

Sexual education in health: ways to empower women who have sex with women

Educação sexual em saúde: caminhos para o empoderamento de mulheres que fazem sexo com mulheres

Educación sexual en salud: caminos para empoderar mujeres que tienen relaciones sexuales con mujeres

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Abstract

Objective: To understand how health education on sexual health can contribute to the empowerment of women who have sex with women.

Methods: This is a descriptive study with a qualitative approach, mediated by action research. It corresponds to the intervention stage, which was based on the situational diagnosis, the focus of another article. **Results:** Three educational actions were carried out with the study participants, with the aim of transforming the reality experienced by these women in terms of the obstacles encountered in promoting sexual health. Each intervention focused on problems found in the situational diagnosis, based on semi-structured interviews with seven university students. **Conclusion:** The promotion of sexual health education expands the role of women who have sex with women through the construction of knowledge, enabling them to be less susceptible to Sexually Transmitted Infections (STIs).

Descriptors: Sexual and Gender Minorities; Sexual Health; Health Education; Nursing.

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Whats is already known on this?

Knowledge about the sexual health of women who have sex with women has gaps that leave them susceptible to sexually transmitted infections.

What this study adds?

Promoting health education provides the opportunity to build knowledge about sexual health and, consequently, generates the empowerment of the women who make up this social segment.



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Resumo

Objetivo: Compreender como a educação em saúde, acerca da saúde sexual, pode contribuir para o empoderamento de mulheres que fazem sexo com mulheres. **Métodos:** Trata-se de pesquisa descritiva com abordagem qualitativa, mediada pela pesquisa-ação. Corresponde a abordagem da etapa das intervenções, que foi feita a partir da realização de diagnóstico situacional, foco de outro artigo. **Resultados:** Foram realizadas três ações educativas com as participantes do estudo, objetivando transformar a realidade vivida por essas mulheres quanto aos entraves encontrados na promoção de saúde sexual. Cada intervenção foi responsável por focalizar em problemáticas encontradas no diagnóstico situacional, a partir de entrevista semiestruturada com sete universitárias. **Conclusão:** A promoção de educação sexual em saúde amplia o protagonismo de Mulheres que Fazem Sexo com Mulheres por meio da construção de conhecimentos, possibilitando que haja menos suscetibilidade quanto ao acometimento de Infecções Sexualmente Transmissíveis (IST).

Descritores: Minorias sexuais e de gênero; Saúde sexual; Educação em saúde; Enfermagem.

Resumen

Objetivo: Comprender cómo la educación en salud, sobre la salud sexual, puede contribuir al empoderamiento de las mujeres que tienen relaciones sexuales con mujeres. **Método:** Se trata de un estudio descriptivo con enfoque cualitativo, mediado por la investigación-acción. Corresponde al enfoque adoptado en la fase de intervención, que se basó en un diagnóstico situacional, tema central de otro artículo. **Resultados:** Se realizaron tres acciones educativas con las participantes del estudio, con el objetivo de transformar la realidad vivida por estas mujeres en cuanto a los obstáculos encontrados en la promoción de la salud sexual. Cada intervención se centró en problemas encontrados en el diagnóstico situacional, a partir de entrevistas semiestructuradas con siete universitarias. **Conclusión:** La promoción de la educación para la salud sexual amplía el papel de las mujeres que tienen relaciones sexuales con mujeres mediante la construcción de conocimientos, lo que les permite ser menos susceptibles a las Infecciones de Transmisión Sexual (ITS).

Descritores: Minorías Sexuales y de Género; Salud Sexual; Educación en Salud; Enfermería.

INTRODUCTION

The National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals and Transgenders, launched in 2011 through decree no. 2,836, aims to promote the comprehensive health of these minorities, seeking to eliminate the prejudice and discrimination that permeate them and thus achieve the objective in accordance with the principles of the Unified Health System (UHS), which guarantees universal, comprehensive and equitable access for all.⁽¹⁾

However, despite some progress in terms of the achievements of this population, there are still impasses that are directly linked to health services as a result of constant government cuts.⁽²⁾ Cuts that have a negative impact on the LGBTQIA+ population, since there is a lack of investment to meet the specific demands presented by this population segment.

