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Towards Unprejudiced Midwifery Care – Midwifery Students' Views on Homosexuality

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Additional information is available at the end of the chapter

<http://dx.doi.org/10.5772/59116>

1. Introduction

Through history and across different social and cultural contexts, homosexuality was and still is presented as a sin, a disease, a crime, or a variation of sexual orientation. Following pressure from strong activist movements, the American Psychiatric Association removed homosexuality from its official diagnostic manual in 1973. In Slovenia, the Criminal Code treated homosexuality as a criminal act until 1976. WHO eliminated homosexuality from its list of diseases in 1991. Nevertheless, misinformation and prejudiced views strongly persist in certain areas, the most discussed currently being same-sex families and the right of gays and lesbians to adopt children. Common, general, and erroneous assumptions that get replicated in public discourse are, for example: homosexuality is not normal/natural; it is impossible to have two fathers or mothers; and it is for the good of the children to prevent their adoption by gay or lesbian couples, to name just a few [1]. These assumptions reflect the prevailing heteronormativity [2], which denormalizes and excludes all other variations of intimate practices and thus regulates our relationships, attitudes, expectations, and behaviour.

More than ever before, homosexuality today is understood in socio-political terms, as a question of social (in)equality. Attention is focused on socially excluding practices; that is, practices that deprive certain people of their basic rights, resources, and opportunities in a society. From the perspective of social psychology [3], these discriminatory practices are grounded in social categorization. The formation of stereotypes involves simplistic generalizations and neglects individual specifics. Stereotyping thereby uncritically overstates typical characteristics of a group at the expense of an individual's unique character. Stereotypes are, furthermore, value loaded. Stereotypical negative claims, usually formed even before coming into contact with the person or group talked about, are called prejudiced judgements. Since they are negative, they are related to behaviour excluding

certain groups of people from the core of the society and relegating them to its margins. The core society, or “us”, is considered normal, righteous, and just, while the margins, “them”, are attributed a negative, abnormal, and endangering character [4]. Applied to sexuality, heterosexuality is considered a norm (hence the term heteronormativity), pushing homo, bi, and transsexuality to a marginal position. Marginalization is justified and naturalized (presented as natural) in several ways, but it is grounded in prejudiced presentation of certain social minorities as endangering the majority [2]. Although it seems to make little sense, dominant discourses employing different representational strategies to depict certain minorities in negative ways, persistently and powerfully persuade the majority to recognize these minorities as a threat and to act defensively.

From the sociological perspective, the relation between expressed attitudes and real life behaviour is not straightforwardly cause-consequential but rather complex [5,6]. LaPiere’s famous study was carried out in 1934 in the United States of America when anti-Asian feelings prevailed. He travelled with a Chinese couple around the country and they were only turned down once out of 251 times, when they asked for a room in a hotel. Later, he sent mail survey to the same hotels and 92% of the respondents claimed that they would not serve Orientals. Prejudices attitudes, therefore, could not simply be taken as predictors of discriminatory behaviour. What had to be taken into account were wider situational social factors. In face-to-face contact, especially, less discrimination was detected. Generalization of the causal relation therefore proved problematic, and the importance of different intervening social and personal variables that were activated when an individual person encountered a unique social situation were stressed. Similarly, considerable problems with defining attitude as a concept appeared. It was established that attitudes were not underlying stable entities but rather varied according to circumstances. Further complexity regarding the distinction between verbally expressed attitudes and their latent constellation was pointed out. Also, presupposing that behaviour could change only if attitudes changed first, neglected the power of social structure to affect behaviour. The latter proved an even greater determinant of behaviour than attitude. Martin Luther King Jr. is often quoted in this respect: “Morals cannot be legislated, but behaviour can be regulated. The law cannot make an employer love me, but it can keep him from refusing to hire me because of the colour of my skin” [6]. It is very important to pass laws prohibiting discrimination. It is of equal importance to then implement them systematically and persistently.

It may seem then that actions speak louder than words, but comparing the two would only be to engage in endless discussion about which is more powerful and influential — actions or words. Instead, we should change the perspective and focus on the interpretation that actions manifest through words. We shall adopt this view by observing the changing manifestations of discrimination. Researchers [7,8,3] distinguished between the old and new forms of racism. Slavery and apartheid, for example, were explained in terms of biological inferiority, brutally enacted in direct physical contact as explicit hatred and violence. People were physically segregated. In such forms, racism was condemned — transparent expressions of racism are now globally socially unacceptable. Racism itself, however, was not rooted out. It transformed

into the new type, which presents itself in democratic lights and denies being discriminatory. It claims to be a defender of the majority's rights that are endangered by minorities claiming to be deprived and fighting for more privileges. New racists avoid direct contact; rather, they keep their distance from their targets. The new racism is symbolic and cultural. Instead of manifest aggression, it deploys a more indirect and covert strategies such as passive decline and ignoring the minorities. The transformation to more subtle and indirect manifestations established a much stronger relationship between attitude and behaviour. Symbolic racism is primarily a discursive racism. Discourse is a concept that helps us to understand language use within its social context, as a specific form of social interaction [9]. Within a social constructionist perspective we not only understand the world as we can describe it through language but we actively (re)create it by making different interpretations of it — texts and talks are, therefore, social practices [10]. Interpretations differ in descriptions and values. For example, there is a great difference between descriptions of a bruise as a consequence of a fall and a push. Contrary descriptions can be used to describe and value the same physical event, but which create two different interpretations with completely different judgemental values, and social and personal consequences — the event can be interpreted as an accident or an act of violence, respectively. Our reality is a discursive one and it is important, and far from coincidental, who possesses the power to interpret, whose version of the world is taken to be the correct and true one.

