DOI: http://dx.doi.org/10.18569/tempus.v11i1.1855

Caminhos e vivências de investigação acerca da saúde da população LGBT em uma capital do nordeste brasileiro

Paths and experiences of the research process regarding the health of the LGBT population in a northeastern Brazilian capital

Caminos y experiencias de investigación sobre la salud de las personas LGBT en la capital brasileña del noreste

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RESUMO: O preconceito por motivos de orientação sexual e por identidade de gênero incide na determinação social da saúde ao desenvolver processos de adoecimento e sofrimento, decorrentes do estigma social reservado à população de Lésbicas, Gays, Bissexuais, Transexuais e Travestis (LGBT) na Saúde Coletiva. Diante disso, esse trabalho trata-se de um relato de experiência que buscou analisar a condução de uma pesquisa nacional, que investigou o acesso e a qualidade da atenção integral à saúde da população de LGBT no Sistema Único de Saúde (SUS). O recorte abrange vivências e reflexões dessa produção em Teresina, Piauí. Aliado a isso, foi ressaltada a necessidade de possibilitar a reflexão sobre as atividades desenvolvidas, a fim de compreender as

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fortalezas, fraquezas, oportunidades e ameaças na execução da pesquisa, e os resultados obtidos por meio desta análise possibilitaram uma visão detalhada da percepção dos pesquisadores sobre o processo de investigação.
Palavras-chave: Sistema Único de Saúde. Sexualidade. Equidade em saúde.

ABSTRACT: Prejudice on the grounds of sexual orientation and gender identity focuses on the social determinants of health to develop disease processes and suffering resulting from the social stigma reserved to Lesbian, Gay, Bisexual, Transgender and Transsexual (LGBT) people in Public Health. Therefore, this work is an experience report that aimed to analyze the conduct of a national survey on the access and quality of comprehensive healthcare of the LGBT population in the Unified Health System (SUS). The outline covers experiences and reflections of this production in Teresina, Piauí. In addition, it was stressed the need to allow reflection on the activities undertaken, in order to understand the strengths, weaknesses, opportunities and threats in carrying out the research. The results obtained through this analysis enabled a detailed view of the perception of the researchers about the investigation process.
Keywords: Unified Health System, Sexuality, Health Equity.

RESUMEN: El prejuicio por motivos de orientación sexual e identidad de género se enfoca en los determinantes sociales de la salud para desarrollar procesos de enfermedad y sufrimiento, resultantes de un estigma social reservado a la población de Lesbianas, Gay, Bisexual, Transgénero y Transexual (LGBT) en salud pública. Por lo tanto, este trabajo es un relato de experiencia que tuvo como objetivo analizar la realización de una encuesta nacional sobre el acceso y la calidad de la atención de la salud integral de la población de los homosexuales en el Sistema Único de Salud (SUS). El esquema abarca las experiencias y reflexiones de esta producción en Teresina, Piauí. Junto a esto, se hizo hincapié en la necesidad de permitir la reflexión sobre las actividades realizadas, con el fin de entender las fortalezas, debilidades, oportunidades y amenazas en la ejecución de la investigación, y los resultados obtenidos a través de este análisis permitieron tener un panorama detallado sobre la percepción de los investigadores en el proceso de investigación.
Palabras clave: Sistema Único de Salud; sexualidad; equidad en salud.

INTRODUCTION

This is a proposal to analyze the research process related to the construction of techno-scientific knowledge in the field of Collective Health based on reports from researchers belonging to one of the Research and Study Groups of the Nucleus of Public Health Studies of the Federal University of Piauí (NPHS-FUPI).

This analysis was related to the conduction of the research entitled “Analysis of the access and quality of the comprehensive healthcare for the LGBT population in SUS” carried out by the

Nucleus of Public Health Studies of the University of Brasília (NPHS/UnB) in partnership with FIOCRUZ/PE, and with the Federal Universities of Paraíba, Piauí and Uberlândia, University of São Paulo, as well as the State Universities of Maringá and Rio de Janeiro. The work was funded by the Department of Participatory Management Support (DPMS) of the Department of Strategic and Participatory Management (DSPM) of the Ministry of Health (MH) and it has been developed since 2014.

