Health and discrimination in the aging process LGBTQIA+

Saúde e discriminação no processo de envelhecimento LGBTQIA+

Salud y discriminación em el processo de envejecimiento LGBTQIA+

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RESUMO

Objetivo: Identificar as experiências e discriminações vividas pela população LGBTQIA+ em envelhecimento durante a prestação dos serviços de saúde. **Método:** Estudo exploratório de abordagem qualitativa, por meio da aplicação de um questionário com informações sociodemográficas e questões sobre experiências anteriores dentro de instituições de saúde e percepção do cuidado recebido. **Resultados:** Participaram nove pessoas, predominantemente, identificadas como homens cisgêneros; e, apenas um estava com idade entre 65 e 70 anos. Em sua maioria buscam o serviço de saúde duas vezes ao ano motivado principalmente por problemas particulares, do sistema respiratório, hipertensão arterial ou dores persistentes. Indicaram não haver desencorajamento para a procura de serviços e a maioria não relatou experiências de discriminação. **Conclusão:** A baixa frequência de discriminação pode indicar a dificuldade de caracterizar a exposição e/ou vivências por esta população. Sendo assim, deve-se buscar entender o que essa população considera discriminação por parte dos serviços de saúde a pessoas LGBTQIA + durante o processo de envelhecimento.

Descritores: Minorias Sexuais e de Gênero; Envelhecimento Populacional; Atenção à Saúde; Comportamento de Procura de Cuidados de Saúde; Acesso aos Serviços de Saúde.

ABSTRACT

Objective: To identify the experiences and discrimination experienced by the aging LGBTQIA+ population during the provision of health services. **Method:** Exploratory study with a qualitative approach, through the application of a questionnaire with sociodemographic information and questions about previous experiences within health institutions and perception of care received. **Results:** Nine people participated, predominantly identified as cisgender men; and, only one was aged between 65 and 70 years. Most seek the health service twice a year motivated mainly by particular problems, the respiratory system, high blood pressure or persistent pain. They indicated that there was no discouragement to seek services and most did not report experiences of discrimination. **Conclusion:** The low frequency of discrimination may indicate the difficulty of characterizing the exposure and/or experiences of this population. Therefore, one should seek to understand what this population considers discrimination by health services to LGBTQIA+ people during the aging process.

Descriptors: Sexual and Gender Minorities; Population-ageing; Delivery of Health Care; Health Care Seeking Behavior; Health Services Accessibility.

RESUMEN

Objetivo: Identificar las experiencias y la discriminación que vive la población LGBTQIA+ envejecida durante la prestación de los servicios de salud. **Método:** Estudio exploratorio con enfoque cualitativo, mediante la aplicación de un cuestionario con información sociodemográfica y preguntas sobre experiencias previas dentro de las instituciones de salud y percepción de la atención recibida. **Resultados:** Participaron nueve personas, predominantemente identificadas como hombres cisgénero; y, solo uno tenía entre 65 y 70 años. La mayoría acude al servicio de salud dos veces al año motivada principalmente por problemas particulares, del sistema respiratorio, hipertensión arterial o dolor persistente. Indicaron que no hubo desánimo para buscar servicios y la mayoría no reportó experiencias de discriminación. **Conclusión:** La baja frecuencia de discriminación puede indicar la dificultad de caracterizar las exposiciones y/o experiencias de esta población. Por lo tanto, se debe buscar comprender lo que esta población considera discriminación por parte de los servicios de salud a las personas LGBTQIA+ durante el proceso de envejecimiento.

Descriptores: Minorías Sexuales y de Género; Envejecimiento de la población; Atención a la Salud; Comportamiento de búsqueda de atención médica; Accesibilidad a los Servicios de Salud.

