LGBT Health Care Access: Considering the Contributions of an Invitational Approach

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Abstract

Lesbian, gay, bisexual and transgender (LGBT) people have historically, and continue today to encounter barriers to accessing health services. This has been attributed to the well-documented heterosexism, homophobia, biphobia, and transphobia that shape all health and social institutions. In this paper, invitational theory offers insight into the challenges faced by a childbearing lesbian couple to access supportive health care, and sheds light on inequities faced by LGBT people when accessing health care in Canada. The author draws on critical feminist research and invitational concepts to build an understanding of four dimensions of this couple's access to supportive care. The invitational approach is combined with an explicitly critical stance to highlight gender and other relations of power, and to provide a theoretical rationale for incorporating invitational concepts into equity-related research, including a current application focused on improving LGBT home care access in the Canadian context. Given the deeply embedded structural inequities that hinder the creation of intentionally inviting environments for diverse groups, this research has implications both for shedding light on areas in need of health care access research, as well as for integrating invitational approaches that align with critical pedagogies into health care education.

Introduction

Invitational Education® (Purkey & Novak, 2008) integrates the concepts of self-construct, caring and social democratic education theories that have been widely applied to enhance teaching, learning, social interactions and group dynamics for diverse student groups in primary and secondary schools, as well as in colleges and universities (Haigh, 2011; Novak, 1992). A range of educational foci have been addressed from an invitational theory perspective, such as welcoming school climates (Okaya, Horned, Laming, & Smith, 2013); reflective teaching practice (Smith, 2010), curriculum (Chant, Moes, & Ross, 2009); and racial/cultural diversity in education and professional practice for teachers and the helping professions (e.g., Lewis, 2008; Schmidt, 2004; 2007; Moeller, Anderson, & Grosz, 2012).

Less attention has been directed to an invitational approach to enhancing health care access, specifically to sexual and gender minorities (lesbian, gay, bisexual and transgender [LGBT] people). This is in spite of the well-recognized need to foster cultural competence in health providers to serve diverse populations, as well as to support diversity in the health care providers themselves. The focus of Invitational Theory on creating respectful relationships and educational environments offers important potential for health provider education that can help create welcoming environments for diverse groups of patients/clients and foster access to equitable health care for patients/clients. LGBT people have historically, and continue today to encounter barriers to accessing health services that have been attributed to the well-documented heterosexism, homophobia, biphobia, and transphobia that shape all health and social institutions (Institute of Medicine [IOM], 2011). Heterosexism is the assumption that heterosexual relationships are preferable to non-heterosexual relationships, and it is embedded in most social institutions by normalizing

heterosexism and contributing to what is known as heteronormativity. The term "heteronormativity" is "useful because it makes it clear how heterosexist 'normalcy' normalizes itself through making homosexuality 'deviant'" (Weiler, 1988, pp. 55-56). Since homophobia, biphobia and transphobia are pervasive, heteronormativity contributes to dynamics in which health providers often lack knowledge and understanding of diverse LGBT people's experiences of health, hold negative attitudes towards them and thus may not provide high quality care. This shapes health inequities for sexual and gender diverse communities (Bauer et al., 2009; Eliason, Dibble, DeJoseph, & Chinn, 2009; Mulé et al., 2009) by contributing to the heteronormative policies and practices that create barriers to equal access, thus disenfranchising and rendering vulnerable LGBT populations. Longstanding historical, social, political, economic, and cultural dynamics sustain a dominant heteronormative society by marginalizing and rendering invisible the range of holistic health issues relevant to LGBT people, and as a result contribute to well-established health inequities ranging from increased mortality and morbidity to an inability to locate responsive and relevant services (Dean et al., 2000; IOM, 2011). Diverse LGBT people across age, race, ethnicity and geography, experience unique health issues. Many LGBT people cannot disclose their same sex relationships or gender identity as trans people, and often would rather avoid care, than chance disrespectful and harmful care (Dobinson, MacDonnell, Hampson, Clipsham, & Chow, 2005; Mulé et al, 2009; IOM, 2011).

The purpose of this paper is to illustrate how invitational theory offers insight into the challenges for childbearing lesbians to access health care, by drawing on observations from a Canadian case study completed in 2001 (MacDonnell, 2001). Findings from this case study have implications for enhancing health care access for diverse groups of LGBT people. A 3-part conceptual framework for access emerged from this qualitative case study that includes: A) four dimensions of access to care: 1) perceived safety of resources, 2) disclosure status, 3) situated privilege, and 4) public and private availability of support; B) consequences of lack of access for childbearing lesbians; and C) recommended changes to the system to enhance access, captured under "future possibilities."[4] The focus will be to describe how invitational concepts inform the four interrelated dimensions of access to supportive care by childbearing lesbians, by drawing on the contributions of the foundational philosophic contributors to Invitational Theory: Kelly's self-construct theory (1955), Dewey's social democratic education (1939), and Noddings' feminist/caring theory (1984) as well as Purkey and Novak's work on Invitational Education ® (1996; 2008). The five indicators of positive educational environments known as the 5 P's (people, places, programs, processes, policies) will be utilized, and attention will be drawn to a 6th P (politics) which emerged as relevant in this research. Findings are situated in feminist literature, affirming some important, seminal lesbian work from the 1990s.

I begin with a brief overview of the research and critical feminist methodology with attention to heteronormativity as it relates to lesbians. I then briefly describe themes emerging from analysis by contextualizing them using the 6 Ps, and describe the four dimensions of access to supportive care that emerged as relevant, sharing relevant links to invitational theory that helped support findings. Finally, I discuss some implications for health care access research and education for health care providers.

Setting a Context for Lesbian Childbearing

Historically, lesbian childbearing couples, like other LGBT people, have been bombarded with stigmatizing messages, which have often rendered them invisible and excluded them from health care programs and services in a way that contrasts with traditional families based on male and female relationships (Biblarz & Savci, 2010; DiLapi, 1989). As Clunis and Green (1995) note, "Starting in the

[4] Detailed study findings have been described previously (See MacDonnell, 2001; MacDonnell & Andrews, 2006).

late 1970s and early 80s there [was] a baby boom among visible lesbians, particularly in some of the larger, lesbian-friendly urban areas in the United States" (p. 11). A similar phenomenon began in Canada at that time. Often, lesbians had become pregnant through heterosexual couplings, however, were increasingly turning to lesbian community resources and mainstream reproductive health services, such as artificial insemination (Ehrensaft, 2008).

