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Challenges in health care for lesbian women: professional unpreparedness and misinformation from a socio-anthropological perspective — a literature review

Desafios no cuidado à saúde de mulheres lésbicas: despreparo profissional e desinformação sob o olhar socioantropológico — uma revisão de literatura

Desafíos en la atención de salud de las mujeres lesbianas: falta de preparación profesional y desinformación desde una perspectiva socioantropológica — una revisión de la literatura

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Abstract: The health of lesbian and bisexual women has historically been neglected, despite legal advances such as the National Policy for Comprehensive LGBT Health (PNSI-LGBT). From a socio-anthropological perspective, this neglect is related to social constructions of gender and sexuality that influence care practices. This study aims to map barriers to access and gaps in health care for this population in Primary Health Care (PHC). A systematic literature review with a qualitative approach was conducted. The results show that access is hindered by attitudinal, structural, and informational barriers. Heteronormativity in health services stands out, generating lesbophobic invisibility and discrimination. In addition, professional unpreparedness contributes to the omission of guidance on STIs/AIDS and to low adherence to preventive examinations. It is concluded that PHC still fails to ensure comprehensive access for lesbian and bisexual women, showing that the existence of public policies is insufficient without cultural and institutional changes. Continuous training for health professionals and inclusion strategies that consider the social and cultural dimensions of sexuality are therefore necessary.

Keywords: Socio-anthropological; Sexuality; Primary Health Care; Heteronormativity.

Resumo: A saúde de mulheres lésbicas e bissexuais tem sido historicamente negligenciada, apesar de avanços legais como a Política Nacional de Saúde Integral LGBT (PNSI-LGBT). Sob uma perspectiva socioantropológica, essa negligência relaciona-se às construções sociais de gênero e sexualidade que influenciam as práticas de cuidado. O objetivo deste trabalho é mapear as barreiras de acesso e as lacunas no cuidado à saúde dessa população na Atenção Primária à Saúde (APS). Foi realizada uma revisão sistemática da literatura com abordagem qualitativa. Os resultados mostram que o acesso é dificultado por barreiras atitudinais, estruturais e informacionais. Destaca-se a heteronormatividade nos serviços de saúde, que gera invisibilidade lesbofóbica e discriminação. Além disso, o despreparo profissional contribui para a omissão de orientações sobre IST/Aids e para a baixa adesão a exames preventivos. Conclui-se que a APS ainda falha em garantir acesso integral às mulheres lésbicas e bissexuais, evidenciando que a existência de políticas públicas é insuficiente sem mudanças culturais e institucionais. Assim, torna-se necessária a formação contínua dos profissionais de saúde e estratégias de inclusão que considerem dimensões sociais e culturais da sexualidade.

Palavras-chave: Socioantropológica; Sexualidade; Atenção Primária; Heteronormatividade.

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Resumen: La salud de las mujeres lesbianas y bisexuales ha sido históricamente desatendida, pese a avances legales como la Política Nacional de Salud Integral LGBT (PNSI-LGBT). Desde una perspectiva socioantropológica, esta desatención se relaciona con las construcciones sociales de género y sexualidad que influyen en las prácticas de cuidado. El objetivo de este trabajo es identificar las barreras de acceso y las lagunas en la atención de salud de esta población en la Atención Primaria de Salud (APS). Se realizó una revisión sistemática de la literatura con enfoque cualitativo. Los resultados muestran que el acceso se ve dificultado por barreras actitudinales, estructurales e informativas. Destaca la heteronormatividad en los servicios de salud, que genera invisibilidad lesbofóbica y discriminación. Además, la falta de preparación profesional contribuye a la omisión de orientaciones sobre ITS/sida y a la baja adhesión a los exámenes preventivos. Se concluye que la APS aún no garantiza el acceso integral a las mujeres lesbianas y bisexuales, lo que demuestra que la existencia de políticas públicas es insuficiente sin cambios culturales e institucionales. Por tanto, son necesarias la formación continua de los profesionales de salud y estrategias de inclusión que consideren las dimensiones sociales y culturales de la sexualidad.

Palabras clave: Socioantropológica; Sexualidad; Atención Primaria; Heteronormatividad.

