RESEARCH

The Polyamorous Childbearing and Birth Experiences Study (POLYBABES): a qualitative study of the health care experiences of polyamorous families during pregnancy and birth

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ABSTRACT

BACKGROUND: As many as 1 in 5 adults practise some type of consensual nonmonogamy such as polyamory; many are married, have children, or both. Polyamorous families face unique challenges when accessing care during pregnancy and birth, and qualitative descriptive studies are needed to understand their experiences and inform health care providers' practice.

METHODS: Participants, who self-identified as polyamorous, had given birth in the last 5 years and received at least some prenatal care, were recruited through convenience sampling on social media. Any of the birthing individual's partners were also invited to participate. All participants completed a short demographic questionnaire and participated in a semistructured interview. Interview transcripts were coded using Braun and Clarke's iterative thematic analysis.

RESULTS: A total of 24 participants, 11 who had given birth and 13 partners, were interviewed. Of those who had given birth, 5 received midwifery care only, 4 received obstetric care exclusively and 2 received shared care. Polyamorous families described sharing many common experiences during pregnancy and birth that were affected by their polyamorous identity. Although participants reported both positive and negative experiences with health care providers, when accessing health care all had experienced some form of marginalization that was related to their polyamorous status. One particular challenge for families was with respect to disclosure of polyamorous identity in hospital environments. Participants offered suggestions for improving the health care of polyamorous families during pregnancy and birth, including creating nonjudgmental spaces, accommodating difference through minimizing administrative barriers and allying with patients by providing patient-led care.

INTERPRETATION: Polyamorous families face marginalization when accessing pregnancy and birth care. Care experiences for polyamorous families can be improved by nonjudgmental, open attitudes of health care providers, and modifications to hospital policies to support multiparent families.

Polyamory, a type of consensual nonmonogamy, is "characterized by simultaneous consensual romantic relationships with multiple partners."[1] Prevalence estimates of polyamory are sparse and often subject to methodological limitations.[2] The most recent estimate suggests that 1 in 5 single Americans have engaged in some form of consensual nonmonogamy in their lifetime.[2] This estimate encompasses all forms of consensual nonmonogamy and does not account for married populations or alternatively arranged families who are engaging in the practice. A Canadian-based survey (n = 547) reported that most polyamorous relationships contain at least 1 married couple.[3] This survey found that 75% of respondents were of child-bearing age and 23.2% of them had at least 1 child younger than 19 years living at home under the care of at least 1 parent or guardian.[3] It has been consistently reported that people who identify as gay, lesbian or bisexual are more likely to engage in consensual nonmonogamy.[2] Debate exists as to whether polyamory should be interpreted as part of one's sexual orientation rather than as a relationship orientation or practice.[5] Many who practise polyamory describe being polyamorous as part of their identity.[5]

Few studies have investigated the experiences of those practising polyamory, and much of the available literature is from the

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fields of psychology and sexuality.[4] Furthermore, few studies have investigated the experiences of polyamorous people in health care settings and no studies have investigated their experiences during pregnancy and birth.

Reports that do exist suggest that 1 in 4 polyamorous individuals have experienced some type of discrimination based on their polyamorous status.[6] As a result, legal arguments have been presented that conceptualize polyamory as a sexual orientation within antidiscrimination legislation.[7] Regardless of whether one agrees with this conceptualization, given the high proportion of polyamorous individuals who are of child-bearing age and the substantial potential for stigma, it is important to investigate polyamorous individuals' experiences with reproductive care providers to better inform practice.

The objective of the Polyamorous Childbearing and Birth Experiences (POLYBABES) study was to gain an understanding of the experiences of polyamorous families during pregnancy and birth. This paper focuses on the health care experiences of polyamorous families when accessing reproductive health services.

Methods

Study design and population

We conducted a qualitative descriptive study using semistructured interviews to identify common themes stemming from polyamorous families' experiences with pregnancy and birth.[8,9] We undertook this study from a constructivist perspective (i.e., there is no single truth; rather, truth is relative and constructed by the researchers, individuals and society). Motivation for the study stemmed from some team members' personal involvement in the polyamorous community and a shared interest in promoting inclusive reproductive care; however, all team members participated equally in study design, implementation and analysis.