The power of discourses is also enabled by structural conditions of dissemination. The basic means of disseminating information today is provided by media of mass communication. People learn more about what is happening around them and in the world from mass media than from their personal experience; their knowledge is therefore mediated through media discourse. As such, media should be the prime locus of our critical attention. Critical discourse analysis developed out of that understanding and need [9,11,12]. Critical discourse analysis of Slovenian mass media texts on homosexuality [2] reveals five basic homophobic strategies: stereotypization, medicalization, sexualization, normalization, and homosexuality as a secret. Discriminatory discourse nowadays is rarely straightforwardly aggressive and explicit, but the same exclusionary effects remain. Some scientists claim its effects are even stronger, because symbolic discriminatory discourses present themselves as democratic, normal, and common sense, something we need not doubt and be critical about. Hate speech nowadays avoids direct disregard; rather it subtly discredits, humiliates, disrespects, and deprives people of dignity. As such, it is no less discriminatory than the older method. Understanding language use as discourse helps us surpass the distinction between actions and words — it stresses doing (discriminating) by using words (interpreting certain people as less worthy). That is why modern activists fighting inequality also operate at the level of legislation, and strive to enforce laws on hate speech. In Slovenia, freedom of speech is written into the Constitution, yet its Article 63 also prohibits the encouragement of inequalities, spread of hatred, intolerance, violence, or war. The Criminal Code was enacted in 2008; article 297 regulates hate speech and article 141 prohibits discrimination on the grounds of sexual orientation.

Surveys on public opinion in Slovenia detected homophobia. The great majority of the respondents did not personally know any people that were homosexually oriented yet more

than half of them would not want a gay or a lesbian to be their neighbour [13,14]. In another study [15] more than half of included gays and lesbians had experienced violence due to their homosexual orientation: 90% characterized it as psychological, 24% as physical, and 6% as sexual violence. It was mostly caused by strangers and enacted in public places (61%), but to a lesser extent also by parents (25.8%), relatives, friends, and school peers (25%). At work, 4% suspected they had been fired due to the disclosure of their sexual orientation. Regarding family planning, 42% of gay and lesbian respondents wished to have a child and 40% did not. It was interpreted as reflecting their understanding of an unfavourable social context and scarce chances they were given to realize this wish, which therefore mainly stayed repressed. These data also indicated the (large) extent of deliberation they invested in this question, given that their wish for a child is often considered to be selfish and without any consideration for that child.

Children of gay and lesbian couples are stigmatized and victimized: that is, attributed the role of the victim from the outside by the prejudiced wider society, not based on their own bad experience or objective data of poor living conditions. It is supposed to be for children's own good not to have same-sex parents, although in most cases one of the partners is a biological parent of a child, making such prejudice an instance of homophobia dressed in altruistic clothes. Namely, there is no evidence of lower quality parenting in gay or lesbian couples. Children do not report problems if the relations within the family are of good quality. Rather, the problems appear once they enter an institution or society at large, where others start telling them that they are different or less worthy. Only then do children become at risk of homophobia, discrimination, and violence. Compared to activist attitudes and the demonstrative silence of gay/lesbian parents and their children in Sweden and Germany, the Slovenian response is to hide — they were afraid of being abused. Homosexuals do have children, either from their previous heterosexual relationships, by in vitro fertilization, or some other kind of arrangement. Rainbow families already exist but they are excluded at the symbolic, legal, and social levels [16].

Social inequalities do not refer only to the economic, political, and cultural conditions of life, but also manifest in health. In the last two decades, WHO has been strongly promoting the awareness of the social determinants of health, especially in terms of the devastating effects of health inequalities [17]. The social determinants of health are defined as economic and social conditions that influence the health of people and communities, and are shaped by policy choices, power, money, and resources that people have. This also means that they could and should be decreased by appropriate socio-political action. Research showed that homophobia and discrimination — negative (pre)judgements, hatred, and practices that deny social participation or human rights — have negative effects on (mental and physical) health of the discriminated and the accessibility and quality of health care services provided to them [18]. Health problems of lesbian, gay, bisexual, and transgender (LGBT) people have only just recently begun to be surveyed [19]. They were found to have worse mental health than the general population, they were more likely to commit suicide, and they had a higher rate of alcohol consumption and misuse of substances/recreational drugs and related problems. They had higher rates of physical ill health, worse self-reported health status, more acute physical

symptoms, and chronic conditions. It is important to understand that this morbidity is caused by psychosocial stress stemming from stigma and discrimination coming from the wider society but also occurring in healthcare settings. On the one hand, health professionals were reported to have denied homosexual people access to certain services, excluded them from decision making, or made inappropriate comments. On the other hand, health professionals were experienced as not being knowledgeable about homosexuals' lifestyle and specific health care needs [20]. Studies showed that homophobia amongst health professionals had negative consequences for the care of lesbian and gay clients [21,22]. This is also one of the reasons why LGBT people keep their sexuality a secret from health care professionals or even fail to engage with health services. A general ignorance of lesbian needs is not only present in the field of health care but also social services [21]. In Slovenia, such a deficit combined with homophobic standpoints was already detected in the field of social and consultant work related to mental health, where evidence was found that homosexuality was still considered to be a disorder [23].

2. Problem and aim

Health care professionals and their respective professional fields are a part of society and thereby prone to be affected by various public discourses and policies. It is a constitutive part of their supportive, therapeutic, and educational work to include and empower people in their endeavour to promote, preserve, or restore health. Their professional ethics require them to be knowledgeable, objective, and non-judgemental, and to provide equally accessible and high quality services to all. Midwives are among the health care professionals that deal most directly with different aspects of human sexuality. One of their important competences, therefore, is to gain knowledge and develop sensitivity towards different forms of (health) inequalities related to sexual orientation, starting by becoming aware of and overcoming their own prejudices.

The aim of the original study was to study attitudes of first year students of different health professions towards homosexuality and homosexual parenting. The focus of this chapter is placed on midwifery students. Right at the start of their studies, the students were not yet exposed to a faculty professional curriculum. The purpose was to get an idea of the extent and types of potential prejudices against gays/lesbians and homosexual parenting. On these grounds, it will be possible to revise and adjust the contents of existing study programmes to provide knowledge supporting equal midwifery care in the future. Another aim was to raise awareness of a special discourse pattern — the disclaimer — which in today's society, especially, effectively supports the hidden persistence of all sorts of prejudices, while giving the illusion of tolerance in the speaker.

