

Reproductive and Sexual Health of Cisgender Lesbian and Bisexual Women in Primary Health Care

Saúde Reprodutiva e Sexual de Mulheres Cisgênero Lésbicas e Bissexuais na Atenção Primária à Saúde
Salud Reproductiva y Sexual de Mujeres Cisgênero Lesbianas y Bissexuales en la Atención Primaria de Salud

RESUMO

Objetivo: Descrever a percepção das mulheres lésbicas e bissexuais sobre atendimentos na saúde reprodutiva e sexual na Atenção Primária à Saúde. **Método:** Estudo qualitativo descritivo, entre janeiro e fevereiro de 2021. Participaram do estudo 42 mulheres (14 lésbicas e 28 bissexuais). Para a coleta de dados utilizou-se um formulário com foco na percepção das entrevistadas sobre os atendimentos prestados, divulgado nas redes sociais. Para análise, utilizou-se o software IRAMUTEq e o dendograma de palavras, provido pela Classificação Hierárquica Descendente. **Resultado:** Na análise, emergiram cinco Classes: 1) experiência das mulheres nos atendimentos; 2) heterossexualidade compulsória; 3) preconceito do profissional de saúde quanto à diversidade; 4) atendimento prescritivo; 5) medo do preconceito. **Conclusão:** Os resultados apontam a necessidade de superar barreiras estruturais e atitudinais nos serviços de saúde, com ações voltadas à formação profissional e ao acolhimento inclusivo, garantindo o direito à saúde sexual e reprodutiva das mulheres lésbicas e bissexuais.

DESCRIPTORES: Bissexualidade; Minorias Sexuais e de Gênero; Direitos Sexuais e Reprodutivos; Atenção Primária à Saúde; Saúde da Mulher.

ABSTRACT

Objective: To describe the perceptions of lesbian and bisexual women regarding reproductive and sexual health care within the primary health care system. **Method:** This was a qualitative, descriptive study conducted between January and February 2021. Forty-two women (14 lesbian and 28 bisexual) participated in this study. Data were collected using a form, which focused on the interviewed women's perceptions of the care they received. For data analysis, the IRAMUTEq software was used, and a word dendrogram was generated from the classification. **Results:** The analysis revealed five classes that were merged for the study: 1) The participants' perception of the primary care service they received; 2) Compulsory heterosexuality; 3) Prejudice experienced from primary care workers related to sexual diversity; 4) The prescriptive nature of customer service in primary care; 5) The fear of being judged while receiving care from a health care professional. **Conclusion:** The data analysis showed the necessity of overcoming structural barriers in primary care services. This requires more actions to build the capacity of health care professionals and create more inclusive reproductive and sexual health care for women who identify as lesbian and bisexual.

DESCRIPTORS: Bisexuality; Sexual and Gender Minorities; Reproductive Rights; Primary Health Care; Women's Health.

RESUMEN

Objetivo: Describir la percepción de las mujeres lesbianas y bissexuales sobre la atención en salud reproductiva y sexual en la Atención Primaria de Salud. **Método:** Estudio cualitativo descriptivo, realizado entre enero y febrero de 2021. Participaron 42 mujeres (14 lesbianas y 28 bissexuales). Para la recolección de datos se utilizó un formulario enfocado en la percepción de las entrevistadas sobre la atención recibida, divulgado en redes sociales. Para el análisis se empleó el software IRAMUTEq y el dendrograma de palabras, proporcionado por la Clasificación Jerárquica Descendente. **Resultado:** Del análisis emergieron cinco clases: 1) experiencia de las mujeres en la atención; 2) heterossexualidad compulsoria; 3) prejuicio del profesional de salud respecto a la diversidad; 4) atención prescritiva; 5) miedo al prejuicio. **Conclusión:** Los resultados señalan la necesidad de superar barreras estructurales y actitudinales en los servicios de salud, mediante acciones orientadas a la formación profesional y a la acogida inclusiva, garantizando el derecho a la salud sexual y reproductiva de las mujeres lesbianas y bissexuales.

DESCRIPTORES: Bisexualidad; Minorías Sexuales y de Género; Derechos Sexuales y Reprodutivos; Atención Primaria de Salud; Salud de la Mujer.

