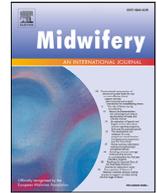




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# Experiences in the delivery of preconception and pregnancy care for LGBTIQ+ people: A systematic review and thematic synthesis of patient and healthcare provider perspectives

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## ABSTRACT

**Background:** The widespread availability of reproductive technology and family planning services has led to an increase in the number of available pathways to parenthood for LGBTIQ+ people. However, emerging research indicates that significant healthcare inequities have been documented among LGBTIQ+ people and attributed to the pervasiveness of structural and systemic discrimination that extends to preconception and pregnancy care.

**Aim:** The aim of this systematic review was to synthesise qualitative research that has explored the experiences of LGBTIQ+ people in navigating preconception and pregnancy care services to inform healthcare quality improvement.

**Method:** Six databases were searched for relevant research published between 2012 and 2023. The findings of all included studies underwent a secondary thematic synthesis, and methodological quality was assessed using the Joanna Briggs Institute Checklist for Qualitative Research.

**Findings:** A total of 37 studies were eligible for inclusion. Four major themes were constructed through thematic synthesis: (1) unavailability of information, services, and support; (2) clinical competencies of healthcare staff; (3) hetero- and cis-sexist care experiences; and (4) discrimination and traumatisation.

**Conclusions and implications for practice:** The findings of this review indicate that LGBTIQ+ people experience significant challenges during the journey towards parenthood, marked predominantly by the pervasiveness of inequity, and defined by discriminatory healthcare processes. This review has led to several recommendations for future healthcare quality improvement through an investment in policies, procedures, and interactions that are sensitive to the needs of LGBTIQ+ people. Importantly, future research must be co-designed and led by LGBTIQ+ community input.

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Abbreviations: LGBTIQ+, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual/Aromantic, and other gender or sexuality orientations.

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## Introduction

A growing body of research indicates that a significant portion of people who identify as sexuality or gender diverse may express a desire for children (Gato et al., 2021). Existing research exploring attitudes and pathways to parenthood among LGBTIQ+<sup>1</sup> people has primarily focused on gay and lesbian same-sex families with a gradual increase in research among bisexual and transgender individuals, while other LGBTIQ+ communities have remained under-represented across the literature (particularly intersex,<sup>2</sup> pansexual, and asexual/aromantic individuals, alongside polyamorous families who remain similarly neglected) (Goldberg and Allen 2020; Reczek, 2020). Similarly, population-based census data has rarely captured accurate prevalence estimates of people who identify as sexuality and gender diverse (Hughes et al., 2021), including LGBTIQ+ families with children (Russell et al., 2020), despite advocacy efforts. In recent years, the widespread availability of reproductive technology has led to an increase in the number of available pathways to pregnancy and parenthood for LGBTIQ+ people (Gato et al., 2021). Although a wide range of services now exists, the accessibility and inclusiveness of these services for LGBTIQ+ people remains an ongoing health equity concern, defined by prejudicial healthcare processes and procedures largely attributed to structural and systemic discrimination that extends to preconception and pregnancy care.

Prominent pathways to parenthood for LGBTIQ+ people include assisted reproduction through intracervical or intrauterine insemination, *in vitro* fertilisation, and surrogacy (Gato et al., 2021). A common pathway to pregnancy for lesbian couples is through donor insemination (Hayman et al., 2015; Patterson and Riskind, 2010), while surrogacy and foster care are common pathways to fatherhood for gay men, in addition to being donor fathers themselves with co-parenting arrangements in place (Carneiro et al., 2017; Riggs and Due, 2014). Pathways to parenthood for transgender individuals have been underexplored across the literature (Biblaraz and Savci, 2010). However, advances in fertility preservation and treatments have opened up family planning options for transgender people, whereas gender affirmation procedures have historically been associated with fertility loss (Besse et al., 2020; Brandt et al., 2019; Rodriguez-Wallberg et al., 2023). Importantly, this research also indicates that some LGBTIQ+ individuals may maintain existing identities as parents with children from previous relationships, or may enter into co-parenting dynamics in relationships with others who have existing children. However, pathways to pregnancy and parenthood for other LGBTIQ+ communities, particularly intersex individuals, remain underexplored.

<sup>1</sup> The umbrella term, "LGBTIQ+", is used throughout this paper and collectively refers to those who identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual/aromantic, and other gender or sexuality orientations. In addition, the term "queer" is increasingly used across the literature and has also been referred to in this paper. Entrenched in a history of its use as a derogatory slur, the term "queer" has been embraced by members of LGBTIQ+ communities as a means to reclaim power and create a sense of unification (Institute of Medicine, 2011).

<sup>2</sup> "Intersex" refers to people who have innate sex characteristics that do not fit medical norms for female or male bodies (Intersex Human Rights Australia, 2021). The social and political movements of those in Intersex communities are unique amongst other rights-based movements, though are often unrecognised, homogenised and excluded within and beyond the communal acronym of LGBTIQ+. Although people who are intersex - of which there are numerous variations - have been included within the scope of this review by the authors, it is important to note that individuals with intersex characteristics should not be homogenised and expected to fit social expectations of an endosex and queer identity. People who are intersex may or may not identify as "queer", within other sexuality and gender diverse communities, and may be cisgender and/or heterosexual (Carpenter, 2022).

Despite the increased availability of pathways to parenthood, research has reported significant inequities in preconception and pregnancy care for LGBTIQ+ people (Croll et al., 2022). Studies report that clinical pregnancy rates among lesbian and bisexual women through successful reproductive assistance may be higher than heterosexual women (Hodson et al., 2016), yet these communities may be more likely to experience a miscarriage, stillbirth, or preterm birth (Barcelona et al., 2022; Croll et al., 2022; Everett et al., 2019). Research exploring outcomes among gender diverse people have been underexplored (Croll et al., 2022; Brandt et al., 2019), however emerging research suggests that miscarriage and stillbirth rates are similarly high (Moseson et al., 2020). These outcomes have been associated with a time of distress, and LGBTIQ+ people often do not receive appropriate support or recognition of their grief following pregnancy loss (Craven, 2019). The physical and psychological impacts of pregnancy loss affects people of all sexuality, sex, and gender experiences, and recent research has advocated for further investment in improving patient care and support following pregnancy loss (Quenby et al., 2021), for both mainstream and minority populations.

The pervasiveness of discrimination against LGBTIQ+ people across healthcare systems may be key contributing factors to antenatal health, pregnancy, and infant outcomes (Croll et al., 2022; Everett et al., 2019). Sexuality, sex, and gender diverse people can experience bias and discrimination in preconception and perinatal services, including experiences related to minority stress and the burden of self-advocacy, navigating outdated legislation and the absence of legal protections, and educating healthcare workers about LGBTIQ+ culturally affirming care. Additionally, the prohibitive cost of private preconception, fertility, and perinatal services could act as an additional barrier to accessing LGBTIQ+ affirming care, and reproductive health care more broadly. In exploring these inequities, recent reviews have synthesised the experiences of LGBTIQ+<sup>3</sup> people in receiving midwifery and fertility care (McCann et al., 2021; Kirubarajan et al., 2021). Indeed, their findings represented the absence of inclusive information regarding available services and pathways, ongoing heteronormativity through standardised healthcare processes, the absence of inclusive language that accurately reflected diversity, gender dysphoria and psychological distress associated with cisnormative medical procedures, and adverse childbirth experiences. Although the experiences of LGBTIQ+ people in navigating broader preconception and pregnancy care services were not captured, these recent reviews indicated that the journey to parenthood is associated with significant inequities. Experiences of discrimination and resulting minority stress can result in a reluctance from LGBTIQ+ to engage with mainstream reproductive health services, and may hamper parenthood aspirations (Gato et al., 2021).

Disadvantages faced by LGBTIQ+ people are entrenched in a long history of structural discrimination and societal stigmatisation that extend to healthcare systems (Zeeman et al., 2018), and action across all socioecological levels will be needed (Aleshire et al., 2019). In order to promote an affirming preconception and pregnancy care environment for LGBTIQ+ people, continued research that explores their experiences is needed. The aim of this qualitative systematic review was to therefore synthesise research on both the experiences of LGBTIQ+ people in navigating preconception and pregnancy care (including their care experiences during childbirth itself), and the perspectives of health professionals who have delivered care to LGBTIQ+ people in these services. The findings from this systematic review will be used to identify gaps

<sup>3</sup> Variation in language and terminology is used throughout this paper according to the context of the research that has been referenced.

**Table 1**  
Summary of search terms mapped to the JBI Population, Concept, and Context (PPC) Framework.

PPC Elements	Search Terms <sup>a</sup>
Population (P)	"queer*" OR "LGBT*" OR "lesbian*" OR "gay" OR "bi?sexual" OR "transgender*" OR "intersex" OR exp disorders of sex development/ OR "transsexual*" OR "gender non-confirming" OR "asexual" OR "gender divers*" OR "non?binary" OR "pansexual" OR "homosexual" OR "gender dysphori*" OR "men who have sex with men" OR "msm" OR "women who have sex with women" OR "wsw" OR "genderqueer" OR "gender identit*" OR "sexual orientation*" OR "gender minorit*" OR "sexual minorit*" OR "polyamo"
Concept (C) <sup>b</sup>	"fertility" OR "reproduct*" OR "preconception" OR "conception" OR "antepartum" OR "prenatal" OR "antenatal" OR "pregnan*" OR "intrapartum" OR "labo?r" OR "birth*" OR "postnatal" OR "postpartum" OR "surroga*" OR "lactation" OR "perinatal" OR "chest?feeding" OR "breast?feeding" OR "midwi*" OR "maternity" OR "paternity"
Context (C)	"family" OR "families" OR "parent*" OR "relationship*" OR "couple*" OR "partner*" OR "mother*" OR "father"

Note. / = term was entered as a Medical Subject Heading (MeSH); exp = MeSH term was exploded in respective databases.

<sup>a</sup> The search strategy was developed with shared input from the authorship team, whose professional expertise and personal experiences in preconception and pregnancy care, childbirth, and sexuality and gender diversity was leveraged and informed the selection of these terms. Members of the authorship team additionally hold previous expertise in navigating academic databases, conducting searches, and undertaking systematic literature reviews.

<sup>b</sup> Concept terms that were associated with the postpartum period were included in the initial search to capture a broader range of literature. This included any relevant studies that may have been missed by including preconception and pregnancy terms alone, such as those that either: (1) explored the perspectives and experiences of participants across the entire preconception, pregnancy, and postpartum cycle, or (2) engaged participants who were in the postpartum period at the time of the study with the intention of exploring their recollection of preconception and/or pregnancy care.

that will inform future research and the development of interventions and policies that promote sexuality and gender affirming preconception and pregnancy care.

## Method

### Design

A systematic review was conducted, and the protocol was informed by the Joanna Briggs Institute's (JBI) methodological guidance for conducting systematic reviews of qualitative research (Lockwood et al., 2020). The systematic review was reported in accordance with the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement (Tong et al., 2012). The protocol was registered with PROSPERO (Registration ID: CRD42023400478).

### Search strategy

The search was conducted in August 2022 and updated in February 2023. The search was limited to January 2012 to provide a contemporary overview of the literature and identify current research on this topic. Six databases were searched: MEDLINE, EMBASE, Emtree, MIDIRS, PsycINFO, and CINAHL Plus. The Joanna Briggs Institute Population, Concept, and Context (PCC) Framework was used to formulate the search terms (Peters et al., 2021). The search syntax was developed using the terms, "LGBTIQ+" (Population), "preconception and pregnancy" (Concept), and "families" (Context) (see Table 1). The search history for each database has been provided in Supplemental File 1.

### Study selection and inclusion criteria

All studies were independently screened against the inclusion and exclusion criteria (see Table 2) at the title and abstract stage by two researchers (K.H. and A.M.). Studies that were not excluded at this stage were then read in full by the same two researchers. Any disagreements were resolved via a discussion and a third researcher was available for consultation if consensus could not be reached.

