 (12)	115 (24)
Infant feeding options for trans and non-binary people	29 (6)	61 (13)
Family formation among trans and non-binary people	22 (5)	57 (12)
Relationship and sexuality diversity (e.g. polyamorous relationships, same-gender couples)	72 (15)	86 (18)
Gender-affirming health care (e.g. prescribing and use of gender-affirming hormone therapy, referral pathways)	27 (6)	80 (17)
The law in relation to family formation, adoption, surrogacy, birth registration	66 (14)	54 (11)
Norms about gender and sex in perinatal care (often called cisnormativity)	45 (10)	67 (14)
Opportunities for self-reflection on your own norms and values related to gender and sex	51 (11)	82 (17)
Trauma-informed care	37 (8)	53 (11)
Health outcomes for trans and non-binary people	34 (7)	71 (15)
Intersectionality relating to trans and non-binary people and mental health	19 (4)	52 (11)
Variations in sex characteristics (sometimes called intersex variations or differences in sex development; DSD)	85 (18)	69 (15)
Cultural safety for intersex people in clinical practice	41 (9)	60 (13)
Information about babies who have an intersex variation from birth	80 (17)	63 (13)
The psycho-social impacts of medicalisation of intersex variations (DSD)	39 (8)	46 (10)
Cultural safety for trans and non-binary people in clinical practice	29 (6)	71 (15)
Takatāpui or diverse genders across cultures	30 (6)	52 (11)

Pre-registration education about trans, non-binary, Intersex, and takatāpui inclusion was mostly provided by a tertiary institution (70%) or multiple providers (25%), with the remainder a mix between DHB (3%), another provider (2%), and professional organisations (<1%). Post-registration education was mostly provided by multiple providers (43%) or another provider (14%), with the remainder a mix between DHB (12%), tertiary institution (12%), professional organisation (9%), community groups (5%) and colleagues (5%).

In some cases, this education was facilitated by trans, non-binary, Intersex and takatāpui people (27% pre-registration, 57% post-registration). While some education about trans, non-binary, Intersex and takatāpui inclusion was a formal part of the curriculum (39% pre-registration and 37% post-registration), often this education was ad hoc or opportunistic in response to scenarios that presented during learning or work situations.

Of 130 practitioners who responded to a question about whether they had self-funded education to upskill themselves for working with trans and non-binary, Intersex and takatāpui people, 61 (47%) respondents reported that they had done so.

Of those who responded to the question about whether they would be interested in attending education on this topic, a high proportion of practitioners agreed they would if it was made available (81%). Their preferred mode for receiving this education would be to have both online and face-to-face options available (39%), with 31% preferring online-only and 31% preferring face-to-face only.

We provided an opportunity for respondents to reflect on the topic of gender inclusion education more generally, and we received 90 comments as text responses. The majority of these comments (25%) related to health practitioners being highly desirous of receiving education in this area or having been personally motivated to access information about working with trans clients in the absence of formal learning opportunities (12%). Eight respondents (9%) reported that they had received most of their education from their own trans and non-binary whanau members. Five (6%) comments related to an expressed discomfort with what was described as “changing the landscape for a small minority” and a small number of people expressed a belief that providing individualised care was “enough” to ensure safe care for all. Including diversity education as a compulsory component of midwifery APC recertification requirements was suggested as an opportunity.

> *All of the education I have received I have actively sought out myself and funded myself. It has not been provided for (or required by) by employer (a DHB). This education is absolutely necessary and essential but at the moment is relying on peoples’ individual motivation and reflection to seek this out rather than been standard practice for all.*
>
> *I understand it is important to be aware of non-binary, intersex and takatapui people's needs. I have assumed perhaps incorrectly that asking them what their needs are and advocating for them in the manner one would for any other person one is caring for and accepting that culturally (for example like deaf people) they have differing needs would be enough.*

I do think it should be part of midwifery standards review that we can demonstrate gender/sexuality safety. For example, if on someone's statistics its apparent they are never working with (out) diverse families, it might be a conversation about why. It's also an opportunity to discuss what supports that midwife needs to feel confident and competent to provide care and partnership. I do think we need to be careful about how it's put forward and how we call midwives in to this work, as we don't want to be forcing unsafe midwives on families before they have the skill and competence… but it's time to normalize that this is absolutely within our scope and we need to upskill to provide safe care if we want to continue to be midwives.

My oldest child is Transgender and we are currently going through his transition process which has added a layer of personal experience and informal learning. I wish there was more available in NZ education wise and more compulsory through our professional body. The midwifery profession is not well equipped for providing care for this next generation of birthing population. We have some catching up to do. Move from second wave feminism towards an intersectional approach.

Section Four: Knowledge, beliefs and clinical preparedness for inclusive practice

In the survey this section was presented as a matrix in which respondents could identify their level of agreement with the statements provided. Presented here in table form, we have aggregated the "strongly agree" and "agree" responses and the "disagree" and "strongly disagree" responses. The statements were designed to identify respondents' knowledge, beliefs and clinical preparedness for working with trans, nonbinary, Intersex and takatāpui people. NB the percentage responses in this section are derived from only the collected data and the 'N' is stated for each item (Table 9).

