



## Article


**Sexual and Reproductive Health Care: a look from the perspective of women who have sex with women**

Cuidado com a saúde sexual e reprodutiva: um olhar a partir da percepção de mulheres que fazem sexo com mulheres

El cuidado de la salud sexual y reproductiva: una mirada desde la perspectiva de las mujeres que tienen sexo con mujeres

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**Abstract**

**Objective:** This study is intended to understand the perception of women who have sex with women, regarding the care they receive in health services, within the scope of their sexual and reproductive health, in order to verify whether the care offered to them meets the integrality of their right to health and, also, highlight the role of health professionals in guaranteeing these rights. **Methodology:** A national literature review was carried out for the elaboration of the data collection instrument and qualitative and quantitative research through an individual form and individual interview via the

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internet. **Results:** 287 responses were obtained, the statements revealed the following categories: A- Physical violence suffered in health services, B- Negligence and lack of acceptance in gynecological consultations and health services, C- Presumption of heterosexuality in health services, D- Invisibility and, moral and psychological violence. **Conclusion:** It was evident that women who have sex with women still suffer a series of discrimination and violence in health services, when seeking comprehensive care, especially with regard to their sexual and reproductive rights.

#### **Keywords**

Reproductive Health. Sexual and Gender Minorities. Comprehensive Health Care.

#### **Resumo**

**Objetivo:** O presente estudo se destina a compreender a percepção das mulheres que fazem sexo com mulheres, referente ao cuidado que recebem nos serviços de saúde, no âmbito de sua saúde sexual e reprodutiva, a fim de verificar se o atendimento ofertado atende a integralidade de seu direito à saúde e, também, evidenciar o papel dos profissionais de saúde na garantia desses direitos. **Metodologia:** Foi realizada revisão de literatura nacional para elaboração do instrumento de coleta de dados e pesquisa qualiquantitativa através de formulário e entrevista individual via internet. **Resultados:** Foram obtidas 287 respostas, as falas revelaram as seguintes categorias: A- Violência física sofrida em serviços de saúde, B- Negligência e falta de acolhimento em consultas ginecológicas e em serviços de saúde, C- Presunção da heterossexualidade nos serviços de saúde, D- Invisibilidade e violência moral e psicológica. **Conclusão:** Evidenciou-se que mulheres que fazem sexo com mulheres ainda sofrem uma série de discriminações e violências nos serviços de saúde, ao buscarem cuidados integrais, principalmente no que tange aos seus direitos sexuais e reprodutivos.

#### **Palavras-chave**

Saúde Reprodutiva. Minorias sexuais e de gênero. Assistência integral à saúde.

#### **Resumen**

**Objetivo:** Este estudio tiene como finalidad conocer la percepción de las mujeres que tienen sexo con mujeres, respecto a la atención que reciben en los servicios de salud, en el ámbito de su salud sexual y reproductiva, con el fin de verificar si la atención que se les brinda cumple con la integralidad de su derecho a la salud y, además, destacar el papel de los profesionales de la salud en la garantía de estos derechos. **Metodología:** Se realizó una revisión de literatura nacional para la elaboración del instrumento de recolección de datos e investigación cualitativa y cuantitativa a través de formulario individual y entrevista individual vía internet. **Resultados:** se obtuvieron 287 respuestas, los enunciados revelaron las siguientes categorías: A- Violencia física sufrida en los servicios de salud, B- Negligencia y falta de aceptación en las consultas ginecológicas y servicios de salud, C- Presunción de heterossexualidad en los servicios de salud, D- Invisibilidad y violencia moral y psicológica. **Conclusión:** Se evidenció que las mujeres que tienen sexo con mujeres aún sufren una serie de discriminaciones y violencias en los servicios de salud, al momento de buscar atención integral, especialmente en lo que se refiere a sus derechos sexuales y reproductivos.

#### **Palabras clave**

Salud Reprodutiva. Minorías Sexuales y de Género. Atención Integral de Salud.

