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Title Page

Research priorities within LGBTQIA+ perinatal care: results of a priority setting partnership

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34 **Abstract**

35 **Background:** LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual or other
36 minority sexual orientations or gender identities) people are less likely to engage in healthcare and
37 may have worse perinatal experiences and outcomes.

38 **Methods:** The aim was to collaboratively identify and prioritise research uncertainties about fertility,
39 pregnancy, birth and the postnatal period for LGBTQIA+ people in the United Kingdom.

40 The established James Lind Alliance methodology for a priority setting partnership was followed.

41 This comprised creation of a collaborative steering group, two cross-sectional surveys, an evidence
42 check and a consensus prioritisation workshop. Those contributing to priority setting were LGBTQIA+
43 people and perinatal health professionals. Outputs of the process were the formation of summary
44 research questions followed by their prioritisation.

45 **Results:** 366 participants (131 health professionals) submitted 1166 questions in the initial
46 consultation survey. Of 48 summary questions formed, one was considered answered by existing
47 evidence (long-term outcomes for children from LGBTQIA+ families). 214 participants (73 health
48 professionals) ranked the remaining 47 summary questions in the subsequent shortlisting survey,
49 facilitating the steering group's selection of questions to take to a final prioritisation workshop. The
50 Top 20 ranking was produced by this workshop and questions 21 to 24 were additionally ranked with

reference to the second survey. The top research uncertainty identified was “How do healthcare responses to LGBTQIA+ people’s intersectional identities affect whether they can become parents and have good perinatal care? (For example, those who may be subjected to disable-ism, fatphobia, racism or faith-based discrimination). What are the barriers to improving this?”. Topics for the subsequent five research uncertainties were: inclusive care, health professional training, impact of puberty blockers and gender affirming hormones on perinatal outcomes, mental health support, and perinatal outcomes for LGBTQIA+ people.

Conclusions: This Priority Setting Partnership identified the Top 24 research uncertainties in LGBTQIA+ perinatal care. Researchers are encouraged to use these questions to design future research. Clinicians are encouraged to use the questions to better understand and improve perinatal care for LGBTQIA+ people. These actions will contribute to reduced inequalities in perinatal outcomes and healthcare experiences for LGBTQIA+ people.

Keywords: Perinatal, Priority setting, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual

List of abbreviations:

LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other minority sexual orientations or gender identities

UK – United Kingdom

CQC – Care Quality Commission

LGB+ - Lesbian, Gay, Bisexual and other minority sexual orientations

PSP – Priority Setting Partnership

JLA – James Lind Alliance

PICOS – patient, intervention, comparator, outcome, study design

PEO – population, exposure, outcome

Declarations:

Ethics Approval

Ethics approval has been deemed unnecessary according to United Kingdom national regulations (NHS Health Research Authority). This is demonstrated by the NHS Health Research Authority Decision Tool. This is because PSPs involve research planning with stakeholder consultation rather than the conduct of direct research. They do not involve any change to treatment/care/services and are not designed to produce transferable findings to any other context. Informed consent was obtained from all participants in the surveys and workshop. The study adhered to the Declaration of Helsinki.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests

Several authors represented LGBTQIA+ community organisations on the project steering group: LGBT Foundation (AM), LGBT Mummies (LRT), and Transparent Change (JS).

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Authors' contributions

IL conceived of the project and led the planning/implementation. She contributed to analysis and evidence review and wrote the first draft of the manuscript. IL was the project lead

MG performed the primary analysis and evidence review. They contributed to project planning/implementation and reviewed the manuscript. MG was the co-Information Specialist for the project and a non-voting member of the steering group

CMe supported the primary analysis and evidence review. She contributed to project planning/implementation and reviewed the manuscript. CMe was the co-Information Specialist for the project and a non-voting member of the steering group

EKZ coordinated the planning and implementation of the project. They contributed to analysis and reviewed the manuscript. EKZ was the project coordinator and member of the steering group

LRT contributed to project planning/implementation and analysis. She reviewed the manuscript. LRT was the engagement lead and member of the steering group

The following authors contributed to project planning/implementation and analysis, reviewed the manuscript and were members of the steering group: AB, JS, NB, AM, DJC, MA, ZD

CMA contributed to project planning/implementation and analysis and reviewed the manuscript. CMA was the James Lind Alliance adviser for the project, overseeing the use of priority setting methodology; supporting the project lead and coordinator; and chairing the steering group meetings

JM contributed to project planning/implementation and analysis. She coordinated the project finances and reviewed the manuscript. JM was an adviser to the steering group

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contributions. Thanks also to the project advocates and partners who shared information about the surveys and workshop and supported people to contribute, particularly Ad'iyah and Cysters.

Background

Annual representative maternity experience surveys in the United Kingdom (UK) show rising numbers of lesbian, gay and bisexual (LGB+) people giving birth (1.3% of births in 2013 and 3.7% in 2024)¹. This may be partly due to increasing publicly funded availability of assisted reproduction for lesbian women as recommended by the Department of Health and Social Care Women's Health Strategy for England² and also due to the increasing number of younger LGB+ people disclosing their identity³. The number of birthing people whose gender is different to their sex assigned at birth has also risen from 0.6% in 2021 (when this question was first included) to 1.6% in 2024¹. Therefore, approximately 1 in 20 birthing people in the UK are likely to be lesbian, gay, bisexual, transgender, queer or other minoritised sexual orientation/gender identity (LGBTQIA+), whether or not they are 'out' to their health providers.

