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The (lack of) healthcare provided to LGBTQIAP+ people by professionals in primary care centers

O (des)cuidado em saúde às pessoas LGBTQIAP+ dispensado por profissionais em unidades básicas de saúde

El (des)cuidado en salud a las personas LGBTQIAP+ dispensado por profesionales en unidades básicas de salud

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ABSTRACT

Objective: to understand the health care provided to LGBTQIAP+ people by professionals in Primary Care Centers, based on the theoretical framework of the National LGBT Health Policy (PNSILGBT) established by the Unified Health System (SUS). **Method:** a descriptive study with a qualitative approach, which interviewed 12 primary care health professionals. The data collected was subjected to Lexical Analysis using the IRAMUTEQ software. **Results:** Three thematic categories emerged which made it possible to understand that professionals recognize the violence practiced in assisting this population, the barriers to access and the difficulties faced by LGBTQIAP+ people. **Final considerations:** the lack of knowledge of the policies and the lack of perception of the consequences of these actions for the health of this population leads much more to (lack of)care than to care in line with their real health needs.

Descriptors: Nursing; Primary Health Care; Comprehensive Health Care; Sexual and Gender Minorities.

RESUMO

Objetivo: compreender o cuidado em saúde dispensado às pessoas LGBTQIAP+ por profissionais em Unidades Básicas de Saúde, a partir do referencial teórico da Política Nacional de Saúde LGBT (PNSILGBT) estabelecida pelo Sistema Único de Saúde (SUS). **Método:** estudo descritivo, com abordagem qualitativa, que entrevistou 12 profissionais de saúde da Atenção Básica. Os dados coletados passaram pela Análise Lexical utilizando-se do software IRAMUTEQ. **Resultados:** emergiram três categorias temáticas que possibilitaram compreender que os profissionais reconhecem as violências praticadas na assistência a essa população, as barreiras no acesso e as dificuldades enfrentadas por pessoas LGBTQIAP+. **Considerações finais:** o desconhecimento das políticas e a não percepção das consequências dessas ações para a saúde dessa população remete muito mais ao (des)cuidado do que efetivamente ao cuidado condizente as suas reais necessidades em saúde.

Descritores: Enfermagem; Atenção Primária à Saúde; Assistência Integral à Saúde; Minorias Sexuais e de Gênero.

RESUMEN

Objetivo: comprender el cuidado en salud brindado a las personas LGBTQIAP+ por profesionales en Unidades Básicas de Salud, partiendo del marco teórico de la Política Nacional de Salud LGBT (PNSILGBT) establecida por el Sistema Único de Salud (SUS). **Método:** estudio descriptivo, con enfoque cualitativo, que entrevistó a 12 profesionales de salud de la Atención Básica. Los datos recogidos fueron analizados mediante Análisis Léxico utilizando el *software* IRAMUTEQ. **Resultados:** surgieron tres categorías temáticas que permitieron comprender que los profesionales reconocen las violencias ejercidas en la asistencia a esta población, las barreras en el acceso y las dificultades enfrentadas por personas LGBTQIAP+. **Consideraciones finales:** el desconocimiento de las políticas y la no percepción de las consecuencias de estas acciones para la salud de esta población reflejan mucho más el (des)cuido que efectivamente el cuidado acorde a sus reales necesidades en salud.

Descriptores: Enfermería; Atención Primaria de Salud; Asistencia Integral de Salud; Minorías Sexuales y de Género.

INTRODUCTION

Caring refers to any individual who can contribute to assisting the lives of others, whether collectively or not, in other words, caring is attention to others, which implies caring and being cared for[1].

The notions of care for collective health are understood more broadly and from various perspectives, whether professional or not. However, it is essential that actions aim to reduce vulnerabilities to the process of becoming ill. Failure to comply with these measures can worsen the state of health of this population, as it does not take into account their experiences and the barriers they face in accessing services in the various care networks[2].

