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AOTEAROA NEW ZEALAND RESEARCH

Understanding midwives' perspectives about trans inclusion in perinatal care in Aotearoa New Zealand: A national survey

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ABSTRACT

Background: As awareness of the possibilities for trans people to attain parenthood grows, trans, non-binary and other people with diverse genders are increasingly accessing perinatal care as part of their family-building journeys. International literature confirms that midwives can feel clinically challenged by, and poorly prepared for, working with pregnant trans people, but also that they are motivated to provide high quality care and desire professional support to do so. This two-phase study included interviews with trans people who were or had been pregnant, and/or whose partners were or had been pregnant, which informed the development of a nationwide perinatal care workforce survey.

Aim: Phase Two aimed to identify current practice relating to inclusion, and the knowledge, beliefs and education needs of the perinatal care workforce in relation to working with pregnant trans people.

Method: An online nationwide survey of perinatal care providers was undertaken in 2022. Data were collected through single- and multi-response questions, Likert scales and open-ended text boxes. Analyses included descriptive statistics and content analysis of open-text responses.

Results: Of 476 respondents, this paper reports only the midwives' responses (67%; n = 317). Fewer than 25% of midwives recalled receiving any specific education about providing culturally safe care for trans people, but most (78%) identified interest in accessing education if it were made available. Midwives are knowledgeable regarding some clinical aspects of gender affirming care, e.g., the effects of hormone therapy on fertility, but we identified some knowledge gaps. Most articulated positive attitudes towards caring for pregnant trans, takatāpui and intersex people but a minority raised concerns about what they perceived as the 'erasure of women' within wider efforts to be inclusive. Many noted workforce pressure as a barrier to progressing change.

Conclusion: Some midwives are already implementing inclusive practices, primarily led by Lead Maternity Carers (LMCs) who champion affirming and inclusive community-based care. Ensuring that trans people and whānau can anticipate consistently affirming care when they engage in services beyond their LMC, particularly during hospital-based care, needs prioritisation as a workforce development strategy. To date, midwives have not been well prepared to provide inclusive care to this community, but they are willing to engage in education to support affirming and inclusive practice.

Keywords: midwifery education, transgender, non-binary, gender diversity, workforce development

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INTRODUCTION

Family building lies at the heart of midwifery engagement with whānau. In Aotearoa New Zealand (Aotearoa) the majority of pregnancy, birth and postnatal care is provided within an integrated system where Lead Maternity Care (LMC) midwives working in community settings, with support from hospital-based services, provide continuity of care from pre-conception to six weeks post-birth. Our midwife-led, continuity-based, perinatal care system, underpinned by the Partnership Model (Guilliland & Pairman, 2010), arguably creates the optimal conditions to support excellent health outcomes for all people who are pregnant and who give birth. While working well for many, there is increasing recognition that this model of care has not materialised equitable outcomes across all sectors of our community (Dawson et al., 2019, 2022; Edmonds et al., 2022; Ratima & Crengle, 2013). Transgender people consistently describe poor experiences of care in our perinatal health system (Parker et al., 2022; Veale et al., 2019). Midwifery education, which both prepares graduate midwives and maintains (via continuing education opportunities) the workforce's provision of safe and effective care to all birthing people, is critical for ensuring improved experiences of care.

Our paper reports on midwives' responses to a nationwide online survey that examined perinatal health practitioners' education experiences and needs, beliefs, knowledge and clinical preparedness for working with trans, non-binary, takatāpui and intersex whānau (the rainbow community). The survey was the second phase of the Trans Pregnancy Care Project funded by the New Zealand Health Research Council and Manatū Hauora | Ministry of Health. The first phase had involved in-depth interviews with trans people and whānau about their experiences within the perinatal healthcare system, and is reported elsewhere (Parker et al., 2022).

Underpinning regulation: Mandates within midwifery for inclusive practice

Midwives have international and local guidance regarding provision of culturally safe and competent care to pregnant people with diverse genders and sexualities. The International Confederation of Midwives (ICM) Position Statement Human Rights of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People (ICM, 2017) recommends that midwives' associations "welcome all those who need midwifery services and provide them with compassionate, culturally safe care regardless of gender identity, gender expression, or sexual orientation" and "advocate for the inclusion of the principles of ethics and human rights within the midwifery curriculum in their country" (p. 2). Progress has been slow in Aotearoa to develop a professional consensus statement on rainbow inclusion in midwifery care, but some education programmes are progressing gender, sex characteristic, sexuality diversity and equity education within their undergraduate and postgraduate midwifery programmes (Parker et al., 2023a).