To the best of the authors' knowledge, there are no equivalent data describing the frequency of perinatal experiences among LGBTQIA+ people globally. However, reports in multiple high-income countries show that pregnancy intentions and experiences are common⁴⁻⁶, and access to assisted reproduction for LGBTQIA+ people is increasing in many countries. The frequency with which minoritised sexual orientations/gender identities are disclosed has also seen similar increases over time in high-income countries^{7,8}, and the trend of increased disclosure among younger people is seen globally⁹.

Limited evidence from the USA suggests LGBTQIA+ people experience higher rates of miscarriage¹⁰, stillbirth¹⁰, very premature birth,¹⁰ and postnatal mental health problems¹¹. Perinatal research and clinical care overwhelmingly assume that their population are cisgender heterosexual women with

male partners^{12,13}. However, some areas, such as assisted reproduction when both partners have the same type of gametes, are very different for LGBTQIA+ people.

LGBTQIA+ people are less likely to engage with healthcare, including perinatal services, because of the structural exclusion and discrimination they face within healthcare and wider society^{11,13–17}.

Healthcare avoidance or delay is known to cause worse outcomes¹⁷. There is a paucity of research about LGBTQIA+ perinatal health^{14,18,19} and a risk that future research may not align with the values or priorities of LGBTQIA+ people²⁰. The UK National Institute for Health and Care Research has recently issued guidance about the importance of considering sex and gender in health research²¹.

Priority Setting Partnerships (PSPs) bring together those who benefit from research (patients and health professionals) to collaboratively identify and prioritise questions not adequately answered by research^{22,23}. This helps focus future research on the questions that are most important to those affected, demonstrates to funders that proposed research is informed by service users, and may encourage potential research participants to take part.

The objective of the LGBTQIA+ Perinatal Care PSP was to identify, prioritise and disseminate research questions concerning LGBTQIA+ fertility, pregnancy, birth and the postnatal period. The PSP aimed to ensure that the process was carried out by those with lived/living experience and health professionals, working together in partnership.

Methods

The PSP used James Lind Alliance (JLA) methodology; establishing a collaborative steering group, two cross-sectional surveys, an “evidence check” and a consensus-building workshop.

Steering Group

A steering group, chaired by a JLA adviser (CMA), included people with lived/living experience of LGBTQIA+ perinatal care and health professionals (many of whom were also LGBTQIA+). Seven

members primarily represented those with lived experience, including four LGBTQIA+ community and voluntary sector organisations. There were six health professionals, working in midwifery, infant feeding, public health and neonatology. Three additional members were non-voting (CMe, JM, MG) and brought relevant academic experience, including the information specialists (CMe and MG). There were lesbian, gay, bisexual, transgender, non-binary, queer and intersex members. Several members were disabled and neurodivergent and several were from racialised minority backgrounds. The project coordinator (EKZ) and engagement lead (LT) contributed expertise through lived experience, and the project lead was a neonatologist (IL). The steering group met approximately monthly between April 2024 and September 2025. Payment was offered for time for lived experience members who were not attending in a clinical or academic capacity. The steering group agreed and published terms of reference and a protocol²⁴.

Scope

The project focused on the physical, mental and social health and care needs of LGBTQIA+ people attempting to conceive, during pregnancy, birth and the year after birth; the relevant UK healthcare systems; and those working with these populations/in these healthcare systems. This included lactation, early parenting, adoption in infancy, perinatal loss and termination of pregnancy. The in-scope population comprised people in the UK who are or have ever identified as LGBTQIA+, and non-LGBTQIA+ people whose experience and/or outcomes may be affected by the (prospective) parent's LGBTQIA+ identity, such as infants, non-LGBTQIA+ partners or co-parents, gamete donors and surrogates.

The project did not cover sexual health that was unrelated to attempting conception or pregnancy (e.g., contraception); health conditions during the perinatal period that are unrelated to pregnancy, birth, lactation, or early parenting; adoption of a child/ren older than twelve months; infants with

differences of sexual development (intersex), or the impact of in-scope conditions or care pathways on out-of-scope individuals.

1. Gathering questions

An online survey was open from 10th October to 31st December 2024 (LimeSurvey, Hamburg, Germany). The scope of the PSP was outlined, and respondents were asked to submit questions they believed are currently unanswered (e.g., by their health professionals, in sources of trusted information, or through looking for evidence).

Respondents were eligible if they lived or worked in the UK and met one or more of the following criteria: currently or formerly LGBTQIA+; a perinatal health professional; a supporter of an LGBTQIA+ person (e.g. a family member or friend); a gamete donor; a surrogate. The survey and promotional materials were provided in English and Welsh, illustrated with images of LGBTQIA+ people and professionals who were diverse in gender presentation, family composition (including single individuals), and racialised minority appearance. Additional support with completing the survey could be requested by prospective participants via a form on the project website. Written information was provided on how to use free web-based services to translate the survey into other languages, but no direct translation or interpretation services were offered apart from the Welsh language survey.

