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"How can we better protect ourselves?": Young lesbians' social representations of sexual health

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Abstract *This article sought to understand the structure of young lesbians' social representations of sexual health, based on their experiences and practices. This is a descriptive, qualitative study based on the Theory of Social Representations. The Free Word Association Test (FWAAT) was used online for 124 self-declared lesbians, aged 18 to 29 years, and of these, seven responded to a semi-structured interview script. The TALP data was processed using IRaMuTeQ software (prototypical analysis), contextualized by excerpts from the interviews that portray experiences and practices, and scientific references on the subject. The results pointed to the terms 'condom', "care" and 'prevention' as core elements in the structure of social representations. In the interviews, these terms refer to the importance attributed to protection and disease prevention, although the condom models are not adapted to the sexual practices of trafficked sex. The participants' practices and experiences also emphasize personal hygiene. The development of effective public policies for lesbian health requires valuing the knowledge they share socially.*

Key words *Sexual and Gender Minorities, Sexual Health, Free Association*

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Introduction

Sexual health refers to the physical, emotional, mental, and social balance related to sexuality[1], encompassing various aspects of human life, including sexuality itself, gender identities, social roles, sexual orientation, and experiences of pleasure, intimacy, and reproduction. Therefore, a respectful and positive[2] approach to sexuality must encompass all manifestations of human sexuality, free from coercion or other forms of violence.

Youth can be understood based on age and biological factors that tend to provide young people with different life experiences, including forms of social integration through the exercise of sexuality. The Youth Statute[3], which addresses the rights, principles, and guidelines for public policies aimed at young people, defines youth as the period between 15 and 29 years of age. In this age range, people who identify as Lesbian, Gay, Bisexual, Trans, and Transvestite (LGBT+) face challenges in social integration, as they do not meet social and family expectations[4,5]. However, public policies and scientific research focused on sexuality have emphasized addressing health issues, with a focus on human reproduction among cisgender and heterosexual people[6].

Given this scenario, the 1st National Lesbo-Census (2021-2022), an unprecedented survey conducted with 19,455 respondents, sought to map the sociodemographic profile and experiences of lesbians. The results showed that 72.94% of participants reported being afraid/reluctant/embarrassed to talk about their sexuality[7], and 14.86% reported having displayed signs or symptoms related to a Sexually Transmitted Infections (STIs) at some point in their lives. It also reported that 37.26% have never been tested for HIV due to a lack of information about where the test could be performed and the belief that sexual intercourse with another woman does not expose them to the virus[7].

Despite the scarcity of Brazilian scientific evidence specifically addressing lesbian access to public assisted reproduction services, cis-lesbians – people with vulvas who self-identify as women and experience affective and sexual attraction to similar individuals – commonly opt for private clinics or unconventional methods, such as home insemination, given their economic circumstances[8,9]. Regarding violence, Brazil recorded 338 reports of human rights violations in the second half of 2023, involving victims who self-identified as lesbians and were between the ages of 15 and 29[10]. In this context, hate crime against lesbians and corrective rape stand out[11].

In the field of Public Health, the Women's Health Care Program provides essential tools for nurses to understand sexual practices, provide guidance on prevention, protection, and diagnosis of STIs and vaginosis, plan for motherhood for cis and trans women, and respond to situations of violence. Furthermore, considering that women who do not perform femininity according to hegemonic standards tend to suffer more from prejudice, including in gynecological appointments[12], a respectful approach must broaden the perspective beyond gender binarism and heteronorms. The training of healthcare professionals is often highlighted as the main intervention for improving the quality of care provided to lesbians[13].

In the field of nursing, studies developed based on the principles of the Theory of Social Representations (TSR) have pointed to the potential for health promotion and disease prevention actions in the context of care provided to vulnerable groups[14]. Social Representations (SR) take as a reference the way individuals think and interpret everyday life. Therefore, they constitute practical knowledge, produced through interactions and communication, and through lived experiences, enabling the creation of a set of images that allow them to interpret their lives and give them meaning[15,16].

This study presents unprecedented content in the field of research, as the sexual health of young lesbians has not been addressed in other studies focusing on the experiences and practices of this group, from the perspective of TSR. This article aims to understand the structure of young lesbians' social representations of sexual health based on their experiences and practices.