Introduction

The health of the LGBTQIAPN+ population has gained greater visibility in recent decades, especially in the context of public policies aimed at promoting equity and universal care in the Brazilian Unified Health System (SUS). Despite institutional advances and the formulation of specific policies, lesbian women still face numerous barriers to accessing and remaining in health services, frequently experiencing invisibilization, prejudice, and professional unpreparedness. This reality shows that health care remains strongly influenced by heteronormative standards that hinder recognition of this population's specific needs (BRASIL, 2013).

Access to health care is not limited to the physical availability of services; it also involves social, cultural, and symbolic dimensions that directly influence users' experience within the health system. In this regard, Assis and Jesus (2012) emphasize that access must be understood as a complex process related both to the structural conditions of services and to the relationships established between professionals and users. Applied to lesbian women's reality, this debate becomes even more relevant because many refrain from seeking care for fear of discrimination, invalidation of their identities, and institutional violence.

Historically, female sexuality was constructed through perspectives marked by heterosexual normativity and the silencing of sexual dissidence. Consequently, lesbian women came to occupy a space of invisibility within care practices and were often excluded from prevention campaigns, gynecological guidance, and health-promotion strategies. Valadão and Gomes (2011) state that female homosexuality in health care moves between invisibility and

various forms of symbolic violence, manifested through discriminatory conduct, embarrassment, and the absence of adequate reception during care.

Moreover, shortcomings in academic and professional education contribute significantly to maintaining these inequalities. Many health professionals receive no adequate preparation for addressing sexual and gender diversity and reproduce social stigmas and exclusionary practices in daily care. According to Portella (2014), lesbian and bisexual users' perceptions show that care provided by SUS is still marked by misinformation and professionals' difficulty in understanding this population's particularities, compromising comprehensive care and the establishment of therapeutic bonds.

From a socio-anthropological perspective, these problems can be understood as reflections of symbolic structures historically constructed in society. Pierre Bourdieu (1998) argues that mechanisms of symbolic power act silently in reproducing social inequalities, naturalizing discriminatory practices and legitimizing relations of domination. In this context, heteronormativity in health institutions can be understood as a form of symbolic violence that marginalizes dissident sexual experiences and hinders recognition of lesbian women's demands in the health system. The author also stresses that these social structures are reproduced through habitus, influencing professional behaviors, perceptions, and practices in everyday institutional life (BOURDIEU, 2009).

Given this scenario, it is essential to broaden discussions of lesbian women's health by considering not only biomedical aspects but also the social, cultural, and political factors that permeate their experiences in health services. Thus, through a literature review, this study aims to analyze the challenges faced in lesbian women's health care, focusing on professional unpreparedness and misinformation from a socio-anthropological perspective, and to understand how these factors contribute to perpetuating inequalities in access and care.

Methodology

This is a qualitative, exploratory, and descriptive study developed through a narrative literature review with a socio-anthropological approach. This type of inquiry enables critical understanding, interpretation, and discussion of the social phenomena related to lesbian women's health care, especially barriers to access, professional unpreparedness, and invisibilization practices in health services.

The research was conducted through a bibliographic survey of national and international scientific databases, including Scientific Electronic Library Online (SciELO), Virtual Health

Library (VHL), PubMed, and Google Scholar. Portuguese and English descriptors combined with the Boolean operators AND and OR were used, including: “Saúde de Mulheres Lésbicas,” “Saúde LGBT,” “Atenção Primária à Saúde,” “Heteronormatividade,” “Assistência à Saúde,” “Mulheres que fazem sexo com mulheres,” “Lesbian Health,” “Primary Health Care,” and “Health Services Accessibility.”

Scientific articles, institutional documents, dissertations, and public policies published from 2010 to 2025 were included when available in full and directly addressing lesbian women's health, challenges in access to health services, health professionals' work, and structural inequalities related to sexuality. Classic theoretical references published before the defined period were also used because of their conceptual relevance and contribution to the study's socio-anthropological foundation. Duplicate studies, incomplete works, publications unrelated to the research object, and articles whose primary focus did not encompass the lesbian population's reality in collective health were excluded.

Material selection occurred in three stages: reading titles, reading abstracts, and reading the selected texts in full. After screening, relevant studies were analyzed interpretively and critically, allowing the identification of central thematic categories such as institutional heteronormativity, lesbian invisibility, symbolic violence, professional unpreparedness, informational barriers, and difficulties in accessing Primary Health Care (PHC).

