Production of nursing care for the LGBTQIA + population in primary care

Produção do cuidado de enfermagem à população LGBTQIA+ na atenção primária

Producción de cuidados de enfermería para la población LGBTQIA + en atención primaria

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RESUMO

Objetivo: descrever a produção do cuidado em Enfermagem à saúde de Lésbicas, Gays, Bissexuais, Travestis e Pessoas Trans Queers Intersexos, Assexuais e outras identidades sexuais e de gênero, a partir das reflexões acerca do trabalho da enfermeira. **Método:** Estudo qualitativo, realizado com 18 enfermeiras que atuavam na Atenção Primária à Saúde em um município da Bahia, Brasil entre o ano de 2018. Realizou-se entrevista individual em profundidade, analisadas pelo método do Discurso do Sujeito Coletivo. **Resultados:** O cenário da produção do cuidado de enfermagem a partir do trabalho da enfermeira na Atenção Primária direcionado à população LGBTQIA+ esteve permeado por fragilidades no reconhecimento desta população no território de atuação, no atendimento clínico empregado na consulta de Enfermagem e no reconhecimento das vulnerabilidades e necessidades de saúde da população LGBTQIA+. **Conclusão:** Há fragilidades, barreiras e dificuldades na produção do cuidado à saúde da população LGBTQIA+ que envolvem dimensões distintas que perpassam pela formação acadêmica, profissional, estrutural, administrativa/institucional e da gestão do cuidado e atenção à saúde no contexto da Atenção Primária. Este cenário é provocador da manutenção de desigualdades e iniquidades em saúde que necessitam ser superados.

Descritores: Análise de Gênero na Saúde. Diversidade de Gênero. Minorias Sexuais e de Gênero. Enfermagem. Atenção Primária à Saúde.

ABSTRACT

Objective: to describe the production of nursing care for the health of Lesbians, Gays, Bisexuals, Transvestites and Trans Queers, Intersex, Asexual and other sexual and gender identities, based on reflections about the nurse's work. **Method:** Qualitative study, conducted with 18 nurses who worked in Primary Health Care in a municipality in Bahia, Brazil between 2018. An in-depth individual interview was conducted, analyzed using the Collective Subject Discourse method. **Results:** The scenario of the production of nursing care based on the work of nurses in Primary Care directed to the LGBTQIA + population was permeated by weaknesses in the recognition of this population in the territory in which they operate, in the clinical care used in the Nursing consultation and in the recognition of vulnerabilities and health needs of the LGBTQIA + population. **Conclusion:** There are weaknesses, barriers and difficulties in the production of health care for the LGBTQIA + population that involve different dimensions that go through academic, professional, structural, administrative / institutional training and the management of care and health care in the context of Primary Care. This scenario provokes the maintenance of health inequalities and inequities that need to be overcome.

Descriptors: Gender Analysis in Health. Gender Diversity. Sexual and Gender Minorities. Nursing. Primary Health Care.

RESUMEN

Objetivo: describir la producción de cuidados de enfermería para la salud de Lesbianas, Gays, Bisexuales, Travestis y Trans Queers, Intersexuales, Asexuales y otras identidades sexuales y de género, a partir de reflexiones sobre el trabajo de la enfermera. **Método:** Estudio cualitativo, realizado con 18 enfermeros que laboraron en Atención Primaria de Salud en un municipio de Bahía, Brasil entre 2018. Se realizó una entrevista individual en profundidad, analizada mediante el método Discurso Colectivo del Sujeto. **Resultados:** El escenario de la producción de cuidados de enfermería a partir del trabajo de enfermeros en Atención Primaria dirigido a la población LGBTQIA + estuvo permeado por debilidades en el reconocimiento de esta población en el territorio en el que se desenvuelve, en la atención clínica utilizada en la consulta de Enfermería y en el reconocimiento de vulnerabilidades y necesidades de salud de la población LGBTQIA +. **Conclusión:** Existen debilidades, barreras y dificultades en la producción de atención en salud para la población LGBTQIA + que involucran diferentes dimensiones que pasan por la formación académica, profesional, estructural, administrativa / institucional y la gestión de la atención y la atención de la salud en el contexto de la Atención Primaria. Este escenario provoca el mantenimiento de desigualdades e inequidades en salud que es necesario superar.