The survey invitation was publicised by LGBTQIA+ organisations, community networks and perinatal professional organisations. Project partners included LGBTQIA+ people and organisations and relevant professional associations (e.g. the Royal College of Midwives). Two advocacy organisations were funded to provide online events to explain the project and provide support with survey completion to potential participants from racialised ethnic backgrounds.

2. Question processing

The information specialists (CMe and MG) classified submitted questions as within or out of scope, overseen by the steering group. In-scope questions were grouped thematically and similar questions within themes were aggregated into summary questions. With iterative reference to the complete question set, the information specialists refined these summary questions in small group sessions with at least one lived experience and one professional steering group member in each.

The information specialists performed an “evidence check” to determine whether any of the summary questions had already been adequately answered by research. The “evidence check” is not a formal systematic review, as PSP scope areas are generally too broad to survey in this way. The JLA defines the process as identifying whether any up-to-date, reliable systematic review of research evidence (or other evidence source considered robust by the steering group) exists to address each summary question, such that the summary question would be considered answered. Searches were conducted between March and June 2025 across bibliographic databases, internet search engines and professional guidelines repositories (fully described in the publicly available JLA Question Verification documentation²⁴). Full-text English language reports of primary research or systematic reviews were eligible for the “evidence check”. Any summary questions considered answered were omitted from subsequent prioritisation stages.

3. Interim prioritisation

A second online survey (LimeSurvey, Hamburg, Germany) was open between 23rd May to 9th June 2025, disseminated similarly to the first survey, but only available in English (as no Welsh language responses were received in the first survey). The survey presented unanswered summary questions in random order and asked respondents to select all questions that were important to them. If respondents chose more than ten summary questions, they were subsequently asked to choose the ten questions that they found most important.

The number of 'votes' received for each summary question, through inclusion in an individual's top ten, were summed to create collective rankings. Where several questions had identical ranking, all were assigned the same rank, which was the mean of the number of ranks that were identical. Collective rankings were identified for all respondents and also for six specific sub-groups, some of which were overlapping: LGBTQIA+ people (not also health professionals); LGBTQIA+ health professionals; health professionals (not also LGBTQIA+); transgender and non-binary respondents; respondents from racialised minority backgrounds; and gamete donors or surrogates. These sub-groups were defined in order to ensure that the views of minority groups were not obscured by the majority, and to gain insight into the homogeneity or heterogeneity of prioritisation by people with different perspectives and experiences. The Steering Group used these rankings to select summary questions to take forward to the priority setting workshop, taking account of the need to represent the interests of different parts of the LGBTQIA+ community by considering the top ten priorities of each sub-group. The JLA adviser initially recommended that 18 questions be taken forward to the workshop. However, consideration of the interim ranking resulted in 24 questions being identified as of higher importance than the remaining questions. Upon advice from the JLA adviser, 20 of these were chosen to take forward to the workshop as a maximum number that could be discussed in the time available and the remaining four were placed in ranked order based on the interim prioritisation results.

4. Final Prioritisation

A prioritisation workshop was held online in two three-hour sessions in July 2025, to agree final priority rankings for the 20 summary questions taken forward to this stage. Expressions of interest were invited from those who provided contact information during the surveys, from people known to steering group members and by promotion on social media. Participants were selected from the information provided on the expression of interest by the PSP lead and coordinator to have

balanced representation from people with lived experience and health professionals, and diversity of type of perinatal experience, identity, disability, and racialised minority background. Three JLA advisers facilitated the workshop, led by the LGBTQIA+ Perinatal Care PSP JLA adviser (CMa). A perinatal psychologist was available throughout the workshop to support any participants experiencing distress related to participation. Participants with lived experience were compensated for their time (£25 per hour) and childcare expenses were available.

The workshop used nominal group and modified Delphi techniques²⁵, with participants working in small groups, each of which included people with a range of professional and lived experiences. Prior to the workshop, participants were sent the 20 questions and asked to select their own top three and bottom three priorities. During the first session, each small group discussed these personal priorities and agreed a group prioritisation of the 20 questions.

The priority lists from the small groups in the first session were combined by equal weighting to form a provisionally ranked top 20. During the second session, three groups with a different assortment of participants considered whether changes in question order were needed to reflect their group's priorities and these revised lists were again combined by equal weighting to form the final prioritised top 20 questions.

Results

Figure 1 presents the flow of participants and research questions over the four phases of the project.

[Figure 1]

1. Gathering questions

A total of 1,166 questions were submitted by 366 survey respondents. Their characteristics are presented in Table 1. The majority of respondents described themselves as LGBTQIA+ (n=302, 82.5%) and female (n=284, 79.6%). Forty-six respondents were from racialised minority

backgrounds (13.0%) and 109 had a disability which affected daily living (30.4%). Of the 131 health professional respondents, half were midwives (n=55, 50.0%).

The mean number of questions submitted by LGBTQIA+ respondents who were not health professionals (n=226), by LGBTQIA+ health professionals (n=76), and by health professionals who were not LGBTQIA+ (n=55) was 4.4, 3.7, and 2.7, respectively.