In addition to the scientific literature, regulatory documents from the Ministry of Health were used, especially the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (PNSI-LGBT), because they constitute important legal milestones for analyzing public policies aimed at the LGBTQIAPN+ population.

Data interpretation was grounded in references from the sociology and anthropology of health, particularly Pierre Bourdieu's theoretical contributions concerning symbolic power, symbolic violence, and the reproduction of social inequalities. This perspective made it possible to understand how discriminatory practices and heteronormative discourses are institutionally reproduced in health services and directly affect the quality of care provided to lesbian women.

Because this research was based exclusively on bibliographic sources and public-domain documents, it did not require submission to a Research Ethics Committee, in accordance with the guidelines of Resolution No. 510/2016 of the National Health Council concerning research in the Human and Social Sciences.

Development

Discussion of lesbian women's health in Brazil still faces major academic, institutional, and care gaps, despite advances in public policies aimed at the LGBTQIAPN+ population. Although SUS is founded on universality, comprehensiveness, and equity, everyday reality shows that lesbian women continue to encounter barriers that hinder full and humane access to health services, especially Primary Health Care (PHC).

Historically, health services were organized according to a heteronormative logic in which heterosexuality is considered the universal standard of behavior and sexual experience. This structure directly influences how professionals provide care, producing invisibility and exclusion of women who do not fit this model. Valadão and Gomes (2011) state that female homosexuality in health care remains marked by invisibility and symbolic violence, since many lesbian women report embarrassment, discrimination, and lack of reception during care.

In this context, lesbophobic invisibility appears in different ways in health services. Rodrigues and Falcão (2021) emphasize that automatically assuming patients are heterosexual is one of the main forms of institutional exclusion, especially in gynecological consultations. In many cases, professionals do not investigate these women's sexual practices, identities, or specific needs, resulting in inappropriate guidance, preventive failures, and withdrawal from health services. This situation directly contributes to low adherence to preventive gynecological examinations and delayed seeking of medical care.

Beyond attitudinal barriers, professional unpreparedness is one of the principal obstacles to comprehensive care. Health education still addresses sexual and gender diversity only to a limited extent, perpetuating biological and exclusionary discourses. According to Portella (2014), professionals often display insecurity and lack of knowledge when faced with the specific demands of lesbian and bisexual women, compromising the quality of care offered and hindering the construction of therapeutic bonds.

Miskolci et al. (2022) reinforce that the absence of professional training remains a major structural challenge within SUS. The authors note that “not knowing” is often used to justify the failure to implement public policies aimed at the LGBTQIAPN+ population effectively, revealing an institutional logic that naturalizes these women's exclusion from care settings. Thus, even with the National Policy for Comprehensive LGBT Health, many discriminatory practices remain present in everyday care.

Another relevant aspect concerns the informational barriers faced by lesbian women in health services. Studies show that this population receives less sexual and reproductive health guidance than heterosexual women. Parenti et al. (2023) found that women who have sex with women have less knowledge about Sexually Transmitted Infections (STIs) and AIDS, a

situation directly related to health professionals' omission of information. This neglect contributes to the false perception that relations between women pose no or little risk of STI transmission, increasing this population's vulnerability.

Supporting this discussion, Doull et al. (2018) show that many lesbian women do not use prevention methods during sexual relations because of inadequate information about safer practices and STI prevention. This reality shows that misinformation stems not only from lack of access to knowledge but also from insufficient inclusive educational strategies within health services.

Institutional discrimination also significantly affects this population's mental health. Through the National LGBT+ Health Survey, Torres et al. (2021) found a high frequency of discriminatory episodes experienced by the LGBTQIAPN+ population, as well as substantial rates of psychological distress and depression diagnoses. Fear of prejudice and symbolic violence leads many lesbian women to avoid health services, interrupt clinical follow-up, and seek less preventive care.

From a socio-anthropological perspective, these inequalities can be understood through Pierre Bourdieu's theoretical contributions. For the author, symbolic power acts silently and becomes naturalized in reproducing relations of social domination (BOURDIEU, 1998). In health services, institutional heteronormativity works as a mechanism of symbolic violence, imposing standards regarded as legitimate and marginalizing dissident identities. Discriminatory practices are therefore reproduced daily, often without being explicitly recognized by the professionals themselves.