The complexities that make it difficult to identify the conditions that obstruct the transversality of care actions also make it difficult to achieve comprehensiveness, and a biologizing approach often prevails. This approach prevents

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professionals from accessing essential information to provide equitable, quality care, taking into account individual specificities. Care focused solely on the biological aspect limits the ability to offer holistic care that takes into account social, psycho-emotional and cultural factors.

Primary Care Center is recognized as the gateway to care, and plays a fundamental role in communicating the different points of health care. It is committed to not excluding people based on sociodemographic data, taking into account the determinants and conditioning factors of health that influence the well-being of the population[3].

In this context, it is essential to adopt strategies to reduce social inequalities, exclusion, discrimination and stigmatization of specific groups, without harming the autonomy and health of these people[4]. Understanding individual demands is fundamental to guiding practice, as each individual is unique and requires personalized care.

Thus, it is essential to break with the (cis)normative and exclusionary view that society imposes, ensuring that people who recognize themselves as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual/Aromantic/Agender, Pansexual, Non-binary and more (LGBTQIAPN+) are welcomed and respected in all instances of health care. The path to comprehensive and humanized care involves promoting inclusive and prejudice-free practices, aiming to provide a safe environment so that all people can seek care without fear of discrimination due to disrespect for their social name, sexual orientation and/or gender identity[5].

As advocated by the National Comprehensive Health Policy for LGBT people (PNSILGBT), health promotion should eliminate discrimination and institutional prejudice, as well as contributing to the reduction of inequalities and the consolidation of the Unified Health System (SUS) as a universal, comprehensive and equitable system. The inclusion of sexual orientation and gender identity questions in SUS identification and notification documents is mandatory and important for improving care and promoting equity[6].

The aim of this study was to understand the health care provided to LGBTQIAP+ people by professionals in Primary Care Center.

THEORETICAL FRAMEWORK

This study takes as its theoretical reference point the National LGBT Health Policy (PNSILGBT), established by the Unified Health System (SUS) to guarantee universal access and the right to care without discrimination and institutional prejudice, as well as to reduce social and health inequalities. Launched in 2010 and instituted in 2011 by MS/GM Ordinance No. 2,836, this policy has emerged as an important milestone in the visibility and inclusion of the health demands of the LGBTQIAP+ population[6].

The policy is based on nine guidelines that guide the development of health plans, programs, projects and activities that respect human rights, inclusion and diversity, and promote inclusion. By adopting these guidelines, the SUS reinforces its commitment to promoting health and providing dignified care to all people, regardless of their sexual orientation or gender identity.

The historical trajectory reveals a progressive change in the scenario in relation to the LGBTQIAP+ population, which for a long time was neglected, made invisible and subject to prejudice. Today, the urgent need to include this population fully in the health system is becoming increasingly evident, guaranteeing the applicability of the principles of the SUS and reducing their vulnerabilities in the face of care which, for many years, has still been exclusionary and insensitive to their specific needs[7].

Despite the progress made throughout the history of public policies and health rights for LGBTQIAP+ people, stemming from the struggles of social movements and communication with government bodies, there is still much debate about its effectiveness and the guarantee of its implementation. However, this policy represents a significant step forward in the SUS's commitment to promoting equity and social justice in the area of health, ensuring that all people have access to health services in a dignified and equal manner[8].

METHOD

This is an exploratory study, with a qualitative approach, to better translate the apprehension of health care offered in primary care to LGBT+ people, considering the range of actions and assistance that can be provided to this segment by health professionals. This is an excerpt from the dissertation entitled: Health Care for LGBTQIAP+ People in Primary Care.

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The primary care network in the municipality studied has 52 Primary Care Center (PCC), six of which were chosen because they are the field of practice of a public higher education institution. These PCCs included health professionals who have been working directly in care for at least six months, providing care in Primary Care Center (PCCs) in a municipality in the agreste region of Bahia, totaling 12 professionals (physician, nurses, dental surgeons and nursing technicians). Professionals on leave, maternity leave and vacation were excluded.