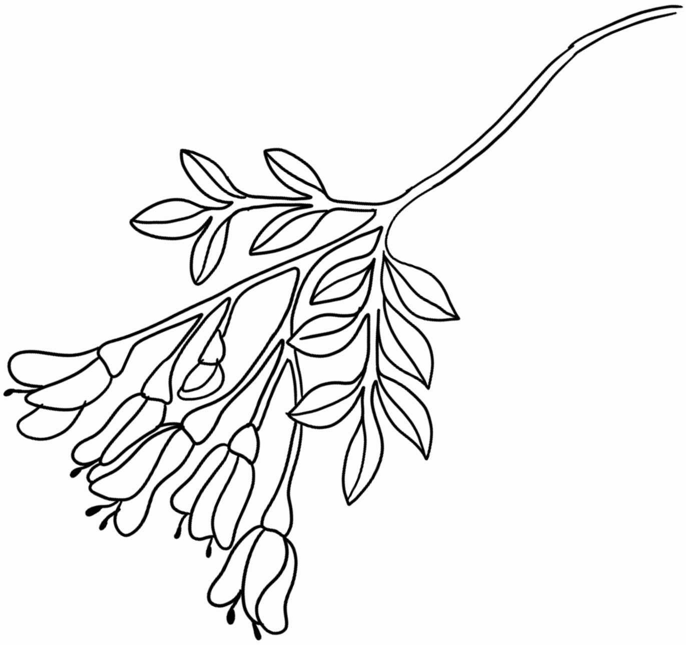


Table 9. Knowledge, beliefs and clinical preparedness of the perinatal workforce

Statement	N	Strongly agree or agree %	Neutral %	Disagree or strongly disagree %
There are health impacts on trans, non-binary, intersex and Takatāpui people when health care does not include them.	353	89.2	5.4	5.4
I assume that clients/patients are women unless they tell me otherwise	357	58.6	21.8	19.6
It is important to adapt my language to make it trans, non-binary, intersex and Takatāpui-inclusive	356	74.2	16.3	9.5
I know how to adapt my language to make it trans, non-binary, intersex and Takatāpui-inclusive.	356	52.2	27.8	20.0
I have strategies for how to respond if I incorrectly assume the gender, sexuality or relationship status of a person in my care and/or their whānau members	356	62.0	21.6	16.4
Facilities and documentation in perinatal care services should be inclusive of trans, non-binary, intersex and Takatāpui people (e.g. provide gender-neutral bathrooms).	356	80.1	12.6	7.3
I should have access to education to support my provision of care for trans, non-binary, intersex and Takatāpui people.	354	87.0	6.8	6.2
Trans and non-binary people who have a uterus and medically transition cannot become pregnant	347	2.4	18.7	78.9
I have seen or heard negative attitudes or behaviours towards trans, non-binary, intersex and/or Takatāpui people in my workplace	356	42.7	16.1	41.2
I think intersex variation/difference in sex development is always a problem that needs to be medically fixed.	349	1.4	7.4	91.2
If I needed information about working with a trans, non-binary, intersex or Takatāpui client, I would ask them to educate me.	355	49.5	27.9	22.6
I feel confident raising concerns about transphobic or intersexphobic discrimination in my facility/ workplace/amongst my colleagues	352	58.6	23.6	17.8
I know where to refer trans, non-binary, intersex and Takatāpui clients to support services.	351	21.4	19.9	58.7
I know how to access resources that support me to provide culturally safe care to Māori and Pacific clients who are trans, non-binary, intersex and/or Takatāpui	350	17.4	19.4	63.2
Our professional organisations should play a leadership role in trans, non-binary, intersex and Takatāpui inclusion in perinatal care.	352	72.2	16.8	11.0
I am comfortable telling whānau their baby has an intersex variation at birth using mana-enhancing language for the baby and whānau	350	27.4	32.1	40.5
People should only be in a romantic or sexual relationship with one other person	347	8.4	16.4	75.2
There are just two genders, male and female.	348	6.3	8.9	84.8
Gender-affirming hormone therapy always makes people infertile.	343	0.6	19.6	79.8
Trans, non-binary, intersex and Takatāpui people should have access to resources to be able to plan a pregnancy	351	91.5	5.7	2.8
I would feel morally conflicted providing care to a trans, non-binary, intersex or Takatāpui pregnant person	350	3.1	4.3	92.6

Final reflections were sought from respondents at the conclusion of the survey. In total, 103 people responded with comments that coalesced into four main topic areas. Here we present a brief summary of these four areas, along with some illustrative quotes from the free-text comments.

Perspectives from Māori respondents

Several Māori respondents noted that inclusivity is a fundamentally intrinsic tenet within a Māori world view. The use of the pronoun 'ia' covers all genders, and names for a wide range of gender and sexuality expressions are known across Indigenous cultures. These respondents expressed frustration that prevailing and enduring colonising practices continue to hinder progress towards more universal acceptance and application of this world view.

> *I am Māori, our worldview is a framework and hononga that is all inclusive and belongs to Māori. If health practitioners were competent in providing safe care to whānau Māori without the ongoing taught/learned systemic and individual racism then the inequitable outcomes that affect Māori, other non-europeans and people who are classed as 'other' would cease to be a problem.*

Knowledge needs and gaps

It was apparent from comments across this topic area that several respondents conflated the concepts of 'sex', 'sexuality' and 'gender' and many used these terms relatively interchangeably even though they represent different concepts. This therefore is a clear area of education need for the perinatal workforce. As an example, one respondent was alert to this potential conflation and recognised a statement that we included specifically in order to surface this knowledge gap. They noted "One of the questions cannot be answered as it is stated in an incorrect way: "there are only two genders: male and female". The terms "male" and "female" are used for sex, not gender*"*. We agree with this respondent and note that 6.3% of respondents strongly agreed or agreed with this statement indicating that they may not have understood that 'sex' and 'gender' are different constructs. Further areas identified as current knowledge gaps included understanding referral processes and how to source resources, in particular for whānau Māori and Pasifika, that support inclusive practice. While 74% of respondents indicated that they felt it important to adapt their language to be more inclusive, just 52% agreed that they knew how to do this, identifying a further area for education. Clinical knowledge, for example about the potential for pregnancy for transmasculine people on GAHT (gender affirming hormone therapy), or the needs of those born with variations in sex characteristics, appears to be good. About half of the survey respondents agreed that if they needed to know more about working with a trans, non-binary, Intersex or takatāpui person they would ask the person in their care to educate them. We note that Phase One participants found the need to educate caregivers to be one of the many exhausting aspects of their emotional labour associated with navigating their perinatal care, and they valued health care practitioners who took responsibility for their own education.

Comments about taking the survey

Several respondents commented that the survey had highlighted their knowledge gaps and was in itself educational and "awareness-raising", inspiring a commitment to seek education and to improve their personal practice.

> *Reading through this survey shows me how little I'm prepared in my practice, even though I'm married to a trans woman. I will do plenty of research and documentation amending to support any individuals that wish to be known, seen or spoken to using 'other' inclusive terminology.*
>
> *This survey has made me reflect and think about my practice and where I can send people for extra support... and I have some homework to do! Thank you!*

The bigger picture

The fourth main cluster of reflections were focused on the professional environment more generally in relation to trans inclusion, with a wide range of opinions expressed. Several respondents noted that the current workforce pressures related to safe staffing levels make prioritising professional development in this area difficult. Mandatory education to meet basic recertification requirements such as adult and neonatal resuscitation refreshers and emergency management education have been seriously affected in some areas by staff shortages and cancellations of designated professional development courses.

> *I actually found it hard to answer some of the questions about my organisation. I don't have time, at work, to look at what my organisation is implementing. They can implement all they like, but if the staff aren't getting breaks in 12-hour shifts then nothing will happen to change. Right now the front line staff are drowning in the work that they cannot complete. Change doesn't happen in this situation, survival does.*

A cluster of comments related to concern that gender justice for cisgender women remains unaddressed and for some the complexity associated with widening the conversation to include trans people was noted:

> *There is a big conflict in my profession about providing care to "women" and people who don't identify as women, even though we will aim to provide excellent care to all. Because women are so often side-lined in health, the drive to get resources to provide care to women specifically is strong, and with good reason. It is a complicated conversation to try to not see this as a zero-sum problem, where the care to one is provided at the expense of care to another. It doesn't have to be this way, but it means real resources need to be invested in a lot of areas. There is a lot to learn here, thank you for getting started.*

Several responses confirmed support for the urgent need for education and practice change, noting this kaupapa is timely, necessary and a positive contribution to equity in perinatal care. However, a small number of comments expressed discomfort that equity remains elusive for other groups also, and promoted a different vision:

> *Although I strongly believe that all members of society are provided with access to Healthcare, I feel there are many other groups who are marginalised. I would like to see a unified Healthcare system, one where we don't have to group people into pigeon holes. Individualized care that meets specific needs of the person rather than assuming because they identify in a particular way, we link them with specific groups.*

Phase Two discussion

The two largest groups of respondents were midwives and doctors, comprising 67% and 19% of the sample respectively. Demographically the midwives' group was closely aligned with Te Tatou o te Whare Kahu Midwifery Council 2022 workforce data with respect to mean age (see Table 10 in Appendix 1). In addition, more midwives who identify as Māori and more as 'another gender' than are represented in the workforce data responded to the survey and fewer 'Asian' and 'MELAA' midwives responded to the survey than are represented in the workforce data.

For doctors, the survey respondents were slightly younger than the mean age of the medical workforce reported in their workforce data. A smaller proportion of Chinese and Indian doctors responded to the survey than are represented in the ethnicity figures for the workforce, and a higher proportion of 'Other non-European', Other European and NZ European/Pākehā doctors responded. The greatest difference was in the reported gender of doctors with 80% of survey respondents identifying as women. This may in part be explained by the speciality area: New Zealand Medical Council workforce data reports that women make up 72% of the obstetrics and gynaecology workforce.