ORIGINAL

Introduction

Due to the development of new technologies and improvement of old techniques, the increase in life expectancy has become increasingly evident, this has been occurring as a consequence of studies and research aimed at improving the quality of life. Considering that the elderly population continues to grow constantly while the birth rate shows a decline, it is necessary to understand aging globally in order to prevent this population from being excluded in psychosocial and environmental areas.[1]

Being an irreversible process that has its unique characteristics, aging is most often associated with the presence of diseases and disabilities that prove the need for a reformulation in the care of this population in primary health care. Greater functional independence on the part of the elderly implies successful ageing despite the inevitable gradual reduction of capacities.[2]

Considering that the senescence process occurs in a natural and progressive way, consequently influenced by the socio-environmental environment, the target person must be understood and analyzed by several perspectives in order to offer a care centered on the uniqueness of each being that needs care.[3]

Added to this context we have the exclusion that is made in an imperceptible way of even smaller groups such as the population of lesbian, gay, bisexual, transgender, queer, intersexual, asexual, pansexual and crossdresser (LGBTQIA+), understand the specific requirements of this community within the aging process increases the satisfaction presented by users of health services, which generates a better support to the proposed care and consequently reduces the aggravation of diseases pre-existing and preventable chronic diseases. Presenting specificities that this mass has to health service providers facilitates care and develops in a complete way strategy with the objective of reducing harm with health promotion at the primary level.[4]

In addition, even with the importance of universality, integrality and equity proposed by the Unified Health System (SUS) in 1988, only 23 years later, in 2011, the need for the creation of public policies was defined in order to understand this group, which, in most cases, because of difficulties already experienced, present some resistance in the search for primary care, thus causing the overload of tertiary care due to problems aggravated over time that could be previously solved in the basic health unit (UBS).[5]

The way that institutions end up internalizing a certain stigma about the community, making the debate about gender identity and sexual orientation occur only within classes on sexually transmitted infections (STIs), employees develop care focused on acting only on prevention and treatment after infection, stigmatized in the form of prejudice and pre-judgment when placed on the agenda during a consultation at the UBS.[5]

Without this baggage of knowledge, professionals most often end up assuming the sexual orientation of their patients, classifying them as heterosexual, thus reproducing a conventional care that results in the non-identification of singularities and part of information that ends up being omitted by the client himself also ceases to be notified, hindering the mapping of the population and diseases that require long-term attention that can modify health indicators of a particular locality.[6]

That said, the present research aimed to answer the question: What experiences and forms of discrimination were experienced during a health care because they belong to the LGBTQIA+ population? Thus, the objective is to identify the experiences and discriminations experienced by the LGBTQIA + aging population during the provision of health services.

Method

This is an exploratory and descriptive study with a qualitative approach, which sought to identify the experiences and discrimination of the LGBTQIA+ population during the aging process within health services. The qualitative descriptive study aims to characterize a certain reality to be studied, which can describe problems, sociodemographic characteristics and others.7 The guidelines of the Consolidated criteria for reporting qualitative research (COREQ) were considered in this study.[8]

The search took place online through the "Google Forms" platform, using a form that aimed at the convenience of participants. Divided into two sections, the first sought to clarify the objectives of the research to the candidate and in the second section, we sought the factors related to health and experiences of discrimination experienced and that occurred in health services. The open questions sought answers to the questions: What are the main reasons/complaints that lead you to seek the health system? Is there anything that discourages you from seeking health care because you belong to the LGBTQIA+ population? Please report.

The inclusion criteria adopted were: participants reported belonging to the LGBTQIA+ target group over 45 years of age, called "middle age", respecting the age classification of aging, and who agreed with the terms of the research. On the other, exclusion criteria were heterosexual participants who did not identify themselves as members of the LGBTQIA+ community.

The participants indicated other possible participants, who were contacted and received the form. The collection took place from May to June 2021, through E-mail, Whatsapp and /or social media. The organization of the data obtained occurred through the use of the Microsoft Office(R) 2010 for Windows software.

As a material of support and theoretical foundation, searches were made in the Virtual Health Library (VHL), Scientific Electronic Library Online (SciELO), Latin American and Caribbean Literature in Health Sciences (LILACS), PUBMED and MEDLINE, as a means of directing for data analysis.

Eight questionnaires comprised the corpus for the data analysis phase because they were answered in full. Tables were developed for descriptive statistical analysis of closed responses with the calculation of relative values.

Content analysis was used for the material from the open questions, with the conformation of two categories following the steps of: pre-analysis, in which the collected material went through the process of transcription and floating reading, to identify and select significant ideas; exploration of the material, with the deepening of the study by exhaustive reading of the statements, to categorize the results; treatment stage, with care regarding the interpretation of the information and the production of the results, capable of generating knowledge.[9]

The research occurred with the authorization of the Ethics Committee of the University Center of Brasília - UNICEUB under opinion number 5,385,069, with approval in April 2022. It is emphasized that the ethical principles recommended by Resolutions No. 466/2012 and No. 510/2016 were respected, as well as the recommendations present in the Circular Office of the National Council of Ethics in Research (CONEP), of February 24, 2021, which deals with the guidelines for procedures in research with any stage in a virtual environment.

