

Various shades of “no”: reports from Primary Health Care professionals assisting lesbians, gays, bisexuals, transvestites and transsexuals (LGBTT)

Vários tons de “não”: relatos de profissionais da Atenção Básica na assistência de lésbicas, gays, bissexuais, travestis e transexuais (LGBTT) (resumo: p. 16)

Varios tonos de “no”: relatos de profesionales de la Atención Básica en la asistencia de lesbianas, gays, bissexuales, travestis y transexuales (LGBTT) (resumen: p. 16)

Breno de Oliveira Ferreira^(a)

<breno.oli@hotmail.com> 

Claudia Bonan^(b)

<cbonan@globo.com> 

^(a) Universidade Federal do Amazonas. Avenida General Rodrigo Octávio Jordão Ramos, 1200, Coroado I. Manaus, AM, Brasil. 69067-005.

^(b) Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira, Fundação Oswaldo Cruz. Rio de Janeiro, RJ, Brasil.

The populations of lesbians, gays, bisexuals, transvestites and transsexuals (LGBTT) experience obstacles in the access to Primary Health Care services and in the assistance offered by them. In this study, we aim to analyze reports of professionals who assist these populations in the Family Health Strategy. It was a qualitative research carried out through oral reports. Thirty-two professionals from different categories who worked in a Primary Health Care unit in Teresina, Piauí, Brazil participated in the study. The analysis was guided by three dimensions - recognition, redistribution and representation - and showed that it is necessary to interconnect, within the same principle of justice, the space of recognition of sexual and gender diversity (cultural field), the space of inequalities linked to the exploration and redistribution of resources (organizational field), and the space of representation and participation of LGBTT populations (political and social field), in the circular logic of the health services.

Keywords: Sexual and gender minorities. Health professionals. Primary care. Healthcare.



Introduction

Although violence against people whose sexual orientation and gender identity are dissonant from the norm has recently been equated with racism and considered a crime in Brazil, we have experienced countless other obstacles to the construction of a project of equality, respect, freedom and justice, as defined three decades ago with the promulgation of the 1988 Federal Constitution. Added to the trumpeted political scene of recent years, marked by recurrent threats of political authoritarianism and reinforcement of stereotypes, the asymmetries and violence that impose sexual binarism have become even more intense in the field of health. The LGBTTT (lesbian, gay, bisexual, transvestite and transgender) populations have suffered discriminations, embarrassments and violence in the health services, the majority of which are modeled by a matrix that imposes heterosexuality and cisgenerity as the standard¹.

To most of the LGBTTT populations, health production is related to ways of experiencing their identities and to their survival and resistance strategies, which eventually materialize in corporal and sexual practices that have some relation to their degree of vulnerability in healthcare. Many lesbian women, for example, are afraid to reveal their sexual orientation during gynecological care and are not assisted in the health services². When gays go to the health services and verbalize their sexual orientation, they suffer stigmas and prejudice deriving from the AIDS-homosexuality association³. Transvestites and transsexuals experience even greater discriminations in the access to the health services, either in the use of their social name or in the guarantee of the transsexualizing process⁴.

Approximately two decades ago, the LGBTTT social movements, by means of conferences, councils, committees and participation in other levels of political negotiation, started an intense dialog with the Brazilian State to ensure equitable public policies in the Brazilian National Health System (SUS). Due to this, the Ministry of Health instituted the National Policy for the Comprehensive Care of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals⁵, which has a specific focus but also interacts with many other health policies.

However, guidelines and policies do not guarantee that the professionals who work in the daily routine of the services offer comprehensive, dignified and respectful care to the LGBTTT populations⁶. When we bring this discussion to primary care, which is the main front door of SUS, the professional practices become even more important in the context of territorialized teamwork, as the action dynamics involves the amplified understanding of the environment where the health-illness-care process, as well as problems, needs and health situations, take place⁷. These are services developed with the highest level of decentralization and pervasiveness of the healthcare network; in these services, the practices are effectively close to the life of vulnerable people, based on bonding, comprehensive care, accountability, humanization and social control in view of the particularities of each region⁸.

