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Reproduction in cisgender same-sex couples: a scoping review

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Abstract *The aim of this article is to present the state of the art, in the field of public health, on cis homoparental reproduction, from 28 studies addressing barriers to reproduction by homoparental couples for legal, ethical, technical or economic reasons, in addition to prejudice and discrimination. Six studies addressed facilitators, such as receptiveness in services, availability of conception and contraceptive methods and training of health professionals. The results show that the discussion has focused more on the barriers than on the facilitating factors. This may indicate a continuing need to problematise the hegemonic model of a heterosexual, nuclear family.*

Key words *Sexual and gender minorities, Family, Reproduction, Health, Review*

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Introduction

The right to sexual and reproductive health is a Human Right recognised in legal documents. Among the international frameworks, two United Nations (UN) conferences stand out. The International Conference on Population and Development (ICPD), held in 1994 in Cairo, stated that reproductive rights are a basic right of individuals and couples. In this sense, ways must be ensured to fulfil this right, with a view to reproductive decision making free from discrimination, coercion and violence. The following year, in Beijing, the 4th World Conference on Women reaffirmed the ICPD agreements and advanced the definition of sexual and reproductive rights, to establish them as Human Rights[1].

In 2013 Brazil's Ministry of Health published a Primary Care Handbook on sexual and reproductive health, reaffirming individual reproductive and sexual rights based on these international conferences and other movements in favour of the rights to sexual health and reproductive health. The handbook stresses that, although these rights have been formally instituted at UN international conferences, it has to be asserted that they extend universally to population groups whose human rights have historically been violated because of their sexual orientation or gender identity[1].

Documents drafted in Brazil relating to its citizens' sexual and reproductive rights include prominently the 1988 Federal Constitution, the 1984 Comprehensive Women's Health Care Programme (*Programa de Assistência Integral à Saúde da Mulher*, PAISM), Law No. 9.263/1996, which regulates family planning, the 2004 National Comprehensive Women's Health Care Policy (*Política Nacional de Atenção Integral à Saúde da Mulher*) and the 2005 National Sexual and Reproductive Rights Policy (*Política Nacional dos Direitos Sexuais e dos Direitos Reprodutivos*)[1].

Sexual rights began to be discussed in the late 1980s, with the participation of gay, lesbian and feminist movements. Reproductive rights were more difficult to debate, especially with regard to homosexuals[2]. One barrier to this debate's progressing was the hegemonic model of the family, which requires this institution to be nuclear, monogamous, heterosexual and procreative in purpose[3]. On the other hand, it can be seen that, as long as the State approaches sexual and reproductive rights with a view to encouraging individual freedom and autonomy, and encouraging responsibility, couples – whether hetero- or homo-affective – will be able to carry out their plans for parenthood[2].

Brazil's legal recognition of the right to homoparenthood means that ways are being considered to make this right workable[2]. These, as highlighted by Zambrano (2006)[3], can include joint and equal coparenting by partners in situations where children are incorporated from a heterosexual relationship prior to setting up the family, legal or informal adoption and use of new reproductive technologies.

As regards reproduction between same-sex couples, which is the scope of this study, resolutions by Brazil's Federal Medical Council ensure access to human assisted reproduction technology (HART) for heterosexual, homosexual and transgender people, without requiring any specific marital status[2].

Despite these advances, which purportedly guarantee the reproductive rights of homoparental families, this population's reproductive health demands and needs are complex and it is important that Brazilian national health system (SUS) be adapted to meet them effectively, comprehensively and with quality[1]. In this respect, it is necessary, at the very least, to discuss the subject and one of the first steps in that direction is to map what the specialised national and international literature has to say about this . Such mapping will make it possible, among other things, to examine issues with a view to informing the debate.

In view of the foregoing, this article is intended to present the state of the art, as identified in the global scientific literature in the collective health or public health fields, as regards cisgender homoparental reproduction.

Methods

This scoping review draws on the methodological framework of the Joanna Briggs Institute[4]. The report followed the recommendations of the PRISMA Extension for Scoping Reviews[5]. A research protocol was developed beforehand and registered in the Open Science Framework (OSF)[6].

This article addresses part of the results of the larger review "Homoparenthood as a collective health issue: a scoping review", which investigated the global scientific production, in the collective health or public health field, on homoparenthood[7].

The guiding question in review – "What aspects of cisgender homoparental reproduction are addressed in the global scientific production in the collective or public health field?" – was formulated with the help of the acronym PCC (Population: cisgender homoparental families; Concept: global scientific production on reproduction; Context: collective or public health).

Inclusion and exclusion criteria

Our inclusion criteria allowed primary and secondary studies, documents, reports, dissertations or theses, available in English, French, Portuguese or Spanish, that addressed issues relating to legislation, policies, programmes, access and fertility and reproductive services for cisgender homoparental families, in the collective health or public health context. In this article, a minor change was made from the original protocol, by including studies published in French. Studies in other health contexts or addressing non-cisgender homoparental families were excluded.

Data sources and search strategies

The following databases were searched in July and September 2022: PubMed, Virtual Health Library (Biblioteca Virtual em Saúde, BVS), SciELO, Scopus, Web of Science, Dimensions and the Brazilian Digital Library of Theses and Dissertations (*Biblioteca Digital Brasileira de Teses e Dissertações*, BDTD). MeSH (Medical Subject Headings) terms were used in PubMed and DeCS (Health Sciences Descriptors) terms in the VHL, with adaptations in other databases. Details of the search strategies and descriptors used can be found in Chart 1.

