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Lesbian health: care experiences of primary care nurses

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Abstract *Lesbians face many barriers in health services, and experience prejudice, stigmatization and the invisibility of their health demands. This article aimed at understanding the meanings attributed by primary care nurses to health care practices directed at lesbians. This is a qualitative research carried out with 15 nurses who worked in primary care in Teresina, Piauí. The analysis was based on Pierre Bourdieu's theoretical framework of habitus, field and symbolic violence. It was observed that the practices of nurses in the field of primary care follow heteronormative protocols. Therefore, it is essential that these nurses develop other habitus, aiming to guarantee different types of identities within the health services.*

Key words *Lesbians, Sexual and gender minorities, Integral attention to women's health, Nursing*

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Introduction

The LGBT populations (lesbians, gays, bisexuals, transvestites and transsexuals) have suffered discrimination, embarrassment and violence in health services due to their sexual orientation and gender identity. It so happens that the health-illness-care process is influenced by several health determinants, which can determine and/or affect the health of some groups[1], with "non-normative" sexual orientation being recognized as a social determinant of health in Brazil[2].

Lesbians, for instance, face several barriers in health services, and experience prejudice, stigmatization and the invisibility of their health demands[3]. These barriers are usually related to the perpetuation of the binary and heteronormative logic, which presumes that all women are heterosexual, not respecting/recognizing different experiences, practices and ways of expressing one's sexuality[4].

Despite advances since the publication of the National Policy on Integral Health for the LGBT population in 2011, there are still failings in the training of health professionals, with a specific focus on sexual and gender diversity, as well as intersectionalities (race/ethnicity, class, gender, generation, among others) that permeate the health-illness-care process of lesbians[5], and that compromise both the access to care and the provided care.

Thus, the practices of the nursing teams that comprise the Primary Care, the main gateway to the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), must be consistent with the care model centered on comprehensive and humanized care. Therefore, primary care can be seen as a privileged field for the materialization of practices based on integrality and equity, especially regarding the care provided to the most vulnerable groups[6]. Based on these considerations, this study sought to understand the meanings attributed by primary care nurses to health care practices with lesbians in the municipality of Teresina, state of Piauí, northeastern Brazil.

Methodological pathway

This is a descriptive-exploratory research, with a qualitative characteristic and the Method of Interpretation of Meanings was chosen to be used in the study, since we aimed to understand the meanings attributed by Primary Care nurses to the care directed at the health of lesbians, taking into account their realities, their work environments and the relationships established there[7].

The study settings comprised seven Basic Health Units (BHUs) that belong to the Primary Care Network of Teresina, capital city of the state of Piauí. Fifteen nurses from the BHUs participated in the research, selected by access criteria, who voluntarily agreed to participate in the study. Professionals who were on vacation or on medical leave or another type of leave at the time of data production were excluded from the study.

Data production was individually carried out at the participants' workplace in January 2021, using the narrative interview technique[8], a semi-structured interview script and a questionnaire to obtain sociodemographic data and information about the participants' training and professional courses. The nurses' speeches were recorded and subsequently transcribed.

Regarding the interpretation of the narratives, the following steps were taken: (a) full reading of the material; (b) identification and problematization of the explicit and implicit ideas in the materials; (c) search for broader (sociocultural) meanings, underlying the speeches and actions of the research subjects, and (d) creation of an interpretative synthesis, aiming to articulate the objective of the study, the adopted theoretical basis and empirical data[7]. The NVivo software was also used in the organization and analysis of data, mainly in data classification and identification of thematic categories (codes).

The study followed the ethical and legal recommendations and guidelines necessary for good research practices, in accordance with CNS resolutions 466/2012[9] and 510/2016[10], and was approved under opinion n. 4,277,719 on Plataforma Brasil. All participants signed the Free and Informed Consent form and the nurses' real names were changed to fictitious names, aiming to preserve their identities.

The analytical process was based on Pierre Bourdieu's theoretical framework of habitus, field and symbolic violence. Bourdieu approaches the concept of field, understanding it as a space that has a set of norms, rules and specific classification schemes, which is hierarchized according to the unequal distribution of the different types of capital among its agents[11]. Habitus, on the other hand, is defined as the knowledge and dispositions incorporated by the agents throughout the learning process, resulting from the contact with the different social structures[12]. Habitus and field are dialectically related and the dynamics of the social field implies the exercise of symbolic vio-

lence by those with better positions, both for imposing and legitimizing their interests. Symbolic violence is the euphemized, mild and invisible type of violence, forged by social relationships[11].