Descriptores: Análisis de género en salud; Diversidad de género; Minorías sexuales y de género; Enfermería; Primeros auxilios.

ORIGINAL

Introduction

In Brazil, in the 1980s, the LGBTQIA + movement became one of the most significant and apparent, for making social demands in search of respect for a sexual identity different from heteronormative standards, the autonomy of the homosexual movement and the right to exercise and freedom for sexual experiences.[1] This mobilization had a positive impact, while gaining visibility and inciting great national and international debates. The way the groups organize themselves gain global strength, the parades appear as a major event capable of awakening many looks at the problems that afflict the LGBTQIA + population, including the violence resulting from homophobia.[2]

The LGBT Policy was an initiative stemming from the requirement of social movements in articulation with the academy and the management of SUS to build an inclusive assistance elaborated from the principles of equity, universality and integrality. The Ministry of Health, aiming to reduce inequalities, set up the Mais Saúde Program - Everyone's Right, which presents specific goals to promote actions to tackle inequalities in health, with emphasis on population groups of blacks, quilombolas, LGBTQIA +, Roma, workers sex, homeless population, among others.[1,3]

The demand for health services by the LGBTQIA + population is limited, certainly influenced by the discriminatory and exclusive context in which health care is organized. The predominant logic of thinking the subjects in terms of a presumed heterosexuality interferes with the quality of the services offered, since they do not meet the real needs of the LGBTQIA + population, in addition to the health practices developed are based on personal values and preconceived concepts. which often repels vulnerable subjects.

Thus, the Ministry of Health determines that sexual and gender identities are properties that expose this specific population to discrimination and the violation of human rights, including restricting full access to health, due to the non-adequacy of gender to biological sex or heteronormative sexual identity. This condition produces setbacks and reinforces the situation of vulnerabilities in which LGBTQIA + people are already.[4]

In the Brazilian context, advances in the health area, with regard to the LGBTQIA + population, are insufficient; since the uniqueness of these identities, being often permeated by stigma and prejudices regarding the adequacy of gender with biological sex, [5] even after the implementation of the National Policy for Integral Health of LGBTQIA +.

It is considered that the inclusion of the LGBTQIA + population in health care depends to a large extent on changes in the way of thinking and acting of health professionals. These subjects must be welcomed, have humanized care free from discrimination, the rights to privacy, autonomy and the free development of personality must be respected, regardless of sexual orientation or gender identity[6.]

The scientific production about health care for this population group requires an increase, therefore, we adopted as a research question: how is the production of nursing care configured in primary care directed to the health of the LBTQIA + population? As an objective, this study sought to describe the production of nursing care in primary care directed to the health of the LBTQIA+ population.

Method

Descriptive, qualitative study, conducted with 18 nurses who worked in the Primary Health Care network in a municipality in Bahia-Brazil. The participants had cisginera gender identity, heterosexual sexual identity, age group between 26 and 33 years old, self-reported brown race / color, average family income of R $ 2,862.00 reais, Catholic religion / belief, graduate education. Other professionals from the family health team, nurses not registered in the territory, who did not work in Primary Care, coordinators of health services and programs, ferists and who were on leave were excluded.

Data collection took place from a hybrid, individual, in-depth interview, scheduled according to the availability of the participants, guided by a semi-structured script, carried out in a reserved place in their workspace, Family Health Units and Basic Health Units , with guaranteed individuality, privacy, image preservation and anonymity in the information collected.

The interviews had an average time of 30 minutes, were recorded with their own recorder and later transcribed in full, coded and organized, with the authorization of the participants and in compliance with the criteria established by the COREQ, for qualitative research.[7]

The seized data were organized and systematized under the support of the NVIVO® 11 Software and subsequently submitted to codification that made it possible to emerge the formulation of Synthetic Discourses, structured through the application of the Collective Subject Discourse (DSC) method. For that, the methodological figures were apprehended: Key Expressions and later the Central Ideas and made it possible to analyze the phenomenon that expresses the thought of a collective.[8-9]

It is worth mentioning that for its execution the project was submitted and approved by the Research Ethics Committee of Faculdade Nobre, under protocol CAAE: 80261917.9.0000.5654, number: 2,395,929 and was in line with the criteria of the Revised Standards for Quality Improvement Reporting Excellence , SQUIRE 2.0. For interviews, the study was presented to the participants and the Free and Informed Consent Form (ICF) was applied to the participants. The term was read and explained, subsequently signed in two copies, one of which is the responsible researchers and the other of the interviewee, in compliance with Resolution 466/2012.

