Rev Rene. 2026;27:e96471.
DOI: 10.36517/2175-6783.20262796471
www.periodicos.ufc.br/rene

Original Article

Breastfeeding experience in lesbian couples

Experiência da amamentação em casais de mulheres lésbicas

How to cite this article:
Carmo ZDR, Paraíso AF, Fernandes LCR, Andrade e Silva E, Carvalho NA, Emidio SCD. Breastfeeding experience in lesbian couples. Rev Rene. 2026;27:e96471. DOI: https://doi.org/10.36517/2175-6783.20262796471

Zaira Dicarlo Ribeiro do Carmo[1]
Alanna Fernandes Paraíso[1]
Luciane Cristina Rodrigues Fernandes[2]
Erika Andrade e Silva[1]
Natália Ana de Carvalho[1]
Suellen Cristina Dias Emidio[1]

[1]Universidade Federal de Juiz de Fora. Juiz de Fora, MG, Brazil.
[2]Universidade Estadual de Campinas. Campinas, SP, Brazil.

Corresponding author:
Suellen Cristina Dias Emidio
Rua José Lourenço Kelmer - São Pedro.
CEP: 36036-900; Juiz de Fora, MG, Brazil.
E-mail: suellen.emidio@ufjf.br

Conflict of interest: the authors have declared that there is no conflict of interest.

EDITOR IN CHIEF: Ana Fatima Carvalho Fernandes
ASSOCIATE EDITOR: Francisca Diana da Silva Negreiros

ABSTRACT

Objective: to understand breastfeeding experiences in lesbian couples. **Methods:** qualitative study conducted with six couples who breastfed for at least one month. Data were produced through semi-structured interviews and submitted to content analysis. **Results:** three categories emerged: Invisibility in care and impacts on breastfeeding; Breastfeeding between mothers: between insecurities and the construction of care; and Barriers to support and the experience of breastfeeding between mothers. Gaps were identified in professional training related to knowledge about parenting in lesbian couples, the clinical management of induced lactation, and the use of inclusive care protocols. Co-breastfeeding was permeated by institutional, emotional, and work-related challenges, requiring physical preparation, use of protocols, and reorganization of routine. **Conclusion:** breastfeeding experiences in lesbian couples involve the shared construction of parenthood and are marked by challenges related to institutional invisibility, the absence of inclusive protocols, and gaps in health training. **Contributions to practice:** the study supports the qualification of care, guides the development of inclusive lactation protocols, and strengthens family-centered care.

Descriptors: Breast Feeding; Homosexuality, Female; Family Relations; Sexual and Gender Minorities.

RESUMO

Objetivo: compreender as experiências de amamentação em casais de mulheres lésbicas. **Métodos:** estudo qualitativo realizado com seis casais que amamentaram por pelo menos um mês. Os dados foram produzidos por entrevistas semiestruturadas e submetidos à análise de conteúdo. **Resultados:** emergiram três categorias: Invisibilidade no cuidado e impactos na amamentação; Amamentação entre mães: entre inseguranças e construção do cuidado; e Barreiras ao apoio e à vivência da amamentação entre mães. Evidenciaram-se lacunas na formação profissional relacionadas ao conhecimento sobre parentalidade em casais de mulheres lésbicas, ao manejo clínico da indução da lactação e à utilização de protocolos assistenciais inclusivos. A co-amamentação foi permeada por desafios institucionais, emocionais e laborais, demandando preparo físico, uso de protocolos e reorganização da rotina. **Conclusão:** as experiências de amamentação em casais de mulheres lésbicas envolvem a construção compartilhada da parentalidade e são atravessadas por desafios relacionados à invisibilidade institucional, à ausência de protocolos inclusivos e às lacunas na formação em saúde. **Contribuições para a prática:** o estudo subsidia a qualificação da assistência, orienta a construção de protocolos inclusivos de lactação e fortalece o cuidado centrado na família.

Descritores: Aleitamento Materno; Homossexualidade Feminina; Relações Familiares; Minorias Sexuais e de Gênero.

Received: Feb. 23rd 2026; Accepted: May 19th 2026.

