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# It Continues to be a Taboo…"Knowledge and Practices of the Health Team Regarding the Attention Towards the LGBTI Population"

## Ainda um Tabu…"Conhecimentos e Práticas na Atenção à Saúde Para a População LGTBI"

## Todavía un Tabú…"Conocimientos y Practicas en la Atención de Salud a la Población LGTBI"

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## ABSTRACT

**Objective:** To identify which are the knowledge and practices of the health team on LGTBI population care. **Method:** qualitative, descriptive study, developed in the first semester of 2017 with members of the health team of a hospital in Cundinamarca, Colombia. After having carried out 16 semi-structured interviews, the saturation criteria have been reached. **Results:** The access and use of health services from LGTBI population can be limited by stigmatization behaviors that, in turn, provoke dehumanization and discrimination; hence, there is the challenge of health care models with differential approach that propitiate respect and trust instead of exclusion and critics. **Conclusion:** it is evident that discrimination mediates health care. The health team reports that it is still a taboo to provide health care to this group of persons; it highlights the gaps in knowledge derived from the weak training processes that may lead to a lack of quality and humanization on health care.

**Descriptors:** Sexual Minorities, Public Health, Taboo, Knowledge and Practices on Health Care.

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## RESUMEN

**Objetivo:** Identificar cuáles son los conocimientos y prácticas del equipo de salud en la atención a la población LGTBI. **Método:** estudio cualitativo descriptivo, desarrollado en el primer semestre del año 2017 con profesionales de salud de un hospital de Colombia. Llevado a cabo 16 entrevistas semiestructurada, se cumplió con el criterio de saturación. **Resultados:** El acceso y utilización de los servicios de salud de estas personas se pueden limitar por conductas de estigmatización que a su vez provocan deshumanización y discriminación; de ahí surge el desafío de modelos de atención con enfoque diferencial que propicien respeto, confianza en lugar de la exclusión y critica. **Conclusión:** la atención en salud esta mediada por la discriminación, visibilizando los vacíos en conocimientos que son derivados de procesos de formación y que pueden conllevar a falta de calidad y humanización en la atención en salud.

**Descriptores:** Minorías Sexuales, Salud Pública, Tabú, Conocimientos y Prácticas en Salud.

## RESUMO

**Objetivo:** Identificar quais são os conhecimentos e práticas da equipe de saúde na atenção à população LGTBI. **Método:** estudo qualitativo descritivo, desenvolvido no primeiro semestre do ano 2017 com profissionais de saúde de um hospital de Cundinamarca de Colômbia. Realizadas 16 entrevistas semiestruturada, foi cumprido o critério de saturação. **Resultados:** O acesso e a utilização dos serviços de saúde dessas pessoas podem se limitar por condutas de estigmatização que, por sua vez, provocam desumanização e discriminação; daí surge o desafio de modelos de atenção com foco diferencial que propiciem respeito e confiança, em lugar de exclusão e crítica. **Conclusão:** a atenção à saúde está mediada pela discriminação. A equipe de saúde relata que ainda é um tabu prestar atenção à saúde deste grupo de pessoas; isto ressalta as lacunas no conhecimento, derivadas de processos de formação e que podem acarretar a falta de qualidade e humanização na atenção à saúde.

**Descritores:** Minorias Sexuais, Saúde Pública, Tabu, Conhecimentos e Práticas em Saúde.

# INTRODUCTION

The United Nations (UN) has indicated that the LGBTI (Lesbians, Gays, Bisexuals, Transgenders and Intersexuals) population may now be up to 10% of the overall inhabitants on Earth. If this proportion maintains itself in Colombia, the LGBTI population here would be, today, superior to 4.9 millions of people.[1] Therefore, what was previously considered a minority is now a stronger group every day, and that has generated the formation of new spaces so that LGBTI people of many cities around the world are able to organize collectively as part of the LGBTI social movement, with a series of demands that have to do, primarily, with the recognition of their rights in the social, political, cultural, legal and economical fields. Moreover, these rights must be recognised into the health systems.[2]

Health care ought to be comprehensive, encompassing all people regardless of their own narrative of gender and sexual identity. Diversity should be transversal to the professional practice itself and not a topic that occasionally is touched, it is important that health professionals reflect on their beliefs and prejudices. As previously described how are the knowledge and practices of the health team when attending the LGTBI population, it can show the difficulties that the health team often faces in approaching this population, due to the lack of knowledge, fear, surprise, anger or the simple taboo it implies our own sexuality in our culture.[3]

