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Care for the sexual and reproductive health of lesbian women

O cuidado às mulheres lésbicas no campo da saúde sexual e reprodutiva

El cuidado de las mujeres lesbianas en el campo de la salud sexual y reproductiva

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ABSTRACT
Objective: to describe and analyze care by nurses and physicians for lesbians' sexual and reproductive health. **Method:** in this qualitative, descriptive study, data were collected in 2014, by semi-structured interviews of 24 nurses and 21 physicians working in primary care in Rio de Janeiro city. Thematic category content analysis was applied. The study was approved by the research ethics committee. **Results:** nurses' and doctors' perceptions and understandings of lesbians are strongly normative in content and personnel display knowledge deficits, inability to communicate and omission in relation to these women's health demands. **Conclusion:** care for lesbians is permeated by heteronormative routines, while nurses' and physicians' omissions in response to lesbian health demands operates as symbolic violence, and is a condition in their more restricted access to health.
Descriptors: Lesbian women; sexual and reproductive health; gender and health; violence.

RESUMO
Objetivo: descrever e analisar o cuidado às lésbicas, por enfermeiras e médicos, no campo da saúde sexual e reprodutiva. **Método:** pesquisa descritiva, qualitativa. Participaram do estudo 24 enfermeiras e 21 médicos atuantes na atenção primária, no município do Rio de Janeiro. Pesquisa aprovada por Comitê de Ética em Pesquisa. Os dados foram coletados em 2014, por meio da entrevista semiestruturada. Desenvolveu-se análise de conteúdo temático-categorial. **Resultados:** os esquemas de percepção e apreciação de enfermeiras e médicos sobre as lésbicas apresentam um conteúdo fortemente normativo e os profissionais apresentam defasagem de conhecimento, inabilidade de comunicação e omissão em relação às demandas de saúde dessas mulheres. **Conclusão:** o cuidado às lésbicas é permeado por rotinas heteronormativas e a omissão de enfermeiras e médicos frente às demandas de saúde de lésbicas opera como uma violência simbólica, sendo condicionante do menor acesso à saúde.
Descritores: Mulheres lésbicas; saúde sexual e reprodutiva; gênero e saúde; violência.

RESUMEN
Objetivo: describir y analizar el cuidado a las lesbianas, por parte de enfermeras y médicos, en el campo de la salud sexual y reproductiva. **Método:** investigación descriptiva, cualitativa. Participaron del estudio 24 enfermeras y 21 médicos que trabajan en la atención primaria, en el municipio de Río de Janeiro. Investigación aprobada por el Comité de Ética en Investigación. Los datos fueron recolectados en 2014, a través de la entrevista semiestructurada. Se desarrolló el análisis de contenido temático-categorial. **Resultados:** los esquemas de percepción y apreciación de enfermeras y médicos sobre las lesbianas presentan un contenido fuertemente normativo y los profesionales presentan desfase de conocimiento, inhabilidad de comunicación y omisión en relación a las demandas de salud de esas mujeres. **Conclusión:** el cuidado a las lesbianas se hace a través de rutinas heteronormativas y la omisión de enfermeras y médicos ante las demandas de salud de lesbianas se muestra como una violencia simbólica y limita el acceso a la salud.
Descriptores: Mujeres lesbianas; salud sexual y reproductiva; género y salud; violencia.

INTRODUCTION

The field of sexual and reproductive health is characterized by the intrinsic requirement of the sexuality approach as a privileged object in the attention to women's demands.

Regarding lesbian women, there are no accurate statistics on their number in Brazil. This is due, in large part, to the heterogeneity of self-classification and the fear resulting from the expectation of discrimination related to the declaration of homosexuality, which may even explain the scarcity of Brazilian research aimed at this group of women[1,2].

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The consequences of this lesbian invisibility include the lack of knowledge about their profile, their demands and difficulties of access to health services.3 Thus, this silence contributes both to the greater vulnerability of lesbian women and to their social invisibility, making it difficult for public policies to better contemplate them[4].

It is known that lesbians in Brazil tend to seek health services less frequently than heterosexual women, and the experiences of discrimination in care by health professionals themselves are indicated as causes[1,5,6].

In addition to the discrimination resulting from prejudice, unprepared professionals to deal with the specificities of this group and the denial by women themselves of the risk for certain diseases, especially gynecological diseases, are reasons for the lower demand for health services[4].

Regarding the discrimination and exclusion of health services, the foundational role that the symbolic and cognitive construct, elaborated and shared by health professionals about lesbian women, is acknowledged, exercises its health care practices, explaining the relationship between the and the woman established in the therapeutic space of the consultation[7].

Whatever the health problem of a woman, early detection is critical, and most of the care recommended to women in the field of sexual and reproductive health is developed within the framework of basic care by nurses and doctors.8 Therefore, professionals in this field can be considered privileged informants about health care for lesbians.

