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"You only have one mother!": institutional violence in experiences of double motherhood in healthcare

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Abstract *The objective was to understand experiences of double motherhood during antenatal, childbirth and postpartum healthcare, using a qualitative method involving individual online interviews and asynchronous, online focus groups of cisgender women, mostly in same-sex relationships. The results revealed how these women's experiences of parenting were marginalised, highlighting institutional violence in Brazilian healthcare services, which are presented here in two thematic dimensions: 1) Cisheteronormativity and its impact on experiences of double motherhood; and 2) Institutional violence in healthcare services: from curiosity to LGBTQIA+phobia. It was concluded that cisheteronormativity hinders healthcare for these experiences, especially by rendering the non-gestational mother invisible. This underscores the urgent need to train healthcare personnel, rethink and challenge cisgender and heterosexual norms and promote inclusive policies to ensure equitable care and combat institutional violence.*

Key words *Sexual and Gender Minorities, Gender norms, Kinship, Sexual and reproductive health, Healthcare policy*

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Introduction

Despite laws guaranteeing universal access to Brazil's Unified Health System (*Sistema Único de Saúde*, SUS)[1,2,] discrimination against certain population groups precludes equal access to health. Minority groups, such as the LGBTQIA+ population, that challenge traditional norms of gender and sexuality, encounter barriers including stigma and prejudice, leading to dropout from health services and unequal access[3-5].

Over the years, the LGBTQIA+ movement in Brazil has won rights through public policies, notably the Brazil Without Homophobia Programme, in 2004, designed to combat violence and discrimination[3], the National Women's Health Policy, in 2004, which recognised the specific needs of lesbian women[6] and, in 2011, the National Comprehensive LGBT Health Policy, directed to combating discrimination and violence and guaranteeing equal access to health in the SUS[7].

Non-traditional parenting faces numerous challenges in Brazil and internationally, oscillating constantly between gaining and losing rights. Bill 580/2007 was tabled by Clodovil Hernandes to modify Law No. 10,406/2002, regulating civil marriage in Brazil, to include same-sex civil unions. In August 2023, however, conservatives opposed the bill on the basis of an interpretation of Article 226 of the Constitution, which stipulates that "conjugal society" occurs between a man and a woman. At the same time, conservatives in Brazil's National Congress[8] supported Bill No. 5,167/2009 seeking to prevent same-sex relationships from being equated with marriage or the family unit. Another eight other bills relating to same-sex unions are under discussion[9].

Drawing on a narrative developed by far-right and neoconservative governments in defence of "traditional families", people who do not identify with heteronormativity and the legitimisation of LGBTQIA+phobia are now being criminalised worldwide. In 2023, under the ultra-conservative government of Giorgia Meloni in Italy, the names of non-biological mothers began to be removed from the birth certificates of children conceived by artificial insemination abroad, leaving only the names of biological mothers on the documents[10].

In the United States, 16 state laws against the LGBTQIA+ population were approved in 2022 and, in February 2023, in the state of Tennessee, drag queens were banned from participating in public events involving children. In Florida, the government banned schools from discussing topics relating to gender identity and sexual orientation[11].

Despite strong criticism from international organisations and governments, in May 2023, Uganda sanctioned a law that establishes a 20-year prison sentence for "allowing" homosexuality and the death penalty for certain acts by people of the same sex. Known as "The Anti-homosexuality act, 2023", this law is among the most severe in the world in legal setbacks to the gains of LGBTQIA+ people[12].

These events, which highlight the significant role of cisheteronormativity in the political sphere, constitute obstacles to the rights of LGBTQIA+ people, especially in health. Cisheteronormativity is understood here as a set of political and social norms that impose standards of cisgenderness and heterosexuality, thus creating barriers to accessing health[5].

Cisheteronormativity excludes those who do not conform with its standards of gender and sexuality and is thus at odds with the principles of universality and comprehensiveness key to the SUS[13]. This article discusses institutional violence in health services, as expressed by norms and procedures that support the status quo. This institutionalised violence is characterised by neglect of individual needs, imposition of unfair restrictions and often disregard for, or prejudice to, individual rights and experiences[14].