There is information that shows that many people who are part of a minority of sexual orientation have delays in care or receive inappropriate care, in their perception of homophobia in the health system. In a study conducted by the Canadian Health System from 2003 to 2005, it is reported that compared to the heterosexual population, the LGTBI population is less likely (approximately 50%) to acknowledge a health professional that provides comprehensive treatment, since there is a greater perception of dissatisfaction in not finding answers to their health problems and lower rate of cervical cancer screening in the last three years (64% in the lesbian population vs. 77% in heterosexual women).[4]

In 2010, the Municipality of Bogotá applied a survey to 1213 people in the LGBT sector of Bogotá 2010, regarding the right to health and access to it, finding that 83% of the transgender workers reported discrimination in the right of health. Who, in a lesser proportion, perceive and present discrimination to the right to health are those who are bisexual (53.24% and 7.29% specifically). From the LGBTI group, gays have the greatest access to health (93%) and transgender people are the ones whom access them the least (82.46%). The answers are statistically different for gays, bisexuals and transgenders. With regard to medical care, those who did not receive it the most when they required it were transgender people (43.84%).[5]Taking into account the above, it is an important group of people who feel the existence of discrimination, inequality and gaps in health care, which highlights the need to understand the knowledge and practices of the health team towards the LGTBI population, considering the great impact it has on public health, as indicated by Carissa Etienne:

> *"Few sanitarian information systems take into account variables such as sexual orientation or gender identity, which makes LGBTI people feel invisible in Health systems. This has severe consequences to the individual and public health, since LGBTI people live harsher disparities and health results than Heterosexual people. LGBTI people still present higher infecction rates of HIV, depression, anxiousness, tobacco consumption, alcohol abuse, suicide or suicidal ideas behind chronic stress, social isolation, and disconnection with a series of health and support services."*

Consulting different sources of information from official entities such as the Ministry of National Education and the Municipality of Bogotá, we found that the lack of information on the LGTBI population in terms of health

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services and factors such as discrimination and lack of access to services in health is a constant. However, since 2014 the staff working at the Municipality of Bogotá aimed at carrying out processes of attention to sexual diversity.

According to reports from the Center for Sexual Diversity of the District Department of Planning, more than 50% of LGBTI people had been discriminated against in the right to health. The transgender population was the one that felt the most discrimination and the one that had least access to health; among the barriers that affect the access to health of the LGBTI population were the lack of information on the part of medical and administrative staff, the lack of knowledge of the differential approach to care, the lack of research on issues that affect this population, discrimination and the presumption of heterosexuality of all people. The Center for Integrated Attention to Sexual and Gender Diversity was created in 2014, with the coordinated participation of the Secretariats of Education, Health, Government, Women, Social

Integration, Planning, Economic Development and Culture, which aimed to help people who have been harmed and mistreated psychologically, sexually and/or physically, through psychological support and training in health and education issues.[6]

Therefore, the understanding of the knowledge and practices of the health team is the first step for the construction of care models that contemplate and include diverse subjectivities, and that can integrate the work of accompaniment, recognition and strengthening of the autonomy for the LGTBI population. This new approach for health teams is fundamental to exist from their academic formation, oriented in the differential attention recognizing the rights of all the people.

## METHODS

An ethnographic approach was carried out, which allowed us to analyze and interpret the information - both verbal and non-verbal - provided by the health team; to understand what they do, say and think about the care of LGTBI people. This is a qualitative research[7] and it was performed in the first semester of 2017 to members of the health team of a Health Services Provider Institution (I.P.S) of the Department of Cundinamarca of Colombia. The saturation criterion was met in the 16 interviews, that is to say that a certain diversity of ideas had been heard earlier, and with the additional ones, no other elements appeared.[8]

The data collection was performed through confidential semi-structured interviews, applied to eight technicians and eight professionals. These interviews were recorded in audio system with informed consent and were, subsequently transcribed for analysis, containing open questions that inquired about the knowledge and practices of health, such as: LGTBI concept, health legislation, projects addressed to this community, definition of gender identity and sexual orientation; and, regarding practices, there were questions of how care was provided to this group of people, and does the staff do when they have doubts about of the patient's sexual orientation.

Subsequently, the coding process was carried out in which the information obtained was grouped in categories that concentrate the ideas, concepts or similar topics discovered during the research process[9,10,11,12] as are the knowledge and practices of the health team for both professionals and technicians. As for the analysis of the information a matrix of data was elaborated in which the declarations of the interviewees were made, discovering in this way the units of meaning that are revealed through the reading of both the individual and collective discourse of the participants.