2. Question processing

A total of 82 questions were deemed out of scope. These included questions that were not about perinatal care or that were not specific to LGBTQIA+ people. The remaining questions contributed to the formation of 48 summary questions. One summary question was removed after the “evidence check”: “What are the long-term physical, emotional and developmental outcomes for children from LGBTQIA+ families?”. The evidence identified to support the decision that this summary question is answered is presented in the publicly available JLA Data Management Spreadsheet²⁴. Additional Table 1 lists the remaining 47 summary questions and how many individual questions contributed to each one. Short accessible summaries of the evidence found for each summary question are available on the PSP website²⁶.

3. Interim prioritisation

The second survey elicited 214 responses (Table 1). The majority described themselves as LGBTQIA+ (n=178, 83.2%) and female (n=152, 71.4%). There were 28 respondents from racialised minority backgrounds (n=28, 13.1%). Of the 73 health professional respondents, the largest single group were midwives (n=34, 46.6%).

Table 2 presents each sub-group’s ranking of the 20 questions taken to the final workshop and the four additional questions that could not be taken to the workshop due to time constraints. The sixth

sub-group is not reported here due to low numbers (n=6 gamete donors/surrogates). The same data for all 47 questions are included in Additional Table 1.

The primary criterion used to identify the most important summary questions was inclusion in the top ten of at least one sub-group. This yielded 21 summary questions. Three additional summary questions were also considered as of increased importance due to the number of original questions submitted on the topic (finding information), potential stigma interfering with prioritisation (abortion) and prevalence in policy and practice agendas (bonding), giving a pool of 24 summary questions of higher importance. Given the large variability in ranking between the sub-groups, there was no simple rule available to choose the 20 summary questions to take forward to the final prioritisation workshop, however any summary question ranked in the top 10 by at least three sub-groups was automatically selected (n=8). When deciding which other summary questions to take to the final workshop, consideration was given to how many sub-groups had ranked them highly, while avoiding questions with extensively overlapping scope. The four questions that were not selected for the final workshop were ranked as priorities 21 to 24 using the rank order for the appropriate subgroup.

4. Final prioritisation

The final workshop included 20 participants: 11 with lived experience and nine health professionals (many of whom also had lived experience). Professionals were from the following specialties: obstetrics, midwifery, infant feeding, fertility medicine/gynaecology, nursing, mental health, doula practice. Nine participants were from racialised minority backgrounds, and several shared that they were neurodivergent and/or had disabilities.

Table 3 presents the final top 20 summary questions in the prioritisation order decided by the workshop participants, as well as summary questions 21 to 24 described above. The top research uncertainty identified was “How do healthcare responses to LGBTQIA+ people’s intersectional

identities affect whether they can become parents and have good perinatal care? (For example, those who may be subjected to disable-ism, fatphobia, racism or faith-based discrimination). What are the barriers to improving this?”. Other areas in the top six research uncertainties were LGBTQIA+ inclusive care, training for health professionals, the impact of puberty blockers and gender affirming hormones on perinatal outcomes, optimising mental health support, and perinatal outcomes for LGBTQIA+ people.

Feedback was invited from workshop participants by the JLA on the workshop process. Ten participants (83%) agreed with the following statements, whereas two (17%) disagreed: “Everyone was encouraged to join in with the discussions equally”, “the workshop facilitators were fair and neutral”. Nine (82%) agreed that the process of agreeing the top ten was fair and robust, while one disagreed (9%). Most participants submitted positive comments about their experience but some reported concerns about whether some participants’ contributions were valued more highly than others (specifically health professionals and white participants). These comments will be reported in full in a separate planned discursive publication. This feedback triggered a review of the final prioritisation against the survey sub-group prioritisation presented above. The level of agreement between the final prioritisation and prioritisation of marginalised groups in the survey was felt by the steering group to be sufficient to proceed with the workshop results.

Discussion

Main Findings

This is the first attempt to collaboratively determine and prioritise research uncertainties in the important but neglected area of LGBTQIA+ perinatal care. The lack of robust research in the area was demonstrated by the fact that only one summary question had been adequately answered by research. Important areas for future research have been highlighted.

374 **Strengths and Limitations**

375 One strength of the project was the close attention paid to representation and accessibility at every
376 stage to reduce barriers to participation. Examples included Welsh translation, in-community
377 workshops and a contact form to facilitate support with surveys. The steering group itself provided
378 wide representation from different parts of the LGBTQIA+ community and those with intersectional
379 marginalisation, and the surveys were particularly successful in gaining responses from those with
380 disabilities, receiving income-dependent benefits and who reported living in poor/unsafe housing.

381 A further strength of the project was its wide reach, with more than 1000 initial questions
382 submitted. Questions spanned a wide variety of subjects. This meant that the summary questions
383 cross medical specialties, academic areas and areas of lived experience, including topics with
384 societal and legal significance such as taking leave from work and parental titles on birth
385 certificates.

386 An inherent weakness of the JLA process (particularly when limited financial resource is available) is
387 that the results are dependent on who is reached by the surveys, and particularly who is able to join
388 the final workshop. Given the large number of different sexual orientations and gender identities
389 under the LGBTQIA+ umbrella, the diversity of professionals involved in perinatal care and the
390 importance of intersectionality, it was impossible to have full representation in the final workshop,
391 and this will have influenced the ranking.