Experiences of parenthood among lesbian and bisexual cis women in same-sex relationships, self-described as "double motherhood" on Brazil's social media, are affected by a number of barriers raised by cisheteronormativity. "Double motherhood" is the shared experience of maternal and parental functions by two women, who decide to parent jointly, whether by adoption, assisted reproduction technology (ART) or when both have children from previous heterosexual relationships. In the legal context, the term reflects the right of both mothers to be included on the child's birth record. This recognition results from legal proceedings by couples which guaranteed this right and set precedents for other couples[15].

In Brazil, when one or both women in double motherhood have children from previous heterosexual relationships, legal recognition for the right of both to be included on the birth record is not automatic. This legal complexity poses an added barrier for same-sex couples and legal action is often requited to make double motherhood official. This challenge underlines the need for legal reforms and greater recognition of dif-

ferent forms of parenting, in line with contemporary realities.

In this regard, this study sought to understand experiences of double motherhood during antenatal, childbirth and postpartum health care. The article offers a contribution to collective health thinking about institutional violence in health services, by presenting master's degree research data on the parenting experiences of lesbian and bisexual cisgender women in the process of pregnancy and postpartum.

Methods

The research field of this qualitative study was online from the outset, as this facilitated access for the women participating. Participants were recruited using the hashtag #duplamaternidade (#doublemotherhood) on Instagram, so as to identify lesbian and/or bisexual couples. Instagram is known to use hashtags to draw attention and the hashtag #duplamaternidade was being widely used in Brazil by bisexual and lesbian women to share experiences of motherhood with another woman. Accordingly, mothers who used that hashtag were invited into the study.

Data were collected asynchronously from July 2019 to March 2020 from nine geographically and socio-demographically diverse women. The number of participants was determined by theoretical saturation, as described by Fontanella *et al.*[16]. This method halts inclusion of new participants when there is significant repetition of information and additional data does not provide substantially different insights, indicating theoretical saturation. This criterion ensures appropriate representation and depth in the analysis of participants' experiences and perspectives.

Data were collected using WhatsApp, so as to accommodate participants' parental and professional responsibilities and make participation more accessible. During the COVID-19 pandemic, women were overwhelmed by remote schooling activities, making data asynchronous collection necessary. The choice of this method was influenced by the impossibility of carrying out the first interview synchronously due to connection problems and interruptions. The asynchronous method proved effective and enabled participants to contribute at convenient times, in the absence of the mediator.

In this way, data were obtained on two occasions: 1) individual open interviews, online and asynchronous; and 2) asynchronous online focus group. The interviews were started off by a trigger question to all participants: "Comment on your trajectory as a lesbian/bisexual woman in the process of your pregnancy and childbirth". The answers consisted of the participants' lived experiences, while the other questions, formulated in accordance with the themes they brought up, covered areas such as "family", "health", "work" and "education".

Most interviewees responded hours or even days later, often apologising for the delay and mentioning time constraints due to the demands of parental and professional activities.

To complement the interviews, an online focus group was held among the participants to explore topics not addressed individually. The second stage of data collection, in May 2020, consisted of a WhatsApp focus group, which was asynchronous, because lack of availability resulting from the demands of motherhood made synchronous meetings unworkable. Only six interviewees agreed to participate, although all were invited; three replied that they were unavailable.

The asynchronous online focus group addressed two key questions: "Comment on double motherhood" and "In your perception, does society grant privileges to women who are pregnant as compared with those who are not?". These questions allowed for spontaneous sharing of information, including images, emoji reactions and messaging interactions.

The choice of the asynchronous method for this group, which affords flexibility and surmounts logistic challenges, reflects a current trend in research. The same format was adopted not only in our research, but also in other investigations, including online focus groups, with the same target public[17,18]. All data generated, including audios and text messages, were recorded and transcribed in full, so as to ensure comprehensive analysis of these interactions.

The data collection approach chosen is unprecedented, in that it was developed to suit the participants' parental and professional needs and responsibilities, given that they are part of a group whose care for their children places constraints on the time they have available to participate in studies. Given these characteristics, this group is difficult to reach with traditional research methods, which often require interlocutors to travel or, in online studies, to participate synchronously.

