

Abstract

Consensual non-monogamous parenting couples are at increased risk for health inequities, especially during the transition to parenthood. This article presents partial results of a more extensive mixed-methods study exploring the conciliation of these couples' parenting role and their sexual lifestyle, more specifically, their perceptions of health care providers including nurses. Semi-structured interviews and online questionnaires were completed with a total of 6 participants. Positive and negative issues were identified that were clients- and health care providers-based. The Expanding the Movement for Empowerment and Reproductive Justice lens was used to discuss the positive and negative consequences. Nurses need to develop, implement and evaluate a different clinical approach with these couples, who are aware of the health risks associated with their lifestyle, yet they always put their families first. Nurse administrators need to assess their institutional policies that are based on hetero-mononormative assumptions.

Key words consensual non-monogamy, couples, health care professionals, parenthood, nurses

Consensual Non-Monogamous Parenting Couples' Perceptions of Healthcare Providers during the Transition to Parenthood

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Introduction

Consensual non-monogamous couples (CNMCs), having made a conscious decision to have more than one sexual partner,[1] identify as swingers, polyamorous or being in open relationships. One in five Americans have engaged in consensual non-monogamy (CNM) at one point in their lives;[2] Canadians also follow this tendency.[3] People identifying as CNM are more likely to be gay, lesbian, or

bisexual,[4] while those considered as swingers are more associated with heteronormative sexuality[5]. Certain studies have looked more closely at societal attitudes in regard to CNMCs[1,6]: CNMCs are viewed less favourably than the general population, with swingers being viewed the least favourably of all of them. For those who practice polyamory, another concern involves the stigma that may extend to their offspring.[7]

Sexual minorities including CNMCs appear to experience more health disparities than the rest of the population. This can be attributed to minority stress,[8] which can increase with discrimination encountered in their daily lives as well as during health care encounters[9]. This population can experience higher levels of mental health issues, and higher rates of tobacco, alcohol, and substance use.[8] The findings from the study conducted by O'Byrne and Watts[5] on CNMCs and their sexual practices indicate that CNMCs may be at greater risk for sexually transmitted infections (STIs), and may delay or refrain from seeking health care for their sexual health. Women in this study were at greater risk of developing

STIs compared to men.

There is a dearth of studies that have considered CNMCs' perceptions with health care providers (HCPs), especially those involving nurses.[10,11] CNMCs have revealed that they have had both positive and negative experiences while engaging with health care providers and the health care system.[5,10] The ever-changing fabric of Canadian society, including CNMCs, combined with the health inequities encountered by sexual minorities, reinforces the need for nurses to be more comfortable with and well-versed in human sexuality and sexual diversity.[11] Yet, nurses have demonstrated a lack of knowledge and discomfort when addressing issues related to human sexuality and sexual diversity.[12] This can be partially attributed to nursing education programmes that do not include sexuality in their curricula, and the approach used in the teaching of sexuality in these programmes is 'haphazard at best'.[13]

This article reports partial findings from a larger study that investigated consensual non-monogamous parenting couples' (CNMPCs) conciliation of their parenting role and their sexual lifestyle during the transition to parenthood,[11] more specifically, the findings that pertain to CNMPCs' perceptions of health care providers including nurses. The underlying conceptual framework that was used is the Reproductive Justice Framework.[14] The Expanding the Movement for Empowerment and Reproductive Justice (EMERJ)[14] lens is a concrete way of integrating the Reproductive Justice Framework both research-wise and clinically, especially when engaging with CNMPCs.

Methods

Study design, sampling, and recruitment

The original study[11] was a mixed methods study using the triangulation design convergence model[15] as part of the first author's master's thesis research study.