### Data extraction and synthesis

Extracted data included: author, year, country, participant characteristics, recruitment and data collection methods, and study aims. Extraction of all studies was performed by one researcher

(A.M.) and verified by a second researcher (K.H.). A secondary qualitative analysis was guided by Thomas and Harden's (2008) proposed method of thematic synthesis for systematic reviews of qualitative research. All included studies were imported into NVivo for analysis (QSR International, 2022). Analysis was performed by two researchers (K.H. and A.M.) who familiarised themselves with the included studies and then analysed all content under the "Results" subheading of each study by following Thomas and Harden's (2008) three stages of thematic synthesis. The researchers first assigned at least one initial descriptive code to each line of text that was extracted from the results of the included studies. The two researchers coded the first five studies independently, followed by a discussion of their coding to create consistency in their approach. Each researcher then coded 50% of the remaining studies. The researchers then reviewed their coding, grouped the codes into a hierarchy, and organised them into descriptive themes, according to their similarities and/or differences. In the final step of synthesis, the researchers generated analytical themes that represented the experiences and delivery of preconception and pregnancy care for LGBTIQ+ people and families in order to respond to the aim of this review.

### Methodological quality assessment

Methodological quality was assessed using the JBI Checklist for Qualitative Research, which consists of 10 methodological quality criteria (Lockwood et al., 2020). Each study was rated against these criteria with one of three responses: "Yes", "No", and "Unclear". The quality of all studies were assessed by two independent researchers (K.H. and E.G.) and any discrepancies were resolved through discussion.

## Results

### Study characteristics

Thirty-seven articles reporting the results of 36 studies were eligible for inclusion (see Fig. 1). The characteristics of these studies have been presented in Table 3. Most studies explored the experiences of either lesbian cisgender women ( $n = 11$ ), any non-heterosexual women and/or co-mothers ( $n = 6$ ), or transgender, transmasculine, or non-binary individuals and their partners ( $n = 9$ ). Only three studies explored the perspectives of health-care professionals, who had worked with either transgender people ( $n = 2$ ) or lesbian women ( $n = 1$ ). Most studies were conducted across Canada ( $n = 10$ ) or the United States ( $n = 10$ ).

**Table 2**  
Inclusion and exclusion criteria.

	Inclusion Criteria	Exclusion Criteria
Participants	Participants were adults over the age of 18 years and were members of any LGBTIQ+ communities or identified as gender and/or sexuality diverse, regardless of sexual orientation or gender identity. Healthcare professionals who delivered preconception and/or pregnancy services to LGBTIQ+ or gender and/or sexuality diverse people.	Participants were under the age of 18 years and/or did not identify as members of any LGBTIQ+ community (i.e., cisgender and heterosexual). Healthcare professionals who delivered preconception and/or pregnancy services to people who did not identify as LGBTIQ+.
Setting	Any family formation, preconception, or pregnancy healthcare services, where participants were actively pursuing parenthood (including care provided during childbirth itself).	Healthcare services that did not focus on family formation, preconception, or pregnancy care, or explored care experiences in the postpartum period.
Design and Study Aims	Studies were qualitative and captured the experiences of participants in accessing and navigating preconception and/or pregnancy care services (or the experiences of healthcare professionals in delivering these services).	Quantitative studies, given that this review was concerned with exploring the perspectives and voices of participants through qualitative research. Studies that measured pregnancy or family formation outcomes (e.g., successful births, prevalence of miscarriage, birthweights, etc.).
Timeframe	Published between January 2012 and February 2023.	Published prior to January 2012.
Language	English language.	Languages other than English.

*Methodological quality assessment*

The quality assessment for each study has been presented in Table 4. The assessment revealed an overall high congruity between qualitative research methodologies<sup>4</sup> and research questions, data collection, analytical approaches, and interpretation of results for most studies. However, congruity between research methods and data analysis across several studies was unclear due to underreporting of analytical details. Although several studies reported underlying philosophical perspectives (including social constructivism, feminist and queer theory, trans\* epistemology, ecological systems theory, and normative resistance and inventive pragmatism), congruity for most studies was unclear as underlying perspectives were not specified. In addition, almost all studies represented the voices of participants to substantiate findings, and conclusions followed logically from interpretations of data. Few studies explicitly located the researchers culturally or theoretically to declare their positionality on the research topic, however those that did reported that members of their research teams identified as gender and/or sexuality diverse. Finally, although the influence of the researchers was often accounted for at the analysis and interpretation stages, their influence during recruitment and data collection was often not addressed.

*Care experiences*

The findings were structured according to four major themes: (1) unavailability of information, services, and support; (2) interpersonal competencies of healthcare staff; (3) hetero- and cissexist care experiences; and (4) discrimination and traumatisation (see Table 5).

*Theme 1: unavailability of information, services, and support*

*Unavailability of information.* Same-sex couples often perceived that information provided about service pathways was designed for heterosexual and cisgendered families (Copeland et al., 2023; Fantus, 2021; Lacombe-Duncan et al., 2022; Topper et al., 2022). Moreover, information about available pathways was often not provided when initially pursuing services, predominantly reported

by lesbian couples and transgender men (Danielson et al., 2022; Ellis et al., 2014; Gregory et al., 2022; Hoffkling et al., 2017; Malmquist et al., 2016; Riggs et al., 2015; Ross et al., 2014; Topper et al., 2022; Van Hoof et al., 2015). The lack of information created uncertainty, confusion, dissatisfaction, and isolation, often causing people to cease service engagement. Families therefore relied on their own research for information, which often prolonged decision making (Danielson et al., 2022; Ellis et al., 2014; Fantus, 2021; Topper et al., 2022). In contrast, some participants reported that information was accessible through intensive education courses, community centres for LGBTIQ+ people that conducted inclusive information sessions, and certified providers who were accommodative of queer people (Fantus et al., 2021; Gregory et al., 2022; Hayman et al., 2013; Hoffkling et al., Malmquist, 2016).

*Inaccessibility of local services.* Limitations in insurance policies that did not cover the costs of fertility services for same-sex couples or transgender individuals was a major barrier to service access (Danielson et al., 2022; Gregory et al., 2022; Lacombe-Duncan et al., 2022; MacDonald et al., 2021; Rausch et al., 2021; Riggs et al., 2020; Rozental and Malmquist, 2015; Topper and Bauermeister, 2022; Van Hoof et al., 2015). Access was also restricted by the absence of legislations that protect their rights to reproductive care, forcing them to either travel abroad for treatment, seek service providers who would look the other way, or lie about their relationship status (Burrow et al., 2018; Carpenter and Niesen, 2021; Chapman et al., 2012; Danielson et al., 2022; Gregory et al., 2022; Hoffkling et al., 2017; Klittmark et al., 2018; Topper and Bauermeister, 2022). In contrast, lesbian couples from a study conducted in Sweden expressed their appreciation for queer-inclusive services, following a recent legislation designed to protect their reproductive rights (Rozental and Malmquist, 2015). Local services were also sometimes lacking altogether, particularly in remote geographical locations (Carpenter and Niesen, 2021; Chapman et al., 2012; Danielson et al., 2022; Ellis et al., 2014; Gregory et al., 2022).

*Value of social support.* Peer support through local community centres for LGBTIQ+ people was reported by gay fathers and transgender men as an avenue to receive information, learn from the experiences of others, and feel reassured (Fantus, 2021; Hoffkling et al., 2017). Information sessions facilitated by local community centres and social media groups designed specifically for LGBTIQ+ people provided opportunities to build relationships

<sup>4</sup> Variation in qualitative research methods was reported, including phenomenological (n = 8), descriptive (n = 4), grounded theory (n = 3), case study (n = 1), narrative inquiry (n = 1), naturalistic inquiry (n = 1), interpretive description (n = 1), and interpretive repertoire (n = 1) methods, while the remaining studies did not explicitly report the specific qualitative methodology that guided their research (n = 17).

**Table 3**  
Summary of study characteristics.

First Author (Year), Country	Service Type(s) or Pregnancy Stage	Participants <sup>a</sup>				Method		Aim(s)
		Participant Group	Sample Size	Age (Years)	Gender: N (%)	Research Methodology, Philosophical Perspective, Data Collection	Recruitment Methods and Setting	
Arseneau et al. (2019), Canada	Pregnancy and childbirth	Polyamorous families	22	M = 34 R = 23 to 48	Male = 8 (36.4) Female = 14 (63.6)	Descriptive; constructivism; semi-structured interviews	Convenience sampling through social media and snowball sampling	To explore the experiences of polyamorous families when accessing reproductive health services.
Burrow et al. (2018), Canada	Childbirth	Queer women (lesbian, gay, bisexual, queer, pansexual, and two-spirit)	13	R = 18 to 42	All participants were labelled as women, but specific gender identity was not reported	Phenomenological; feminist and queer theories; semi-structured dialogical interviews	Recruited through hospitals, health clinics, community bulletin boards, social media, and word-of-mouth	To capture the birthing experiences of queer women and the vulnerabilities and harms they have faced.
Carpenter (2021), United States	Family formation processes and pregnancy	Queer cisgender women and non-binary individuals assigned female at birth	22	Majority were in their 20 s (n = 9)	Cisgender women = 15 (68.1) Non-binary = 3 (13.6) Genderqueer = 2 (9.1) Other = 2 (9.1)	Grounded theory; not specified; semi-structured interviews	Advertising through social media	To understand how pregnancy and parenting fit into the lives of queer cisgender women and non-binary people assigned female at birth.
Chapman et al. (2012), Australia	Conception and childbirth	Lesbian parents	8	R = 35 to 52	Women = 8 (100)	Descriptive; not specified; semi-structured and dyadic interviews	Leaflets and flyers distributed during a pride event, and snowball sampling	To explore the experiences of Australian lesbian parents in conceiving and birthing children.
Charter et al. (2018), Australia	Pregnancy (and parenthood)	Transgender men	25	M = 35.6 SD = 6.66 R = 25 to 46	Transgender men = 25 (100)	Not reported; not specified; semi-structured interviews	Distribution of an information sheet to transgender support groups and community organisations, and social media	To explore transgender men's experiences of gestational pregnancy, and their experiences with parenthood.
Cherguit et al. (2012), United Kingdom	Conception and pregnancy	Lesbian co-mothers	10	M = 41.5 R = 33 to 51	Women = 10 (100)	Interpretive phenomenological; not specified; semi-structured interviews	Emails distributed through a donor conception charity organisation, and snowball sampling	To explore lesbian co-mothers' experiences of maternity healthcare services throughout the preconception, pregnancy, and post-birth care periods.
Copeland et al. (2023), Australia	Pregnancy and childbirth	Transgender/non- binary and agen- der/genderfluid	2	M = 21	Transgender/non- binary = 1 (50) Agender/genderfluid = (50)	Case study; not specified; semi-structured interviews	Participants expressed a desire to share their stories during their antenatal care. Healthcare professionals and academics developed a research project to capture their voices.	To derive a deeper understanding of transgender and non-binary people's experiences of pregnancy and birth to inform inclusive care.
Dahl (2015), Norway	Pregnancy and childbirth (and post-birth)	Lesbian co-mothers	11	R = 30 to 52 years	Women = 11 (100)	Not reported; not specified; semi-structured interviews	Information advertised on a LGBT community organisation's website and social media groups	To explore the experiences of lesbian co-mothers throughout maternity care.
Danielson et al. (2022), United States	Fertility counselling	Female partners	6	R = 32 to 48	Cisgender women = 6 (100)	Interpretive phenomenological; feminist theory; semi-structured interviews	Emails and flyers distributed to counsellors, colleagues, and queer support organisations	To explore the experiences of female partners receiving third-party fertility treatments and counselling services.