The transcribed data were treated by thematic content analysis to identify indicators from which to infer how the data were produced and

collected[19]. Thematic content analysis comprised three distinct phases, as outlined by Minayo[19]. In the first stage, content was selected, the initial study objectives and hypotheses were reviewed and indicators were formulated to guide interpretation of the data. The second stage involved exploring the material, for the team to identify categories consisting of meaningful words or expressions. The third phase consisted in treating and interpreting the results.

The project was approved by the human research ethics committee (Opinion No. 3.853.350) administered by Brazil's National Ethics Committee. All participants signed a declaration of free and informed consent. So as to protect the identities of the interlocutors, names that appear in the excerpts have been changed to fictitious names.

Results and discussion

Nine cisgender women, three of them self-declared bisexuals and six lesbians, participated in this study. Eight of the participants were in same-sex relationships at the time. Participant sociodemographic characteristics are shown in Chart 1.

Analysis of the results identified two thematic areas: 1) cisheteronormativity and its impact on experiences of double motherhood; and 2) institutional violence in health services: from curiosity to LGBTQIA+phobia.

Cisheteronormativity and its impact on double motherhood experiences

Cisheteronormativity regulates experiences of double motherhood in both public and private health services, resulting in situations of exclusion and violence. Although double motherhood is recognised in law in Brazil, women who share motherhood face numerous challenges in parenting. Research participants reported situations where their having constituted a family was erased by relatives, health personnel and public policies, stressing that the main obstacle is the invisibility of the mother who did not gestate, on the premise that "you only have one mother":

Society sees those who give birth to be mothers, because even in these margarine advertisements [reference to a famous Brazilian advertisement that features a happy heteronormative family enjoying breakfast together], as they say, they say, right, you only have one mother. Who got pregnant? Who carried it? Who breastfed? I think we still have a long way to go in this militancy to reach the point where both mothers are recognised as equals in raising the child. It really is activism, it's a movement that needs to have strength, that needs to continue for mothers to have equal rights and be equally recognised by society (Online Focus Group).

The premise that "you only have one mother" reflects a hierarchisation of motherhood, according to which the most appropriate figure to exercise motherhood is a married heterosexual mother. In that context, lesbian mothers are regarded as less suitable for motherhood, less even than single mothers and teenage mothers, who are also hierarchically lessened in relation to married women in a heterosexual relationship[20]. As for lesbian motherhood, this hierarchy serves to erase such mothers, as underscored by the results of this study. That erasure is explained by the stigma and prejudice that lesbian women suffer, as highlighted in 2021 by a literature review that found LGB families of lesbian or bisexual mothers receiving less social support from motherhood-related support networks, even from members of their own families[21].

Double motherhood destabilises the device, which in society – as pointed out by Foucault[22] – regulates sexuality on the basis of traditional norms. It transcends the binary relationships of female and male gender, mother and father and, even more comprehensively, poses searching questions of the process of constructing bodies, gender identities and desires, upsetting a world traditionally structured in binary and gendered terms. The place of lesbian or bisexual women and mothers is effaced in this way by a hierarchy that confers legitimacy on mothers. Only heterosexual women are recognised to be legitimate mothers, perpetuating a model that achieves a universal understanding of what it is to be a mother, which is shared socially and also present in health services, as observed in this study.

The universal conception of women and of cisheteronormativity can be seen in the instruments for systematic monitoring of pregnant women and children in the Family Health Strategy, including the "Pregnant Woman's Handbook", "Child Health Handbook" and even in the "SUS National Card", as revealed by the interviewees:

The difficulty is the issue of the pregnant woman's card, which does not have the option "Parents", but "Mother" and "Father". Like other issues, it is different from birth records: birth records offer "Parent", in our names, but for the pregnant women, it doesn't. We've even talked about… how do

Chart 1. Sociodemographic characteristics and reproduction methods used.

