


# Experiences of gynecological care by lesbian and bisexual women: (in)visibility and barriers to the exercise of the right to health


Vivências de atendimentos ginecológicos por mulheres lésbicas e bissexuais: (in)visibilidades e barreiras para o exercício do direito à saúde

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## Abstract

Although lesbian and bisexual women have been included in health policies, in the search for comprehensive care, including the recognition of sexual diversity, discrimination persists in health care spaces, especially in clinical consultations. Based on the perceptions and experiences of these women, this qualitative study discusses, the relationships established in gynecological consultations, addressing the disclosure of the status of being lesbian/bisexual, experiences with exams and guidelines relevant to sexuality and the difficulties of negotiating conduct. The production of empirical data took place through semi-structured interviews with twelve lesbians and five bisexuals. The results point to bisexual invisibility in the clinical context. Difficulties in gynecological consultation involve fears regarding the exposure of sexual orientation, as well as the non-validation of their sexuality. Consultations in gynecology remain centered on heteronormative assumptions. Thus, they operate with a preponderance of reproductive aspects to the detriment of sexual aspects of life.

**Keywords:** Lesbian; Bisexuality; Sexuality; Comprehensive Health Care; Qualitative Research.

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## Resumo

Embora lésbicas e mulheres bissexuais tenham sido incluídas nas políticas de saúde, na busca por uma atenção integral e que inclua o reconhecimento da diversidade sexual, a discriminação persiste nos espaços de atenção à saúde, especialmente nas consultas clínicas. Este trabalho, de vertente qualitativa, teve por objetivo discutir, a partir das percepções e vivências dessas mulheres, as relações estabelecidas nas consultas ginecológicas, abordando especificamente a (não) revelação da condição de lésbica/bissexual, as experiências com exames e orientações pertinentes à sexualidade e as dificuldades de negociação de condutas. A produção dos dados empíricos deu-se por meio de entrevistas semiestruturadas com doze lésbicas e cinco mulheres bissexuais. Os resultados apontam para a invisibilidade bissexual no contexto clínico, para as dificuldades na consulta ginecológica tanto para lésbicas quanto bissexuais e para o temor das mulheres quanto à exposição da orientação sexual, bem como o não reconhecimento de sua sexualidade. Nesse sentido, as consultas em ginecologia continuam centradas em pressupostos heteronormativos, preponderando aspectos reprodutivos em detrimento dos aspectos sexuais da vida.

**Palavras-chave:** Lésbica; Bissexualidade; Sexualidade; Cuidado à Saúde; Pesquisa Qualitativa.

## Introduction

The visibility of LGBT (Lesbians, gay, bisexual, transgender) raises questions about “sexuality,” both in activist groups and in researchers from several fields of knowledge. Problematization surrounding the LGBT theme brings discussions about sexual and reproductive rights previously devoted to heterosexuals. Thus, sexual diversity and its unfolding in the medical, legal, and social fields rise several questions and reflections from human and social sciences researchers and about the interface of these sciences to health.

In the academic field, studies (Aquino, 1995; Guimarães, 2004; Heilborn, 2004; Parker, 1999) from the 1980s onwards, ignited the debate about the freedom of sexual orientation and expression, moving from approaches centered on the individual and on the “etiology” of homosexuality to an approach centered on inter-relation subject-society and on the sociocultural context. Important authors, such as Jeffrey Weeks (2010), Henrieta Moore (1997), Gayle Rubin (1975), and Carol Vance (1991), fostered discussions about sexuality, understanding it as a field for powers and political struggles permeated by power games, beyond a biological function.

Deconstructionist authors, as Butler (2003), not only criticize the naturalization of sexuality, but also the gender concept in itself. Butler sees gender as a performance that can occur in any body, hence disconnected from the idea that a body corresponds to a single gender (Butler, 2003). The body, thus, is no longer a given fact, and no identities precede the exercise of the gender norms; the exercise in itself creates the norms.

In Brazilian health, we see a few advancements, with the elaboration of public policies, a result of research projects and claims from the LGBT or feminist social movements. Thus, claims for rights in the national landscape are disputed since the late 1970s, ensuing the partial incorporation of demands by the federal government, specifically through the National Policy of Comprehensive Women’s Health Care (Brasil, 2003) and the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, and Transgenders (Brasil, 2010) in the 2000s. Among the goals of the later, the promotion of

comprehensive health, the exclusion of homophobia and any other form of discrimination, the inclusion of educative actions in health care services for the promotion of self-esteem in LGBT individuals, the expansion of access to qualified treatment of gynecological cancer, and the prevention of new cases among lesbians and bisexual women.