Results

The collective speeches allowed to explain the empirical phenomena from three macro categories of discourse-synthesis, composed by the subcategories of Central Ideas that composed the object under analysis.

Synthesis 1: scenario of care production from the perspective of recognition of the LGBTQIA + population in the territory

Central Idea 1A: Stereotypes of the LBTQI + population

I realize that he is an LGBTQIA + person due to his behavior and sometimes the Community Health Agent who reports, although since the time I entered the unit where

I work, I have not seen anyone. I am not close to the LGBTQIA + public registered in the unit where I work. (DSC of nurses from ABS).

Central Idea 1B: Invisibility of LBTQIA + identity

In my appointments, I never identified and never reported I attend childcare, prenatal care that is everyone at first straight, in family planning I also did not identify anyone with a homosexual relationship, in HYPERDIA, they are older and I didn't notice and I don't ask the option their sexual The LGBTQIA + audience that I can most easily recognize are gay men. Transvestites are more difficult to appear in the unit, as well as lesbians, as they do not usually report during consultations. I find it difficult to differentiate what it is to be homosexual or transsexual. I care for many patients who are registered in the unit where I work, but sexual orientation is not a requirement to be worthy of investigation in the history of Nursing in the medical record. (DSC of nurses from ABS).

Central Idea 1C: Ignorance of the demands for care directed to the LGBTQIA + population

Indirectly I attend the LGBTQIA + public, after all, the demand for care is free, but I never made a specific consultation. The public does not report that it is LGBTQIA +. Here at the unit there is no specific LGBTQIA + group, the care demands are for childcare, children's health, women's health, men's health, we don't have LGBTQIA + health. I imagine that they exist in my area of coverage because I care for many men and women, and some are yes homosexuals, others I end up not knowing because particularly I think invasive is asking if the person is LGBTQIA +, it's kind of embarrassing. Once, during the cervical cancer preventive exam, during the questions about sexual intercourse, the patient reported having sex, but not with a man. When I heard that report, I was a little scared, because I didn't expect to come across that answer. It is still something that scares and makes me apprehensive because I don't know how to deal with this person. (DSC of nurses from ABS).

Synthesis 02: scenario of care production from the perspective of needs and demands

Central Idea 2A: Reception

I have tried to provide the service with welcome and receptivity, without dealing with difference or any prejudice. The service does not change due to sexual orientation, there are no impediments in my practice for this reason. Before arriving at the nursing office, patients are received by the reception, hygiene and nursing technicians and need, as well as me to attend spontaneously.

Central Idea 2B: Nursing Assistance in Sexual and Reproductive Health

The patients I recognize who are LGBTQIA + tend to show up at the family planning program. I perform testing for the detection of Sexually Transmitted Infections (STIs) such as Syphilis and HIV. I request serological exams, distribute condoms and attend to emergency demands related to sexual health, for example, discharge and urethral pain and emergency contraception. I also provide guidance on STI prevention, safe sexual intercourse and reproductive planning. (DSC of nurses from ABS).

Central Idea 2C: Nursing Care in Endocrine Health - Hormone
In the case of the trans population, the demand for hormonal control has come to the service, especially in relation to the interruption of menstrual flow and contraception. (DSC of nurses from ABS)

Central Idea 2D: Nursing care in immunological health - immunization
During the consultation I seek to provide guidance related to immunization and provide care about the vaccines, their effects, contributions and possible adverse effects.

Central Idea 2E: Recognition of health vulnerabilities
The few patients I saw were experiencing prejudice and health risks. They were afraid during the service, afraid to be in the unit and with a significant lack of guidance on health care, preventive measures, condom use during sexual relations and vulnerability to STIs, such as HIV. Some were in a situation of prostitution and came to the clinic more frequently to perform preventive exams and access condoms. They had social problems such as low financial condition, precarious employment, family problems and violence expressed in mistreatment and even beatings and beatings. (DSC of nurses from ABS).