Women Mothers (1)	Participated in the Focus Group	Age	Colour (2)	Sexual orientation	Place of residence	Education	Income	Reproduction Method (3)
M01	No	49	White	Lesbian	São Paulo-SP	Technical	6 minimum wages	HR*
M02	Yes	38	White	Bisexual	Florianópolis-SC	Postgraduate	10 minimum wages	HI**
M03	No	23	White	Lesbian	São Paulo-SP	Upper secondary	2 minimum wages	IVF***
M04	No	21	Brown	Bisexual	Picos-PI	Upper secondary	3-7 minimum wages	AI****
M05	Yes	37	White	Lesbian	Rio das Ostras-RJ	Undergraduate	Not informed	AI
M06	Yes	29	White	Lesbian	Campo Grande-RJ	Undergraduate student	5 minimum wages	AI
M07	Yes	31	Yellow	Lesbian	Brasília-DF	Undergraduate	6 minimum wages	AI
M08	Yes	26	Brown	Lesbian	Goiânia-GO	Undergraduate student	2-3 minimum wages	HI
M09	Yes	35	White	Bisexual	Paris region, France	Postgraduate	4-5 French minimum wages	IVF

Note: (1) study participants are represented by letter M and from 01 to 09; (2) self-declared skin colour, by criteria of Brazil's official bureau of statistics (Instituto Brasileiro de Geografia e Estatística, IBGE); (3) method of reproduction used to achieve pregnancy. *Consensual heterosexual relationship for the purpose of pregnancy only; **Home insemination; ***In vitro fertilisation; ****Artificial insemination or intrauterine insemination.

Source: Authors, based on study results.

you say…, denouncing this part, right? (Interview 4).

The hospital card came, our daughter's vaccination card also doesn't have the option of two mothers, it has "Mother" and "Father". The right thing would be "Parent". "Parent 1", "Parent 2" or something like that, but the vaccination card comes with "Mother" and "Father". Things that we want to change from now on. The hope is that they will change (Interview 6).

[...] Then we went to get the SUS card, it was a performance. There was no way to get a SUS card with the names of two mothers, because it said "Father" and "Mother". We said, so, in the place for "Father", put Janaína, and they said, I can't. I said, so, in the place for "Mother", first put Janaína and then Patrícia. I can't. Then they called one in, called two in, called 10 in and, in the end we left there with Luís. I don't know exactly how it is in the system, if the name is in the place for "Father" or if both are in the place for "Mother", but we're both there (Interview 2).

The implications of cisheteronormative communication lead to instances of violence by raising barriers to the these women's exercising their citizenship to the full. Moreover, subjection to the rules and codes laid down by health personnel exposes the reproduction of unfair, formal and informal social structures, that violate identities that fail to align with the normative model.

The participants also raised the topic of home insemination (HI) as a common practice for reproduction among non-heterosexual women. In Portuguese, Home Insemination (HI) is referred to as *Inseminação Caseira* (IC), and it's crucial to note that while IC may not carry the same legal implications in Brazil, we have chosen to use HI to enhance comprehension within the English context. Importantly, it should be noted that Home Insemination (HI) is not legal in Brazil.

I have always researched methods, because it was always my dream and so on and I had already looked into HI once, what the procedure was like and so on, but I left it alone, right? And when we

decided, I always knew that I would have Debora by HI. Because it's very difficult for poor people to do IVF, you know? It's very expensive, it's unrealistic for us, right? (Interview 8).

In addition to ART, women are turning to HI as an autonomous approach to achieving pregnancy, without the need for healthcare services. HI involves collecting donor sperm and introducing it close to the prospective pregnant woman's cervix. Instruments such as speculums, catheters and syringes can be used to optimise the technique by protecting sperm from exposure to light[23]. HI is popular in Brazil, because it is affordable, and two participants in this survey chose to use it:

We tried twice at an IVF clinic and Luis was made in a single attempt at Home Insemination with a donor from Vitória. We already had a trip arranged for another reason and we had access to this donor, who already had a lot of positive results and we booked him! And so there was a little pot, a syringe and my partner injected it. We broke up laughing, because it was impossible it would work. We'd spent a lot on clinics and, 15 days later, there was Luís (Online Focus Group).