3. Methods

A qualitative study was designed and carried out. It involved the first year students of different study programs at the Faculty of Health Studies (University of Ljubljana) at the beginning of

the school year 2013/2014. The participation of students was voluntary, free from any pressure, and anonymous. They were informed of the aim of the study and given enough time to ask for additional information. They were asked to provide descriptive answers to eight open ended questions regarding their conceptualization of sexuality in general, sexology as a science and its relevance to their professional field, and their attitudes towards homosexuality and same-sex parenting. They wrote their answers on a piece of paper. Textual material was generated from 49 students of occupational therapy, 16 of orthotics and prosthetics, 39 of radiologic technology, 36 of sanitary engineering, 28 of nursing, and 29 of midwifery. Their answers were typed into an electronic format, and then coded and analysed using a critical discourse analytic framework [9,11]. Acknowledging the purpose and theme of this book, the primary analytic attention was attributed to the answers of midwifery students. In particular, the analysis focused on disclaimers.

In democratic societies, social norms prescribe tolerance and prohibit prejudice and discrimination among citizens. Speakers breaking this social norm by expressing negative opinions against certain individuals or social groups, therefore, need to apply denials or at least some form of mitigation strategy to maintain positive self-presentation in public. A disclaimer enables this impression management. According to van Dijk [7], a disclaimer (an apparent denial) is a specific structure of language use, the prototype being: "I have nothing against them, **but**..." In the first part of the structure, a generally tolerant attitude is stated while the second part continues with a specific negative opinion. This structure does not support inference from specific to general and as such presents a defensive strategy against potential accusations of socially unacceptable intolerance. On the other hand, the denial is only apparent, because the specific disregard is nevertheless inconsistent with the prevailing social norm. What is negatively stated is not really denied, at least not completely. Rather, the speaker wishes to deny the possible negative inferences about his social intolerance and to establish positive self-presentation. The tolerant attitude is left unsupported by evidence that the speaker really does not have anything against them. At its best, it therefore expresses limited social acceptance.

Billig [24] claimed that the social value of not being prejudiced is so general and deep-rooted that is also shared by the most extreme political agents. The disclaimer represents an advanced justification against the accusation of being prejudiced. It is not merely public impression management. Speakers also justify themselves to those who hold similar values and to themselves. It is therefore also a discursive strategy of self-justification: by the self to the self.

The analysis focused on disclaimers, through which prejudiced viewpoints against gays, lesbians, and same-sex parenting were identified. Results are presented by excerpts from direct writing collected from the midwifery students that participated in our study. Each excerpt is labelled with a code in brackets, where M stands for midwifery and the number for a random number attributed to the study participant. Excerpts are grouped under several sub-headlines according to themes that appeared to be most prominent.

4. Results and interpretation

Among midwifery students, 12 of 29 were supportive of gays and lesbians in all aspects of their lives, 10 expressed prejudiced opinions against homosexual couples having the right to get married and especially to adopt children, and seven struggled in forming a clear standpoint on the matter. In comparison to the first year students of other programs participating in our study, the ratio of supportive answers was quite high. Their positive attitude was related to the ethical principles of (post)modern societies — accepting and respecting diversity:

I accept homosexuality, I treat it equal to heterosexuality, which I believe is the only appropriate way of thinking in a modern society. (M3)

I accept them, they do not bother me. We are not all the same, I accept differences. (M17)

Homosexuals are completely common people, the same as heterosexuals. We all have the right to choose a partner at our own will. (M13)

My attitude to homosexuals is positive as I have two friends who are homosexuals. I can talk to them practically about everything. I have never scorned them and I never will. They are people just like us. (M15)

All of our respondents were aware of the social norm prescribing the same rights and treatment for all citizens, and consequently condemning discrimination. That is why homophobia was rarely explicitly stated; in all 29 cases of midwifery student answers, it appeared only once:

Personally I do not approve of homosexuality. I believe it is some sort of a mistake (in thinking, genes, development of a human being), as it is not natural. (M4)

On the other hand, the responses of those who expressed some sort of disregard or did not yet form a clear opinion on that matter, were full of disclaimers. Two different patterns were recognized. Intolerance was either disclaimed within a single sentence or across larger meaningful instances of talk:

*They do not bother me, **but** I avoid them (if I can). (M19)*

*I have nothing against them. I am tolerant to people different from me. If somebody is a homosexual, it does not bother me. **But** I do think they expose too much in public. That is why they are often laughed at or attacked. (M23)*

Before we tackle the topic at hand in greater detail, we shall consider student opinion on sexuality and midwifery in general from a broader perspective. From this context, we shall then return to our respondents' attitudes towards homosexuality

5. Sexuality

Mostly, the students agreed that in Slovenia sexuality persisted as a taboo topic in public discussions. In their opinion, the older generations still found it very difficult, even inappro-

priate, to talk about it publicly, while the younger generations were becoming much more relaxed and ready to discuss it among themselves and in public. Also, in their opinion sexuality was related to health. They not only explained this relation in terms of pathology and sexually transmitted diseases, they often defined it as a vital human need and an element of happiness and quality of life. In broader terms, they explained it as an intimate relation between two people who loved and cared for each other, which means they also took consideration of partnerships in terms of a much wider perspective. Focusing on the intercourse, they stressed:

Sexual intercourse with the right person relaxes, which bears influence on wellbeing, means less stress. (M5)

It is known that during sexual intercourse the hormones of happiness are released. Our body is more relaxed and at the same time it is a type of physical exercise and contributes to our health. (M19)

These aspects become very important when interpreting standpoints expressing negative attitudes towards homosexuality and the rights of homosexuals. If sexual relations with the partner of one's own choice can have such positive effects on a person's health and wellbeing, why is it acceptable for heterosexuals but not homosexually oriented people? Standpoints against homosexuality do not only deprive a group of people of the free choice of a sexual partner, but also prevent them from the positive effects of sexuality and partnership on their health, wellbeing, and general quality of life.