Thus, it is intended to describe and analyze the care of lesbians, by nurses and physicians, in the field of sexual and reproductive health, with a view to proposing actions that will have a favorable impact on the quality of health care of these women.

THEORETICAL-METHODOLOGICAL REFERENCE

This research is delineated as a qualitative and descriptive nature because it aims to describe lesbian care practices, analyzing them based on the opinions, beliefs, knowledge and attitudes of the group of nurses and doctors participating in the research[9].

The theoretical position adopted is based on the recognition that in the professional relationship and women, capital inequality is a criterion that hierarchically structures the social space, simply because it refers to resources that empower those who have them, and also that social representations organize the symbolic relations between individuals and groups, affecting the positioning, corroborating the idea that what nurses and doctors talk about and think about lesbian women affect their interrelationships and health care practices[7,10-12].

The study scenario involved 16 units of primary health care in the city of Rio de Janeiro, representing seven of the 10 program areas. Of the total number of professionals working in the field of sexual and reproductive health of these units, 24 nurses and 21 physicians were included as participants, being this number reached by the saturation criterion[13].

As an inclusion criterion, the professional was required to start working in the field before or even in 2011, when the Brazilian National Health Policy for Lesbians was set up under the Unified Health System (SUS), *Gays*, Bisexual, Transvestite and Transsexual (PNSILGBT) [14], in order to ensure that all participants have experienced the process of its implementation.

The research project complied with Resolution No. 466/12, and was approved by the Research Ethics Committee under protocol No. 531.660/2014 and all the participants signed an Informed Consent Form[15].

Data collection was carried out from March to September 2014.

The data collection instrument was the semi-structured interview, in the course of which the substitution technique was applied to reduce the normative pressure exerted on the individual.[16]

The thematic interview itinerary presented a central question, which asked professionals to talk about their most remarkable memories regarding the care practices of lesbian women.

The characterization of the study participants involved personal and professional attributes, through a questionnaire applied at the end of the interview.

The testimonials were recorded, transcribed and submitted to the analysis of thematic-categorical content, with the help of the *software NVivo 10 for Windows*[17].

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The content analysis involved a floating and exhaustive reading process, accompanied by the delimitation of *free nodes*, its clustering by proximity of meaning in *tree nodes* and subsequent groupings of the latter, from which the categories emerged: the interaction between health professionals and lesbian women; prevention of sexually transmitted infections (STIs); and adherence to cervical cancer screening.[17,18] It should be noted that *free nodes* were identified in the text according to the professional category, nurses (E) and doctors (M), and the numerical order of the interviews (E1, E2 ... M1, M2 ...).

RESULTS AND DISCUSSION

The group of 45 professionals investigated was predominantly composed of young women, between 25 and 34 years old. Most self-declared white, heterosexual, with only two homosexuals, both males; the time of professional exercise between 3 and 10 years; the majority, family health specialist, with only four physicians and two nurse specialists in obstetrics and gynecology.

The interaction between health professionals and lesbian women

From the statements of nurses and physicians, it was possible to reaffirm that the consultations carried out in the field of sexual and reproductive health obey a true ritual guided by routines instituted in the services, supported by heteronormativity, in which the asymmetry between the professional and the women, with the nurses and doctors controlling the subjects to be treated, the power to interrupt the client's speech, and the domain of the questions they ask, leaving her the duty to respond, knowing that she is being evaluated.[19]

> *Our anamneses are very much embedded in routines. Generally, I ask all the questions of the routine, but, I see that there are cases that we end up asking the wrong way and even what should not. (E24)*

> *We asked, implying that the woman is heterosexual. It is common, for example, to start the conversation by asking if you use the pill. (M14)*

Although the PNSILGBT recommends the approach and registration of sexual orientation and gender identity in the medical records and in all SUS documents, this is an infrequent practice among nurses and physicians, which is especially noteworthy because they are social determinants of health.[14]

Although we do not talk about these issues, from the moment the woman enters the office, her gender expression is minutely observed and her sexual orientation deduced. Thus, if the woman has a masculine gender expression, she will be promptly classified as homosexual by the professional, even if she does not declare herself a lesbian, or even say otherwise.

> *The lesbian, just by looking at her, you already know that is a dyke. [...] but she says that she is married and lives with her husband. Sometimes I still have doubts about her. I do not believe. (E6)*

> *You soon see that she is [lesbian], by her masculinized presentation, by her dress, by her behavior, even if she does not speak. When you are masculinized you can see between the lines. You do not have to ask. (M3)*

This assumption of a lesbian identity based on the observation of gender expression constitutes an act of simplification and demonstrates that the health professionals investigated tend to perceive and classify as lesbians women with a male stereotype.[12,20] This form of categorization reveals not only a prejudice, but also the non-consideration of the sexual experiences expressed by the women themselves, pointing to an act of disrespect that highlights the professional exercise of a power, which is institutionally authorized and recognized, and which functions as a substrate for the institution of asymmetric relations and permeated by symbolic violence.[21,22]

Knowledge about sexual identity and especially about the sexual practices of women is very important so that the health professional can guide the consultation, adapting its guidelines to the singularities of these women, especially with regard to their sexual practices, while addressing vulnerabilities related to health.