Methodology

This is a qualitative, descriptive study, supported by Moscovici's TSR[17], focusing on the structural approach. This allows us to understand the structure of representations based on their central core (CC) and peripheral elements (PEs)[17], which respectively organize and give meaning to representations. This theory has contributed to uncovering prejudices sustained by common sense and strongly associated with LGBT+ people in various contexts[12,18].

This study was disclosed through the publication of an image on the Instagram profile of the Research Group on Sexualities, Vulnerabili-

ties, Drugs, and Gender of the School of Nursing of the Federal University of Bahia, containing a call-to-action phrase and the desirable characteristics for participants, namely: self-identified lesbians, over 18 years of age. The non-probability "snowball" sampling technique was used, as it has proven useful for studying populations for which there is no precise location or number of individuals[19], such as lesbians. The technique is also suitable for private discussions[20], such as issues related to sexual health care. The survey was disseminated between September and December 2023.

Three independent but complementary data collection techniques were used: a sociodemographic data questionnaire and Free Word Association[21], administered through the Google Forms® online platform; and a semi-structured interview, administered online using the Google Meet® platform. The use of multiple techniques is essential for research based on TSR, as it not only ensures the reliability of the analysis and interpretation of results, but also allows for a deeper and more comprehensive understanding of the phenomenon under study.

The identification questionnaire allowed for the characterization of the investigated group, a relevant condition for research based on TSR, since representations have a dynamic nature when developed by a given group about a given object at a given moment[16,22]. To this end, it consisted of sociodemographic variables, such as age, gender identity, race/skin color, religion, involvement with social movements and non-governmental organizations, and sexual debut.

Free Association is a projective technique used in TSR research that allows for contact with the latent content in the field of individuals' thoughts through contact with verbal, iconic, or audiovisual inducing stimuli. This technique was applied through the Free Word Association Test (FWAT), consisting of an identification questionnaire and verbal inducing stimuli consistent with the topic in question[21].

The FWAT consisted of the inducing term "sexual health", for which participants were asked to recall up to five words, each recorded in the provided dialog boxes. After recording, each participant was asked to choose the most important word and justify their choice. A total of 620 words were evoked, of which 59 were different. All participants completed a sociodemographic identification questionnaire and the FWAT. Consent to participate in the study was obtained by confirming that they had read the Informed Consent Form, which was checked by checking a box. By agreeing to participate, participants also agreed to participate in a semi-structured interview.

The semi-structured interview constituted a complementary resource in contextualizing the elements that characterize the participants' sexual health care, as it allows for the acquisition of meanings, as well as experiential, emotional, and reflective aspects, which can only be obtained with the contributions of the people involved[23]. A script was developed with open-ended questions about women's affective-sexual journeys, understanding of sexual health concepts, and forms and spaces for sexual health care. Two interviews were conducted as pilot tests.

For the interviews, participants were approached through the contact details provided in the identification questionnaire. After weekly contact attempts, 13 interviews were conducted according to the participants' availability, of which eight were young women. The interviews were conducted between September 14 and December 8, 2023, with an average duration of 25 minutes.

The data from the identification questionnaire were organized and analyzed using Google Sheets® to generate graphs that could characterize the participants' profiles based on the collected variables.

The information from the FWAT was organized in Microsoft Excel 2016 and Word 2016 for lemmatization. The evocations were analyzed based on the criteria of simple frequency, mean order of evocation, and occurrences, using the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (iRaMuTeQ), which offers tools for prototypical and similarity analyses[24,25].

Prototypical analysis allows us to identify the structure of social representations based on the frequency and average order in which terms produced by participants are evoked. This technique organizes the data into a four-box framework, as proposed by Abric[16], distinguishing central and peripheral elements based on the regularity and cognitive salience of the evocations. Similarity analysis involves the minimal relationship between two elements of the same SR. Its use allows us to identify and explore the connections between the terms presented in the four-box framework, providing a comprehensive view of the organization and structure of the SR in relation to the represented object.

The interview content was recorded and transcribed in its entirety by team members. The transcripts were read exhaustively, and frag-

ments of their content were used to interpret and contextualize the results generated from the prototypical and similarity analyses. Both the justifications for the most important terms derived from the FWAT, as well as the interview excerpts, are anchored in the participants' practices and experiences, thus allowing for the objectification of the investigated object.

The collected material was stored in an online database, access to which was restricted to the research team's institutional email addresses, under the moderation of the project coordinator. This research was approved by the Research Ethics Committee of the Federal University of Bahia, logged under opinion No. 4.650.818.

