

Sexual and Reproductive Health: Gender Inequities in Care for Sexual Minorities

Saúde Sexual e Reprodutiva: Iniquidades de Gênero no Atendimento a Minorias Sexuais

Salud Sexual y Reproductiva: Desigualdades de Género en la Atención a las Minorías Sexuales

RESUMO

Objetivo: Desvelar como mulheres lésbicas e bissexuais compreendem as práticas de saúde sexual e reprodutiva em serviços de atenção primária no Brasil. **Método:** Estudo qualitativo, descritivo, com mulheres cisgêneras brasileiras. A coleta de dados sociodemográficos e de saúde ocorreu por entrevistas digitais analisadas por análise temática dedutiva com NVIVO 14. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa (CEP) Humanas/UFF parecer nº 6.510.570. **Resultados:** Participaram 61 mulheres, majoritariamente jovens, brancas, solteiras, bissexuais, com ensino superior, religião de matriz africana e residentes no Rio de Janeiro. Emergiram duas categorias temáticas: cuidado centrado no modelo heteronormativo e violências de gênero e suas repercussões sociais. **Conclusão:** Evidenciou-se um cenário preocupante no atendimento à saúde sexual e reprodutiva dessas mulheres, marcado por negligência e preconceito, que comprometem a integralidade do cuidado.

DESCRIPTORES: Estudos Populacionais em Saúde Pública; Saúde da Mulher; Minorias Sexuais e de Gênero; Saúde Sexual e Reprodutiva.

ABSTRACT

Objective: To unveil how lesbian and bisexual women understand sexual and reproductive health practices in Primary Health Care services in Brazil. **Method:** A qualitative, descriptive field study conducted with Brazilian cisgender women aged 18 years or older. Sociodemographic and health data were collected through digital interviews and analyzed using deductive thematic analysis with NVivo 14. The study was approved by the Research Ethics Committee (CEP) Humanas/UFF, opinion no. 6,510,570.

Results: Sixty-one women participated, mostly young, white, single, bisexual, with higher education, affiliated with Afro-Brazilian religions, and residing in Rio de Janeiro. Two thematic categories emerged: care centered on the heteronormative model and gender-based violence and its social repercussions.

Conclusion: A concerning scenario was identified regarding the provision of sexual and reproductive health care for these women, marked by negligence and prejudice, which compromise the comprehensiveness of care.

DESCRIPTORS: Population Studies in Public Health; Women's Health; Sexual and Gender Minorities; Sexual and Reproductive Health.

RESUMEN

Objetivo: Revelar cómo las mujeres lesbianas y bisexuales comprenden las prácticas de salud sexual y reproductiva en los servicios de atención primaria de salud en Brasil. **Método:** Estudio cualitativo, descriptivo y de campo realizado con mujeres cisgénero brasileñas mayores de 18 años. Los datos sociodemográficos y de salud se recopilieron mediante entrevistas digitales y se analizaron mediante análisis temático deductivo con NVivo 14. La investigación fue aprobada por el Comité de Ética en Investigación (CEP) Humanas/UFF, dictamen n.º 6.510.570. **Resultados:** Participaron sesenta y una mujeres, en su mayoría jóvenes, blancas, solteras, bisexuales, con educación superior, de religiones de matriz africana y residentes en Río de Janeiro. Surgieron dos categorías temáticas: atención centrada en el modelo heteronormativo y violencias de género y sus repercusiones sociales. **Conclusión:** Se evidenció un escenario preocupante en la atención de la salud sexual y reproductiva de estas mujeres, marcado por negligencia y prejuicio, que comprometen la integralidad de la atención.

DESCRIPTORES: Estudios Poblacionales en Salud Pública; Salud de la Mujer; Minorías Sexuales y de Género; Salud Sexual y Reprodutiva

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INTRODUCTION

The National Policy on Comprehensive Women's Health Care represents a significant advance for women's health; however, there are still gaps in care directed toward women who have relationships with other women. In light of this, the 2004 public policy emphasizes the need for trained professionals to serve this clientele, seeking comprehensive care as one of its objectives⁽¹⁾.

