**Nurses' Knowledge, Attitudes, Skills, and Behaviors in Supporting Lesbian and Gay (LG) Parents at** **Mother and Child Health Clinics, and LG Parents' Experiences**

**Scientific Background**

*LGBT parenting*

In recent decades, a new family form has emerged in addition to the traditional model of a married heterosexual couple and their biologically related children in many Western countries [1-3]. This development is associated with advancements in reproductive technologies as well as with significant social and legal changes [4,5]. The LGBT-parent family is an emerging family form that is currently on the rise. Approximately 29% of LGBT US adults are estimated to be parenting a child under the age of 18 [6]. According to reports, between 2 million and 3.7 million children have an LGBTQ parent, with many being raised by a single LGBT parent [7]. Based on the 2016 household census, approximately 114,000 same-sex couples were reported to be raising children. Here, 28,000 were male same-sex couples and 86,000 were female same-sex couples [8]. Although there is anecdotal evidence suggesting a dramatic increase in LGBT-parent and same-sex parent families in Israel, there is currently no formal estimate of these families due to the absence of this demographic information in state surveys [9].

The growing phenomenon of LGBT-parent families in Western countries has led to an increasing number of studies aimed at examining their impact on child development. Until recently, these studies have primarily focused on comparing children in these families with those in heterosexual two-parent families [10,11]. The general impression conveyed by these studies suggests that there are either no differences at all or differences that are in favor of the children in LGBT-parent families [12]. It has been reported, for instance, that children and adolescents raised by both single and partnered lesbian or gay parents are well-adjusted [10,13-18]. It has also been reported that children raised in two-parent gay and lesbian families exhibit lower levels of externalizing problems [19], demonstrate higher levels of prosocial behaviors [20], and achieve better academic outcomes [21] compared to those raised in heterosexual two-parent families. More recently, research has shifted focus from comparisons between same-sex and heterosexual parent families to investigation of differences within same-sex parent families, with findings showing that family processes and relationships have a greater impact on children's adjustment compared to the family structure [10, 22-24].

The proposed study focuses on families headed by cisgender lesbian mothers and gay fathers, both single and coupled. Common routes to motherhood among Israeli lesbian women who have received less research attention in Israel compared with gay fathers [25], include donor insemination, co-parenting arrangements with men, or adoption. Currently, gay men in Israel are seeking fatherhood primarily through surrogacy and co-parenting arrangements with women outside of marriage, particularly within the hetero-gay family context [26,27], due to their limited opportunities for adoption [28]. Following the 2021 amendment to the Israeli surrogacy law, which previously prohibited gay men, whether partnered or single, from utilizing local surrogacy services [11], gay men now have the opportunity to use both national and international surrogacy as a means to achieve fatherhood. This shift will likely lead to an increase in the number of gay men contemplating the option of becoming fathers [25].

Despite the increasing numbers of LGBT-parent families in Western countries and the extensive research revealing discriminatory experiences of LGBT people when accessing healthcare, there is limited research specifically exploring the experiences of LGBT parents seeking healthcare for their young children [29,30]. The proposed study attempts to fill this gap by investigating the experiences of Israeli lesbian and gay (LG) parents in maternal and child healthcare clinics (MCHCs, known locally as “Tipat Halav” – “a drop of milk”). This investigation may provide insight into the unique needs and challenges encountered by LG parents and their children in MCHCs, which are regarded as the primary preventive health service in the community for newborns and children up to the age of 6, and as a major source of guidance for parents [31].

*LGBT health and well-being*

Research reveals higher rates of physical and mental health difficulties within the LGBT community compared to the cis-heterosexual population, including depression, anxiety, and substance abuse [32-36]. These health disparities can be understood through the lens of the minority stress model, which asserts that sexual minorities encounter excess exposure to social stress due to their stigmatized social status, negatively affecting their health and well-being [37,38]. The excessive stress and burden of sexual minorities encompasses both proximal and distal stressors [38], which are manifested in discriminatory policies and laws, as well as in individuals' experiences of discrimination or microaggressions [37]. Discrimination is one such distal stressor encountered by LGBT individuals within the healthcare system. Research has documented adverse and discriminatory interactions between healthcare professionals and LGBT individuals, linked to stigma and cis-heteronormativity [35, 39, 40]. LGBT individuals in healthcare settings are often subjected to discriminatory behaviors including stigmatization, denial or refusal of healthcare, verbal or physical abuse [39], heteronormative attitudes, and judgment [41]. The impact of stigma on the healthcare experiences of the LGBT population is further exemplified by the negative attitudes toward this population observed among both students and providers in health professions, including nursing [41-44].

The discrimination encountered by LGBT individuals in healthcare settings creates a major obstacle for this population in accessing health services [35] and high-quality healthcare [45]. This discrimination is in part attributed to the absence of tailored LGBT training programs designed to aid health professionals in addressing their distinctive needs [42,46,47]. Indeed, health professionals acknowledge their insufficient training in the context of LGBT-specific health needs [46-48]. Inadequate training results in a lack of familiarity with LGBT-related health issues [40] as well as deficiencies in knowledge about LGBT healthcare [41, 42] and the provision of culturally competent care within healthcare settings [40, 49, 50].