Selection of studies

The Rayyan QCRI[8] literature review manager was used to select studies. After duplicates were excluded, studies were selected by two reviewers, independently reading titles and abstracts against the inclusion and exclusion criteria. Divergences were resolved by seeking consensus between the two reviewers or were resolved by a third reviewer. Dissertations and theses were selected manually by reading the abstracts. Eligible studies were read in full by two reviewers, not in a duplicate manner, and validated by a third reviewer. The references cited in included studies were checked so as to include other eligible studies not retrieved in the searches.

Data extraction

The following information was extracted from the included studies: i) author and year of publication; ii) objective; iii) study design; iv) study population; v) number of participants; vi) participants' age; vii) sex/gender; viii) race/colour; ix) family characteristics; x) country where the study was conducted; xi) study location; xii) approach focus and central theme; xiii) outcomes or thematic categories; xiv) findings; xv) limitations; xvi) gaps; xvii) conclusion; xviii) funding; xix) conflict of interest; and xx) authors' institutional affiliation. The first articles were extracted independently by three reviewers, until the process achieved homogeneity (calibration). Data were then extracted by two reviewers, not in a duplicate manner, and validated by a third reviewer.

Data analysis

The extracted data were analysed with an eye to the reproductive health of cisgender homoparental families in the public and collective health context. The studies' findings were examined using the content analysis technique adapted by Gomes[9] and described by Bardin[10]. The results are presented in narrative form. The studies were not evaluated for methodological quality, considered as an optional step in scoping reviews, as this was not an exclusion criterion[11].

Results and discussion

The searches retrieved 1,350 records and, after excluding duplicates, 725 records were screened in the Rayyan manager, by titles and abstracts. Of 47 eligible reports read in full, 29 were included. An additional 42 records were screened, from the survey of theses and dissertations and the reference lists of studies included; of these, 34 eligible papers were read in full and also included. In this way, 63 studies were selected and this article will examine the 31 that addressed the issue of reproduction in cisgender homoparental families. The selection process is shown in Figure 1, and the 18 eligible studies excluded are listed in Chart 2.

Chart 1. Search strategy terms and results.

Database	Date	Estrategy	Result
BVS	12/07/2022	(homoparentalidade OR "parentalidade gay" OR "Parentalidade lésbica" OR "Parentalidade LGBT" OR "Mães do mesmo sexo" OR "Parentalidade homoafetiva" OR "Pais homossexuais" OR "Pais homoafetivos" OR "Mães homossexuais" OR "Mães Lésbicas" OR "Família homoafetiva" OR "Famílias homoafetivas" OR "Família Gay" OR "Maternidade homoafetiva" OR homoparenthood OR "Homosexual parenthood" OR "Gay parenthood" OR "LGBT parenthood" OR "Lesbian parenthood" OR "Lesbian motherhood" OR "Gay motherhood" OR "same sex mothers" OR "Same sex fathers" OR "Same-sex mothers" OR "Same-sex fathers" OR "Same-sex parents" OR "Same sex parents" OR "Parenting homosexual" OR "Same sex parenting" OR "Same-sex parenting" OR "homoparental family" OR "Homoparental families" OR "homoaffective family" OR "Homoaffective families" OR "Homoaffective fathers" OR "Homoaffective mothers" OR "homosexual fathers" OR "Homosexual mothers" OR "Homosexual father" OR "Homosexual mother" OR "LGBT family" OR "LGBT families" OR "Gay family" OR "Gay families")	340
SciELO	12/07/2022	(Homoparentalidade OR "parentalidade gay" OR "Parentalidade lésbica" OR "Parentalidade LGBT" OR "Mães do mesmo sexo" OR "Parentalidade homoafetiva" OR "Pais homossexuais" OR "Pais homoafetivos" OR "Mães homossexuais" OR "Mães Lésbicas" OR "Família homoafetiva" OR "Famílias homoafetivas" OR "Família Gay" OR "Maternidade homoafetiva" OR Homoparenthood OR "Homosexual parenthood" OR "Gay parenthood" OR "LGBT parenthood" OR "Lesbian parenthood" OR "Lesbian motherhood" OR "Gay motherhood" OR "same sex mothers" OR "Same sex fathers" OR "Same-sex mothers" OR "Same-sex fathers" OR "Same-sex parents" OR "Same sex parents" OR "Parenting homosexual" OR "Same sex parenting" OR "Same-sex parenting" OR "homoparental family" OR "Homoparental families" OR "homoaffective family" OR "Homoaffective families" OR "Homoaffective fathers" OR "Homoaffective mothers" OR "homosexual fathers" OR "Homosexual mothers" OR "Homosexual father" OR "Homosexual mother" OR "LGBT family" OR "LGBT families" OR "Gay family" OR "Gay families") AND (Health)	1
PubMed	12/07/2022	Homoparenthood[Title/Abstract] OR "Homosexual parenthood"[Title/Abstract] OR "Gay parenthood"[Title/Abstract] OR "LGBT parenthood"[Title/Abstract] OR "Lesbian parenthood"[Title/Abstract] OR "Lesbian motherhood"[Title/Abstract] OR "Gay motherhood"[Title/Abstract] OR "same sex mothers"[Title/Abstract] OR "Same sex fathers"[Title/Abstract] OR "Same-sex mothers"[Title/Abstract] OR "Same-sex fathers"[Title/Abstract] OR "Same-sex parents"[Title/Abstract] OR "Same sex parents"[Title/Abstract] OR "Parenting homosexual"[Title/Abstract] OR "Same sex parenting"[Title/Abstract] OR "Same-sex parenting"[Title/Abstract] OR "homoparental family"[Title/Abstract] OR "Homoparental families"[Title/Abstract] OR "homoaffective family"[Title/Abstract] OR "Homoaffective families"[Title/Abstract] OR "Homoaffective fathers"[Title/Abstract] OR "Homoaffective mothers"[Title/Abstract] OR "homosexual fathers"[Title/Abstract] OR "Homosexual mothers"[Title/Abstract] OR "Homosexual father"[Title/Abstract] OR "Homosexual mother"[Title/Abstract] OR "LGBT family"[Title/Abstract] OR "LGBT families"[Title/Abstract] OR "Gay family"[Title/Abstract] OR "Gay families"[Title/Abstract]	198

