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The health of lesbian and bisexual women: experiences of healthcare professionals in Belford Roxo/RJ

A saúde de mulheres lésbicas e bissexuais: experiências das profissionais de saúde no município de Belford Roxo/RJ

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ABSTRACT This study aims to understand the perception of healthcare professionals regarding the care of lesbian and bisexual women. This qualitative research project involves 12 professionals from several fields and Belford Roxo, Rio de Janeiro, healthcare facilities. Regarding the results, we underscore two main themes with their respective core meanings: 1) Care provided to Lesbians and Bisexuals in Healthcare Facilities; 2) Facilitators and barriers for Lesbians and Bisexuals to accessing services. Despite the recognition that diversity in women's healthcare is part of the daily routine of the interviewed professionals, the health needs and specificities of lesbian and bisexual women are still undervalued in care practices, preserving heteronormative protocols. Dialogue on female diversity, knowledge, and the materialized LGBT policy is essential for professionals and managers, enabling changes in this setting and minimizing access difficulties. Finally, we should discuss how LGBTQIA+ health policy is being addressed in curricula and is on municipal management commitments' agenda to guarantee this population's rights in health services.

KEYWORDS Sexual and gender minorities. Health services accessibility. Women's health. Homosexuality, female.

RESUMO *O trabalho visa conhecer a percepção das profissionais de saúde no cuidado de mulheres lésbicas e bissexuais. Trata-se de uma pesquisa qualitativa, com 12 profissionais de diferentes áreas e unidades de saúde da cidade de Belford Roxo (RJ). Em relação aos resultados, destacam-se duas temáticas com seus respectivos núcleos de sentidos: 1) o atendimento prestado a mulheres lésbicas e bissexuais na unidade de saúde; 2) facilitadores e dificultadores do acesso de mulheres lésbicas e bissexuais aos serviços. Apesar do reconhecimento de que a diversidade no cuidado à saúde da mulher faz parte do cotidiano das profissionais entrevistadas, as demandas e as especificidades de saúde de mulheres lésbicas e bissexuais ainda são pouco valorizadas nas práticas de cuidados, mantendo protocolos heteronormativos. O diálogo sobre a diversidade feminina, acerca do conhecimento e da materialização da Política LGBT é essencial para os profissionais e gestores, propiciando mudanças nesse cenário e minimizando as dificuldades de acesso. Por fim, é preciso discutir em que medida a política de saúde da população LGBTQIA+ vem sendo abordada nos currículos e está na agenda de compromissos da gestão municipal de modo a garantir os direitos dessa população nos serviços de saúde.*

PALAVRAS-CHAVE *Minorias sexuais e de gênero. Acessibilidade aos serviços de saúde. Saúde da mulher. Homossexualidade feminina.*

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Introduction

Although the 1988[1] Constitution guarantees the right to health, some population groups struggle to access health services when they seek care. Lesbian and bisexual women have been reporting that their demands and specificities are made invisible by health professionals, influenced by compulsory heterosexuality, which contributes to 'erasing' these women – and when they do gain access, they are exposed to discrimination and prejudice.

Concerning lesbian and bisexual women, specificities and singularities emerge and are crossed by the issue of gender, sexual orientation, and gender identity, and can even derive from an ethnic-racial and class perspective[2].

Given the existence of these social markers, these women's invisibility, promoted consciously or unconsciously, can compromise the experience of lesbian women during care by health services[3], leading to lower demand for gynecological appointments than heterosexual women and vulnerability, illness, deteriorated health condition, or even death.

Despite the advances and achievements resulting from the fight for guaranteed health rights by feminist and lesbian movements, the specificities and demands of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transgenders, Queer, Intersex, Asexual, and others (LGBTQIA+) have not yet been duly recognized[4]. Complaints of rights violations and exclusion in health services have escalated since the publication of the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (PNSI-LGBT)[5], a milestone in recognizing the demands of this population group[6].