Data was collected from March to May 2023, in person, by applying an instrument consisting of a socio-professional profile and eight open-ended questions that sought to identify the perspective of care for LGBTQIAP+ people. The data collected through the interviews was transcribed by two independent researchers and submitted to the IRAMUTEQ software using Reinert's method[9], whose textual lemmatization was carried out prior to the lexical analysis. Data analysis was based on the characterization and organization of information through the stages of corpus preparation and processing by IRAMUTEQ, with the construction of study categories based on the words and classes derived from the Descending Hierarchical Classification (DHC).

To protect the identity of the professionals, we used identification codes beginning with the letter P (participant), accompanied by the order number in which the interviews took place, plus gender, religion, age and sexual orientation. The speech excerpts complement the terms that make up the DHC classes.

The research protocol complied with current National Health Council resolutions and was approved by the institution's Research Ethics Committee.

RESULTS AND DISCUSSION

Understanding the diversity of the professionals involved in this study and their insertion in the job market, especially in primary care, is relevant. These elements can have a significant impact on their perspectives in the context of care for the LGBTQIAP+ population.

Among the 12 participating professionals, ten declared themselves to be women and two men; only two were over 50 years old and the others ranged from 26 to 45 years old. As for color, ten professionals declared themselves black. According to IBGE data[10], 53% of the Brazilian population declare themselves to be black or brown.

In terms of education, one person had a doctorate, two had a technical degree and nine had a bachelor's degree. All the participants said they worked for companies contracted to provide services to the municipality. Most of the interviewees professed the Christian faith, seven of them were evangelicals, three Catholics and two said they had no religion. In terms of sexual orientation, ten professionals declared themselves heterosexual, one homosexual and one bisexual. All declared themselves cisgender. As for marital status, seven were single and five were married. As the majority declared themselves heterosexual and all were cisgender, this may indicate that the care provided may follow a cis-heteronormative pattern.

In addition, all the interviewees have traditional, formal employment contracts.

The software processed the data and came up with the following results: 11,093 occurrences and 1,613 forms (lexical unit); 179 words appeared only once in the entire corpus; and, the percentage of use of the corpus was 83.80%, higher than the recommended limit.

Figure 1 shows the words with the highest frequency and a p-value equal to or less than $p < 0.001$. This graphical representation is organized into five classes and should be read from left to right. Classes 1 and 2 make up the 1st category; classes 3 and 4 come together to make up the 2nd category; and the 3rd category is made up of class 5. The three categories were named a posteriori.

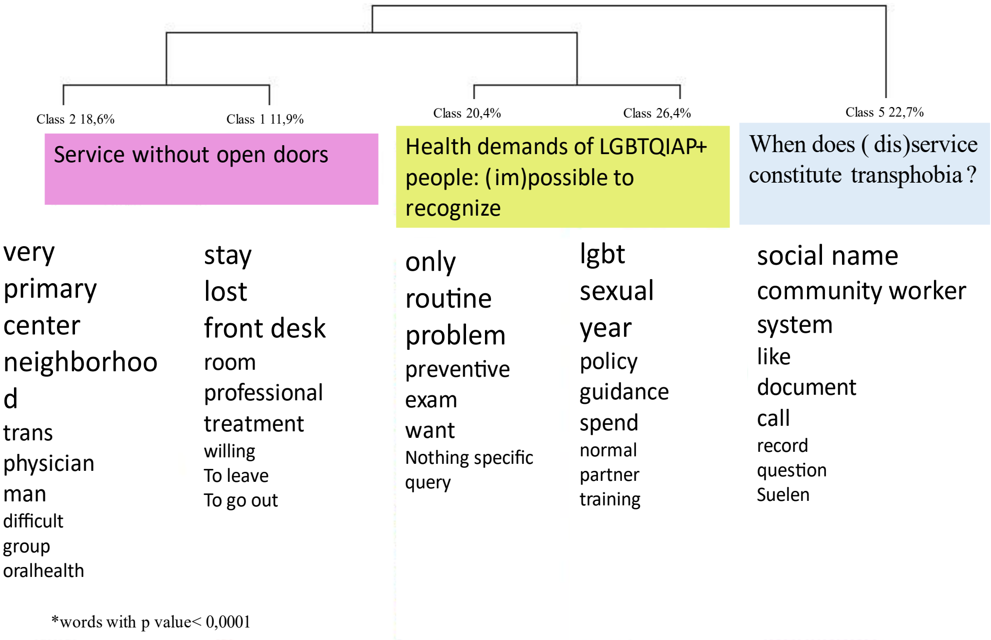

Figure 1: Denogram provided by IRAMUTEQ with adaptations by the authors. Feira de Santana, BA, Brazil, 2023.

