Queer Birthing:

a qualitative Investigation on Expertise of queer-sensitive Midwifery in Germany

By

Theresia Lutz

Submitted to

Central European University
Department of Gender Studies

In partial fulfillment of the degree of Master of Arts in Gender Studies.

Supervisor: Professor Elissa Helms

Vienna, Austria

2024

ii. Abstract

This thesis studies midwifery for (and by) queer people in Germany. The focus is on the construction of expertise among queer-sensitive midwives, who practice within a profession that understands itself as a field "by women for women", historically as well as in the present. The question hence becomes how people who do not identify as cis-female can act in this field, providing and receiving care around pregnancy and birth. How might the practices of midwives change among newly forming, explicitly queer-oriented collectives? Will it resist or align with traditional ideas of who or what a midwife or a mother is?

In Germany, two such collectives have been established in the past years, promoting themselves as a space for queer birth. These collectives are the objects of this study. Based on semi-structured interviews with midwives who are part of these collectives – as well as some who are not, but still understand their practice as queer-sensitive – I argue that queer-sensitive midwifery does not contradict the basic assumptions of the profession, but rather expands on them. My findings show that the negotiation of gender against a patriarchally structured medical system align with the critical perspective inherent to the profession of midwives. Rather than claims to expertise being troubled with the introduction of queerness, I argue that it is the profession itself that keeps the patriarchal system of professionalization at a critical distance. Queer-sensitive birthing and midwifery hence build upon an ideal of individualized and holistic support and care, while expanding this practice through a continuous reflection of the self, one's positionality and communication. Referring back to a perspective on "Queer Reproductive Justice", this research is interested in the social situatedness of queer folks experiencing pregnancy and birth, and ultimately finds the feminist claim of midwifery newly expanded by a queer-feminist practice.

iii. Declaration

I hereby declare that this thesis is the result of original research; it contains no materials accepted for any other degree in any other institution and no materials previously written and/or published by another person, except where appropriate acknowledgment is made in the form of bibliographical reference.

I further declare that the following word count for this thesis are accurate:

Body of thesis (all chapters excluding notes, references, appendices, etc.): 21, 231 words
Entire manuscript: 23, 609 words

Signed _____ (Theresia Lutz)

iv. Table of Contents

v. List of Abbreviations

ICM – International Confederation of Midwives

DHV – Deutscher Hebammenverband [The German Midwifery Association]

QJI – Queer Reproductive Justice

SBGG – Selbstbestimmungsgesetz [Self-Determination Act]

1. Introduction

A cocoon is a case that protects insects as pupae from any harm outside, providing space and time to develop until they are ready to become a colorful butterfly. This image, only lightly sketched, appears on the top of the website of the eponymous queer-feminist midwives* collective in Germany. Just below, five *white* people smile at the viewer – each one very differently presenting. They have short, medium or long hair – blond or pink, they wear black or gray, but also very colorful clothes. The viewer sees their uncovered arms with tattoos and without, piercings on some faces but not all. Some of them are female presenting, others not. They use she, he, or no pronouns.

Despite their visible differences, they have their arms around each other, nestling heads together and expressing a loving and warm aura, demonstrating unity. As their name already indicates, in this team they want to provide "queer-feminist midwifery." Formulating their vision in a common philosophy, they want to attend diverse people during the whole birthing process; "regardless of their gender or sexual identity or family constellation." On their website they welcome every person whether trans*, cis, hetero, or queer. Hence, "Cocoon" sees birthing and its attendance as a diversity and makes this visible by marking 'midwife*' with an asterisk[1]. It is apparent that these queer-feminist midwives* clearly demarcate themselves from the conventions of the midwife´s profession.

The German midwifery profession is institutionally represented by an association called "Deutscher Hebammenverband" (German Midwives Association, short DHV). In their public documents, the association defines principles, values and philosophy for all midwives in Germany, thus grounding its professional knowledge. Among other things these argue for holistic maternity care that is driven by respect, tolerance and openness towards all people (DHV, 2021). Following the "International Confederation of Midwifery" (ICM), the German association in the last few years started to acknowledge gender diversity in its positioning. In its current revised code of ethics or public statements it claims women's right to their sexual and reproductive self-determination, accepts "diverse roles of women and families", and rejects all kinds of discriminatory structures or entry barriers to medical healthcare (DHV, 2023; 2024). Whereas the profession has been attempting to address and integrate the growing diversity in sexual orientation and gender identities, as well as diverse family constellations, in the public presence of DHV "woman" remains

[1] This study adopted this spelling for references to the midwives in this collective and the other interviewees, while dropping the * when referring to sources or a more historical context.

a recurring concept. This is not surprising, as the profession of midwife is historically deeply intertwined with female identity: Midwifery is support provided by women for women (Crossan et al., 2023), accompanying the moment of becoming what is called a "mother."

The question then is what happens to a profession that is fundamentally based on the idea of the 'essential female' as it faces challenges to a binary gender system in the 21st century?

Looking at queer-sensitive oriented midwifery as promoted by newly emerging queer-feminist midwives* collectives, this research focuses on how ideas of midwifery are affected when queer people enter the birthplace. Further, the overarching research question is how queer-sensitive midwives* claim their 'expertise' and to what extent this is distinct from conventional midwifery practice? This study is tied to a previous research project in 2022 that focused on formulating the features of a queer-sensitive midwifery,[2] while the recent project clearly focuses on professional understanding. Both studies use semi-structured interviews with queer-sensitive midwives* in Germany, such as members of the two queer-feminist midwives* collectives. Some of the 2022 data is reused for this analysis.

This study aligns with Critical Queer Studies, viewing 'queer' as a vague concept, which is expressed contextually in opposing heteronormativity (Warner, 1993), and as such always a political practice. Further, I view queer reproduction through the intersectional framework of "Queer Reproductive Justice." So, this study builds its knowledge in line with achievements of materialist feminism, postcolonial feminism, and a poststructuralist view of sex and gender.

With this, the study enhances the recently upcoming German academic discourse on reproductive justice in the context of birth, reflecting on the violent aspects of childbirth (eg., Jung, 2021; Leinweber et al., 2021). The perspective on queer-sensitive midwifery can provide valuable insights into this, and thus also contributes to better visibility of queerness in research, given there is widespread consensus on this need (Jung, 2021; McCann et al., 2021; Goldberg et al., 2023; Salden, et al., 2023). So far, research on queer experiences in birth and healthcare in Germany is very limited. This can be partly attributed to the fact that just very recently midwifery science

[2] A "queer-sensitive midwifery" includes the following components: Creation of the birthing space as "safe space", holistic approach (birthing person is seen as part of a and in relation to a societal and family system), anti- hierarchical organization, Language as tool of creation of the space, birthing person seen as "Expert for herself" (main principle), humble attitude.

appeared as a field of research.[3] Hence, only one comprehensive (quantitative) study on queer pregnancy and birthing in the healthcare system has been published yet (Salden et al., 2022).[4] Their findings align with existing literature: queer individuals face discrimination at various stages of childbirth and pregnancy indicating inadequate maternity care for LGBTIQA+ individuals (Roosevelt et al., 2021).

The initial remarks on the DHV website resonate in the previous international research: Cis-normative assumptions on sex and gender are still dominant in healthcare as a whole and the profession of midwifery in particular. As several studies have shown, this pervades the atmosphere as well as the concrete interaction of queer people with the healthcare staff (Spidberg, 2007; Stewart and O'Reilly, 2017; Malmquist, 2019; Goldberg et al., 2023; McCann 2023; Salden, 2023). In their literature review, Stewart and O'Reilly (2017) speak of a prevailing "culture of heteronormativity," which reveals itself mostly through the used language. Several scholars concluded that not adapting a particular wording of the health care staff, such as speaking of "lesbians" or the "donor child", or the act of "misgendering", meaning that incorrect names, pronouns, and forms of address were used, show automatically assumed heterosexuality (Spidsberg, 2007; Salden et al., 2023). In other words, a verbally explicit omission of differences from the norm maintains heteronormativity in (reproductive) healthcare settings. It is then still just the cisgender woman who can fit the birthing role, which consequently leads to discrimination against queer individuals. A striking result of Salden et al.´s study (2023) was that especially trans*men, non-binary, and intersex people face discrimination on multiple levels (ibid.). Queer family constellations are not addressed, which leads to fear and influences choices in birthing places (Malmquist et al., 2019; Heggie et al., 2023; Salden et al., 2023) as well as the whole birthing experience. As LGBTQ+ individuals in Griggs et al.'s study highlighted, it was the specific maternity care treatment that significantly impacted their birth experience.

However, the ambition to practice queer-sensitive midwifery seems to be on the rise. Griggs et al. (2021) show that midwives voiced positive attitudes towards the attendance of queer birthing individuals. But again, the structures seem to still be highly shaped by their 'heteronormativity,' since studies emphasized that midwives and nurses often lack the knowledge and education to

[3] Only since 2010 has it been possible to become a midwife in Germany through a university degree. Before that, only midwifery training was done. Since 2022, midwifery is fully academic and it is mandatory to study Midwifery Science.

[4] In an online survey of nearly 1,500 individuals, both queer and non-queer, about their experiences before, during, and after giving birth in German healthcare institutions.

properly address the needs of queer clients due to a dominant heteronormative culture and insufficient training (e.g., Stewart and O'Reilly, 2017; Roberts et al., 2018; Heggie et al., 2023). McCann et al. (2021) speak of intended invisibilization, whereas the interviewed nurses in another study perceived it even as a "taboo" discussing perinatal care for queer people (Echezona-Johnson, 2017).

There hence appears to be a decisive tension between the theoretical ambition and the effective translation of knowledge on queer needs into practice: Whereas ICM stated gender sensitivity as part of midwives` competence, in practice queer needs are not adequately represented in policy guidelines or curricula (Butler et al., 2018; McCann et al., 2021; Jung, 2021). While the research has suggestions on how to overcome heteronormative assumptions and provide unbiased care for sexual and/or gender minority populations (Griggs et al., 2021; McCann et al., 2021), the reasons seem to lie deeper in the midwifery profession. Crossan et al. (2023) show that there are conflicting stances on a recommended gender-affirmative, thus gender-inclusive, language that would speak less of 'women' than 'people' – in particular among midwives. Engaging with the international discourse, in focusing on the key aspects of the expertise in queer-sensitive midwifery in Germany, this research wants to make a contribution here.

This study is structured as follows. First, I will briefly situate the legal and medical conditions for queer individuals in Germany who want to have a child, thus creating a family. In Chapter 3 and 4, I depict the theoretical and analytical lens of the study and elaborate on the concepts of 'queer' and 'expertise', contextualizing them to reproductive health care and/or key aspects of a midwifery tradition. The following Chapters will provide a comprehensive analysis of the data material towards my research question. Finally, I sum this up with final remarks.

Overall, this study argues that a queer-sensitive midwifery practice extends its inherently feminist stance by a queer-feminist one, described as an "ethic of accountability" (Mamo, 2018). Using Goldensher's concept of "counterprofessional expertise," I argue that gaining expertise in queer-sensitive midwifery primarily requires radical self-reflection on one's own heteronormative positioning as a person and midwife*. This self-reflection consequently shapes midwifery practice and, I contend, leads to a "reflexive way of talking."

Queer Birthing in Germany: Legal and Medical Situation

Even though there are currently some changes in the German political and legal situation towards a greater attention and recognition for queer individuals, queer people in Germany who

want to have children face considerable obstacles and discrimination. The legal recognition of so-called "rainbow families" is still not equivalent to that of a heterosexual family constellation. A modernization of family law, as defined in the 2021 coalition agreement of the current government, has not yet been fully implemented. However, some changes are anticipated with the draft of the Self-Determination Act (SBGG),[5] which is fully set to come into force November 2024. Thus, the legal and political framework in Germany regarding childbearing and family formation mainly favors heterosexual norms, while discouraging queer individuals and families.

So far, the German civil law regulates parentage as the mother is the woman who has given birth to the child. The father is the man who is married to her (see BGB §1591). Whereas since 2017 in Germany same-sex marriage is legal, until January 2024 the wife of a birthing woman was not automatically the second "mother", but only possible through a "Stepchild adoption". For lesbian couples this has recently changed whereas homosexual-male couples are still not accepted as two "fathers" (BMJ, 2024). Further, the new Family Law will not accept more than two legal parents. However, prospectively besides the "woman, who has borne the child," the other parental position can be independently defined. This brings the possibility of accounting private sperm donors. Otherwise, queer family constellations with more than two parents are not accepted (ibid.). For trans* individuals, the binary division of parents also applies. Even after the legal gender change of the birthing person, the child's birth certificate continues to reflect the assigned gender (resulting in misgendering) and the name assigned at birth (resulting in deadnaming). With the full implementation of the SBGG in November 2024, the trans* parent can declare before the birth that their current "gender marker should be decisive" and be adopted for the birth certificate of the child (SBGG, 2024).

Reproductive options for queer family constellations in Germany are small and fraught with obstacles. Assisted Reproduction Technologies, such as IVF, are legally possible, but associated with high costs. While health insurances cover them for heterosexuals, lesbian couples are not covered. Another option is the procedure of "insemination," where the sperm cell is directly transferred into the uterus. This can take place privately or in so-called fertility centers. However, for example, cis-lesbian couples would receive less support there compared to heterosexual couples (Regenbogenportal.de, n.d.). The use of sperm banks shall be easily regulated in the future. Transgender and non-binary individuals can also become pregnant and give birth if they retain all

[5] The "Self-Determination Act" is intended to replace the "Transsexual Act" (TSG) from 1981. The TSG has been repeatedly deemed "unconstitutional" by the German Federal Constitutional Court.

necessary organs (ovaries, etc.). In addition, the intake of testosterone must be interrupted during this time so that the hormone balance can regulate and produce eggs for fertilization again. Generally, there is sparse medical education on reproductive options. Until 2011, in Germany forced sterilization was required during transition.

After this contextualization of queer birthing in Germany, I will elaborate in the following on the methodological framework of this study.

2. Methods

2.1. Research Design

My approach to the research question and my field is fundamentally qualitative and interpretative. In line with ethnographic research, I want to explore the subjective "opinions, beliefs, motivations" (Potrata, 2005, p. 131) of midwives* in their dealings with queer individuals. Thereby, I see them as involved and influenced by social contexts and broader structures within which they interact (ibid.). In particular, I approach my research question and fieldwork primarily through the interpretative understanding of Reflective Grounded Theory (R/GTM). Characterized as "theory-generating", this research style is particularly suitable for small or as of now unexplored phenomena (ibid., p.9), which applies to my field of research. Since R/GTM views the researcher's inherent subjectivity as a positive and productive aspect and makes the (self-)reflection of the researcher a central component of the research process (Breuer et al., 2019), this methodology is closely linked to my aspiration as feminist researcher.

For the research, I conducted ten semi-structured interviews with queer-sensitive working midwives* in Germany. In the conception of the interview guide, I was inspired by Weiss (1994) and Helfferich (2009). Five interviews were conducted in October 2022, the other five in April 2024. The data collected in 2022 was originally used for another research project on a similar topic, but is still completely up-to-date. The interviews were conducted in person, with two exceptions due to time constraints. The interview guide was slightly revised for the interviews in 2024 due to the current topic, but essentially remained the same. All of them were tape-recorded, for which consent was obtained in advance, and generally lasted between an hour and a half to two hours.

2.2. Sample

My sample was recruited using various methods, including "qualitative sampling" as described by Kruse (2015). I focused on midwives* with various gender identities and sexualities who practiced a queer-sensitive approach. I identified two queer-feminist midwives*' collectives

as the best fit to recruit interviewees. Despite contacting them in 2022, I initially only heard back from two midwives working in the same collective. In 2024, I interviewed two midwives* from the other collective. Additional interviewees were found using the 'snowball method,' starting with a call in a queer group on a messenger service and followed by interviewee recommendations.

