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Access to health services for lesbian women: a literature review

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Abstract *This study explores access to health services for lesbians in the light of current literature. A literature search was conducted using various databases and an interpretive synthesis of the findings of the selected articles was produced anchored in the concepts of habitus and symbolic violence developed by Pierre Bourdieu. Two main themes and their respective units of meaning were identified: (a) barriers and difficulties experienced by lesbians in accessing healthcare (issues related to coming out as a lesbian and difficulties experienced by health services and professionals in dealing with lesbian women); and (b) lesbian women's experiences in health services (unequal care, invisibility, and feeling uncomfortable). We conclude that, despite advances in policy and care protocols, sexual and gender diversity needs to be widely discussed in social, educational, and health settings.*

Key words *Female homosexuality, Lesbians, Healthcare access*

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Introduction

In many countries, access to quality health care is particularly poor among disadvantaged groups. This problem should be understood in a context of political, economic, social, organizational, technical, and symbolic dimensions[1].

Specific problems influence access to health services among lesbian women and the quality of care received by this population group. Since feminine sexuality is commonly denied[2], some of these problems intersect with those of heterosexual and bisexual women. With regard to the political demands of this population group, the lesbian movement was born out of, and to a certain extent maintains itself at, the intersection between the general homosexual movement and feminist movement, despite seeking its own autonomy and visibility.

A study by Facchini and Barbosa[3] showed that, despite the fact that Brazil's public health system is supposedly designed to ensure universal and equal access to comprehensive healthcare, invisibility and the lack of policies tailored to this group adversely affected the quality of care for lesbians and the performance of healthcare professionals, who, in the absence of specific information, act according to stereotypes.

Another study by Valadão and Gomes[4] based on articles and documents published up to 2008 found problems in relation to access to services and the quality of care delivered to lesbian women. Drawing on Bourdieu, they concluded that lesbians were invisible and, in some cases, victims of symbolic violence.

Some policy advances have been made domestically and internationally since Valadão and Gomes' study, including the creation of the National Lesbian, Gay, Bisexual, Transvestite, and Transgender Health Policy[5] in Brazil. It remains to be seen, however, whether these advances will resolve the problems related to access to health services and quality of care for lesbians.

To bring the discussion of this question up to date, it is important to synthesize the findings of the literature on this topic to obtain a better understanding of current knowledge on access to health services for lesbians. Like Valadão and Gomes[4], we believe that Bourdieu's perspective, more specifically the concepts of habitus and symbolic violence, can help in this venture.

Within Bourdieu's theory[6-9], *habitus* refers to acquired knowledge, a state of being, capital, indicating ingrained dispositions. It consists of socially and historically constructed matrices, whose enactment is determined by an individual's social position, allowing him/her to think, see, and act in a wide variety of situations. For Bourdieu, unlike the word habit, which is associated with something concrete, the term *habitus* involves a creative, active, inventive capacity. From this perspective, the subject receives and reinvents "inheritance" to form *habitus*[6-9].

Bourdieu[10] frames the concept of symbolic violence within the sphere of domination, observing that there are two ways of dominating someone: outright violence and symbolic violence, where the latter is understood as that which is euphemized, gentle, and invisible[10]. For Bourdieu, to emphasize symbolic violence does not mean to minimize the role of physical violence or to forget it. It is important that symbolic violence is not understood as the opposite of real violence, a purely 'spiritual' violence that has no real effects[11]. He also maintains that symbolic violence is not exerted in the logic of knowing consciousnesses, but rather in the obscurity of the dispositions of *habitus*[8].

From Bourdieu's perspective, *habitus* and symbolic violence are intertwined since heteronormativity is opposed to homosexuality[11].

Based on these initial considerations, this study explores the specificities of access to health services for lesbians in the light of current literature.

Method

A qualitative review of articles on the topic was conducted. This method enables the collection of a wide range of information and data dispersed throughout various publications and helps develop a conceptual framework for the phenomenon of concern[12].