Open door services

In category 1, entitled "Service without open doors", the professionals provide a clear description of the organization of the service and the care available for the demands of LGBTQIAP+ people. They also highlight the trans population's interest in attending the FHS and seeking medical care.

Primary care is the organizer of care and its role is not to exclude anyone who enters the health system[3]. The participants in this study perceive these people as part of a group that is difficult to integrate into the unit, which makes it challenging to understand their specific needs.

The findings that made up category 1 point to the importance of promoting greater inclusion of LGBTQIAP+ people in health services, with the aim of guaranteeing welcoming, accessible and qualified care. In this sense, in the context of primary care, the menu of services offered is still based on compulsory cisnormativity, which can mean that these people need to 'adjust' to what is established for care, in which professionals do not consider their singularities and the complexity of each individual[11].

For a better understanding of health care, in a broader way and with a view to reducing the process of illness and vulnerability[2], this study reveals the need for a more sensitive and inclusive approach. This approach must recognize the specificities and needs of this population, promoting more appropriate and respectful care. Based on the analysis of these situations, it is possible to identify the challenges/opportunities for improving care and ensuring adequate reception for LGBTQIAP+ people in the excerpt.

> *We provide our care as if it were any other person, because being trans or bisexual, whatever it may be, the person's sexual option, for me, doesn't influence the question of my care. I'm here to provide my service regardless of judgments. (P8, female, Catholic, 35 years old, heterosexual)*

The professionals' statements, although they emphasize neutrality in their care, reveal a possible resistance to people who are dissident in terms of gender and sexuality and a limited view of existence, reflecting a social conformation that considers only one form of identity to be "normal" or "standard". This perspective, based on the cis-heteronorm, ignores the diversity of sexual orientations and disrespects self-determination in relation to gender[12].

This conception is a construction rooted in the patriarchal context, which assigns value judgments based on the functionalities imposed by society, which can create barriers/obstacles to welcoming and offering specific care for the needs of LGBTQIAP+ people[13]. Thus, assuming that all users are heterosexual and cisgender runs the risk of neglecting the demands of this population, reinforcing stigmas and prejudices that contribute to the silencing of the LGBTQIAP+ population.

Unequal access to health policies reflects the reality of social and programmatic vulnerability faced by LGBTQIAP+ people. In this context, the barriers that hinder access are visible, as are the historical prejudices and stigmas faced by this population in care environments. These difficulties in accessing health services have various origins, including the lack of adequate training for professionals to deal with the specificities of LGBTQIAP+ demands[13,14].

The importance of providing quality care with a holistic approach that considers all dimensions of care is recognized, with the aim of achieving better results and avoiding harmful transitions[15]. It is essential to understand that the health team carries out its actions directly in environments that can either facilitate or hinder personal, community, family or population transitions. Furthermore, it is essential that professionals are sensitized/trained to deal with the particularities of the transitions experienced by people, especially the LGBTQIAP+ population[16].

> *There's still a certain amount of rejection, a certain amount of prejudice towards the staff, not that the staff are going to mistreat them, but they're still surprised, some people don't really understand what it's like to deal with trans people. (P5, female, no religion, 28 years old, heterosexual)*
>
> *There are no problems of this kind, thank God. We serve everyone, no one is turned away. (P10, female, Catholic, 42, heterosexual)*

Users' insecurity ranges from seeking out and accessing health facilities to revealing issues related to sexuality during anamnesis, fearing that the service will not be appropriate to their needs. In addition, the fear, discrimination and violence they may experience end up worsening their state of health, making it even more difficult to access services and seek preventive care and treatment[17,18].

