Lesbian mothers' experiences of maternity care in the UK

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Objective: **to explore the maternity care experiences of a sample of lesbians in the UK in order to evaluate service delivery to this group.**

Design: **a descriptive study, using both qualitative and quantitative survey methods to elicit 'rich' accounts of women's experiences.**

Participants: **a convenience sample of 50 women, reporting on a total of 65 pregnancies.**

Findings: **while participants were generally appreciative of the care they received, they also reported high levels of anxiety about the implications of disclosure, together with acute awareness of midwives' personal attitudes and prejudices. Their comments demonstrate the extent to which these issues may negatively impact on quality of care, and the study reveals examples of discomfort, inappropriate service delivery and even hostility.**

Key conclusions and implications for practice: **'booking in' and antenatal education are identified as the two areas where service delivery is least effective in meeting the needs of this client group. Findings were used in drawing up the Royal College of Midwives' position paper on the care of lesbian mothers.** **© 2001 Harcourt Publishers Ltd**

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INTRODUCTION

There are no accurate figures for the number of lesbian mothers in the UK or elsewhere, but commentators agree that increasing numbers of women are choosing to start a pregnancy as self-acknowledged lesbians (Saffron 1994, Dunne 1998). The social meanings attached to lesbianism and to motherhood in Euro-American culture mean that a combination of the two is generally regarded as inherently self-contradictory (Richardson 1993). As one of us has written elsewhere (Wilton 1999), this makes it easy for service providers to avoid acknowledging the existence of lesbian clients or recognising their needs.

In response to growing recognition that professional practice with this client group is perceived as inconsistent, the Royal College of Midwives recently published a Position Paper (RCM 2000). It was based on specially designed research, since existing evidence was inadequate. Continuing stigma, and the difficulty of obtaining funding for research, mean that existing studies draw on small convenience samples (e.g. Harvey et al. 1989, Larson 1993, Tash & Kenney 1993, Leiblum et al. 1995, Wilton 1996; Percy 1997, Saffron 1999, Stewart 1999).

The needs of lesbian mothers are of intrinsic interest to maternity care providers, and they also constitute a 'litmus test' of service sensitivity. It is relatively easy to learn crude facts about particular minority groups and their perceived needs; it is less easy to develop the conceptual tools and inter-personal skills to provide the truly woman-centred care which is the hallmark of midwifery excellence. Assessing the degree to which services meet the needs of lesbians tests the flexibility, responsiveness and woman-centredness of service provision as a whole, and should be regarded as an indicator of professional development by reflexive midwifery practitioners.

METHODS

The research used self-completion questionnaires, designed to extract qualitative data on experiences of antenatal, intrapartum and postnatal care. Two established community networks – the UK-wide Stonewall Parenting Network

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and a local network of lesbian mothers living around Bristol – agreed to distribute questionnaires. A certain amount of 'snowballing' also appears to have taken place, with some women passing the questionnaire on to friends.

This convenience sample inevitably included a wide range of lesbians and gay men with an interest in parenting. It is not known how many of the 400+ people who received the questionnaire are women who have borne children as self-identified lesbians, and therefore the response rate cannot be established.

Completed responses were subject to univariate analysis via SPSS.

Comments on sample

The openness of the responses suggests that a high level of trust resulted from the method of recruitment and the associated confidentiality. It is unlikely that alternative methods of recruitment would have been so successful. However, using established networks had an inevitable impact on the social characteristics of the sample. By their very nature, self-help networks attract like-minded or like-situated individuals. In this case, survey respondents were disproportionately likely to:

- live in London, where lesbian visibility is relatively high and where service providers are more likely to have encountered clients from a diversity of social backgrounds;
- belong to lesbian support groups or networks, which may increase their confidence and willingness to be open to service providers;
- be older than most maternity service users, and so perhaps have greater confidence and higher expectations of service provision;
- be white, and less likely to need to negotiate issues around racism and cultural identity in their use of maternity services.