Purposive sampling utilizing key informants and the snowball technique[16] were used to obtain a sample of CNMPCs living in Winnipeg, Canada and who identified as consensual non-monogamists during the transition to parenthood. The methods of recruitment included the use of the Fetlife platform, and sending invitations to the local swinging clubs and hangouts of CNMCs in Winnipeg. A total of eight participants were recruited, but only six of them completed both the online questionnaire and the interview. The two participants who chose not to continue with the study did so for personal reasons. Three interviews were conducted before the initial data analysis. Interviews were then added in

groups of three until no new themes emerged, and when data saturation had been obtained.[17,18] Informed consent was obtained by all subjects prior to the start of the study.

Data collection and analysis

To follow Plano Clark and Creswell's[15] triangulation design convergence model, both quantitative and qualitative data were collected at the same time. The qualitative data were first analyzed, followed by the quantitative data. Once all of the data had been analyzed, they were then converged.

The quantitative data were collected using an online questionnaire that contained 24 questions regarding sociodemographic, relational, and parenting characteristics. This same questionnaire also included the following scales: the Parenting Sense of Competence Scale (PSCS);[19] the Personal Assessment of Intimacy in Relationship Inventory (PAIR);[20] as well as the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) which was created for this study.[11] The online questionnaire took the participants between 15 and 20 minutes to complete. The obtained quantitative data were analyzed using descriptive statistics (mean, SD). SPSS Statistics version 24[21] was applied for this part of the analysis.

The qualitative data were collected using a semi-structured interview guide.[16] This guide was developed incorporating the themes from the EMERJ lens,[14] Cowan and Cowan's Ecological Model,[22] as well as the various themes that emerged from the literature review. The interview guide contained 32 questions divided into four different sections. The first section explored the participants' perceptions of their transition to parenthood. The second part focused on their particular sexual style. The third part delved into the conciliation of their parental role and their sexual lifestyle. The final section assessed CNMPCs and their experiences with healthcare professionals including nurses and the health care system. Participants were given the option of conducting the interview in person, over the phone, or via Skype. The interviews were audiorecorded and took between one and two hours to complete. The Schreir approach[23] for qualitative data analysis was applied for this part of the data analysis.

Results

This article presents partial results from the larger study. The participants' profile will first be presented, followed by the qualitative results in regard to CNMPCs' perceptions of health care providers including nurses during their transition to parenthood.

Participants' profile

There were four female and two male participants who were part of the sample. The participants' ages ranged from 31 to 45 years ($M = 37.67$ years, $SD = 6.37$). Five participants identified as bisexual or pansexual and the other one as heterosexual. At the beginning of the transition to parenthood, four participants identified as swingers, one was in an open relationship, and the last one was polyamorous. At the time of data collection, four participants identified as being polyamorous and two others as swingers. Four participants were married, one was common-law, and the last one was separated. The number of children for each participant ranged from 1 to 3, with an average age of 10.63 years at the time of the interviews. Their incomes ranged from \$19 000 to over \$60 000. All participants were Canadian born.

Qualitative data results

Several themes were identified during the general qualitative data analysis, however for this article, only the 'Relationships with Health Care Providers' theme is presented. This theme contains four categories: fear of judgment, health risk awareness, health care providers' lack of training, and factors facilitating and hindering this relationship. Eight subcategories were identified.

Fear of judgment

The first category, 'Fear of Judgment', contained three subcategories: 'Heteronormative Assumptions', 'Perceived Judgment', and 'Fear of Repercussions of Lifestyle on Parenting'.

For the first subcategory of 'Heteronormative Assumptions', five out of the six participants indicated that their healthcare providers (HCPs) demonstrated heteronormative assumptions, meaning that the HCPs assumed that the participants were in a heterosexual monogamous relationship. The HCPs questioned the participants' need for STBBI testing in two circumstances because their clients were married (Participants P1 and P4). One participant (P1) chose to disclose her lifestyle which she later regretted, and the other (P4) chose to instead lie about her situation, claiming that she thought that her husband was cheating on her. Another participant (P3) delayed seeking care for her postpartum depression after the birth of her second child due to the heteromononormative assumptions demonstrated by her Public Health Nurse, which eventually led to postpartum psychosis.