Although there is alignment in some key demographic areas, we accept that the sample may reflect a respondent bias towards those who have an interest in this area of clinical practice. Notwithstanding, the survey has identified some important examples of emerging practice change in this area that can be expanded to wider service delivery, and despite potential pre-existing interest in the topic area the education needs and knowledge gaps of the respondents provide useful direction for future education resource development.

The findings of our survey are highly resonant with studies that have been conducted internationally. Stewart and O'Reilly (2017) similarly found that perinatal clinicians have a wide variety of attitudes and beliefs that can impact their care provision to gender diverse parents, noting also that the heteronormative culture of perinatal care and limited or no education hinders progress towards inclusion. Clinician 'readiness' to work with LGBTQI+ communities has been explored in both the USA (e.g. Rojas, 2020) and the UK (Pezaro et al., 2023), with both studies reporting that clinicians were on the whole open-minded and supportive of measures to improve inclusive practice, and concluding that increased opportunities for education were a key component to improving the confidence and competence of practitioners. Our survey respondents reported limited opportunities for accessing education, but most indicated that they were keen to learn more about the 'practicalities' of affirming and inclusive practice. This included support to adapt their language and to better understand referral processes and how to access resources for trans people and whānau.

Organisational development strategies proposed by Effland et al. (2020) and Lichtman et al. (2020) suggest that the provision of trans-inclusive healthcare – a part of Rainbow-inclusive healthcare more generally -- should be integrated into wider efforts to ensure other forms of justice, such as racial equity. This would involve developing anti-discrimination policies and processes, the inclusion of Rainbow people in the planning and evaluation of health services, inclusive data systems and consensus statements by health professional bodies that affirm commitment to Rainbow-inclusive care. Education programmes for health professionals (pre- and post-registration) designed to cultivate core competencies in Rainbow health are also likely to be key in addressing Rainbow health disparities. Education programmes should support health professionals in mastery of basic Rainbow concepts and terminology, as well as norm criticism and openness towards and acceptance of Rainbow communities. Core concepts, language and positive attitudes can be instilled alongside clinical skill in delivering Rainbow-inclusive health care, through novel educational strategies and paradigms for clinical implementation (Eckstrand et al., 2017; Keuroghlian et al., 2017; McCann & Brown, 2018; Mitchell et al., 2018).

Singer et al. (2019) demonstrated in a pre-test/post-test study of 187 perinatal health care clinicians that even a 40-minute training for clinicians about gender and sexuality could "immediately improve knowledge, attitudes and intended behaviour towards LGBTQ patients" (p. 303). In a free-text comment within our own survey, a respondent stated:

> *we had a Trans, neuro diverse whanau who candidly reported their experience of a 3-day stay in our unit. They came across some very resistant, unaware health professionals, some incredibly aware supportive health professionals but were very very strongly impacted by the auxiliary staff, like the food services, the cleaners, the health care assistants making inappropriate comments and treating them badly. They expected that their status would be shared with all people who provided service within the hospital. This was interesting as I look through education provision and realise a growing body of education and information sharing for health care providers will not necessarily trickle down to these services.*

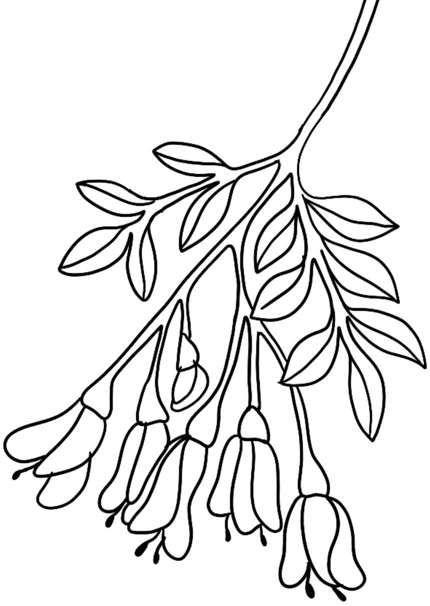
Brief education sessions such as those described by Singer, et al. (2019) could include not just midwives and doctors but also other staff who encounter childbearing whānau during their hospital stays, such as cleaners, meal service people, phlebotomists, healthcare assistants and so on. There is a precedent in Aotearoa for such broad-based education: the Baby Friendly Hospital Initiative (BFHI) has included service-wide education about infant feeding practices and improved breastfeeding rates were reported following implementation of the initiative (Martis & Stufkens, 2013). Such an education roll-out would require a commitment to funding the production of resources such as online education packages, visual resources for display in workplaces *and* (as the BFHI example confirms) paid coordinators within facilities to champion the mahi and ensure education is accessed by the full range of care providers.

We noted that a high number of our survey respondents reported both in the direct question about (knowingly) working with trans, non-binary, Intersex and takatāpui people, and also in the free-text responses, that they had never (or rarely) worked with people from these communities. Our Phase One findings confirmed that several of our participants felt unable to be themselves and have their identities known within perinatal services that failed to include them. This raises a question about the likelihood that clinicians are in fact providing care to people with diverse genders and sexualities but have not recognised ('seen') them due to lack of opportunities for people to self-determine their gender within services.

International and local mandates are in place that require health practitioners to provide care that is "humanised and inclusive… regardless of sexual orientation, gender identity or gender expression" (e.g. ICM, 2017) and which acknowledge specific commitments to stronger primary and community care for trans and Intersex people and whānau (Te Whatu Ora, 2022). In order that practitioners are well prepared to respond to these directives, it is crucial that they are supported to do so by the provision of strong leadership in the form of policies and guidelines that give full effect to the aspirations of these strategic guidance documents.

Strengths and limitations

Key strengths of this perinatal workforce survey include that the development of survey questions was informed by participant responses in Phase One and then broad community and professional consultation on survey questions was undertaken. Feedback was provided from organisations such as Te Kāreti o ngā Kaiwhakawhanau ki Aotearoa: New Zealand College of Midwives, Gender Minorities Aotearoa, Intersex Aotearoa and the Tīwhanawhana Trust. Feedback was sought to ensure questions were strengths-based, used appropriate language, were culturally appropriate and addressed items seen as priorities for these communities. This resulted in a survey tailored to the cultural and perinatal practice contexts of Aotearoa NZ. A further strength was the large sample size of 476 health professionals and the broad representation from over 15 professions associated with perinatal care that were subsequently coalesced into midwives (67%), doctors (19%) and other health professions (15%). Given the nature of the topic and the strong views that some people hold, it could be argued that a biased sample responded to the survey, but the comprehensive demographic information collected provides some perspective on this.



Despite the large sample, caution should be exercised when generalising to the entire perinatal workforce. However, consistency of responses often supplemented by qualitative comments gives some confidence that the survey collected views of a broadly representative sample of the perinatal health workforce. Finally, there was a significant amount of missing data. It is unclear why respondents preferred not to answer some questions.

Overall we suggest this comprehensive survey with both quantitative data and free-text responses provides valuable data on the knowledge and attitudes of the perinatal workforce in the provision of services to trans, non-binary, Intersex and takatāpui people and whānau, and as such provides evidence to support the development of a quality improvement culture, including policy recommendations and targeted education interventions to improve equitable access to and delivery of perinatal services to trans, non-binary, Intersex and takatāpui pregnant people and whānau.

