interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

"*Sapatão*" is only for the intimate: link in the care of lesbian and bisexual women

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"Tortillera" es solo para los íntimos: vínculo en el cuidado de mujeres lesbianas y bisexuales (resumen: p. 18)

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Lesbian and bisexual women face difficulties in having their health needs recognized resulting in inequities. The objective of this study was to understand the creation of bonds in the health care for lesbians and bisexuals. A qualitative methodology was adopted, using face-to-face and online semi-structured interviews. The population consisted of 14 women, living in São Paulo (SP), Brazil. For the analysis, carried out through content analysis, the social markers of difference and the interviewees' relationship with social movements were considered. It was evidenced that the articulation of social markers of difference can contribute to the potentiation of exclusion and that participation in social movements projects women more actively in claiming their care. These two components are important intermediaries in bond creation.

Keywords: Homosexuality female. Intersectionality. Social participation. Right to health. Equity in access to health services.

Pereira AG, Nasser MA, Chioro A. "*Sapatão*" is only for the intimate: link in the care of lesbian and bisexual women. Interface (Botucatu). 2022; 26: e220430 https://doi.org/10.1590/interface.220430

Introduction

Cisgender women (when the individual experience of their own gender corresponds to the sex assigned at birth), lesbians and bisexuals, due to still present discrimination and prejudice, face inequities and vulnerabilities that make their health situation quite complex[1]. The entry of their agendas into health policies took place in the face of a long process of struggles and the construction of a political agenda.

The first registered Brazilian lesbian social movement emerged in 1979 as a subgroup of *SOMOS – Grupo de Afirmação Homossexual*, called the Lesbian-Feminist Group (LF), which was initially expressive in São Paulo. In 1980, it definitively withdrew from SOMOS and the name was then changed to *GALF – Grupo de Ação Lésbica Feminista*, which acted significantly towards the lesbian agenda visibility and defense, becoming known nationally[2].

The entry of the movement demands into public policies took place through health, more specifically by means of the policy to combat Aids. Since the mid-1980s, homosexual groups, mostly composed of gay men and financed by state programs, began to coordinate projects to prevent and fight against HIV/Aids, which allowed some of them to organize themselves as non-governmental organizations (NGOs). Gradually, lesbian NGOs began to vocalize their own discourse on this topic, which ended up becoming a strategy for strengthening the right to sexual health[3].

In 2003, the Brazilian Lesbian League (LBL) was created, a network composed of feminist and Marxist lesbians and bisexuals[2]. In relation to health, the LBL and the lesbian and bisexual movement, in general, criticized the perspective on women's health focused on the reproduction control, pointed out the frequent discrimination suffered in gynecological care, and brought as a central demand the recognition of diversity in policy formulation[4].

In 2004, the National Policy for Integral Attention to Women's Health (PNAISM) recognized, based on the organized movements' demands, the need to pay attention to the particularities of different groups of women, such as black, indigenous, and lesbian[5].

The 1st National Conference of Gays, Lesbians, Bisexuals, Transvestites and Transsexuals took place in 2008, when, not without conflicts, the use of the initialism LGBT (which stands for Lesbian, Gay, Bisexual, Transvestite and Transgender) was approved and standardized by the movement and the government, and the order of the terms was justified by the proposal to give visibility to the lesbian segment. The heterogeneity of the movement and the alternation between cooperation and disputes reflected in subsequent discussions regarding the initialism, as well as the coexistence of different denominations[6].

In 2011, the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals and Transgender People was finally enacted and marked the recognition of the effects of discrimination and exclusion on the health-disease process of this population[1].

Despite the achievements expressed in policies and regulatory frameworks, there are still many obstacles in the implementation of these proposals. Scientific production points to the invisibility of homosexuality in women in health practices, and the scarcity of studies itself can be understood as a disqualification of this theme as relevant[7,8].

Carvalho *et al*.[9], based on Deleuze, consider the health nucleus of lesbians as a scheme crossed by lines of force of knowledge-power, from the negotiation between discourses and practices, and suggest that the device of heteronormativity scheme is favored with this invisibility. Thus, the assumption of heterosexuality as a guide for health practices can be seen as the main obstacle to lesbians' and bisexual women's health, as it makes it difficult to dialogue about their sexual practices and, consequently, to identify specific health needs.

