The care of the LGBT population from the perspective of Primary Health Care professionals

| [1] Alexandre Costa-Val, [2] Mariana de Sousa Manganelli, [3] Vitor Miguel Fernandes de Moraes, [4] Hugo Alejandro Cano-Prais, [5] Gustavo Meirelles Ribeiro |

Abstract: The LGBT people face difficulties and barriers that hinder their access to health services. The lack of preparation and sensitivity of the professionals, in this context, are some of the elements that reiterate the health inequities and the vulnerability of these bodies. In order to understand this phenomenon, we interviewed 15 Primary Health Care workers and analyzed their speeches following the Foucauldian discourse analysis perspective. The results showed that although the professionals know the theme, they use discursive strategies, which veil their prejudices and resistance, making it difficult to recognize the possibilities of the agency in the transformation of this reality. The mobilization of categories related to sexual identities and rights in their discourses indicates displacements in the contemporary sexuality regime that should be considered in health education interventions. The implication of each one in the materialization of the differences that mark the sexual field proved to be, in this sense, fundamental to the discussion of care forms that are truly welcoming and do not reinforce the inequalities of bodies that challenge binarism and social heteronormativity.

➤ **Keywords:** Sexuality. LGBT people. Access to health services. Primary Health Care. Health Education.

[1] Universidade Federal de Ouro Preto. Ouro Preto-MG, Brazil (alecostaval@yahoo.com.br). ORCID: 0000-0003-1334-6054

[2] Universidade Federal de Ouro Preto. Ouro Preto-MG, Brazil (marianamanganelli@hotmail.com). ORCID: 0000-0003-0064-9347

[3] Universidade Federal de Ouro Preto. Ouro Preto-MG, Brazil (vmfmoraes@gmail.com). ORCID: 0000-0003-0614-6812

[4] Universidade Federal de Ouro Preto. Ouro Preto-MG, Brazil (hugoalejandro@hotmail.com). ORCID: 0000-0001-8432-1650

[5] Universidade Federal de Ouro Preto. Ouro Preto-MG, Brazil (gustavomeirelles@ufop.edu.br). ORCID: 0000-0001-6018-8226

Received on: 04/27/2021
Revised on: 05/06/2021
Approved on: 07/09/2021

DOI: http://dx.doi.org/10.1590/S0103-73312022320207.en

Introduction

Lesbian, gay, bisexual, *travestis*[1] and transgender (LGBT) people, since they do not conform to the norms that define the standards of sexuality and gender, are targets of stigma, discrimination, and violence. The reiterated violations of their rights and social exclusion generate suffering, illness, and premature death (LIONÇO, 2008; CARDOSO; FERRO, 2012). Despite presenting worse health conditions than the general population, access to and use of care services are marked by difficulties and barriers (GONZALES; PRZEDWORSKI; HENNING-SMITH, 2016).

Lesbians, for example, seek gynecological consultations less frequently than heterosexual women. The lack of professional preparation contributes to insufficient and unwelcoming assistance (BARBOSA; FACCHINI, 2009; VALADÃO; GOMES, 2011). There is also the misconception that these women have a reduced risk for developing sexually transmitted infections (STI) and cervical cancer (ALMEIDA, 2009), a fact that contributes to their withdrawal from health services.

In the case of *travestis* and transsexuals, the situation is more worrying. Despite the precariousness of data produced by the State, surveys conducted by non-governmental organizations show that Brazil is the country where *travestis* and transsexuals are killed the most. In general, the life expectancy of these people is 35 years, less than half the average life of the national population (BENEVIDES; NOGUEIRA, 2020). Such findings become more alarming when we consider other forms of violence such as, for example, expulsion from home and precarious access to health and education services. Prejudice, discrimination, pathological interpretation of their conditions, and non-recognition of their social name by professionals are recurrent reasons for these people to stop seeking formal health care. In light of this, self-medication is common, a situation that leaves these bodies even more vulnerable (MULLER; KNAUTH, 2008; ROCON *et al.*, 2016; SILVA *et al.*, 2017; BEZERRA *et al.*, 2019).

This scenario coexists with the efforts of various social actors who fight for a health system that is less prejudiced and more inclusive. In Brazil, one of the effects of these disputes and negotiations was the formalization, in 2011, of the National Policy of Integral LGBT Health (PNSI-LGBT), which recognized the effects of discrimination and exclusion in the health-disease process of this population. This document established guidelines aimed at changes in the social determinants of

health to reduce inequities, reaffirming the commitment of the Brazilian Unified Health System (SUS) to universality, integrality, and social control. Promotion, prevention, recovery and rehabilitation actions, in addition to encouraging the production of knowledge aimed at the care of this public, would thus become the focus of investment by the National State (BRASIL, 2013).

Despite the existence of this project, as well as other commitments made by the state, it is observed that little progress has been made regarding the concrete improvement of the access conditions to the health of LGBT people (BEZERRA *et al.*, 2019). The low involvement is notable of states and municipalities in recognizing the particularities of this population in their territories to foster local policies and actions that contribute, in an articulated manner, to the consummation of the national proposal (GOMES *et al.*, 2018). Primary Health Care (PHC), in this case, assumes an important role, since it is the main gateway to the SUS and has the mission to articulate and monitor the access of the users to services, ensuring longitudinal and continuous care (PAULINO *et al.*, 2019).