The purpose of this research was to map, identify and understand the dimensions of access to health services in their various possibilities of supply and demand, as well as the quality of care in the city of Teresina, in Piauí. From this, it will be possible to articulate a set of actions and programs that should be practiced in all the spheres of management of the Unified Health System (SUS).

The analysis presented here sought to relate the factors that facilitated or hindered the work process of this Group of Studies and Research during the execution of this type of investigation. As a way of conducting this study the following guiding question has been formulated: what experiences and reflections could be rescued from the development of an investigation about the health issue of the LGBT population in the city of Teresina?

From this, we will discuss: the importance of developing research regarding the health issue of the LGBT population; and the interactions between the various stages of the work and its different actors.

WHY TO RESEARCH ON THE HEALTH OF THE LGBT POPULATION?

In western societies, among them the Brazilian, the human sexuality has been the central theme in the most diverse debates. In general, each has been permeated, to a greater or lesser extent, by common sense or technical-scientific discussions. However, they have brought connotations of a process of (dis)constructing meanings and meanings of culture, subjectivity and body at different times.

For Foucault[1], first of all, it is necessary to make a historiography of sexuality, in order to understand in depth sexuality and its practices throughout the times. This is justified by the fact that it is important to elucidate their forms of repression, where the control of bodies legitimized patterns of normality through a moralistic and institutional discourse until the period of sexual freedom.

The discussion of the Foucauldian epistemology allows us to analyze the interpersonal relations through the triad know-power-pleasure, allied to the construction of ‘absolute truths’ about sexuality[1]. These unquestionable premises engendered senses and conditions that make sexuality narcissistic movements, thus, generating the reproduction of these without the reflective use of

intelligence in different social environments, as in health services.

Regarding the recurrent topics related to the social issues that deal with sexuality and sexual behavior, there is a consensus regarding the themes of discrimination and violence. When we extend this discussion to the health area and enter the discussions about the access to basic and specialized actions and services, there seem to be several other factors that make it difficult.

Cardoso and Ferro[2] pointed out that it is common to see discrimination by health workers in relation to the LGBT population and that this is associated with the lack of preparation of these professionals to deal with the different demands of these subjects. In fact, the health training process does not seem to meet this social demand in the most diverse courses. When allowed to discuss this subject, they are limited to a strictly biomedical model. This posture can trigger different forms of violence, either by the inadequate approach of professionals to the people, or by the absence of devices that respond to the needs of the LGBT population in the various levels of healthcare.

According to the Ministry of Health, all types of violence, either veiled or explicit, should be considered as factors that drive the production of physical and/or mental illness[3]. In this sense, it is necessary to gather efforts and bring together resources that are capable of overcoming this exclusionary logic that health services have assumed.

With regard to the public policies of comprehensive care to the LGBT population, even with the struggles waged by the social movement, there was a gap in this field, characterized by the invisibility and not vocalization of demands for singular and specific needs. The first actions, in the early 1980's, were focused on prevention and care with the then HIV / AIDS epidemic, at that time heavily known as 'gay plague'[4].

It was only in 2004 that some actions were initiated, such as health education actions. On this occasion, the Federal Government launched the 'Brazil without Homophobia - Program to Combat Violence and Discrimination against LGTB and Promotion of the Homosexual Citizenship', which brought civil society and government together for the rights of the LGBT population. It was a true historical milestone in the fight for the right to dignity and respect for difference. This has contributed to the consolidation of political, social and legal advances in the area, besides promulgating the citizenship of this segment with the equalization of rights and facing violence and discrimination, respecting the singularities[3].

In the field of health, the fact that institutions such as WHO/OPS have assumed and disseminated the reference of the social determination of health and disease in order to devise comprehensive strategies for their confrontations, has contributed decisively to the fact that social exclusion and discrimination of any kind were characterized as a determinant of suffering, illness and death. In this way, the effects of gender exclusion and discrimination began to be considered as academic research topics and governmental policies.

In the search for explanations about the invisibility of lesbians and bisexual women in the area of comprehensive healthcare for women, some studies indicate that, in SUS, there are weaknesses in the reception of this demand. In general, in the search for healthcare, women do not even receive support from health professionals to verbalize their sexual orientation. This compromises the comprehensive healthcare and causes a form of symbolic violence[5].

