Original article

Sexual practices and health care of women who have sex with women: 2013-2014*

doi: 10.5123/S1679-49742018000400005

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Abstract

Objective: to describe sexual practices and health care of women who have sex with women (WSW). **Methods**: this was a cross-sectional study with data obtained by means of an electronic questionnaire answered by WSW from the five regions of the country (2013-2014). **Results**: among 582 WSW, oral sex (95.2%) and digital penetration of the vagina (97.3%) were predominant, with rare use of barrier methods (6.7% and 5.8%, respectively); in the last five years, women who had sex exclusively with women, compared to those who had sex with women and men, were less likely to use barrier methods with women (28.3% versus 41.1%; p=0.041), less likely to have an annual check-up with a gynecologist (38.9% vs. 70.8%; p=0.033), less likely to receive guidance about sexually transmitted infections (STI) (44.0% vs. 59.1%; p=0.034) and about sexual doubts (50.0% vs. 63.0%; p=0.044). **Conclusion**: infrequent use of barrier methods may be a vulnerability factor for STI; it highlights the importance of guidelines for adequate health care for WSW.

Keywords: Sexual Health; Sexual Behavior; Homosexuality, Female; Public Health; Cross-Sectional Studies.

*Study funded with resources from the National Council for Scientific and Technological Development (CNPq) /Ministry of Science, Technology, Innovation and Communications (MCTIC): Process No. 472995/2013-8.

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Introduction

The impact of non-heterosexual sexualities on the health care of women has been on the global research agenda since the 1980s.[1-3] There is an abundance of data pointing to access difficulties[2-7] and negative experiences during medical care for lesbian and bisexual women in a diversity of countries.[7,8-15] Financial, structural and cultural aspects in health care services have been considered obstacles for appropriate health care for these women.[2,3] Less frequent use of health care services[4,8-11] and worse health indicators are generally associated with lesbian and bisexual women when compared to heterosexual women.[5,6,9,10,16]

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Different criteria have been used to characterize lesbianity and bisexuality in health studies, such as sexual practices (sexual behavior), object of desire (sexual orientation) and sexual self-identity.[2,5] In some studies, lesbianity is defined only by having sex exclusively with women or with men and women, resulting in the invisibility of bisexual women owing to their being included in the definition of lesbians.[2] The impact of lesbianity and bisexuality on health can also go unnoticed when sexual identity is the only criterion for the definition used.[4,7] In this sense, suggestions have been made that the research on lesbianity and bisexuality should consider the three criteria mentioned above, in order to avoid bias in the evaluation of health indicators for this female group.[2]

Frequent inconsistency between reported sexual identity and sexual practices can make women's health care invisible.[4,7] Self-care and seeking medical care differ among heterosexual, lesbian and bisexual women.[7] There is evidence that women self-identified as heterosexual have fewer cervical and breast cancer screening tests, even when these same women reported having exclusive sexual practices with women or with women and men, when compared to women self-identified as lesbians and bisexuals.[4]

The sexual and reproductive health needs of the lesbian and bisexual female population have specificities related to their sexual practices.[9,10,14,16,17] Health vulnerabilities can be better detected by knowledge of sexual practices, regardless of sexual identity. This argument justifies the use of the expression 'women who have sex with women' (WSW) to group lesbian and bisexual women together in a large number of studies on health, lesbianity and bisexuality.

The vulnerability conferred by exercising a non-heterosexual sexuality is associated with social invisibility and also with experiences of prejudice in health care services.[3,7,14,18] There are reports of recurrent experiences of discrimination and violence against lesbian women (lesbophobia) and bisexual women (biphobia) and invisibility, caused by heteronormative attitudes of health professionals.[7,18] Heterosexuality, when affirming itself as a social norm, determines its existence in a compulsory form and its superiority in relation to other sexualities.[19] The imposition of normative and compulsory heterosexuality is the mainstay of lesbophobia and biphobia.

