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Main Questions from Brazilian Family Physicians on Lesbians and Bisexual Women's Healthcare

Renata Carneiro Vieira
Family Physician
State Health Secretariat of Rio de Janeiro

Rita Helena Borret
Family Physician
Municipal Health Secretariat of Rio de Janeiro

Translation from Brazilian Portuguese
Bruna Barros & Jess Oliveira

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Translated from Brazilian Portuguese by Bruna Barros and Jess Oliveira.

Abstract

In Brazil, being a lesbian or a bisexual woman represents an important social determinant of health. An important aspect of the health-sickness process is the non-recognition by lesbians and bisexual women of the healthcare system as a possible safe environment. This is due both to the LGBT-phobia they face in health units and to the lack of knowledge and training skills by health professionals on the specificities of this population. It is important to acknowledge that this community is in the intersection of at least two different social oppressions: sexism and heteronormativity. This article aims to systematise the main doubts and questions of family physicians, medical residents, and students from Brazil concerning the care of LGBT people at the primary healthcare level, in order to stimulate and guide training activities with this theme both in undergraduate and postgraduate courses as well as in continuing education for health professionals.

Keywords: Lesbians; Primary health care; Medical education.

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Introduction

In the elaboration of this paper, the authors have decided to use the acronym LGBT when referring to all the diversity of gender identity and sexual orientation present in our society. This decision is in accordance with the Lesbian, Gay, Bisexual and Transgender's (LGBT) National Health Policy, launched by the Brazilian Ministry of Health in 2011 (Brasil 2011b).

Primary Health Care (PHC) is the first level of contact for individuals, families and the community with the healthcare system. It is responsible for the health care network's coordination and the provision of longitudinal and integral care. In addition to these essential attributions, PHC also proposes family approach, community orientation, and cultural competence as its derived attributions. It dedicates its services to individuals, families, and communities, having as obligation the approaches of social determinants of health (Stewart et al. 2010).

Family Medicine (FM) is the medical specialty that, within the scope of Primary Health Care, proposes an integral approach to the person, considering all aspects that interfere in the health-sickness process, including familiar, community and social contexts (McWhinney and Freemann 2010). Therefore, FM is the most appropriate medical specialty to handle and coordinate the healthcare of lesbians and bisexual women considering its complexity.

The healthcare of lesbians and bisexual women is an unusual topic through medical schools curricula (Negreiros et al. 2019), even though the National Curriculum Guidelines (NCG) for medical education, published in 2014 (Brasil 2014), state that:

> The student will be trained to always consider the dimensions of biological, subjective, ethnic-racial, gender, sexual orientation, socioeconomic, political, environmental, cultural, ethical diversity, and other aspects composing the spectrum of human diversity that uniquely characterises each person and each social group (Brasil 2014, 8).

In the Brazilian competency-based curriculum (Lermen 2015) for Family and Community physicians, LGBT healthcare and sexuality both appear as essential assignments:

> To manage in a timely manner the demands related to human sexuality, sexual identity, homosexuality, transsexuality, sexuality in special situations (physically rehabilitated, people with mental illnesses or disabilities; pregnancy and postpartum; seropositive; advanced clinical diseases) and sexual prejudice situations (homophobia, heterosexism) (Lermen 2015, 60).

Even though these aforesaid excerpts represent important progress, they are still very limited. In order to truly address these subjects entirely, it is essential to acknowledge and recognise LGBT-phobia as a social determinant of health (Brasil 2011b) and to take into account the specificities of each group within this community.

Family Medicine applies the patient-centred clinical method as a tool to improve the doctor-patient interaction. This method consists of six components (Stewart et al. 2010): (1) Exploring illness and disease (personal experiences with the sickness process), (2) Understanding the person in its individual, familiar and community context, (3) Developing a shared plan of care for the problems identified, (4) Incorporating health prevention and health promotion, (5) Intensifying the relationship between patient and physician, (6) Being realistic.

This method allows an improved comprehension of the suffering and illness processes. However, the method on its own is unable to meet the demands of the LGBT community, because, first and foremost, it is necessary to understand gender identity and sexual orientation as social determinants of health, recognizing aspects related to the causes of sickness of this community in a cis-heteronormative society. Furthermore, it is necessary to acknowledge the

cultural and scientific lack of information about this community in order to offer it comprehensive health care.

Aware of this situation, since 2017 we have been offering not only family physicians but also FM residents and medical students several training activities concerning lesbians' and bisexual women's health. The major purpose of this training is to present the specificities of these communities. These activities have not been focused on sexual behaviours and practices only; they also address networks support, mental health, reproductive health, and preventive disease screening.

The Workshop

The Brazilian National Society of Family Medicine (SBMFC) is a scientific institution that brings together family physicians throughout the country as well as general physicians that work in various Primary Health Care scenarios. The institution arranges the National Conference of Family Medicine every other year. In the organization of this event, the numerous Working Groups (WG) - groups of family physicians and SBMFC's collaborators - participate in the elaboration of the scientific programme. The WG's purposes are to improve the quality of healthcare assistance, to promote professional development and to develop scientific criticism and research on specific topics of interest.