We included participants if they self-identified as polyamorous during their pregnancy, had given birth within the last 5 years and had received some prenatal care from a health care provider. We also invited partners of the birthing individual to participate in the study. We recruited a convenience sample through announcement of the study on social media (Facebook, Twitter and Instagram). Snowballing occurred through online sharing and posting to targeted polyamorous Facebook groups from major cities across Canada.

Data collection

Participants completed a demographic questionnaire (Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.190224/-/DC1) and semistructured interview. The demographic questionnaire was created using the standard Statistics Canada format. Additional questions were added to inquire about the relationship structure of participants. Both the questionnaire and interview tool were piloted on other members of the McMaster Midwifery Research Centre.

Once we had identified participants and screened them for eligibility, we sent them a link to complete the online consent form. Upon consenting, they were prompted to complete the questionnaire and we then contacted them to conduct an interview in person or via Web-video platform (Zoom). Interviews were offered in English or French and participants were offered individual or group interviews (birthing individuals and partners together).

At the start of each interview, the interviewers prompted participants to define any polyamory-related terms or jargon throughout the interview. The interview contained 2 primary questions: "Can you tell us about your relationship structure at the time of your pregnancy and now?" and "Please tell us about your pregnancy and birth experience." We asked each participating partner to share their experience individually, to ensure all views were captured. We also asked probing questions regarding disclosure, experiences with health care providers, child-rearing and future intentions. The interviewers (E.A. and S.L.) digitally recorded the interviews, transcribed them, removed identifying information and reviewed them for accuracy.

Data analysis

We used Braun and Clarke's thematic analysis to analyze the data,[10] using the 3-step iterative approach shown below.

Preliminary coding

E.A. and S.L. compared reflexive journal entries and preliminary coding after each interview. When preliminary themes began to repeat and no new important themes arose, we determined that data saturation had been reached.[11]

Line-by-line coding

Two independent coders (E.A. and S.L.) performed line-by-line thematic coding using NVivo. Both coded the first transcript simultaneously; they independently coded the second and compared the 2 independently coded transcripts for consistency. The remainder were divided and coded by a single investigator. E.A. and S.L. met regularly to compare coding and ensure consistency.

Generation of themes

All the authors then conducted axial coding and concept grouping. Through this process, we grouped common or related codes together to identify themes, our main unit of analysis. The coding tree is available in Appendix 2 (at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.190224/-/DC1). We also assembled participant-defined terms into a glossary and sent them to all participants for review and feedback.

Ethics approval

The study was approved by the Hamilton integrated Research Ethics Board (HiREB project #3339).

Results

Of the 24 study participants, 45.8% (11) had given birth within the past 5 years and 13 (54.2%) were their partners (Table 1). We interviewed 3 birthing individuals alone; 8 were interviewed with some or all of their partners. The mean number of children per household was 1.8 (Table 2). We assigned participant IDs in the

Table 1: Study participant demographics*

Characteristic	No. of participants (%)† *n* = 22
Age, yr	
Mean	34
Range	23–48
Gender	
Male	8 (36.4)
Female	13 (59.1)
Woman	1 (4.5)
Ethnic background	
White or European	18 (81.8)
Black, African or Caribbean	2 (9.1)
Aboriginal, First Nations or Métis	2 (9.1)
Mother tongue	
English	18 (81.8)
French	2 (9.1)
Serbian	1 (4.5)
Bulgarian	1 (4.5)
Education	
Completed college or university	10 (45.5)
Completed graduate education	3 (13.6)
Some college or university	3 (13.6)
Apprenticeship training and trades	3 (13.6)
Professional degrees	2 (9.1)
Completed high school	1 (4.5)
Sexual orientation	
Straight or heterosexual	7 (31.8)
Bisexual	6 (27.3)
Pansexual	4 (18.2)
Heteroflexible	2 (9.1)
Polyamorous	2 (9.1)
Biromantic grey-asexual	1 (4.5)

*All responses to the demographic survey were open ended and text based, except for education and ethnic background, which were provided as a dropdown list based on Statistics Canada reports. As such, sexual orientation was self-defined and prescribed definitions or categories were not provided. Two study participants did not provide responses to the demographic survey.
†Unless stated otherwise.