Results and discussion

The 124 participants who responded to the FWAT were between 18 and 29 years of age. The majority identified as cisgender women (120); Black women (71); with a college degree (57); and non-religious (74). Regarding participation in collectives, entities, social movements, or involvement in non-governmental organizations30, participants reported having some type of experience.

The FWAT data, processed using the iRaMuTeQ software, was analyzed using the four-box table (Chart 1) and the maximum similarity tree (Figure 1), organized with terms that had a minimum frequency of 12. The frequency of different words corresponded to 9.51%, demonstrating data homogeneity, while discarded evocations corresponded to 6.6% of the corpus, revealing a 93.4% utilization rate. The Mean Order of Evocations (MOE) established by the software was 2.81, which validates the occupation of the largest number of words in the second and third positions in the evocations, and 23.16 as the cutoff point for frequency, equivalent to 33% of the sample value. Of the 124 participants, 116 simultaneously evoked two or more words contained in Chart 1.

The composition of the probable CC (upper left quadrant) tends to concentrate elements that are more frequent and were evoked more quickly and, therefore, are considered to be consensual and more stable elements, linked to the collective memory of the investigated group and organizers of the SR[17]. Considering hierarchy and salience, among the terms that make up the CC (condom, care, and prevention), the term "condom" stood out for the investigated group, since it was evoked 54 times and was justified as the most important eight times.

I think in this case, thinking about health, it would be a condom, even knowing that for us lesbian women it's unusual (P115, 27 years old, cis-brown woman).

In the interviews, participants reported recognizing and adopting sexual health care practices, revealing a tendency to prioritize practical knowledge based on hygiene concepts over condom use. From this perspective, condom use as a barrier method for STIs in sapphic sex was identified as a source of discomfort for both themselves and their partner:

Until then, using condoms or finger cots or cutting condoms or anything like that was never something I felt comfortable doing [...] I think they take a lot of the sensuality out of sex, it's not easy to use them at all (P014, 25 years old, white cis woman).

Condom disuse among young people has been primarily associated with preventing pregnancy and STIs in cisgender sexual practices involving penises and vaginas, or has been focused on the homosexuality of cisgender men[26]. A survey of 1,146 lesbians revealed that only 4.5% used condoms in all sexual relations[27].

The lack of access to accurate and culturally sensitive sexual health information for young lesbians may contribute to condom disuse. Significant gaps in knowledge about STI prevention among lesbians and among young people of different sexual orientations, as well as a lack of adequate sex education that addresses specific needs, were highlighted in a recent study[28]. The lack of sexual health campaigns targeting lesbians was also identified as a factor hindering access to information about prevention practices[29].

Still based on the terms that comprise the CC (condom, care, and prevention), the participants' statements reveal a complaint that the globally disseminated STI prevention strategies for young people and adults do not meet the needs, specificities, and possibilities of sexual practices among cisgender lesbians, exposing them to unsafe practices in accessing pleasure.

"Care" (F=48; MOE=2.7) is the second term comprising the CC. It was mentioned 19 times as the most important and is related to the participants' attitudinal dimension toward the represented object. The justifications highlight, for example:

Chart 1. Structure of social representations of young lesbians about sexual health. Salvador. Bahia. Brazil. 2025.

Average Frequency	MOE<2.81			MOE≥2.81		
Central Core				**First Periphery**		
≥23.16	**Evoked term**	**F**	**MOE**	**Evoked term**	**F**	**MOE**
	Condom	54	2.1	Disease	47	2.9
	Care	48	2.7	Exam	30	3.3
	Prevention	44	2.2	Information/Knowledge	26	3.1
				Sex	26	3.0
Contrast Zone				**Second Periphery**		
<23.16	**Evoked term**	**F**	**MOE**	**Evoked term**	**F**	**MOE**
	Gynecologist	19	2.5	Lack	19	3.1
	Doctor	14	2.1	Education	19	3.1
	Pleasure	13	2.7	Safety	16	3.4
				Vulnerability	15	3.3
				Hygiene	13	3.2
				Prejudice	13	3.3
				Necessary	12	3.4
				Follow-up	12	3.1

Source: Adaptation from iRaMuTeQ 0.7.

