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Sexual health and access to services for lesbian women in Manaus, Brazil

Gabriela Rith Beltrão de Azevedo (https://orcid.org/0009-0004-3783-5877) [1]
Munique Therense (https://orcid.org/0000-0002-5433-9267) [1]
Sérgio Antônio Saldanha Rodrigues Tamborini (https://orcid.org/0000-0002-5843-670X) [1]
Gabriel Ponce de Leão Almeida (https://orcid.org/0000-0002-2335-5117) [1]
André Luiz Machado das Neves (https://orcid.org/0000-0001-7400-7596) [1]

Abstract *This study aims to understand the meanings related to sexual health and the delineations that define the experience of accessing health services for lesbian women in Manaus, Brazil. This study followed a qualitative approach, counting on the participation of ten women who self-reported themselves as lesbians. Semi-structured interviews were carried out and their analyses occurred through three thematic axes. The first addressed the representations concerning prevention and sexual practices, highlighting the notion of fidelity in the relationship as a "protective factor". Difficulties in the use of condoms in relationships between two women were reported. The second discussed heteronormativity and its effects on self-care, reporting the participants' difficulties in being understood and welcomed by health services. The third addressed the search for one's own knowledge as a care tactic, highlighting the importance of information and autonomy for health promotion and prevention of Sexually Transmitted Infections (STIs). It can therefore be concluded that there is a need for public policies aimed at promoting the sexual health of lesbian women and the recognition of their specificities by health services.*

Key words *Female homosexuality, Sexual and gender minorities, Equity in access to health*

[1] Universidade do Estado do Amazonas. Av. Carvalho Leal 1777, Cachoeirinha. 69065-001 Manaus AM Brasil. almachado@uea.edu.br

Introduction

Health care for lesbian women is deficient in terms of both access and services rendered. The existence and continuation of these problems must be considered in a scenario that involves political, social, economic, organizational, technical, and symbolic aspects[1].

This article uses a concept of gender as a social construct and as a result of a mandatory heterosexuality, which forges means of health care for lesbian women though a rationale that assumes an indissociable connection among the concepts of sex, gender, and desire, defined by the heterosexuality model[2,3]. Such a presumption is present in medical appointments, recommendations, prescriptions, among other activities, for the *persona* of the cisgender and heterosexual woman. In this light, one study[3] indicated that such rationality keeps aspects of the health-disease process visible or invisible, creating specific characteristics in the providing of health care to female users who are lesbian or bisexual.

Since the health-disease process is not restricted to the understanding stemming from a perspective based on biological determinism[4], it is our understanding that care based on the heterosexual and disgender model may produce disease that can hamper access to quality health care. Therefore, the discussion and production of knowledge explaining the phenomenon of health care for lesbian women at both national and regional levels is justifiable, thus locating patterns of knowledge-power, which operate as hampering or facilitating mechanisms for the expression of subjectivities and diversities.

Corroborating with this understanding, Aline Bento[5] claims that there are less studies regarding the health of lesbian women when compared to heterosexual women. Since lesbian women have specificities in terms of access to healthcare and permanence in the services[3], that may interfere with integrality in health care[1,3] and, occasionally, support violent professional practices, which result from a set of social aspects[1] and can take place in both public and private scenarios[3]. Such violence can increase the chance of the exposure of lesbian women to disease, hamper access to healthcare services, or even intensify the lack of health prevention.

This study is justified by the need to include women's health in the North region of the country in the national health agenda. When looking into the scientific literature on the subject, the marginalization or invisibility of this population is noticeable. A poor performance in the female healthcare indexes can be observed[6], and the data about mother mortality[7] is alarming. We therefore seek to include the issue of health care for lesbian women in the Amazon region, in the health agendas for LGBTQIA+, thus expanding the representativeness of the North region beyond the state of Pará[8].

Considering the problem presented here, this article aims to better understand the significance related to sexual health and the outlines which define access to health services for lesbian women from Manaus, Amazonas, Brazil.

Methodology

This is an exploratory and descriptive study, in a qualitative approach, from the Social Theory perspective, and focused on the description and comprehension of the meanings produced in daily life.

The field research took place between July 2021 and May 2022, with its starting point being an invitation in the format of a folder posted in the social networks of Twitter and Instagram. Hence, two women made contact by responding to the *post* from the folder in the social networks. Both resided in the city of Manaus, Brazil. Through them, the *snowball*[9] technique was used to invite and conduct the study with other interviewees. In total, ten lesbian/cis women were interviewed.

The data gathering instrument was a semi-structured interview script, with themes dealing with socioeconomic characteristics; the search for medical appointments, mostly and gynecological; sexual frequency; regular sexual partner; frequency of exams; and use of prevention methods in sexual relations. According to Minayo[10], semi-structured interviews are based on subjective and objective questions, and the interviewers can ask questions freely, without being restricted to the questions themselves.

