Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.4
DOI: 10.1590/1413-81232024294.19732023EN

Lesbian and bisexual couples experiencing dual motherhood: (dis)encounters in the provision of healthcare

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Abstract *The bond with healthcare services is a crucial dimension in facilitating the maternal journey of lesbian and bisexual women couples. This study aimed to analyze the culturally constructed meanings regarding the bond with healthcare services and professionals by lesbian and bisexual women who experienced dual motherhood. It is a qualitative investigation grounded in interpretative anthropology. The research corpus was built based on in-depth interviews with 10 lesbian and bisexual women, aged 30 to 39 years. The results indicate that access to parenthood, until its realization, involved a journey permeated by satisfactions and sufferings triggered by failed attempts and gestational losses. Challenges experienced in healthcare provision were also reported due to prejudices, lack of empathy, and unpreparedness of professionals in dealing with prenatal care for lesbian and bisexual women couples. Manifestations of discrimination were more pronounced concerning non-gestational mothers. The findings offer insights into implementing policies that prioritize humanization and planning programs and healthcare services based on culturally sensitive care for lesbian and bisexual women couples as they transition into dual motherhood.*

Key words *Sexual and gender minorities, Woman's health, Health services, Patient satisfaction*

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Introduction

We cannot lose sight of the fact that the social, cultural, economic, political, and scientific changes that drive the dynamics of contemporary society have driven profound transformations in the concepts and meanings of practices that regulate family relationships[1]. Although a dominant conception still prevails of a monogamous, heterocentric and patriarchal nuclear family, this issue takes on new contours, as this hegemonic model has been challenged in recent decades with the mutations observed in the sociocultural scenario, which have impacted the organization and functioning of contemporary families[2,3]. Values and the symbolic legacy of patriarchy still resist, but they are being put to the test[4].

The contemporary era has fostered openings that allow visibility to be given to a variety of family configurations that challenge traditional kinship and filiation relationships[5,6]. One of the most persistent questions calls into question the essentialist notion that there is complementarity between men and women, which would be expressed in the reproductive function and in the idea that only heterosexual unions can provide an ideal environment for the psychological development of children[2,7].

The affirmation of stable romantic relationships between people of the same gender has gained prominence in the public debate both in Brazil and in the Western world[5]. Homoparental families have gained prominence in studies on families in recent decades precisely because they promote a development context that does not follow the traditional heterocentric paradigm, as they are made up of affective relationships and parental bonds between people with sexual orientations that differ from the heteronormative standard, such as family groups made up of lesbians, gays, bisexuals and trans or non-binary people[7,8].

Among the family configurations that are systematically erased and made invisible by the limiting norms of the heteronormative framework, we find the experiences of double motherhood. This construct, which is sometimes referred to in the literature with terms such as lesbian motherhood, refers to the experience of couples of women who maintain an affective-sexual relationship and who experience the project of being mothers[9]. Such family configurations challenge the stereotypes of heterocisgenderity and question the supposed complementarity between feminine and masculine, binary assumptions that underlie the construction of gendered roles, regulated by scripts to be followed in the parental itinerary.

The literature shows that strategies for accessing parenthood can include different devices – adoption, coparenting, and previous heterosexual relationships, as occurs in stepfamilies, and may or may not involve the use of reproductive technologies[10]. The use of different means and resources sometimes reproduces the binary heterosexual model, sometimes deconstructs and denaturalizes it, highlighting original and plural ways to fulfill the desire to build and live in a family[5,7]. From this perspective, it is important to focus, from different perspectives, on the subjective and intersubjective aspects that contribute to the constitution of the homoparental family, without disregarding the socio-historical character of the family institution, whether in its hetero or homoparental configuration[4,8].

Public policies, programmatic actions, and social technologies aimed at the LGBTQIAPN+ community (Lesbian, Gay, Bisexual, Transvestite and Transgender, Queer, Intersex, Asexual, Pansexual, Non-binary, and others who fall within the field of sexual and gender dissent) originate in the recognition that the lack of social policies to combat prejudice, discrimination, and exclusion make this part of the population vulnerable[11]. It is enough to remember that, until recently, there was no health promotion policy aimed at the community within the scope of the Ministry of Health.