It is important to discuss the distinctions that arise when the lesbian and bisexual identities are crossed by other social markers of difference, such as, for example, socioeconomic status. Using a study with gay men as a reference, because there is little research on homosexuality in women, marked differences are described between homosexuals from class A and B and classes C, D and E, with the last ones showing a greater loss of self-esteem related to the prejudice experienced[10]. Ethnicity or race can also play a similar role, as structural racism in Brazil has strong expression in the most varied spheres[11].

The reflection on the specificities of health care for this population refers to the map of health needs proposed by Cecílio[12]. There are four quadrants in this representation: need for good living conditions; consumption of available health technologies to improve and prolong life; bonding with a professional or health team, and autonomy in the ways of living life.

Bonding is highlighted here, since, in general, this need is still little explored in the design of unique therapeutic projects and planning of health actions. According to Cecílio[12], bonding has important implications for health care, as it favors access and the path to equity and integrality. But it is evident that it can also be strongly permeated by discrimination and prejudice and therefore even denied to lesbian and bisexual users.

The object of this article is the bond creation in the health care for lesbians and bisexuals. The assumptions considered for this study were: a) the discrimination and prejudice suffered by lesbians and bisexual women in society are reproduced by services, health teams and professionals, which makes it difficult to create bonds, impacting health care; b) lesbians and bisexual women who participate in social movements have access to more knowledge of their rights, health policies and the functioning of services, which favors their protagonism and facilitates the bond creation in health care, and c) in the face of certain social markers of difference, the lesbian and/or bisexual identity is secondary, since such markers anticipate the situation of exclusion.

The objective of the study was to understand the ways of creating bonds in the health care for lesbians and bisexual women, based on the analysis of social markers of difference and participation in social movements.

Methodology

This qualitative research sought to understand processes, relationships and meanings in view of a complex and contradictory object in permanent transformation[13].

The population was intentionally chosen and invited to participate in the study using the snowball sampling technique, in which each interviewee was asked to indicate other women who belonged to the same target population, until a saturation point was reached[14]. The participants were divided into two groups, one with six participants in social movements, and the other with eight non-participants, totaling 14 women. As inclusion criteria, the following were considered: cisgender women with a lesbian or bisexual orientation, over 18 years of age, and residing in the city of São Paulo. We sought to guarantee diversity within the two groups in relation to social markers of difference.

On this, Zamboni[15] clarifies that:

> Social markers of difference are classification systems that organize experience by identifying certain individuals with certain social categories. [...] Each of these classification categories is associated with a particular social position, has a history and attributes certain characteristics in common to the individuals grouped into it[15]. (p. 14-5)

The author emphasizes that they are always articulated in individual experience, in discourses and in politics, intimately linked to power relations.

In this sense, Saffioti[16] proposes an articulated reflection on gender, race/ethnicity and class categories based on the metaphor of the knot. According to her, we should not seek the primacy of one or another category, isolate them as separate structures, or even consider them a sum, since they have merged historically, in an overlapping that makes the analysis complex.

Motta[17] adds that, in the overlapping of these structures, other forms of differentiation pass as lines between this loose knot, and mentions age, sexuality, religiosity, and nationality, among others.

In dialogue with the Saffioti's knot, the concept of intersectionality, coined by Kimberlé Crenshaw, "[...] aims to give theoretical-methodological instrumentality to the structural inseparability of racism, capitalism and cisheteropatriarchy"[18] (p. 14). She also criticizes hierarchies between axes of oppression, which should be observed through the understanding of which structural conditions cross the bodies, considering the identity contours in each subject or context.

Historically, the majority of people involved in social movements were middle-class white gays, lesbians and bisexuals. This fact brings non-whites a feeling of exclusion and the perception that activism is incapable of considering racism and cultural differences[19]. In recent decades, this criticism has led to the emergence of black lesbian and bisexual movements, but the transformation is procedural. Therefore, when discussing the differences between activists and non-activists, it is important to consider this historicity, even though in this study there was a racial diversity among the women interviewed.

The semi-structured interview was used as the instrument for data collection. It followed a previously defined question script, but maintained some flexibility to modify or formulate new questions in order to obtain the information of interest to the study objective[13]. Face-to-face and online interviews were conducted individually, from January to June 2020, with 1-hour duration on average. The script sought to know aspects of the women's history, such as: experience in relation to sexuality, health history and experience with health and illness, use of services, and relationships with health teams and professionals. In order to preserve the participants' identity, they were identified by names that played a role in defending the lesbian and bisexual women's agendas in Brazil.