This choice of this theoretical contribution is due to the belief that primary care nurses are responsible for holding power in their field of action and use such power to legitimize themselves and employ sovereignty over different social agents, permeating the exercise of symbolic violence and of several habitus[13].

Results and discussion

In the analyzed data set, five categories of analysis appear: Meeting with the primary care nurses of Teresina, Piauí; Nurses' conceptions about sexual orientation; Lesbian women's health care: from invisibility to false equality; Gynecological nursing consultations and the heteronormativity of practices; Knowledge about health policies directed at lesbians and; Nursing training for lesbian health care.

Meeting with the primary care nurses of Teresina, Piauí

As for the 15 nurses who were interviewed, it was observed that, in sociodemographic terms, there is a predominance of cisgender (100%), heterosexual (100%) and Catholic (73%) women, aged between 41 and 50 years old (40%).

The participants have extensive experience in the field of Primary Care, as most have more than ten years of experience. Regarding professional training, it was observed that nurses have a training course focused on collective health. Most participants had at least two graduate degrees, with specialization in Family Health being predominant among the participants, in 87% of the sample; followed by Public Health, in 20%. One participant reported having a *lato sensu* postgraduate degree in Women's Health; while another had a Master's Degree in Nursing, in the area of Sexuality.

Nurses' conceptions about sexual orientation

Two conceptions stand out in this thematic: the lack of knowledge about gender and sexuality issues, and the heteronormative and binary habitus, imbued with morality concepts and sexist views. Knowledge of the concepts of sex, gender and sexuality in the field of health allows for the opening of debates. When the nurses were asked about what they understood by sexual orientation, the meanings were constructed in a simplistic way, and pointed out as a choice merely characterized by sexual preferences. However, it was also possible to perceive doubts and contradictions, as evidenced in the highlighted narratives:

Wow, now you got me. It's hard, it's about sexual partnerships (Brenda, 45 years old).

Here comes the confusion (laughing), uh-oh! [...] Sexual orientation is the sex you are attracted to, right? With whom you have sex (Carmelia, 32 years old).

Sexual orientation refers to each person's "feelings, attraction, desire, fantasies, emotional attachments, interpersonal bonds and fundamental relationships"[14] (p. 108). In other words, it is a broad concept, which permeates human existence itself. However, the participants showed little openness to talking about the topic, pointing out, either through laughter or initial reservations, that it was a "difficult" and "confusing" topic, restricting sexual orientation to sexual partnerships and preferences.

Another important point was the misunderstanding between sexual orientation and gender identity. When some nurses were narrating their knowledge about sexual orientation, and despite the existence of lesbian transsexual women, they brought their own reports of their experience with transvestites and trans people:

[...] they did not want to be called by their birth name, and they wanted to be called by their social name, they wanted to be addressed as [...] he would say "She", and would not accept saying "He" [...]. That's sexual orientation, right? (Inácia, 41 years old).

Inácia's speech showed that the concepts of sexual orientation and gender identity are little known by the participants, resulting not only in theoretical, but also practical confusion about the reality. This situation was also pointed out in other national and international studies[15,16].

When the nurses were asked about their experiences in the daily life of the health unit, the term "women who have sex with women" appeared a few times. The use of the term "women who have sex with women" has been a source of conflicts and divergences, especially due to the political place engendered by social movements in the arenas of dispute[17]. However, for Silva[18], the use of the term "women who have sex with women" in health services can favor the recognition of the demands and specificities of lesbians, allowing the establishment of a bond and

strengthening the care relationship. Based on the use of the term, it is also considered as a strategy to bring lesbians closer to health services. Carmélia (32 years old) pointed out, for example, *I think there are women who have sex with women, this is sexual orientation, as I understand it*.

Regarding the attempts to understand homosexuality or how that is perceived by nurses, several narratives were found, including the genetic factor, sexual abuse, previous negative affective-sexual experiences, and even the influence of the media:

[...] there are some here, there are even children who you can see from afar, you look at them and you know! (Vania, 59 years old).

