

# **Have we forgotten lesbian co-mothers during Covid? Two case studies showing the lack of policy consideration for breastfeeding co-mothers in maternity services.**

## **Abstract**

This article reports on two cases of lesbian non-gestational mothers whose breastfeeding intentions were disrupted by the postnatal-ward visitor restrictions imposed by NHS Trusts during the Covid-19 lockdowns in the UK. One case came to the attention of the author as part of a wider study using an online survey to examine experiences of birth during the first Covid-19 lockdown in April 2020. In the second case, the author was approached by the non-gestational mother for support in her capacity as a doula in April 2021. In both cases, the non-gestational mothers intended to breastfeed their babies, and had taken steps to ensure they were lactating, but the heterosexist restrictions for partners in the early postnatal period created complications that impacted their breastfeeding intentions. In the second case perinatal mental health care for previous birth trauma was also potentially indicated. Both non-gestational mothers also reported that they were not receiving antenatal support to overcome these difficulties, as they were mothers-to-be who were not pregnant.

---

Keywords: case report; lesbian; birth; breastfeeding; discrimination; Covid-19

## **Key points**

- In some same-sex families, the non-gestational mother may intend to breastfeed her baby, either alongside or instead of the gestational mother.
- During Covid-19, there were strict visitor restrictions to postnatal wards, which were based on heterosexist assumptions about infant feeding.

- This paper shows that these heterosexist policies caused significant distress, made access to lactation support difficult, and limited babies' access to human milk. Policies must be updated to reflect that some babies have two mothers, who may both wish to feed their baby.

## **Background**

Perinatal services are organised around the assumption that there will be one pregnant parent, who is a woman, and that the other parent will be a man, who lives with the woman, and is the father of the baby (Spidsberg 2007). These heteronormative assumptions can cause difficulties for all families who fall outside of this model, including single women, pregnant trans men and non-binary people, and pregnant women whose partner is also a woman. The literature shows that pregnant sexual minority women using perinatal services face both indirect homophobia (Dahl et al. 2013) such as inappropriate forms which only refer to one father and one mother (Röndahl et al. 2009). They may also face direct homophobia, which can include everything from refusing assisted conception services to lesbians (Spidsberg 2007), to physically rough vaginal examinations whilst in labour (Spidsberg 2007). Amongst sexual minority women, co-mothers may also be affected by heterosexism and homophobia. The literature shows that - similarly to sexual minority birth mothers - they may face exclusion either because organisational structures are heterocentric, or because of professional incompetence and homophobic attitudes from perinatal healthcare providers (Cherguit et al. 2013). Pandemics reinforce existing inequities within societies (Dingwall et al. 2013). This case report will demonstrate how the pandemic has reinforced has reinforced inequality for co-mothers in perinatal care.

The global coronavirus pandemic has affected expectant parents in the UK in several ways. Since March 2020, the antenatal support and restrictions attached to birth support that is offered by the NHS has changed repeatedly. Postnatal care has also been affected, with changes to the services available from the NHS and from private care. One aspect of these changes has been to limit the involvement of the non-birthing parent in antenatal appointments and scans, during the birth, and in postnatal visiting. These limits have come under scrutiny, with a national campaign entitled But Not Maternity campaigning for the limits on partner's involvement to be lifted in line with the lifting of

other Covid restrictions (Pregnant then Screwed 2020). The limits of non-birthing parents' attendance do not discriminate by gender. However, for some lesbian couples, it is not the birthing parent who is intending to be the breastfeeding parent, or not the sole breastfeeding parent. In these cases, the non-birthing parent may require direct antenatal support with lactation. If the baby needs to remain in hospital, the non-birthing parent may need to remain with the baby to feed them. In the restrictions imposed during the pandemic, no national guidance or NHS Trust policy has recognised that co-mothers have specific needs.

This article reports on two cases where the specific needs of lesbian co-mothers were not taken into account in the provision of perinatal services. Permission has been given by the mothers for the publication of this case report, which follows the CARE Guidelines (Riley et al. 2017).