The content analysis technique[20], whose primary function is a critical unveiling, was used for the material analysis. The objective was to understand what is behind word meaning and divided into three phases: pre-analysis, material exploration, and result treatment.

Specific thematic fields were identified, which reflected repetitions, similarities, and differences in the participants' statements, systematized in visibility plans. From them and through the dialogue with the literature, we sought to answer or even point out new directions for the research questions.

This article is based on a master's thesis, which received a funding grant from the Coordination for the Improvement of Higher Education Personnel (CAPES). The study was approved by the Universidade Federal de São Paulo's Research Ethics Committee (CEP), under CAAE 17221919.0.0000.5505. All participants signed the Informed Consent Form (ICF).

Results and discussion

Identity and self-recognition

The interviewees' age ranged between 27 and 57 years. Three identify as bisexual, but in the study there were no significant differences in statements between bisexuals and lesbians. Regarding race, half of them identify as non-white, with the greatest participation of brown and black women in this group. Most have completed higher education, which was not necessarily linked to income. The three women with the lowest income – less than one minimum wage – do not participate in social movements. Among the activists, there are members from the LGBT, feminist and black movements. Frame 1 describes the participants.

Frame 1. Characterization of the participants

NAME	SEXUAL ORIENTATION	AGE	PLACE OF BIRTH	RACE / ETHNICITY	EDUCATION	FAMILY INCOME PER CAPITA	USE OF SUS	MILITANCE IN SOCIAL MOVEMENT
Maria Aparecida Kopcak	Bisexual	32	Fortaleza (CE)	White	Post-Graduation 'Lato Sensu	R$ 3.000,00	Only for vaccine	Yes
Marcela Maria	Lesbian	55	São Paulo (SP)	White	Higher education	R$ 4.000,00	Yes	Yes
Luana Barbosa dos Reis	Lesbian	40	São Sebastião (SP)	Amarela	Higher education	R$ 5.000,00	No	No
Elizabeth Calvet	Lesbian	34	Manaus (AM)	Indigenous	Higher education	R$ 3.000,00	Only for vaccine	Yes
Lotta de Macedo Soares	Lesbian	56	São Paulo (SP)	White	Post-Graduation 'Lato Sensu	R$ 2.080,00	Yes	No
Maria de Lourdes Alves	Lesbian	30	São Paulo (SP)	White	Higher education	R$ 5.000,00	Yes	No
Claudete Teixeira Costa	Bisexual	57	São Paulo (SP)	White	Higher education	R$ 3.000,00	No	No
Cassandra Rios	Lesbian	43	São Paulo (SP)	Brown	High school	R$ 3.000,00	Yes + private	No
Vange Leonel	Lesbian	31	Not informed (BA)	Brown	Higher education	R$ 346,66	Yes	No
Josenita Duda Criaco	Lesbian	37	São Paulo (SP)	White	High school	R$ 666,66	Yes	No
Maria Ednalva Bezerra	Lesbian	27	São Paulo (SP)	Brown	Elementary School	R$ 333,33	Yes	No
Márcia Dangremon	Lesbian	51	Natal (RN)	White	Elementary School	R$ 1.200,00	Yes	Yes
Cássia Eller	Bisexual	38	São Paulo (SP)	Brown	Post-Graduation 'Lato Sensu	R$ 3.600,00	Yes	Yes
Marielle Franco	Lesbian	48	São Paulo (SP)	Black	Post-Graduation 'Lato Sensu	R$ 3.135,00	Yes	Yes

When telling about themselves, each of the women brought a little of their identity construction, showing different ways of recognizing themselves as social subjects, including the perception of their sexuality.

Among women who do participate in social movements, especially those of lower social class, the stories were perceived and narrated as not very interesting or relevant to the study. Regarding sexuality, they presented different ways of understanding and expressing it, adopting both discretion and confrontation, particularly in relation to the family.