The present study was carried out in the primary care of the city of Teresina, the capital of the state of Piauí. Located in the Northeast, an isolated and little known region in Brazil, Piauí is one of the least recognized states, both nationally and by

its neighbors. The only Northeastern capital that is not bathed by the sea and the most Catholic capital of the country, Teresina has the highest rates of LGBTT deaths in Brazil and, paradoxically, is located in a state that is nationally recognized by its protection laws to these populations⁹. Due to this, we aimed to understand the experiences of professionals who work in primary care and must assist LGBTT populations. To analyze these issues, we used the concepts proposed by the feminist Nancy Fraser.

Fraser¹⁰ proposes three dimensions of a universal principle of justice that help us face problems related to social inequalities in contemporary societies: recognition, redistribution and representation. She defends the need to interconnect, within this universal principle of justice, the space of recognition of sexual and gender diversity (cultural field) and the space of inequalities caused by the exploration and unfair redistribution of resources (organizational field). Representation (political and social field) complements the dimensions of recognition and redistribution, strengthening channels of visibility and participation of groups that do not predominate and, many times, are not even present in the representative structures of organization in society.

This perspective brings the reflection that the barriers faced by the LGBTT populations in the health services are a product of the depreciation or lack of recognition of their identities, which, in a circular logic, produce or intensify restrictions related to access to social goods and resources, including healthcare. This process is also a result of lack of representation, of the invisibilities and of the stigmas associated with the LGBTT populations in society and, consequently, in the health services. Thus, the recognition-redistribution-representation triad was used throughout this study to analyze experience reports of primary care professionals in the health assistance provided for LGBTT populations in the city of Teresina, Piauí.

Methodology

We carried out a qualitative research in which the applied method was the study of oral reports¹¹. Telling stories plays an essential role in the conformation of different social and cultural phenomena in many societies, and the stories told facilitate the apprehension of interactional and representational aspects from the experiences of subjects and their collectives. We selected a referral Primary Care Unit (UBS) in the city of Teresina, Piauí, located in the central region, which has the highest number of teams in the network: six family health teams (eSF) and one Mobile Consulting Room team (eCR). In addition, it is linked to the Amplified Family Health and Primary Care Teams (Nasf-AB). It is considered an amplified primary care unit by the Ministry of Health, managed locally.

The universe of eligible subjects to the research included thirty-two professionals who worked in the selected unit, like doctors, nurses, dentists, dental health technicians and/or assistants, nursing technicians and/or assistants, community health agents (ACS) and coordinator, as well as some professionals who integrated the Nasf-AB teams (psychologist, physiotherapist and nutritionist) and professionals of the eCR team (nurse, social worker, doctor and social agent). Obviously, the total number of subjects was not calculated by means of probabilistic criteria, as the ideal qualitative sample is the one that reflects the totality of the multiple dimensions of the object



of study and not the number of subjects per se¹². We attempted to ensure diversity among the participants, including at least one from each professional category, with a minimum of six months' work at the unit; in addition, we included different markers of age, race/color, sex/gender, level of schooling and others. We also adopted the saturation criterion, that is, we stopped the interviews when the produced data started to be repetitive in the studied context.

We used the narrative individual interview¹¹ with twenty-six participants, and we conducted a focus group¹³ with six other health professionals. The field activities occurred between August and October 2019.

To develop the narrative plot, we followed the proposal of Gomes and Mendonça¹⁴, who, in terms of analytical sequence, suggest fundamental stages to this process: a) understanding the contexts in the reports; b) disclosing the structural aspects in the reports; c) constructing an interpretative synthesis.

As for ethical procedures, the research was approved under opinion no. 3.443.926 in *Plataforma Brasil* and complies with Resolutions 466/2012 and 510/2016. The real names of the health professionals were replaced by fictitious names.