Bourdieu (2009) also emphasizes that habitus influences institutional behavior and practices, contributing to the maintenance of exclusionary social structures. In this sense, professional unpreparedness should not be analyzed only as an individual failure but as the result of education historically constructed through biomedical and heteronormative perspectives that render the lesbian population's specificities invisible.

Despite advances in recent decades, such as the creation in 2011 of the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals, there remains a considerable distance between legal guidelines and the daily practice of health services. Alves, Moreira, and Prado (2020) state that public policies alone do not guarantee the realization of this population's rights, especially when structural barriers, institutional prejudice, and lack of professional training persist.

It is therefore evident that promoting comprehensive health for lesbian women requires changes that extend beyond biomedicine and involve cultural, institutional, and educational

transformations. It is essential to strengthen continuing health education strategies, broaden discussions of sexual diversity in academic training, and develop care practices grounded in reception, equity, and respect for individual singularities. Only through these changes will it be possible to build truly comprehensive and humane care committed to SUS principles.

Results and discussion

The literature review identified the main challenges lesbian women face in accessing health services as institutional heteronormativity, professional unpreparedness, invisibility in care, and lack of specific sexual and reproductive health information. The analyzed studies show that, despite legal advances and public policies aimed at the LGBTQIAPN+ population, structural and symbolic barriers persist and hinder comprehensive care in SUS.

Author/Year	Study objective	Main results	Contribution to this study
Valadão and Gomes (2011)	Discuss female homosexuality in health care	Identified invisibility, discrimination, and symbolic violence in health services	Shows institutional exclusion and difficulty in welcoming lesbian women
Portella (2014)	Analyze the perceptions of SUS professionals and users	Demonstrated professional unpreparedness and difficulties in comprehensive care	Supports the discussion of misinformation and shortcomings in health education
Rodrigues and Falcão (2021)	Investigate gynecological experiences of lesbian and bisexual women	Identified assumptions of heterosexuality and embarrassment during consultations	Reinforces lesbophobic invisibility in gynecological care
Miskolci et al. (2022)	Reflect on health challenges for the LGBTI+ population in Brazil	Found access barriers, lack of training, and failures in public-policy implementation	Supports the analysis of structural limitations in SUS
Torres et al. (2021)	Characterize demands and access barriers for the LGBT+ population	Found high rates of discrimination and psychological distress	Links institutional exclusion to mental-health impacts
Parenti et al. (2023)	Assess knowledge of STIs/AIDS among women who have sex with women	Identified low knowledge of STIs and less access to information in services	Shows the effects of misinformation on health vulnerability
Doull et al. (2018)	Investigate the use of prevention methods among lesbian women	Found low adherence to the use of prevention barriers	Links lack of professional guidance to increased sexual risks
Alves, Moreira, and Prado (2020)	Discuss heteronormativity and public policies	Identified a gap between public policies and care practices	Supports the critical analysis of LGBT health-policy effectiveness

Source: Prepared by the authors (2026).

The results show that heteronormativity remains one of the principal barriers to comprehensive care for lesbian women. Valadão and Gomes (2011) point out that dissident female sexuality is still rendered invisible within health services, which encourages

discriminatory practices and hampers humane reception. This invisibility is especially apparent in Primary Health Care (PHC), considered the main entry point into SUS.

Rodrigues and Falcão (2021) show that automatically assuming heterosexuality during gynecological consultations directly compromises care quality. Many lesbian women report embarrassment, fear of discrimination, and a lack of qualified listening, factors that contribute to low adherence to preventive examinations and withdrawal from health services.

Professional unpreparedness was also identified as a recurrent barrier in the studies analyzed. Portella (2014) notes that health professionals often have difficulty addressing issues related to the sexuality of lesbian and bisexual women, reproducing heteronormative discourses and exclusionary practices. Miskolci et al. (2022) reinforce that the lack of professional training and deficiencies in implementing LGBTQIAPN+ public policies are major obstacles to health equity.

Regarding sexual and reproductive health, Parenti et al. (2023) found that women who have sex with women have less access to information about STIs/AIDS than heterosexual women. This reality contributes to the false perception that relations between women involve no risk, increasing vulnerabilities. Doull et al. (2018) also found low adherence to prevention methods, directly related to insufficient specific guidance provided by health services.