Non-Londoners, younger women, and black and lesbians from minority ethnic groups may be less likely to have access to the necessary resources to embark on lesbian motherhood, or to seek out support from existing community networks (Mugglestone 1999). In any case, the concept of representativeness is only notionally useful when working with sexual minorities of any kind. Put simply, nobody knows what a representative sample of lesbian mothers would look like. Sexuality is not a fixed characteristic, but a fluid concept which embraces behaviour, desires, shifting social constructs and self-perception and which may not have a straightforward relationship to identity (Whisman 1996, Wilton 2000). No studies claim to accurately capture even the crude total of lesbians living in the UK; even a national sex survey admitted its failure to achieve this apparently simple objective (Wellings et al. 1993). It is, therefore, impossible to model a sample for this area of research which would be valid in narrowly statistical terms. Clearly, there is a need for further research into the diverse needs of different groups of lesbian mothers.

FINDINGS

The participants

Fifty women responded, reporting a total of 65 pregnancies. Since most studies in this area have noted the difficulty of reaching this relatively 'invisible' group, to have 50 participants is an enviable result. Of the total, 45 identified themselves as white, all but one were over the age of 30, and over half lived in London (fuller demographic data are available from the authors). Six were pregnant at the time of responding; two of these were expecting their first baby, two their second, one her third and one her fourth. Of the others, most (33) had one child, six had two and one had three. Over half of these children (33) were under three years old and two thirds (43) were under five years old.

Booking and disclosure

One clear difference between the experience of these women and that of non-lesbians is the necessary decision on whether or not to 'come out' as lesbians to service providers. The complexity of this is often unappreciated by heterosexuals, who enjoy much greater freedom to be themselves without fear of hostile reaction. Pregnant lesbians, like all women, want their midwives to understand their social and emotional needs and, if they have a partner, will want her to be included appropriately. They also have to decide how to respond to seemingly straightforward questions such as 'When did you last have sex?', or 'what is the father's name?'.

Users of maternity services face this very early on, as 'booking' will usually elicit information on the woman's partner, the baby's biological father, and the woman's social needs. Of this sample, 32 recalled being asked about their relationship status or sexual orientation as part of their maternity care, while 24 did not remember having been asked. Most participants wanted to be 'out' to their care providers, and 42 had voluntarily disclosed their sexual identity to their midwife. Some identified lack of continuity of care as a reason for non-disclosure, with one commenting, 'I told a few, but there were so many different ones involved'. Similar proportions came out to their GP or health visitor, whilst of those who saw an obstetrician, less than half did so.

Health professionals' response

Of those who were asked at 'booking' in about their relationship status or sexual orientation, 25 found the question and the way it was posed acceptable but seven reported that the way they were asked was unacceptable. Some women found the health professionals' response a reassuring affirmation of their 'normality' and acceptability. One commented, 'I was treated excellently, like a 'normal' pregnant mum to be, which is what I wanted.'

However, some health professionals exploited the opportunity afforded by this disclosure to express their own moral views to their clients in an inappropriate way:

> 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.

> My GP stated that he did not agree with two women bringing up children.

> The midwife said she had never heard of people like us. She wouldn't book me in; espoused her Christian beliefs.

This last comment affirms the findings of other researchers (e.g. Gruskin 1999, Solarz 1999) that some health-care professionals use religious affiliation to justify an unprofessional approach to their lesbian (and gay) clients. It should be noted that the sole service area where midwives are entitled to refuse to participate on moral or religious grounds is termination of pregnancy. Refusing to provide equitable services to lesbian clients is unethical and unprofessional, and may rightly be regarded as a disciplinary issue.

Of those who voluntarily disclosed their sexual orientation, most (40) reported that the information was received appropriately. However, several cited reactions which seem insensitive or offensive. For example:

> [They] placed [my] child on [the] concern list! Because of the nature of our relationship, i.e. lesbians.

Women were also discomfited by responses that were too studiedly 'neutral', when the health professional was so determined to show that the information was not bizarre or unwelcome, that they ended up implying that it was of no significance at all. This may be analogous to the experience of women from minority ethnic groups whose midwives are too determinedly 'colour blind' – rather than feeling accepted, they feel invisible, or merely tolerated, or they wonder if the health professional is covering up discomfiture. As one respondent said:

> Our sexual preference was acknowledged but not discussed. We perceived embarrassment on their behalf.