Results and discussion

Within the universe of participants, the majority were women (83%). A significant number were aged between forty and sixty-years (48%). Regarding the length of subjects' professional career, the mean was sixteen years. As for the length of service in primary care, the mean was twelve years. Concerning courses after university, 42% had attended at least one specialization course, preferably in public health, family health or mental health, and 3% had a Master's or a doctoral degree. Among those whose position required that they had completed High School, many had attended an undergraduate course or were attending it (30%). Cisgenderity was a common point to all the interviewees and the majority identified themselves as heterosexual (94%). Regarding marital status, 50% were single and 50% were married. As for the race/color item, the majority declared themselves black (60%). Finally, concerning religion, the majority stated they were Catholics (65%).

What can be expected from this universe constituted by a majority of cisgender, heterosexual, middle-aged women with many qualification courses, married or single, predominantly black and Catholic? The data will be presented following the three axes proposed in Fraser's¹⁰ theoretical framework.

Non-recognition

Through this category of analysis, we identified reports from the place of "non-difference" in the assistance provided for LGBTTT populations in primary care. Most health professionals mentioned that knowing the person's sexual orientation/gender identity was not important to the conduction of the health assistance; the most important thing was to cure the pathology, as they do with any user. Cristiane's discourse exemplifies this issue:



I think the assistance must be equal to everybody, because if we specify, they will become worse. I do the cytological examination exactly in the same way [when she was talking about the exam in lesbian women]. (Cristiane, nurse, eSF)

I treat everybody in the same way. But I wonder if there is some specific disease. The mouth is the mouth. (Joana, dentist, eSF)

In the center of the assistances, according to the reports, there is an attempt to “equalize the assistances”, without establishing any relation to sexual orientation and/or gender identity, which supposedly would make the assistance equal for everyone. In this conception, the services should follow equal protocols and routines; in this way, according to the professionals, they would be ethical and respectful towards people, including the LGBTT populations. Jose’s report strengthens this perspective:

I treat everybody in the same way, no matter if they are this or that. These things don’t interest me. When the person arrives here, if they are hypertensive, they are hypertensive. If they want to say what they have, okay, if they don’t, there’s nothing to be done. (Jose, doctor, eSF)

The report above expresses the denial, the concealment and the invisibility of the differences. Thus, the LGBTT populations and their expressions, desires and health needs are hidden by the discourse of equality or clearly objectified as “this” or “these things”, in a posture of distance and coldness on the part of the professionals. In the search for equality, they also try to hide any motivation for prejudice and end up removing from this place of care any issue that can put their standards, beliefs and moralities in check. In the attempt to be “ethically correct”, they may not approach important situations to the different users of the network.

When the health professionals referred to equality of care in the assistances provided at the unit, narrating they assisted all users “without distinctions”, we perceived that, right after they alleged equality of care, they compared the LGBTT populations with the “populations in general”. There certainly is a mental imagery of a standard user, cisgender and heterosexual, who also attends the unit’s services assiduously (and “commit” themselves to following the provided orientations).

It seems to us that this comparison is imbued with normative and conservative beliefs, values, views and expressions, and also that it can be maintained with the purpose of justifying the absence of specific actions in the healthcare provided for LGBTT populations at the unit. As subjects are not identified by names, histories and singularities and are assisted “like any other person”, this other person seems to be very characteristic - they are stigmatized, veiled, restrained or simply forgotten. In addition, some reports showed that the LGBTT user is considered guilty of and/or responsible for their non-recognition: “but they don’t say it”, “they don’t want it”, “they don’t come”. The burden of their precarious lives are projected on the LGBTT populations.



A study¹⁵ conducted with primary care professionals from Brazil's Center-West and Northeast regions showed little involvement, lack of knowledge and disrespect for the LGBTT populations in the services. Quoting Foucault, the author states that the "repressive hypothesis" and the "silences" about sexuality have been updated. There is a delay between the theoretical historicity of the understanding of sexualities and the professionals' and society's knowledge about them.