Results and Discussion

Even using far-reaching tools such as email, WhatsApp among others, the number of participants was low. The support of the target group that received the form was good, but there was difficulty in finding possible candidates with age within the applied parameters and obtaining forms answered in completeness. Thus, the number of responses obtained reaches a total of nine people, with its predominance of people who identify as cisgender men (55.6%), being three cisgender women and one Agender. Among the participants eight were between 45 and 65 years old and only one was between 65 and 70 years old.

Taking into account the age of the participants, the younger ones - those who fall into middle age - participated more. Studies such as that of the Brazilian Institute of Geography and Statistics (IBGE) in 2019 present results that prove the predominance of younger groups in the participation of research.[10]

The difficulty of adhering to the form demonstrates that age may have been a hindrance to a greater number of responses. The insertion of elderly people in technology facilitated access to information and promoted the inclusion of this group in the participation of activities, be they leisure, research and approximation of communities and family members from long distances. The fact that elderly individuals experience a double burden of stigmas and prejudices related to age and sexual orientation itself can cause fear to answer such questions.[11]

Regarding schooling data, all participants have at least completed high school. Data are at odds with those released by the National Household Sample Survey (PNAD), which in 2019 pointed out that about 11.1% of people over 40 years of age and 18% of those over 60 years of age were illiterate, a study in which it identified that illiteracy may be associated with high age.[10]

In view of the variable sexual orientation, it is possible to identify a predominance of homoaffective ones in relation to other sexualities. In a recent National Health Survey, it was pointed out that the prevalence of the heterosexual population was about 94.8%, and among the others, the majority are homosexuals with 1.2%. Followed by bisexuals with 1.1% and surpassing this part we have the population who did not know their own sexual orientation.[12]

Considering the barriers that have decreased regarding the acceptance and understanding of society of the existence of different sexualities and genders, portions of the group still encounter difficulties and fears in fitting in and assuming themselves before society. Since during the process of self-acceptance, prejudices are experienced in different ways, causing part of the people who identify the possibility of externalization of their particularities, decide not to assume their differences for their cycle of coexistence.[13]

After the characterization of the group, the questions about the frequency in which they perform consultations or exams after having completed 45 years, showed that six (66.7%) search once every six months and three (33.3%) when they have any complaints.

Considering the answers, it is possible to observe that the majority seek sane health services on good frequency. Age is a factor that leads the person to have more complaints and demands for health services, but much is discussed about the issues that may be associated with low demand for health services. With regard to LGBTQIA+ people, there is no doubt that the discrimination suffered is a factor that keeps the individual away from the hospital environment and/or UBS.[5]

Points of creation of pre-concepts, stereotypes and the construction of a heteronormative posture hinder care and create barriers between the patient and the health professional, causing underreporting, underdiagnosis and discare to this population.[5,11]

When starting the discussion observed in the need to implement studies aimed at humanized care for the LGBTQIA+ population, we also see the need to seek to improve health education, in which the incentive to seek care is frequent by the community at certain times of life, such as during senescence, where the risk of developing comorbidities is increased by physiological issues.[14]

Despite the inequalities and prejudices experienced by LGBTs during the search for health services, there has been a growth in recent decades in the attempt to include this population, as an individual being that needs specific care.[15-17]

Table 1 - Answers regarding the type of care and discrimination. Bahia, 2023 (n=9)

Questions	n (%)
Do you usually consult in the public or private network?	
Public (SUS)	1 (11,1%)
Toilet	6 (66,7%)
Both	2 (22,2%)
Total	**9 (100%)**
Have you ever experienced any discrimination because of sexual orientation/gender identity during consultations or exams?	
Yes	2 (22,2%)
No	7 (77,8%)
Total	**9 (100%)**
Have you stopped looking for care for fear of discrimination?	
Yes	0
No	9 (100%)
Total	**9 (100%)**
Do you know anyone who has ever suffered any kind of discrimination because of sexual orientation/gender identity during a health service?	
Yes	4 (44,4%)
No	5 (55,6%)
Total	**9 (100%)**

n: number of individuals in the sample, %: percentages in the weighted sample.