392 Despite our efforts, the surveys did not get responses from as many people from racialised minority
393 backgrounds or deprived backgrounds as would be expected in an unselected perinatal population,
394 and there may have been people with communication/intellectual difficulties who were excluded
395 by the survey formats and the way they were promoted and disseminated. Translation of written
396 material into more languages, increased use of interpretation services, easy read resources and
397 increased intensity of proactive outreach to those with potential communication difficulties over a
398 longer period of time might have helped to improve this. However, half of workshop participants

were from racialised minority backgrounds, a purposeful decision to address the potential impact of racial privilege on power dynamics during group prioritisation. Considering the specific rankings of sub-groups of respondents to the second survey also ensured that the views of some marginalised groups were not obscured by the majority.

A further weakness of the JLA approach is that ranking research questions introduces an element of competition between disparate topics. This involves particular cultural assumptions and complex ethical decision-making about, for example, whether topics that affect more people are more important than those that affect fewer people, or whether topics that have greater influence on an individual's experience and outcome are more important than those with smaller influence.

While the process was highly collaborative between people with lived experience and clinicians, clinicians were in the minority in the survey responses. This could be considered a strength or a limitation. Several other perinatal PSPs have experienced a similar imbalance towards those with lived experience^{23,27} whereas one experienced an imbalance towards health professionals²². Health professionals who were not LGBTQIA+ also submitted fewer questions than LGBTQIA+ respondents. This may represent a relative lack of insight of some clinicians into the needs and experiences of LGBTQIA+ people, which supports the necessity of this kind of process.

Interpretation

The wide range of question topics and the divergence in rankings of the summary questions between different sub-groups demonstrates the impact of different perspectives and shows why collaborative projects such as this are important. The fact that the impact of intersectional marginalisation was the highest ranked question may reflect some success in ensuring that the voices of those who are more rarely reached by research projects were heard. Our decision to present four additional questions that could not be considered within the time constraints of the workshop was also made to ensure that the voices of numerically smaller sections of the population

are not downplayed. JLA questions are not designed to be precise structured research questions that follow established frameworks, such as a patient, intervention, comparator, outcome, study design (PICOS) or population, exposure, outcome (PEO) format. It is intended that researchers will use these overarching questions to develop more precise questions for conducting research of the most appropriate type.

Conclusion

This PSP has identified a list of the top 24 collaboratively prioritised research uncertainties in the area of LGBTQIA+ perinatal care using the widely accepted JLA process. Given the increasing numbers of LGBTQIA+ people experiencing perinatal care in the UK and globally, this is a vital springboard to direct future research to start to reduce inequalities in experience and outcomes. Research teams are encouraged to use the top 24 and all the submitted questions to choose and design future research projects. Clinicians are encouraged to use the results to understand the experience of LGBTQIA+ families and improve their care.