Literature searches were performed between November 2018 and May 2019 using the following databases: Latin American and Caribbean Health Sciences Literature (LILACS); *Base de dados bibliográficas especializada na área de enfermagem* (BDENF - Nursing Database); US National Library of Medicine (PubMed); Medical Literature Analysis and Retrieval System Online (MEDLINE); and Scientific Electronic Library Online (SciELO).

The following DeCS (Health Sciences Descriptors) were used in Portuguese and English together with the Boolean operator "and": "female homosexuality" combined with "access to health services" and "comprehensive healthcare".

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This search resulted in only a small number of articles from SciELO, BDENF, and LILACS and a larger number from MEDLINE and PubMed. The searches were therefore broadened by adding the following terms: "sexual and gender minorities" and "homosexuality".

The following article inclusion criteria were applied: full text articles addressing themes related to lesbian women's health in Portuguese, English, or Spanish published between 2004 and 2018 and with wide circulation in both in the academic and professional world. The year 2004 was chosen because it was the year in which the Brazilian government created the National Women's Healthcare Policy[13], which encompasses lesbians. Editorials, letters to the editor, dissertations, theses, duplicate articles, and articles that took an exclusively clinical/epidemiological approach were excluded.

The searches yielded 273 articles. A total of 204 articles (including 12 duplicate articles) were excluded after reading the titles and abstracts and applying the selection criteria, resulting in 70 publications that were read in their entirety. Thirty-three of these publications were excluded because they did not discuss access to health services for lesbians, their demands, and the specificities of lesbian healthcare, resulting in a final sample of 36 articles.

The articles were analyzed using an adaptation of a thematic analysis technique described by Bardin[14]. According to this author, a theme is a unit of meaning that breaks away from the text in question and can be translated using a summary, phrase, or word. This technique makes it possible to identify what lies behind the manifest content[15]. In the present study, the theme is understood to be a wider category that may encompass more than one unit of meaning. The analysis consisted of the following steps: (a) identification of the central ideas expressed in the text of the articles; (b) classification of the underlying meanings of the ideas into themes that summarize the production of knowledge on the study topic; and (c) production of an interpretive synthesis of the findings extracted from the selected articles, using the concepts of *habitus* and symbolic violence as a theoretical and analytical frame of reference.

Results

Characterization of the sources

We identified 21 articles published between 2006 and 2014 and 15 published between 2015 and 2018. Twenty-three were in English, ten in Portuguese, and three in Spanish. Half of the studies were published on MEDLINE and PubMed and half on LILACS, SciELO, and BDENF. The articles were from a variety of countries: the United States (nine), Brazil (nine), Africa (five), Argentina (two), Chile (one), United Kingdom (two), Canada (two), Portugal (two), Germany (one), Norway (one), Sweden (one), and New Zealand (one).

The 36 articles were published in 32 journals, 11 of which were Brazilian, 13 from the US, four English, one Canadian, one Colombian, one Swedish, and one Norwegian.

The academic background of the lead author varied: Medicine (20), Nursing (three), Psychology (four), and Sociology (six). The number of authors involved in each publication also varied: three authors (13 articles), two authors (eight articles), one author (five articles), five authors (three articles), four authors (three articles), seven authors (two articles), six authors (one article), and nine authors (one article). Nine articles showed a high level of interaction between different areas of knowledge and interdisciplinary dialogue.

With regard to methodology, 24 articles took a qualitative approach and 12 used quantitative methods. The fact that the majority of studies were qualitative suggests that this is the most appropriate approach for reflecting on and understanding subjective issues. In this respect, qualitative methods address a level of reality that cannot or should not be quantified, since they deal with the world of meanings, motives, aspirations, beliefs, values, and attitudes[16]. The quantitative studies were predominantly cross-sectional studies involving the LGBT population and lesbian women.

Study participants included lesbian women, lesbians and bisexuals, the LGBT population, and health professionals. Since the initial search limited to articles including only lesbian women resulted in an inadequate number of articles, the descriptors were broadened, resulting in articles encompassing lesbians, lesbians and bisexuals, and the LGBT population.