> I've never had problems with my sexuality, including my homosexuality, but I've never put it in the open for work reasons, right? As I work with children and teenagers, I pretend to be an asexual person. (Cassandra Rios)

> [...] since I came out, the first thing I did was tell it to my family, I'm kind of crazy, you know, I'm kind of *"atura ou surta,"* I am this way and that's it. You are the ones who have to struggle to accept this my new phase. (Maria Ednalva Bezerra)

In relation to women who participate in social movements, a common aspect was the construction of analytical narratives, with an emphasis on contributions to the lesbians' and bisexuals' demands. Some similarities were also highlighted in the interpretation on sexuality, which is brought up as a political issue, an experience related to a way of being in the world and that can have different social impacts.

> I used to see my sexuality in another way. All these political, institutional, network, and also practical experiences, right? I started seeing my sexuality differently. Today I see that it has an expression in the world, which is very decisive in some cases. (Maria Aparecida Kopcak)

Differences were identified between these two groups and, without the intention of homogenizing or reducing them within such systematization, the objective was to understand the subjectivities that emerged from the narratives.

Participation in social movements seems to play an important role in the development of a certain way of living the identity. This action brings knowledge, signifiers and meanings, awareness of issues that are sometimes veiled and usually drives transformation in the scope of personal relationships and processes of rejection experienced. A way of re-signifying the pain that marked their stories would be through stressing pride, related to an ideology of visibility presented by most of the lesbian movement[19]. Thus, we understand that a lesbian or bisexual activist brings conceptions about her sexuality and right to health that project her in a potentially more active manner in the relationship with health professionals when compared to a non-activist.

Prejudice and discrimination

Identity is also crossed by social markers of difference, which relate to different experiences of prejudice.

In the statements, it was identified that the social interpretation of women's bodies, based on a sexist pattern, impacts those who adopt masculinized appearance in greater degrees of prejudice. Deleuze and Parnet [21] point to the existence of a binary machine that dictates the distribution of roles, making all the possibilities of subjectivities necessarily fit into them, making what does not fit unintelligible. Thus, by rejecting traditional female roles, some lesbians position themselves outside the dominant gender paradigm, generating social malaise.

From another aspect of physical appearance and based on experiences, the highlight is stories were racism, fatphobia and prejudice in the face of a congenital malformation are evidenced first or bring greater suffering than homophobia. At other times, such identities are seen as cumulative, in the sense of increasing exclusion.

> I'm going to start from that speech, right? "The first impression is the one that stays," so my first impression as a person is to be this black woman. In a second moment, sexuality may appear, right? By the stereotype, the way of wearing clothes or wearing something like that, it's a little out of that feminine standard, right? So it may have an impact at a second moment, but color, race and gender, they always come first. (Marielle Franco)

> [...] I keep imagining: she's a woman, it's already difficult... she's a woman and black, it's already difficult... she's a woman, black, and a lesbian... and she's a woman, black, a lesbian, and fat, then you say "fuck." [...] There are restrictions by society, then there's prejudice, and more restrictions appear. (Claudete Teixeira Costa)

The concepts of social markers of difference, intersectionality and Saffioti's knot metaphor, discussed earlier, dialogue with the different ways of managing gender, race/ethnicity, sexuality, body image, and disability – among others – of each of the interviewees regarding how they build and experience their identities, impacting the uniqueness of discrimination processes.

With the authors[15-18], it is possible to understand that the idea of lesbian/bisexual identity being subsumed or secondary to certain social markers of difference that would anticipate exclusion, raised in the assumptions, would be a simplistic analysis that isolates the categories and reproduces the generalized hierarchy between axes of oppression. Each woman ends up making this hierarchy or considering the sum of these markers from the unique conditions that cross her identity, history, experiences, and context.

Consequently, such contours also impact their health care processes.

Approaches and strategies to use health services

It was found that little is said about homosexuality in women in health services and that when they reveals being lesbian or bisexual even in the face of the initial obstacle, those women are subject to explicitly homophobic approaches, which even propose heterosexuality as a solution for their health issues.

> [...] there were cases of doctors saying that I needed to have a relationship with a man to know if I could solve my problem, right? So... that's it, this kind of thing that we end up listening in public health, unfortunately. (Cassandra Rios)

Even when there is no such violence, sexuality is rarely considered in the definition of health needs. Non-activists see this approach in a natural and positive manner.

> [...] depending on whom you have an appointment with, this professional makes you so comfortable that it ends up not being relevant at the moment. Thank God I always met good professionals, so this is irrelevant. (Maria Ednalva Bezerra)

In turn, activists criticize and think it interferes in health care. They show discomfort in the face of questions in appointments related to sexual and reproductive health that presupposes heterosexuality and, when they answer that they have sex with women, the women realize that the professionals change their behavior.