At the 14th Brazilian Conference of Family Medicine in Curitiba, the ´Gender, Sexuality, Diversity and Rights WG organised a workshop entitled "*Homem com homem, mulher com mulher: o que você precisa saber e outras conversas sobre pessoas homossexuais*" [Man with man, woman with woman: what you need to know and other conversations about homosexual people]. The aim was to discuss issues related to specificities in the health-sickness process and health demands of the homosexual community with family physicians, medical students and other health professionals. Although initially designed to specifically address issues related to homosexuality and bisexuality, several topics related to

gender identity and the LGBT community in general ended up arising and were also included in the activity.

During the workshop, participants were given blank tags and encouraged to anonymously write any questions concerning the health of women who have sex with women and men who have sex with men. This method has been chosen in order to make it easier for the public to talk about sex and sexuality, since it is still a taboo. This way, people could genuinely ask what they do not know. The WG then tried to raise and clarify the main questions the audience had made on the subject.

The WG members who had organised the activity answered the questions throughout the activity. Together with the audience, they had a debate on scientific literature on the theme in which the participants were enabled to share their personal and professional experiences. Due to the great demand, this activity was offered several times at different national and regional conferences and seminars throughout the country.

Objective

In order to help the development of teaching and training activities to a more comprehensive and equitable care for lesbians and bisexual women in the primary healthcare system, this paper organises and acknowledges the main doubts and questions raised among family physicians during workshops carried out between 2017 and 2019. We have chosen to analyse questions on lesbian and bisexual women. This choice was made in acknowledgment of the invisibility they suffer. We do realise that this phenomenon occurs due to the intersection of social oppressions suffered while being women and non-heterosexual. In addition to that, other intersections can interact in the health-sickness process such as race, social class, age, capability and so on.

Methods

This paper is a retrospective study that aims to analyse questions raised in two different editions of the same workshop. The questions can be understood as a convenience sample. The questions were formulated and gathered during two national editions of the workshop. One in Curitiba (2017) and another in Cuiabá (2019). We have decided to organise the questions to understand which are the main doubts of family physicians and medical students concerning the healthcare assistance for lesbians and bisexual women. We selected the questions asked at these events because of their wider range and heterogeneous audiences. In total, 349 people attended both workshop editions. Family physicians, medical students and other primary healthcare professionals were able to present their doubts and difficulties regarding the approach, care, and clinical management of the non-heterosexual community.

The questions related exclusively to gay and/or bisexual men or specifically related to gender identity were not used in this systematization. Of the 221 readable questions received, 56 (25.33%) were excluded and the other 172 were used as the basis of this study. The questions were initially split between two different categories: (1) Lesbians and Bisexual Women Specificities and (2) General LGBT Population Specificities. After this first subdivision, the questions were analysed and combined by repetition and/or affinity of the covered subjects. In each subgroup, the questions were grouped in five different subcategories, each of which represents specific aspects of healthcare.

Results

The CBMFC workshop in 2017 had a total audience of 250 people, while the workshop in 2019 had 99 participants. In the sum of the two editions, women's participation (220) was 99% higher than that of men (111), as shown in Table 1. If we analyse gender and sexual orientation combined, the group that sought the most from the workshop was heterosexual women (156), followed by

homosexual men (66) and bisexual women (41). Of the 172 questions analysed, 93 of them (54.06%) concerned the health specificities of lesbians and bisexuals; 79 (45.93%) posed broader questions related to the entire LGBT population.

	Homosexual	Bisexual	Heterosexual	Total
Fenale	23	41	156	220
Male	66	11	34	111

Table 1: Gender Distribution and Sexual Orientation of CBMFC Participants in 2017 and 2019

After a thematic analysis, both general and specific questions on lesbians and bisexual women were divided into five categories: (1) Non-heteronormative Approach, (2) LGBT-phobia as a Social Determinant of Health, (3) Conduct against LGBT-phobia, (4) Approach to Sexuality and (5) Sexual practices, STIs and Barrier Methods. The category "Sexual practices, STIs and Barrier Methods" corresponds to 54.65% of the questions, followed by "Approach to Sexuality," with 17.44%, and "Non-heteronormative Approach," with 11.62% of the questions.

Among the questions addressed to the whole LGBT population, 31.64% of them cover "Approach to Sexuality" and 16.45% cover "Conduct against LGBT-phobia." The "Non-heteronormative Approach" category includes questions on the approach of the healthcare professional as well as the staff and other members of the health unit. In the Conduct against LGBT-phobia category, most questions dealt with difficulties to address the LGBT person's family of origin. Among the questions on "Approach to Sexuality," in addition to general doubts and difficulties on how to perform this approach in the ambulatory setting, there were also questions on the sexuality of children, adolescents and the elderly. Furthermore, there were questions related to the healthcare professional's sexuality and how it can interfere in the relationship established with patients.