In the wake of the fight for social legitimacy, the National LGBT Comprehensive Health Policy, established in Ordinance No. 2,836, of 2011, is considered an important historical milestone for recognizing the perverse consequences of discrimination and exclusion, and for reaffirming the rights of this population[12]. The creation and subsequent implementation of this policy stems from a process of maturation of emancipatory struggles and the gradual conquest of spaces by past generations, which need to be continually reaffirmed in everyday life[13].

The demands that are currently placed in the field of public health contribute to reorganizing social movements and reflect demands from specific groups that feel relegated to the margins, who request understanding from the perspective of differentiated care[13]. In recent decades, specific actions geared toward the LGBTQIAPN+ population were focused on partial policies to combat HIV and the spread of AIDS. Even in this context, the health of lesbian and bisexual women

was largely neglected, reflecting the biases that permeate the relationships between gender and health. For this reason, the need for a plural and multifocal approach to this topic has been increasingly valued, with its implications in the field of women's sexual and reproductive rights[14].

The issues reported by women involved in creating the couple show the need for specific studies on their needs, including psychosocial support through different modalities of support and care, at different levels of health promotion, prevention, and intervention, especially in the Brazilian reality, which still lacks reliable studies on the issue[9]. In recent years, this topic has gained increasing space, but double motherhood still faces barriers to impose its agenda and increase its visibility.

Advances in biomedical knowledge have made it possible to use new reproductive technologies to facilitate the maternal project of couples of lesbian/bisexual women, who now have procedures that allow for the pregnancy of one or both partners, using or not their genetic material[14,15]. Furthermore, families built through adoption have always been part of – and continue to be part of – the dual motherhood scenario, and the adoption process can be requested by the couple or by one of the partners[5].

Considering this panorama, the present study was designed, which aimed to analyze the culturally constructed meanings about the bond with health services and professionals by lesbian and bisexual women who experienced double motherhood.

Method

Methodological design

This study is an investigation based on a qualitative approach and conducted in the field of health anthropology[16]. In international scientific literature, as well as in the Brazilian context, there is a consistent body of research that results in vast bibliographical production with the application of qualitative methods in Collective Health[17]. The basis of these studies is the interpretation that social actors give to their actions and practices, based on culture, and their resonances in the production of health[16].

Qualitative research seeks to understand the meanings that subjects attribute to their experiences and, to this end, it must be flexible and dynamic[17]. The methods and aspects related to the study design can be modified as new information is collected. The analysis and interpretation of data also changes over the course of the study as new elements are incorporated and we gain better knowledge of the studied context. In the qualitative approach, the research process is dynamic, flexible, alive, non-linear, non-homogeneous, and non-sequential.

Participants

Ten adult women participated in the study, who self-identified as cisgender lesbian or bisexual women who shared the experience of motherhood with another woman. The following inclusion criteria for the study were established: age over 18 years, self-identification as a lesbian or bisexual woman, who experienced double motherhood. The exclusion criteria were: not having an online access device or internet connection, necessary for data collection; and the impossibility of securing a safe and private place (at home or at work) to participate in an online interview.

Participants were selected using the snowball method. The index person (first to be interviewed) was an active member of an online group on the topic of double motherhood and suggested potential interviewees, including contacting women who were not members of that group, which boosted data collection and ensured the diversity of the set. The first person indicated by the index participant was contacted and, upon confirmation of her availability, data collection continued. This was done successively with the others, until sample saturation was reached, which occurred with eight participants. To ensure this, we carried out two more interviews, which corroborated the recurrence of information, ensuring that saturation was reached. Therefore, the number of interviewees was defined *a posteriori* using the data saturation criterion[17] (Chart 1).

Data collection

The precautions recommended by the literature regarding the use of online interviews were observed. The research *corpus* was constructed based on individual interviews, complemented by the researcher's notes containing a detailed record of impressions, reflections, and feelings aroused by the participants' experiences.

The material produced in the interactive context with the interlocutors is based on the perspective of listening and the perspective of a researcher who defines herself as a cisgender

Chart 1. Sociodemographic profile of the participants.