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Table/Figures

Figure 1: Priority Setting Partnership flow of participants and questions

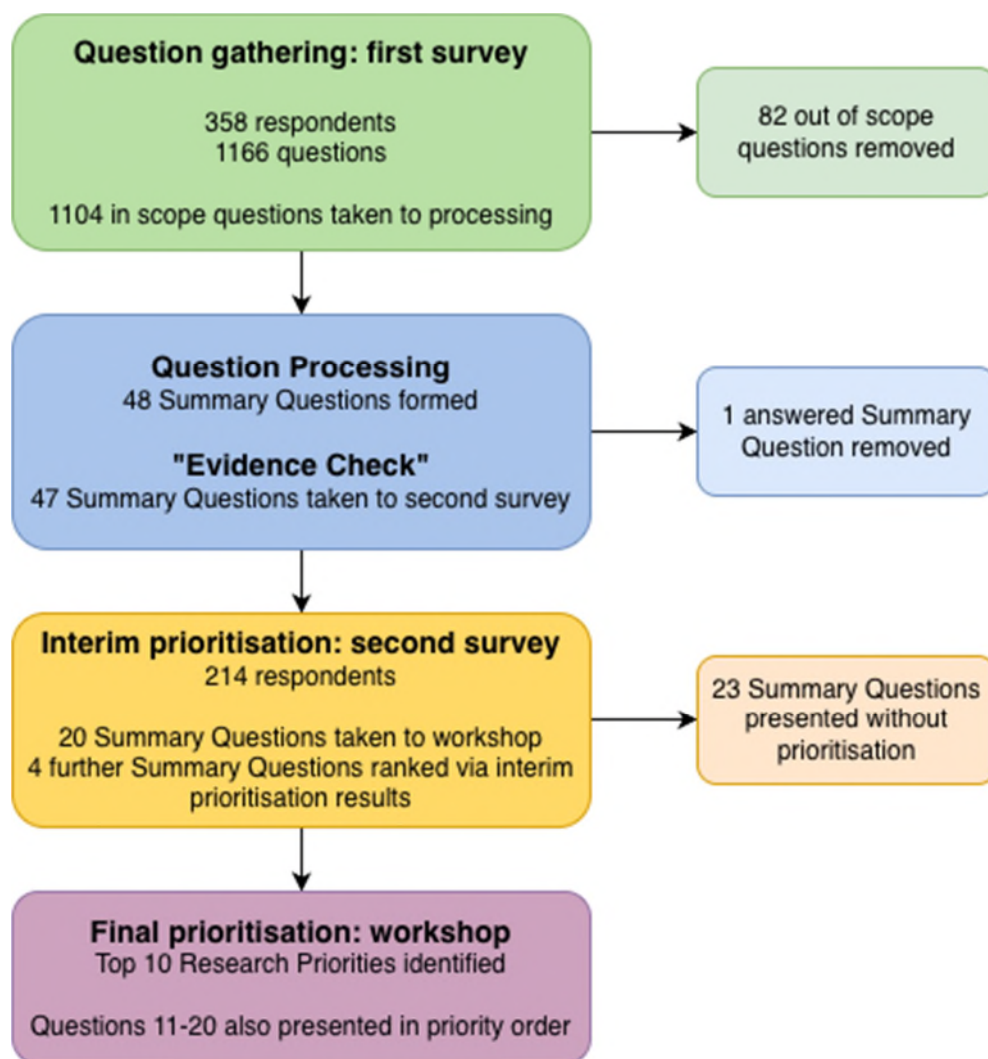


Table 1: Demographic information about respondents to the first and second surveys

Category	First survey; n (%)	Second survey; n (%)
Eligibility question* (multiple options could be selected)	N=366	N=214
LGBTQIA+	302 (82.5)	178 (83.2)

Healthcare professional	131 (35.8)	74 (34.6)
Friend/family/supporter	78 (21.3)	51 (23.8)
Gamete donor or surrogate	6 (1.6)	6 (2.8)
Sexual Orientation** (multiple options could be selected)	N=349	N=214
Lesbian	154 (44.1)	67 (31.3)
Gay	17 (4.9)	11 (5.1)
Bisexual	73 (20.9)	52 (24.3)
Pansexual	39 (11.2)	23 (10.7)
Queer	68 (19.5)	48 (22.4)
Asexual	11 (3.2)	3 (1.4)
Other minority sexual orientation	6 (1.7)	7 (3.3)
Heterosexual	44 (12.6)	28 (13.1)
Gender	N=357	N=210
Female	284 (79.6)	152 (71.4)
Male	17 (4.8)	12 (5.7)
Non-binary	50 (14.0)	35 (16.7)
Other gender identity	6 (1.7)	11 (6.2)
Transgender and/or non-binary	N=70	N=51
Trans woman/transfeminine	5 (7.1)	3 (5.9)
Trans man/transmasculine	9 (12.9)	4 (7.8)
Non-binary	51 (72.9)	36 (70.6)
Other (including agender, genderqueer, gender fluid)	5 (7.1)	8 (15.7)
Intersex	5/349 (1.4)	Not asked
Healthcare professional role, including students	N=110	N=73
Midwife	55 (50.0)	34 (46.6)
Doctor/nurse practitioner	28 (25.5)	16 (21.9)

Nurse/healthcare assistant/infant feeding specialist/allied health professional	16 (14.5)	12 (16.4)
Psychologist/psychotherapist	10 (9.1)	3 (4.1)
Other profession	1 (0.9)	8 (11)
Age	N=357	N=211
<25 years	30 (8.4)	11 (5.2)
25 to <35 years	144 (40.3)	89 (42.2)
35 to <45 years	134 (37.5)	84 (39.8)
≥45 years	49 (13.7)	27 (12.8)
Ethnic background*** (multiple options could be selected)	N=354	N=214
Black, Caribbean, African	11 (3.1)	13 (6.1)
East Asian	3 (0.8)	0
South Asian	10 (2.8)	6 (2.8)
White	321 (90.7)	187 (87.4)
Other	20 (5.6)	19 (8.9)
Country of residence	N=358	N=209
England	296 (82.7)	182 (87.1)
Scotland	36 (10.1)	21 (10.0)
Wales	23 (6.4)	5 (2.4)
Northern Ireland	3 (0.8)	1 (0.5)
Lives in an area that feels unsafe or poor housing	39/291 (13.4)	18/213 (8.5)
Has a disability affecting daily living	109/350 (31.1)	Not asked
Receives income-dependent state benefits	39/289 (13.5)	Not asked

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542 *N = denominator for the specific category. *The eligibility question was presented before the*
543 *question submission stage of the first survey, and before the prioritisation stage of the second*
544 *survey, and was mandatory. The remaining demographic questions were presented after the*

freetext submission stage of the first survey, and after the prioritisation stage of the second survey, and were non-mandatory. **Although respondents could in principle select heterosexual and also minority sexual orientations, no respondents did so. ***In the first survey, there were 308 individuals who selected only white as a descriptor and 46 individuals who selected any racialised minority descriptor, either alone or in combination with white or another racialised minority descriptor. In the second survey, there were 186 individuals who selected only white as a descriptor and 28 individuals who selected any racialised minority descriptor, either alone or in combination with white or another racialised minority descriptor

Table 2: Top 24 unanswered Summary Questions demonstrating rank order within the interim prioritisation survey, by specified sub-groups. These are presented in order of interim prioritisation by LGBTQIA+ people who are not health professionals (the largest of the sub-groups presented). Further explanatory notes were included in the question wording for some questions but have not been presented here (full wording is provided in Table 3 and Additional Table 1). Green marks sub-group rank 1-10, yellow marks sub-group rank 11-15, blue marks sub-group rank 16-20

Provided as separate file

Table 3: Final ranking of the Top 24 Research Uncertainties within LGBTQIA+ Perinatal Care. The top 20 priority order resulted from the final collaborative workshop. The order of priorities 21 – 24 resulted from the interim prioritisation survey. Colour demonstrate the four quarters of the Top 24.