Negative health care experiences have made WSW more resistant to using health care services.[7,18] A study in England published in 2011, exposed the attitudes of doctors during care provision to women. Doctors observed in that study demonstrated the mistaken belief that women they saw were heterosexual, awakening in these women feelings of shame, anger or discomfort.[18] Heterosexist logic, when it values social difference between heterosexual and non-heterosexual women, is one of the more subtle forms of lesbophobia and biphobia, because it silences and makes lesbian and bisexual women invisible.[19] A qualitative study conducted in France evidenced lower access of lesbian and bisexual women to health services. They justified the non-disclosure of their sexual practices during health care because of fear of being judged by doctors.[7]

In Brazil, there are gaps in scientific production on the demands of WSW related to sexual and reproductive health. There are no nationwide quantitative studies on such needs, nor studies that offer data about health care provision related to problems with exercising sexuality. In addition, the quality of gynecological care provided to this population in both public and private health care services is unknown. This study aims to describe sexual practices and health care of women who have sex with women.

Methods

This was a cross-sectional study with women who have sex with women from the five macro-regions of Brazil and was conducted between July 2013 and January 2014. An anonymous structured questionnaire was made available at a specific electronic address. Agreeing to the terms of a Free and Informed Consent form was a prerequisite for participation in the study.

A population survey on Brazilian sexual behavior estimated the population of lesbian and bisexual women to be between 1.7% and 3.0% of sexually active women.[20] However, the conditions of vulnerability to which this population is subject, owing to experiences of stigma and social discrimination, makes accessing these women more difficult.[20] A considerable number of them do not want to divulge their sexual practices and sexual identities, thus imposing obstacles to the use of a probabilistic and random sample.

Initially, contact was made with a group of lesbians, gays and bisexuals (LGB) in Northeast region of Brazil for them to let their peers know about the study. They in turn made telephone contact and provided the study's electronic address to LGB groups in other regions of the country through social networks such as Facebook and WhatsApp. Lesbian and bisexual women leaders from each region of the country also acted as promoters, disseminating the invitation to participate in the study among their networks. In turn, women who answered the questionnaire also indicated others to participate, through the 'snowball' mechanism, this being a methodology that has been used in studies on WSW sexuality.[4,21] WSW accessed the electronic address that contained the Free and Informed Consent form and the electronic questionnaire which was sent when it was completely answered.

The questionnaire was built with closed-ended questions divided into three topics. The first topic collected sociodemographic data and data relating to self-definition of sexual practices and sexual identity: age group (in years: 18-19; 20-29; 30-39; 40-49; ≥50), education level (in years of study: ≤8; 9-11; ≥12), region of residence (North, Northeast, Midwest, Southeast, Southern), sexual practices in the last five years (had sex with women and never had sex with a man in their lifetime; has sex with women but has had sex with a man at some time in their lives; has sex with women and men) and sexual identity (lesbian, bisexual; other [open-ended answer]). The second topic addressed information on types of sexual practice and sexual health care, especially as regards the adoption of methods to prevent sexually transmitted infections (STI) and AIDS: type of sexual practice with women (oral sex, vaginal penetration with fingers; vaginal penetration with toy; anal penetration), type of sexual practice with men (oral sex, digital penetration of the vagina; vaginal penetration with a penis; anal penetration) and the use of barrier methods (plastic film; finger cot; male and female condoms) when having sex with women and having sex with men. The third topic questioned the frequency of seeking gynecological care in the last five years (none, six-monthly, yearly, no fixed periodicity) and WSW experiences in public and private gynecological health care services, related to these women's attitudes during consultations (disclosure of sexual orientation; asking about STI and HIV/AIDS prevention; asking about cervical cytology examination; asking about sex-related doubts) and physicians' attitudes (asking about sexual orientation/sexual practices; guidance on STI and HIV/AIDS prevention; guidance on cervical cytopathology examination; guidance on sex-related doubts).

A pilot project was developed for the purpose of testing and improving the questionnaire. Initially, three gender study specialists evaluated the instructions for answering the questionnaire, the clarity of the statements, the relevance of the questions and their adequacy in relation to the objectives of the study. The questionnaire was then made available to 20 WSW. At this stage, difficulties were analyzed regarding accessing and using the electronic questionnaire, sending answers and understanding the questions, besides the time spent to answer them. After making the necessary adjustments, the data collected in the pre-test were discarded.