Social hierarchies and structural oppressions linked to gender norms, continue to influence the social context of childbearing lesbians' lives. Patriarchal dominance shaped by historical, economic, social, and cultural forces (Mandell, 1998) remains a powerful influence over individuals and societal institutions, yet is often not perceived at the conscious level (DiLapi, 1989). As sexism assumes an inherent superiority of one gender over another, women, regardless of sexual orientation, encounter oppression based on gender. This dominant patriarchal perspective is produced and reproduced within most societal institutions, through mechanisms of heterosexist values and homophobia. Lesbians experience heterosexism compounded by sexism (Canadian AIDS Society, 1992). Rigid gender stereotypes, which recognize heterosexual difference and reject same-sex orientation, rank heterosexuality as inherently superior to homosexuality. The roots of this pervasive heterosexist thought within society are "founded on the subordination of women's needs, issues, and perspectives to those of men and on the denial of the potential bonds of love and friendship between women" (Eliason, Donelan, & Randall,1992, p. 32). Lesbians' rejection of economic, physical, and emotional dependence on patriarchal authority ensconced in the nuclear family accounts for the extensive social repercussions they encounter (DiLapi, 1989). The ways in which difference is created by dominant groups shape their vested interest in maintaining this hierarchical power. Homophobic strategies preserve the heterosexist perspective of hegemonic institutions at the expense of other ways of knowing and being which are excluded or minimized, producing power and reproducing dominance in ways that are taken for granted and naturalized so that most members of society are often unaware of how intersecting oppressive relations of power structure their everyday lives. This process of oppression and counter-oppression known as hegemony, "is never complete, always in the process of being reimposed, always capable of being resisted, and the dominant classes are always struggling to reimpose an hegemony" (Weiler, 1988, p. 13).

Overview of the Study

In 1998, I completed an extensive literature review on childbearing lesbians and the context of health professional practice in relation to lesbian health. I uncovered twenty years of research about childbearing lesbians and lesbian health. However, with few exceptions, this evidence for practice had not been integrated into nursing education, clinical practice or programming (MacDonnell, 2001). In response to this gap in research on meaningful educational support for childbearing lesbians and based on my own lack of knowledge as a public health nurse and childbirth educator, I undertook research to explore the issues. That study was completed in 2001 (MacDonnell, 2001; MacDonnell & Andrews, 2006).

Certainly, over the last decade, recent changes to federal and provincial legislation in Ontario, Canada, acknowledge that lesbian families are entitled to benefits as common-law couples and both media and public support have increased awareness of sexual minorities (Rickard, 2013). Yet, it is clear that current gaps in health professional curriculum and training contribute to practitioners' discomfort, limited understanding of how to create inclusive care environments, and the unique issues faced by diversely situated lesbians (Abdessamad, Yudin, Tarasoff, Radford, & Ross, 2013; Beagan, Fredericks, & Goldberg, 2012). Given the need to foster meaningful professional education, invitational education's focus on affirming educational practices and environments, and the urgent need to respond to the barriers to care faced by LGBT people, this topic is relevant to this journal.

Methodology

This feminist ethnographic research (MacDonnell, 2001) is a descriptive exploratory study examining educational needs perceived by expectant lesbian women. It aims to facilitate the development of inviting informational community support for childbearing lesbians in a public health context and focuses on childbirth educators and related programming. Given the exploratory nature of this work, a qualitative case study design (Stake, 2003) was used to undertake an in-depth examination of lesbian childbearing from preconception through to the postpartum period as experienced by one lesbian couple. Ethnographic interviewing was suitable to understand their everyday experiences and ways in which they constructed meanings through their educational interactions. Denzin and Giardina (2010) advocate for self-reflexive qualitative studies such as case studies to explore social justice issues and demonstrate the interconnectedness between individual experiences on the micro level and structural dynamics on the macro level.[5]

This inductive research, congruent with constructivist and naturalistic paradigms, aims to understand the phenomenon of lesbian childbearing in the context of socially constructed knowledge, norms and realities. It reflects a critical feminist lens in which complex relations of power as it pertains to gender and its intersections with sexuality, inform knowledge claims for both researchers and participants. There is a focus on everyday lived experiences which mirror larger cultural, historical, economic, political, and social relations in order to identify injustices and bring to light subjugated knowledge, which reflects the voices and experiences of minorities such as lesbians that have often been dismissed or overlooked. Through social action, the study aims to challenge social structures and improve the everyday lives of these minorities (Kirby & McKenna, 1989; Reinharz, 1992).

At the time this research was undertaken, almost all health research which addressed sexual minorities focused on gay men and to a lesser extent, lesbians. That literature, which has grown enormously over the last 15 years, now also examines the particular issues that bisexuals and trans people encounter in accessing health care. Nevertheless, our understanding of the particular needs of diverse LGBT people across geography, age, ethnicity and other social strata remains limited. As will be shown in this paper, by identifying a conceptual framework which is grounded in thematic findings, this case study offers insight into issues of access that move beyond the particular experiences of this one lesbian couple.

Sample

Ethics approval was obtained from Brock University Research Ethics Board and Hamilton-Wentworth Department of Public Health Services. The study employed purposeful convenience sampling to recruit one or two available childbearing lesbian couples, given the few who would be openly "out". Study postings were shared through the researcher's contacts with lesbian community resources and professional networks to locate childbearing lesbian couples in the Greater Toronto/Hamilton area of Ontario, Canada. Two couples expressed interest and one, living in an urban area, agreed to participate. Sharon and Ellen (pseudonyms) are white, middle class women in their early 30s; one is a physician and her partner is highly involved with midwifery care. Given their experience with the Ontario reproductive health systems, and as mothers who had each taken roles of biological mother and co-parent, they were key informants regarding childbearing support for lesbian couples in an urban setting. At the time of the first interview, the couple had a toddler and subsequently their second child was born.

[5] Case study findings including the reflexive components are detailed in MacDonnell & Andrews (2006).

Procedures

Informed consent was obtained from each participant and they completed a short demographic form. Two in-depth 2-hour couple interviews, one prenatally and one post-natally were audiotaped and transcribed. The first visit to the couple's home took place close to the end of the couple's second pregnancy and the second visit was made at 2 months postpartum to facilitate data collection relevant to the delivery and early postpartum periods. Semi-structured interviews focused on their personal decisions surrounding the pregnancy; how they accessed, interpreted, and acted on the healthcare information, supports and services that were provided to them; and how they evaluated the care they received, both by the healthcare system and by the community (See Appendix A for prenatal and postnatal interview guides). Computer files and transcribed interviews were stored in a locked filing cabinet in my home study, secured for 5 years and then destroyed.

Rigor

In order to foster confidentiality, pseudonyms were used and no identifying information was shared in the reporting of findings. Strategies to ensure rigor included prolonged contact with the participants, member checking and use of verbatim narratives to provide rich context. Strategies to ensure trustworthiness involved disciplined subjectivity that included the use of a personal reflection journal to document any emerging insights and reflections on how my own social location as an outsider to lesbian communities and as a public health nurse influenced the emerging study (McMillan & Schumacher, 1997). This case study approach was not intended to offer generalizability but it had the potential to generate extension of the findings. Situating the findings in the social and historical context of the literature and interpreting the findings with respect to theory, facilitated that process.