Synthesis 03: care production scenario from the perspective of frailties

Central Idea 3A: Weaknesses in health education
We try to give lectures, health actions to carry out rapid tests, but it is restricted only to this area. We need more disclosure because the lack of knowledge of the professional health team is very large. Health education is essential and our team has already tried to form a group with the LGBTQIA + population, but it was not very successful, on the day there was only one person and since there are few of those who come to us, they end up going unnoticed. (DSC of nurses from ABS).

Central Idea 3B: Weaknesses in professional training
In Primary Care, we should have greater support to serve the LGBTQIA + population. Specific training and qualifications are lacking. I never received specific training to work with the health demands of the LGBTQIA + population here at the unit. Because of these reasons, I end up facing greater difficulties in dealing, approaching and providing care to the LGBTQIA + population, which makes me feel unprepared. (DSC of nurses from ABS).

Central Idea 3C: Weaknesses in interprofessional health work
The health unit is always open to receive the LGBTQIA + public, but I face great difficulty in establishing strategies with the team to reach this audience. The number of Community Health Agents in the unit is low, medical professionals are not sensitive and creates difficulties in performing health work dedicated to this area. (DSC of nurses from ABS).

Central Idea 3D: Weaknesses in overcoming stigma and discrimination
I have been looking for conversations with my team at meetings to disentangle any kind of prejudice from users. Even though there was no situation of embarrassment on the part of the team I work with, it has been a challenge to attend LGBTQIA + free from discrimination. One problematic factor found is religion, as many professionals who work in the health unit end up treating patients differently due to sexual orientation. (DSC of nurses from ABS).

Central Idea 3E: Weaknesses in matrix support
The team that works with me has not carried out actions to map and monitor the population in the territory. We are not sure how many LGBTQIA + people are part of the health unit's coverage area. The home visit aimed at serving the LGBTQIA + population is absent and the active search carried out by Community Health Agents is precarious. (DSC of nurses from ABS).

Central Idea 3F: Weaknesses in the development of specific actions
I do not have a program or health care directed at the LGBTQIA + population in the territory where I work. Concrete health policy actions aimed at this population are lacking. We do not have a specific day of service for the LGBTQIA + population as I fear for non-LGBTQIA + women and men. The campaign actions carried out by the municipal health department also do not address the health issues of the LGBTQIA + population, which affects the link of this population to the health unit in your locality. (DSC of nurses from ABS).

Central Idea 3G: Weaknesses in the fulfillment of the social name in the Unified Health System (UHS)
I already know about the social name in health facilities at UHS, but in the unit where I work, the reality is that this right is not respected. Health professionals are not yet qualified to ensure that the name is guaranteed. There is a great lack of information that results in non-compliance. (DSC of nurses from ABS).

Discussion

The study revealed the production of Nursing care for the health of Lesbians, Gays, Bisexuals, Transvestites and Trans Queers, Intersex, Asexual and other sexual and gender identities. It became expressed by invisibilities, difficulties in recognizing the population in the territory, as well as the fragility of the professionals' approach to work aimed at contemplating sexual diversity and gender identities.

It also proved to be a work based on rigid organizations of the work process in the Family Health Strategy, without the construction of actions aimed at serving the LGBTQIA + public, such as the production of specific and singular care for the same, which expresses the existence of weaknesses in the performance of professionals to conduct assistance and incipience regarding the research carried out in the Nursing consultation, by demonstrating that they feel ashamed or uncomfortable in approaching patients about their sexual orientation and gender identity.

As for the care for the LGBTQIA + population, nurses mentioned that they did not receive this public frequently, which may be associated with fragility in the active search and even recognition of the territory, and even the presence of prejudices.[11-12] Therefore, it is important to highlight existence of symbolic barriers in accessing services, especially due to the manifestation of stigma and discrimination in health, which reinforce stereotypes, formulate and strengthen prejudices and cause the erasure of people and the expression of their sexual and gender identities.