1. **Intersectional Identities:** How do healthcare responses to LGBTQIA+ people's intersectional identities affect whether they can become parents and have good perinatal care? (For example, those who may be subjected to disable-ism, fatphobia, racism or faith-based discrimination). What are the barriers to improving this?
2. **Inclusive Care:** What does LGBTQIA+ inclusive care look like? What models of perinatal care (for example, specialist midwives, LGBTQIA+ 'out' healthcare professionals, continuity of carer) work for LGBTQIA+ people?
3. **Training:** What training do healthcare professionals and their educators need about how LGBTQIA+ people become parents (including family creation, perinatal care and infant feeding)?
4. **Puberty Blockers and Gender Affirming Hormones:** How do puberty blockers and gender affirming hormones (both regulated and unregulated) affect fertility, pregnancies, the foetus, birth and postnatal healing?
5. **Mental Health:** What does good perinatal mental health support look like for LGBTQIA+ people, and is this different for gestational and non-gestational parents, or for people with different genders or gender identities?
6. **Outcomes:** Are perinatal outcomes different for LGBTQIA+ people, and are they affected by how someone attempted pregnancy or became pregnant? By perinatal outcomes we mean live birth rates, stillbirths and miscarriages; pregnancy, labour and birth complications; interventions to start labour or during labour; mode of birth; gestational parent/surrogate mortality rates; birth trauma; mental health; infant feeding, health, developmental and mortality outcomes
7. **Emotional Labour:** How much emotional labour are LGBTQIA+ people doing when accessing (or thinking about accessing) perinatal healthcare? How can this situation be improved? By emotional labour we mean the mental work people do in order to access services or meet someone else's needs. It might include giving explanations of how LGBTQ+ people conceive, answering homophobic comments, dealing with your own emotions when forms or systems don't fit your family, or thinking about any of these issues before making or going to an appointment.
8. **Inclusive Language Impact:** How does using inclusive language throughout any treatment, pregnancy and birth, healthcare encounters, and within the first year of a baby's life affect LGBTQIA+ families?
9. **Loss:** How does perinatal and reproductive loss affect LGBTQIA+ people's mental health and decisions about trying to conceive again? What are their experiences of support during perinatal loss, and how can this be improved? By perinatal loss we mean being unable to try to conceive (can't find a surrogate or donor, can't afford fertility treatment); not getting pregnant; miscarriage; stillbirth; death of a baby
10. **Geographical Location:** How does where LGBTQIA+ families are in the UK affect their access to reproductive options, and how are their decisions and experiences affected by this?

11. Healthcare Recommendations: How does the way LGBTQIA+ people got pregnant (home insemination, IUI, IVF with own egg, IVF with someone else's egg) affect healthcare recommendations (for example, obstetric-led care and induction of labour)? How do these recommendations affect parents and babies?
12. Abortion: What are LGBTQIA+ people's experiences of abortion and abortion support in the UK?
13. Information: Where do LGBTQIA+ people and healthcare professionals look for information about reproductive choices (including success rates, health, legal, financial and employment implications)? Is the information they get accurate, and how can access to information be improved, including from NHS sources?
14. Inducing Lactation: What are the most successful methods for inducing lactation in a non-gestational parent? What are the barriers to healthcare professionals providing lactation support to a non-gestational parent and how can these be overcome?
15. Timing of Gender Affirming Hormones: When planning a pregnancy, what are the right timings to pause and restart gender affirming hormones?
16. Surrogacy: What increases good experiences of care and good perinatal outcomes for surrogates and LGBTQIA+ people becoming parents through surrogacy?
17. Parental Titles on Birth Certificates: How do the parental titles on birth certificates affect LGBTQIA+ parents?
18. Inclusive Language Competence: How confident and competent are perinatal staff in using up to date LGBTQIA+ inclusive language, and how can this be improved?
19. Bonding: What are the similarities and differences for gestational and non-gestational LGBTQIA+ parents bonding with their baby, and how can bonding be maximised?
20. Leave from Work: What are LGBTQIA+ people's experiences of taking leave from work when trying to conceive, during pregnancy or as new parents?
21. Experiences of Gender: How do transgender parents' experiences of their gender in the perinatal period affect their relationship with their baby?
22. Lactation experience and impact: What are non-gestational parents' experiences of inducing lactation, and/or sharing lactation? What are the effects on the parents, and on the baby who is drinking induced milk?
23. Written Language: How often is written language (for example, letters, forms and policies) used by perinatal services inclusive or exclusive of LGBTQIA+ people? How can institutions keep up to date with inclusive language?
24. Sperm Donor Diversity: How can the number and range of sperm donors available to LGBTQIA+ people be increased, including those from racialised ethnic backgrounds?