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INTRODUCTION

The vulnerability of lesbian and bisexual (LB) women in their sexual and reproductive health is a result of individual, social, and pragmatic factors. The invisibility of these women is evident, as professionals base their care on compulsory heterosexuality, which drives them away from health services⁽¹⁻²⁾.

The Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO) conducted a study on the relationship between gynecologists and patients seen in primary care. The results showed that 76% of women have gynecological appointments annually. Considering only women who have sex with women (WFW), this percentage dropped to 47%, according to the Ministry of Health's report "Comprehensive Health Care for Lesbian and Bisexual Women"⁽³⁾.

Studies that investigate the experiences of health professionals who provide services to this population reveal that the main reasons for inadequate care are the presumption of heterosexuality and the still incipient

knowledge of the specific demands of this population, generating the reported lack of support⁽⁴⁻⁵⁻⁶⁾. Furthermore, despite the existence of the National Health Policy for Lesbians, Gays, Bisexuals and Transsexuals (LGBT), institutional homophobia still excludes the population from health services⁽⁷⁻⁸⁾.

In a mixed-method study conducted in 2024, preventive strategies, barrier use, and risk perception regarding sexually transmitted infections (STIs) were analyzed among 1,225 lesbian and bisexual women. Participants perceived STI risk in their practices, but also a lack of available and effective prevention information, as well as the absence of specific supplies for lesbian sex, such as⁽⁹⁾.

A qualitative study aimed to understand the meanings related to sexual health and the contours that define the experience of accessing health services for lesbian women in Manaus, Amazonas, interviewed 10 women who identify as lesbians. The results revealed three main themes: representations of prevention and sexual practices; heteronormativity and its

effects; and the pursuit of self-knowledge as a care tactic. Furthermore, reports indicated that feelings of shame and insecurity, fearing judgment, are common when approaching gynecologists⁽⁵⁾.

The general objective of this study was to describe the perception of lesbian and bisexual users about reproductive and sexual health care, carried out during services provided in Primary Health Care (PHC).

METHOD

This is a qualitative descriptive study in which women who identified as lesbian or bisexual participated, excluding those under 18 years of age. Data collection was carried out in 2021 using the snowball sampling technique⁽¹⁰⁾. An online questionnaire was used, made available on social media until data saturation was reached, with each new participant being asked to share the link with their personal network. The online questionnaire consisted of sociodemographic data (sexual orientation, age, and education) and open-ended

questions, such as: "Tell me how you felt about the welcome you received at the women's sexual and reproductive health service?" "Were you asked about your sexual orientation during the consultation? How was the question asked? If not asked, did you disclose it at any point?"

Forty-two women participated in the study, identified by codes: B for bisexual women and L for lesbian women. Therefore: B1, B2, L1, L2, and so on.

Data analysis was performed using thematic content analysis, using the R Interface for Multidimensional Text and Questionnaire Analysis (Iramuteq) software⁽¹¹⁻¹²⁾. Iramuteq uses different types of analysis, from word frequency calculations to multivariate analyses, such as descending hierarchical classification (DHC), the method chosen for this study.

Descent hierarchical classification (DHC) divides each participant's responses into classes. Furthermore, text segments associated with each class can be retrieved from the original corpus, providing the context for statistically significant words and the interview in question.

Participants' responses were organized in a UTF-8 file in Notepad, constituting a single textual corpus (n). In this file, each questionnaire comprises an Initial Context Unit (ICU), which is subdivided into Elementary Context Units, consisting of three lines of text from the corpus. The software uses the chi-square test (χ^2), which reveals the associative strength between words and their respective class. The higher the chi-square number, the greater the associative strength.

This study followed Resolution 466/2012 of the National Health Council, which deals with guidelines and regulatory standards for research involving human beings⁽¹³⁾. The project was submitted to the Ethics and Research Committee of the Universi-

ty of Vale do Rio dos Sinos – UNISINOS and approved under opinion no. 4,340,700 and CAAE no. 38883720.2.0000.5344.