Many other studies¹⁻³ have shown that the LGBTT populations face health problems that are similar to the ones identified in the general population, but they also have demonstrated the need to identify the care specificities for each group of letters that compose the acronym L, G, B, T and T. This makes us look at vulnerabilities, risks and susceptibilities not only in the individual level, but also in the social, economic and institutional ones. The concept of equity was incorporated in the conformation of SUS precisely to tackle the inequities of each subject, of each group or of each city⁷.

A study⁶ with primary care professionals identified "non-difference discourses" in the assistance provided for LGBTT populations, especially among doctors. As the LGBTT populations are made invisible and the majority of them are not recognized, we wonder how the health units have organized their resources and received these subjects. This theme is in the axis of the second dimension proposed by Fraser¹⁰.

Poor distribution of resources

Some doctors simply assist four patients together in the consulting room! Then you want to tell the doctor about something intimate, you want to tell something [...] he doesn't assist the person if the person wants to be assisted alone; he sends the person away, can you believe it? (Caio, nursing technician, eSF)

The report provided by Caio, a gay man, represents a counterpoint to the standardization of the discourses of a large part of the interviewed professionals. It revisits the old discussion about the organization of the working processes in the health units according to the needs of the professionals and/or of an abstract entity, the "service", and not according to the care provided for people. His discourse introduces countless ethical and political questions referring to the recognition of the other's right to singularity, privacy and confidentiality in healthcare, with important repercussions to the LGBTT populations. What happens when LGBTT people face a "collective consultation" when they need healthcare? How do they feel in the situation mentioned by Caio? How can they reveal their sexual orientation and gender identity or talk about their lives and experiences in situations like that? Do they ever go to these services again? Based on Fraser's¹⁰ theoretical framework, we already know that injustices of recognition bring injustices in the distribution of resources; in the case studied here, the defective organization of the primary care services is related to lack of recognition of these subjects in the territories. And it is in this field of the organization of the services and working processes that some aspects will be approached here.



For us to begin to understand better the category “access and accessibility in primary care”, let us return to the classic study developed by Starfield¹⁶. The author approaches the difference between access and accessibility, and defines access as the opportune and adequate utilization of the health services with the purpose of achieving better results in healthcare itself, and accessibility as what enables the user’s contact with the health services. Therefore, accessibility is a possibility of contact that is made effective through access, and many times, to the LGBTTT populations, it does not happen due to the presence of many barriers; among them, organizational barriers.

Based on the redistribution paradigm, the reports showed that the LGBTTT populations possibly try to hide or conceal their sexual orientation and gender identity in an attempt to be better received and assisted in the health services. These data have also been identified in other studies^{3,6}.

The conception of passing applied to the principle of redistributive justice, within the reality of the studied unit, can also imply gender performativity. The reports showed that, through a set of regulated and repeated acts that ensure a substantial gender image, inscribed in a heterosexual and cisgender matrix, many LGBTTs forge their identities to be assisted in the health services, as mentioned by Carina:

many of them dress up in such a way that we can’t even notice. (Carina, nurse, eSF)

The health professionals’ views about the LGBTTT populations’ accessibility and access to the unit were also discrepant; those who worked in the amplified territory - ACS and eCR members - seemed to identify the LGBTTT users and their accessibility conditions more easily than doctors, nurses and dentists of the Family Health Strategy, the majority of whom work inside consulting rooms.

In this construction, we present the reports of the professionals who are more sensitive to the LGBTTT populations in the territory:

There are nightclubs near here, there are brothels, and these people work in these nightly activities. Oh! There are many of them here; we are in the downtown area, there are lots and lots of them here. (Leticia, ACS)

Patrícia (social worker, eCR) says:

As there are more opportunities in the downtown area, they end up concentrating mainly on this region. (Elda, nurse, eCR)

Corroborates:

I assist many couples. I can’t give you a number, you know? But I can think of at least five transvestites who come to me and say it and are characterized. (Elda, nurse, eCR)



According to the reports, the LGBTT populations are in the community in general, in the form of couples, working or consuming the services. They have always been in the city and, somehow, were seen by the ACS and by the eCR members - professionals who formally work close to the people in their daily realities.

