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SEXUAL AND REPRODUCTIVE HEALTH IN PRIMARY HEALTH CARE: REPORTS OF LESBIAN WOMEN

SAÚDE SEXUAL E REPRODUTIVA NA ATENÇÃO PRIMÁRIA À SAÚDE: RELATOS DE MULHERES LÉSBICAS

SALUD SEXUAL Y REPRODUCTIVA EN LA ATENCIÓN PRIMARIA DE SALUD: INFORMES DE MUJERES LESBIANAS

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Objective: to analyze reports of lesbian women about sexual and reproductive health care in Primary Health Care services. Method: descriptive exploratory qualitative study conducted in 2019. Ten lesbian women exposed their reports in two focus group sessions, a strategy that generated the research data. These were submitted to thematic content analysis. Results: the participants expressed challenging cultural aspects for the quality of approaches, such as prejudice, body objectification, acceptance of homosexuality and ignorance of their affective-sexual practices. They understood that their sexual and reproductive health needs were not met, as they defined themselves, but recognized empathy and welcoming in the interaction with some health professionals. Final Considerations: care was revealed influenced by gender and sexuality stereotypes, which reduces access to quality Primary Health Care, which would support health care for lesbian women.

Descriptors: Sexual and Reproductive Health. Primary Health Care. Women's Health. Sexual and Gender Minorities. Stereotyping.

Objetivo: analisar relatos de mulheres lésbicas acerca dos atendimentos à saúde sexual e reprodutiva em serviços de Atenção Primária à Saúde. Método: estudo qualitativo do tipo exploratório descritivo realizado em 2019. Dez mulheres lésbicas expuseram seus relatos em duas sessões de grupo focal, estratégia que gerou os dados da pesquisa. Estes foram submetidos à análise de conteúdo do tipo temática. Resultados: as participantes expressaram aspectos culturais desafiadores para a qualidade das abordagens, como preconceito, objetificação do corpo, aceitação da

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homossexualidade e desconhecimento de suas práticas afetivo-sexuais. Compreendiam que suas necessidades de saúde sexual e reprodutiva não eram atendidas, conforme elas mesmas as definiam, mas reconheceram empatia e acolhimento na interação com alguns profissionais de saúde. Considerações Finais: revelaram-se atendimentos influenciados por estereótipos de gênero e sexualidade, o que reduz o acesso a uma Atenção Primária à Saúde de qualidade, promotora do cuidado para com a saúde de mulheres lésbicas.

Descritores: Saúde Sexual e Reprodutiva. Atenção Primária à Saúde. Saúde da Mulher. Minorias Sexuais e de Gênero. Estereotipagem.

Objetivo: analizar las denuncias de mujeres lesbianas sobre la atención de la salud sexual y reproductiva en los servicios de Atención Primaria de Salud. Método: estudio cualitativo exploratorio descriptivo realizado en 2019. Diez mujeres lesbianas expusieron sus informes en dos sesiones de grupos focales, una estrategia que generó los datos de la investigación. Estos fueron sometidos a análisis de contenido temático. Resultados: los participantes expresaron aspectos culturales desafiantes para la calidad de los enfoques, como el prejuicio, la objetivación corporal, la aceptación de la homosexualidad y el desconocimiento de sus prácticas afectivo-sexuales. Entendieron que sus necesidades de salud sexual y reproductiva no estaban satisfechas, como ellos mismos las definieron, pero reconocieron la empatía y la acogida en la interacción con algunos profesionales de la salud. Consideraciones finales: la atención se reveló influenciada por los estereotipos de género y sexualidad, lo que reduce el acceso a la Atención Primaria de Salud de calidad, que apoyaría la atención de salud para las mujeres lesbianas.

Descriptores: Salud Sexual y Reproductiva. Atención Primaria de Salud. Salud de la Mujer. Minorías Sexuales y de Género. Estereotipo.

Introduction

Free sexual orientation is one of the fundamental human rights, but sexual and gender minorities continue to be affected by less social protection and less legal benefits, especially in the Latin American context[1]. Despite the advances related to respect for this right, there are still discriminations based on homoaffective ways of exercising sexuality, which can affect other rights, as commonly occurs in access to health[2-5].

