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The lesbian woman's perception of prenatal care

La percepción de la mujer lesbiana sobre la acogida en el prenatal

A percepção da mulher lésbica sobre o acolhimento no pré-natal

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Abstract

This study investigates lesbian women's perceptions of the care provided by nurses and physicians during prenatal care. The objectives were to describe how sexual orientation and lesbian motherhood are addressed during prenatal care, understand participants' perceptions regarding the adequacy of professional guidance and care to their specific needs, analyze the facilitators and barriers experienced in their relationships with healthcare professionals, and discuss how these demands are addressed in prenatal services. This is an exploratory, descriptive study with a qualitative approach. Six women who received prenatal care between 2004 and 2019 participated in the study. Participants were recruited using the snowball sampling technique and interviewed using a semi-structured script. Data were analyzed using Bardin's content analysis. Two thematic categories emerged: "Methods to achieve the dream of pregnancy and influencing factors" and "Prenatal care for lesbian women and its specificities," the latter subdivided into "Professional unpreparedness to care for lesbian women during prenatal care" and "The relationship between lesbian women and healthcare professionals." The findings revealed that welcoming care is undermined by discriminatory attitudes and by healthcare professionals' lack of preparation to meet the specific needs of this population.

Descriptors: Female Homosexuality; Prenatal Care; Sexual and Reproductive Rights; Obstetric Nursing; Health Equity.

Resumén

Este estudio tiene como objeto la percepción de las mujeres lesbianas sobre la acogida brindada por enfermeras y médicos durante la atención prenatal. Los objetivos fueron describir cómo se aborda la orientación sexual y la maternidad lésbica durante el control prenatal, comprender la percepción de las participantes sobre la adecuación de las orientaciones y de los cuidados profesionales a sus necesidades específicas, analizar las facilidades y dificultades experimentadas en la relación con los profesionales de la salud y discutir la atención de estas demandas durante el seguimiento prenatal. Se trata de un estudio exploratorio-descriptivo con enfoque cualitativo. Participaron seis mujeres que realizaron control prenatal entre 2004 y 2019, seleccionadas mediante la técnica de bola de nieve y entrevistadas a través de un guion semiestructurado. Los datos fueron analizados mediante el análisis de contenido propuesto por Bardin. Surgieron dos categorías temáticas: "Métodos para alcanzar el sueño del embarazo y factores influyentes" y "Atención prenatal para mujeres lesbianas y sus singularidades", esta última subdividida en "La falta de preparación profesional para el cuidado de mujeres lesbianas durante el control prenatal" y "La relación entre la mujer lesbiana y el profesional de la salud". Los resultados evidenciaron que la acogida se ve afectada por actitudes discriminatorias y por la insuficiente preparación de los profesionales para atender las necesidades específicas de esta población.

Descriptores: Homosexualidad Femenina; Atención Prenatal; Derechos Sexuales y Reproductivos; Enfermería Obstétrica; Equidad en Salud.

Resumo

Este estudo tem como objeto a percepção de mulheres lésbicas acerca do acolhimento realizado por enfermeiras e médicos durante o pré-natal. Objetivou-se descrever como a orientação sexual e a maternidade lésbica são abordadas nesse contexto, compreender a percepção das participantes sobre a adequação das orientações e dos cuidados profissionais às suas demandas específicas, analisar as facilidades e dificuldades vivenciadas na relação com os profissionais de saúde e discutir o acolhimento dessas demandas durante a assistência pré-natal. Trata-se de um estudo exploratório-descritivo, de abordagem qualitativa. Participaram seis mulheres que realizaram acompanhamento pré-natal entre 2004 e 2019, selecionadas pela técnica snowball e entrevistadas por meio de roteiro semiestruturado. Os dados foram submetidos à análise de conteúdo proposta por Bardin. Emergiram duas categorias temáticas: "Métodos para alcançar o sonho da gravidez e fatores influenciadores" e "Assistência pré-natal específica para mulheres lésbicas e suas singularidades", esta última subdividida em "O despreparo profissional para o cuidado às mulheres lésbicas no pré-natal" e "O relacionamento entre a mulher lésbica e o profissional de saúde". Os resultados evidenciaram que o acolhimento é comprometido por atitudes discriminatórias e pelo despreparo dos profissionais para atender às necessidades específicas dessa população.