In this sense, it is essential to develop strategies that take into account the particularities of each individual, especially when dealing with health issues. By adopting a sensitive approach, it becomes possible to establish a caring relationship that respects differences and promotes the well-being and dignity of each person[3].

Health demands of LGBTQIAP+ people: (im)possible recognition?

Category 2, "Health demands of LGBTQIAP+ people: (im)possible recognition?", corresponds to classes 3 and 4. Health professionals present the idea of equality in care, believing that this approach is appropriate for all users. However, by adopting a generalist approach, without taking into account the specificities of population groups, they end up violating the principle of equity in the SUS.

Although some professionals mention the importance of individualized care, in practice the scheduling of appointments and tests is done equally for the general population, without considering the specific needs of LGBTQIAP+ people. This lack of sensitivity/training to adequately serve this population ends up creating barriers and difficulties in accessing these services[17].

The lack of contact and incipient knowledge about PNASLGBT+ leads to processes of illness and vulnerability in this population. The scarcity of professionals trained to deal with the specificities of LGBTQIAP+ people results in unqualified care that lacks adequate reception. The lack of public policies and clear guidelines for health promotion contributes to the invisibility of their needs and hinders access to health services[18]. The speeches highlight the lack of knowledge and training in relation to PNASLGBT, as they claim not to have had access to information about it in their professional training, which suggests a gap in the preparation of health professionals.

> *I don't know about the National LGBT Policy, I haven't seen it in any training space or in the network. (P1, woman, evangelical, 55 years old, heterosexual)*

In some situations, it is common for them to attribute the cause to something other than their own interest or lack thereof, as a way of avoiding responsibility for their actions. This can happen following a politically correct discourse, diverting attention from their own responsibility and attributing it to third parties, such as other professionals or even the population itself.

This behavior can be harmful, because by not taking responsibility for their actions, professionals can perpetuate inadequate practices and fail to contribute to improving health services. It is essential to recognize limitations and seek training in order to offer more appropriate care that is sensitive to users' needs.

There is a need for public policies and normative documents to be effectively implemented through awareness-raising, training and education for health professionals, with the aim of promoting more humanized, inclusive and prejudice-free care for the LGBTQIAP+ population.

To promote spaces for dialogue and reflection on health practices, in order to encourage self-assessment by professionals and the constant improvement of their skills and competencies. In this way, it will be possible to overcome the shortcomings and challenges of the transitions, guaranteeing the humanization of care for the entire population[18].

> *I understand the specificities of this care [...] I think this issue of health education is lacking for these people to understand that however they behave or like to be one way, they need to take care of their health as a whole. (P5, female, no religion, 28 years old, heterosexual)*

When does (dis)service constitute transphobia?

The third category, entitled "When does (dis)service constitute transphobia?", reinforces the findings of the two previous categories by showing that health professionals are not adequately prepared to deal with the rights won by the LGBTQIAP+ population. The lack of preparation becomes contradictory, since the professionals recognize the needs of these people, but attribute them to the health system and blame the community health workers.

These professionals, who are responsible for registering people in the health services, are singled out as responsible for not inserting the social name at the time of registration. This means that the social name is not recognized and later changed on the user's documents, resulting in a situation of disrespect and violence, as these people continue to be called by their civil name.

The regulation of decree 8.727 in 2016[19], which ensures the inclusion of a field for the social name on SUS healthcare documents, allows people to use their preferred name, regardless of their civil registration. The decree represents a milestone in the promotion and inclusion of these people in the healthcare context, ensuring that they are welcomed and respected in their gender identities.

Ignoring this reveals the transphobia present in health care, as the failure to include the social name contributes to perpetuating violence and discrimination[14]. In addition, the requirement for rectified documentation in order to make the change to the register is yet another bureaucratic barrier that hinders access to adequate and respectful care, since not everyone has the same interests and/or resources available. In this respect, the use of the social name in the SUS has been guaranteed by Ministry of Health Ordinance 1820 since 2009[20].