Finally, among the questions on "Sexual Practice," many HIV related questions appeared.

Concerning questions that specifically relate to lesbians and bisexual women, the largest number belong to the category "Sexual practices, STIs, and Barrier Methods," summing 90.32% of the questions. Among the questions on "Approach to Sexuality," there are general questions about bisexuality, and again, about the healthcare professional's own sexuality. Most of the questions about "Sexual Practices, Barrier Methods, and STIs" were about sexually transmitted infections and possible barrier methods in sex between women. These included doubts about specific barrier methods for oral sex as well as queries related to the cytopathological screening programme for lesbian and bisexual women, and questions about sexual practices.

Discussion

The great number of people interested in the workshops shows how much this subject has been neglected in medical education but also how much of it is already identified by healthcare professionals as relevant for their practice. The plurality of topics covered in the questions draws special attention since they went from the discussion on the sexuality of the child, the adolescent and the elderly, through the process of development and disclosure of sexual identity and the familiar and community dynamics related to these processes, to issues related to family planning, STI prevention and care to the health impacts of LGBT-phobia throughout life, etc. This diversity shows how fundamental it is for lesbians' and bisexual women's integral healthcare to be given in the Primary Healthcare level by a family physician as part of a multi-professional team.

The intense difficulty in addressing sexuality in general is noteworthy. Addressing sexuality seems to be a big taboo in clinical meetings, either because of embarrassment, lack of practice and/or knowledge or by fear of how this approach might be perceived by the person-seeking healthcare. This fact

reflects the lack of spaces for discussion about this essential aspect of medical training and postgraduate education and practice.

There were many questions regarding the sexuality of health professionals themselves, about the process of building up their sexual identity and how it interferes in the patient-physician relationship. These questions refer to another aspect of medical education: the lack of safe environments to discuss self-knowledge, self-perception, the subjectivities of health professionals, and their impacts on patient-physician relationships. Providing healthcare is not an aseptic duty. Recognizing it means understanding the need to make room for the physicians' subjectivities.

There were many doubts concerning sexual intercourse between women. This fact points once again to the lack of knowledge and unfamiliarity with these sexual practices and, consequently, with aspects related to the transmission of STIs, including the use of barrier methods. Understanding that non-penetrative sexual practices exist, both men can pursue realising the variety of possibilities for sexual pleasure without penises, and accepting that anal pleasure, and women seem to be major challenges for physicians in training and those already graduated. The medical fraternity's non-recognition of sexual practices among women has stimulated the discourse over the years that there is no risk of STI transmission among them (Saúde 2006). This untrue statement has stimulated risky behaviour among women who have sex with women. Moreover, very little progress has been made towards thinking about specific barrier methods for lesbian sexual practices.

The number of questions regarding the relationship of LGBT people with their families of origin suggests how important it is to address this issue within LGBT's medical care. The family, often seen as a safe environment provider and people's main support network, can also present itself as a source of suffering and illness, further weakening the LGBT person (Saúde 2006). Still regarding family relationships, we have realised that, among the medical community,

there is little knowledge about legislation, reproductive rights and family planning for LGBT people.

Another important aspect in the set of specific questions is the apparent conflict in recognizing and understanding bisexuality. All questions about bisexuality were on whether it is a stage of confusion and/or transition between heterosexuality and homosexuality or whether the person can be considered more or less bisexual accordingly to the frequency with which they change partners. This difficulty is a source of great suffering for the entire bisexual population and for rejection of this group by homosexuals and heterosexuals. It also shows how much society is still held hostage to binary thinking and unable to dialogue with the fluid and complex dynamics that characterise us as individuals and permeate our affective/sexual/romantic relationships.

One last question worth thinking about is why there is a greater visibility of gay men within the LGBT movement and how lesbian and bisexual agendas tend to be silenced. Recognizing the intersectionality of oppressions is an important factor in approaching diversity with equity. That is why it is noteworthy that, although gender oppression and sexual orientation were approached in the questions, no question addressed oppressions such as race or class, which act directly on the health and illness process of the Brazilian population.

Conclusion

The National Policy for Integral Health of the LGBT Population (Brasil 2011b), launched in 2013 because of the great struggle of social movements, has been facing great difficulties in being implemented in the health services around the country, either due to the lack of knowledge about the Policy or the lack of institutional incentive to do so. It is noticeable that there is a large gap between the health needs of lesbians and bisexual women and the technical-scientific capacity of health professionals, especially family physicians, to respond to this demand. This hiatus is fuelled by the still strong presence of sexism and cis-heteronormativity, which hinder the development of medical knowledge. The great demand for specific training activities on the LGBT community demonstrates that this knowledge gap is increasingly being noticed. It points out the need for expansion and diffusion of existing information, as well as for further research on the subject, mainly for the specificities of the Brazilian lesbian and bisexual population.

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