

## **Mistreatment and violence against lesbian and bisexual women and trans persons during reproductive health care with a focus on childbirth**

*Submission to the Special Rapporteur on violence against women, its causes and consequences*

17 May 2019

This paper has been prepared by ILGA World as a response to [call for submissions](#) published by the Special Rapporteur on violence against women, its causes and consequences. It provides an overview of recent studies of the experiences of lesbian and bisexual (LB) women and trans persons in reproductive health care, primarily when it comes to conception, pregnancy, childbirth and postnatal period; identifies main challenges faced by LB women and trans persons; illustrates examples of good practices; and suggests recommendations to improve the situation.

### **Introduction**

The political, social and scientific developments of last decades allowed LB women and trans persons to include parenthood experiences into their life strategies and to practice different forms of reproduction. This also provoked some developments in practice of the United Nations Treaty Bodies,<sup>1</sup> though questions and recommendations on the topic are still very limited.

The level of health care system involvement may be different with different combinations of reproductive choices made by LB women and trans persons, however in general at least some participation of health professionals is needed or required. At the same time, reproductive health care, being based on heteronormative assumptions and a very narrow concept of family and birth, may exclude, marginalize or discriminate against LB women and trans persons. These issues may negatively impact the quality of care, and prevent LB women and trans people from either providing significant information about their health and personal or family status, or from referring to the health care system at all.

At the same time, concrete situation of LB women and trans people in reproductive health care and particularly in childbirth differs significantly in different countries. Despite the emerging pool of studies of the reproductive health care implications for LB women and, more recently, trans people as well, these are mostly qualitative studies of quite privileged cohort of the population living, with a very few exception, in countries such as Australia and New Zealand, North America or some countries in Western Europe. Though even in these territories, with comparatively favorable legal and political situations, there is still a room for mistreatment, discrimination and marginalization of LB women and trans persons in reproductive health care. And there is almost complete lack of data on the situation of LB women and trans persons in reproductive health and childbirth in other countries, especially where their identities are officially denied or punished.

Therefore, information provided in this submission, is mostly based on the experiences of a very limited cohort of LBT population, and it could only be assumed that LB women and trans people outside of this cohort face much more difficulties, mistreatment and violence.

### **I. Challenges faced by LB women and trans persons in reproductive health care**

- LB women and trans persons may have no access to assisted reproductive technologies (ART) at all, or it could be deteriorated because of a number of barriers: legal (for instance, in Europe only 13 out of 49 countries provide access to ART to same-sex couples<sup>2</sup>; some forms of ART, such as IVF, may require an established medical infertility

diagnosis), financial (because of the cost of ART, their exclusion from insurance coverage, or because friendly clinics are only the private ones) or geographical (in remote areas there may be even harder to find a friendly clinic or just a doctor). Some jurisdictions still require trans persons to be sterilized in order to obtain legal gender recognition and new documentation.

- LB women and trans persons have to make a specific decision on whether or not to disclose information about their sexual orientation, gender identity and family status to health professionals.<sup>3</sup> While this information may be relevant from a medical point of view or just to ensure open communication and support, the fear of mistreatment based on negative perceptions of LBT persons may prevent patients from disclosing data. Sometimes LB women and trans persons indeed face negative reaction after coming out to medical personnel.

*“When I first disclosed my relationship status with my GP she was very disappointing. She stated outright that a woman should not consider childrearing unless married to a man; she was in fact quite rude.”<sup>4</sup>*

*“The midwife said she had never heard of people like us. She wouldn’t book me in; espoused her Christian beliefs.”<sup>5</sup>*

Trans persons may be mistreated by providers and medical staff because of the lack of cultural competency. Concrete forms of inappropriate treatment include using wrong titles and pronouns, calling by legal name rather than the name used by a person, or presuming to know the shape of a patient’s genitals by their name or face.<sup>6</sup>

Trans people who are pregnant and give birth face a multitude of legal barriers resulting from the fact that only a few States recognize pregnant trans men as fathers or parents of their children, even if their legal gender is male, but rather enter them as “mother” in their child’s birth certificate. This constitutes state-driven discrimination and may trigger stigma and discrimination towards both the trans person who is pregnant and towards the baby once born. The same problem exists for trans women having children with other women who will not be recognized as co-mother or parent but as father, even if their legal gender is female. Many trans people therefor avoid becoming pregnant or having children of their own or will travel to states that offer appropriate recognition when delivering the child.