During the study itself, the answers to the questionnaire were sent to an electronic database and subsequently exported to an electronic spreadsheet. Collected data were analyzed by means of descriptive statistics, by distributing the frequencies of three aspects: 'sexual practices', 'health self-care' and 'experiences of WSW in health care services'. A comparison was made between the group of women who have sex exclusively with women (women who have never had sex with a man) and the group of women who have sex with women and men (women who have had or have sex with a man). The

difference in the proportion of answers was evaluated using Pearson's chi-squared test. Data were analyzed using STATA version 12.1.

The study was approved by the Research Ethics Committee: Certification of submission for ethical appraisal (CAAE) No. 12710513.9.0000.5209, 16 July 2013.

Results

Six hundred and fifteen women who have sex with women, from all over Brazil, accessed the questionnaire and 582 (94.6%) answered it. Among WSW answering the questionnaire, 28.4% were from the Midwest, 27.1% from the Southeast, 22.3% from the Northeast, 16.5% from the South and 5.7% from the North of the country. Most of them belonged to the 20 to 29 years age range (60.3%) and had 12 or more years schooling (85.2%). The majority (66.5%) identified themselves as being lesbian and 31.6% as bisexual. Over the last five years, a third of them (34.0%) reported having had exclusive sexual practices with women, while about half (49.5%) had had sex with men in the past and 16.5% had sex with women and men (Table 1). Half the women who identified as lesbians mentioned having sex with women and having had sex with men in the past (data not shown in the tables).

The types of WSW sexual practices are shown in Table 2. WSW described oral sex (95.2%) and digital penetration of the vagina (97.3%) as frequent practices when having sex with women. The male condom was the most frequently used barrier method for vaginal penetration with toys (56.5%) and anal penetration (52.9%). Use of plastic film when having oral sex (6.7%) and finger cots for vaginal penetration (5.8%) occurred rarely. With regard to having sex with men, WSW reported that vaginal penetration with a penis was the most common sexual practice (66.1%). The use of male condoms was more frequent in vaginal penetration (87.0%) and anal sex (71.4%) with a penis.

Annual gynecologist appointments were the most prevalent (46.7%), preferably in private medical services (83.8%). WSW reported that during consultations 19.0% of gynecologists asked about their sexual practices: with men, women, or with women and men. 58.3% of WSW disclosed their sexual practices to the gynecologist, whether they were exclusively with women or with women and men. WSW rarely asked the gynecologist questions about STI and HIV/AIDS prevention (14.9%) or cervical cancer prevention (10.7%), or about their sexual doubts related to desire, excitation and orgasm (8.5%). They reported that, when asked, slightly more than half the gynecologists gave the guidance on STI and AIDS prevention (51.4%), cervical cancer prevention (66.7%) and sex-related doubts (58.1% %) (Table 3).

Table 4 shows that in the last five years women who have sex only with women, when compared to women who have sex with women and men, were less likely to use a barrier method in sexual intercourse with women (28.3% vs. 41.1%, p = 0.041) and to have an annual consultation with a gynecologist (38.9% vs. 70.8%, p = 0.033). In addition, when they asked physicians for information, women who had sex only with women received less guidance on STI and AIDS (44.0% vs. 59.1%, p = 0.034) and their sexual doubts (50.0% vs 63.0%, p = 0.044).