We underscore situations such as disrespect during the visit or screening in light of the sexual practices of lesbian and bisexual women, compromising the establishment of bonds and individualized care. This moment should be one of listening, reception, and focused on comprehensive and humanized care. As a result, lesbian and bisexual women have been moving away from health services due to the barriers and difficulties that contribute to deteriorated health conditions. Based on these considerations, this study aims to understand health professionals' perceptions of the care of lesbian and bisexual women in Belford Roxo, Rio de Janeiro.

Material and methods

This qualitative, descriptive, exploratory study adopted the interpretation of meanings to understand the meanings attributed by health professionals during care for lesbian and bisexual women[7]. The study settings were health units in Belford Roxo, Rio de Janeiro. Twelve professionals selected by gender criteria from different areas and health units voluntarily agreed to participate in the research. We excluded male professionals, those who were away on leave, special leave, or sick leave during the period of interviews.

Data were produced using the narrative interview technique[8], using a semi-structured roadmap, with the interview conducted at the participants' place of work in May 2022. There was also a sociodemographic questionnaire and information about the training process and work seniority. The narratives of the health professionals were recorded and later transcribed.

The steps for interpreting the narratives were: a) Comprehensive reading of the material; b) Identification and problematization of explicit and implicit ideas in the materials; c) Search for meanings related to the statements and actions of the research subjects; and d) Preparation of an interpretative synthesis, seeking to articulate the study's objective, the theoretical basis adopted, and empirical data[8].

The research followed the ethical and legal recommendations and guidelines necessary

for good research practice under Resolutions Nº 466/2012 and Nº 510/20161 of the National Health Council. It was approved by the Research Ethics Committee of the Sergio Arouca National School of Public Health of the Oswaldo Cruz Foundation – ENSP/FIOCRUZ (Certificate of Presentation for Ethical Assessment – CAAE 57021522.1.0000.5240, Opinion Nº 5.434.546). All participants signed the Informed Consent Form, and each was assigned a code S1 to S12 to preserve their anonymity. We should underscore that the research was self-funded by the authors.

Pierre Bourdieu's theoretical framework was used for data analysis, namely *habitus*, field, and symbolic violence[9,10] since these concepts are fundamental to understanding how inequalities are perpetuated in the field and how these professionals build their care since they are responsible for legitimizing the health needs of the population in the field.

Results and discussion

Three categories of analysis appear in the dataset analyzed: 1) Knowing Belford Roxo's health professionals; 2) Care provided to lesbian and bisexual women in the health unit; and 3) Facilitators and hindrances to lesbian and bisexual women's access to services.

Knowing Belford Roxo's health professionals

All 12 female health professionals interviewed were cis women. Most defined themselves as heterosexual (66.7%). The predominant religion was Roman Catholic (33.3%), and most women were in the 50-56 age group (41.7%).

The participants had healthcare experience and worked in the field for over seven years. Most participants had some kind of *lato sensu* specialization but with a predominance of specialization in mental health (33.3%), followed by specialization in violence (16.6%). One participant reported *lato sensu* specialization in social psychology and another in clinical nutrition.

Care provided to lesbian and bisexual women in the health unit

Two concepts can be highlighted in this category: approach during care for lesbian and bisexual women and women's demands. When the professionals were asked how these services occur, the answers were similar among the respondents regarding the fact that the search for care is not necessarily related to health issues, which can be observed in the narratives:

> *[...] family conflicts issues. They sought help because of family conflicts, and they verbalized their sexual orientation during the appointment.* (S1).

> *[...] it is hard to identify. I do not remember having attended to any of them. Only one trans man using a social name.* (S5).

In this sense, seeking health services is related to other problems, such as family conflicts and a lack of knowledge about having served this population. Another fact that appears in the statement of one respondent refers to the feminine symbolism:

> *[...] There was a symbolically feminine identification.* (S1).

> *[...] The fact that I am a lesbian woman helps me, I think.* (S9).

There is a need to refine the approach to the issue of access to gynecological care among lesbian and bisexual women, considering these women's diversity, their experiences and bodies' different representations, the risk of illness, and the role of seeking gynecological care, in order to produce more effective actions to reduce access hardships[11].