## **Findings**

### **Demographics**

This article reports on the cases of two lesbian non-gestational mothers, and includes details about the gestational mother who is the partner to one of the non-gestational mothers. All have been given pseudonyms. The first, Ayesha, is a 28 year old Black African woman who completed an online survey run by the author in April 2020, which asked about new and expectant parents experiences of approaching birth during the first UK lockdown. Consent to the publication of the responses was obtained as part of the survey.

The second case discussed is Jane. Jane approached the author for support (in her capacity as a doula) in April 2021. Jane and her wife Joanne have one child already, who Jane gave birth to around 6 years ago. Joanne is currently pregnant with their second child. Further demographic information is not available for Jane or Joanne. Consent to the use of their data in the case study was obtained separately from both Jane and Joanne.

Due to the differences in how the cases came to the attention of the author, they will be relayed

separately.

## Contact summaries

### Case 1 – Ayesha

The full open questions and narrative responses provided by Ayesha in the online survey are shown below in Table 1.

*Table 1 - Survey responses from Ayesha, received April 2020*

Questions	Responses
Before the pandemic, what were your plans for birth?	Birth in labour ward. My partner has some medical complications which mean this is safest.  She won't be able to breastfeed. The plan was that I would stay in the hospital, and breastfeed. I have been following a lactation protocol.
Have your preparations for birth (such as attending antenatal classes, using a doula, having pregnancy massages) changed because of COVID-19?	I can't go to antenatal appointments any more, which means I can't talk to the midwives about me breastfeeding. I've got lots of questions but I can't speak to anyone to get answers.
What effect has it had on your plans for birth?	Not really on the birth, but on breastfeeding. I don't know what will happen. Will I be able to take the baby home after 2 hours - but that will leave my partner who has just given birth alone in the hospital. If I can express milk, will our baby be able to be cup fed milk? I don't think I'll be able to get the support I was going to get from the midwives postnatally

to breastfeed either, and I'm really worried. My partner can't breastfeed at all due to the medication she takes.

---

## Case 2 – Jane

Contact between Jane, her wife Joanne, and the author are summarized below in Table 2.

*Table 2 – Contact with Jane and Joanne*

Date	Summary of contact	Quotations from text messages
<u>Mid April</u>	<p>Jane contacts the author with a request for breastfeeding support. In her text she explains her breastfeeding intentions, and describes the local postnatal restrictions, which allow partners to remain with the parent who has given birth and their baby on the postnatal ward for only two hours after birth, to mitigate the Covid infection risk.</p> <p>During a subsequent zoom call Jane explains she is fearful that her wife (Joanne) would not be able to breastfeed, but that due to the Covid restrictions, their baby would then be given formula, rather than Jane being allowed to come back into the ward to breastfeed him. Formula was an unacceptable option to both Joanne and Jane. In the conversation it also emerged that Joanne had not been given information about how to introduce co-breastfeeding without endangering her milk supply. Jane had</p>	<p>“I have been pumping my breasts for months to relactate so I can breast feed our baby (potentially along side my wife, she isn't yet confident she can or not) who is due to give birth mid June. After she's healed from maternity leave I will be the main carer for the baby as I am with our other child I gave birth to... The covid restrictions for [the local] hospital are heartbreaking for me and causing me so much distress”</p>

---

not been offered appropriate support to re-lactate. Joanne has a medical condition which means a hospital birth is advisable. The mums had been given little information about how Joanne's medical condition might affect her birth choices, and no-one had made a postnatal or breastfeeding plan that included Jane.

In the course of the conversation, it became clear that both Jane and Joanne had a negative experience of the care Jane received postnatally, which had left both of them with some trauma. Joanne was uncomfortable with giving birth in the hospital, and Jane was very concerned about leaving her wife and baby alone in the hospital after birth. Previous birth trauma had not been considered for Joanne, because this was her first pregnancy. Jane did not appear to have been considered as a mum who might have experienced birth trauma, but rather as the partner of a primigravida. Self-referral routes were complicated as Jane was not allowed to attend midwife appointments with Joanne.