Discussion

This article reports on research into sexual practices, health care and experiences during gynecological care among WSW in Brazil. The data collected showed that, compared to women who had sex with women and men, women who exclusively had sex with women were less likely to use a barrier method in their sexual practices and less likely to have an annual consultation with a gynecologist; and when they asked the physician for information, they received less guidance on STI and less clarification about their sex-related doubts. The decision to categorize women according to their sexual practices was not intended to hide their self-reported sexual identities or to disregard them as a vulnerability factor. Rather, the intention of this approach was to evaluate sexual behavior, regardless of sexual identity, in order to understand health care practices among WSW. Research carried out in various parts of the world shows that 80% of lesbian women reported having sex with a man at some point in their lives, this being evidence of the fluidity of their practices.[21-23] This data reinforces the importance of practitioners asking about sexual practices and sexual identity over the course of women's lives during medical consultations in order to provide appropriate care for their health specificities.[7]

Table 1 – Sociodemographic characteristics, sexual practices and sexual identities of women who have sex with women (n = 582), Brazil, 2013-2014

Variables	n	%
Age (in years)		
18-19	63	10.8
20-29	351	60.3
30-39	92	15.8
40-49	55	9.5
≥50	21	3.6
Education level (in years of schooling)		
Up to 8	3	0.5
9-11	83	14.3
≥12	496	85.2
Region		
Northern	33	5.7
Northeast	130	22.3
Midwest	165	28.4
Southeast	158	27.1
Southern	96	16.5
Sexual practices		
Sex with women and never with a man	198	34.0
Sex with women and with men in the past	288	49.5
Sex with women and men	96	16.5
Self-reported sexual identity		
Lesbian	387	66.5
Bisexual	184	31.6
Other[a]	11	1.9

a) Pansexual/queer/without labels women who have sex with women outside the binary /heterossexual system.

In this study, WSW reported greater diversity of sexual practices and increased frequency of oral sex and digital vaginal penetration when having sex exclusively with women, in comparison with sexual practices with men. However, the use of barrier methods proved to be infrequent, especially in the most commonly reported sexual practices. Even in penetrative practices with sex toys, male condom use was reported by only half of the WSW. The deep-rooted belief in the risk of contracting STI and AIDS when having sex with men may have influenced the higher frequencies of male condom use by WSW in their sexual practices with men, according to the findings of this study. The lack of medical knowledge about sexual practices among women, coupled with heteronormative behavior during health care, makes WSW invisible and doomed to precarious care in health care services.[7,15,17]

The belief shared by WSW and physicians that they are not susceptible to STI and HIV/AIDS is recurrent, according to several studies, favoring the lack of interest of these women in seeking health care.[7,17] There is evidence of prevalence of STI and HIV/AIDS in women who have sex exclusively with women, although at lower percentages than among women who only have sexual intercourse with men.[21-26] A study published in 2013 analyzed the use of barrier methods by 1,557 WSW from several countries and more than 80% of them reported never having used barrier methods when having oral sex with women or men.[27] Similar to the findings of our study, there was low prevalence of barrier use during digital manipulation of the vagina

Table 2 – Type of sexual practices and use of barrier method among women who have sex with women, Brazil, 2013-2014

Variables	n	%
Type of sexual practice with women (n=582)		
Oral sex	554	95.2
Digital penetration of the vagina	566	97.3
Vaginal penetration with toy	322	55.3
Anal penetration	157	27.0
Type of sexual practice with men (n=384)		
Oral sex	223	58.1
Digital penetration of the vagina	201	52.3
Vaginal penetration with penis	254	66.1
Anal Penetration	63	16.4
Barrier method in practice sex with women		
Oral Sex (plastic film) (n=554)	37	6.7
Digital penetration of the vagina (finger cot)	32	5.8
Vaginal penetration with toys (n=322)	182	56.5
Anal Penetration (n=157)	83	52.9
Barrier method in sexual practice with man		
Oral Sex (n=223)	65	29.1
Digital penetration of the vagina	10	5.0
Vaginal penetration with a penis (n=254)	221	87.0
Anal Penetration (n=63)	45	71.4

(11.3%) and with sex toys (34.4%), in sexual practices with both women and men.