Although society at large, in the opinion of our respondents, was becoming more relaxed and open, sexuality was still considered to be a fairly intimate matter. Even the younger generation was not always willing to discuss it seriously and frankly with anyone. As one of the students said, she was more likely in public to exaggerate, make things up, and present herself in a more socially favourable light. For the practice of midwifery it is important to stress that in the opinion of one of our respondents, some people also considered health professionals (potentially also midwives) as strangers, that is, people they did not feel able to discuss their sexuality with completely openly and frankly:

I can talk about it quite relaxed with friends and my partner. But I feel uncomfortable to discuss it with strangers (a nurse at gynaecologist). (M18)

On the one hand, therefore, sexuality is perceived as a highly intimate matter, but on the other hand, it also exposes the influence on public health and is a topic of public discussions and political action.

6. Midwifery

Midwifery students included in our study expressed their understanding that midwives were involved in the most intimate and vulnerable aspects of the lives of women and couples:

Midwives "enter" the intimate sphere of human beings. (M4)

A midwife deals with the intimacy of a woman in her most frail moments. (M8)

It is therefore of utmost importance to establish a safe and trustworthy relation:

Our work reaches to the very intimate sphere. It is up to us, how to approach the intimacy, in what way, showing respect. (M22)

Midwives affect the lives of women, couples, babies, and families. Our respondents enumerated the facts that midwives give advice and teach about, for example, good relations in partnerships, sexual practices, the safety of intercourse, contraception, problems related to sexuality, family planning, healthy pregnancy, sexuality during pregnancy, labour, and parental roles. Knowing and understanding the type of partnership is a precondition of their work. Our respondents were aware that it was therefore important to respect the sexuality of women and couples they came into contact with in order to be able to provide relevant and high quality information and midwifery care.

7. Homosexuality

The presentation of the students' standpoints and attitudes towards homosexuality is divided into several thematic parts. First, the established distinction between public and personal opinions is illustrated and interpreted. Several adverse judgements were found, the most controversial among them being related to homosexual parenting. The analysis then focuses on different defensive strategies our respondents used in trying to avoid giving the impression of being discriminatory. The most common justification strategies to keep an apparently tolerant social demeanour despite expressed disregard were: the necessity of parents of different sexes, the social exclusion of children of homosexual parents, the questioned normality and naturalness of homosexuality, and the perception of homosexual orientation as a voluntary and conscious decision. The revealed tensions testified to the complexity of expressed attitudes towards homosexuality, which was further illustrated by reported feelings of being caught in contradictions among social norms, public opinion, and personal attitudes.

7.1. The society is discriminatory — I am not

Almost all respondents agreed that society at large persisted in being very negative, prejudiced, and discriminatory towards homosexuals, although they judged that the overall situation was becoming more tolerant. A common strategy of denying their own homophobia was to attribute it to others. At least that looked convincing at the beginning of their talk; as it continued, the disclaimers helped to reveal much more prejudiced talk than the speakers were ready to admit:

I personally do not mind, but I know a lot of people who do mind very much, even though I do not know why. Everyone should live as they want. I think the most important thing is to be happy and if that makes them happy, that is fine. But I do not agree with homosexual parenting because I would not want to be a child of two mums/dads. (M10)

In my opinion most of the people still look at homosexuals in a different way — in a way as if something was wrong with them, in a mocking way... I have no comments against the homosexuals. Everyone has

the right to decide, choose their partner. But regarding homosexual parenting, my standpoint is that it is inappropriate, as homosexual partners cannot raise a child. (M16)

In both cases, the speakers started by establishing a difference between others that disregard homosexuality and themselves, who were not bothered by distinctions in sexual orientation. They even elaborated their views by acknowledging some basic human rights: everyone should live as they want, everyone has the right to be happy, and everyone has the right to make their own decisions. At least that was what they believed in principle. Right after that, a discursive turn followed: in their opinion, homosexuals, unlike heterosexuals, did not have the right to decide they wanted children and attain happiness through parenting. The speakers thereby set limitations to these universal rights and freedoms of people with homosexual orientation, which was very much in contradiction with their alleged tolerant attitude and much closer to the homophobia they attributed to others.

7.2. Citizens with limited rights

As illustrated above, there are still areas of social life where the apparently universal rights and freedom of certain individuals or groups of people clearly end. In our respondents' opinions, homosexually oriented people did not have equal opportunities in today's society, mainly when searching for employment, but they did not agree with that injustice. On the other hand, they identified several types of behaviour that were completely unproblematic for heterosexuals but perceived as endangering their heterosexual identity when observed with homosexuals:

I have no problems meeting a homosexual couple; they as well are just humans. But I believe they should be a little bit more reserved when showing it in public. (M19)

They do not bother me personally until they wish to have children. (M8)

In most cases, our respondents were personally bothered by the public appearance and disclosure of homosexuals, even if it was just holding hands. Some of them objected to homosexual marriages. The most controversial topic of all, however, proved to be homosexual parenting.

7.3. Homosexual parenting: the social exclusion of children with two mums or dads

Some midwifery students were supportive of homosexuals in all aspects of their lives, including parenting. They grounded their opinion in their belief that characteristics of good parenting were not related to sexual orientation, and stressed the importance of a child's personal satisfaction and wellbeing:

I support homosexual parenting. I believe homosexual parents can offer equally warm shelter (if not more) as heterosexual ones. (M3)

I support them if they decide to have children as they too have the right to create their own family. (M7)

I am not prejudiced. It is important that the child feels well. (M9)

I have nothing against the adoption of a child by homosexual partners, as a child needs love and care and for that you do not need different sexes. The inner side of a human is important. (M12)

Parents of the same sex could also raise a child appropriately. Also, not all heterosexuals are suitable for parenting and cannot take this responsibility but their pregnancy is not controlled. I do not believe the sex of parents is so important for raising a child. The missing role of a father or a mother could be taken up by somebody else, other relative. (M18)