#### **Introduction**

Since gender studies are an important provider of debates on sexuality and sexual and reproductive rights, in order to guarantee them in accordance with constitutional norms, it is understood that it is necessary to question and produce knowledge in order to overcome social standards and the control of bodies, especially female bodies, disassociating sexuality from reproduction (1).

While during the Middle Ages and the repressive policies following the world wars, sexuality was restricted to the goal of reproduction, the 1970s saw the rebirth of social movements that sought freedoms in ways of being and existing, often delegitimized and made invisible, such as women who have sex with women (WSW) (2).

One of the main consequences of this historical period of erasure and violence is compulsory heterosexuality and heteronormativity. Compulsory heterosexuality was a term coined in 1980 and names the naturalization of a sociocultural conduct of sexuality as heterosexual, established as normal, common and universal, and anything, consequently, that varied from this would be considered abnormal, dubious, sick and problematic (3).

Although sex and gender are often considered to be the same thing, a binary between man and woman, they are not. Butler (4:24) already points out that “even if the sexes seem unproblematically binary in their morphology and constitution (which will be questioned), there is no reason to suppose that the genders should also remain two in number”. Today, it is clear that not even sex - considered to be something strictly genetic, from the branch of nature - is actually binary (5). With the possibility of multiple characteristics considered “intersex”, which distance sexual differentiation from the binarism between male and female.

Nevertheless, gender is “a sociological category that refers to the social and cultural construction of the roles that men and women play in everyday life” (6:154). As such, the subject is increasingly being discussed in order to overcome the binary and biological concepts imposed previously.

If cisheteronormativity imposes a culture where the world is heterosexual and everything that differs from this is unhealthy (7), it is important to realize that strongly held beliefs can harm health care, which becomes discriminatory.

Despite the enormous damage done to the understanding that human beings are diverse, studies on the impact of cisheteronormativity on health fields in Brazil are still scarce, especially when it comes to the health of women who have sex with women (WSW).

Considering the right to health as a fundamental right guaranteed by law, Ministry of Health Ordinance Nº. 2836 of December 1, 2011, which establishes the Comprehensive LGBTQIA+ Health Policy, and the definition of sexual rights (8) as the right to live and express sexuality freely without violence, discrimination and with the right to health services that guarantee privacy, confidentiality and quality care without discrimination, including the right to adequate information and sexual and reproductive education.

In view of the gap presented, this article aims to understand the perception of WSW regarding the care they receive in health services, in the context of their sexual and reproductive health, in order to verify whether health care is offered to them in a way that is consistent with their sexual orientation and, consequently, whether it manages to guarantee the integrality of their right to health. It also aims to highlight the importance of health professionals in guaranteeing these rights, and the need for these professionals to be better trained to attend to the health of the LGBTQIA+ population.

## Methodology

After submission and approval by the Research Ethics Committee (CEP), under CAAE: 51061621.3.0000.8093 and Opinion Number: 5.360.056, the research was carried out in three stages: literature review; data collection using an individual form via the internet; and an individual interview via an online meeting. During the first stage, there was a systematic review of the available literature focusing on the sexual and reproductive health of women who have sex with women, mainly in the

national literature. The descriptors used were: Sexual and gender minorities; Women who have sex with women; Comprehensive health care. The search was carried out on the LILACS, PUBMED and BVS platforms, totaling 46 relevant files, 28 of which were submitted for analysis, as they were more comprehensive, as well as classic titles not included in the publication date criteria. Data collection took place between April and June 2022, the period planned for development, according to the research project schedule

The second stage, which involved collecting data using an online form, sought to gather initial information on WSW, their access to affective-sexual health and the design of health services, and was carried out between June 10, 2022 and June 28, 2022, the deadline set for data collection in the research schedule.

In the third stage, an individual interview was scheduled via Whatsapp and carried out in a comfortable and private virtual environment on the “Google Meet” meeting platform, without recording or storing data. The interview took an average of 30 minutes and was guided by a semi-structured script that aimed to achieve greater humanization and connection with the women interviewed and their personal experiences, and took place between 11 July 2022 and 26 July 2022.