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Table 3 (continued)

First Author (Year), Country	Service Type(s) or Pregnancy Stage	Participants <sup>a</sup>				Method		Aim(s)
		Participant Group	Sample Size	Age (Years)	Gender: N (%)	Research Methodology, Philosophical Perspective, Data Collection	Recruitment Methods and Setting	
Ellis et al. (2014), United States	Conception, pregnancy, and childbirth	Male-identified and gender variant gestational parents	8	M = 33 R = 29 to 41	Solely male = 2 (25.0) Multiple identities = 6 (75.0) (male, transgender, genderqueer, female-to-male, gender variant, two-spirit)	Grounded theory; not specified; semi-structured interviews	Information distributed by health and social care providers and snowball sampling through community networks	To investigate the conception, pregnancy, and childbirth experiences of male and gender-variant gestational parents who underwent social or medical gender transition prior to pregnancy.
Fantus (2021), Canada	Gestational surrogacy	Gay fathers and gestational surrogates	21	M = 39	Male = 21 (100)	Interpretive phenomenological; not specified; semi-structured and dyadic interviews	Electronic advertisements distributed through same-sex parenting groups, surrogacy services, and social media	To examine heteronormative experiences of gay fathers pursuing gestational surrogacy as a parenting pathway and explore inclusive practices and policies.
Fischer (2021), Canada	Conception, pregnancy, and childbirth	Non-binary people	5	M = 34.8 SD = 5.26 R = 31 to 44	Non-binary = 5 (100)	Narrative inquiry; not specified; semi-structured interviews	Recruitment materials circulated to community contacts and posted on social media.	To better understand the reproductive experiences of non-binary individuals throughout conception, pregnancy, and birth.
Goldberg et al. (2017), Canada	Perinatal health care	Male-partnered sexual minority women	28	M = 31.39 SD = 4.97 R = 22 to 44	Women = 28 (100)	Not reported; not specified; semi-structured interviews	Recruited through midwifery clinics and OB/GYNs.	To explore male-partnered sexual minority women's views of and experiences with disclosure to healthcare providers during perinatal care.
Gregory et al. (2022), Canada	Assisted reproduction services	Lesbian women	11	R = 25 to 45	Women = 11 (100)	Not reported; not specified; semi-structured and dyadic interviews	Convenience and snowball sampling via social media	To investigate the experiences of lesbian women and their interactions with assisted reproductive services.
Hayman et al. (2013), Australia	Conception, pregnancy, and childbirth	Lesbian women	15	M = 39.8 R = 28 to 58	Women = 15 (100)	Not reported; feminist theory; semi-structured and dyadic interviews	Convenience sampling through women's healthcare services and snowball sampling	To examine the experiences of lesbian mothers throughout the journey to motherhood.
Hoffkling et al. (2017), United States	Conception, pregnancy, and childbirth	Transgender men	10	N/R	Transgender men = 10 (100)	Grounded theory; not specified; semi-structured interviews	Convenience sampling from respondents of an online survey from a broader study	To identify the needs of transgender men throughout the family planning process and peripartum period.
Hudak (2021), United States	Pregnancy	Queer pregnant couples (homosexual, bisexual, queer)	32	R = 28 to 46	N/R	Not reported; not specified; semi-structured and dyadic interviews	Social media advertisements in closed Facebook groups	To explore how healthcare providers communicate with queer couples during pregnancy periods and experiences of heteronormativity.

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Table 3 (continued)

First Author (Year), Country	Service Type(s) or Pregnancy Stage	Participants <sup>a</sup>				Method		Aim(s)
		Participant Group	Sample Size	Age (Years)	Gender: N (%)	Research Methodology, Philosophical Perspective, Data Collection	Recruitment Methods and Setting	
Lacombe-Duncan et al. (2022), United States	Conception, pregnancy, and childbirth	LGBTQ+ individuals who had experienced pregnancy loss (lesbian, bisexual, queer, asexual)	17	M = 34.4 SD = 3.3 R = 29 to 40	Cisgender women = 15 (88.2) Transmasculine person = 1 (5.9) Non-binary = 1 (5.9)	Not reported; minority stress theory; semi-structured interviews	Social media networks/groups for LGBTQ+ parents and word-of-mouth	To explore the experiences of stigma and resilience among LGBTQ+ across conception, pregnancy, and pregnancy loss.
James-Abra et al. (2015), Canada	Assisted reproduction services	Transgender individuals and their partners	9	N/R	Male = 1 (11.1) Female = 1 (11.1) Transwomen = 1 (11.1) Transmen = 5 (55.5) Other = 2 (22.2) Female = 5 (100)	Descriptive phenomenological; not specified; semi-structured interviews	Flyers distributed through clinics and pride celebrations	To explore the experiences of transgender people engaging with assisted reproduction services.
Johansson et al. (2020), Sweden	Childbirth	Midwives (who support transgender men)	5	M = 43 R = 28 to 56		Descriptive; not specified; semi-structured interviews	N/R	To explore midwives' perceptions regarding caring for transgender men during labour and childbirth.
Klittmark et al. (2018), Sweden	Reproductive health care	LGBTQ expectant and new parents (lesbian, gay, bisexual, transgender, queer, pansexual)	12	R = 30 to 45	Female = 8 (66.7) Male = 2 (16.7) Transgender = 2 (16.7)	Not reported; not specified; semi-structured interviews	Convenience sampling using flyers through social media groups for LGBTQ families	To explore the experiences of LGBTQ expectant and new parents in navigating reproductive health care.
MacDonald et al. (2020), Canada	Pregnancy and childbirth	Transmasculine individuals	22	N/R	N/R	Interpretive description; not specified; semi-structured interviews	Convenience sampling through social media	To explore the experiences of transmasculine individuals with pregnancy, birthing, and feeding their newborns.
Malmquist et al. (2014), Sweden	Conception, pregnancy, and childbirth	Lesbian couples	96	M = 36	Women = 96 (100)	Interpretative repertoire; not specified; semi-structured interviews	Identification of eligible parents through second-parent adoption courts	To analyse lesbian parents' stores and accounts of received treatment in their encounters with professionals working in fertility clinics and maternity and child healthcare services.
Malmquist (2016), Sweden	Antenatal education	Lesbian couples	96	N/R	Women = 96 (100)	Not reported; not specified semi-structured interviews	N/R	To explore lesbian couples' experiences of and reflections on antenatal education, and to compare regular classes with LGBTQ-certified alternatives.
Malmquist et al. (2019), Sweden	Pregnancy and childbirth	Lesbian and bisexual women, transgender men, and non-binary individuals	17	R = 25 to 42	N/R	Not reported; critical realism; semi-structured interviews	Advertisements posted in social media groups for LGBT families	To explore the thoughts of LBT people and their experiences throughout pregnancy, childbirth, and reproductive healthcare

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Table 3 (continued)

First Author (Year), Country	Service Type(s) or Pregnancy Stage	Participants <sup>a</sup>				Method		Aim(s)
		Participant Group	Sample Size	Age (Years)	Gender: N (%)	Research Methodology, Philosophical Perspective, Data Collection	Recruitment Methods and Setting	
Parker et al. (2022), Aotearoa New Zealand	Perinatal care services	Transgender people	20	N/R	Genderfluid = 2 (10) Gender nonconforming = 1 (5) Nonbinary = 10 (50) Agender = 3 (15) Transman = 3 (15) Takatapui = 1 (5) Genderqueer = 2 (10) Transmasculine = 1 (5) Transfeminine = 1 (5) Trans woman = 3 (15)	Not reported; trans* epistemology; semi-structured interviews	Purposive sampling through social media and word of mouth	To understand how cisnormativity operates in perinatal care settings, and explore the impacts of cisnormativity on transgender and non-binary people accessing care.
Rausch et al. (2021), United States	Fertility treatment	Lesbian couples	13	M = 38.29 R = 33 to 48	Cisgender women = 13 (100)	Phenomenological; ecological systems theory; semi-structured interviews	Purposive sampling through a fertility treatment organisation's Facebook group	To understand the social support experiences of lesbian couples engaging in fertility treatment.
Riggs et al. (2015), Australia	Surrogacy	Gay fathers	12	N/R	Men = 12 (100)	Not reported; not specified; semi-structured interviews	Study information circulated to members of Surrogacy Australia	To explore the experiences of Australian gay men who became parents through surrogacy arrangements in India.
Riggs et al. (2020), United Kingdom	Conception and pregnancy	Transmasculine and non-binary individuals	51	M = 33 years)	Transmen/transmasculine = 21 (41.1) Men = 11 (21.6) Non-binary = 11 (21.6) Genderqueer/androgynous/fluid/grey gender = 8 (15.7)	Not reported; normative resistance and inventive pragmatism; semi-structured interviews	Purposive sampling via social media, community conferences, events, and researcher/participant networks	To explore the experiences of men, transmasculine, and non-binary people during pregnancy and conception.
Ross et al. (2014), Canada	Assisted human reproduction services	Lesbian, gay, bisexual, transgender, and queer people	66	N/R	Cisgender female = 48 (72.7) Cisgender male = 9 (13.6) Transgender men = 7 (10.6) Transgender women = 2 (3.0)	Not reported; not specified; semi-structured interviews	Flyers circulated within relevant service organisations and pride celebrations	To explore the experiences of lesbian, gay, bisexual, transgender, and queer people in navigating assisted human reproduction services.
Rozental (2015), Sweden	Assisted human reproduction services	Lesbian couples	29	R = 26 to 45	Women = 29 (100)	Not reported; social constructionism; semi-structured interviews	Identification of eligible parents through second-parent adoption courts	To explore deficiencies in fertility treatment identified by participants.

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**Table 3** (continued)

First Author (Year), Country	Service Type(s) or Pregnancy Stage	Participants <sup>a</sup>				Method		Aim(s)
		Participant Group	Sample Size	Age (Years)	Gender: N (%)	Research Methodology, Philosophical Perspective, Data Collection	Recruitment Methods and Setting	
Ruderman et al. (2021), United States	Reproductive genetic counselling (preconception)	Genetic counsellors (of transgender patients)	9	N/R	Cisgender women = 9 (100)	Not reported; not specified; semi-structured interviews	Short survey distributed to genetic counsellors	To explore the experiences of genetic counsellors in providing reproductive care to transgender patients and their partners.
Searle et al. (2017), Canada	Perinatal	Queer women (lesbian, gay, bisexual, queer, pansexual, and two-spirit)	13	R = 18 to 42	Women = 11 (100)	Phenomenological; feminist and queer theories; semi-structured interviews	Recruited through word of mouth using a website advertising the study	To examine queer birthing women's experiences of trauma and disempowerment during perinatal care.
Spidsberg (2011), Norway	Pregnancy and childbirth (and postnatal)	Midwives (of lesbian women)	11	M = 50 R = 30 to 59	N/R	Phenomenological-hermeneutical; not specified; semi-structured interviews	Invitation circulated within two major hospitals, advertisement in a midwifery journal, and snowball sampling	To explore the lived experiences of midwives caring for lesbian women and their partners.
Topper & Bauermeister (2022), United States	Assisted human reproduction	Sexual minority women (lesbian, queer, bisexual, or other non-heterosexual identity)	20	R = 28 to 40	Cisgender women = 20 (100)	Descriptive; not specified; semi-structured and dyadic interviews	Advertisements disseminated through social media, pride events, and within participant and research networks	To explore how sexual minority women couples describe their shared experiences in navigating assisted reproduction.
Topper et al. (2022), United States	Assisted human reproduction	Sexual minority women (lesbian, queer, bisexual, or other non-heterosexual identity)	20	M = 33 Range = 28 to 40	Cisgender women	Naturalistic inquiry; not specified; semi-structured and dyadic interviews	Flyers posted in establishments frequented by sexual minority women, pride events, within peer networks, and social media	To explore and describe fertility information-seeking experiences of sexual minority women couples using assisted reproduction.
Van Hoof (2015), Belgium	Assisted reproductive services (sperm donation and embryo transfer)	Lesbian couples	24	M = 33.3 R = 23 to 42	Women = 24 (100)	Not reported; not specified; semi-structured interviews	Purposive sampling through a university hospital.	To identify the challenges encountered by lesbian couples in navigating reproductive treatment and seeking donor sperm.

Note. M = Mean; SD = Standard Deviation; R = Range; N/R = Not Reported.

<sup>a</sup> Sexual orientation and gender identity labels given to participant groups have been listed exactly as they were reported in their respective studies.