Name	Age	Educational Level	Profession/ Occupation	Marital Status	Economic Classification	Religion
Samantha	34	Higher Education	Self-employed	Divorced	C1	None
Talita	35	Post-graduation	Housewife	Married	B1	None
Camila	30	Higher Education	Microentrepreneur	Married	B2	None
Vivan	35	Higher Education	Fashion designer	Married	B1	Pagan
Tarsila	31	Post-graduation	Doctor	Married	B1	None
Débora	34	Incomplete Higher Education	Public servant	Married	B1	None
Alice	36	Incomplete post-graduation	Advertiser	Married	B1	Spiritist
Coral	39	Incomplete post-graduation	Public Health Consultant	Married	B2	None
Maria	39	Incomplete Higher Education	Administrator/ Proofreader	Married	A	Catholic
Renata	32	High School	Housewife	Married	B2	Catholic

Source: Authors.

lesbian and white woman, researcher in the field of lesbianities. The open, in-depth interview included a guiding question, which asked the participant to talk about her experiences with dual motherhood. The interview was conducted in such a way as to make the interlocutor feel comfortable and free to express herself in relation to the events and thoughts that she considered relevant in her motherhood journey. The use of this specific type of interview is consistent with the objective of the study, as it allows the interlocutors to freely express their experiences, feelings, and meanings attributed to the events they identified as relevant to understanding their experiences with dual motherhood.

Initial contact with the participants was made through messaging applications and digital social networks. For those who accepted the invitation, the Free and Informed Consent Form (FICF) was sent. For those who were contacted via Instagram, the FICF was sent by email or WhatsApp, due to the limitations of the digital platform. Participants were asked to sign the form before carrying out the interview and to ensure that the meetings took place in a private place and under conditions of security and confidentiality. It is important to guarantee a virtual environment free from interference from third parties and that offers comfort and privacy, considering the possibility that sensitive topics related to the interviewees' privacy could be addressed during the conversation.

The interviews were conducted online, via the Google Meet digital platform, between July and December 2022, lasting between 51 and 92 minutes. The conversations were recorded using the video calling feature provided by the digital platform, with prior consent from the participants. The material was later transcribed in full by the researcher, respecting the literalness of the statements.

Data analysis

The research development process included careful analysis of the collected material, which included the researcher's reflective and observational field notes, describing in detail facts, acts, and feelings awakened from her observation of the field. Exhaustive readings of the material were carried out based on an analysis procedure, which made it possible to identify units of meaning that gave rise to the thematic axes, providing support for the interpretation of data and the construction of results[17].

The collected data were successively organized and refined into themes and the analysis

consisted of the constant comparison of elements that emerged from the different observations, seeking to capture common/convergent elements and possible differences/divergences in the records. At this stage of the analysis, it was possible to establish the recurrences and singularities observed in the situations and contexts reported by the interviewees, taking care to separate and differentiate the convergences of singularities (unique marks)[17].

Geertz's Interpretative Theory of Culture was used as a theoretical framework for data interpretation[18]. This framework emphasizes the importance of cultural diversity as a multifaceted and innovative resource, used to broaden the view of the complexity of the meanings of human actions, drawing inspiration from values such as divergence, respect, and sharing of ideas and experiences of the mothers interviewed in the construction of their experiences and social practices related to double motherhood.

In this epistemological conception, anthropological knowledge arises from symbolic practices and discourses fueled by differences and their borders. In interpretative anthropology, the search for knowledge takes place through the effort to get closer to others, understood as a way to embrace otherness and legitimize what is different. In the path outlined to understand reality, it is admitted that uncertainties, paradoxes, and ambiguities are an inherent part of the process. The valorization of such elements replaces the search for causal, regular, cyclical relationships, as it privileges a range of attempts at understanding produced in local and particular contexts, in which it is expected that unforeseen events and previously unknown challenges will appear during the research itinerary[18].

The affirmation of double motherhood offers a catalytic context for the destabilization of certainties and established beliefs in relation to the family and raising children, introducing unpredictability into a field scrutinized by hegemonic and standardizing discourses, at the same time that the production of local knowledge is valued[18].