The second subcategory, 'Perceived Judgment', was expressed by four participants. This influenced whether or not the

participants were disclosing their lifestyle to their HCPs. They believed it was on a more 'need to know basis' (Participant P2). Perceived judgment was demonstrated when one of the participants (Participant P4) sought out an abortion after a pregnancy that occurred after a swinging encounter:

...it was met with, you know, almost a, well you know, this was a decision that you made to do and this kind of the consequence of your decisions and it's like, well, you know it was an accident just like it would have been between a normal couple but I don't think they would have come at us with that sort of mentality, if it was just my partner and I going in and saying, you know: "We're young, we're in school, this is an accident, and you know this is not what we are looking for" vs. "I am might be pregnant with my husband's best friend's kid." (Participant P4)

The third subcategory, 'Fear of Repercussions of their Lifestyle on Parenting', was demonstrated by all participants in that they did not want their lifestyle choices to affect their offspring. This fear was demonstrated by one of the participants (Participant P4) when the Child and Family Services initiated an investigation into her lifestyle. This investigation was halted, and apologies were made after the participant informed the worker's supervisor, reinforcing the fact that her sexual lifestyle had no bearing on her ability to parent.

Health risk awareness

Two subcategories: 'Informed Consumer' and 'Pregnancy and STI Prevention', are included in the second category of 'Health Risk Awareness'. The first subcategory, 'Informed Consumer', highlights that all participants were well aware of how their sexual lifestyle could affect their health. They went for regular STBBI screenings and chose to inform others before engaging in the sexual lifestyle. Participant P4 highlighted the need for advocacy because HCPs lacked education when it came to sexual minorities and sexuality in general, stating that participants had "the need to have a voice".

When it comes to pregnancy and STBBI prevention, all participants chose to be more careful while trying to conceive and during their pregnancies. Five out of the six participants decided to be monogamous while trying to conceive in order to ensure the paternity of their child. Participant 1 expressed it in the following way:

during the trying phase, during the pregnancy, during the postpartum experience as well there was no sexual ah contact with anybody outside of umm.. my husband for myself and for when my husband did have ummm...a couple of encounters during the pregnancy, it was done extremely safely and just... I mean that's part of the lifestyle that we live and the you know the making sure that we were being safer for our family. (Participant P1)

All participants expressed concerns for people who participate in CNM and are not aware of the risks associated with it due to the HCPs' lack of knowledge.

HCPs' lack of training with CNM

This section on the third category of 'HCPs' Lack of Training with CNM' contains two subcategories: 'Lack of Sexual Education in Schools' and 'Providers' Lack of Training during the Prenatal Period'.

Participant P6 expressed her concern with the training that HCPs receive during the precursory programs to which the rest of the participants alluded to. She did not believe that HCPs received enough training when it came to sexuality and sexual minorities. However well-intentioned they are, HCPs did not always provide the support she needed for her particular sexual health concerns. She partially attributed this to the HCPs' lack of knowledge about the use of the correct terminology:

...they are interested, but they don't know what it means. So then you have to get into, delve into an explanation um, and with the lifestyle, there always needs to be a definition anyways, because my definition of a full swap might not be the same thing as what someone else might consider a full swap is in the lifestyle. But you do need to know what the basic terminology means. What is the risk, what does it refer to and that doesn't seem to be the case. (Participant P6)

This lack of training appeared to be even more problematic during the prenatal period. Only one of the six participants attended prenatal classes, two used a doula, and the other three preferred not to take prenatal classes because they felt these classes were "rudimentary at best" (Participant P2). All participants claimed that the prenatal classes, reference books as well as the doulas did not have or give very much information about sexuality during the transition to parenthood. They all felt that more information is needed to be given about sexuality in prenatal classes and after childbirth, and that resources should be developed for different levels of education.

Factors facilitating and hindering the relationship

This last category focuses on the factors that facilitate the relationship between HCPs and their clients followed by those that hinder it.