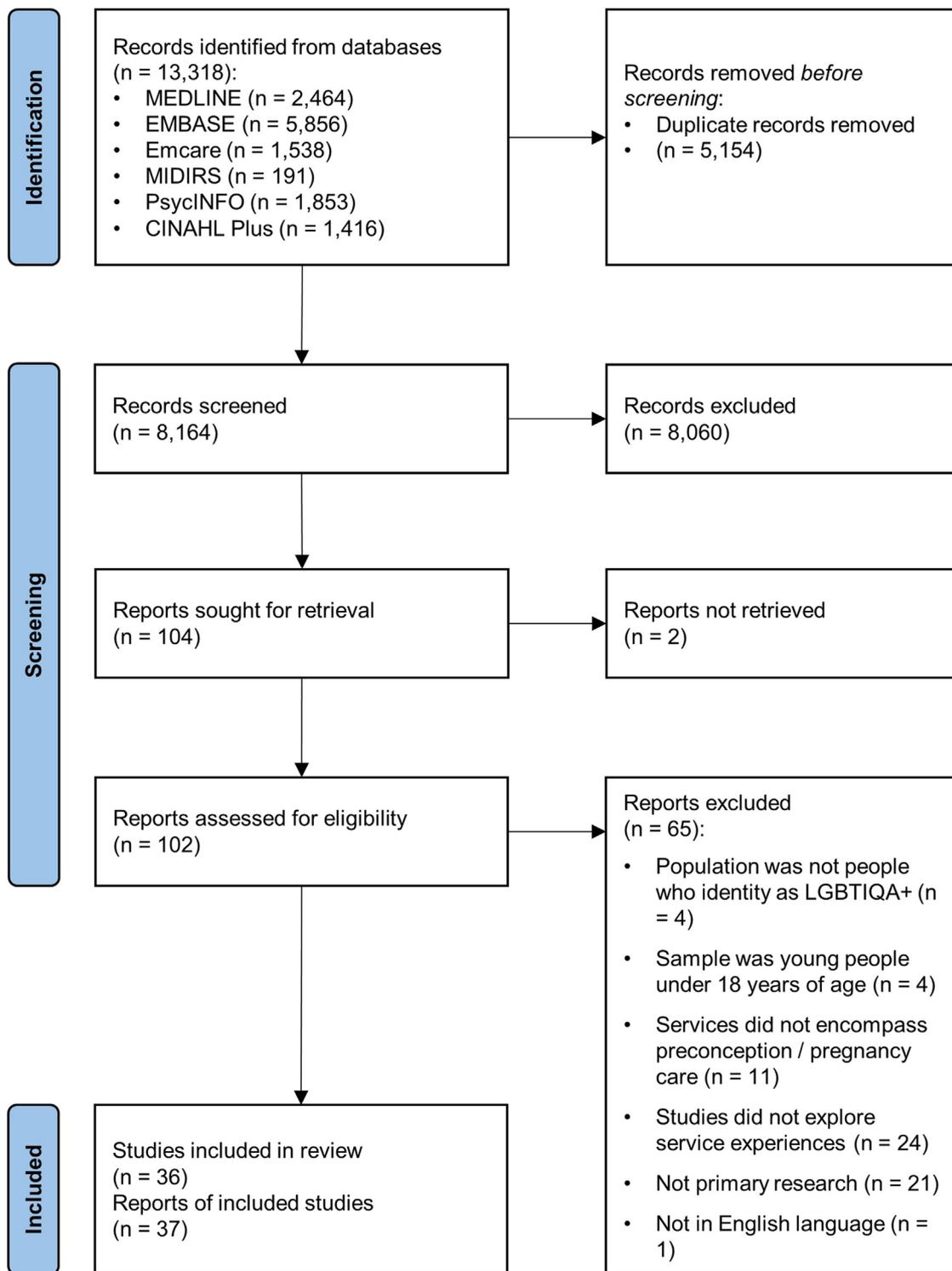


Fig. 1. PRISMA flowchart illustrating the study selection process.

with others and created a sense of belonging (Gregory et al., 2022; Hoffkling et al., 2021; Lacombe-Duncan et al., 2022; Rausch et al., 2021). Pregnant non-binary participants in one study expressed feeling alienated as engaging with peer support groups were often gendered experiences where pregnancy was contextualised as a solely female phenomenon (Fischer, 2021). Social connectedness (including support from extended families and friends), promoted resilience and provided reassurance, however, gay, lesbian, and transgender participants across several studies expressed that their

journey towards parenthood was an isolating experience and exacerbated the difficulties they faced (Fantus, 2021; Fischer, 2021; Hoffkling et al., 2017; Lacombe-Duncan et al., 2022; Rausch et al., 2021; Topper and Bauermeister, 2022).

*Theme 2: interpersonal competencies of healthcare staff*  
*Poor communication.* The absence of open and honest communication from healthcare professionals was reported across several studies (Burrow et al., 2018; Carpenter and Niesen, 2021;

**Table 4**  
Summary of methodological quality assessment using the JBI checklist for qualitative research.

Included Studies	Quality Criteria for the JBI Checklist for Qualitative Research									
	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>	8 <sup>h</sup>	9 <sup>i</sup>	10 <sup>j</sup>
Arseneau et al. (2019)	Y	Y	Y	U	Y	Y	N	Y	Y	Y
Burrow et al. (2018)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Carpenter (2021)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Chapman et al. (2012)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Charter et al. (2018)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cherguit et al. (2012)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Copeland et al. (2023)	U	Y	Y	U	Y	N	N	N	Y	Y
Dahl (2015)	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Danielson et al. (2022)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Ellis et al. (2014)	U	Y	Y	U	Y	N	N	Y	Y	Y
Fantus (2021)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Fischer (2021)	U	Y	Y	U	Y	Y	Y	Y	Y	Y
Goldberg et al. (2017)	U	Y	Y	U	Y	N	N	Y	Y	Y
Gregory et al. (2022)	U	Y	Y	N	Y	N	N	Y	Y	Y
Hayman et al. (2013)	Y	Y	Y	U	Y	N	N	N	Y	Y
Hoffkling et al. (2017)	U	Y	Y	N	N	N	N	Y	Y	Y
Hudak (2021)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lacombe-Duncan et al. (2022)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
James-Abra et al. (2015)	U	Y	Y	U	Y	Y	N	Y	Y	Y
Johansson et al. (2020)	U	Y	Y	Y	Y	N	N	Y	N	Y
Klittmark et al. (2018)	U	Y	Y	Y	Y	N	N	Y	Y	Y
MacDonald et al. (2020)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Malmquist (2014)	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Malmquist (2016)	U	Y	Y	U	Y	N	N	Y	U	Y
Malmquist et al. (2019)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Parker et al. (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rausch et al. (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Riggs et al. (2015)	U	Y	Y	U	Y	N	N	Y	Y	Y
Riggs et al. (2020)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ross et al. (2014)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Rozenal (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Ruderman et al. (2021)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Searle et al. (2017)	Y	Y	Y	U	Y	N	N	Y	Y	Y
Spidsberg (2011)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Topper & Bauermeister (2022)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Topper et al. (2022)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Van Hoof (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
<b>Total Number of Yes Ratings</b>	12	37	37	25	36	15	9	35	35	37
	/37	/37	/37	/37	/37	/37	/37	/37	/37	/37

Notes. Y = Yes; N = No; U = Unclear.

- <sup>a</sup> Congruity between the stated philosophical perspective and the research methodology.
- <sup>b</sup> Congruity between the research methodology and the research question or objective.
- <sup>c</sup> Congruity between the research methodology and the methods used to collect data.
- <sup>d</sup> Congruity between the research methodology and the representation and analysis of the data.
- <sup>e</sup> Congruity between the research methodology and the interpretation of results.
- <sup>f</sup> Statement locating the researcher culturally or theoretically.
- <sup>g</sup> Influence of the researcher on the research, and vice-versa addressed.
- <sup>h</sup> Participants and their voices are adequately represented.
- <sup>i</sup> Research is ethical according to current criteria or evidence of ethical approval.
- <sup>j</sup> Conclusions drawn flow from the analysis or interpretation of the data.

Danielson et al., 2022; Riggs et al., 2015). For example, queer women in one study reported a lack of transparent communication from their physicians, which contributed to discomfort and vulnerability during medical procedures (e.g., vaginal examinations) (Burrow et al., 2018). Compromised ethics was also reported as the details of these medical procedures were not communicated, and informed consent was not sought. Another study reported that gay fathers who utilized surrogacy services were not informed when their surrogate went into labor, and missed the birth of their child (Riggs et al., 2015). The lack of communication prompted disappointment and families reported feeling unheard. Conversely, some were satisfied with the communication from providers who adopted a conversational approach, where people were encouraged to ask questions and felt listened to (Danielson et al., 2022; Goldberg et al., 2017; Ruderman et al., 2021; Searle et al., 2017).

*Exclusion from decision-making.* Instances of compromised decision-making and a lack of autonomy were reported, primarily by lesbian couples and transmasculine people, including

assumed decisions on the basis of their gender identity, a denial of traditional or ceremonial practices, pressure to purchase unnecessary add-on services, and enforcing invasive medical procedures such as c-sections (Burrow et al., 2018; Gregory et al., 2022; MacDonald et al., 2021; Malmquist et al., 2019). Participants also reported that their decisions were often questioned (including their decisions to have a child) (Charter et al., 2018; Klittmark et al., 2018; Lacombe-Duncan et al., 2022). In several studies, lesbian couples reported that the lack of autonomy created a sense of disempowerment and negatively impacted their mental health (Burrow et al., 2018; Malmquist, 2016; Malmquist et al., 2019).

*Limited knowledge of LGBTIQ+ affirming practice.* Limited knowledge maintained by healthcare staff towards available parenting pathways for LGBTIQ+ families, and sexuality and gender diversity more broadly, were believed to influence their clinical competency and the subsequent sensitivity of care (Copeland et al., 2023; Johansson et al., 2020; Klittmark et al., 2018; Riggs et al., 2020;

**Table 5**  
Summary of themes constructed through thematic analysis alongside supporting excerpts.

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
Theme 1: Unavailability of information, services, and support	Unavailability of information	Information optimised for heterosexual families and cisgendered people	N = 4 (Copeland et al., 2023; Fantus, 2021; Lacombe-Duncan et al., 2022; Topper et al., 2022)	“However, even with community membership, most participants reported difficulties in accessing inclusive information. Mark, a 37-year-old financial advisor ‘found a lot of information on surrogacy regarding traditional families that could not have children. There was not a lot of publication regarding same-sex families.’” (Fantus, 2021, pp. 1366)
		Absence of information provided by healthcare services	N = 6 (Danielson et al., 2022; Gregory et al., 2022; Hoffkling et al., 2017; Riggs et al., 2015; Topper et al., 2022; Van Hoff et al., 2015)	“Furthermore, participants described their struggles to gain information from providers. Teagan described her frustration with wanting more information and guidance from providers, ‘I just needed somebody to like hold my hand and tell me that, and I, I felt like I needed to kind of figure it out myself.’ Sara recalled specifically asking providers for additional information, yet providers were not forthcoming, ‘We tried to get clarification about what’s the purpose of it, we, we couldn’t.’” (Danielson et al., 2022, pp. 113)
		Reliance on self-research and subsequent delays in decision-making	N = 4 (Danielson et al., 2022; Ellis et al., 2014; Fantus, 2021; Topper et al., 2022)	“When asked about the sources of information that were most helpful or unhelpful, the participants described various experiences. Several participants voiced concerns about self-directed internet-based searches that could yield “whatever answer you want to find,” in the words of one participant (15G)...Once the participants were engaged in information seeking, additional gaps in knowledge became apparent.” (Topper et al., 2022, pp. 402)
		Confusion, uncertainty, and dissatisfaction	N = 7 (Danielson et al., 2022; Ellis et al., 2014; Gregory et al., 2022; Hoffkling et al., 2017; Malmquist, 2016; Ross et al., 2014; Topper et al., 2022)	“The participants reported uncertainty and ways in which the practical aspects of [assisted reproductive technology] were neither self-evident nor intuitive. As one participant noted: ‘I had very basic knowledge. That you could use a donor that you knew, or you could use donor sperm. And I didn’t even really know how it worked in both of the scenarios.’” (Topper et al., 2022, pp. 118)
	Inaccessibility of local services	Community-based information sessions for LGBTIQ+ communities	N = 5 (Fantus et al., 2021; Gregory et al., 2022; Hayman et al., 2013; Hoffkling et al., 2017; Malmquist, 2016)	“A community-organized example offered in Ontario’s largest urban center includes the intensive course “Dykes Planning Tykes” that takes lesbians through all aspects of the assisted reproduction process. This program was identified as a valuable resource and system of sharing, enabling relationship building and bringing a sense of belonging to the members who engaged with it.” (Gregory et al., 2022, pp. 3)
		Financial challenges and insurance policies do not cover financial costs of treatment	N = 9 (Danielson et al., 2022; Gregory et al., 2022; Lacombe-Duncan et al., 2022; MacDonald et al., 2020; Riggs et al., 2020; Rausch et al., 2021; Rozental and Malmquist, 2015; Topper and Bauermeister, 2022; Van Hoof et al., 2015)	“Sara described the influence of policy on female partners engaging in family formation and the additional financial barrier when insurance does not cover fertility services, ‘if you’re a heterosexual couple and the reason that, if male infertility is a problem, like low sperm count...and the sperm is deemed medically necessary then insurance covers it. I’m like but it technically is medically necessary for us because we don’t have any.’” (Danielson et al., 2022, pp. 315–316)
		Restriction vs protection of reproductive rights and care at a legislative level	N = 9 (Burrow et al., 2018; Carpenter and Niesen, 2021; Chapman et al., 2012; Danielson et al., 2022; Gregory et al., 2022; Hoffkling et al., 2017; Klittmark et al., 2018; Topper and Bauermeister, 2022; Rozental and Malmquist, 2015)	“Prior to legislative change, some doctors suggested lying about marital status and bringing a male friend along to deceive the clinic staff. One couple explained: ‘we would have to pretend that one of us was an unmarried couple, we would have to find a male and bring him along, a prospect that left us feeling awful, absolutely devastated.’” (Chapman et al., 2012, pp. 1881)
Lack of local services in remote geographical locations	N = 5 (Carpenter and Niesen, 2021; Chapman et al., 2012; Danielson et al., 2022; Ellis et al., 2014; Gregory et al., 2022)	“When faced with geographical inconsistencies and system-level restrictions, it was logical for Alice to abandon the health system entirely and just hope that home insemination would suffice. Some participants understood home insemination with a known donor to be outright illegal. Others used this constraint to decide which fertility clinic to use, based on its geographical proximity to the only sperm bank available.” (Gregory et al., 2022, pp. 3)		