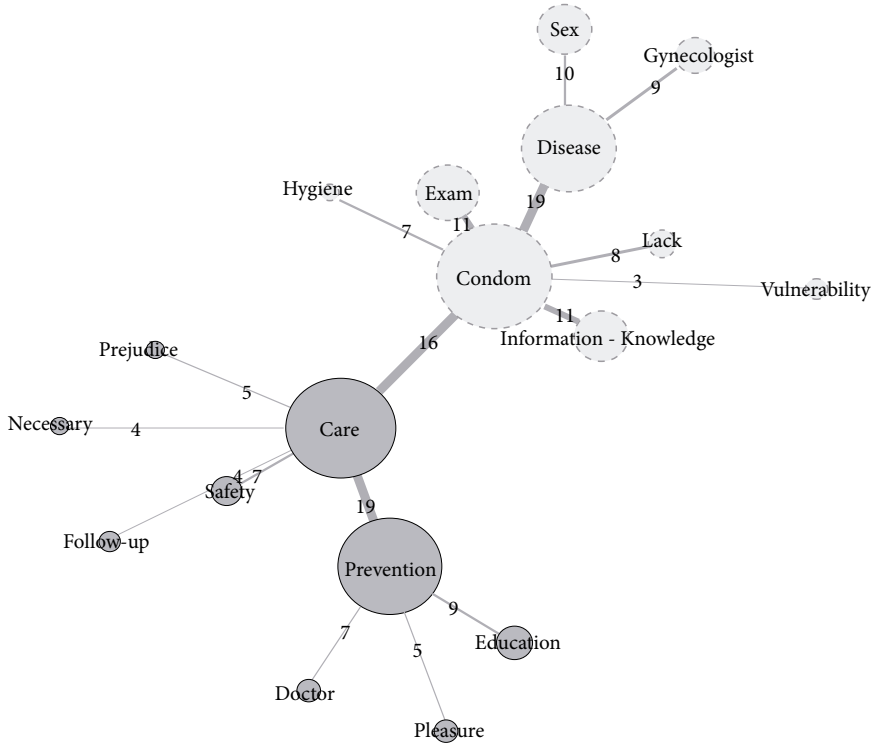

Figure 1. Similarity tree of social representations of young lesbians about sexual health. Salvador, Bahia, Brazil, 2025.

Source: Reproduction iRaMuTeQ 0.7.

Sexual health is a global approach to sexuality that is not limited to preventing STIs, but that respects our bodies and stories (P113, 29 years old, white cis woman).

"Prevention" (F=44; MOE=2.2) is a core element of the evaluative dimension, providing criteria for evaluating the object[30]. In the context of sexual health, prevention refers to a set of measures taken in advance to avoid potential harm. The interviewees shared their search for cervical screening as a prevention strategy:

I've never even had a preventive exam. The gynecologists I went to said I didn't need one because I was still a virgin, and I hadn't had sex with a man (P002, 29 years old, cis-gender woman).

Although preventive examinations are the most well-known form of care among lesbians, they are also the least frequently performed. Other preventive measures were listed: restricting specific sexual practices (such as oral sex and tribadism), cutting nails, having a steady partner, washing hands, asking if the partner is tested, and not performing oral sex if the woman is menstruating[4,27].

The upper right quadrant, or first periphery, consists of highly frequent terms that were evoked later[17]. The terms that comprise this quadrant (disease, examination, information/knowledge, and sex) refer to the cultural dimension of SR and suggest the anchoring of sexual health in hegemonic notions of risk and surveillance, which may be a reflection of public campaigns, medical discourse, and shared experiences in formal health settings. The terms information/knowledge and sex, on the other hand, indicate an attempt to objectify sexual health, that is, the transformation of abstract concepts into concrete and communicable elements[15].

When the terms "disease and examination" emerged as the most important terms, the justifications convey the idea that, in a context where safe and accessible methods that encompass lesbian sexual practices are lacking, examinations become a peripheral attitudinal element that contributes to minimizing the place of vulnerability experienced by the group:

I always end up thinking that STI transmission among cis women is more difficult, and I never think of ways to protect myself, but then I worry and get tested (P218, 23 years old, white cis woman).

The term "information/knowledge" was justified as the most important eight times. The justifications reveal that this is a necessary resource for taking care of sexual health and, consequently, the lack of concrete, scientifically referenced and accessible information, as a factor that can contribute to the condition of vulnerability in the health of lesbians, leading them to a movement toward individual searches:

I started learning about my sexual health, a lot through self-taught activities/internet knowledge, like that. And then I started understanding what a possibility was (P068, 28 years old, Black cis woman).