In addition, access is further hampered by subjective social attitudes associated with prejudice and embarrassment, even with policies aimed at resolving this situation.⁽³⁾ There is also a lack of knowledge on the part of health professionals about the particularities of these minorities, reflecting in inefficient reception in health services.⁽⁴⁾

Women Who Have Sex with Women (WSW), lesbians and bisexuals with an active sex life, a segment of the LGBTQIA+ population, are subject to these difficulties because their needs and specificities are not well recognized in care settings, especially with regard to sexual health. A study carried out in the United States with 5,141 women, including lesbian, bisexual and heterosexual participants, points out that WSW have less contact with sexual health guidelines than heterosexual women, which ends up distancing them from correct information about these practices⁽⁵⁾, making them more vulnerable and predisposed to diseases and illnesses.

In a study carried out in Brazil with 15 professionals working in Primary Health Care (PHC), there was a certain lack of knowledge about the sexual practices of WSW and, consequently, these professionals did not provide guidance that could prevent sexually transmitted infections (STIs). This gap makes this group even more invisible, given that the vast majority of information is directed towards prevention for heterosexuals⁽⁶⁾, which can lead to a false sense of protection from STIs and a distancing from essential knowledge about sexual health that results in empowerment for this social segment.

Despite the fact that many health risk practices are identified in this population, gaps in the development of specific public health care plans increase the problems experienced by these women.⁽⁷⁾ The possibility of reversing this situation is the promotion of health education actions which, in addition to providing knowledge about health-related aspects, are capable of generating individual autonomy through educational and motivational processes.⁽⁸⁾

As a result, by promoting health education practices, nursing can enhance the potential of care when they are effective and manage to generate transformations. In this sense, by getting to know the

weaknesses presented by this social segment, the WSW, it becomes possible for this nursing practice to contribute to changing the scenario of weaknesses presented in terms of sexual health.

Although there is an implicit and explicit understanding of certain demands presented by all the groups that make up the LGBTQIA+ population, this study focuses on the needs and specificities of WSW, since they are also significant targets of prejudice and stigmatization that generate invisibility as a result of the heteronormative standard.

From this perspective, as we see gaps that are deep-rooted and make it difficult to achieve effective knowledge about the sexual health of WSW, the following question emerges: Is sexual health education a path to empowerment for women who have sex with women?

Therefore, this study aimed to understand how health education can contribute to the sexual health empowerment of women who have sex with women.

METHODS

This is a descriptive study with a qualitative approach, mediated by action research. The study is part of the conclusion of an undergraduate nursing course at the *Universidade Federal de Campina Grande* (UFCCG), campus Cajazeiras, Paraíba, Brazil. This study will focus on the interventions stage, which originated from the situational diagnosis, the focus of the other article. The methodology applied is aimed at identifying and resolving collective problems through cooperation between the researcher and the participants in the study.⁽⁹⁾

The research followed four phases: situational diagnosis; action planning; implementation of the planned actions; and evaluation of the actions developed by the research participants. The process of constructing the phases took place between March and April 2022.

The inclusion criteria adopted in this study were: women regularly enrolled in a Public Higher Education Institution (HEI) in the *Alto Sertão Paraibano* region who had already engaged in sexual practices with other women. In addition, the exclusion criteria corresponded to female students living in rural areas who did not have constant access to the internet during the research, as the study was developed during the COVID-19 pandemic period, and data collection was carried out exclusively through virtual platforms.

The first stage – situational diagnosis – was carried out through semi-structured interviews with seven students. The reason for choosing the location of the research was convenience, as the researchers belong to this institution. The interview was based on questions about the experiences of WSW, and took place individually with each participant for approximately thirty minutes, using the Google Meet and Google Forms virtual platforms.

After identifying in the data analysis of the situational diagnosis factors that contribute to the obstacles in promoting the health of WSW, interventions were designed and developed with the aim of giving new meaning to the negative aspects presented by the participants, with their subsequent participation in the evaluation of the interventions carried out.