Descritores: Homossexualidade Feminina; Cuidado Pré-Natal; Direitos Sexuais e Reprodutivos; Enfermagem Obstétrica; Equidade em Saúde.

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Introduction

In recent decades, policies and actions for the visibility of lesbians, gays, bisexuals, transsexuals, and travestis (LGBT+) have been created and developed in Brazil. This population, which lived on the margins for many years, has built its space and acquired rights like any other citizen. It is known that these actions and policies represent necessary and urgent advances, since discrimination and violence against this public have alarming rates and are increasingly growing. In Brazil, every 34 hours an LGBT+ person is barbarically murdered or commits suicide, a victim of LGBTphobia, which makes Brazil the world champion of crimes against sexual minorities. According to international human rights agencies, far more homosexuals are killed here than in the 13 countries of the East and Africa where there is a death penalty for LGBT+ people[1].

The high rates of prejudice and discrimination are the cause of the LGBT+ population being classified as vulnerable before society. Prejudice is any judgment, whether cognitive or behavioral, directed at a certain group in an offensive, disrespectful, and/or negative way, according to what the person believes. Discrimination, in turn, would be the behavioral manifestation of prejudice, attributing hostile, negative, and/or aggressive actions to a certain group[2].

In 2007, during the 13th National Health Conference, sexual orientation and gender identity were recognized as social determinants of health, reaffirming the vulnerability of the LGBT+ population before discriminatory attitudes in society. Through this conference, the implementation of policies and actions aimed at this population was requested, and it was determined that sexual orientation and gender identity should be included in all documents of the Unified Health System (SUS) network[3].

The protection of the LGBT+ population against different forms of prejudice constitutes a duty of the State, and it is incumbent upon public bodies to implement policies and measures that ensure the promotion of equity and the confrontation of discrimination[4].

Only in 2011 was there the implementation of a specific policy for the LGBT+ public. Ordinance No. 2,836, of December 1, 2011, was created, which instituted the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Travestis, and Transsexuals (PNSILGBT). This policy aims to promote broader health care, with quality and respect, and that contemplates all the needs of the LGBT+ population[5]. Among the guidelines aimed at this population, one of the main ones is the right to adequate health care. Violence against the LGBT+ population and the unpreparedness of professionals to deal with this population adequately cause greater harm to health and provoke distancing from the search for care. Hence, the need to increasingly improve the implementation of this policy is perceived[6].

In this context, the recognition and reception of singularities related to sexual orientation and gender identity are configured as essential competencies for the practice of health professionals[7].

Among the different segments of the LGBT+ population, lesbian women remain exposed to multiple forms of vulnerability resulting from prejudice, gender stereotypes, and institutional and social discrimination. Considering this vulnerability, the preparation of health professionals for the reception of these women must contemplate the singularities they present, such as, for example, the difficulty of assuming their sexual orientation for fear of discrimination by professionals; the possibility of never having undergone the colpocytological exam because they consider it unnecessary, since they do not maintain sexual practices with men; and the need for the professional to conduct the consultation in a way that avoids presuppositions and stereotypes, among other situations[6]. The best way to meet the demands of these women is to discuss the theme and include them in health actions, as recommended by policies aimed at women and the LGBT+ population.

Only in 2004 was the lesbian woman recognized and included in the National Policy for Comprehensive Care of Women's Health (PNAISM), in which their health rights were contemplated. The policy addresses various aspects related to the health of lesbian women, such as sexually transmitted infections, low demand for health services, violence, and reproduction[8]. According to Lima[6], one of the least explored aspects refers to motherhood and reproductive planning among same-sex couples. When analyzing issues related to lesbian motherhood, it is observed that doubts and inquiries are common among more conservative people, who understand motherhood only when associated with a heterosexual relationship and consanguinity bonds[9].

During pregnancy, the woman needs prenatal follow-up, which is important to avoid negative impacts on maternal health, whether psychological, social, or physical, in addition to favoring the healthy evolution of pregnancy, childbirth, and the newborn. For this, it is expected that the singularities of each woman are heard, respected, and welcomed[10]. Not enough to have to overcome all the social pressure that falls on the lesbian who wants to gestate, this woman still has to submit to the possibility of being accompanied by a professional unprepared to deal with her case. Health professionals still believe that lesbians do not become totally complete in their desire to be mothers because they do not have a child with genetic sharing between her and her partner. From a cultural baggage of socially constructed representations, professionals may adopt inadequate postures in the care of lesbian women, failing to consider their sexual orientation and treating them like any other woman, according to the normative standard of heterosexuality. The consequence of the lack of attention to the singularities of lesbian women in the context of health care is configured as a form of symbolic violence[9].