Note that, for years, Assisted Reproductive Technology (ART) has made conception possible without the need for sexual intercourse. Initially developed to treat infertility in heterosexual couples, ART has been used by lesbian and bisexual women for some time now[24,25]. However, its use was only "regulated" in 2010, by Federal Medical Council Resolution No. 1,957[26], a resolution considered innovative, because it made single people and same-sex couples eligible for ART[27]. Note also that there is still no specific legislation regulating the performance of reproductive techniques in Brazilian territory, even though bills on the issue have been before Congress for years. As a result, it can be seen that public health policies exclude lesbian and bisexual mothers, whose needs are not met when they seek health services. This translates into limited effectiveness and the persistence of deep-rooted stereotypes that many health personnel maintain and perpetuate, without any proper review[28].

However, HI is examined as a technological device, after reading Foucault[22], Paul Preciado[29] and Donna Haraway[30], the practice constitutes a subversion of the norms imposed by the device of cisheteronormativity. That conclusion follows because, by producing repetition-based discourse, the device allows subversions of such discourse and, consequently, of norms, enabling new discourses to emerge. In this context, double motherhood emerges as a discourse in the device of sexuality present on social networks and in the legal sphere.

Institutional violence in health services: from curiosity to LGBTQIA+phobia

Institutional violence was identified in the situations experienced in health services by women mothers and expressed as institutional norms, discourses and conduct. Accordingly, this category identifies health service norms, discourses and practices responsible for "effacements" and "de-legitimisation" based on reified models and frozen identities, such as man and woman, male and female, father and mother[31].

What was said in the interviews and the focus group demonstrated situations in which the participants observed odd looks and comments from health personnel regarding their parenting setups, which constituted episodes of violence, as in the following excerpt: "*They were perplexed, but they didn't say anything. 'This here is my girlfriend. I'm pregnant!' [...] They looked like having little difficulty understanding*" (Interview 1). In other situations, perplexity was expressed openly through comments:

I went alone to all my antenatal appointments in the SUS, because my wife worked and when she happened to go, there was always that question: "What are you? Are you a sister? Are you an aunt?" and "No, she's the baby's mother, too". "How's that?". Sometimes it was a moment when we didn't want to talk about it, right? We were excited about the appointment, about the ultrasound, and didn't want to talk about it, but I ended up having to explain the situation (Interview 3).

That experience reveals barriers that keep these women from health care, because their experiences are marred by prejudice, negligence and institutional violence, sometimes resulting from inappropriate conduct on the part of health personnel[32].

Failure to recognise non-pregnant mothers as mothers, as well as their exclusion from antenatal exams and appointments, highlights the urgency of incorporating the new family configurations as a key theme in professional training[33]. We know that exclusion of lesbian or bisexual mothers is not specific to this research, because similar reports exist in the international context. One study showed that, in Australia, lesbian women raise issues similar to those observed here. The former study, of 20 families of lesbian women, showed that they awee more likely to postpone

healthcare for fear of suffering some kind of prejudice[32].

Cisheteronormative assumptions about patients in health services contribute to lesbian and bisexual women's difficulties in accessing healthcare, as confirmed in research by Rodrigues and Falcão[31] in the context of gynaecological healthcare. Health personnel often consider lesbian and bisexual women to be heterosexual women, and refer them according to care protocols intended for the latter group, at odds with the realities of the women involved. It is not uncommon for health personnel, when faced with a situation at variance with their cisheteronormative assumptions, to end up excluding and perpetuating forms of violence against these populations. This is reflected in both healthcare and bureaucratic decisions that fail to question cisheteronormativity.

In this way, undesirable events, such as prohibiting a companion during ultrasound exams, constitute forms of violence, as they deprive the mother of emotional proximity to her child being gestated by her partner. Institutional violence perpetrated in health services and directed at these women represents the direct form of structural violence[34], because not only does it reflect the hierarchisation of society, but it is responsible for reproducing an ideal model of sexuality and family[20].

The lack of knowledge about health care for lesbian and bisexual women is also reflected in relation to motherhood. To these personnel, conception independent of sexual acts is impossible, which forces the women they receive to explain how the pregnancy occurred. That situation was described in this account: "*[...] we always had to tell the story, right? Of what was involved, that there were two mothers, and that the ovule was mine, everything was mine*" (Interview 2).