The first interviews in 2022 were with Laura and Joris. Both of them are part of the second queer-feminist midwives* collective to be founded in Germany. At the time of the interviews the collective was still very much in its infancy and as Laura told me, it was not yet well established in the local 'queer community'. Joris had just joined. The collective does not have its own facilities, so the midwifes* only offer home births, meaning they meet the families in their homes. The services include counseling for those wishing to have children, support during pregnancy, assistance during home births and postpartum care, as well as prenatal courses for queer families. In addition to their work in the collective, Laura and Joris both conduct teaching sessions and workshops for students of midwifery science upon request.

Evelyn is a co-founder of a small midwives*' collective, established in 2022. This collective does not explicitly identify as "queer feminist," but, as Evelyn emphasized, they do claim an "intersectional feminist and power-critical perspective, as well as an anti-racist stance" on their website. So far, only home births can be offered there. My last two interviewees Sina and Vera both work as self-employed midwives* in a birthing center, where Vera is a partner. Among queer people who responded to my call, this birthplace was highly recommended for its diversity-friendly atmosphere.

In 2024, I conducted the first interview with Fritzi, who Vera suggested I talk to. Fritzi works in a big hospital in the city, since they finished midwifery training in 2021. Midwifery is her second career. Although she liked working in the birth center, she wanted to establish herself in a clinical setting. Katja and Ivy also work in a big hospital in Berlin. As part of a team of 25 midwives* they run the maternity yard at this hospital autonomously. Lastly, I conducted interviews with Lara and Luca from the first queer-feminist midwives* collective in Germany. The collective includes six midwives*, and like the other collective, they are mainly a collective in terms of their common philosophy and public image as a team, which they present on a common website and on Instagram, but they don't have a physical space. Therefore, they, too, only offer homebirths with the meetings usually taking place at the families' homes. Beside the maternity care pre- and post-partum, they offer insemination workshops, as well as perinatal courses for

queer parents. Until this year, they also did annual seminars for other midwives* on queer-sensitive midwifery. Recently, Lara moved to another city in Germany, where she currently consults in queer-sensitive midwifery and advises queer families on their path to pregnancy. Due to the distance and time constraints, the interview with Lara was held on zoom.

Regarding the educational paths of the interviewees, it is relevant that they all completed their training between 2010 and 2021, thus all are between 25 and 45 years old. More than half of the interviewees completed midwifery training, while four of them earned a bachelor's degree in Midwifery Science.

2.3. Ethics, positionality, limitations

As mentioned earlier, the group of midwives* in Germany that has experience who claim to work queer-sensitive, is very little. To protect their privacy as much as possible, I decided to assign pseudonyms to the midwives* and avoid providing much information regarding their location in Germany, with the exception of Berlin. The midwives* of "Cocoon" agreed on naming their place, but I don't assign who of the interviewees exactly work there. All of them work and live in big German cities. After the interviewee's confirmation, I held preliminary conversations with all of them, explaining the purpose of my research and offering space for questions. I want to note that getting in touch with the midwives* who were not part of a collective was very easy and clear, while contacting the midwives* affiliated with collectives was a lengthy and unstable process taking several months. In most of the cases this was due to little time capacities as well as mental health. Although I had personal contact with Luca before, it was hard to reach them through the established channel. I eventually had to go back to an official request via the collective's email. With Lara I shared some voicemails through which a very personal contact arose. In the end, most of my repeated inquiries were answered positively. With the exception of Evelyn and Lara, I talked to all the interviewees in person, and at a place of their choice: Mostly at home, or in a quiet spot of their working area. Only Ivy I met at a public coffee shop, which in retrospect I would assess as not optimal as there was a perceived distance maintained throughout the conversation – an issue I rather would have expected for the digital interviews. I began each interview by expressing that I view it as a conversation to which both parties contribute. I encouraged interviewees to only share what they felt comfortable with, to take breaks when needed, and to let me know if they ever

felt uneasy. I informed them in advance how their data would be used, reassured them of their right to retract information at any point, emphasized the importance of maintaining their anonymity to the greatest extent possible, and asked for their consent.

In account to Farhana Sultana (2007), especially for feminist ethnographic research "it is important to pay greater attention to issues of reflexivity, positionality and power relations in the field" (ibid., p. 374). I agree with Sultana, when they argued, that the self, its representation, but also the specific political and social contexts define the research process, but also how the researcher impacts on the field and its participants (ibid., p. 376). The feminist standpoint theory, which was mainly influenced by Donna Haraway´s essay on "Situated Knowledges" (1988), supports this stance. Haraway´s remarks in this regard influenced me during the research process significantly, shaped my positionality as a researcher, as did the entire analysis. Through this, I was reflecting on how I, as a person, am socially "situated" – how my (geographical) location, education, and other attributes have shaped me as a social subject and expressed me in this "specific embodiment" (Haraway, 1988, p. 582), eventually with certain positions of power. Based on this, I will reflect on my position as a researcher in the following.

Just like Sultana described, I constantly felt in an "in-between status" (ibid., p. 377). As a person who never experienced childbirth, or has any obstetric knowledge, I clearly took an outsider position. However, as a *white,* educated, cis-gendered female presenting but queer person, socialized in Germany, I also felt like an insider. I noticed a "cognitive and emotional resonance" (Breuer et al., 2019, p. 7) with each person during the interview sessions. In addition to sharing a similar age with most of them, our conversations enabled the development of a close and personal bond with trust. I attribute this in particular to the sharing a queer-feminist political stance, which got revealed over time. Thinking about Sultana again, I didn't feel like an outsider in their presence. Instead, the borders between personal and professional roles became blurred on both sides. Despite this, a certain hierarchy between me as the researcher and the interviewees remained apparent. While I appreciated their admiration for my academic approach and 'writing it all down,' there was still a sense of hierarchy, as evidenced by the meeting with Luca, where they sat on pillows while I sat on a chair slightly above them.

This study is limited regarding variability in class and race. Because all the interviewees – so I am as the research subject – are *white*, as well as highly educated, also their clients are mostly

middle class. Insofar this study fulfills an explorative approach, I can just state these limitations as also part of its findings.

In the following two chapters I will describe my theoretical and analytical lens, which informs this research.

3. The Expertise of Midwifery

3.1. How expertise evolved in the history of the profession

What makes expertise in queer-sensitive midwifery distinctive? To answer this question, we must explore the concepts of 'profession' and 'expertise', and how they are interconnected.

Expertise is something that people do, and not possess, writes Gil Eyal, simultaneously attesting to a *Crisis of Expertise* (Eyal, 2019). According to Eyal, in the US/Western discourse there is a current assault on expertise. While trust in experts shrinks, it is the Western society which is the most "reliant on expertise" (Eyal, 2019, p. 4). But, what makes it into the "keyword of our time" (ibid., p. 14)?

Originally, the close association between 'expert' and 'profession' persisted until the 1960s: An expert was someone belonging to a professional group. With mid-20th-century sociologists viewing expert knowledge and skills as pivotal in the transition from traditionalism to reason and innovation as a modern industrial society. For example, medical sociologist Eliot Freidson saw professions as characterized by autonomy, intentionally granted by state authority (Goldensher, 2020, p. 143). Thus, to establish and uphold its authority, the profession must also ensure its skills remain distinctly valuable. The monopoly on their knowledge led to the hierarchical relationship between professionals and laypeople (Goldensher, 2020), which the sociologist Andrew Abbott in 1988 termed as their 'jurisdiction', possessed unique knowledge that only they as a profession could use (ibid., p. 122). So, the dominant understanding of expertise in the last century was shaped by its institutionalization of professions, which required standardization, conformity to rules and hierarchies, and the accumulation of factual knowledge. However, with the emergence of feminist health and AIDS movements in the 1970s and 1980s, a new understanding of expertise emerged, challenging the notion of professionals shaping laypeople's understanding of the world (e.g., Epstein, 1996; Murphy, 2012). Activists criticized healthcare providers and researchers for neglecting the bodily experiences and health needs of marginalized groups. This led to the recognition of laypeople as active participants in the creation of expert knowledge, resulting in the incorporation of alternative practices into scholarship (Epstein, 1996). Thus, some social movements of the late 20th century challenged the established

understanding of expertise, leading to the questioning of the cultural authority of the medical profession (Goldensher, 2020, p. 143). Hence, Michelle Murphy (2012) characterizes feminist healthcare as a "counter-conduct," emphasizing its departure from established norms and practices of the dominant profession (of physicians) in addressing human issues (ibid. p. 2, 29, 49). The contested nature of expertise, as described by Eyal (2019), became evident in the early 2010s through various phenomena. Spanning from climate change denial to skepticism towards vaccines, with the growing tendency of right-wing politicians who used anti-expert narratives and the doubt of scientific knowledge (Eyal, 2019, p. 5), the claim for expertise has been based on rhetorics of individual choice and individual freedom. A claim that also reflects genuinely in a queer desire for representation and social acceptance of their non-normativity.

For the present, 'expertise' cannot seen anymore as exclusive to 'experts, but as Eyal suggests it consists of various forms, including concepts, discourses, techniques, and institutional arrangements, evolving in historically contingent "ways of talking" (Eyal, 2013, p. 876; 2019, p. 19). Following from that, I want to focus the evolved concept of "counterprofessional expertise." Observing homebirth midwives, Liora O'Donnell Goldensher (2020) proposes this as a form of expertise that critiques traditional professional power and forms care outside normative frameworks.

3.2. Remarks on the Expertise of the Midwifery Profession

The Western professionalization of obstetrics in the 18th century led to the emergence of male-dominated obstetrics, shifting birth from traditional midwifery practices to a medicalized approach (Jung, 2021).[6] This trend continued into the 20th century with the medicalization of childbirth, leading to a hierarchical relationship between midwives and birthing individuals. The German feminist historian Barbara Duden (1991) criticized that with the medicalization of birth, "the act of giving birth was taken out of the woman's hands." (Metz-Becker, 2019, p. 119). Though, as feminist researchers emphasized, technoscientific advancements of reproductive health have

[6] This study is conscious of the impact of the knowledge of Black, immigrant, and indigenous community for midwifery as such. The German historical discourse on midwifery thus keeps silent about it, as it is more a phenomenon in the context of the US. This becomes also empirically evident in this research. Thus, reading Goldensher (2020) has enriched my knowledge on this.

both empowered and constrained women (Murphy, 2012). Feminist interventions from the 1960s onward sought to reclaim agency over reproductive health and challenge the medicalization of birth. In line with the neoliberal ethos of the late 1990s, economization and rationalization of the health care system also took place (Jung, 2017; 2018). This had significant consequences for the midwifery profession today. As a historical study on the daily lives of midwives in Germany comprehensively presented, today´s clinic midwives feel overworked and understaffed, which lead to excessive medical interventions and a lack of time for personalized care (Metz-Becker, 2019). Despite aspirations for 1:1 care, this ideal is often unattainable in hospital settings. So, if the 20th century was a time of paternalistic healthcare (Oh, 2021), the clinic as a "repressive apparatus of power" continues to exist into the 21st century (Metz Becker, 2019). Indeed, as Goldensher (2020) noted for the context of the US, that in the last decade homebirth has not been more common than in the last 30 years, this can also be recorded in Germany.[7]

With this contrasting background, I want to ask now, what kind of expertise would contemporary midwives claim to have and how does this profession defend it? And how essential are the differences between the nurse-midwife in the hospital and the non-nurse midwife, as the literature distinguishes? The following remarks will give me a bit of context to approach the overarching question of this study.

Drawing the Boundary to Paternalistic, Medicalized Healthcare

As the fundamental distinctive feature of midwives to build on their expertise is the contrast of pathology and physiology, which is supported by current position papers of the ICM. Midwives' expertise is rooted in the belief that childbirth is a natural process, contrasting with the medicalized view of doctors. Marita Metz-Becker (2019) argues, childbirth is in essence a "natural physical process that women are in control of" and that can usually manage without medical intervention (ibid., p. 243). Midwifery practice is constructed in the rejection of paternalistic healthcare with its slogan "the doctors know best" (Oh, 2021). This feminist stance rejects patriarchal healthcare norms, shaping the entire practice of midwifery.

[7] The QUAG, an association which is doing annual reports on non-clinical birthing, shows a steady increase of births in the non-clinical environments since 2001. For 2022, it is estimated that around 1,94 % of the births happen not in the hospital. This is historically the highest number.

This brings me to ponder what midwives see as their jurisdiction. Sociologist Andrew Abbott described in 1988 'jurisdiction' as the "core heartland of work" (Goldensher, 2020, p. 122). Midwives Kathleen Fahy and Jenny Parratt view their jurisdiction as the authority to create and manage the birth environment (Fahy & Parratt, 2006, p. 47). According to Foucault, this power is ethically neutral and productive, enabling midwives to empower birthing individuals to make choices about their bodies. Their concept of "midwifery guardianship" opposes physicians' roles by creating a "birth territory" where birthing persons, exclusively referred to as 'women' in the literature, feel empowered to give birth according to their embodied knowledge. In line with anti-patriarchal feminist ideals, midwifery practice aims to be aware of its power, supporting and empowering women in their birth decisions through shared decision-making. From this, we understand midwives' expertise as both creating the birthing environment and helping women retain control over their bodies. Goldensher (2020) sees "informed choice" as key to "counterprofessional expertise," contrasting traditional medical practice where experts make decisions ("informed consent") (ibid., p. 93), emphasizing support for individuals in making their own choices, especially by non-nurse midwives.

Decentering the Professional, Centering the "Lay"

This consequently means for the midwife as a person of values, attitudes, and knowledge to step back in order to "listen carefully" (Davis-Floyd, 2004, p. 12). It seems that midwives justify their expertise not on the standardization of birth but rather assume that each birth remains unpredictable (Maher & Torney Souter, 2002; Eckardt, 2020), demanding their wholly individualized support. *Knowing*, in this regard, always seems a relational created entity. According to Robbie Davis-Floyd, midwives build their knowledge on evolving 'belief systems', now drawing from diverse sources to meet individual needs (Davis-Floyd, 2004). Contemporary midwives prioritize the birthing person, challenge the techno-medical approach, and adapt to social and historical changes by integrating allopathic, indigenous, traditional, biomedical, and alternative knowledge. In Davis-Floyd´s own words, they are "responsive and attentive to the needs of individuals" and "think beyond" (ibid., p.9). Hence, Goldensher agrees on that, and sees contemporary midwives` expertise in "managing epistemic pluralism" (ibid., p.11). For homebirth midwives, this involves navigating between a populist claim for individuality and liberal state

critique, while also recognizing feminist critiques of expert knowledge and advocating for bodily autonomy and reproductive rights (ibid.).

The preceding remarks have shown that the midwifery profession justifies their practice mainly in opposition to the perceived paternalistic system of medicine which follows the slogan "the doctor knows best." Indeed, they lay claim on decentering themselves as professionals, but centering the lay birthing person.

Building Expertise on Narratives and the Birthing Body

Another significant aspect is midwives' creation of "birth narratives," shaping their expertise and influencing birth experiences (Maher & Torney Souter, 2002), concealing their yet inherently powerful position (Mazanderani et al., 2020).

Midwives play a dual role as co-producers of biomedical, social, and personal birth stories, adeptly transitioning between private and professional spheres, which are both seen crucial in forming their expertise. Maher and Torney Souter emphasize the necessity for midwives to flexibly navigate between these roles (ibid., p. 39), deciding when and to whom to share specific narratives to best respond to the birth environment and its stakeholders. Midwives consistently juggle different roles. Despite aiming to challenge the traditional hierarchy between doctors and laypeople, midwives still wield power in their role. This power dynamic places midwives' expertise above that of the birthing person, despite the latter's authoritative bodily experience. According to Mazanderani et al. (2020) to grant a patient´s experiences as significant knowledge, a reflexive dimension is required. Through "telling, hearing, and retelling stories," healthcare staff can integrate patients´ experiences into their broader life stories, creating even a community. In this sense, midwives can become "experts-*of*-experience", insofar they build their practice on shared experiences with the birthing person (ibid.). Consequently, qualities such as attentiveness, respect, anticipation, and flexibility are deemed essential (ICM, 2021), emphasizing the requisite competence to empathize and meet clients' needs.