By contrast, respondents seemed reassured by health professionals taking a little interest (without straying into being intrusive). Several commented that they were happy to take an 'educating' role, as they understood that many health professionals have not encountered lesbian mothers, and needed information. One said, 'They were intrigued, curious into my choices for being pregnant and using donor insemination, but this was dealt with in a sensitive, caring manner' while another commented, 'People are curious and I don't mind being open – I hope it may broaden their experience and attitude.'

Information exchange

Respondents who had 'come out' were asked a range of questions which may not have been asked of heterosexual women. Questions which have obvious relevance for the woman's care may need particular sensitivity to ensure the client understands why they are asked. For example, 26 women were asked about the child's biological father, while 22 were not. Obviously this question can be legitimate – to ascertain the baby's medical history – but, without care, it could be interpreted as nosiness. Similarly, 16 were asked if they wanted information on safer sex and contraception, while 30 were not. There are good reasons for offering *all* women such information, but some respondents bristled at what they saw as a refusal to recognise their particular situation.

Some questions were asked which seem frankly irrelevant. For example, 25 women were asked how they got pregnant, six what they would tell their child about its biological father, and four were asked if they had ever been heterosexual. It is difficult to understand why midwives would need this knowledge, and tempting to suspect simple curiosity. There is, of course, nothing wrong with learning from clients' experiences, but it is unlikely that answers to these questions would yield any benefits for maternity care.

This does not mean that midwives should avoid asking questions to establish clients' wishes and needs – or even as part of a natural, friendly relationship. Some midwives – perhaps fearful of being seen as intrusive – did *not* ask questions where they could usefully have done so. For example, 24 respondents were not asked if they had a partner who would be co-parenting; 16 did not recall being asked if they had support at home; only 11 were asked if they had support in

the community; 31 were not asked about how their partner was feeling, and what support she might need; and 37 did not remember being asked about their wishes regarding confidentiality, giving them no control over who knew their sexual identity. This last is particularly important, since health professionals cannot assume that a woman wants her sexual orientation recorded – some may want it kept entirely private, unless they choose to disclose themselves, while others do not wish to keep 'coming out' repeatedly, and would prefer all their caregivers knew upfront. Where respondents were happy being asked about their sexual and social situation, it was usually because they could see the benefits to themselves and other women. For example:

> Some of the questions were asked in order to gain an idea of the environment my son was going to be born into, some questions were asked on a more personal level and in order to satisfy genuine curiosity. Neither motive I have a problem with, because my main midwife was so nice and was happy to accommodate any of my wishes and hopefully she was learning from the experience.

Others felt that questions were asked which would yield no perceptible benefit, and which may have been guided by other agendas:

> My midwife asked me questions ... that I didn't really want to answer.

> Asking about D's father was irrelevant – I knew enough about him to know his health history and that of his family. I felt pressurised to give his name.

> I do not feel the question of how I got pregnant is of any relevance to health professionals and [I] feel it is inappropriate as I do not understand this is asked of heterosexuals.

Non-disclosure

Of those 17 respondents who did *not* disclose their sexual identity, 15 said they would have liked to. Of these, 14 did not because of their fear of a prejudiced reaction, 12 worried that it would affect the care they were offered, nine were concerned that their confidentiality would not be respected, and five said the opportunity never arose. A specific fear was that they might be considered, and treated as, 'bad mothers'. One said, 'I had been told that health visitors could make things very difficult if they were prejudiced.' Another mentioned feeling, 'Fear that our parenting would be put under the microscope before we had a chance to bond with our baby.'

Nevertheless, a number reported that *not* disclosing their sexuality had itself caused problems. Chief of these was that their partner was excluded or marginalised. Others felt that it complicated interactions with their health care providers – for example, in declining contraception without feeling able to explain why. Two respondents cited specific ways in which non-disclosure impeded the ability of their health professionals to deliver appropriate care. One couple had experienced relationship difficulties after the birth of their first child, and felt that the health visitor may have been able to help them with this, if only they had felt able to confide in her. Another respondent, who was pregnant at the time of completing the questionnaire, wrote: 'I'm not sure how it will affect the birth but I do have anxieties about not having been able to be completely open with the midwives – it has created a barrier when I need to be able to trust them.'