Thus, it is emphasized that among the LGBTQIA + population, Transvestites and Transsexuals are the ones who suffer the most from prejudice and discrimination in the family and social environment, as well as in health services.[13] The prejudice of health professionals towards the public LGBTQIA + results in the disqualification of health care for this population, showing the extent of these discriminatory processes to the health system itself.

The LGBTQIA + population has its basic rights attacked and is in a situation of vulnerability. In the context of confronting prejudice and discrimination, organized social movements such as the Brazilian LGBTQIA + Movement appear, in which they demand the free expression of their sexual identity, the change of name in identification documents, access to health policies and protection the State in the face of violence motivated by prejudice.

Regarding the recognition of the health demands required by the LGBTQIA + population, the study revealed, based on the collective discourse that nurses mentioned, that this LGBTQIA + population when accessing the service, seeks health care directed to family planning, as well as to attention to Sexually Transmitted Infections (STIs), conducting rapid tests and purchasing condoms. It was also noted that these specific demands, such as those related to sexual health, are only exposed by the population when there is a development of the bond between professional and user.

The identification of the LGBTQIA + population as a key population for the STI affection, with emphasis on HIV / AIDS, led to specific health actions for this population, which contributed to the discrimination of homosexuality in the general and scientific community.[13-14]

The vulnerabilities of the LGBTQIA + population, recognized by nurses, were associated with fear, prejudice, stigma, family breakdown, financial difficulties, exposure to STI, lack of knowledge and lack of education and guidance and violence, factors that, according to them, are determinant for dismissal of this public of health services.

In this context, efforts should be made to develop actions aimed at combating institutional invisibilities towards this population, with an emphasis on women, who are in a greater situation of vulnerabilities and erasures of their sexuality, with increased access and guaranteeing the integrality of attention.[16]

Faced with this reality, the Ministry of Health recognizes that sexual and gender identities are attributes that expose the LGBTQIA + population to discrimination and violation of human rights, including non-integral access to health, which must be constantly reflected on by health professionals and managers, as well as social control bodies.[17]

Regarding the health care produced by health professionals, the results show that nurses reported providing the same care to anyone, and claimed not to know how to deal differently with the LGBTQIA + population. However, it is relevant to reflect that the search for respect for multiple identities runs through the issue of equity in health care, as in Nursing. In this sense, it would not be just a matter of treating everyone "as anyone", which would be a basic aspect to be guaranteed, when we reflect on the concept of equality, but, rather, to direct care from the deconstruction of barriers that exist between those who can be served and those who want to be served, in addition to those who cannot be served, and pay attention to those who do not feel belonging to services, as they are marginalized and segregated.[18]

It is noteworthy that entry into services, as in the Family Health Strategy, demands awareness of the different modalities of constitution of family networks, distinct from the heterosexual pattern, striving for respect for the singularity of the subjects and combating all forms of standardization that involve exclusion and discrimination of people. This is only achieved by breaking institutionalized discriminatory processes.

Assistance to the LGBTQIA + population currently provokes public health professionals to create care actions aimed at this population that overcome the historical stigmatizing and limited approach, but that are associated with the creation of these identity categories and health needs that are not met.[19]

From the point of view of health needs, it should be noted that they are organized into four groups, namely: good living conditions; the need to have access to and be able to take advantage of all health technology capable of improving and prolonging life; the creation of effective links between each user and a team and / or a professional; and finally, the autonomy of each subject in the way they conduct their lives[20], which is necessary to contemplate the production of health care for the LGBTQIA + population. Thus, they need to be considered in the production of nursing care for the health of these people.

The greatest actions taken by nurses at the units were based on health education, such as lectures and waiting rooms. The LGBTQIA + population experiences some disparities in health care, resulting in reduced production of care in health services, becoming limited.[21]

The professionals' unpreparedness and lack of knowledge regarding the needs of this population are evident, resulting in insecurity on the part of users and resistance in seeking specialized services.[22]

Access to the guarantee of care and the construction of bonds between subjects, for example, are influenced by the way in which institutions provide assistance to individual and collective health needs. The attitude of the health worker, when placing himself in the user's place and perceiving his needs, is understood as one of the forms of reception as he meets and responds to these demands. Access, a determining factor for the effective use of health services, also results from individual, contextual and quality-of-care factors that influence the use and effectiveness of care.[23]