On the other hand, they believe that the visibility of 'masculine' lesbian women would

facilitate care. The heteronormative *habitus* in health practices leads professionals to provide heterosexuality-focused care, which can contribute to the naturalization of heterosexuality and the failure to recognize plural sexual and gender experiences[12].

Another critical point was the lack of recognition of lesbian and bisexual women's actual demands. When professionals were asked about their knowledge of the main demands and the lack of connection with services and teams, the answers were troubling:

> *[...] The health demands identified by the team are emotional health and seeking care for women's health.* (S4).

> *[...] We have few demands, and my peers contact me only when they have questions.* (S10).

> *[...] They don't come back because of prejudice. Mainly at the unit's doors...* [welcoming and reception]. *Depending on how they are asked, the questions at the care entrance make people withdraw and not feel welcomed. Or worse, they feel embarrassed.* (S2).

The respondents' perception indicates that the experiences of lesbian and bisexual women when they receive care contribute to their not returning. Considering this reality, it is necessary to keep a close eye on the inclusions, exclusions, possibilities, and limits that they set on the daily process of bringing a given political subject, with their demands, to the public space. This view allows us to consider the subjects enunciated by the movement as always open to inclusion, receiving new and different demands, and questioning hierarchical arrangements[11].

Regarding the organization of services to meet the demands of lesbian and bisexual women, the narratives showed that there is a lack of support that allows their experiences to be heard. Moreover, the service protocols keep a format for serving heterosexual women, which is shown in the narratives:

> *It lacks inclusion...* (S1).

> *I don't see any action.* (S3).

> *They are not organized.* (S4).

> *There are no actions...* (S6).

> *No work and no action.* (S7).

> *There is no organization for this service.* (S8).

Corroborating these narratives, other studies indicate that one of the challenges faced by lesbian and bisexual women in accessing health services is humanized care, with a focus on the specificities of lesbian and bisexual patients, which requires professionals to be prepared and qualified to recognize the needs of this population, which implies redefining skills and competencies during the training process of health professionals to recognize the actual demands of the population under their care, promoting a receptive space, and creating bonds that respect singularities and deconstruct any form of institutionalized violence[12].

Furthermore, not including the PNSI-LGBT in the training of professionals, the use of protocols and interventions from a heteronormative perspective has hindered building bonds and providing care, thus producing fragmented care, which leads to exclusion and symbolic violence, hampering these women's access and permanence in health services[12,13].

The invisible demands and specificities of lesbian and bisexual women in healthcare are linked to the heteronormative *habitus*[9,10] in health practices and the training process of health professionals who direct their care to heterosexual women[12]. This naturalization has facilitated symbolic violence and fragmented comprehensive care.

Facilitators and hindrances to lesbian and bisexual women's access to services

When asked about the facilities for providing care to lesbians and bisexual women in health services, we observed that the presence of lesbian and bisexual professionals on the team facilitates the care experiences:

> *[...] It's because they are feminine. Maybe the fact that they still carry within themselves this issue of the feminine. There was a symbolically feminine identification.* (S1).

> *[...] The fact that I am a lesbian woman helps me.* (S9).

> *[...] We believe that any health unit must have a holistic view, where we can see the whole equally since a broad perspective of care can facilitate patient reception. I also add that we have lesbian or bisexual women on our team, which empowers us every day.* (S12).

Also, on the subject of access and service facilitators, when asked about which facilities they believe are necessary to conduct these services, the professionals stated that:

> *[...] It would be very valuable if these professionals were trained within the units to open up the space for listening, much more than treatment. Listening is secondary and opening listening groups to discover what these women bring regarding demands, experiences, distress, family issues, and relationships. There is a lack of listening!* (S1).

> *Not being prejudiced.* (S9).

> *[...] the network could facilitate access to the demands of frontline professionals.* (S11).

However, we observed that facilitators depend exclusively on the perspective of each professional. Furthermore, it is necessary to establish bonds and recognize and respect lesbian and bisexual women's uniqueness for their comprehensive care, deconstructing all forms of violence, stigma, and discrimination[4,12]. This initiative influences the construction of spaces that can receive these women and health professionals who, on the one hand, have not been aware of their real needs and, on the other, when affected by prejudice and discrimination, contribute to fragmented care.