There is no consistent data about the vulnerability of WSW to human papillomavirus (HPV) infection and, consequently, vulnerability to cervical cancer.[22,26] A North American study published in 2001 revealed the existence of oncogenic HPV types and prevalence of cancer precursor lesions of the cervix in women with sexual practice exclusively with women throughout life.[26] Varied sexual practices between women were reported and included oral sex and vaginal and anal manipulation with fingers and sex toys,[26] similar to those reported by WSW in this study. This evidence reinforces WSW believing they are susceptible to cervical cancer and, therefore, perceiving the need for periodic preventive examinations, since the highest percentages of not having preventive examinations were found in women identifying as lesbians and having sex exclusively with women.[22,26]

The difficulties in WSW accessing health services include structural, financial and cultural barriers. The heteronormative attitude of health professionals was cited as the greatest obstacle to appropriate health care.[2,3,15] The difficulties faced in disclosing sexual practices[5,6,14,15] and previous experiences of discrimination, even following disclosure, are reported recurrently by WSW in studies conducted around the world.[7,14,17,21] In our study in particular, almost half the WSW sought annual gynecological care predominantly in private health services. The high schooling rates of the WSW respondents could have influenced the choice of these services, as suggested by the 2013 National Health Survey.[28] However, the demand for gynecology checkups was significantly lower among those who reported having sex exclusively with women in the last five years. Only a minority of gynecologists asked WSW about sexual practices with women, with men or with both sexes. Normative heterosexuality predominant in medical discourse imposes difficulties for dialogue and health care with respect to the individualities of WSW.[7,13-15,17]

Table 3 – Experiences of women who have sex with women during gynecological care, Brazil, 2013-2014

Variables	n	%
Consultation with a gynecologist in the last five years (n=582)		
None	76	13.1
Six-monthly	87	14.9
Annual	272	46.7
No fixed periodicity	147	25.3
Consultation service provider (n=506)		
Private Service	424	83.8
Public Service	82	16.2
Women's attitude during the consultation (n=506)		
Revelation of sexual orientation	295	58.3
Ask about STI[a] and HIV/AIDS prevention	74	14.6
Ask about cytopathological examination of the cervix	54	10.7
Ask about sex-related issues	43	8.5
Physicians attitude		
Ask about sexual orientation/sexual practices (n=506)	96	19.0
Guidance on STI[a] and HIV/AIDS prevention (n=74)	38	51.4
Guidance on cytopathological examination of the cervix (n=54)	36	66.7
Guidance on sex-related issues (n=43)	25	58.1

a) STI: sexually transmitted infections.

Table 4 – Sexual practices and reported experiences during medical consultations among women who have sex only with women and women who have sex with women and men, Brazil, 2013-2014

Variables	WSW[a] (N=198)	WSWM[b] (N=384)	P -value[c]
	%	%	
Barrier method in oral sex with women	6.1	6.5	0.437
Barrier method in vaginal sex with women	28.3	41.1	0.041
Barrier method in anal sex with women	53.5	52.6	0.451
Annual consultation with a gynecologist	38.9	70.8	0.033
Disclosure of having sex with women	63.5	57.2	0.323
Ask about STI[d] and HIV/AIDS	15.7	14.5	0.364
Guidance on cytopathological examination of the cervix	10.7	10.9	0.763
Ask about sex-related issues	10.1	8.0	0.512
Doctor asked about having sex with women	20.1	18.9	0.215
Guidance on STI[d] and HIV/AIDS	44.0	59.1	0.034
Guidance on cytopathological examination of the cervix	64.7	67.7	0.344
Guidance on sex-related issues	50.0	63.0	0.044

a) Women who have sex with women exclusively.
b) Women who have sex with women and men.
c) Pearson's chi-square test.
d) STI: sexually transmitted infections.

The decision to reveal sexual practices and sexual identity is reported by WSW as a moment of tension and anxiety, accentuated by the fear of experiencing discrimination and prejudice.[4,14] The life story marked by lesbophobia and biphobia experienced by many WSW can interfere negatively in this decision.[4-6,14] In Norway, the health service experiences of 121 lesbian and bisexual women were the subject of research published in 2009. According to the reports of these women, most doctors and psychologists neither asked about nor facilitated the disclosure of their being lesbian or bisexual; the quality of care provided to them was compromised by heteronormative attitudes and lack of professional knowledge about non-heterosexual sexualities and their unique health needs.[15] In our study, 88% of WSW did not ask gynecologists about STI and cervical cancer prevention, nor did they ask them about their sex-related doubts. When they did ask gynecologists for information, three out of five WSW received guidance, although this tended to be lower among women who reported having sex only with women in the last five years, particularly with regard to broaching sex-related doubts and reporting health complaints of a sexual nature or seeking clarification on STI prevention. This data may reflect doctors' lack of knowledge about sexual practices between women and consequently how give them guidance on preventing STI. The belief in women's compulsory heterosexuality can comprise listening, delay diagnosis and result in inadequate treatment being offered.[7,14,17,21] There have been reports of inappropriate attitudes of professionals when faced with information or questions on women's sexual practices with women or with women and men. In the perception of WSW, physicians act inadequately when faced with such situations and this is prejudicial to identifying their specific health needs.[7,13,14,17]