The National Primary Care Policy⁸ attributes to the ACS the “demographic, social, cultural, environmental, epidemiological and sanitary diagnosis of the territory where they work, contributing to the process of territorialization and mapping of the team’s action area”. Therefore, these professionals have a privileged access to the realities of the families - for one thing, the majority of them also live in the territory where they work. The eCR perform activities preferably in the space of the street, offering services in the field, which enables them to know about the territory and circulation of users.

On the other hand, the health professionals who work basically in consulting rooms and live in other neighborhoods with different social and territorial characteristics - dentists, doctors, nurses and nursing technicians - were not so successful in identifying the LGBTT populations, not only their circulation in the amplified territory of the neighborhoods located in the catchment area, but also within the organizational dynamics of the unit itself, as it can be seen in the descriptions of the reports:

I don’t think we have many of them here, at least I don’t see many. (Marta, nurse, eSF)

People who told me they were gay? No! Only if it was in the assistance I provided for a hypertensive man, but he never told me he was gay. (Ana, nurse, eSF)

I’ve never seen anything for them here at the unit, and there are no gays here in the community. I think people bring other people, but not here. (Joana, dentist, eSF)

The discourses of Marta, Ana and Joana, whose activities take place almost exclusively inside the unit, presented another interpretation of reality: according to their versions, the LGBTT populations do not access (or almost never access) the health unit. As we saw in the previous topic, these subjects are not recognized; now they do not access the health services? What do these reports of “no” want to tell us?

The poor distribution of the services is also present in the area of permanent health education. No professional was able to list qualification courses, training or other educational events that focused on the health of the LGBTT populations. As Aline said:

Here we only have courses about vaccines, tuberculosis, new medicines, but there has never been a course of this type. (Aline, ACS)



This consideration is directly related to the LGBTTT populations' organizational access - the way in which institutions prepare themselves to meet health demands - to the primary care services.

The non-inclusion of sexual orientation and gender identity in the work dynamics can weaken the user-professional relationship¹ and hinder the success of some specific care actions³; in addition, it can be related to the way in which these contents are approached in undergraduate courses⁶. A study showed that the discussion about sexual and gender diversity within higher education institutions, especially in health courses, is fragmented and infrequent, and this has generated more and more professionals who are distant from the theme². Another study highlighted religious discourses linked to knowledge-power discourses in the field of health¹⁵. In short, the health professionals disagree about the LGBTTT populations' accessibility to the services, and this has generated other obstacles to the analysis, planning and organization of actions inside the unit. If a portion of the LGBTTT populations does not access the services, we will describe, in the category below, where they appear, according to the professionals' reports.

Weak representation

The mere public existence of bodies and identities that destabilize the sex-gender system is, in itself, a political (f)act that shakes what Butler calls "policies of appearance". Butler¹⁷ interacts with the concepts of precarity and performativity to understand the forms of representation of sexual and gender minorities in society, showing that, more than the right to participate in legitimated spaces, through voting, for example, the performative exercise of gender is related to the right to appear, to exist, to have corporal and vocal expression, that is, to participate in formal and informal spaces of public and daily life.

Since the first moments of the history of the LGBTTT social movement in Brazil, a mosaic of struggles has been constructed, and its agendas have intertwined with different threads tacked by public agents, the civil society, professionals from distinct knowledge areas, researchers and many other actors. For this reason, we asked the health professionals what they knew about the LGBTTT social movements. André (nursing technician), a heterosexual and cisgender man, was one of the few who mentioned the understanding about the interrelations between the history of the construction of the right to health, of SUS and of contemporary care practices and the social movements:

If you are a professional here and you'll assist this population, I think you need to unite with the social movements, to call these groups. (André, nursing technician)

Furthermore, it is important to recognize the sexual orientation and gender identity of the interviewed professionals in order not to open a gap in this construction, standardizing and homogenizing the subjects. In this case, André was a counterpoint to the other health professionals.