Warming the Whare: A Te Whare Takatāpui informed guideline and recommendations for trans inclusive perinatal care

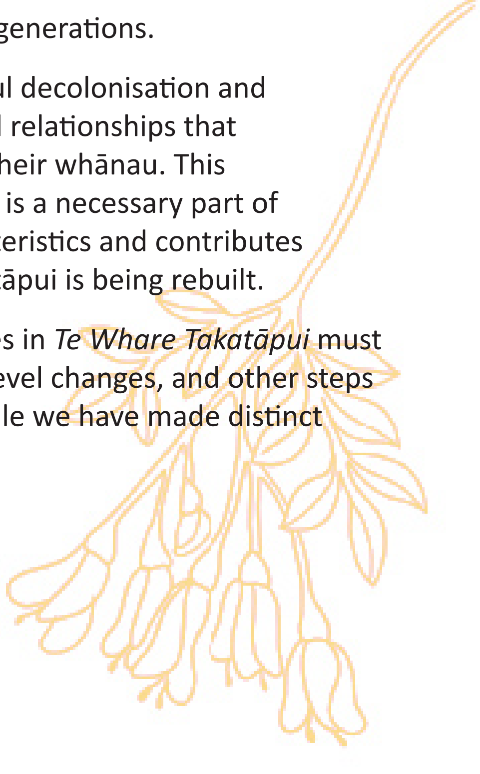
Co-investigator Dr Elizabeth Kerekere has offered us her framework *Te Whare Takatāpui* (Kerekere, 2017, 2023) an indigenous Te Ao Māori model of wellbeing based on *Te Whare Tapa Whā* (Durie, 1985), to develop the following guidance for improving perinatal care for trans people and their whānau. The framework provides conceptual and practical ways to improve takatāpui and Rainbow peoples' health and wellbeing. The six values that make up *Te Whare Takatāpui* are Whakapapa (genealogy), Wairua (spirituality), Mauri (life spark), Mana (authority/self-determination), Tapu (sacredness) and Tikanga (rules and protocols), with each representing a different part of a wharenui (ancestral meeting house). When these values are accounted for, the Whare can shelter and nurture all people with diverse genders, sexualities, and sex characteristics and their whānau.

Te Whare Takatāpui is a tūrangawaewae (a place to stand/be) for takatāpui and Rainbow people and their whānau. The Whare in Te Ao Māori once stood strong and resplendent as a place where people with diverse genders, sexualities and sex characteristics were welcomed. The Whare was adorned with intricate whakairo (carvings), woven tukutuku (latticework), and painted kōwhaiwhai (patterns). The gardens were abundant, relationships were healthy and strong, and children ran free and wild. The Whare was held up equally by Mana Wāhine, the authority held by women, Mana Tāne, the authority held by men, and Mana Tipua, the authority held by trans, intersex and non-binary people.

Through colonisation, *Te Whare Takatāpui* was damaged by the Eurocentric patriarchal ideas introduced to Aotearoa, about gender roles, sexuality, relationships and whānau building. In the Whare, the whakairo, tukutuku and kōwhaiwhai were pulled down, the roof caved in, and the gardens were contaminated. The stories and memories of takatāpui were suppressed and stolen from future generations.

Te Whare Takatāpui is being rebuilt and adorned through mindful decolonisation and challenging the rigid norms relating to gender, sex, sexuality, and relationships that continue to harm both cisgender women and trans people and their whānau. This guidance emphasises that trans inclusion in perinatal healthcare is a necessary part of ensuring equitable care for people of all genders and sex characteristics and contributes to Te Tiriti o Waitangi informed care. In so doing, Te Whare Takatāpui is being rebuilt.

For trans people and whānau to thrive in perinatal care, all values in *Te Whare Takatāpui* must be enacted. Some of these recommendations promote system-level changes, and other steps that individual care providers can take in their own practice. While we have made distinct recommendations, they are interwoven.



Whakapapa

Whakapapa reminds us that “people with diverse genders, sexualities and sex characteristics have always existed” and will always be here (Kerekere, 2023, p. 78). In *Te Whare Takatāpui*, once the walls are rebuilt and the roof secured, whakapapa is represented by the photographs on the wall – we remember and honour where we came from and all of those who came before us. It reminds us to acknowledge the history of mistreatment of trans and non-binary people in the health system, while we focus on building a Whare where trans whānau can flourish in their perinatal care journeys, now and into the future.

Be aware that the journey into perinatal care may have been challenging for trans people and whānau. Trans people and whānau may have experienced previous harmful health encounters, challenges to accessing support and services for conception and assisted reproduction, non-affirming whānau and social contexts (such as not having disclosed gender to immediate whānau), and a lack of accurate and positive representation of trans people and whānau-building.

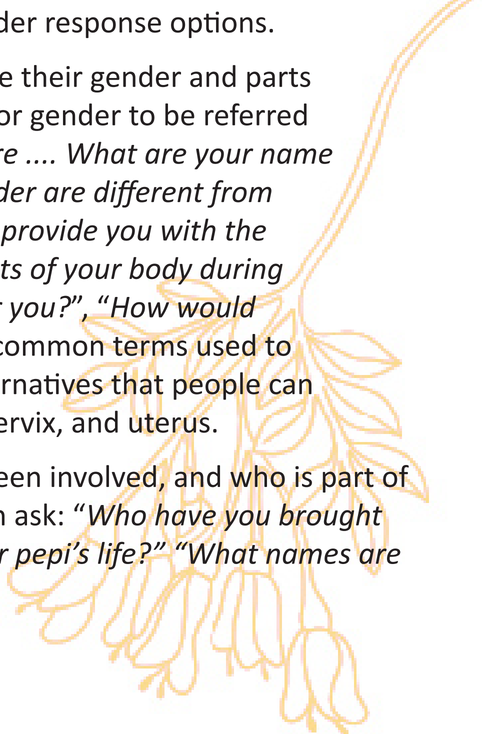
- Invite trans people and whānau to tell you about their journey to pregnancy and consider what influences these contexts of whānau building have on their health and wellbeing. For example, you can ask trans people and whānau: “*Can you tell me about your journey to pregnancy? I can provide the best care to you when I know what is important to you.*”

Engage in critical self-reflection about your preconceptions and understandings of gender, sexuality, sex characteristics, and whānau building norms.

- Ask yourself, where have these preconceptions and understandings come from? Where are they embedded in my service and/or how do they shape my practice?

Create opportunities within services for trans people to self-determine their gender and pronouns, the words they use to describe parts of their bodies, their baby’s gender, and who is part of their whānau.

- Ensure people have the opportunity to self-identify their gender, distinct from their sex assigned at birth, in all perinatal data collection processes including provider registration and/or service enrolment forms. This can either involve ‘another gender’ and an open-textbox or include ‘gender diverse’ in your gender response options.
- Ask people in your care about the words they use to describe their gender and parts of their body, and how they would like their baby’s sex and/or gender to be referred to. For example, “*Kia ora, my name is ... and my pronouns are .... What are your name and pronouns?*”, “*Can you tell me your gender? Sex and gender are different from each other and it is important for me to know about both to provide you with the best care*” “*We are going to need to talk about different parts of your body during your care, what are the words that are most comfortable for you?*”, “*How would you like me to refer to your baby?*” Consider having a list of common terms used to refer to body parts during perinatal care and offer some alternatives that people can choose from, such as different ways to refer to the vagina, cervix, and uterus.
- Avoid assuming how conception has taken place, who has been involved, and who is part of the whānau engaging in perinatal care. For example, you can ask: “*Who have you brought with you today?*” and “*Who are the important people in your pepi’s life?*” “*What names are you using for these people?*”



Evaluate the preparedness of your workplace or practice to provide responsive care to trans people and whānau in the future.

- Ask yourself, what are you and/or your service currently doing to be inclusive of trans people and whānau? What are the current barriers and enablers for trans inclusive care? How will you know your care is trans inclusive in the future (such as getting feedback from trans people and whānau, trans consumer representation)? How will you distinguish between low expectations of care and satisfaction with care in your feedback from trans people and whānau about your care?

"... regardless of where you come from in the world, we recognise that your identities have their own histories, their own languages, their own cultural context, and we honour that."