In their systematic review, note that the concept of cultural competence, a standard of practice in healthcare [51], is commonly described as the complex integration of knowledge, skills, attitudes, and behaviors that enhance cross-cultural communication and interpersonal relationships. In recent years, the utilization of the cultural competence concept has evolved beyond its initial focus on race, ethnicity, and immigrant or refugee status to include considerations of sexual orientation and gender identity [47]. The concept of cultural competence has served as a conceptual framework for the development of training programs aimed at reducing healthcare disparities related to marginalized populations by enhancing health professionals’ knowledge, skills, attitudes, and behaviors [47, 52]. Research on cultural competence in healthcare professionals challenges the assumption that knowledge acquisition in itself is adequate for delivering culturally competent care, emphasizing the importance of training programs that address professionals’ attitudes and skills in addition to their knowledge, for the enhancement of inclusive practice [47,48,52, 53]. Practical experiences and frequency of caring for clients from different cultural backgrounds have also been found to be related to cultural competence in healthcare professionals [54].

*Experiences of LGBT parents seeking healthcare for their children*

Deficiencies in the provision of culturally competent health services have also been documented concerning LGBT parents seeking healthcare. The overall picture that emerges from the limited research on the healthcare experiences of LGBT parents reveals the stress they encounter in the process of becoming parents [55], as well as the negative attitudes, discrimination, and stigmatization they face within maternal and child healthcare settings, both of which are attributed to heteronormativity and a lack of knowledge among healthcare professionals about LGBT-parent families [29, 56-58]. It should be noted, however, that some LGBT parents experience both positive and negative attitudes in their interactions with child healthcare providers [56]. Moreover, not all LGBT parents experience direct discrimination within healthcare settings [30]. This is evident in reports of encounters with healthcare professionals who, despite their positive attitudes and a desire to provide inclusive services, either pose inappropriate questions or refrain from asking any questions at all regarding their family constellation [50].

Inappropriate remarks and questions posed by health professionals are attributed to their lack of knowledge about LGBT-parent families [57, 59]. Health professionals indeed perceive their lack of knowledge about these families as a major barrier to delivering them inclusive health services. While many hold positive views towards LGBT parents, they emphasize their lack of confidence in working with them, attributing it to their limited knowledge and unfamiliarity with LGBT families as well as to insufficient skills to effectively engage with these families [50].

Health professionals' lack of confidence is manifested, among other issues, in their apprehension about language use, particularly the fear of using inappropriate or offensive language [50]. Language use is a major challenge also reported by LGBT parents. This includes the language used in maternity and child healthcare settings’ forms and in their face-to-face encounters with healthcare professionals, which they interpret as an indication that their parenthood is not being acknowledged [58- 60]. The absence of acknowledgment, which is especially prominent in the context of non-biological parents, diminishes LGBT parents’ trust in health professionals [57].

The overall findings, portraying both LGBT parents’ negative experiences within maternal and child healthcare settings and healthcare providers’ lack of knowledge, skills, and confidence in assisting them, stress the need to develop LGBT cultural competency training for healthcare providers. Such training may enhance their competence to assist LGBT-parent families, enabling them to implement LGBT-inclusive practices. This, in turn, may promote the health and well-being of parents and children in LGBT families.

To the best of our knowledge, no previous study has addressed the experiences of Israeli LGBT parents seeking healthcare for their children. The proposed study seeks to advance our understanding of the healthcare experiences of Israeli LGBT parents by focusing on cisgender gay fathers and lesbian mothers, who have served as the focal point of studies on LGBT parent families in Israel [25]. Through the lens of the minority stress model [37, 38], the study will explore the healthcare experiences of lesbian and gay (LG) parents within Maternal and Child Health Clinics (MCHCs), which serve as the primary health service for newborns and their parents in the community, providing preventive healthcare and guidance up to the age of 6 [31].

*Maternal and Child Health Clinics (MCHCs) in Israel*

In Israel, the provision of personalized preventive medicine for parents and children is largely facilitated by MCHCs (“Tipat Halav”), which are also referred to as “Family Health Centers”, under the supervision of the Israeli Ministry of Health [61]. The first health service encountered by newborns and their parents in the community is provided by MCHCs [62], as part of the National Health Insurance Law 1994 [63]. At present, approximately 900 MCHCs are operating throughout Israel [64], distributed across seven districts. These MCHCs serve about 136,000 babies (according to 2019) [65]. Their services include the prevention of infectious diseases employing routine immunization up to the age of 30 months; routine examinations, such as growth monitoring, aimed at early detection of health and developmental issues; and referrals to diagnostic tests, such as eye tests, hearing tests, communication tests, and language tests [62, 65]. MCHCs also dedicate special attention to parent-child contact and care. In addition, they provide parental guidance and advice on various topics such as nutrition, breastfeeding, child development, dental health, hygiene, parenting, and child safety [31, 62, 65].