If the parents are OK, I do not see any problems. A lot of children have a father and a mother, but they experience violence or something similar. I think we should ask children how they feel (for example when asked by schoolmates about their mother or father). If they do not mind, neither should we. (M20)

They do not have the same rights, but they should, for example, two homosexuals could raise a child better than parents if there is alcoholism, quarrelling or violence present in the family. (M21)

I believe a child should grow up in a loving family, traditional or some other, as sometimes living with a father and a mother that do not take good care of their children is worse than with two loving mothers. (M26)

Regarding today's society and events that are reported on radio and TV, I think sometimes homosexual partners could offer a child a better life than parents that have no consideration of when to have a child. (M28)

Not all students were so straightforwardly supportive. Aware of the potential accusation of intolerance, our respondents' arguments involved quite complex justifications for their prejudiced and discriminatory views. Several times, the inappropriateness of homosexual parenting was backed up by a claim that a child needed parents of both sexes:

I am not bothered until they wish to have children. In my opinion a child needs a man and a woman. (M8)

I don't consider it appropriate that some children would have two mums and dads. (M5)

Literally speaking, a child cannot have two mothers or two fathers, at least if we understand these terms in their traditional, biological sense. Raising and taking care of a child, however, is also or even primarily a socio-cultural phenomenon, which is not unconditionally related to gender, blood ties, or the number of persons involved. The key question in this discussion therefore seems to be: is sexual orientation related to the ability to be a good parent? As one of the respondents, expressing her supportive standpoint towards homosexual parenting, noticed:

Sexual orientation is not the only thing that defines a man. (M19)

Once we deconstruct the misunderstanding of parenthood in purely physiological terms (as an ability to conceive a child), it becomes clear that social acceptability or appropriateness (who is allowed to take care of a child) is a quite different question. Instead of focusing on the economic/material, socializing, and protective aspects of raising a child, it is frequently turned into a political question that has also been on the public agenda in the past, when laws were discussed and passed regarding adoptions, foster care, and in vitro fertilization, to name just a few.

The second identified strategy used to justify prejudiced claims was intertwined with the first one, and referred to the presupposed negative reaction of society, social exclusion, and victimization of children:

I don't consider it appropriate that some children would have two mums and dads. Such children would probably be excluded from the society. (M5)

Although I said that I have nothing against these persons, I do not agree that they could adopt children. I think it could influence their lives because the Slovenians are still much closed and we do not know how to accept difference and a consequence would be that such a child would be mocked (mockery depression suicidal thoughts). (M14)

Although I hold no prejudice towards homosexually oriented people, I consider homosexual parenting unacceptable because of the child, who would be exposed to mockery and rejection. (M27)

Mockery and rejection by society were mentioned several times in combination with the perception of homosexual parents as two mums and dads as the terms themselves, stressing the biological aspect of parenting, alluded to their very inconsistency. Prejudiced and discriminatory society was frequently (mis)used as an argument for depriving a certain group of people of the opportunity to establish a family instead of recognizing the urgent need to promote tolerance and acceptance of differences. The most extreme instance of this line of thought can be illustrated by the following excerpt in which the speaker explicitly acknowledged that homosexual parents could even be more loving than heterosexual ones, before drawing a negative conclusion:

Homosexuals do not bother me personally, although if I see something like that in the street, it looks strange, because I am not used to it, but it does not bother me. Of course they have the same rights as the rest of citizens; I believe that sexual orientation should not influence human rights. But I do not consider homosexual parenting to be appropriate. Otherwise they can be even more loving as normal parents, but mainly from the child's perspective, I do not think it is appropriate. (M11)

According to this excerpt that claimed to speak in favour of the child, it was more important to conform to prejudiced social attitudes than to allow the child to be raised by loving homosexual parents. Was this speaker really not bothered personally by homosexuals and convinced that they had the same rights as heterosexuals? The speaker was no expert on homosexual parenting and was repeating prejudiced and superficial judgements about homosexual parenting in general. It was an act of discursive discrimination, because such judgements, not supported by any sound evidence, still have social consequences. Namely, they perpetuate still further the prejudiced social talk that is usually attributed to others and so easily disclaimed by the speaker. Our respondents referred to this public opinion (the society, the others) as very influential in many excerpts. Who, then, is the one that really objects to homosexual parenting? As another midwifery student noticed, social disregard of same-sex parenting is today's reality, but the key question promoting tolerance should be: who is the society? Who creates social relations? Is it them or is it us, perhaps even me?

I believe that many homosexuals would care for a child better. Homosexual parenting is not problematic for me, I support it. Society is the problem — we teach our children that homosexuals are different. If we didn't then the children of homosexuals would not be condemned by their peers. (M15)

Changing public opinion is not a new phenomenon. Life is a process involving constant change and one commonly attended by rejection of that change. The social exclusion once experienced by children born out of wedlock is now happening to children in rainbow families and will continue to happen to children of another marginal social group in the future. It is important to recognize that exclusion is never determined by nature or the children themselves but by social relations and the attitudes of adults, by norms reflecting social power.

The third identified type of justification of prejudiced and discriminatory talk was found in the interpretation of homosexuality, homosexual partnerships, and/or parenting as abnormal and unnatural. This can, again, be done fairly straightforwardly (that is, explicitly stated), or implicitly alluded to (inferring difference from a “normal” couple or family):

They do not bother me personally; it is not their fault that it is happening to them. But it gets on my nerves that they would have equal rights as couples (marriage, adoption of children) as I do not think it is natural. (M2)

My opinion is relative to the matter. As a friend I do not have any problems, but I would personally have to think very hard if it was a very important decision to be made, for example adoption of a child by a normal or homosexual couple. I would prioritize a normal couple as I think every child has the right to live in a normal family, not in a family that is not accepted by the society. (M22)

It is a common but erroneous belief that “normality” is a property of nature and that both categories exist irrespective of their social context. From the discursive perspective, normality and nature are both social constructs — something is not “normal” or “natural” in and of itself, it is interpreted as such within discourse. Following this line of thought, attention should be put on the speaker’s constructions. Instead of claiming that something is normal or natural, a critical thinker should be attentive to what is normal to whom, and to ask according to whose criteria is something is deemed natural? Interpretation is related to the social position and power of the speaker. Abnormality of homosexuality exists only in heteronormative societies.