[...] what worries me is this influence at the beginning of adolescence that leads the teenager to have a sexual identity that may not be theirs [...] (Paula, 70 years old).

[...] she had this pain of dealing with this homosexuality, she is a person who had a life history of abuse. When you see the stories of homosexuality, when it's not the influence of the media today, it is one thing, it is another thing, right? But there was the influence, there was the thing about the family history of abuse, right? (Paula, 70 years old).

[...] besides, one of these girls, she has been married, already had... I even knew her husband, her husband also came here, you know, then her husband was going out with someone else, then she became angry and got this girlfriend [...] (Maria, 67 years old).

Based on the above narratives, Foucault[19] argues how sexualities have been structured into a "punitive" social framework in Western societies, and how power relations are ingrained into their construction. Rubin[20] highlights the need to break with a model of "sex hierarchization", in which there is a tendency for social control devices to divide sexuality into "good" or "bad". Thus, based on the reports, people who do not fit into current standards of femininity or masculinity are strongly identified as deviant from the norm, as also identified in other studies[21,22].

The study by Toledo et al.[23] states that the most frequent stigmas to justify female homosexuality are: the hypothesis about romantic frustration with an unfaithful man or who physically or emotionally hurt his partner; sexual abuse in both childhood and adulthood; and, finally, the suggestion that some women are unattractive when compared to the standard of femininity imposed by society. All assumptions for the origin of the existence of lesbian experiences are based on the figure of the man, and not on the authentic affective-sexual desire of one woman for another.

Understanding and demystifying issues related to sexual and gender diversity is essential for offering care that is free of stigma and prejudice. These topics, added to the markers of race, ethnicity, class, generation, regionality and others, collaborate to make it difficult for these women to have access to health care, who live deeply under different contexts of vulnerabilities, and which can translate into the symbolic violence displayed in the field of health institutions.

Lesbian women's health care: from invisibility to false equality

Based on the interviews, the presence of the heteronormative habitus in the production of care for lesbians in primary care is reproduced in scripted actions, in a generalized and naturalized way by the presumptions of a heterosexuality typical of relationships in health services. The obliteration of the existence of these women was observed when the nurses were asked about their experiences in health care:

I haven't had experiences so far of having patients who have a different sexual preference than the heterosexual one, right? (Antonia, 35 years old).

So, I must have had, but I don't remember a specific person, so that I can say "No, I haven't" to you (Carmelia, 32 years old).

No! I never had the experience of a woman reporting this to me (Clarice, 27 years old).

I have had no experience, right? If someone with a homosexual orientation came to me, they didn't talk about it or it wasn't taken into account, right? (Regina, 43 years old).

Corroborating the narratives, other studies indicate that the low demand or non-recognition of lesbian experiences in health services may be related to the non-disclosure of sexual orientation, the presumption of heterosexuality, the nurses' lack of knowledge about sexual diversity and gender, as well as discriminatory environments[3,5].

The nurses also blamed the lesbians themselves for omitting their sexual orientation and the low demand for care, and according to their perceptions, lesbians have difficulty with self-accepting as lesbians, in addition to fear, the prejudice and shame, as observed below:

[...] sometimes people have difficulty accepting themselves, difficulty coming out to society [...] (Brenda, 45 years old).

[...] I feel they still feel ashamed, feel embarrassed to speak openly, right? That one lives with the other (Juliana, 57 years old).

[...] there are no patients who identify themselves. They don't speak for fear of people knowing... of the CHA [Community Health Agent] speaking in the territory (Regina, 43 years old).

The decision to seek health services, disclosing their sexual orientation, can be related to several individual and collective issues of lesbians and health services, which need to be understood in the relational, institutional, symbolic and social dimensions. This complex of dynamic and intertwined factors can contribute to the understanding of health inequalities and their mechanisms in everyday actions[18].

An important information apprehended from the nurses' statements is the non-recognition that the professionals' prejudice and discrimination constitute barriers that keep lesbians away from health services, preventing them from creating bonds and having the guarantee of having their health demands met.