The growing phenomenon of LG-parent families in Israel suggests that MCHCs are increasingly involved in assisting these families. However, no research to date has investigated the experience and competency of Israeli healthcare providers in MCHCs to work with LG-parent families. The proposed study attempts to fill this gap by examining the experiences and competency of MCHCs’ nurses, who serve as primary health providers in these settings [31], to support these families, using the conceptual framework of cultural competency.

**B. Research Objectives and Expected Significance**

The proposed study focuses on both LG parents utilizing MCHC services and nurses in MCHCs. The specific aims of the study are to: (1) examine nurses’ level and source of acquaintance with LG people and LG parents, knowledge level about homosexuality, attitudes toward LG parenting, perceived skills to work with LG-parent families and practice behaviors with these families; (2) examine the association between nurses’ knowledge level about homosexuality and attitudes toward LG parenting; (3) examine the association between LG-related variables (e.g., level of acquaintance with LG people and LG parents, level of LG-specific training, and the number of LG parents the nurses had previously supported) and nurses’ knowledge level about homosexuality, attitudes toward LG parenting, perceived skills to work with LG-parent families and practice behaviors with these families; (4) identify the variables predicting nurses’ practice behaviors with LG-parent families; (5) explore the experiences of nurses in providing care to LG-parent families; and (6) explore the healthcare experiences of LG parents within MCHCs.

The proposed research marks the first effort to investigate both the experiences and competency of Israeli MCHCs’ nurses to support LG-parent families and the healthcare experiences of Israeli LG parents within MCHCs. As such, it may enrich the scant body of knowledge [30,60] on sexual minority parents’ experiences in accessing healthcare for their children, as well as extend the limited research [66] on nurses’ perspectives regarding challenges in providing culturally competent services. The study will also illuminate LG parents’ interactions with nurses in MCHCs, and the factors that shape them. The contribution of the proposed study may extend beyond the specific case of LG-parent families in the context of MCHCs, as it may enhance our understanding of how sexual minority status shapes the interactions between sexual minority individuals and healthcare providers.

The insights derived from this study may assist nurses in MCHCs in recognizing the unique needs and challenges faced by LG parents when accessing healthcare for their children. This may facilitate the development of interventions tailored to address their specific needs. Insights derived from the proposed study may also contribute to health policymakers in establishing training programs designed to aid nurses in MCHCs in implementing LG-inclusive practices.

**C. Detailed description of the proposed research**

*C.1 Research Hypotheses*

1. Level of knowledge about homosexuality will be (a) positively associated with the perception of benefits of LG parenting, and (b) negatively associated with negative beliefs about LG parenting.
2. Level of acquaintance with LG individuals will be (a) positively associated with knowledge about homosexuality, perception of benefits of LG parenting, skills competence, and practice behaviors; and (b) negatively associated with negative beliefs about LG parenting.
3. Level of acquaintance with LG parents will be (a) positively associated with knowledge about homosexuality, perception of benefits of LG parenting, skills competence, and practice behaviors; and (b) negatively associated with negative beliefs about LG parenting.
4. The number of LG parents the nurses had previously supported will be (a) positively associated with knowledge about homosexuality, perception of benefits of LG parenting, skills competence, and practice behaviors; and (b) negatively associated with negative beliefs about LG parenting.
5. Level of training focused on issues related to LG individuals will be (a) positively associated with knowledge about homosexuality, perception of benefits of LG parenting, skills competence, and practice behaviors; and (b) negatively associated with negative beliefs about LG parenting.
6. Level of training focused on issues related to LG parentswill be (a) positively associated with knowledge about homosexuality, perception of benefits of LG parenting, skills competence, and practice behaviors; and (b) negatively associated with negative beliefs about LG parenting.

*C. 2 Research Design and Methods*

The proposed study will employ a mixed-method design, incorporating both quantitative and qualitative methods. Specifically, we will use a convergent parallel mixed-methods design, whereby the qualitative and quantitative data will be collected concurrently and analyzed independently [67].

*C. 2. 1 Quantitative Research Component*

*Sample and procedure*

The required sample size for our research hypotheses was estimated a priori with G\*Power 3.1.9. A hierarchical multiple regression analysis used to detect a medium prediction effect (f2 = 0.15) for nurses’ behaviors measure, with a 5% risk of type one error (two-tailed α), and a power of 80% (1-β), indicated that an estimated sample size of 157 nurses is required. However, given the possibility of missing data, we plan on sampling a total of 200 female nurses. The nurses will be recruited from MCHCs located in 7 different districts and the Tel Aviv-Yafo Municipality. The number of nurses sampled in each district and the Tel Aviv-Yafo Municipality will be proportional to the total number of nurses in each of these locations.