It is important to note that none of the interviews were recorded, in order to make the environment as welcoming and uncomfortable as possible, so the data was described in a research diary during the course of the study. In order to be included in this study, the women had to have sex with one or more other women, whether cisgender or transgender. The exclusion criteria were women under the age of 18 and/or women who had never had access to sexual and reproductive health services.

It is understood that the research sample is still small ( $n=287$ ) compared to the national population of WSW, however, the lack of research and investment in the area makes the research relevant to discussing health care for these women.

The survey instrument was an electronic form, and the response parameters (to categorize the response as adequate or not) were based on the literature and were also subjected to analysis by professional experts in the field, as to their clarity and content, and tested beforehand.

In order to ascertain the perceptions of these women, we used the qualitative and quantitative methodology of Collective Subject Discourse (CSD), as well as the “Snowball” sampling technique - where each participant sends the initial response form to two or more people who match the survey’s target audience. In this way, the sample is self-generated, relying on the voluntary collaboration of the MSM contacted initially and those that follow (9). It should be noted that the sample was drawn from a young, female audience in the Brasília region. Based on the “Snowball” methodology, it is understood that the sample becomes less diverse in terms of socio-cultural patterns. However, with the advent of the internet, the responses were able to go beyond the social sphere in which it was initially launched, reaching women of varying ages (18 to 51), who use both the public and private health systems and with samples in all regions of Brazil.

The discourse was analyzed using the Discourse of the Collective Subject (DSC) methodology, where the central ideas of these women were identified. As Lefèvre and Lefèvre (10) point out, when social research seeks to retrieve the thoughts of a group on a given topic, it is necessary to “consider that the thoughts or opinions of the individuals who make up this group can only legitimately be seen as a discursive statement, understanding as such the linguistic manifestation of a position on a given topic” (10).

## Results and discussion

The data was analyzed qualitatively and quantitatively. We'll start with the quantitative data obtained from the forms.

Among the 287 respondes analyzed, the predominant sexual orientation was “lesbian”, with 50.9% of the responses, followed by “bisexual” with 43.6%. Pansexuals and “not defined” accounted for 5.2% of the responses. With regard to gender identify, 96.9% of the women identified themselves as female and only 3.1% as non-binary. 97.9% of the responses were from women who declared themselves cisgender, with only 2.1% (6 responses) coming from transgender women.

With regard to the age profile of the respondent population, there is a predominance of young people in the 18-25 age group, with 64.1% of the responses, with a range of ages between 18 and 51. 51.2% of the respondents called themselves white, while the black and brown population accounted for 47% of the responses. With regard to schooling, 90.2% had at least higher education, with the majority in this bracket (62.4%). There was no in-depth study of the social class of those interviewed, with a view to providing a global view, but a comparative study of the different social classes is planned for future projects.

Among the occupations, student and trainee positions stood out, accounting for 92 responses (32%), while another large proportion had higher education occupations, correlating with the high level of education obtained in the responses. There was no further quantitative analysis of the use of the public or private health care network, but comparative research is encouraged to develop the results further.

With regard to health care, 12.2% of the women had never received any sexual and reproductive health care. It's important to note that among the reasons for this disconnection of WSW from the health environment, the main ones are fear of being poorly attended to or raped in health environments, lack of correct information about the care they should take of themselves, which leads them to believe that there is no need for sexual and reproductive health consultations because they are WSW.

As this was a criterion for remaining on the questionnaire, women who had never visited a health center were sent to the end of the form. In this way, the data collected included 254 WSW.

Of this sample, 85.4% of WSW said that no health professional had asked them about their sexuality, and 38.6% said they had not informed them of their sexuality spontaneously. A 2018 study (1) showed that there is a relationship between being seen more quickly or not being examined after revealing having sex with women. This is confirmed by the response of the WSW in this study, where 68.1% of the women said that their last appointments were between 10 and 30 minutes, which correlates with 59.6% of the women who are always changing health facilities in order to find decent care, or who would change if they could.

