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BIRTH ISSUES IN PERINATAL CARE WILEY

LGBTQ+ new and expectant parents' experiences of perinatal services during the UK's first COVID-19 lockdown

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Abstract

Background: COVID-19 created specific challenges for new and expectant parents and perinatal services. Services changed rapidly in the United Kingdom (UK), including the withdrawal of home birth services, birth center closures, and restrictions on the number of birth partners allowed in the birth room. The purpose of this study was to examine how these changes affected the experiences of LGBTQ+ parents in the UK.

Methods: An online survey was conducted in April 2020 to provide real-time data capture of new and expectant families' experiences. It was open to those in the third trimester, or to those who had given birth since the beginning of the first UK lockdown period, and their partners. The survey asked open-ended questions about perinatal experiences. Demographic data were also collected, including sexual orientation and gender. Responses were collected from 1754 participants, including 76 who self-identified as LGBTQ+.

Results: Thematic analysis identified that LGBTQ+ new and expectant parents faced similar issues to cisgendered, heterosexual expectant parents, though additional concerns were also noted relating to support and recognition. Heterocentric policies negatively affect lesbian families. Non-birthing co-mothers feared invalidation as parents. Sexual minority pregnant women were more likely than heterosexual pregnant women to consider additional birth supporters and to consider freebirthing.

Discussion: Service changes introduced in the pandemic were cisheteronormative, creating additional challenges for LGBTQ+ new and expectant parents and compounding existing inequalities. When planning, changing, or evaluating perinatal services, specific consideration is needed to include birthing parents who are not mothers and mothers who did not give birth. If appropriate care is not available, consequences may include impaired perinatal wellbeing and restricted birth choices. Including sexual orientation and gender in data collection enables different perspectives to be considered.

KEYWORDS
birth, COVID-19, LGBTQ+, perinatal

1 | INTRODUCTION

Perinatal services (e.g., midwifery, obstetrics, health visiting, and child health services) are both cisnormative, in that it is assumed that pregnant people are women, and heteronormative,[1] as they are assumed to be in heterosexual relationships with (cisgender) men—assumptions which together are referred to as cisheteronormative. A recent systematic review highlighted that lesbian, gay, bisexual, transgender, and other Queer (LGBTQ+) people have variable experiences in accessing midwifery services.[2] Pregnant sexual minority women using perinatal services face both direct and indirect homophobia.[3] This includes forms that only refer to one father and one mother;[4] maternity ward signs that state that only the baby's father and siblings may visit;[5] refusing to provide conception services to lesbians[1]; and physically rough intrapartum examinations.[1] Non-birthing mothers or partners can face exclusion through heterocentric organizational structures, transphobic and homophobic attitudes from healthcare practitioners, or professional incompetence.[6]

Pregnant non-binary people and trans men similarly experience exclusion through not being represented in parent-facing pregnancy and birth information,[7] being refused access to fertility services despite legal protections,[8] or being forced into choosing more expensive fertility services because they are trans.[9] Some non-binary people and trans men also experience poor care during pregnancy or birth due to ignorance or transphobia,[10] with fear of poor care leading up to 30% of trans men and non-binary people in one study to freebirth— a figure that rose to 46% among trans men and non-binary people of color.[11]

COVID-19 affected expectant parents in several ways. Some expectant parents (and many healthcare practitioners) contracted COVID-19, and many were fearful of contracting it. Illness and redeployment meant a reduced workforce, and there were disruptions in supply chains, with perinatal services in low- and middle-income countries particularly affected.[12] In the UK, antenatal support and conditions attached to birth support from the National Health Services (NHS) and other sources were changed repeatedly and with local variation. Postnatal care was also affected, including changes to the NHS and other services available, and the availability of family support, which was restricted by legislation. Advice to expectant parents from the UK Government, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, and individual NHS Trusts (i.e., local health service organisational units) also changed repeatedly in a short timeframe.