There are three facilitating factors. The first facilitating factor for CNMPCs appears to be the inclusion of all parenting partners when care is provided during the transition to parenthood. The second facilitating factor is when HCPs including nurses are able to understand that CNMPCs put their families first.

Participants took their safety and that of their children very seriously. Participants wanted reassurance from HCPs that the participants' lifestyle would not have repercussions on their children's health and wellbeing, and that they could live a complete and rewarding life free of discrimination.

The third facilitating factor revolved around relationship building using the following six strategies. Participants believed that the first strategy for relationship building should start at the intake interview with a questionnaire:

...verifying if the person leads an alternative sexual lifestyle of some form, would probably help open a conversation, without actually asking, just questionnaires would open doors for them. (Participant P5).

The second strategy involves using language that is neither heteronormative nor mononormative; this would normalize sexuality and lead to more clients disclosing their lifestyle to their primary care providers. The third strategy mentioned by five out of six participants was using a harm reduction approach, starting with assessing their knowledge about STBBIs or other risks associated with their lifestyle. The fourth strategy would be for HCPs to give care without judgment and to work with this sexual minority. The fifth strategy involves HCPs working in partnership with their clients, and recognizing their clinical limitations, as stated by Participant P6:

Don't just sit there and wait for me to disclose my life story. It's not going to happen... When they go to the doctor's they're sick, and they want to know what's wrong. They're not going to bring in all kinds of things which might have been factors in what's happened to them, but if you're not disclosing that you are open to ah... hearing what might happen and truly find a solution to what's happened um that's appropriate and fitting to their lifestyle and their sexuality, then, that makes it complicated... You know your partner happens to be infected, so that could have happened. (Participant P6)

The last strategy that would help these particular parents would be to have HCPs specialize in sexual minorities along with being well versed in human sexuality.

Participants mentioned that when the facilitating factors were not present, their relationship with the HCPs could be adversely affected, meaning that the facilitators became obstacles. Another hindering factor mentioned by the participants was when HCPs assumed that they were a homogenous group. All participants explained that there are many differences among CNMPCs which could be problematic when HCPs assume that they are the same. This was expressed by Participant P4:

Every non-monogamous relationship is different... whether there is an extra partner or not... or however the dynamic is, ask questions respectfully.... So that you know... who

to address and how to address. How they play a role in... Cause I mean I believe now, very holistically, that everything in your life has to work together. So it... my biggest advice would ask respectful questions. And don't be afraid to... If they're sharing that they are in a non-monogamous relationship with you, they have already opened up to you. (Participant P4)

Discussion

There were both positive and negative issues that affected the participants' relationships with their health care providers. Some of these issues stemmed from the clients themselves, while others were HCP-based. Using the EMERJ lens,[14] the consequences of these issues for the relationship between the participants and the HCPs were both positive and negative.

The positive issues that emerged from the findings related to the clients are based on resilience. Young and her collaborators[24] conducted a scoping review on the application of resilience theories in the transition to parenthood. According to these authors, resilience is a useful concept for synthesizing information about the transition to parenthood. Although the authors do not present a definition of resilience in their article, they do indicate that resilience theories gather around two critical components. The first component is the presence of a significant threat or challenge, while the second component is the positive adaptation despite the stressor.[24] Young and her colleagues[24] consider the transition to parenthood as enough of a challenge due to the vulnerability associated with it that it requires a resilient response. CNMPCs, in the present study, demonstrated this resilience by being health-focused during their transition to parenthood. They did this at three levels involving their relationship, their children, and with their HCPs. At the relationship level, all of the participants had a great awareness of their sexual lifestyle and its potential consequences on their health. They demonstrated this by going for regular STBBI testing, informing potential lifestyle partners of their health status before sexual encounters, and having a more holistic view of health (physical, mental, emotional, and sexual). At the level of their children, the participants became protective of them by returning to monogamy during conception, pregnancy, and in the first few months after birthing in order to better control their situations and to prevent any risks occurring to their health and that of their unborn and born children. At the level of HCPs, the participants were actively involved in their health care, sought health care services when mental health and sexual health concerns had to be addressed, and tried to find HCPs who were caring, non-judgemental, and more aware of the reproductive justice approach to care. The participants were very well aware of the health risks associated with their

lifestyle during the transition to parenthood.