We ought to recognize that the basis for frameworks of these policies is the language of sexual rights from the 21<sup>st</sup> century, which brings a new morality: the exercise of sexuality anchored in the search for personal fulfillment, happiness, health and well-being, through the good use of pleasure (Carrara, 2015). The enjoyment of sex as an autonomous activity concerning the choices of one's sexual partners represents "the recognition of the several sexual orientations and the legitimacy of their expressions" (Villela; Arilha, 2003, p. 136). Thus, heterosexuality, bisexuality, and homosexuality are equally free practices.

In a bibliographic study about the health of lesbians and bisexual women, we notice that other countries conducted studies, especially the United States (Denberg, 1995; Diamant; Schuster; Lever, 2000; Diamant et al., 2000; Aaron et al., 2001). It seems to us that the production of knowledge in Brazil remains shy, in spite of efforts seen in the past 15 years to discuss the health of women who engage in lesbian relationships (Barbosa; Facchini, 2009; Barbosa; Koyama, 2006; Melo, 2010; Moscheta; Fébole; Anzolin, 2016; Paulino; Raserá; Teixeira, 2019; Pinto, 2004; Rodrigues, 2011).

The health conditions of lesbians and bisexual women also urge relevant reflections on how they appropriate their own bodies and their perceptions about the risks of a disease. Considering the main subject in this article, we emphasize that the gynecological consultations, for being an extremely delicate moment and a place of exposure, may present difficulties, which range from the decision of either disclosing or not the homo/bisexuality to the doctor to the doctor's reaction and the consequences of it to the care. We emphasize that concepts and practices of the biomedical knowledge guide the meeting between a person seeking assistance and the doctor. From the 19<sup>th</sup> century on, gynecology, as other areas in medicine, started to produce a scientific discourse concerning the health and

the disease, based on a cause-effect relation, with a strong objectification of patients (Moulin, 2009).

The accounts about visiting the gynecologist in the few studies contemplating lesbians and bisexual women reinforce factors associated to gender conventions explaining the low access to consultations (Barbosa; Facchini, 2009). The study by Rodrigues (2011) also shows that the imaginary associated to "being careful and aware of health," in addition to other characteristics of female sexuality - few partners, enjoyment of sex in the presence of affection, control of sex activity etc. - favor the occurrence of unprotected sexual activities in the female homosexual experiences. Thus, hegemonic values of womanhood, by demanding women to restrain their sexuality, in addition to infrequent sexual involvement, foster the idea that having a relationship with a woman is more "naturally" safer. Such perceptions echo among health professionals (Melo, 2010).

The assumption of heterosexuality of users as the basis for the organization of health care services is the hypothesis behind the analysis of the contingent of lesbians and bisexual women excluded from these services. This assumption of heterosexuality favors a discriminatory context and biased practices by professionals (Barbosa; Facchini, 2009; Melo, 2010; Pinto, 2004; Rodrigues, 2011). During the access and use of services, professionals are unlike to question the type of relationship of their patients, by assuming they are heterosexuals, disregarding diverse sexual identities and practices (Moscheta; Fébole; Anzolin, 2016; Pinto, 2004; Rodrigues, 2011). Heteronormativity, built on the assumption that every individual is heterosexual, and standardized in health care practices, contributes, thus, for turning homosexuality socially invisible and of a lesser legitimacy (Bjorkman; Malterud, 2009).

Definitely, when women distance themselves from the alleged sex-gender-sexuality line, they become vulnerable to stigma and bias. In the scenery where relationships between lesbians and bisexual women and health care professionals took place, the theoretical-conceptual contributions about stigma, bias, and discrimination are valuable for our understanding on hinders and deadlocks surrounding care sought by women and offered by the professionals. The notion of stigma, first raised by Goffman (1982), has been revisited, in a search for

expanded and useful perspectives for health. Parker and Aggleton (2003) state that the valorization of certain attributes/characteristics, to the detriment of others, does not occur in an open and decontextualized manner; the stigma is always close to cultural senses and systems of power, which is why understanding their creation and maintenance directs the focus to expanded structures of social inequality and process of social exclusion.

Given the low expressivity of scientific production about the relation among health, female homo and bisexuality, the social disadvantages related to stigma and discrimination in the health care services, we see the timeliness and pertinence of investigating the conceptions of lesbians and bisexual women about the relationships within the context of gynecology care. Yet another reason is the recognition that health may be the social scenery where the subjects put into action values, norms, and their gender performances. Therefore, this work aims to discuss the senses and meanings emerging from the previous experiences of lesbians and bisexual women in gynecological attention and in the relationship with medical professionals. We will explore the dimensions of (the lack of) disclosing being a lesbian/bisexual woman, the perceptions about the doctor's reaction in face of the disclosure of a non-heterosexual orientation, the experiences with examinations and orientations concerning sexuality, in addition to the (im)possibility of negotiating conducts.