After receiving ethical approval from the ethics committee of Ben-Gurion University of the Negev’s Faculty of Health Sciences, a letter outlining the study's objectives and significance, along with a link to an online anonymous questionnaire, created using Qualtrics (a web-based survey software), will be sent by the District Nurses to all the nurses working in the 7 districts of the MCHCs of the Ministry of Health and the Tel-Aviv-Jaffa Municipality (about 975 nurses overall) via their organizational email. The criteria for inclusion in the study is that participants have a minimum of one year of experience working in the MCHC and provide support to parents with children up to the age of 2 years, aligning with the focused age range in MCHC clinics. Nurses will receive symbolic remuneration for their time and effort invested in the study.

*Measures*

The proposed study's questionnaire includes background information (e.g., socio-demographic, professional, and LG-related characteristics) as well as several well-established scales.

*Socio-demographic characteristics* consist of age, place of birth, sexual orientation, religion, religiosity level, settlement type (e.g., city, village, kibbutz), and district of residence.

*Professional characteristics* include type of nursing degree, participation in an advanced practice course (yes/no), type of advanced course, and years of experience in nursing.

*LG-related characteristics.* Nurses will be asked to indicate their level and source of acquaintance with

gay men and/or lesbian women, level, and source of acquaintance with gay fathers and/or lesbian

mothers, the number of gay fathers and lesbian mothers they have supported during their work at the MCHC, and the level of professional training they have acquired for the support of lesbian and gay parents.

*Knowledge about Homosexuality*. Nurses’ knowledge will be assessed by the Hebrew version [39] of the 20-item Knowledge about Homosexuality Questionnaire [38]. This 20-item questionnaire was designed to evaluate factual knowledge about homosexuality. Nurses will be asked to indicate whether each statement is true or false (sample items: ‘The gender identity of a lesbian woman does not align with her assigned sex at birth’; ‘According to the American Psychological Association, homosexuality is a mental disorder’). The summation of the answers forms a general score ranging from 0–20. A high score indicates a greater degree of factual knowledge concerning homosexuality and sexual orientation issues. The reliability obtained for the Hebrew version was α = .70.

*Attitudes toward Lesbian and Gay Parenting*. Nurses attitudes will be evaluated using the Attitudes Toward Gay and Lesbian Parenting Scale [37], which includes 11 items that encompass two dimensions: (1) Negative Beliefs about gay and lesbian parenting (6 items; sample items: ‘Gay men and lesbians should not have children because it is a sin’; ‘Children of gay and lesbian parents will become homosexuals or will be confused about their sexuality’) and (2) Perception of Benefits of gay and lesbian parenting (5 items; sample items: ‘Children of gay and lesbian parents are more tolerant’;

‘The difficulties that lesbian and gay parents face help to prepare them to be good parents’). Nurses will be instructed to indicate their level of agreement with each item on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores on the Negative Beliefs dimension will reflect stronger agreement with statements suggesting a negative perception of the children and parents in LG-parent families. Whereas, higher scores on the Perception of Benefits will reflect stronger agreement with statements suggesting a positive perception of the children and parents in LG-parent families. High Cronbach's alphas have been reported for the two dimensions of this scale, ranging from 0.82 to 0.87 for the Negative beliefs dimension, and from 0.79 to 0.84 for the Perception of benefits dimension [37, 69]. In the present study, we will utilize the Hebrew version of the questionnaire, which has been translated and validated as part of our preliminary study (detailed information is provided below).

*Perceived skills to work with LG parents*. Nurses’ skill competency will be assessed by two items: (1) I possess the professional skills necessary to communicate effectively with lesbian and gay parents and; (2) I possess the professional skills necessary to address the unique needs of lesbian and gay parents. Nurses will be asked to indicate their agreement with each item on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate a higher level of perceived skill competency.

*Practice behaviors*. Nurses’ behaviors will be assessed using the Behaviors dimension (15 items) of the Gay Affirmative Practice Scale (GAP), [70] which considers clinicians’ behaviors with clients in clinical settings. Nurses will be asked to rate the frequency of engaging in each behavior presented in the 15 items in the context of their work with gay and lesbian parents at the MCHCs. Ratings will be on a 5-point scale, ranging from 1 (never) to 5 (always). Sample items include ‘I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation’ and ‘I inform clients about gay affirmative resources in the community’. Higher scores reflect more affirmative practice with gay and lesbian clients. The questionnaire will be translated into Hebrew.

*Data Analysis*

First, an exploratory factor analysis (EFA) with principal component extraction and varimax rotation will be performed to determine the factor structure of the Behaviors dimension of the GAP scale [70]. The number of factors will be estimated via parallel analysis, Velicer’s minimum average partial test [71], and the scree plot. Reliability analysis will be calculated using Cronbach's α. Data will be described using ranges, means, and standard deviations for continuous variables and frequencies and percentages for categorical data. Non-normal continuous variables will be transformed. Additionally, associations between continuous variables will be examined via zero-order correlations. Independent sample t-tests will be conducted to determine associations between dichotomous and continuous variables. Finally, hierarchical multiple regression analysis will be conducted in four steps to examine which variables predict nurses’ behaviors. In step 1, socio-demographic variables will be entered. In step 2, professional characteristics will be entered. In step 3, LG-related variables will be entered. In the final step, knowledge about homosexuality, attitudes toward LG parenting, and skills competency measures will be entered. Variance inflation factor (VIF) values will be examined to check for multicollinearity issues. Data will be analyzed using IBM SPSS statistics version 29 with an alpha level set to .05 (two-tailed) for all statistical tests.