it continues

Chart 1. Search strategy terms and results.

Database	Date	Estrategy	Result
Scopus	12/07/2022	(TITLE-ABS-KEY (homoparenthood OR "Homosexual parenthood" OR "Gay parenthood" OR "LGBT parenthood" OR "Lesbian parenthood" OR "Lesbian motherhood" OR "Gay motherhood" OR "same sex mothers" OR "Same sex fathers" OR "Same-sex mothers" OR "Same-sex fathers" OR "Same-sex parents" OR "Same sex parents" OR "Parenting homosexual" OR "Same sex parenting" OR "Same-sex parenting" OR "homoparental family" OR "Homoparental families" OR "homoaffective family" OR "Homoaffective families" OR "Homoaffective fathers" OR "Homoaffective mothers" OR "homosexual fathers" OR "Homosexual mothers" OR "Homosexual father" OR "Homosexual mother" OR "LGBT family" OR "LGBT families" OR "Gay family" OR "Gay families") AND ALL (health))	520
Web of Science	12/07/2022	Homoparenthood OR "Homosexual parenthood" OR "Gay parenthood" OR "LGBT parenthood" OR "Lesbian parenthood" OR "Lesbian motherhood" OR "Gay motherhood" OR "same sex mothers" OR "Same sex fathers" OR "Same-sex mothers" OR "Same-sex fathers" OR "Same-sex parents" OR "Same sex parents" OR "Parenting homosexual" OR "Same sex parenting" OR "Same-sex parenting" OR "homoparental family" OR "Homoparental families" OR "homoaffective family" OR "Homoaffective families" OR "Homoaffective fathers" OR "Homoaffective mothers" OR "homosexual fathers" OR "Homosexual mothers" OR "Homosexual father" OR "Homosexual mother" OR "LGBT family" OR "LGBT families" OR "Gay family" OR "Gay families" (Todos os campos) and health (Todos os campos)	142
Dimensions	12/07/2022	(Homoparenthood OR "Homosexual parenthood" OR "Gay parenthood" OR "LGBT parenthood" OR "Lesbian parenthood" OR "Lesbian motherhood" OR "Gay motherhood" OR "same sex mothers" OR "Same sex fathers" OR "Same-sex mothers" OR "Same-sex fathers" OR "Same-sex parents" OR "Same sex parents" OR "Parenting homosexual" OR "Same sex parenting" OR "Same-sex parenting" OR "homoparental family" OR "Homoparental families" OR "homoaffective family" OR "Homoaffective families" OR "Homoaffective fathers" OR "Homoaffective mothers" OR "homosexual fathers" OR "Homosexual mothers" OR "Homosexual father" OR "Homosexual mother" OR "LGBT family" OR "LGBT families" OR "Gay family" OR "Gay families") AND (Health)	149
Biblioteca Digital de Teses e Dissertações (BDTD)	09/09/2022	(Homoparentalidade OR "parentalidade gay" OR "Parentalidade lésbica" OR "Parentalidade LGBT" OR "Mães do mesmo sexo" OR "Parentalidade homoafetiva" OR "Pais homossexuais" OR "Pais homoafetivos" OR "Mães homossexuais" OR "Mães Lésbicas" OR "Família homoafetiva" OR "Famílias homoafetivas" OR "Família Gay" OR "Maternidade homoafetiva") AND (Saúde)	21
Total			1 371

Source: Authors.