Te Pae Tata Interim New Zealand Health Plan from Te Whatu Ora | Health New Zealand (2022) also provides a focus for the improvement of rainbow people's health. Te Pae Tata acknowledges that health inequities exist for rainbow communities and Health New Zealand | Te Whatu Ora is committed to developing a more equitable health system that is accessible, cohesive and people-centred, which includes better meeting the needs of rainbow communities. The Pae Ora strategies described within Te Pae Tata will be embedded across the Kahu Taurima (first 2000 days) work plan and midwives will continue to play a key role in supporting whānau through the period from pre-conception to the first six weeks postpartum.

Finally, Te Tatau o te Whare Kahu | Midwifery Council has recently released a revised Midwifery Scope of Practice (2024), which has embraced a more inclusive approach, reflecting a fundamental philosophical underpinning within Te Ao Māori that inclusivity is a given – since takatāpui and people with other Indigenous expressions of genders have existed for generations (Kerekere, 2017; McBreen, 2023).

Midwives in Aotearoa have had limited opportunities to engage in education which equips them to provide culturally safe and affirming care to the trans community, although respect for individual circumstances and working in partnership to understand people's needs are fundamental underpinnings for midwifery practice. This being the case, extending these practice norms to include trans people and their whānau should not represent a major shift for midwives, except that they occur within the context of our perinatal care system being predicated on cis- and hetero-normative beliefs about who perinatal care is for (Parker et al., 2022).

Literature review

A burgeoning body of literature has explored the perinatal workforce's readiness, beliefs and education needs in relation to the provision of safe and affirming care for trans, non-binary and other gender diverse pregnant people. Recent literature from the USA (Kukura, 2022), along with a systematic integrative review which included 24 studies from seven countries (Stewart & O'Reilly, 2017), confirms that perinatal care practitioners are generally willing to engage in education to support more inclusive practice but are often unsure where to access such education. Studies identify that individual midwives sit along a wide spectrum of beliefs and knowledge (Stewart & O'Reilly, 2017); can feel challenged by working with trans and non-binary pregnant people (Johansson et al., 2020); and note that the cis/heteronormative structures, that are ubiquitous within perinatal care, present barriers to improving care outcomes for this population (Pezaro et al., 2023). Authors urge systems-level change and an increased availability of education for practitioners (Brown et al., 2021; Parker et al., 2022; Pezaro et al., 2023; Stewart & O'Reilly, 2017). As Kukura (2022) notes: "The omission of childbearing TGE [transgender, non-binary, and gender-expansive] people from research on reproductive health, their exclusion from clinical settings, and their neglect in the training and skills of healthcare providers are forms of systemic bias" (p. 478).

Several studies have presented recommendations for health practitioner education which include specific strategies for embedding gender diversity and equity education into curricula (Arias et al., 2021; Arseneau et al., 2019; Brown et al., 2023; Effland et al., 2018, 2020; Falck et al., 2020; Gedzyk-Nieman & McMillian-Bohler, 2022; Singer et al., 2019; Walker et al., 2016; Wilson-Mitchell & Handa, 2016). While the extant literature can contribute to our understanding of how to work effectively with pregnant trans people and provides some guidance for how to achieve change through education, the reviewed studies do not attempt to address Indigenous perspectives and nor have they been conducted within continuity-based perinatal care environments. Glover et al. (2009) note that takatāpui experience the same "cultural assumptions" within their whānau as heterosexual Māori, i.e., that they will have children. The authors contend that homophobia and heterosexism present barriers for takatāpui to pursue parenthood and raised concerns about how the "current underground pathway to parenthood taken by some takatāpui may result in health risks and uncertain legal status" (Glover et al., 2009, p. 309). Although their article refers predominantly to takatāpui who are cisgender lesbian rather than to takatāpui who

are trans and non-binary, it acknowledges the focus on continuing whakapapa as an important cultural driver for takatāpui who seek to conceive. The Honour Project Aotearoa (Pihama et al., 2020) has provided a comprehensive picture about takatāpui health and well-being, describing issues of inequity and limited access to inclusive services with respect to reproductive rights. This information is fundamental knowledge for midwives to appreciate and thus the views of Māori midwives, who responded to our survey about inclusive midwifery practice, add depth to our understanding.