It is well documented that pandemics reinforce existing inequities within societies.[13] Although several studies have examined inequalities in relation to COVID-19 and perinatal services, noting compounding inequalities faced by Black and Asian families,[14] the perinatal experiences of LGBTQ+ people have been neglected. In part, this may reflect the cisheteronormative approach of most research relating to birth,[15] where, for example, questions relating to gender and sexuality are commonly not included. This study, therefore, focused on the experiences of LGBTQ+ participants as captured through a national online survey designed to answer the question:

> What are the experiences of perinatal care among expectant and new parents, where they or their partner had or were due to have a baby in the first UK lockdown period, and how do they feel about these experiences?

2 | METHODS

This research was intended to rapidly gather a snapshot of participants' experiences of the changes to perinatal services as they occurred in real time. An online survey was chosen due to the need to collect information quickly and to adhere to safety considerations in the pandemic's early days.

2.1 | Recruitment

The first lockdown in the UK was announced on March 16, 2020, and began on March 23, 2020. The online survey ran April 10–April 24, 2020, and was advertised online by means of two UK perinatal organizations involved in the project (Birthrights and the Association for Improvements in Maternity Services, AIMS), the University's networks, and wider social media (including platforms such as Facebook and Twitter). Recruitment materials encouraged readers to share the invitation with other appropriate groups.

The survey was open to all new and expectant birthing or non-birthing parents (regardless of parity) whose babies had been born after March 9, 2020 (when the UK Government first added pregnant women to the list of those especially vulnerable to COVID-19) or whose babies were due to be born within 12 weeks of the survey opening (i.e., due before July 3). These dates were chosen to ensure that participants had experience with contact with perinatal services, including planning or receiving intrapartum care, during the time that COVID-19-related changes were affecting services.

2.2 | Data collection

The survey was divided into three sections. The first asked for demographic information, including the

baby's age or estimated due date, which local NHS Trust was providing care, and the respondent's ethnicity, gender, age, and sexual orientation. It also asked whether the participant was pregnant, had given birth, or was the partner of someone who was pregnant or who had given birth.

The survey's second section asked a series of open-ended questions about how participants' found out about COVID-19-related changes to perinatal services; any changes they had experienced to their antenatal care; any changes to their birth or the plans for birth; and how they felt about any changes they experienced. Example questions include:

> Before the pandemic, what were your plans for birth?

> Have your preparations for birth (such as attending antenatal classes, using a doula, having pregnancy massages) changed because of COVID-19?

> How have these changes made you feel?

The full survey questions are available in the Appendix S1. The survey also included psychometric tools, which are due to be published shortly.

2.3 | Analysis

All survey responses were analyzed using reflexive thematic analysis methodology.[16] This enabled us to identify three main themes relating to parents' perceptions of perinatal services in the first days of the pandemic; these were described as unclear, unpredictable, and unsafe.[17] Comparisons were made according to demographic characteristics (for example, by age, ethnicity, gender, and sexual orientation categories). LGBTQ+ and cisheterosexual participants' responses were compared in relation to other demographic categories, psychometric scores, birth choices, and core themes. Then, the LGBTQ+ participants' responses to open-ended questions were analyzed separately, again using thematic analysis, as described by Braun and Clarke,[18] using NVivo to support data management and analysis. Thematic analysis was selected as the most appropriate methodology given the rich detail provided in the open-ended comments, while also providing an overall organizational structure to compare and discuss findings.

Six stages of the analytic process are described by Braun and Clarke[16,18] as part of a robust reflexive thematic analysis process. These are: familiarization, initial coding, searching for themes, reviewing themes, naming and describing themes, and producing a report. The lead researcher read and re-read the responses from LGBTQ+ participants to provide the necessary familiarization before transferring the data to NVivo. An inductive approach was then used to generate initial codes from the open-ended questions. This initial coding was organized into themes, providing a map of the data. Each theme was then named and described, drawing on data to ensure that participants' voices were foregrounded. Both authors then discussed the preliminary themes and illustrative quotations, considering alternative explanations and refining the themes further.