It can be inferred that the use of this system of sexual classification, based exclusively on the observation of the body and some verbal and / or non-verbal cues emitted by women, may lead to misunderstandings among professionals, as to knowledge about the sexual identity and sexual practices of women.[20]

The quality of the dialogue between the professional and the woman is decisive on the therapeutic relationship of care. Only open dialogue free from prejudice will provide the space adequate to the verbalization, by the woman, of her sexuality, her sexual practices, her health demands, showing her vulnerabilities. This knowledge is fundamental to

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the professional, so that he can understand the singular context of life, the impact of the experience of homosexuality on his quality of life and health, the social determination of aspects of his health, to, from this, to plan his care.[23]

It is advisable to recommend that the verbal and non-verbal cues expressed by women regarding sexuality or other issues that point to difficulties in their approach are deepened by professionals and that the manifestations of hesitation, delayed speech production and camouflage of some terms by the patients. Health professionals should collaborate with women in coproducing terms that they have difficulty expressing. The difficulties of communication in this interaction point to the unpreparedness of the professional and his lack of sensitivity to issues of this nature.[24]

It is also recognized that the affective behavior of the professionals contributes to the satisfaction of the woman, her participation in the planning of the care, the greater adherence to the treatments, her quality of life and recovery. This affective behavior is what provides and privileges the construction of a bond, a relationship of trust between the professional and the subject of care, essential for humanized care. Affective behavior means encouraging, being friendly, showing concern, providing security, calling the woman by the name.[25]

The prevention of STIs

It is a consensus among participating nurses and physicians that most lesbians believe they are immune to the risk of contracting any type of STI, assuming that such infections occur exclusively in heterosexual intercourse, and more specifically at vaginal penetration. From this observation, professionals realize that this belief, among lesbians, contributes decisively to the fact that they do not adopt the recommended STI prevention measures.

Another situation very common among lesbians, according to professionals, is the lack of knowledge about the need to use condoms in sex toys, when shared with the partner.

> *We always advise that everyone should have their toy for penetration and that if it is just a toy for both of them, they should use the condom, because one thing you notice is that they do not know that need. They know that a condom is used on the penis, but if it is rubber, they do not think it is necessary. (E1)*

STIs are among the most common public health problems worldwide, with particular attention being paid to facilitating the transmission of the Human Immunodeficiency Virus (HIV) and the significant relationship between Human Papilloma Virus (HPV) and cervical cancer.[26]

Another situation that deserves attention is the perception of some lesbians as to the inadequacy of the prevention measures recommended by professionals for use in certain sexual practices. From the testimonies, it is clear that these women suggest to the professionals their perception of the inappropriateness of the condom to certain sexual practices, which does not seem to be understood or even unknown by the professional.

> *She asked me: When you have a relationship with a man, do you use a condom and my partner? Then I explained that I should use it too. I got the impression she did not understand, but she did not say anything else. (E22)*

> *She asked me: Doctor have any remedies to avoid getting sick, by sex? Then I said I had a condom. Then she said: But for us, we cannot [...] When it is rubbed, the plastic comes out. [...] At the time, I did not even know what that was [referring to tribadism]. (M13)*

In relation to the technologies for prevention of STIs used by lesbians, one has the *cling film* and films of latex or polyurethane, adapted from gloves and condoms, male or female, that can be used in sex toys, oral sex practice, but, for tribadism, there is no effective technology available for use.[27]

The lack of technologies for use in certain sexual practices, exclusive of these women, as is the case of tribadism, in addition to enhancing their vulnerability to STI,[28] points to the lack of interest and investments in studies and research, directed at the specificities of these women. This situation indicates that both health professionals and health authorities insist on not recognizing these women, helping to keep them invisible and on the margins of health rights. This is a situation of exclusion that clearly demonstrates the symbolic violence to which these women are subjected.[21]

Women need to feel that their needs, concerns and hesitations are understood and integrated by the professionals with whom they relate. These are the basic elements for establishing collaborative and trustful relationships.[2]

It should be noted that none of the health professionals participating in this study recognizes the responsibility of conducting studies and research that contribute to the updating of their knowledge and to the development of new IST prevention technologies as one of the functions of their professions.

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With regard to the lack of professional knowledge about sexual practices and appropriate prevention measures for lesbians, health professionals are responsible for undergraduate courses in health and silence on this subject in manuals and other educational materials prepared by the Ministry of health.