Considering that pregnancy is a singular moment, in which each woman should be welcomed and assisted according to her particularities; that there are still few health professionals trained and updated to work with the lesbian population; and that these women remain more vulnerable to situations of prejudice, intentional or not, this article sought to understand the perception of lesbian women

about the reception received during prenatal care, both by nurses and physicians.

Given the above, the following questions are presented: "How does the approach to sexual orientation and lesbian motherhood occur during prenatal care, from the perspective of lesbian women?", "What is the perception of these women about the guidance and care provided by professionals regarding their demands?", "What are the facilities and difficulties experienced by lesbian women in the relationship with professionals, considering their specificities?" and "How does the reception of lesbian women by professionals occur during prenatal care, according to the perspective of these women?".

To answer these questions, the article aims to: describe the approach to sexual orientation and lesbian motherhood during prenatal care, from the perspective of lesbian women; describe the perception of these women about the adequacy of professional guidance and care regarding their specific demands; analyze the facilities and difficulties experienced by lesbian women in the relationship with professionals during prenatal care; and discuss the reception of the demands of lesbian women by professionals during prenatal care.

Methodology

This is an exploratory-descriptive study of a qualitative nature. The research participants were six cis lesbian women who experienced prenatal care from 2004 onward. For this article, the terms "cis" and/or "trans" will not be repeated, since gender identity was not the object of analysis and all participants were cis women. When referring to men, the term cis men is used.

Data collection began after approval by the Research Ethics Committee of the State University of Rio de Janeiro (UERJ), under CAAE No. 04898918.5.0000.5282, on February 18, 2019. Collection occurred between March and August 2019.

To meet the research objectives, the following inclusion criteria were established: women residing in the state of Rio de Janeiro who had declared their sexual orientation during prenatal care performed by physicians and/or nurses, from 2004 onward, the year of establishment of the PNAISM. As exclusion criteria, lesbian women classified as adolescents were defined, according to the Child and Adolescent Statute, that is, aged between 12 and 18 years.

The data collection instrument was the semi-structured interview which, according to Minayo[11], allows the use of a previously formulated question, enabling the participant to speak freely about the proposed theme.

The guiding question was presented at the beginning of the interview: "Could you tell me about your relationship with the health professional who attended you during prenatal care, considering your sexuality and your specificities?".

The interviews were audio-recorded in MP3 format, with an average duration of 30 minutes, and later manually transcribed. The script was divided into three parts: the first destined for the characterization of the participants; the second composed of the guiding question and the interjections used during the interview; and the third corresponding to the field diary, in which the researcher's impressions about the participants were recorded. The interviews were conducted by the first author, a nurse and resident in Obstetric Nursing at the time of data collection, with prior training in qualitative research and conducting semi-structured interviews. The researcher had no prior bond with the participants.

Considering the possible difficulty of access to this population, the snowball technique was employed, widely used to reach hard-to-access groups[12]. The first participant, called the seed, was selected by indication of the author's social circle. The others were successively indicated by the previous participant, if they met the inclusion criteria and expressed interest in participating in the research.

The participants were identified by the letter M, representing the word woman, followed by a numeral in ascending order, corresponding to the sequence of interviews. In this way, the anonymity of the participants was guaranteed. The interviews occurred in person, at a time and place defined according to the participants' preference. For their realization, the room of the Research Group of the Department of Maternal-Child Nursing (DEMI) of the Faculty of Nursing of UERJ was used.

Initially, 11 women agreed to participate in the research. However, due to the political context in force during the data collection period, marked by public discourses considered discriminatory, sexist, and homophobic, five participants requested the withdrawal of their consent, resulting in a final sample composed of six women. The closure of the interviews occurred when the data presented theoretical saturation, evidenced by the recurrence and redundancy of the information obtained[12]. Although data saturation was reached, the finalization of the collection was also influenced by the refusal of other lesbian women to participate in the research, justified by the political context of the time, perceived by potential participants as a stimulator of attitudes of violence and discrimination against the LGBT+ population.