3 | RESULTS

3.1 | Demographic data

Of the 1754 participants, 76 identified themselves as LGBTQ+, and 1673 identified themselves as cisgender and heterosexual. A further three did not complete the sexual orientation questions, with two questioning their relevance. Two more did not complete the gender question, both strongly objecting to the question:

> My sex is obviously female as I'm pregnant. What a ludicrous question, please consider returning to reality and stop pandering to delusions during this awful time

and

> My sex is female you absolute twat [derogatory colloquialism intended to cause insult].

These five were omitted from the analysis conducted for this paper due to not having the data available to categorize.

With respect to participants' sexual orientation, 95.6% identified as heterosexual, 2.9% as bisexual women, 1.0% as lesbian or gay women, and 0.1% ($n=2$) as gay men. Other participants self-defined their sexual orientation, with four participants identifying as pansexual and one as a queer woman. Less than 0.5% of the data was missing. With regards to gender, the majority were cisgender, with one gay trans man and one pansexual non-binary person answering the survey, both of whom had given birth. See Table 1 for further details.

TABLE 1 Composition of the 76 LGBTQ+ participants by gender, sexual orientation, and new or expectant parent status.

	Cis bisexual women	Cis lesbian women	Cis gay men	Trans gay men	Non-binary pansexual people	Cis pansexual women	Cis queer women	Total
Pregnant	41	10	0	0	1	2	1	55
Given birth	8	3	0	1	0	2	0	14
Partner pregnant	1	1	0	0	0	0	0	2
Partner given birth	1	3	1	0	0	0	0	5
Total	51	17	1	1	1	4	1	76

3.2 | Qualitative findings

In general, LGBTQ+ new and expectant parents had similar concerns to cisheterosexual new and expectant parents in this survey. Both groups described perinatal services that were unclear, unpredictable, and unsafe. For example, some LGBTQ+ and cisheterosexual participants who perceived hospitals as unsafe environments linked this to a fear of contracting COVID-19, while for others, it was due to a previous upsetting birth experience in a hospital. Other shared concerns included the lack of clarity and predictability of service closures, especially the closure of birth centers and midwife-led units (MLUs) and the withdrawal of home birth services.

> I can no longer have a home birth and the natural birthing ward of the hospital I am due to give birth at has been turned into an isolation ward in case any Covid-19 patients come in to give birth.
>
> (white gay pregnant trans man, age 24)

> [The NHS Trust has] switched to definitely not doing home birth.
>
> (white cis gay man age 31, whose partner had given birth)

Thematically analyzing LGBTQ+ participants' responses helped us to identify differences between their experiences and the experiences of cisheterosexual participants'. This led to the development of five themes, three of which—*partner support*, *additional birth support*, and *birth without healthcare support*—described issues that were amplified or appeared more commonly in the responses from LGBTQ+ participants relative to the responses from cisheterosexual participants. The other two themes—*denial of non-gestational parents' parenthood* and *unrecognized by bureaucratic heterosexism*—did not appear at all in the qualitative responses from cisheterosexual participants. The five themes coalesced around two superordinate themes: support and recognition. Some of the themes related only to one superordinate theme, while others related to both, as shown in Figure 1.

3.2.1 | Superordinate Theme A: Support

LGBTQ+ participants expressed their need to be supported in their birth choices. The physical presence of the gestational parent's partner, and sometimes additional supporters, was both a fundamental part of these choices and essential to ensuring their other birth choices were respected. In some cases, where LGBTQ+ participants felt that support for their choices was impossible within the NHS, they considered giving birth without the support of healthcare professionals or facilities.