Introduction

Breastfeeding, in addition to being a fundamental process for infant nutrition, constitutes a relational practice that fosters bonding, food security, and the child's physical, cognitive, and emotional development, while also bringing benefits to maternal health[1]. The World Health Organization and the Ministry of Health recommend exclusive breastfeeding during the first six months of life, with continuation until at least two years of age, combined with the gradual introduction of age-appropriate complementary foods[2-3]. In the Brazilian context, breastfeeding is widely recognized as one of the main strategies for promoting child health and reducing infant morbidity and mortality[4].

Despite the consolidation of public policies and clinical guidelines encouraging breastfeeding, their implementation is still largely based on heteronormative and cisgender family models, rendering different parental arrangements invisible and creating barriers to equitable care. In the case of lesbian women, breastfeeding experiences are crossed by issues related to recognition of dual motherhood, parental legitimacy, the definition of caregiving roles, and interaction with health services that are not always prepared to address their specific demands[5-6].

Couples of women have increasingly formed families and experienced pregnancy, childbirth, and lactation. In this context, breastfeeding goes beyond the biological aspect, becoming a practice for constructing parenthood and strengthening family bonds. In addition to lactation by the gestational mother, the non-gestational mother may breastfeed through induced lactation, a process involving frequent breast stimulation and, in some cases, the use of hormonal therapies and galactagogues[7-8]. Co-breastfeeding is also part of this context, understood as the sharing of breastfeeding between two mothers and constituting an experience of caregiving and shared parental bonding[9-10].

Studies indicate that the possibility of both mothers breastfeeding is related to the recognition of their parental identities by health services, access to information, and qualified professional support[7,9-10]. However, lesbian women frequently report institutional invisibility, delegitimization of their family bonds, and technical unpreparedness among professionals to deal with non-heterosexual family arrangements[11]. Lack of knowledge about induced lactation and co-breastfeeding favors exclusionary practices and limits families' autonomy in making decisions about breastfeeding[12].

Although health professionals play a central role in promoting and supporting breastfeeding, gaps in professional training persist[9-10], as do the absence of inclusive protocols and institutional, emotional, and work-related challenges associated with co-breastfeeding in lesbian couples[5-8]. In the Brazilian context, qualitative investigations on induced lactation, co-breastfeeding, and the construction of parental bonds in female couples remain scarce. Therefore, this study aimed to understand breastfeeding experiences in lesbian couples.

Methods

Type of study

This is a qualitative study[13], grounded in the understanding of lived experiences and the meanings attributed by participants to their practices and experiences. Qualitative research[14] was adopted as the theoretical-methodological framework, understanding experience as a social construction permeated by symbolic, cultural, and relational dimensions, accessible through participants' narratives.

The study was conducted in accordance with the recommendations of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ), in line with EQUATOR Network guidelines, in order to ensure methodological rigor and transparency in the description and interpretation of qualitative data.

Research team

The team consisted of three researchers: two

nurse researchers with doctoral degrees, research experience, and clinical specialization in breastfeeding, and one nursing student previously trained to conduct the interviews. One of the researchers had formal training in qualitative research and was responsible for analytical supervision.

Six lesbian couples who had breastfed individually or together for at least one month participated in the study. Recruitment was conducted through intentional and network-based strategies, resembling the "snowball" technique"[14-15], with support from breastfeeding consultants who identify as Lesbian, Gay, Bisexual, Transsexual/Transgender/Transvestite, Queer, Asexual, Pansexual, Non-Binary, and Intersex (LGBTQIAPN+) breastfeeding consultants, associations, researchers, and digital influencers. One participant, previously known to one of the authors, was intentionally included; this was the only in-person interview. The others were recruited via Instagram, through forms, private messages, hashtags, and "suggested profiles."

The inclusion of the previously known participant was problematized during analysis, and a reflexive stance and collective discussion were adopted to minimize bias. Sample sufficiency was defined by thematic recurrence and the absence of new elements in the final interviews. Couples in a stable union for at least two years, with biological or adopted children, who had experienced breastfeeding and had access to the internet and digital platforms were included.