At last, midwifery places significant emphasis on the body as the primary source of expertise and knowledge. ICM regards the "woman's body" as the "body of knowledge," guiding midwives in their practice (ICM, 2021). Beyond scientific evidence and experiential learning,

contemporary midwives draw on their embodied knowledge and historical experiences to enrich their understanding (Davis-Floyd, 2004, p. 13). This "body knowing" endures alongside scientific studies. Here, intuition emerges as a crucial concept in midwifery practice, validated by Davis-Floyd and Floyd (1996) as a legitimate source of knowledge. Described as a "physicality of knowing," arises from a deep connection with oneself and the birthing process. It involves receptivity to intuitive messages and prioritizes the inner voice over accumulated intellectual knowledge. Patricia Benner introduced the concept of "expert intuition" in the 1980s, describing nurses' expertise (Downe et al., 2010; Gobet & Chassy, 2008). This form of knowledge is not innate but accumulates over time.[8] Thus, intuition plays a crucial role in nursing care, complementing scientific information and diagnostic skills. But despite its importance, intuition remains challenging to capture and "professionalize" due to its abstract and subjective nature (Davis-Floyd & Davis, 1996, p. 260).

To conclude, contemporary midwifery justifies itself as a profession foundational in the opposition to a medicalized obstetric as anti-paternalistic care, valuing childbirth as a natural process and prioritizing the birthing person's bodily autonomy. In claiming their expertise, they do combine scientific knowledge with embodied intuition, creating supportive birth environments and claim to provide personalized care, whereas they see the birthing person with their *story* and in a wider social and personal context. However, Goldensher (2020) proposes the concept of "counterprofessional expertise" to describe the practice of homebirth midwives. In practicing their way of "informed choice", Goldensher sees them critical of the normative way the profession approaches the practice and thus creating "an alternative body of expert knowledge" (ibid., p. 4).

How does this understanding of 'expertise' interact with the concept of queer? I will now provide my understanding of queer as a concept and then apply it to the idea of "Queer Reproductive Justice," which can be used as a theoretical lens to frame a queer-sensitive midwifery, as I propose in this work.

[8] The following five features describe according to Benner an expert intuition: 1. rapid perception, 2. lack of awareness of the processes engaged, 3. presence of emotions, 4. holistic understanding of the situation, and 5. overall good quality of the proposed solution (Gobet & Chassy, 2008, p. 129).

4. *We are elsewhere*[9]: Approaching the Category of Queer

4.1. Queer as a Set of Non-Normative and Subversive Practices

The concept of *queer* can be defined above all by the fact that it is not definable, so what does it mean to deploy this term? The variety of struggles of queer activists of the social movements in the 1990s (Laufenberg, 2022) displayed itself also in the academic debate of queer theorists. In *Queer and Now* (1991) Eve Kosofsky Sedgwick, a central figure of Queer Theory, writes, "It is organized around multiple criss-crossings of definitional lines." (Hall & Jagose, 2013, p. 8). In this essay, Sedgwick proposes different possible definitions. One of them frames *queer* as "destabilizing the 'common sense'." (ibid., p.3). By this 'common sense,' Sedgwick refers to the smallest common ground, all theorists and activists agreed on: heterosexuality. This depicts the central reference point insofar that it is this that is being rejected. Michael Warner´s term "Heteronormativity"' framed this more broadly to describe heterosexuality as the basis that structures Western societies (Warner, 1993). Warner thus circumscribes the system of discourses, institutions, and practices that qualify heterosexuality as normal, morally right, and considered superior concerning other sexual forms (Laufenberg, 2022, p. 133). In this system where heterosexuality is compulsive (Rich, 1984) *queers* become the *others who threaten* (Ahmed, 2014, p. 144). Because it's their bodies that do not fit into the heteronormative imaginaries and narratives. Thus, compulsory heterosexuality "shapes bodies and lives"' and determines how we orient ourselves and set in different kinds of social space (Hall & Jagose, 2013, p. 423). To put it into words of Judith Butler, the claim of "naturalized heterosexuality" is set on the ideas of "man" and "woman", which must be constantly repeated by performing them (Butler, 2004, p. 128). Starting with the interpellation of "It's a girl / It's a boy" at birth, certain ideas, behaviors, and appearances get inscribed on the subject, and materialized in the gendered body. Thus, heteronormativity becomes the "original" in the sense of natural essence (ibid.), whereas queer is seen as the "specialized" like Warner put it (Laufenberg, 2022, p. 133). But, as stated by Butler, it is rather the *effect* of the constant imitation of its ideas (Butler, 2004), whose demarcation is homosexuality, or queerness, so to speak. That's why Butler speaks of *gendering* as practice, even though there is

[9] Warner, 1993, p.xxiii

nothing autonomous about this way of "embodying of norms" (Butler, 1993, p. 6)[10]. This is their key point of theory: The (gendered) subject is inevitably always situated.[11] As Butler clarifies, there is no pre-social, or pre-historical subject; its full expression of gender, sexuality, identity, et cetera, is always produced by and negotiated through these norms and their repetition (ibid.). Heinz-Jürgen Voß (2010) justifies this assumption from a sexual scientific view and argues that Sex exists always on a continuum, whereas its binary categorization is made by "invisible" structures. Yet, Sex shows itself always individually and in diverse facets (ibid., p. 235, 319). Sara Ahmed conveys this understanding in our affective structure. The "not fitting" of the queer subject affects the level of experience that Ahmed titles "queer discomfort" (Ahmed, 2014, p. 151-155). In other words, the constant failing being non-normative is inscribed on what queers feel.

Therefore, everything has to start with a "self-identification" (Warner, 1993, p. xvii) of the person "who comes to a queer understanding" (ibid., p. xiii). Already for the early queer theorists *queer* was understood broadly on the level of stigmatization, which is connected to several issues, and not just about sexuality, desire, or gender identity ("as lesbians, gays, and homosexuals"). Thus, *queerness* in the sense of Warner means not just *being queer but* is more seen as a practice. In Warner´s words, it is "a kind of practical social reflection just in finding ways of being queer" (ibid., p. xiii). Thereby, even if there might be a shared experience, queer struggles would "differ in important ways" (ibid., p. xvii). If we take this with Eve Sedgwick's description as a "dramatization of [the] locutionary position itself" (Hall & Jagose, 2013, p. 9), the use of *queer* in relation to oneself means something different than in relation to someone else. Conceiving *queer* must therefore take into account the radical individualization that it entails.

Queer theory often frames itself as a productive challenge to heteronormative society. Eve Sedgwick sees it as a strategy to dismantle traditional concepts like "the family." (ibid., p.8). Michael Warner views queerness as an ongoing, localized struggle (Warner, 1993, p. xvii), and Judith Butler highlights how repetition of gender norms can be subverted to expand gender identity. Drawing from this, the German academic Magdalena Müßig suggests queer pregnancy inherently challenges normative expectations (Müßig, 2021).

[10] Judith Butler writes that femininity is not a product of choice but a "forcible citation of a norm" (Butler, 1993, p.7).
[11] Here, I refer to the term as Donna Haraway intended. A subject is always already in a certain way socially located and positioned, what needs to be reflected (Haraway, 1988).

To conclude, conceiving *queer* means first a non-normative and subversive set of practices of sexualities, gender, and the body on the level of the individual experience merging with social and structural conditions. Here, I mainly want to refer to members of the LGBTQIA+ community[12], as this reflects also the understanding of my interviewees. Further, also in line with the literature, they refer to *queer* as a vague concept, as an 'umbrella term' where a lot of things fit under. Joris, who was in transition by the time of the interview, "really like[s]" the word queer, because in its openness it presents a "leave me alone"-attitude, and so also a kind of protection. Fritzi, who self-identifies as genderqueer, referred in her narrations on queer very much to its dimension of non-normativity as "simply not wanting and being able to conform to the binary system". Subsequently, Joris pointed to queerness as the practice "to bring a different perspective to it" and refers here to an established *way of life* that conforms with the "hetero norm". Lastly, Luca, whose identification as non-binary evolved through time, emphasized the pivotal point of *being queer* as its "self-definition".

4.2. Doing Queer as a queer-feminist Ethic of Care

In discussing 'queer' in this work, it's important to link it to reproduction. As Sara Ahmed stated, living queer in a heteronormative society means "failing to reproduce" (Hall & Jagose, 2013, p. 428). Reproduction here includes cultural norms, values, and family structures dictated by heteronormativity (ibid., p. 423).

From a queer theoretical perspective, procreation is thus ambivalent. Early queer activists aimed to break free from heteronormative patriarchy, and both second-wave feminists and gay liberation movements were seen as anti-family and anti-natalist. Donna Haraway's *A Cyborg Manifesto* (1984) blurred human boundaries, bringing queer reproduction into the discourse (Stacey, 2018, p. 5). Thus, feminist discourses embraced women's differences and procreative abilities. Since then, emphasis on genetic and biological creation in queer kinship practices has grown significantly, thanks to Assisted Reproductive Technologies (ART) (Leibetseder, 2018; Stacey 2018), due to increasing public acceptance of gay sexuality and family life, signaling a shift from traditional queer family ideals

[12] LGBTIQA+' is an evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual.

Considering queer reproduction, there's initially an ambivalence in academic, activist, and public discourse: Judith Stacey critically reflected on her earlier work regarding parents' gender and sexual orientation, noting its possible influence in normalizing gay marriage and family life.[13] Marcin Smietana's work on surrogacy (2016, 2017) highlights how these norms are becoming less queer and more exclusionary (Stacey, 2018). Lisa Duggan coined the term "homonormativity" to describe this kind of desire for a certain assimilation into the heteronormative structure (Duggan, 2002). This term expresses the politically promoted equality of LGBTQIA+ individuals in alignment with neoliberal ideologies, while broader issues of social justice and systematic change are neglected. Thereby, more radical queer voices got marginalized, which reinforces social inequalities by fulfilling rather than challenging dominant cultural norms (ibid.). Though queer reproduction is critically viewed in queer theory, it aligns with the aspiration for "futurity and a utopian vision" and an affirmative approach to queer life within societal structures, what can happen simultaneously with a rejection of heteronormative assimilation (Leibetseder, 2018, pp.5). The main issue is to accompany these processes without losing the 'queer' dimension. Very recently the literature discusses this as 'queer bioethics.' Upcoming in the 2010s, queer bioethics want to redefine what "health/sickness and ability/disability" mean in the context of reproduction and give all people a voice who are involved in the process (ibid., p.8, 26).

A key example of a queer ethical framework is "Queer Reproductive Justice" (QRJ), which has become a crucial analytical tool for my research. QRJ was preceded by the concept of "Reproductive Justice", which framed a social movement of primarily Black women in the US during the 1990s to address their exclusion from reproductive topics. This movement united various marginalized groups to approach theoretically the questions of choice and access in the context of reproduction. Loretta Ross, a central figure, described its purpose as addressing "the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny" (Ross, 2006, p. 15). Reproduction does not happen in a vacuum but is always linked to broader social issues, making individual choices influenced by societal structures, communities, or institutions. As Ross and Solinger (2017) noted, reproductive rights for many communities are a matter of social justice (ibid., p. 180). In response to recent global political shifts, including rising religious extremism and white supremacy, the demand for "Reproductive Justice" has expanded to include queer and trans* people. According to Sonja Mackenzie, the 2022

[13] References in Stacey (2018) on Biblarz and Stacey (2010) and Stacey and Biblarz (2001).

repeal of abortion rights in the USA significantly impacts those oppressed by white male supremacy (Mackenzie, 2022). Despite the UN declaring the right to have children a global human right in 2023, LGBTQIA+ individuals still face many challenges. Considering the "unfitness of reproduction" for certain social groups (Smietana, 2024[14]) and the rise of right-wing agendas, the question remains: who has the right to be a parent? (Price, 2018). The queer Latinx feminist activist Miriam Pérez put QRJ in 2007, as something more than just the right to reproduce. Claiming QRJ means being granted autonomy and integrity of everyone's body as a human right (Pérez, 2007). It's about forging alliances for a movement where everyone finds space to express their needs, not just advocating for queer rights or representing a specific feminist stance (ibid.). Accordingly, QRJ inherently follows an intersectional perspective, and acknowledges that queer reproduction always happens on the intersections between sex and gender, but also between class and race. Within a postcolonial feminist approach, QRJ as an analytical framework considers queerness not only as exposing harmful hetero- and homonormativity, but also as racism and other structures that shape and support oppression (Smietana, 2024). Moreover, in line with Sonja Mackkenzie´s concept of "structural intimacies", reproduction as such, is seen as already part of and embedded within structures of inequality in its political environment (Mackenzie, 2013). QRJ adds to it categories of race, sex, and gender. Consequently, as Laura Mamo emphasized, QRJ describes an "ethic of accountability", encompassing not just individual behavior but also the societal contexts and relationships that shapes it (Mamo, 2018, p. 31). Mamo's emphasis on this ethic highlights the importance of acknowledging ambivalences and complexities in human reproduction, advocating for their acceptance within a queer theoretical tradition. What falls then under the sign of *being queer* is the attempt to create a framework for reproductive justice concerns as such. Consequently, in this specific field of reproduction, the political dimension of *queer* as a concept becomes evident again.

With the preceding remarks on the term queer, I make no claim to a definitional framework, but rather attempting to clarify my theoretical perspective. I place myself in the tradition of queer theorists such as Michael Warner, Sara Ahmed and Judith Butler, who link the claim of queer to a genuine non-normativity on various levels, which is always already situated within heteronormativity. Their celebratory understanding of queer and thinking of it as a political

[14] This source is not published yet, and its used information was part of a lecture that Marcìn Smietana held in February 2024 at the University of Graz within a conference on Reproductive Justice in the context of queer and trans reproduction. Smietana presented findings of a collaborative project together with Laura Mamo and Sonja Mackenzie.

subversive practice that manifests and realizes itself in social interactions shines through current claims for queer bioethics, thereby pursuing QRJ.

Bringing this together with an understanding of 'expertise' as established knowledge of a profession, queer as inherently resistant practice might seem contradictory. But, as it has been shown, claiming 'expertise' has been changed over decades, and as Eyal (2019) points out, it is not seen any more as exclusive to 'experts', but rather historically contingent and publicly effective "ways of talking" (ibid.). What still seems to be true is that claiming 'expertise' always comes with certain knowledge, experiences, and practices of an individual, and in distinction to something one 'does not know'. By claiming an 'expertise,' or an "counterprofessional expertise," there is always linked to the drawing of boundaries. This also applies to queer as a social practice. Even though the depiction of queerness remains vague, it is fundamentally defined by its resistance to heteronormativity. If I now, in the following elaborate on the understanding and meaning of queer-sensitive working midwives*, is brought together.

5. The Shared Experience – Expertise of Doing Queer Birthing

As a short reminder, the profession of midwife is genuinely understood as a support provided by women for women (Crossan et al., 2023). As the leading association for the profession of midwives, the "International Confederation of Midwives" asserts that midwifery care "is, and always has been, a women-centred profession." (ICM, 2021) So, as outlined above, and as the ICM recently specified this as part of its professional framework (ibid.), against a male dominated healthcare, the midwifery profession has always placed the focus on "women." Moreover, in the center of all this stands the assumption of a genuine female empathy for birthing as such. Or to put it differently, the unique expertise of midwives* is their experience of being a woman. But what happens when the birthing person identifies not as a "woman"? How do midwives then justify, or build on their expertise to support queer people in giving birth?