In order to evaluate the educational actions, we opted for the Collective Subject Discourse (CSD), which consists of the Social Representation (SR) methodology that aims to build representations, keeping the individual dimension together with the collective one. In this way, opinions and expressions in the collected speeches that show similarities are brought together in categories responsible for building the SR.⁽¹⁰⁾

To form the CSD, segments of speech from each participant are used. Called Key Expressions (KE), they are gathered according to the semantic similarity of the discourse presented, from which the central ideas (CI) are assembled. The CI are made up of categories that provide a succinct approach to each CSD.⁽¹¹⁾

The research began after it had been approved by the Research Ethics Committee of the UFCCG Teacher Training Center, under Report No. 5.141. 194, and developed in accordance with Resolutions 510/2016 and 466/2012, both of the National Health Council, respecting and taking into account all the cultural, moral, religious and ethical values of the participants interviewed in the study, ensuring the confidentiality of information and the protection of identity.⁽¹²⁻¹³⁾ The students' participation began only after reading, understanding and signing the Informed Consent Form (ICF).

In order to guarantee the anonymity of the participants, the codes UNIV were determined, followed by the numbering corresponding to the order in which the seven university students were interviewed, and they were then identified as UNIV 01, UNIV 02, UNIV 03, UNIV 04, UNIV 05, UNIV 06 and UNIV 07.

RESULTS

Three educational actions were carried out with the study participants, with the aim of transforming the reality experienced by these women in terms of the obstacles encountered in promoting sexual health. All the interventions took place remotely, via the Google Meet platform, due to the COVID-19 pandemic. The first intervention focused on discussing STIs, which can affect the WSW group. The second intervention dealt with the experiences of WSW in health services. Finally, the third intervention addressed aspects of the National Policy for the Integral Health of LGBT people.

The first meeting took place on February 9, 2022, lasting an hour and a half, and was attended by six women from the aforementioned HEI. The identification of weaknesses in the knowledge of STIs to which WSW are susceptible was the basis for the construction of health education. Initially, the participants were welcomed and at the start of the intervention they were asked to address, in a single sentence, the thought that emerged when they heard the word STIs.

This was followed by a presentation on the most common STIs, using interactive slides. The following topics were divided into the organizational structure of the presentation: signs and symptoms; form of transmission; treatment and other topics related to the subject. For each of the STIs presented, there was room for discussion.

To improve interaction with the interviewees, Kahoot was used, a platform that allows the creation of quizzes that are applied in game models. It was produced by the mediator and used by the participants to work on the theme of health education in order to assess, in a ludic and dynamic way, the knowledge built up during the presentation on STIs.

The second intervention, held on February 10, 2022, lasted one hour and forty minutes and involved five university students. The focus was on addressing the experiences of WSW in health services. A welcome was given along with a brief presentation of the topic. This was followed by the presentation of a video report showing the scenario of health care provided by gynecology professionals in this social segment.

From there, a discussion was opened up between the mediator and the participants, since it was possible to present experiences from two perspectives in health services: the professional and the user. During the educational activity, the mediator encouraged the creation of mind maps that could translate, in an interactive and summarized way, the subject that had been discussed collectively at the time. At the end of the health education, the WSW were instructed to get tested for certain STIs, such as syphilis, HIV and hepatitis B and C. The aim of this was health promotion by the WSW, as well as the early identification of STIs to which the participants might be susceptible.

The third moment, corresponding to the last intervention, took place on February 11, 2022, and lasted approximately one and a half hours, with the participation of five university students. Following the pattern of the previous interventions, there was a welcoming and a brief presentation of the topic. This was based on the difficulties experienced by WSW in relation to STIs, and the National Policy for Comprehensive LGBT Health was then addressed.

Initially, the mediator asked the participants if they had had any contact with this policy, and then went on to provide information about its history, achievements and the importance it has for the LGBT population segment. The entire educational process took place horizontally, based on the participants' previous knowledge and making them protagonists in the process of building knowledge. During the approach, the positive impacts of building knowledge about the policy were emphasized, given that it is capable of promoting empathy in the care provided by professionals in health services, as well as demonstrating the recognition that exists about the needs and specificities presented by WSW.