Nine years have passed, and in 2013, the National Policy on Comprehensive Health Care for Lesbians, Gays, Bisexuals, Transvestites, and Transgender People noted that approximately 40% of lesbian women did not disclose their sexual ori-

entation during health care visits. However, the policy also highlights inequalities regarding cervical cancer screening through cytopathological testing (Pap smear), where lesbian women (66.7%) undergo this procedure less frequently compared to heterosexual women (89.7%). Once again, the elimination of institutional prejudice was reinforced as a goal, as well as the reduction of inequalities through the consolidation of the SUS⁽²⁾.

Data released by the Federal Government in 2019 through the National Health Survey indicate that there were 159.2 million people aged 18 or older in the country; 1.7% of women identified as lesbian (0.9%) or bisexual (0.8%), that is, equivalent to

2,706,400 people. The same survey states that there are limitations to the study, one of which is the existing social stigma regarding people who do not fit the heteronormative standard; this fact highlights the difficulty in accessing this population and, consequently, understanding their needs and individualities⁽³⁾.

Studies indicate that this group of women faces difficulties in accessing health services, with multiple factors contributing to this reality, particularly the intersection of race, sexuality, and class when discussing sexual and reproductive health (BRASIL, 2013), that is, there are few relevant studies that address these issues by interconnecting social determinants; as a result, the health of this population

remains exposed to immeasurable risks, exacerbated by invisibility and prejudice⁽³⁾.

The Clinical Protocol and Therapeutic Guidelines for Comprehensive Care of People with Sexually Transmitted Infections, from 2022⁽⁴⁾ outlines the principles for conducting a consultation aimed at a respectful and effective professional approach to the population, using inclusive language, a welcoming environment free of prejudice, and guaranteed confidentiality, thereby promoting a safe environment for listening and comprehensive care. Thus, one should not assume the patient's gender or sexual orientation; it is essential that this information be provided by the individual themselves. When addressing "specific questions," the document recommends that the sexual health approach include, regardless of the sexuality reported by the patient or client, aspects such as gender identity, sexual orientation, partnerships, sex, history of STIs, protective measures, and family planning.

Considering these technical and scientific premises, the objective of this study was defined as uncovering how lesbian and bisexual women understand sexual and reproductive health practices in primary health care services in Brazil.

METHOD

A qualitative, descriptive study conducted in a virtual environment via digital platforms with participants who identified as lesbian and bisexual women, cisgender, Brazilian, residing in Brazil, and over 18 years of age. The exclusion criteria for study participants were: heterosexual men, heterosexual women, women under 18 years of age, and lesbian/bisexual women who were illiterate and/or had limitations in completing the *online* form.

The first stage involved data col-

lection from January to November 2024 via an *online* form using the *Google Forms* survey management tool, which was self-administered by the study participants. Invitations were sent to *Instagram* user profiles of institutions addressing gender and sexuality issues. The snowball** technique was used to recruit new participants, where the first participants recommended new ones, with the aim of reaching a larger number of women and achieving greater regional coverage, as well as obtaining a wider variety of responses, in order to produce results that present a national overview of the sexual and reproductive health of the studied group.

This online form included socio-demographic, behavioral, and sexual and reproductive health-related variables: age, sexuality, gender identity, race, city of residence, education level, marital status, number of sexual partners in the past 6 months, number of pregnancies, births, and abortions, religion, frequency of gynecological visits, frequency of testing for STIs/HIV/AIDS and viral hepatitis, undergoing tests for and screening for breast and cervical cancer (clinical breast exam, mammogram, and Pap smear), methods of prevention for STIs/HIV/AIDS and viral hepatitis, use of legal and illegal drugs, and types of violence. At the end, the participants expressed their interest in participating in the second stage of the study.