We agree with André when he highlights the importance of the LGBTTT social movements' participation in the construction process of healthcare in SUS and, particularly, in primary care which, by means of the Family Health Strategy, acts directly in the territories. Bearing in mind that community participation is one of the organizational principles of SUS is of utmost importance⁷.

The responses given to the AIDS epidemics in Brazil produced solidarity networks constituted, mainly, by the LGBTTT social movements. At the beginning of the 1990s, the inexistence of a public health policy structured by the Brazilian State caused the multiplication of leaderships of LGBTTT groups and, with a strong representativeness in social control spaces, they could make the AIDS issues become priorities in the government's agenda in the area of health¹⁸.

But where are the LGBTTT social movements of Piauí? In the state and in the capital, the history of the LGBTTT movements and leaderships is long and relevant, and their agendas were included in many plans and in the development process of different policies. The politically correct but uninformed discourse of Marta (nurse, eSF) - "they need more policies" - says a lot about the need to effectively implement those public policies. The achievements of years of LGBTTT struggles do not seem to have been sufficiently incorporated by the professionals in their work. What lies behind another "no"?

As the participants do not know and, therefore, have not incorporated the guidelines of the LGBTTT policies, the healthcare practices have also become imbued with difficulties, preventing the policies from being an effective redistribution device. In addition, there is no recognition of the needs, specificities and situationalities of the LGBTTT populations - "they treat everybody in the same way", as we discussed above. Thus, thinking along Fraser's¹⁰ lines, inside the health services, the recognition and redistribution principles are weak. On the other hand, the professionals identified and mentioned in the interviews (sometimes in problematic ways) other places - outside the health services - of representation and appearance of these subjects, namely the Diversity Parade, the LGBTTs of the soap opera, and the LGBTTs in the family.

I participated in the last Diversity Weeks that happened before my baby was born and I loved the experience. (Claudia, physiotherapist, Nasf-AB)

The Diversity Week, popularly known as Gay Pride Parade or Diversity Parade, was also mentioned by other professionals, who emphasized that the event is an important place of mass appearance of the LGBTTT populations; perhaps the best known among the informants. These participations and celebrations show us that the social fabric still needs to change its values and conceptions, bringing to light new possibilities of interaction with the other and with ourselves. Strategies like this are arranged between the old and the new, between what dies and what is born, between evolution and transformation. In short, the Parade, which can be seen both as a party and as a small opening to diversity, can also act as a bridge between the historic past and the idealization of a present with new life projects linked to a format of mass appearance and corporal and symbolic visibility¹⁹.



When Conceição, an eSF doctor, was asked about the forms of appearance of the LGBTT populations, she said:

I don't have in-depth knowledge about it, I haven't had close contact with them; I've only heard about them. (Conceição, eSF doctor)

And what do we hear people say about the LGBTT populations? How has the media been treating these issues? Andrea, for example, speaks her mind about the matter.

I think that, sometimes, it is presented in a very invasive way. Sometimes, a father comes home in the evening and it's the only time he has to watch television with his son; he sits down and sees this type of scene. In the last soap opera, there was a girl who wanted to become a man; she was encouraged to remove her breasts and take hormones, and this encourages the child, too. I thought it was so invasive, even more so because it was broadcast at a time when children are watching television. (Andrea, coordination, eSF)