Antenatal classes

The aspect of care that attracted most negative comment was antenatal parent education. Most of the women (37) attended parent education organised by community or hospital midwives; a further 13 attended National Childbirth Trust (NCT) classes, and six attended classes at the Active Birth Centre. One woman had tried to enrol with the NCT, but was turned away: 'They said they only taught couples.' Five women attended no parent education, one volunteering that 'I thought it would be awkward.'

Although half (24 women) received parent education that was useful and appropriate to their needs, a similar number volunteered that the classes were very heterosexual in orientation, and that they and their partners frequently felt excluded or overlooked. Thirteen respondents felt that the classes did not meet their needs. Typical comments include:

> The midwives seemed very uncomfortable and unfamiliar with our relationship as lesbians.

> NCT was a bloody nightmare! My partner ended up with the fathers and felt awful, as I did.

> NCT I found helpful and open to including my partner. The community education I went to once and felt alienated by its heterosexual orientation.

One respondent reported that particular efforts were made to help her feel welcome and included, and this was much appreciated:

> The midwife who ran the antenatal classes was so supportive – she realised that we were

lesbians, rang us the first night after the class to check that we felt welcome, always acknowledged my partner.

There is clearly a strong message here for providers of parent education. It is obviously easier for a midwife to adjust her language and assumptions when dealing with service users on a one-to-one basis, than when communicating with a group. Nevertheless, it is worth pointing out that, if such a high proportion of lesbian mothers felt marginalised by their parent education, so, too, may single mothers and members of minority cultures.

Labour and birth

Over one-quarter of the respondents (14) delivered at home, with two pregnant women intending to do so; the remainder had a hospital birth. This relatively high proportion of home births may reflect the respondents' demographic profile, and/or a desire to give birth in an atmosphere which was under their control, and where they were less vulnerable to the assumptions and prejudices of others.

Compared to their experiences of antenatal parent education, the women reported far higher levels of satisfaction with their intrapartum care (45 saying it was appropriate and sensitive to their needs, compared to 13 for whom it was not). A strong factor in this seemed to be the extent to which the partner was acknowledged as the other parent, with nearly half volunteering information on this:

> My partner and I were so well treated. It was a difficult labour and we both felt very cared for. I was particularly aware (in retrospect) of how sensitive the midwives were to my need for emotional support from my partner.

> Most were great, but the first midwife was aggressive and excluding to my partner.

Continuity of carer was also an important factor for some, enabling them to feel more confident and trusting in their health professional. One cited as:

> Particularly helpful – a midwife who knew us and with whom we had developed a relationship, who was able to be there for most of the labour.'

However, some had experiences which imply lack of sensitivity and respect on the part of the service providers:

> Homophobia was very apparent in hospital.

> 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 acknowledgement/respect.

> Staff at the hospital stated that it was not their job to push my partner in her wheelchair to the ward.

Postnatal care

Surveys of women's views of maternity care tend to cite postnatal care as the 'Cinderella' of the maternity services (Audit Commission & National Perinatal Epidemiology Unit 1998). However, our respondents reported generally positive experiences. Forty-one felt their postnatal care was appropriate and sensitive to their needs, with only three reporting that it was not. There were far fewer reported incidents of heterosexism or homophobia during this time; maybe it is easier for some care professionals to see a lesbian as 'just like any other mother' once she has a baby in her arms, or maybe it is simply easier to provide appropriate care on a one-to-one basis than in a group environment.

It is also possible that these women – who nearly all had a female partner – received more support at home, and so felt less in need of professional care. A recent study found that women in lesbian partnerships routinely enjoy higher levels of emotional and practical support and more egalitarian co-parenting arrangements than is usual in heterosexual households (Dunne 1997, 1998, 1999, 2000).

Many respondents reported being made to feel comfortable by a simple affirmative comment from their health professional. This did not need to be an elaborate statement of support – almost any response which was good-humoured and relaxed seemed to do the trick. For example, one woman's health visitor responded to her self-disclosure with a jokey, 'Oh, it's just like that programme on the telly!' Another said of her midwife, 'She was really accepting and on the last visit wished us well and hoped to see us again next year!'