The findings that have just been highlighted are compared to those reported in the literature in terms of those that are similar, the ones that are contrary, and the others that are distinct. A part of these findings in the present study in which the participants were found to be health-focused is supported by those published in the Jenks study (25). The participants in the Jenks study[25] did seek out mental health care and counselling services when needed. However, the other findings reported here are different from those presented by Fernandes[26] and by O'Byrne and Watts[5]. In these latter two studies, the participants who were CNMCs would delay seeking preventative and sexual health care, which is contrary to the findings revealed in the present study, as the participants did seek health services. Lastly, the findings presented here are distinct in that they contribute to a beginning understanding of those individuals who are parents and engage in the 'lifestyle' during the transition to parenthood. There is a dearth of studies that have focused on this unique sexual minority regarding their health and their health behaviours during a period of vulnerability involving the perinatal period from conception to life with baby. It would appear that the participants in this study demonstrated resilience through their focus on health: it is this health consciousness that appears to underlie their resilience during the transition to parenthood.

Although there were positive client-based issues based on resilience, there were negative issues based on fears, particularly two fears related to disclosure of their sexual lifestyle and stigmatization of their children. The participants expressed the fear of having to disclose their lifestyle, especially when they had prior negative experiences. Also, for those participants who identified as swingers, they valued non-disclosure as a priority. These findings in regard to this first fear are supported from the literature, in that sexual minorities tend to not disclose their sexual lifestyle due to HCPs' judgemental attitude.[27] The participants also expressed a second fear involving the stigmatization of their children, more so for the participants who identified as being polyamorous. This fear is similar to that reported by other researchers.[7,25,28] The findings that were published by these three studies[7,25,28] indicate that their respondents did not want their children to be treated differently in school, have their lifestyle negatively affect their various sexual opportunities, and have their children taken away as they did not abide by heteromononormativity. HCPs need to be aware that this sexual minority has these two particular fears. Other fears may be present that may not have been identified by this study.

There were both positive and negative issues that emerged from the findings in regard to the HCPs themselves. Two positive issues were connected to the HCPs but from the perspective of the participants. All six participants revealed how some of their HCPs demonstrated respect toward them by being supportive of them and their children, and of their sexual lifestyle. The HCPs also had a non-judgemental attitude toward them. When participants perceived this, they were more open and willing to discuss issues regarding their health and chosen sexual lifestyle, even when they perceived that their HCPs lacked knowledge and training in human sexuality. This respect likely stems from HCPs being more aware of the emerging family structures in Canada. According to Leonardi-Warren et al.,[29] when HCPs are more aware of the role they play in building relationships with clients and emerging family structures, they are more likely to use inclusive language and question institutional policies that do not support the inclusion of all families in their care. Nurses can do this by being conscious of the importance of building a therapeutic relationship built on trust.[9] Pallota-Chiarolli[7] indicates how this can be done by including all family members in the care provided by HCPs during the transition to parenthood; however, it also includes stressing the importance of recognizing CNMPCs' strengths as families, all while acknowledging their differences.