Given the evidence that perinatal care practitioners are generally willing to engage in education to support more inclusive practice, but are often unsure where to access such education, we decided to explore the needs of perinatal health practitioners in Aotearoa in relation to providing inclusive care.

Thus, the aim of this study was to better understand perinatal health practitioners' education experiences and needs, beliefs, knowledge and clinical preparedness for working with trans, non-binary, takatāpui and intersex whānau by conducting a nationwide online survey.

METHOD

Following preliminary analysis of the data from the Phase One interviews, we designed an anonymous online survey. This survey sought to assess, among other things, whether the perinatal workforce was currently working in ways and within environments that aligned with the needs of our interview participants. The survey was drafted by the research team and shared with stakeholders and relevant community groups, e.g., Intersex Aotearoa, Gender Minorities Aotearoa, New Zealand College of Midwives (the College) and obstetric colleagues with expertise in this area. Their feedback was incorporated. The survey was pre-tested by eight health professionals, who were not eligible to participate in the research but were familiar with the health research environment, to test the survey logic, establish the length of time to complete the survey and assess the clarity of the questions. We designed our study using a strengths-based and educative approach so that practitioners had an opportunity to highlight inclusive practice already being undertaken in their workplaces and to also recognise Indigenous experience as an important component of our work.

Inclusion criteria

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

Recruitment

Following ethics approval (Victoria University of Wellington Human Ethics Committee #0000030433) the survey was loaded into Qualtrics and a link to the survey was disseminated widely via the membership database of the College, a RANZCOG [Royal Australia and New Zealand College of Obstetricians and Gynaecologists] Pānui (newsletter) and a variety of social media platforms that perinatal care providers follow. The survey consisted of 45 items which included tick box responses, 5-point Likert rating scales and opportunities for free-text comments. It remained open online for six weeks between August 8 and September 19, 2022.

Data analysis

Data were extracted from the Qualtrics platform, after removal of duplicate entries, and anonymised by the research assistant, who had signed a confidentiality agreement. Data were uploaded into IBM SPSS Statistics (Version 28.0.1.0) and further cleaned by removing respondents who had not progressed past the demographic questions. The full data set comprised 476 respondents and analysis of this dataset has been reported elsewhere (Parker et al., 2023b). Although a sub-analysis was not originally intended, we see there is added value for the profession in providing sub-analysis that is specific to the responses from the large cohort of midwives and is not confounded by responses from other health professionals. Midwives' data were analysed to produce descriptive statistics (frequency tables, means and standard deviations). Content analysis of midwives' open-text responses focussed on the reoccurrence of similar concepts, to build a picture of the frequency of comments in specific content areas, and thus infer midwives' commonly expressed interests and concerns.

RESULTS

In total, 476 practitioners responded to the survey, with the majority (67%) of these respondents being midwives (n = 317). A precise response rate was unable to be calculated due to the wide dissemination of the survey link; however, based on the College's distribution to 2877 practising midwives, the response rate would be 11%. As discussed, the results presented in this paper relate only to the midwife respondents and are therefore calculated from a denominator of 317.

Who responded to our survey?

Table 1 describes our midwife respondents' demographic characteristics.

One question was asked about the respondent's gender (Table 1) and another asked whether the respondent considered themselves trans or non-binary. Affirmative responses to the latter question accounted for 2.5% of our midwifery sample, takatāpui for 1.6%, and no-one identified as being born with a variation in sex characteristics, with one respondent selecting "I don't know" for that item.

Respondents identified that they "never" or "rarely" provided perinatal care to trans or non-binary people (78%) or to those with variations in sex characteristics (VSC, sometimes called intersex; 90%) but some midwives reported they "occasionally" or "frequently" provided perinatal care to trans or non-binary people (19%) or to those with VSC (4%). Three percent of midwife respondents were "unsure" if they had provided care to trans or non-binary people, and 6% were unsure about having provided care to people with VSC.

Inclusive practices in the workplace

The survey included questions about specific aspects of practice that the trans people and whānau in Phase One of the study determined were important to them in making them feel safe and included in their care. Midwife respondents described the activities that they were currently undertaking or working towards in their personal practice and in their workplaces, in relation to providing more inclusive environments and midwifery care. These practices include such things as asking people about their pronouns and the words they use to describe their bodies, creating welcoming and inclusive physical environments, and providing opportunities for people to self-identify their gender and family formations. Table 2 reports on the midwives' responses to questions about their practice environment.