Moreover, knowing how the LGBT population circulates in these instances of specific geographical locations, as well as specifying the challenges, difficulties and possibilities of action from the perspective of professionals is, therefore, fundamental to foster debates about concrete strategies that can ensure the effectiveness of the PNSI-LGBT and improve the health conditions and accessibility of this public. In order to contribute to this discussion, we present the results of an investigation that focused on the analysis of the workers speeches from the Basic Health Units (SUS) in a city of Minas Gerais. We sought, in addition to comprehending more pragmatic aspects related to the access and care of the LGBT population already highlighted in other studies (BEZERRA *et al.*, 2019; GOMES *et al.*, 2018; PAULINO *et al.*, 2019), to advance the debate from the problematization of some particularities of the very regime of sexuality that has been configured in contemporary Western society (CARRARA, 2015).

For this, we appropriated the idea of Foucault (2001) that sexuality is a set of said and unsaid that, since modernity, shows that the control of bodies occurs more effectively not through repression or silencing, but through the production of practices and discourses that assume, in specific socio-historical conditions, effects of truth. This field, which for a long time was characterized by the empire of the biomedical discourse, currently seems to undergo transformations from the

emergence of discourses related to "sexual rights" (CARRARA, 2015), which deserve a more careful analysis. Following this path, we will discuss, based on our empirical data, the effects of this phenomenon in the health field to, in the sequence, think about strategies that can improve the quality of access to care by LGBT people.

Methodological course

This study follows the assumptions of qualitative research and had as corpus of analysis (MINAYO, 2007) the speeches of UBSs workers in the municipality of Ouro Preto, Minas Gerais. This field was particularly rich because it is a historical and university city, where traditional moral and religious values coexist with a variety of often dissident and contradictory worldviews.

We chose four UBS's that already welcomed students from the University for teaching, research and extension activities. We visited these spaces to meet professionals and their routines. We explained the project to the team and, according to availability and consent, we intentionally selected some participants, trying to cover different areas of work. The interviews took place in the workplace and were guided by a semi-structured script (MINAYO, 2007), with questions about beliefs, knowledge, difficulties, challenges and possibilities of care in relation to the LGBT population.

We conducted, between June and December 2018, 15 interviews with workers from different areas. All were recorded, transcribed and analyzed according to the Foucauldian perspective of discourse, "not as a set of signs (signifying elements that refer to contents or representations), but as practices that systematically form the objects they speak about" (FOUCAULT, 2008, p. 55). We tried to describe them in order to evidence historical rules that determine their formations in our social context. We organized the results into three groups: (Dis)knowledge and (pre)concepts; Regimes of sexuality: "are we all equal?"; (De)constructions. The discussion was structured to allow a tensioning with theoretical references from the Collective Health, and Human and Social Sciences.

The research was approved by the institutional Research Ethics Committee (CAAE 79745317.1.0000.5150). In order to maintain the anonymity of the participants, we designated each of them with a code (table 1).

Table 1. Research Participants. Ouro Preto-MG, 2018

CODE	PRACTICE	TIME OF WORK AT SUS
P1	Physician	1 year
CHA1	Community Health Agent	6 years
TN1	Technical Nurse	11 years
N1	Nurse	11 years
TN2	Technical Nurse	15 years
P2	Physician	11 years
CHA2	Community Health Agent	6 years
CHA3	Community Health Agent	7 years
CHA4	Community Health Agent	6 years
P3	Physician	20 years
N2	Nurse	10 years
A1	Administrative Agent	9 years
A2	Administrative Agent	1 year
P4	Physician	25 years
CHA5	Community Health Agent	6 years

Origin: elaborated by authors.

Results and Discussions

(Mis)knowledge and (pre)concepts

During our incursions at the UBSs, we were very well received by the professionals. As we approached the themes of sexualities and genders, however, they all said they knew almost nothing, as if they had no way to contribute to the investigation:

> [...] I haven't had much training in relation to this, therefore I don't know what I can be helping with. (P1)

This posture revealed itself many times, often as resistance to reflection, since everyone had some knowledge about the theme. Besides the knowledge acquired in personal and professional experiences, five participants had taken courses on the PNSI-LGBT at the Open University of SUS (UnA-SUS). The justifications for the (mis)knowledge often fell on the absence of the theme in undergraduate studies,

the excess of terminologies that have emerged in this field and in the little use of nomenclatures in their daily professional practice.

The deficiency in the training of health professionals regarding sexualities and genders is particularly well documented in the literature (PAULINO *et al.*, 2019; RUFINO; MADEIRO, 2017). One of the central aspects, however, is not exactly that the topic is not talked about. On the contrary, as already pointed out by Foucault, when questioning the repressive hypothesis, it is notable that, throughout training, one talks (and talks a lot) about sexuality. The approach, however, is focused on biological aspects (VAL *et al.*, 2019) that re-update a binary and heteronormative matrix and sediment a supposed continuity between sex, gender, and desire (BUTLER, 2003). The way this materializes in everyday care could be observed, for example, in discourses in where interviewees were somewhat confused about certain terms:

> [...] because it has sexual orientation, gender identity, then you really have to stop and think. Then, since it is not routine, it is a little difficult. (N4)

Faced with the supposed not-knowing, the professionals reacted in different ways. Many used this justification not to get involved in this issue and, consequently, not to bring it into their care practices. Some, however, were not immobilized and engaged in the active construction of knowledge from the literature on the subject and from the contact with their patients:

> I'm not much of a definer, I go more by what people fit into [...]. (TN1)