With regard to lesbian women, a group formed by women who relate sexually and/or affectively to other women[6], it is worth analyzing whether the absence of strategies promoting equity in health may be related to the increase of risks to certain injuries, especially those related to sexual and reproductive health. As an example, a study[7] conducted in the United States of America (USA), with the objective of evaluating the prevalence of screening of some types of cancer in groups recognized as sexual and gender minorities, concluded that lesbians were significantly less likely to be adhering to periodic cervical cancer screening.

In Brazil, public policies seek to compensate for the damage caused to sexual minorities, but they cannot sustain structural transformations in the life and full sociability of Lesbian, Gay, Bisexual and Transgender (LGBT), which may reflect the increase in vulnerable health conditions[8]. Even so, it is worth highlighting, as an important milestone of these policies for the health of lesbian women, the implementation of the Protocol for Primary Care of Women's Health[6]. This document guides the teams working in Primary Health Care (PHC) in the recognition of lesbian identity. One of the expectations of this recognition is to correct the false conviction of health professionals and women themselves that they are not at risk of infection, for example, by the Human Papilloma Virus. It also highlights the right of lesbian and bisexual women to plan sexual and reproductive life, reproductive technologies, legal abortion and humanized care during pregnancy, childbirth and the puerperium[6].

In PHC, professionals can promote health and reduce inequalities that keep lesbian and bisexual women away from services, because it is possible to have a structure prepared to address health in their biopsychosocial conception,

which includes determinants related to prejudice and social discrimination[9].

The scientific literature on the health of lesbian women, especially in relation to meeting their needs in the sexual and reproductive sphere, has been gaining prominence in recent years. To collaborate with the advancement of this knowledge, a study was proposed, and the main question was: What reports of lesbian women express the ways in which PHC services meet their needs in the field of sexual and reproductive health? The objective of this study was to analyze reports of lesbian women about sexual and reproductive health care in Primary Health Care services.

Method

An exploratory-descriptive study was conducted with a qualitative approach. Thematic analysis and interpretative line based on theories about the social construction of sexuality supported the treatment of data[10-11]. The participants were ten lesbian women assisted in PHC services in a capital of southern Brazil. The inclusion criteria were: lesbian women aged 18 years or older, who had already had experience of consultation in PHC services in the public network. The exclusion criterion was: women who also declared themselves bisexual. Contacts with the participants were made through an invitation in a specific group of the social network Facebook, which brings together the population of lesbian women from the region where the study would be conducted. The data were produced in the first half of 2019, in two focus group sessions, with the participation of five women in each meeting.

The focus group technique consists of the interaction between the participants and the researcher with the objective of collecting data about a given theme and knowing significant aspects of the reality of the group[12]. In this research, in both sessions, the following guiding questions were used: Tell us about what it is like to experience the condition of lesbian women in society; *Tell us about their health experiences as lesbian women, focusing on the care received in Primary Health Care services (health centers, family health units and clinics) in relation to their sexual and reproductive health; How do you think it is the best approach by a professional in your unit in relation to your health needs?* Each session lasted approximately 1 hour and 45 minutes. The saturation criterion occurred when the information generated in the group sessions began to repeat itself, in quantity and intensity. Saturation was also verified by the research team when they found sufficient density of the information needed to meet the study objective[13].

For operationalization, the meeting was organized in five moments: presentations and group contract; presentation of the objectives; animation technique (games and games) for relaxed and stimulating debate; discussion/ debate; at the end, synthesis and collective validation. The focus groups were held in a room, located in the premises of the School of Nursing of the Federal University of Rio Grande do Sul, which was previously reserved, in order to provide comfort and privacy to the participants. One of the researchers had previous experience in conducting focus groups and played the role of moderator of the discussions, with the help of two other researchers who positioned themselves as observers and collaborated in logistics aspects. The information was recorded in audio, fully transcribed and encoded. The final material constituted a total of 55 transcription reports.