Data collection

Data collection took place between April 2024 and February 2025 through semi-structured interviews conducted predominantly online, via Google Meet, telephone call, or WhatsApp, due to the geographic distribution of participants across different Brazilian states. Meetings were held in private locations chosen by the participants, ensuring comfort and confidentiality. Text-message and audio-message modalities via WhatsApp were also offered, taking into account care demands, work, and family routines.

Joint interviews sought to understand the relational dimension of co-parenting and shared breastfeeding, making it possible to access negotiations and collective constructions between the mothers. However, it is acknowledged that this format may have limited the expression of individual experiences and marital divergences. A previously prepared interview guide was followed, with guiding questions such as: How was your experience with breastfeeding? and How was the support from health professionals? With an average duration of 30 minutes, the interviews were audio-recorded with consent and fully transcribed.

To ensure anonymity, couples were identified by the letter "C" followed by the interview number (C1–C6). Within each couple, the gestational mother (GM) and non-gestational mother (NGM) were differentiated. There was no prior relationship between researchers and participants, except in the case of the intentionally included participant.

Data analysis

Data were submitted to thematic content analysis[16]. Initially, the transcripts were read repeatedly for familiarization with the corpus. Next, open manual coding of units of meaning was carried out, with the inductive construction of initial codes. Subsequently, the codes were grouped by similarity and thematic convergence, giving rise to interpretive categories that were continuously reviewed for internal coherence and representativeness of the meanings expressed by participants.

The analysis was conducted independently by two researchers, who later compared codes and categories in discussion meetings until analytical consensus was reached. Divergences were critically debated, strengthening the reliability of the process.

Researcher reflexivity was considered throughout the study, acknowledging that their trajectories in maternal-child health and breastfeeding could influence assumptions favorable to breastfeeding and family-centered care. Such assumptions were conti-

nuously problematized in pursuit of a critical analytical stance anchored in participants' narratives.

Ethical aspects

The study complied with Resolution No. 466/2012 of the Brazilian National Health Council, on research involving human beings, and was approved by the Research Ethics Committee of the Federal University of Juiz de Fora (Certificate of Presentation for Ethical Consideration No. 79206424.0.0000.5147; Opinion No. 6.946.963/2024). Participants provided informed consent through the Free and Informed Consent Form. Considering that this is a historically marginalized group, care related to relational ethics was adopted, with attention to symbolic protection and minimization of risks of indirect exposure, ensuring anonymity, confidentiality, and respectful conduct of the interviews.

The Grammarly® Artificial Intelligence tool was used exclusively for grammatical and spelling revision and to improve textual coherence, without interfering with the scientific content or authorship of the manuscript.

Results

Six lesbian couples were interviewed. In two cases, both mothers shared breastfeeding, whereas in the other four only the gestational mother breastfed. Regarding self-reported race, 11 women considered themselves White; among them, three were between 25 and 30 years old, four between 31 and 35, two between 36 and 40, and two were 40 years old or older. Regarding education, eight had higher education and a fixed income above one minimum wage. Four couples had one child each, resulting from singleton pregnancies, whereas two couples had two children each, from twin pregnancies. Among the gestational mothers (GM), one had a vaginal birth and five had cesarean births.

Qualitative analysis of the reports enabled the construction of three thematic categories related to the experience of family formation in couples with two mothers and to experiences in lactation management: Invisibility in care and impacts on breastfeeding; Breastfeeding between mothers: between insecurities and the construction of care; and Barriers to support and the experience of breastfeeding between mothers.

Invisibility in care and impacts on breastfeeding

In this category, couples described joint pregnancy planning as a shared process of discussions, agreements, and decision-making. This planning involved defining the type of birth, choosing the multiprofessional team, and including a doula, highlighting the search for care aligned with the couple's expectations and needs, as illustrated in the following report: *We... planned it... planned a home birth, with a team of three nurse-midwives and a doula, then there was the pediatrician, and we did the entire prenatal care only with a nurse-midwife and ultrasounds separately, but we even had more ultrasounds than necessary to make sure everything was okay* (C2 – GM).