Table 2: Participants' relationship structures*

Birthing individual	No. of partners interviewed	No. of children in household
A	3	1
B	2	3
C	1	2
D	2	4
E	1	1
F	2	2
G	0	2
H	1	2
I	0	1
J	0	1
K	1	1

*Data are representative of participants' relationship structures at the time of the interview. All participating partners identified themselves as contributors to the household.

following manner: we assigned a letter to each family, the number 1 to the birthing individual and consecutive numbers to the partners (i.e., birthing individual = X1, partners = X2, X3, etc.) (Table 2). Average interview length was 49 minutes (range 23–99). Participants were from British Columbia, Alberta, Ontario and Quebec. The mean age of participants was 34 years (range 23–48). Nearly half of participants had completed a college or university degree (45.5%) and the majority self-identified as white or European (75.0%) and female (54.2%). Most participants identified as either heterosexual (31.8%) or bisexual (27.3%).

Owing to complexity of reporting and in efforts to maintain participant anonymity, we have not presented details regarding relationship structure. The distribution of participants who received midwifery care and obstetric care was nearly even, with 5 having received midwifery care exclusively, 4 receiving obstetric care exclusively, and 2 receiving shared care.

We received feedback from 11 of the 23 participants regarding the glossary of terms and preliminary themes from the interviews. Terms and their associated definitions and quotes are available at www.polybabes.ca/glossary.

From thematic analysis, we derived 4 overarching themes describing common elements of polyamorous families' experiences of pregnancy and birth: deliberately planning families, more is more, presenting poly and living in a mono-normative world (Table 3). The participants extensively discussed experiences with health care providers, which created many subthemes that intersected with 1 or more of the 4 overarching themes (Appendix 1).

Although out of the scope of this study, participants also shared the difficulty that lack of recognition of additional partners presents in a medicolegal context in terms of shared decision-making among all parents. Participants shared other legal concerns with respect to having more than 2 parents, such as extended benefits coverage, wills and travelling.

Deliberately planning families

All participants expressed a strong sense of deliberateness in their decision-making regarding family planning, which was complicated by the presence of multiple relationships. With respect to health care providers, this manifested as extensive planning and considerations when choosing a primary care provider. Choice of health care provider was often rooted in ensuring emotional safety and perceived avoidance of discrimination based on relationship structure. For example, many participants