I used Kirby and McKenna's (1989) approach to analyzing data by examining transcripts for identification of descriptive narrative sections of information, phrases, or paragraphs which could be identified and grouped under a mini-theme. These were then gathered under broader thematic categories and during the final scan for themes, the transcripts were colour-coded to ensure that all data had been accounted for under the themes. Themes included: co-parent experiences, biological childbearing experiences, isolation, determination, barriers to support, childbearing as a turning point, diversity of lesbian communities, public or private availability of support, strategies, and recommendations captured under "future inviting possibilities".

A key theoretical underpinning of this research draws on Invitational Education ® (Purkey & Novak, 2008). This approach systematically addresses the 5 P's, that are indicators of educational environments: people, places, programs, processes, and policies that can create environments that are "intentionally inviting"; and that are consistently perceived to reflect relevant, respectful care. The study results also supported the addition of a 6th P: politics, since the political component of invitational interactions is a key to enabling supportive processes.[6] Power is inherent to all individual and institutional interactions. Study findings framed in relation to these 6 P's are detailed elsewhere (MacDonnell, 2001; MacDonnell & Andrews, 2006). This paper briefly discusses the value of systematically addressing interactions with individuals and environments as advocated by an invitational approach. This is integral to understanding how providers can work towards creating high quality support.

[6] Dean Fink (2013) identified a 6th P, politics. Findings from this study extend his focus from organizational change to a broader notion of political action and a focus on structural dynamics in relation to equity

Using a critical gender lens to apply the Invitational Approach and identify a 6th P, "politics" aligns with other educational approaches that have similar goals of disrupting the status quo and creating space for subjugated world-views (hooks, 1994). Critical and queer theories which focus on oppression and strategies to counter oppression, and which incorporate the fluidity of identities and world-views, have fostered important understanding of LGBT issues in an educational context. This has implications for inclusive education spaces where LGBT voices across race and gender have often been invisible (Kinchloe, 2004; Kumisharo, 2002; Misawa, 2010; Murray, 2015). Making LGBT issues visible in relation to Invitational Education is an important first step. The systematic approach that Invitational Education provides for assessing educational environments using the 5 Ps, also offers an important tool for educators in a health care context to gauge and enhance the relevance and quality of health care education that will improve access for LGBT people. Attention to the complex dynamics of power and privilege when applying Invitational Education concepts can enhance inviting, inclusive spaces for diverse LGBT people.

Given the heteronormativity embedded in all social institutions and the ways that this marginalizes and often renders invisible the holistic health issues of lesbians in the health care system, the findings from this ethnographic study (MacDonnell, 2001) suggest that access to high quality health care for this group involves reflective rethinking the complex dynamics of power and gender. Four interactive dimensions of access were found to be relevant to childbearing lesbians' capacity to locate supportive care: 1) perceived safety of resources, 2) disclosure status, 3) situated privilege, and 4) public and private availability of support.

Narrative Findings: The 6 Ps

It was clear through this case study that childbearing lesbians can encounter unique issues relevant to their childbearing. With few exceptions, the language used in reproductive health services and resources addressing pregnancy, prenatal classes and parenting assumes that the childbearing couples consist of a male and female partner. Achieving pregnancy often depends on assisted reproduction such as artificial insemination with its associated anonymous donor policies and/or prohibitive costs. A couple's ability to secure resources or find supportive providers may require them to disclose their sexual orientation, and this can elicit hostile or neutral responses from providers. Sometimes harmful care can follow, especially for women who are part of minority groups defined by disability or ethnicity. For women who are birthing, such responses exacerbate their vulnerability during the birth process. The challenges of negotiating the couple relationship for biological and non-biological mothers from pregnancy planning to the postpartum time frames are often overlooked as being relevant to childbearing. Subtle and more overt recognition of the biological mother as the legitimate mother can precipitate relationship tensions. Furthermore, as this couple's experiences have shown, the arrival of a child can prompt both unexpected support and upheaval in extended family relationships. For some couples, families of choice rather than families based on kinship relationships become significant. Responsive and relevant educational support and care provision requires an understanding of these unique issues. This will foster the creation of supportive climates both within individual interactions with clients, as well as within organizations that consistently convey the respect, optimism and trust that reflect intentionally inviting interactions and environments.

In this section, I share some narrative excerpts from the findings using the 6 P's to ground the invitational concepts addressed in more abstract ways later in the paper. In addition to the 6 P's, Invitational Education also focuses on four elements of educational environments on a spectrum that includes 1) Intentionally Disinviting (purposefully hostile); 2) Unintentionally Disinviting (the interaction is intended to be positive but the impact is negative); 3) Unintentionally Inviting (the interaction is positive but

inconsistent); and 4) Intentionally Inviting (interactions convey optimism, respect and trust because they are reliable and consistent at both the individual and organizational level).

People

The first P, People, focuses on human interactions between patients/clients and health care providers in educational environments

Sharon remarked that her work environment was inviting, and she attributed this to the progressive workplace, as well as the accepting colleagues there. "I am in family medicine. There are public health nurses, plus the staff there. Everyone is great, wonderful to myself and Ellen. It's unique. I don't know whether it is just because there is inherent power in my position. Regardless, it still feels wonderful" (p. I-2).

Many well-intentioned individuals were unintentionally disinviting. Ellen described her network of friends:

> I spend my time with other extremely privileged white, upper-middle-class, heterosexual women, which is fine on the one hand, and difficult in many other ways. They don't have a clue about the upward struggle we have in life… They don't have to fight for recognition of family and partner. They don't have to struggle to adopt their children. People are continually asking questions. "How is your baby?" and "How's Sharon's pregnancy?" They don't have any concept of the fact that these children are ours. So at times, I find it overwhelming, this sense of profound isolation and oppression that we have, and that although these women are extremely nice . . . and positive parents, they're not in any way, very conscious… every day, that we're surviving. (p. I-2)

Places

The 2nd P, Places, focuses on environments in which childbearing lesbians receive clinical, informational or other support. A key aspect is how healthcare providers communicate caring through responsive and relevant support.

When discussing places that invite, the participants often referred to their knowledge of Toronto, Ontario which has visible, organized services for childbearing lesbian women. Ellen had learned from an acquaintance that it was:

> very clear that growing up in Toronto their children knew tons of kids, AI kids [kids born through artificial or alternative insemination]. It's a very common experience, that one woman was saying, for her children to know children born from AI, children who [have] gay fathers who are donors, who are gay men, who are in their lives…. (p. I-23)

The visibility of lesbian families is considered supportive as it publicly validates their family structure for both the parents and children. Gays and lesbians have a number of well-known resources in Toronto. In their search for information on AI, the couple "talked to the Hassle Free Clinic in Toronto and they gave us two or three pages of clinics, individual doctors' names and feedback on each of them" (Ellen p. I-9). As well, certain hospitals and clinic facilities had reputations for being lesbian-positive. Their chosen AI clinic was inviting in the information on donor selection. "They provided a lot more information about their donors. They also used Canadian donors and . . . we were looking for cultural diversity . . . Sharon has some native background" (Ellen, pp. I-10-11; II-7).