The material was the analysis was through the thematic analysis proposed by Minayo, characterized by three stages[14]. In the first stage – exploratory – which constitutes the pre-analysis, we sought to establish the characterization of the researched group and the understanding of the reports as lesbian women in social relations, focusing on relationships in health services. In addition, the form of categorization and the coding modality were delineated. The second stage - exploration of the material - was characterized by a classification operation to reach the core of understanding the text. At that moment, the data were organized into thematic categories, reducing the text to meaningful

expressions or words. The third stage consisted of the processing of the obtained data and the interpretation. Inferences and interpretations were then performed, correlating them with the pre-established theoretical framework, but also allowing the opening of new theoretical and interpretative dimensions, suggested by reading the collected material.

The discussion was based on theoretical perspectives that sought to understand the social construction of conducts related to sexuality as opposed to the essentialist and binary conceptions[10-11] that dominate the theme, especially in the health field. The use of such perspectives in the analysis of health issues has been expanding since the advent of HIV/AIDS, and the movement that elaborated multidimensional explanations of life and sexual experiences is successful in line with the defense of social interests and political rights of vulnerable communities[10].

The research respected the ethical aspects provided for in Resolution nº 466/12 of the National Health Council and was approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul under Opinion nº2,646,913 and Certificate of Presentation of Ethical Appreciation (CAAE) on 87126418.2.0000.5347. To maintain confidentiality, in the presentation of the results, the statements were identified with the following code: letter W (of woman) accompanied by sequential numbers (W1, W2, W3... and W10) and letter G (of group), accompanied by the number corresponding to the group session from which the speech was selected, followed by the participant's age.

Results

Ten women of an age group ranging from 18 to 40 years of age participated in the study. Regarding the current status of affective-sexual relationships, seven women said they were single and three had a partner with whom they had a stable relationship. Regarding race/color, two declared themselves black and eight were white. On schooling, two women reported having completed high school, four had incomplete higher education and four had completed higher education. Among the occupations, five reported studying (undergraduate or graduate), three performed autonomous activity and two maintained a formal work bond.

The analysis of the information generated by the research showed two thematic categories. The first denotes the invisibility of lesbian women in health services and the unpreparedness of PHC professionals to deal with their needs in the sexual and reproductive sphere. The second shifts the problems of reality to present what would be desirable for the participants in terms of attention and reception to their needs.

Invisibility, prejudice and mistreatment of services in meeting the needs of lesbian women

Before mentioning the specific cases that occurred in health services, women reported the difficulties in coping with prejudice/homophobia permanently experienced in the most diverse contexts. The process of acceptance of a sexuality diverging from the heterosexual norm is presented in the statements and points to aspects such as self-acceptance, social belonging and social invisibility.

> *The question of being gay is traumatic. It's a whole understanding to be able to face it, understand and face prejudice.* (W1 – G1, 19 years old).

> *Whatever you do in your life, you're going to be three times more looked at or judged, because besides you being a woman, you're a lesbian.* (W2 – G1, 18 years old).

> *There's the question of belonging. To this day it happens to me to assume myself or not lesbian in some group or space. If I get into a group that I think can be harmful to my sexuality, I'm not going to talk, I don't take it.* (W5 – G2, 21 years old).

> *Lesbian woman is a place of great invisibility. Everything is strongly related to love, romanticism, heterosexual sexuality and the rest practically does not exist.* (W1– G2, 29 years old).

Compulsory heteronormativity, one of the constant elements in the social imaginary, was evidenced in the reports obtained from the participants. This phenomenon, according to them, was present in the way of treating some

health professionals, with great potential to generate discomfort, constraints and approaches in which they felt violated.

> *I said, "The relationship was with a woman." And she* [primary health care professional] *said, "There's nothing you're doing here. When you have sex with a man, then you come back here."* (W5 – G1, 29 years old).

> *They always check out what you're saying. People said, "Stay with a boy"* [...] *it's very uncomfortable, because you are treated totally as an object.* (W3 – G2, 32 years old).

About being lesbian women with health demands presented in PHC, the participants mentioned the lack of knowledge of society and health professionals, in particular, about the sexual practices of lesbian women, experimentation of their bodies and prevention of health problems.

> *You do not have any information on the part of professionals; have to search the internet.* (W2 – G1, 22 years old).

> *This exposes us, leaves us in a risk group* [...] *Little is known about the incidence of transmission of sexually transmitted infections.* (W6 – G2, 29 years old).