During prenatal care, couples reported a lack of guidance on shared breastfeeding between the two mothers. The NGMs reported not feeling included in the gestational process and were often perceived merely as companions. The position assigned to the NGM in health services revealed a biological hierarchization of motherhood, in which parental recognition remains predominantly linked to the gestational experience. In this context, the NGM was often positioned as a companion rather than as a participant in the care process.

Another point highlighted was the lack of information about fertilization methods, the costs involved, and possibilities for family participation, which made access and decision-making about available services more difficult: *This doctor who saw us through our health insurance... knew it was a two-mother family, but at no point did he include me in anything... as if I didn't really exist in all the prenatal appointments I attended with her... So that was it, and learning that I could breastfeed, I think that came more from social media... through Instagram... following other mothers... some mothers in our personal circle that we already knew and who I think ended up telling us about it...* (C4 – NGM). *We hardly knew any stories of dual motherhood, so*

we were a couple of women who didn't know how to have a child without sperm... I think this is a major issue for many couples of women, right? Very little is said about the possible processes for forming a family, so we had to go after that information, understand a little about how it worked, understand what a clinic was like, the costs, and go there... (C5 – NGM).

The exclusion of the NGM from clinical interactions shows that recognition of parenthood remains anchored in biological gestation. By reporting that she felt "as if I didn't exist," the participant makes explicit the delegitimization of motherhood by health services still centered on heterocentric and biologically hierarchical models. In this context, assisted reproduction constituted a space for negotiating the body, motherhood, and parental belonging, involving decisions about eggs, embryo transfer, and which mother would carry the pregnancy, crossed by factors such as age, individual desire, and meanings attributed to motherhood: *In the insemination process, we did the insemination using my eggs and my partner was the one who carried the pregnancy; first we did the whole process, we... anyway, collected the eggs, froze them... and waited until we were more mature about the issue. Because actually, when I decided to freeze my eggs, it was because of my age, and then we did it and later my partner... when it was time to do the transfer, right, of the eggs, my partner really wanted to carry the pregnancy... and...I never wanted to be pregnant, I always wanted to be a mother, so for me being a mother was independent of pregnancy* (C6 – GM).

The reports indicate that access to parenthood was built through intense informational work carried out by the participants themselves, shifting responsibilities that should be institutionally assumed by health services into the private sphere. The need to seek information on social media, in personal contacts, and through other mothers' experiences shows that recognition of dual motherhood remains scarcely incorporated into care practices.

Breastfeeding between mothers: between insecurities and the construction of care

The narratives highlighted both mothers' desire to participate in breastfeeding as a practice of bonding and shared care. However, experiences were heterogeneous, ranging from the desire to strengthen parental bonding to insecurity, physiological limitations, overload, and less interest in lactation. Regardless of co-breastfeeding, feelings of fear, insecurity, and lack of preparedness emerged, related to the scarcity of specific guidance and the limited institutional support for shared parenthood, as illustrated in the following report: *What stayed with me was learning, the experience that with a next child I will definitely breastfeed...* (C4 – NGM). *Breastfeeding was something I was very afraid of, very afraid... I was really scared it would hurt a lot, because we always hear many stories, very difficult ones, I had already talked to many people who had difficult experiences... so I looked for a lot of information after I got pregnant and I didn't listen to anyone, because everyone has some crazy piece of advice... So I went looking for this information and I also looked for the SUS Human Milk Bank, which was very... it was essential for my breastfeeding, but I already started out terrified* (C6 – GM).

Although breastfeeding was often associated with the construction of the maternal bond, the reports also showed ambivalent feelings, simultaneously marked by desire, fear, pressure, and exhaustion in the face of the physical and emotional demands of the process.

In cases of shared breastfeeding, the mothers reported using induced lactation protocols, including medications, manual expression, and breast pumps: *But it was a laborious process, right, very challenging, with medication, taking medication every day, pumping every 3 hours even in the middle of the night, so I would wake up simply as if the babies already existed...* (C1 – NGM). *Since the induction process was a simple process, but with a very exhausting routine... I started taking this medication and started stimulating with the little pump... I think this also prepared me for what the routine would be like when the children were born...* (C5 – NGM).