The purposive sample reached 61 participants in this first stage, and of these, four women agreed to and participated in the second stage of individual data collection, which involved conducting semi-structured *online* interviews in 2024 via the *Google Meet* app, according to a pre-scheduled timeline for these meetings. For this online interview, all participants agreed to audio recording, which was subsequently transcribed and analyzed by the researchers while pre-

serving each participant's anonymity. The interviews lasted an average of 30 minutes and were conducted according to a predefined script that covered the following areas: the reasons for non-adherence to methods for the prevention of STIs/AIDS and viral hepatitis, receptiveness during consultations, the types of health concerns that led them to seek care, and the approach taken by the healthcare team.

The data were subjected to deductive thematic content analysis using the NVIVO 14 software, which contributes to high-quality scientific output⁽⁵⁾. The NVIVO 14 software enabled the creation of a word cloud and the organization of records from various data sources based on pre-existing patterns or codes, and facilitated relevant interpretations and conclusions⁽⁶⁾. The thematic content analysis was conducted through pre-analysis of the material, exploration of codes and meanings of the statements, grouping into record units for data coding, and construction of thematic categories⁽⁷⁾. Thus, the identified themes were: STI screening, cervical and breast cancer screening, prejudice, apprehension about revealing one's sexuality, reproductive health counseling, adherence to gynecological follow-up, care, specific and unique demands, and training of health professionals. These units were grouped and constituted two thematic categories, titled: care centered on the heteronormative model and gender-based violence and its social repercussions.

This study strictly adhered to CNS Resolution No. 510 of 2016, ensuring compliance with free and informed consent and the protection of participants, particularly in a virtual environment, and to CNS Resolution No. 466 of 2012, item III.2.i, which establishes procedures to ensure confidentiality and privacy, image protection, and the non-stigmatization

of research participants, ensuring that the information is not used to the detriment of individuals and/or the group, including in terms of self-esteem, prestige, and/or economic/financial aspects. This research was approved by the Institutional Review Board (IRB) of the Humanities Division at Fluminense Federal University, under opinion No. 6.510.570.

RESULTS

Of the initial sample of 60 (100.0%) study participants, it was found that the predominant age group was between 20 and 29 years old (53, or 87.3%); the majority of participants are residents of the state of Rio de Janeiro (37, or 60.0%), followed by São Paulo (12, or 20.0%); the prevalence concentrated in the Southeast region highlights the importance of considering regional disparities in the implementation of public policies. Difficulties in reaching women from other regions were addressed through an intensified outreach effort on social media and the expansion of the support network, including academic centers, lesbian and bisexual women's groups, feminist collectives, among others.

Furthermore, there is an almost equal distribution between bisexual women (32, 52.7%) and lesbian women (29, 47.3%), highlighting the diversity within the study population. The predominant educational level is a completed higher education (31, 50.9%), indicating a population with a higher level of formal education. Most participants are single (51, or 83.6%), which may influence their needs and priorities regarding reproductive health. Regarding race, the majority identify as white (37, 61.1%), highlighting the need for culturally sensitive approaches. In terms of religion, the majority identify as practitioners of Afro-Brazilian religions (30, 49.6%), suggesting the

importance of considering different religious perspectives in healthcare.

The findings regarding the health conditions and vulnerabilities of the study participants point to a high prevalence of legal and illicit substance use, including alcohol (59, or 96.4%) and marijuana (50, or 81.8%); have experienced psychological 50 (81.5%) and sexual 25 (40.7%) violence; do not use any method of protection against STIs/HIV/AIDS and viral hepatitis 58 (94.4%); reported having contracted an STI at some point in their lives, such as HPV 41 (66.7%) and gonorrhea 15 (25%); have never been pregnant 57 (92.7%); have not received any guidance on reproductive health (regarding whether they wish to have children, or whether mechanisms that enable pregnancy within a same-sex relationship—such as artificial insemination, for example—are discussed) 47 (76.4%); and 32 (52.7%) felt that, in some way, they had experienced prejudice regarding their sexuality during their gynecological visits.