Cerqueira-Santos *et al*.[6] point out several obstacles experienced by the LGBT population regarding the access and quality of the access to health services. However, it is mentioned that these are more dramatic in the case of transvestites and transsexuals. It happens not only because they demand specialized care for demands that are not placed on other segments of the population, such as the bodily changes associated with the use of hormones and silicone, but also due to the intensity of discrimination and exclusion that usually affects healthcare settings.

In this scenario of violence, the invisibility of gender issues in health practices is highlighted, and sexuality experiences are ignored. In general, the heterosexual modality has been attributed as a standard, with direct implications for the healthcare of the LGBT population. In this sense, the heteronormativity acts together with other forms of structural violence, generating a hostile and segregating environment in health services.

To that end, Lionço[4] signaled the need for a specific health policy for this segment, however, based on the promotion of equity, based on the reflection and recognition of the vulnerability condition that this population is in relation to human rights.

In the midst of this set of strongly denied needs, questions have been raised in the light of human rights proposed by social movements. The National Policy on Integral Health of the LGBT Population was formulated as a response to the muted demands and specificities of the LGBT population, its processes of exclusion and vulnerability, as well as a focus on the structural centrality in health equity, in order to promote citizenship and a public policy guaranteeing their rights. Within this framework, the National LGBT Integral Health Policy was approved by the National Health Council in 2009 and published through the Administrative Rule No. 2,836, dated of December 1, 2011, and agreed by the Tripartite Interagency Committee (TIC), pursuant to the Resolution No. 2 of December 6, 2011[7].

Despite all this effort, there is still much to be discussed. Regarding the academic production on this subject, we perceive a multitude of works on sexuality and sexual behavior related only to HIV/AIDS. Is the demand of the LGBT population only that?

The issue of access and quality of care is also a topic that should be better explored in investigations. This has been a trend of analysis in Collective Health in view of the valorization of the right to health, associated to the respect of the principles of universality, equity and integrality.

From this, other demands can be redeemed and improved. However, we can point out a number

of difficulties in the process of conducting researches.

INTERACTIONS BETWEEN THE VARIOUS STAGES OF WORK AND THEIR DIFFERENT ACTORS

The operationalization of the research on the health of the LGBT population in the Teresina (Piauí) substation required the adoption of a series of important measures. It was necessary to think about the strategies of adaptation of the national proposal at the local level. To this end, a Conducting Group (CG) was created, consisting of participants from several professional categories (among them: medicine, nursing, psychology and dentistry), in view of the need to stimulate thematic appropriation, as well as to share knowledge and practices about the process of research development and the organization of the work process.

Regarding the thematic approximation, in fact, weaknesses in health training were pointed out regarding the care to the LGBT population among the participants of the group, as we had mentioned previously. In general, there is little space in the academy to discuss this issue, when we believe that in this universe it is indispensable to offer a constant discussion about the most diverse social issues, whether through teaching, research and/or extension strategies. However, there is little investment, especially in research that deals with the health of the LGBT population[8].

In this same sense, the participants mentioned failures experienced by each one of them in the most diverse training periods, regarding the teaching-service-community integration strategies. There is no doubt that it is necessary to promote a dialogue between the theoretical and practical field since the beginning of the course, but we know that this has not always been encouraged.

In this way, the first questions have emerged: how to overcome the fragilities of health education about this theme? What strategies can be put forward in the attempt to bring the research universe closer to the reality lived by the LGBT population?

In our reality, a space of studies and experiences on this theme was organized, as a way of overcoming some weaknesses identified in the formation. At each discussion, new issues were pointed out, which should be deepened and related to the methods for appropriating each of them.

These meetings also made it possible to strengthen the bond between the group's participants in the research for a theoretical-conceptual and practical unit that seemed indispensable for the continuity of the work. This was all because the research process involved a "collective thinking and doing" around a task.

There was also the need to exercise interaction and communication among the group participants to foster thinking and creativity in the work process. In addition, it was emphasized the need to enable reflection on the activities developed, particularly when it came to understanding the

strengths, weaknesses, opportunities and threats in the execution of the research[9].