The impacts of these barriers extend beyond physical health and significantly affect mental health. Torres et al. (2021) found high rates of discrimination and psychological distress among LGBTQIAPN+ people, showing that negative experiences in health services contribute to feelings of exclusion, anxiety, and emotional illness.

From a socio-anthropological perspective, these inequalities can be understood through Pierre Bourdieu's contributions on symbolic violence and symbolic power. Institutionalized heteronormativity operates as a mechanism for reproducing inequalities, naturalizing discriminatory practices within health services, and hindering recognition of lesbian women's specific needs.

Thus, the studies analyzed demonstrate that public policies, although essential, are insufficient to ensure comprehensive care. Investing in continuing education for health professionals, strengthening equity policies, and developing care practices based on reception, respect for sexual diversity, and humanized care are indispensable.

The joint analysis of the selected scientific literature and Brazil's public-health regulatory frameworks reveals a scenario of persistent care asymmetries. Although the institutional architecture of SUS is guided by the democratic principles of universality and equity, the operationalization of care for lesbian and bisexual women in PHC is crossed by

invisible yet rigidly structured barriers. To understand the complexity of these obstacles, the findings were organized into four integrated socio-anthropological axes.

The historical organization of Western health services was consolidated in the image of the traditional biomedical model, which operates not only from presumed technical neutrality but also under the aegis of the heterosexual matrix as a compulsory norm and standard of organic and behavioral normality. The reviewed data show that institutional heteronormativity is not manifested solely through verbal violence or explicit refusal of care; far more perversely, it is established through tacit exclusion and silencing. In dialogue with Pierre Bourdieu's theoretical framework, the PHC clinic can be understood as a social field with its own rules, where medical and multiprofessional bodies hold a monopoly over technical capital and legitimate discourse. In this field, automatically presuming users' heterosexuality—unanimously identified in the literature as a critical barrier to gynecological care—is a clear expression of symbolic violence. As Bourdieu argues, symbolic violence is exercised over an agent with their complicity or forced submission because structures of domination are internalized in everyday schemes of perception. When a health professional begins a gynecological history by assuming that the patient has a male partner and demands heterosexual contraceptive methods, an arbitrary identity frame is imposed. Faced with this institutionalized embarrassment, the lesbian woman reaches a crossroads: either she is forced to self-declare her sexual orientation, exposing herself to the imminent risk of judgment and a breakdown in reception, or she remains silent and undergoes a clinically inappropriate examination disconnected from her actual preventive needs. This constant tension saturates the user's experience in the service, transforming the health unit—which should be a locus of safety—into an environment of vulnerability and moral surveillance. As a direct consequence of this silent oppressive dynamic, these women systematically withdraw from routine gynecological screening, resulting in late diagnoses of preventable conditions.

The results show that PHC professionals' unpreparedness cannot be interpreted merely as an individual cognitive gap or an occasional oversight by frontline workers. It is fundamentally a structural product of academic education in the health sciences, which has historically prioritized a strictly biological, fragmented perspective alienated from the social determinants of health, gender, and sexuality. To understand the persistence of this technical misinformation in daily services, Bourdieu's concept of habitus is useful: a system of durable, transferable dispositions that generates structured and structuring practices. During medical and nursing education, students internalize a professional habitus that assumes the heterosexual reproductive body as the standard object of clinical intervention. Anything outside this

normative measure is pushed to the curricular margins or treated as a behavioral eccentricity without solid epidemiological relevance. This systematic educational deficit engenders what contemporary literature calls the politics of “not knowing.” As the reviewed studies indicate, frequent claims of lacking technical training or being unaware of the National Policy for Comprehensive LGBT Health guidelines do not operate as admissions of failure, but as socially accepted and institutionalized justifications for perpetuating the omission of care. “Not knowing” becomes a bureaucratic shield: professionals feel released from offering comprehensive care because the institution itself legitimizes the absence of this knowledge from their practical repertoires. Thus, the reproduction of stigmas and the veiled refusal of gynecological or preventive care to women who have sex exclusively with women are perpetuated without sanction or ethical discomfort in the daily life of Basic Health Units. In this way, medical habitus sabotages the practical implementation of the equity standards advocated by the Ministry of Health.