What follows is the elaboration on the expertise, or the knowledge of queer-sensitive working midwives* and how does this become an "authoritative knowledge" (Davis-Floyd & Davis, 1996). As an introduction, I let Luca speak, who I talked to in 2024. Luca, 30 years old, is working as a midwife* for eight years. After their studies in midwifery science, they moved to the German metropolis to work there in a birth center, where they also had a leading position for some years. At one point this position, but also the whole working atmosphere became challenging. Luca, a non-binary queer person, wanted to work in a more respectful and queer-feminist context, so they got in touch with the queer-feminist midwives* collective, and in 2022 they became part of it. For the German community of midwives* this collective is seen as the pioneer for queer-sensitive midwifery. From their beginning in 2018, they offered training for interested midwives* and did public lectures. The demand is so high, that Luca has only been coordinating these requests for the collective for a year now. When I asked them about how they as a collective assess their standing as this provider of knowledge, Luca referred to themselves as an expert,

> What makes me an expert? Um, on the one hand, to understand your own queerness, of course. It's also super individual, but perhaps more to understand what it means to be queer in today's world, the obstacles, the challenges, but at the same time also the enrichment and beautiful things that being queer brings. Exactly. I simply see us midwives* as experts for pregnancy, birth, and the time afterward, much more than doctors. Because we have the chance to accompany them from the beginning to the end, and so we have the chance to accompany the whole physiology and doctors only see the pathology. But pregnancy and birth are first of all totally physiological.

So, there seems to be two kinds of expertise which converge in the midwifery praxis of Luca. It is the expertise on the "own queerness", as well as the understanding of "us midwives* as experts." Rather than a conflicting relationship, Luca as a queer identified person places themselves in the legacy of the midwife*`s profession. For Luca, being queer and being a midwife* seems to be in harmony. Rather than contrasting themselves to non-queer midwives*, Luca moved on in describing the conventional role of midwives* in contrast to doctors as this is an essential part of a philosophy as midwife*, as I have outlined in Chapter 3. The midwife* identity seems to win over the queer identity for most of this statement, defining the relevant expertise as that of midwife, not that of queer person. My analysis explores how this harmony is discursively produced and where its limits lie.

At this point, I will frame my understanding of *queer* to continue with a more differentiated category for the analysis. Taking up the descriptions in Chapter 2, I want to stress, what *queer* means is always contextual. As I made it clear before, to a certain extent, it is inherent to *queer* as a concept that there are no absolute delineations; the literature provides impulses rather than definition. Thus, *Queer* is seen as an 'umbrella term', which gathers different identifications and definitions together. To be concrete, in the upper elaborations the interviewees indicate two directions of understanding. First, there is the understanding to which I refer as "queer community"; people who see themselves identified in the group of LGBTQIA+ people, meaning their sexual orientation and/or gender identity does not correspond with a cis heterosexual lived identity. Six of my interviewees assigned themselves under this acronym, whereas three of them identify themselves as not cis-gendered females. Whereas Lara expressed uncertainty about her own queerness, Laura and Evelyn classify themselves as *allies*. For the LGBTIQA+ community, an *ally* is a heterosexual and cisgender person who supports queer people and stands up for their rights and concerns. The understanding of *being a queer ally,* becomes important for the second direction of the understanding of queer. Thereby, the political dimension of the midwifery profession becomes apparent, which all my interviewees emphasized. This goes hand in hand, what I understand as *'being queer outwards',* the political activist dimension of being queer, which is represented to the outside world. The interviewees described their political stance as "queer feminist", which I understand as a fundamental perspective of how they ingest the world. Mainly, this refers to an intersectional power-critical perspective of the patriarchal structured system. In

other words, a queer feminist attitude rejects heteronormativity as such and tries to work against its reproduction. Luca, who clearly aligns with the first understanding, nevertheless articulated the heart of the matter. Simultaneously, they frankly explained in the conversation how difficult it was for them to embrace this understanding of queer:

> So, people who identify as queer themselves also include cis people. For example, did I already accompany a cis woman who lives with a cis man in a relationship and has had a child, but this cis woman has identified herself as queer. So, I also mean this person, so this family constellation also belongs to the queer family constellations for me.

To conclude, I want to emphasize that *being queer* can be understood in both directions. The narrations of my interviewees reflect on a wide understanding of queer, is neither a cumulation of certain 'queer' features, but rather the "self-definition" as queer, as also Michael Warner stressed it in the beginning of the 1990s (Warner, 1993). Therefore, it is not relevant if one is part of the LGBTQIA+ community, or 'just' driven by the queer feminist view, which I see in line with the concept of QRJ on the intersections between sex and gender, but also between class and race.

5.1. Being Queer as Being Expert aids Midwifery

At first, I have identified that for a practicing a queer-sensitive midwifery, the midwife* itself had to have a kind of private confrontation and an understanding of queerness individually, on which they built their knowledge on. This finding can be linked to one important feature, which is in the literature on the expertise of a conventional midwife pointed out. In their study Maher and Torney Souter (2002) argued that in their practice midwives must constantly balance their private and professional role they take. More precisely, discursively there are certain biomedical, social or personal narratives on birth, which will get transferred during midwifery practice, which impacts the individual birth experience. So, midwives are seen as mediators of these "birthing narratives", through which they can "develop and negotiate satisfactory birth narratives that could encompass the intense and sometimes difficult experience of birth" (ibid., p. 37). Consequently, they do switch between a professional (medicalized) and a personal level during their work practice. Similar to the midwives interviewed in Maher and Torney Souter's early 2000s study, my interviewees also highlighted the challenge of what Ivy referred to as "drawing a line" between the private individual and the professional midwife*. Ivy, a 27 years old cis-gendered female

midwife*, finished her midwifery training in 2018 and works since then in a hospital, which is known for its anthroposophic approach. In Ivy´s description this means a human and respectful contact with people in and outside of the clinic, which was the reason why she wanted to work there. As another reason she mentioned the autonomous way of working, which they as midwives have in the hospital. Even though they are part of the clinical system, and each birth has to be confirmed by a doctor, in their team of around 25 midwives they carry many decisions concerning their working processes. As an example, they decided to work in 12-hour shifts, because this is beneficial in the contact with the families. Because of its alternative approach, birthing people come there on purpose. But Ivy said it's very popular, precisely because of these characteristics, that also brought her there. Accordingly, people who come there for birthing are usually registered before, but still, as Ivy told me, there are some shifts, where she attended three births. Although Ivy pronounced clearly her wish to work at this place and how she likes it, during the interview, she often seems exhausted from her work. We met this April on Tuesday morning in a café. Sometimes, I had big problems understanding her, and I thought this was due to the noisy environment of the meeting place. But I recognized in this clear but gentle way of talking a characteristic of Ivy, which can describe how she handles her midwifery practice, unexcitedly and practicable, but touched. In her announcement of "drawing a line", Ivy expressed what Maher and Torney Souter (2002) refer to midwifery as a "flexible and strategic border crossing" (ibid.). Hence, when it fills a purpose, Ivy does reveal her queer identity, for example when she accompanied lesbian couples:

> Yes, of course, if I make it clear to a lesbian couple that I'm married to a woman myself, then of course I create trust and security. And I usually just do that because I think it helps them to relax. I usually do it with a subtle hint, or I know my way around the scene, so to speak, so that people somehow realize it. Or I mention the rainbow family center or something, or say that I know people there or something.

So, although the queer identity is seen as something intimate and private, it can get important for the delivery support. But the identification with the role as midwife* has limits. Luca said that they didn't even know who they were as a private person, so they recently started this process of delimitation themselves as a private person from being a midwife*. During Luca´s narrations, it became clear that there was a simultaneity between evolving their identity as queer and their desire to delimitate themselves from their identity as midwife. Their growing understanding of "their own queerness" was closely tied to a heightened awareness of their needs, abilities, and overall

self-perception. Almost every interviewee experienced the struggle of identifying with the job as a midwife* while facing personal limitations. Luca returned to work after a break, Laura plans to take a break, and Lara described setting clear boundaries between her personal and professional roles in her early years as a midwife*. That helped her to cope with her mental health, they told about strong depressions. Lara, 34 years old and cis-female gendered, has been working as a midwife* since 2013 in various settings. In the birth center, where she worked until 2017, she already became a little bit more confident in balancing her private and professional role as midwife*. But first during her work as part of the queer-feminist midwives* collective, she could find her stance on this:

> I set myself apart a lot more and I don't think I said anything about my private life. And then, I actually somehow realized that it was much more mixed, that the midwives simply revealed more about themselves. And I think I also picked that up a bit from [name of a midwife* of the collective], because she often made appointments in her living room and brought people to her because it was somehow more practical because of the CTG machine, which didn't have to be lugged around. And so I thought, okay, maybe I should get over the idea that it might come across as unprofessional or something. When I show something about myself, I think that it's also really important for me to show something about myself in terms of queerness. For example, when I offer a course, I tell people that I'm straight and cis, because I think that's kind of important when people sign up for a queer prenatal course, so that they know, okay, from which perspective is the person at the front speaking like this, I don't even know if that's totally true anymore, but at the moment it's maybe still okay to formulate it like that. Yes, and I think to myself, "I learn so much from you, private things, and you let me so deeply into your life, I think it's only fair that I also reveal a little bit about myself.

As Lara did in this quote, during the interview she referred for many times to the other midwives* of the collective from whom she has learned and adopted certain practices and attitudes. This highlights how close they as a team created together their queer-sensitive midwifery practice, which they describe on their homepage as their queer-feminist philosophy. Through an old school friend, Lara came to the city and started together with her and two other queer identified midwives* the foundational process of the first queer-feminist midwives* collective in Germany. This was in 2018. In her five years, she was an active part of the collective, she gained increasingly certainty in her midwife*`s identity as such. When we spoke in April 2024, she had been living in another city for two years. As the preceding narration underlines, Lara´s practice as midwife* has been developed by the personal and professional confrontation with queerness and more precisely a queerfeminism that had become practical.

Hence, this narration of Lara makes clear, how midwives* has always been conflicted about drawing a line and showing up as a person. Even though Luca and Ivy drew a different conclusion from it, all of them went through a process to find their stance on how much of the

private person is into the worker's role. But in the end, my interviewees uniquely admit that to be a *good midwife** they must become visible as a private person in their practices to some extent. Further, the "social and personal narratives" (Maher & Torney Souter, 2002), that shape the midwifery practice and thus the "birth narratives" as such, are in a queer-sensitive midwifery inevitably linked to their own understanding of queer, thus their queer identity. Luca and Lara's stories show that a queer identity involves challenging established norms, respectively conventional midwifery attitudes. with Luca establishing clear boundaries as a facet of their queer identity, while Lara became increasingly involved with birthing individuals. So, the question here to pose is, how do you show up and draw a line when you attempt to practice a decidedly queer midwifery?

5.2. Doing queer as Shared Expertise

In all the cases, the personal experienced queerness became a shared experience of midwife* and the birthing person, which helped in building a trust relationship. Katja emphasized this connection on a deeply emotional level. Like Ivy Katja also wanted to work in the hospital, where both of them working now as midwives*. When I talked with Katja in April 2024, she had been living in Berlin for almost six years. Due to private reasons, she moved there in her early thirties. At that time, she already worked for five years as midwife* in several settings, also in clinics with 2.000 births a year. After she had already completed training in nursing, she studied midwifery science in 2010, as one of the first in Germany. During the talk with Katja it became very clear that her life in the metropolis also shaped her identity essentially, in particular her identity as queer lesbian person. She consistently exuded such a pride of being queer, as part of this "community" she has friends in. Often, I got reminded of a celebrative moment of queerness and embracing her non-normativity as a lesbian woman, which is described by many of the early queer theorists, or even the lesbian feminists of the 1980s. She feels very comfortable living as a lesbian, that means practicing her *queer way of life* (Ahmed). She mentioned her queer friends as well as queer-feminist literature, that impact her and strengthen her confidence as a lesbian. And she wants to contribute to making queer life more normalized, in her practice as well as in her workplace. At one point in the interview, she pulled out a folder and told me about a presentation on queer people giving birth that she has currently prepared to present to her team. When queer

parents give birth in the hospital, that is still not often the case, and then predominantly *white* lesbian couples with an academic background, Katja wanted to share her own queerness. In the following statement it is indicated, that for Katja there is obviously a shared experience as a lesbian:

> Yes, of course, I think the fact that I'm queer myself makes it kind of exciting for me and somehow, I feel comfortable there, simply because it's a bit, well, not because I have children myself or anything, but because it's a similar reality of life, so to speak. I'm more likely to be able to bond somehow.

As Katja puts it here, making herself visible as lesbian in her midwifery practice with a lesbian couple feels good, and is supportive of building a trustful relationship. What does it mean then, when Katja refers the "similar reality of life" between her as the lesbian midwife* and the lesbian parents? She described a comfortness, an easier ability to bond, and an excitement of sharing this together. There seems a desire to bond with the queer lesbian couple also on the side of the midwife, not just for them, but also for herself. According to Eyal (2019) trust is a core precondition to be considered as an "expert". He writes, "To place one's trust in somebody or something means to direct the arrow of responsibility on them" (ibid., p. 54). So, at the same time it is a stable and fragile relationship of trust. First when the trusting part "trust responsibly" (ibid.), there can be a trust relationship. Still, Katja wanted to remain vague in her statement. A vagueness which indicates also a lot of uncertainty or enables contradictions, but likewise she pointed something existential, queer people share a 'reality of life', which enables them to empathize with each other. It is something Ivy and Sina also shared. When Ivy supported a lesbian couple and set the information that she herself is married to a woman, this built trust and safety and helped the family to relax. One´s own queer self becomes visible in the other. As Mazanderani et al.´s study (2020) underlined the significance to acknowledge experiential knowledge as foundational in claiming expertise. The authors found that sharing personal stories can turn the individual experience into knowledge, put in a broader context of a 'community' one can also serve as a proxy for a group (ibid., p. 275), which becomes apparent in the case of queer-sensitive midwives*. Building on Maher and Torney Souter´s emphasis on a "strategic and flexible border crossing" of the private person and the worker's role as midwife (Maher & Torney Souter, 2002, p. 39) is even more requested in a queer-sensitive midwifery. When Ivy, for example, asked on the side, if the lesbian queer couple already thought about the things to do concerning the stepchild adoption, she shared her own experience in dealing with legal issues as a queer person in Germany and showed

understanding and further knowledge about their living situation. So, since *being queer* is the shared experience of the midwife* and the birthing person and their company, it conveys a certain sensitivity about the social, medical, or legal circumstances the queer families face, because the midwife* might have experienced similar situations. Here, Mackenzie's "structural intimacies" should be noted, which suggest that reproduction is inherently embedded within inequalities, both nationally and globally (Mackenzie, 2013). When Luca talked about their felt "protective instinct" of birthing queers from their colleagues in former working places, a certain kind of "gut feeling" of protecting their own "community" becomes apparent. As already touched before, in the interview with Luca became clearest, how their own path of identifying as a non-binary queer person went hand in hand with their developing towards a queer-sensitive midwife*. Their narrations are always underlined by the description of situations which lead to a shift in their personal and professional life. In the beginning for example, Luca talked very long about an experience in their midwifery practice, when they named the baby of a *white* woman and a Black man as "choco baby". The feedback of the parents on its rassist impact, resulted for Luca in increasingly sensitive practice towards discrimination, and led eventually to the change to the queer-feminist midwives* collective. Followed by such situations, Luca insisted that their experiences as a queer person might not be the same at all, but it can sensitive one for the other´s "heteronormativity":

> I think because of my own queerness, I may already have similar situations or experienced similar lived realities, but maybe not at all. I've also accompanied queer people who live in their heteronormative nuclear family, are married, and so on, where I've also somehow encountered resistance in my basic queer-feminist attitude. I don't know if I would say that per se, but it just brings exactly, it just really brings a kind of sensitivity that I have, because I have perhaps already experienced similar things that I and the people can share with each other, because we have perhaps already similarly experienced them in some way.