Induced lactation went beyond the technical management of the body and milk production, becoming a strategy for recognizing non-gestational motherhood and constructing parental belonging. However, the process was marked by physical and emotional demands, involving pumping, medication use, bodily adaptations, and reorganization of daily life. In some

cases, co-breastfeeding was associated with fatigue, overload, and emotional challenges in shared care.

Barriers to support and the experience of breastfeeding between mothers

The reports highlighted family reorganization after birth, especially co-motherhood in the division of infant care. Parenthood was built through flexible arrangements in which both mothers' participation was not always associated with shared breastfeeding. Care division occurred heterogeneously: in some experiences, breastfeeding remained concentrated in the gestational mother, while the NGM assumed complementary functions, showing different negotiations about bonding and parental participation in daily care: *My partner ended up leaving work... so she left her job, today she works from home, and then she can stay with the girls* (C1 – GM). *When she was five and a half months old and I went back to work, the other mother was the one who stayed taking care of her... until she was one year old she took care of the child all day and started giving her breast like a pacifier* (C3 – GM).

The centrality of social media as a source of information highlights the fragility of the institutional support offered by health services. In this scenario, access to knowledge about induced lactation and dual motherhood occurred predominantly through informal circuits of exchange among women, shifting to digital networks educational and support functions traditionally assigned to health services: *Man, I think our source of information was very scarce, right... my safest source was social media, Facebook and Instagram... that's how we found the clinic, the doula, and the breastfeeding consultant* (C5 – NGM).

The denial of maternity leave to the NGM makes explicit that legal and institutional recognition of parenthood still remains strongly associated with biological gestation. This limitation had a direct impact on the possibilities for participation in care and on the experience of co-motherhood: *Because in my condition as a lesbian non-gestational mother, I did not have my right to maternity leave... and because of that I gave it up, not because of a matter of desire* (C6 – NGM).

The absence of legal recognition of maternity leave for the NGM highlights institutional limits to co-motherhood, conditioning shared parenthood on legal and labor recognition of both as legitimate mothers. These barriers reveal that breastfeeding in couples of women is crossed by processes of parental legitimization and invisibilization, since health services and social institutions still operate predominantly with models centered on biological motherhood.

Discussion

The findings reveal that institutional recognition of parenthood remains strongly anchored in biological gestation, limiting the legitimacy of co-motherhood in health services. Participants' experiences show that lesbian parenthood is continuously negotiated among desire, affective bond, social recognition, and institutional validation. In this context, the absence of welcoming care and specific guidance for couples of women reinforces heterocentric practices that render shared forms of care and motherhood invisible[10-12,17-20].

From this perspective, breastfeeding goes beyond nutritional and biological dimensions, becoming a practice of affirming parental belonging. For many participants, breastfeeding meant symbolically occupying the place of mother, becoming a strategy for legitimizing the motherhood of the non-gestational woman[5]. Thus, co-breastfeeding and induced lactation can be understood not only as practices of infant care, but also as ways of claiming parental recognition in contexts where maternal legitimacy remains associated with gestation and biology[9-10].

Pregnancy planning was marked by co-responsibility and negotiations about the body, motherhood, and parental belonging. Assisted reproduction proved central to enabling parenthood among the couples, although informational, financial, and institutional barriers that limit the equitable exercise of parenthood persist[20-24]. The findings also suggest that access to assisted reproduction, specialized counseling, and information on induced lactation was related to the par-

ticipants' socioeconomic conditions, revealing social inequalities that cross experiences of parenthood and breastfeeding among couples of women.

The exclusion of the mother who did not carry the pregnancy from clinical interactions highlights institutional difficulties in recognizing dual motherhood as a legitimate family configuration. The absence of guidance on shared breastfeeding and reproductive possibilities reinforces care that is still centered on biologizing models of motherhood, conditioning recognition of the mother who did not carry the pregnancy on institutional and social validation[17,20].