Care centered on the heteronormative model

The results showed that the gynecological care provided to lesbian and bisexual women is still centered on a heteronormative model that disregards the specificities and needs of this population. There was a significant lack of guidance on reproductive planning (76.4%) and on the use of methods for protection against STIs (94.4%); a large proportion of these women (52.7%) also reported having experienced prejudice expressed through words or professional behavior regarding their sexual orientation during their appointments.

The logic of care centered on the heteronormative model can be illustrated by the participants' statements below:

No, it wasn't brought up at all; none of the doctors I saw asked me directly

[about my sexuality]; which I think should be one of the first things in a gynecological consultation. (Participant 2)

And then when I told her I was in a relationship with women, she was kind of surprised, mainly because I'm a feminine woman, you know, a woman who fits the stereotype. (Participant 4)

Furthermore, according to Lima and Tavares (2022), care centered on the heteronormative model impacts the sexual health of lesbian and bisexual women, given that the possibility of STI transmission between vulvas occurs primarily through the sharing of vaginal secretions, the use of unprotected sex toys, or direct contact between mucous membranes⁽¹⁰⁾.

The lack of knowledge about specific methods also emerges as a significant barrier. The reports emphasize the importance of education and information on prevention methods, highlighting the need for awareness campaigns targeted at this population. The results reveal a significant gap in STI prevention, which can be attributed both to a lack of knowledge and to the inadequacy of available methods. The invisibility of these women in the healthcare system leads to the assumption that they are not at risk, resulting in a systematic failure to advise them on preventive practices.

No, it was never offered. The only time I ever did it—and I know this isn't right—was when I donated blood back when it wasn't yet legal for LGBT people to donate blood, but I did; and then I used those tests—they gave me my blood test results—but it was never requested by a doctor. (Participant 2)

But in none of the relationships I've had—including when I was also dating men—was I ever offered an STI test, never, at any time. (Participant 3)

Regarding cervical cancer screening, the responses revealed neglect,

misinformation, and prejudice. The participants' accounts of their gynecological visits reveal an experience marked by negligence, prejudice, and a lack of support from healthcare professionals. One of the testimonies reveals that, upon learning the patient had sexual relations with a woman, the healthcare provider completely disregarded her needs and concerns, stating that they could not help her and suggesting she return only when she had relations with men. This attitude reflects the heteronormativity entrenched in the healthcare system, which marginalizes lesbian and bisexual women, denying them access to essential and appropriate care. The episode also highlights the importance of training healthcare professionals to ensure humane, inclusive, and respectful care that accommodates sexual and gender diversity.

Now, regarding sexuality, I've had instances of prejudice from gynecologists, some of whom said I don't need preventive care because I'm a lesbian. (Participant 1)

I questioned one of the doctors I saw about this; I said, 'I understand, but isn't the screening also so I can check if there's any risk?' And then she told me no, it's only if I had sex with a man, that it wouldn't make sense and I wouldn't be at risk for cervical cancer because I don't have sex with men. (Participant 2)

Additionally, it is crucial to highlight that the research also revealed the significant influence of prejudice regarding the sexuality of lesbian and bisexual women on the quality of gynecological care. The accounts obtained point to situations where professional unpreparedness regarding the specificities of these women results in negative experiences during consultations. A lack of sensitivity and understanding on the part of healthcare professionals can create a hostile environment where pa-

tients feel uncomfortable discussing their sexual and reproductive health. During the interviews, participants expressed that they feel their needs are not met during appointments.

Relationships with women bring different needs, right? So, to disclose this status and explain that I'd need closer attention—not just a heterosexual perspective—so contraceptive methods wouldn't be the priority—it would be the quality of my health, the possible implications of that, whether there's any type of infection that's more common in lesbian women or straight women, and whether that would imply any medical difference—I wouldn't know, but maybe she would, right? (Participant 4)

Lesbian and bisexual women often face significant neglect of their reproductive needs during gynecological appointments. This type of approach reflects the heteronormative assumption that permeates the healthcare system, where reproduction is often viewed solely in the context of heterosexual relationships. Such neglect disregards the reproductive desires of women who are in relationships with other women, limiting their access to adequate information and care regarding family planning, fertility, and reproductive rights.