## Methodology

Empirical data supporting the discussion in this work are part of an expanded qualitative research, which investigates the health conditions of lesbians and bisexual women. The University Ethics Research Committee approved it. In-depth interviews based the production of empirical data because of its potentiality to capture, from a flexible script, the values, and meanings that subjects attribute to events in the personal experience.

The research invited lesbians or bisexual women aged 18 years or above, using the snowball sampling strategy. From a few initial contacts, we invited a number of lesbians that were not part of the personal circles of one of researchers;

from them, we sought for referrals. Other participants accessed the research invited by friends who knew about this project and diffused it in their social circles. The invitations mentioned sexual orientation as an inclusion requirement. We conducted 17 interviews, of which, 5 with bisexual women and 12 with lesbians, between November 2016 and December 2017, after explaining, reading, ensuring understanding and signing the informed consent form. Interviews consisted of guiding questions, following a thematic script, elaborated and tested during the pilot stage. This allowed assessing its directness and pertinence towards the proposed objectives, whose axes were: the homoaffective in the different social spaces, including family; the moralities within the affective-sexual relationship; the actions of health care; situations of discrimination and bias in and out the medical care, if any; and, lastly, what could be implemented to improve health care services. The participants chose the locations for interviews, provided locations granted privacy and adequate acoustics for the recording.

We recorded all interviews uninterruptedly in digital audio, fully transcribing them for later analysis, respecting common expressions, slangs, and pauses. The average length of interviews was 1 hour and 10 minutes. To ensure anonymity and confidentiality of data, we used aliases. We finalized data collection when we found them sufficient to enlighten the phenomenon proposed by this work. With this purpose, we used the theoretical saturation criterion (Fontanella; Ricas; Turato, 2008). The material obtained from the interviews proved itself rich for producing a *corpus* of statements about perceptions and experiences of health care for lesbians and bisexual women, allowing sufficient resources for the interpretation of the empirical categories investigated.

For the data analysis, we used the hermeneutics conception, in which comprehension "emerges as something produced in the dialogue, rather than something merely reproduced by an interpreter when facing a text or action in a pursuit for comprehending it" (Batista, 2012, p. 108, our emphasis). We reached results in the process of interpretation, with the purpose of analyzing data and discussing them based on theoretical explanatory schemes (Strauss; Corbin, 2008). We read the transcription material

carefully until absorbing its contents, understanding its internal logics, peculiarities and, at the same time, understanding the whole. After this absorption, we conducted an attentive and targeted reading, aiming to identify the thematic axes, which included those previously explored in the interview script and those emerging. In a second stage, we conducted a horizontal reading of accounts, to compare the narratives of participants according to the researched themes. During this stage, we compared the apprehension of findings to literature on the subject and to the theoretical framework of this project.

## Results and discussion

Before discussing proposed subjects, we must emphasize the importance participants self-identifying their sexual orientations (Chart 1). Five participants self-referred as bisexuals, although presenting significant differences as to how they perceived and experienced their sexualities. Manuela and Any felt attracted to men and women and considered the possibility of being emotional and sexually involved with both, while for Cristina, Danila, and Giane, bisexuality found an expression in their preference for women, especially for long-term relationships. In these cases, they chose

the bisexual reference, once they could engage in casual sex with men, also revealing a bisexual way of being. Nayara, who also acknowledged the possibility of having sex with men, self-identified as a lesbian, rather than bisexual. Most lesbians - Luiza, Thalita, Lia, Naira, Tatiana, and Karen - started their sexual lives with men. These women saw themselves as heterosexuals for a while, until they could, in their own pace, reach their desire for women, and recognize themselves as lesbians. Others, as Magda, Keyla, Lara, Alana, and Carol have never felt attraction to men, and “from the beginning,” as they said, “they knew” they were lesbians.

The self-identification of participants reveals the need of comprehending that sexual orientation implies a complexity of practices, desires, and sexual trajectories that must be critically assumed, avoiding classifications supposing immutability and linearity. The self-naming of sexual orientation seemed to us having an important meaning for the participants, regarding to self-recognition and social belonging (Costa, 1996). However, the **lesbian** and **bisexual woman** expressions do not translate a fixed way of being and may not comprehend entirely the complex dynamics of sexuality, as warned by Judith Butler (2003) and researchers of social constructionism (Weeks, 2010; Vance, 1991).