What is at stake here is developing a fundamental sensitivity to the lived reality beyond the "culture of heteronormativity" (Stewart and O'Reilly, 2017). As shown by the literature, this culture only accepts cisgender women in the birthing role, therefore queer people have to be protected. Salden et al. (2023) talks about that discrimination in this context even increases for not cis queer people. Because they know, how it is to live a queer person, especially as a queer person who wants to start a family, in present Germany with its heteronormative shaped family politics (see Chapter 1), the queer-feminist midwives* collectives wanted to create a "safe space", as Luca and Laura pronounced it.

Laura, 31 years old, was the first midwife* I met in autumn 2022, shortly after she co-founded the second queer-feminist midwives* collective in Germany, where they were supported a lot by the colleagues in Berlin. Like Lara, Laura identifies as a cis-gendered heterosexual woman, and sees herself as a queer ally. As usual in Germany, Laura did a traditional midwifery training in a clinic, where she also worked afterwards. She mentioned how she realized after some time, how patriarchal the clinical setting of prenatal care and the German birthing culture as such was. She described her daily working in a way that Metz-Becker (2019) described the feeling of today´s clinic midwives as "workhorse column". Laura mentioned generally a lack of time and therefore a not respectful, discriminating contact with birthing people. Due to this, she decided to step out of this "repressive apparatus of power" (Metz-Becker, 2019), and founded with a friend the collective guided by a queer-feminist philosophy. In her narrations it became clear that her motivation lies in abolishing this patriarchal birthing culture, which just sees cis-gendered heterosexual *white* women in the birthing role, and wanted to create a birthing environment, who everyone is welcomed and seen as an equal part of be part of its formation. In Laura´s own words:

> First of all, I think in this safe space, not having to explain that you are a pregnant trans* person, but simply being able to be there for yourself and being a participant in a birth preparation course without having to question or prove or explain your own identity.

In particular, creating a safe birthplace means to the collectives not feeling 'othered' or being measured against a norm. In the words of Sara Ahmed, to create a space where queers feel discomfort, which do shape their feeling of being queer in a heteronormative culture. At the same time, they also created a safe working space for them, where they don't have to explain themselves and share the same values, which the members of the collectives refer to as queer-feminist ones. In this understanding, a safe space is organized in a horizontal way, where the line between the one who provide care and the others who receive it is blurred, and the midwife* can also appear with a person of needs and limits. Luca discussed instances at their former workplace, a birth center, where male and female colleagues repeatedly disregarded practicing "informed consent," leading Luca to no longer support such behavior in their leadership role. Additionally, unable to fully express their queer identity there, they also realized their political differences, resulting in their decision, they needed their queer-feminist community to be in particular their "safe space" for working as a midwife*:

> I really pushed myself beyond my limits, even in obstetrics anyway. And that's when I really burnt myself out completely and I was okay with that. I can no longer work in this setting; I need a different kind of team. A different kind of structure, (…) and also a team in which I can feel safe as a queer person and don't have to fight queer feminist battles on top of that.

So, but if there is a certain "protective instinct" for Queers, how Luca expressed, can we speak then also of a certain embodied knowledge which queer-sensitive working midwives* have due to their own queer identity?

Is there a Queer Intuition?

In forming their expertise, midwives have always built their knowledge essentially on the body, who give birth. To take it literally, their understanding of attending a birth as a 'guardian' (Fahy & Parratt, 2006), means to protect first and foremost the birthing body from any harm. At this point the female-gendered foundation of the midwifery profession becomes apparent. From a feminist standpoint, where the midwifery profession views itself as truly liberating women from a male-dominated obstetrics, providing protection for women from the women-centered profession of midwives, reveals itself as an essentializing idea of gender.

That is a paraphrase for 'intuition,' as the literature on midwifery practice would call it. In reference to the study by Davis-Floyd and Floyd (1996), which aimed to validate intuition as a legitimate source of midwifery knowledge, defined it as a "physicality of knowing." (ibid.), instead of its commonly understood "gut instinct" which is distinctive from all reason, rational or hierarchical (ibid., pp. 245) and not verifiable. Gobet and Chassy (2008) put it as a genuine phenomenon, that is based on evidence (ibid., p. 130). Hence, being a midwife is historically associated with and built on its intuition as their "authoritative knowledge" (Davis-Floyd & Davis, 1996, p. 258) and still is. So, if the midwifery profession traditionally defines itself by distinguishing from a male domain, by defining what it means to be a woman and supporting women in their unique experience of childbirth, does intuition in midwifery practice then naturally become a trait 'by nature'?

Hence, in response to the question of whether they have something like 'intuition' and whether they would also use it in their midwifery praxis, none of the interviewed midwives* referred to

their own queerness. Still, everyone would use intuition in their practice. But to what extent does this become prevalent in queer-sensitive midwifery? When I asked Lara about how the idea of intuition resonates in her and how she would this to her own expertise as a midwife*, she just finished talking about her language as the most recent development in her practice. I felt the impulse to ask her something, that contradicts for me the most the idea of *learning a language* and its ability in making something expressible, intuition. As Lara also thought about this a lot, found a rich answer to it:

> I would say that I have an intuition, which I definitely use. Behind that, of course, there are also certain abilities to have emotional knowledge or to be able to read people, to be able to respond to body language, in other words, to be somewhat emotionally ready, and to have a certain intuition based on experience. Okay, my gut feeling right now is that the child is so stressed that we should perhaps move now and not think about it again in half an hour, but I think that's also linked to the term midwife because that's something that was perhaps more attributed to women. They are somehow able to realize this emotionally and they have a good intuition. So, I think that also comes from this history, because it's a woman's profession and (…) it is, of course, a huge wealth of experience on which the whole thing is based and which has been imparted to us, and that is precisely why it is perhaps much more justified than one would now somehow assume from the term intuition, not just a gut feeling, but a gut feeling arises from a wealth of experience.

So, Lara perceives intuition rather as acquired, hence not essentialist. She clearly refers to its historical dimension, a women-centered accumulated knowledge that informed her intuition and thus her expertise. This fits with the "Benner's Theory", a concept of "expert intuition" from the 1980s. Based on the observation of nurses, Patricia Benner described intuition as an expertise through practice (Downe & Simpson, 2010). The rapid perception of situations and their decisions relies rather on "extensive knowledge" than on certain analytical rules (ibid., p. 108). Further, someone´s intuition evolves; in contrast to the *nurse novice,* the *nurse expert* relies on "continued clinical experience" over time, so that 'she' the nurse "sees a situation as a whole rather than in parts" (ibid.). Described as a "huge wealth of experience", also Lara refers to intuition not as an instinctive feeling, which is just innately there, but to an accumulation of experiences over time and passed down through generations of midwives.

Moreover, Lara deconstructed the common understanding of "intuition" as a patriarchal concept. Building on Haraway (1988) I describe the concept of intuition as "situated knowledge", which evolved in a patriarchal society as female "embodied knowledge" (ibid., 1988, p. 582). Thus, the ability to empathize, or as Lara put it, to have "emotional knowledge" and being sensitive with *others,* knowing their needs – even non-verbally – are women-attributed features and therefore also linked to the midwifery profession. This understanding corresponds with that of the

other interviewees. To get a certain "gut feeling" was very much the focus of their professional training, which is shaped essentially on women-specific attributes, but they had to figure it out on their own through their practice. "You need a lot of experience to understand all this, because women's bodies (sic.) are not all the same", Katja emphasized. In Katja´s perception as a cis-female lesbian, the birthing body remains predominantly female. Due to her little experiences with other queer birthing people, she talked mostly about 'women'. Moreover, this narration also indicates an understanding of gender as a social construction (Butler, 1991), because at the center is the body, not a specific gender.

So, drawing from this, intuition appears to be built on experiences. But these are less certain embodied experiences than more working experiences. This is also evident in the narrations regarding whether, as a midwife*, it is central to have given birth yourself. Because that is exactly what the slogan "by women for women" alludes to. Just like not all of the interviewed midwives* identify as queer in their sexual orientation and/or gender identity, not all of them have born children yet. Just Evelyn, Sina, and Vera had the experience of bearing a child at the time of the interviews. But as the three of them not refer to the significance of their own birthing experiences, the other midwives* put this not an essential prerequisite to provide good delivery support. That resonates in their claim of a holistic, individualized, and evidence-based approach. Luca supported this stance very strongly. While talking they envisioned a former intern who had given birth, drawing parallels between themselves and the birthing person. Luca perceived this practicing as not helpful:

> I'm relatively sure that I don't need to have given birth myself to be a good midwife. Of course, it's the most blatant experience, but somehow, it's still the case that every birth is totally individual and different. And I also think the fact that I haven't had a child of my own gives me a kind of healthy distance in order to be able to work in this profession in a professional and unbiased way.

Luca continued that this "kind of healthy distance" would even help them to stay open for every new birthing situation and each birthing person. So again, the embodied experience of bearing a child is so individualized that no one can have a certain "intuition" or "gut feeling" for this situation, even though they might have had the same experience. Analyzing Luca´s narrations, this can be highlighted as the biggest challenge and claim at the same time in their practice as midwife*. Practicing "radical particularity" means to see the other, while not losing appearing as a subject, or being professional in providing evidence-based knowledge, but being constantly reflexive on

its own bias and being able to apply this into each interaction. To put it differently, the same experiences are not the same at all.

So, for Lara intuition is the ability of *reading* and *responding* to people, Katja addressed a certain *understanding* for "women´s bodies", and for Luca it is *listening* to their own feeling but also to the feeling of the birthing person. As mentioned, all of them admit having an "intuition", paraphrased as "gut feeling" [*Bauchgefühl*], which they see rather as experience-based than inherently and innately there. Nevertheless, as their narratives indicate, there has to be a bodily level of experiencing the *other*. They use their bodily senses to get a feeling of their counterpart, so to speak, the person who is giving birth. In other words, they empathize with them. Thereby, it is of secondary importance, whether the midwives* themselves had this bodily experience, it is rather about a conscious *reading, listening,* and *understanding* of the other person in the space, perceiving the other´s body and integrating this into their practice. To say it with the words of Sara Ahmed, the midwife*'s acting is oriented on the other´s "way of inhabiting" the space (Ahmed, 2006).

So, if we were to ask if there was a *queer intuition,* we must negate this. On the one hand, the midwives* became sensitized for certain processes during their – feminized – training, on the other hand they got sensitized through their social contacts, (bodily) experiences, and environment. In line with Joan Scott, I will therefore argue that the claimed instinctive intuition ("*Bauchgefühl*") has to be seen as an accumulation of (bodily) experienced situations as queer and/or female socialized subjects. According to Scott, experiences can never be considered in isolation, they happen always in and due to a social and political context. We are never just individuals doing experiences, but as subjects constituted through experience (Scott, 1991, p. 779). Hence, 'experience' as a category always stands for the context and the very situation in which it is situated, Scott argued. Following this feminist theorizing, I understood to question the authority of experiences, because they are always already embedded in certain discourses, respectively power hierarchies, which helped to understand a certain queer identity always as a *doing queer*. As Luca mentioned, there can be similarities in the experience of *being queer* or "not at all". Experiences always display themselves differently. To pursue a queer-sensitive approach as a midwife* primarily means to put yourself in relation to this range of experiences especially queer people might have had on their way to getting pregnant, as Joris aptly pointed it out:

> It's an even more difficult situation of discrimination, so there are probably a thousand different ways of describing it, but it's simple, becoming parents is difficult enough as a hetero-normative, 30-year-old, white German couple and all the different variations of this description that you can change make it even more difficult and that's why I want to be able to respond to these people even more specifically. Anyway, this individual – I don't think you can say 'queer parents need this' because no, some queer parents need this, some don't, or some need something else. So, our view of seeing people as individuals is a good basis for saying, 'Yes, we'll pay more attention to that'.

This narration makes clear what I want to point out by the claim of *Doing queer.* On the one hand, queer-sensitive working midwives* acknowledge their situatedness (Haraway, 1988) of Queers in the current German political and social system and consider the discriminating and possibly traumatizing experiences which this entail. But on the other hand, rather than universalizing they perceive the uniqueness of each parent and enter into an active and relational dialogue, which is essentially their expertise. And all this is founded on their "view". What Joris is referring to can be described as the queer-feminist stance that all the interviewees see as fundamental to their understanding as a midwife*. First, this goes together with the fundamental criticism of power relations, respectively of patriarchal structures with its "compulsory heterosexuality" (Rich, 1984). But there is more to this attitude than just a queer critique of heterosexuality. The ideas of heteronormativity are manifest in our ways of birthing. Laura described, "that we simply have a birth culture that is very much implicated in fear", and consequently, the "birth assistance is simply still very strongly influenced by patriarchal structures", as Luca underlined. They refer here to the two confronting discourses on the *safe,* medicalized hospital birth versus the unsafe, *natural* birth in the non-clinical setting. Simultaneously, this reflects also on the juxtaposed professions of the obstetrician versus the midwife. Healthcare systems, including birthing settings, are often shaped by cis-normative assumptions (e.g., Salden et al., 2023), heightening fear for queer individuals in patriarchal birthing cultures, which Malmquist (2019) announced as "minority stress." This became also evident in the motivation of my interviewees to provide queer-sensitive midwifery. Similar to Joris, Lara emphasized, that it was not the purpose of the queer feminist collective to focus "on the care of queer families because we think queer people have special or different needs", but because, as long as "the world works the way it does right now" particular "safe spaces" are needed for people, as Luca spelled it out, who cannot serve the features of the *white* academic cis-gendered woman, who lives in an heterosexual marriage.

So, from a queer-feminist perspective, my interviewees want to question, expose, and address these structures in their midwifery practice. That's why for the midwives* interviewed,

their job has always had a political dimension. As part of one of the queer feminist midwives* collective, Lara summed it up:

> Well, I think what we all agreed on, is that we all believe that political convictions cannot be separated so well from midwifery work, because midwifery work is ultimately also deeply political and precisely and outwardly, even with the name 'queer feminist midwives* collective', we very consciously named it that way and always introduced us that way. We also want to make this visible to the outside world, i.e. that a team is put together that wants to deal with power structures, for example, patriarchal power structures or heteronormative power structures, and that we want to try to integrate this into our work to the extent that we are aware that we as midwives* also occupy a certain position of power.

Thus, the political dimension of the identification of *queer* is prevalent. Especially in the case of Evelyn, Fritzi, Lara, and Laura – all of them are AFABs[3] and part of a heterosexual relationship – it becomes clear that a certain queer sensitivity is there even though neither their sexual orientation nor their gender identity can be attributed to the LGBTQIA+ community. They state a certain queer-feminist socialization through their close relationships, which in part led to start their queer-feminist midwives* collectives. Fritzi and Katja also mentioned queer-feminist literature, which educated them.

So, to sum this up, to some extent a queer identification shapes the knowledge for providing a queer-sensitive midwifery. Through previous elaborations I wanted to make clear three important points, which become evident in the delivery support with queer people. First, there is the own queer identity of the midwife* which builds trust in the relationship between midwife* and the birthing person. Thereby, I follow a wide understanding of the concept queer. Considering the narrations of the interviewees, queer is described as the affiliation to the LGBTQIA+ community in terms of one's own sexual orientation and/or gender identity, as well as the identification with a queer-feminist stance and the support for system change on this behalf. Following that, I see queer as a social practice, as *Doing queer*. By this I mean, secondly a certain sensitivity for the *queer way of life* contextualized in the social, historical, and political situation, and so the acknowledgement of a queer situatedness in current Germany in the shape of certain experiences, which transmit in their midwifery practice. Thirdly, the midwives* build upon the legacy of their profession while extending their feminist perspective to a queer-feminist one, particularly focusing on their heteronormative context, as I will discuss in the following chapter.