One of the most alarming findings in the analyzed literature concerns the informational gulf surrounding the sexual health of lesbian and bisexual women. A persistent and mistaken perception, shared by health professionals and the wider community, holds that sexual relations between women pose no or negligible risk of transmitting Sexually Transmitted Infections (STIs) and AIDS. This unfounded premise creates a chain of inadequate care that substantially increases this population's epidemiological vulnerability. Informational barriers operate along two complementary paths. On one hand, traditional educational materials, prevention-campaign leaflets, and SUS mass-communication strategies are mainly directed toward heterosexual practices or men who have sex with men, systematically omitting the anatomical and sexual-practice specificities of relations between women. On the other hand, in the microspace of the consultation room, professionals avoid giving explicit guidance on prevention barriers—such as latex sheets, cleaning sex toys, and condoms on fingers—because of their own technical ignorance or moral discomfort in verbalizing these practices. This clinical silence actively produces misinformation. When health services fail to educate, they endorse discontinuity in preventive care. Users deprived of specific scientific support and suitable preventive supplies freely distributed through the public network adopt practices that underestimate transmission routes for infections such as HPV, HIV, syphilis, and genital herpes. Vulnerability, therefore, is not intrinsic to lesbian women's sexual orientation but a condition socially and institutionally produced by the health system's refusal to universalize access to qualified information and barrier supplies.

Finally, it is imperative to analyze how the social determinants of sexual orientation have profound and harmful repercussions on lesbian women's psychological dimension. The mental suffering identified in the data—characterized by substantial rates of generalized anxiety, chronic depression, and suicidal ideation—cannot be separated from systematic experiences of discrimination and exclusion throughout users' paths in seeking care. Institutional lesbophobia acts as a chronic stressor. The recurrent need to suppress one's identity, the anticipated fear of rejection or disapproving looks from reception and nursing staff, and the memory of previous traumatic care trigger a process of ethical-political suffering. This dynamic of subtle hostility culminates in the definitive breakdown of the principle of reception and prevents the establishment of the therapeutic bond, the backbone of Primary Care. From the perspective of Assis and Jesus's (2012) access-analysis model, entry into health services presupposes alignment between subjects' needs and the network's ability to respond effectively. When PHC fails to offer a psychologically safe space, the constitutional right to health is summarily violated. On realizing that her existence is invalidated in the public arena of care, the lesbian woman opts for self-isolation from assistance, resorting to the system only in extreme medical emergencies or acute clinical episodes. This overloads medium- and high-complexity services and breaks with the logic of contractuality and prevention advocated by SUS.

Final considerations

This literature review showed that lesbian women still face major barriers to accessing and remaining in health services, despite advances achieved through public policies aimed at the LGBTQIAPN+ population. The studies analyzed demonstrated that institutional heteronormativity, professional unpreparedness, invisibility in care, and misinformation remain central factors in producing health inequalities in this population.

Health services, especially PHC, were observed to operate through a predominantly heteronormative logic that disregards lesbian women's experiences, sexual practices, and specific needs. This reality favors embarrassment, discrimination, and symbolic violence, compromising comprehensive care and contributing to these women's withdrawal from health-care settings.

In addition, insufficient academic education and continuing training for health professionals were found to be among the main limitations to implementing existing public policies. Difficulty addressing sexual diversity ethically, receptively, and humanely directly

affects the quality of care, particularly in sexual health, STI prevention, gynecological follow-up, and comprehensive health promotion.

The results also showed that misinformation is an important aggravating factor in lesbian women's health vulnerability. The absence of specific guidance on prevention, sexuality, and gynecological care reinforces false perceptions of low risk, encourages unsafe practices, and reduces adherence to preventive services.

From a socio-anthropological perspective, these inequalities are understood as being produced not only by individual failures but by historically constructed social and institutional structures that reproduce power relations, exclusion, and invisibility within health services. In this context, it is essential to recognize that achieving health equity depends not only on public policies but also on transforming care practices and health-education processes.

It is therefore essential to strengthen continuing-education strategies focused on sexual and gender diversity, expand discussions of LGBTQIAPN+ health in academic education, and promote care practices based on reception, respect, and humanization. Only through these changes will it be possible to realize SUS principles—universality, comprehensiveness, and equity—and ensure lesbian women dignified, inclusive, and truly comprehensive care.

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