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Table 5 (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts	
Theme 2: Interpersonal competencies of healthcare staff	Value of social support	Peer support through local community centres and social media groups	N = 5 (Fantus, 2021; Gregory et al., 2022; Hoffkling et al., 2017; Lacombe et al., 2022; Rausch et al., 2021)	"Many participants worked to support others in the community. Carmen shared, 'I'd been running peer-support groups for LGBT folks around infertility, which had been like a real catharsis for me.' Elise stated, 'we have plenty of lesbian couple friends with whom we've shared the stories before.'" (Rausch et al., 202, pp. 223)	
		Resilience and reassurance through social support	N = 5 (Fantus, 2021; Hoffkling et al., 2017; Lacombe-Duncan et al., 2022; Rausch et al., 2021; Topper and Bauermeister, 2022)	"In the queer community and the leather community I had an overwhelmingly positive reaction. When it was really obvious that I was a pregnant tranny, I actually received a lot of positive love and affection from queer stranger and I actually had strangers stop and ask if they could hug me and thought that it was beautiful." (Hoffkling et al., 2021)	
		Isolation and the absence of social support	N = 4 (Fantus, 2021; Fischer, 2021; Hoffkling et al., 2017; Rausch et al., 2021)	"A central theme in all five narratives was how the gendered nature of being pregnant impacted their experiences. Some linked the gendered ideas surrounding pregnancy with their experiences of loneliness and isolation. For example, Alex stated: 'I find that pregnancy is an incredibly gendered experience. Everything from the support groups and the online causal peer groups to the culture of it, the expectations, the apps that are designed for it, everything is incredibly gendered. It's really alienating... they just have these assumptions that pregnancy is an inherently female thing.'" (Fischer, 2021, pp. 81)	
	Poor communication	Absence of transparent and honest communication from healthcare staff	Absence of transparent and honest communication from healthcare staff	N = 4 (Burrow et al., 2018; Carpenter and Niesen, 2021; Danielson et al., 2022; Riggs et al., 2015)	"Maggie's experience of facing a physician who failed to engage in discourse with her reveals harmful and non-collaborative communication strategies that reinforce the vulnerability of queer birthing women: '...My daughter had made a bowel movement. So, when they broke my water, it was green in colour. I had no idea what that meant at the time. I had to get a nurse to explain it to me because he wouldn't. It was just bad. Everything about it was bad ... the whole process was just scary, terrifying. I had questions that weren't answered.'" (Burrow et al., 2018, pp. 516)
			Absence of informed consent and compromised ethics	N = 2 (Burrow et al., 2018; Riggs et al., 2015)	"Estelle reports a distinct lack of communication when she reports that her physician did not speak to her, even when performing vaginal examinations: '...[my physician was] just sort of popping in, not being there for the labour, popping in at random points, and not speaking to me. Like speaking at me or like to my mom even...He wouldn't really talk either to the nurse about me...Like it was really uncomfortable because he would just come in to do a vaginal exam but then not really talk to me. Even though, you know, you've just done something very personal.'" (Burrow et al., 2018, pp. 517)
		Disappointment, discomfort, and feeling unheard	Disappointment, discomfort, and feeling unheard	N = 2 (Burrow et al., 2018; Riggs et al., 2015)	"Sally recalls harshness in both tone and environment. She felt processed as if moving through the stages of labour were less about her or her baby and more about her healthcare providers moving her through the system, like packing meat or something." (Burrow et al., 2018, pp. 516)
			Open communication and the importance of a conversational approach to communication	N = 4 (Danielson et al., 2022; Goldberg et al., 2017; Ruderman et al., 2021; Searle et al., 2017)	"A respectful, collaborative, and 'nondogmatic' style was named by a few women as typical of midwives (n = 4), such that discussions regarding their care and birth plan were a 'conversation, [not] an instruction.'" (Goldberg et al., 2017, pp. 110)
	Exclusion from decision-making	Compromised decision-making and a lack of autonomy over healthcare choices	Compromised decision-making and a lack of autonomy over healthcare choices	N = 4 (Burrow et al., 2018; Gregory et al., 2022; MacDonald et al., 2020; Malmquist et al., 2019)	"Several participants reported feeling pressured by service providers to purchase add-on services, such as acupuncture, or herbal remedies, to increase insemination success. Lara shared that her lack of medical expertise made her feel vulnerable to this pressure: 'they were, like, pushing all these tests on us that cost extra, and we didn't know- so we said yes to everything, and it turned out... I was like extremely fertile so, it was not an issue, but they kind a fear-mongered some of that stuff.'" (Gregory et al., 2022, pp. 4)

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**Table 5** (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
		Patients' decisions were questioned by healthcare providers	<i>N</i> = 3 (Charter et al., 2018; Klittmark et al., 2018; Lacombe-Duncan et al., 2022)	"Trent (36) stated: 'The doctor we saw was so awkward with us, kept misgendering me and repeatedly asked why my (cisgender) partner wasn't the one to have the baby.'" (Charter et al., 2018, pp. 70).
		Disempowerment and negatively impacted mental health	<i>N</i> = 3 (Burrow et al., 2018; Malmquist, 2016; Malmquist et al., 2019)	"Many of our study participants indicated lack of support: 'I left at the end with just an overwhelming sense of disempowerment. And it's not that anybody was outright rude or that anybody was, you know, mean or ... I mean the obstetrician was at a certain point. But there were lots of supportive people and lots of nice comments, but it was just like an overarching sense of disempowerment.'" (Burrow et al., 2018, pp. 520)
	Limited knowledge of LGBTQIA+ affirming practice	Limited knowledge regarding gender/sexuality diversity and pathways to parenthood for LGBTQIA+ families	<i>N</i> = 7 (Copeland et al., 2023; Johansson et al., 2020; Klittmark et al., 2018; Riggs et al., 2020; Rozental and Malmquist, 2015; Topper and Bauermeister, 2022; Topper et al., 2022)	"The participants described how RHPs lacked knowledge about LGBTQ issues, as well as ways to become pregnant, which was described as tiresome and annoying. One pregnant trans person had to explain at a parent education class that one can be trans and pregnant: she wasn't able to piece it together and believed that only the partner could be a trans person and I said, 'you know, sterilization has been banned since 2013, of course trans people can be pregnant'". (Klittmark et al., 2018, pp. 421)
		Patients were more knowledgeable and educated staff	<i>N</i> = 4 (Fischer, 2021; Klittmark et al., 2018; Rozental and Malmquist, 2015; Van Hoof et al., 2015)	"Several interviewees contrast an ideal patient role, where one is cared for and kept informed, to their experiences of instead being the ones providing the staff with information about their rights and the jurisdiction of the Swedish health care system. Rebecca calls this being "an information center for the health care system", thus putting the spotlight on another form of vulnerability: 'When it's just regular people then I think it's a lot of fun. It's worse when it's, when you have to serve as an information center for the health care system. Cause then I think really it's us patients, it's us who need answers to our questions.'" (Rozental and Malmquist, 2015, pp. 135)
		Trust in staff who were forthcoming about their uncertainty	<i>N</i> = 2 (Hoffkling et al., 2017; Ruderman et al., 2021)	"Participants spoke highly of providers who responded well to being outside familiar territory, either medically or culturally, "She took it upon herself to educate herself, ... and learned what she could before my next visit." They appreciated when providers did not expect their patients to teach them, but listened and learned when the patient did teach." (Hoffkling et al., 2017, pp. 14)
		Care provided by healthcare staff who were knowledgeable about gender and sexuality diversity, and/or identified as queer themselves	<i>N</i> = 2 (Copeland et al., 2023; Fischer, 2021)	"Understanding and mutual respect is paramount in the delivery of client centred continuity of care. Client 1 revealed knowing they were cared for by a staff member who was in the LGBTQIA+ community enhanced their journey lowered their anxiety levels and helped them feel more comfortable and respected." (Copeland et al., 2023, pp. 6)
		Need for professional development through inclusivity training	<i>N</i> = 4 (Copeland et al., 2023; Klittmark et al., 2018; Rozental and Malmquist, 2015; Van Hoof et al., 2015)	"All of this also points for a need for training medical staff, as some of these recommendations may not be intuitive. But training should not just be for the main providers as Maggie, a co-mother, explained in her individual interview: 'On a systemic level, I think they need to have diversity training. Because it's like, I can't say that it's somewhat at a certain level should implement something with their subordinates because it's like those people might need it too. So it should be like a hospital system wide, like approach that people are different from each other and this is a holistic environment where we are here to meet their needs.'" (Hudak, 2021, pp. 9)

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Table 5 (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
Theme 3: Hetero- and cis-sexist care experiences	Failure to affirm gender identity and sexual orientation	Heterosexist assumptions about sexuality, relationships, and family composition	N = 9 (Goldberg et al., 2017; Hayman et al., 2013; Hoffkling et al., 2017; Hudak, 2021; Lacombe-Duncan et al., 2022; James-Abra et al., 2015; Klittmark et al., 2018; Malmquist et al., 2019; Rozental and Malmquist, 2015)	“RHPs showed their lack of knowledge for example by asking irrelevant questions and by being unable to assess the responses from the participants. After a lesbian participant stated that she had relationships with men earlier in her life, the physician wrote in the referral to a fertility clinic abroad that the participant was bisexual, without her consent...Participants described how they had been wrongly perceived as heterosexual, how that assumption led to other expectations and preconceptions about how women and men ‘are’, rendering the participants’ identities invisible. It also led RHPs to state irrelevant advice.” (Klittmark et al., 2019, pp. 421)
		Consistent misgendering and subsequent gender dysphoria	N = 11 (Charter et al., 2018; Dahl and Malterud, 2015; Fischer, 2021; Hoffkling et al., 2017; Lacombe-Duncan et al., 2022; Johansson et al., 2020; James-Abra et al., 2015; Klittmark et al., 2018; MacDonald et al., 2020; Parker et al., 2022; Ruderman et al., 2021)	“The fact that clinic documentation largely did not easily accommodate trans identities likely contributed to providers’ use of inappropriate names and/or pronouns: ‘Even though on my chart it would say [my chosen name] and then my legal name beside it in brackets, and they had highlighted [my chosen name] and put it in bold, people would still call me by my legal name’. (John)” (James-Abra et al., 2015, pp. 1370)
		Hesitation towards disclosing sexual orientation or gender identity	N = 5 (Arseneau et al., 2019; Ellis et al., 2014; Fischer, 2021; Goldberg et al., 2017; Parker et al., 2022)	“Many participants explicitly described feeling that it was not important or relevant to disclose their sexual history or identity to their perinatal providers. They stated unequivocally that their sexual history had not only not come up, but also, they did not see it as relevant to disclose, although three provided the caveat that they felt that it was important to disclose to providers ‘on the behavioural health side of things’ (i.e., therapists). Greta, who was bisexual, stated, ‘It never came up and did not feel particularly relevant to the current situation.’” (Goldberg et al., 2017, pp. 110)
	Queer-affirming care defined by inclusive language	N = 9 (Cherguit et al., 2012; Copeland et al., 2023; Dahl and Malterud, 2015; Hoffkling et al., 2017; James-Abra et al., 2015; Johansson et al., 2020; Klittmark et al., 2018; Ross et al., 2014; Ruderman et al., 2021)	“All trans participants appreciated when providers used gender-neutral language (e.g., ‘parent’ instead of ‘mother’ or ‘father’) when referring to them, rather than gender-specific language that would typically be used when referring to the person getting pregnant (e.g., ‘mom’ or ‘mommy’). Participants emphasized that this use of gender-neutral language was a necessary component of a positive clinic experience.” (James-Abra et al., 2015, pp. 1369)	
Hetero- and cis-sexist healthcare policies and procedures		Administrative processes and organisation of space designed only for heterosexual couples and cisgender people	N = 8 (Copeland et al., 2023; Hoffkling et al., 2017; James-Abra et al., 2015; Klittmark et al., 2018; Lacombe-Duncan et al., 2022; MacDonald et al., 2020; Parker et al., 2022; Ruderman et al., 2021)	“Some genetic counselors also reported challenges with labs when ordering tests for their trans patients and/or partners. These issues appeared to have stemmed from the sex listed in the medical record or on the test requisition form and needed to be resolved by the counsellor: ‘So, for the scenario in which my patient was a transgender male, I was filling out the test requisition form in front of him and my first instinct was to mark him as a male. And the laboratory called and was very confused. And I explained the situation to them and they said, ‘Okay well, you need to mark this as female or we can’t run the test.’” (Ruderman et al., 2020, pp. 1113)
		Inappropriate and unnecessary pregnancy and fertility testing prior to commencement of care	N = 8 (Danielson et al., 2022; Gregory et al., 2022; Hoffkling et al., 2017; Hudak, 2021; Lacombe-Duncan et al., 2022; Rozental and Malquist, 2015; Topper and Bauermeister, 2022; Topper et al., 2022)	“Joanna in the couple interview discussed how the hospital asked her to come in for a pregnancy test while going through fertility testing prior to becoming pregnant. She stated: ‘You had to prove that you’re not pregnant because obviously if you expose a baby to dye and radiation then you have an alien and not a baby. So when the lab called they were like oh you have to come and take a pregnancy test. And like I understand that it’s hospital protocol better than anyone...But at the same time, it would have been nice for an acknowledgement of I understand that you don’t really need a pregnancy test, but this is hospital policy...It’s even more annoying because look at my damn chart. I’m here because I have a lady.’” (Hudak, 2021, pp. 118)