The reports indicate that breastfeeding takes on affective, identity-related, and relational dimensions[12]. However, experiences of co-breastfeeding were heterogeneous: while some women wished to share lactation to strengthen parental bonding, others reported physiological limitations, overload, insecurity, or less desire to participate directly in this process[21-22,25].

Induced lactation emerged as an experience that goes beyond the technical management of milk production, also becoming a practice of recognizing non-gestational motherhood[26-28]. As a parental bonding strategy, it involved pumping, medication use, bodily adaptations, and reorganization of daily life. The reports showed that the desire to breastfeed was related to the construction of parental belonging and shared care, although the process was also marked by physical strain, emotional overload, and everyday challenges[23-24].

Despite the existence of clinical protocols for induced lactation, access to information and specialized follow-up is still limited and often dependent on women's individual initiative. The findings suggest that the viability of co-breastfeeding depends not only on physiological aspects, but also on the institutional recognition of the mother who did not carry the pregnancy as a legitimate potential lactating mother[1,5-6,25-27].

Some participants reported feelings of distance from the parental role and regret for not having participated directly in breastfeeding, especially when they later realized that possibilities for induced lactation previously unknown to them had existed. In this context, the absence of professional support and qualified information directly interferes with the possibilities for participation of the mother who did not carry the pregnancy in care and in the experience of shared parenthood[9].

The reports also showed that shared breastfeeding requires a high level of emotional commitment, time availability, and reorganization of family routine. Many participants reported overload associated with the demands of frequent pumping, continuous infant care, and difficulties reconciling motherhood, work, and personal life. The absence of labor rights, such as maternity leave for the mother who did not carry the pregnancy, directly impacted the feasibility of co-breastfeeding and limited both mothers' possibilities for participation in daily care[21-22,26-27].

The predominance of White women with higher levels of education in the sample shows that access to reproductive technologies, specialized counseling, and qualified information is crossed by structural inequalities of race and class. Although the study was not specifically designed from an intersectional approach, the findings suggest that social markers such as race, class, and education influence possibilities of access to care, professional support, and institutional recognition. In this sense, experiences of parenthood and breastfeeding among couples of women proved heterogeneous and modulated by different social and economic conditions[28].

Dependence on social and informal networks as the main source of information and support shows that access to co-breastfeeding and induced lactation still occurs in a weakly institutionalized manner. This dynamic reveals that recognition of lesbian motherhood, including in the field of breastfeeding, often remains sustained by individual initiatives and informal exchange circuits rather than by consolidated care guidelines. Thus, it becomes necessary to expand professional training, develop inclusive protocols, and strengthen public policies that recognize different family configurations and ensure equitable care for families formed by two mothers[17,28-29].

Although the National LGBT Comprehensive

Health Policy recommends the development of specific protocols for lesbians and travestis, its implementation remains incipient[29]. In this scenario, induced lactation and co-breastfeeding are configured not only as practices of infant care, but also as strategies for affirming lesbian motherhood. Expanding access to information, technical support, and institutional recognition is a fundamental step so that shared breastfeeding ceases to occupy a marginal position and comes to be recognized as a legitimate possibility in maternal and child care.

Study limitations

Among the study limitations are predominantly digital recruitment, which may have favored participants with greater access to information and support networks, and the sample composition, mostly made up of White women with higher education and access to reproductive technologies. Joint interviews and different data collection formats may have influenced the depth and autonomy of the statements. In addition, limited regional diversity and the reduced number of participants restrict the transferability of the findings.

Contributions to practice

The study gave visibility to breastfeeding experiences in lesbian couples, which are still little explored in the literature, highlighting implications for health practice, especially in nursing. The findings point to the need to include content on sexual diversity, co-motherhood, and lactation management in different family configurations in the education and continuing professional development of health professionals, in addition to the development of more inclusive care guidelines and protocols on induced lactation and co-breastfeeding. Thus, the importance of family-centered care, guided by equity and recognition of parental diversity in health services, is reinforced.