The results of the analyses were systematized and interpreted based on studies in the area of dual motherhood, guided by the theoretical framework of interpretative anthropology, which made it possible to unveil the dimensions of the living experience revealed from the viewpoint of its protagonists.

This study obtained prior approval from the institution's Research Ethics Committee (CAAE No. 58782922.5.0000.5407) and followed the recommendations recommended by Resolution No. 510/2016, safeguarding the right to privacy of participants and their families.

Results and discussion

Regarding the sociodemographic characteristics of the participants, the age range varied between 30 and 39 years (average age 34.5 years). Regarding the level of education, three had completed higher education (Samantha, Camila, and Vivan), two had incomplete higher education (Débora and Maria), two had completed postgraduate studies (Talita and Tarsila), two had incomplete postgraduate studies (Alice and Coral) and Renata had completed high school. In relation to work activity/occupation, eight participants were active in the exercise of their professions. Camila was a micro-entrepreneur (innkeeper), Vivan was a stylist, Tarsila was a doctor, Débora was a municipal public servant, Alice was an advertiser, Coral was a public health consultant, and Maria was an administrator and proofreader. Samantha declared that she works as a freelancer. Talita and Renata were not engaged in paid work at the time of the interview and reported having left the job market after having children.

Nine participants declared themselves married (Talita, Vivan, Tarsila, and Débora for three years; Alice and Renata four years; Camila and Coral seven years; and Maria eight years), and one was recently separated (Samantha). All the women had regularized their relationships, some even before stable unions were equated with marriage between people of the same sex, as a way of guaranteeing social and legal rights.

It is noted that all interviewees used assisted reproductive technologies and none had children from previous relationships. A common element in the reported experiences was the loss of babies and successive failed pregnancy attempts during the *in vitro* fertilization process.

Regarding family composition, eight interviewees (Talita, Camila, Vivan, Tarsila, Débora, Alice, Coral, and Renata) reported having a nuclear family, one participant reported having a single-parent family at the time of the interview (Samantha, in the process of recent separation) and another classified her family as extended (Maria, who lives with her wife, son, and mother-in-law).

Family income ranged from R$ 1,000.00 to R$ 40,000.00. Regarding religious affiliation, six par-

ticipants declared no affiliation (Samantha, Talita, Camila, Tarsila, Débora and Coral) or were atheist (Samantha). Vivan claimed to be a "practicing pagan", attending her religious practices monthly. Alice declared to be a spiritualist, but stated that, after the birth of her son, she became lax in her religious practices, which were weekly in the period before the transition to motherhood. Maria claimed to be Catholic, with weekly religious practices. Renata also declared herself Catholic but stated that she has not practiced it recently.

With the support of interpretative anthropology, we seek to understand the ways in which the women interviewed express and interpret their experiences of gratification and suffering within the scope of reproductive health services to enable motherhood. The theme was created: "Building links with health services and professionals". The statements were coded as follows: MG: pregnant mother; MN: non-pregnant mother.

The results show that the desire to be a mother was inscribed early in the participants' history:

I had always wanted to be a mother, ever since I understood [...] what it was like to be a mother, what it was like, so around the age of 17, I was already researching how a lesbian woman could have a child, and I already knew, even at that age, that I could have access to SUS (Camila, 30, MG).

The pregnancy-puerperal process was experienced as a sensitive experience that establishes the foundations of mother-child bonding, along with the desire and, at the same time, fear of what it would be like to care for a child. To make pregnancy viable, women resorted to *in vitro* fertilization techniques. Reproductive technologies currently allow, through the Reception of Eggs from the Partner (ROPA) method, for one of the women in the couple to have children with the implanted egg of the other. It is also possible to use donated semen, whether from known men or an unknown donor[9,15]. The experience with medical treatment was assessed as "terrible" by one of the interlocutors:

I was eight months pregnant, I had high blood pressure, reading 16, 16.1, 15.9, and she [obstetrician] didn't give medication, didn't give anything. And in the case of my wife, when she became pregnant, there was also a change in care when the obstetrician found out that she would not pay for the birth. From the moment she said that she wasn't going to pay for the birth, that she was going to have the birth with a person on duty at the hospital, [...] you could see that his care changed, you know? "Oh, you're not going to do it to me, so I don't have to waste [makes quotation marks with hands] my time" (Renata, 32, MG and MN).