Table 3 (part 1 of 2): Thematic analysis

Theme	Description	Quotes
Deliberately planning families	All study participants expressed a strong sense of deliberateness in their communication and decision-making regarding family planning. This primarily included decisions about planning biological parentage and which partners would participate in parenthood.	"Our family very strategically planned to have children. I wanted to have a child with both of the guys being dads ... Of course there was a process in terms of who would be the first biological parent. Something that we put out there is that we kind of agreed to not tell our families. We didn't want to reveal the biological parentage of our kids. We wanted them to both be their dads" (F1). "So many years ago, we decided we wanted to have children, but we both have uteruses …" (H2). "Managing multiple adult relationships is hard and so people should never go into it expecting it's easy. Same with parenthood, and if you're going to be parents and be poly, unless you're happy keeping your other partners that aren't parents kind of on the sidelines, you're going to have to talk to them about parenting, particularly if they come in while you're pregnant or when you already have a kid because they're joining a nest. … [Parenting is] not a decision somebody else should make for you …and it's really all about communication" (J1). "What occurs to me is home births as being a really good way of alleviating [hospital] concerns, effectively if you're worried about what the care at the hospital is going to be like, cut out the hospital, right? If you have people who are in a poly situation, you'll suggest home births if it's possible as being a way of keeping these family centred ..." (K2) "Our family doctor's [very feminist, very queer friendly]. She knew all about our poly-ness. She took on [my partner] and [their daughter] as patients simply because they were part of our family" (C1).
More is more	All study participants expressed that having multiple partners garners more support (e.g., financial, emotional, logistical).	"Since the beginning we've been co-parenting and we've been, like, everybody contributes to the household. We act as, like, one sort of parenting team" (C1). "There's extra one-on-one. When the 13-year-old middle child is sad and sick and whatever and just wants Momma, and the 3-year-old just wants Dad, great, there's still another adult to take care of those other kids" (D1). "I had 2 very close female friends at the time that I have on and off had sexual-ish relationships with. And those two friends I had as my intended doulas kind of thing, not in an official capacity but as okay, I really wanted to have female friends in the room with me if possible for support because — my husband's going to go crazy. So I had them sort of on-call" (I1). "There are times when I certainly want to bring it up, especially in regards to the mental health piece. Like, whenever someone asks what's your support network? Well, like, I want to talk about it. It's very tempting to be, like yes, I have these 2 very wonderful people involved who listen to me and are emotionally supportive and all of that, but then it's just easier not to, unfortunately" (K1). "There's one other thing that I think is important … and that is that the hospital rooms don't provide for room for 3 people. And that isn't a big problem, but it meant that we couldn't actually all be there for a long period of time" (F1). "Sure, the mom is going through childbirth; it doesn't mean that the husband, or boyfriend, or partner is …" (A2). "The only person allowed to be there" (A1). "Yeah, or just privy to the information that's going on" (A3). "Yeah. That was the biggest thing for me was, like, just not knowing" (A2). "Every now and then they'd pop out, say, '"Oh, this minor thing's going on. Everything's all right.' But it wasn't enough" (A1).

Table 3 (part 2 of 2): Thematic analysis

Theme	Description	Quotes
Presenting poly	All study participants engaged in discussion on disclosure of their polyamorous status. Decisions on whether to disclose were made primarily based on a risk–benefit assessment.	"… Over the years, our experiences have been really mixed and variable. Some really good things have come out of telling certain people. And I also feel like we've also lost some friendships and people have been really weird and judgmental and had all sorts of assumptions, and so to me it's not worth it. … [My partner] and I talk a lot about the concept of social monogamy … which I would define as you're not monogamous, but you would like to appear to be monogamous to other people in your social circle and at work and here and there. And so different people have different views on that; a lot of polyamorous people feel like part of creating more safety and understanding of polyamory is that you have to come out, similar to the kind of fights that other LGBT people have … and I'm not really much of an activist type. I'm very comfortable with social monogamy"(E2). "… Someone in my position might not want to be open with somebody that they don't trust. It could be a different situation. Someone would not want to go to an OB appointment with you because they don't want to chance being outed as poly or things like that … So that's why I'm not fully out at work, but I'm not hiding it" (B2). "I was going to [disclose], depending on what her blood type was going to be, because there was one instance while we were trying that I didn't use a condom with [my boyfriend] but we were using spermicidal — like, a strip or whatever as a backup. And so the big question was going to be if her blood type ends up being different from mine or [my husband's], we were going to have to have that conversation with [my boyfriend]. Maybe not necessarily with the midwives, but if they asked, I would have told them … I didn't feel like [my poly status] was going to be something they needed to know, mostly because of the nature of my relationship with [my boyfriend] … It was very separate from my home life, whereas in my and [my new partner's] relationship, I would disclose it to anybody" (A1). "If it was 1 nurse the whole time, I probably would have explained it to her, but because there was so many different people coming in and out, I was just, like, I don't want to have this conversation 5 times" (C1).
Living in a mono-normative world	All study participants discussed difficulties navigating society and systems as a polyamorous family when these systems privilege monogamy. This often left individuals feeling as if there was a lack of acknowledgement of their partners.	"… On their intake school forms, it's what do you classify [your partners] as?" (B1). "An additional thing about care being polyamorous and care is like there are never enough spaces for parents' names on stuff" (F1). "Back when I started more actively being poly, shall we say, I had to talk to my doctor about it because I wanted to get tested more often, and he was willing to help me get the testing I needed but he had only slightly veiled comments on the situation. Definitely not approving and also assuming that I would be settling down eventually. It was uncomfortable talking to him about it" (I1). "We break the system in so many ways. We break the income tax system and we break the legal system. There's so many. We would break the family law, although there's more in family law, I have to say" (F2). "It's kind of funny because the hospitals have these situations where they're like, 'We're used to 1 man, 1 woman, a baby or 2, maybe 3.' And so they can adapt to that scenario. But … the hospital freaks because they're like, 'Crap, we can't make 3 bracelets for the [parents]!'… it's become this huge ordeal about who is getting bracelets. It's like *The Bachelor*, I think. Who gets a rose?" (B1). "… They asked who is allowed to make appointments for your child, and I said me, my husband and my girlfriend. And I had to give her name and her number. And they asked me several times, are you sure? What's her relationship to the child? I'm like, well, I guess she's technically his mother. And they're like, well, we'll just put down his aunt because we can't put down multiple mothers when you already have a father, apparently" (J1).