> *The other issue is the knowledge of the body of the woman and this woman who is a lesbian, because she relates differently than a straight woman* [...] *so she is exposed to different issues.* (W4 – G1, 18 years old).

The discussion about the scenarios and experiences in sexual health care in PHC revealed a lack of knowledge of professionals in meeting the health demands and needs of lesbian women. Health practices, regulated by a heteronormative approach, restrict the provision of services and guidance to lesbian women. Doubts, taboos and prejudices permeate this care scenario.

> *The first time I went to the doctor's was after my first sexual intercourse, which was with a woman. I had sex and then I thought, "Okay, what do I do now?" Because I was trained to protect myself, if I had sex with a man* [...] *And then, when I went to the gas station, she already assumed that I had sex with a man. She asked if I'd used a condom and I said no. She asked, "Do you use birth control?" And I said, "Not either." And she said, "You're not helping yourself." I said, "It's just that I had sex with a woman." And then she said, "Then you know you're still a virgin."* (W1 – G1, 19 years old).

> *So I had my first relationship. Only, when I went, I said, "It was with a woman." And she [doctor] found herself in more doubt than I did. She sat down and said, "Now, what are we going to do?" And I said, "Are you at risk of any disease?" And she's like, "I don't know."* (W4 – G1, 18 years old).

> *When I arrived to be attended, the doctor had a pattern of heterosexual questions.* (W2 – G2, 18 years old).

Insufficient appropriation of specific knowledge to meet the needs of lesbian women generated frustration for one of the participants. For another, it was apparent how much the professionals end up forging a standardized care or, according to one of the interviews, conducted on the basis of a "combo" of options that detonator their expectations of care.

> *That's what you get out of there knowing. Use a condom. There's nothing else for me that I've learned and that I've discovered.* (W4 – G2, 21 years old).

> *Came the "combo"* [cytopathological examination and guidance on the use of contraceptive methods] *in the first consultation. I told the doctor, "I'm a lesbian woman, so you don't have that pill."* [...] *He replied, "Yes, yes, there is not much even right... would have to see. He was visibly embarrassed, but he wasn't violent, at least.* (W5 – G2, 21 years old).

The issue of violence in care was also mentioned in the following report:

> *I was referred to the cervical smear and I felt raped. I'm not an isolated case. Most of my lesbian friends don't take any kind of exam, afraid to go through it again* [...] *lack of care.* (W1– G2, 29 years old).

In addition to experiences of violence, some participants expressed that they felt neglected by health professionals, which was reinforced by the lack of reception and resolution of their health needs, as highlighted in some reports:

> *I went to see because my partner had an infection, and I was not with the symptoms she had, but I had doubts. I asked her if I could take it and she* [professional] *couldn't answer me. Because this issue of sexual transmission, we don't know that* [...] *and then, how are you going to preserve yourself? You need to know for the pros!* (W3 – G1, 26 years old).

> *On the blood test came from high prolactin, and I always had low vaginal lubrication. Then I went to research, and I said, "It has nothing to do with this, doctor?" I had to research him because he couldn't guide me.* (W1 – G2, 29 years old).

> *Can you imagine something happening? I've got some disease, maybe it infects other people, or you have some more serious problem in the future, because a professional hasn't given you decent care. He didn't give you anything for guidance, treatment, because if I hadn't gone there, it would be the same thing.* (W8 – G2, 23 years old).

> *It was desperate. I left the consultation with more doubts than when I came in* [...] *and I was scared. So it took me a long time to get back on duty. I think it was the first time I suffered lesbophobia so explicitly.* (W4 – G1, 18 years old).

Sexual and reproductive health care of lesbian women in PHC should cover the preservation of sexual health and the guarantee and promotion

of sexual and reproductive rights. However, implementing it in an integral way is still a great challenge for professionals working in this care context. The participants' statements revealed the professionals' lack of knowledge about sexual practices and prevention measures appropriate to lesbians, in addition to approaches based on gender and sexuality stereotypes, inequities of access to health and tendency to rape their bodies.

Between the real and the ideal: the approach to lesbian women in Primary Health Care

Even with the lack of knowledge of its particularities, the women reported being satisfied with some consultations by the professionals in the consultations. In these cares, empathy and welcoming were strengths of the interaction, as well as the care in performing the technique during the gynecological examination.