6. The Reflexive Way of Talking

6.1. The Impact of Heteronormative Socialization

The aspiration and principle of every interviewee´s midwifery practice, as the analysis made clear, is individualized delivery support, which further means focusing in particular on the needs of the birthing person. Providing individualized care presents in the literature as well in the statements of the German and international associations of the profession the ultimate goal.

So, as already outlined in the last chapter, to have a certain sensitivity for non-heteronormative lifestyles and family constellations, becomes very crucial in the delivery support of queer people. Guided by this sensitivity, they create a queer-sensitive space, as it is pointed out by Vera and Sina. Both of them worked at the time of our interviews in 2022 together in a birth center, which does not convey a particular queer-sensitive approach in their name, but was recommended to me as queer friendly.

In the birth center the delivery support of each family is structured in teams. That means, each family will get supported during the whole process of birth by three midwives*, and they get to know all of them during this time. Vera, a 41 years old cis-gendered woman, mother of two kids, conveys a lot of life and working experience already in her presence. Something calm, warm, and welcoming emanates from her, and from the very beginning, I felt calm and confident in her present. Vera has been working as a midwife for almost 15 years now in several clinical and non-clinical settings. When in 2017 the birth center was founded with the claim to work together in a "people-friendly model and on equal footing", Vera joined the group of midwives, and is very happy there. For Vera her work is all about an attentive and mindful contact with people, as individuals not as gendered subjects:

> So, it creates a framework, especially for queer people, to have confidence that they and their history or their needs are dealt with sensitively.

It's the same for Sina. They, a 35-year-old non-binary queer person, have chosen the birth center as their workplace, because its structure and the team responded well to their needs in balancing their working and family life. Sina lives in a poly-constellation with two kids, which requires her to work flexibly and independently. Following on from the remarks in the last chapter, Sina has a

certain “embodied knowledge” due to their life as a queer person, which results in a sensitivity for others and their uncertainties, where they as midwife* is able to counter something:

> In queer couples, I think there are more uncertainties at the beginning, what kind of space will I be in, and will it be held in a way that is comfortable for me? And can I come there with my issues and is there a kind of resonance that I can do something with?

Even though the interviewees outline this generally as an essential quality as midwife*, they also admit that they would need time to let this sensitivity for the individual birthing person unfold. This would not be the case in the institutional structure of a hospital, as I described before a ‘Patriarchal Birthing Culture’ prevails, and queer birthing people face multiple discriminations (Salden et al., 2021; 2023). Consequently, as Sina indicated in their statement, due to their “minority stress,” (Malmquist, 2019) they are more afraid of the first contact with the midwife/health care staff. Following from Heggie et al. (2023) Fritzi confirmed that whenever queer people give birth at her hospital, they are always seen as a “speciality”. The 35-year-old gender queer midwife* works in a very conventional hospital, and is telling about how her colleagues label her as “as different,” in the sense of being more open to gender differences. During our conversation this April in her living room, Fritzi talked about an occasion, when a trans*man gave birth in their hospital and how this has caused an uproar within the team. Even though all of them strived to do everything right, it was hard for them to deal with this situation, because they never dealt with that before, as Fritzi described. In Fritzi´s narrations I could clearly feel the anger about how narrow-minded her midwife colleagues were about other than the heteronormative family constellation. But at the same time Fritzi expressed her exhaustion with having “this political discussion” at work, which she has already gone through, especially by reading queer-feminist literature. These descriptions underline the manifest cisnormative assumptions of birthing, which several studies have uncovered (e.g., Spidsberg, 2007; Salden et al., 2023).

In contrast, expertise on queer-sensitive midwifery is, I contend, crucially built on the reflection of the midwives*´own heteronormative positioning. Evelyn put that into words, “We have simply grown up in this society, we have been socialized the way we have all been socialized and we want to reflect on this and question ourselves from time to time.” Evelyn, a 45-year-old *white,* cisgendered woman in a heterosexual marriage, is part of a 2021 founded midwives* collective, when we talked in 2022. For her another form of discrimination was motivation to found this collective with another midwife*. Both of them are married to Black men and

experienced in their former working places (clinical and non-clinical) lots of racism, which led them to create their own birthplace, where they claim to work critical of racism and queer-sensitive. Thus, recognizing and addressing discrimination in their midwifery practice shows how aware my interviewees are of the heteronormative embedding and socialization.

That's what the queer-feminist midwives* collectives want to point out by the chosen prefix "queer-feminist" in their names, as Lara emphasized. Defined as their philosophy, they make their political convictions the cornerstone of their midwifery work, seeing them as inherently intertwined:

> Well, we have very consciously named it that way and have always imagined it that way, we want to make it visible to the outside world, so that a team is put together that wants to deal with power structures, for example, patriarchal power structures or heteronormative power structures, and we want to try to integrate this into the work in such a way that we are aware that we as midwives* occupy a certain position of power and want to deal with it sensitively.

Accordingly, the assumed hierarchy between the 'knowing professional expert' and the 'unknowing layperson' wobbles. All in all, the midwives*´ stories create a birthing space in which a "respectful, open encounter", as Laura expressed, decisions for the birth process are made 'together', what Luca defined by "shared decision making" and "real consent". Both procedures, Luca emphasized as the ones which they have evolved the most towards a queer-sensitive working midwife*. In this context, they understand the first one as a decision-making process that can also be reversed at any time. By the connotation "real" in the latter, Luca underlined how this practice has evolved. Resulting from some assaultive situations in their former working place, by this they want to clearly distance themselves from the "informed consent" practiced there, which does not really wait for the consent of the birthing before touching but doing it anyways. In their practice now, Luca addresses each touch in advance, asks for consent two times, one time while explaining the following examination, and another just before doing it. By continuously reflecting on and refining their practice, in their queer-sensitive approach, they do show a "counter-conduct" of midwifery work. Murphy´s description of feminist healthcare involves not just thinking about a human problem differently than it is already defined by a dominant profession, but also doing different things about it (ibid., pp. 49). Moreover, following from Liora O'Donnell Goldensher, I want to suggest conceiving queer-sensitive midwifery as a "counterprofessional expertise" (Goldensher, 2020). In the following, I will underline this terminology in the elaboration on the midwives*´narratives.

6.2. Queer-sensitive Midwifery as Counterprofessional Expertise

The Strategy of Open Questions Creating Trust

Through my analysis, I was able to identify language as the most decisive feature. Thereby, the delivery support with queer people can be headlined by the question, 'How do I as a midwife* communicate with my clients?' For every one of my interviewees, it was their language that developed the most over time to a queer-sensitive and gender-inclusive form of communication. As I will outline in the following, to evolve a queer-sensitive midwifery praxis means to find the power-critical, anti-hierarchical, and gender-inclusive "way of talking", borrowed from Gil Eyal. In Laura's way of talking herself and in communicating during the interview situation, this impact of a used language became apparent. Her sensitive but confident use of gender-inclusive language created already the interview situation itself as very welcoming:

> Language is an important instrument for creating a sense of well-being and designing it in such a way that people feel comfortable with it and don't feel hurt or triggered by my language. Um, that I use it, so to speak, the language to open up and create a space for this support of pregnancy, birth, and postpartum, where I listen to the topics brought in, provide some input, and see then how they can be processed.

So, it is the *How* that is at stake here. In this context, the use of gender-inclusive language is highlighted as a key queer-sensitive approach to interacting with the birthing person and their companions from the very start. This, as Laura expressed it, creates a space which was not there before. She meant that gendered language in a patriarchal birthing culture is exclusive, while gender-inclusive language creates a space that goes beyond heteronormative assumptions. Here, the strategy of the "open questions" is important. It is more important to ask open questions than to assume any kind of fact in advance. Luca´s descriptions of a first meeting, when they meet a pregnant person for the first time, are very fruitful in this regard:

> I usually initiate a round of introductions with names and pronouns, which I always say first. And then I say, if you feel like it, introduce yourself, with or without your pronouns and, if you like, share something about yourself that you would like to share. I don't know, I'll also tell you a bit about who I am, how long I've worked in the profession, how I'm currently working, and what my main focus is. Exactly, and depending on the situation, but usually there is always a lot of information with this open introduction, where I then ask follow-up questions or have my questions, where I know, ok, these are important for me to know today, or I tell people again, I'm here today to get to know each other, to explain to you what midwife support actually is, what the scope is, what the support looks like and that we also talk about what is important to you, that

> you can share things that are important to you. Exactly. And then I have a few questions. So that´s exactly what I ask again, sometimes explicitly: What do you want to be called? Then I often ask first of all, if they want to share, how the pregnancy came about, as a very open question, so it doesn't suggest that this is a couple who have naturally become pregnant with their own egg and sperm, so to speak. That's why the question is how the pregnancy came about.

Let's look a little closer at Luca´s 'way of talking'. This detailed description of getting to know each other is mainly about opening up space, as also Laura mentioned. Formulations are rather made as an invitation to speak than a concrete request. Luca "initiates" the space for the people to introduce themselves, let them tell and speak of what they "feel like" to share, or "what is important" to them. In this 'way of talking,' there are no answers anticipated. Using open questions provides people with a wide scope to answer. By this, the midwife* opens the interactional space to the other party, and thus, power imbalances are minimized. Luca is transparent about their role and purpose in the meeting, leaving space for others to respond without assumptions about the birthing party. The significance of the latter especially in contact with queer people is emphasized by Lara:

> For example, if the person comes alone, then you can ask, are there other people who are somehow involved in your pregnancy or who will have responsibility for the child, so try as much as possible to ask open questions that don't assume anything, that is, that neither assumes that the person is in a partnership nor that the person will also live parenthood in the partnership because that's also not something that we sometimes take for granted, that children only arise from romantic relationships.

As Lara continued, with this awareness in the initial conversation she as a midwife* can impact that "a bit of excitement can be put aside" and "many doors can be opened". What is described here again, is the building of a trust relationship by conscious communication. Referring to Eyal (2019) trust on an expert means to place responsibility on someone, but this has to happen from both sides. Thus, by their strategy of open questions the midwives* promote a space where nothing is "take[n] for granted", but everyone and everything is welcome to bring oneself into the space. This emphasizes that a queer-sensitive expertise is built collaboratively, fostering interactive practices that involve both parties equally.

Getting into Dialogue: The Approach of a Queer-Sensitive Language

Several studies have confirmed that the used language and the form of communication by the healthcare staff indicate heteronormativity (e.g., Stewart and O`Reilly, 2017; Goldberg et al., 2023), and this can create an atmosphere where people get afraid of disclosing their queer identity

(e.g. Spidsberg, 2007). As especially structuralist and poststructuralist feminist thinking pointed out, language is a structured system of signs and symbols which underlies society shapes how we see the reality. Poststructuralist thinkers like Michel Foucault added here a power dimension, which Judith Butler incorporated into their theory of gender performativity, suggesting that gender is constructed as a set of rules and attitudes, wherein individuals are categorized as either man or woman and perform accordingly.

The first queer-feminist midwives*collective in, one Luca is part of, was aware of this and created their queer-sensitive language, which they communicate to their clients, as this quote shows:

> So, in prenatal classes, we always say at the beginning that the language is very powerful and very gendered, especially around the topic of birth, pregnancy and also always very feminine and that's why we have agreed in the courses to use the Latin terms and then we also explain with the help of a PowerPoint, so what is the uterus. So, we always use the term uterus and that's what we call the uterus here. We explain all these terms again. In one-to-one support, I often say I use the Latin terms, or I say the term and then see what the reactions are like, how the person reacts to it, and then ask how you would like me to talk about your body? What do you call this part of your body, or what do you call your uterus?

Since they offer training in this queer-sensitive language to other midwives*, in their narrations on their used language many of the midwives* I interviewed, referred to guidelines of the collective on this. Vera, for example, shared that she was part of one of those training, cited "vulva and vagina" as examples of a wording to exclude "all possible words that also indicate such [gender] roles". In German the vocabulary on birthing indicates mainly female-associated practices, or even puts them negatively. In other words, already describing birth processes in German "indicates heteronormativity" (Stewart and O`Reilly, 2017). To make this concrete, *Uterus* means "Gebärmutter" [birthing mother], *Cervix* means "Muttermund" [mouth of the mother], and lastly the *labia* can be translated with "Schamlippen" [lips of shame]. In the German case, a queer- and gender-sensitive language in this context means above all a switch of the vocabulary which is per se cis-female gendered. One last example should still be done. To speak of the maternity pass, the queer-feminist midwives* collectives use rather than the common "Mutterpass" [mother´s pass] the neutral terminology of "Schwangerschaftspass" [pregnancy pass].

Still, for them it is not about implementing a certain way of talking once the birth person enters the space, it is about finding a common language. Thereby, neither the midwife* nor the birthing person should lose their language or way of speaking. This demonstrates that midwives

also endeavor to counter accusations of being classist. *White,* primarily academic trained, socialized midwives* with whom I did interviews, using the latin language is not very challenging. But others might have problems with that, it is not their "ressource" as Lara repeatedly called it. According to her, it is therefore rather about identifying a used language with them, so everyone is feeling good:

> Yes, I also try to adapt, because even a hetero constellation or a queer person can also be that, for example, if I have a lesbian couple in front of me, that word mother is still really important for the person who is pregnant, because that is somehow a totally super resource because they associate a lot of positive things with it. Or something like that, and it can also be the same in the hetero constellation. I try to find out, okay, what is your language and try to adapt to the language, so to speak.

The importance of gender-inclusive language for midwifery practice is also strongly reflected in the semantics of the interviewees themselves. It should be particularly emphasized that all interviewees make great efforts to use gender-neutral terms for people (e.g. caregivers, birthing person, etc.), and generally use very refined and sophisticated language. For Laura, Lara, and Luca, also members of the queer-feminist collectives, the gender-neutral vocabulary already seems very intuitive. Laura for example used the gendered role designations "mother" and "father" only once she contextualized how her understanding is of them, and thus they are not reproduced thoughtlessly. Whereas all of the interviewees were concerned about using a certain gender-inclusive and queer-sensitive "wording" in their narrations, it can be shown that there are institutional differences or difficulties in its applicability. Therefore, the degree of a midwife*'s integration into a clinical setting will determine their language approach. This pattern is evident in Katja's narrative. She, a cis-gendered female who identifies as queer-lesbian, predominantly supported cis-female lesbian couples and non-binary individuals in her midwifery work. While she felt more comfortable with cis-female couples, she strived to be correct in her approach with non-binary individuals. Analysis of Katja's language revealed a consistent use of "Women," unlike other interviewees who employ gender-neutral terms like "birthing person." Further, Fritzi, Ivy, and Katja acknowledged experiencing partial inflexibility by the hospital structures regarding the representation of queer family constellations. Fritzi said that after two years of request new birth cards of newborns are used which are not pink and blue anymore but yellow. But Fritzi stated that it could be just her individual practice, which she can adapt in a more queer-sensitive way:

> I think what I try to do is simply not to use this feminine gendered language. So, I try to talk about the cervix rather than the 'mothermouth' or the uterus rather than the 'birthing mother'. And breast milk and all these

> other terms in a different way, a gender-sensitive language to use, so to speak. But I have the feeling that's the only thing I can do.

Ivy and Katja highlighted in this regard an information evening of their hospital for the becoming parents, which they hold. Both of them present this occasion as the possibility to appear as a queer-friendly birthplace in public. In opposition to many of their colleagues, they see it as crucial to talk about "the accompanied person" instead of "the father", to welcome also queer family constellations, such as lesbian couples. Further, Ivy noted a sign at the entrance of the obstetrics ward, where the Visiting Hours are listed for "fathers and/or the accompanied person". These instances appear to be outliers. While hospitals' reality remains influenced by heteronormativity, posing obstacles to fully developing queer-sensitive midwifery in this environment. That's not surprising given that the DHV is still very reserved in its approach to gender diversity, whereas ICM attests to the need for more engagement on this (ICM, 2021). Based on Stewart and O'Reilly's findings, my data suggests that even queer-sensitive midwives eventually conform to institutional heteronormativity in their language use.