Note: LGBT = lesbian, gay, bisexual and transgender, OB = obstetrician.

chose midwifery care expressly for the purpose of having a home birth, as this option eliminated concerns regarding potential barriers that polyamorous people face in hospital settings:

"What occurs to me is home births as being a really good way of alleviating [hospital] concerns, effectively if you're worried about what the care at the hospital is going to be like, cut out the hospital, right? If you have people who are in a poly situation, you'll suggest home births if it's possible as being a way of keeping these family centred ..." (K2).

Others chose obstetric care as a way of ensuring continuity of care with the family physician from whom they had received care at the beginning of pregnancy.

"Our family doctor's [very feminist, very queer friendly]. She knew all about our polyness. She took on [my partner] and [their daughter] as patients simply because they were part of our family" (C1).

More is more

Many participants said that having multiple partners garnered more support. Having support from multiple partners was seen as a facilitator for positive pregnancy, birth and postpartum experiences. However, in the context of interactions with health care providers, some participants were not able to share the presence of this support with their health care provider because they did not feel comfortable about disclosing their polyamorous status.

"There are times when I certainly want to bring it up, especially in regards to the mental health piece. Like, whenever someone asks what's your support network? Well, like, I want to talk about it. It's very tempting to be, like yes, I have these 2 very wonderful people involved who listen to me and are emotionally supportive and all of that, but then it's just easier not to, unfortunately" (K1).

In addition, participants often saw physical space and administrative rules as barriers to receiving quality perinatal care. Participants said clinic and hospital rooms often lacked the physical space to accommodate additional partners.

"There's one other thing that I think is important… and that is that the hospital rooms don't provide for room for 3 people. And that isn't a big problem, but it meant that we couldn't actually all be there for a long period of time" (F1).

Furthermore, hospital policies limiting the number of support persons allowed in the birthing room sometimes prevented more than 1 partner from attending births:

A2: "Sure, the mom is going through childbirth; it doesn't mean that the husband, or boyfriend, or partner is …"

A1: "The only person allowed to be there."

A3: "Yeah, or just privy to the information that's going on."

A2: "Yeah. That was the biggest thing for me was, like, just not knowing."

A1: "Every now and then they'd pop out, say 'Oh, this minor thing's going on. Everything's all right.' But it wasn't enough."

Presenting poly

Disclosure of polyamorous status was a central theme in each interview. Some participants felt compelled to play an advocacy role and openly present as polyamorous to demystify their relationship and with the hope of reducing stigma for others disclosing in the future. Other participants preferred to present as monogamous in social settings, for a variety of reasons. In contrast, discussions regarding disclosure of polyamory to health care providers were often rooted in the concept of medically necessary disclosure; i.e., only disclosing polyamorous status when it was believed that it would affect or be medically relevant to their care. Disclosure to health care providers revolved primarily around medical relevance, while social disclosure considered more long-term repercussions and relationship negotiations.