Most of the studies used snowball sampling to recruit study participants.

Sixteen articles involved lesbians and bisexuals, nine the LGBT population, and 11 exclusively lesbian women.

Chart 1 provides a synthesis of the main characteristics of the articles.

Themes

The articles addressed two main themes: (a) barriers and difficulties experienced by lesbians in accessing healthcare; and (b) experiences of lesbians in health services. It is important to stress that – given the nature of the study – the analysis did not compare the epidemiological profiles of diseases related to homosexual, bisexual, and heterosexual women reported by some studies.

Barriers and difficulties experienced by lesbians in accessing healthcare

Two units of meaning stood out in this theme: issues related to coming out as a lesbian and difficulties experienced by health services and professionals in dealing with lesbian women. These meanings are intertwined due to the naturalization of heterosexuality highlighted by some of the articles.

Within the naturalization scenario, the decision to disclose sexual orientation ("come out of the closet") is one of the main barriers faced by lesbians in seeking health services. In general, the logic behind women's health care in health services is based on the heterosexual model, without taking into account – neither implicitly nor explicitly – people who deviate from this hegemonic model, including in this category lesbians[35]. This has consequences in the form of discriminatory attitudes, meaning that lesbians often fail to access health services because they feel vulnerable[50].

The decision to seek health services and disclose sexual orientation may be related to various problems, such as: tension and anxiety[52]; fear of discrimination, prejudice, and stigmatization[19,21,37,45,48,49]; lack of assurance of confidentiality[31]; and shame of being naked in front of a stranger and exposure to intimacy that is often socially devalued[22].

Conversely, some lesbian women believe that disclosing their sexual orientation to their doctor does not negatively affect their healthcare[28] and that it can even build confidence in the relationship[20]. Nonetheless, disclosure does not necessarily mean that lesbians will receive treatment that is specific to their needs, contradicting the assumption that "coming out of the closet" is a solution to improve healthcare[22]. However, the inclusion of sexual orientation in public health systems can help address health inequalities and understand their underlying mechanisms[25].

Difficulties in accessing health services are also related to the fact that health professionals do not always know how to deal with lesbian women. One study observed that some health professionals apply the religious belief that heterosexuality pleases God to their professional life[46]. Other articles suggest that inadequate training means that professionals are ill-prepared for or feel uncomfortable in dealing with the array of sexual orientations[40,50,51], meaning that the specific demands and needs of lesbians often go unseen. Other studies attribute the explicit and implicit naturalized heterosexuality found in general practice[26] to the attitude of health professionals[35,52].

Within this scenario, numerous factors compromise both access to services and the quality of care: failure to address sexuality in general with lesbians[38]; "erasure" of the homosexual orientation[32,47]; non-debate about sexually transmitted diseases[29,42,44]; absence of specific protocols[50]; indeterminacy of lesbians' health needs[32]; and unsafe, fragmented, and non-comprehensive healthcare[43].

Lesbian women's experiences in health services

Three units of meaning synthesize lesbian women's healthcare experiences: unequal care, invisibility, and feeling uncomfortable.

Some of the studies show that the healthcare experiences of lesbian women differ from those of heterosexual women: lesbian women tend to receive poorer health care[17]; heterosexual women were more likely to have received a timely Pap test[27,33]; and lesbian women seeking to build a homoparental family are discriminated during perinatal care[41] and receive less guidance and advice[27,33].

The literature also associates invisibility with lesbians' healthcare experiences. This association is based on certain situations: silencing sexuality[23]; the lack of a welcoming and comfortable environment that promotes listening to patients' experiences[34,36] and bonding[39]; assumptions of heterosexuality in the forms of verbal and published health care information and education[31,35]; and the lack of collaborative relationships and relationships of trust[40].

Invisibility – whether consciously or unconsciously intended – can compromise lesbians' healthcare experiences. One of the studies suggests that homosexuality is more visible in the

Chart 1. Articles by year, country, method, and central focus.