These interviews took place in the facilities of the Universidade do Estado do Amazonas (UEA), more specifically at the Psychosocial Care Center (EPSICO) and online through *Google Meet*. The choice of these locations occurred after negotiation with the interviewees, according to their availability to participate in the study: times, days of the week, and preferred locations were chosen. The interviews lasted between 30 and 50 minutes. Each interview was registered in audio format using electronic devices and transcribed in full.

On the days prior to the interviews, conversations were held with the interviewees in so-

cial networks, such as Twitter and Instagram, to negotiate the conditions of the meeting. In the end, contacts with some participants became common, even after the study. Such moments were guided by methodological zeal and care in the construction of connections, especially by demonstrating that interaction in the study was not restricted to only one interview. While conducting the field work, we noticed that those contacts, sociabilization, and preparation were key to the quality of the interactions.

The analysis of the conducted interviews was concomitant with its very production. Since clues were identified in the field work, reflections took place regarding the studied literature and meetings were held among the researchers in the team. The technique of thematic codification was used, which allowed us to identify, analyze, and describe patterns and regularity through empirical data and field experiences, making it possible to create a thematic codification that allowed for the identification of the concepts and codes present in the material[10].

Regarding ethical aspects, the interviewees were informed about the justification, objectives, and procedures of the study, and were invited to sign a Free and Informed Consent Form. The study was approved by The Research Ethics Committee of the Universidade do Estado do Amazonas, logged under decision no. 4.854.307, Ethical Appreciation Certificate (CAEE) 46823321.0.0000.5016.

Results and discussion

This study counted on the participation of ten women, aged 20 to 48 years, who identified themselves as lesbians, who had at least once been to some kind of healthcare service, and who were users of both the private and public healthcare networks. All of the participants were from the city of Manaus, Brazil.

Among the participants, eight reported being brown-skinned and two white-skinned. Regarding marital status, seven were single and three were in a stable homoaffective relationships. The level of education ranged from incomplete to complete higher education, given that those who reported incomplete higher education were still attending college.

Three theme axes were created, which describe the understandings of lesbian women regarding sexual health and access to services: (1) representations regarding prevention and sexual practices; (2) heteronormativity and its effect in self-care; and (3) the search for self-knowledge as a care strategy.

Representations regarding prevention and sexual practices

Representations regarding prevention are anchored by the idea of a serious relationship and the reliability attributed to a stable relationship. These representations become concrete by not using sexual protection barriers, with penetration or not. Still regarding the sexual prevention methods, the participants mentioned difficulties present in the handling of prevention methods, such as the use of condoms made for sexual relationships between two women.

I believe that it has a lot to do with the kind of relationship (E1).

In the beginning, I even had doubts…oh, it is a relation between two women, is it necessary, really, to use [sexual protection]*? And even more so, in a stable relationship?* (E3).

I do not wear protection, I have a stable partner, so I do not use…but if there is no stable partner, I think that barriers are necessary, for sure, really necessary (E6).

In terms of the protection barrier between women, there is no protection, as in the case between a man and a woman, like condoms. Among women, being careful means to know your partner, know if she takes care of her health, women are not like men who catch everything, cankers and venereal diseases. Between two women, it is all a matter of knowing and trusting (E7).

Among the interviewees, it is important highlight that prevention and sexual practices happen through a subjective concept of serious relationships and a lack of knowledge about techniques and the use of barriers to prevent sexually transmitted infections (STIs).

This data corroborates the study by Barbosa and Facchini[11], which shows that lesbian women have understandings in the sense that involvement with men makes them more prone to the occurrence of STI, than with other women, which are reported as being safer relationships.

Among the ten participants, nine mentioned that they do not use protection methods when they are in stable relationships. This information agrees with the findings by Gogna[12], who identified that lesbian women seek sexual prevention through fidelity in relationships, which also interferes with the use of STI prevention methods. The study by Pinto[13] coincides with the testimo-

ny of the participants, in terms of identifying the lack of the use of preservatives among lesbian women, so other strategies for sexual prevention are needed.

Through public policies, the Ministry of Health, together with some lesbian women organizations, distributes sexual prevention kits with scissors, nail clippers and gloves[14]. Although it was a solution for safe sex, there were some hindrances, such as the difficulty to clean the material, the transportation, and even hiding the material from the family.

Another study, focusing on sexuality and gender, showed a model of the State which is more interventionist regarding the focus on protection, by means of an ombudsman system for women with the purpose of promoting more efficient subsidies[15]. Although many of the participants in the study dismissed the use of protection barriers when in relationships considered to be stable, they are contradictory regarding the recognition of its importance in general.