"I was going to [disclose], depending on what her blood type was going to be, because there was one instance while we were trying that I didn't use a condom with [my boyfriend] but we were using spermicidal — like, a strip or whatever as a backup. And so the big question was going to be if her blood type ends up being different from mine or [my husband's], we were going to have to have that conversation with [my boyfriend]. Maybe not necessarily with the midwives, but if they asked, I would have told them … I didn't feel like [my poly status] was going to be something they needed to know, mostly because of the nature of my relationship with [my boyfriend] … It was very separate from my home life, whereas in my and [my new partner's] relationship, I would disclose it to anybody" (A1).

In cases in which participants did disclose to their health care provider, reactions ranged from positive to negative. In many instances, the challenges of repeated disclosure were a central concern. In hospital settings where clients were exposed to many health care providers, it was especially difficult to communicate to each provider the nature of romantic and personal relationships.

"If it was 1 nurse the whole time, I probably would have explained it to her, but because there was so many different people coming in and out, I was just, like, I don't want to have this conversation 5 times" (C1).

Living in a mono-normative world

Polyamorous families report difficulty navigating social systems as these often privilege monogamy, and this was reflected in participants' experiences when navigating the health care system. Participants often noted administrative barriers, particularly with respect to not having enough space for listing all partners on intake forms, or not having all partners recognized as parents of the newborn. For example, identification bracelets, which are often used to link newborns to their parents for security reasons, are usually created in sets of 3 (2 parents, 1 baby). One participant expressed the difficulties in overcoming some of these barriers.

"It's kind of funny because the hospitals have these situations where they're like, 'We're used to 1 man, 1 woman, a baby or 2, maybe 3.' And so they can adapt to that scenario. But … the hospital freaks because they're like, 'Crap, we can't make 3 bracelets for the [parents]!'… it's become this huge ordeal about who is getting bracelets. It's like *The Bachelor*, I think. Who gets a rose?" (B1).

Participants also said that in their experiences with health care providers, recognition was often given only to relationships bonded by marriage or to a partner of the opposite sex. Sometimes this manifested in the lack of appropriate labels for additional partners, referring to them as a "friend," "aunt" or "sister."

"… They asked who is allowed to make appointments for your child, and I said me, my husband and my girlfriend. And I had to give her name and her number. And they asked me several times, are you sure? What's her relationship to the child? I'm like, well, I guess she's technically his mother. And they're like, well, we'll just put down his aunt because we can't put down multiple mothers when you already have a father, apparently" (J1).

Overcoming barriers

Throughout the interviews, participants made suggestions for improving health care experiences for polyamorous families. Suggestions for health care providers based on our participants' experiences are provided in Table 4.

Interpretation

Polyamory is practised by diverse individuals with unique experiences. However, our participants shared common concerns related to the intersection of their polyamorous identity and their pregnancy and birth experiences. Participants reported both positive and negative experiences with their health care providers, but when accessing health care, all had experienced some form of marginalization that was related to their polyamorous status. To minimize the stigma experienced, participants reported selectively disclosing their relationship structure based on their assessment of its medical relevance. Although multiple partners offer additional support for the child-bearing person, partners are often not equally acknowledged and their participation is limited by mono-normative policies.

Our findings align with recent reports that individuals engaging in consensual nonmonogamy face stigma with respect to accessing health care.[12] Our results also suggest that polyamorous individuals face concerns similar to those of other gender and sexual minorities