**Chart 1 – Characteristics of participants**

Participant	Age	Orientation	Affective status	Color or Race	Educational level	Place of residence
Lara	21	Lesbian	Dating	white	Some higher education	Vila Nova Cachoeirinha
Lia	68	Lesbian	Single	White	Higher education	Vila Madalena
Giane	30	Bisexual	Common-law marriage	Black	Higher education	Centro
Luiza	28	Lesbian	Single	Black	Some higher education	Vila Elídia
Cristina	34	Bisexual	Single	Black	Some higher education	Butantã
Carol	20	Lesbian	Single	White	Some higher education	Brooklin
Thalita	20	Lesbian	Dating	White	Some higher education	Vila Medeiros
Naira	19	Lesbian	Single	White	Some higher education	Vila Madalena
Nayara	19	Lesbian	Dating	White	Some higher education	Butantã
Keyla	40	Lesbian	Single	Black	High school	Osasco
Alana	22	Lesbian	Dating	Black	Higher education	Saúde
Any	29	Bisexual	Single	Brown	High school	Cambuci
Magda	45	Lesbian	Dating	White	Elementary school	Parque Cocaia
Karen	26	Lesbian	Dating	White	High school	Francisco Morato
Manuela	31	Bisexual	Single	White	Higher education	Brooklin
Tatiana	27	Lesbian	Single	Brown	Some high school	Francisco Morato
Danila	35	Bisexual	Single	Black	Higher Education	Cidade Ademar

## **(Un)disclosure of being a lesbian/bisexual woman during gynecological care**

The disclosure of homo/bisexuality for the medical professional proved crucial because this was a key moment in consultations. Thus, the decision of either talking or not acted as a turning point for the unfolding of the established relationship. It is noteworthy that identifying one-self as lesbian/bisexual women is not merely sharing an information, such as age or last menstrual period, both often asked; it requires instead to rupture with heteronormative premises, demanding an exposure from patients that does not guarantee them, *a priori*, humanized care.

The constraint of women towards disclosure of sexual partnership (female/male partner) and the ways of addressing this topic in the gynecological consultation were not homogeneous, deserving an analysis. Sexual orientation and appropriation of femininity/masculinities while gender expressions are relevant categories for our understanding of some peculiarities of the (un)disclosure of sexual orientation during gynecological care.

We notice a difference between lesbians and bisexual women; the first, in spite of having verbalized several discomforts and difficulties, sought for opportunities in their interaction with the doctor to affirm themselves as lesbians. While for the bisexuals, none of them verbalized or tried to verbalize sexual orientation. The bisexual invisibility stands out, not as result of an individual choice, but attached to contexts of health care in which the sexual practices of women cannot be legitimated unless they involve men instead (Moscheta; Fébole; Anzolin, 2016).

The social place assigned to men and women, supported by a binary conception of gender, constitutes a field of meaning concerning bodies, sexual behaviors, and affective relationships (Moscheta; Fébole; Anzolin, 2016). The acceptance of some ways of life as more acceptable than others, heterosexuality among them, may contribute for bisexual women to omit their sexual orientation and disclose only the facet of relationships with men. In addition, we risk interpreting that the invisibility of the bisexual woman in the health care spaces reinforces

hardships faced in other social circles. Often seen as confused or undecided, especially for not defining a single object of desire, they feel less authorized to stating they are bisexuals within the context of gynecological consultation, as is the case in other social contexts. In these terms, we see sexual orientation attached to gender performance, favoring visibility only to the parcel of population that meets normative standards - in this case, engaging in relationships with men. Manuela's account expresses this situation:

*It is an extremely formal relationship, it is distant. Quite distant! Every time, once a year, he recommends exams, because that is routine, but he won't ask me anything about my life.*

*Doesn't he know that you are a woman who engages in sexual activity with men and women?*

*No, he does not.*

*Você avalia que seria pertinente ele saber disso? Do you think it would be pertinent for him to know that?*

*He should [know], right, but I cannot get myself to say. I think it does not matter, for medicine it could not be less important. The questions asked, the way care is rendered, what he wants to see in the clinical examination, it makes no difference whether it is a dick in my pussy or if I am scissoring another pussy. (Manuela, 31 years, bisexual, white)*

Manuela's account states the category of analysis developed by Paulino, Rasera, and Teixeira (2019), the "No Discourses," which, in this case, refers the "no difference." Doctors use this to minimize the difference between the LGBT population and other populations, under the argument of an alleged equality. However, one of the effects of these statements is precisely the annulation of the subject. As emphasized by Baker and Beagan (2014), in their study consisting of 38 women and 24 doctors, in an attempt to equally treat all patients, the professional contributes even more for lesbo/biphobia, given that the alleged neutrality reinforces normative conceptions of sexuality and gender.