Theme 1: Partner support

Pregnant LGBTQ+ participants expressed a need to have support from their partners through physical presence antenatally at appointments and scans, during labor and birth, and postnatally as a visitor to the postnatal ward. Cisheterosexual participants also expressed a strong desire to have their partners' presence, but the feelings evoked by the policies limiting a partners' presence appeared amplified for LGBTQ+ participants, who described being desperate, terrified, and angry about the potential limitation.

> I'm so angry that as soon as I've given birth or whilst I'm being induced, my husband will be sent home or simply not allowed with me.
>
> (white pregnant pansexual non-binary person, age 37)

Participants' desire for their partner's presence related to both recognition of their family and the participants' own need for support during what was anticipated to be a difficult experience.

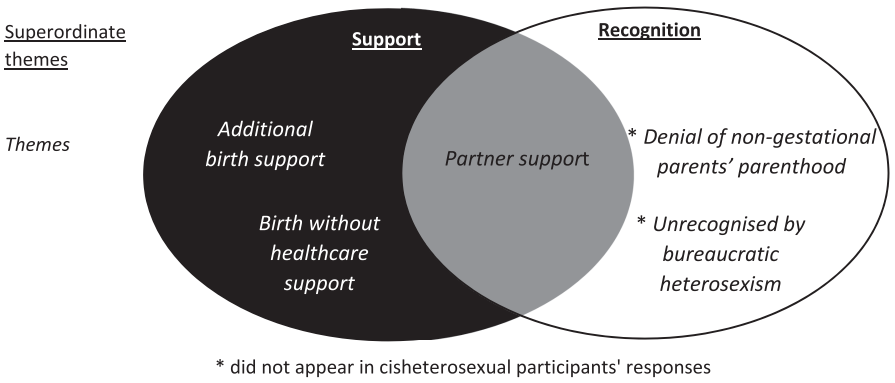

FIGURE 1 Relationship between superordinate themes and themes.

> I'm about to go through an extremely painful experience and my partner can't be there for half of it.
>
> (white gay pregnant trans man, age 24)

In addition, a partner's physical presence was related to feelings of safety. A high proportion of sexual minority participants felt that giving birth in a hospital was unsafe for their health, both physically and mentally. For some, the lack of trust in NHS maternity care practitioners extended beyond hospital settings.

> I would feel safer giving birth at home than in a hospital. I am not worried about contracting the virus. I am more worried about the lack of maternal support and what this could mean for my mental health.
>
> (mixed ethnicity pregnant cis bisexual women, age 34)

> [I am] very unsure and untrusting. I haven't established trust with my current NHS care providers.
>
> (white pregnant bisexual cis woman, age 31)

The care offered by healthcare professionals during appointments was seen as insufficient by many participants.

> [I feel] unsettled and unsupported by NHS staff.
>
> (white pregnant bisexual cis woman, age 30)

Support from partners during antenatal and postnatal appointments and especially intrapartum care was seen as essential by many LGBTQ+ participants as a way of improving safety and protecting their mental health.

Theme 2: Additional birth support

Having additional support during birth from people other than a partner was considered critical by some cisheterosexual participants and some LGBTQ+ participants. There were no differences in the types of people that participants considered additional supporters; in both groups, this included independent midwives, doulas, family members, and friends. LGBTQ+ people were, however, more likely than their cisheterosexual peers to have considered additional support. Comments about support from people other than their partners were not explicitly linked to gender or sexual orientation. In some cases, participants employed additional birth supporters as a way to address their high levels of anxiety about the potential threat to their partner's presence.

> My NHS trust has suspended home births and ... [has] restrictions on birth partner attending hospital. I decided to hire an independent midwife because of this.
>
> (white cis bisexual pregnant woman, age 32)

In other cases, the desire for additional birth supporters reflected a way to obtain the desired kind of birth, sometimes as a reaction to a previous birth experience.