I know that the right thing is to always use it, but I don´t (E1).

I don´t have the habit of using prevention methods… they are necessary (E2).

That could be an issue for the sexual health of lesbian women, so that they can understand the importance of using prevention technologies.

Still regarding the use of barriers against STI, one of the interviewees mentioned that protection methods for lesbian women are complicated and difficult to handle.

[...] but for those who have sexual relations with women, it is even more difficult because the protection for oral sex, there is no such thing…and what we can adapt is that odonto device that I forget the name, but how do we get that? Then, we have to resort to creativity (E4).

[...] since there is no device specifically for this, we have to resort to makeshift…so, even though you can do that, it will not be 100% appropriate… (E4).

Out of the ten women interviewed, nine said that they did not have detailed knowledge of specific sexual protection methods for sex between lesbian women. One of the participants, however, mentioned that she knew more than two methods, even though they were difficult to use. Those findings corroborate the understanding that there is no clarification regarding the sexual health of lesbian women[16], nor investment in private or public policies to recognize lesbian sexuality and health. What is available today was built through the interviewee's creativity, as if the narrative had been produced by her sociability network, but was defined as a "makeshift" or "adaptation", not always appropriate. This also reveals the sense that the prevention practices are perceived as insecure.

Therefore, it is possible to make connections between the testimonies in this study and Butler's[17] *Precarious Life* study, in which this segment is associated with a group that has difficulty to be legitimized, or even seen. Considering lesbian women, the very act of not being seen, of not receiving care because of their sexuality, contributes to their vulnerability in terms of not using protection.

Heteronormativity and the effects of self-care

This theme axis organizes the meanings produced by the participants and the health professionals. A mandatory order was established during clinical appointments for the patients, as well as situations which generated discomfort and present vulnerability in the resolution of problems.

[...] I think to myself, when someone asks a question, and I know the answer; however, in order to answer I have to tell my sexual orientation… as if I was pregnant… I usually say that I have a homoaffective relationship… (E6).

[...] as soon as I get there, the health professional asks about "my boyfriend", we realize that they can´t even ask about my sexual orientation; we realize from that moment that they just made conclusions and start the procedure (E7).

The quote from interviewee E6 relates to Butler's[2] reflections on the mandatory order of heterosexuality. The narrative reveals the rationality of the doctor. When the patient is female and goes to the gynecologist, the doctor assumes that she is in a heterosexual relationship. The story by E6 criticizes the mandatory character of the appointment, as if every woman who walks into a doctor's office is in a heterosexual relationship, seeking anticonception methods and even treatment for pregnancy. The stories show that most professionals, when providing care to patients, are guided by the presumption of heterosexuality. Therefore, all women are assumed to be heterosexual. That has a negative impact on the recognition of sexual diversity and the promotion of sexual and reproductive health. The data corroborate a study from a Foucaultian point of view[19], which interconnects the comprehension of sexuality and the recognition by the health profes-

sionals of a power among bodies, determining what is legitimate and what is not, and in the case of interviewees E6 and E7, invisibility.

The effect of heteronormativity[20] is evident in institutions, and it can result in marginalization in relation to seeking care, putting the women in a condition of vulnerability in health care.

Among the interviewees, the collected results indicate that they are embarrassed about tallying about their sexuality with gynecologists. The 10 interviewed women in the study reported that they were never asked about sexuality in routine appointments, and four of them decided to speak out on the matter even without being asked. Among the participants, three mentioned that they felt fear, insecurity, and a feeling of a lack of openness when dealing with the reaction of the professional during periodic appointments.

[...] I was afraid of the reaction by the professional, a couple years ago I mentioned it, and I felt a different look (E3).

I go to a gynecologist annually, and I do not feel openness to speak about my sexuality... (E2).

I do not feel safe at all to speak; I'm leery about being mistreated (E4).

The identification of this result goes against the leaflet for lesbian and bisexual women: *Rights, Health, and Social Participation*[21], which informs that the lesbian woman should be informed that she will be cared for and examined, and a relationship will be built with the health professional should she wish to inform her sexual orientation.

Regarding exams, six out of the ten participants had already done the Pap smear exam. The participants who had the procedure done reported that, even though it is an invasive exam, there was no embarrassment nor questioning by the professionals who performed it.

When I did it, it was just fine; it was a technician who had that contact with me, gave me instructions; it was gentle, fine; she just collected a sample, I got dressed, and that was it. She did not ask me anything about me being active or about sex (E1).

When I did the Pap smear, they did not ask me questions about sex and sexual orientation (E3).