(Kerekere, 2023, p. 79)

"The idea of there being a system that is affirming for people like me and other trans people is, oh, it would bring me to tears to be honest."

(Jesse, non-binary, TTC gestational)

Wairua

Wairua "refers to the spiritual dimension; the soul or essence we are born with that exists beyond death [...] the interconnectedness of all things in the universe" (Kerekere, 2023, p. 80). In *Te Whare Takatāpui,* wairua is represented by the whakairo of our tīpuna (ancestors), kaitiaki (guardians) and tipua (shapeshifters); captured in wood and celebrated for who they are. How we talk about and frame gender diversity and takatāpuitanga, and our attitudes towards them, impact the wairua of trans whānau when entering services. Acknowledging the wairua of gender diversity as a positive and natural part of human diversity can shift the way we practice and interact with trans whānau. Perinatal care services should be places in which the wairua of trans whānau "can be at peace" (Kerekere, 2023, p. 82) during the vulnerable and joyful time of pregnancy.

Understand the positive impacts of affirming and inclusive perinatal care on the health and wellbeing of trans people and whānau. Affirming and inclusive perinatal care minimises stress and improves the wellbeing of trans people and whānau. The building blocks of affirming and inclusive care are: *knowledge and awareness* and *self-reflection and cultural humility* (see Phase One, Theme 5).

Ensure services are welcoming and accessible for trans people and whānau.

- Provide all-gender or gender-neutral wharepaku/bathroom facilities
- Commit to using gender-inclusive language in perinatal care. This includes in the names of services, signage, information resources, when talking about your practice or services,

and in interactions with your service users. Gender-inclusive language demonstrates a commitment to welcoming both cisgender women and gender diverse people into your service or practice. You can either use ‘people’ to refer to both cisgender women and gender diverse people or you can use an additive approach (e.g., women and pregnant people). Where possible, use ‘whānau’ as the smallest unit to describe your service users. Whānau-centred care begins with the individual (Walker, 2017) and recognises that there are often many people involved in a pregnant person’s perinatal care journey, including people, such as non-gestational parents or intergenerational support people who may not be related to the individual by blood or marriage.

- Develop and audit childbirth and parenting education/educational resources to ensure that all parents and whānau, including those who are gender, sex characteristic and sexuality diverse, are recognised and included.

Respect and reflect the words people use to describe their gender, pronouns, different parts of their bodies, their babies’ sex/gender, and who is part of their whānau. Ensure you do this when engaging directly with trans people and whānau ***and*** when talking about them (e.g., in handover notes, when talking with colleagues about the person and whānau).

Anticipate whānau diversity in your practice or service. Avoid default assumptions that people are heterosexual and cisgender, and about what and who makes a family. Anticipate and affirm diverse parenting identities, whānau forms, and ways of building family. Ensure non-gestational parents and other whānau members, as self-determined by the pregnant person, are proactively included in care.

“Every person sees themselves reflected in the Whare Takatāpui and they know they belong.”

(Kerekere, 2023, p. 82)

“I feel like birth and pregnancy is one of those critical moments where if you provide great care you can really influence the outcomes for people as parents and further down the track [...] maybe it’s just when you have a stink experience, being able to go, it wasn’t always like this, there was one time that we felt good, you know, and that has a long term effect on the shape of your mental health and the number of resources you have to draw on because those resources are memories”

(Lor, non-binary, gestational parent)

Mauri

Mauri "is your life spark, that essential quality that is yours alone. Unlike wairua that exists beyond death, when you die your mauri dies with you […] it encompasses your special skills, talents and superpowers" (Kerekere, 2023, p. 82). In *Te Whare Takatāpui*, mauri is represented by the weaving and patterns of the tukutuku panels. As we weave our unique stories, we are seen, we are recognised and we are valued. Trans whānau need ways for their gender, relationships and whānau formations to be seen, recognised and valued in perinatal care – where they are at the centre of and active decision-makers in their own care.

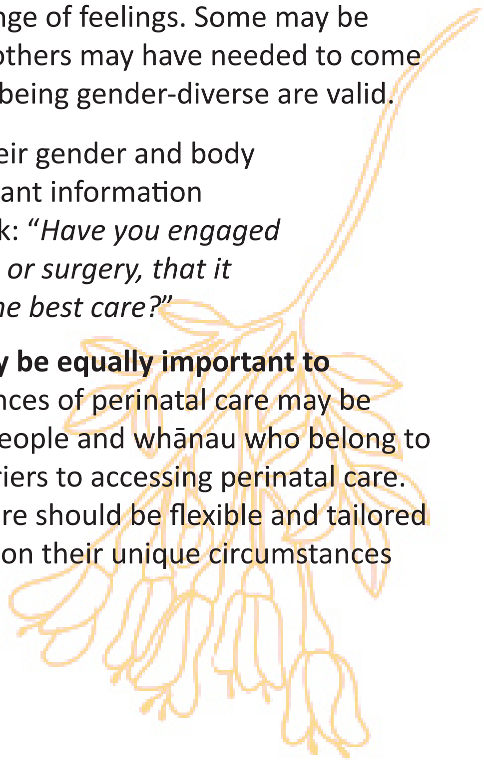
Include visual representations of trans people and whānau and other signs of inclusion where possible in your services. This signals that services are proactive about trans inclusion, and that trans people and whānau can expect safe and affirming care. It is also a way for services to help normalise gender diversity and different kinds of families. It is important that there is always meaningful action behind signaling inclusion, to ensure people's expectations of trans inclusion in a service are met. For example:

- Add pronouns to name badges and email signatures, and state your own pronouns when introducing yourself to whānau
- Display Rainbow or trans pride flags and images of diverse whānau on your walls or websites
- Be explicit about the inclusion of trans people and whānau in the information you provide about your practice or service. Here are some examples from the Find Your Midwife website: "I am experienced working with LGBTIQ+ takatāpui individuals/whānau and providing competent care for this community is a passion of mine" (Jess Tombs, MW). "I have an interest in supporting LGBTIQ+ takatāpui people to access meaningful care" (Keli van Gerwen, MW)

Understand that trans people self-determine and express their gender differently, and there are many ways of being trans. Some trans people do not disclose their gender in perinatal services for various reasons. Some (but not all) trans people may experience gender-related distress because of physical changes through pregnancy, and others may have positive feelings about their gender and body through pregnancy, some may experience a range of feelings. Some may be actively exploring their gender during the perinatal period, and others may have needed to come off gender-affirming hormones to become pregnant. All ways of being gender-diverse are valid.

- Avoid assuming people's gender, and their relationship to their gender and body during pregnancy. Invite trans people to share clinically relevant information about themselves if they choose to. For example, you can ask: "*Have you engaged in any gender affirming medical healthcare, like testosterone or surgery, that it might be helpful for me to know about to provide you with the best care?*"

Consider that trans people have intersecting identities that may be equally important to recognise. People are more than their gender, and their experiences of perinatal care may be shaped by other aspects of who they are. Recognise that trans people and whānau who belong to multiple marginalised groups may experience compounding barriers to accessing perinatal care. Inclusive practice is not about following a checklist of actions. Care should be flexible and tailored to meet the individual needs of trans people and whānau based on their unique circumstances and self-determined identities.



- Understand that uplifting takatāpuitanga in your service or practice means uplifting Māoritanga because within takatāpui identity being Māori and being LGBTIQ+ are inherently connected.
- Inform yourself about neuro-affirming care provision for neurodivergent people (kanorau ā-roro) and whānau.