Partners

The recurring emphasis on how partners were treated suggests just how important it is for lesbian mothers to be treated as a family. Only three respondents did not have a partner, and very few partners did *not* accompany the mothers to antenatal appointments, parent education, childbirth and postnatal visits. It was clearly important to them that their role be acknowledged. Most midwives did acknowledge partners (46, compared to 10 who did not). Sometimes, lack of continuity of carer was a problem ('I had lots of different midwives – one I

saw twice and she remembered'). Thirty-seven of the respondents said their partners had had the opportunity to discuss their concerns with the midwife, but 18 reported that they had not, while 16 said their partners had felt excluded at some stage.

> My partner had to fight to be acknowledged as the baby's mother, and to be included in her care.

> The very first postnatal visit was conducted by a locum midwife and she didn't talk to or even look at my partner, which upset her.

> We had to work HARD to make our relationship and our role as potential parents very clear.

Some partners were themselves biological mothers. Thus, some respondents who encountered the maternity service as primagravidae were also already mothers. One respondent was particularly angry that her other children (her partner's biological children) had been excluded and ignored by health professionals: this is clearly an issue in areas such as 'family only' visiting, not just for lesbian families but for stepchildren, adopted children and a range of others from 'blended' families.

A large number of the respondents (41) reported positive experiences of midwives making efforts to include and support partners, and this was clearly significant for them. It seems that even small gestures of acceptance and support can make all the difference in helping lesbian parents feel that the midwife is 'on their side':

> My main midwife would direct questions at my partner and ask how she was feeling, how she was coping with my pregnancy sickness (it was bad throughout) and would say hello and goodbye to her. She was seen as being as much a part of the pregnancy as I was.

> Midwife related to her as being an equal partner and equal parent (not just as my partner who was going to help me out with 'my' baby). She and my partner worked together during the labour to support me.

> My partner was able to stay with me 24 hours a day during my two week stay in hospital. We were both visited by staff for no reason other than to see how we were. My partner would have expected not one thing more.

> She was acknowledged as my partner from the start and they were really relaxed about us. At one point they told her to cuddle me when the going was tough.

Overall satisfaction

Overall, a clear majority of the respondents (35) felt that the maternity care they received met their physical, emotional and social needs. In addition, 40 women said they felt comfortable with the care they received *as a lesbian* using the maternity services, while nine did not. However, this may reflect the confidence of this generally urban sample.

It is heartening that so many lesbian mothers reported positive experiences of maternity care. Even where midwives clearly felt uncomfortable, they mostly tried to deal with their own attitudes and provide the best possible care – and these efforts were noted and appreciated by their clients. Twenty-seven women cited examples of things their midwives said or did that made them feel welcomed and accepted as a lesbian. Half of these involved the midwives making special efforts to acknowledge and involve the partner. A number of respondents stressed that they did not want special treatment – just to be treated as 'normal'; however, a little explicit acknowledgement of their particular situation helped them to feel that they were welcomed, not just tolerated:

> My midwife made us feel like we were good parents by saying we had planned well and done all the right things.

> We explained our situation to her – she said, 'Oh great, one of my cousins is a lesbian!' It was really nice.

> They were accepting of us, made us feel very normal, but were able to talk to us and were interested. They wanted to learn about lesbian parenting.

> 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, apologising for the inadequacies of the form.

> She treated us as normal respectable people!

However, 17 respondents referred to incidents where, often unwittingly, health professionals had made them feel misunderstood or uncomfortable. For example, one cited a midwife making disparaging comments about Lesbian and Gay Pride Day, another midwife suggested that a baby conceived by donor insemination might be disabled, and one woman was distressed to find that her sexuality had been

discussed on the maternity ward without her knowledge. One traumatic experience is worth quoting at length:

> I did see one particular midwife a few times in my first pregnancy, who I feel did not like me at all. She was particularly rough with me – every injection left many bruises as she'd jab up and down my arm, each time blaming me for having bad veins. An internal examination at nine months was so rough it made me bleed, and worse, was so painful and frightening I felt I had been assaulted. No other midwife has ever hurt me like she did, nor laughed at my questions or put me down as she did. She ignored my partner, turning her back to her during my antenatal appointments. Before appointments, when she saw us in the waiting room, she'd roll her eyes and point at us to the receptionist. Because of my experience with her, I was frightened each time I met another midwife that she would hurt me or my baby because she didn't like lesbians.