*“I am a pregnant trans man and my country will not recognize me as the father. I will therefore have to travel to Sweden to deliver my baby in order to obtain a birth certificate for my child that properly reflects our family.”<sup>7</sup>*

Another concrete form of challenges faced by LB women and trans persons is inappropriate questions asked by health professionals in relation to their patients’ sexual orientation, gender identity or family status. Such questions are not asked of heterosexual/cisgender persons, and they as such do not relate to health services being provided.

*Out of 50 lesbian mothers participating in a research conducted by Wilton and Kaufmann, 25 were asked by health professionals how they got pregnant, six what they would tell their child about its biological father, and four if they had ever been heterosexual.<sup>8</sup>*

Coming out to health professionals also could raise some issues related to confidentiality. Some LB women, for example, may not want their sexual orientation to be recorded and instead keep it entirely private, while others would prefer all their caregivers knew their sexual orientation upfront in order to avoid repeating experience of coming out.<sup>9</sup>

*“I know that in [name of the clinic in Saint Petersburg] they have been writing in the medical history sheet with big red letters – HOMO. It is like a stigma; of course, it is at once some ‘other’ person in front of you.”<sup>10</sup>*

- Health care providers may have not enough medical knowledge on LB women' and trans persons' reproductive experiences, and consequently patients do not receive any or full information relevant for their health. This is particularly problematic for trans persons as such procedures as hormonal therapy and gender reassignment surgeries may affect reproductive capacity, and in order to take truly informed decisions trans persons need to have relevant information in advance.<sup>11</sup>

*"...they [providers] didn't have anything to refer to. [A transgender man seeking pregnancy] was too new and too different for them, and they didn't have studies to look at. They didn't know if this was safe, none of that."*<sup>12</sup>

- Antenatal and postnatal education usually does not take into account LB women and trans persons. The classes provided to patients are oriented exclusively to heterosexual/cisgender persons. Partners of LB women and trans persons who are going to give birth to a child, may feel particularly overlooked and excluded.
- Non-birth parents, such as non-biological mothers in lesbian couples, face particular challenges because of the specificity of their role in the parental project (the lack of biological linkage presupposed under the traditional understanding of parentage), but also because they may not be recognised as co-parents in law and/or by health professionals. For example, in Europe, only 10 out of 49 countries provide automatic co-parent recognition.<sup>13</sup>

*"My partner was not given automatic rights equal to that of a male partner, not included fully in decision making, not taken seriously or given proper acknowledgment/respect."*<sup>14</sup>

*"And when we went into the room, the birth mother went into the bathroom, and her partner was sitting holding the baby in the rocking chair... and the postpartum nurse came in, and kind of looked around and said, who are you? The patient's partner said, 'I'm the mom', and she [the nurse] said, 'no you're not', and it was really terrible. She said, 'no, where's the baby's real mom'."*<sup>15</sup>

*"I read in a book that postpartum blues are hormonal, but in our relationship I was the one who had the postpartum blues. It started in the hospital when someone referred to the donor as the baby's father, and then every form referred to the father, not the other parent."*<sup>16</sup>

- Pathologisation of LB women' and trans persons' identities, especially when it comes to their ability to raise children.