In open-text responses, midwife respondents additionally described simple steps such as wearing rainbow lanyards and pronoun badges and including their pronouns in email communications. They described practice change as being easier in community settings (e.g., midwifery clinics) than in large institutional settings, where several barriers were identified, both "structural" and "social":

Table 1. Demographic characteristics of midwife respondents*

Characteristic		
Age (*n* = 317)	Range 21-74	Mean 46 (SD 12) yrs
Time registered in NZ (*n* = 302)	<1 to >40	Mean 17 (SD 12) yrs
Time practising in NZ (*n* = 305)	<1 to >40	Mean 15 (SD 10) yrs
		n (%)
Ethnicity (*n* = 314)	Māori	34 (11)
	New Zealand European	208 (66)
	Other European	60 (19)
	Pasifika, Chinese, Indian, other non-European*	12 (4)
Gender (*n* = 317)	Wahine/woman	310 (98)
	Tane/man or another gender*	7 (2)
Sexuality (*n* = 313)	Heterosexual	234 (74)
	Bisexual	32 (10)
	Pansexual	14 (4)
	Fluid	9 (3)
	Queer	8 (3)
	Lesbian	6 (2)
	Asexual	5 (2)
	Something else	5 (2)
Geographical location (*n* = 316)	Major urban	174 (55)
	Smaller urban	91 (29)
	Rural	31 (10)
	More than one setting	20 (6)
Area of clinical practice (*n* = 317)	Community-based practice	150 (47)
	Hospital clinic	25 (8)
	Hospital ward/suite	118 (37)
	In-home care only	12 (4)
	Another setting	12 (4)

*some categories have been aggregated to support non-identification of respondents. Percentages are rounded.

Table 2. Progress on activities in the workplace to be inclusive of trans people (percentages rounded). Midwife respondents *n* = 317

	Yes	**Working toward**	**No**	**Missing response**
My online professional/practice profile specifically mentions that I welcome trans and non-binary people.	41 (13%)	61 (19%)	132 (42%)	83 (26%)
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'.	111 (35%)	43 (14%)	121 (38%)	42 (13%)
Some of the documents I use (e.g. enrolment or hospital admission forms) have space for recording personal pronouns.	88 (28%)	51 (16%)	140 (44%)	38 (12%)
Some of the documents I use (e.g. enrolment or hospital admission forms) have space for recording details of more than one support person.	193 (61%)	19 (6%)	69 (22%)	36 (11%)
My workplace's social media, website or marketing materials include reference to trans and non-binary people.	55 (17%)	57 (18%)	127 (40%)	78 (25%)
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).	30 (9%)	44 (14%)	193 (61%)	50 (16%)
The name of my practice is gender-neutral (e.g. Birth Care, Peoples' Place).	131 (41%)	10 (3%)	101 (32%)	75 (24%)
The signage in my workplace is gender-neutral or gender-inclusive (e.g. service name signage for an antenatal clinic, waiting room signs).	103 (32%)	22 (7%)	133 (42%)	59 (19%)
My workplace has gender-neutral bathroom facilities.	180 (57%)	6 (2%)	88 (28%)	43 (13%)
My workplace has a policy on gender-inclusive employment practices.	73 (23%)	42 (13%)	105 (33%)	97 (31%)
My workplace or practice has policies or guidelines to support trans and non-binary inclusion.	45 (14%)	59 (19%)	133 (42%)	80 (25%)
I have received formal feedback from my trans and non-binary clients/patients about their care.	50 (16%)	9 (3%)	136 (43%)	122 (38%)

Writing policy to be gender inclusive has been very tricky and it seems I am the only one in our team who cares about it as I often go through documents when they are almost finalised to adjust the wording to include those who don't identify as mothers or women, while still wanting to recognise that the majority of who we serve do use those terms.

I attempted to suggest changes to our booking forms in a previous work environment. I was told it was already in progress but 2-3 years later nothing's changed. Massive barriers.

Some of my LMC colleagues in the group are a bit older than me and while I think they were generally pretty accepting, there was often joking around/poking fun at the idea of gender inclusivity for example at our group meetings.

Midwife respondents described enablers for change too, such as proactivity about seeking inclusive resources, and commitment to personal practice change and role modelling:

We are actively opening the discussion around pronoun use in our hospital. I am part of a team who are looking at ways to gather info graphics that are non-binary/trans inclusive. We have met some resistance. We have put up weekly slides in our handovers to bring up the discussion around trans inclusive language, behaviours, care approaches.

Leading by example has been helpful. I started with changes like adding pronouns and have noticed more and more people doing so. Generally, staff have been responsive and keen to learn.