This respondent had since had two subsequent pregnancies, during which she travelled to a midwifery team on the other side of her borough – taking 45 minutes by bus with a double pushchair – to avoid this particular midwife. And *still* she gave an overall positive evaluation for her maternity care.

Respondents' suggestions for improvement

Respondents were asked if anything could be done to make lesbians feel more comfortable using the maternity services. Twenty-seven said yes. Their suggestions for positive action were not ambitious, mainly focusing on simple acknowledgement and recognition:

> Any kind of recognition that we were not the only lesbian couple having a child.

> More acknowledgement of my relationship and choices.

> Using the word LESBIAN! (It's not catching.)

A number suggested that it would have been useful to have been offered information specific to their situation, such as contact with other lesbian mothers or local support groups (and two said that this had been done for them):

> . . . by letting us know if any other women were in the same situation as us. We felt very alienated.

> It would have been helpful if literature and other spoken information gave examples from lesbian or gay families bringing up children/caring for babies/giving birth so that it was clear from the outset that there was not prejudice against us.

Also popular was the wish for greater continuity of carer, so that they did not have to repeatedly 'come out' to a series of health professionals:

> Continuity of care is very important . . . [the] midwives changed [with] every appointment and often I just let the 'father' and 'husband' comments go as I knew I would not be seeing them again so there was no point putting myself through an embarrassing situation.

> I really wish I could have had continuity of care, the same midwife throughout, and to have known who would be midwife at the birth. This would have spared me so much anxiety.

Other comments and suggestions were offered. A number asked midwives simply to be *aware* that not all pregnant women are heterosexual. One suggested, 'Questions at initial contact should give the gentle opportunity to come out.' Another summed up her wishes as follows:

> Educate midwives on the politics of diversity. Don't assume that all women giving birth are heterosexual. Also, read the birthplan and respect it, and please don't call me 'Mrs'.

Two others pointed to the particular difficulties facing lesbians in the intimate environment of childbirth: one felt that her midwife would not sit close and make eye contact with her, at a time when she badly needed that support, while the other found the atmosphere inhibited her intimacy with her partner, and envied the easy closeness enjoyed by heterosexual couples.

DISCUSSION

Although national data are not available, it is apparent that increasing numbers of women are choosing to bear children within lesbian relationships. Sexuality, reproduction and parenting are the focus of many of our most deeply felt social norms and values and, as lesbian parenting challenges many of those norms and values, we cannot assume that lesbians' experiences of maternity care are unproblematic.

Our findings suggest that lesbians in the UK do encounter specific problems when using the maternity services. It is reassuring that most participants in this RCM survey reported generally positive experiences, and that many of them were extremely complimentary about the

midwives who cared for them. However, researchers investigating women's experiences of maternity care regularly comment on a tendency for respondents to report high levels of satisfaction while at the same time recounting instances of disappointment or detailing numerous specific complaints (Stimpson & Webb 1975, Audit Commission 1997). Joy in a healthy baby seems to act as a powerful counterbalance to negative experiences. In this case, we would note that *most* of the women who participated in this survey were forced to negotiate a range of obstacles to good care, including ignorance of their needs, assumptions which made them feel excluded or marginalised, moral disapproval or even, albeit rarely, outright hostility and negligence.

If lesbians are not welcomed and understood by the maternity services, the quality of the care they receive will be compromised. On the basis of previous negative experiences, lesbians may avoid or delay essential treatment (Zeldenstein 1990). They may withhold important information, or supply misleading information, in order to avoid being 'exposed'. They will certainly be unable to develop open, trusting relationships with their care providers. This makes it especially important for care providers to 'go the extra inch': just a welcoming smile can make all the difference. While an attitude of studied neutrality may be seen as 'professional' to the health carer, the client may perceive it as masked hostility or disapproval, and a welcoming smile can make all the difference.