Author	Year	Country	Method	Central focus
Kerker et al[17]	2006	US	Comparative study	Sexual behavior and access to health
Araújo et al[18]	2006	Brazil	Case study	Experiences of lesbians with healthcare
Heck et al[19]	2006	US	Comparative study	Health care for lesbians and heterosexual women
Mravcak[20]	2006	US	Document analysis	Access to health among lesbians and bisexual women
Tjepkema[21]	2008	Canada	Comparative study	Healthcare for gays, lesbians, and bisexuals
Barbosa and Facchini[22]	2009	Brazil	Ethnographic study	Healthcare for lesbians
Matebeni et al[23]	2009	Africa	Exploratory study	Experiences of lesbians with HIV/AIDS
Bjorkman and Malterud[24]	2009	Norway	Exploratory study	Sexual orientation and access to health services
Dilley et al[25]	2010	US	Comparative study	Access to health among gays, lesbians, and bisexuals
Fish and Bewleys[26]	2010	UK	Qualitative exploratory descriptive study	Human rights and lesbian and bisexual women's health
Austin and Irwin[27]	2010	US	Comparative study	Healthcare utilization among lesbians and women from the general population
Formby[28]	2011	UK	Qualitative exploratory descriptive study	Lesbian and bisexual women's sexual health
Charlton et al[29]	2011	US	Comparative study	Sexual orientation and reproductive health.
Marques et al[30]	2012	Brazil	Reflexive study	Lesbians and health services
Corbett et al[31]	2013	Canada	Qualitative exploratory descriptive study	Lesbians and fertility services
Carvalho et al[32]	2013	Brazil	Document analysis	Health policies for lesbians
Carvalho et al[33]	2013	Brazil	Qualitative exploratory descriptive study	Lesbian women's experiences in health services
Mosack et al[34]	2013	US	Comparative study	Healthcare for lesbians and heterosexual women
Araújo and Penna[35]	2014	Brazil	Reflexive study	Sexual and gender identity in health services
Brown et al[36]	2014	Argentina	Qualitative exploratory descriptive study	Healthcare experiences of lesbians and health services
Marques et al[37]	2014	Portugal	Exploratory study	Experiences of lesbians with medical consultations.
Poteat et al[38]	2015	Africa	Cross-sectional study	Health service experiences of lesbians, bisexual women, and heterosexuals
Rubin[39]	2015	US	Exploratory study	Health inequalities between gay, lesbian, and bisexual patients
Hirsch et al[40]	2016	Germany	Quantitative exploratory descriptive study	Lesbian women's health and primary care
Videla and Munoz[41]	2016	Chile	Cross-sectional exploratory study	Experiences of lesbians with perinatal care
Daly et al[42]	2016	Africa	Document analysis	Sexual violence, lesbians and bisexuals, and the right to health
Munson and Cook[43]	2016	New Zealand	Descriptive study	Access to health among lesbians and bisexuals
Silberman et al[44]	2016	Argentina	Cross-sectional descriptive study	Difficulties in access to sexual health care among lesbians

it continues

Chart 1. Articles by year, country, method, and central focus.

Author	Year	Country	Method	Central focus
Bränström et al[45]	2016	US	Comparative study	Health inequalities between gays, lesbians, and bisexuals
Vitiritti et al[46]	2016	Brazil	Qualitative exploratory descriptive study	Discourse of health professionals on sexual diversity
Moscheta et al[47]	2016	Brazil	Qualitative exploratory descriptive study	Relationship between health professionals and gays/lesbians/bisexuals
Alpert et al[48]	2017	US	Exploratory study	GLBT and access to health
Müller[49]	2017	Africa	Qualitative exploratory descriptive study	Healthcare for gays, lesbians, bisexuals, and transsexuals
Müller[50]	2017	Africa	Qualitative exploratory descriptive study	GLBT and access to health services
Rufino et al[51]	2018	Brazil	Qualitative exploratory descriptive study	Experiences of lesbians with gynecological care
Rufino et al[52]	2018	Brazil	Cross-sectional study	Sexual practices and healthcare for lesbians

Source: Elaborated by the authors.

private health system, in which people pay for their own care[41].