I've never been asked if I want to be a mother; once they know you're a lesbian, that question doesn't come up. (Participant 1)

Everything I know about the subject is from the internet because I find it a very interesting topic, so I've always researched it extensively. So everything I know comes from the internet, from research and articles, but never during a consultation—no one ever asked me, never offered me options like freezing eggs, in vitro fertilization, or artificial reproduction; nothing like that was ever offered or even asked. (Participant 2)

And so, it's not a topic that comes

up; if you plan to have children at some point, discussing possible methods of having children—it was never discussed between us. (Participant 3)

The results point to the systematic denial of these women's right to access assisted reproductive methods, perpetuating an unjust disparity in access to reproductive technologies. This reality highlights the need for a comprehensive review of health policies, ensuring that all women, regardless of their sexual orientation, have equal access to reproductive options and family planning. In light of these findings, it is imperative that healthcare professionals, government institutions, and civil society remain attentive to these disparities, working together to promote a more inclusive, respectful, and effective healthcare system for all women, regardless of their sexual orientation.

The data reveal pertinent issues regarding professional training in the health field, suggesting that the absence of an inclusive and respectful approach toward sexual diversity may contribute to the perpetuation of discriminatory practices. Thus, it is legitimate to question whether professional unpreparedness is not, in part, derived from gaps in educational training, highlighting the urgent need for a curriculum revision that incorporates the diversity of sexual orientations and gender identities.

So, I think that to start with, professionals also need to update their knowledge, because things are constantly changing and we can't assume that the person being treated is heterosexual. [...] And if you have patients and the possibility of treating people who aren't heterosexual, then you need to update your knowledge, you understand? (Participant 3)

Gender-based violence and its social repercussions

This study also showed that gen-

der-based violence is a pervasive element in these women's lives, with 81.8% having experienced psychological violence and 40.7% having experienced sexual violence. Additionally, it is crucial to highlight that the research also revealed the significant influence of prejudice regarding the sexuality of lesbian and bisexual women on the quality of gynecological care.

A lack of sensitivity and understanding on the part of healthcare professionals can result in a hostile environment, where patients feel uncomfortable sharing important aspects of their sexual and reproductive health. During the interviews, participants felt that their needs were not met during appointments; some noted that they face significant difficulties in this regard and recognize how lesbophobia undermines their right to health.

When I was a teenager, I was put in therapy to be "cured." The therapist never really tried to cure me, but I was a 15-year-old teenager, and at a certain point in the therapeutic process, she tried to frame my sexuality as the reason I didn't have a relationship with my father—a very "Freudian" thing—but I was 15, so I didn't really understand it. She said it, and I let it slide; it wasn't until I was older that I started to think there was something wrong with that. (Participant 1)

She [the gynecologist] said: 'I can't do anything for you; I can't help you at all in this regard. When you have relationships with men, come back.' So I thanked her and left because I was very upset; I didn't want to stay there, so I left. (Participant 2)

Consequently, the impacts of this discrimination are profound, encompassing psychological distress, feelings of rejection, social isolation, and a higher incidence of psychological disorders, such as anxiety and depression⁽¹⁶⁾.

I was already nervous because I

needed to tell her that I wanted to have my IUD removed and that I no longer had relationships with men, but I was already sure that I would go in and say: "Look, I'm in a relationship with women and I don't want to use an IUD anymore." (Participant 3)

I was a little anxious when I went to tell her because of the doctor who used to treat me before, and I was like, "Oh no, if she treats me badly, I'll have to find another gynecologist—how am I going to find one?" (Participant 4)

They conclude, therefore, that these individuals often avoid accessing certain services due to the embarrassment and stigma they face during care. This avoidance not only compromises continuity of care but also increases the vulnerability of this population, reinforcing structural inequalities and inequity in access to health services⁽¹⁷⁾.