All lesbian participants understood as extremely important giving visibility to sexual orientation during the consultation, corroborating a similar result found by Johnson and Nemeth (2014), by Bjorkman and Malterud (2009), and by Baker and Beagan (2014), in a qualitative research with North-American, Norwegian, and Canadian lesbians/bisexual women, respectively.

Barriers surrounding the disclosure of sexual orientation among lesbians also refer to the gender performances and identity. Accounts about the most expressive hardships in disclosure stood out in those “performing” in a more masculine manner. According to Barbosa and Facchini (2009), the visit to the gynecologist may be an affirmation of female needs, hence, a conduct for lesbians who see themselves as feminine. For lesbians who have masculinized characteristics and body postures, the consultation assumes a meaning of exhibiting the deviant traits that, added to the representation that lesbian relationships do not offer risk nor require specific health actions, turn the pursuit for gynecological care especially complex and hard. An example: Magda, lesbian of masculine performances, recalled visiting the gynecologist once, when she was young, and feeling uncomfortable. Two years ago, she had to undergo an emergency uterus removal surgery and, because of it, accumulated more visits to the gynecologist than the sum of all previous visits. She described the procedures and exams as extremely uncomfortable, even worse if performed by a male professional.

These findings emphasize that accessing and perceiving health needs relate to sexual orientation and to the manner gender identity is “performed.” It means that the health care sensitive to lesbians and bisexual women depends on the sexual orientation and gender performances, understood as a continuous construction of corporeal styles, which give the illusion of an abiding gendered self (Butler, 2003).

For some participants, the opportunity of disclosing their sexual orientation appeared after the question about contraceptive methods, a unique moment for deconstructing the assumption that they are heterosexuals:

*I said, because the first question is: “what do you do to prevent babies?”. “I have sex with women,*

*this is what I do,” I tell the doctor. (Lara, 21 years, lesbian, white)*

*I say it when I have an appointment. “What is your contraceptive method?”. “I have sex with women,” this is usually how I tell doctors. (Giane, 30 years, bisexual, Black)*

*I tell them because the first thing they ask is “Are you on birth control pills?”. (Cristina, 34 years, bisexual, Black)*

Although part of participants took the questioning about contraceptives as the entry door for positioning themselves as lesbians, such questioning reinforced heteronormative premises and hindered the disclosure about the diversity of their sexual practices. In addition, the questioning about contraception early in the consultation, in the perception of many interviewees, relates to the medicalization of the female body, as if any woman of reproductive age were dealing with contraception. Cristina clearly expressed her discomfort:

*I think this is a stupid question; it is a stupid, stupid question! First, because being on birth control pills is shit. [...] Second, because it does protect you from any disease. Third, what about those who have sex with women?*

The simple strategy of asking open questions (De Oliveira; Almeida; Nogueira, 2014) and questioning about how sexuality is perceived and experienced (Baker; Beagan, 2014), without anticipating an assumption on the sex of the partner and without questions about birth control pills right at the beginning, could favor the disclosure of sexual orientation. However, none of the accounts by the participants stated a professional conduct like this.

### **The reaction of the medical professional in face of a non-heterosexual patient**

The description of the doctor reaction in face of a disclosure of homosexual or bisexual orientation stands out for the inability of the professional in dealing with the information. Just two interviewees,

Magda and Keyla, did not identify something negative in the reaction presented by the professional. All others reported reactions that ranged from “embarrassed” to “not knowing how to proceed with the consultation” and “biased comments and delegitimization of lesbian sex.”

*When I break the news that I am a lesbian, they nearly fall off the chair. You can tell they completely lost it. (Lara, 21 years, lesbian, white)*

*I think it is super important stating you are a lesbian and I have seen it all... I have seen they get quite upset! They often do not know what to do next. (Lia, 68 years, lesbian, white)*

Regardless their lesbian or bisexual orientation, it was frequent for all of them to receive an unwelcoming or even disrespectful treatment from the professionals in face of the disclosure. This reinforces the hypothesis that a heterosexual and lesbo/biphobic culture is in place in the medical formation, enacted in the health care based on exclusion and subjugation practices (Raimondi et al., 2019). One of the consequences is the holding women accountable for the tough decision of disclosing their sexual orientation and dealing with a possible hostility or remaining invisible and subject themselves to inadequate treatment, which Davis (2005) also addressed.