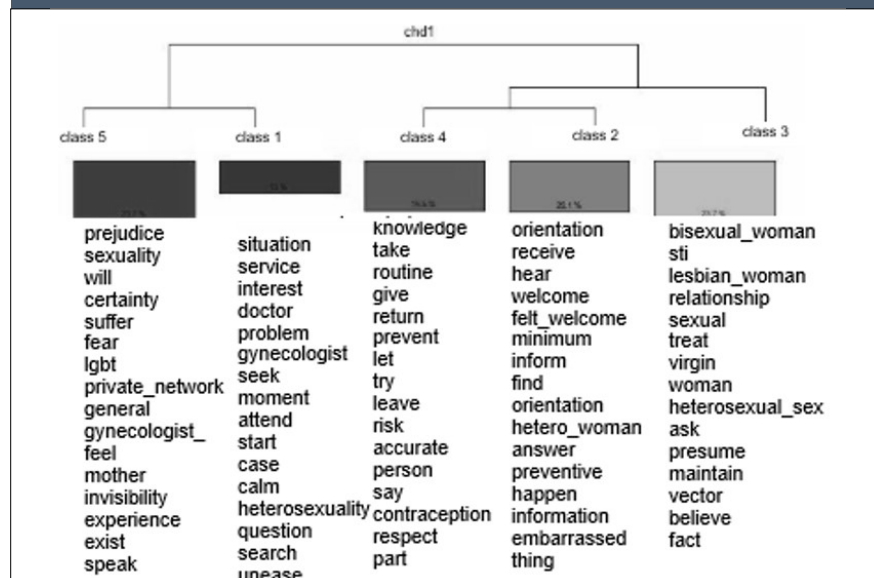
RESULTS

It was found that among the 42 women who responded to the online questionnaire, 67.4% (28) were bisexual and 32.6% (14) were lesbians. The most frequent age group was 19 to 24 years old, totaling 71.5% (30); followed by 25 to 30 years old with 19% (8) and +35 years old with 9.5% (4). Regarding education, 76.7% (33) had incomplete higher education, 16.3% (6) had completed higher education, 4.7% (2) had completed high school, and 2.3% (1) had a postgraduate degree. The majority of participants reported seeking care in the private healthcare network (53.3%), followed by 27.9% who accessed health-

care in the public network and 18.6% who accessed healthcare in both.

In the Dendrogram (Figure 1), the corpus was subdivided into two subcorpora: a) Class 5 - Fear of prejudice and judgment, with 40 ECUs (23.67%), and Class 1 - Women's experience in care, with 22 ECUs (13.02%), which reveals an association between the classes. b) Class 3 - Health professional prejudice towards diversity, with 22 ECUs, corresponding to 23.7% of the total. In the same subcorpus, a second subdivision occurred, giving rise to Class 4 - Prescriptive care, with 33 ECUs (19.53%), and Class 2 - Compulsory heterosexuality, with 34 ECUs (20.12%). This shows an association between the classes according to the reports. Each class obtained a list of words generated from the chi-square test. The classes are presented from left to right, as shown in Figure 1.

Figure 1 – Dendrogram of Classes extracted by Iramuteq. S  o Leopoldo, Brazil, 2021.



Source: Research data, 2021.

The name of each Class was defined considering the most frequent words, with the highest χ^2 and the content of the Initial Context Units

(ICUs).

Class 5 – Fear of prejudice and judgment

Class 5 was named "Fear of Preju-

dice and Judgment." The top words in this class were: prejudice ($x^2 = 36.03$), sexuality (33.06), will (22.2), certainty (20.06), fear (16.62), suffering (16.62), private network (13.21), LGBT (13.21), and invisibility (9.85).

Regarding fear of prejudice, women reported that even though they sought out private networks hoping to receive better care, this did not happen. They also reported that they felt uncomfortable discussing their sexual orientation due to fear of judgment and prejudice. Another theme that emerged was invisibility.

[...] prejudice occurs, and it seems that healthcare professionals are disgusted to ask about sexual orientation [...], or even deny medical care for the patient being a lesbian and don't need it [...].