Conclusion

This study made it possible to understand that breastfeeding experiences in lesbian couples are constructed in a shared manner, involving negotiations about pregnancy, care, and participation in breastfeeding. Breastfeeding was experienced not only as a practice of feeding the baby, but also as a relational experience linked to the construction of co-motherhood, the strengthening of bonds, and the recognition of non-gestational motherhood, especially in cases of induced lactation and co-breastfeeding.

The narratives also highlighted insecurities, overload, and institutional barriers related to the scarcity of information, the absence of specific guidance, and the limited recognition of parenthood in couples with two mothers within health services. The findings indicate that breastfeeding experiences in this context are crossed by affective, social, and institutional dimensions that influence the way care and parenthood are experienced.

Author contributions

Conception and design or analysis and interpretation of data: **Carmo ZDR**, **Carvalho NA, Emidio SCD**. Manuscript writing or relevant critical review of the intellectual content; final approval of the version to be published; agreement to be accountable for all aspects of the manuscript related to the accuracy or integrity of any part being appropriately investigated and resolved: **Carmo ZDR**, **Paraíso AF, Fernandes LCR, Andrade e Silva E, Carvalho NA, Emidio SCD**.

Data availability

The authors report that the data supporting the findings of this study are available from the corresponding author upon request, provided that a justification is included and ethical aspects and participant confidentiality are respected.

References

1. Fernandes LCR, Sanfelice CFO, Carmona EV. Lactation induction in women who never got pregnant: Experience report. Esc Anna Nery. 2022;26:e20210056. doi: https://dx.doi.org/10.34019/1982-1247.2022.v16.30075
2. Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Guia alimentar para crianças brasileiras menores de 2 anos – versão resumida [Internet]. 2021 [cited Feb 4, 2026]. Available from: http://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/g/guia-alimentar-para-criancas-brasileiras-menores-de-2-anos
3. World Health Organization (WHO). Infant and young child feeding: key facts [Internet]. 2023 [cited Feb 4, 2026]. Available from: https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding
4. Machado MED, Christoffel MM, Velarde LGC, Linares AM, Silveira ALD, Gomes ALM, et al. Prática dos profissionais da saúde em aleitamento materno e fatores associados: estudo transversal. Online Braz J Nurs. 2023;22:e20236646. doi: https://doi.org/10.17665/1676-4285.20236646
5. Schnell A. Successful co-lactation by a queer couple: a case study. J Hum Lact. 2022;38(4):644-50. doi: https://doi.org/10.1177/08903344221108733
6. Tordoff DM, Lunn MR, Ariel D, Crowe S, Lubensky ME, Flentje A, et al. Breastfeeding and chestfeeding experiences of cisgender sexual minority women, transgender, and gender diverse parents. J Hum Lact. 2025;42(1):82-93. doi: https://dx.doi.org/10.1177/08903344251391163
7. Marandi SA, Zanjani NE, Ravari M, Mazloom M, Khanlou ZM, Kasaeian A. Induced lactation in non-gestational mothers in Iran: outcomes and predictors of breastfeeding success. Arch Iran Med. 2025;28(3):135-9. doi: http://doi.org/10.34172/aim.33516
8. Gargiulo-Welch S, Parker G, Miller S. The lactation and chestfeeding/breastfeeding information, care and support needs of trans and non-binary parents: an integrative literature review. N Z Coll Midwives J. 2023;59:47-55. doi: https://doi.org/10.12784/nzcomjnl59.2023.6.47-55
9. Jenkins V, Everett B, Steadman M, Mollborn S. Breastfeeding initiation and continuation among sexual minority women. Matern Child Health J. 2021;25(11):1757-65. doi: https://dx.doi.org/10.1007/s10995-021-03218-z
10. Juntreal NA, Spatz DL. Breastfeeding experiences of same-sex mothers. Birth. 2020;47(1):21-8. doi: https://doi.org/10.1111/birt.12470
11. Jenkins V, Everett BG, Steadman M, Mollborn S. Breastfeeding initiation and continuation among sexual minority women. Matern Child Health J. 2021;25(11):1757-65. doi: https://dx.doi.org/10.1007/s10995-021-03218-z
12. Bolissian AM, Ferreira BEC. Aleitamento humano e a perspectiva da interseccionalidade queer: contribuições para a prática inclusiva. Interface (Botucatu). 2023;27:e22044. doi: https://dx.doi.org/10.1590/interface.220440
13. Gil AC. Como elaborar projetos de pesquisa. São Paulo: Atlas; 2002.
14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec; 2014.
15. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temáticas. 2014;22(44):203-20. doi: https://dx.doi.org/10.20396/tematicas.v22i44.10977
16. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2016.
17. Fernández DL. Maternidad lesbiana: otra cara del cambio social. Áreas Rev Int Cienc Soc. 2021;42:65-9. doi: https://doi.org/10.6018/areas.468791
18. Geerts A. Making a family: kinning and conception in lesbian families. J Homosex. 2025;73:327-48. doi: http://dx.doi.org/10.1080/00918369.2025.2469579
19. Soled KRS, Hoatson T, Monseur B, Everett B, Chakraborty P, Reynolds CA, et al. Differences in medically assisted reproduction use by sexual identity and partnership: a prospective cohort of cisgender women. Hum Reprod. 2024;39(6):1323-35.doi:http://doi.org/10.1093/humrep/deae077
20. Gomes R, Toma TS, Silva JDL, Domene FM, Silva A. Homoparenting as a public health issue: a scoping review. Rev Saude Publica. 2023;57:80. doi: http://doi.org/10.11606/s1518-8787.2023057005447