Programs

The 3rd P, Programs, addresses curriculum for health care providers in both workplace training and professional education contexts, and comprehensive curriculum for childbearing lesbians that meets the needs of diverse lesbians. The quote below addresses the latter context:

Neither the local lesbian community nor mainstream parenting resources available to childbearing women provided resources that met their needs. Prenatal classes were perceived as disinviting. Ellen explained:

> It is our understanding from colleagues, friends, and other health care professionals that prenatal classes... [are] so…focused on marriage, and male and female relationships… [that] even friends of ours who had been to prenatal either left for that reason, [or] highly recommended that we don't go. (p. I-1)

Visibly lesbian-positive postpartum supports geared for mothers with newborns were not available locally in the same way that parenting supports were available for lesbian parents with school-age children.

The participants emphasized that while organizations and resources which focus on women's issues may profess to be lesbian-positive, this is not necessarily so. Direct programming may be disinviting by conveying homophobic and heterosexist messages and even when resources are managed by lesbians, disinviting messages may inadvertently be conveyed when family stereotypes are not challenged. Heteronormative understanding maintains that families are comprised of heterosexual couples and this fosters the invisibility of lesbian families. The couple pointed out that lesbians who are in leadership positions may not challenge this invisibility either because their own experiences of lesbian communities do not include same-sex families or because they perceive barriers such as career costs if they were to speak out. They recognized that individuals may not have the power to control curriculum or program directions, and this may perpetuate the barriers.

Processes

The 4th P, Processes, attends to ways that inviting interactions are achieved by involving lesbians and representing lesbian voices when developing programs, resources and policies.

Ellen felt that "setting up a really good complaints or concerns process that is accessible to people of different privilege, those of different language or whatever" is important (p. II-47). She noted that many organizations offer this service, but it is effectively inaccessible when a person feels powerless to make a complaint and anticipates that individuals concerned may be homophobic. In the couple's view, an organization that is determined to facilitate access would benefit from a systematic assessment of their programs and policies. Ellen stated:

> You would have to commit the institution to assessing all their documents, all their tools, interviewing assessment tools. If you could get representatives of various groups, race, colour, privilege, sexual orientation to actually look at some of their assessment interview tools, the very least they can say is they have done that process, and that says a lot to the public because word will spread. (p. II-47)

Following diversity-sensitive policy when drafting documentation would also be inviting. Sharon suggested a policy statement which mandated the use of a generic term such as "spouse", instead of

"husband and wife" (p. II-47), along with other measures that included education of healthcare providers. Both participants agreed that education alone would be insufficient to create welcoming and safe care.

Policies

The 5th P, Policies, includes both formal and informal organizational, professional and social policies that reflect inclusion and democratic principles. The following is an example of organizational policies that present barriers to access.

The process of AI presented many issues for the couple. As the participants checked out possible sources of support for AI they encountered barriers to accessing the system that women assumed to be heterosexual would not face. Ellen notes:

> We heard that with lesbian women . . .[this fertility clinic] would make you see a social worker, and they'd ask you who's going to be the positive male role model in your child's life, and what are you going to do if you have a boy—totally inappropriate and homophobic . . . . The majority of AI clinics in Ontario (17 out of 23) won't serve heterosexual single women or lesbians (Ellen, p. I-9-10).

Even resources they considered lesbian-positive were problematic at times. Ellen explains:

> We were very interested in [this hospital clinic] because we had heard such positive feedback, so we called them. They sent us an information package and all the information was on, "Now that you know you are infertile." First of all, for most women, that is a hard thing to hear. But you would think that they would want to explore further before they drew that conclusion. Secondly, we did not know if we were fertile or infertile. We just didn't have a male factor, which makes things a little more difficult, but not infertile. (Ellen, p. I-10)

Even this particular service which was considered lesbian-positive required a physician's referral, which could be disinviting to women whose access to lesbian-positive practitioners is limited. As well, this clinic was "exceedingly expensive" (Ellen, p. I-9). Since the AI system is not regulated, the costs per month for donor sperm might range from $500 to $1,300 per month on top of any fertility medications which could be required (with an average cost of $1,000 per month).

Politics

The 6th P, Politics, addresses the dynamics of power and privilege across a spectrum from individual to community levels; and action for social change through political and professional leadership and advocacy for LGBT people.

Although the participants applauded the recent gains in legal status for lesbian couples, they noted that the persistence of negative stereotyping of lesbian women continues to put them at risk for custody and access issues when there are children in the family. Sharon relates that:

> The courts have been really horrible, especially in low-functioning families. The lawyers can be just horrible…just awful. People have lost custody over their kids just because she is lesbian. Husbands are concerned their partner is going to molest the child. (p. I-7)

Such attitudes continue despite evidence from well-respected psychological sources that children who are part of same-sex families are not at increased risk for harm. The women note that media images that focus on and sensationalize the sexuality of gays and lesbians perpetuate these stereotypes. They observed that funding and opportunities for promoting lesbian-focused and family-focused Gay Pride celebrations are less available than those for the high-profile Pride parade in Toronto (p. II-49).

By analysing the narratives provided by Sharon and Ellen, a conceptual framework emerged for access. This framework includes four dimensions of access: perceived safety of resources; disclosure status; situated privilege; and public and private points of access to support. In the next section, invitational concepts are linked to the part of that framework that addresses these four dimensions.

Findings: Considering Invitational Concepts in Four Dimensions of Access

The first dimension of access is the perceived safety of resources. This couple placed a priority on safety as they sought support for their childbearing. In their view, a favourable outcome for childbearing was one in which interactions were intentionally inviting processes and conveyed caring and respect for their lives as childbearing lesbian women. They saw disinviting relationships as posing heteronormative barriers to care and having the potential to marginalize or dismiss the holistic health issues relevant to their lives, and so were perceived as unsafe (MacDonnell, 2001). Invitational theory (Purkey & Novak, 1996) maintains that human self-concept shifts in relation to different life experiences, and the role of positionality[7] is key (Misawa, 2010). Individuals marginalized by gender, race, or sexuality, will interpret their worlds in a different way from those who are privileged and have power.

Personal construct theory (Kelly, 1955) can be useful to understand how interactions can be perceived as safe (intentionally inviting) or unsafe (disinviting) from the perspective of sexual minorities living in a heteronormative world. Kelly (1955) uses personal construct theory to explain how information is processed on conscious and unconscious levels into ways of viewing the world. Existing information is structured according to previous experiences in specific historical, social, and cultural contexts. Dominant social attitudes which privilege certain beliefs, values, and world-views are unconsciously internalized and form the framework for understanding new experiences. This structure increases the predictability of interactions in the environment. As responses to events are largely based on prevailing constructs of the world, when conflicts arise between experienced and predicted interactions, opportunities emerge to modify existing constructs. Kelly uses this concept of "cognitive dissonance" to describe gaps between existing constructions of the world and current life experiences such as those that emerge when marginalized groups encounter mainstream intolerant attitudes.