The data were analyzed based on the content analysis proposed by Bardin[13], whose steps comprise pre-analysis, exploration of the material, and treatment of the results, with inference and interpretation. In the pre-analysis phase, a projection of ideas was performed after their organization based on the theoretical framework, on the transcribed interviews, without disregarding or modifying any element found in the testimonies.

In the exploration phase of the material, criteria were used for cutting, enumeration, choice of categories, classification, and grouping of the information collected during the interviews. It was in this phase that the testimonies were cut and organized into recording units, units of meaning, subcategories, and categories established according to the theoretical framework.

The data were manually coded by the main researcher, with the aid of Microsoft Excel, and later revised and refined in meetings with the other authors. The last phase, treatment of results: inference and interpretation,

consisted of the search for meanings behind the collected data. The researcher performed evident interpretations through what was manifested in the discourses, and performed a latent interpretation, that is, interpreted the subjective data explicit behind a speech or behavior.

The analytical categories were supported by excerpts from the participants' speeches, favoring the transparency and reliability of the interpretation of the results. The testimonies were presented preserving the original language of the interviews, including oral marks, language tics, and slang, without suppressions or vocabulary substitutions to guarantee greater fidelity to the analysis and discussion of the data. Subsequently, the results were submitted to the appreciation of an examining board, whose contributions were incorporated into the analytical process, strengthening the consistency and methodological rigor of the study.

Results

A total of 578 recording units were identified, grouped into 11 units of meaning. These were organized by affinity of ideas and contents, resulting in two central categories and two subcategories. Category 1 gathered 218 recording units distributed in two units of meaning. Category 2, including its two subcategories, gathered 360 recording units distributed in nine units of meaning. The analysis of the interview data resulted in the elaboration of two categories: (1) Methods to achieve the dream of pregnancy and factors that influence it; and (2) Specific prenatal care for lesbian women and their singularities. The latter was subdivided into two subcategories: (2.1) Professional unpreparedness for the care of lesbian women in prenatal care and (2.2) The relationship between the lesbian woman and the health professional.

Six women aged between 18, and 40 years participated in the study. Regarding self-declared race/color, three participants identified as white and three as Black. Heterogeneity was observed regarding education, ranging from incomplete elementary education to doctorate. Occupations included housewife, manicurist, animal scientist, petroleum engineer, environmental engineer, and advertising professional. Family income ranged between one and eight minimum wages, with four participants married and two in a stable union.

Regarding obstetric history, four participants were primigravida and two had previous pregnancies. Regarding the place of prenatal care, three underwent follow-up exclusively in the private network, two exclusively in the Unified Health System (SUS), and one used public and private services concomitantly. The follow-up was performed predominantly by physicians; two participants also received assistance from nurses, while one was accompanied exclusively by a nurse. The number of pre-natal consultations varied between five and ten.

Regarding the methods used to obtain pregnancy, two participants became pregnant through sexual intercourse, two resorted to artificial insemination, one underwent in vitro fertilization, and one used home insemination. Prenatal follow-ups occurred between 2016 and 2019.

Discussion

Methods Used to Achieve the Dream of Pregnancy and Influencing Factors

In this category, the methods used by lesbian women to achieve the desired pregnancy were explored. Different reproductive techniques were addressed, such as in vitro fertilization, sexual intercourse, artificial insemination, and home insemination, as well as the factors that influenced these choices, including financial issues, previous conceptions, and personal decisions.

For couples formed by lesbian women, the decision to constitute a family through motherhood initially involves the choice between adoption and gestation. When they opt for the gestational experience, the need arises to define the method by which pregnancy will be achieved, and they may resort to sexual intercourse, in vitro fertilization, artificial insemination, or home insemination[8].

Of the six women interviewed, two became pregnant through sexual intercourse, one through in vitro fertilization, two through artificial insemination, and one through home insemination. The participants who resorted to sexual intercourse or home insemination reported that the choice was motivated mainly by the low cost of these methods.

This scenario stems from the fact that Ordinance No. 426/GM, of March 22, 2005, which instituted, within the scope of SUS, the National Policy for Comprehensive Care in Assisted Human Reproduction, was elaborated with a focus on heterosexual couples with infertility of pathological cause, not contemplating social infertility, a condition that encompasses same-sex couples[14].