The fourth strategy apparently justifying the speakers in expressing discriminatory claims was identified in our respondents’ conception of sexual orientation as an individual’s conscious decision. Within this perception, homosexually oriented people voluntarily decided against the prevailing social heterosexual norm and were thus themselves intentionally challenging society to accept them. Following this line of thought, it is homosexuals themselves who should take the blame and responsibility for the consequences that follow from such socially unfavourable decisions:

They have certain rights, but not all, for example the right to adopt children, as it was their own decision to be different, not able to conceive a baby. (M8)

I see no sense in homosexual orientation, but I think it is a personal decision of each individual and that is why I have no prejudice towards these people but there appear many doubts when such a couple wishes to adopt a child, because a child could have problems... We all know that it takes a man and a woman to create a new life. Who intentionally decides against this must accept also the facts that follow as a consequence. (M27)

The same principle of social responsibility for one's own decisions is followed also in contrary cases:

I accept homosexuality; a man on his own cannot influence his sexual orientation. (M1)

I think they are completely normal people like the rest as they do not have any influence over their orientation. (M19)

People not having any say in or power over the phenomenon were also not to be blamed and punished for the (unintended) consequences. They deserve our sympathy and support.

7.4. Torn between social norms, public opinion, and personal attitudes

It has become evident from the excerpts so far that the current debate about homosexuality involves many contradictory aspects. On the one hand, the prevailing social norm is tolerance and the reduction of inequalities. On the other hand, the alleged public opinion is still very negative and, although dispersed and intangible, very strong and influential. Civil movements are quite active but marginalized. This leaves many people bewildered and wandering among different discourses: the traditional attitudes they were socialized into, and their own experiences and critical observance of the society they live in. For our respondents, it was sometimes really difficult to form a clear personal standpoint:

Although I do not want to accept them differently, I keep a certain distance towards them. (M5)

I do not yet have a clear opinion on homosexual parenting. I have not thought about it thoroughly, but I feel inclined to think that everyone should have the right to have children, irrespective of their sexual orientation. (M1)

I think the important thing for a child is to have loving parents, but it is also true that children today do not yet understand difference and would probably experience much harm from their peers. (M19)

I have not taken sides yet. On the one hand I do not support it because of the children, on the other hand I support it because the child and this relationship can be more sound and the child more loved as in certain partnerships... A child should have a mother and a father, but a homosexual couple can love a child very much and a child can grow in a loving environment. (M23)

Homosexual parenting — why not? Better two mums than none or a careless one. But I think that the public is not ready yet and a child would suffer the consequences in the end. (M25)

As we learned from sociological research, it is not enough to study attitudes and expect that by changing them, we will automatically change behaviour; it is necessary to simultaneously change social structures:

I object to homosexual parenting and adoption, because of the child and the society, but I will accept it, if such law will ever be passed. (M24)

My opinion towards homosexual persons is not really formed — sometimes it bothers me more, at other times not at all. It is difficult to describe my attitude, mainly because the public opinion is at many occasions clearly stated (that it is not right). (M26)

The real name of the game therefore seemed to be striving to represent oneself positively to others as well as to themselves. Even when personally tolerant, our respondents felt pressed to conform to what they detected was (negative) common sense as the prevailing public attitude. To mitigate disregarding standpoints and make them conform to the highest social norm of respecting differences, they (we?) learned to apply various justification strategies in order to defend from potential accusations of intolerance.

8. Discussion

The respondents in our study were the future providers of health care. Many of them expressed very tolerant and well-supported views. On the other hand, analysis also identified prejudiced and discriminatory standpoints towards homosexuality. It is therefore important to include the deconstruction of common prejudices in health care curricula. They should include knowledge of the roots and consequences of homophobia. Identification of prejudiced talk and instances of discrimination should be followed by open critical discussion, which should result in the weaker presence of prejudices and thereby, hopefully, fewer inequalities in health.

This discourse analysis showed many different types and instances of prejudiced standpoints against gays/lesbians, and especially their families, among the first year students of midwifery. The ratio of supportive answers among midwifery students compared to their colleagues from other programmes was relatively high, yet less than half were supportive in all respects. In general, students interpreted sexuality as a human intimate need that was positively related to a person's health and quality of life if the partner was chosen according to their preferences. By rejecting homosexuals, they therefore deprived gays and lesbians of this basic right and need. The respondents who expressed their negative attitudes towards homosexually oriented people proved that sexual orientation was not only a personal but also a social matter, the latter having influence over the former. It became evident that choosing the partner of one's own preference was acceptable only within socially accepted heterosexual norms. A code of ethics binds the professional to be objective and apolitical. Professional curricula should therefore also address these topics to enable midwives to become aware of the discriminatory attitudes and norms, and to provide non-discriminatory care.

In the views of our respondents, midwifery spanned private and social spaces. People usually find it difficult to reveal and discuss their private matters with others. Midwives could be experienced as strangers. An important professional question, especially in cases of socially unfavourable sexual practices and relations, was how to develop sensitivity to a person's discomfort and vulnerability, establish a safe, respectful environment, and build trust. Our respondents claimed that midwifery provided a women-centred care. Besides acknowledging individuality and respecting the rights and dignity of a person, this also brought to the fore the question of client involvement. Namely, it is not enough to care for the clients' health and their needs, the clients themselves should be supported to express their own experiences, needs, and preferences. Caring professions should not only provide care but also empower clients to take an active role in decision making related to their care [25].

It was seen from our respondents' answers that homophobia was easily attributed to others and rarely identified in the self. Through the analysis of apparent denials, it was nevertheless found that even students that claimed to be tolerant considered homosexuals as citizens with limited rights. Gays' and lesbians' rights to live as they chose was partly accepted, but tolerance mostly ended when the question of parenting came to the fore. The rejection was explained in terms of social discrimination and victimization of children. Four sub-themes were identified: a child needs parents of both sexes; society rejects same-sex families and victimizes the children; homosexuality is not normal and natural; (homo)sexual orientation is a conscious decision of an individual. We shall address them respectively below.