My experience made me reluctant to return [...]. I definitely felt erased, largely because social discourse tends to enable prejudice and make it commonplace. (L43)

Invisibility is common. We don't receive medical advice about illnesses or how to protect ourselves, or anything like that. (B38)

[...] I don't usually see healthcare professionals as the people I feel most comfortable talking to about sexuality. (B29)

Class 1 – Women's experience in care

Class 1 addresses "Women's Experience in Care." The following words were considered for analysis: service (27.16), situation (27.16), interest (20.42), doctor (17.73), problem (13.9), male_gynecologist (12.84), seek (12.56), moment (10.14), and attend (9.36).

In their reports, women reported feeling "unprepared" on the part of healthcare professionals who treat women in relationships with other women.

[...] it was horrible, I dread going to the doctor. I know it's wrong, but I feel judged every moment I'm in the room, and that's

why I don't go. (L16)

[...] he questioned me about my sex life and refused to do the exam (transvaginal ultrasound) even though the doctor who's treating me had requested it. The doctor's reaction was more humiliating than the cancellation of the exam itself. (L8)

Class 3 – Health professional prejudice towards diversity

In Class 3: "Healthcare Professional Bias Regarding Diversity," the following words were considered for analysis: bisexual_woman (39.86), STI (25.45), lesbian_woman (22.36), man (19.88), sexual_relationship (19.96), treat (18.67), virgin (13.21), woman (13.01), and heterosexual_sex (11.57).

The reports revealed weaknesses in healthcare professionals' approach to diversity, which resulted in the omission of information by women seeking care.

[...] there was never a time when I felt comfortable saying that I am a lesbian woman, because they always treated me as if, because I am a lesbian, I don't need to undergo a series of tests and, because I haven't had heterosexual sex, I am somehow a virgin. (L22)

Women report that gynecological consultations follow the "heterosexual standard," addressing virginity and hymen rupture, as if lesbian and bisexual women remain virgins because they don't have sex with men, demonstrating heteronormative care.

I didn't report being bisexual. I feel intimidated about disclosing my sexual orientation. I know a nurse who doesn't order exams for lesbian women because she believes there's no penetration and no risk of STIs. (B14)

[...] even though I say I'm a lesbian woman and that I have relationships with women, sometimes they continue to treat me like a straight woman or end my appointments quickly, as if a lesbian woman didn't need medical care from a gynecologist. (L33)

Furthermore, a story emerged that reflects society's imposition that every woman wants to be a mother.

[...] during a breast exam, she (the gynecologist) saw that I had a piercing in my breast and said, "This is going to be horrible when you start breastfeeding." I never told her I wanted children. She just assumed I would have children in the future and, on top of that, I would get pregnant. (B15)

The specific prejudice against bisexual women, associating them with promiscuity and a higher risk of contracting STIs, in addition to feeling judged after the professional changed their behavior, often requesting tests that they wouldn't have ordered before discussing sexual orientation.

[...] Today, I believe these doubts still linger for me. I believe that there's a particular erasure when it comes to bisexual women, that is, you're either lesbian or straight." (B11)

She was very rude and began saying that I had to request additional tests because, as a bisexual woman, I could have contracted diseases from relationships with both men and women. I hadn't had heterosexual sex for about five years and had already had the tests she requested with other doctors. (B15)

The women highlighted in their accounts the need for guidance on STI prevention in relationships involving lesbian women.

[...] the doctor treated me with indifference and made no specific considerations about homosexual relations and STI protection. Much later, I learned that transmission was also possible and that care was needed. (B23)

Since I started going to the gynecologist talking about heterosexual relations, when I mentioned that I was starting to date women, nothing was explained about the relationships. I just felt ashamed. (B30)

Class 2 – Compulsory heterosexuality

Class 2 addressed compulsory heterosexuality, and considered the following words: guidance (35.15), listen (23.72), receive (23.72), welcome (16.67), minimum (16.27), felt_welcomed (16), inform (15.54), think (15.47) and guide (11.57).

In this Class, the participants' reports indicate that even bisexual women who had reported having been partially covered by the guidance provided during consultations, still felt harmed by the reception provided by health professionals, especially regarding their sexual orientation.