Although most of the participants had the preventative exam done, it is relevant to remember that one international study[22] and another national study[20] highlighted that the issues of lesbian women's health are related to having a low frequency of preventive exams. The results reveal that questioning those women about their sexual orientation and demonstrating in-depth matters regarding sexuality and gender, not imposing the cisgender relations, might promote access to health care and permanence with more quality and excellence.

The search for self-understanding in health as a care strategy

This axis aims at analyzing the ways of accessing knowledge available to the interviewees, who, although find difficulties in accessing information regarding self healthcare, still manage to reach their objective by different means, under the current norms.

Among the ten participants, three reported that they did not achieve full or even partial satisfaction in medical appointments. They end up seeking, by unofficial means, self-care in terms of health (Internet pages and social media of lesbian women with some understanding in terms of health). Regarding this issue, the study by Fraser[23] is relevant, indicating that there are injustices in recognition that lead to injustices in the distribution of resources, resulting in a poor structure of primary care, and affecting directly or indirectly the care provided to this segment of the population.

In the same context, Starfield[24] differentiates between access, defined in terms of the adequate use of health services, and accessibility, which connects the user to the specific service. Due to several difficulties, such as the lack of structure and recognition mentioned by Fraser[23], the concepts of accessibility and access become compromised for this minority group.

This thematic axis deals with the concept of tactics, as developed in the study conducted by Michel de Certeau[25]. Tactics is understood as something which belongs to the repertoire of wittiness that individuals have, defining it as the "art of the meek", in which it is possible for someone to transfigure, to his/her benefit, silently, the disciplinary systems. Hence, daily practices (strategic and tactical) are configured as places and spaces of competition, struggle, and disagreement, which strengthen and corrupt the usual configurations of power and knowledge[25]. In the case of the narratives by the participants, the search for self-knowledge about health may be interpreted as a strategy in their favor, when faced with the lack of recognition of their sexuality in situations involving health services:

I know too well how to protect myself, especially because I have always had this sexual responsibility regarding who I get involved with… (E7).

[...] but she [health professional] *did not say anything about wearing protection, like "you*

should protect yourself by doing this or that…" all I know is from the Internet and my own research (E3).

I think exams are important, I have friends in the health field, and we talk a lot about this (E8).

When asked about receiving some sort of sexual education during appointments, the participants reported that they had no conversations on this issue. The participants themselves did some research to find information about protection, especially in terms of sex.

It is possible to notice that in the stories told by the women, there are power relationships, as described by Foucault[19], in which knowledge is a product of the struggles, of the power relationships between subjects and powers. Therefore, the individual fights to survive, although not being able to assert him/herself in a normative manner and seeking other means, conditions, and tactics to achieve wellbeing. Tactics, such as the search for knowledge from third parties like leaflets and information in social media – which can at times be refutable – is indeed a means of protest when faced with the attempts to annihilate sexualities that are not heterosexual.

In the testimonies quoted here, it is evident that the women received only information regarding protection from a heterosexual perspective in their experiences with healthcare services, or that they simply received no information at all during appointments. However, although informally, they search for knowledge about sexual practices and how to be protected in certain situations, through their social networks, in an informal manner.

Final considerations

The understanding of sexual health by lesbian women and access to healthcare were categorized in this study by three thematic axes. The first thematic axis deals with representations regarding prevention and sexual practice, emphasizing the fact that the participants have a subjective notion of faithfulness in the relationship as a "protection factor", and there was no knowledge regarding the techniques for the use of prevention methods and barriers against STI. The second thematic axis approaches heteronormativity and its effects of one's own personal health care, highlighting that the participants do not feel that they have an inclusive and caring atmosphere, and must suffer with stigma, prejudice, and invisibility from the health professionals, be it in private or public institutions.

Finally, the third thematic axis discusses the search for one's own knowledge as a care strategy, demonstrating that the participants look for information regarding their health and care by their own means, on the Internet and from other lesbian women.

The results of this study indicate the importance of thinking about public policies that promote inclusion and equity in access to healthcare services, taking into consideration the diversity of gender identities and sexual orientations. Moreover, it is essential that health professionals be trained to meet the specific demands of lesbian women, ensuring a humanized and personalized care. In conclusion, the present study provides evidence that the understandings regarding sexual health and the experiences in access to healthcare services are comparable to those of women from other parts of Brazil, and it corroborates with the importance of having the issue of health for lesbian, Amazonid women in the national agendas of health for the LGBTQIA+ community.

Collaborations

GRB Azevedo worked on the conception, data collection, writing, analysis and final review of the article. M Therense worked on writing, analyzing and final reviewing the article. SASR Tamborini and GPL Almeida worked on writing, data analysis and final review of the article. ALM Neves worked on guiding and coordinating the research, writing, data analysis and final review of the article.

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