In 2015, the Federal Council of Medicine (CFM) published Resolution No. 2,121/2015, ensuring access to assisted reproduction techniques even in the absence of proven infertility and recognizing the possibility of shared gestation between couples of lesbian women[15]. However, this regulation does not guarantee the full gratuity of these procedures in SUS. Thus, many women still need to bear high costs related to exams, medications, and, in some cases, the acquisition of the semen sample, which makes access unfeasible for couples with lower purchasing power.

It is observed, therefore, that the financial condition directly influenced the choice of the method used to obtain pregnancy. In some cases, this limitation led the participants to resort to home insemination or sexual intercourse with men, even when this did not correspond to the desired method, configuring an experience reported as traversed by suffering and renunciation. These aspects can be observed in the reports of participants W1 and W4:

> *"I really wanted to have a child, but I didn't have money to do all those procedures. So, I decided to have sexual relations with a man [...]" (W1).*

> *"Until then I was going to do it at, I even went to visit one and get a quote. Then I saw a report on television about home insemination and started researching the subject on the internet, saw that the cost was almost nothing and decided to try" (W4).*

Home insemination can also expose the woman to a greater risk of sexually transmitted infections (STIs), with possible repercussions for maternal and fetal health. This risk stems from the absence of clinical, social, and laboratory screening of the donor, a procedure routinely performed in specialized assisted reproduction services[16].

On the other hand, artificial insemination and in vitro fertilization present high costs, restricting their access, in general, to women with better socioeconomic conditions. Despite the financial investment, the participants who resorted to these techniques highlighted as an advantage the possibility of performing the procedure without sexual contact with a man. Furthermore, they reported believing that procedures conducted by specialized professionals would present greater chances of success, as illustrated in the following testimony:

> *"Despite being expensive to do the procedure at the clinic, it is what works best, and we didn't want to risk it; we wanted it to work" (W6).*

The women who became pregnant through sexual intercourse or home insemination also reported concerns related to the legal security of the agreements established with the donors, especially regarding the possibility of future paternity claims. Given this concern, they sought to formalize agreements that would guarantee legal protection. However, due to the absence of legal backing and specialized guidance, these documents could not be registered in a notary's office nor recognized judicially, remaining only as verbal agreements, without legal validity.

> *"I even made a contract for me and the donor to sign, but later I discovered that judicially it serves no purpose" (W4).*

The participants who resorted to assisted reproduction clinics also reported experiences of lesbophobia by some professionals, motivated by the decision to constitute a family in a relationship between women. In some cases, the desire for motherhood made them endure situations of discrimination to continue the treatment.

> *"At the first clinic we went to, at the first consultation, where the doctor went and said exactly like this: 'If it were some years ago, I wouldn't even do your treatment; today, as it is required by law, I will do it.' He [doctor] wouldn't do it just because we are two women; he made that very clear when talking to us. But in that eagerness, we were in to have the child, and that, according to our research, he was the best in in vitro fertilization in Rio de Janeiro; he was the reference here in the state. Then we thought: 'he will do it obliged, but he will do it" (W5).*

Although the professional stated he was "obliged" to perform the procedure, CFM Resolution No. 2,168/2017 provides, in Part II – Patients of Assisted Reproduction Techniques, item 2, that the use of techniques is permitted in same-sex relationships and for single people, respecting the right to conscientious objection on the part of the physician[17]. Thus, from an ethical-normative point of view, if he chose not to perform the procedure, the professional could resort to conscientious objection, avoiding subjecting the patients to discriminatory attitudes during care.

Despite the challenges experienced, all interviewees were successful in pregnancy, materializing the motherhood project, regardless of the method used. The participants who resorted to sexual intercourse or home insemination reported that only one attempt was enough to achieve pregnancy.

> *"My friend and I had casual sexual intercourse only once, and it was enough for me to show up pregnant" (W3).*

> *"[...] it worked on the first try with home insemination. I didn't even imagine it would work on the first try" (W4).*

Although the participants attributed the success of the pregnancy to luck, it was observed that they previously adopted strategies to increase the chances of conception, such as calculating the fertile period and using the Billings method, based on the evaluation of cervical mucus, in order to identify the most favorable moment for performing the insemination.

The reports also evidenced that the belief that only procedures performed under medical intervention would result in reproductive success was not confirmed among the participants of this study. However, considering the small number of interviewees, further research with larger samples is recommended, capable of deepening the understanding of this phenomenon.