In addition to communication barriers, situations were reported in which mothers faced difficulties stemming from hospital bureaucracies used to cisheteronormative relationships. This resulted in the non-pregnant mother not being able to visit her baby, who was admitted to the neonatal intensive care unit, as described in this excerpt:

She couldn't enter during visiting hours, because they were from 4 pm to 4:30 pm, but the mother has the right to enter four times during the day, at breastfeeding times, for mothers only. [Non-pregnant mother's name] was not recognised to be mother. And she could not enter at any of those times (Interview 8).

Institutional violence also takes the form of [the non-pregnant mother's] being unwelcome during childbirth, as reported below. The hospital antenatal record stated that the baby was the result of insemination, which apparently piqued the curiosity of health personnel and students. The study participant explained that the interest went beyond the fact of insemination:

On the day of the birth, the students wanted to watch, as if it were different [...] Because people wanted to see here an artificial insemination baby [...]. I don't know if people wanted to see just an insemination baby or a lesbian couple's baby. [...] They claimed there weren't enough clothes in the surgical centre for me to wear, because they had two obstetricians, the nurse, the anaesthesiologist, and four residents in to watch. [...] (Interview 5).

Revisiting the situation, the participant suggested the possibility that what may have most caught the team's attention was the fact that the baby had two mothers, rather than the method of conception.

At this point, the event can be seen to qualify as institutional violence on three counts. On the first, the pregnant mother is interpreted as an experiment for the group to analyse out of curiosity and is even deprived of having her companion present during the birth; the second targets the baby, which is presented as a fruit materialising from a non-normative family configuration; and on the third, the non-pregnant mother was deprived of attending the birth of her child "for lack of special clothes in the surgical centre". This episode reveals a scenario supported by a series of institutionally legitimised norms – from it being important to training to witness, in the name of science, a "different" birth, through to the mandatory use of specific clothing in the sector – that assume one single commitment: to reproduce forms of structural violence and thus perpetuate the institutional violence of depriving people of the right to exercise parental functions in the context of health care[35].

Thus, the points discussed during the sharing of experiences of double motherhood raised multiple situations of stigma, prejudice and exclusion, which materialise in health services in access barriers resulting from forms of institutional violence that assume a wide range of interpretations, ranging "from curiosity to LGBTQIA+-phobia". Prejudice against lesbian women on the part of health personnel was widely discussed in the work of Chaves[36], who pointed out, from interviews with health personnel, that they did not understand lesbian women's health needs.

She argued the importance of training and discussion on stigmas and prejudices with regard to homosexuality. In this respect, it is imperative to problematise the training of health professionals and public policymaking that calls cisheteronormativity into question. This will result in the creation of a welcoming environment that promotes bonding and a personnel-patient relationship capable of providing equitable care.

Final remarks

From understanding experiences of double motherhood in antenatal, childbirth and postpartum health care, it was found that cisheteronormativity regulates relationships in both public and private health services, which results in situations of exclusion, dominant among which is the invisibility of the mother who was not pregnant.

Double motherhood is seen as a practice that challenges traditional norms of identity and questions the binary nature of gender and maternal and paternal roles. Moreover, assisted reproductive technology and home insemination, strategies for autonomous conception by non-heterosexual women, feature as breaks with social norms. The experiences of double motherhood in health care revealed that, in Brazil, sexual and reproductive health practices prioritise heterosexual reproduction and neglect sexual and reproductive rights, resulting in the perpetuation of stereotypes.

Neglect for the rights of these women who do not fit with traditional standards of heterosexual parenting materialises in situations of institutional violence perpetuated through norms, discourses and practices that efface and delegitimise their experiences, resulting in barriers to these women's access to health care. In this regard, lack of receptiveness in the form of exclusion of "different" family configurations constitutes institutional violence, especially during antenatal, childbirth and postpartum care.

Capacity-building for health personnel – throughout their training and through permanent institutional processes – for them to understand and accommodate the needs of different family configurations is key to this issue and essential to combating institutional violence in experiences of double motherhood. This study does not address issues of lesbian and bisexual motherhood involving trans women and this factor is acknowledged to be a limitation of this study.

Collaborations

SY Ril contributed to the study conception and design, played an active role in carrying out the research project and collecting data. She also conducted the data analysis and interpretation, participated in writing the original manuscript and critical review of the version for publication. JB Oliveira Junior, MMC Mello and VM Portes contributed substantially to data analysis and interpretation, collaborated actively in writing the original manuscript and in critical review of the version for publication. RO Moretti-Pires played a fundamental role in the study conception and design and supervised the data analysis and interpretation, as well as participating in writing the original manuscript and critically reviewing the version for publication.