> *"When you see who someone really is; when you ask questions about pronouns and then you use them correctly; when you make sure someone knows they are included and welcomed; you will see their mauri respond. Their life spark will glow and so will yours."*
>
> *(Kerekere, 2023, p. 84).*

> *"I want to engage, it brings me joy, I feel seen […] [h]aving this gender affirmative care is like, you don't need any of the boxes, and we're going to walk with you in whatever space that is."*
>
> *(Guiseppe, non-binary, pregnancy loss)*

Mana

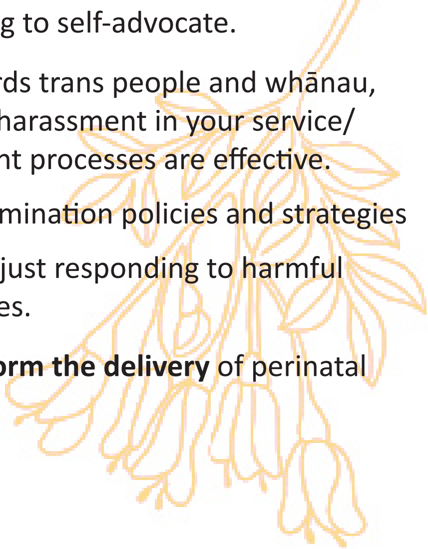
Mana is about authority, dignity, respect, advocacy, and power. "Cisgender, trans and intersex women gain mana from our Earth Mother, Papatūānuku, as do those who are able to give birth, including trans men, and intersex and non-binary people" (Kerekere, 2023, p. 84). In *Te Whare Takatāpui*, mana is represented by the pou (posts) for Mana Wāhine and Mana Tāne and the tāhuhu (ridgepole) for Mana Tipua. Trans people and whānau have the right to positive and joyful perinatal care experiences and to good beginnings with their pēpi, free from discrimination. When the perinatal workforce takes responsibility to learn, to challenge the enablers of discrimination and to enhance the mana of trans people and whānau, trans people and whānau can focus on their pregnancy and their wellbeing improves.

Advocate for trans people and whānau to safely navigate their journeys through perinatal care. Doing this can relieve trans people and whānau from having to self-advocate.

- If you witness discriminatory attitudes and behaviours towards trans people and whānau, follow the appropriate channels for addressing bullying and harassment in your service/practice and commit to ensuring anti-bullying and harassment processes are effective.
- Ensure trans people and whānau are included in anti—discrimination policies and strategies

Proactively champion trans inclusion in your service rather than just responding to harmful incidents. Include trans inclusion in quality improvement activities.

Provide opportunities for trans people and whānau to help inform the delivery of perinatal services to ensure services meet their needs.



- Include trans people in consumer advisory mechanisms for your service/practice
- Actively seek consumer feedback from trans people and whānau and incorporate this feedback into service improvements
- Establish a Rainbow Liaison role in your practice/service to lead service improvements for trans and other rainbow people and whānau.

Build your own knowledge and awareness about trans inclusion

- Access information from Gender Minorities Aotearoa and other transgender and rainbow support organisations rather than expecting trans people and whānau to educate you.
- Ensure your service/practice is aware of existing trans specialist services and resources such as those related to gender affirming healthcare, lactation and infant feeding support, and Rainbow specialist childbirth education classes like EMPWR (https://www.empwr.nz/) to provide tailored options for whānau
- Make sure you don't signal inclusion if you have not prepared yourself to follow through with inclusive practice

Identify and support practitioners in your service/practice who can champion trans inclusive care. Ensure that Rainbow perinatal providers who have lived experience are supported in their care of trans whānau but ensure your wider service or practice shares responsibility for trans inclusion.

> *"If health practitioners were competent in providing safe care to whānau Māori without the ongoing taught/learned systemic and individual racism then the inequitable outcomes that affect Māori, other non-europeans and people who are classed as 'other' would cease to be a problem."*
>
> *(Survey respondent)*

> *"As takatāpui, it is mana that gives us the authority to reject discrimination in all its forms, and to advocate for takatāpui health and well-being."*
>
> *(Kerekere, 2023, p. 85)*

Tapu

Tapu is about those things that are sacred and are often breached in body and mind. "The physical and mental scars of historical and current violations are laid bare… We collectively mourn what has been lost and privately we embrace journeys to heal our wairua and mauri; to restore our sense of self. Working together, we may all learn how to heal and assert our own tapu again." (Kerekere, 2023, p. 90). In *Te Whare Takatāpui*, tapu is represented in healing places and the planting and preparation of rongoā. It is our collective responsibility to ensure that tapu of trans people's minds and bodies is protected from harm in perinatal care settings. Tapu reminds us of the importance of creating safe environments and providing trauma-informed care that acknowledges the past harm done to whānau.

Provide trauma-informed care. Acknowledge that trans people and whānau may carry trauma from past experiences both within healthcare, and through their lived experience as a trans person. Some people may have internalised messages that they do not have the right to be pregnant and this might be a source of distress for them during their perinatal care.

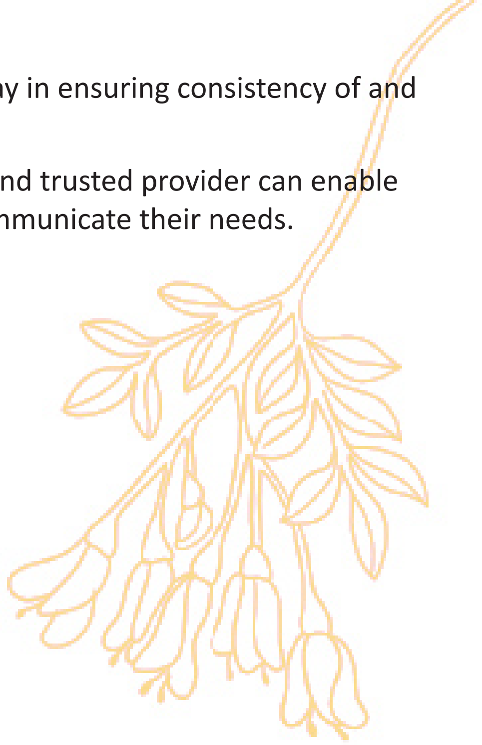
- Centre self-determination when inviting trans people and whānau to share information about themselves. For example, you can affirm: "It is up to you how much you disclose to me and when"
- Uphold informed choice and consent at all times and actively invite trans people and whānau to tell you what they need to be able to make informed choices. For example, you can ask: *"tell me what is important to you" and "what kinds of information help you to make decisions?"*
- Include trauma awareness in all actions undertaken to improve trans inclusion in perinatal care, including workforce education.

Avoid assuming how trans people's bodies work, and only seek information about people's bodies when it is clinically relevant. Always use the words that trans people self-determine for their own bodies.

Audit your service/practice for trans inclusion especially in large services with multi-disciplinary teams

- All professional groups and service settings have a role to play in ensuring consistency of and access to safe care for trans people and whānau.

Practice relationship-centred and continuity of care. A known and trusted provider can enable trans people and whānau to safely disclose their gender and communicate their needs.