*Several participants in a study conducted by Hoffkling et al., trans men, reported social services threatening or attempting to remove their children from their care, even before the birth.*<sup>17</sup>

## II. Examples of good practices

- Collecting information about clinics friendly to LB women and trans persons
  - The GLMA (Gay and Lesbian Medical Association) provider directory, US, [https://glmaimpak.networkats.com/members\\_online\\_new/members/dir\\_provider.asp](https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp)
  - The National Lesbian and Gay Health Foundation, Inc., of Washington, D.C. had developed a directory of friendly health care providers<sup>18</sup>
- Guidelines for health care providers
  - Nursing Guidelines for Assessing Adaptation to Parenting in the Lesbian Childbearing Couple (includes such developmental tasks as acceptance of the pregnancy by others, binding-in, safe passage, self-giving, maternal role development and the co-parent role development; provides concrete questions for the lesbian couple assessment)<sup>19</sup>

- Schemes developed for primary care physicians dealing with lesbian women (including counseling and testing, preconception care, donor choice, donor testing, ordering the semen and insemination process)<sup>20</sup>
- Recommendations for providers on trans men's pregnancy and birth support<sup>21</sup>
- Creating welcoming environment for LB women and trans persons at antenatal or postnatal education (*"The midwife who run the antenatal classes was so supportive – she realized that we were lesbians, rang us the first night after the class to check that we felt welcome, always acknowledged my partner"*<sup>22</sup>)
- Accepting the role of non-birth parents, such as partners of lesbian women giving birth to a child (*"My main midwife would direct questions at my partner and ask how she was feeling, how she was coping with my pregnancy sickness [...] and would say hello and goodbye to her. She was seen as being as much a part of the pregnancy I was."*<sup>23</sup>)
- Amending medical forms and documentation to reflect the realities and needs of LB women and trans persons (*"When we went to the initial booking-in interview they very patiently amended the form, changing reference to 'father' to either 'donor' or 'partner' depending on the circumstances, apologizing for the inadequacies of the form."*<sup>24</sup>)
- Specific projects aimed at ensuring that LB women and trans persons are well-received in maternal care and during childbirth
  - Together with a county-owned hospital, the MamaMia clinic started a project under which the hospital's delivery ward had staff trained in lesbian health and other issues; during pregnancy, couples had the opportunity to meet other couples in a lesbian relationship who were expecting children; the couples made two visits to the delivery ward with their midwives; in MamaMia, there were also openly lesbian midwives who could be chosen by couples.<sup>25</sup>

### III. Recommendations

- Facilitate further research of experiences of LB women and trans persons, particularly those facing intersecting forms of discrimination and oppression, in reproductive health care<sup>26</sup>
- Ensure adaptation of the clinics' routine, from antenatal care to postnatal care and including forms, journals, verbal communication etc., to the needs and realities of LB women and trans persons, including language and medical forms (using more neutral terms such as 'partner' or 'parent', gender-neutral pronouns etc.)<sup>27</sup>
- Develop and disseminate among health care providers and in LGBT communities materials on LB women's and trans persons' reproduction and parenting<sup>28</sup>
- Provide trainings to medical professionals dealing with LB women and trans persons accessing reproductive health care services, including with possible participation of local LBT parent who went through the process of childbirth<sup>29</sup>
- Adopt and implement policies which prevent harassment or discriminatory treatment based on sexual orientation or gender identity of reproductive health clinics' patients<sup>30</sup>
- Organise support groups for LB women and trans persons willing to have children, already going through the reproductive process or recently becoming parents<sup>31</sup>
- Organise databases of LBT-friendly health care facilities and make them available to LB women and trans persons<sup>32</sup>

- Ensure legal, financial and geographical assess of LB women and trans persons to sensitive and professional reproductive health care services and information, particularly related to assisted reproductive technologies
- Ensure legal recognition and acceptance of LB women and trans persons' families, particularly their partners and their children

---

<sup>1</sup> See e.g. Human Rights Committee, Concluding Observations on Slovenia (2016), para. 9 (concerns on same-sex couples to reproductive treatment); Human Rights Committee, Concluding Observations on Italy (2017), paras. 10-11 (concerns and recommendations on access of same-sex families to in vitro fertilization); Committee on Economic, Social and Cultural Rights, List of Issues for Argentina (2017), para. 24 (data on sexual orientation in the context of coverage for reproductive health services); Committee on the Elimination of Discrimination against Women, Concluding Observations, Luxembourg (2018), paras. 51-52 (concerns and recommendations on filiation after assisted reproduction); Committee on the Elimination of Discrimination against Women, List of Issues, Serbia (2018), para. 16 (access of LGBTI persons to family-planning services and artificial insemination).