> So, as it is something I am learning, sometimes I find it difficult to define how that person presents him/herself, right? Then, I've had patients who had a gender identity orientation that identified themselves as a cis man, who had a homosexual sexual orientation, but questioned whether they were transsexuals. [...] And this was interesting, because I was able to work that out in my head [...]. (P2)

Paulo Freire (1996) is emphatic when he defends that learning does not occur through the passive posture of the learner in relation to the transmitted contents, but from the maintenance of a living "epistemological curiosity", which permanently restores the creative force of learning. The encounter with contingencies in care practices is, in this sense, very powerful for deconstructing pre-established knowledge and to allow the surge of unprecedented forms of knowledge. In the case of the interviewees cited, it was clear the willingness to learn from patients, a situation that contributes not only to the rupture of hierarchies so common in

the health field, but also for the transformation of subjectivities and the ways professionals act (VAL *et al.*, 2019). As highlighted by the second interviewee, at the moment when he mentioned some trans patients he accompanies, "[...] we are living the transition with them." (P2).

In fact, pre-established knowledge does not represent any guarantee that care will be adequate. This is the case of a nurse who, despite saying that she had no difficulty in using the social name, told us about a situation in which her knowledge was not operative:

> The first time of a patient here who is in this phase of transsexuality from boy to girl […]. And I even apologized later, because I kept calling in the waiting room and I didn't see a woman. And I kept calling... Then I asked: "who is it?", with my back to the person. Then she said: "it's me". I was very embarrassed, because, in fact, I already knew him. But I didn't know he had already changed his social name. The reception didn't inform me. (N3)

Several participants admitted having difficulties with the use of the social name. Although the Letter of Rights for the SUS Users guarantees, since 2007, this use in medical records and other system documents (BRASIL, 2009), its effectiveness seems to depend on the goodwill of professionals and the unit managers (SILVA *et al.*, 2017). It is no coincidence that situations of violence like the one reported, even if unintentional, are common in health services, constituting one of the main reasons why *travestis* and transsexuals do not attend these spaces (MULLER; KNAUTH, 2008; ROCON *et al.*, 2016; BEZERRA *et al.*, 2019).

Another recurring question was about the violence against the LGBT population. Most professionals said they had never been aware of situations of violence against these people in the territory covered by their UBSs. None of them knew the need to fill out the Compulsory Notification Form (BRASIL, 2016) in case of a patient with this type of report, nor did they know how to proceed. In the work environment, all of them denied having witnessed episodes of aggression directed at this public. Despite that, some reported events, not only the one related to the social name, but also others that involved derogatory comments from staff members or users of the unit, as if these occurrences did not constitute forms of symbolic violence (BOURDIEU, 2003).

The "unawareness" of the various forms of violence that are part of the daily lives of LGBT people, as well as the non-notification, make precarious the production of

fundamental indicators for the elaboration of public policies that can help combat this issue (LIONÇO, 2008; CARDOSO; FERRO, 2012; BEZERRA *et al.*, 2019). Thus, a vicious cycle is perpetuated, structured by a violence that not only reiterates the binary and heterosexist norms, but also exempts State and citizens from any responsibility regarding this situation.

Some interviewees pointed out that older people and people with certain values show more prejudice and stigma toward the LGBT population. Aspects such as age and religion appeared, many times, as "understandable", almost "natural" justifications for a reality that would have little chance of changing:

> I even feel prejudiced comments, also at times, by the staff. A question of religion, right? A question of being older. [...] The population is older, there are people who are not interested in what is new or who remain more... right? (P1)

This scenario becomes a propitious space for the permanence of an "institutionalized LGBT phobia" where violence and prejudice are permanently invisibilized (LIONÇO, 2008; CARDOSO; FERRO, 2012; VALADÃO; GOMES, 2011; BEZERRA *et al.*, 2019; RAMOS; CARRARA, 2015). The non-recognition in the participation of each one in this process, locating it in others and/or denying it in oneself, was recurrent. One doctor, for example, while saying she was open to differences, at the moment when we introduced the topic of sexual diversity, pointing out that it has been more and more addressed in the media, commented, "I never see it, thank God!" (P4).

Butler (2003) clarifies that there is a "matrix of intelligibility" of genders and sexualities that is sedimented from social-historical processes characterized by power games and establishes bodies that will be unintelligible and, therefore, excluded from the social system. The norm, in this case, is not something that comes "from outside", but is constituted as a product that materializes through repeated acts of social actors who, at the same time that they reaffirm it, can deny or subvert it. In this dynamic in which everyone is implicated, there is no rigid dichotomy between the "I" and the "other. After all, the affirmation of the difference in the other is "indispensable for the very existence of the subject: [difference] would be within, integrating and constituting the self" (LOURO, 2018, p. 45). In order to destabilize this system and reveal the arbitrary character of the norm, it requires a willingness to recognize oneself in the different and engage in this game that involves permanent repositioning, negotiation, and rearrangement.