In Slovenia today, the proportion of families composed of a married couple with children is dominant, but has been on the decrease ever since 1991. In 2011, the ratio of single parent families increased to 25% and the ratio of unmarried couples with children to 10.8%. In the same year for the first time, the national statistical office recorded the ratio of reconstituted families (defined as families composed of two partners with children, where at least one child is not a biological child of both partners) as 4.1% [26]. Other sources estimate the ratio of reorganized families is much higher, around 30% [1]. Statistics about different types of social parenting (especially homosexual parenting) are difficult to obtain and are currently very dispersed, largely because people do not feel comfortable and safe to disclose data about their private lives for the fear of stigma and social exclusion. There is no doubt, however, that many different types exist in growing numbers that cannot be neglected or pushed to the margins. Using terms and numbers alluding to blood ties (two parents; a mother and a father) is therefore primarily a way of naturalizing and normalizing only one of the many existent family relations and thereby implicitly stigmatizing and excluding all the rest.

Social parenting is established in opposition to a blood related conception of parenting. It is primarily focused on care and is as such defined as a social-emotive and intimate relation between an adult and a child that involves economic responsibility and is constant in temporal terms [27]. Blood relation is not unconditionally related to the quality of parenting. The quality of a family is related to the quality of relations and processes within it — such as taking care, taking responsibility, showing respect, enabling a sense of self-worth, allowing autonomy, providing means, and support and security — rather than to its form or structure [28,1,29]. Furthermore, contemporary conceptualizations of the family stress the prime importance of the subjective, lived judgements of people over structural, blood, or legal ones [28]. It is therefore important how family members feel about, treat, and take care of each other, factors not determined by the blood that circulates through their veins.

Society rejects gay and lesbian families, although the usual argumentation follows a paradoxical pattern. Commonly, the exclusion is explained in terms of the harm done to the children, which is said to come from the unfavourable social surrounding itself. The discriminatory society is therefore taken as an argument for not letting gay and lesbian couples take care of children instead of being criticized for being discriminatory. The discrimination of society is thereby sustained instead of challenged. Namely, the same people who accuse society are its very components; they themselves could therefore make a difference and be tolerant. As Urek

[28] said, accusing society of being immature only acknowledges and perpetuates discrimination but does not contribute to any changes.

In Slovenia, studies [1,28] identified and rejected the following common arguments against gay and lesbian families in Slovenia, all referring to the care of children: children have difficulties in developing their sexual identities; children have more behavioural and personality problems; they are victims of discrimination due to their parents' sexual orientation; and they are forced to live in same-sex families. According to Golombok [30], children living in single parent families or with social parents (homosexual partners included) from their earliest age showed no more psychological distress than peers from more conventional backgrounds. They had the same positive self-esteem and were considered by their peers to be good friends. The most emotionally stressful experience for the children was not having same-sex or social parents but in witnessing hatred and abuse. According to research, children of same-sex families were happy, intellectually successful, and tolerant [31]. Golombok [30] also proved that the presence of a father (or a mother) was not necessary for the development of sexual identity. Biological parents were considered a prototypical constellation for the development of a child, but children living with a single parent or social (homosexual) parents developed their sexual roles equally well. A comparison of children of homo and heterosexual families showed no difference in their sexual identity; children of homosexual parents formed their sexual identity without any confusion. The negative effects of single parenting had to do with the negative socio-economic consequences of a divorce: that is, poor economic conditions (if separation was related to diminished social standard) or small social networks and support received by them. If a single parent was well situated and had a large social network, no differences from other children were detected. On the contrary, some reported closer and warmer contacts, which reflected in life satisfaction. The important risk factor in any family type, therefore, was the lack of trust and good communication. All children face problems and dilemmas when growing up. They can all experience rejections and discrimination of some sort, due to their weight, figure, or some other physical characteristic; behaviour; or family arrangements they live in. It is difficult to avoid such negative experiences, but children can be supported in overcoming them. Good quality family life therefore depends on what is going on in the family, not who belongs to it.

It was interesting to observe the persistence of arguments related to normality and nature despite existing evidence that homosexuality had existed in different regimes and cultures at approximately the same ratio throughout history, regardless of social attitudes. Due to varying definitions and favourability of the social context, it is very difficult to calculate exact numbers. The commonly accepted data originate from Kinsey, the famous researcher of sexual behaviour; he claimed that each society included approximately 10% homosexual people [15]. Same-sex behaviour was also documented as a nearly universal phenomenon in animals, across species, from worms to frogs and birds, and it was further discussed how it had also contributed to the evolution of the species [32]. From the sociological perspective, it is soundly argued that what is established as normal (in opposition to pathological) is at each point in time defined by culture and ideology rather than being grounded in nature [33]. Presuppositions that heterosexuality is natural, normal, and right, thereby marginalizing other orientations and

practices as unnatural, abnormal, pathological, and wrong, is one of the basic tenets of heteronormative ideology/discourse/society.

Also, the analysis identified misconceptions about sexuality as a conscious decision. Science has not yet provided its final answer on the origins of homosexuality. Research spanned across various topics, but none has managed to prove the existence of a homosexual gene, specifics in the structure of the brain, or any other physiological differences. Social factors also did not prove to be able to change sexual orientation, they only made people suppress or deny it. Today, homosexuality is understood as a variation in human sexuality [15]. Gays and lesbians themselves typically do not think that they voluntarily chose their sexual orientation and heterosexuals would probably claim the same.

Our respondents' reporting to be torn between the social norm of tolerance, discriminatory public opinion and their own more tolerant attitude could be interpreted as a sign of society's development. It proves the plurality of opinions, but also their competing powers. It is important to support this process by providing places and times for discussion within workplaces, professional education programmes, and public places.