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Table 5 (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
		Importance of respecting preferences for gender-neutral language when referring to babies	N = 2 (Copeland et al., 2023; Johansson et al., 2020)	"Knowing they would be using gender neutral pronouns for their baby, the MGP midwife asked about their preferences and thoughts regarding their baby's cot card during an antenatal appointment. The MGP midwife suggested they could print out a different colour. Client 1 reflected that the consideration this demonstrated from their midwife made them happy and relieved, as it was something they had been upset and stressed about, but hadn't mentioned." (Copeland et al., 2023, pp. 5)
		Invalidation of identity through equal treatment that overlooks queer needs	N = 5 (Danielson et al., 2022; Malmquist, 2016; Ross et al., 2014; Searle et al., 2017; Spidsberg and Sorlie, 2011)	"While Sara and Terra identified heteronormative culture's influence on their family formation process, Jesse appeared less cognizant of its presence, "[provider], was just like, I would think that she would act the way she was with any couple, I didn't feel like she was singling us out, you know, I just felt like a normal person, like, I didn't feel like she had given us any special treatment or told us anything different that she, if it was a straight couple coming in for fertility treatments." This is viewed as heteronormative due to the denial and invisibility of uniqueness of female partners' experiences. Female partners have unique challenges and experiences during family formation and cannot simply be treated like heterosexual couples." (Danielson et al., 2022, pp. 116)
	Exclusion of partners from processes of care	Exclusion of lesbian partners and co-parents, and transgender non-gestational parents from conversations, decision-making process, and procedures	N = 13 (Arseneau et al., 2019; Cherguit et al., 2012; Dahl and Malterud, 2015; Hayman et al., 2013; Hudak, 2021; Klittmark et al., 2018; Lacombe-Duncan et al., 2022; Malmquist and Nelson, 2014; Malmquist, 2016; Malmquist et al., 2019; Parker et al., 2022; Spidsberg and Sorlie, 2011; Topper and Bauermeister, 2022)	"A few encounters indicated that not all healthcare providers felt comfortable encountering lesbian families. One co-mother described how she felt when she was left out of the conversation by an older, male paediatrician: 'Who's the biological mother? he asked. When my wife said 'It's me', he turned to her. That made me feel I was not equally important, and I noticed that I withdrew in order to avoid staying inside that unpleasant feeling.'" (Dahl and Malterud, 2015, pp. 170)
		Healthcare systems privilege monogamy and are not tailored for polyamorous families	N = 2 (Arseneau et al., 2019; Burrow et al., 2018)	"Polyamorous families report difficulty navigating social systems as these often privilege monogamy, and this was reflected in participants' experiences when navigating the health care system. Polyamorous families report difficulty navigating social systems as these often privilege monogamy, and this was reflected in participants' experiences when navigating the health care system." (Arseneau et al., 2019, pp. 1124)
		Inclusion and acknowledgement of partners	N = 5 (Cherguit et al., 2012; Dahl and Malterud, 2015; Klittmark et al., 2018; Malmquist and Nelson, 2014; Spidsberg and Sorlie, 2011)	"In some situations, co-mothers experienced that staff stopped and needed to "re-start" when they introduced themselves as a couple, but generally they experienced healthcare providers to be well-educated, open-minded, and unbiased." (Dahl and Malterud, 2015, pp. 170)
Theme 4: Discrimination and traumatisations	Discriminatory care against queer people	Expectations of prejudicial treatment and fear of discrimination	N = 12 (Cherguit et al., 2012; Copeland et al., 2023; Ellis et al., 2014; Fischer, 2021; Gregory et al., 2022; Hoffkling et al., 2017; Hudak, 2021; Klittmark et al., 2018; MacDonald et al., 2020; Malmquist et al., 2019; Riggs et al., 2020; Ruderman et al., 2021)	"The first 'fearing the system', highlighted a general anticipatory fear of prejudice and discrimination from staff. For example, Carolina initially anticipated 'a negative response that makes you feel...not as, I don't know, not on the same level, you know, that they look down on you somehow, you know, you're ... not as good as them or something'" (Cherguit et al., 2012, pp. 1271)
		Rejection from services and a refusal of care	N = 7 (Chapman et al., 2012; Charter et al., 2018; Fantus, 2021; Hayman et al., 2013; Hoffkling et al., 2017; James-Abra et al., 2015; Klittmark et al., 2018)	"Because of the long waiting lists for those doctors, the participant tried unsuccessfully to make an appointment with another at the same service provider and was told she could not see him: 'when I called his reception she was like 'who's your husband?' and I say 'no I have [a] same sex partner' and she 'well we won't see you then' I [thought] oh that's right 'cause I'm a lesbian I forgot about that. You just go about life thinking that everything is easy, and everything is normal.'" (Chapman et al., 2012, pp. 1881)

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Table 5 (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
		Exacerbated waiting lists and/or greater financial costs	N = 5 (Gregory et al., 2022; Lacombe-Duncan et al., 2022; Malmquist and Nelson, 2014; Riggs et al., 2020; Topper and Bauermeister, 2022)	<p>“Interviewer: Did you place yourselves on the waiting list [for insemination]?”</p> <p>Ida: No, but we were about to [...] And it took ages to explain over the phone. I called then and was going to explain, and anyway they'd already had a [female] gay couple, but she didn't understand a thing. But, so unbelievable, I said: ‘we want to have a child and we want help getting on the waiting list for insemination.’ I don't know how many times I had to go through it.” (Malmquist and Nelson, 2014, pp. 63)</p>
		Voiced concerns left ignored and unaddressed	N = 6 (Chapman et al., 2012; Ellis et al., 2014; Hudak, 2021; Malmquist et al., 2016; Rozental and Malmquist, 2015; Ruderman et al., 2021)	<p>“One parent, who lived in a small country town, described the lack of privacy and sensitivity to a difficult situation where she felt threatened and compromised. She shared a room in an inner-city public hospital (after a difficult birth) with a customer of the government agency for which she worked: We did ask to be moved [away from the customer] and they didn't move us even though the other woman was saying ‘if I get you outside, I'll thump the s**t out of you’. It was a horrific experience which they [staff] could have just avoided by just putting us [a]round the corner”. (Chapman et al., 2012, pp. 1882)</p>
		Refusal of treatment despite legal protections	N = 1 (Charter et al., 2018)	<p>“Whilst trans people are protected legally in Australia from discrimination by HCPs (New South Wales Government, 1977) these protections are not necessarily born out in their actual experiences. No participant in this study who attempted to access a fertility clinic was actually granted treatment.” (Charter et al., 2018, pp. 70)</p>
		Exacerbated discrimination on the basis of intersectionality	N = 2 (Lacombe-Duncan et al., 2022; MacDonald et al., 2020)	<p>“In both Emmett's and Dagan's cases, an additional aspect of their identity compounded their experience as a pregnant trans person: Emmett: ‘It's really hard to untangle the issues that are just related to me being a first-time pregnant person with no other pregnant people for support in my area you know versus being trans. And being an immigrant, you know like it's really hard to disentangle all of these things. Because my immigrant experience is also a really big part of the experience.’” (MacDonald et al., 2021, pp. 25).</p>
		Disempowerment, diminished sense of self, stigmatisation, and disengagement	N = 7 (Burrow et al., 2018; Goldberg et al., 2017; Hayman et al., 2013; James-Abra et al., 2015; Klittmark et al., 2018; Malmquist and Nelson, 2014; Searle et al., 2017)	<p>“And so I felt a little disempowered and had to struggle a little bit with that, and tell myself that it was okay to ask questions or to say no or to. You know, I felt a little bit at the mercy of the medical system.” (Searle et al., 2017, pp. 3581)</p>
		Affirming care experiences eroded expectations for prejudice and created a sense of acceptance	N = 4 (Cherguit et al., 2012; Fantus, 2021; Goldberg et al., 2017; Malmquist and Nelson, 2014)	<p>“The co-mothers' positive interactions with maternity staff had an eroding effect on their expectations of prejudice and discrimination in maternity services. This resulted in a fourth sub-theme, ‘positive experiences with staff lowering co-parents' expectations of prejudice and discrimination’. Amy said: ‘Well legally we had to be treated, but in reality, how would we be treated? I was quite nervous about that. I came away feeling a lot better with how lovely they were’. Rebecca went on to say: ‘because we had a very positive first experience that's what our expectation was as it went [along].’” (Cherguit et al., 2012, pp.1272)</p>
		Absence of discrimination perceived as a rare exception	N = 2 (Cherguit et al., 2012; Parker et al., 2022)	<p>“Participants' experiences of gender-affirming care were made sense of as a catching a lucky break, rather than an expectation of their care. Lor (non-binary, gestational parent) described the gender-affirming care from their midwife as “lucky, it just felt like sort of real one-offs, real one-offs, like lottery wins.” (Parker et al., 2022, pp. 10)</p>

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Table 5 (continued)

Major Themes	Subthemes	Descriptors	Number of Studies + References	Supporting Excerpts
	Traumatic birthing experiences	Forceful handling, verbal hostility, and inadequate anaesthesia during childbirth	N = 2 (Burrow et al., 2018; MacDonald et al., 2020)	“Assumptions about the gender binary and the inherently feminine nature of pregnancy were integral to hospitals’ and insurance companies’ computer systems. Emmett described how he was unable to receive the epidural he requested because the hospital’s computer system would not allow a patient with a male gender marker to have the fetal monitoring necessary for the epidural. The hospital staff did not successfully work around the issue. The patient never received the epidural, much to his distress.” (MacDonald et al., 2021, pp. 25)
		Uninformed decision-making processes and compromised ethics during childbirth	N = 1 (Burrow et al., 2018)	“Jackson further remarked that nurses disclosed a motive for the physician preferring that Jackson have a caesarean section rather than attend a full labour and vaginal delivery, namely that the physician had a Valentine’s day dinner date arranged: ‘I found out that evening that the doctor who delivered me. This nurse came in and she goes, Oh, you had your baby already. Oh, that makes a lot of sense. And I’m like, what are you talking about? She goes, well, Doctor [on call] had a dinner engagement with his wife at 8:30 for Valentine’s Day.’” (Burrow et al., 2018, pp. 517)
		Gender dysphoria associated with pregnancy and childbirth	N = 4 (Ellis et al., 2014; Hoffkling et al., 2017; Johansson et al., 2020; MacDonald et al., 2020)	“Sometimes gender dysphoria was centered specifically around the pelvic area, and pelvic-related medical procedures or the process of giving birth became triggers. One participant, Ben, specified that he would have preferred to have a c-section rather than a non-surgical birth due to anticipated gender dysphoria. However, he stated that he was unable to choose to have a c-section because it would be considered optional and not covered by insurance in his country’s health system.” (MacDonald et al., 2021, pp. 22)

Rozental and Malmquist, 2015; Topper and Bauermeister, 2022; Topper et al., 2022). Further, participants demonstrated a higher level of knowledge regarding available pathways and barriers faced by LGBTIQ+ people, and often found themselves educating their providers (Fischer, 2021; Klittmark et al., 2018; Rozental and Malmquist, 2015; Van Hoof et al., 2015). In contrast, transgender people in some studies expressed a greater sense of trust when staff were forthcoming about their uncertainties and listened to their patients (Hoffkling et al., 2017; Ruderman et al., 2021). Continuity of care from healthcare staff, particularly midwives, who were knowledgeable about sexuality and gender diversity, and who invested time into understanding patients’ needs, ensured that they felt understood, respected, and safe (Copeland et al., 2023; Fischer, 2021; Johansson et al., 2020). Care that was provided by staff who identified as queer themselves similarly created a sense of comfort and relieved anxiety associated with expectations for heteronormativity (Copeland et al., 2023). In response, participants frequently recommended that healthcare providers undergo training on inclusive and affirming care, alongside the provision of evidence-based guidelines to increase their knowledge regarding the barriers experienced by LGBTIQ+ people.