The decision to use an exploratory method with a non-probabilistic sample placed limitations on this study. The profile of the convenience sample comprised of WSW connected to the LGB community may not be representative of Brazilian WSW as a whole, thus preventing generalization of the results. However, the choice of a larger convenience sample is justified, given the difficulties in accessing this female population, as reported by several studies carried out in other countries.[21,25-27] This type of sample may also have limited access to older women, women with less schooling and those living in regions where internet access is difficult: in the Northern region, for example, there were more obstacles to contacting WSW, resulting in lower effectiveness of the 'snowball' mechanism and, as a consequence, a smaller number of study participants. However, the use of the internet enabled a high response proportion, coupled with a reduction in operational costs, given the dimensions of the country. Despite the limitations described, it is Brazil's first nationwide quantitative study of WSW sexual practices, health care and gynecological care.

The attitude of those WSW who reveal their sexual practices and sexual identity may mean an attempt to break a cycle of vulnerabilities imposed by the heteronorm. Participation in LGB militant groups is likely to empower WSW in the sense of positive self-esteem in relation to lesbian and bisexual identity. On the other hand, non-disclosure of this identity by almost half the WSW respondents could possibly reflect previous experiences of discrimination and prejudice in various contexts; in addition, other vulnerability markers not studied here may have contributed to this limitation, such as age, race/ethnicity, and socioeconomic status. Ethnographic studies based on semi-structured interviews may lead to a better clarification of this issue. Faced with this panorama, the proactive attitude of health professionals in asking about sexual practices and sexual identity may result in the recognition of vulnerabilities as well as friendly and humanized care for these women.

The diversity of sexual practices reported by WSW, associated with the infrequent use of barrier methods, makes them more susceptible to STI and HIV/AIDS. On the other hand, practitioners having knowledge of the sexual practices of WSW, regardless of their self-reported sexual identity, can have a positive influence on identifying their susceptibility to cervical cancer, IST and AIDS. In turn, knowing the sexual identity of WSW allows their vulnerabilities and how these intensify negative impacts on health to be identified. For health professionals, this is knowledge that favors the provision of health care that meets the unique health needs of this female population.

The high demand for gynecological care may mean a self-care attitude on the part of WSW with regard to their health, as may seeking gynecological care, as a result of health needs specific to that medical specialty not attended to by health professionals from other specialties. A minority of WSW asked gynecologists

about topics related to sexual and reproductive health. Even so, their questions were answered by only half of the professionals they were seen by. The gynecological care received by the WSW in our study exposes the precarious nature of recognition of and attention to their sexual orientation by Brazilian health care services. The importance of the visibility of WSW in public health care policies needs to be emphasized. Medical training geared to the health singularities of WSW and the definition of guidelines for addressing these specificities are mandatory, especially regarding HPV, other STI and HIV/AIDS infection. The negative impact of invisibility can also result in lost opportunities for the prevention, diagnosis and treatment of several different diseases.

Authors' contributions

Rufino AC and Madeiro A contributed to the design of the study, data analysis and interpretation and writing the manuscript. Trinidad A, Santos R and Freitas I participated in the data collection and analysis and critical review of the intellectual content of the article. All the authors have approved the final version and declared themselves to be responsible for all aspects of the study, ensuring its accuracy and integrity.

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Received on 07/01/2018
Approved in 25/07/2018