The intervention ended with thanks from the mediator, who emphasized the importance of the participation of these women throughout the stages of building the study, which can sponsor change in the existing pattern on the subject, in the future, helping to combat the stigma present in health services and, with this, promoting effectiveness and equitable care plans for the reception of WSW.

The participants' behavior throughout the three interventions was analyzed as positive, as there was intense interaction during the discussions. They also verbalized, at certain moments during the health education, their gratitude for the learning space that was being created. They also showed comfort in being listened to about their feelings and/or complaints about the gaps in care, and in having their doubts answered.

Thus, after all the health education actions had been implemented, the WSW were able to evaluate the moments offered through individual meetings. The CSD was created based on the findings of the

participants' speeches, assessing the effect of the interventions promoted based on the gaps found in the situational diagnosis. Five university students took part.

CI01 - Perception of WSW on health education actions:

CSD01: The actions proved to be a place for listening, as it was something new in terms of this topic. So, I loved that it was so open and that I was able to hear stories from people who had experiences like mine. And it's something very interesting, because there was also a questionnaire at the end of the action, and I found it super didactic and explanatory, I found it very interesting. My mind became much more open, right? Especially because I didn't know all the infections that could cause it, I only knew a few. So, I was able to learn a lot more about the subject. It was also necessary, in terms of the lack of information, which I didn't have access to, and it was all in a very dynamic way, with images, definitions, everything in a very explanatory way, which made it much easier for me to understand what various infections are. Because, before the actions, I thought that syphilis was an STI that had no cure, it just stayed there and then it came back, and there was no cure. And knowing that it has a cure, knowing that, reassured me, not because I have it, but I can reassure other people who don't have this knowledge either. (UNIV 01, UNIV 02, UNIV 03, UNIV 04 and UNIV 05).

DISCUSSION

The implementation of the health education actions was built and directed on the basis of the obstacles identified in the analysis of the data from the situational diagnosis. Interactive and dynamic tools were used to involve the WSW, such as the use of a digital games platform, ludic slides and the opening up of dialog spaces for the participants to exchange experiences with the mediator. This process aimed to transform the multidimensionality of WSW in terms of recognizing their own needs and specificities in the field of sexual health, reframing their outlook by promoting a sense of appreciation that is usually invisible.

Once the educational activities were over, it was possible to collect the participants' words through the evaluation carried out, and the CSD01 showed the positive aspects that the interventions were able to generate, demonstrating gratitude and comfort to the researchers for providing these moments. They also appeared more confident about the problems encountered in the first stage of the study, in the semi-structured interview.

With this experience, bridges are created that comprise the intentionality of health education practices, whose purpose is aimed at transforming the subject into the protagonist of their own process, since this type of intervention is an instrument that generates dialogic knowledge.⁽¹⁴⁾ In addition, the use of active methodology during health education proposals aims to increase the subject's autonomy⁽¹⁵⁾, as this type of methodology consists of building knowledge from the sharing of experiences between the individuals participating in this process, breaking the pattern of unilateral transmission of information from the teacher to the student.⁽¹⁶⁾

In CSD01, the participants' comfort after the intervention was noticeable, because as well as having contact with the experiences of other WSW, they were able to enrich the moment with their own experiences. This can be explained by the fact that they often feel invisible and alone when it comes to sexual health. Corroborating this discussion, a study carried out in Colombia with six health professionals revealed that the participants had no knowledge of the sexual practices of WSW, and were only aware of the transmission of STIs in general, without delving into the needs and specificities of this group.⁽¹⁷⁾

Also in the survey, the participants had no knowledge of public programs or policies aimed at the LGBTQIA+ population, according to the situational diagnosis, and one of the justifications was linked to the fact that the dimension of the heterosexual public is still hegemonic, which highlights the issues that manage to serve them.⁽¹⁷⁾ This differentiation contributes to the silence that permeates this population segment, without a change in perspective, and can serve as a potentiating factor for the invisibility felt by WSW.