Table 3 identifies that the sharing of, asking about and use of pronouns have yet to be embedded into routine practice, although some midwives reported working towards this in their personal practice.

Professional learning and development

Many midwives had not received any education specific to working with trans, non-binary, intersex and takatāpui people in their undergraduate (pre-registration) education. Few had engaged in elective post-registration continuing education in this area, although this may reflect the scant availability of such education (Table 4).

In response to a question about whether they would access education about gender diversity and inclusion if it was made available (which 234 midwives answered), 78% (n = 182) indicated that they would be interested, 8% (n = 19) indicated that they would not and 14% (n = 33) were unsure. About half the midwife respondents (52%, n = 33 of 63 responses) indicated that they had self-funded gender diversity education. When asked for reflections about gender diversity education, midwives' text responses expressed a range of views:

Going back to the topics taught in my tertiary education - many of the topics I highlighted were only acknowledged they were a "thing", or very briefly touched on how to engage with in a "safe" way. The majority of any LGBTQI info was based on cis lesbian experiences, and then mostly acknowledging it exists and how there might be IVF considerations. The education I've had on it has all been self-sought, mostly through online resources, Instagram platforms, and speaking with supportive colleagues.

Both my children… are gay, and they have friends who are non-binary and trans so I am learning more through them than I am through any "professional education".

Midwives' knowledge, beliefs and clinical preparedness for providing inclusive care

The final section of the survey asked respondents to rate their agreement with a range of statements on a 5-point scale from *strongly agree* to *strongly disagree* (Table 5). As the final item on a lengthy survey, there was a consistent lack of response from roughly a quarter of respondents. We cannot know why respondents did not answer the items in this question. We have elected in this table to present the percentage calculated from the available responses to each statement (n provided for each item). Percentages are rounded.

Overall, midwives' responses indicated they were knowledgeable about clinical aspects of perinatal care for trans, non-binary, intersex and takatāpui people. Some aspects of their clinical preparedness, such as knowing where to refer people and how to access resources to provide culturally safe care for Māori and Pacific clients, were identified as knowledge gaps and provide opportunities for future education. While most (72%) midwife respondents agreed that it is important to adapt their language to be more inclusive, just over half (54%) agreed that they knew how to do so. Midwife respondents generally appeared to hold supportive beliefs about working with pregnant and birthing trans people and two-thirds (68%) believed their professional organisation should play a leadership role in promoting gender-inclusive practice.

Sixty-one midwives responded in the final text box asking for more general comments about gender diversity in perinatal care. A wide variety of opinions was expressed and, as reported elsewhere (Parker et al., 2023b), we coalesced these comments into clusters reflecting the main topic areas and offer some quotes to illustrate these. Five of the 61 comments indicated the respondent had no further reflections to add, and there were 16 comments that did not relate to the four identified topic areas below, but were, for

Table 3. Midwife respondents' use of inclusive language (n = 317)

	Never	Sometimes	About half the time	Mostly	Always	Missing response
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
When I introduce myself to clients/patients I share my pronouns	159 (50)	45 (14)	9 (3)	16 (5)	11 (4)	77 (24)
I ask clients/patients about their pronouns	116 (37)	81 (26)	10 (3)	19 (6)	20 (6)	71 (22)
Staff at the place I work ask for clients'/patients' pronouns	112 (35)	73 (23)	3 (1)	10 (3)	10 (3)	109 (35)
I ask my clients/patients about the words they use to describe their body parts	109 (35)	83 (26)	9 (3)	23 (7)	19 (6)	74 (23)
I use a client's/patient's self-determined pronouns	25 (8)	11 (4)	1 (<1)	26 (8)	163 (51)	91 (29)
I use the words that my clients/patients use to describe their body parts in my interactions with them	38 (12)	30 (9)	7 (2)	56 (18)	89 (28)	97 (31)

Table 4. Midwife respondents' previous education about trans, nonbinary, intersex and takatāpui people

	Yes	No	Can't remember	Missing response
	n (%)	*n* (%)	*n* (%)	*n* (%)
In your undergraduate education did you receive any specific education about the following groups?				
Trans and non-binary people and their whānau	45 (14)	180 (57)	10 (3)	82 (26)
Intersex people and their whānau	72 (23)	141 (44)	23 (7)	81 (26)
Takatāpui people and their whānau	28 (9)	191 (60)	17 (5)	81 (26)
In your post-registration education did you receive any specific education about the following groups?				
Trans and non-binary people and their whānau	65 (21)	162 (51)	3 (1)	87 (27)
Intersex people and their whānau	60 (19)	165 (52)	4 (1)	88 (28)
Takatāpui people and their whanau	54 (17)	174 (55)	1 (< 1)	88 (28)