Negative aspects resulting from the doctor’s inability also appeared and, among them, cutting the consultation short or failing to request exams are the most mentioned. The research conducted by Barbosa and Facchini (2009) corroborate these behaviors in the city of São Paulo. Karen verbalized a consultation cut short after the disclosure:

*When you say “I am a lesbian,” then the bias may start, as was the case with him, when I got there, he was normal, but then when I said it, he [the doctor] started cutting the consultation short.” (Karen, 26 years, lesbian, white)*

The delegitimization of sexual practices between women expressed the disrespect. The situation narrated by Alana is an example

of it. Alana said she had already had an unpleasant experience when consulted the gynecologist at the Primary Care Unit (PCU), in Francisco Morato; Alana said she is a lesbian and the doctor wrote “virgin” in her medical record. She felt uncomfortable because she did engage in sexual practices and did not recognize herself as a virgin. However, despite the unpleasantness, she could not get herself to contest nor correct the mistake. Alana says she never returned for the follow-up appointment, abandoned treatment, and went on for years without seeking medical care.

When she moved to São Paulo, resumed gynecological care and, in her second time visiting a doctor, a similar situation occurred: the professional called her “sort of a virgin” while quickly reading the notes from the previous appointment, mentioning that the patient had never had a sexual intercourse with a man. Alana once again felt disrespected, given that sexual intercourse with women was not considered as “sex.”

*She treated it as a joke, “sort of a virgin.” “Oh, you are sort of a virgin, half virgin,” said the doctor, mocking it. I put on a serious face, but she did not realize it. So I am not sure whether I can go on an appointment with her again. (Alana, 22 years, lesbian, Black)*

Karen, who had no history of frequent gynecologist consultations, had a similar experience. Friends encouraged her to see a doctor, warning her about the need of a Pap smear. Karin was afraid of undergoing the exam, because she had only had one sexual intercourse with one man, years before. She was unsure about the collection of the Pap smear because of the insertion of a spatula in her vagina, but her friends encouraged her to tell the doctor she was a lesbian, asking for advice. During the consultation, the doctor asked her if she had a sexually active life, to which she answered:

*I said “I do,” and told him I have sex with women. He said: “No, I am asking about men!”. What? What is that supposed to mean? I even told him: “Is having sex with men the only way for a sexually active life?”. He stared at me... He was an older man,*



*and from the way he stared at me, I understood that sex, for him, is a male-female relationship only.* (Karen, 26 years, lesbian, white)

Both cases presented the delegitimization of sexual intercourse between women, establishing the sex with male partners, **and male partners only**, as the referential for sexual activity. The disregard about erotic relationships among women expresses the phallogocentric stereotype connecting sexual activity to penile penetration, disseminating the erroneous idea that lesbians/bisexual woman do not have sex. The erotic relationships between women become unthinkable or negligible in a misogynistic culture, which transforms the female sexuality in an instrument of the male desire (Borrillo, 2010).

In the health care relation, in spite of the information volunteered by women about their sexual practices, the normative knowledge about gender and compulsory heterosexuality remains activated, with the invisibilization of sexual practices between women (Moscheta; Fébole; Anzolin, 2016). Data similar to ours are also present in the international literature (Johnson; Nemeth, 2014), accounting for biased reactions by doctors and even rude behaviors during examination.

### **Experiences with examinations and orientations concerning sexual life and (im)possibility of negotiating conducts**

Other difficulties permeating the relationship to the doctor were the Pap smear collection and receiving orientation. The participants emphasized that information offered by the professionals were confused and did not apply to them. The gynecological consultation, often, resulted in implausible orientations and not applicable instructions, in spite of the disclosure of the sexual orientation by the patient. Reducing the effectiveness of care, participants had not felt comfortable in asking for further explanation when the terms used by the professional were unclear and imprecise, leaving the feeling of an unnecessary and dispensable appointment.

An aforementioned study conducted in Norway, showed that receiving medical orientation targeted

at heterosexual activities, the prescription of birth pills, and even pregnancy tests, in spite of disclosing a long-term lesbian orientation, were some of medical conducts found towards lesbians (Bjorkman; Malterud, 2009). In our findings, like those of other Brazilian studies, we evidenced that, even if women disclosed being lesbians or bisexuals, receiving information related to their sexuality was not a certainty (Barbosa; Facchini, 2009; Pinto, 2004; Rodrigues, 2011), with their statements and requests for advice on health care being disregarded (Moscheta; Fébole; Anzolin, 2016).