Some participants, in this sense, by refusing to (re) acknowledge this field marked by exclusion, not only revealed the binary and heterosexual norm that governs our society, but also actively contributed to it to keep it naturalized and unaltered. This was reinforced in discourses that revealed an "inverted prejudice", that is, the belief that it is the LGBT people who promote episodes of prejudice and violence against society, and not the other way around:

> [...] I think that information is important for everyone, because it's just like I said, there is homophobia, but there is the opposite, right? (P1)

> [I think so, I don't know if it is because of vulgarity or if it is the question of transforming oneself, men transforming into women and women into men. The gay men who are really men and only have a preference for men. I feel that they are more accepted in society than transgender people. [...] because I don't see anyone that looks like that, in the environment that I frequent, with a better social condition, you know? I see more the marginalized people. Even the question of attitude towards society is different... It's vulgar, right? Sometimes, even their lack of education, do you understand? It's not that I am discriminating, but maybe I already am... (N2)

It is evident, in this last line, how the empire of the binary and heterosexual norm is only sustained from the segregation of dissident erotic-sexual bodies and practices (LOURO, 2018; MOTTA, 2016). A gay man, for example, in order to enter the field of intelligibility needs to reproduce the heteronormative matrix, presenting himself as a "real man". This man, it seems, would be white, he would identify with the gender he was assigned at birth, he would have good socioeconomic conditions and would present behaviors that are socially attributed to the male universe. This idealized perspective is reinforced by public policies aimed at men, which end up taking them as a generic category without considering their diversity of experiences. The normativity can thus cause suffering and weaken the care not only of gay, bisexual and transgender men, but also of those who, despite identifying as cisgender and heterosexual, do not fit the hegemonic masculinity model (COUTO; GOMES, 2012).

Something similar happens with lesbians, who, faced with previous experiences of indifference or prejudice from professionals, start to avoid health services. Moreover, it is not rare when this search happens, they prefer to omit their sexual orientation (BARBOSA; FACCHINI, 2009; VALADÃO; GOMES, 2011):

> Woman, for example, that I was aware of being a lesbian from my unit... there was one who came to me and didn't know the need for her to do a preventive, for example. So, they think that because they don't have a relationship or penetration with a man, they think they don't have the necessity to do the exam. (N1)

Such discourse reinforces how heteronormative stereotypes contribute to inadequate health care, without contemplating the real needs of specific groups. Lesbians, in this context, often have their bodies invisibilized, a situation that prevents a true recognition of their health demands and reinforces certain imaginaries such as, for example, that they are immune to STIs and cervical cancer (ALMEIDA, 2009). In this speech, particularly, it is clear the strategy of erasing the experiences of the lesbian women from this idea that these women do not frequent the UBSs or even that they do not seek care for lack of information. Blaming these people, in this case, while contributing to keep them away from care services, camouflages the active participation of professionals and the system itself in this issue.

Transsexuals and *travestis* face even more insurmountable barriers, since their bodies expose the precariousness of gender norms, ultimately revealing that there is no male or female essence. These people are relegated to a field where not only there is an absolute lack of guaranteed rights, but also where the very condition of being human is denied (BUTLER, 2003). Obviously, the chances of existence, in this scenario, are scarce, a situation that will have direct repercussions in the educational, professional, and economic spheres.

This does not mean - as indicated by one of the speeches mentioned above - that these people are "vulgar" and "uneducated", but that they need, day after day, to fight to guarantee the minimum for survival in a system that repudiates them. Accusatory categories like these, when triggered, not only veil the lack of empathy and communication skills of many professionals (MULLER; KNAUTH, 2008; ROCON *et al*., 2016), but also sediment "symbolic, moral, and aesthetic barriers" that impede access to health care for this population. This becomes evident when it comes to people with precarious socioeconomic conditions, or even people who more clearly subvert binarism and heteronormativity, including in this group not only transvestites and transsexuals, but also "masculinized" women and "effeminate" men (MELLO *et al*., 2011).

In this scenario, among the (un) awareness and the (pre) judice, the said and the unsaid, the impossibilities and the possibilities of action, a type of discourse called our attention, both for its recurrence, and also for indicating a particular trend of thought in our time. Next, we will discuss this finding based on the following reflection: are we living the same sexuality regime as before?

Regimes of sexuality: are we all the same?

During the interviews, when we asked about the particularities of the LGBT population, several interviewees said that there were no differences, emphasizing that "we are all human beings". This type of discourse was sometimes accompanied by explanations in which sexual diversity was naturalized and/or essentialized based on references to biology or the history of humanity itself:

> [...] we are also animals, in quotes, rational, right? But among animals, 40% of animals are also either bisexual or something happened there. It is in our nature. [So, I mirror this as a normal thing. (CHA1)

> And today... we know that, since the primordial times, this has existed, but today the media, in a shouting way, I can't even tell you if it's the correct way, right? [Because it has existed since ancient times, but it was not something that was so exposed, right? (CHA2)

Such arguments, although associated with a position of the interviewees against prejudice, in practice, contribute little to reveal the power games and the performativities of the actors that reiterate the binary and heteronormative logic that segregates bodies who do not fit the gender norms. Moreover, as highlighted by the second interviewee, this same type of discourse that naturalizes and essentializes sexual and gender performances can be used by conservative sectors that position themselves against sexual diversity, based on the idea that there is a divine nature that only includes two genders and a single sexual orientation (MIGUEL, 2011):

> [...] we live in a very religious situation that is based on the fact that man is a similar image of God. Therefore, God goes and creates the man and creates the woman. [...] it is difficult for people who already have this religious background to sometimes absorb how this [sexual diversity] is. (CHA3)

In other words, if this discursive strategy can contribute to "dissident" sexual behaviors becoming socially acceptable, on the other hand, it can also corroborate the phenomenon of exclusion and pathologization[2] (MIGUEL, 2011). The paradox becomes more evident when we realize that these discourses, despite being based on the idea of "nature", are interconnected to socially valued moral principles, such as, for example, "respect", "tolerance" and "love for others".

