

# Sexual Minority Individuals and Pregnancy Outcomes: A Commentary

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## Sexual Minority Individuals and Pregnancy Outcomes: A Commentary

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### *Introduction*

Sexual minority individuals who are pregnant or want to become pregnant face worse pregnancy outcomes than heterosexual patients.<sup>1, 2</sup> The American College of Obstetricians and Gynecologists (ACOG) endorses quality care to all people regardless of sexual orientation or gender identity.<sup>3, 4</sup> This includes providing gender affirming care throughout a patient's pregnancy, acknowledging risk factors for diverse sexual minority populations that affect reproductive outcomes, and utilizing appropriate evidence-based clinical recommendations

to tailor care.<sup>3, 4</sup> Despite that, these patients still encounter many barriers to health care and have limited access to obstetric care and fertility clinics.<sup>3, 5</sup> As clinicians and scientists, it is crucial that we continue to promote equitable care to pregnant individuals of any background.

The aim of this commentary is to describe pregnancy outcomes of sexual minority individuals, identify research gaps, describe clinical perspectives, and propose future directions from a research, clinical care, and educational perspective.

### *Pregnancy outcomes for lesbian and bisexual women*

Sex and gender minority individuals comprise a vast range of sexual preferences that contribute to their specific reproductive needs.<sup>6</sup> Worse outcomes have been reported in sex and gender minority individuals in both their ability to achieve a successful pregnancy, and in perinatal outcomes. Pregnancy success rates are overall poorer as compared to heterosexual women. For lesbian and bisexual women, the pregnancy success rate overall is greatly reduced (9-fold lower in lesbian and 2-fold lower in bisexual patients) as compared to heterosexual women, despite parental wishes to become pregnant.<sup>2, 7</sup> Additionally, sexual minority women are over 12 times more likely to use fertility treatments, with up to 80% of same-sex couples using anonymous sperm donors.<sup>8</sup> Though there are higher success rates of reproductive assistance in lesbians as compared to heterosexual women, both lesbian and bisexual populations reported increased rates of preterm birth (OR 1.84, 95% CI 1.11-3.04) and stillbirth (OR 2.85, 95% CI 1.34-2.35).<sup>1</sup> Pregnant lesbian and bisexual patients also exhibit higher risk for depression (OR 2.85, 95% CI 1.47-5.52) and mental distress with onset in pregnancy (OR 3.13, 95% CI 1.45-6.75), and are at a higher risk for pre-existing chronic medical conditions (OR 2.09, 95% CI 1.11-3.93) as compared to pregnant heterosexual women, after adjusting for sociodemographic factors.<sup>5</sup> Of note, sexual minority women have equal to or higher rates of unintended pregnancies as compared to heterosexual women, and significantly higher rates of sexual violence.<sup>9</sup>

### *Risk factors for poor obstetric outcomes among lesbian and bisexual women*

Risk factors for poor pregnancy outcomes among lesbian and bisexual women remain poorly understood. It has been hypothesized that discrepancies in these outcomes are related to disenfranchised sexual minority status, low socioeconomic status, limited access to health care and health insurance, and limited healthcare services equipped to treat the specific needs of these populations.<sup>3, 10</sup> Even prior to conception, sexual minority women are reported to underutilize routine health care services, including basic services such as screening for sexually transmitted infections, or attending influenza vaccination clinics.<sup>5</sup> All of these factors negatively affect the pregnancy outcomes of lesbian and bisexual women.

### *Pregnancy outcomes for transgender and non-binary parents*

Much less is known about pregnancy outcomes for transgender and non-binary parents, and many other sex and gender minority populations are left out of the literature entirely.<sup>5</sup> Studies show that transgender men face many obstacles to pregnancy. Barriers include hormone therapy, fertility preservation, birth trauma, gender dysphoria, difficulties in post-partum care, as well as underutilization of contraception, lack of abortion access, and care from healthcare professionals who are equipped to manage their complex hormonal and psychosocial needs prior to, and after birth.<sup>10, 11</sup> There is less known about non-binary individuals. ACOG has recently recognized how marginalization of transgender and gender diverse communities leads to poor health outcomes, and acknowledged the need to improve training amongst healthcare providers regarding specific reproductive needs of these diverse populations in order to reduce inequities that have traditionally limited access to inclusive healthcare.<sup>4</sup>