Concerns about the pregnancy-puerperal process, which sometimes accompany experiences of transition to motherhood, need to find a welcoming environment in the health sector. However, the majority of participants reported some critical incident during meetings with health service professionals:

Once, one of the doctors who came into the office, on the chart it was written that there were two mothers, such and such, and he insisted on... it was an older man, and he insisted on saying: "Oh, where is the child's father, oh, call the father", you know? I had to explain a thousand times that no, there is no father, there are two mothers, and I don't know what else (Renata, 32, MG and MN).

Most interlocutors accessed specialized services from the private network. Camila highlighted the good experience she had with the service provided by SUS ("they are more receptive than in private"). All couples initially chose to use reproductive technologies based on the understanding that the biological route would be the fullest way to experience motherhood. When couples made the use of technology their first choice, they experienced setbacks and disruptive experiences, such as interrupted pregnancies. In most couples, the resulting suffering was mitigated thanks to the relief provided by the successful outcome after several unsuccessful attempts:

Difficult process because the first stage, which is the hormone stimulation stage, ovulation, I had to take daily injections in the belly, I applied myself, [..] to be able to have a positive result [...] of stimulation. So, it's difficult in that sense, because hormones affect everything (Maria, 39, MG).

And then she [wife] went, tried with her eggs, it took three attempts, it didn't work, but the doctor said it would be difficult due to her age [...] and that's where she tried to do it with my eggs , [...] she got pregnant, at eight weeks, she lost it, and then she said: "Oh, I have no mind anymore, you go now", and that's where I went. I did, I got pregnant with [the eldest daughter] and [...] we still had two [...] embryos [...], and she said: "Oh, I'm going to go there and transfer just for release." [...] so we went, already thinking that it wouldn't work, and then she did it. And she got pregnant (Renata, 32, MG and MN).

I was going to get pregnant with her eggs, so the two of them needed to be together during the ovulation, fertilization part of the cycle [...] it was the first time that we managed to get pregnant [...] we were already 35, so, we thought it would be a longer process (Alice, 36, MG).

There were those who ended up choosing the path of adoption, as they were unable to com-

plete the process after several failed pregnancy attempts. Mishaps experienced during health care were also reported regarding the quality of the bond established with professionals. The most striking manifestations of lesbophofia were directed at non-pregnant mothers:

This was one of the most serious forms of violence that I consider we suffered because, at no time were we considered a couple, at no time were we considered people, there we were uteruses, you know? And so, "is there a stretcher so I can see the uterus?", "is there a machine to put her legs on?", so go on, there are two machines, there are two uteruses, let's separate them, completely, you know, without the slightest fuss (Vivan, 35, MN).

In many other environments, like for example, the pregnancy circle, we were there sharing experiences and everything, and she was never included, [...] even though everyone knew that there was a couple with two mothers there, it was rarely said : "Oh, the father or the other mother, or the non-pregnant mother", or something like that, is... so, this invisibilization, right, [...] of not putting the [wife's name, non-pregnant mother daughter] exactly in the place of being as much a mother as I am (Samantha, 34, MG).

There are people who only address me because I'm the pregnant woman, and we always end up getting tired [...] of having to prove motherhood when it's in relation to the non-pregnant mother, which is very difficult, [...] so there's always: "Ah, but what about you, are you going to have yours?", or if she already has hers (Camila, 30, MG).

Because then, I don't know, like, if it's [wife's name] genetics and [wife's name] is pregnant, you're a companion, there's nothing that would make you recognized as a mother there (Vivan, 35, MN).

At the health center: "It's fine, but who, who is the mother?" And we: "The mother is both of them". "It's fine, but who did it?". "Okay, come on, [in an indignant tone] she's the real mother, I'm the fake mother". I have to say this. It's my way of protesting (Vivan, 35, MN).

We were very well supported, very well received, it's... by SUS, by the hospital that we created, and, along the way, there are several questions that are more about [...] how the system deals [...] hospital, clinic [...]. People still have this difficulty putting their name there, the name 'responsible' or 'affiliation', as it appears on a document (Camila, 30, MG).