> *In college we do not study STIs among lesbians. So I did not know anything. The little that I know today, I learned [at work], talking and deducing. (E16)*

> *Here, among residents and even among some older colleagues, I see many difficulties in counseling these women about STI prevention. But it's not their fault. We do not have it in college. (M5)*

It is important to note that the manuals of the Ministry of Health are written by health professionals. Therefore, it is incumbent on professionals to keep up-to-date to meet people's health demands, so as to have a positive impact on health indicators and thus on social reality.

As for the undergraduate courses in the health area, it is fundamental that their political-pedagogical projects[29] issues such as gender, sexuality, as well as health issues among lesbians *gays*, bisexuals, transvestites and transsexuals (LGBT), with a view to a critical-reflexive formation that puts in check the bases that create and sustain stereotypes, discriminations, inequities and violence, contributing to the construction of an ethical, respectful and humanized professional position.

Adherence to cervical cancer screening

Cervical cancer is considered a public health problem in developing countries because of high prevalence rates and mortality. However, the mortality due to this type of cancer is totally avoidable, since the advancement of the technologies allows the early diagnosis of precursor lesions, thus preventing its progression to cancer.[8]

The most used strategy, with a highly effective result, is the screening in asymptomatic women, by means of the cytopathological exam, which allows the diagnosis still in the initial phase, being possible to obtain cure in up to 100% of cases.[8]

As regards lesbian adherence to the preventive examination by lesbians, nurses and doctors were unanimous in perceiving difficulties only among lesbians who, based on gender stereotypes, classified as masculine. Among women, this difficulty was not verified by any of them.

> *These more masculine have sex without penetration because they do not like. Generally, they do not like penetration because they do not like men. Hence, they are almost always afraid of the preventive, because of the speculum. The other [women] are more like us [referring to heterosexuality]. (E24)*

> *I also notice that they take a very long interval between exams [preventive]. Higher than recommended. These heavier [men] do not like it at all. I think they associate the speculum with the penis [...] As for the female ones, I've never seen problems with the exam. (M16)*

The classification system of lesbians in males and females, by the participating professionals, therefore refers to the male and female binarism present in the collective memory and the analysis of the lesbian woman, compared to the prototype of a woman considered *normal*, the heterosexual, classify them, even more or less strange, hierarchizing them.[5,7,12]

Thus, the classification of lesbians occurs in two ways: generalizing the feminine and particularizing the masculine. Generalizing, we reduce the distances of the *normality* prototype. Particularly, as in the case of male lesbians, we widen the distance and keep the object under analysis, as something divergent from the prototype. Therefore, to classify, by generalization or particularization, is not a purely intellectual choice, but reflects a specific attitude towards the object, a desire to define it as normal or aberrant. And so, male lesbians are perceived as strange, weird.[30,31]

Also regarding the adherence to the examination, the attention of the nurses and doctors is that the male lesbians do not like to take the test because they do not like the vaginal penetration, by the speculum, which they believe is associated with the fact that they do not like the sexual practices involving penetration. Thus, they understand that the lower adherence of male lesbians to the preventive examination, and also the disrespect to the periodicity recommended for their accomplishment, are based on a supposed association, made by the male lesbian, between the speculum and the penis and between the vaginal insertion of the speculum and the sexual practice of penetration.

Despite this, nothing has been done to overcome these difficulties. In addition, practitioners relinquish the direct responsibility of doing so by recommending that health campaigns do so, as mentioned by many of them.

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The professional attitude of omission and transfer of responsibility, faced with a need for health care, camouflages discrimination and an unfavorable attitude toward lesbians, which contributes to their being kept out of the care and services, showing the symbolic violence to which are subject to.[21]

CONCLUSION

Considering the testimonies of nurses and doctors who assist lesbian women, the vulnerabilities that they present stand out. Some of the vulnerabilities of lesbian women are derived from their own beliefs and others result from prejudices and experiences of discrimination in health services. The fact is that there is an omission of the professionals, facing the health demands presented by these women, which operates as symbolic violence, being a condition of the lower access of lesbians to the goods and services in health.

Nurses and doctors, on the other hand, make clear the existence of innumerable gaps in their knowledge about these women, their ways of living, their singularities and their vulnerabilities. It is important to highlight the inability of communication skills, which are so necessary to approach issues considered difficult, especially sexualities and sexual practices, which seems to favor the uncritical use of heteronormative routines.

Considering the complexity of the presented situation, it is recognized as a limitation of this study the non-inclusion of the lesbians as participants, which is to be done at another time.

There is an urgent need to recognize the need to strengthen social control by people suffering from discrimination in health services and to promote, among health professionals, the appropriation of knowledge about sexualities, awareness of discrimination processes participant, critical self-reflection for the deconstruction of prejudices and the eradication of symbolic violence present in the care of lesbians.

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