> *“[When] people that make the effort, it really helps contribute to feeling safe, especially in that vulnerable environment [...] you’re being poked at, you’re being prodded, they’re wanting to touch you and it’s, they can at least make the effort to address you properly”*
>
> *(Annika, genderfluid, gestational parent)*

> *“Working together, we may all learn how to heal and assert our own tapu again.”*
>
> *(Kerekere, 2023, p.89)*

Tikanga

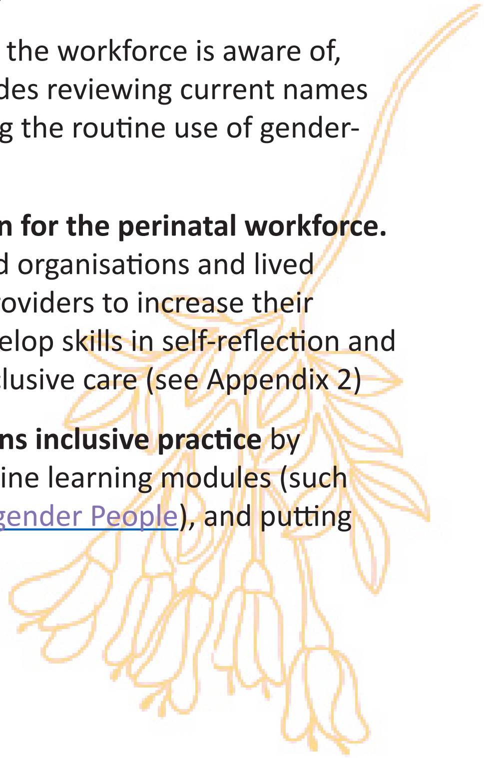
Tikanga denotes the right ways of doing things and what happens if we do something wrong, based on the mātauranga (knowledge) we have. In *Te Whare Takatāpui*, “the tikanga is being refined. Traditional gender roles and responsibilities are being analysed so we may understand the intentions of our tīpuna and the heart of our culture, while we honour the range of gender identities and expressions amongst us” (Kerekere, 2023, p. 91). Tikanga requires us to think about the systems, structures, and processes in perinatal care that will ensure the safety and flourishing of trans whānau. Our participants’ experiences indicate that current practices in perinatal care must be improved to meet the needs of trans people and whānau, and providers can take practicable steps to meet these needs.

Provide leadership for trans inclusion at all levels. Professional bodies, policy-makers and service leaders have a role to play in overseeing system readiness for trans inclusion in perinatal services, and addressing the systemic barriers to effecting change (e.g., resource allocation, workforce shortages).

Develop trans-inclusive policies and consensus statements that the workforce is aware of, and ensure they understand how to implement these. This includes reviewing current names of services and clinics to be more trans-inclusive and encouraging the routine use of gender-inclusive language.

Mandate pre- and post-registration education on trans inclusion for the perinatal workforce. This education should be developed in partnership with trans-led organisations and lived experience advocates. Workforce education support perinatal providers to increase their knowledge and awareness of trans people and whānau, and develop skills in self-reflection and cultural humility, as the building blocks of trans affirming and inclusive care (see Appendix 2)

Ensure on-going professional development opportunities in trans inclusive practice by organising in-service training, encouraging staff to undertake online learning modules (such as Gender Minorities Aotearoa’s online course Supporting Transgender People), and putting together resource lists for staff.



Identify opportunities to use gender-inclusive language in your own practice and services. If you make mistakes (such as if you misgender someone), apologise, correct yourself, and move on with humility. Commit to developing your familiarity and confidence with the use of inclusive language.

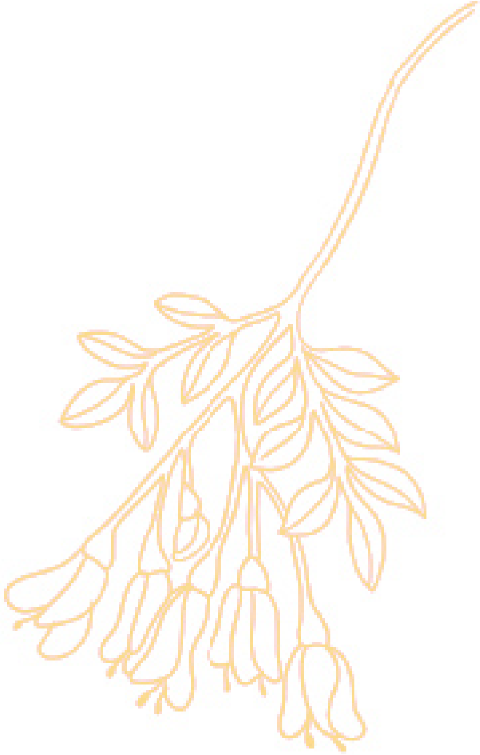
Take a 'walkthrough' of your service or practice, imagining how this space would be experienced by a transperson in terms of the signage, facilities, intake forms. This might help to identify areas that are already trans-inclusive in your workplace, and areas you could improve on.

"I do think it should be part of midwifery standards review that we can demonstrate gender/sexuality safety. For example, if on someone's statistics its apparent they are never working with (out) diverse families, it might be a conversation about why. It's also an opportunity to discuss what supports that midwife needs to feel confident and competent to provide care and partnership."

(Survey respondent)

"... right now, who does the tikanga include and keep safe in your spaces, and who does it exclude? What challenging conversations are you prepared to have? Having increased your mātauranga, what judgements might you re-examine? What tikanga might you change: in your whānau, in your workplace and in your communities?"

(Kerekere, 2023, p.91).



Project Conclusion

The Trans Pregnancy Care Project has been undertaken in response to growing calls both globally and in Aotearoa to improve healthcare access and delivery for trans people as a fundamental part of achieving health equity. There are unique considerations for health services that have historically assumed that users of care are cisgender women, including gynaecological and reproductive health services, to ensure system and workforce readiness to provide trans affirming and inclusive care. Collectively, findings from both phases of our study highlight both the challenges that trans people and whānau can face in these services, and strategies that all perinatal services and professions can implement to better serve trans people and whānau.

As our findings show, some providers and services are already implementing these initiatives, primarily led by Lead Maternity Carers who champion affirming and inclusive community-based care. Improvements are needed to ensure that trans people and whānau can anticipate care that is consistently affirming and inclusive when they engage in all types of perinatal care beyond their lead provider, particularly when they receive hospital-based care. Historically, the perinatal workforce has not been adequately prepared to provide affirming and inclusive care and most providers are willing and open to engaging in education to support affirming and inclusive practice. *Warming the Whare: A Te Whare Takatāpui informed guideline and recommendations for trans inclusive perinatal care* provides guidance and recommendations to promote both system and individual provider level changes to ensure all trans people and whānau can thrive in perinatal care. This guidance should ideally be implemented holistically, noting that each of the six values presented in the framework are interwoven.

Appendices

Appendix 1. Data tables

Table 1. Demographics of interview participants (N = 29; total response)

Demographic		n
Gender		
	Genderfluid	3
	Gender nonconforming	2
	Non-binary	15
	Agender	3
	Trans man	3
	Takatāpui	1
	Genderqueer/queer	2
	Transmasculine	1
	Transfeminine	1
	Trans woman	3
	Cisgender woman, partner of trans participant	5
	Cisgender man, partner of trans participant	1
Ethnicity		
	Māori	4
	Pākehā/NZ European	17
	Other European	8
	Missing	4
	18 - 24	1
	25 - 29	7
	30 - 34	6
	35 - 40	7
	Missing	8
Stage of conception, pregnancy or parenthood		
	Trying to conceive (TTC)	6
	Experienced pregnancy loss	1
	Pregnant with first child	2
	Postnatal (one child ≤ 6 weeks)	2
	Postnatal (one child > 6 weeks)	8
	Postnatal (two children or more)	1