A recurring element, in this context, was the reference to human rights or to what, more contemporarily, has been recognized as "sexual rights" (CARRARA, 2015):

> I insist on saying that libido is universal, as long as each one respects the right of others, don't want to have hegemony and keep your right and respect of the right of others, there is room for everyone. (A1)

Now, we know that sexuality, since the XIX century, has been sedimented as a complex social process, marked by disputes and negotiations which produce knowledge, bodies and subjectivities. In this dynamic, the productive aspect of power assumes different guises according to the tension between discourses, practices, beliefs and values that make up the various "styles of moral regulation" of a certain time. Carrara (2015), following this path, indicates horizons of transformations when comparing the sexuality regime of Modernity, as described by Foucault (2001), with the one that has been profiled in the 21st century.

The anthropologist highlights injunctions and disjunctions between rationality, politics and morality that mark sexuality in different eras. On the level of rationality, sex, in the 19th century, was understood as an incoercible instinct whose translation was given, eminently, by the biomedical language. Sexual relations were legitimized based on the moral value of biological reproduction, a situation that was directly linked to the State's political interest in maintaining a certain "race" or "nation". Within this eugenic logic, those who did not fit into the framework of the heterosexual monogamous couple were excluded and, in the limit, physically executed (CARRARA, 2015).

From the late twentieth century on, different actors and social processes contributed to the fact that the sexuality regime began to be organized around human rights or, more specifically, sexual rights. An important role in this change was played by the actions of the feminist and LGBT movements, the growing valorization, by socially validated discourses, of sexual pleasure without being associated to its reproductive aspect, and the sedimentation of a varied erotic-sexual market. Morality has shifted from a eugenic and reproductive logic to be anchored in values such as "happiness," "personal fulfillment," "consent," and "respect." In parallel, an individualizing rationality emerged in which each person is responsible for his or her choices, and should regulate them in order to achieve full satisfaction without, however, hurting socially established principles (CARRARA, 2015). It is an apparently libertarian regime in which the exercise of sexuality is possible as long as certain values are respected:

> [...] from the moment that the person has that option, is not transgressing, is not offending anyone, she has the right to be respected, right? [...] We have to see that these people, from the moment that they are acting in their role as an individual, as a citizen like any other, they have to be respected, they have the right to come and go, they have to be accepted like any other human being. (CHA3)

The biomedical language in this "new" regime is, little by little, replaced by a socio-legal language that engenders organized identity movements originating from demanding rights:

> [...] the minority is always going to be massacred. But the minority has to fight for its rights. And you are only a citizen when you fight for your rights and have them guaranteed. [...] I talk about human rights, it's not only the rights that we have... the layman thinks that human rights... is to defend criminals. No! Human rights are in another category. (CHA1)

If, on the one hand, this regime outlines a policy whose main thrust is the guarantee of citizenship and social rights, on the other hand, it can incur in a reification of identities that reinforces stereotypes and sediment norms (CARRARA, 2015; LOURO, 2018; MOTTA, 2016). In our research, this was notable when we asked about specific demands of the LGBT population. Besides the already known association between this public, mental disorders, promiscuity, and STIs (MULLER; KNAUTH, 2008; ROCON *et al.*, 2016; VAL *et al.*, 2019), some professionals associated the low demand of trans people to the fact that UBSs do not disponibilize hormones. Transsexualities, in this case, were taken as a homogeneous category and not as an existential field marked by multiple experiences and nominations. This not only overshadows recurring demands from certain groups, but also promotes a universalization of care. Some trans men, for example, construct their bodies using resources that do not include hormonal or surgical interventions, such as the use of binder/bands to hide their breasts, haircuts, and the use of specific clothing. Others wish to make use of hormones and/or perform masculinizing mammoplasty, but do not feel uncomfortable with their vaginas (SOUSA; IRIART, 2018). Similarly, there are women who identify as transvestites and wish to perform transgenitalization surgery, countering the common idea that this demand is present only in trans women (CARVALHO, 2018). That is, although the particularities of each group should be considered, there is no way, in clinical practice, to stop singularizing care (GOMES *et al.*, 2018).

This tendency to universalization appeared, in several interviews, in an even more radical way. Many professionals, based on the idea that "we are all equal", denied that the LGBT population had specificities in their demands. Some even alleged that a particularized treatment could foster segregation and prejudice:

> I think that if we take this initiative, we end up creating a way to scare them away from the unit. I think that it is up to us to receive them as any other person, regardless of what they did outside. It is their right, it is their problem, they know what is good for them. (A1)

Paulino and colleagues (2019) found this same type of discourse, naming it as "discourse of non-difference." It is a socially acceptable strategy that, while veiling prejudice against LGBT people, denies the particularities of this group, the processes of exclusion that these people go through, as well as their very existence. Health equity, in this case, is ignored, increasing the vulnerability of this population. In the discourses we analyzed, the mention to this challenge was rare, but it was present in an enlightening way in one of them:

> I think that, in the face of a cultural context, of a history, of an education, I do need to have a specific trained ability to deal with this public. I wish I didn't, I wish it was a very natural question, but I know that it is not natural because of a real difficulty, taboos that we build up. I am 48 years old. So, I come from a society that maybe is not prepared for the contemporary world. Therefore, I think that there has to be something specific to achieve equity. (P3)

In fact, to overcome the differences regarding the social vulnerability of specific groups, it is necessary to treat them differently, respecting their specific needs and inequalities that have been sedimented over time. The principle of equity, in this sense, is not opposed to the principle of the human rights universality, since its central objective is the inclusion of populations historically ostracized in the division of socially produced goods and services (COHEN; FRANCO, 2007). Maintaining a homogeneous offer to meet heterogeneous situations, in this case, would only serve to preserve inequalities and social hierarchies.