> [I was] worried [about not being able to have more than one person with me at the birth] as the doula was to provide support after previous bad experiences.
>
> (white cis bisexual pregnant woman, aged 37)

For participants who had planned before the pandemic to have birth support from multiple people, the potential absence of their partner and their other birth supporters caused fear and anxiety. For some participants, the effect was so significant that at the time of the survey they had decided to, or were seriously considering, give birth without midwifery or medical support—referred to as a "freebirth"—in order to ensure that they could have the presence of the people they most wanted support from.

Theme 3: Birth without healthcare support

Freebirth can be defined as when someone "intentionally giv[es] birth without health care professionals (HCPs) present in countries where there are medical facilities available to assist them".[19] A higher proportion of sexual minority participants than heterosexual participants said that they were considering giving birth at home, without midwives or other healthcare professionals present. No participant reported their reasons for considering freebirth as directly relating to their sexual orientation or their partner's gender. Rather, all participants described similar reasons for considering freebirth regardless of their sexual orientation. These included a lack of choice in place of birth, hospitals feeling physically and emotionally unsafe, sometimes due to previous hospital birth experiences, and a fear of partners' not being allowed to be present during labor and/or birth.

> I desperately don't want to birth in hospital after my previous traumatic birth, also because hospitals don't feel like safe places at the moment. So I'm feeling on edge as I'm aware that my hospital's policy [home birth service available] could change at any time. If it does, I may consider free birthing. I know also that even if I achieve a home birth, complications and transfers can happen and I'm very anxious about that. I'm also really worried about being in hospital without my partner, that is something I would find extremely difficult.
>
> (white cis bisexual pregnant woman, aged 39)

None of the LGBTQ+ participants who were considering freebirth had planned a freebirth before the pandemic. Yet without the presence of a partner or additional person to advocate for them and support their choices, freebirth was considered a potential option for many LGBTQ+ participants. Paradoxically, by restricting the presence of birth supporters as part of risk management, policies may have placed people at greater risk of birthing without healthcare support.

3.2.2 | Superordinate Theme B: Recognition

Participants expressed a need to be recognized relationally as a family unit that included their partners and their babies. They also needed recognition as LGBTQ+ people, and these needs were distinct from cisheterosexual participants.

Theme 1: Partner support

LGBTQ+ participants who were pregnant or had given birth wanted their partners present not only in order to receive *support from* them but also to secure *recognition for* them, that is, recognition of them both as a partner and as a parent.

> My partner may not be allowed in during the induction and we were planning for her to be there throughout for support and for her to feel involved.
>
> (white cis pregnant lesbian woman, aged 33)

As Figure 2 shows, support and advocacy among gestational and non-gestational LGBTQ+ parents were bidirectional, whereby partner support flowed from the non-gestational parent to the gestational parent to secure birth choices and from the gestational parent to the non-gestational parent to secure involvement and recognition as a family unit.

Theme 4: Denial of non-gestational parents' parenthood

Alongside the amplification of language about partners' absence (described in Theme 1: Partner support section), LGBTQ+ participants described the restrictions themselves in more negative ways and in ways that suggested restrictions were experienced as targeted or as amplifying existing inequalities among sexually diverse families. The idea that non-gestational parents were being denied the opportunity to fulfill their role as both partners and parents was expressed by several LGBTQ+ gestational parents.

> Huge stress [over] birth about whether my partner could be present during labour and on labour ward. She was denied access to my OB [obstetrics] appointments, denied access to MAU [Maternity Assessment Unit] to establish whether I was in labour (36+2) and had to wait in the car for four hours. She was then asked to leave four hours after our premature baby was born and not allowed back for four days.
>
> (white cis lesbian woman, age 36, had given birth)

Pregnant LGBTQ+ participants' concerns centered around whether non-gestational parents would feel recognized as parents. The need to be recognized as a family unit and the fear that this recognition might not be available was shared by non-gestational mothers, several of whom experienced concerns about denial of their parenthood. Non-gestational mothers who took part pre-birth expressed worries that they might be relegated to the

FIGURE 2 Bidirectional support between gestational and non-gestational parents. [Color figure can be viewed at wileyonlinelibrary.com]

status of birth partner only rather than being recognized as an expectant parent. For some non-gestational mothers' whose babies had already been born, this fear had proven a realistic concern.