## RESULTS AND DISCUSSION

The homophobic environment (rejection to LGTBI people) affects health, causing the "stress of sexual minorities". This situation becomes more complex when it shows certain attitudes of the health team towards LGTBI people, since they show little understanding and sensitivity, which often results in less quality care.

One of the biggest barriers in the access to health services - and consequently to a timely and quality care for the LGTBI population, is the lack of recognition by the members of the health team of the existence of diverse ways of expressing, transiting and identifying with genders, as well as the multiple ways of understanding and experiencing sexualities3; which prevents on many occasions the possibility of achieving an accurate diagnosis to understand a disease, achieving adherence to treatment and providing health education in an appropriate manner.

Among the professionals interviewed in the health team were two doctors, two nurses, one odontologist, two bacteriologists and one administrative officer. Within the technical personnel interviewed there were three laboratory assistants, three auxiliary nurses, one administrative assistant, one auxiliary of health services. Of the 16 people interviewed, 15 were women. The age ranges are between 23 and 56 years; mostly of Catholic religious orientation, with a level of work experience between 2 and 32 years (**Table 1**).

**Table 1** - Characterisation matrix

| Age | Current profession | Religious Orientation | Work experiences (in years) | Current level of study | Marital status |
|---|---|---|---|---|---|
| 32 | Nurse | Catholic | 32 | Professional | Single |
| 35 | General Practitioner | Catholic | 6 | Professional | Married |
| 26 | Odontologist | Agnostic | 26 | Professional | Cohabitation |
| 23 | Bacteriologist | Christian | 23 | Professional | Single |
| 56 | Bacteriologist | Catholic | 20 | Professional | Married |
| 28 | Administrative Assistant | Catholic | 10 | Professional | Cohabitation |
| 24 | Nurse | Catholic | 2 | Professional | Married |
| 49 | Clinical Family Doctor | Orthodox Jewish | 21 | Professional | Married |
| 38 | Auxiliary Nurse | Catholic | 14 | Technician | Married |

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| 47 | Auxiliary Nurse | Catholic | 25 | Technician | Married |
|---|---|---|---|---|---|
| 38 | Auxiliary Nurse | Catholic | 16 | Technician | Married |
| 31 | Clinical Laboratory Assistant | Catholic | 3 | Technician | Single |
| 29 | Secretary | Catholic | 15 | Technician | Single |
| 25 | Clinical Laboratory Assistant | Catholic | 7 | Technician | Single |
| 43 | Clinical Laboratory Assistant | Catholic | 15 | Technician | Single |
| 36 | General Services | Catholic | 4 | Technician | Single |

**Table 1:** Characterisation Matrix

**Source:** Original What the staff knows

Knowledge is a set of information stored through experience (a posteriori), or through introspection (a priori). Within the collected data, all the members of the health team interacted with LGTBI people in their work. They said that *"People **who are not**, who have a sexual inclination different from the heterosexual would be lesbian, gay, bisexual; I know, they are using the way of having very, very direct sexual relations and they are very very susceptible to being infected by their, by their choice, by sex."*

Regarding health legislation, the concept issued by a significant number of interviewees, made an association with adoption between gay couples and marriage between same-sex couples, no person made any reference to differential health care: *What they accepted if they could get married and suddenly adopt children is what I think they can do?*

In 2011 in Colombia, the Constitutional Court recognized, for the first time, that those who maintained romantic relationships with people of the same sex could have the vocation of forming a family nucleus. In 2012, through sentence T-276/12, adoption was approved for homosexual parents.

The interviewees refer that they obtained the vast majority of knowledge regarding LGTBI people from the media and that in their training processes was not contemplated: *Suddenly because of the media, the television does not comment the topic in depth but touches it if one does have the theme included.*

A review was made of the academic curriculum of seven health education institutions in Bogotá and none of them evidenced the inclusion within the training process of differential attention to the LGTBI population.

**What does the staff do regarding attention in health**

The *practice* is the action that is developed with the application of certain knowledge and with respect to sexual orientation. It should be noted that health professionals consider the performance of their activities regularly is questioned by the patient and that is essential during the anamnesis to carry out promotion and prevention activities. While technicians consider that they only ask if it is strictly necessary and often avoid doing it because this population can take it as "a lack of respect" and that they often feel "ashamed" to ask about the sexual orientation of patients.