*C. 2. 2 Qualitative Research Component*

As noted above, another aim of the proposed study is to give voice to both the healthcare experiences of LG parents within MCHCs and the experiences of MCHC nurses who assist them. Therefore, a phenomenological approach will be used, which focuses on the meanings ascribed by a particular group of people to the experience under study [72].

*Sample and procedure*

*MCHCs nurses*. The sample will consist of 40 female nurses (5 nurses from each of the 7 districts under the Ministry of Health’s MCHCs and 5 nurses from the Tel-Aviv-Jaffa Municipality’s MCHCs). As stated in subsection C.2.1., the District Nurses will send all the MCHCs’ nurses a letter outlining the study's objectives and significance. This letter will also outline the objectives and significance of the qualitative component of the proposed study, inviting nurses to participate in either or both the quantitative and qualitative parts of the study. The nurses who agree to participate in the qualitative study will be instructed to contact the research coordinator via email or phone. Efforts will be made to include nurses from various religions and different levels of religiosity in the study.

*LG parents*. The sample will include 40 LG parents: 20 lesbian mothers and 20 gay fathers. In an effort to provide a voice to LG parents accessing healthcare services in MCHCs who are raising their children in different family constellations, the following inclusion criteria were specified: openly gay men and lesbian women, who are the biological or non-biological parents of children up to the age of 2 years, who have become parents through various pathways (e.g., co-parenting arrangements, adoption, surrogacy or donor insemination in the case of lesbian mothers), and who are raising their children as single parents or with their partner. The exclusion criteria will include parents whose children are coping with developmental challenges or chronic illnesses. We will use several methods to recruit LG parents including an appeal to Internet groups and websites focusing on LG parenthood, a call for participants that will be posted on Facebook, and snowball sampling.

*Data collection*

In-depth semi-structured interviews based on an interview guide framed by the PIs will be conducted to tap the subjective experiences of the nurses and the parents. During the initial interviews, the nurses will be asked to speak freely about their experiences in providing care to LG-parent families, whereas the parents will be asked to speak freely about their healthcare experiences within MCHCs. In the following interview, they will be presented with specific open-ended questions from the interview guide. The questions presented to the MCHC nurses will cover topics such as their perspectives on the hegemonic concepts of parenthood, family, and biogenetic kinship; their attitudes

toward children raised without a mother or a father; the nature of their interactions with gay fathers and lesbian mothers; their insights from working with LG-parent families, as well as their suggestions for enhancing MCHCs’ nurses' abilities to provide inclusive services for these families. The specific questions presented to the LG parents will cover topics such as the nature of their interactions with MCHC’s nurses; the reaction of the nurses to their family configuration; attitudes of the nurses to their parenting; issues related to the language use of the nurses concerning their family constellation; their level of satisfaction with the services they receive within MCHC; and their suggestions for promoting the provision of inclusive services for their families. The interviews will be conducted either via Zoom or face-to-face, following participants’ preferences. All interviews will be recorded and fully transcribed, with the participant's permission.

*Data Analysis*

Data analysis will be based on the six-stage thematic analysis method proposed by Braun & Clarke (2006) [73]. In Stage 1, the researchers will read and re-read all the interview transcripts to become familiar with the different aspects of the data and identify initial ideas for coding. In Stage 2, initial codes will be generated and matched with data extracts. In Stage 3, the initial codes will be sorted into potential themes and relevant data extracts will be assigned to each theme. In Stage 4, the themes will be reviewed and examined concerning both the coded extracts and the entire dataset. In Stage 5, the themes will be defined and named. In the final stage, the analysis report will be produced by selecting vivid and compelling extract examples from the interviews.

To establish inter-rater reliability (IRR), The data will be analyzed separately by each of the researchers [74] both during the coding process and in all other interpretative stages of the study. This will serve as a crucial step in ensuring trustworthiness. Trustworthiness will also be established through reflexivity, which will enable the researchers to examine the possible effects of their perceptions and values on the research [75].

**Preliminary Results**

After receiving ethical approval from the ethics committee of Ben-Gurion University of the Negev’s Faculty of Health Sciences, a pilot study focusing on nurses working in MCHCs was conducted with two major aims: (1) to examine MCHC nurses' knowledge level about homosexuality and attitudes about LG parenting and; (2) to examine the association between knowledge about homosexuality and attitudes about LG parenting among these nurses.

*Sample*

Nurses were recruited from MCHCs of the Ministry of Health, located in two districts (e.g., Ashkelolon and the North district). The District Nurses were asked to send the nurses working in their district a link to the study's online questionnaire via their organization email. Of the 104 nurses who began to complete the questionnaire, 39 (37.5%) were excluded from the sample as they did not complete a significant number of items. The final sample, thus, included 65 nurses. Table 1 presents the socio-demographic, professional, and LG-related characteristics of the sample.