Table 5. Knowledge, beliefs and clinical preparedness among midwife respondents

Statement	*n*	Strongly agree or agree	Neutral	Disagree or strongly disagree
		n (%)	*n* (%)	*n* (%)
There are health impacts on trans, non-binary, intersex and takatāpui people when health care does not include them.	228	203 (89)	14 (6)	11 (5)
I assume that clients/patients are women unless they tell me otherwise.	230	139 (60)	55 (24)	36 (16)
It is important to adapt my language to make it trans, non-binary, intersex and takatāpui-inclusive.	229	164 (72)	45 (19)	20 (9)
I know how to adapt my language to make it trans, non-binary, intersex and takatāpui-inclusive.	229	124 (54)	56 (25)	49 (21)
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.	230	141 (61)	49 (21)	40 (18)
Facilities and documentation in perinatal care services should be inclusive of trans, non-binary, intersex and takatāpui people (e.g. provide gender-neutral bathrooms).	230	185 (80)	32 (14)	13 (6)
I should have access to education to support my provision of care for trans, non-binary, intersex and takatāpui people.	230	200 (87)	16 (7)	14 (6)
Trans and non-binary people who have a uterus and medically transition cannot become pregnant.	224	4 (2)	40 (18)	180 (80)
I have seen or heard negative attitudes or behaviours towards trans, non-binary, intersex and/or takatāpui people in my workplace.	229	97 (42)	42 (18)	90 (40)
I think intersex variation/difference in sex development is always a problem that needs to be medically fixed.	225	2 (1)	19 (8)	204 (91)
If I needed information about working with a trans, non-binary, intersex or takatāpui client, I would ask them to educate me.	230	120 (52)	65 (29)	45 (19)
I feel confident raising concerns about transphobic or intersex-phobic discrimination in my facility/workplace/amongst my colleagues.	227	130 (57)	52 (23)	45 (20)
I know where to refer trans, non-binary, intersex and takatāpui clients to support services.	227	45 (20)	41 (18)	141 (62)
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.	226	41 (18)	43 (19)	142 (63)
Our professional organisations should play a leadership role in trans, non-binary, intersex and Takatāpui inclusion in perinatal care.	227	154 (68)	49 (22)	24 (10)
I am comfortable telling whānau their baby has an intersex variation at birth using mana-enhancing language for the baby and whānau.	227	75 (33)	73 (32)	79 (35)
People should only be in a romantic or sexual relationship with one other person.	224	20 (9)	36 (16)	168 (75)
There are just two genders, male and female.	226	15 (7)	22 (9)	189 (84)
Gender-affirming hormone therapy always makes people infertile.	222	1 (<1)	55 (25)	166 (75)
Trans, non-binary, intersex and takatāpui people should have access to resources to be able to plan a pregnancy.	227	206 (91)	14 (6)	7 (3)
I would feel morally conflicted providing care to a trans, non-binary, intersex or takatāpui pregnant person.	226	5 (2)	12 (5)	209 (93)

example, reflections about a personal experience or a comment that we were unable to sufficiently interpret e.g., "don't throw the baby out with the bathwater".

Comments about the survey itself

In the largest cluster, fifteen respondents expressed that they had found the survey format with links to relevant websites and glossaries educational, and that formulating their responses had further raised their awareness and stimulated their commitment to making changes in their practice:

> *Reading through this survey shows me how little I'm prepared in my practice… 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.*

Knowledge needs and gaps

It was apparent from comments in this 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. As one example, "There are two genders - male and female. The rest is a delusion". Along with the education needs previously mentioned, over half (52%, n = 120 of 230 responses) of the midwife 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. Twelve text responses confirmed support for the urgent need for education and practice change, noting this kaupapa is timely, necessary and a positive contribution to equity and safety in perinatal care:

> *It's certainly highlighted a point in practice I have very little knowledge about and hope in the future resources and education for midwives are made widely available.*

> *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 it's 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.*

Perspectives from Māori midwives

Six Māori respondents noted that inclusivity is a fundamentally intrinsic tenet within a Māori world view. The pronoun "ia" is used for all genders, and a wide range of gender and sexuality expressions are known across Indigenous cultures. As reported elsewhere (Parker et al., 2023b), Māori respondents expressed frustration that enduring colonising practices continue to hinder progress towards more universal acceptance and application of this inclusive 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.*