When qualifying health care in terms of humanization - feeling listened to, welcomed and respected - only 18.5% fully agreed, showing that, in some way, more than 80% of the health care provided to these women was embarrassing or disrespectful. And only 13.4% agreed that they had their questions answered satisfactorily in healthcare environments. 40.9% of women say that they have never received relevant information about Sexually Transmitted Infections (STIs) in healthcare settings, despite the fact that 91.7% of respondents consider specific health information to be “very important”.

Despite the fact that 35% of WSW say that they have had tests requested, the qualitative analysis shows that there is a huge segregation of essential tests for the health of WSW, such as Pap smears and



transvaginal tests, which were denied after they reported that they were WSW. This is confirmed by the response of 79.9% of the women, who say that there was no conduct on the part of health professionals capable of meeting their needs as WSW, revealing the immense disregard for the health of this population. This disregard is confirmed when 67.3% of women say that they have felt embarrassed in healthcare environments.

However, 78.3% of women say they have not felt violated in healthcare settings. It is interesting to note that this figure reiterates that many people are unable to recognize the violence they have suffered. It is well known that the perception of situations of violence is influenced by various factors, such as institutional violence, which is less perceived due to an already stratified structure that theoretically guarantees safety. In addition, it is known that traditional gender roles have a major influence on the perception of and reaction to situations of violence (11). When it comes to the perception of lesb, bi, pan or transphobia, the data is equally lower, with only 27.6% stating that they perceived themselves as victims of such violence. However, the survey reveals that only 34.7% of women say they are satisfied (29.2%) or very satisfied (5.5%) with their healthcare environments.

Qualitatively, 99 discursive reports of violent and/or embarrassing situations in healthcare environments were collected and may present more than one central idea at the same time. Considering the total number of women who completed the form (254), the 99 reports show that 38.9% of the women felt comfortable briefly reporting some of the embarrassing events, but it should be reiterated that, objectively, 80% of the respondents revealed that they had already felt embarrassed or disrespected in healthcare environments.

The 2018 study by Crispim et al. (12) shows that there is a significant deficit in care for MSM, causing health vulnerabilities for this population group. According to Crispim et al. (12) part of this deficit can be remedied with greater study and understanding by the health professionals responsible for providing care. Considering that the opinion of WSW is an essential factor in better structuring health care, the reports were categorized, highlighting the following central ideas: A- Physical violence suffered in health services, B- Neglect and lack of reception in gynecological consultations and in health services, C- Presumption of heterosexuality in health services, D- Invisibility and moral and psychological violence.

Central idea A - Physical violence suffered in health services, highlights practices that lead to physical harm to these women. The WHO emphasizes that violence is "the intentional use of force or power [...] that results in, or is likely to result in, injury, death, psychological harm, developmental problems or deprivation" (13). There were 6 reports, most of which were made during more invasive physical examinations, such as pap smears or transvaginal ultrasounds. The reports range from extremely uncomfortable exams, with unnecessary use of force, introduction of instruments without prior warning, exams without narration by the professional during the procedure, and even introduction of instruments in places that were not part of the procedure, as reported:

The professional's finger was inserted into my anus (I later understood that it wasn't a necessary procedure). (A1, 37 years old)

I felt violated when I went for a test, a transvaginal ultrasound, the doctor who was doing the test didn't even talk to me, didn't even mention the test, I felt invaded and violated. (A2, 22 years old)

The discussion of physical violence against WSW during medical procedures related to sexual health becomes even more frequent as other layers of vulnerability are added. When the WSW is a trans woman, or does not perform standard femininity, or is a black woman, the risks of suffering institutional violence grow substantially, as it is necessary to consider the intersectionality present in these violences, in terms of the racial and cisnormative issue.