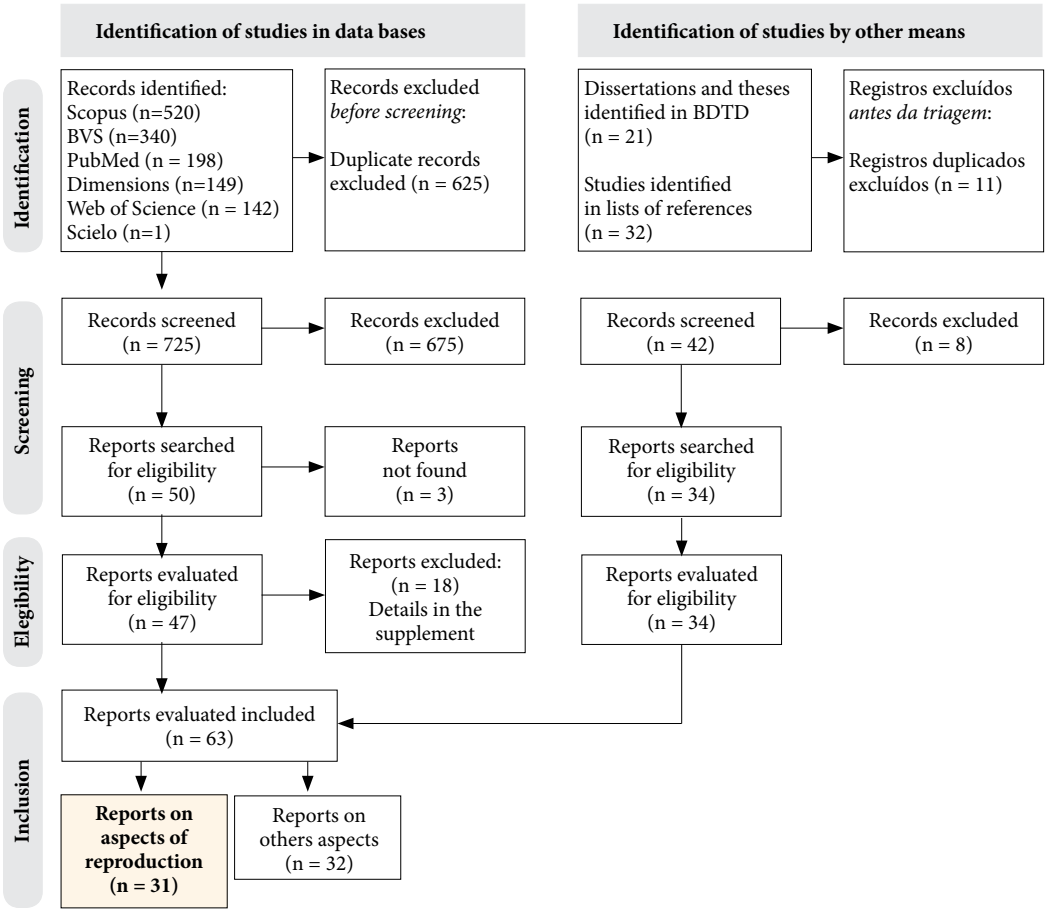

Figure 1. Flow diagram.

Source: Authors based on PRISMA[12].

Chart 2. List of studies excluded, with rationale.

Reference	Reason for exclusion
Boggis T. The Real Modern Family... Can Be Real Complicated. *Journal of Gay and Lesbian Mental Health* 2012; 16(4):353-360.	Report of author's experience providing services to the LGBT population.
Brewaeys A. *et al*. Counselling and selection of homosexual couples in fertility treatment. *Human Reproduction* 1989; 4(7):850-853.	Outcomes of artificial insemination services with anonymous sperm donors at the teaching hospital of the Centre for Reproductive Medicine, Brussels University.
Carvalho PGC. *Homoparentalidade feminina: nuances da assistência à saúde durante concepção, gravidez, parto e pós-parto TT*. 2018. Disponível em: http://www.teses.usp.br/teses/disponiveis/6/6136/tde-12042018-143259/	Includes article resulting from thesis.
Corrêa MEC *Duas mães?: mulheres lésbicas e maternidade TT*. 2012. Disponível em: http://www.teses.usp.br/teses/disponiveis/6/6136/tde-29042012-124625/publico/tese_maria_eduarda_cavadinha_correa.pdf	Does not relate to health services, but to women's conceptions of homoparenting.

it continues

Chart 2. List of studies excluded, with rationale.