> *Within Midwifery, we have not honored te tiriti first and foremost, which if we did, a lot of this survey would be covered. Midwifery is now wanting to have this discussion and add into fundamental documents, however has only just started convos on our view, our reo, our cultural responsiveness. Although I applaud and tautoko the discussion, our reo language should be first and foremost. If we adopted COM* [College of Midwives] *being te tiriti people this discussion wouldn't have needed to come about.*

The bigger picture

Other responses related to the wider social and professional context of inclusion in perinatal care. The current workforce pressures midwives are experiencing were noted to be having an inhibitory effect on the ability to make space and time for education initiatives in this area:

> *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.*

Four midwives expressed concern about the "erasure" of women and woman-centred language that they considered accompanies initiatives to make space for including all people who have babies. One reflection further noted a concern that gender justice for cisgender women remains unaddressed and noted the complexity associated with widening the conversation to include trans and non-binary people:

> *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.*

Two comments expressed discomfort that equity remains elusive for other groups also, for example:

> *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.*

DISCUSSION

Our findings suggest that trans inclusion is an aspect of practice change that most midwives are open to engaging with and they would like support to improve their practice in this area. These findings are largely resonant with the findings of international studies (Brown, 2023; Johannson et al., 2020; Pezaro et al., 2023; Reis, 2020; Rojas, 2020; Stewart & O'Reilly, 2017) and also perhaps reflect a wider societal acceptance and affirmation of gender and sexuality diversity. Our respondents shared their commitment to providing excellent care to all and to optimise outcomes for all people and whānau. Midwife respondents identified a range of ways they are already being more inclusive in their practice,

but they also identified barriers to change, particularly in large institutional settings.

The majority of respondents identified gaps in their knowledge but, importantly, also their willingness to learn more and build their capability. Notable is that over half (52%) of the respondents to one question 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. However, the interview participants from Phase One of our study described the need to educate their caregivers as being one of the more exhausting aspects of the emotional labour associated with navigating their perinatal care, and they highly valued healthcare practitioners who took responsibility for their own education (Parker et al., 2022).

Another area of data alignment to note across the two phases of our study was that 78% of respondents reported that they had "never" or "rarely" provided care to trans people. In Phase One, trans people reported that they were not commonly invited to self-identify their gender, and this was confirmed by survey participants who reported that gender information was not routinely sought in their institutional data capture mechanisms. This raises the question about whether care providers have not "known" and "seen" trans people in their care because clients have not been supported or invited to share these aspects of their identity with their caregivers. Phase One participants experienced the continuity of care as provided by gender-affirming LMC midwives as a crucial determinant of positive experience for them within the perinatal care system. This highlights the benefit of creating relationships of trust and reciprocity that support engagement with care and thus the potential for improved and more equitable outcomes.

The desire and need for education to support midwives' capability to provide trans-inclusive care are echoed internationally (Murdock, 2024; Pezaro et al., 2023; Wilson-Mitchell & Handa, 2016) and collaborative work across midwifery schools has been undertaken (Parker et al., 2023a), leading to improved understanding of successful strategies and sharing of resources for educators to adapt to their local contexts. Our study findings shed light on the topic areas that midwives in Aotearoa request specific support with, and provide a path forward for ongoing education initiatives.

A further contribution our study can make is to give voice to the perspectives of some Māori midwives. Indigenous scholars remind us that binary constructs of sexuality and gender are in themselves colonising constructs (Kerekere, 2023; McBreen, 2023). Pihama and Green (2023) contend that: *Aspects of Indigenous cultures that were rendered invisible in the process of colonisation include the diversity of sexual expression* (p. 15).

Practising inclusively and acknowledging the ongoing impact on people's self-expression due to imposed colonising gender constructs has the potential to be transformational. Kerekere (2023) notes:

> *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.* (p. 84)

Some Māori survey respondents articulated how "inclusion" is a given within te ao Māori and suggested that if we organised our systems around this, the foundation for trans-inclusive practice would be established. While we can all take steps to educate ourselves and build inclusion into our everyday practice, change is not just about individuals – institutions and professional bodies also need to enable and lead change. We acknowledge the workload pressures that midwives are currently experiencing, but believe that even small incremental changes, particularly when institutionally led, can change workplace cultures.