Marginalization shapes pervasive feelings of oppression which may be overwhelming. Dewey (1933) uses the term "felt difficulty" to describe the discord experienced when the biological, social, and historical aspects of a particular environment are in conflict within oneself. Tensions between an individual's worldviews and those of society as experienced in institutional environments may cause significant emotional upheaval and affect perceived options for action.

Invitational theory (Purkey & Novak, 1996) recognizes that inconsistency, unreliability, or uncertainty in interactions contributes to environments which are either unintentionally inviting or unintentionally disinviting, depending on whether the messages received are those which incorporate respect, optimism, and trust or suspicion, contempt, and pessimism. For Sharon and Ellen, because supportive institutional

[7] Positionality is discussed in more detail in the section on Situated Privilege starting on page 25

interactions were unpredictable, the anticipation of not knowing what to expect in terms of a safe environment was very draining. Purkey and Novak (1996) differentiate between intentional and unintentional invitations. They stress that intentionality "suggests a purposive act intended to benefit the recipient" (p. 53). There is a conscious component inherent in the process of intentionality as discussed by Purkey and Schmidt (1996) of which the unconscious opposite is unintentionality. Optimal encounters are intentionally inviting. Actions are goal directed with the purpose of offering invitations to others which convey genuine respect, validation, and unconditional acceptance. For Sharon and Ellen, this predictability was integral to their ability to find relevant resources that were affirming and safe.

When a society is dominated by heterosexist and homophobic values, it cannot be expected that the actions of individuals (regardless of sexual orientation) or the policies of institutions will reflect inclusive perspectives. Paolo Freire is an educational theorist committed to praxis. He noted the importance of having teachers and students both "seek[ing] to understand the forces of hegemony within their own consciousness, as well as the structured, historical circumstances in which they find themselves" (cited by Weiler, 1988, p. 18). Being aware of the sociopolitical structures that maintain dominant attitudes requires critical reflection to understand how lesbian perspectives are marginalized and excluded, and how this can be changed.

Dominant discourses which privilege heterosexual mothers over lesbian mothers are learned unconsciously and influence the information available to educators and potential advocates. Because power shapes social environments, high quality communication between lesbian childbearing women, and their personal and professional supports and institutional providers frequently remains elusive. As a result, educators often remain unaware of the intensity of feelings of oppression and marginalization (Dei, 1999; Onken, 1998). These feelings are intensified by issues concerning disclosure and safety, particularly during times of vulnerability such as childbearing when contacts with healthcare institutions and providers can contribute to the marginalization (Stevens, 1998). Without deep reflection, health care providers limit their own capacities to acquire skills that reflect the respect, nurturance, and support necessary for advocacy (Riddle, 1991, as cited in Canadian AIDS Society, 1992).

Dewey (as interpreted by Gatens-Robinson, 1999) attributes this to deeply entrenched habits. In his view, to function in democratic and inviting ways, individuals must develop skills which connect thinking and actions so that responses are attuned to current environments. His view of democracy is one in which "conflicting [interests are brought] out into the open where they can be seen and appraised . . . in the light of more inclusive interests" (p. 185). This is in line with Riddle's (1991) focus on the need to reflect on current behaviours and values in order to achieve more effective ways of functioning. For Dewey, resistance to such change is found in the "inertia of our habituated social, emotional, and moral responses" (as cited in Gatens-Robinson, 1999, p.184). Social norms facilitate the perpetuation of individual habits which promote heteronormative strategies.

Disclosure Status

The second dimension of access is disclosure status. For lesbians, the decision to be totally invisible or selectively or completely "out" is often dependent on whether there are messages from the environment that are inviting, or that convey threat to safety (Peterson, 2013). The participants described a medical colleague who faced homophobic reactions in her hospital workplace as she attempted to locate support for disclosing as a lesbian. She anticipated significant challenges to having a child given that hostility. Organizational work settings which avoid addressing homophobia or heterosexism exhibit disinviting characteristics. Despite this woman's high social privilege as a physician, heteronormativity shaped the life options that she perceived to be available to her.

When this research was completed in 2001, openness about same-sex parenting was quite different from the current climate of openness in Canada. Of the parents in same-sex relationships surveyed across all regions of Ontario for the 1997 CLGRO report, 70% were "generally open about their sexual orientation [but] . . . almost all had to hide the fact they were parenting with a same-sex partner" (p. 85). This is not to say that in 2014, disclosure is a non-issue. For instance, in her recent (2013) dissertation entitled, *Authenticating Family: Re/Claiming Legitimacy by the Lesbian Headed Stepfamily*, Tracey Rickard points to the uneven progress in acceptance for lesbian families in Eastern Canada, and questions whether open disclosure is even possible for biological lesbian mothers or co-parents. Certainly, for diverse groups defined by ethnicity, age, ability and language, in both North American and global contexts, sexual and gender minorities continue to face dilemmas about disclosure and this extends to health care encounters.

The premise that inviting interactions involve sharing authentic issues of self with significant others within appropriate contexts lies at the heart of Invitational theory, and characterizes relationships that promote trust. Childbearing lesbians may claim many subject positions and this influences disclosure. Claiming a specific self-identity may depend on the acceptance of a perceived fit within a named category such as lesbian or lesbian mother. Self-disclosure as a lesbian in a given context will depend on a number of factors including an inherent non-dichotomous nature of sexual orientation (Onken, 1998); heterogeneity in sexual practices; and fluidity of sexual identities over a lifetime. Non-biological mothers/co-parents may or may not claim a mothering identity; but when they do claim it, others in their social worlds may deny them this identity.

Environments which encourage honest disclosure and genuine communication between individuals are considered optimal for educational exchanges (Purkey & Novak, 1996). Context and perceived safety will determine what information is disclosed and how it is represented to others. As demonstrated in the participants' narrative, the daily lived experiences of lesbians may be described as a constant vigilance about their "outness" combined with anticipation of homophobia (O'Hanlan, 1997). The "narrative structure of the closet" (p. 12) is described by Sedgwick (as cited in Armstrong, 1996) as one in which the public has the power to name the space in which affection can be displayed or concealed.

Verbal and non-verbal information sharing is contingent on how individuals experience and understand themselves in relation to their environments. Purkey (1992) explains: "what an individual believes to be true about his or her personal existence . . . enables the individual to assume a particular role or stance" (p. 17). Understanding bodies as sites of knowledge production and resistance (Abbey & O'Reilly, 1998) contributes to the complex ways in which women negotiate their multiple representations of childbearing with themselves and others. Disclosure is influenced by "felt difficulties" (Dewey, 1933), which represent disparities between the ways we know and value ourselves relative to how we know the world and what it values.

For these participants, the exclusion until very recently of lesbian motherhood from public discourse contributed to the disapproval and misconceptions that shape their everyday encounters. Negative messages perpetuate the subordination of lesbian childbearing women in society through stereotyping and myths which promote their invisibility and exclude them from institutional supports. These homophobic messages are internalized and contribute to self-talk or internal dialogue (Purkey & Novak, 1996) which shapes the self-concept and is shared with others.