> [...] then I said: "I have sex with women," and he: "Oh no, so it's ok, It's ok, ok", right? Then I asked if he wasn't going to ask any tests and he said that it wasn't necessary. Just because we're lesbians, huh?
> We can also have any type of disease. [...] They think that because there's no penis penetration, we are not at risk of contracting a disease. (Elizabeth Calvet)

A study carried out by Barbosa and Facchini[22] indicates the disappointment of lesbians with the professionals' lack of preparation to assist them with the same readiness that they do regarding heterosexuals, which ends up putting them in illegitimacy because their sexual health demands are not met or due to lack of essential information that they should be provided with.

As already pointed out, the construction of identity within activism facilitates access to knowledge of sexuality, one's own body, needs, health rights and, therefore, provides a critical look at the situations experienced.

From the narratives, it became evident that, based on their life stories and accumulated (lack of) care, strategies to use health services are developed in order to avoid or manage prejudice situations. One of them is not attending health services, failing to perform, for example, screening tests at the recommended frequency. Although worrying, such a strategy is a refusal to accept biased or even disrespectful care, and it cannot be used to blame the user for an alleged non-adherence to treatment. For Merhy[23], resistance is a place of power, as it is a way of denying acts that exclude individuals as desiring and singular subjects.

Some women reported that, faced with negative experiences or the fear that they would occur, they seek services or health professionals who clearly do not have discriminatory approaches. It is necessary to consider that this strategy would collide with the way the Brazilian National Health System (SUS) is organized and operate, in which choosing the professional is rarely possible[3]. Thus, it ends up being more adopted by middle-class women, who are able to afford the costs of a private health plan.

(In)visibility of sexuality in the search for care

Connected to the ways of dealing with some situations already mentioned, the attempt to make sexuality invisible, as a way of minimizing discrimination, is particularly important, as it is full of meanings and significations. In addition to considering that talking about sexuality is not necessary, there are some interviewees who believe that it should be put on hold during care.

> When I go to the doctor for an appointment, I'm not thinking I'm a lesbian, I'm thinking I'm a woman and I need someone to see me, right? (Lotta de Macedo Soares)

> [...] I go to the health center and take the tests like any other woman. (Josenita Duda Criaco)

However, a contrary gesture was evident among some activists: to make their sexuality clear and speak spontaneously about it. Among these, the adoption of pride or combative postures was also highlighted, in contrast to the others' appeasement attitudes.

> [...] she (an activist friend) went to the doctor ready to fight, you know? Something like: "if anyone says anything, I'm not letting it lie." [...] and then she says, "I get there this way, because if they attack me, I'm ready to react." (Marcela Maria)

Rich[24] popularized the term "compulsory heterosexuality" based on the understanding of heterosexuality as a political institution that works in favor of maintaining male domination. Its inevitable consequence would be the invisibility of lesbian existence in the various spheres of society, since it is seen as a rejection of domination and this compulsory way of life.

Medeiros[25] understands that being linked or not to the lesbian movement produces different lesbian policies: non-activists tend to protect themselves and claim for themselves a status of normality, trying to adapt to the homophobic social environment, while the activists adopt the policy of assuming themselves politically and understanding sexuality as a way of life, facing lesbophobic reactions whenever necessary.

In this sense, one of the interviewees, participant in social movements, brought a symbolic statement:

> We say *sapatão* for the sake of intimacy, right? I also use the word lesbian a lot, but it's also a political question, unlike when I'm walking down the street and someone calls me *sapatão*, right? (Elizabeth Calvet)

She refers to using the term "sapatão" [dyke] as a political issue, that is, as a form of self-affirmation and visibility through the re-signification of a historically pejorative term, but also because of intimacy, within the scope of trusting relationships. Thus, it can be thought that intimacy favors visibility and freedom, and can permeate the ways in which women circulate and interact with professionals. When talking about trusting and intimate relationships, we are talking about bonding.

Bonding and acceptance

The path taken so far indicated the various aspects that impact the process of creating bonds in the health care for these women. In an expanded perception, and thinking about the bond between anyone and a health professional, this was pointed out as a great challenge, considering the structure and functioning of the services. However, these are aggravating factors for lesbians and bisexual women, since there is difficulty in access due to fear of judgment.