On the other hand, the findings from the present study seem to indicate that HCPs who are open and non-judgemental are the exception and not the norm. The majority of participants expressed how they had received care from HCPs who held heteromononormative assumptions. This highlights two negative issues that were revealed by the participants, namely, that the HCPs lacked both knowledge and training in human sexuality. The lack of knowledge and training frustrated participants at times, which led them to try to find HCPs who were more knowledgeable about sexual minorities. The participants also delayed seeking care, or seeking care without disclosing their lifestyle. These findings support previous literature[12,29-33] that highlights that HCPs receive very little education and training in sexuality in their undergraduate programmes, and even less about alternative sexual lifestyles.[34] This lack of education leads to HCPs being uncomfortable discussing sexuality, regardless of the health care setting.[12,29] The findings from this present study indicate that, although sexuality is a crucial aspect during the prenatal period, the participants received little or no education in this area during this particular phase of the transition to parenthood. Education for sexuality should be available throughout this transition.

When HCPs are uncomfortable discussing sexuality, it can

be advanced that it is more difficult for them to move beyond society's heteronormative assumptions. The HCPs' discomfort and their lack of education in sexuality translate into starting discussions about sexuality with their clients with underlying heteronormative assumptions. The findings suggest that these assumptions can lead to non-disclosure on the part of the clients, which can be especially problematic during the transition to parenthood. On the other hand, no published study could be found that corroborates these findings. Therefore, it can be posited that similar to Landry and Kensler's study,[9] miscommunication can ensue, especially when the HCPs do not understand the terminology being used when discussing their clients' lifestyle, or they can present themselves as being curious without having the appropriate tools to help their clients.

So far, the discussion has been considered in light of the positive and negative issues that are clients-based and HCPs-based. However, the consequences of these issues on the relationship between clients and HCPs need to be discussed in terms of the positive relationship between them and of the negative one. In order to accomplish this, this discussion needs to be put into a greater context by its integration with the Reproductive Justice Framework which is represented by the EMERJ[14] lens. The three arenas of the Reproductive Justice Framework that are crucial to this integration are family, health and safety, and access and opportunity. For the Family arena, it is important to identify the ways in which parents maintain their family unit. For the Health and Safety arena, this involves how health and safety are promoted and save-guarded. For the last arena of Access and Opportunity, opportunities must be put in place so that sexual minority parents' gender, body and sexuality are respected as well as they having access to HCPs including nurses and healthcare services.

For a positive relationship to be present between clients and HCPs, while considering the three arenas of Family, Health and Safety, and Access and Opportunity, this means that this particular sexual minority follows the philosophy of 'Family First, Lifestyle Second' (Family arena), while being supported by an underlying resilience and health consciousness on their part (Health and Safety arena), which is also accompanied by HCPs who have both sexual minority knowledge and training (Access and Opportunity arena). On the other hand, the negative relationship between clients and HCPs may occur in the following way when involving the three arenas. Although the participants do put 'Family First' (Family arena), they are still worried about the repercussions of their lifestyle on their children and the stigmatisation that they may face. In the arena of Health and Safety, CNMPCs may decide not to

divulge their lifestyle to their HCPs. They may also be more likely to encounter greater health risk, especially in the initial exploration phase of consensual non monogamy, as they do not necessarily have the tools to be able to say 'no' to unwanted sexual contact. Lastly, regarding the Access and Opportunity arena, CNMPCs have very limited access to HCPs who are well versed in human sexuality and sexuality minorities.

Strengths and limitations

The first strength of this study is that it was able to identify factors that facilitate and hinder the relationship between this particular type of sexual minority clients and HCPs. Secondly, this study was able to look more closely at the CNMPCs' conciliation of the parenting role and their sexual lifestyle during the transition to parenthood. These two strengths are especially important for nurses as frontline workers, as they will be better equipped to understand this subgroup of parenting couples.

On the other hand, the first limitation involves the small sample size, yet it appears to be adequate enough,[35] as the findings paint a rich contextual picture of CNMPCs and their perceptions of HCPs. The few studies that have been conducted on sexual minorities used similar sample sizes.[35] The second limitation is that the study concentrated on a small geographical area within the province of Manitoba, so it may be difficult to generalize the findings to other parts of this province, to the rest of Canada, and elsewhere. As this is one of the first studies of its kind, it can lead to further research on this sexuality minority in a parenting context that is underrepresented in both research and health care.