But how to guarantee the equity of access to care for LGBT people without incurring in discourses that homogenize their bodies, or that particularize them based on identity fixations? Maybe this is one of the biggest challenges in the health field, when we are dealing with an extremely heterogeneous population, crossed by singularities regarding sexualities, genders, races, ethnicities, social classes, among other aspects that mark each one's life.

(De)constructions

In our research, when we asked how it would be possible to improve access of LGBT people to the UBSs, many triggered the terms "training" and "empowerment" without, however, problematizing them (BEZERRA *et al.*, 2019). Some made clearer proposals, such as, for example, conversation circles and interactive dynamics:

> I think that, in a first moment, it could be something like a lecture, a... Yes, a first moment to identify the problems, right? Among people, what are the difficulties. And, in

> a second moment, think about a training, like a qualification, let's say, with dynamics, right? Discussion of cases, for the person to identify: "ah, I don't have prejudice", but, in fact, they do. (P4)

The literature highlights that, considering that the lack of awareness from the professionals is one of the main barriers for the access of LGBT people to care, it is fundamental that the theme be addressed both in the undergraduate courses as well as in the daily health practices, through permanent educational strategies (LIONÇO, 2008; PAULINO *et al.*, 2019). Studies show, in this context, that merely expository classes are not very efficient when it comes to raising the awareness of students and workers, indicating the importance of investing in dialogical and participatory methodologies (VAL *et al.*, 2019; RUFINO; MADEIRO, 2017). Strategies such as those indicated by the interviewee are, therefore, more appropriate for people to express their experiences, beliefs and prejudices in order to promote changes in postures and attitudes.

This (de)construction requires the sedimentation of democratic and plural spaces (BUTLLER, 2003; MELLO, 2011) where everyone - students, professionals, managers, users and representatives of other social sectors - are involved in the construction of knowledge that can effectively alter the reality of care practices. It is not about creating spaces in which differences are tolerated or taken as "exotic curiosities" (LOURO, 2018), something that we locate in other discourses:

> And to have the public also taking part, which I think is very important. Because we have a vision, but the person who is there in their place... Sometimes, we don't have the vision, we can't understand. That is why I think it is very important that in this round of conversation we have each one with his or her own gender so that we can also see how their vision is, right? Because they are not aliens, that is what I mean... (CHA5)

This type of discourse of welcoming differences, although it may seem well-intentioned, in practice, it contributes to the maintenance of a binary epistemology in which the different always occupies the opposite side. Louro (2018) indicates that one of the paths to destabilizing this logic is paved by pedagogical practices in which each participant can ask himself about the construction of their own identity. It is important, in this process, the use of deconstructivist methodologies for each one to realize the instability of all and any identity and to break with the binary logic in which the different is on the outside.

Insofar as it becomes clear that identity is only affirmed through the demarcation and negation of its opposite, it is possible to realize that difference is not on the

other side, but is part of the very constitution of each subject. This type of strategy would have the potential to displace a discussion focused on a mere recognition of sexual diversity, based on fixed identities, for a discussion in which it is possible to problematize the very constitution of binarism and heterosexuality as a norm.

Especially in the field of health, there is no way to discuss public policies disregarding the differences related to genders (COUTO; GOMES, 2012). We should, however, be warned about the risk that the "new" sexuality regime (CARRARA, 2015) reduces this issue to rigid and stereotyped identities, reaffirming norms and hierarchies. There is, in this sense, the possibility that identities are taken as temporary fragments that can guide policies and care practices, without reducing the subjects and their subjectivities to a definitive and individualizing essence (MOTTA, 2016).

Perhaps, as Louro (2018) points out, this challenge demands an epistemological shift that dislodges all those involved in care from a convenient posture of contemplation in a diversified society, engaging them in a permanent, democratic, and plural questioning of the political and social processes that produce identities and differences. Such indication is a way for care practices to become critical and creative actions in which all those involved affect and are affected, in order to effectively promote health, both in the individual as well as in society.

Final considerations

The analyzed speeches revealed that, although many of the professionals have some knowledge regarding the approach to the LGBT population, there is no effective engagement in the construction of caring forms that can truly welcome the differences. Prejudices and resistance are often veiled from certain discursive strategies, such as blaming the other, naturalizing the phenomenon, mobilizing accusatory categories to refer to LGBT bodies, and denying their differences. Beyond these more pragmatic issues, we evidence the coexistence of different regimes of sexuality whose rationalities and moralities are in permanent disputes and negotiations. Such process gives rise to politics whose mark is an increasingly subtle regulation of sexual practices and expressions of gender that reaffirms the binary and heteronormative matrix that governs our society.

The health field is, in this sense, a powerful space to break this logic and to promote new forms of care that include differences, transforming the social. We understand that, for this, it is necessary to invest in democratic and plural education

strategies that facilitate the involvement of all from the recognition of the difference in each one. This is not a ready-made recipe, but an indication that must be reviewed and reformulated according to the local realities and the contingencies of the day-to-day care practices.