<sup>2</sup> Austria, Belgium, Denmark, Finland, Iceland, Ireland, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden and UK. Source: ILGA-Europe, Rainbow Europe Index – May 2018, [https://ilga-europe.org/sites/default/files/Attachments/index\\_2018\\_small.pdf](https://ilga-europe.org/sites/default/files/Attachments/index_2018_small.pdf) (accessed on 16 May 2019).

<sup>3</sup> Wilton, T. & Kaufmann, T. (2001). Lesbian Mothers' Experiences of Maternity Care in the UK. *Midwifery*, 17(3), pp. 203-211; Hoffkling, A., Obedin-Maliver, J. & Sevelius, J. (2017). From Erasure to Opportunity: A Qualitative Study of the Experiences of Transgender Men around Pregnancy and Recommendations for providers. *BMC Pregnancy and Childbirth*, 17(Suppl 2), p. 332.

<sup>4</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>5</sup> Ibid.

<sup>6</sup> Hoffkling, A., Obedin-Maliver, J. & Sevelius, J. (2017).

<sup>7</sup> Communication with a trans men who is pregnant (anonymous).

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Zhabenko, A. (2014). Reproductive Choices of Lesbian-Headed Families in Russia: From the Last-Soviet Period to Contemporary Times. *Lambda Nordica*, 3-4, pp. 54-85.

<sup>11</sup> Hoffkling, A., Obedin-Maliver, J. & Sevelius, J. (2017).

<sup>12</sup> Ibid.

<sup>13</sup> Austria, Belgium, Denmark, Ireland, Malta, Netherlands, Norway, Portugal, Spain and UK. Source: ILGA-Europe, Rainbow Europe Index – May 2018.

<sup>14</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>15</sup> Goldberg, L., Harbin, A. & Campbell, S. (2011). Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. *Sexualities*, 14(2), pp. 173-192.

<sup>16</sup> Wojnar, D.M. & Katzenmeyer, A. (2014). Experiences of Preconception, Pregnancy, and New Motherhood for Lesbian Nonbiological Mothers. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 43(1), pp. 50-60.

<sup>17</sup> Hoffkling, A., Obedin-Maliver, J. & Sevelius, J. (2017).

<sup>18</sup> Wismont, J.M. & Reamy N.E. (1989). The Lesbian Childbearing Experience: Assessing Developmental Tasks, *Journal of Nursing Scholarship*, 21(3), pp. 137-141.

<sup>19</sup> Wismont, J.M. & Reamy N.E. (1989).

<sup>20</sup> Steele, L.S. & Stratmann, H. (2006). Counseling Lesbian Patients about Getting Pregnant. *Canadian Family Physician*, 52 (5), pp. 605-611.

<sup>21</sup> Hoffkling, A., Obedin-Maliver, J. & Sevelius, J. (2017).

<sup>22</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>23</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>24</sup> Ibid.

<sup>25</sup> Røndahl, G., Bruhner, E. & Lindhe, J. (2009). Heteronormative Communication with Lesbian Families in Antenatal Care, Childbirth and Postnatal Care. *Journal of Advanced Nursing*, 65(11), pp. 2337-44.

<sup>26</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>27</sup> Wilton, T. & Kaufmann, T. (2001); Røndahl, G., Bruhner, E. & Lindhe, J. (2009).

<sup>28</sup> Wilton, T. & Kaufmann, T. (2001).

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> Hayman, B., Wilkes, L., Halcomb, E.J. & Jackson, D. (2013). Marginalised Mothers: Lesbian Women Negotiating Heteronormative Healthcare Services. *Contemporary Nurse*, 44(1), pp. 120-127.