National surveys frequently point to a lack of knowledge or inaccurate knowledge about preventive methods associated with the lack of technical standards for sexual health care guidance for lesbians[31]. The scarcity of services and health professionals knowledgeable about the specificities of LGBT+ issues is cited as a factor that encourages care strategies based on personal experience and without professional supervision[12,13].

The elements present in the upper right quadrant (disease, examination, information/knowledge, and sex) suggest that the lack of information and knowledge about lesbian sexual health encourages the sharing of self-care and prevention strategies among peers, ensuring disease prevention based on their experiences. Even when lesbians access health services, their sexual practices and exercise of sexuality are not always prioritized and valued within disseminated biomedical knowledge, which makes it impossible to provide assertive and personalized health care.

The lower right quadrant, as recommended by the TSR structural approach, consists of terms deemed to be weaker in determining behaviors and attitudes related to the object of representation, interfering with less force when compared to the other structures[17,30]. In this study, the terms that make up this quadrant (STI, lack, education, safety, and vulnerability) and the justifications made for them, suggest a scenario where needs and inequities experienced by lesbians in the context of sexual health are highlighted:

It's lacking, because I feel there's a lot of misinformation about lesbian sexual healthcare methods. How can we better protect ourselves? (P189, 22 years old, white cisgender woman).

Research on the frequency and risk of STI infection in cisgender women who have sexual relations with cisgender women revealed, in addition to a high incidence of these conditions, an increased likelihood of contracting an STI related to the number of sexual partners, smoking, a history of non-consensual sex, and the stigma associated with sexuality[32].

The terms in this quadrant reinforce and denounce political and structural issues that permeate the sexual health of lesbians, who live with the insecurity and vulnerability of contracting an STI, but who also neglect the possibility of comprehensive care.

The lower left quadrant contains elements that were readily evoked, although by a small number of participants[30]. The first two terms that make up this quadrant (gynecologist and doctor) reinforce the CC, referring to care and prevention. However, the term pleasure appears as a necessity for healthy sexual practice and was interpreted as a new element in the set of representations, since the experience of pleasure is not seen as central to sexual health for this group. For TSR, these are possible evocations that constitute the CC of some individuals. This was explored by one participant:

[...] I think it involves self-esteem, the feeling of deserving pleasure and that you are not just a body to give pleasure to others; and that sex is not just for reproduction and that it must be done safely, consciously, with consent (P063, 29 years old, black cis woman).

The participants' statements are consistent with the scientific literature on sexual health among young people and individuals who identify as LGBT+, with a significant body of research focusing on STI prevention[29,31].

In the similarity analysis (Figure 1), the elements "care" and "condom" stand out to group together both CC elements that give rise to other subgroups and to make the greatest number of connections with other elements in the universe of evocations. The similarity analysis is based on frequency analysis (represented by the size of the circle) and the simultaneous occurrence (or co-occurrence) between the terms (represented by the size and thickness of the lines, as well as the numbers that follow them)[25].

The centrality of the terms (Chart 1) suggests that sexual health is permeated by preventive care actions beyond condom use alone, as current models are not aligned with the group's sexual practices. This is attributed to the strong symbolic connection between the term "condom" and the represented object, while "care" is related to the participants' attitudinal dimension.

The similarity analysis (Figure 1) reveals co-occurrences based on the frequency of connections between the elements that make up the social representation[17,30]. The organization and structure presented in Figure 1 indicated the terms "condom" and "care" as possible CCs, which organized the other elements into two large poles that strongly represent the symbolic and attitudinal dimensions of the SRs. It can also be observed that the aforementioned main cores give rise to two subgroups organized around the terms "prevention" and "disease," ensuring the structuring function of the SRs. The terms "condom, care, prevention, and disease" strongly suggest they may become part of the SR CC or may have already been part of it at some point, requiring further centrality tests to confirm this hypothesis.

There are a significant number of co-occurrences between the terms "care and prevention," as well as between the terms "care and condom", which gives meaning to the care practices adopted by lesbians. Interview excerpts also point to the centrality of this term in the set of evocations:

I've never had sex with a woman using any kind of... I don't know if you can call it a condom. To this day, the practice I've always adopted is to maintain good hygiene. Short nails, clean nails. If you're going to use a toy, also clean it, don't share it, but clean it between exchanges (P050, 21 years old, white cis woman).