Following this idea, we seek, in this article, to contribute to the debate on this theme, leaving gaps for new research and dialogues. What are the differences in the discourses of the workers according to their backgrounds, personal and professional experiences? How does the care of these heterogeneous bodies occur, which, although they are reduced in health policies to the acronym LGBT, present specificities regarding their sexual and gender performativities? We hope that these and other questions will keep this field open, guaranteeing the necessary vivacity so that we can advance in relation to this issue.[3]

References

ALMEIDA, G. Argumentos em torno da possibilidade de infecção por DST e Aids entre mulheres que se autodefinem como lésbicas. *Physis*, Rio de Janeiro, v.19, n.2, p.301-331, 2009.

BARBOSA, R. M.; FACCHINI, R. Acesso a cuidados relativos à saúde sexual entre mulheres que fazem sexo com mulheres em São Paulo, Brasil. *Cad.Saúde Pública*, Rio de Janeiro, v. 25, supl. 2, p. s291-s300, 2009.

BENEVIDES, B. G.; NOGUEIRA, S. N. B. (Orgs.). *Dossiê dos assassinatos e da violência contra travestis e transexuais brasileiras em 2019*. São Paulo: Expressão Popular, ANTRA, IBTE, 2020.

BEZERRA, M. V. R. *et al.* Política de saúde LGBT e sua invisibilidade nas publicações em saúde coletiva. *Saúde debate*, Rio de Janeiro, v.43, n. spe8, p.305-323, 2019.

BOURDIEU, P. *A dominação masculina*. Rio de Janeiro: Bertrand Brasil, 2003.

BRASIL. Ministério da Saúde. *Portaria nº 1.820*, de 13 de agosto de 2009. Dispõe sobre os direitos e deveres dos usuários da saúde. Brasília, 2009.

BRASIL. *Portaria nº 204*, de 17 de fevereiro de 2016. Define a Lista Nacional de Notificação compulsória de doenças, agravos e eventos de saúde pública nos serviços de saúde públicos e privados em todo o território nacional, nos termos do anexo, e dá outras providências. Brasília: MS, 2016.

BRASIL. *Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais* - LGBT. Brasília: MS, 2013.

BUTLER, J. *Problemas de gênero*: feminismo e subversão da identidade. Rio de Janeiro: Civilização Brasileira, 2003.

CARDOSO, M. R.; FERRO, L. F. Saúde e população LGBT: demandas e especificidades em questão. *Psicol.cienc. prof.,* Brasília, v.32, n.3, p.552-563, 2012.

CARRARA, S. Moralidades, racionalidades e políticas sexuais no Brasil contemporâneo. *Mana*, Rio de Janeiro, v. 21, n. 2, p. 323-345, 2015.

CARVALHO, M. "Travesti", "mulher transexual", "homem trans" e "não binário": interseccionalidades de classe e geração na produção de identidades políticas. *Cad. Pagu*, Campinas, n.52, e185211, 2018.

COHEN, E.; FRANCO, R. *Gestão social*: como obter eficiência e impacto nas políticas sociais? Brasília: ENAP, 2007.

COUTO, M. T.; GOMES, R. Homens, saúde e políticas públicas: a equidade de gênero em questão. *Ciênc. saúde coletiva*, Rio de Janeiro, v. 17, n. 10, p. 2569-2578, 2012.

FOUCAULT, M. *História da sexualidade 1*: a vontade de saber. Rio de Janeiro: Graal, 2001.

FOUCAULT, M. *A arqueologia do saber*. Rio de Janeiro: Forense-Universitária; 2008.

FREIRE, P. *Pedagogia da autonomia*: saberes necessários à prática educativa. São Paulo: Paz e Terra, 1996.

GOMES, S. M. *et al.* O SUS fora do armário: concepções de gestores municipais de saúde sobre a população LGBT. *Saude soc*., São Paulo, v.27, n.4, p.1120-1133, 2018.

GOMES, R. *et al.* Gênero, direitos sexuais e suas implicações na saúde. *Ciênc. saúde coletiva*, Rio de Janeiro, v. 23, n. 6, p.1997-2006, 2018.

GONZALES, G.; PRZEDWORSKI, J; HENNING-SMITH, C. Comparison of health and health risk factors between lesbian, gay, and bissexual adults and heterossexual adults in the United Stades: results from the Nacional Health Interview Survey. *JAMA Intern Med*., v. 176, n. 9, p. 1344-1351, 2016.

LOURO, G. L. Um corpo estranho: ensaios sobre sexualidade e teoria queer. Belo Horizonte: Autêntica, 2018.

LIONÇO, T. Que direito à saúde para a população GLBT? Considerando direitos humanos, sexuais e reprodutivos em busca da integralidade e da equidade. *Saude soc*., São Paulo, v.17, n.2, p.11-21, 2008.

MELLO, L. *et al.* Políticas de saúde para lésbicas, gays, bissexuais, travestis e transexuais no Brasil: em busca de universalidade, integralidade e equidade. *Sexualidad, Salud y Sociedad*, Rio de Janeiro, n.9, p.7-28, 2011.

MIGUEL, F.P.V. "Sexy Nature": a naturalização da (homo)sexualidade em uma exposição museográfica. *Anuário Antropológico*, Brasília, v.39, n.1, p.99-123, 2014.