While this group are as deserving of good care as any other, they are not particularly numerous nor, on the evidence of this survey, particularly demanding. All they want is to be made to feel accepted *as a lesbian mother*. This means some recognition, a few warm words of welcome, and some discussion of their particular needs – in short, woman-centred care.

Woman-centred care should extend to partners, too. Helping couples make a confident, effective transition to parenthood is intrinsic to the midwifery task. Perceived or actual homophobia will only add to the isolation and exclusion that many female partners feel at this time. Lesbian parents are relatively unsupported and isolated in our society. Midwives have a vitally important role to play in reducing this isolation, and helping babies born to lesbian mothers make the best possible start in life.

Recommendations

Responding effectively to the needs of lesbian clients involves sensitivity, self-awareness, perceptiveness, confidence, and flexibility. These are traits that are more learned than taught; nevertheless, every midwife can and should take steps to meet the needs of lesbian clients. These steps can be summarised as: developing awareness and understanding, signalling acceptance, and improving service delivery.

Developing awareness and understanding

All NHS Trusts should already have policies which prevent harassment or discriminatory treatment of clients or staff on a range of grounds, including sexual orientation. If these are not in place, midwives can use the appropriate channels to make sure they are developed. It is more likely, however, that such policies are in place but are not well known or understood; or perhaps their application to daily working life is obscure. In particular, midwives should discuss with their colleagues how best to handle anti-lesbian remarks or behaviour from other clients. It is not always easy to challenge these in ways that are constructive and that do not further isolate lesbian clients; it is important that the unit as a whole develops a coherent approach to such incidents, *before* they arise.

Midwifery managers should also identify and address staff training needs. It may be useful to host a visit from local lesbian mothers prepared to talk about their experiences, but this should not be done without adequate preparation to ensure the visitors' confidentiality and dignity. It may also be helpful to keep informed about relevant local and national services.

Signalling acceptance

Health-care professionals should be careful with their use of language. Terms such as 'partner', 'parent' and 'sex' may mean different things to the woman and her midwife. Midwives should also resist the temptation to take refuge in hints or euphemisms, such as 'special friend'. These may be perceived as offensive – unless the midwife is echoing terms which the woman herself has chosen to use and clearly feels comfortable with. Taking the initiative to signal openness to sexual diversity – for example by asking if the woman has a partner, and then asking for 'his or her' name – is more likely to encourage women to be open about their sexuality than forcing them to contradict an assumption.

Most important of all, perhaps, is the need to ensure that co-parents and partners are acknowledged and welcomed. It is easy to create an environment that acknowledges sexual (and other) diversity. For example, midwives can include female couples in waiting area displays of 'parent and baby' photos, and stock leaflets from lesbian support groups.

Improving service delivery

'Booking' forms, information sheets, and other documentation used in maternity services should

all be checked to ensure that they are not perpetuating narrow assumptions which may cause clients discomfort, for example, by assuming that the woman's partner is necessarily the baby's father.

All staff should understand the appropriate use of terms such as 'next of kin', 'partner' and 'family'; clients should be explicitly asked who will be supporting them and who should be given information. Lesbian co-parents should not have to argue or justify themselves to gain information about their partner or child.

Antenatal parent education is an area of particular concern, as this survey shows. Few communities will boast a critical mass of pregnant lesbians large enough to justify dedicated groups. Many women, however, may appreciate the option of women-only antenatal classes, and this service could be offered more widely. Antenatal teachers may benefit from specific training to help them identify how to signal acceptance, and achieve inclusion, of women from all forms of family. This should address the issue of possible hostility from other group members, and emphasise the importance of *not* expecting lesbian mothers to educate everyone around them.

Appropriate care for lesbian mothers is not a fringe issue, but an affirmation of woman-centred care. Midwives should take pride in their ability to welcome and respond to diversity, and should welcome opportunities to develop their skills in providing effective care to *all* women, whatever their background and life choices. We should all take a lead in challenging discriminatory language and behaviour, however covert or subtle, positively and constructively. This should not be left to 'the radicals', or to lesbian colleagues; creating a safe environment for clients and colleagues is intrinsic to good midwifery practice.

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