For example, the participants described a range of strategies they used to locate meaningful support at various points of the childbearing process. As Sharon noted, a primary decision, prompted by their first pregnancy, was to "face our own homophobia" (p. 1-3) by increasing disclosure to others. The couple

decided to be more open about their relationship in order to receive validation from others for their family. This commitment required immense courage and determination. Ellen had been "out" to family and much of her community for over a decade. Sharon, on the other hand, had disclosed only to her family and a group of friends in their lesbian community. Her family was initially supportive, but then reacted more negatively, projecting blame onto Ellen and refusing to acknowledge her status as Sharon's life partner. With these disinviting messages from those close to her, Sharon's decision to disclose to workplace colleagues that her partner was pregnant was an important step forward to resist this silencing.

Situated Privilege

A third dimension of access is situated privilege that is linked to one's social location. At any one time, an individual can be identified in terms of her/his position or status in social groupings such as race, class, gender or sexuality. Social power is based on binary hierarchies where one group holds power over the other. An example of this occurs when males are the privileged group and hold power over females. Patriarchal dominance remains a powerful influence over individuals and societal institutions, and women, regardless of sexual orientation, encounter oppression based on gender. All individuals have a sexual orientation that includes heterosexual, gay, lesbian or bisexual identities, and rigid gender stereotypes that recognize heterosexual and reject same-sex orientation rank heterosexuality as inherently superior to homosexuality. Heterosexism, like other oppressions, involves power and prejudice (Canadian AIDS Society, 1992). It operates as a dominant social value and permeates most societal institutions, including those that are involved in the education of expectant lesbians (DiLapi, 1989). Educators often don't recognize heterosexism as having a powerful influence on health, legal, media, and educational institutions, and this enables patriarchal influence to continue with limited resistance.

Peggy McIntosh, in her ground-breaking work (1988) on the notion of "unearned privilege," points to the ways in which privilege is so entrenched in gender and race that it is naturalized and institutionalized and often not apparent at a conscious level. Hegemonic forces operate to enforce male, White, heterosexual dominance and simultaneously subordinate those who are defined as female, non-White, non-heterosexual. She notes that it takes ongoing work and deep reflection to examine one's unearned privilege, in order to grasp how privilege operates to favour male dominance and Whiteness. At any time, one's positionality or situated privilege is socially constructed, fluid, and contextual (MacDonnell & Andrews, 2006; Misawa, 2010). As stated by Misawa (2010), "Because positionality impacts everyone's daily life, marginalization and discrimination are particularly inescapable issues for minorities in contemporary society" (p. 1). For instance, in predominantly White lesbian communities, lesbians living with a disability or who are racialized can be marginalized in relation to White able-bodied lesbians.

The privileging of heterosexual over other sexual orientations is reinforced by myths and stereotypes that pathologize, exclude and stigmatize them, and claim them to be "unnatural". These processes contribute to the social marginalization and invisibility of minority sexual orientations and the complexity of their holistic lives and needs. So, although individuals can challenge this invisibility by disclosing their sexual orientation, powerful social norms and structures operate to reinforce this invisibility (Onken, 1998).

Situated privilege is that ascribed by society to a social position, which is claimed or assumed; and it includes features like sexual orientation, race, class, ethnicity, gender, ability, professional authority, to name a few. It may be based on visible markers, verbal disclosure, or affiliations with specific communities. A distinguishing feature of situated privilege is how it confers access to geographic, financial, or other resources. Strategies such as disclosure that individuals utilize as they seek support, contribute to the societal privilege available to them.

Whereas the decision to disclose a largely invisible social location is under the control of the individual, given the oppressive circumstances that shape these actions, situated privilege is ultimately based on the perceptions of others within a specific context and not those of the individual. For instance, health care organizational practices that overlook or discount the unique childbearing issues faced by lesbians, in effect privilege heterosexual families by stratifying support based on perceived social location. This can influence decisions to disclose sexual orientation. For lesbians, situated privilege is further related to mothering roles, be they biological or co-parenting, and to associated acceptance within lesbian communities (Abbey & O'Reilly, 1998; Peterson, 2013). For the participants, childbearing was a turning point in terms of the altered privilege conveyed to them as openly lesbian women within their communities.

Public and Private Points of Access to Support

The Canadian public health system is based on democratic principles, in which equality of access to publically funded health care resources is considered a basic right of citizenship. However, it became clear through this study that childbearing lesbians in Canada face systemic barriers to reproductive health service access based on their sexual orientation. Participants in this study sought access to information, social support and clinical care and resources for childbearing from preconception, through pregnancy, labour and delivery into the postpartum period. They encountered challenges at each point of the childbearing process as they navigated the publically funded services, such as reproductive health clinics, prenatal classes and postpartum/parenting support provided through public health reproductive health programs; and found themselves relying more on personal and professional networks, which could point them to lesbian-affirming supports (MacDonnell & Andrews, 2006).

Despite the couple's extensive situated privilege and connections, the support they sought was based on whether it was inviting: safe, validating, celebrating, and available in ways that maintained confidentiality or anonymity when desired. Even as members of an active lesbian community in their city, they often felt excluded from public venues for pregnancy and parenting, and depended on private points of access such as friends or medical colleagues for information and support. Although some specific reproductive health support for lesbians had already been created by the year 2000 in Toronto's lesbian community, such as the "Tykes for Dykes" program, lesbians were still largely unrepresented in public health childbirth education and maternal child programming. Preconception resources, such as artificial insemination programs were geared to heterosexuals, and private fertility clinics required and continue to require significant financial resources. In 1989, DiLapi described how public support for motherhood by social institutions was based on gendered hierarchies influenced by heterosexism and ableism. Heterosexual mothers in traditional nuclear family relationships garner more resources than single or same-sex mothers or mothers with disabilities, and this has implications for creating welcoming programs for lesbians who disclose their mothering status.

I turned to Dewey, Noddings and others with respect to democratic ideals and issues of access in the public realm. For instance, according to Seigfried (1998), John Dewey maintained that the goal of philosophy is to emancipate us from prejudice. His belief in "linking knowledge with action, and thinking with emancipation" (p. 194) supports a concept of social justice that requires action with consciousness. "Dewey was commit[ted] to a philosophy in which individual growth can only develop and thrive in an atmosphere [where] all of society supports these goals for growth collectively; individual growth occurs through interaction with others in society" (p. 189). Validation of lesbian identities that include parenthood has been noted as essential to establishing an authentic motherhood and facilitating individual rights to self-determination (Abbey & O'Reilly, 1998). As Nodding (1984) indicates, caring involves a moral consistency that implies a responsibility to a larger community. Caring communities are those that

validate and affirm diversity within humanity. As Iris Marion Young (1990) stresses, "The primary meaning of public is what is open and accessible" (p. 108). The explicit and implicit exclusion of lesbian mothers from public awareness and resources sends a strong message about who has the rights to claim citizenship in a community. There are implications for establishing respectful inclusive environments with publically funded programs and resources that affirm lesbian parents.