**Health Professional's Response:** *What do I do in the medical part? Well, as I always tell you, it's up to you to investigate, because the medical part does not have to ... get the complete information to be able to make a diagnosis in order to be able to to help the patient, then in that case, he has to tell him - Hey, look, I need to know your sexual condition, because if that has to do with the picture that is presenting at that moment, it is clearly important to know it!*

**Health Technician Response:** *Well, one is ashamed to ask them - Hey, are you? But suddenly one would be detailed and one would look at his face, it would be touching if he dressed very well, so that he would not note his features, the face because in any case, they are people that no matter how much the face you notice that they are men, yes? And to ask him not because that would already be disrespectful to tell him! - Hey, is that you're like this? No. I would not ask him.*

For some interviewees, religion is linked to the conception of normality as only of heterosexual people: *"Emm, I have nothing against that if, each person can freely choose their sexual life sexual orientation, but then there is to share it or accept it, I do not accept it. I come from a Catholic family that is very clear, like that part of God that made man and woman to procreate. Not dad and dad or mom and mom then, I do not accept it." (Nursing Assistant)*

The majority of the interviewees interacted with people from the LGTBI population and stated that they had a "normal" relationship with them and did not feel any discomfort in the attention provided to them. It was observed that in their statements there were comments with some kind of prejudice in particular, specially prejudices from the point of view of the religious beliefs of the members of the health team such as: *"Normal, normal. I see them exactly the same as any other person. They tell me their stories, and even advice I could give them but then really, eee I have a daughter and No!, and I speak very clearly about those things. I go back and I repeat I am Catholic my family is very Catholic and, and they instilled a lot of that then, I try to make my daughter learn the same thing that I have learned respecting others, because my daughter spotted them in shopping malls and I say that the most common thing in the world, and that even friends and acquaintances have, but if I would have to accept to that I would not accept it. (Nursing Assistant); Well, I think that in terms of health care, there is no exclusion or inclusion because, as the person arrives without saying their orientation, simply for one to attend the person refers to the name and the person and their exams that it brings; It brings the person already as before but one does not ask - What sexual orientation do you have? Also, they do not arrive saying - I'm from the community I'm gay I'm a lesbian."*

Most of the interviewees agree that from their experience one of the recommendations that would make the health system to improve the LGTBI community's service is to prepare more staff, especially the care staff, in addition to generating processes and spaces in which sensitize and

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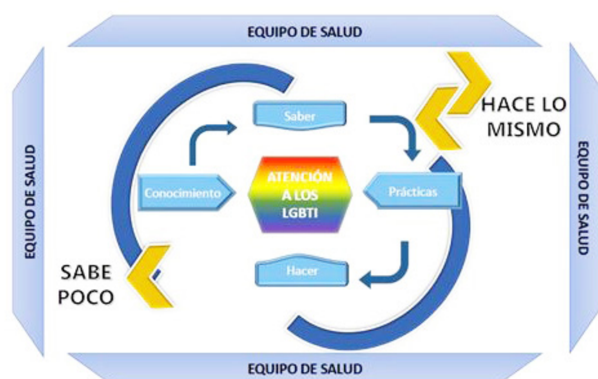
prepare the health team on issues of policies for the LGTBI population and differential health care for this population. That would be in order to eliminate the possible barriers that appear in access for non-attendance to health services the LGTBI population because they feel discriminated against and will allow them to provide the appropriate routes and protocols of care.

By describing the knowledge and practices of the health team to the LGTBI population, it was possible to analyze behaviors that "should" be known and practices that "should" be performed, understanding why people do what they do. In the study conducted, the trend was reflected to continue with traditional processes, in which little is known and consequently the same is done.

**Figure 1.** Comprehensive Scheme




**KNOWLEDGE AND PRACTICES OF THE HEALTH TEAM IN DIFFERENTIAL ATTENTION**

**Source:** Original

SIt reflects the tendency to continue with traditional processes, in which little is known and, therefore, the same is done.

Regarding **knowledge**, there is a divergence since the interviewees know the operative definition of the LGTBI term, but when asked about sexual orientation and gender identity, only one person was clear about the concept, with a marked erroneous tendency to consider that it is like: *I feel like a woman, I express myself as a woman, and if I feel like a man, I express myself as a man*. However, everyone agreed that the treatment given to the patient is more important than the administrative issue of naming him, so they treat them according to the gender they are perceived as and they ask their name of choice. In comparison, a similar study conducted in Argentina and in most of the interviews conducted some factors are relevant, such as the difficulties and/or conflicts that are generated in relation to how trans people should be named by the professional. They agree that the names "legal" or "real" are the ones that appears in the document, and are the ones that are written in the clinical history. Yet, as in the case of Colombia, the treatment of the patient prevails over administrative issues. In Argentina there is a resolution which refers to the fact that all the health dependencies of that Ministry must under all circumstances respect the gender identity adopted or self-perceived of those who attend to be assisted.[13]