One of the interviewees declares that within her community of lesbian “truck drivers” (who don't perform a standard femininity, taking on traits seen as more masculine in a more obvious way) there is one:

Trauma that is shared, it's a collective trauma. It's a violent thing that happens very often, otherwise there wouldn't be so many women talking about it. (A3, 33 years old)

Central idea B - Negligence and lack of reception in gynaecological consultations and health services - groups together reports in which the women interviewed do not have their demands met or requests taken seriously because they have sex with another woman, which also characterizes violence. Since there is a constancy and high distribution of episodes of violence, negligence and a lack of reception are characterized as institutional, in other words, there are elements within the structure of the relationship between the service and the user that lead to violent relationships (14). This central idea encompassed more than 38 reports of serious negligence, ranging from women who were never asked for tests or who didn't have enough information about how to protect themselves from STIs and therefore avoided having sex. This demonstrates that the lack of correct information is a negligence that directly interferes with the construction of WSW lifestyles.

The doctor didn't want to do the preventive exam because I'd only had sex with women. (B1, 24 years old)

This is an extremely serious negligence that exemplifies why cervical cancer, which is 100% curable when referred for early treatment, has an increased lethality of more than 10% in non heterosexual women (1). A survey of around 40 health professionals in 2014 in Rio de Janeiro, aimed at finding out how health professionals cared for lesbian women, revealed a central stigma in relation to the pap smear and the performance of femininity (15).

Clinical prejudice was very present in the words of the professionals who made a distinction between “feminine and masculine” lesbians and constructed an image in which lesbians who were less “feminine” had no problem with the speculum, while the others who were “more masculine” “didn't like men, that's why they didn't want the speculum”. Araújo et al. (15) point out that factors of gender expression directly determine the quality of care, where women who least conform to standards of femininity were the only ones considered lesbians, but even so, as this study reveals, only 14.6% of WSW are asked about sexual orientation, and the information is therefore presumed. And when sexuality and race are intertwined, the reports of violence and invisibility increase even more for black lesbian and bisexual women (1).

This evidence already leads us to the next central idea, C - Presumption of heterosexuality in health services: treating every woman who presents herself at the doctor's office as a straight woman and refusing to ask about her sexuality is to declare that the only possible sexuality is straight, which summarily characterizes compulsory heterosexuality. Each of the 217 WSW who have never been asked about their sexuality in healthcare settings reveals a part of the compulsory heterosexuality that

prevails. And it is strongly related to the embarrassment felt by 67.3% of WSW in healthcare settings. There is a consultation script that is common to WSW,

It's always like this, 'Oh, you have sex? Yes. What contraceptive method do you use? I have sex with women' and then I always felt the atmosphere was heavy. (C1, 25 years old)

I had to take Roacutan and the doctor insisted I take a Beta HCG test. I was reluctant and did it. Until I said I was 'dating a girl' and silence reigned. As if it wasn't even a possibility. (C2, 21 years old)

Another difficulty is the lack of importance given to this demand in the educational institutions responsible for training these professionals. While gay issues are always fraught with prejudice and the stigma of the HIV/AIDS pandemic, lesbian issues are not discussed at any point in many undergraduate courses, making them invisible (15).

Closely related to the topic above, central idea D - Invisibility and moral and psychological violence. There were more than 20 reports where professionals, due to their own prejudices, made the sexual and reproductive health agenda invisible and invalidated.

When asked if I had an active sex life, I said yes, because I had been in a same-sex relationship for four years. The doctor then said that I didn't have sex because I only 'masturbated' because women don't have sex with women. (D1, 25 years old)

I've never had the courage to broach the subject with my gynecologist and I lie that I'm a virgin so I don't have to give any more explanations. (D2, 24 years old)

What seems to be just a way of avoiding embarrassment hides and makes invisible an entire trajectory and life choices. Bisexual women are also victims of this invisibilization, as she reveals:

As a bisexual woman, I notice that health professionals are more concerned when I have a male partner; when I have a relationship with a woman, it's kind of 'passed over', as if there were no forms of prevention or specific concerns. (D3, 24 years old)

In relation to STIs and forms of protection, MSM shows that professionals fail to exemplify effective forms of protection that do not compromise their enjoyment (15).

Moral violence ranges from gynecologists making referrals to psychiatrists for being lesbians, or to the church:

[...] because we were made to get pregnant, that's what god made us for. (D4, 25 years old).