While the majority of our respondents expressed support for inclusive practice and willingness to expand their knowledge, a minority of midwives raised concerns about the erasure of women when language change and other initiatives are undertaken to include all people giving birth. We concur with their legitimate exasperation that reproductive justice has not yet been fully realised for cisgender women. Tensions around sex-essentialism within midwifery are well documented (Gribble et al., 2022; Parker et al., 2022; Pezaro et al., 2023, 2024) and this evolving dialogue is crucially important to the ongoing development of our professional identity. Cisgender women have historically been deprioritised from healthcare, policy development and research, and their struggles to be counted, included in clinical research and active within social policy development are also well documented. McGlothen-Bell et al. (2023) contend that their struggles are mirrored in the ongoing battles that trans- and gender-expansive people have, to be acknowledged and included within healthcare settings. Similarly, midwives' experience of historic professional oppression by obstetric hegemony ensures that midwives are well-placed to resist and dismantle systems of power imbalance that seek to exclude marginalised groups.

McGlothen-Bell et al. (2023) articulate it thus:

> *… being inclusive does not mean excluding one group for the sake of another. With a commitment to honoring differences, inclusion can make room for embracing people with many different access needs. In intersectional feminist movements, opportunities for liberation have long been sought; however, relying on narrow (often White, cisgender, and nondisabled) notions of what it means to be a woman limits our ability to liberate ourselves from the confines of exclusive practices. Without exploring the assumptions and stereotypes of what the term "woman" means, whom it includes and excludes, and whom we are here to serve, equity and inclusion can only partially be achieved.* (p. 447)

Recommendations for practice

Our recommendations for practice at both service and individual practitioner level are available within the project's final report (Parker et al., 2023b). We encourage all midwives to familiarise themselves with our Warming the Whare: A Te Whare Takatāpui informed guideline and recommendations for trans inclusive perinatal care and to work towards embedding this practice guidance into their midwifery work. Further, we recommend that Schools of Midwifery, Te Whatu Ora facilities, and regulatory and professional bodies take up the challenge to develop policy statements and education resources that move beyond inclusion to a more affirming and celebratory recognition of the diversity both within our own profession and among those who seek midwifery services.

STRENGTHS AND LIMITATIONS

A key strength of this study was that the health practitioner survey was developed with extensive input from stakeholders and incorporated the reflections of gender and sexuality diverse service users about what constitutes safe and affirming care. The size of our sample and diversity of ethnicities give us confidence that our interpretations of the data that midwives supplied reflect the views of a wide range of midwives, while acknowledging that there may be some bias within the sample due to the relatively high number of

respondents who were sexuality diverse. On some items there were missing data which limits the generalisability of our findings, and we acknowledge that some questions did not include a not applicable response which may be related to the amount of missing data on those items. While it is a strength that our findings relate to the specific context of perinatal care within Aotearoa, the converse is that this limits generalisability to other countries due to differences in their demographic characteristics and perinatal care systems.

CONCLUSION

This research confirms that some midwives are already implementing strategies that enhance inclusive midwifery practice for trans, non-binary and other gender and sexuality diverse people, primarily led by LMCs who champion affirming and inclusive community-based care. Ensuring that trans people and whānau can anticipate consistently affirming and culturally safe care when they engage in perinatal care beyond their LMC, particularly when they receive hospital-based care, needs to be prioritised as a workforce development strategy. Our data reveal that, to date, midwives have not been well prepared by their education programmes to provide culturally safe and inclusive care to this community, but they are willing to engage in education to support their professional development in this evolving area of practice.

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DECLARATION OF INTEREST

Authors Suzanne Miller, Sally Baddock and George Parker are involved in midwifery education. The authors declare that the research reported in this paper was funded by the Health Research Council of New Zealand (HRC 20/1498) and Manatū Hauora | Ministry of Health.

GLOSSARY

Terms	Sources used in this article for definitions
Kupu Māori (words from te reo Māori, one of Aotearoa New Zealand's official languages)	**Source:** Te Aka Māori Dictionary https://www.maoridictionary.co.nz/
Words associated with gender and sexuality	**Source:** Gender Minorities Aotearoa https://genderminorities.com/glossary-transgender/

KEY POINTS

- Surveyed midwives articulated a wide range of views about providing trans-inclusive midwifery care.
- Most midwives surveyed desire support to provide more affirming and inclusive care for trans, non-binary, takatāpui and intersex people.
- Most midwives surveyed have not received education to support practice change in this area but are enthusiastic to extend their knowledge.

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