Two studies report situations that may be perceived as uncomfortable for lesbian women. One showed that lesbians had had past negative experiences with health care[21], while another reported that many informants had felt forced to disclose their sexual orientation when questioned about being sexually active and not using contraception[24].

Interpretive synthesis

In general, the studies highlight the need to recognize the specific demands and health needs of lesbian women so that they are able to access health services and receive quality care. Policy advances that, to a certain extent, guide this recognition can be observed in some countries. In Brazil, for example, a number of documents may be highlighted: National Policy on Comprehensive LGBTT Healthcare[5]; Lesbian Women's Health Dossier[3]; Report of the Workshop on Lesbian Women's and Bisexuals' Healthcare[53]; and the booklets Lesbian and bisexual women: rights, health, and social participation[54] and If you are a lesbian, the health professional needs to know[55].

In contrast, the studies implicitly or explicitly show that the heteronormative *habitus* found in health practice means that lesbian women tend to be treated as heterosexual. This can lead to both the idea of the naturalization of heterosexuality, which views lesbian existence as deviant, and the non-recognition of multi sexual and gender experiences such as those of lesbians.

At the same time, the articles highlight that, besides the physical and psychological violence generated by the prejudice lesbian women face in public and private places, symbolic violence is present in health services, given that they commonly fail to consider the specific demands and needs of this group, contributing to the erasure of lesbian existence.

To change this situation, actions need to extend beyond the field of health and shake up institutions in order to confront the *habitus* that disregards lesbians and other sexual orientations that contest heteronormative hegemony. These actions should give special prominence to social movements, particularly the gay and lesbian movement. According to Bourdieu[11], this movement cannot draw the line at symbolic breaks

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even though they may be effective. He maintains that the gay and lesbian movement "must perform and impose a durable transformation of the internalized categories (schemes of thought) which, through upbringing and education, confer the status of self-evident [...] on the social categories that they produce". However, he warns that achieving recognition of the particularity (moving from invisibility to visibility) can imply its annulment. Hence, as in the case of other movements born out of dominated and stigmatized groups, the gay and lesbian movement lives in a pendular structural contradiction between "invisibilization and exhibition, between the suppression and celebration of difference. As a consequence [...] they adopt one or the other strategy according to the circumstances..."[11].

Final considerations

The literature shows that inequalities in access and barriers to healthcare faced by lesbian women who disclose their sexual orientation are directly related to normative gender presumptions, which in turn influence whether to come out or not to health professionals. Despite advances in policy and care protocols, sexual and gender diversity needs to be widely discussed in social, educational, and health settings to ensure health equity and more comprehensive care.

Public health policy formulation and the creation of protocols and interventions from a heteronormative perspective hampers bonding and care, resulting in fragmented care and thus contributing to exclusion and symbolic violence.

According to Bourdieu's theoretical framework, one way to change this habitus is to intensify the discussion of this theme in spaces of dialogue between the lesbian movement, government, and academia in order to improve policy-making and protocols and promote research on lesbian health. It is also important to incorporate this theme into technical courses, undergraduate degree programs, and residencies and develop specialist training courses to develop the necessary skills to help make patients feel comfortable and welcome and promote a better understanding of the specific demands and health needs of lesbian women.

Health professionals should develop skills and competencies that enable them to understand and value the real needs of this population group and create a welcoming environment that fosters bonding, an open patient-care provider relationship, and inclusive, comprehensive, and humanized care. This requires a break with institutional abuse in healthcare settings marked by stigma, discrimination, and fear, respect for the singularity of the other, and the deconstruction of all forms of violence and discrimination against lesbians.

Collaborations

AN Silva worked on the conception, research, methodology, and final draft. R Gomes, the doctoral student's advisor, participated in all stages of the article.

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