Early May After a meeting between Jane, Joanne and the Head of Midwifery, Jane texts the author a list of phrases used in the meeting, which she found difficult.

"No other lesbians or paternal parents have behaved the way you have"

"Your wife is fully capable to care for the baby, you trust her don't you, they'll be fine"

"Well you don't want to compromise your wives breast feeding journey or affect her milk levels?"

"Your wife's colostrum is more beneficial for baby than yours as you are regarded a donor, so you would be unfortunately the last resort"

Mid May It is agreed that Joanne can have a private room on the postnatal ward, and that Jane can remain with her and their baby after the birth.

24<sup>th</sup> May morning Joanne gives birth at 36 weeks. Jane is not allowed into the hospital, and misses the birth. Jane is informed that if she leaves the postnatal ward to go to the canteen for food, she will not be allowed to return.  
Both Joanne and Jane feed their baby on the postnatal ward.

24<sup>th</sup> May evening Later their baby is admitted to neonatal care to be treated for jaundice. A doctor working in NICU says the baby needs to be 'topped up' after Joanne has fed him, but Joanne is informed that Jane's milk is not appropriate. Jane is directly informed that she is not allowed to feed her baby. Their baby is given formula.

"Its been much nicer and calmer on the wards without partners coming and going ,the women have even said they prefer it this way"

"You'll be needed at home to look after your daughter won't you, won't she be needing her mum?"

"She said if I go to get food I'll have go home as exposed to covid"

"They told Jane my milk could make him poorly"

"They said they'll have to look in to whether its OK for me to feed as donor milk is normally tested and paturised [sic] and I'm a donor"

## **Discussion**

The written narratives from both Jane and Ayesha show mothers-to-be in a great deal of emotional distress. NHS antenatal services for lactation support do not always guarantee support for mothers-to-be who are not pregnant, but may have been provided on an ad hoc basis by individual midwives, or through peer-support (Farrow 2014). In the absence of face-to-face appointments that can include partners, these parents seem to have been left without services. The Covid-19 restrictions have exposed this gap in the structure of service provision, but this gap existed prior to and outside of the pandemic. It has also been highlighted in the recent creation of 26 new perinatal mental health 'hubs', where services for mothers experiencing mental health difficulties, birth trauma, or bereavement assume that they have themselves been pregnant (NHS England 2021).

There are complexities to reproductive journeys where both partners have the ability to become pregnant, give birth, or breastfeed that are not recognised by these policies. Two such complexities are shown in the cases of Ayesha and Jane. The first complexity is around infant feeding, where there is an assumption that breastfeeding will be carried out by the person who has given birth, and that if this does not happen, the baby will be bottle-fed infant formula. This situation could be resolved with an inclusive infant feeding policy, which made provision for co-mothers to breastfeed (Juntereal and Spatz 2019).

The second complexity is around emotional and psychological support. Ayesha's survey responses show emotional distress, and indicate a need for support during the antenatal period. Jane and Joanne's case demonstrate the effects of a previous negative birth experience, and potentially untreated birth trauma. The literature shows that when women have experienced a traumatic birth, they may disappear from perinatal services once discharged from midwifery care. Negative sequelae may or may not be treated by their GP practice. Frequently the birth trauma itself will not be addressed until the women reappear within perinatal services though, during a subsequent pregnancy. For families where both partners have the ability to conceive, this situation can become complex. In this case, the unresolved issues from Jane's early postnatal care were impacting both hers and Joanne's experiences in Joanne's pregnancies, but services were not available to Jane,

because she was not pregnant. Her experiences after Joanne had given birth of being denied access to her child and told that she was not a mother may have caused additional trauma, which services may not be experienced in resolving. The resolution to this complexity for families may be more complicated than the issue of infant feeding, as it requires policy makers and practitioners to redesign pathways into services that take account of non-heterosexual families. Importantly, it also highlights the need for consideration of non-heterosexual families across services, including as a minimum maternity, perinatal mental health and neonatal departments.