Table 4: Suggestions for health care providers and health care institutions

Suggestion	Detail	Quotes
Acknowledge (e.g., partner's presence, partner's roles)	Show openness and remain nonjudgmental	"Sometimes it's a matter of terminology. There are a lot of assumptions that people make with language and … they're always going to be assuming that if you're having a kid, it's a married couple and that's it. And it's a heterosexual married couple, for that matter. The midwives that I talked to, they were more apt to use language that was partner or nongender specific, so I guess even just that kind of language can help [you] feel more comfortable because I feel like if one is poly, one is more likely to be adjacent to the LGBT community" (I1).
	Provide space for patients or clients to disclose; do not perceive lack of disclosure as deception	"And, just like at an STI clinic, people are assessing you ... They're accessing your clinic and they're kind of trying to figure [it] out — it's not uncommon at all to get people who will tell you they're straight the first 3 or 4 times they come in for testing and then you finally see them and they're ready to tell you a little bit more about what kind of sex they're actually having that maybe they weren't comfortable saying before" (E1).
	Self-educate	"… This seems very obvious — but, like, if there was some kind of element of their training, like if there's a module on family structures and family diversity or something like that, if the basics of polyamory could be included … That would be wonderful so that if someone is in that situation — if they were already aware that polyamory is a thing that exists, then [me bringing it up] would not be the first time that they'd ever heard it before and I wouldn't feel responsible for completely explaining everything and making it sound good" (K1).
Accommodate (e.g., physical space, hospital bracelets, intake forms, questions to clients)	Explain the medical relevance of the questions you ask	"Yeah, because that process was really, like, 'Okay, here is how your sexual behaviour affects your risks based on your situation. Here's what you need to know. Here is maybe a suggestion about this or a suggestion about that,' like very much centred on 'Okay, here's how your life affects what I can tell you as a medical professional'" (K2).
	Create, modify or adapt intake forms	"I think just space in application forms to be able to put down … maybe you need to put down person 1, person 2, persons 3 or whatever" (F2).
Ally (e.g., avoid assumptions; advocate for your patients or clients and their families)	Show openness and remain nonjudgmental	"It's about [being] patient led and it's about not starting with assumptions, I guess. You start open and then you get narrower considering how the patient responds" (H2).
	Provide client-led care	"I think families look a lot of different ways, and that may include romantic relationships or not. Maybe family is with grandma, auntie and mom … the birthing person should get to be able to say who are their important people that they want with them, or to want to be recognized, or want to be able to be at appointments with them or things like that" (F1).

Note: LGBT = lesbian, gay, bisexual and transgender, STI = sexually transmitted infection.

regarding administrative barriers and challenges with disclosure to health care providers.[13–15] However, unlike other alternatively arranged families (e.g., blended families, same-sex couples), multiparent polyamorous families face unique challenges regarding judgment associated with nonmonogamy.[12] Some participants even expressed being fearful that health care providers would find their nonmonogamous status to be grounds for calling child protection services. Additionally, multiparent polyamorous families face lack of recognition of additional partners.

Our findings are consistent with existing recommendations that health care providers should educate themselves to gain awareness about polyamory so as to provide better care.[4,15,16] Some literature suggests midwives are perceived as being more open-minded, and gender and sexual minorities may prefer to use their services.[17] Although our study supports this finding, it is important to note that participants shared positive and negative experiences with both midwives and obstetricians, and often considered the quality of person-to-person interactions to be most important. We acknowledge that all groups of people interacting with the health care system will have complaints. However, these results show how lack of inclusive care can limit disclosure of pertinent medical information and result in both real and perceived stigma toward nonmonogamous people.

Limitations

Our study has some limitations. Given our convenience sampling, using recruitment exclusively through social media, our results are subject to selection bias. Our recruitment poster containing midwifery-specific logos may have biased our sample toward individuals who had specifically sought out or had a preference for midwifery. Given that our sample was evenly split between participants who used obstetricians and midwives, that we recruited participants from 4 provinces and that most Canadians use social media, we believe our findings are still generalizable to the polyamorous community.

Additionally, our study was limited by recall bias, as participants were required only to have given birth in the last 5 years. It is also possible that interviewing birthing participants with their respective partners may have biased what participants shared. To reduce observer bias, a third team member who did not conduct the interviews participated in data analysis and interpretation. Future studies that prospectively evaluate the experience of pregnant polyamorous individuals should be performed to eliminate recall bias and to better capture changes in relationship dynamics around the time of pregnancy and birth, as well as the shift into parenthood.

Conclusion

Substantial work remains to be done to eliminate marginalization experienced by polyamorous families within the health care system. The needs of polyamorous families during pregnancy and birth are best met by health care providers with nonjudgmental, open attitudes who avoid making assumptions. Adjustments should be made to intake forms and administrative systems so that these are inclusive of multiparent families, as well as changes to hospital policies that limit the number of support people for birthing individuals. Future research should explore how best to ensure optimal care experiences for polyamorous families.

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