Also noteworthy is the importance of the nurse's role in this context, especially in providing information about the different methods of conception, in guidance regarding the prevention of sexually transmitted infections, and in referral for legal support, when necessary.

Prenatal Care for Lesbians and Their Singularities

The Professional's Unpreparedness for the Care of Lesbian Women in Prenatal Care

In this category, it was evidenced that many health professionals are still not adequately prepared to meet the specific needs of lesbian women during pregnancy. Possible factors related to this unpreparedness were also discussed.

Each woman presents singularities and specific needs, an aspect that becomes even more evident among lesbian women who, in addition to the demands inherent to women's health, have needs related to sexual orientation.

As part of the prenatal routine, it is recommended that, still in the first gestational trimester, an ultrasound be performed to determine with greater precision the gestational age, early identify multiple pregnancies and fetal malformations, in addition to evaluating the viability of the pregnancy. This exam can be performed abdominally or transvaginally, the latter being the preferred route in this gestational period[18].

Participants W2 and W6 were the ones who reported the greatest discomfort during the transvaginal ultrasound, attributed mainly to the introduction of the probe into the vaginal canal.

> *"Many lesbian women have the barrier of penetration during transvaginal ultrasound. That caused me enormous discomfort. Nobody wants to know about that, they just go and stick that*

thing in there, and that's it [...] I think the professional should have more sensitivity" (W2).

It was observed that the main reason for discomfort was related to the introduction of an object into the vaginal canal. Some lesbian women may present discomfort with procedures involving penetration because they associate this practice with the absence of interest in penetrative sexual activities[19].

The lack of guidance on the part of the professionals responsible for prenatal follow-up was pointed out by the participants as one of the main factors that intensified the discomfort during the exam. When previously informed about the procedure, the woman can prepare psychologically for its realization, reducing anxiety and making the experience less uncomfortable.

"I had to do that ultrasound that puts the device inside the vagina and the prenatal doctor didn't explain any of these procedures to me [...] if he [doctor] had explained to me, I would go to the exam prepared to face what was to come, it wouldn't be a surprise and certainly wouldn't have bothered me so much" (W6).

Prenatal consultations are still largely structured from a model aimed at heterosexual women. Consequently, many professionals concentrate their practice on knowledge and conduct directed at this public, failing to adequately contemplate the specificities of women who do not fit this standard.

Regarding sexual practices between lesbian women and guidance related to condom use, the participants reported unpreparedness of professionals to address these issues. According to the reports, the lack of knowledge on the theme can generate embarrassment and weaken the relationship between professional and user.

"They [professionals] should avoid being curious, asking too many questions [...] that constrains us! She [nurse] even asked me how our sexual relationship is. And that's annoying, having to explain how it is [...] and after I explained how we had sex, I felt that she [nurse] treated me differently from the other women" (W1).

The professionals' lack of knowledge about sexual practices between women, associated with the maintenance of a heteronormative approach, can contribute to the invisibilization of this population and compromise the quality of care provided. Therefore, important aspects of sexual health may fail to be addressed, including measures of prevention, diagnosis, and treatment of sexually transmitted infections (STIs)[20]. The insufficiency of information during prenatal care can also favor the emergence of doubts and beliefs without scientific backing. Some participants reported fear that sexual relations between women could cause spontaneous abortion.

"My partner and I were dying of fear of having sexual relations with penetration, because we know that between a heterosexual couple, sexual relations do not harm pregnancy, but we were afraid that, since our penetration is with the finger, it would end up causing some change in the cervix without wanting to. And the doctor didn't explain anything about this to us, and we also didn't feel comfortable asking because we thought he wouldn't understand us" (W6).

Although the causes of spontaneous abortion cannot always be identified, it is known that they are related to various factors, such as genetic and chromosomal alterations, uterine anomalies, endocrine disorders, chronic diseases, infections, immunological mechanisms, use of medications or drugs, maternal age, reproductive history, and emotional factors[21]. Sexual intercourse, regardless of whether it occurs by penile or manual penetration, is not recognized as a causal factor of spontaneous abortion.

Breastfeeding was the theme most frequently mentioned by the participants, being addressed by four of the six interviewees. The existence of two mothers in the family context makes it possible for both to participate in the breastfeeding process.

The technique mentioned by the participants was translactation, which consists of stimulating suction on the breast of the woman who did not gestate, promoting milk production through the neuroendocrine reflex triggered by suction[22,23].