> *My experience was very quiet with preventive examination* [...] *I said I had not had sex with men and she had a little more care.* (W4 – G1, 18 years old).

> *She didn't have all the knowledge she would need to have to attend to me, but the reception was great* [...] *so if this welcome is aggressive or doesn't exist, don't pay attention to the issue there, maybe you already stop asking questions.* (W4 – G2, 21 years old).

> *I had private consultations that weren't as good as with her* [Primary Health Care nurse]. *So I think she was welcoming to me, even on her own cytopathological exam. It was the quietest exam I've ever taken. Nobody likes that thing, I thought she was careful.* (W5 – G1, 29 years old).

The participants also expressed how an equitable and integral consultation should be. The need to make sexuality an important part of the service repertoire was perceived. This would be the strategy to respect the differences of lesbian women and to promote empathy and resolution in the professional approach.

> *Why not include a question about sexuality? Normally, it had to be the first question, even to direct the approach.* (W1 – G1, 19 years old).

> *This part of the reception that I think is missing a little* [...] *you have to have a little compassion, to talk, to try to understand how the person feels, not only to arrive and "lie there and spread your legs"* [...] (W3 – G1, 26 years old).

> *Hearing "I don't know" from a health care professional is terrifying. It is necessary to see how this professional is trained, because it does not agree with what today's women need.* (W3 – G2, 32 years old).

Considering the scenario and obstacles faced in health services, women shared the strategies they used in search of care that is more appropriate to their sexual health needs. Among these strategies, information acquisition was highlighted through specific literature on sexual protection, support from Non-Governmental Organizations and recognition of the likely reaction of professionals, depending on their gender perspectives.

> *When I understood that there is no way for us to protect ourselves, for example, from sexual infections, I went after literature* [...] *I found a feminist Non-Governmental Organization that created some things that also did not exist.* (W1 – G1, 29 years old).

> *I had the internet, which gave me a very great help to deal with sexuality issues too, but it's complicated* [...] *because you only see things about the health of the woman who is womb and breast.* (W4 – G2, 21 years old).

> [...] *if you're going to be served by a man, usually, they don't know how to react to these "taunts": okay, I'm* [lesbian] *and what do I do? Woman, still for a while and think, put a little in your place.* (W2 – G2, 18 years old).

The participants' reports revealed that, in the scenario of consultations in PHC, many advances would need to occur in the direction of coping with homophobia, attention focused on the needs of lesbian women and the right to comprehensive health, as ideally predicted by public policies. A set of theoretical references related to the understanding of the social construction of conducts related to sexuality and its repercussions on sexual and reproductive health care offered in PHC helped in the debate of the research results.

Discussion

In line with the theories about the social construction of behaviors related to sexuality[10-11], it is possible to identify recent publications that incorporate the aspects highlighted in this research[15-16]. Regarding homophobia/lesbophobia and its social damage, a study conducted in Argentina,

conducted with the old people who identified themselves as lesbian and gay, found advances and points of stagnation in the debate[15]. The laws of same-sex marriage and the recognition of gender identity symbolized, for the participants of the Argentine study, an era of greater tolerance, in which the recognition of the sexual and reproductive rights of sexual minorities was achieved. On the other hand, doubts remain about the depth and authenticity of the changes. Another study, with English and Brazilian participants, revealed the health consequences of a restrictive thought about the sexuality of women who have sex with women[16]. In their results, it was found that sex between women, constructed discursively as safe, leads to the false idea of low risk of contracting/transmitting sexually transmitted infections[16].

In general, the results obtained with this research pointed to possible weaknesses in the health care of lesbian women, when attended in the PHC scenario. It is important to consider, however, that, perhaps, it is less opportune to find explanations about such weaknesses in the positioning of professionals, seeking to deviate from the error of blaming them. It is necessary to be in mind that, as in other social institutions, what occurs in health services is consistent with a predominantly heteronormative perspective in the various scenarios of interpersonal relationships[3]. A study conducted with PHC nurses in South Africa explored this premise and allowed participants to reflect on cognitive and affective processes that suppress values, beliefs and exclusionary attitudes of LGBTQIA+ patients in PHC services[4].