Table 2. Ethnicity , gender and age of survey respondents

		n	(%)
Prioritised ethnicity*			
	Māori	52	10.9
	Pacific peoples	7	1.5
	Chinese	5	1.1
	Indian	6	1.3
	Non-European	6	1.3
	European	91	19.1
	NZ European (Pākehā)	304	63.9
	missing	5	1.1
Respondent's gender			
	Wahine/woman	444	93.3
	Tāne/man	18	3.8
	He ira kē anō/another gender	10	2.1
	Prefer not to say	4	0.8
Indication if respondent is trans or non-binary			
	Yes	10	2.1
	No	449	94.3
	Don't know	6	1.3
	Prefer not to say	7	1.5
	missing	4	0.8
Indication if respondent was born with variations in sex characteristics			
	Yes	1	0.2
	No	465	97.7
	Don't know	1	0.2
	Prefer not to say	5	1.1
	missing	4	0.8
Indication if respondent is Takatāpui			
	Yes	7	1.5
	No	461	96.8
	I'm not sure	7	1.5
	missing	1	1.5

Respondent's sexual identity			
	Lesbian	17	3.6
	Gay	4	0.8
	Queer	14	2.9
	Bisexual	40	8.4
	Heterosexual	351	73.7
	Pansexual	18	3.8
	Asexual	8	1.7
	Fluid	10	2.1
other?	Something else	6	1.3
	I'm not sure	3	0.6
	Missing	5	1
		mean	sd
Age (years)		44.4	11.7

* We used ethnicity prioritisation as described by the Medical Council of New Zealand in their 2022 workforce data. Respondents could identify up to 8 closed-ended ethnicities and specify another ethnicity/ies in an open-text box. Each respondent was subsequently assigned a single ethnicity using a simplified version of Statistics New Zealand's prioritisation standard. The priority order is: 1. Māori 2. Pacific Island (Pasifika) 3. Chinese 4. Indian 5. Other non-European 6. Other European 7. New Zealand European/Pākehā. The ethnicity used in analysis is the one reported by the respondent with the highest priority.

Table 3. Characteristics of survey respondents related to profession

		n	(%)
Prioritised profession*			
	Midwife	317	66.6
	Doctor	88	18.5
	Another health profession	69	14.5
	Missing	2	0.4
Country of registration			
	Aotearoa New Zealand	346	72.7
	United Kingdom	74	15.5
	Australia	16	3.4
	Another country	40	8.4
		mean	sd
Years since registration		17.4	10.99
Number of years practising in NZ		15	9.8
Setting of practice			
	Major urban area (e.g. AKL, CHC, WLG, DUD)		58
	Large urban area (e.g. ROT, IVC, WHG)		19
	Medium urban area (e.g. Cambridge, Taupō)		7
	Small urban area (e.g. Gore, Stratford, Thames)		4
	Rural area (e.g. Ngunguru, Cromwell, Pirongia)		8
Most hrs working in	Community-based clinic/practice		46
	Hospital-based clinic (e.g. antenatal clinic)		10
	Hospital ward or birthing suite		34
	Care in clients/patients home only		4
	Another setting (please describe): TEXT		6
Frequency of providing care to gender diverse people		TNB	VSC
	Never/rarely	76%	84.6%
	Occasionally/Frequently	7.10%	7.1%

*Respondents could identify as many professions as they wished. Each respondent was subsequently assigned a single profession with the priority order of 1. Midwife, 2. Doctor, 3. another health profession. The profession used in analysis is the one reported by the respondent with the highest priority.

Table 5. Progress on activities in the workplace to be inclusive of intersex people

	Yes n (%)	Working toward n (%)	No n (%)	Missing n (%)
My online professional/practice profile specifically mentions that I welcome intersex people.	24 (5%)	59 (12%)	242 (51%)	151 (32%)
My workplace's social media, website or marketing materials include reference to intersex people.	27 (6%)	50 (11%)	275 (58%)	124 (26%)
The waiting area or ward space in my workplace visibly displays intersex inclusive imagery or information materials (e.g. trans pride flags, posters with welcoming messages).	35 (7%)	50 (11%)	283 (60%)	108 (23%)
My workplace or practice has policies or guidelines to support intersex inclusion.	53 (11%)	60 (13%)	249 (52%)	114 (24%)
I have received formal feedback from my intersex clients/patients about their care.	28 (6%)	12 (3%)	238 (50%)	198 (42%)

Table 6. Progress on activities in the workplace to be inclusive of Takatāpui people

	Yes n (%)	Working toward n (%)	No n (%)	Missing n (%)
My online professional/practice profile specifically mentions that I welcome Takatāpui people.	23 (5%)	51 (11%)	247 (52%)	155 (33%)
My workplace's social media, website or marketing materials include reference to Takatāpui people	33 (7%)	60 (13%)	257 (54%)	126 (27%)
The waiting area or ward space in my workplace visibly displays Takatāpui inclusive imagery or information materials (e.g. intersex pride flags, posters with welcoming messages).	30 (6%)	47 (10%)	282 (59%)	117 (25%)
My workplace or practice has policies or guidelines to support Takatāpui inclusion.	50 (11%)	52 (11%)	246 (52%)	128 (27%)
I have received formal feedback from my Takatāpui clients/patients about their care.	25 (5%)	11 (2%)	234 (49%)	206 (43%)

Table 10. Comparison of survey respondents in relation to 2022 workforce data

		Survey sample ~ midwives	Te Tatou o te Whare Kahu Midwifery Council	Survey sample ~ doctors	New Zealand Medical Council
Mean age		46.2 yrs	47 yrs	41.7 yrs	45.3 yrs
Ethnicity	Māori	10.7%	7.7%	5.7%	4.6%
	Pacific peoples	1.9%	1.5%	1.1%	2.2%
	Chinese	0.9%	'Asian' 4.9%	2.3%	6.6%
	Indian	0.6%		3.4%	6.2%
	Other non-European	0.3%	'MELAA & other' 3%	3.4%	11.8%
	Other European	18.9%	'European' 82.3%	23.9%	19.2%
	NZ European/ Pākehā	69.6%		60.2%	45.7%
	Missing	0.3%	0.6%	0%	3.7%
Gender**	Female	97.8%	99.6%	79.5%	47%
	Male	0.3%	0.1%	17%	53%
	Another gender	1.9%	0.3%	1.1%	pls see *
	Missing or prefer not to say	0.9%	0%	2.3%	
Mean years registered		17.6 yrs	15.1 yrs	17 yrs	NA

*Te Tatou o te Whare Kahu Midwifery Council ethnicity figures presented here report 'primary ethnicity' for the ethnicities included.

** the NZMC workforce survey only reports male and female. P.41 of the report states "…as noted in the Gender section of the report on page 11, the number of doctors identifying as gender diverse was too small to report without breaching privacy standards". However, the Gender section page 11 makes no mention of this.

Appendix 2. Community organisations and resources

Supporting Rainbow Community Families is a resource created by Perinatal Anxiety and Depression Aotearoa (PADA) with information for care providers on caring for trans and non-binary people throughout their pregnancy, birth, and early parenting years.

The Professional Association for Transgender Health Aotearoa (PATHA) is an interdisciplinary professional organisation working to promote the health, wellbeing and rights of transgender people. We have over 200 members who work professionally for transgender health in clinical, academic, community, legal and other settings.

Gender Minorities Aotearoa is a nationwide transgender organisation. It is run by and for transgender people; including binary and non-binary, intersex, and irawhiti takatāpui.

InsideOUT Kōaro is a national charity working to make Aotearoa safer for all rainbow young people. It provides resources, workshops, consulting, advocacy and support for anything concerning rainbow (LGBTQIA+) communities.

Te Ngākau Kahukura is a national initiative that works to make communities, environments and systems more safe and inclusive for Rainbow people. Te Ngākau Kahukura works collaboratively with professionals, organisations and wider systems that support people across Aotearoa, including health, housing, social, education and justice.

OUTLine NZ provides free counselling services to rainbow people. Their support line is staffed by trained counsellors who are part of rainbow communities themselves. 0800 OUTLINE (0800 688 5463)

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