### *Research gaps*

The current literature presents several limitations on this topic. The terminology used over the past ten years to define sexual minority individuals has been quite heterogeneous and inconsistent limiting the ability to perform adequate data synthesis to assess the state of the science, identify gaps or suggest adequate clinical recommendations.<sup>4</sup> Lack of consistent terminology also affects the possibility of performing national population studies. Only in 2020, the United States Census Bureau attempted to remedy the lack of

data on sexual minority individuals, by including responses from the lesbian, gay, bisexual, transgender, or queer community and persons in a same-sex relationship.<sup>12</sup> Additional limitations are that previous studies have focused more on sexual behaviors and risk of pregnancy rather than health, access to care, or pregnancy outcomes in this population.<sup>5</sup> Other factors to be considered are the paucity of prospective studies on this research topic, and difficulty in recruiting sexual minority patients due to their limited access to health care and academic centers, as well as possible stigma that these individuals experience.<sup>4</sup> All of these limitations affect the information and knowledge available to health care providers, advocates, policymakers, and researchers. For the healthcare provider, this translates into limited training. In 2018, less than half of board-certified American obstetricians-gynecologists reported having any training with regards to care for sexual minority patients.<sup>10</sup>

### *Clinical perspectives*

From a clinical perspective, it is important to emphasize that sexual minority individuals may approach perinatal and reproductive care with higher levels of anxiety compared to heterosexual women.<sup>13</sup> Both sexual minority and heterosexual pregnant patients may experience fear of childbirth, which refers to fear caused by different events, such as becoming pregnant, being pregnant, or giving birth.<sup>13</sup> However, sexual minority individuals may also experience discrimination which can ultimately lead to higher levels of perinatal stress.<sup>13</sup> Therefore, prenatal clinics should be more inclusive, as recently advocated by ACOG.<sup>4</sup> This can be obtained by promoting training and education among all medical and non-medical staff, regarding aspects of a prenatal care visit of sexual minority individuals. Added to the above stressors are the logistical issues of financing reproductive care: from assisted reproductive technology procedures like in vitro fertilization to finding healthcare professionals trained in the diverse needs of this population, pregnancy for sexual minority individuals is costly.<sup>1, 7</sup> The creation of multidisciplinary services and collaboration with policymakers to make prenatal care more affordable is crucial, similarly to what has been advocated for transgender and nonbinary pediatric patients.<sup>14</sup> Multidisciplinary prenatal clinics in this population would include obstetricians, midwives, lactation consultants, psychologists, psychiatrists, social workers and medical subspecialists as needed, with expertise in pregnant sexual minority individuals, and would facilitate the delivery of much needed physical and mental health services.

### *Future directions*

Based on the described gaps in clinical care, research, and educational, we propose several key points for future directions in these areas (Box 1). It is essential for researchers to educate themselves on the use of the correct terminology more consistently in order to curate future knowledge that would be of value to clinicians. Research priorities would include the examination of discrepancies in pregnancy outcomes and associated predictors and risk factors, utilize qualitative methods to examine prenatal care experiences and identify barriers to care, and assess interventions aimed at improving access to care as well as perinatal and pregnancy success outcomes. Similarly to mandates to include women and sex as a biological variable in research proposals instituted in the past couple of decades by some governmental funding bodies, sexual minority individuals should only be excluded for scientific reasons rather than convenience. In regard to clinical care, efforts should be made to create an inclusive environment, with presence of multidisciplinary clinical teams at least at larger medical centers to provide appropriate patient care before, during and after pregnancy. From an educational point of view, training on sex and gender minority individuals should be incorporated in medical school curricula, in obstetrics and gynecology graduate medical education, and into subspecialty care at all levels. Finally, from a societal standpoint, we need to rise above societal stigmas that feed into the disenfranchisement of this population and impact health in general, and mental health of sexual minority populations.

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**Research** Require justification for exclusion of sexual minority individuals from studies Fund studies focused on perinatal o

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**Box 1.** Key points for future directions in gender inclusive research, care, and education in reproductive health of sexual minority individuals

### *Concluding remarks*

Equitable prenatal care for sex and gender minority individuals is not a given with regards to the pregnant patient. While physicians are bound to do no harm, disparities in reproductive healthcare remain prevalent.<sup>1, 4, 10</sup> Sexual minority individuals deserve the same level of reproductive autonomy and healthcare access that is given to heterosexual patients, and we must continue to build the physical, emotional, and psychosocial structures necessary to provide comprehensive gender affirming quality care.

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The authors have no conflicts of interest to disclose.

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