Implications for midwifery already documented in the literature are vast and manifold. For the purpose of inciting further systematic research and study, we shall only briefly outline key areas: the clients' perspective, the midwives' perspective, and the students' perspective. Starting from acknowledging the client perspective, there are many qualitative studies giving voice to lesbians. A study on lesbian parents' experience of antenatal care, childbirth, and postnatal care identified the extensive presence of heteronormative communication, which was experienced as embarrassing for the participant parents as well as for care providers [34]. There is evidence of positive experiences of lesbian women during pregnancy and childbirth. Lesbians, however, also raised worries about postnatal care, parent education, and the structure of the patient records with no place for the female partner. They stressed that confirmation of parenthood was important, especially for the co-partner. In a study of experience of care provided during their partner's pregnancy, childbirth, and the postnatal period [35], the co-mothers' message was that they felt treated like everyone else, but not quite. They pointed out the need for acknowledgement, need for care designed to suit same-sex couples and the need for midwifery staff to recognize co-mothers as an equal parent of the child [36]. The least discussed topic seems to be midwifery acknowledgment of their role in supporting gay parenting. The needs of two men searching for information and possibilities to start a family, attend parental training, and receive good care [37] remains to be put on the professional and political agenda. Our respondents enumerated that midwives give advice and teach about good relations in partnership, sexual practices, the safety of intercourse, contraception, problems related to sexuality, family planning, healthy pregnancy, sexuality during pregnancy, labour, and parental roles. How many of these tasks, and in what aspects, relate to a male gay couple?

Evidence exists that health care outcomes for lesbians improved when health care providers were knowledgeable about and sensitive to the unique needs of lesbian clients [38]. It is of utmost importance to the lesbian's health and specifically to the outcome of labour, potential post-natal depression, and bonding with the baby, for example. The key question arises [21]:

how well equipped are midwives to provide effective and appropriate midwifery care to them? Following that finding, guidance for health care providers in supporting the childbearing lesbian couples was prepared on the basis of literature overview regarding lesbian experiences. Four areas of concern were identified: disclosing sexual orientation to caregivers and finding lesbian-sensitive caregivers, considering options of conception, assurance of partner involvement, and legal considerations related to the protection of both parents and the child [38].

There are many barriers that midwives themselves identified within their current practice. Wilton [21], in her discourse analytic study, documented the following five themes: anxiety about sexual difference, fear of female sexuality, the sexualization of lesbianism, the characterization of lesbianism as “sick” or “unnatural”, and an inability to identify lesbians with any certainty. According to Jackson [39], many midwives fell into a conceptual trap stemming from reducing lesbians solely to their sexual orientation: namely, that they did not come into contact with lesbians because by the very nature of their sexuality they could not become mothers. They also made heterosexist and erroneous assumptions about pregnant women being in a sexual relationship with a male. It was repeatedly evidenced in inattentive heterosexist use of language: for example, referring to a father instead of a partner or an important supportive other. It led to malpractice, where lesbians were ignored and left invisible in midwifery care. Many midwives saw the positive side and described the lesbian love-relationship as strong and caring, but also detected their vulnerability stemming from their being different. It was important for midwives to acknowledge their own attitudes and culturally sensitive non-verbal communication, as well as considering the co-mother’s needs and role as different compared to those of fathers. Although caring for lesbian couples was seen as unproblematic, midwives described experiences of ambivalence or anxiety in the encounter and they had noticed that some couples had negative experiences with maternity care [40]. The theme is also gaining grounds in Slovenia. Božnar, in a review of foreign literature on lesbian motherhood [41], aimed to motivate midwives to consider the topic. In the relation of the midwife towards a lesbian, her partner, and their baby she stressed the importance of knowledge, understanding, and respect for lesbian mothers and their partners. Another important practical concern and research topic is homosexuality among midwives. A literature review showed little relevant literature on lesbian, gay, bi, and transsexual midwives in the UK. The lack of their recognition carried personal and organizational implications, as it was supposed that homophobic attitudes negatively affected also their acceptance at the workplace [42].

Research also focused on future health care professionals. Jones [43] in a study of attitudes of higher education students in health profession educational programs showed high levels of discomfort when working with lesbians or gays. The majority of them believed their study programme had not adequately dealt with this issue. It was also one of the main results of our study that students found the topic relevant to their field of expertise and expected their study program to equip them with relevant knowledge. Regarding their unique position in the health care system (the field of sexuality and reproduction), midwives therefore need to know how to establish a safe environment for a lesbian to “come out” to the midwife and the knowledge to understand and support the patient’s lesbian lifestyle. Midwives should become knowledgeable about lesbian culture and sexuality, learn to use nonheterosexist language, be non-

judgemental, to raise awareness, and reject socially constructed prejudice [39]. This should also involve the visibility of homosexuals in informational material on sexuality, family planning, pregnancy, labour, parenting and partner support, and midwifery.

9. Conclusion

Homophobia is neither inevitable nor universal. It is socially constructed and maintained through homophobic discourse. Discourse is a powerful means of inciting and perpetuating prejudiced and discriminatory talk at the more implicit levels of communication. Disclaimers proved powerful discursive strategies of impression management. Their structure is such that it enables the speaker to express prejudiced attitudes, yet keeps the facade of tolerance. Language use perceived in its social context goes beyond mere articulation, it involves simultaneous action. Constructing and maintaining prejudices and discriminatory talk about homosexually oriented people may also result in unequal health care. Evidence was collected from gays and lesbians, midwives, and midwifery students. Gaining knowledge helps us overcome prejudice and fight discrimination. Understanding the powers of discourse gives us tools to deconstruct discriminatory messages and practices, triggers our critical thinking skills, raises our awareness, and enables us to act more tolerantly. Knowledge about homosexually oriented people and their health needs empowers health care professionals to provide better and more equal health care. In Slovenia, research should systematically be deployed to provide knowledge on LGBT people and their health needs, and professional education programs should adequately address them to deconstruct prejudices, raise awareness of discriminatory practices, and thus enable midwives to provide relevant, emphatic, holistic, and equally accessible midwifery care.

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