> My wife having to wear a mask in late labour just after having vomited was stressful - I was worried it would make it harder for her to breath[e] properly. Me having to leave her and the baby alone for one night after a very difficult and traumatic birth was emotional for me (and played into my fears of how valid a parent I was considered, as a non-bio mum) and tough for her.
>
> (white cis bisexual woman, aged 41, whose partner had given birth)

Theme 5: Unrecognized by bureaucratic heterosexism

During the UK lockdowns, visiting policies were designed around heterosexist assumptions about infant feeding. Families in which non-gestational parents might be lactating and feeding their babies had not been accounted for. One non-gestational mother reported that her baby would need to be born in the hospital and that her partner would need to remain in hospital after the birth. She stated that her partner required medication that was incompatible with breastfeeding, but that she herself had been following a lactation protocol so she could breastfeed their baby. Before the pandemic, she had planned to remain in the hospital with her partner and baby to facilitate breastfeeding, but the new visiting policies meant that was not possible. The removal of partners from antenatal appointments also meant she was not able to create a new plan, and that she:

> do[es]n't know what will happen after the birth... Will I be able to take the baby home after 2 hours - but that will leave my partner who has just given birth alone in the hospital. If I can express milk, will our baby be able to be cup fed milk? I don't think I'll be able to get the support I was going to get from the midwives postnatally to breastfeed either.
>
> (Black African cis lesbian aged 28, whose partner is pregnant)

Heterosexist assumptions about pregnancy and birth that underpinned bureaucratic policy decisions about perinatal services rendered invisible the unique needs of LGBTQ+ families and failed to acknowledge the ways differences in family structures might affect service user experiences; such discrimination is a well-documented form of structural violence.[20]

4 | DISCUSSION

This paper examines the responses of LGBTQ+ participants from a larger online survey that explored the experiences of those becoming new parents during the first UK lockdown.[17,21] While there have been several studies relating to perinatal services and the pandemic,[22,23] some of which will have included LGBTQ+ people among a general perinatal population, disaggregation of LGBTQ+ people's experiences is not possible where this demographic information is not collected. To our knowledge, this paper is the first to focus on the perinatal experiences of LGBTQ+ people during the initial UK COVID-19 lockdown.

In our analysis of open-ended responses, we identified similar concerns to those discussed by cisheterosexual parents in this survey and in the wider literature.[14,22] However, we also identified areas of amplification or difference centring around support and recognition. Together, these highlight the importance of ensuring LGBTQ+ families' needs are recognized and met, with tailored rather than generic support offered so these communities can feel safe and seen as they access perinatal services. Our findings echo wider research showing that lesbians' experiences of perinatal services include facing ignorance and overt and covert prejudice.[1,3] Restrictions concerning who counts as "visitors" versus partners have the potential to exacerbate this form of discrimination—not only for any non-gestational parents' validation as parents (including cisgender fathers), but particularly so for non-gestational mothers who may be less visible as parents. This is relevant too because lack of social and legal recognition as a parent has been identified as a particular challenge for non-gestational mothers in same-sex families.[24]