Implications for nursing practice and health and social care policy

The findings from this study lead to a number of implications for nursing in all areas of nursing practice such as nursing education, practice, administration and research, as well as health and social care policy.

Nursing education

Prelicensure nursing programs need to include content on sexuality and sexual diversity. Nurse educators need to be taught how to deliver patient education using a sex-positive approach, defined as "respecting the wide range of human sexuality. It involves talking with your clients openly and without judgement about their sexuality",[36 p1] and how to transfer this knowledge to undergraduate students. These educators would also need to learn to take special considerations for dialogue using clarification and a common language.[36]

Once these students graduate, they can transfer their new knowledge and skills to the workplace. Such frontline nurses would apply them (knowledge and skills) in sexual-cultural safety environments.[37] Knowledge and training about sexuality and sexual minorities can help address health inequities through the lens of cultural safety, as nurses must "acknowledge that we are all bearers of culture, expose the social, political and historical contexts of health care",[37 p2] and look at "difficult concepts such as racism, discrimination, and prejudice"[37 p2].

Nursing practice

Nurses who do not receive prelicensure training in human sexuality and sexual minorities must be given the opportunity to attend this type of continuing education training. The onus of responsibility is on both the nurses and their administrations as such training will help them to improve their clinical practice. Through cultural safety, frontline nurses and other HCPs will not make assumptions about their clients based on sex, sexual orientation and sexual practices, age, gender, race, relationship status, ability, socioeconomic status, and other aspects.[36] For example, during health visits, nurses can ask questions pertinent to what the visits are for, including those relating to sexuality, thus promoting the relationship between nurses and their clients. Also, nurses can be encouraged to have an open and honest, inclusive intake interview when seeing new clients that does not use heteromononormative language[9] Nurses need to develop, implement and evaluate a different clinical approach with CNMPCs who are a particular type of sexual minority, who are well aware of the health risks involved with their lifestyle, and who put their families first, yet they do not let their sexual lifestyle interfere with their ability to parent their children.

Administration and advanced nursing practice

Nurse administrators need to assess their institutional policies that govern health care based on hetero-mononormative assumptions.[38] They also need to be more aware of newly emerging family structures, and how political and societal institutions that are grounded in mononormativity can negatively affect CNMPCs and their families.[11] Taking on a more leadership role through their advanced practice, nurse administrators and managers can emulate behaviours that frontline staff can adopt, and promote continuing education workshops that allow for a greater representation of sexual minorities.[9]

Research

Researchers should be encouraged to be more aware of their biases and the pervasive heteromononormative assumptions in nursing research.[39] They can get around these issues by adopting critical theory, queer theory, and intersectionality theory, and integrating them into their research studies. By adopting such theories, they can better recognize how structures including academia inherently perpetuate heteromononormative assumptions. By doing so, the responsibility lies not only on the oppressed, but also on the oppressor, who can change the status quo. Promoting participatory action research will set the stage for their voices to be heard and to be at the forefront of such change.[40]

Health and Public Policy

There has been an increased focus on nurses' advocacy role being combined with changes to Canadian legislation and code of ethics, leading to a politicization of nurses.[38] They have a responsibility to use their emancipatory, sociopolitical platform to inform health and public policy for this particular group of parents. Nurses can advocate for changes to structural policies that limit access and opportunities for sexual minorities such as CNMPCs, thereby decreasing health inequities that are often associated with such groups.[38]

Conclusion

Sexual minorities including CNMPCs continue to be underrepresented and underserved in nursing practice and research, and in health and public policies, potentially leading to health inequities for them. The CNMPCs in this study have demonstrated a certain resilience in navigating the health care system. Nurses and other HCPs need to increase their capacity to better serve this sexuality minority during their transition to parenthood by basing it on respect that includes their clients' sexual diversity, and meeting them where they are at on their life's journey. For this group of parents, family is always first.

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