To protect themselves from possible exposure to prejudice and discrimination in healthcare settings, some anticipated and took some precautions:

It was already a recommendation from someone, and from someone very close to the doctor, so we [...] didn't have this barrier [...] of talking about the topic [double motherhood], or suddenly encountering some prejudice and not being well received (Coral, 39, MN).

From the perspective of the interlocutors, health professionals often ratify the prescriptions of heteronormativity:

Then the doctor [...] said this: "Normally we do this because [...] if the father faints, we will have to pay attention to the father, and the one who should pay attention is the woman in labor", you know? And I even told him: "But I'm not the father, I'm the mother!" [in an indignant tone] I needed to be there to give birth, understand? (Vivan, 35, MN).

There was a bit of this burden, like: "Ah, so [wife's name] is the mother who is carrying the baby, and you are the mother who goes to work". So, like: "You're a man" [makes sign of quotation marks with your hands] (Coral, 39, MN).

We were in a pandemic [...] [wife's name] couldn't accompany me to all the appointments, she only managed to go to the last appointments, but we didn't feel any hostility towards that either (Alice, 36, MG).

There is a socially constructed space for non-pregnant mothers: a discredited and invisible place. It's as if there were a constant validation of the popular adage that states: "there is only one mother". The difference culturally attributed to whoever bears and carries the baby is evident even in the (im)possibility of expressing one's own suffering in the face of painful experiences of pregnancy loss:

She [wife] got pregnant and lost the baby, then it was devastating [...] for me it was very difficult, because I put my pain in my pocket so I could hold hers. Because, in my head [...] it was inside her, so she was suffering more than me, and today I see that I was totally wrong, you know? There is no such thing, I suffered just as much. [...] people didn't [...] see my suffering, they only saw hers, because she was generating it (Renata, 32, MG and MN).

There are situations in which the couple themselves seem to reproduce the heteronormative and gendered division of parental roles:

We have a lot defined like this, I am the mother of [son's name], I gave birth. So, I am the mother of [son's name], [wife's name] he calls Memê (Maria, 39, MG).

The perception of parenthood among female couples is influenced by controversies fueled by family and naturalistic ideologies, which are cur-

rently sharpened by the conservative offensive[3]. The lesbian/bisexual couple who share the motherhood project contest the supposed "naturalness" of the essentialist system based on sexual difference and gender norms. This system reproduces the nuclear family model inherited from the patriarchal system and, in so doing, reaffirms a certain hierarchy of prestige and valuation. For this reason, by asserting themselves as mothers, the couple of lesbian and bisexual women subvert the dominant relationships of alliance, affiliation, and sexuality, turning them upside down[19,20].

Health professionals may feel uncomfortable addressing these relationships, which contributes to their invisibility and silencing in the field of reproductive health. Furthermore, due to the normative prescriptions of patriarchy, women are inferior in various social spheres in which men enjoy privileges and power[4]. Therefore, it is important to expand the domains and spaces of speaking and listening where words can be clearly articulated and audibly loud and clear, without subterfuge and without subtle prejudices disguised as tolerance.

Special attention should be paid to the place of the non-pregnant mother in healthcare. It is necessary to deconstruct the naturalization of the primacy of the biological bond, as an element of the collective imagination that gives legitimacy to kinship relationships and that is reproduced in health[21]. The literature states that this socially naturalized conception is an untouchable belief that constitutes a persistent challenge for couples that contradict heteronormativity[22]. Added to this is the tendency towards objectification and biological reduction that permeates biomedical discourse: "*At no point were we considered a couple, [...] there we were uteruses*" (Vivan, 35, MN).

What is frequently seen is that, in the eyes of health professionals, the mother responsible for the child's biological pregnancy seems to enjoy more rights and responsibilities over the child[7,14]. The non-pregnant mother does not have her voice heard and legitimized, which suggests that there is the production of different meanings for the lesbian/bisexual woman's motherhood, depending on the perception of its biological implication in the child's pregnancy[21]. The non-pregnant mother hardly has her participation in the pregnancy-puerperal process recognized, respected, or endorsed. To deal with these vicissitudes, women can access reproductive technology strategies, in which one of them creates a child with the other's egg or one becomes pregnant with the semen of one of her partner's relatives, in order to ensure the child's biological bond. with both mothers, or they can even resort to registering the names of both mothers on the birth certificate[14].