Allied to this, the work of the Conductor Group favored the design of the study in this city, as well as the elaboration of strategies of action in the field of the research. In the initial phase, this group elaborated a proposal of formation of an Operational Group that involved the selection of monitors. This selection was based on the presentation of a letter of intent and report of experience in research and extension activities related or not to the theme of the study being developed.

With the extended group, we had theoretical-conceptual moments with all the participants, in order to promote theoretical alignment. In the first workshop, a dynamic was suggested with the intention of perceiving how each of the participants perceived the approach to the LGBT population. In the midst of a series of situations, the group began to form an identity of values that needed to be rescued in terms of their driving.

At other times, important actors were invited to contextualize this social issue, as well as the life story of each one of them. It is worth mentioning that these moments provided unique experiences among the participants of the group and made possible the reflection of the universe that we would be involved in the research field.

After the formation of a unit to the group, we operationalized the research. In the selection of research fields, we sought to contemplate different territories, now distributed in three different parts of the city: northern side; south side; and east/southeast side. In general, 7 (seven) territories were identified, two in the north and south and three in the east/southeast. The monitors were divided into pairs and each of them had the support of two tutors (professors, health professionals and/or masters).

Once the reference territories for the investigation have been identified, we set out to identify the reference health teams for each of the areas. Right after, the process of interviews with the managers of the Family Health Centers and professionals began. About 42 health professionals (doctors, nurses and community health agents) and 7 managers were interviewed. The interviewers reported being welcomed by each of the survey subjects. However, we perceived limited knowledge about the subject of the study, confirming the weaknesses in the professional training. In addition, the demand in the service seemed not to be frequent and this made it impossible the contact of the health team with the LGBT population.

It is important to mention that there was resistance from some professionals in deepening the discussion about this subject and it has made the investigation process difficult. In fact, the professionals did not seem to be comfortable dealing with the health issue of the LGBT population. There seemed to be a functional, social, and even cultural barrier that kept each of them from the subject under investigation. But should not the health service be the place of reference for this type of demand? Being a 'gateway' to the health system implies in having access limitations? These and

other answers would require a greater contact with the service in order to get to some conclusions, but this was already sufficient to mobilize the interviewers' team and give them the opportunity to reflect on the issues that would need to be better discussed in the area of teaching and service.

After the completion of this stage, a workshop was held to analyze this work process. In this opportunity, the SWOT matrix was used to identify the strengths, weaknesses, opportunities and threats related to the research process based on the researchers' statements. In the light of this analysis, it was possible to find internal forces (strengths and weaknesses) and external forces (opportunities and threats). Through the SWOT matrix, we could: analyze and best use the strengths; eliminate weaknesses; know and enjoy the external opportunities; and avoid threats.

The results obtained through this analysis allowed a detailed view of the researchers' perception of the research process. Through this, we perceive that the receptivity of the field opens paths to health education and offers freedom of action in the development of activities. In addition, it favors the growth of the future professional.

However, there is a need to involve more community and healthcare professionals in activities like this. We believe that this could be a powerful device for recognizing the fragility of the health services and stimulating change in the working practices.

FINAL CONSIDERATIONS

Given the various gaps between SUS and the LGBT population, and the evidence that the sexual orientation and gender identity are social determinants of health, The LGBT Policy has emerged as a proposal to recognize the socio-historical and cultural antecedents of inequities and social exclusion of the LGBT people in the health agenda, and proposed to expand the knowledge, skills and attitudes of its main actors in order to resolve prejudices and negative value judgments in relation to the segment and to recognize that, like all Brazilian citizens, the LGBT people have varied health needs and must receive humanized and comprehensive care at all levels of attention.

In this way, the work developed by the Conductor Group has favored the design of this Policy in the city, as well as the elaboration of strategies of action in the field of research, which faced access resistance to the professionals, as well as their possibilities to participate in the research, and, in general, it can be translated by the obstacles faced by the LGBT users when they look for health services.

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Article submitted on 03/05/2016

Article approved on 30/06/2017

Article posted in the system on 21/09/2017