The South African study demonstrates that actions that mobilize the awareness of health professionals about their sexual and reproductive health care practices to lesbian women can stimulate the qualification of their professional conduct and the provision of more comprehensive services to the needs of this public[4]. In this study, women reported obtaining information about sexual and reproductive health on their own initiative, seeking them on the Internet, for example. It is evaluated that it would be opportune for health professionals to know these sources of information and also to interact with them in a movement of mutual learning and improvement of their practices[17].

Regarding the actual sex practiced among women and the forms of risk prevention, it was possible to identify that these are also difficult to manage, both for users who are assisted in PHC and by health professionals themselves[18]. In access to the service, homophobia and discrimination are obstacles to the development of equitable and quality care[5]. Another problem is violence against LGBTQIA+ people, which should be brought to the debate about the institutional practices that reproduce it. When it comes to analyzing this theme, it is worth pointing out that violence involves acts and subjects, but also symbols, inferences and languages that correspond to the structures of social power relations related to gender inequalities[5].

In the case of sexual health, the prevention of Sexually Transmitted Infections (STIs) is present as necessary and urgent. A study on the prevalence of STIs among women who have sex with women demonstrated a high prevalence of these diseases, especially chlamydia, HIV, Trichomonas vaginalis and syphilis infection[19]. A systematic review on the risk of STIs and vaginosis showed that the prevalence of these diseases increases due to the number of sexual partners, being or having been smokers, having a history of forced sex and sexual stigma[20].

In this study, women problematized the reductionist view of PHC professionals about their sexual health. There is little information on HIV transmission in sexual relations between women, but there are records, as was recently reported in the USA, of a case of HIV transmission. In the analysis of viral load, performed to elucidate the case, a similarity of 98% was identified, which is representative of the transmission of the virus that occurred in sexual intercourse maintained by women[21]. Another data that deserves attention is that the transmission of infectious agents, in general, is associated with the use of sexual accessories, a practice that can go unnoticed in health care[22].

Among the evidences related to the transmission of STIs among women, the question remains that there are no effective preventive methods to control these diseases. There is a booklet aimed at lesbian and bisexual women produced by the Brazilian state[23], in which there is no information related to the subject. More complete materials are likely to exist, produced by Non-Governmental Organizations, but in general cannot be accessed by a high number of readers due to the low circulation. In this way, they can reach only a limited audience.

The unpleasant experiences in the care received, related to the limitation of knowledge of professionals in relation to the specificities of lesbian women, eventually depart them from health services. There is evidence that women who have sexual relations exclusively with other women receive less guidance regarding STIs and less clarification related to their doubts about sexual and reproductive practices[24]. A study conducted with PHC medical and nursing team in a municipality of Rio de Janeiro, Brazil, corroborates the results of this research, revealing that the schemes of perception and appreciation of these professionals about lesbian women have a strongly normative content, with professionals who present knowledge gap, inability to communicate and omission in relation to the health demands of these women[14].

Information on women's homosexuality to health professionals did not seem to promote any type of intervention, guidance and information related to specific care. Silence in the face of these health demands of women whose sexual practices are outside the hegemonic erotic patterns is one of the main problems in the care bond. Silence is produced because they do not know what to say, because they are not able, because they are not resolutive and do not offer a space of welcome. This silence was expressed by the women in this study, when they reported that their questions, regarding their sexual and reproductive health, were misguided by orientations that considered the heteronormative pattern of sexuality, with the probable outcome of the offer of contraceptives.

The experiences related to the procedure of collecting material for cytopathological examination of the cervix made a kind of myth about the virginity of lesbian women be noted. This myth is based on representations about sexual behaviors and on the agreement as to whether certain acts should or should not be classified as sex or loss of virginity[25]. From a dominant heteronormative perspective, it is possible to assume that the idea that women only cease to be a virgin at the moment when the hymen is ruptured, when it is penetrated into sexual intercourse with a man.

The sexuality addressed by some professionals seems to have, in this conception, a reference for health care practices related to the theme. This logic can lead, on the one hand, to the unpreparedness to deal with the plurality of sexual orientation and, on the other hand, to the view of women only from the perspective of their heterosexual relationships and their reproductive functions[26].