I went many years without seeing a

gynecologist because I get all my care through the SUS; I don't have private health insurance, so I get my care through the SUS, and seeing a gynecologist has always been very difficult for me because I was never able to build a connection with the doctor who was treating me—whether female or male; I've also been treated by a man, I always felt that my concerns were dismissed (Participant 1)

Illustrating the participants' discourse, we present below the word cloud (Figure 1), which highlights the words most frequently cited in the interviews, with similar colors indicating words that appeared in the same context. These words confirm the disparities in care, with "prejudice," "outdated," "lack of warmth," "private healthcare," "care only by a male doctor," "terrible care," and "reproductive health" emerging most frequently.

Figure 1: Word cloud based on the transcripts of the four interviews conducted in the study, Brazil, 2025.



Source: author's own work.

DISCUSSION

Heteronormativity, as a central concept, refers to a set of social expectations that position heterosexu-

ality not only as predominant but as mandatory⁽⁸⁾. It is an ideal of sexual and affective behavior imposed from childhood, which shapes identities and regulates relationships, guiding society to structure its norms of gen-

der and sexuality based on a heteronormative assumption⁽⁸⁾.

This heteronormative imposition occurs in a subtle and continuous manner throughout the entire process of the subject's formation⁽⁸⁾. When heterosexuality is naturalized and other experiences are marginalized, a system is established that not only renders dissident identities invisible but also pathologizes and criminalizes them⁽⁸⁾. This logic sustains a persistent cycle of exclusion and silencing, in which LGBTQIAPN+ people must constantly justify their existence, affections, and bodies, even in spaces that should be welcoming and protective, such as school, family, and health services⁽⁸⁾.

According to Lopes and Silva⁽⁹⁾, in healthcare settings, many professionals lack adequate training to address the unique needs of this community, perpetuating barriers to access, stigma, and discrimination in daily care. The absence of inclusive institutional guidelines and effectively implemented public policies reinforces the vulnerability experienced by this population, thereby denying their right to comprehensive and equitable care⁽⁹⁾.

In contexts of growing conservatism, Porcellis and Krause⁽⁸⁾ note that this discussion becomes even more urgent: denaturalizing heterosexuality does not mean denying it, but rather recognizing that it is one of several legitimate possibilities for emotional and sexual experience. Above all, it is a fundamental step toward ensuring that all forms of gender and sexual expression can exist with dignity, recognition, and respect⁽⁸⁾.

The absence of products and campaigns geared toward this sexual practice demonstrates how these experiences are systematically ignored and fuel the logic of silence and secrecy as a means of controlling bodies⁽¹⁰⁾.

It also reveals that condoms available on the market are still designed for penetration-centered sexual prac-

tices, requiring adaptations by those who experience sexualities outside this norm. This structure, in turn, reinforces the idea that the vulva is valued only within a reproductive, cisgender, and heteronormative framework, erasing other existences⁽¹⁰⁾.

Ordinance No. 497, dated May 9, 2016, establishes the Brazilian Guidelines for Cervical Cancer Screening, highlighting that the Pap smear is essential for all women who have become sexually active, regardless of their sexual orientation or the gender of their partner. The exclusion of women from access to adequate screening perpetuates inequalities in access to healthcare and demonstrates the strong influence of prejudice in clinical practice, disregarding scientific evidence. This behavior hinders the early detection of cervical lesions, which are caused by HPV, transmitted through intimate contact, including sexual practices between women⁽¹¹⁾.

Care protocols often assume heterosexual relationships as the norm, ignoring diverse sexual practices and gender identities that do not fit this normative model. This invisibility of diverse identities, in turn, results in exclusion and inadequate care, reinforcing inequalities and perpetuating barriers to access to care⁽¹²⁾.

As stated in the National Policy on Comprehensive Health Care for Lesbians, Gays, Bisexuals, Transvestites, and Transgender People⁽¹³⁾ the reproductive rights of lesbian women represent a crucial aspect of promoting comprehensive health, guaranteed by the SUS, based on the principles of equity and universality⁽¹³⁾.