*Theme 3: Hetero- and cis-sexist care experiences*

*Failure to affirm gender identity and sexual orientation.* Inclusivity was recognised as a critical component of affirming care, yet healthcare staff often made heterosexist assumptions about relationships, referred to same-sex partners as relatives or friends, treated bisexual people as heterosexual, and incorrectly documented or ignored information about sexual orientation on intake forms (Goldberg et al., 2017; Hayman et al., 2013; Hoffkling et al., 2017; Hudak, 2021; Lacombe-Duncan et al., 2022; James-Abra et al., 2015; Klittmark et al., 2018; Malmquist et al., 2019; Rozental and Malmquist, 2015). Similarly, transgender people recounted situations where providers consistently misgendered

them or used their deadnames,<sup>5</sup> contributing to distress and gender dysphoria (Charter et al., 2018; Dahl and Malterud, 2015; Fischer, 2021; Hoffkling et al., 2017; Lacombe-Duncan et al., 2022; James-Abra et al., 2015; Klittmark et al., 2018; MacDonald et al., 2021; Parker et al., 2022; Ruderman et al., 2021). In one study, midwives recognised the importance of addressing transgender people appropriately, yet were weary of unintentionally misgendering them (Johansson et al., 2020). As a result of this hetero- and cis-sexism, participants often reported feeling invalidated, a loss of trust in their care, and compromised safety, adding vulnerability to an already overwhelming situation. Where gender identity and sexual orientation were unknown by staff, participants often avoided disclosure for fear of discrimination and only shared this information if it was medically necessary (Arseneau et al., 2019; Ellis et al., 2014; Fischer, 2021; Goldberg et al., 2017; Parker et al., 2022). Conversely, the use of gender inclusive language and correct pronouns, and the documentation of gender identity, were behaviors that were believed to create an affirming healthcare environment (Cherguit et al., 2012; Copeland et al., 2023; Dahl and Malterud, 2015; Hoffkling et al., 2017; James-Abra et al., 2015; Johansson et al., 2020; Klittmark et al., 2018; Ross et al., 2014; Ruderman et al., 2021).

*Hetero- and cis-sexist healthcare policies and procedures.* The delivery of standard healthcare processes that were perceived as hetero- or cis-sexist was prominent (i.e., policies and procedures catered only to cisgender people in heterosexual relationships). Examples included the gendered organization of space (e.g., lack of gender neutral washrooms, maternity wards, and childbirth edu-

<sup>5</sup> Deadnaming describes the act of referring to a transgender person using the name they were assigned at birth or prior to transitioning which they no longer use. The act of deadnaming is widely considered to be harmful and may negatively impact a person’s mental and emotional wellbeing, and can contribute to gender dysphoria.

**Table 6**  
Summary of key recommendations for future research and healthcare quality improvement.

Research and Practice Priorities	Recommendations
<b>Recommendation 1:</b> Protection of reproductive rights at a legislative level	Continued investment in anti-discrimination policies, protective legislations, and decriminalisation to uphold the reproductive rights and autonomy of sexuality, sex, and gender diverse people should be a priority for local, national, and international governing bodies.
<b>Recommendation 2:</b> Greater accessibility of services and availability of information	Increased availability of accessible and inclusive information about services and pathways to parenthood for LGBTIQ+ people. Healthcare providers should explicitly indicate whether they offer services for LGBTIQ+ people, and work towards creating clinical environments as a safe place that is sensitive to and appreciative of patient diversity. Family physicians should offer information in rural or remote communities where local fertility specialists may not be available. Available information should be tailored to the needs of sexuality, sex, and gender diverse people and disseminated through active outreach to LGBTIQ+ communities.
<b>Recommendation 3:</b> Inclusive healthcare systems and processes	The redevelopment and implementation of inclusive healthcare systems and processes that are responsive to the needs of sexuality, sex, and gender diverse people will work towards creating a safe and welcoming environment. Administrative systems, procedures, and processes must be sensitive to gender identity, sexual orientation, intersex status, and family composition. This includes, but is not limited to, the documentation and subsequent acknowledgement of sexual orientation, gender identity, pronouns, and romantic partners and/or co-parents, in addition to the use of gender-neutral language when referring to children where preferred by parents (e.g., gender neutral pronouns, cot cards, and other documentation). Physical healthcare environments must also be inclusive and accommodative to the needs of sexuality, sex, and gender diverse people.
<b>Recommendation 4:</b> Further exploratory research that acknowledge diversity and the importance of individualised care	Investment in research and practice quality improvement that is tailored to the unique needs and experiences of all sexuality, sex, and gender diverse people is needed, while also avoiding homogeny by actively recognising the importance of individuality in delivering safe and affirming care. It is recommended that future research aims to explore the preconception and pregnancy experiences of LGBTIQ+ people that have remained underrepresented across the literature, such as intersex, bisexual, asexual/aromantic, and pansexual people, alongside polyamorous families. In excluding certain communities, researchers and healthcare providers are unable to recognise the unique differences and needs across different sexual orientations or gender identities.
<b>Recommendation 5:</b> Incorporate the perspectives of healthcare providers	Although research grounded in the voices of LGBTIQ+ people is of critical importance, the perspectives of healthcare staff hold great value. Research that seeks to engage staff and enquire about the barriers to providing inclusive care that they experience will be important in highlight current gaps in clinical competency. This will in turn inform the development of initiatives to support their practices, such as inclusivity training, organisational policies, and models of care that are focused on the needs of LGBTIQ+ people during preconception and pregnancy care.
<b>Recommendation 6:</b> Implementation of trauma-informed approaches to care	The development and implementation of trauma-informed models of care that are tailored specifically to sexuality, sex, and gender diverse people in preconception and pregnancy care is needed. A trauma-informed approach to service delivery will work towards increasing the sensitivity of healthcare systems and professionals to the potential presence of trauma histories. This will aim to avoid re-traumatisation and prevent the exacerbation of psychological distress during preconception and pregnancy care. This may also include supporting alternative and non-hospital-based methods of conception, such as support for home-based insemination and birthing, to avoid exposure to clinical environments that may be sites of significant trauma.
<b>Recommendation 7:</b> Queer education and inclusivity training for healthcare professionals	Training initiatives for healthcare staff offer opportunities to address shortcomings in existing professional development and clinical competencies by providing education on queer history and ongoing issues in health equity. In doing so, healthcare professionals can be supported to develop an appreciation for diversity and enhance the sensitivity and inclusivity of interactions with patients and their provision of care.
<b>Recommendation 8:</b> Ensuring transparent communication and involvement in decision-making	Professional development opportunities for healthcare professionals working with sexuality, sex, and gender diverse people across preconception and pregnancy care are recommended to encompass capacity building in communication and shared decision-making processes. This also includes the importance of addressing and including partners and co-parents in decision-making processes. Importantly, these actions are critical in upholding principles of ethical conduct in healthcare practice by ensuring that patients are knowledgeable about available pathways, details regarding medical procedures, potential complications, and treatment options to enhance their decision-making capabilities and ensure that consent is informed.
<b>Recommendation 9:</b> Acknowledge and address the importance of intersectionality	Explore the health disparities experienced by LGBTIQ+ people to consider the presence of intersectionality associated with the multidimensional components of identity, and recognise the subtly of healthcare barriers during preconception and pregnancy care that arise at the intersection of queer identities and other characteristics, particularly race and/or disability where queerphobia, racism, and ableism intersect.
<b>Recommendation 10:</b> Co-design healthcare interventions, policies, and initiatives	Consumer and community involvement offers an opportunity to listen and incorporate the needs of those with a lived experience. It is recommended that future research and healthcare interventions designed to improve the quality of preconception and pregnancy care are guided by queer researchers and co-designed with LGBTIQ+ people. By engaging and collaborating with sexuality, sex, and gender diverse people in service, policy, and research development, healthcare improvement can be optimised according to their unique needs and experiences. Longitudinal research that evaluates the impact of co-designed initiatives by elucidating the voices of service users is also essential.

cation classes), and intake systems that could not record information for same-sex partners, document gender identity, or order services and fertility tests for transgender people (Copeland et al., 2023; Hoffkling et al., 2017; Lacombe-Duncan et al., 2022; James-Abra et al., 2015; Klittmark et al., 2018; Lacombe-Duncan et al., 2022; MacDonald et al., 2020; Parker et al., 2022; Ruderman et al.,

2021). In one study, transgender people expressed their appreciation for gender-neutral language when referring to their children (Copeland et al., 2023), however midwives in another study reported that documenting this information was an administrative challenge (Johansson et al., 2020). Lesbian women and transgender men who were partnered with cisgender women also ex-

pressed frustration towards heterosexist protocols that required them to undergo pregnancy tests prior to commencing assisted reproduction, alongside fertility testing to determine why they were unable to conceive with their partner (Danielson et al., 2022; Gregory et al., 2022; Hoffkling et al., 2017; Hudak, 2021; Lacombe-Duncan et al., 2022; Rozental and Malquist, 2015; Topper and Bauermeister, 2022; Topper et al., 2022). Information provided through fertility services, antenatal care, and parenting education was also frequently reported as inappropriate. For example, timed heterosexual intercourse was included in fertility education and reproductive guidance for women who were in same-sex relationships (Topper et al., 2022). While some participants expressed a desire to receive equal treatment to heterosexual and cisgender people, others recognized that such treatment may overlook the unique needs and challenges of being sexuality or gender diverse (Danielson et al., 2022; Searle et al., 2017; Spidsberg and Sorlie, 2011).

*Exclusion of partners from processes of care.* Naturally, participants expressed a desire for their partners and co-parents to be involved throughout their care, however a discrepancy between this need and their care experiences was prevalent. These discrepancies were reported primarily by lesbian mothers and parents-to-be, and often manifested through: a refusal to refer to partners as co-parents and ignoring them during consultations; using heterosexist language when referring to partners; assuming the birth parent; persistence with identifying a biological father; and excluding partners from decision-making and medical procedures (Arseneau et al., 2019; Cherguit et al., 2012; Dahl and Malterud, 2015; Hayman et al., 2013; Hudak, 2021; Klittmark et al., 2018; Lacombe-Duncan et al., 2022; Malmquist and Nelson, 2014; Malmquist, 2016; Malmquist et al., 2019; Spidsberg and Sorlie, 2011; Topper and Bauermeister, 2022). Further, the exclusion of transgender non-gestational partners from processes of care was also reported (Parker et al., 2022). Exclusion of partners was similarly experienced by polyamorous families, who reported unique challenges in having multiple partners recognised as co-parents, acknowledging that these systems are often privileged towards monogamy (Arseneau et al., 2019). For example, hospital intake systems were only able to record the names of two parents, healthcare providers insisted on referring to additional partners as friends or relatives, physical spaces did not accommodate multiple partners, and hospital policies limited the number of people allowed in the birthing room (Arseneau et al., 2019; Burrow et al., 2018). In contrast, several studies reported situations where lesbian partners were included and acknowledged at all stages of care, provided with information, addressed during decision-making processes, and whose presence in the birthing room was supported (Cherguit et al., 2012; Dahl and Malterud, 2015; Klittmark et al., 2018; Malmquist and Nelson, 2014; Spidsberg and Sorlie, 2011).