The media has been increasingly including LGBTT characters in soap operas. Would this be an agenda of representation or reproduction of stereotypes? How many of them are, in fact, LGBTT actors representing their life issues? Who is LGBTT and is in the cast in general? Apparently, the LGBTT agenda and its flashes do not interact with the viewers nor foster a democratic dialog about what is seen. Andrea, for example, thinks this theme should not be seen by children. Between the media stereotypes and its silences, the LGBTT populations continue to be targets in/of society as a whole. To democratize does not mean to approach multiple representations; rather, it means strengthening the construction of a process of social, cultural and, above all, family re-readings, and this threatens the status quo that feeds on male chauvinism, racism, patriarchy, sexism and heteronormativity. As Carla (nurse, eSF) argued:

The struggle of the LGBTT groups has awakened the population to view this in a more natural way. These themes have been more included, but everything still involves complex relationships. (Carla, nurse, eSF)

The complexity of relationships, as mentioned by Carla, is also connected with the place of speech of each subject and their groups. Place of speech is an individual and/or collective *locus* that emerged as a counterpoint to the silencing of the turn and voice of those who have been historically excluded due to race/color, gender, social class, generation, sexuality and other markers imbued with oppression relations in the structure of society²⁰.

Some professionals were able to talk from this place with more intensity, highlighting that some life events happened with more vehemence in their individual or collective processes. For example:



My nephew is gay, he dresses like that. I love him so much, but I know he has to tolerate a lot of jokes. (Suzana, ACS)

I'm gay and I'm okay with it, I don't have problems to say it, but I think people will never accept it. (Caio, nursing technician, eSF)

This also shows that the professionals' sexual orientation and gender identity can interfere in the dynamics of action in the services, as the work carries with it part of the identities of each subject. In our study, the discourses of LGBTTT professionals were more sensitive to the care for sexual and gender diversity.

Relatives are people who, in their place of speech, can militate with the minorities, articulate in a sensitive way towards the collective and activate other networks in the care processes in view of the violence they witness. Manuela (ACS) reported that she defended her brother when he suffered bullying at school. In another situation, Manuela defended a gay user who was abused by an "evangelizer" who distributed leaflets of her church at the unit. There is a militancy, a transfer of care or, at least, a differentiated look at the vulnerabilities of the LGBTTT populations in these cases. Furthermore, Caio brought a political, critical and conscious discourse about being gay and about the LGBTTT collectives. His place of speech is related to his point-of-departure, his social responsibilities and his commitment to justice.

Throughout this discussion about representation, appearance and participation of the LGBTTT populations in society, we noticed that this struggle is still distant from the health professionals. The LGBTTT social movement, for more than forty years, has not only made the voices and demands of the LGBTTT populations visible, but has also recognized the dissident bodies, protecting sexual and gender citizenship and offering shelter free from any discrimination. This shows us that the health services have a lot to learn with the social movements.

Final remarks

Throughout the study, we could perceive that the health professionals, the majority with large experience in primary care, have been providing "equal" care to the service's users for years. These are professionals who have witnessed the implementation of the Family Health Strategy in Teresina and whose modus operandi codes this type of care, especially because "it has worked out" in this way. It is as if there was an operational chain, which is also a subjective chain, that does not allow to include the LGBTTT populations in the practices of health work - not as LGBTTT subjects -, neither before nor after the implementation of the National Policy for LGBT Care in Brazil. This chain organization also involves other apparatuses that form subjectivities, like health management, councils of professional categories, educational institutions and many others.

If, on the one hand, the LGBTTT populations have not been recognized as subjects within the health territories, on the other hand, the health professionals who work outside the consulting room were able to identify them. This fact can



cause a mismatch in the planning and organization of health actions, as the work is performed in interdisciplinary teams. However, some professionals identify these subjects, which can facilitate the access to the services.

As it happens, the dissident populations have been patrolled in their own right of existing as such¹⁷, and that is why we asked about their appearance and visibility in daily life, not necessarily in spaces that have been formally legitimated. In the reports, representation was activated in the context of social movements, diversity parades and in the place of speech of relatives and of the LGBTTT professional. Some could talk about the importance of this representation and others showed they do not ally with emancipatory processes in their health practices.