In this way, the implementation of health education actions manages to give voice and empower the WSW from the knowledge that is added and shared during the interventions, since the lack of knowledge about STIs is reflected in the lack of guidance and knowledge on the part of the WSW themselves, as shown in the evaluation of the participants in CSD01. In a national study with 260 WSW and women who have sex with men (WSM), a questionnaire showed that knowledge of STIs was more

prevalent in the latter group. It was also possible to identify that WSW have less guidance on STIs in health services.⁽¹⁸⁾

In a study carried out in Puerto Rico with 560 participants, including WSW and WSM, data collection showed that, in addition to WSW having more sexual health risk practices throughout their lives compared to WSM, they also had a higher rate of anal infection with the HPV virus.⁽¹⁹⁾ These practices may be linked to the lower number of guidelines given to WSW, influencing this constant lack of protection during sexual acts.

Although some of the participants in this study had some knowledge of STIs, during the health education activities it was noticed that a lot of the information was wrong. The interventions were then used to develop learning and to elucidate any existing doubts.

The existence of gaps in knowledge about the importance of promoting prevention, as well as making them more susceptible to infection, can lead to less interest in sexual health issues. Thus, in a study in France with 2023 participants, it was revealed that WSW, especially lesbians, consider gynecological care to be less important than other general health care.⁽²⁰⁾ This situation can lead to an increase in the transmission of STIs among WSW, as well as neglect of other health care that is essential for the promotion and prevention of women's health.

The use of ludic tools was the strategy used as a way of engaging the participants and facilitating the assimilation of knowledge, given that these active dynamics can enhance learning.⁽¹⁶⁾ The CSD01 thus shows that, in the participants' assessment, the use of these instruments had a positive impact.

The effectiveness of the actions makes even more sense when it is shown, at the end of the CSD, that there is a certain interest on the part of the participants in being multipliers of the information they were exposed to during the creation of the three moments. This gives WSW a place in the spotlight, which is usually hindered by the intense heteronormativity that permeates society and causes this group to be invisible, especially in health services.

In addition, giving this group a voice in matters that should be of extreme interest to WSW, can reflect the demand for qualified care and equitable health plans for this social segment, symbolizing, even if in slow steps, the claiming of rights that have been achieved since the creation of public policies aimed at the LGBTQIA+ population. Thus reducing the obstacles created in relation to the sexual health of WSW.

There were limitations to the research, related to the number of participants as a result of low adherence during the period of isolation from the COVID-19 pandemic, since there were students from rural areas with limited access to the internet, which made it difficult to meet with WSW. There was also the decision by some women not to participate because they were afraid of exposure related to their sexual orientation, even though it was exclusively for research purposes and their identities were guaranteed protection.

It should be noted that this study contributes to the importance of promoting health education for the public that includes lesbian and bisexual women as a way of adhering to safe sex practices and, consequently, less susceptibility to STIs. It also brings visibility to this issue, which has not yet been widely discussed, thus helping to encourage nursing to develop effective health education actions on the subject.

CONCLUSION

The implementation of health education for WSW is seen as a tool with a positive impact on providing knowledge about the gaps that still exist to the detriment of heteronormative behavioral patterns that permeate society. With this, it is responsible for bringing protagonism to this population segment, while the interventions allow spaces to be opened up to resolve doubts, build knowledge and enable WSW to feel valued and less invisible by understanding their rights in the health services provided.

It is necessary to investigate future studies aimed at building care-educational technologies, with a focus on promoting continuing education for health professionals in the face of welcoming WSW into health care services.

CONTRIBUTIONS

Contributed to the conception or design of the study/research: Dantas ARA, Fernandes MC. Contributed to data collection: Dantas ARA. Contributed to the analysis and/or interpretation of data: Dantas ARA, Adriano AKCG. Contributed to article writing or critical review: Dantas ARA, Adriano AKCG, Sousa JP, Baralho ILA, Fernandes PKRS, Fernandes MC. Final approval of the version to be published: Fernandes MC.

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