Reference	Reason for exclusion
Crouch SR *et al*. The health perspectives of Australian adolescents from same-sex parent families: A mixed methods study. *Child: Care, Health and Development* 2015; 41(3):356-364.	Addresses adolescents' perceptions, understanding of experiences with parents, self-reported health, scale results.
Azeredo RF. *Maternidade lésbica no Brasil: uma revisão de teses e dissertações nas Ciências Sociais, Humanas e da Saúde TT*. 2018. Disponível em: http://www.bdtd.uerj.br/tde_busca/arquivo.php?codArquivo=14253	Does not address collective health: the only thesis it included (Correa) on that topic was excluded for that reason.
Everri M *et al*. Cultivating practices of inclusion towards same-sex families in Italy: a comparison among educators, social workers, and healthcare professionals. *Journal of Community and Applied Social Psychology* 2021; 31(6):659-672.	Compares contact with educators, social workers and health personnel.
Goldberg AE *et al*. Health behaviors and outcomes of parents in same-sex couples: an exploratory study. *Psychology of Sexual Orientation and Gender Diversity* 2019; 6(3):318-335.	Individual health-related behaviour.
Goldberg AE *et al*. Lesbian, Gay, and Heterosexual Adoptive Parents' Experiences with Pediatricians: A Mixed-Methods Study. *Adoption Quarterly* 2020; 23(1):27-62.	Focuses on homo and hetero experiences of adoption.
Juntereal NA, Spatz DL. Same-Sex Mothers and Lactation. *MCN The American Journal of Maternal/Child Nursing* 2019; 44(3):164-169.	Cites only 3 individual experiences.
Lee R. Queering Lactation: Contributions of Queer Theory to Lactation Support for LGBTQIA2S+ Individuals and Families. *Journal of Human Lactation* 2019; 35(2):233-238.	Offers an overall analysis of the queer population.
Logan R. Gay Fatherhood in the NICU: Supporting the "gayby" Boom. *Advances in Neonatal Care* 2020; 20(4):286-293.	Addresses health personnel, citing the study by Andersen 2017, which is already included in the scoping review.
Machin R, Couto MT. Making the right choice: Reproductive technologies, lesbian practices and use of semen banks. *Physis* 2014; 24(4):1255-1274.	Addresses sperm-bank searches.
Machin R. Sharing motherhood in lesbian reproductive practices. *BioSocieties* 2014; 9(1):42-59.	Only private clinic clients.
Nau J. De l'homoparentalité légalisée. *Rev Med Suisse* 2011; 3(280):324a-325a.	Does not address homoparental reproduction.
Ryan-Flood R. Negotiating Sexual Citizenship: Lesbians and Reproductive Health Care. In: *New Femininities*. [s.l: s.n.]. p. 246-262. 2011	Book chapter not retrieved.
Scali T, D'Amore S. Challenges and needs of psychologists and public health workers confronted to same-sex parenting issues in family planning centres. *Ther Fam* 2016;37(2):187-204.	Does not address homoparental reproduction.
Webster CR, Telingator CJ. Lesbian, Gay, Bisexual, and Transgender Families. *Pediatric Clinics of North America* 2016; 63(6):1107-1119.	From a literature review, considers difficulties that this population may face in various – not specifically health-related – contexts.

Source: Authors.

General characteristics of the studies

Of the 31 studies included[13-43], sixteen (51.6%) were primary studies, two (6.5%) were opinion articles, one (3.2%) was a dossier, two (6.4%) were trials and ten (32.3%) were reviews. The primary studies were qualitative (n = 13), mixed methods (n = 1) and quantitative evaluation (n = 2) studies. Authors cited the reviews as review (n = 2), integrative literature review (n = 1), clinical guidelines review (n = 1), literature review (n = 1), systematic literature review and meta-synthesis (n = 1) and narrative review (n = 4).

The authors of just over half the studies (51.6%) gave no information on conflicts of interest, while 41.9% reported no conflicts. In two studies, conflicts were reported: one author of one review[24] was a member of the advisory board of Gilead Sciences, Inc. and Merck; the author of the other study[19] was a consultant on ethical issues at the Unilabs company. About 38% of studies received funding, 11% did not and 50% provided no information in this regard.

The studies examined the formation of lesbian homoparental families (61.3%), gay families (6.4%) or both homoparental family formations (32.3%) (Figure 2). Study sample size ranged from 8 to 1,735 participants and ages, from 23 to 58 years.

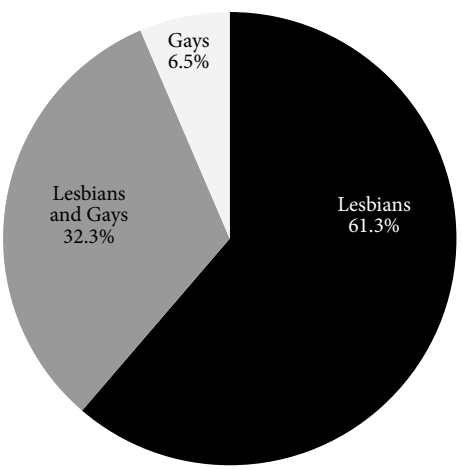

Figure 2. Distribution of studies, by study population.

Source: Authors.

The primary studies, including also those cited in the reviews, were conducted in Australia, Brazil, Canada, Spain, the United States of America, Finland, France, Italy, Norway, New Zealand, Portugal, the United Kingdom, Sweden and Switzerland. Two reviews[29,39] did not state which countries the primary studies were conducted in.

Barriers to reproduction and reproductive health of cis same-sex couples

The themes of 28 of the included studies were found to relate to the barriers faced by cis same-sex couples wanting to have children in identifying or accessing reproductive health services. The barriers related to legal, ethical and technical issues involved in human assisted reproductive technology, surrogacy and sperm donation; financial matters; prejudices, discrimination and stigma; and health personnel's homophobic attitudes and limited understanding of same-sex couples' needs.

One of the barriers to assisted reproduction has to do with legal, ethical and technical issues. In some countries, such as France, insemination as a means of enabling reproduction is anchored in two rationales. The first is that such procedures constitute a therapeutic remedy for clinically confirmed infertility or subfertility and is not a response to any form of desire to have a child. Demand for assisted reproduction from homosexual couples does not necessarily obey that logic[14,19,30,40]. Jean-François Guerin (2018) found that most homosexual women reported being unable to consider having sex with a man. The second rationale for insemination, which is connected with the first, concerns the fact that this procedure is intended exclusively for heterosexual couples[19].