These statements highlight the urgent need for awareness-raising, training and education of health professionals, as well as the implementation of policies and practices that guarantee respect for the rights and dignity of LGBTQIAP+ people. Only with effective and inclusive actions will it be possible to overcome transphobia and promote truly equal and welcoming healthcare for this population.

> *Only if they have the document because the system requires the document to register, you can't edit it and put it in because the system doesn't give us this possibility. (P8, female, evangelical, 35 years old, heterosexual)*
>
> *The way it is here in the register there's no way to change it, for example the social name you call João, you see a person in a dress and everything and there's no way to change it. (P3, female, evangelical, 26 years old, bisexual)*

It reveals an approach that is geared towards the binary system, where gender and sex are considered in a linear perspective, as being the only ways of being and existing, thus excluding those people who do not identify with the definitions imposed on their existence. This restricted and exclusionary view ends up neglecting and marginalizing gender dissidents, disregarding the existence of individuals who do not correspond to the heteronorm imposed by the (cis)system.

> *So far, no different demands have arisen for this population. I've also seen someone who is a hermaphrodite and she uses the social name Marta [fictitious name], even though she dresses as a man, so I respected her wishes, if she was registered as Marta and wanted to use a male name then I would call her by her male name. (P8, female, evangelical, 35 years old, heterosexual)*

This binary and limited perspective imposes a rigid division between men and women, ignoring the diverse existences beyond this dichotomy. By perpetuating this view, health services can fail to recognize and respect self-determination in relation to gender, hindering access to inclusive care[21]. It is essential to recognize the existence of non-binary people or those who do not 'fit' into the imposed (cis)norms. This implies guaranteeing access to information on gender issues.

> *We know that we have to call people by the name they want. It's not what we want, or what's on the register. So we're aware of all this and we take care of it that way. (P1, female, evangelical, 55 years old, heterosexual)*

The results obtained from the analysis of the categories express the non-use of the principles of the SUS in relation to LGBTQIAP+ people, emphasizing the unequal assistance and the problem in the speeches in not perceiving the violence perpetuated in their care, the absence of specificities in the face of insufficient assistance, in addition to the denial of the barriers to access and permanence of these people in the health center[22,23].

Limitations of the study

As this is qualitative research with locoregional data, it is not possible to generalize the data. The application to research and health care practice stems from the aspects presented, as they enable reflection on care in the face of the specific demands of care for this population group. The limitations of this study lie in the number of interviewees, so future studies should be carried out.

FINAL CONSIDERATIONS

The participants found it difficult to understand that violence is the main cause of (lack of)care. Realizing this is part of a process of (re)construction necessary for the practice of caring for LGBTQIAP+ people.

It was noticeable that they used strategies to avoid taking responsibility for this (lack of) care, revealing care centered on the biomedical model, as opposed to the principles of the SUS, which advocates a model based on bonds, comprehensiveness and humanized care.

The distancing of LGBTQIAP+ people from the UBS is linked to the lack of comprehensive care, invisibilization and discriminatory approaches that keep them away from health promotion. The veiled speeches/acts end up having repercussions in health problems that lead them to seek emergency services, becoming a 'gateway' and characterizing the care provided as unequal and inequitable.

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Authors' contributions

Conceptualization, B.A.S.O., C.S.S.S., C.P., H.M.C. and S.L.S.; Methodology, B.A.S.O., C.S.S.S. and C.P.; Software, C.S.S.S.; Validation, C.S.S.S. and C.P.; Formal Analysis, B.A.S.O., C.S.S.S. and C.P.; Investigation, B.A.S.O.; Data Curation, B.A.S.O. and C.S.S.S.; Manuscript Writing, B.A.S.O., C.S.S.S. and C.P.; Writing – Review and Editing, B.A.S.O., C.S.S.S., C.P., H.M.C. and S.L.S.; Supervision, C.S.S.S. and C.C.P.; Project Administration: C.S.S.S. and C.C.P. All authors read and agreed with the published version of the manuscript.