These rights include equal access to reproductive health services, the right to clear and up-to-date information, and autonomy over their reproductive decisions. Furthermore, sexual and reproductive rights, as well as access to health care, education, housing, and food, are considered Fundamental Human Rights, and respecting them

is essential to ensuring a good quality of life in society, free from any form of discrimination⁽³⁾. Despite this, lesbian women face significant barriers in accessing dignified reproductive care, and this inequity is often marked by discriminatory and violent practices that undermine their reproductive experiences or desires⁽²⁾.

According to Paranhos and Willearding⁽¹⁴⁾, the training of healthcare professionals has significant gaps in preparing them to address the specific needs of this population. The absence of content addressing the needs and particularities of these care settings remains prevalent, resulting in the perpetuation of stigmas and discrimination within health services. This scenario is reflected in the lack of awareness and training among these professionals, creating barriers to access and compromising the quality of the services provided⁽¹⁴⁾.

In the Gender-Based Violence Primer published by the Public Defender's Office of the State of Rio Grande do Sul in 2023, gender-based violence is defined as any type of physical, sexual, psychological, or symbolic aggression against someone due to their gender identity or sexual orientation⁽¹⁵⁾.

Tagliamento and Silva⁽¹⁶⁾ analyze the consequences of LGBTphobia on the mental health of LGBT individuals and state that the discrimination experienced occurs in various contexts that, ideally, should be spaces of support and development, but often become environments of exclusion and hostility. The presence of discriminatory discourse reinforces prejudices and delegitimizes non-normative identities and orientations, contributing to the perpetuation of prejudiced practices and intensifying the challenges faced by this population⁽¹⁶⁾.

When Santos and Silva et al⁽¹⁷⁾ discuss the LGBT population's access to Primary Health Care services, they highlight that the low uptake of

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health services by the LGBTQIAPN+ population is directly linked to a scenario of exclusion and persistent violence in these settings. The lack of adequate support profoundly impacts the pursuit of care, worsening in the face of the multiple forms of violence and exclusion experienced, which perpetuate stigmas and reinforce cycles of marginalization in access to health care⁽¹⁷⁾.

One of the greatest challenges faced by this population in accessing sexual and reproductive rights is the contradiction between existing policies and daily practice in health services⁽¹⁸⁾. Indeed, discrimination, the lack of preparation among health professionals, and the absence of effective public policies create barriers that prevent the full exercise of these rights. Discrimination affects these individuals' lives, limiting their access not only to healthcare but also to education, employment, and housing, thereby perpetuating a cycle of social exclusion⁽¹⁹⁾.

The study on gynecological care for lesbian and bisexual women in Brazil

has some limitations. First, it is based on a limited sample, which may compromise the generalizability of the results. The absence of quantitative methods and more comprehensive statistical analyses may limit the objective measurement of the data's impact. Furthermore, the study did not have the same scope across all regions of the country and may not reflect the challenges and opportunities faced by participants with different sociodemographic or regional profiles.

This study offers significant contributions to all those working in the health field, particularly in nursing, by broadening understanding of the specificities of these patients' experiences and the impacts of heteronormativity on the care provided. By highlighting existing barriers such as prejudice, the invisibility of this group, and the lack of preparation among professionals, the research was able to corroborate, above all, the promotion of more inclusive, welcoming practices grounded in skilled listening, thereby strengthening the bond between patients and health services by promot-

ing comprehensive access, respect for diversity, and equity in gynecological care, in accordance with the principles of the SUS and human rights.

CONCLUSION

The study highlights a concerning situation regarding sexual and reproductive health care for lesbian and bisexual women in Brazil's health services. The negligence and prejudice of health professionals reveal inappropriate professional and ethical conduct that is not aligned with the ethical care mandated by Brazilian law. It is understood that sexual orientation in relation to heteronormativity intersects with and limits access to essential care. This erasure of the reproductive needs of lesbian and bisexual women perpetuates a cycle of misinformation and marginalization. Thus, the struggle for equity in access to healthcare must include the promotion of a culture of acceptance and respect for diversity, where all women, regardless of their sexual orientation, can be heard, attended to, and cared for.

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