All participants classified the Pap smear as undoubtedly uncomfortable. In spite of it, none of them verbalized a refusal in collecting it. For the bisexuals or those who have ever had sex with men, the exam was less repulsive, for the familiarity they have (or have had) with penetration. For some lesbians who had never engaged in sexual intercourse with men, the exam raised more concerns, especially about its adequacy and real need. For women who presented masculine performances, the irregularity in collecting Pap smears was stronger, in comparison to the other lesbians and bisexual women. To Magda, a lesbian presenting a male performance, collecting a Pap smear conflicted with limits related to gender identity and to the way she experienced her sexuality. The insertion of a tool into the vagina for women whose identification diverges from the normative standards of womanhood may acquire a sense of great aversion or even violence. We found that the standardization of care does not include an approach for performing examinations in women who does not engage in penetration, leading to invasive examinations and embarrassing situations (Moscheta; Fébole; Anzolin, 2016).

*I had it [Pap smear] collected once in my life, and found it outrageous, what a terrible situation! I had it a long time ago, and then never again, I guess I avoided gynecologists' appointments precisely because of it; I have never liked it. If they have to do a blood test, then be it, if they have to insert something into my throat, then be it, but I do not want any touching down there. [...] It is a terrible situation, I do not feel comfortable with it, I'd rather not do it. So health ended up neglected...* (Magda, 45 years, lesbian, white)

Yet another issue was getting information related to their sexual practice. This was because, among other reasons, professionals unclearly stated the practices they were referring, in addition to not stating the sex of the sexual partner. For the erroneous assumption that women were heterosexuals and for the manner as services were rendered, with a preponderance of reproductive aspects, the expressions referred to sexual activity with men.

Luiza stated that, when she expressed sexual practices with women, this not necessarily echoed in the consultation, as she believed that the doctor did not know which advice should be passed on to a heterosexual or to a lesbian patient and the similarities and differences between the two:

*He notes it down that I am a lesbian and so what? Does he really know the needs of a lesbian? What advice to give? With the resources they have, they should provide useful information. But this is not what happens.* (Luiza, 28 years, lesbian, Black)

When professions argue not knowing the needs of the LGBT population, we identify the “I do not know discourse” (Paulino; Rasera; Teixeira, 2019). It is not about being a true or false discourse, but rather a supposed easiness with which the professionals exempt themselves from their responsibility in the care relation.

While relevant gaps concerning gender and sexual orientation exist in the medical formation, the fact of allegedly having no knowledge on the matter is not, in itself, a reason for doctors to neglect the practice (Paulino; Rasera; Teixeira, 2019), nor for disregarding the singularities of the users to whom they render services. Thus, despite the heteronormative logic being strongly present in the medical formation, the appropriation of the singularities in the affective-sexual trajectory is part of the medical ethical commitment.

Corroborating our findings, a research project about the health status of lesbians and bisexual women in Argentina concluded that, in fact, three of the main problems concerning access to health for lesbians and bisexual women directly

relates to the heteronormative nature of the consultation. These are: (1) the concealment of the affective-sexual orientation or the management of the homosexuality secrecy and, consequently; (2) the invisibility of the female homoerotic practices; and (3) the poor information provided to women, in addition to wide spread myths and biases (Brown et al., 2014). In the same sense, the lack of specific knowledge about LGBT health care was alarming among doctors participating in the study by Baker and Beagan (2014).

The (im)possibility of dialoguing with doctors about the functioning of the female body and the negotiation of conducts were also relevant topics. Concerning conducts, the recommendation of birth control pills was frequent, even in face of the refusal of the patients or doubts as to why doctors prescribed it.

The core hardship about the gynecological consultation mentioned by our participants, regardless of being lesbians or bisexual women, was the unreceptive posture of the professional, both in the public and the private health care network. For Naira, Luiza, and Lia, for example, there were important topics, such as period cramps, endometriosis, and ovarian cysts, respectively, which, because of the little openness to dialogue, they would not discuss.