A 2008 narrative review signalled that public policies in the United States continued to resist any restructuring of the sexual and reproductive rights of lesbians and gays[41]. An anthropological essay from Spain, concludes about the differences between female and male couples: women, whether single or married to another woman, can access artificial insemination and in-vitro fertilisation with no legal impediments; male couples, on the other hand, are prevented from accessing fatherhood by biological means (because their gender is not reproductive), through adoption (their sexual orientation makes them ineligible in most countries) or through assisted reproductive technologies (they can only access fatherhood by involving a woman, who will have the legal filia-

tion ties). The study also notes that surrogacy is considered an illegal procedure in Spain[22].

A 2013 narrative document review focused on legal issues faced by gay men who choose to become parents through surrogacy. Prominent among its findings were that surrogacy remains illegal in many European countries, including Germany, France, Spain, the United Kingdom and Italy, while countries such as India and Ukraine impose few restrictions and accept the practice of commercial surrogacy when paid for by the intended parents. Commercial surrogacy is also acceptable in the United States[32].

One difficulty for Canadian gay parents was finding surrogates who were open to talking to same-sex prospective parents, with surrogates refusing on heteronormative assumptions of reproduction and fertility. Fertility clinics have helped intended parents with sperm donation, but fertility clinic policies sometimes prohibit gay men from donating sperm in the same room due to sanitation and sperm mixing concerns[17].

One review found that lesbian couples who needed sperm, ultrasounds, laboratories and experienced personnel are often alone medically and financially. Heterosexuals may get financial assistance to reproduce, but members of sexual minorities often go without medical, government, employer or social assistance. While reproductive health is covered by heterosexual spouses' employment benefits, not all jobs extend the same benefits to same-sex partners. Moreover, there are restrictive policies on reproductive and fertility health coverage, to benefit heterosexual couples trying to conceive[39]. Another literature review highlighted three primary legal issues that must be addressed with lesbian couples – the legal relationship between the women, the legal relationship between the child and the non-pregnant mother and the legal rights and obligations of the donor. Although many facilities are beginning to recognise relationships between same-sex partners, many remain bound by state laws or facility policies (or both) that require a legal or blood relative to be designated as next of kin. The law is often confusing about who can be recognised as the legal next of kin and, even with appropriate documentation, lesbian couples can encounter difficulties[29].

The narrative review by Silva et al. published in 2019[38] focused on Brazilian legislation with regard to assisted reproduction, family formations in the same-sex population and family planning. It finds that the legal nature of family planning-related factors has been widely debated to determine whether or not family planning is a fundamental right. While family planning is supported by Brazilian legislation, the same is not true of assisted reproduction.

Even when legal discrimination disappears, couples may encounter unexpected barriers. In Canada, for example, while there is no legal impediment to assisted reproduction for homosexual couples, they have to cope with prejudice and discrimination in health services, schools and communities[26].

In Brazil, for example, lesbians have limited access to public services, because they are beyond the scope of the protocol for receiving reproductive technology treatment, added to which are the financial barriers to accessing private services[15]. Also in Brazil, three studies have reported heteronormative barriers, both in the imaginations of health professionals who stipulate that biological reproduction is impossible for these couples, disregarding other alternative means of forming a family[13], and in the configuration of reproduction clinics designed for heterosexual families, whose environments feature only photographs of cisgender couples of men and women[34]. Some lesbian couples could not participate in choosing the assisted reproduction technology and reported a lack of information, a lack of receptiveness in response to their anguish and, at times, dubious looks, although they considered the process as a whole in a positive light, either because they underwent the procedure and valued the experience of motherhood more than the difficulties of the process or also because the clinic did not deny care in view of their sexuality at variance with the hegemonic norm[37]. There were also situations where clinics denied care, explaining that it was because the family formation differed from the standard served by the service[34].

Stigmatisation can contribute to difficult access. A review in Australia indicated that six lesbian couples reported difficulties in the process of becoming mothers, because of stigmatisation and prejudice on the part of health professionals, even after the country's legislation change in 2002 to ensure lesbians access to reproductive technology[27]. Also in Australia, there were situations where lesbian couples travelled to another state to access fertility services, which were unavailable in their state of origin[20,21]. In another Australian study, all participants started their search for fertility clinics to conceive by consulting a general practitioner, which was not always reported as a positive experience. One example cited is of a couple who changed clinics during

treatment and were very frustrated with the process of having to obtain a new referral, although the reason for their infertility was obvious[16]. One review included in that article highlighted the issue of finding a provider to provide services during insemination as among the barriers[18]. The author reported that one problem that emerged in several of the studies evaluated, particularly those in Australia, was finding a provider for referral to a fertility specialist. In the United States and Australia, referral to specialists often requires a documented diagnosis of infertility. The review explains that such a diagnosis is complicated for lesbian women, because they are not making monthly attempts to achieve pregnancy with a male partner[18].