For 2017, despite the fact that there is a differential care policy, the outlook is not very different from what was experienced in 2013, since it is evident that there is a lack of awareness of the differential care policy for the vast majority of the health team. Furthermore, it is striking that most of the knowledge regarding the LGTBI population has been acquired from the media and not from the training processes, either from the technical or professional focus, which is having an impact on the lack of solid knowledge about care for this population showing the same lack of information that existed years ago by medical and administrative staff, which increases stigma, discrimination and has repercussions on the increase of the burden of disease.

In Colombia, unlike countries such as Argentina, there is no structured guide for health care for the LGTBI population addressed to health personnel, which ranges from the person of admissions to auxiliaries, nurses and doctor; in which tools are provided to be able to solve the main health problems that afflict them. Nowadays, there are many management guides for different pathologies and/or people, which include diagrams and flowcharts, which would be of great importance and usefulness so that the existing gaps in knowledge are affirmed and the stigmatization and discrimination towards this population is left behind.

According to Terrasa, "*The Health professional who attends a LGBTI person may feel uncomfortable during the session, and might feel that is not trained to answer some of their doubts or to give some health advice.*"[14] This argument contrasts with what was found in this study, since the interviewees stated that if they could participate in a project aimed at this population, they would be interested in focusing on the promotion and prevention activities, especially among young people. It is evident that the people of this population go to the health services when there is already some kind of illness that is often acquired due to ignorance when exposed to risk situations and as in most cases the members of this population they feel vulnerable because of their orientation they take refuge in alcohol and drugs, which can increase the risk of diseases. In the United States, according to the report, the needs of LGBT people in Health Centers are as in Colombia: people from the LGBTI population have specific health care needs and concerns. These include higher rates of depression, suicide, homelessness, drug abuse, smoking, HIV infection, hepatitis B and other sexually transmitted diseases.15 In addition, stress due to discrimination and stigma leads to suicide or abuse of hallucinogenic substances or alcohol, because it is their only way to deal with all this.

Regarding the **practices**, where you inquire about whether you have doubts on sexual orientation, our technical interviewees reported that they did not ask because of embarrassment. The professionals who did it within their routine, contrasts with what Terrasa[14] refers to students and professionals they who that one should not inquire about the sexual orientation

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of people and only emphasize on objective risk behaviors in order to recommend preventive practices of sexually transmitted diseases, etc. Likewise,[4] more than 90% of people in the LGTBI population wish to be able to share their sexual orientation with the health team that provides assistance, they say that the possibility of talking makes them more comfortable during the interview, increases the perception of warmer and integral care. It is stated[16] that only between 9% and 30% of professionals ask their patients about sexual orientation and of those who do, only 13% use open questions.

It is evident that the values, beliefs and religious conceptions of health providers are very present at the time of care for patients in general, in addition to the stereotypes based on the constitution of the male and female sexes and what society assigns or accept as normal or natural[3] have become the main barriers in the health of the LGTBI population. This was not only evident in this study but also in the manual prepared by the Ministry of Public Health of the Republic of Ecuador, where it was also evidenced that health services must provide psychological guidance sensitive to sexuality of LGBTI people through their staff, who should be oriented to support this population in order to support the process of consolidation of sexual identity and gender to strengthen relationships with the social environment.[3]

## CONCLUSION

Within our study it was evident that there is a lack of training by the health team that allows us to reflect on sexual diversity, paradigms, vulnerability and the needs of attention in the health services of this population. In Argentina, the training is directed to the health service from the perspective of gender and respect for sexual diversity, which arose from the motivation and need of health teams due to the growing demand of trans people who, when accessing their services, questioned limited and discriminatory practices13 all in order to reduce stigma, discrimination and, thus, be able to offer services that are more appropriate to the needs of the LGTBI population.

Stigmatization and discrimination by the health team are a public health problem, since people in the LGTBI community prefer not to attend health services, which can increase the burden of both physiological and mental illness of an individual, leading to an escalation in costs to the General System of Social Security in Health and often leaving transient sequelae or permanent disability.

Among the people belonging to the LGTBI population, it should be noted that transgender people were the ones who most reported discrimination in the right to health care, which generates specific training opportunities for the health team to provide comprehensive care and a differential approach, without neglecting the humanization and understanding of health needs that this community presents so that it stops being a taboo in health institutions.

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