**Table 1**

*Socio-demographic, professional, and LG-related characteristics of the sample (N=65)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Socio-demographic** | **Range** | ***M*** | ***SD*** |
| Age (years) | 27 - 68 | 47.9 | 10.4 |
|  | ***N*** | **%** |  |
| Religion |  |  |  |
| Jewish | 45 | 69.2% |  |
| Muslim | 10 | 15.4% |  |
| Christian | 4 | 6.2% |  |
| Other | 6 | 9.2% |  |
| Religiosity |  |  |  |
| Secular | 23 | 35.4% |  |
| Traditional | 30 | 46.2% |  |
| Religious | 9 | 13.8% |  |
| Orthodox religious | 1 | 1.5% |  |
| Other | 1 | 1.5% |  |
| Place of residence | |  |  |
| City | 45 | 69.2% |  |
| Other | 20 | 30.8% |  |
| **Professional** | **Range** | ***M*** | ***SD*** |
| Experience in nursing (years) | 1 - 36 | 20.6 | 11.2 |
|  | ***N*** | **%** |  |
| Education |  |  |  |
| Practical nurse | 4 | 6.2% |  |
| Academic nurse with a non-nursing bachelor's degree | 19 | 29.2% |  |
| Academic nurse with a bachelor’s degree | 27 | 41.5% |  |
| Academic nurse with a master’s degree | 12 | 18.5% |  |
| Advanced practice course | | |  |
| No | 28 | 43.1% |  |
| Yes | 37 | 56.9% |  |
| District of MCHC | |  |  |
| Ashkelon | 40 | 61.5% |  |
| North | 25 | 38.5% |  |
| **LG-related** | ***N*** | **%** |  |
| Personal acquaintance with an LG individual | | | |
| No | 36 | 55.4% |  |
| Yes | 29 | 44.6% |  |
| Source of acquaintance with LG individual | | | |
| Family member | 9 | 13.8% |  |
| Friend | 15 | 23.1% |  |
| Colleague | 1 | 1.5% |  |
| Patient | 3 | 4.6% |  |
| *Note.* Age was missing for 32 cases.LG = Lesbian and Gay; MCHC = Mother and Child Health Clinics. | | | |

*Measures*

*Socio-demographic characteristics included* age, place of birth, religion, religiosity level, and settlement type (e.g., city, village, kibbutz).

*Professional characteristics* included years of experience in nursing, type of nursing degree, participation in an advanced practice course, and the MCHC district

*LG-related characteristics.* Nurses were asked to indicate whether they had personal acquaintance with LG individuals as well as the specific source of their acquaintance.

*Knowledge about Homosexuality*. Nurses’ knowledge was assessed by the Hebrew version [39] of the 20-item Knowledge about Homosexuality Questionnaire [38], described above.

*Attitudes toward Lesbian and Gay Parenting*. Nurses’ attitudes were evaluated using a Hebrew version of the Attitudes Toward Gay and Lesbian Parenting Scale [37], which was described above. The Hebrew version was developed for the pilot study using the back-translation method and evaluated using an exploratory factor analysis.

*Data analysis*

An EFA with principal component extraction and varimax rotation was conducted to determine the factor structure of the attitudes toward the LG parenting questionnaire. The number of factors was based on parallel analysis, Velicer’s minimum average partial test [71], and the scree plot. Then, reliability analysis was examined via Cronbach's α. Descriptive statistics were used to describe the levels of outcomes (knowledge about homosexuality and measures of attitudes toward LG parenting) among the nurses. Then, bivariate analyses tested the associations between socio-demographic, professional, and LG-related characteristics and outcomes. Zero-order correlations were performed for continuous variables and independent sample t-tests for dichotomous variables. Finally, a zero-order correlation was also conducted for the association between the outcomes. Data was analyzed using IBM SPSS Statistics version 29 with an alpha set at .05 for all statistical tests.

**Results**

*Validation of the Attitudes Toward LG Parenting Questionnaire*

EFA on the eleven items resulted in two factors, which explained about 57.5% of the variance. Item

loadings ranged between .51 to .88 on the relevant factor suggested by Costa and colleagues (2014) [76]. Reliability analysis for the two factors yielded satisfactory results (Table 2). In addition, both factors were negatively intercorrelated, *r*(62) = -.30, *p* = .017.