21. Brandão P, Ceschin N, Gómez VH. The pathway of female couples in a fertility clinic. Rev Bras Ginecol Obstet. 2022;44(7):660-6. doi: https://doi.org/10.1055/s-0042-1744444

22. Ril SY, Oliveira Junior JB, Cunha e Mello MM, Portes VM, Moretti-Pires RO. "You only have one mother!": institutional violence in experiences of double motherhood in healthcare. Ciênc Saúde Coletiva. 2024;29:e19802023. doi: https://doi.org/10.1590/1413-81232024294.19802023EN

23. Conselho Federal de Medicina (CFM). Resolução CFM nº 2.013, de 15 de maio de 2013- Adota as normas éticas para a utilização das técnicas de reprodução assistida, anexas à presente resolução, como dispositivo deontológico a ser seguido pelos médicos e revoga a Resolução CFM nº 1.957/10 [Internet]. 2013 [cited Feb 4, 2026]. Available from: https://portal.cfm.org.br/images/PDF/resolu%C3%A7%C3%A3ocfm2013.pdf

24. Conselho Federal de Medicina (CFM). Resolução CFM nº 2.168, de 9 de novembro de 2017- Adota as normas éticas para a utilização das técnicas de reprodução assistida [Internet]. 2017 [cited Feb 4, 2026]. Available from: https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2017/2168

25. Santos MA, Minari AB, Oliveira-Cardoso EA. Lesbian and bisexual couples experiencing dual motherhood: (dis)encounters in the provision of healthcare. Ciênc Saúde Coletiva. 2024; 29:e19732023. doi: https://dx.doi.org/10.1590/1413-81232024294.19732023EN

26. Cazorla-Ortiz G, Obregón-Guitérrez N, Rozas-Garcia MR, Goberna-Tricas J. Methods and success factors of induced lactation: a scoping review. J Hum Lact. 2020;36(4):739-49. doi: https://doi.org/10.1177/0890334420950321

27. Szymoniak K, Szczurowska A, Zimny M, Sipak-Szmigiel O, Cwiek D. Non-heteronormative women's views on motherhood. Pomeranian J Life Sci. 2025;71:69-75. doi: http://dx.doi.org/10.21164/pomjlifesci.1080

28. Goldberg A. LGBTQ-parent families: diversity, intersectionality, and social context. Curr Opin. Psychol. 2022;49:101517. doi: https://dx.doi.org/doi:10.1016/j.copsyc.2022.101517

29. Ministério da Saúde (BR). Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais [Internet]. 2013 [cited Feb 4, 2026]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2836_01_12_2011.html