In this regard, even in cases where the right to assisted reproduction is guaranteed, lesbians may encounter frustrations. Three qualitative studies in Sweden identified discomfort and stigma experienced by cisgender same-sex couples in their relations with reproductive services and health professionals. Interviewees reported that medical procedures originally tailored for different-sex couples did not always meet the needs of same-sex couples. By asserting a difference between heterosexuals with fertility problems and themselves as "completely healthy lesbian women", one participant made a clear distinction between the two groups' points of departure. This vulnerability was illustrated in relation to the treatment offered, where lesbian couples asserted a need for "other types of treatments", adapted more specifically to them as patients[36]. The Swedish participants described different kinds of inappropriateness and mistreatment in reproductive health care. They reported that reproductive health professionals were unaware of LGBTQ (Lesbian, Gay, Bisexual, Transvestite, Transsexual and Queer) matters, as well as of means of impregnation, all of which was described as tiring and uncomfortable. Personnel showed their lack of knowledge, for example, by asking irrelevant questions and being unable to evaluate participants' responses. Several participants felt that midwives did not know how to work through the emotions arising from a difficult path to pregnancy, often involving infertility and miscarriages, or about the difficulties arising from this difficult path in intimate relationships. Participants described how they questioned the inappropriate treatment openly, had to explain themselves and/or their situation repeatedly to professionals and how they were obliged to educate professionals about pathways to pregnancy and the rules and legislation on assisted reproduction[25]. One lesbian couple were planning to get pregnant with the help of the Swedish public healthcare system and one of the mothers-to-be called a fertility clinic to make an appointment. She said that, on the phone, despite her clarity and frankness, she was misunderstood or ignored when asking for help to get onto the insemination waiting list. The woman at the clinic didn't want to "understand anything". The participant stressed that "it took ages to explain" and that she didn't "know how many times" she had to explain. Like a number of other couples, they argued that hostile treatment at Swedish fertility clinics was the only reason they contacted a well-known lesbian-friendly fertility clinic in Denmark. Their account presented the poor treatment as a consequence of heteronormativity; it alleged that fertility clinic staff lacked knowledge about how to respond to lesbian couples as future mothers[28].

A study in New Zealand found that the power imbalance left some lesbian participants unable to express concerns about their treatment and the power they held over their reproductive opportunities. Thus, they were effectively silenced. One participant's difficulties had to do with the nurses, who were "horrible" when providing treatment and care for her and her partner. She also met with homophobic attitudes from a social worker who was assessing them for fertility assistance at a clinic they were hoping to use. The participant stated that the balance of power led her to submit to mistreatment, so as not to hinder the process they were trying to get through. The feeling that, on the heteronormative worldview, she and her partner were not "doing things right" was added to a sensation of being perpetually marginalised, which placed undue stress on the relationship. The process the participant was undergoing at the time included invasive procedures, as well as depending on nurses for clear and honest information, which she did not receive. Some participants felt additional pressure relating to the feeling of being under constant scrutiny and judgment by the heterosexual community, particularly health professionals[33].

There are other important issues in reproductive care for lesbian couples that must be taken into account in order to achieve equity and comprehensive care. A study in the United States reported that lesbian couples needed to decide and agree on the conception process and who would be the mother of the pregnancy, because she would consequently become the predominant mother to provide the child with

human milk. Gestational mothers can also carry the non-gestational mother's egg, and services can offer that choice. The study noted that each family's lactation experience is different, but all mothers believed that clinical support could be improved to support same-sex mothers better. Many mothers voiced the opinion that health professionals could be more respectful and informed about lactation care. They reported that personnel needed to know more about what they went through to get pregnant. Mothers often felt that professionals dismissed their real health concerns and approached them as a pregnancy issue, rather than listening to their needs. They knew little or nothing about induced lactation or breastfeeding[23].

Another issue that arises in acquisition of donor sperm is choosing between anonymous and known donors[23]. Whether or not it is possible to choose anonymous, open-identity or known donors differed widely between the countries evaluated in the studies. Anonymous donors were often chosen out of concern for the non-biological mother, in order to strengthen her role as mother[43]. A study in Australia cited the logistic and ethical challenges of finding a donor. These challenges involved issues of using a known or unknown donor, retaining sperm and/or eggs for future children, donor availability for multiple families, and identification and parental rights of donors. Most participants conceived using an unidentified donor and ensured that subsequent children had the same donor. Simply locating a donor proved difficult[16]. Lesbian couples in Norway sought assisted reproduction in Denmark, so that the sperm donor would remain anonymous[42]. One narrative review addressing donor insemination technique found that the challenges of finding a donor, deciding on the desired level of interaction with the donor and deciding how much and when to tell the child about their origins were key issues that should be discussed before insemination. The search for a donor is influenced by the outcome of the couple's decision as to whether or not to use a known or anonymous donor and what role, if any, the donor is to play in the child's life[29].

Factors facilitating rights and reducing discrimination

Six studies addressed possible facilitating factors that would help lower or eliminate these barriers: reproductive health services adapted to welcome all sexual orientations openly and non-judgmentally; conception and contraceptive methods available and supplied also to the LGBT population and an informed approach to reproductive options; strategies to facilitate sperm donation; and service environments modified without the assumption that all users are heterosexual.

A review of clinical guidelines provided a summary of recommendations on provision of primary care and family planning services for the LGBT population. Seven guidelines underlined the importance of reproductive health services that meet the needs of all sexual orientations, of providers informed of the specific sexual and reproductive health needs of LGBT people and of services modified to meet individual needs. Ten guidelines included clinical recommendations on pregnancy prevention adapted to LGBT populations. They emphasised the importance of contraceptive methods, including emergency contraception, being available and provided to all who want them, regardless of sexual orientation, as well as of avoiding assumptions that lesbian women are not (or will not be) sexually active with men, which may result in pregnancy. Nine guidelines discussed pregnancy planning and fertility services, encouraging providers to counsel LGBT people, including lesbian or bisexual women and transgender clients, as to their reproductive options. The recommendations were that fertility counselling and services be made available to lesbians, including details on fertility preservation methods and the various manners of having a child and integrating them into the family. The guidelines also recommended that, before initiating any hormone therapy or surgery, doctors discuss reproductive options with people, including the implications of gender transition on future fertility[24].