A psychologist told me I was a lesbian because I had been sexually abused by a man. (D5, 24 years old)



There are common reports of embarrassment when donating blood, despite the fact that the right to donate blood is currently guaranteed by law, free from any prejudice regarding sexual orientation (16).

The structure that underpins healthcare environments, which are still extremely hierarchical, where doctors and other healthcare professionals are the holders of all knowledge, descends until it reaches the patient, who, depending on their level of vulnerability, has no information and no right to consent over their own body. This establishes a vertical power structure, or biopower, in the relationship between the health team and patients, as Foucault (17) points out, where the health professional appropriates the peculiarities of this relationship between the bodies of individuals and their vital processes and turns women into coadjuvants of their own lives (17,18). Apart from this rigid power structure within the consulting room, the connection between professional and patient is fragile. It's well known that building a stronger bond between caregiver and patient increases the viability of long-distance, effective care.

Sousa et al., (7) show that there is a greater abandonment of health follow-up among American lesbian women, as well as a 10% greater chance of developing chronic diseases when compared to heterosexual women, which demonstrates that these non-heterosexual women do not feel comfortable seeking care, let alone having continuity in the health system. This research shows that the situation of Brazilian MSM is no different.

Knowing more about the experience of women who have sex with women can be an important factor in promoting quality health care for this population, with greater acceptance and less prejudice (7).

For the MSM, care would be more dignified and welcoming with simple actions, such as open dialog with women, especially during more invasive procedures.

The environments are adapted for everything these days, for children in pediatrics, for the elderly in geriatrics, but when it comes to MSM health there is no conduct that is capable of welcoming us. (D6, 33 years old)

These are simple procedures, such as asking about sexual orientation, offering the possibility of changing the size of the speculum, information specific to MSM and which breaks with cisheteronormativity, and which make all the difference in health care.

## Conclusion

It is clear that WSW still suffer a series of discriminations and violence in health services when they seek comprehensive care, especially with regard to their sexual and reproductive rights. Even more than 10 years after the launch of the National LGBT Health Policy, it is still far from being implemented and practiced in healthcare environments, and even more so when it comes to the health of MSM. No public policy is actually effective and there are few comprehensive studies in this área.

The health of WSW should be discussed more broadly, to encompass factors that extend to protection against STIs and invasive tests to prevent breast and cervical cancer. With the expanded concept of health adopted by the WHO, where health is more than just the absence of disease, but rather "the result of conditions of nutrition, housing, education, income, environment, work, transportation, employment, leisure, freedom", prejudice within consultations is an important social

determinant of health, as it directly influences the well-being of the LGBT public and the way in which they will build their healthy lives.

This study suggests that other factors should be considered in research, such as the fact that female pleasure is still taboo, even within academia. Men, even within the LGBTQIA+ world, are Cad. Ibero-amer. Dir. Sanit., Brasília, 13(1), 2024 9 <https://doi.org/10.17566/ciads.v13i1.1033> often asked about pleasure in relationships, orgasms, premature ejaculation and other factors dissociated from their fertility, while women's health is always the main focus.

This study hopes that this information will be discussed more and more. The more MSM are aware of their vulnerabilities, the more they will be able to demand dignified and targeted care for their health conditions. In this way, they will be able to demand targeted public policies and health professionals who are trained to provide more humanized care.

At the forefront, by listening directly to the experiences of MSM, and what their priorities are in health care, further studies can be carried out with the aim of training health professionals and restructuring the cultures of care, increasingly aiming to create an effective and fruitful bond in health environments, whether public or private.

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The authors declare that there is no conflict of interest.

### Author's contribution

Ferreira BF contributed to the conception/design of the article, data analysis and interpretation, writing of the article, critical revision of its content and approval of the final version. Marques SB contributed to the conception/design of the article, data analysis and interpretation, writing of the article, critical review of its content and approval of the final version. Andrade J contributed to the conception/design of the article, data analysis and interpretation, writing of the article, critical review of its content and approval of the final version. Bruno CTS contributed to critically reviewing the content and approving the final version.

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