#### *Theme 4: discrimination and traumatisation*

*Discriminatory care against queer people.* LGBTIQ+ individuals frequently reported a hesitation towards service engagement due to expectations of discrimination (Cherguit et al., 2012; Copeland et al., 2023; Ellis et al., 2014; Gregory et al., 2022; Hoffkling et al., 2017; Hudak, 2021; Klittmark et al., 2018; MacDonald et al., 2020; Malmquist et al., 2019; Riggs et al., 2020; Ruderman et al., 2021). This expectation contributed to participants feeling unsettled and insecure, being fearful of a loss of control, opting for less favourable treatment options, and a pressure to hide their identity. Discrimination predominantly manifested as a rejection of gay, lesbian, and transgender individuals and families from assisted fertilisation and surrogacy services (Chapman et al., 2012; Charter et al., 2018; Fantus, 2021; Hayman et al., 2013; Hoffkling et al., 2017;

James-Abra et al., 2015; Klittmark et al., 2018). Frustration towards longer waiting times and greater financial costs was also expressed (Gregory et al., 2022; Lacombe-Duncan et al., 2022; Malmquist and Nelson, 2014; Riggs et al., 2020; Topper and Bauermeister, 2022). Participants also frequently reported being ignored during conversations about decision-making and that their concerns often remained unaddressed (Chapman et al., 2012; Ellis et al., 2014; Hudak, 2021; Malmquist et al., 2016; Rozental and Malmquist, 2015; Ruderman et al., 2021). In one Australian study, transgender participants reported the pervasiveness of discrimination that manifested as a refusal of fertility treatment, despite legal protections through the Anti-Discrimination Act 1977 (Charter et al., 2018). In two studies, LGBTQ+ individuals also described instances of discrimination that were exacerbated based on the intersectionality of identifying as transgender and other characteristics, such as ethnicity, religion, age, immigration status, language, socioeconomic status, weight, and disability (Lacombe-Duncan et al., 2022; MacDonald et al., 2020).

The impacts of these experiences included: disempowerment; frustration; alienation; a diminished sense of self; impeded autonomy; psychological distress; purposeful avoidance of further confrontation; emotional distancing; hiding queer identities; feeling stigmatised; and complete disengagement from services (Burrow et al., 2018; Goldberg et al., 2017; Hayman et al., 2013; James-Abra et al., 2015; Klittmark et al., 2018; Malmquist and Nelson, 2014; Searle et al., 2017). In contrast, gay fathers and queer women from a small portion of studies reported affirming care experiences through the attentiveness of their healthcare providers that eroded expectations of prejudice and created a sense of acceptance (Cherguit et al., 2012; Fantus, 2021; Goldberg et al., 2017; Malmquist and Nelson, 2014). Yet, in two studies, lesbian co-mothers and non-binary parents remained sceptical and believed that their affirming experiences were a rare exception (Cherguit et al., 2012; Parker et al., 2022).

*Traumatic birthing experiences.* Queer women and transmasculine individuals recognized childbirth as a time of vulnerability, often describing traumatic healthcare experiences through the forceful handling of their body, verbal hostility, threats of harm, heterosexism during childbirth, and inadequate anesthesia (Burrow et al., 2018; MacDonald et al., 2020; Malmquist et al., 2019). In addition, some queer women encountered fearmongering from healthcare providers in response to their preferences for a homebirth, while others reported uninformed decision-making processes during childbirth that compromised ethics (Burrow et al., 2018). Moreover, unique challenges surrounding gender dysphoria associated with childbirth were encountered by transgender men and transmasculine individuals (Ellis et al., 2014; Hoffkling et al., 2017; Johansson et al., 2020; MacDonald et al., 2020). While some participants reported feeling emotionally connected to their childbirth, others dissociated themselves from the process as they perceived vaginal birth to be a 'female' experience (Ellis et al., 2014). For this reason, several transmasculine individuals expressed a preference for a c-section, however administrative challenges were encountered as optional c-sections were not covered by insurance systems (MacDonald et al., 2020). For those who pursued a vaginal birth and dissociated themselves emotionally, transgender men reported that healthcare providers insisted on forcing a relationship with their own body (Hoffkling et al., 2017; MacDonald et al., 2020).

## **Discussion**

Research exploring the experiences of LGBTIQ+ people in navigating preconception and pregnancy care has been underexplored, however evidence indicates that significant inequities are experienced by LGBTIQ+ people across these healthcare systems. The

findings of this review have provided compelling insights to inform future research and healthcare quality improvement.

#### *Representation of queer communities across research*

The literature most prominently reflected the experiences of lesbian couples, co-mothers, and other queer women, consistent with previous research that has predominantly encompassed the perspectives of lesbian women (Gato et al., 2021; Kirubarajan et al., 2021; McCann et al., 2021). Encouragingly, the findings reflect the recent rise in research exploring parenthood aspirations among transgender communities (Gato et al., 2021). Transgender individuals have often been overlooked in research exploring reproductive care, and historically, parenthood has been perceived as incompatible with medical gender affirmation (Riggs and Batholomaeus, 2018). However, advancements in advocacy, standards of care, and research in transgender fertility care have captured the importance of maintaining transgender reproductive rights (Coleman et al., 2022). Additionally, several communities remain underrepresented, particularly intersex people. Broader clinical spaces have rarely been inclusive of intersex individuals, and these systems are often the sites of significant trauma and violations of human rights (Hart and Shakespeare-Finch, 2022). Historically, intersex people have been pathologized within healthcare systems and have undergone invasive medical interventions during infancy and childhood, often without informed consent (Carpenter, 2016). As recognized within the Darlington Statement, calls have been made for greater access to reproductive care for intersex people, with protection of their reproductive autonomy (Intersex Human Rights Australia, 2017). Although pathways to parenthood for intersex individuals have been underexplored (Reczek, 2020), the authors recognize that the trauma associated with healthcare engagement may extend to preconception and pregnancy services, given the binary and cissexist nature of healthcare practices illustrated herein. In order to deliver safe and affirming care for LGBTIQ+ people, including intersex people, research informed and led by community input is necessary.

#### *Pervasiveness of discriminatory healthcare practices and victimization*

This review has emphasised the pervasiveness of neglectful healthcare practices experienced by LGBTIQ+ people. The findings are consistent with those of previous reviews (Kirubarajan et al., 2021; McCann et al., 2021), and discrimination predominantly manifested as a systemic refusal of reproductive care and the absence of inclusive information. Recent changes in anti-discrimination laws that emphasise the rights of LGBTIQ+ people in accessing reproductive care have been introduced in several countries, however studies from such countries indicate that a refusal of these human rights is still prevalent. Moreover, LGBTIQ+ people remain criminalised and unprotected in over 67 countries (Human Rights Watch, 2022), and although gradual changes have been made to protect the human rights of LGBTIQ+ people, discrimination still manifests across all socioecological levels. In addition, abusive healthcare practices and compromised ethics have been reported, particularly during childbirth. Previous research indicates that LGBTIQ+ individuals generally experience increased exposure to traumatic events (Katz-Wise and Hyde, 2012), including intimate partner violence (Decker et al., 2018; Edwards et al., 2015; Peitzmeier et al., 2020), adverse childhood experiences (Schneeberger et al., 2014), or violence perpetrated through hate crimes (Blondeel et al., 2018; Jonas et al., 2022). As such, LGBTIQ+ people likely bring histories of trauma when entering healthcare services (McKinnish et al., 2019), and previous trauma exposure may also instil a severe fear

of childbirth among those who are pregnant (Grundström et al., 2023).

Gradual improvements in health equity have occurred through significant cultural shifts, however LGBTIQ+ people still report physical and psychological victimisation within healthcare (Burton et al., 2020). Broader research has partly contextualised these inequities as having stemmed from the historical pathologisation of sexuality and gender diversity that resulted in widespread violations of human rights across healthcare systems (Hollenbach et al., 2014). While many healthcare professionals and service providers may not be considered violent or abusive, most do not maintain a complete awareness of the specific histories, challenges, and needs of LGBTIQ+ people to inform inclusive care (McCann and Brown, 2018). Previous work has sought to establish guidance for healthcare providers in delivering inclusive care for LGBTIQ+ families (e.g., McNamara and Ng, 2016; Pratt-Chapman et al., 2022; von Doussa et al., 2015), however research indicates that traumatisation across healthcare settings is still prevalent and healthcare professionals may not be sensitive to the intersectionality of trauma (McKinnish et al., 2019). In response, the importance of adopting a trauma-informed approach that recognises histories of trauma has been acknowledged (McKinnish et al., 2019). However, the findings of this review indicate that trauma-informed approaches to preconception and pregnancy care for LGBTIQ+ people have been absent, highlighting a need to build the capacity of healthcare systems in responding sensitively to the unique ways in which LGBTIQ+ people experience discrimination.

#### *Microaggressions in preconception and pregnancy care*

Research also highlighted microaggressions that predominantly manifested through hetero- and cis-sexist healthcare interactions and processes. Microaggressions are subtle behaviours that may unintentionally communicate prejudice, and differ from overt discrimination, exclusion from services, and abusive practices (Sue, 2010). In this review, microaggressions included assumed identities, intake systems that could not record gender or sexual orientation, consistent use of deadnames and incorrect pronouns, and the exclusion of partners. Growing literature indicates that microaggressions create an unwelcome environment that contributes to minority stress, negatively impacts psychological wellbeing, and perpetuates distrust (Dean et al., 2016; Nadal et al., 2016). In exploring the factors that contribute to the prevalence of microaggressions, the clinical competencies of healthcare professionals and the need for professional development are key considerations. However, international research suggests that LGBTIQ+ diversity training remains absent from undergraduate education and professional development across healthcare disciplines (Barber et al., 2022; McCann and Brown, 2018; Siller et al., 2020; Streed Jr et al., 2018).

Sexuality and gender affirming practice training may indeed improve the knowledge, inclusivity, and preparedness of healthcare professionals in working with LGBTIQ+ people (Lindsay et al., 2019; Morris et al., 2019; Utamsingh et al., 2017), however the implementation of inclusivity training alone is unlikely to contribute to sustainable change. Although inclusion may in part be a question of knowledge, education, and clinical competencies, hostility and resistance towards accepting sexuality and gender diversity has also been attributed to queerphobic attitudes among healthcare professionals that may have been formed on the basis of their morality or religion (Stewart and O'Reilly, 2017; Westwood, 2022). There is recognition that microaggressions are also embedded within systems through hetero- and cis-sexist organisational policies, administrative processes, and physical healthcare spaces that stem from a long history of discrimination (Dean et al., 2016). Con-

sequently, further research on the organisational, systemic, and societal barriers to providing LGBTIQ+ affirming care is needed to inform the development of new healthcare practices, policies, and procedures.

### Limitations

The findings of this review must be considered alongside several limitations. First, this review was limited to the last 10 years and cannot provide an overview of how research in this area has changed over time. While this timeframe provided a contemporary overview that captured current gaps across healthcare systems, the findings do not indicate whether there has been an increasing trend in health equity over time. In addition, the evidence herein represents research and healthcare from predominantly Western countries that are considered to be more progressive, while other continents were not represented and reflected a gap in research. Further, the absence of staff perspectives has been flagged as another significant limitation. Although healthcare professionals were included within our scope, only three studies engaged staff as research participants. The lack of staff perspectives highlights a significant gap in the literature as the barriers that they experience in providing queer-affirming care have not yet been captured.

### Conclusion

This review synthesised research exploring the experiences of LGBTIQ+ people in navigating preconception and pregnancy care. Compelling insights to direct future research have been provided and several recommendations to guide research and healthcare quality improvement were developed. These recommendations have been presented in Table 6 and highlight the importance of investment in LGBTIQ+ affirming healthcare. The findings indicate that significant healthcare disparities have been experienced, and investment in healthcare quality improvement that aims to deliver safe and affirming care is needed. Importantly, research and practice that is sensitive to individual variation and directed by the voices of lived experience are needed to provide queer people and prospective parents with equitable care.

### Data availability statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

### CRedit author contributions statement

Ruth P. McNair, Amelia St Clair Arnold, Jess Permezel, Jacob Thomas, Rhonda Brown, Trish Hafford-Letchfield, Helen Skouteris: Study Conceptualisation; Writing – Review & Editing

Kostas Hatzikiakidis and Anita Maepioh: Methodology, Data Curation, Formal Analysis, Visualisation, Writing – Original Draft; Writing – Review & Editing

### Declaration of Competing Interest

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### Supplementary materials

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