A study in Canada proposed broad measures regarding fertilisation for lesbians and gays: 1) involve all parties desired by users, including partners, known sperm donors and co-parents; 2) provide affordable fertility services to known sperm donors, including gay men; 3) expand selection of sperm donors, particularly with regard to donors from diverse ethnic and cultural backgrounds and open-identity donors; 4) minimise service costs and communicate a consistent fee structure; 5) provide opportunities for women to make informed choices about interventions consistent with their known or presumed fertility; 6) offer infertility support that is specific to lesbian and bisexual women (e.g., specialised groups) or provided by individuals knowledgeable about is-

sues relevant to lesbian and bisexual women; 7) provide cues that the service is lesbian and bisexual positive; 8) Strive for a unified standard of care across all geographic regions and facilitate access for women living outside large urban centres; 9) whenever possible, offer specialised services or services in partnership with the lesbian and gay community; 10) help lesbian and bisexual women to connect with other relevant services and supports[35].

Some studies included gave a voice to cisgender same-sex couples in order to understand, from their perspectives, what could facilitate their family-building. One review addressed lesbian couples who actively sought out parenting groups with other lesbian couples in order to discuss and think about issues specific to their situation. Future mothers raised important issues for quality reception in healthcare services: open and non-judgmental attitudes; appointments, posters and forms free of the assumption that all users are heterosexual; knowledge about the situation of lesbian women; and recognition of the co-mother[43]. A Swedish qualitative study reported that participants expressed thoughts about what kind of care and support they would like to have and how professionals could be more inclusive of prospective and new parents. They said that they would feel supported if health professionals could reflect on the limitations of the health system and legislation, and they approved the attitudes of personnel when they tried to help them find solutions and access care. Participants reported wanting to be understood and supported when some of them chose to go abroad for help with assisted reproduction. They also said that it would be supportive if health professionals expressed sympathy regarding normative and exclusive arrangements, restrictive legislation that excludes LGBTQ people who wish to become parents, and for the questions put to LGBTQ people needing to undergo psychosocial assessments in order to access assisted reproductive care[25].

An evaluation study in Italy investigated the differences between two groups of Italian health professionals, one trained and the other untrained, by sexology educational programmes, which influence how well gays' and lesbians' same-sex marriage and parenting needs are met. Healthcare professionals who participated in these programmes reported significantly lower levels of homophobia towards gays and lesbians as compared with those who did not participate. The participating group also showed lower levels of total and benevolent sexism, although no significant differences were reported in levels of hostile sexism, with both groups returning low average scores on this subscale. Both groups achieved high average scores on both variables, homophobia and benevolent sexism, and displayed positive overall attitudes to gays' and lesbians' marriage and parenting rights, while the group that participated in sexology educational programmes reported significantly higher scores than the non-participating group. The participating group scored significantly higher on same-sex adoption, artificial insemination and in-vitro fertilisation for lesbians[31].

Lavoie and Greenbaum (2013)[26] described a project of a Canadian association for homoparental families, involving family members, educators, community activists and researchers. The project, operating since 2009, is described as a knowledge transfer project designed to raise awareness and support health and education professionals working with these families and to contribute to social recognition for homoparenthood.

Final remarks

In the literature reviewed, the discussion evidently focuses more on barriers and difficulties in homosexual couples' using assisted human reproduction technology than on related facilitating factors. This may indicate that – in the context in which the studies were conducted – there is still a need to problematise the hegemonic model of nuclear, heterosexual family.

Other evidence of this is that, even in countries where assisted reproduction by homosexual couples is legal, awareness among health professionals still needs to be raised in order for this right to be guaranteed to such couples, and social measures are needed to reinforce social recognition for the rights of homoparental families.

In that none of the studies reviewed questioned the right of access to assisted reproduction as a means to homoparenthood, the academic consensus that this right is assured also constitutes evidence.

Among the limitations of this review is the fact that the "grey literature" publications were not searched. No studies on the subject were excluded for reasons of language.

One gap observed in the literature reviewed was a lack of studies of families of gay men in discussions of reproduction by cis same-sex couples. Future studies may ratify or rectify the hypothe-

sis that, regardless of whether couples are homosexual or heterosexual, the mechanical association between women and reproduction remains.

Lastly, discussion on the subject discussed here needs to shift from the academic world to the more general social universe. Alignment between academia and social movements can be a powerful strategy for sexual and reproductive rights not only to become a political agenda in the collective health field, but also gain feasibility through programmatic strategies in this field. The case of AIDS, nationally and internationally, attests to the efficacy and effectiveness of that alignment.

Collaborations

FM Domene, JL Da Silva and TS Toma developed the protocol, worked on the planning, selection process, extraction, data analysis, interpretation and description of results and writing the paper. R Gomes participated in preparing the protocol, analysing the data, interpreting and describing the results and writing the text. JL Da Silva planned and developed the search strategy. All authors reviewed and approved the final version.

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