The cases which I have presented here have been limited by the restrictions of brief contact with the women. The report is limited to discussion of the data reported by the individuals, without triangulation from clinicians or medical notes. However, despite the difficulties inherent in such self-reports, these cases highlight the difficulties faced by non-gestational mothers when accessing perinatal services. Further work to examine the numbers of those affected by such difficulties, and to create policy and practice solutions is required.

### **Conclusions**

Heterosexist policies and practices within perinatal services presented difficulties for these two co-mothers during their partners' pregnancies. Co-mothers may need access to lactation support during the antenatal period, which may require new national policies around who is a patient within maternity care. Visitor policies for postnatal and neonatal wards need to take account of breastfeeding co-mothers. Perinatal mental health services need to take account of individuals who may have been both the pregnant parent, and the non-pregnant parent at different times during their reproductive history. Making these adjustments will prevent other parents from receiving the inadequate care that the case studies presented here demonstrate.

### **Reflexive questions**

1. Where do the services that I work within make heterosexist assumptions?
2. Where within my own practice might I make assumptions about sexual orientation, or parent's roles?

3. Can I undertake activities which improve the inclusivity of the services I work within?
4. Do I have the knowledge and skills to support a non-gestational mother who wishes to breastfeed?
5. How can I update my knowledge about LGBTQ+ parents' needs?

### **Acknowledgements**

My thanks to Ayesha, Jane and Joanne for sharing their experiences. Without their generosity, we could not improve services.

The research project which the first case study came via is funded via [redacted for peer review]

This project is also supported by [redacted for peer review]

### **References**

1. Spidsberg BD. 2007. *Vulnerable and strong -- lesbian women encountering maternity care. J Adv. Nurs.* 60(5):478-486
2. Dahl B, Fylkesnes AM, Sørli V, Malterud K. 2013. *Lesbian women's experiences with healthcare providers in the birthing context: a meta-ethnography. Midwifery.* 29(6):674-681
3. Rödahl G, Bruhner E, Lindhe J. 2009. *Heteronormative communication with lesbian families in antenatal care, childbirth and postnatal care. J Adv. Nurs.* 65(11):2337-2344
4. Cherguit J, Burns J, Pettle S, Tasker F. 2013. *Lesbian co-mothers' experiences of maternity healthcare services. MIDIRS Midwifery Digest.* 23(4), 448-448
5. Dingwall R, Hoffman LM, Staniland K. 2013. *Introduction: why a Sociology of Pandemics? Sociol. Health and Illn.* 35(2):167-173
6. *Pregnant Then Screwed.* 2020. Letter to Simon Stevens, 14<sup>th</sup> November. [Internet, accessed 14 June 2021] Available from: <https://pregnantthenscrewed.com/but-not-maternity/>
7. Riley DS, Barber MS, Kienle GS, et al. 2017. *CARE Explanation and Elaborations:*

*Reporting Guidelines for Case Reports. J Clin. Epidemiology, 89:218-235*

8. Farrow A. 2014. *Lactation Support and the LGBTQI Community. J Hum. Lact. 31(1):26-28*
9. NHS England. 2021. *New dedicated mental health services for new expectant and bereaved mums [Internet]. England.nhs.uk. [accessed 14 June 2021]. Available from: <https://www.england.nhs.uk/2021/04/dedicated-mh-services/>*
10. Juntereal NA, Spatz DL. 2019. *Same-Sex Mothers and Lactation. MCN American J Matern. Child Nurs. 44(3):164–169*

**Table 1** - *Survey responses from Ayesha, received April 2020*

Questions	Responses
Before the pandemic, what were your plans for birth?	<p>Birth in labour ward. My partner has some medical complications which mean this is safest.</p> <p>She won't be able to breastfeed. The plan was that I would stay in the hospital, and breastfeed. I have been following a lactation protocol.</p>
Have your preparations for birth (such as attending antenatal classes, using a doula, having pregnancy massages) changed because of COVID-19?	I can't go to antenatal appointments any more, which means I can't talk to the midwives about me breastfeeding. I've got lots of questions but I can't speak to anyone to get answers.
What effect has it had on your plans for birth?	<p>Not really on the birth, but on breastfeeding. I don't know what will happen. Will I be able to take the baby home after 2 hours - but that will leave my partner who has just given birth alone in the hospital. If I can express milk, will our baby be able to be cup fed milk? I don't think I'll be able to get the support I was going to get from the midwives postnatally to breastfeed either, and I'm really worried. My partner can't breastfeed at all due to the medication she takes.</p>