Alongside the masculine ethic which espouses rights (Shogan, 1993), a caring ethic with a focus on responsibility, espouses and promotes social justice (Noddings, 1984) This requires development of a collective empathy for others, which is attained by critical reflection of our position within society and more than token support for those whose voices are weakened by their relative value to those who purport to speak for all. The pevasive influence of heterosexism and homophobia limit the rights of expectant lesbians to information and resources, which promote acceptance of lesbian identity and support motherhood. These barriers preclude genuine reflection and communication within the health provider institutions and communities that could initiate change. According to Purkey and Novak (1996), "democratic practice is a guiding ideal that focuses on developing continuous dialogue and mutual respect among people regarding shared aspects of their lives . . . . [It] is founded on open and free dialogue which promotes social responsibility" (p. 37). There are implications for social action to foster the visibility and affirmation of lesbians and publically accessible and inclusive resources for their care.

The needs of marginalized groups can be made visible by reviewing service provision through their lived experience lenses and including their diverse voices in the democratic process. Invitational Theory is based on the philosophical premise that democratic and caring processes must align with ethical, human rights and legal justifications for inclusivity. A systematic invitational approach with its potential to foster equitable environments for diverse groups is a practical strategy for health providers and educators to use in this context of improving access.

Discussion and Implications

Findings from this study shed light on the everyday issues of living in relationships with self and others that lesbians face in the context of childbearing and co-parenting. These include negotiating role identities and decision-making strategies, as well as working through the emotional and behavioural impacts that childbearing has on their lives. These findings highlight the determination and energy required to cope with the pervasive hetero-normativity that shapes their lives and that denies them equitable access to healthcare.

At the heart of the invitational perspective lies an understanding of the processes of living in relation to others, in ways that facilitate mutual caring. Its theoretical base is comprised of principles focused on perception, self-concept, caring, and democratic processes. It offers opportunities to address the quality of interactive relationships by assessing people, places, processes, programs, policies, and politics. Invitational theory is also premised on an optimistic stance. Consistent with an invitational approach, the findings of this case study help to identify potential avenues for improving relationships between individuals and communities and relationships between individuals and institutions. Educational programming and policy development are key to making providers aware that services need to be made responsive and relevant to all users, particularly those who are marginalized. This will allow trust to build regarding the safety and consistency of resources and as a result, disclosure will be possible (Peterson, 2013).

Understanding the social context in which lesbian women seek information and connections with others in ways that meet their needs for childbearing education, facilitates the development of intentionally

inviting environments. The goal is to develop educational environments and community contexts, that convey respect and provide support that is meaningful to individuals from their perspectives. The systematic approach espoused by Invitational theory of assessing educational structures, offers a means of critically examining the dynamics between people, places, programs, processes, and policies within institutional communities, with respect to expectant lesbian women and provides an avenue for change.

My analysis of this case study demanded a focus on the dynamics of power and privilege to explain the findings and make suggestions for practice. This supports the use of a 6th P, "Politics" to understand the perspectives of all players, and their interactional dynamics on both an interpersonal level, as well as an individual to institutional level. The study began with an examination of the perceived barriers to the prenatal and birth education that this expectant lesbian couple needed to access, and the findings support a conceptual framework that addresses access to care. There are implications for public health prenatal educators and other providers to critically reflect on their own individual practices and become aware of the political influences arising from their professional education, organizational priorities and larger social dynamics which inform their practice and prescribe possibilities for taking action (Misawa, 2010; MacDonnell & Andrews, 2006; Peterson, 2013). Developing this critical consciousness is key to becoming a social justice educator (Mthethwa-Sommers, 2013).

As this paper has illustrated, invitational concepts in conjunction with a critical feminist lens are instrumental in explaining how childbearing lesbians perceive, interpret and experience their engagement with the health care system and thus offer insight into the challenges of health access for this group. Since this study with childbearing lesbians was completed, an improved policy climate and increased awareness of LGBT issues have emerged to shape Canadian health care for LGBT people. However, these findings continue to resonate with more recent research within North American and beyond that identifies gaps in service provider consideration of lesbians and their reproductive health (Arita, 2008; Goldberg, 2005, Hayman, Wilkes, Halcomb, & Jackson, 2013; Hequembourg, 2007; McManus, Hunter, & Renn, 2006; Rohndahl, Bruner & Lindhe, 2009; Rickard, 2013).

By identifying four dimensions that shape access to healthcare for childbearing lesbians as part of a larger conceptual framework for access, these findings can also be applied to other sexual and gender minorities. So while resonating with other research that explicitly or implicitly identifies situated privilege, disclosure, and safety as relevant to LGBT health care access (e.g. Brotman, Ryan, Jalbert, & Rowe, 2002; Dobinson et al., 2005, IOM, 2011; Makadon, Mayer, Potter & Goldhammer, 2008) these findings can also inform the basis for future research with trans people who are creating families. Rachel Epstein (2014) in her recent dissertation, indicates that while in the course of creating families, gays and lesbians still encounter reproductive health service access barriers, and trans families face even more challenges. Certainly the focus on public and private health care access in a Canadian health care system that prioritizes universal access to care is relevant, especially for sexual minorities who have been excluded from reproductive health clinics (Ross, Epstein, Goldfinger, & Yager, 2009; Yager, Brennan, Steele, Epstein, & Ross, 2010). These findings also extend the literature base on frameworks that address access to care for LGBT people (e.g., Daley, & MacDonnell, 2011; *Gay, lesbian, bisexual and transgender health access project,* 2010; Makadon, Mayer, Potter, & 2008).

Aiming for fair and just practices is not equal to treating everyone the same. Instead, it is crucial to recognize that particular groups, populations, and communities consistently encounter challenges in their everyday interactions with society, and the health care environments that everyone relies on to achieve good health. The social determinants of health, such as gender and socioeconomic status, suggest that good health and access to healthcare can be related to social privilege. As John J. Schmidt (2007) notes, invitational theory offers the potential for meaningful and inclusive health and education practice. In his

review of the *Journal of Invitational Theory and Practice* issues up until 2006, Schmidt (2007) proposed the use of the six elements (Six Es): "empowerment, encouragement, enlistment, enjoyment, equity, and expectation"(p.1) as a tool for a range of practitioners to use in relation to working with diverse populations. Of these invitational concepts, equity and empowerment are most aligned with the critical stance of this research on equitable health access for LGBT people. His proposed tool/rubric resonates with my initial application of the 5 Ps of Invitational Theory (people, places, programs, processes and policies) to research with marginalized groups, such as childbearing lesbians. Rather than "managing diversity" which may not address underlying structures that contribute to inequitable care, this focus on equity and attention to underlying structures at both the individual and institutional level is consistent with the World Health Organization's (1986) philosophy of primary health care with social justice aims.