For the participants, there is consensus that protective methods during sex among cisgender lesbians are uncommon among the general public. This is likely due to the fact that they are not designed based on their sexual practices and rely on adapted materials, such as plastic wrap and dental dams – plastic pieces used in dental practice.

When considering the term "care" as a central element of the first core meaning, the surrounding elements: "prevention, safety, monitoring, necessary, and prejudice," reveal that, although the young women understand the need for preventive care, which requires professional monitoring to prevent harm, their sense of safety in this process is compromised, as their experiences are permeated by prejudice.

In the literature, the prejudices perceived by self-identified LGBT people in the healthcare process are associated with the need to increase the visibility of this topic in formal curricula for higher education in health[12,13,27,31]. The data from this study corroborate the understanding that SRs reflect social attitudes and practices[12,14,16], since the young interlocutors circumscribe the object in their practices and adopt certain behaviors, such as using/not using condoms, seeking medical care, visiting a gynecologist, undergoing exams, and seeking information. It is important to note that the organization of the

connections points to elements of sexual healthcare promotion related to the term "prevention," such as the evocations "doctor, education, and pleasure", reiterating the idea that promoting sexual health care requires intersectoral actions that encompass health, education, and the individuality of the subjects.

Similarly, considering the term "condom," the significant number of co-occurrences identified with the term "disease" reinforces the idea that, for the investigated group, the concept of sexual health is related to the risk of STI contamination and, consequently, to the use of condoms as a protective barrier. Regarding the terms grouped with the element "disease", it can be inferred that the risk of contracting a disease through sexual intercourse is possible, given the prevention practices and/or care strategies not adopted by the participants. The presence of two terms related to doctors is noteworthy, as it infers the extent to which hegemonic models of care – biologically and medically centered – are reinforced by the SRs.

Furthermore, the elements "hygiene, exam, lack, vulnerability, information/knowledge" cluster around them to form a graph that both highlights the perceived challenges and demonstrates practices adopted by people who identify as lesbians in sexual health care. An excerpt from the interviews demonstrates some behavioral strategies that lesbians use to feel safer/less insecure when considering sexual health care:

While I was in relationships with people I didn't know, who I was seeing at the time and ended up having sex with, I thought it would be safer for me if I didn't give or receive oral sex, but I made sure the person washed their hands so that penetration could occur with fingers and well-trimmed nails. So, that was the way I protected myself, the way I thought I was safe (P063, 28 years old, Black cis woman).

The importance of producing evidence-based, widely accessible technical and scientific materials that address sexual practices aligned with the experiences of lesbians is evident, promoting comprehensive, inclusive, and reality-based care for these populations. The development of initiatives focused on lesbian sexual health is closely linked to the empowerment and active participation of youth in society, the strengthening of family and community relationships, health education, and the prevention of health problems.

This research recognizes that, although there are multiple expressions and intersections that characterize lesbian youth, it was not possible to include participants who self-identify as transgender lesbians in the sample. Nevertheless, the data obtained offer important contributions to improving healthcare, especially regarding the promotion of safe and inclusive sexual care.

Final considerations

This article reinforces the need for investment in barrier methods that address the specific sexual practices of young cisgender lesbians. The lack of accessible and lesbian-specific information on sexual health also emerged as a challenge to be overcome with new research, outreach activities, and educational practices promoted by health and education institutions and social movements, enabling a voice for people who identify as lesbians. Participants reported relying on self-taught information sources, such as the internet, and facing difficulties interacting with health professionals who do not understand their specific needs, coupled with experiences of discrimination and stigma in health services.

Furthermore, it reinforces the importance of developing public policies aimed at promoting the sexual health of young people who identify as lesbians, valuing their socially shared knowledge. The experience reported seeks to ensure universal access to safe, inclusive, and culturally competent sexual health care, especially for the studied population.

Collaborations

LKL Conceição participated in all stages of the article's preparation, read and approved the final version. JF Oliveira contributed to the study design, analysis and interpretation of results, writing the paper, and approval of the final version. MEF Jesus participated in data analysis and writing the article, and read and approved the final version. BCJ Santana and GS Mota contributed to the search for references, formatting, and writing of the article, and read and approved the final version.

Data availability statement

The data sources adopted in the research are indicated in the article's body.

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