The concept of equality was present in the nurses' narratives. However, the perspective of "treating everyone the same" can promote the obliteration of lesbian health specificities, as well as the lack of understanding and applicability of the principle of equity:

[...] for me, whether the woman is a lesbian or straight, she needs to have the same care related to health, you got it? (Carmelia, 32 years old).

It's like, I'll tell you, for me they are people who are seen as any other person [...] (Luiza, 47 years old).

It is evident in the nurses' statements that there is a great concern to show themselves as having ethics and respect in the developed practices; however, these speeches can also be seen as a compensatory way of denying the prejudice and stigma hidden behind a narrative of equality[15,24].

In the theoretical conception of Bourdieu[13], the discourse of "non-difference" translates into invisibility and inattention to the singularities and specificities of lesbian health, contributing to the process of these women's exclusion in health services, and promoting the perpetuation of symbolic violence in the primary care field.

Silva et al.[25] show that the heteronormative habitus, present in health practices, leads health professionals to carry out the production of care aimed at lesbians as if they were heterosexual women. This can lead both to the idea of naturalization of heterosexuality, which considers lesbian existence as deviant, as well as the non-recognition of plural sexual and gender experiences, such as those of lesbians.

Sposati[26] (p. 128) states that "the concept of equality is only complete if shared with the concept of equity". A universal standard is not enough if it does not include the right to difference. Equity is understood as an essential factor for social justice, considering the context of social inequalities in which primary care is included[27]. Hence, the promotion of equity is not only related to access to services, but also to care that is sensitive to the needs and vulnerabilities of each woman, respecting the influence of gender, age, race/skin color, social class, sexual orientation and other intersections that permeate the health-illness-care process.

Another aspect portrayed to a lesser extent was the psychological problems present in the lesbians' health demands. The nurses pointed out two reasons for the development of mental diseases: the non-acceptance of the lesbian identity and the situations of prejudice and discrimination experienced by these women, as demonstrated in the following speeches:

[...] I think there is still a lot of prejudice among them, and it even generates a certain mental disorder among them (Inacia, 41 years old).

[...] I think if they had psychological help, they would live better, you know? Because this is what I observe, they have difficulty even talking to us (Mary, 67 years old).

[...] in my experience it's more of an emotional issue (Paula, 70 years old).

In the narratives, it can be observed that the nurses correlate mental disease with the prejudice that lesbians themselves have to express and live their lesbian identity. They also point out that the difficulty of living in a prejudiced world can influence psychological suffering, suggesting the need for specialized mental health care. Research has shown that the mental health of lesbians is compromised by several factors linked to internalized lesbophobia, family and social prejudices, heteronormative social rules, stigmas, processes of exclusion and social rejection, which sometimes lead to depression, anxiety, substance abuse, and even suicide. Nevertheless, these associations cannot incur a psychopathologizing habitus of lesbian experiences in a sexist, sexist and lesbophobic society[2,3,28-30].

Studies indicate that the nursing staff needs to develop embracement practices that demonstrate openness, respect and understanding towards lesbians and their health demands. For the nursing practices to be more inclusive of these

women's needs, it is necessary to understand and respect the issues surrounding the fears associated with the disclosure of sexual orientation, violence and harassment[31].

Questions related to the risk and vulnerability of lesbians to sexually transmitted infections (STIs) were also raised in this study. Health professionals reported that most lesbians believe there is no need to use condoms during sexual intercourse, and the lack of use can be justified by these women's false perception that they are immune to STIs and also because they find it unnecessary since there is no risk of pregnancy[5,32]. Corroborating the aforementioned studies, this perspective can also be observed in the interviewed nurses' statements, as shown in the excerpts below:

[...] She had an STI. And I offered condoms, and she said: "But I don't use them, I don't have sex with men" (Fernanda, 52 years old).

[...] she does not have this risk of becoming pregnant, so in that sense it goes until she becomes careless regarding the use of condoms, the fact that they do not use condoms, there is no report of condom use [...] (Geovana, 49 years old).

The trend of lower use of barrier methods regarding the protection against STIs by lesbians is a matter of concern; besides the fact that health guidelines on prevention are usually focused on heterosexual practices, due to the very institutional structure of health services, which are defined by this heteronormative habitus, it generates a process of invisibility of these women's sexual health needs. Also noteworthy is the nurses' lack of knowledge about the multiple possibilities of sexual practices. Clarice and Antonia's reports reinforce this perspective:

[...] Then we even fail a little regarding this issue, this flaw, right? Of also giving advice that in the sexual intercourse of a woman with another woman, [STIs] can also be transmitted you know? (Clarice, 27 years old).