MINAYO, M. C. S. *O desafio do conhecimento*. São Paulo: Hucitec, 2007.

MOTTA, J. I. J. Sexualidades e políticas públicas: uma abordagem queer para tempos de crise democrática. *Saúde debate,* Rio de Janeiro, v. 40, n. esp., p.73-86, 2016.

MULLER, M.I; KNAUTH, D.R. Desigualdades no SUS: o caso do atendimento às travestis é 'babado'! *Cad. EBAPE.BR*, Rio de Janeiro, v. 6, n. 2, p. 1-14, 2008.

PAULINO, D. B.; RASERA, E. F.; TEIXEIRA, F. B. Discursos sobre o cuidado em saúde de Lésbicas, Gays, Bissexuais, Travestis, Transexuais (LGBT) entre médicas(os) da Estratégia Saúde da Família. *Interface*, Botucatu, v.23, e180279, 2019.

RAMOS, S.; CARRARA, S. A constituição da problemática da violência contra homossexuais: a articulação entre ativismo e academia na elaboração de políticas públicas. *Physis*, Rio de Janeiro, v.16, n.2, p.185-205, 2006.

ROCON, P. C. *et al.* Dificuldades vividas por pessoas trans no acesso ao Sistema Único de Saúde. *Ciênc. saúde coletiva*, Rio de Janeiro, v.21, n.8, p.2517-2526, 2016.

RUFINO, A. C.; MADEIRO, A. P. 6 Práticas Educativas em Saúde: Integrando Sexualidade e Gênero na Graduação em Medicina. *Rev. Bras. educ. med.*, Rio de Janeiro, v.41, n.1, p.170-178, 2017.

SOUSA, D.; IRIART, J. "Viver dignamente": necessidades e demandas de saúde de homens trans em Salvador, Bahia, Brasil. *Cad. Saúde Pública*, Rio de Janeiro, v.34, n.10, e00036318, 2018.

SILVA, L. K. M. da *et al.* Uso do nome social no Sistema Único de Saúde: elementos para o debate sobre a assistência prestada a travestis e transexuais. *Physis*, Rio de Janeiro, v. 27, n. 3, p. 835-846, 2017.

TENÓRIO, L.; PRADO, M. A. M. As contradições da patologização das identidades trans e argumentos para a mudança de paradigma. *Revista Periódicus*, v. 1, n. 5, p. 41-55, 2016.

VALADÃO, R. C.; GOMES, R. A homossexualidade feminina no campo da saúde: da invisibilidade à violência. *Physis*, Rio de Janeiro, v. 21, n. 4, p. 1451-1467, 2011.

VAL, A. C. *et al.* "Nunca Me Falaram sobre Isso!": o Ensino das Sexualidades na Perspectiva de Estudantes de uma Escola Federal de Medicina. *Rev.bras.educ.med.*, Brasília, v.43, n.1, supl.1, p. 108-118, 2019.

Notes

[1] The authors preferred to use the term *travesti* throughout the text translated into English instead of *transvestite,* as a way of keep the name of this national specific trans identity of Brazil; as well as *muxe* in Mexico, *hijra* in India and *lady boys* in Thailand.

[2] The pathologization of "dissident" sexualities and genders has been a major focus of discussion today. The central issue concerns the impossibility of reducing a field marked by the multiplicity of experiences to a homogeneous and prescriptive description, which undermines the autonomy and effective participation of people in their care processes (TENÓRIO; PRADO, 2016; ROCON et al., 2016; SOUSA; IRIART, 2018).

[3] A. Costa-Val: idealization and design of the study, transcription and analysis of the interviews, literature review, writing of the article and approval of the final version. M. de S. Manganelli and V. M. F. de Morais: execution, transcription and analysis of the interviews, literature review, writing of the article and approval of the final version. H. A. C. Prais: analysis of the interviews, bibliographical review, critical revision of the article and approval of the final version. G. M. Ribeiro: mapping of the field, conducting of the interviews, critical revision of the article and approval of the final version.

Resumo

O cuidado da população LGBT na perspectiva de profissionais da Atenção Primária à Saúde

As pessoas LGBT se deparam com dificuldades e barreiras que prejudicam o acesso aos serviços de saúde. A falta de preparo e de sensibilidade dos profissionais, nesse contexto, são alguns dos elementos que reiteram as iniquidades em saúde e a vulnerabilidade desses corpos. Para conhecer esse fenômeno, entrevistamos 15 trabalhadores da Atenção Primária à Saúde e analisamos suas falas seguindo a perspectiva da análise do discurso foucaultiana. Os resultados evidenciaram que, apesar de os profissionais conhecerem a temática, eles usam estratégias discursivas que velam seus preconceitos e resistências, dificultando o reconhecimento das possibilidades de agência na transformação dessa realidade. A mobilização de categorias relativas às identidades e aos direitos sexuais em seus discursos indica deslocamentos no regime de sexualidade contemporâneo que devem ser considerados em intervenções de educação em saúde. A implicação de cada um na materialização das diferenças que marcam o campo sexual se demonstrou, nesse sentido, fundamental para discussão de formas de cuidado que sejam verdadeiramente acolhedoras e que não reforcem as desigualdades dos corpos que desafiam o binarismo e a heteronormatividade social.

➤ **Palavras-chave:** Sexualidade. Pessoas LGBT. Acesso aos serviços de saúde. Atenção Primária à Saúde. Educação em Saúde.