"We had already researched that there was that possibility of stimulating both to breastfeed, but the doctor didn't go much into the subject and said she didn't know much about it and that she would research [...], but in the end she didn't touch the subject again, and neither did we" (W2).

"My partner and I really wanted to breastfeed our son. She [doctor] explained that if she [partner] wanted, there was a treatment and she [partner] could breastfeed too" (W4).

It was observed that the studies consulted on translactation and lactation induction do not specifically address the situation of couples of lesbian women who share motherhood. It is considered that, in these cases, the practice can be conducted through clinical evaluation and prior performance of exams for screening of infections transmissible through breast milk, such as HIV, HTLV-1, and HTLV-2[24]. It is emphasized that the medical professional was mentioned more frequently in the participants' reports because most of them underwent prenatal follow-up in the private network.

The Relationship Between the Lesbian Woman and the Health Professional

In this category, it was explored how the bond between the lesbian woman and the health professional can influence the quality of care during prenatal care. It was evidenced that prejudice, lack of empathy, and heteronormativity can compromise this relationship, directly affecting the care provided. One of the main factors influencing the quality of prenatal care is the relationship established between the health professional and the pregnant woman. In the care of heterosexual women, this bond tends to be built more easily, since the training of professionals has historically privileged care for the demands of the heterosexual population and, in general, does not face conflicts arising from social or religious beliefs related to sexual orientation.

During the interviews, several participants reported that both the care received and the relationship established with the professionals did not meet their expectations.

According to their reports, the unpreparedness of professionals to care for lesbian women caused their specific needs to be ignored or addressed inadequately and embarrassingly.

> *"The nurse didn't know how to attend me. When I said I was a lesbian, the first thing she said was 'huh, if you're a lesbian, how are you pregnant?', as if only heterosexual women could get pregnant [...]. She also kept asking me a lot about what a sexual relationship between two women is. She asked me to explain in detail; I found it unnecessary. They are totally unprepared for this!" (W1).*

> *"In prenatal care, they asked me once about the father even though I said I was a lesbian" (W3).*

> *"Professionals are unprepared to attend us, either they act as if we were heterosexual or they act as if we were something from another world" (W6).*

The testimonies evidenced the unpreparedness of part of the professionals to address sexual orientation during prenatal care, demonstrating surprise before the pregnancy of lesbian women. All participants reported having spontaneously revealed their sexual orientation, without this information having been previously investigated by the professionals. According to them, the consultations were initiated from heteronormative presuppositions.

> *"I had to tell her [doctor] right away so that in the consultation she wouldn't come with those questions for heterosexuals. She [doctor] said there was no problem at all, but even so she asked me the questions about my partner" (W4).*

> *"I remember that it was I who addressed my sexuality, but the doctor's reaction was not homophobic. In fact, she [doctor] didn't even mention the fact that I was a lesbian; it was as if that were not relevant to the pregnancy" (W5).*

The reports indicate that, when the woman informs her sexual orientation and presents her partner, many professionals demonstrate discomfort or difficulty in conducting the consultation. Consequently, the partner may be invisible during care or even face discriminatory situations. Some participants reported that their partners were excluded from prenatal follow-up, failing to be recognized as members of the gestational process. In certain cases, this exclusion assumed contours considered unethical by the interviewees.

> *"The nurse told my partner, when she was going to enter the office, that she [partner] should wait outside the room; she didn't want to let her participate. And every time she [nurse] spoke about her [partner] the nurse called her 'my case' instead of calling her by name" (W1).*

The exclusion of the partner during prenatal care can be understood as a manifestation of institutional lesbophobia, expressed through the denial of recognition of the family configuration of these women. This type of practice compromises the comprehensiveness of care and reinforces processes of discrimination in the context of health services[9]. However, some participants reported positive experiences regarding the inclusion of their partners in gestational follow-up. In these cases, the professionals welcomed both women and favored the active participation of the partner during the consultations.

> *"The doctor [doctor] called my partner by an affectionate nickname and always included her in the consultations and asked if she had any doubts about anything" (W2).*

> *"We scheduled a consultation with her [doctor], and she [doctor] was super receptive. When I introduced my partner, she [doctor] treated us very well and always asked things to her [partner] too" (W5).*

The presence of a companion during prenatal care is associated with greater satisfaction of the pregnant woman with the care received, in addition to strengthening the emotional support offered during this period. The fear of suffering discrimination was pointed out as one of the main reasons for choosing care in the private network. Many participants believed that the fact of directly remunerating the service would increase the chances of receiving respectful care[25].