[...] I don't think we even know how to give information about STIs in these cases [...] (Antonia, 35 years old).

For STI prevention among lesbians, it is known that the existing methods were not created or designed specifically for these women's sexual practices, since most of these means of prevention would be adaptations of the existing methods, or adaptations of items intended for other purposes (plastic PVC film, surgical gloves, latex barrier for dental practices and others). The lack of specific methods can be interpreted as a lack of interest and investment in research on the sexual practices of lesbians, reiterating the place of risk and vulnerability to STIs among lesbians[33,34].

The invisibilization of lesbian women in the Primary Care field of is an important issue to be discussed, since its perpetuation constitutes symbolic violence[13]. In this category, it is possible to perceive this violence materialized in the presumption of heterosexuality, in the absence of space for the discussion of sexuality and pleasure for lesbians and in the scarcity of methods for STI prevention.

Gynecological nursing consultations and the heteronormativity of practices

During gynecological consultations, nurses reported little about their experiences with lesbians; however, one nurse pointed out that there is no difference in the care of these women, making a correlation to physical issues of the female body:

The lesbian woman's anatomy is the same as ours, there is no difference. I perform their preventive health care in the same way (Vânia, 59 years old).

It is important for nurses to recognize the need for Pap smears as a strategy to prevent cervical cancer, as this is one of the most prevalent cancers in developing countries. However, one can perceive in Vânia's report the false idea of equality and the failure to address the specificities of each woman. Studies have demonstrated some negative episodes experienced by lesbians during these procedures, such as: discomfort and/or pain during gynecological exams, silencing about their sexual practices[24,32], lack of embracement that allows qualified listening to their experiences[35] and difficulties in creating bonds[20].

The gynecological nursing consultations in the field of Primary Care follow a true ritual that almost always comprises two stages: 1) filling out the form of the Cancer Information System (Siscan, *Sistema de Informação do Câncer*), where the anamnesis is carried out; 2) carrying out the cervical cancer screening test. Almost all nurses described the consultation in this way, as shown by Inácia's report:

We fill out that form, we have our own form for the cervical cytology screening, it already includes some clinical data, the date of the last menstrual period, whether she has any type of bleeding, or is in menopause. It is a form focused very much on cancer screening. And then we ask: "Do you have a history?" before taking the patient to the room

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where perform the sample collection (Inacia, 41 years old).

According to Silva et al.[25], the heteronormative habitus in care practices, which also originates from the technicist and biologicist training, results in a consultation characterized by the relationship of knowledge and power, where nurses display themselves as holders of scientific capital, imposing their care practices and devaluing the experiences of these women, even in the presence of the demands and specificities displayed by lesbians, contributing to the obliteration of their existence.

In the same direction, regarding the approach of sexual practices in gynecological nursing consultations, it was observed in the nurses' narratives that sexual practices are not approached dialogically, and when they are, the heteronormative characteristic of the practices is observed, accentuating the obliteration of the multiple possibilities of living and expressing sexuality. This is shown in the following statements:

[...] I'm not going to lie, I don't address it, so in relation to sexuality, what you say is a question in relation to whether the person is heterosexual or homosexual, that I don't ask; what I can ask is regarding the use of condoms in sexual relations, the issue of multiple partners, advice on sexually transmitted diseases, that I do (Carmelia, 32 years old).

Yes, I do, I ask how many partners, even because of HIV and STDs. I do that, I've always done it (Vania, 59 years old).

Assuming that the consultation should be guided by the declaration of sexual practices and not by their assumptions, since lesbians have the free will to disclose or not their sexual orientation, nurses should consider the different possibilities of prevention and conducts for each one of the informed sexual practices. However, not addressing sexuality during the health education/training process for care based on the heterosexual model contributes to the persistence of the heteronormative habitus that translates into symbolic violence.

Knowledge about health policies directed at lesbians

When we assess the nurses' knowledge about health policies directed at lesbians, the lack of knowledge appears in most of the statements, as shown in the discourses:

No! Is there? I believe it even exists. I don't know (Luiza, 47 years old).