[...] it didn't make a difference when I told the doctor. The healthcare system treats all women as if they were straight. (B25)

[...] this happened in every medical appointment I went to. I was never questioned, nor did I inform anyone. It was assumed I was straight, and since I had a boyfriend at the time, I never corrected them. (B5)

[...] it's important that healthcare professionals don't assume that every woman who walks into their office is straight. (B15)

The term "compulsory heterosexuality" is used when it is assumed that all people are and should be heterosexual, which renders the study population invisible. The reports reveal situations involving embarrassment, indifference, unpreparedness, and disinterest among professionals in caring for lesbian or bisexual women. Among the reports expressing embarrassment, the following stand out:

[...] embarrassment. I haven't had any luck finding a good professional yet. I'd heard that since there's no penetration and no chance of pregnancy, I didn't need to worry, and I ended up feeling a bit lost after my medical appointment. (L12)

[...] I actually feel helpless because there's no guidance given by health professionals for lesbian women. I've never heard of any guidance, from my perspective and expe-

rience. (L33)

[...] I think there's a lack of information for health professionals, and it's necessary to break paradigms about the beliefs of these health professionals, who sometimes believe they own the truth and act unprofessionally. (B18)

Class 4 – Prescriptive care

Class 4 refers to "Prescriptive Care," highlighting the following words: knowledge (29.05), take (16.88), routine (16.12), give (14.57), leave (13.44), prevention (13.44), return (13.44), leave (12.59), and try (12.59).

The participants' expectations regarding the care and the reality of how it occurs emerged in the class. The fact that the care is prescriptive, following a "script" with questions such as: "Do you have a boyfriend?"; "Do you use a condom?"; "What contraceptive method do you use?" This type of care alienates a population that already feels invisible. A sense of exclusion is evident in the reports.

[...] the first time I was 15. The gynecologist saw me, and I remember the first question he asked me was whether I'd ever had sex and whether I used a condom. (L33)

Normally, people already consider a heterosexual relationship; I need to interrupt the conversation and say that I'm in a relationship with a woman [...]. (B30)

They just told me to use a condom and take birth control. [...]. (B2)

The indiscriminate prescription of oral contraceptives disregards women's autonomy and interest in their use. This is revealed in women's accounts:

I was misdiagnosed with polycystic ovary syndrome during my first medical appointment, so I started taking birth control pills at age 14. (B5)

They usually don't take me seriously and tell me to take birth control pills, even though I say I'm dating a woman. In short, it's these subtleties that make us feel

embarrassed [...]. (B30)

For some participants, the appointments made them withdraw from healthcare services.

I left there devastated and furious. I didn't do any of the tests she requested and never went back. At the same time, it was an episode that kept me from seeing a gynecologist again for about two or three years. (B40)

I don't remember much about the last time, as it was 10 years ago. I understand it was a long time ago and that I should have sought out information about my sexual health, but I've always only had sex with people I've been romantically involved with. (L43)

DISCUSSION

This study presents reports that lack of preparation, prejudice and changes in conduct, when combined with a lack of interest on the part of the health professional, cause LB women to omit their sexual orientation during consultations for fear of prejudice and judgment by the health professional, in agreement with published articles^(5, 2, 14, 15).

The women who contributed to the study reported feeling that "professionals are reluctant to question sexual orientation and address specific aspects of the population" (L16). Moral and religious factors fuel prejudice and discrimination, which can influence care delivery due to pressure from groups that reject sexual diversity. The health demands and specificities of lesbian and bisexual women are still undervalued in care practices, maintaining heteronormative protocols, thus devaluing their sexual trajectories and practices. This reinforces the perception that those who do not adhere to cis-heteronormativity are seen as incorrect and unacceptable based on moral and religious values, which drives users away from health

services⁽¹⁶⁻¹⁷⁾.

A study published 24 years ago found that in gynecological consultations with lesbian women, 59.5% of respondents revealed their sexual orientation to the doctor, 88.6% on their own initiative and 5.1% after being questioned by the professional. These results are consistent with what women reported on the topic in 2021 when they answered questions in this study. Thus, the omission of information about their sexuality may be related to fear of how the care will be conducted⁽¹⁸⁾.

Invisibility through heteronormativity and prescriptive care, especially through the indiscriminate prescription of OCPs, is one of the factors that makes women feel uncomfortable talking about their sexuality with health professionals^(2, 18, 19).