The addition of the 6th "P", Politics, has implications for both providers and clients/communities in the context of health. In fact, Peter (2000) argued that the political dimension is the most integral to the feminist approach to ethics and bioethics. While the notion of bioethics informed by the biomedical model is often focused on ethical/moral crises in clinical and hospital settings, Peter (2000) identifies politics as the key element in attaining social justice and equity. These inquiries examine how relations of power and privilege, including gender and other social relations are relevant to health and nursing practice, and scrutinize the processes whereby knowledge is created and authorized (MacDonnell & Andrews, 2006). Critical self-reflection is an integral aspect of practice where power is conceptualized on the one hand, in terms of oppression, and on the other hand in its positive form, in terms of producing knowledge through action. Such inquiries lend themselves to focus on context and everyday lives, provider experience and their relationships. These phenonmena nicely align with invitational concepts.

On a personal level, the opportunity to learn about Invitational Education in a graduate course was a crucial turning point in my engagement with equity issues, from my first research inquiry on childbearing lesbians to a research trajectory that has been focused on equity and engagement with political action. Invitational theory has been formative in my understanding of equity-related research and education, and the ways that an invitational approach could be applied using critical feminist lens. There are implications for enhancing graduate student research capacity, in relation to equity focus using invitational concepts.

Reflecting on my own engagement with equity and LGBT-focused research over the last 15 years, invitational concepts, in conjunction with a critical lens, are robust in terms of their potential for LGBT-focused research. Equity and dynamics of power in research are addressed using invitational concepts from an interpretive/constructivist paradigm with its goal of understanding, and from a critical paradigm with its focus on power and privilege to attain the explicitly political goals of social justice and action for social change (Guba & Lincoln, 2005).

This case study combines an invitational approach with an explicitly critical stance, foregrounds gender and other relations of power, and thus provides a theoretical rationale to incorporate invitational concepts into current practice with a focus on improving LGBT home care access in the Canadian context. Invitational Theory provided the ideal framework when a recent opportunity emerged to consider a theoretical perspective to underpin strategies that address an identified gap in LGBT health care access to home care (Moore, 2009). A rubric was created for use by health care providers to address the spectrum of intentionally disinviting, through intentionally inviting care. It stresses the need to consider both provider and patient/client perspectives, along with a systematic approach using the 6 Ps when assessing environments and developing strategies to work toward intentionally inviting health care environments. Preliminary feedback from a range of home care stakeholders, including health professionals and educators indicates that Invitational Theory can prompt engagement with otherwise challenging anti-oppression education concepts, such as critical self-reflection and can promote an interest in examining

care environments to enhance inclusivity (Daley & MacDonnell, 2010). There are implications for creating spaces to engage in interdisciplinary dialogue on inclusion in educational contexts, and undertake further equity-related health care access research that incorporates a critical lens in relation to applying an invitational approach.

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Appendix: Guidelines for Interviews

Prenatal Interview:

1. Tell me about the pregnancy. How have you both been feeling? Is this the way you expected to feel during the pregnancy? Can you tell me about planning for the pregnancy and making it happen? How did you make your decision? What factors were involved: information, supports, resources, networks for donor sperm, pre-conceptual counseling/information, and cost incurred?

2. What words do you use to describe your partnering with a female (e.g., do you identify with lesbian, gay, queer, or women loving women)? What language issues are relevant for an expectant couple in a lesbian relationship (e.g., co-mother, co-parent, mom, other-mom, first names, legal names and assisted, artificial, alternative insemination/conception/ baby dancing)?

3. Whom are you seeing to met your health needs during pregnancy (include all providers)? How did you choose your caregivers for the pregnancy? How do your caregivers meet your needs? What would you consider ineffective in meeting your needs? How do you figure out whether a health care provider is lesbian-positive? Is disclosure of lesbian status usually necessary in order to obtain specific information? How do you access lesbian-positive resources (e.g., written information/human supports/networks/videos)?

4. Whom do you consider to be personal supports during this pregnancy? Have these changed since you announced the pregnancy? Does this differ with biological or comother roles? What concerns do you have about supports during the pregnancy, labour, or after the baby arrives?

5. What do you see as important education issues for expectant lesbian couples? What would be important component of education that would be meaningful to your prenatal experience? How do you obtain information on these issues? What kind of legal and ethical issues are you concerned about? What are specific educational issues for the coparent? In what ways are these issues similar to or different from those of heterosexual couples? What have you heard or experienced with regard to expectant lesbian regarding prenatal classes?

6. How are families involved in expectant lesbian women's experiences? How is the lesbian community involved? What kind of connections do you have with other expectant lesbian women or parents? How did you connect with them? What makes this easier? Are you aware of specific groups/resources for women partnering in a pregnancy who want to get pregnant, are pregnant, are postpartum, or have kids? Are on-line supports part of the life of those expectant lesbian couples you have known? How are males part of the parenting experience/your lives? Bisexual women? Lesbian grannies?

7. Couples in an expectant lesbian relationship may experience role conflict and/or stress during pregnancy and with the birth of a child. How does this apply to your relationship? What relationship issues did you deal with when you planned this pregnancy (if applicable)? How do you manage stress during the pregnancy? What kinds of issues are particularly stressful during the pregnancy? Who might be considered supportive community contacts?

8. What are your experiences of disclosing lesbian status to others? Has this changed with the pregnancy? How is disclosure of lesbian stature to other expectant couples and providers of care facilitated (if desired)?

9. How can providers of care offer gay-positive information if anonymity is desired? There is often no provision for identification of sexual orientation status on intake forms. Many providers of care are not aware of the expectant lesbian population/do not perceive the need to know/feel uncomfortable knowing the sexual orientation status of couples. How do you deal with this?

10. Do you identify yourself with a particular political philosophy (e.g., have political affinities or participation in women's groups, etc.)? Has this affected your approach to seeking care (i.e., information and support) during the pregnancy? Many feminists feel that motherhood is the telling time in many relationships because of the birth link and work that is done by mother (often not celebrated/valued) and the default roles which are assumed. Has this been an issue (with a toddler) and to you have plans to change this with the birth?

Postnatal Interviews

1. What have you learned about yourself and your partner through this childbirth experience (e.g., strengths, vulnerabilities)? What would you have done differently knowing what you know now?

2. How has this childbearing experience been similar to and different from your previous childbirth experience in terms of identity as biological mother, co-mother (and your preferred language for these)?

3. The heterosexism and homophobia that you have both named have been present through your childbearing experience: the decision-making, prenatal, intra-natal, and postpartum phases. How would you say you have resisted this everyday presence?

4. In light of having accomplished childbearing together, what characteristics does it show—what does it say about you as a person? What would your partner say about his? What implications does this have for your decision to experience childbearing as a lesbian couple?

5. What kinds of issues have contributed to your postpartum experiences—the good times

6. As you reflect on your childbearing, what kinds of experiences, information or support were helpful or not so helpful in shaping your lives?

7. What factors contributed to inviting individual interactions and institutional interactions (e.g., policies, etc.)?