Understanding the spectrum of vulnerabilities that this part of the population is, which is multidimensional and involves several contexts, is a step to clarify the reasons for this low demand for health services. Not only for the psychological scope, but in all aspects of violence, whether verbal or physical, which cause damage to the health of any person.[17]

Because it is not a homogeneous group, the LGBTQIA+ community tends to recognize itself and be sensitive to the problems faced, such as stigma and discrimination, and end up seeking some strategies to cope with the difficulties encountered that can be harmful, such as drug use to alleviate the pain caused by the situation of vulnerability in which they are found.[18]

In addition to the discrimination caused by society, there is the one that is internalized in these individuals themselves, causing negative outcomes related to mental health, chronic health conditions, impairments in quality of life and loneliness, presenting greater chances of limitations of mobility, muscle failure, fragility and immobility.[11]

With the visible growth of the search for rights and greater access to information, populations previously excluded as elderly and LGBTQIA+ demand more from professionals the knowledge to better offer reception within SUS units, ensuring sensitivity, perception of true needs during contact with the user and compliance with the right to health, even if there is a shortage of research and training courses and continuing education in health aimed at this public.[16-17]

In view of the population's fear of seeking care, studies tend to recognize factors linked to recurrent evasion of those who started follow-up or those who avoid starting because of the lack of knowledge about the development of LGBTQIA+ well-being. Higher education institutions already identify the need for inclusion in the training curriculum of professionals such as physicians, nurses and community health agents (CHA) the theme, but they find challenges during this inclusion by reduced teaching resources and evidence-based providers and this situation is responsible for the training of professionals unprepared for the labor market.[19]

Due to this deficiency of care, access to health should be provided in an integral way, which could at the end generate a certain link with the units and professionals in this population. Studies show that a large part of this population has mental disorders, excessive use of psychoactive substances, use of hormones without follow-up and suffer violence, whether they are of any kind.[18-19]

When it does not originate from health professionals, discrimination occurs because of moral policies that are mostly of religious origin, which influences the behavior and way of acting of all who agree with the policy discussed. It is possible to see religion as a starting point for some servers to act with revulsion, hatred and repression against LGBTQIA+ people weakening the bond between professional-user.[13]

Although it occurred a few decades ago, the HIV/AIDS epidemic, which caused numerous deaths of LGBT's, being disseminated by the media as "gay cancer" and other extremely pejorative terms that gave way to violence to homosexuals, still has a negative impact generated by stigmas. According to the United Nations Joint Program on HIV/AIDS (UNAIDS) only 10% of the world's lesbian, gay, bisexual and transgender (LGBT) population has access to health in general.[20]

As a result of the open questions it was possible to perform analyses, conform two categories and finally discuss them from their central ideas, as can be seen below:

Category 1: Main reasons why you seek care

The search for care is mainly motivated by: "Particular problems, complaints of the respiratory system such as allergic rhinitis and asthma, problems that come out of the usual, hypertension and persistent pain".

The study population has a decreased chance of seeking the health service for fear of being the victim of exclusions due to their age, sexuality and gender identity, generating poor results regarding the health of a general population. Part of this group suffers from financial barriers to seek specialized care in private units, thus increasing the rates of depression and untreated physical disabilities during this phase of life. Even if they seek care, 1/5 of lgbtqia+ elderly do not reveal their sexual orientation during the consultation for fear of not receiving the necessary care or suffering discrimination.[21]

It is possible to identify a pattern among the participants of the research, where the search for care is only made when there is a complaint or a deviation from normality. The attempt to identify the challenges experienced by the LGBTQIA+ population in Brazil has been made most often accompanied by political and sociological analyses so that in the end the gaps in other studies already done are filled.[4]

With the indication that the population during aging presents vulnerabilities, public policies were created with the intention of guaranteeing and regulating rights in order to stimulate the aging population assisted so that it occurs actively, autonomously and integrally within the community. Although a small portion of this public can take advantage of its guarantees, most studies highlight the prerogative that aging results in public health expenditures.[22]

In general, mental health is one of the most important guidelines for gays, lesbians and other members of the LGBT collective, because it appears as support or reception to gays and lesbians who suffer depression and abandonment because they assume their sexual orientation, besides having an important role in prevention in suicide cases.[4]