> In general, this difficulty in having a bond is because there's a turnover of professionals. [...] but in the case of lesbians it is an aggravating factor, she doesn't come back. [...] She has difficulty getting there, if she doesn't feel confident about the service, about how this service will receive her, why is she going there? (Marcela Maria)

For them, it became evident that creating a bond, in addition to the aforementioned aspects, also involves the acceptance of their identity and sexuality.

> And at no time he made any kind of... he didn't use any jokes to talk about my relationship with my partner, none of that, she [partner] went with me to the office, [the doctor] talked about his wife, as if my relationship was a normal relationship, right? (Cassandra Rios)

It is important at this point to focus on the meaning of the word "bonding." Pichon-rivière[26], anchored in psychoanalysis, argues that the concept of bonding belongs to the psychosocial field of interpersonal relationships, which are governed by a permanent game of assumed and assigned roles, which fulfill a certain function, giving them coherence. In this way, it is in continuous movement and is triggered by psychological motivations, outlining the particular way in which each individual relates to others.

This conception instigates the reflection that lesbian and bisexual users, from their psychological motivations and based on their life history, discrimination and health care experiences, assume and attribute certain roles in the relationship with the professional. The same can be thought about the health professional, who also brings psychological motivations to that encounter, which can be based on their life history, relationship with the chosen profession, understanding and valuation of homosexuality. The meeting of these motivations and roles seems to determine how each one will place themselves in this particular relationship and how it will then be structured.

Cecílio[12], an author working in the field of Public Health, characterizes as a bonding constitutive element an intersubjective meeting that has strong components of spontaneity, empathy, and exchange. According to him, bonding has a therapeutic nature, especially when it favors a more autonomous user posture. From the perspective of producing user-professional relationships, the ability to create a bond is identified as one of the elements that make up the professional dimension of health care management.

Bonding is a central element for the person to feel cared for, and it is considered a health need[12]. Nevertheless, the acceptance of lesbian and bisexual women's sexuality for the establishment of this relationship is resumed. Because it is a topic still seen as taboo by society, a bond is created only with the acceptance of the other, that is, it is only with the professional's endorsement that the possibility of dialogue and bond creation exists.

In this sense, the establishment of a bond with certain professionals working in the field of mental health, specialized in sexually transmitted infections (STIs), who are part of the LGBT population or linked to institutions that have the trust of women – such as university services and services linked to social movements –, stood out in the interviews. Whether due to more progressive individual and collective values, or because they usually deal with already stigmatized diseases in their practice, or because they also experience discriminatory processes, these professionals and services seem to have greater openness, empathy and care regarding the issue of sexuality, which articulates with the psychological motivations pointed out by Pichon-rivière[26].

Among the activists, creating a bond with health professionals who also participate in social movements was relevant.

> I have an ace up my sleeve. It is called [doctor's name]. [...] We met in the LGBT movement, in the movement in defense of women. [...] and then I call her, "for God's sake, what's going on? What should I do?" then she oriented me, you know? She guided me. [...] and I didn't need to go there, to expose myself in a health center, that's it. I prefer accessing this parallel network, you know? Which is of the movement, you can talk calmly, the person knows that you were married to a woman, in short, they know that these are things that can happen. At the health center I didn't have that same close relationship, that's it. [...] It is different with the gynecologist who is in the health center. Ah, she is the gal who raises the flag with us. (Cássia Eller)

In this "parallel network" described by the interviewee, there is no need to worry about acceptance, since it is already obvious, and the fact that they share ideals and a space for struggle favors relationships of empathy and care. However, she mentioned this alternative as "an ace up her sleeve," that is, a strategy, which requires initiative and contacts.

Almeida[3] points out that when the LGBT movement was mobilized to face the HIV/Aids epidemic, it had the collaboration of some health professionals in the preparation of materials with scientifically legitimized information. Some of these professionals have since become references for lesbian NGOs and started receiving their members in their offices.

In addition to the importance of creating a bond in health care, as discussed so far, the women explained its relevance and the desire to create it with health professionals, through the statements and also the strategies adopted for using the services, seeking safety and fulfillment of their needs.

Bonding is from the relational field and includes subjective components. It is delicate and complex to try to make recommendations to make it effective. As a health need and a way to meet other needs, it demands a careful look from health services and professionals.