**Table 2**

*Results of exploratory factor analysis on the Attitudes Toward LG Parenting**Questionnaire (n=60)*

|  |  |  |
| --- | --- | --- |
| **Item** | **Negative beliefs about LG parenting** | **Perception of benefits of LG parenting** |
| It is not natural for gay men and lesbians to have children | .88 |  |
| Gay men and lesbians should not have children because it is a sin | .87 |  |
| Children of gay and lesbian parents do not have the needed masculine and feminine references for their normal development | .82 |  |
| Gay and lesbian parents do not care about their children’s best interests | .81 |  |
| Children of gay and lesbian parents will be homosexual or will be confused about their sexuality | .65 |  |
| Children of gay and lesbian parents are more victimized in school | .61 |  |
| Children of gay and lesbian parents are more accepting of other people’s differences |  | .80 |
| Children of gay and lesbian parents are more tolerant |  | .78 |
| The difficulties that gay and lesbian parents face prepare them to be good parents |  | .60 |
| There are gay and lesbian people with a high desire to have children and to be available for them | -.42 | .55 |
| The main difficulties of gay and lesbian parents are due to societal prejudice |  | .51 |
| Eigenvalue | 3.94 | 2.38 |
| % of variance explained | 35.8% | 21.6% |
| Cronbach's α | .88 | .72 |
| *Note.*  Factor loadings above .40 are shown. LG = Lesbian and Gay. | | |

*Levels of Knowledge About Homosexuality and Attitudes About LG*

Table 3 presents descriptive statistics for knowledge about homosexuality and measures of attitudes about LG parenting. As can be seen from this table, on a scale of 0-20, the mean score of knowledge about homosexuality was moderate. Namely, nurses showed moderate levels of knowledge about issues related to sexual orientation. Regarding attitudes about LG parenting, the mean scores of negative beliefs and perception of benefits of LG parenting, on a scale of 1-5, indicated generally low levels of negative attitudes and moderate levels of positive attitudes toward LG parenting, respectively.

**Table 3**

*Descriptive statistics of Knowledge About Homosexuality and measures of Attitudes About LG Parenting*

|  |  |  |  |
| --- | --- | --- | --- |
| **Variable** | ***M*** | ***SD*** | **Range** |
| Knowledge about homosexuality | 13.00 | 2.52 | 7 - 19 |
| Negative beliefs about LG parenting | 1.99 | 0.89 | 1.00 - 4.50 |
| Perception of benefits of LG parenting | 3.26 | 0.76 | 1.60 - 5.00 |
| *Note. N* = 65, Perception of benefits of LG parenting was missing for one case. LG = Lesbian and Gay. | | | |

*Knowledge About Homosexuality and Attitudes About LG Parenting by socio-demographic, professional, and LG-related characteristics*

Table 4 presents means and standard deviations of knowledge about homosexuality and measures of attitudes about LG parentingby categorical explanatory variables and associations between these variables and continuous explanatory variables. Age was negatively associated with knowledge about homosexuality. Regarding religion, religiosity level, and place of residence, differences were found in knowledge about homosexuality and negative beliefs about LG parenting. Results showed that nurses who are Jewish, secular, or living in a city scored higher on the knowledge about homosexuality measure and lower on the negative beliefs about LG parenting measure than other nurses. Differences by district of MCHC and personal acquaintance with LG were found for negative beliefs about LG parenting, with nurses from Ashkelon district or with acquaintance with LG individuals scoring higher than nurses from the north district or without personal acquaintance with LG individuals, respectively. Note that all analyses with the perception of benefits of LG parenting yielded non-significant results.

Association between Knowledge About Homosexuality and Attitudes About LG Parenting

Results revealed that knowledge about homosexuality was negatively correlated with negative beliefs about LG parenting, *r*(63) = -.37, *p* = .002, and positively correlated with perception of benefits of LG parenting, r(62) = .29, p = .019. Namely, as knowledge about homosexuality increased, negative beliefs about LG parenting decreased, and perceptions of the benefits of LG parenting measures increased.

**Resources at the Disposal of the Researchers**

The combination of the different professional backgrounds of the two principal investigators constitutes a valuable asset for exploring the issues of interest in the proposed study. Dr. Orli Grinstein-Cohen, PhD, is an expert in the field of public healthcare and an Advanced Nurse Practitioner in Health Policy and Administration. Currently, she is conducting a large study on the use of telenursing among nurses in MCHCs, funded by the Israel National Institute for Health Policy Research. Prof. Dorit Segal Engelchin is an expert on new family forms. Recently, she has served as a Guest Editor of a special issue dedicated to new family forms. She has vast experience in conducting both quantitative and qualitative research and has previously led a large mixed-methods study that was funded by the ISF.

The proposed study has the full support of Prof. Natalya Bilenko, the Ashkelon District Physician (see letter of support); Ms. Ilana Gans, the National Supervising Nurse at the Public Health Services (see letter of support); and Dr. Sharon Alroy Preis, Head of Public Health Services, at the Israeli Ministry of Health. Dr. Oren Vacht will assist with the data collection and analysis (see letter of support).

**Expected Outcome of the Research**

By examining the experiences of MCHCs’ nurses in supporting LG-parent families alongside the healthcare experiences of LG parents within MCHCs, the proposed research is expected to provide a comprehensive and holistic perspective on the interactions between the nurses and parents within the MCHC context. From a theoretical standpoint, the research will enhance our understanding of the dynamics and the micro and macro-level factors (such as organizational and social-level factors) shaping these interactions. By investigating the self-reported competency of MCHC nurses in providing care for LG-parent families, the proposed research is also expected to add a valuable dimension to our understanding of the healthcare process encountered by both nurses and LG parents. The research findings are expected to provide important developments on the practical level as well, as inform and assist policymakers and nurses working directly with LG parents.