It is evident that, in the 21st century, ideas about what constitutes a family are becoming more inclusive, which reinforces bonds of belonging. Based on her personal experience as a lesbian mother with her wife, Meisner[23] mobilizes the "natural" category to question the "nature" of what is considered "normal" within each culture at a local level, showing that double motherhood challenges the meaning of family today. Traditional notions of gender and gender roles are easily deconstructed when looking at families comprised of people of the same gender.

The care provided in health services constitutes a fundamental part of the support network to strengthen care actions for women and their homoparental families in the various areas of health. For this reason, the concepts of health professionals, often saturated with prejudices, clichés, and stereotypes about family and marital ties, must be continually questioned and stressed.

Final considerations

The results showed that the mothers' first choice was the desire to conceive a child from their own womb or from their partner. Once this decision had been made, our interlocutors began to think about the method of conception, as well as study the means of making pregnancy viable. Access to health services and reproductive technologies was favored by the good social condition of the majority of participants. Few used the public health system. However, couples encountered several setbacks in their health journeys, including manifestations of discrimination and a lack of empathy, which were more striking in relation to the non-pregnant mother.

It is necessary to expand the body of knowledge about the relationship between users and professionals who work in the field of collective health, training them so that they can build references and implement guidelines to improve access to diversity-sensitive care for non-heterosexual women in the reproductive age. The expansion of knowledge production is necessary to provide subsidies that allow for the guidance of inclusive policies in various care centers and community resources, such as the Family Health Strategy, which incorporates the basic principles of the SUS, such as universalization and compre-

hensiveness, in addition to valuing active community participation. As part of the fight against stigmatization and invisibilization, it is necessary to integrate homoparental families, expanding their sense of belonging to the territory. Between erasures and resistance, the problems listed by this study call for the visibility and appreciation of new ways of thinking about collective health, capable of contemplating the plurality of modes of existence.

There is a certain perplexity with the persistence of prejudiced postures and attitudes in services. The results of this study indicate that the reproduction of lesbophobia in healthcare settings has repercussions on the quality of the bond established between professionals and couples who experience double motherhood. This contributes to restricting the differentiated care to which this population is entitled, which goes against the shared values of human dignity in the production of health care. Another controversial factor is the relationship between biomedical knowledge and the naturalization of motherhood in confluence with heteronormativity. The dichotomy induced by the biomedical care model fuels persistent tensions between the needs of lesbian and bisexual women who wish to have children and the knowledge produced by biomedical rationality and the hegemonic models that prevail in health services. This phenomenon unfolds at different levels of health care, increasing the challenges of professional performance in women's health care, particularly in the care of those who experience the spectrum of sexual dissent.

This study's limitation is the participant recruitment strategy, since the technique used may restrict the diversity of informants. Studies that focus on the organization of the maternal and child health care network and the indicators for monitoring the performance of care offered to users who experience dual motherhood can contribute to improving the quality of the bond. The implementation of the National Comprehensive Health Policy, defined by Ordinance No. 2,836, requires the qualification of professionals and managers, as well as the organization of the care network in search of coordinated intra- and intersectoral action, which makes it possible to destabilize naturalized notions about family and deconstruct prejudices about homoparenting. One potential of this study is that the data analyzed comes from dense descriptions obtained through in-depth interviews carried out with the interlocutors.

Collaborations

MA Santos conceived the study, guided the second author in the planning and theoretical-methodological design of the research, contributed to data analysis, preparation, and critical review of the intellectual content of the manuscript. AB Minari conceived the study and participated fully in field activities, data collection, and analysis, and in the preparation of the manuscript. EA Oliveira-Cardoso collaborated in the analysis and interpretation of data, critical review of the intellectual content, and final approval of the version to be published.

Funding

Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) and Programa Institucional de Bolsas de Iniciação Científica (PIBIC).

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Article submitted 21/11/2023
Approved 26/12/2023
Final version submitted 26/12/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva