HEALTH SERVICES FOR LESBIANS, GAYS, BISEXUALS AND TRANVESTITES / TRANSEXUALS

SERVIÇOS DE SAÚDE PARA LÉSBICAS, GAYS, BISSEXUAIS E TRAVESTIS/TRANSEXUAIS SERVICIOS DE SALUD PARA LÉSBICAS, GAYS, BISEXUALES Y TRAVESTIS / TRANSEXUALES

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ABSTRACT

Objective: to analyze, from the perspective of professionals of the Family Health Team, the access of Lesbian, Gay, Bisexual and Transvestite / Transsexual to the Basic Units of Family Health. **Method:** this is a quantitative, field, exploratory and descriptive study. The sample was composed by the snowball technique with 54 professionals, using a questionnaire, semi-structured interview script and the Free Word Association technique. The data was processed by IRAMUTEQ® software. **Results:** the classes generated, defined in subcategories << Equality in the care of LGBT people >>, << Attitudes and behaviors of the LGBT population that hinder the search for the health service >>, << Prejudice and restriction in the access of the LGBT person to health >> and << Right to LGBT access to health service >>. **Conclusion:** it was shown that professionals perceive LGBT people as human beings deserving of equal access in the spaces of the FHS so that they have access to serological tests, rapid tests, consultations and inputs for the prevention of STIs. **Descriptors:** Health Services Accessibility; Patient Care Team; Health Services; Family Health; Sexual Minorities; Nursing.

RESUMO

Objetivo: analisar, sob a ótica de profissionais da Equipe Saúde da Família, o acesso de Lésbicas, Gays, Bissexuais e Travestis/Transexuais às Unidades Básicas de Saúde da Família. **Método:** trata-se de estudo quantificativo, de campo, exploratório e descritivo. Compôs-se a amostra pela técnica *snowball* com 54 profissionais, utilizando-se de questionário, roteiro de entrevista semiestruturada e a Técnica de Associação Livre de Palavras. Processaram-se os dados pelo *software* IRAMUTEQ®. **Resultados:** emergiram-se as classes geradas, determinadas de subcategorias << Igualdade no cuidado a pessoas LGBT >>, << Atitudes e comportamentos da população LGBT que dificultam a procura pelo serviço de saúde >>, << Preconceito e restrição no acesso da pessoa LGBT à saúde >> e << Direito ao acesso da pessoa LGBT ao serviço de saúde >>. **Conclusão:** mostrou-se que os profissionais percebem as pessoas LGBT como seres humanos merecedores de acesso igual nos espaços da ESF tanto que dispõem de acesso aos exames sorológicos, testes rápidos, consultas e insumos para a prevenção de IST's. **Descritores:** Acesso aos Serviços de Saúde; Equipe de Assistência ao Paciente; Serviços de Saúde; Saúde da Família; Minorias Sexuais, Enfermagem.

RESUMEN

Objetivo: analizar, bajo la óptica de profesionales del Equipo Salud de la Familia, el acceso de Lesbianas, Gays, Bissexuales y Travestis / Transexuales a las Unidades Básicas de Salud de la Familia. **Método:** se trata de un estudio cuantitativo, de campo, exploratorio y descriptivo. Se compuso la muestra por la técnica *snowball* con 54 profesionales, utilizando cuestionario, guión de entrevista semiestructurada y la Técnica de Asociación Libre de Palabras. Se procesaron los datos por el *software* IRAMUTEQ®. **Resultados:** Se emergieron las clases generadas, determinadas de subcategorias << Igualdad en el cuidado a personas LGBT >>, << Actitudes y comportamientos de la población LGBT que dificultan la procura por el servicio de salud >> y << Derecho al acceso de la persona LGBT al servicio de salud >>. **Conclusión:** se mostró que los profesionales perciben las personas LGBT como seres humanos merecedores de acceso igual en los espacios de la ESF tanto que disponen de acceso a los exámenes serológicos, pruebas rápidas, consultas e insumos para la prevención de IST's. **Descritores:** Accesibilidad a los Servicios de Salud; Grupo de Atención al Paciente; Servicios de Salud; Minorías Sexuales; Enfermería.

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INTRODUCTION

In discussing issues related to the health and sexuality of the LGBT population in the primary health services, a reflection on how the Family Health Team (FHT) professionals see this population, their health needs, how these needs are sought and if all these factors influence the care and treatment given, is enabled.

It influences, through the cultural factors derived from the heterosexual pattern, subjectively, the care of health professionals to this population. It is considered in this sense that the transformations of the health networks for the best care of this population also depend on the changes in the way of thinking and acting of these professionals.¹

The National Policy for the Integral Health of Lesbians, Bisexuals, Transsexuals and Transsexuals (NPIHLGBT) aims to ensure health, without discrimination or institutional prejudice, in order to favor the reduction of social and health inequalities, increasing access of this population to the primary, secondary and tertiary services of the Unified Health System (UHS) and generating respect, providing assistance with quality and resolution of their demands and health needs.²

Therefore, this study proposal is based on the perspective of strengthening the health of the population in general, but especially that of specific groups such as the LGBT population, within the framework of the Basic Family Health Unit (BFHU), where health care should be based on the principles and objectives of the Unified Health System, based on an integral and equitable model that is in line with the National Policy on Integral Health of Lesbian, Gay, Bisexual, Transvestite and Transsexual.

Therefore, it should be emphasized that this elucidation about the real health needs of the LGBT group can guide health planning measures in promotion, prevention, rehabilitation and healing actions guided by normative instruments that guarantee the support and responsibility of the LGBT group, health professional, in the presence of the assisted client, which enables a more qualified assistance contemplating the proposal of universal access to health without distinctions.

It is intended, therefore, that this study respond to the following guiding question: how does the access of the LGBT population to the health services of the Family Health Strategy from the perspective of the professionals of the family health team?

OBJECTIVE

- To analyze, from the perspective of professionals of the Family Health Team, the access of Lesbian, Gay, Bisexual and Transvestite / Transsexual to the Basic Family Health Units.

METHOD

A quantitative, field, exploratory and descriptive study was carried out at the Basic Family Health Units of the urban area of the city of Cajazeiras, State of Paraíba. The sample was composed of 14 professionals who are part of a Family Health Team composed of a physician, nurse, dentist, nursing technician, oral health technician and community health agents, duly registered in the National Register of Health Care Establishments. Health, and was given by the technique of snowball sampling, of non-probabilistic type, in which one participant indicates another possible participant until the repetition of indications and the exhaustion of the possibilities of participations.³ After the application of this procedure and its saturation, a quantitative of 54 professionals was reached.

The following data collection instruments were used: semi-structured questionnaire, interview script and the Free Word Association technique, carried out from March to June 2016, by scheduling. For the Free Speech-Language Technique, each participant expressed himself freely when mentioned the following phrase: when I say access to the services of the Basic Health Units of the Family for lesbian, gay, bisexual and transvestites / transsexuals, tell me five things that immediately come to their head.

Based on the free evocations, the lexicographic dictionary was forwarded to two experts for the determination of the root word and its derived words. After the feedback of the experts, the substitutions were made of words derived by the root words.

With the results of the 54 interviews transcribed in their entirety and the lexicographic dictionary coming from the Free Word Association Technique, the elaboration of the database for processing in Iramuteq® software was started. Empirical (qualitative) data analysis was performed using the Content Analysis Technique.⁴ The lexicographic dictionary was added after the floating reading and the material selection, validated by two experts, and the data was processed by Iramuteq software ® emerging the

generated classes, determined from subcategories.

The following variables were included in the corpus: age group id_1 - age between 25-36 years; id_2 - age between 37-48 years; id_3 - age above 49 years; sex sex_1 - female; sex_2 - male. The classification of the age groups was made from the lowest and the highest age of the study subjects.

For the categories generated, the sense environment of the words: access or exclusion of lesbians, gays, bisexuals and transvestites / transsexuals to the services of the Basic Units

of Family Health from the point of view of the health team. The letter P was listed to relate it to the speeches of professionals in the speech segments described.

The formal requirements contained in the national and international standards of research involving human beings were respected.

RESULTS

Table 1 - Characterization of professionals of the Family Health Team. Cajazeiras (PB), Brazil, 2017.

		Professionals		
		n	%	Average (SD)
Sex				
	Woman	43	79.60	
	Man	11	20.40	
Gender				
	Female	41	75.93	
	Male	13	24.07	
Sexual orientation				
	Homossexual	6	11.10	
	Heterossexual	48	88.90	
Age group				
	25-36	24	44.40	40.07 (10.16)
	37-48	18	33.30	
	49 over	12	22.20	
Income				
	4 to 7 salaries MW	41	75.93	
	Over 7 MW	7	12.95	
Schooling				
	Complete highschol	20	37.10	
	Incomplete higher	8	14.80	
education	Complete higher	26	48.10	
education				
Race				
	White	15	27.75	
	Brown	35	64.75	
	Black	2	3.70	
	Yellow	2	3.70	
Working time at the BFHU				
	6 months to 3 yearss	19	35.15	
	4 to 10 years	15	27.75	
	More than 10 years	20	37.10	
LGBT training				
	Yes	35	64.75	
	No	19	35.15	
Sexuality training				
	Yes	30	55.50	
	No	24	44.50	

Following the characterization of the professionals of the family health team, the analysis of the interviews with the words exhorted in the TALP, which were processed by the IRAMUTEQ® software and presented in Figure 1, are shown. Subsequent classes were created as follows: Subcategory 1 - Equality in care for LGBT people; Subcategory 2 - Attitudes and behaviors of the LGBT

population that hinder the search for the health service; Subcategory 3 - LGBT person's right to access to health service and Subcategory 4 - Prejudice and restriction on LGBT access to health.

Figure 1. Shows the distribution of the vocabulary of the classes, according to the descending hierarchical classification, corresponding to the professionals of the Family Health Team. Cajazeiras (PB), Brazil, 2017.

◆ **Subcategory 1 - Equality in caring for LGBT people**

It should be noted that subcategory 1 represents 14.9% of the corpus and was composed of health professionals, gender and female, with ages ranging from 25 to 48 years. Even culturally carrying characteristics such as caretaker, submissive and servant and accomplished training on LGBT politics and sexualities (Table 1), still show themselves as replicators of cultural patterns pre-established within the spaces of the Basic Family Health Unit.

Access to health is the same for every person, there is no specific program offer for LGBT (...) Regardless of sexual choice ... everyone is equal within the service and must be treated in a humanized way (... .) access to care should be the same for everyone ... because these people need more because of the vulnerable conditions of living in the promiscuous world and running various health risks (...) in care, normal and always respectful (...). (P40, P43, P47)

◆ **Subcategory 2 - Attitudes and behaviors of the LGBT population that make it difficult to find the health service**

It is clarified that subcategory 2 represents 23.4% of the corpus and was composed of members of the Family Health Team, of both genders, aged between 37 and 61 years. This subcategory indicates that the Family Health Team realizes that some attitudes and behaviors of LGBT people make access difficult in the search for the health service.

The vast majority of LGBT people are collected, shy, do not speak directly about their sexual health problems, they seem to be afraid of how they will be treated, welcomed and possibly disrespected (...) fear and shame are clear of the population (...) they should have a specific health, mainly for mental and psychological accompaniment, for dating a man today and tomorrow with a woman. (P04, P05, P13, P27)

◆ **Subcategory 3 - LGBT person's right to access to health service**

It is shown that subcategory 3 represents the greater part of the corpus, with 36.2%, being mostly composed of female health professionals, aged between 25 and 37 years. The perspective of the professionals shows the attempt in the LGBT person's right to access to the health service. The speech fragments below show this thought.

Today, the LGBT person's right to access to the Basic Family Health Unit is much greater. They have the right to the social name at the time of the consultation (...), access to the ladies' room if it is a transvestite. The population has been

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gaining space, (...) a transvestite can use whatever name he wants, it is a way to promote health ... the assistance happens according to the physical or psychological demand. We try to respond even though we have never received guidance on the subject. (P09, P10, P26)

◆ **Subcategory 4 - Prejudice and restriction on LGBT access to health**

It is explained that subcategory 4 represents 25.5% of the corpus, was composed of professionals of the Family Health Team, mostly female and aged between 25 and 48 years. In this subcategory, the LGBT person's mention, restriction and prejudice to access to health is observed, as observed in the speech fragment below.

There is no real access for the homosexual to the health services (...) the search is restricted to consultations already with aggravations of the process of sickness ... the population suffers prejudice, assistance resistance by the professionals, access should (...) there is already a new law to reduce prejudice to the LGBT person in the Basic Family Health Unit ... they have a certain priority in the issue of prevention, access to examinations and, especially, the serologies to take condoms because they are categorized in the groups of vulnerability and risk (...), has almost no specific tests directed to the LGBT population in the Family Health Unit. (P28, P33, P50, P51)

DISCUSSION

It is observed, in this study, the predominance of female participants evidencing the feminization of the participants. The gradual process of feminization is related to the traditional feminine roles in which women are linked to care, education and service, a situation very similar to what happens in health.⁵

Regarding sexual orientation and age, young adults who work in the primary health care spaces that responded to have a heterosexual orientation can be perceived. It is known that, with public policies aimed at the LGBT population, its visibility has been increasing, although timidly.

It is considered, with respect to the income of the professionals, the value as reasonable, respecting the cost of living of the Northeast region and, with respect to race / color, the majority of the workers is considered brown. It is seen that these data are consistent with the Brazilian demographic census that shows the majority of the population of the northeastern self-declared brown region.⁶

When it comes to professional practice time in the Family Health Strategy, it is revealed that professionals have more than

ten years of work experience in the FHS. The Pan American Health Organization (PAHO) focuses on the need for improvements in the service provided to the population by health professionals based on the training and improvement of their performance, taking into account the time of professional experience.⁷

It is emphasized that it is important to focus on what acquired knowledge, through training, may help, in part, in the technical improvement of specific actions in the work process of the professionals of the Family Health Team, with or with few years of work in the field. However, with regard to changing patterns of cultural thinking and actions arising from these thoughts, enabling, in order to reproduce knowledge, will probably not resignify health care.

This statement becomes clear once understanding that the culture permeates a set of elements that mediate and qualify attitudes, habits and actions physical or mental, not biologically determined, being shared by social actors that construct concrete and temporal social meanings sustaining prevailing social standards, institutions and their operational models, and culture includes values, symbols, norms and practices.⁸

In this sense, is it possible that the materialization of the vision of health professionals about the access of lesbians, gays, bisexuals, transvestites and transsexuals within the BFHU may be associated with the cultural reproduction of the professional or the lack of capacities?

In the speech fragments of subcategory 1, there is an attempt to offer equal care in the health care of LGBT people, within the scope of the Family Health Strategy, once the professional perceives the LGBT person as anything a human being who needs health care by classifying it as normal and worthy of equal care in the Unified Health System.

It is necessary, however, that there is equity and not equality, since the demands are specific and still have characteristics within the health services that could alienate the LGBT person or not to insert.

A reflection on this is observed, observing the view of the workers regarding the need for equity generated from a vulnerability that is linked to unprotected sex with promiscuity and to the multiplicity of partners as conduct developed by the population in question. It is considered that this behavior can also be seen in heterosexual individuals, but when mentioned that homosexuals ... need more because of the vulnerable conditions of living

in the promiscuous world and running various health risks ..., we can see the representation of inequality by associating the choice of living a reverse sexuality of the heteronormatized one showing gaps in the understanding of the real events that generate the true vulnerabilities to the LGBT.

It is inferred that this understanding may be intrinsically linked to the prejudice and / or stigma of these workers, and it is more comfortable to consciously offer LGBT people health practices according to the heteronormative needs, failing to investigate the real need of that individual and making unequal attendance.⁹ A proof of this rooted practice of prejudice is contained in Table 1 when it was observed that most workers have already done training related to LGBT politics and sexualities and yet reported stereotyped thoughts.

It is pointed out that there are still specific needs, through sexual diversity, going beyond the insertion of policies directed to the LGBT population including, here, the need to also reformulate health spaces working with cultural issues derived from heteronormative patterns.¹⁰

It should be noted that, for the MH, since the creation and implementation of UHS, equality in access to health care has been discussed and analyzed, as well as the development of new practices to strengthen and reorganize services. It is in this scenario that the National Policy for Integral Health to Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (NPIHLGBT) emerge in an attempt to promote equity in the health of this population.²

Equality and equity are also highlighted in favor of the refined practice of care, and in the elucidation of gender identities and sexual orientations, the Ministry of Health recognizes sexual orientation and gender identity as determinants and determinants not only because they involve specific sexual and social practices, but also because they expose lesbians, gays, bisexuals, transvestites and transsexuals to grievances resulting from stigma and social exclusion.²

It is perceived that the generalization of the LGBT class and the lack of knowledge of the specificities of the diversity and sexual practice, by the FHS workers, imply inequality of access to the care directed to this public, since generalizing induces a subjective reflection that the health needs to be the same for all, thus making them vulnerable. On the other hand, knowledge of the specificities elucidates the professional to the real need of lesbians, gays, bisexuals, transvestites and

transsexuals directing the same to promotional and assistance care practices in a more equitable way.

Health workers need to deepen their knowledge of public policies and the specific issues of LGBT people in order to better qualify the services provided by its various areas so that the principles of universality, completeness and equity, constitutive of the UHS, be implemented in public policies that provide the coping of the exclusionary consequences of LGBT phobia and heteronormativity.¹¹

It is observed that, even though most of the workers in this study participated in training on this subject, they need to know more deeply the nuances inherent in human sexualities in order to understand their complexity, mutability and the everyday construction within a society during the life cycle. In addition, the specificities of the way of living sexuality should be debated in the health spaces to be used in the attempt to break existing cultural paradigms that impede the integral assistance of specific groups.

It meets these specificities truly when, for example, it is recognized that a transsexual or transvestite must perform hormone therapy to meet his or her real gender identity, promoting mental health for this individual, in order to have a homeostasis between body and mind avoiding more serious illnesses, such as suicide,¹² but even if we have seen the nuances of this group, it is still common practice for the family health team to carry out heteronormatized practices that do not address the needs of this public.¹³

It is feared that the professional is afraid of being perceived by society from the moment he meets and accepts the LGBT person in his uniqueness. It is inferred that this situation occurs because these professionals are inserted and pass through the process of acculturation in a society with strong religious influence where possibilities are permeated from exclusion to professional failure, a characteristic still strong and present in the city under study.

It should be noted that the existence of obstacles goes beyond the need for professional training and the recognition of sexual prerogatives of lesbian, gay, bisexual, transvestite and transsexuals for equitable access in the territory of the Family Health Strategy, being, a priori, a field of investigation of measures that diminish these punitive actions materialized through social prejudice.

It is shown by the transcript in subcategory 2 that the health professional

believes that the shame, shyness and fear of LGBT people in the search for the service of the Basic Family Health Unit are associated with the fear of speaking the real needs due to disrespect and the way in which they will be accepted. In addition, they refer to the need for psychological support for lesbians, gays, bisexuals, transvestites and transsexuals because they have lived their sexuality different from hetero-normatized. It is seen that there is discomfort to expose their sexual orientation, perhaps for fear of being exposed in their communities, due to the unpreparedness of health professionals and the prejudice in relation to the other forms of sexuality experience.¹⁴

It is important to mention that, in order to guarantee the proposal of access in the spaces of the Basic Family Health Unit, it is essential to identify barriers related to the characteristics and needs of the population in general and, later, the promotion of equity in groups socially defined, such as the LGBT.¹⁵

It is therefore essential for the family health team to approach what is recommended by the NPIHLGBT for a better understanding of the assistance that should be provided to individuals whose sexual practices are not heterosexual, but what these workers are to get closer to this group, once this understanding has been obtained?

It is of the utmost importance that health care managers and professionals have the sensitivity to identify that attitudes and behaviors, such as shame, shyness, fear, fear and disrespect, raise barriers between professionals and users, making it possible to distance the LGBT person from the Basic Family Health Unit Program and providing a cascade of episodes that include increased risk factors for the installation of the disease process, aggravation of diseases already installed, the low demand in health promotion and prevention going contrary to the guarantee of access integral approach advocated by UHS.¹⁶

It is also emphasized that the biological particularities of sex, cultural factors related to being a woman and being a man, potentiate the occurrence of specific diseases and distinctions to access and technologies of attention and health care. It is seen that the health problems due to the link between gender stereotypes and specific stigmas are still perceived, and it is highlighted that stigma impedes the exercise of citizenship and, above all, the right to health.¹⁷⁻⁸

It is proposed, in order to reduce harms, by promoting health promotion and by guaranteeing access to professional development in relation to the right to free expression of sexuality and gender identity free of violence, disrespect and discrimination, the application of the guidelines contained in Health Users' Charter.¹⁹

It is necessary, on the face of it, that the health professional must understand sexual diversity and gender identity as something intrinsic, non-exclusive, in construction and inherent to the human being as a mutable and unfinished constitution. It is also considered that besides identifying these aspects, respecting them, it is important that the professional of the family health team launches strategies in which the user feels welcomed and free from stigma, fear, shyness and other feelings that promote exclusion by preventing accessibility in health services.²⁰

The main function of the reception is the guarantee of access to health, objectified by qualified listening, materialized in care actions, strengthening the link between professionals and users. It complements that the effectiveness in the reception results in the change of the thinking and acting of the community and the professionals of the Family Health Strategy in the sense of respecting and recognizing the different sexualities and forms of new family constitutions.²¹⁻²

In this context, it should be emphasized that, for the professional, it is not enough to have policies that guide practices for improving access to LGBT health, but it is essential to change prejudiced behaviors and actions that make it difficult to build the foundation of a truly humanized host.

Therefore, it is necessary to take care of reception strategies based on the awareness of the professional in order to promote a humanized care that results, in particular, in the integral care of the LGBT person, increasing their access to health.

In subcategory 3, an attempt is made to offer LGBT access to the health service. It was observed that the professionals perceive the advances of the LGBT population in the struggle of the rights to access in the spaces of the Basic Family Health Unit, mainly in the case of transvestites and transsexuals, when they refer to the right to use the social name and the bathroom within and outside health settings.

However, this assistance vision of the right to reductionist health becomes, if it is associated with the attempt of the right established to the access of a human being

(be it transvestite or transsexual or lesbian masculinized) in society and the spaces of the Unified Health System, according to the Brazilian Constitution.

The National Policy on Integral Health for the LGBT Person, in its legal basis, is available on the right to health as a social component and, for its implementation, the Constitution has integrated it into the Social Security System. In this way, social development is considered as an essential condition for the achievement of health.²

It is opposed to the idea of some authors when they refer that lesbians, gays, bisexuals, transvestites and transsexuals, more especially transsexuals and transvestites, are perceived as incapacitated by professionals of the family health team, inside or outside health spaces, due to their non-adequacy or sexual definition tied to their socially inappropriate behavior thus exposing them to violence, ridicule, stigma and marginalization.²³

It is inevitably perceptible, in this reflection, to the members of the family health team, when they come across individuals who openly declare their sexual orientation, or simply verbalized, without a stereotyped and prejudiced appearance, that the existing health demands only pervade the use of the social name going against the deep needs as in the case of biopsychosocial, from the moment in which the health professionals agree to only tolerate the social minorities castrating them of their rights as citizens, as well as treating them like second category characterized as social exclusion.²⁴

It is therefore apparent that it is important to note that only the right to the social name, as advocated by the MH, provides the right to health. However, it is possible to envisage that the host permeated by empathy, as it is necessary in this case, makes it possible to narrow the construction of the bond and reduce the gaps left by exclusion by minimizing vulnerabilities. With this, they value the rescue of citizenship and the free expression of sexuality if, in this way, to understand them as the exercise of inclusion of the subject in society.²⁵

It is advised that, instead of excluding, the health professional should use light technologies, such as qualified listening, promoting safety to the user and facilitating the collection of health information and empathy based on the understanding of health needs, the link, strengthening ties, developing trust and, finally, with the articulation of all, improving health care. It should be emphasized that these actions, if

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practiced in a harmonious way, will aid in the effective development of the work process in order to direct and welcome LGBT people so that they are assisted with quality while maintaining the right to full access within the Basic Health Unit, as a human being, regardless of gender identity, social behavior or sexual orientation.^{2,15,25}

It is pertinent to reflect the professionals of the family health team on the advances on the rights to health of LGBT people, in the spaces of basic health units, where they usually suffer different technical and assistance inequalities, because, from these reflections, the professionals will be able to see beyond these achievements weaving strategies with truly integral health care offerings and equanimous.

It is pointed out, in the words of the workers, in subcategory 4 that prejudice exists and can be reduced by a law. But should the professional of the family health team not know the origin of prejudice (which would probably lessen prejudice), understand it and then extinguish it, thus eliminating prejudice? Most of the professionals participating in this study have a complete upper level, more than ten years of service in the basic health units, and have sought training on LGBT politics and sexuality, as can be seen in table 1. Even so, show themselves with care traits covered by prejudice and curativism.

Lesbian, gay, bisexual, transvestite and transsexual access is restricted within the BFHU, when it is focused on limiting the access of LGBT people in the health sphere to the search for condoms, the serological examinations and consultations by means of the installation of.

It is conceived that prejudice and discrimination go together and originate in heterosexism and heteronormativity, which are consistent with the pathologization of these subjects, since they are not normal and do not have natural behaviors. In this perspective, they should be treated and healed as if there is something to be embedded in their sexuality, or in their subjectivity.^{2,12}

Despite the implementation of the National Comprehensive Health Policy for Lesbian, Gay, Bisexual, Transvestite and Transsexuals, it advocates the reduction of damages and injuries to this public, which still exists the distorted view of professionals in the family health team, that homosexuality needs treatment with measures imposed by policies and / or guidelines, as it is verbalized when a 48-year-old doctor mentions that:

Public health does not guide the treatment of LGBT people to change their sexuality. (P41)

It is identified that this affirmation, as well as the conformity in reducing the prejudice, despite the recognition of its origin, brings that the perception of the professionals of the family health team, unfortunately, is tied to the ignorance before the sexual diversity in the health scope, which leads to reflect: how is the work of this worker being developed to a person of the LGBT population? Given that LGBT people are subjected to various forms of prejudice, including in the territories of the health services, the resistance of the workers to the care and execution of procedures that really meet the needs of the LGBT person can not be forgotten, since the offer of examinations and the delivery of condoms must meet the need for vulnerability installed in the LGBT person.

It is understood, even in the face of the advances in the field of sexual rights in the construction of a public policy for the recognition of the effects of discrimination, prejudice and exclusion of these subjects in various social segments, and in particular homophobia / lesbophobia and transphobia, this phenomenon as a social determinant of the health-illness-care process that causes more suffering and illness in LGBT people.²⁶

It is believed that despite all the advances in this segment of health, affirming, in contemporary society, that a human being needs treatment for not following sexual behaviors in accordance with the recommended norms shows that, regardless of the area of action and knowledge acquired by this professional, intrinsically will exist in him the root contrary to the sexual diversity. This conduct of non-acceptance of differences causes, on a daily basis, exclusion, rejection and differentiation in the service offered which, possibly, over time, will result in psychic suffering for the LGBT person due to internalized self-rejection.

In this context, there are moral and aesthetic barriers that prevent access to health services by the LGBT population of quality, free of prejudice or discrimination, especially those with gender binarism (masculinized women, effeminate men, among others).²⁷⁻⁸

They are generated by the rapid recognition of alterations related to the sexual characteristics of the heterosexual society normalized, restlessness, penetrating looks, exhortation of aggressive words, laughter and disregard on the part of professionals to the group of LGBT people, more specifically to those with gender

binarism. In addition, it causes the user to be separated so that the search for the same to the basic health unit of the family is only for curative and non-preventive measures.²⁸⁻⁹

It is understood, therefore, that there is not only ignorance, but above all resistance, fear or prejudice, on the part of these professionals, to approach revealed sexuality or to deal with a subject with a different body, thus restricting the access of the users (s) for consultations on injuries, condoms and serologies.²⁶

In this case, the cultural, social, and paradigm shifts that limit, impede or hinder the access of this population to the assigned territory of the Family Health Strategy are becoming emerging, so that the assistance will be able to go through the punctual searches, becoming integral through the extinction of prejudice.

CONCLUSION

It has been shown that professionals perceive LGBT people as human beings deserving of equal access in the spaces of the FHS so that they have access to serological tests, rapid tests, consultations and inputs for the prevention of STIs / STIs, but it is emphasized that the FHS proposal goes beyond curative measures and punctual searches for basic health care.

It is stressed that practitioners recognize the need for equity for the vulnerable public due to risky sexual behavior, but it is definitely not developed due to repulsive social and cultural values imprinted in the professionals' own attitudes toward LGBT people.

It was considered that in the attempt to align care, the team tends to develop standardized care practices according to heterosexual protocols, creating a proposal for universal access, often distant from the real needs of this group.

It is recognized that, even in the face of the permanent education in which they are inserted, through themes related to sexuality, professionals still continue to conceive of homosexuality as a disease needing to be treated and that there is in the BFHU the imposition of policies for inhibition and not exclusion from prejudice. It was seen that they believe that the use of the social name and the women's room by transvestites and transsexuals is sufficient to materialize, in the spaces of the BFHU, a humane reception. It is emphasized that the reductionist perception of the real needs of LGBT people prevails, as well as the focus of the National Humanization Policy.

It is hoped that this study may instigate changes in the work process of the professionals who make up the family health team, clarifying doubts and stimulating the search for new knowledge that favors the construction of a fortified foundation in the professional-user relationship, especially in order to to develop standards of care that support the principles of equality, inclusion and respect for diversity.

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Submission: 2018/06/26

Accepted: 2018/07/24

Publishing: 2018/10/01

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