Hence, for now, this finding underlines how much of a heteronormative character the hospital as a birthing place still has, while claiming a queer practice of midwifery for themselves is not really regulated.

When then midwives* see their language and communication as key to supporting queer individuals during delivery, they focus on enhancing sensitivity and acknowledging power dynamics, considering "the birthing person in their vulnerable position" and their own acknowledged powerful position as midwife*. For this, the feedback of the clients is used. Two narrations of Lara show how this was integrated into their praxis. One instance involves a BiPoC individual providing feedback after a prenatal course, expressing that they felt unrepresented as the only Black pregnant person present, thus being pushed into a vulnerable situation. In the second scenario, Lara received feedback that she asked too many questions during the birthing process, causing disturbance for the birthing person. According to Mazanderani et al. (2020) "transforming experiences into knowledge requires reflexive practices of telling, hearing and retelling stories" (ibid., p. 276). By re-telling these situations, Lara emphasized how her own used language evolved. In the first scenario, she as part of the collective realized the power of language of (public) images[2], in the second, she recognized how much communication at birth happens non-verbally. Using the

example of Lara in the dialogue with Mazanderani et al. (2020) I want to outline the importance of critical self-reflection on the own practices for a queer-sensitive midwifery. The maternity care they propose is seen as a resonating space of learning from each other, and together. This echoes in Davis-Floyd´s classification of the present midwife who "learns from many sources," including the "woman" and other midwives (ibid., 2004, p. 9). That includes, the midwives* are transparent about things they do not know or don't have evidence on yet. For example, Ivy talked about her current support of a queer family constellation of three parents, where she admitted that she has neither experience nor evidence on how to divide and handle time after birth well.

This demonstrates that established expertise is continually challenged, while the unknown remains acceptable. Each interaction with a birthing person necessitates reflection on their own position relative to the other.

Radical Particularity: The Holistic, Individualized Approach of Queer-Sensitive Midwifery

This resonates with the holistic and individualized approach of the midwives* I spoke to, as well as the midwifery profession as such. The birthing *other* becomes the direction for midwifery practice, as the ICM framed the holistic approach of midwifery as part of its "nature" (ICM, 2021).

Joris referred to holistic medicine, emphasizing the interrelationship between body and mind and considering the person's social context, thus meeting the person as well as the accompanying person "in their reality." Joris' remarks here reflect somehow their own identity. Joris, 29 years old, identified at the point of the interview in 2022 as gender-expanding, but was at that time at the beginning of their transitioning. Their gender-neutral name was already a chosen one, and even though Joris was fine by using she/her pronouns, the felt discomfort with it was noticeable. Due to this, I decided to use they/them to address Joris. In Joris's narrations, a significant issue was their desire as a queer individual to be seen and accepted as they are, without being categorized. In 2022, Joris joined a queer-feminist midwives' collective, hoping to find acceptance. Before, they practiced a holistic, queer-sensitive approach in perinatal courses as a freelancer in an area of Germany with few similar offerings. When she talked about them, Joris` principle of a resonating communication and attendance became explicit, like their former theoretical studies in communication were translated into practice.

Also, Fritzi highlighted the significance of acknowledging in her practice that each birthing person has a "very individual experience and brings their own story with them." The extent to which she embraces her identity as a female-presenting but genderqueer individual, living in a polyamorous relationship, can be understood. To refer back to the argument of the last chapter, it also shows here that there is a connection between the own (lived) queerness and the individual midwifery practice. Moreover, the holistic aspiration is getting more depth, because that also means the mutual acceptance of a non-heteronormative lifestyle, in the way Katja claimed:

> This basic assumption, 'I'm OK, you're OK' and you have the expertise for your body, and I bring my specialist knowledge and my experience, and we try to bring that together. And I also see your biography, so to speak, I see your history, I perhaps also somehow see the difficulties that you have or had, also in order to be here, that is, to be where you are now, and to somehow accompany you well so that you come out of the birth stronger and not completely traumatized.

Hence, the midwives* interviewed see their own role literally as 'helpers' of the birth, as the German synonym for midwife, "Geburtshelferin" implies. This does not mean, however, that they leave the birthing person alone. Moreover, they aim to, in the way of Goldensher, "cast the parents as agents" (Goldensher, 2020, p. 122) to enter the birthing process as empowered and autonomously as possible. In their wording of being "expert for oneself" Joris brought it concisely to the point. As prescribed by DHV, midwives should encourage and strengthen "the women" to stand up for their decisions (DHV, 2023). Additionally, a queer-sensitive approach always keeps its power-critical implication and its own positioning in this decision-making process in mind. Even though, we did not talk about how this challenges her midwifery 'expertise', Laura expressed this by herself:

> I see myself as an observing companion and as a person who is always giving input and advice and I see myself as a person with this somehow enormous expertise. [But] there is also a hierarchy in this, I am this person with this huge knowledge, and you are now this person who is just in this life-changing process and is dependent or [has] the desire to get a lot of knowledge. At the same time, I always try to spread the knowledge and look at it together with you to create a basis so that you can make the best decision for yourself. Because I don't feel like I'm the person to make the decision for you.

Consequently, underlined by this statement, I contend that a queer-sensitive midwifery is about providing an "informed choice," as emphasized by Liora O'Donnell Goldensher (2020). Goldensher notes that rather than seeking 'informed consent' for recommended medical procedures, the midwives* aim to partner with parents to guide their own care decisions, reflecting

a deep engagement with critical and constructivist approaches to science and medicine (ibid., p. 11). As Laura expressed, it is important to be aware of the wealth of knowledge she possesses as an 'expert' for midwifery care, to open rather than dominate the space with this "professional competence." They want to break with the "unequal distribution of knowledge" (Goldensher, 2020, p. 9), and put the autonomy of the birthing person as a whole as the highest principle of their practice. In harmony with a traditional midwifery practice, they gain their knowledge from "multiple sources" (ibid.). Above all, this is the body of the birthing individual with its inscribed experiences. It therefore only remains for them to make offers of options but letting the birthing person / parents take the decision for themselves. Recalling Luca´s remarks on this matter, this whole interplay of active and passive, of giving input versus just listening and accepting, seems to be central to the midwifery practice of my interviewees. I aim to prioritize non-judgmental care, echoing Luca's emphasis on focusing on education and information without judgment, and empowering individuals to be the 'experts for oneself' while the midwife* provides the space where they act freely, and decisions can also be taken back. According to Goldensher, this practice in its "radical particularity of birth, bodies, institutional context, families" makes the difference to conventional midwifery (ibid., p.11). This whole idea of practicing "radically personalized" goes against the understanding "the provider knows best". Therefore, it is seen as a rejection of a common understanding of expertise in medical perinatal care (ibid.), which makes them counterprofessional. With Andrew Abbott, Goldensher calls providing an "informed choice" its "core heartland of work", so to speak what they as professionals aim for (ibid., p.123). In other words, this radically individualized approach and practice is their *jurisdiction.* Regarding a queer-sensitive practice, and here I am primarily referring to the concept of QRJ, I like to add the reflexive inclusion of one's own heteronormative pattern and their intersectional implications on different identity levels (class, race, national origin etc.). Thus, Goldensher's study on American homebirth midwives' expertise can be extended to German midwives practicing queer-sensitive midwifery, given the limitations faced by the interviewed midwives, who are part of a queer-feminist collectives that can only offer home births.

But the underlying idea for me here is, that the claim of "informed choice" means providing a space where each relation of power gets negotiated, where the common heteronormative shaped understanding of hierarchies, knowledge, and communication gets mixed up. And consequently, and as I want to argue, queer-sensitive midwifery is a constant negotiation of language and

communication about this. It is about providing and receiving space, knowledge, and thus, language. It's about stepping into this *inter-action*, this dialogue with the willingness to adapt what is brought in. With Sara Ahmed (2006) I note this as *queering the space.*

Consequently, I want to suggest conceiving queer-sensitive midwifery as a reflexive 'way of talking'. As I tried to outline in the last two chapters, the delivery support with queer people shapes the understanding of the individual midwifery praxis. Building on the narrations of my interviewees, it is their "way of talking", which changed. So, to gain expertise on queer-sensitive midwifery it is essential in the role of the midwife* to be reflective on the own professional as well as private (social) position[3] in its heteronormative shape, critical of the own verbal and non-verbal practices, and lastly willing to adapt these in the dialogue with the birthing party. As it is crucial for the midwives* to perceive the birthing person as individual, and not as gendered person, in line with the concept of QRJ, this midwifery practice is applying an "ethics of accountability" (Mamo, 2018).

7. Final Remarks

This study inquired into the question how queer birthing individuals potentially challenge ideas of expertise in midwifery which is traditionally seen and practiced as a feminized profession with the focus on ‘women’ giving birth (Crossan et al., 2023). As an institutionalized form of queer-sensitive midwifery, the recent establishment of two queer-feminist midwives* collectives in Germany was the point of departure for this study. In focusing on the narrations of several queer-senstive working midwives* I asked what makes their ‘expertise’ distinctive from a conventional midwifery practice. Placed in the small field of national and international research on queer birthing, this study provides a better understanding of queer needs in maternity care by analyzing queer-sensitive midwifery – can inform and guide improvements in midwifery education.

In line with Critical Queer Studies, this study sees ‘queer’ as a vague concept, which is expressed contextually and combines a set of practices which genuinely are in contradiction to a “culture of heteronormativity” (Steward and O'Reilly, 2017). Thus, expressing queer means always practicing resistance towards the assumptions of traditional cis-normativity.

The study has found that there are two kinds of expertise which inform a queer-sensitive midwifery: There is an understanding – the expertise – of queerness as well as the knowledge of midwifery, which is clearly built on the legacy of its profession. The analysis has shown that developing a queer understanding, respectively a queer identity, triggered changes in midwives* practices. For my interviewees, queerness doesn't only mean a certain subsumption under the LGBTQIA+ community but practicing a certain non-heteronormativity which results in a queer-feminist political stance. It was not important to them whether they themselves lived in a homo- or heterosexual relationship, but that their practice as midwives* aligned with a critical stance toward the medical profession – as an extension of a patriarchal, hierarchical and thus exclusive birthing culture. Their queer resistance hence showed in an emphasis on non-hierarchical relationships, mutual respect and empathy for the others experiences as individualized. This also implies that the formation of a queer-senstive midwifery is inherently linked to a constant negotiation aiming to balance the private person and the worker's role, which consequently results in the “dramatization of [their] position” (Sedgwick) as midwife* itself. This approach challenges but does not reject conventional midwifery. Rather, proposing to understand queer-sensitive

midwifery as “counterprofessional expertise” (Goldensher, 2020), this study argues, that this form of midwifery extends its inherently feminist stance by a queer-feminist one. As the asterisk behind “midwife*” already indicates, queer-sensitive midwifery turns the midwifery practice not upside down, but supplements and shapes its essential characteristics.

Traditionally, the midwifery profession has positioned itself in opposition to the male-dominated and medicalized health care system. Ever since, a midwife*´s practice can hence be read as a critique of patriarchal structures. In applying a “counterprofessional expertise”, queer-sensitive midwives* simply take this critique (of a male-dominated and medicalized healthcare system) further. By incorporating their personal experience of queerness in their professional practice they developed a sensitivity for queer birthing people – their expertise – that led to an ambition to create a “safe space” with dedicated attention for queer people, opposing the discrimination Salden et al. (2023) found in German obstetric care.

As the literature revealed, and as is still evident in the public image of the profession`s associations (eg. ICM or DHV), midwifery is oriented towards a cis-gendered ‘women`s’ body, shaped by cis-normative assumptions. A queer-sensitive midwifery wants to counter this by acknowledging a novel queer dimension in reproduction. In alignment with the political concept of QRJ, my interviewees saw reproduction as a fundamentally social product, which is always already influenced by race, class or status, gender, and sexual categories, along with social and political contexts (Mamo, 2018; Smietana, 2024). Thus, queer-sensitive midwives* aim to perceive the individual birthing body instead of a certain gender. For this to occur, two essential factors shape their expertise. First, working as a queer-sensitive midwife* show a high level of critical self-reflection. Beyond their fundamental critique of the birthing culture as patriarchal, they also critically reflect on their own heteronormative patterns from a queer perspective, learning from this introspection and integrating it into their ongoing practice. They reject the term ‘women’ as central for a midwife's identity (Crossan et al., 2023). Approaching a “radical particularity” in their practice, queer-sensitive midwives* constantly reflect their own standpoint and ‘situating’ (Haraway, 1988), responding to the birthing person´s lived reality and integrating as feedback to their practice. Hence, in line with Haraway’s notion of “situated knowledge”, a queer-sensitive midwifery particularly reflects on its own power relations towards the birthing person, aiming to dismantle these. By practicing “informed choice” as Goldensher (2020) defines it, the parents are cast as agent “experts for oneself”. Thus, queer-sensitive midwifery provides a birthing space

equally shaped by the midwife* and the birthing party. Thereby, an "embodied knowledge" is acknowledged on both sides and shapes the interactional space. A gender inclusive and queer-sensitive language and form of communication, as it has been highlighted in previous studies (eg., Griggs et al., 2021; McCann et al., 2021)), supports this process. Queer inclusive communication and language are constitutional for the space queer midwives* strive to create. Using open questions, preferred names and pronouns, and Latin vocabulary for body parts, midwives* create an inclusive language, negotiating with the birthing person. They embrace the poststructuralist view that language is a powerful tool in the performance of gender roles, emphasizing the crucial importance of gender-inclusive and affirmative language in the context of queer birthing (Heggie et al., 2021). Hence, a queer-sensitive midwifery grounds its expertise on acknowledging its language as "situated" and reflexive, thus aware of its impacts. In this sense, I found queer-senstive midwifery to be essentially a "reflexive way of talking," which highlights the significance of a constant reflection in dialogue with the birthing part.

Diverse lifestyles and queer families are here to stay. In the future, all aspects of society regulating family life – up until now based in heteronormative assumptions – will need to acknowledge this new social reality. Midwifery is an especially interesting profession to study here as it rests on fundamentally essentialist understandings of femininity, motherhood and female community. Yet, this study suggests that the midwifery profession (at least in some of its pockets) seems to be adjusting seamlessly to the diversification of its clientele, renegotiating what it means to support a birthing person outside of a binary gender system. Hopefully, this expansion of a self-understanding of the midwifery profession will not remain isolated in a small number of alternative collectives. Potentially, queer reproduction will change midwifery for good. For now, this remains pure speculation in the conclusion of this study – in the future it may prove an intriguing theme for further research.

Appendix

Sample Overview

Name	Pronouns	Gender Specification	Year of Birth	Relationship / Family Constellation	Training / Study	Institution	Year and Location of Interview
Evelyn	she, her	cis-gender female	1979	heterosex. marriage, 2 children	BA Anthropology and Geography BA Midwifery Science	Collective	Zoom, 2022
Fritzi	she, her	cis-gender female / genderqueer	1990	Open relationship	Midwifery Training	Hospital	Private Space, 2024
Ivy	she, her	cis-gender female	1996	Married, Homosex. PS	Midwifery Training	Hospital	Café, 2024
Joris	she, her	gender-expanding	1995	no indication	BA Rhetorics & Communication, Midwifery Training	Collective	Private Space, 2022
Katja	she, her	cis-gender female	1987		Nurse, BA Midwifery Science	Hospital	Private Space, 2024

Name	Pronouns	Gender Specification	Year of Birth	Relationship / Family Constellation	Training / Study	Institution	Year and Location of Interview
Laura	she, her	cis-gender female	1993	heterosex. relationshio	BA Midwifery Science	Collective	Private Space, 2022
Lara	she, her	cis-gender female	1989	heterosex. relationshio	BA Midwifery Science	Collective, Freelancer	Zoom, 2024
Luca	they, them	nonbinary	1993	In relationship	BA Midwifery Science	Collective	Private Space, 2024
Sina	they, them	nonbinary	1989	poly relationship 2 children	Midwifery Training	Birth Center	Birth Center, 2022
Vera	she, her	cis-gender female	1981	heterosex. marriage, 2 children	Midwifery Training	Birth Center	Birth Center, 2022

Bibliography

Ahmed, Sara (2006). *Queer Phenomenology. Orientations, Objects, Others*. Duke University Press.