We bet on hearing as one of the keys to respect sexual and gender diversity in primary care. That is, the LGBTTT bodies need to be recognized as health users. When the professionals try to homogenize or trivialize the assistance, the very notion of the subjects' autonomy is lost, a fundamental right in care provision. And who has the power? Certainly, the health professionals do, and they even decide what vulnerability is or is not. The discourses clearly showed that the LGBTTT populations are made invisible in their possibilities of expressions, appearances and participations and, as they escape from the normal sex and gender standards, they stay in the place of "control", "verification" and "examination" of their abjections. And as they - health professionals - have the alleged knowledge, the majority of them apply the negative particle - "no" - to the provided assistance. Either as an adverb, an interjection or a noun, "no" had the functions of denying, interdicting, justifying or closing the subject. There were many shades of "no"! The word appeared almost three thousand times in the interviews and in the focus group.

Finally, as a continuous flow, the non-recognition of the LGBTTT populations as primary care users generates obstacles in the access and quality of the provided care, either by means of the relationships (user-professional), through the organization and dynamics of the services, or through the elements in this context, which are also related to the form in which these subjects are made visible in the appearance channels. Only the recognition-redistribution-representation triad allows the correction of social inequities and injustices. These three axes of justice signaled by Fraser¹⁰ enable us to perceive that the efforts must be guided by organizational initiatives (in the services themselves, in educational institutions, etc.) and also by culture (in the media, on the streets, in churches, etc.), and that, together, they must make different gender performativities appear. When these axes take only one side, or when they become deficient, the entire triad is affected.



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Dulce Aurélia de Souza Ferraz

Translator

Carolina Siqueira Muniz Ventura

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As populações de lésbicas, *gays*, bissexuais, travestis e transexuais (LGBTT) vivenciam obstáculos no acesso e na assistência ofertada pelos serviços da Atenção Básica. Neste estudo, buscamos analisar relatos de profissionais na assistência dessas populações na Estratégia Saúde da Família (ESF). Tratou-se de uma pesquisa qualitativa realizada por meio de relatos orais. Participaram 32 profissionais que atuavam em uma Unidade Básica de Saúde (UBS) em Teresina, Piauí, Brasil. A análise foi pautada em três dimensões – reconhecimento, redistribuição e representação – e mostrou que é preciso interligar, dentro de um mesmo princípio de justiça, o espaço do reconhecimento da diversidade sexual e de gênero (campo cultural), o espaço das desigualdades atreladas à exploração e redistribuição de recursos (campo organizacional) e o espaço de representação e participação das populações LGBTT (campo político e social), na lógica circular dos serviços de saúde.

Palavras-chave: Minorias sexuais e de gênero. Profissionais de saúde. Atenção Básica. Assistência à saúde.

Las poblaciones de lesbianas, *gais*, bissexuales, travestis y transexuales (LGBTT) experimentan obstáculos en el acceso y en la asistencia ofrecida por los servicios de la Atención Básica. En este estudio, buscamos analizar relatos de profesionales en la asistencia de esas poblaciones en la Estrategia de Salud de la Familia (ESF). Se trató de una investigación cualitativa realizada por medio de relatos orales. Participaron 32 profesionales que actuaban en una unidad básica de salud (UBS) en Teresina, Estado de Piauí, Brasil. El análisis se pautó en tres dimensiones: reconocimiento, redistribución y representación, mostrando que es preciso interconectar, dentro de un mismo principio de justicia, el espacio del reconocimiento de la diversidad sexual y de género (campo cultural), el espacio de las desigualdades vinculadas a la explotación y redistribución de recursos (campo organizacional) y el espacio de representación y participación de las poblaciones LGBTT (campo político y social), en la lógica circular de los servicios de salud.

Palabras clave: Minorías sexuales y de género. Profesionales de salud. Atención básica. Asistencia a la salud.