**Table 4**

*Knowledge About Homosexuality and measures of Attitudes About LG Parenting by socio-demographic, professional, and LG-related characteristics (n=65)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Knowledge About Homosexuality** | | | **Negative beliefs about LG parenting** | | | **Perception of benefits of LG parenting** | | |
|  | ***M*** | ***SD*** | ***t* / *r*** | ***M*** | ***SD*** | ***t* / *r*** | ***M*** | ***SD*** | ***t* / *r*** |
| *Socio-demographic* | |  |  |  |  |  |  |  |  |
| Age (years) | - | - | *r*(31) = -.38, *p* = .006 | - | - | *r*(31) = .10, *p* = .588 | - | - | *r*(30) = -.06, *p* = .711 |
| Religion |  |  | *t*(63) = 2.94, *p* = .005, *d* = 0.79 |  |  | *t*(23.29) = -5.13, *p* < .001, *d* = -1.76 |  |  | *t*(62) = 0.96, *p* = .341, *d* = 0.26 |
| Jewish | 13.58 | 2.33 |  | 1.61 | 0.50 |  | 3.32 | 0.76 |  |
| Muslim / Christian / Other | 11.70 | 2.49 |  | 2.83 | 1.01 |  | 3.12 | 0.77 |  |
| Religiosity |  |  | *t*(62) = 2.04, *p* = .045, *d* = 0.53 |  |  | *t*(60.55) = -2.39, *p* = .020, *d* = -0.52 |  |  | *t*(61) = 1.42, *p* = .162, *d* = 0.37 |
| Secular | 13.74 | 2.68 |  | 1.70 | 0.51 |  | 3.42 | 0.70 |  |
| Other | 12.46 | 2.23 |  | 2.16 | 1.02 |  | 3.14 | 0.78 |  |
| Place of residence | |  | *t*(63) = 3.20, *p* = .002, *d* = 0.86 |  |  | *t*(29.12) = -2.25, *p* = .032, *d* = -0.67 |  |  | *t*(62) = 0.02, *p* = .985, *d* = 0.01 |
| City | 13.62 | 2.37 |  | 1.81 | 0.78 |  | 3.26 | 0.76 |  |
| Other | 11.60 | 2.33 |  | 2.39 | 1.02 |  | 3.25 | 0.78 |  |
| *Professional* | |  |  |  |  |  |  |  |  |
| Experience in nursing (years) | - | - | *r*(63) = -.17, *p* = .164 | - | - | *r*(63) = .10, *p* = .435 | - | - | *r*(62) = -.04, *p* = .771 |
| Education |  |  | *t*(60) = 0.30, *p* = .769, *d* = 0.08 |  |  | *t*(60) = -0.65, *p* = .520, *d* = -0.17 |  |  | *t*(59) = 0.45, *p* = .656, *d* = 0.12 |
| Practical nurse / academic nurse with non-nursing degree | 13.17 | 2.99 |  | 1.89 | 0.84 |  | 3.35 | 0.71 |  |
| Academic nurse with bachelor or master's degree | 12.97 | 2.29 |  | 2.04 | 0.95 |  | 3.26 | 0.78 |  |
| Advanced practice course | | | *t*(63) = 0.40, *p* = .694, *d* = 0.10 |  |  | *t*(63) = -1.23, *p* = .225, *d* = -0.31 |  |  | *t*(62) = -0.18, *p* = .857, *d* = -0.05 |
| No | 13.14 | 2.45 |  | 1.83 | 0.79 |  | 3.24 | 0.74 |  |
| Yes | 12.89 | 2.60 |  | 2.11 | 0.96 |  | 3.27 | 0.79 |  |
| District of MCHC | |  | *t*(63) = 1.53, *p* = .130, *d* = 0.39 |  |  | *t*(32.20) = -4.44, *p* < .001, *d* = -1.30 |  |  | *t*(62) = 1.14, *p* = .258, *d* = 0.29 |
| Ashkelon | 13.38 | 2.20 |  | 1.61 | 0.53 |  | 3.34 | 0.78 |  |
| North | 12.40 | 2.90 |  | 2.59 | 1.02 |  | 3.12 | 0.73 |  |
| *LG people related* | |  |  |  |  |  |  |  |  |
| Personal acquaintance with LG individual | | | *t*(63) = -1.60, *p* = .114, *d* = -0.40 |  |  | *t*(49.33) = 4.47, *p* < .001, *d* = 1.03 |  |  | *t*(62) = -1.40, *p* = .167, *d* = -0.35 |
| No | 12.56 | 2.38 |  | 2.36 | 1.00 |  | 3.14 | 0.76 |  |
| Yes | 13.55 | 2.61 |  | 1.53 | 0.42 |  | 3.41 | 0.75 |  |
| *Note. N* = 65.Age was missing for 32 cases.LG = Lesbian and Gay; MCHC = Mother and Child Health Clinics. | | | | | | | | | |

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