[...] the policies are also kind of forgotten, there are no targeted actions either. I think there should have more (Clarice, 27 years old).

The lack of knowledge of public policies is related to the absence of this discussion in the training processes[18]. This weakness translates into the interface between symbolic violence[13] and the lesbians' access to health services. Or, when this discussion occurs, it takes place from the heterosexuality bias, which contributes to the persistence of a habitus that guides actions inside a field where care practices for lesbians are carried out[11,12].

In Brazil, there have been some advances in the field of health policies, with the recognition of lesbian health specificities. This can be observed through the publication of some public documents, such as the National Policy for Integral Attention to Women's Health[36]; Dossier: Lesbian Women's Health – promoting equity and integrality[37]; National Policy on Integral Health for the LGBT population[38] and Report of the Workshop on Integral Health Care for Lesbian and Bisexual Women[39].

Silva[18] stated that the fact of naturalizing the culture of heterosexuality in the materialization of political texts in the field of health care for lesbians has contributed to the non-recognition that gender norms are potentially oppressive, since the system itself has been reproducing the unequal recognition of the demands and specificities of heterosexual sexuality in relation to homosexual sexuality.

Nursing training for lesbian health care

In this category, we sought to understand how nurses evaluated their preparedness to deal with lesbians and their health demands. Initially, some of the interviewed nurses' feelings and sensations during the care of lesbian women were listed:

I get a little... I don't feel comfortable, do you understand? (Maria, 67 years old).

I offered male condoms and then I got all embarrassed. [...] I was kind of scared, because we are not prepared for this in college, right? (Juliana, 57 years old).

The nurses were surprised, scared, ashamed and unprepared when caring for lesbians, and these feelings can be understood and analyzed both due to the difficulties of academic and in-service training. Studies have shown the precarious discussions of issues related to sexual and gender diversity in primary care, as can be seen in the narratives below:

During [academic] training, there was no discipline directed at this topic (Clarice, 27 years old).

In college it was never talked about, because it's something much more [recent]. I graduated in 2002, I think this topic has been around more recently [...] (Inácia, 41 years old).

We never had any further training, I don't remember having addressed this topic (Brenda, 45 years old).

Corroborating the reports, some studies showed that health professionals were concerned about the scarcity and absence of the topic from health education and/or the difficulties in accessing information inherent to lesbians' health particularities[40,41]. The study by Dorsen et al.[42] showed that nurses feel more comfortable in caring for lesbians, when in their academic training they were provided with reflections on sexual and gender diversity and their impact on health.

Ferreira et al.[15] bring similar data to the reports of nurses Brenda and Fernanda about the lack of training, courses and qualification promoted by the health institution where they work. The lack of such training is directly related to the non-recognition of lesbian health demands in health territories, as these are usually not included in the diagnoses of the health situation.

This fact contributes to exclusion and symbolic violence, since the lack of knowledge about lesbians' demands and needs in health care can promote the creation of protocols and interventions from a heteronormative perspective, making it difficult to create bonds and provide care, resulting in a fragmented and merely technicist assistance[25].

Conclusion

The perpetuation of symbolic violence in the field of primary care may be related to the perpetuation of the heteronormative habitus in care practices directed at lesbians, which contributes to the reproduction of exclusion, discrimination and obliteration of this existence. In this sense, it is necessary to list the social indicators of sexual orientation in care practices and make them visible, since health units are places where policies directed at lesbians are materialized, and the recognition of these indicators contributes to humanized care and embracement.

The recognition and understanding of the needs of these women by a care management that favors the construction of bonds based on the acknowledgement of sexual trajectories and practices, with the nurses' welcoming and proactive attitude, contributes to comprehensive health care. Academic training and training processes in the health service can offer important ways to build more inclusive spaces.

Finally, it is essential that these nurses be able to develop other habitus, aiming to guarantee different types of identities within the health services. A debate on sexual and gender diversities is necessary, as well as the recognition of the problems that permeate the guarantee of nursing care based on freedom, human dignity and social justice.

Collaborations

LS Milanez, APP Nabero, AN Silva, JIS Pedrosa and BO Ferreira participated in all phases of the writing of the manuscript.

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