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References

1. Brasil. Constituição da República Federativa do Brasil de 1988. *Diário Oficial da União* 1988; 5 out.
2. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 20 set.
3. Ferreira BO, Nascimento M. A construção de políticas de saúde para as populações LGBT no Brasil: perspectivas históricas e desafios contemporâneos. *Cien Saude Colet* 2022; 27(10):3825-3834.
4. Miskolci R, Signorelli MC, Canavese D, Teixeira FB, Polidoro M, Moretti-Pires RO, Souza MHT, Pereira PPG. Desafios da saúde da população LGBTI+ no Brasil: uma análise do cenário por triangulação de métodos. *Cien Saude Colet* 2022; 27(10):3815-3824.
5. Silva AN, Gomes R. Acesso de mulheres lésbicas aos serviços de saúde à luz da literatura. *Cien Saude Colet* 2021; 26 (Supl. 3):5351-5360.
6. Brasil. Ministério da Saúde (MS). *Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes*. Brasília: Editora do Ministério da Saúde; 2004.
7. Brasil. Ministério da Saúde (MS). *Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais*. 1ª ed. Brasília: Editora do Ministério da Saúde; 2013.
8. Cavalcante L. *Parlamentares e famosos desaprovam PL que proíbe casamento homoafetivo* [Internet]. Estado de Minas; 2023 [acessado 2023 set 30]. Disponível em: https://www.em.com.br/app/noticia/diversidade/2023/09/12/noticia-diversidade,1560651/parlamentares-e-famosos-desaprovam-pl-que-proibe-casamento-homoafetivo.shtml.
9. Brasil. Projeto de Lei nº 580/2007: Apensados: PL nº 4.914/2009, PL nº 5.167/2009, PL nº 1.865/2011, PL nº 5.120/2013, PL nº 3.537/2015, PL nº 5.962/2016, PL nº 8.928/2017 e PL nº 4.004/2021. Altera a Lei nº 10.406, de 10 de janeiro de 2002- Código Civil, para dispor sobre o contrato civil de união homoafetiva. *Diário Oficial da União*; 2007.
10. Nadeau BL, Guy J. *Itália começa a remover nomes de mães lésbicas de certidões de nascimento* [Internet]. CNN Brasil; 2023 [acessado 2023 set 18]. Disponível em: https://www.cnnbrasil.com.br/internacional/italia-comeca-a-remover-nomes-de-maes-lesbicas-de-certidoes-de-nascimento/.
11. Movement Advancement Project (MAP). *Under fire: silencing supporters of LGBTQ people* [Internet]. Colorado: MAP; 2023 [acessado 03 dez 2023]. Disponível em: https://www.mapresearch.org/under-fire-report.
12. Madowo L, Nicholls C. *Parlamento da Uganda aprova projeto de lei que criminaliza a identificação como LGBTQ+* [Internet]. CNN Brasil; 2023 [acessado 2023 dez 3]. Disponível em: https://www.cnnbrasil.com.br/internacional/parlamento-da-uganda-aprova-projeto-de-lei-que-criminaliza-a-identificacao-como-lgbtq/.
13. Have HT. Respect for Human Vulnerability: The Emergence of a New Principle in Bioethics. *J Bioeth Inq* 2015; 12:395-408.