Respect for the right to health was identified in the narratives of the respondents and was seen as a hindrance in the care of lesbian and bisexual women. However, we noted a difficulty due to religious issues and conservative attitudes:

> *[...] It is about showing through someone else who works with you that that person has rights and needs respect. However, what makes me anxious is professionals wanting to indoctrinate this person* [religiousness]. (S2).

> *[...] I struggled when she asked me whether the professional I was referring to would be a sensitive person.* (S10).

There is concern about the need for a change in the outlook of professionals with conservative positions. Corroborating a document from the Ministry of Health, conservatives believe that this is not a problem to be debated in the Unified Health System (SUS) and that this debate is seen as an agenda not addressed in services, except in specialized services for care for Sexually Transmitted Diseases (STD)/AIDS[3].

Another relevant aspect of the interviews concerns the embarrassment of lesbian and bisexual women in revealing or not their sexual orientation due to having endured negative experiences during care when pressured to reveal their sexual orientation[12].

> *[...] listening to the distress and not knowing where to direct it at the moment.* (S7).

> *[...] noticing the patient's embarrassment.* (S9).

We should highlight that appointments should be permeated by bond construction, leading these women to freely reveal their sexual orientation, when they have the right to reveal it to professionals or not, which implies considering the many possibilities of prevention and existing conducts for each sexual practice reported[14] during care. The lack of support spaces for lesbian and bisexual women is a reality they face daily. It appears as a hindrance in the professionals' reports:

> *[...] lack of space in the unit so that we could provide this service, physical and professional space, starting with management, so that the professional can create this work.* (S1).

> *[...] Because I am a woman, I don't have any difficulties. The most significant difficulty is that these women don't feel comfortable being attended to by men.* (S5).

The professionals expressed discomfort due to the lack of spaces to serve lesbian and bisexual women. This feeling can be understood by the lack of this dialogue in educational spaces and the understanding that the SUS is universal, equitable, and comprehensive. However, the lack of visibility and representation of these women perpetuates the stigma, discrimination, and symbolic violence[9,10] that they face. Therefore, lesbian and bisexual women should share their experiences with health professionals[3].

Conclusions

Despite the recognition that diversity in women's health care is part of the daily lives of professionals, the demands and health specificities of lesbian and bisexual women are still undervalued in care practices, preserving heteronormative protocols, thus devaluing their sexual trajectories and practices.

In Belford Roxo, health units are not prepared to meet the demands of these women, i.e., having programs that cover gender and sexual orientation issues. Although the respondents showed empathy for this social group, this is knowingly not enough to improve the quality of care in general, as these are specific and not structural actions. In this sense, there is a need to reflect on the care process from the perspective of gender and sexuality. Moreover, we emphasize the need for professional training and continuing education that encompasses comprehensive health care, which implies dialogue on LGBTQIA+ public policies and the approach and recognition of the demands and specificities of this population. This action enables greater acceptance and belonging when this population seeks health units for care, a path to deconstructing the perpetuation of the heteronormative *habitus* in care practices and symbolic violence.

Finally, dialogue on female diversity, knowledge, and implementation of the PNSI-LGBT is essential for professionals and managers to promote changes in this setting, minimizing hardships of lesbian and bisexual women in accessing health services in which their experiences are valued. Furthermore, we should stress knowledge about the extent to which the health policy for the LGBTQIA+ population has been addressed in the curricula and is on the agenda of commitments of the municipal administration in order to guarantee the rights of this population in health services.

Collaborators

Silva SCC (0000-0001-6452-221X)* contributed to developing and constructing the research design, data analysis, and interpretation, discussing the results, and drafting and approving the manuscript's final version. Silva NA (0000-0001-5383-2618)* contributed to the paper's elaboration, actively discussing the results and the review and approving the manuscript's final version. Tenenblat MJT (0000-0002-8109-5712)* and Pereira EA (0000-0001-6681-5016)* contributed to the manuscript's review. ■

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