Table 2 - Contact with Jane and Joanne

Date	Summary of contact	Quotations from text messages
<u>Mid April</u>	<p>Jane contacts the author with a request for breastfeeding support. In her text she explains her breastfeeding intentions, and describes the local postnatal restrictions, which allow partners to remain with the parent who has given birth and their baby on the postnatal ward for only two hours after birth, to mitigate the Covid infection risk.</p> <p>During a subsequent zoom call Jane explains she is fearful that her wife (Joanne) would not be able to breastfeed, but that due to the Covid restrictions, their baby would then be given formula, rather than Jane being allowed to come back into the ward to breastfeed him. Formula was an unacceptable option to both Joanne and Jane. In the conversation it also emerged that Joanne had not been given information about how to introduce co-breastfeeding without endangering her milk supply. Jane had not been offered appropriate support to re-lactate. Joanne has a medical condition which means a hospital birth is advisable. The mums had been given little information about how Joanne's medical condition might affect her birth choices, and no-one had made a postnatal or breastfeeding plan</p>	<p>“I have been pumping my breasts for months to relactate so I can breast feed our baby (potentially along side my wife, she isn't yet confident she can or not) who is due to give birth mid June. After she's healed from maternity leave I will be the main carer for the baby as I am with our other child I gave birth to... The covid restrictions for [the local] hospital are heartbreaking for me and causing me so much distress”</p>

---

that included Jane.

In the course of the conversation, it became clear that both Jane and Joanne had a negative experience of the care Jane received postnatally, which had left both of them with some trauma. Joanne was uncomfortable with giving birth in the hospital, and Jane was very concerned about leaving her wife and baby alone in the hospital after birth. Previous birth trauma had not been considered for Joanne, because this was her first pregnancy. Jane did not appear to have been considered as a mum who might have experienced birth trauma, but rather as the partner of a primigravida. Self-referral routes were complicated as Jane was not allowed to attend midwife appointments with Joanne.

Early May After a meeting between Jane, Joanne and the Head of Midwifery, Jane texts the author a list of phrases used in the meeting, which she found difficult.

"No other lesbians or paternal parents have behaved the way you have"

"Your wife is fully capable to care for the baby, you trust her don't you, they'll be fine"

"Well you don't want to compromise your wifes breast feeding journey or affect her milk levels?"

"Your wife's colostrum is more beneficial for baby than yours as

		you are regarded a donor, so you would be unfortunately the last resort"
		"Its been much nicer and calmer on the wards without partners coming and going ,the women have even said they prefer it this way"
		"You'll be needed at home to look after your daughter won't you, won't she be needing her mum?"
Mid May	It is agreed that Joanne can have a private room on the postnatal ward, and that Jane can remain with her and their baby after the birth.	
24 <sup>th</sup> May morning	Joanne gives birth at 36 weeks. Jane is not allowed into the hospital, and misses the birth. Jane is informed that if she leaves the postnatal ward to go to the canteen for food, she will not be allowed to return.  Both Joanne and Jane feed their baby on the postnatal ward.	"She said if I go to get food I'll have go home as exposed to covid"
24 <sup>th</sup> May evening	Later their baby is admitted to neonatal care to be treated for jaundice. A doctor working in NICU says the baby needs to be 'topped up' after Joanne has fed him, but Joanne is informed that Jane's milk is not appropriate. Jane is directly informed that she is not allowed to feed her baby. Their baby is given formula.	"They told Jane my milk could make him poorly"  "They said they'll have to look in to whether its OK for me to feed as donor milk is normally tested and paturised [sic] and I'm a donor"