Thinking about the bond creation process, Moscheta[27] advocates responsiveness as a relational resource for the qualification of health care for the LGBT population. According to him, responsiveness is an attitude, "[...] a disposition to human relationships that is based on ethical choices and that aims to create a context that favors the emergence of interaction that articulates differences creatively"[27] (p. 155). Throughout the discussion, elements that make it difficult to create a bond with lesbian and bisexual women were pointed out – presumption of the user's heterosexuality, discriminatory practices, non-recognition and/or delegitimization of sexuality – and attitudes that make it easier – free-judgment listening, recognition of identity /sexual practices, investigation of needs and involvement in meeting them. Such information can indicate ways to both confront discourses that lead to detachment and develop discourses and practices that bring people closer, placing emphasis on the joint creation of possibilities in health care.

Conclusion

Activist women, in their way of placing themselves in the world and in their relationship with others, express pride and an ideology of visibility, projecting themselves in a more active manner when claiming for their health care.

Social markers of difference such as race, class, territory, in addition to physical appearance, were presented as important intermediaries in the prejudice and discrimination experiences, often increasing them. In contrast to the primacy of one or another category, the articulated understanding of the categories is presented as a more productive path, based on the analysis of how the structural conditions impact each subject uniquely.

These two components interpenetrate their maps of care, based on different ways of perceiving (lack of) care and the adoption of different strategies to meet professionals and use health services.

In view of all these aspects, creation of a bond between lesbian and bisexual women and health professionals is a challenge and involves the logic of their identities and sexualities being accepted. Considering this, powerful relationships were identified between some specific profiles of professionals who agree with non-oppressive moral values and diversity valuation. Among the activists, the establishment of bonds with health professionals who are fellow activists stood out.

It is understood that bonding presents itself as a possibility to face situations of vulnerability. Therefore, knowing the challenges, strategies and paths taken by these women is relevant so that there is investment in services and organization of processes that favor this care.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

This article is based on a master's thesis, which received a funding grant from the Coordination for the Improvement of Higher Education Personnel (Capes).

Acknowledgements

We thank each of the women interviewed, who generously shared their life story with all pain and love, making this research possible.

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Ana Flávia Pires Lucas d'Oliveira
Associated editor
Elaine Reis Brandão

Translator
Carlos Eduardo Chiba

Submitted on
04/13/22
Approved on
08/10/22

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Mulheres lésbicas e bissexuais enfrentam dificuldades para o reconhecimento de suas necessidades de saúde, resultando em iniquidades. O objetivo deste estudo foi compreender a construção de vínculo no cuidado à saúde de lésbicas e bissexuais. Adotou-se metodologia qualitativa, utilizando-se entrevistas semiestruturadas presenciais e on-line. A população foi composta por 14 mulheres, residentes em São Paulo, SP, Brasil. Para a análise de conteúdo, foram considerados os marcadores sociais da diferença e a relação das entrevistadas com movimentos sociais. Evidenciou-se que a articulação de marcadores sociais da diferença pode contribuir com a potencialização da exclusão e que a participação em movimentos sociais projeta as mulheres mais ativamente na reivindicação de seu cuidado. Esses dois componentes são atravessadores importantes na construção de vínculo.

Palavras-chave: Homossexualidade feminina. Interseccionalidade. Participação social. Direito à saúde. Equidade no acesso aos serviços de saúde.

Las mujeres lesbianas y bisexuales enfrentan dificultades para el reconocimiento de sus necesidades de salud, resultando en iniquidades. El objetivo de este estudio fue comprender la construcción de un vínculo en el cuidado de la salud de lesbianas y bisexuales. Se adoptó la metodología cualitativa, utilizándose entrevistas semiestructuradas presenciales y online. La población fue formada por 14 mujeres, residentes en São Paulo (SP) Brasil. Para el análisis, realizado por medio del análisis de contenido, se consideraron los marcadores sociales de la diferencia y la relación de las entrevistadas con movimientos sociales. Se puso en evidencia que la articulación de marcadores sociales de la diferencia puede contribuir para potencializar la exclusión y que la participación en movimientos sociales proyecta a las mujeres más activamente en la reivindicación de su cuidado. Esos dos componentes son factores atravesadores importantes en la construcción de vínculo.

Palabras clave: Homosexualidad femenina. Interseccionalidad. Participación social. Derecho a la salud. Equidad en el acceso a los servicios de salud.