As a counterpoint, it is worth highlighting the positive influence of the welcoming and empathic professional posture of some professionals who interacted with the study participants. According to the reports, this attitude served as a mitigating factor for the deficiency of technical preparation in dealing with the specificities of lesbian women and for the absence of a critical awareness about homophobia and its consequences on women's health. A study[27] on interventions performed to overcome prejudices of sexual orientation and gender identity showed several possibilities, some more effective than others. The particularly promising interventions, with the prospect of an ideal and satisfactory approach to this segment, seemed to be those that evoked empathy and the taking of the perspective of the other on the subject, in addition to those aimed at developing alliances between people with different senses of belonging regarding the exercise of sexuality.

In the context of these interventions, it is worth emphasizing the performance of nurses and nurses as an expressive workforce in PHC in Brazil, with the potential to innovate them through nursing consultations guided by the

premises of integrality and humanization of care. To this end, the investment in education, since graduation education, is crucial in the deconstruction of discourses about sexuality that make expressions invisible outside the heteronormative standard. In this sense, in the formation processes, it would be important to focus on the intersubjective, interpersonal and cultural contexts that hinder the insertion of the theme of sexuality in care practices.

Nursing care, supported by an expanded conception of health[5] and under a multidimensional discursive matrix about sexuality, would contribute to a better care to the population of women in its widest diversity. As repercussions, there could be greater scope of the guidelines related to sexual practices, in addition to greater range of information on risk factors, prevention actions and early detection of cervical-uterine cancer. In this sense, it is understood that it is necessary to create a welcoming environment, through the confrontation of prejudices, while defending the qualification of care to these women.

Thinking and practicing professionally the care given to these women inevitably implies considering their existences and expressions, in order to recognize their specific needs and appropriate approaches, being the focus of attention already in professional training. Moreover, it is necessary to consider human plurality in its varied possibilities of expression and enjoyment of its sexuality as a pre-condition for the practice of health care in the face of the complexity inherent to the fields of health, nursing and care[4].

As limitations of the study, we recognize the non-generalizable scope of qualitative results, its temporal contextualization and the absence of the perspective of health professionals in view of the interviewees' placements, aspects that should be explored in other studies. It is also worth mentioning the difficulty of recruiting lesbian women to participate in the focus group, since many access private health services and/or recognize themselves as bisexual, which would express other demands and health needs. It is recommended incentives in research that deepen the understanding of women's experiences with the contribution of statistical data and the incorporation of other research subjects, such as health professionals.

The results of this study may enable the development of strategies for the qualification of PHC health professionals, either through the training of human resources in health or by continuing health education.

Final Considerations

The study allowed us to analyze the reports of lesbian women in sexual and reproductive health care provided by PHC professionals. These experiences revealed weaknesses in the assistance offered. With regard to sexuality, it was revealed ignorance of professionals when addressing orientations about safe sexual practices. It was observed the predominance of heteronormative character in the conduct of health professionals, in addition to a reduced view of the demands and needs of sexual and reproductive health, which referred to a decontextualized and insufficient care provided to lesbian women in the consulted accessed in PHC.

It is emphasized that the data obtained in this research corroborate the need for a more welcoming approach of PHC health professionals and directed to the specificities of lesbian women, abandoning the model of practices guided by heteronormativity imposed culturally and socially. In this sense, it would be important to resume the idea that the care of lesbian women should be ethically the same as that directed to women in general, but focusing on diversity in sexual practices. For these women, it is necessary to provide the necessary information, so that they receive good care, sustained in a relationship of bond, listening and resolution in the face of health demands.

With regard to nursing, as an indispensable health workforce, it needs to engage in coping with homophobia, incorporating, in its practices, an understanding of sexual and affective behavior open to sexual diversity. Such engagement may

result in the accumulation of knowledge and technical skills that may determine protection and safety for users.

Finally, when we look at the visualization of these women and the non-reproduction of a mechanized health care, it is worth noting some conceptions. Among these, as pointed out in this research, is the understanding that all sexually active users have relationships with men and, also, the point of view that relationships with women are maintained, then, they are immune to certain health problems.

Collaborations:

1 – conception, design, analysis and interpretation of data: Nicole Ketzer, Letícia Becker Vieira, Camilla Alessandra Schneck, Juliana Strada and Gregório Patuzzi;

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