The idea of resistance of this population to go to work, for fear of repression or prejudice, is prevalent in all nurses' statements. A study showed that the population in question is highly resistant to seeking health services, which demonstrates the existing discriminatory context, constituted by a presumed heterosexuality, the lack of qualification and the prejudice of health professionals to serve this population.[13]

Thus, it is observed that the LGBTQIA + population does not have its health needs met because it is subordinated to rejection or irrational intolerance to homosexuality and other sexualities deviating from heterosexuality and heteronorm. The authors add that the group does not expose their sexual orientation in health services, thinking of the negative impact that this will bring to the quality of care.[13] A discussion about the assistance of nurses to the LGBTQIA + community is necessary, collaborating to trace a diagnosis of local reality, identifying needs and creating opportunities to rethink professional practice.[11]

Some health professionals, if influenced by the heterosexual standard imposed by our culture, make use of discriminatory practice, which can constitute a harmful obstacle to the access of the LGBTQIA + population to health services.[24] One of the ways to generate quality in health services is listen to these users, knowing their opinion in relation to the services and access to them.[22]

During the interviews, there was a lack of knowledge about comprehensive health policies for the LGBTQIA + population. A further consideration of the complexity of the health of LGBTQIA + people determined the creation of more comprehensive public health policies in order to meet the demands that would protect the specificities of lesbians, gays, bisexuals, transvestites and transsexuals and more related to the process health-disease-care.[25]

Based on the Brazil without Homophobia Program and in accordance with SUS guidelines, in 2010, a historic landmark was created to recognize the health demands of this population in vulnerable conditions: the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals.[15] Their guidelines and objectives are, therefore, geared to changes in the social determination of health, in order to reduce inequalities related to the health of the LGBTQIA + population. HUS guidelines reaffirm the commitment to universality, integrality and effective popular participation, for the recognition of the needs for actions, for the promotion, prevention, recovery and rehabilitation of health.[25]

Among the limitations expressed by nurses, the lack of knowledge about the characteristics of the LGBTQIA + population was mentioned, as well as the lack of training promoted for the workers of the units. Thus, recognizing the full citizenship of all human beings, more specifically, of the LGBTQIA + population, one can think about the search for coexistence between these users and health professionals. The changes in the health networks for the better care of this population also depend on the changes in the way of thinking and acting of health professionals. Cultural issues arising from the heterosexual pattern subjectively influence the care provided by health professionals to this population.[12]

Thus, the difficulty of accessing transvestites, transsexuals and transgender people to health services is a dilemma that must be discussed by health agencies, demonstrating the fragility of the user and health professional relationship with respect to the communication process, in which important issues about sexuality end up being omitted, missing opportunities for health promotion.[13,26]

In the field of health, important advances are noted in the Brazilian context, such as the Brazil Without Homophobia Program and the Comprehensive Health Care Policy of the LGBT population.[27] However, there is still a difficulty to be faced by the LGBTQIA + population in the face of violence and discrimination experienced as a result of free sexual identity. In addition, access to health care goes through difficulties, such as discriminatory care by professionals in the units, inappropriate conduct, constraints, prejudiced connotations or even verbal offenses said by professionals during care.[13]

In view of this context, "there are still several obstacles regarding the implementation of government proposals".[28] Thus, for health policy to be integrated, investment in professional training focused on the development of

professionals' communication skills is necessary, in order to enable them to use non-discriminatory language in serving the LGBTQIA + population.[25]

Conclusion

The collective discourse of nurses working in Primary Health Care allowed to reveal the production of Nursing care for the health of Lesbians, Gays, Bisexuals, Transvestites and Trans Queers, Intersex, Asexual and other sexual and gender identities.

The study is limited to highlighting the assistance reality of a Brazilian municipality, however in view of the still incipient production on the theme, this framework offers subsidies for the development of strategies to improve the health care of the populationLGBTQIA +, as gaps and weaknesses of the attendance.

Here we can point out possibilities to qualify the production of nursing care, considering the hard work to be done from training to uninterrupted in-service training, involving the different sectors and spheres of care. The responsibility for free access, production of inclusive and resolving practices must be shared between the social subjects who use the service and health professionals.

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