14. Bozza FS. *A tutela penal dos direitos humanos nas democracias de opinião (II)* [Internet]. Canal Ciências Criminais; 2022 [acessado 2023 out 9]. Disponível em: https://canalcienciascriminais.com.br/a-tutela-penal-dos-direitos-humanos-nas-democracias-de-opiniao-ii/.
15. Amorim ACH, Oliveira MB. Dupla Maternidade: conexões entre antropologia e direito. In: *Anais do Seminário Internacional Fazendo Gênero*. Florianópolis, Brasil; 2012. p. 1-12.
16. Fontanella BJB, Ricas J, Turato RE. Amostragem por Saturação em Pesquisas Qualitativas em Saúde: contribuições teóricas. *Cad Saude Publica* 2008; 24(1):17-27.
17. Prabhakar AS, Guerra-Reyes L, Kleinschmidt VM, Jelen B, MacLeod H, Connelly K, Siek KA. Investigating the suitability of the asynchronous, remote, community-based method for pregnant and new mothers. In: *Proceedings of the Conference on Human Factors in Computing Systems*. Mendoza, Argentina; 2017.
18. Skelton K, Evans R, LaChenaye J, Amsbary J, Wingate M, Talbott L. Utilization of online focus groups to include mothers: A use-case design, reflection, and recommendations. *Digit Health* 2018; 4:2055207618777675.
19. Minayo MCS. *O desafio do conhecimento: pesquisa qualitativa em saúde*. 12ª ed. São Paulo, Rio de Janeiro: Hucitec, Abrasco; 2010.
20. DiLapi EM. Lesbian Mothers and the Motherhood Hierarchy. *J Homosex* 1989; 18(1-2):101-121.
21. Leal D, Gato J, Coimbra S, Freitas D, Tasker F. Social Support in the Transition to Parenthood Among Lesbian, Gay, and Bisexual Persons: A Systematic Review. *Sex Res Soc Policy* 2021; 18:1165-1179.
22. Foucault M. *História da Sexualidade 1: a vontade de saber*. 3ª ed. São Paulo: Paz e Terra; 2015.
23. Felipe MG, Tamanini M. 2021. Inseminação Caseira como possibilidades de lesboparentalidades no Brasil. *Encuentros Latinoam* 2021; 5(2):180-201.
24. Vitule C, Couto MT, Machin R. Same-sex couples and parenthood: a look at the use of reproductive technologies. *Interface (Botucatu)* 2015; 19(55):1169-1180.
25. Vitule C, Machin R, Couto MT. Práticas reprodutivas lésbicas: reflexões sobre genética e saúde. *Cien Saude Colet* 2017; 22(12):4031-4040.
26. Brasil. Resolução CFM nº 1.957/2010. Normas éticas para a utilização das técnicas de reprodução assistida. *Diário Oficial da União* 2011; 6 jan.
27. Leite TH. Análise crítica sobre a evolução das normas éticas para a utilização das técnicas de reprodução assistida no Brasil. *Cien Saude Colet* 2019; 24(3):917-928.
28. Gonzaga PRB. Psicologia, Saúde Sexual e Saúde Reprodutiva: Urgências para a Formação Profissional. *Psicol Cien Prof* 2022; 42(n. esp.):e262847.
29. Preciado PB. *Manifesto contrassexual: práticas subversivas de identidade sexual*. São Paulo: n-1 edições; 2017.
30. Haraway D. A manifesto for cyborgs: Science, technology, and socialist feminism in the 1980s. In: Seidman S, editor. *The Postmodern Turn: New Perspectives on Social Theory*. Cambridge: Cambridge University Press; 1994.
31. Rodrigues JL, Falcão MTC. Vivências de atendimentos ginecológicos por mulheres lésbicas e bissexuais: (in)visibilidades e barreiras para o exercício do direito à saúde. *Saude Soc* 2021; 30(1):e181062.
32. Vieira BL, Silva MEC, Carvalho Filha FSSC, Barbosa HRA, Moraes Filho IM. Assistência à saúde da mulher lésbica durante o ciclo gravídico-puerperal. *Rev REVOLUA* 2022; 1(1):1-5.
33. Pontes MF, Carneiro TF, Magalhães AS. Homoparentalidade feminina: laço biológico e laço afetivo na dinâmica familiar. *Psicologia USP* 2017; 28(2):276-286.
34. Martin-Baró I. *Acción y ideologia: Psicología Social desde Centroamérica*. San Salvador: UCA Editores; 2012.
35. Ribeiro CR, Gomes R, Moreira MCN. A paternidade e a parentalidade como questões de saúde frente aos rearranjos de gênero. *Cien Saude Colet* 2015; 20(11):3589-3598.
36. Chaves JPV. *Análise da assistência sexual e reprodutiva de mulheres lésbicas, sob o olhar da Perspectiva dos Funcionamentos* [dissertação]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2023.

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