Ahmed, S. (2014). *The Cultural Politics of Emotion* (NED-New edition, 2). Edinburgh University Press. http://www.jstor.org/stable/10.3366/j.ctt1g09x4q

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Breuer, F., Muckel, P., & Dieris, B. (2019). *Reflexive Grounded Theory. Eine Einführung für die Forschungspraxis* (4. durchgesehene und aktualisierte Auflage). VS, Verlag für Sozialwissenschaften.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. Routledge.

Butler, J. (1993). Critically Queer. *GLQ: A Journal of Lesbian and Gay Studies, 1*(1), 17–32.

Butler, J. (2002). Is Kinship Always Already Heterosexual? *Differences: A Journal of Feminist Cultural Studies, 13.1*, 14–44.

Butler, M. M., Fullerton, J. T., & Aman, C. (2018). Competence for basic midwifery practice: Updating the ICM essential competencies. *Midwifery, 66*, 168–175. https://doi.org/10.1016/j.midw.2018.08.011

Crossan, K.-A., Geraghty, S., & Balding, K. (2023). The use of gender-neutral language in maternity settings: A narrative literature review. *British Journal of Midwifery, 31*(9), 502–511. https://doi.org/10.12968/bjom.2023.31.9.502

Davis-Floyd, R. (2004). Ways of knowing. Open and closed systems. *Midwifery Today with International Midwife, 69*, 9–13.

Davis-Floyd, R., & Davis, E. (1996). Intuition as Authoritative Knowledge in Midwifery and Homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. https://doi.org/10.1525/maq.1996.10.2.02a00080

Deutscher Hebammenverband (2021), *Unser Selbstverständnis [Our Self-Understanding]*. https:// hebammenverband.de/wp-content/uploads/2023/09/IB1.1.06-DHV _Selbstverstaendnis2021.pdf

Deutscher Hebammenverband (2021), *Gemeinsam für Menschenwürde, Respekt und Toleranz [Together for Human Dignity, Respect, and Tolerance]*. https:// hebammenverband.de/wp-content/uploads/2024/04/2024 _Gemeinsam-fuer-Menschenwuerde-Respekt-und-Toleranz.pdf

Deutscher Hebammenverband (2023), *Eine Ethik für Hebammen [An Ethics for Midwives]*. https://hebammenverband.de/wp-content/uploads/2023/02/ DHV_Ethik_fuer_Hebammen2022.pdf

Deutscher Hebammenverband (2024), *Gegen Rassismus und jede Form von Diskriminierung. Für Demokratie, Akzeptanz und Gesundheit für alle.* Netzwerkkommentar Empowerment und Diversität *[Against Racism and all Forms of Discrimination. For Democracy, Acceptance, and Health for all]*. https://hebammenverband.de/wp-content/uploads/2024/02/ Netzwerkkommentar-Empowerment-fuer-Diversitaet_2024-02-22.pdf

Downe, S., Byrom, S., & Simpson, L. (Eds.). (2010). *Essential Midwifery Practice: Leadership, Expertise and Collaborative Working (*1st ed.). Wiley. https://doi.org/10.1002/9781118784990

Duggan, L. (2002). The New Homonormativity: The Sexual Politics of Neoliberalism. In R. Castronovo & D. D. Nelson (Eds.), *Materializing Democracy: Toward a Revitalized Cultural Politics.* Duke University Press, 175-194.

Eckardt, S. (2020). *Die unbekannte Geburt. Subjektivierungsweisen von gebärenden Frauen zwischen individueller Praxis und öffentlichem Diskurs [The Unknown Birth. Modes of*

Subjectivation of Birthing Women Between Individual Practice and Public Discourse]. transcript.

Epstein, S. (1996). *Impure Science: AIDS, Activism, and the Politics of Knowledge.* University of California Press.

Eyal, G. (2019). *The Crisis of Expertise.* Polity Press.

Fahy, K. M., & Parratt, J. A. (2006). Birth Territory: A theory for midwifery practice. *Women and Birth, 19*(2), 45–50.

Gobet, F., & Chassy, P. (2008). Towards an alternative to Benner's theory of expert intuition in nursing: A discussion paper. *International Journal of Nursing Studies, 45*(1), 129–139.

Goldberg, J. M., Shokoohi, M., Graf, T., & Ross, L. E. (2023). Measuring the attitudes of midwives toward sexual and gender minority clients: Results from a Cross-Sectional survey in Ontario. *Birth, 50*(2), 349–361. https://doi.org/10.1111/birt.12658

Goldensher, L. O. (2020). *Homebirth Politics: Feminists, Conservatives, and the Struggle over Expert Knowledge* [Ph.D.]. https://www.proquest.com/docview/2456420820/abstract/F8DE70ACB9D9438CPQ/1.

Griggs, K. M., Bice, A. A., Ward, N., & Waddill, C. B. (2021). Care During Pregnancy, Childbirth, Postpartum, and Human Milk Feeding for Individuals Who Identify as LGBTQ+. MCN: *The American Journal of Maternal/Child Nursing, 46*, 43–53.

Grundström, H., Malmquist, A., Karlsson, A., & Nieminen, K. (2023). Previous Trauma Exposure and Its Associations with Fear of Childbirth and Quality of Life among Pregnant Lesbian, Bisexual, Transgender, and Queer People and Their Partners. LGBTQ+ Family: *An Interdisciplinary Journal, 19*(2), 175–185. https://doi.org/10.1080/27703371.2023.2167760

Hall, D. E., & Jagose, A. (Eds.). (2013). *The Routledge Queer Studies Reader.* Routledge.

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies, 14*(3), 575–599.

Heggie, C., Cowal, G., MacIntosh, C., & Paynter, M. (2023). Supportive and Affirming Queer Perinatal Health Care: A Qualitative Study. LGBTQ+ Family: *An Interdisciplinary Journal, 19*(5), 405–415. https://doi.org/10.1080/27703371.2023.2242319

Helfferich, C. (2009). *Die Qualität qualitativer Daten. Manual für die Durchführung qualitativer Interviews [The quality of qualitative data. Manual for conducting qualitative interviews]*. VS Verlag für Sozialwissenschaften.

International Midwifery Confederation (2024), *Philosophy and Model of Midwifery Care. Model of Practice, Philosophy.* https://internationalmidwives.org/resources/philosophy-and-model-of-midwifery-care/

Jung, T. (2021). Geburt [Birth]. In L. Y. Haller & A. Schlender (Eds.), *Handbuch feministischer Perspektiven auf Elternschaft [Handbook feminist persectives on parenthood]*. Budrich, 347–381.

Jung, T. (2017). Die ‚gute Geburt' - Ergebnis richtiger Entscheidungen? Zur Kritik des gegenwärtigen Selbstbestimmungsdiskurses vor dem Hintergrund der Ökonomisierung des Geburtshilfesystems [The 'good birth' – the outcome of right decisions? Critique of the current discourse on self-determination against the backdrop of the economization of the obstetrics system] *GENDER. Zeitschrift für Geschlecht, Kultur und Gesellschaft, 9*(2), 30–46.

Jung, T. (2018). Sichere Geburten? Aspekte der Versorgungsqualität in der Geburtshilfe in Zeiten der Ökonomisierung des Gesundheitssystems [Safe births? Aspects of quality of care in obstetrics in times of the economization of the healthcare system]. In H. Krüger-Kirn & L. Wolf (Eds.) *Mutterschaft zwischen Konstruktion und Erfahrung. Aktuelle Studien und Standpunkte* [*Motherhood between Construction and Experience. Current Studies and Perspectives*]. Barbara Budrich, 63–78.

Kruse, J. (2015). *Qualitative Interviewforschung: Ein integrativer Ansatz [Qualitative Interview Research: An Integrative Approach*]. Beltz Juventa.

Laufenberg, M. (2022). *Queere Theorien. Zur Einführung [Queer Theory. An Introduction]*, Hamburg: Junius.

Lee, R. (2018). Breastfeeding and sexual difference: Queering Irigaray. *Feminist Theory, 19(*1). https://doi.org/10.1177/1464700117742876

Leibetseder, D. (2018). Queer reproduction revisited and why race, class and citizenship still matters: A response to Cristina Richie. *Bioethics, 32*(2), 138–144. https://doi.org/10.1111/bioe.12416

Leinweber, J., Jung, T., Hartmann, K., & Limmer, C. (2021). Respektlosigkeit und Gewalt in der Geburtshilfe – Auswirkungen auf die mütterliche perinatale psychische Gesundheit Disrespect and Violence in Obstetrics – Effects on Maternal Perinatal Mental Health] *Public Health Forum, 29*(2), 97–100. https://doi.org/10.1515/pubhef-2021-0040

Mackenzie, S. (2013). *Structural Intimacies: Sexual Stories in the Black AIDS Epidemic.* Rutgers University Press.

Mackenzie, S. (2022). Social movement organizing and the politics of emotion from HIV to Covid-19, *Sociology Compass 16*(5), e12979. https://doi.org/10.1111/soc4.12979

Madlala, S. T., Ngxongo, T. S. P., & Sibiya, M. N. (2020). Perceptions of pregnant women regarding student accoucheurs' involvement in maternal health care in the Free State Province. *International Journal of Africa Nursing Sciences, 13*, 100255. https://doi.org/10.1016/j.ijans.2020.100255

Maher, J.-M., & Torney Souter, K. (2002). Midwifery work and the making of narrative. *Nursing Inquiry, 9*(1), 37–42. https://doi.org/10.1046/j.1440-1800.2002.00123.x

Malmquist, A., Jonsson, L., Wikström, J., & Nieminen, K. (2019). Minority stress adds an additional layer to fear of childbirth in lesbian and bisexual women, and transgender people. *Midwifery, 79*, 102551. https://doi.org/10.1016/j.midw.2019.102551

Mamo, L. (2007). *Queering Reproduction: Achieving Pregnancy in the Age of Technoscience.* Duke University Press.

Mazanderani, F., Noorani, T., Dudhwala, F., & Kamwendo, Z. T. (2020). Knowledge, evidence, expertise? The epistemics of experience in contemporary healthcare. *Evidence & Policy, 16(*2), 267–284. https://doi.org/10.1332/174426420X15808912561112

McCann, E., Brown, M., Hollins-Martin, C., Murray, K., & McCormick, F. (2021). The views and experiences of LGBTQ+ people regarding midwifery care: A systematic review of international evidence. *Midwifery, 103*, https://doi.org/10.1016/j.midw.2021.103102

Metz-Becker, M. (2019). *Drei Generationen Hebammenalltag. Wandel der Gebärkultur in Deutschland [Three Generation of midwifery everyday life. Evolution of Childbirth Culture in Germany]*. Psychosozial-Verlag.

Morgen, S. (2002). *Into Our Own Hands: The Women's Health Movement in the United States,* 1969–1990. Rutgers University Press.

Murphy, M. (2012). *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience.* Duke University Press.

Müßig, Magdalena. (2021). Unter anderen Umständen. Queere Perspektive auf Schwangerschaft [Under Different Circumstances: A Queer Perspective on Pregnancy]. In *Elternschaft und Gender Trouble. Geschlechterkritische Perspektiven auf den Wandel der Familie [Parenthood and Gender Trouble: Gender-Critical Perspectives on the Transformation of the Family]*. Barbara Budrich, 195-209.

Oh Nelson, H. (2021). Doctor–Patient Relationship. In W. C. Cockerham (Ed.) *Medical Sociology,* 496–515. https://doi.org/10.1002/9781119633808.ch24

O'Shea, A., Boaz, A. L., & Chambers, M. (2019). A Hierarchy of Power: The Place of Patient and Public Involvement in Healthcare Service Development. *Frontiers in Sociology, 4*, 1–12. https://doi.org/10.3389/fsoc.2019.00038

Pérez, M. Z. (2007, May 31). Queering Reproductive Justice. *Rewire News Group*. https://rewirenewsgroup.com/2007/05/31/queering-reproductive-justice/

Price, K. (2018). Queering Reproductive Justice in the Trump Era: A Note on Political Intersectionality. *Politics & Gender, 14*(4), 581–601.

Regenbogenportal.de (n.d.). *Als LSBTIQ* eine Familie gründen [Starting a Family as When LGBTQ*].* Accessed on 6 June 2024, from https://www.regenbogenportal.de/informationen/als-lsbtiq-eine-familie-gruenden/

Roberts, S. C. M., Ingraham, N., & Wingo, E. (2018). Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study. *Women's Health Issues, 28*, 350–357.

Roosevelt, L. K., Pietzmeier, S., & Reed, R. (2021). Clinically and Culturally Competent Care for Transgender and Nonbinary People: A Challenge to Providers of Perinatal Care. *The Journal of Perinatal & Neonatal Nursing, 35*(2), 142. https://doi.org/10.1097/JPN.0000000000000560

Ross, L. (2006). Understanding Reproductive Justice: Transforming the Pro-Choice Movement. *Off Our Backs 36* (4), 14–19.

Ross, L., & Solinger, R. (2017). *Reproductive Justice: An Introduction.* University of California Press Books.

Salden, S., Graf, T., & Roth, U. (2023). Cisnormativity, Erasure, and Discrimination: How Do Trans, Non-Binary, and Intersex Persons Experience Obstetric Care Compared to Endosex Cisgender Individuals in Germany? *Women's Reproductive Health, 10*(4), 550–571. https://doi.org/10.1080/23293691.2023.2179904

Salden, S., & Netzwerk Queere Schwangerschaften. (2022). Queer und schwanger. Diskriminierungserfahrungen und Verbesserungsbedarfe in der geburtshilflichen Versorgung [Queer and Pregnant: Experiences of Discrimination and Areas for Improvement in Obstetric Care] *[Policy Paper]*. Heinrich-Böll-Stiftung.

Salis, B. (2022). Wir feiern die bessere Sichtbarkeit [We celebrate the greater Visibility], *Deutsche Hebammenzeitschrift, 22*(8), https://www.dhz-online.de/news/detail/artikel/wir-feiern-die-bessere-sichtbarkeit

Scott, J. W. (1991). The Evidence of Experience. *Critical Inquiry, 17*(4), 773–797.

Spidsberg, B. D. (2007). Vulnerable and strong – lesbian women encountering maternity care. *Journal of Advanced Nursing, 60*(5), 478–486. https://doi.org/10.1111/j.1365-2648.2007.04439.x

Stacey, J. (2018). Queer reproductive justice? *Reproductive Biomedicine & Society Online, 7*, 4–7.

Stewart, K., & O'Reilly, P. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Education Today, 53*, 67–77. https://doi.org/10.1016/j.nedt.2017.04.008

Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME*, 6, 374–385.

Timmermans, S., & Oh, H. (2010). The Continued Social Transformation of the Medical Profession. *Journal of Health and Social Behavior*, *51*(1_suppl), 94-106.

Voß, H-J. (2010). *Making Sex Revisited. Dekonstruktion des Geschlechts aus biologisch-medizinischer Perspektive [Making Sex Revisited. Deconstruction of Sex from a Biomedical Perspective]*. transcript

Warner, Michael (1993). *Fear of a Queer Planet: Queer Politics and Social Theory.* University of Minnesota Press.

Weiss, R. (1994). *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. The Free Press.