The inequality of experience matters not only for immediate perinatal experiences but also has repercussions for vulnerability to perinatal mental health problems, which in turn carries implications for short- and

long-term mental health and relationship outcomes. Research has shown that sexual minority women in the UK experience worse mental and physical health than heterosexual women and face ignorance, prejudice, and discrimination when accessing healthcare.[25] International data shows similar health disparities for trans men and nonbinary people.[26] Specifically in the perinatal period (i.e., conception to 1 year postnatal), there is some indication of increased vulnerability among LGBTQ+ people.[15,27] From the current study, it is evident that service changes introduced during the COVID-19 pandemic contributed to vulnerability to mental health difficulties in the immediate and subsequent perinatal periods, largely by restricting birthing choices. Given that loss of choice and control during birth are well-established vulnerability factors for traumatic birth,[28] attending to the needs of LGBTQ+ new and expectant parents when changing or planning services is a critical step. Centering the needs of communities made vulnerable by systems of oppression is a core component of committing to trauma-informed care, the aim of which is to "promote feelings of psychological safety, choice, and, control" (p.13).[29]

Findings from this and other research highlight the potential for changes in perinatal services to compound existing inequalities in relation to sexual and gender minority groups. It therefore builds on existing literature that shows that pandemics reinforce inequities within societies;[13] specifically that COVID-19 has reinforced inequities within perinatal services.

The research also shows the value of conducting perinatal research that moves away from the usual grounding in heteronormative frameworks.[8] Collecting demographic data about gender and sexual orientation is an essential first step in understanding the different experiences of LGBTQ+ new and expectant parents; the overarching challenge then is to use that data to improve practice and promote equitable services.

4.1 | Strengths and limitations

In collecting data about sexual orientation and gender, this study appears to have generated the largest data set of responses from known LGBTQ+ parents in the UK during the perinatal period in a COVID-19 context, and potentially outside COVID-19. Findings offer insights into the experiences of those becoming parents during the first UK lockdown, in sufficient numbers to consider similarities and differences between the experiences of LGBTQ+ participants and the experiences of cisheterosexual parents.

While this research points to areas for future investigation, it cannot provide large-scale quantitative comparisons between LGBTQ+ parents' experiences and cisheterosexual parents' experiences. It is also unknown as to whether the findings from this research have applicability outside the first UK lockdown, nor does it illuminate any long-term consequences of these parents' experiences. Longitudinal work will be needed to measure such effects. A further limitation of this research is that while the sexual orientation and gender of the participant were collected, the gender of their partner was not. It is therefore not possible to examine the different experiences that might come from visibility or invisibility, which may be a particular issue affecting single lesbian birthing women, bisexual birthing women currently partnered with men, and transmasculine nonbirthing parents partnered with women.

4.2 | Implications for practice

This research has demonstrated the need for perinatal services to take greater account of the differences between LGBTQ+ families and cisheterosexual families and to ensure that their services are accessible to all families. Our findings align with a wider body of literature about experiences of midwifery care[2] and provides specific examples of how inequalities were compounded in the early days of the COVID-19 pandemic. Currently, very few NHS Trusts collect data on the sexual orientation or gender of pregnant people or their partners; without this knowledge, we cannot shape services to ensure that they are appropriate for LGBTQ+ new and expectant parents. The first practice implication is, therefore, to begin collecting appropriate demographic data. We recognize here that approaches—both within practice and within research—will need to take into account the local legal and social contexts and that in many countries, it will not yet be safe to introduce monitoring. We recognize too that some survey respondents viewed these questions as challenging, as was evidenced in the responses we excluded. Consideration should be given to the institutional support available for service users who find these questions challenging and for healthcare workers and patients who may face homophobic and transphobic responses to demographic data gathering.

Alongside the collection of demographic data, we must ensure that perinatal care is culturally aligned and humble. Student midwives report lacking confidence in working with LGBTQ+ families, and midwifery educators report being unsure about appropriate curricula and how to "prepar[e] students to meet the diverse needs of the population that they serve."[30] Culturally competent care is therefore a priority to be tackled in both education and practice in the UK.

Finally, this research demonstrates implications for policymakers. Whether at a national, local, or service-based

level, if policies assume that all expectant parents are cisgender and heterosexual, inequalities will persist.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in UK Data Service ReShare at https://reshare.ukdataservice.ac.uk/, reference number 855852.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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