The reports reveal that the prejudice expressed by health professionals goes against the principles of the National LGBT Health Policy, reinforcing the paradigm of invisibility and social exclusion of people from the LGBT group, especially when it involves women^(7, 20).

In situations where the reception disregards the individuality of the user, it also fails to meet the principles of equity, which is one of the principles of the Unified Health System (SUS). The inability of health professionals to welcome, listen to, and address the specific needs of the population results in exclusion from health services. This further demonstrates the importance of establishing a bond during care for the spontaneous expression of sexual orientation^(7, 8, 17).

In the women's reports related to the reception and lack of preparation of health professionals to address the specificities involving lesbian and bisexual women, it is observed that the women reported that they did not feel welcomed, precisely because health professionals did not consider their particularities, as if the care was

based on a heteronormative script, going against other studies carried out with the population^(5, 2, 1).

Silva et al. (2023) observed in a study conducted in Belford Roxo, Rio de Janeiro, with health professionals regarding care for LB women that the professionals interviewed are aware that their lack of preparation, combined with the experiences they have in care, contribute to their disengagement from health services. Furthermore, the main challenges, according to bibliographies, are misconceptions about affective and sexual practices, lack of professional qualifications, pathologization of homosexuality and bisexuality, and lesbo-biphobic discrimination in health services^(17, 22).

It is also possible to identify, both in the reports of this study and in previously conducted studies, symbolic barriers to access, resulting from intolerance to sexual behaviors that deviate from the heteronormative standard, triggering processes of suffering, dissatisfaction, lack of regularity in consultations, low adherence to treatment, illness and early mortality within this group^(8, 20, 21).

It is important to note that the processes of suffering, dissatisfaction, lack of regular consultations, low adherence to treatment, illness and early mortality within this group are the result of intolerance towards homosexual sexual behavior⁽⁸⁾.

Study participants report a lack of specific guidance on promoting the sexual health of same-sex women. As previously reported, women do not disclose their sexual orientation, which is not investigated by the professional treating them, following a heteronormative approach, failing to request preventive exams, and making women more vulnerable and exposed to STIs, as reported in this study and others, highlighting the importance of developing studies and public policies^(5, 23, 24).

Addressed by the bisexual women

who contributed to the study, biphobia was one of the topics observed in their reports, marked by discourses referring to greater vulnerability and exposure to STIs due to having sexual relations with both men and women. Bisexuality is marked by struggle and resistance in Brazil and around the world. The work of bisexual activists, particularly the contribution of feminist bisexual women, was essential in advancing the recognition of bisexuality in existing legal and regulatory frameworks at the national and international levels⁽¹⁹⁾.

Furthermore, points that represent the influence of machismo can be observed, such as the imposition that every woman will be a mother. Compulsory motherhood emerged during the process of naturalizing motherhood as an experience inherent to all women, reducing the feminine being to motherhood, centralizing this event as the most important or obligatory destiny of their experience^(2, 24, 25).

CONCLUSION

In the perception of the lesbian and bisexual women participating in this study, sexual and reproductive health care is prescriptive, permeated by prejudice, and guided by heteronormativity. Most women reported seeking health insurance; however, their perception of the quality of care did not differ significantly between the SUS and private health care settings.

Among the gaps identified, the lack of specific protocols for the care of lesbian and bisexual women, as well as the absence of health education strategies aimed at this population, stands out. The research also found that, even in partner services, the quality of care remains unchanged, suggesting a broader structural deficiency in team training.

The study highlights the urgent need to overcome structural and at-

titudinal barriers in health services, with actions focused on professional training and inclusive care, guaranteeing the right to sexual and reproductive health for lesbian and bisexual women. Furthermore, it highlights the role of managers in creating safe institutional environments that en-

courage users to express their needs without fear of discrimination.

Therefore, we suggest future research that explores not only the experiences of lesbian and bisexual women in health services, but also the training and qualification processes of professionals working in primary

care. Furthermore, there is a clear need for research and investment in the training and qualification process for primary care professionals, thus ensuring compliance with the legal principles of the Unified Health System: universality, equity, and comprehensiveness.

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