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Table 1: Top 24 unanswered Summary Questions demonstrating rank order within the interim prioritisation survey, by specified sub-groups. These are presented in order of interim prioritisation by LGBTQIA+ people who are not health professionals (the largest of the sub-groups presented). Further explanatory notes were included in the question wording for some questions but have not been presented here (full wording is provided in Table 3 and Supplementary Table 1). Green marks sub-group rank 1-10, yellow marks sub-group rank 11-15, blue marks sub-group rank 16-20

	Combined ranking by sub-group				
	LGBTQIA + and not HCP (n=133)	LGBTQIA + and HCP (n=45)	HCP and not LGBTQIA + (n=29)	Trans/ non-binary (n=53)	Racialised minority (n=28)
Summary questions with at least one demographic group Top 10 ranking:					
What does LGBTQIA+ inclusive care look like? What models of perinatal care (for example, specialist midwives, LGBTQIA+ ‘out’ healthcare professionals, continuity of carer) work for LGBTQIA+ people?	1	1	10	1	2
What does good perinatal mental health support look like for LGBTQIA+ people, and is this different for gestational and non-gestational parents, or for people with different genders or gender identities?	2	4	2	3.5	3
Are perinatal outcomes different for LGBTQIA+ people, and are they affected by how someone attempted pregnancy or became pregnant?	3.5	2	1	2	4.5
How much emotional labour are LGBTQIA+ people doing when accessing (or thinking about accessing) perinatal healthcare? How can this situation be improved?	3.5	18	17	9	15
What are LGBTQIA+ people’s experiences of taking leave from work when trying to conceive, during pregnancy or as new parents?	5	29.5	22	10	4.5
How do healthcare responses to LGBTQIA+ people’s intersectional identities affect whether they can become parents and have good perinatal care? What are the barriers to improving this?	6	15	17	5	1
How does where LGBTQIA+ families are in the UK affect their access to reproductive options, and how are their decisions and experiences affected by this?	7	38.5	28	17	6
How confident and competent are perinatal staff in using up to date LGBTQIA+ inclusive language, and how can this be improved?	8	9	6.5	7.5	20.5
How do the parental titles on birth certificates affect LGBTQIA+ parents?	9	36.5	11.5	13.5	15
What training do healthcare professionals and their educators need about how LGBTQIA+ people become parents (including family creation, perinatal care and infant feeding)?	10	9	3.5	22.5	9
How often is written language (for example, letters, forms and policies) used by perinatal services inclusive or exclusive of LGBTQIA+ people? How can institutions keep up to date with inclusive language?	11	18	13.5	7.5	38
Where do LGBTQIA+ people and their healthcare professionals look for information about reproductive choices (including success rates, health, legal, financial and employment implications)? Is the information they get accurate, and how can access to information be improved, including from NHS sources?	12	11.5	28	19	25
How does the way LGBTQIA+ people got pregnant (home insemination, IUI, IVF with own egg, IVF with someone else’s egg) affect healthcare recommendations (for example, obstetric-led care and induction of labour)? How do these recommendations affect parents and babies?	13	6.5	11.5	26.5	31.5
What are the similarities and differences for gestational and non-gestational LGBTQIA+ parents bonding with their baby, and how can bonding be maximised?	14	22.5	22	26.5	25
How does perinatal and reproductive loss affect LGBTQIA+ people’s mental health and decisions about trying to conceive again? What are their experiences of support during perinatal loss, and how can this be improved?	16	26	17	22.5	9
How do puberty blockers and gender affirming hormones (both regulated and unregulated) affect fertility, pregnancies, the foetus, birth and postnatal healing?	16	3	6.5	3.5	9
How can the number and range of sperm donors available to LGBTQIA+ people be increased, including those from racialised ethnic backgrounds?	18	33.5	42.5	22.5	9
How does using inclusive language throughout any treatment, pregnancy and birth, healthcare encounters, and within the first year of a baby’s life affect LGBTQIA+ families?	20	22.5	8.5	29.5	20.5
When planning a pregnancy, what are the right timings to pause and restart gender affirming hormones?	22.5	5	22	6	20.5
What are the most successful methods for inducing lactation in a non-gestational parent? What are the barriers to healthcare professionals providing lactation support to a non-gestational parent and how can these be overcome?	25	6.5	3.5	16	15
What are LGBTQIA+ people’s experiences of abortion and abortion support in the UK?	33	18	17	13.5	25
What increases good experiences of care and good perinatal outcomes for surrogates and LGBTQIA+ people becoming parents through surrogacy?	36	29.5	8.5	34.5	31.5
How do transgender parents’ experiences of their gender in the perinatal period affect their relationship with their baby?	36	9	34	13.5	9
What are non-gestational parents’ experiences of inducing lactation, and/or sharing lactation? What are the effects on the parents, and on the baby who is drinking induced milk?	39	13.5	5	37.5	15

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [AdditionalTable1.docx](#)