> *"I never sought SUS because I always had health insurance and because of some stories of prejudice that I have heard around. I think that my prenatal consultation would not be as well accepted by the doctor as it is in my private one. Maybe because it is private, they [professionals] have differentiated treatment because you are paying, right?! (W4).*

Despite the reports of prejudice and discrimination, some participants evaluated the care received positively. According to them, although the professionals presented limitations regarding the specificities of care for lesbian women, it was possible to establish a relationship of trust during prenatal follow-up.

> *"My partner and I had a very good relationship with the nurse; I thought she [nurse] was a 10. After the delivery, she [nurse] came here to our house to see how we were […]. Her care was excellent" (W3).*

> *"I am totally satisfied with the doctor. I have nothing to complain about her; I have nothing to say about her conduct; her treatment was always 100%. I knew I could talk about anything with her and there would be no problem at all" (W4).*

When reflecting on strategies to qualify prenatal care for lesbian women, the participants highlighted respectful care and the training of professionals as the main elements for building comprehensive and discrimination-free care.

> *"I think it also needed better selection and professional training, because the person there is a professional who will attend to various types of people, and she should have an open mind for that, not treat badly. Especially because, if she doesn't like it, it's her problem that she can take into her own house, not in the work environment where she will attend to people. Not that a professional has to be my best friend, but I think they have to be prepared to attend to me as a lesbian woman and who has a partner" (W3).*

The provision of care to lesbian women requires that professionals recognize and reflect on possible prejudices, stereotypes, and gaps in their training related to sexual diversity. Overcoming these barriers favors the offer

of more welcoming, equitable care centered on the needs of users. In this sense, critical reflection on heteronormative practices constitutes a fundamental element for reducing discriminatory attitudes and promoting respect for diversity, contributing to the realization of the comprehensiveness of health care[9]. It is evidenced that the qualification of prenatal care for lesbian women goes beyond the acquisition of technical knowledge, also requiring the development of relational and communicative competencies that favor reception, the recognition of different family configurations, and the overcoming of heteronormative practices in health services.

Final Considerations

Prejudice and discriminatory attitudes on the part of health professionals have significant impacts on the reception of lesbian women during prenatal care. These situations compromise the establishment of the bond between users and professionals, negatively affecting the quality of care provided. Although no form of discrimination is justifiable, the results indicate that many professionals do not have the necessary qualifications to meet the specific demands of lesbian women. This unpreparedness refers mostly to the gaps existing in academic training, which still addresses insufficiently the health needs of the LGBT+ population. Most of the interviewees reported satisfaction with the prenatal care received. However, they also recognized the unpreparedness of professionals to adequately meet their specificities. The reports provide evidence that professional training, historically guided by heteronormative presuppositions, still contemplates in a limited way the demands related to the health of lesbian women. To qualify prenatal care for lesbian pregnant women, the participants highlighted two central aspects: respectful care and the training of professionals.

The recognition of sexual and gender diversity should constitute a guiding principle of care, associated with the development of technical and relational competencies that enable comprehensive, welcoming, and discrimination-free care. Despite the challenges identified, the results demonstrate that lesbian women continue to claim the recognition of their rights and access to health care based on equity. The strengthening of professional training, continuing health education, and the effective implementation of public policies aimed at the LGBT+ population constitutes a fundamental strategy for the promotion of more inclusive and qualified care. New studies on prenatal care for lesbian women are necessary, especially with larger and more diversified samples to deepen the understanding of this phenomenon.

As the main limitation of this study, the small number of participants (n=6) stands out. It is also emphasized that the political context in force during the data collection period influenced the development of the research. Although initially 11 women agreed to participate in the study, five requested the withdrawal of their consent due to fear and insecurity related to the political scenario of the time, which is why their testimonies were not included in the analysis.

This study contributes to broadening the understanding of the experiences of lesbian women during prenatal follow-up, evidencing challenges related to reception, communication, and the preparation of health professionals. It is hoped that its results will subsidize the training of professionals to be more sensitive to the specificities of this population and strengthen the implementation of care practices committed to the principles of comprehensiveness, equity, and non-discrimination in the Unified Health System.

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