Despite not being a study objective, the exaggerated recommendation for birth control pills stood out, even in that circumstances of inadequacy as a method for avoiding pregnancy. This was Naira's experience:

*I left with a prescription for birth control pills and for that ring for insertion. She did not ask me anything [about sexual practices], she just assumed it and I let her assume. She started talking and imposing things, so I just let her. I did not take the birth pills, nor did anything else.*

*And did she say why prescribe birth control for you?*

*For avoiding pregnancy! (Naira, 19 years, lesbian, white)*

In short, such repeated recommendation is a result of gynecology consultations primarily targeted at reproductive issues, leaving other symptoms and complaints about sexual health behind:

*The gynecological consultation mainly addresses whether or not a woman wants to get pregnant. Period.* (Luiza, 28 years, lesbian, Black)

*As soon as I entered, I told him I was a lesbian, and then he stopped paying attention. Like “Oh, well, she won’t get pregnant, she does not want a child, all done.” It felt like there was no point in me being there.* (Karen, 26 years, lesbian, white)

These data relate to the argument by Barbosa and Facchini (2009), who state that, given that the starting points for gynecological consultations are the starting of a (hetero) sexual life or motherhood, the relations established by the doctors with the women operate in the logic of reproductive issues (Moscheta; Fébole; Anzolin, 2016), based on the heterosexuality naturalization (Lionço, 2008). As a result, sexual health has a poor approach, and doctors seem to have little knowledge about lesbian sex; doubts concerning Sexually Transmitted Diseases (STD) are left unsolved and, often, are not even discussed during the consultation. Our participants stated how they missed concise information about STI prevention, in addition about the transmission of frequent diseases or those requiring most attention:

*STD [Sexually Transmitted Diseases] is something I worry about, I asked the doctor for information, but could not get it.* (Lara, 21 years, lesbian, white)

*The last doctor I saw asked me if I used any protection. I said I did not, she suggested a finger cot, but they do not even know it. It is complicated.* (Luiza, 28 years, lesbian, Black)

The results in this study are close to that of the study by Rodrigues (2011), in which the STD prevention among lesbians was central. Being in a steady relationship and the understanding that sexual practices between lesbians are naturally safer

contributed to reducing the relevance of prevention (Rodrigues, 2011; Barbosa; Facchini, 2009).

The conceptions of gender cross the field of sexuality, inferring different values and behaviors to male and female sexuality. It is noteworthy that, among the participants in our study, the difficulty in talking about prevention methods against STDs during the gynecological care relates to the perception that the professional has no knowledge about the sexual practices of lesbians and bisexual women. Again, we find the “I do not know discourse” (Paulino; Raseira; Teixeira, 2019), in which not having information is not an excuse to exempt the doctors from their responsibilities and from the ethical commitment in face of a person in seek of care.

## Final remarks

We took the context of gynecological care in this study as a privileged space for analyzing the perceptions of lesbians and bisexual women about the doctor-patient relationship and health care, especially regarding to sexual health. The narratives of women about their perceptions and experiences in different health care services (hospitals, primary care unit, private practices) clearly show that gynecological consultations constituted social spaces that restrain the sexual rights of lesbians and bisexual women.

Gender performances and identity permeate the relations that women establish with gynecologists within the context of consultations, either turning (in)visible the affirmation of sexual orientation and practices with women, especially among bisexuals, or conforming an effective need of disclosing and affirming their affective-sexual experiences.

The difficulties and barriers for the disclosure of sexual orientation, expected and experimented in different circumstances throughout life by the participants, result in less frequent visits to the gynecologist or irregularity in the search for care. The obstacles faced for disclosing sexual orientation and, even more serious, the lack of recognition of their social practice as legitimate by the doctors are important findings of this work, corroborated by the literature review in the few national and international works available.

Bias and discrimination following the disclosure of sexual orientation proven to be decisive for preventing an integral and humanized care, resulting in women disavowing the space of gynecological consultation as belonging to effective health care and, ultimately, revealing institutional violence to which they are subjected. In addition, not receiving proper information during the consultation or the lack of referral to diagnostic exams reinforce some of the wrong assumptions by the professionals (for example, that sex between women is safer), showing a lack of technical skills for addressing the needs of lesbians and bisexual women.

Based on the premises defended in the field of sexual rights, we question how the spaces for gynecological care are operating in a very negative manner. It hinders the inclusion of the diversity of lesbians and operating in the production of exclusion and invisibility, reinforcing heteronormative standards in relation to gender, sexual orientation, and sexual practices among women. Thus, in a context of expanding the visibility of lesbians and bisexual women, we reinforce the importance of recognizing their rights to sexual right and, at the same time, to humanized and integral care.

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### Authors' contribution

Rodrigues conducted the doctoral dissertation "Lesbians and bisexual women: an intersectional view of health care," from which this article unfolds. Rodrigues elaborated the script for the interview, performed fieldwork, analyzed the empirical material, and wrote the thesis and this article. Falcão oriented the doctoral research by Rodrigues, supporting the development of the entire work. Falcão also contributed with the theoretical-methodological tools both for the fieldwork and for the analysis of the empirical material and supported the writing of this article.

Received: 02/22/2019

Resubmitted: 08/10/2020

Approved: 10/06/2020