There is a higher risk of alcohol, tobacco and drug use disorders in sexual minorities than in heterosexuals, with bisexual men and women having higher prevalence of psychological distress and alcohol and tobacco abuse than heterosexuals.[18]

In this group it is possible to observe that STIs are widely discussed, but applied with sexual education projects and health policies for those who have risky sexual behavior, as well as the prevention and screening of Chronic Noncommunicable Diseases (NCDs) such as anal canal cancer.[4]

Multisexual people, due to disinformation both by professionals who sometimes do not know the handling with this population, as well as due to lack of guidance, end up becoming more vulnerable to risky sexual behavior and, finally, being aggregated in parts of the three groups (Gays, Lesbians and Heterosexuals), generating a difficult understanding of the real needs of this portion of the acronym.[23]

For the trans and transvestite population, the health issue is more complex because this group, besides presenting great vulnerability, exhibits needs ranging from mental health, which is very close to physical and sexual health. Thus, the monitoring of the group will present a range of pathways such as prevention of STIs due to sexual behavior, cancers that are influenced by the use of hormones, mental health that is also of great relevance in this group and NCDs such as osteoporosis and heart diseases that are also caused by the use of hormones, in addition to body changes that occur in large numbers in this group.[4]

The results of this category indicate that the motivations need to be better understood and that the provision of care to LGBTQIA+ people can be performed in a qualified and empathic manner. In this sense, studies point both the need for technical/scientific basis, as well as the empathy of professionals who care for these individuals when favoring care to this community, especially the elderly, ensuring trust and facilitating their entry into health services, contributing to the identification of problems pertinent to physical and mental health.[6]

Category 2: Impediment and/or disincentives in the search for health services

According to those who participated and were willing to answer this question, all presented the same answer: "No, nothing that causes an aversion to seeking assistance." Regarding the data collected in this question, the participants indicate that there is no discouragement for the search for services and care aimed at the population, on the other hand in the literature, low compliance by this group is observed.[6]

A study shows that structural determinants such as stigmas cause a barrier to access to the community. Such stigmas add up when people, already marginalized by sexual orientation or gender identity, are black or peripheral and even more influence health outcomes.[17]

The recognition of the person centered on the gender identity of birth and sexuality focused on the corresponding initial gender, generates stigmas and prejudices that hinder and end up reflecting on the health result.[6,18] Thus, the use of the social name reiterates the appropriation of rights, and generates closer relations and respect during care.

Deepening for the aging of the population, we have even more factors that predispose to contexts of marginalization and exclusion of individuals who need follow-up when they reach a certain age, characterizing the particularities that differ from other age groups that are added to the biopsychosocial, resulting even more difficulties for the provision of care and therapeutic adherence.[18]

In addition, there is on the part of the person himself and some professionals the difficulty of dealing with the aging process, especially when it adds to sexuality that is a factor present in the lives of the elderly and that is often not given the importance necessary by health professionals.[4,6]

The results of this category indicate that impediments or demotivations are difficult obstacles to overcome and are linked to the unpreparedness of professionals in the planning of care by not considering the real needs and peculiarities of this population. For, if they implemented programs aimed at this public, with the provision of humanized care, the demand for health services would be avoided only in more severe cases and decreased the demand at the three levels of health care.[6]

The development of the research presented some barriers, such as reduced access to the target population, mainly due to availability or incompleteness when answering the questionnaire. Even though they were instructed about the confidential nature of the shared information and anonymity there was resistance to participation. Moreover, the limited and/or inadequate familiarity of the use of technology by middle-aged individuals, as well as even more restricted use as age increases were limiting factors considered.

Conclusion

For the population surveyed, some factors imply low demand such as reduced training of professionals at the tip, pre-established stigmas and fear of discrimination during care, but among the participants of this study, a minority reported having suffered discrimination, but when asked if they know someone who has suffered, almost half of the interviewees said yes. The low frequency of discrimination in health services may indicate the difficulty of characterizing exposure and/or experiences by this population.

Considering that the world population tends to be mostly elderly over the years, we have to understand the needs whether social, biological, mental or environmental that will be carried and needy of every government that seeks to improve the quality of life of its population. Thus, one should seek to understand the real needs of different population groups during the aging process.

Aknowledgment

This study was not granted to be done.

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