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Where are LGBTT populations in the Family Health Strategy? narratives of health professionals in Teresina, Piauí, Brazil

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Abstract *The populations of lesbians, gays, bisexuals, transvestites, and transsexuals (LGBTT) have not had a place in the "official history" of humanity, except as secondary actors that deviate, distort, or even tarnish popular memory, guided by cisheteronormativity. These same subjects often experience obstacles in the care provided by the Family Health Strategy (ESF) within a universal, comprehensive, and equitable system. This paper seeks to analyze experiences narrated by primary care professionals in health care for LGBTT populations in Teresina, Piauí, Brazil. This is qualitative research conducted with 32 professionals working at a PHC unit. The analysis was based on three dimensions – relational, organizational, and contextual – inspired by the Giovanella and Fleury theoretical discussion. Primary care, which should be one of those responsible for community health actions and prioritize health promotion and prevention, is the same that has provided denials, violence, and neglect in the care of LGBTT people. Therefore, we selected listening as one of the keys to respecting sexual and gender diversity so that these people are recognized as ESF users.*

Key words *Sexual and gender minorities, Health professionals, Primary Care, Health care*

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Introduction

In Brazil as a whole, and especially in Piauí, violence against LGBTT populations (lesbians, gays, bisexuals, transvestites, and transsexuals) expressed and quantified in reports is appalling. In 2017, the data collected by the Gay Group of Bahia (GGB), which are released annually in the report of deaths of these populations, pointed out that an LGBTT individual is killed or commits suicide in Brazil every 19 hours, which makes the country the world champion in crimes against sexual and gender minorities. The number of violent events against these populations was three times greater than that observed ten years ago, and transgender people were considered to be at greater risk of death[1].

The data from the same report released in 2015 showed that, in relative terms, the state of Piauí was identified as the second most risky place for LGBT people to be violently killed. The state of Piauí ranked third[2] in the balance of the Dial 100 data in 2018. Paradoxically, it is known on the national scene for its pioneering spirit in elaborating laws and regulations for the protection of LGBTT populations.

However, how has the Family Health Strategy (ESF) contributed to improving indicators of violence against LGBTT populations in the state? Or rather, how do primary care professionals take care of LGBTT populations in Teresina, Piauí? Starting from an understanding of health based on a social determination, we situate the sexual orientation and gender identity of those escaping sexual binarism as health conditions/determinants. These subjects are sources of stigmas and prejudice and exposed to several situations of discrimination, denials, blockages, and impediments as from access to care in the several services of the network[3].

Countless conditions can compromise the health production of LGBTT people: the ways of living constructed by these subjects – often as survival, resistance, and coping strategies –, which may end up materializing in bodily and sexual practices that expose them to illness; the lack of motivation to seek health services due to fear, history, or third parties' stories of judgment, ill-treatment, and other constraints; the lack of reflection and knowledge of professionals on LGBTT health issues; and situations of poverty and other unsafe conditions hindering access to services and the effectiveness of health care[4-6].

Sexual and reproductive health care is one of the priority areas of primary care, and, therefore, the Ministry of Health has been working in several areas to ensure that health policies are in line with the guidelines for the promotion of sexual and gender equity[7]. Several actions have been developed to achieve the very principle of equity in the Brazilian Unified Health System (SUS).

In partnership with representatives of the LGBTT social movement, the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals was approved in December 2011. It aims to eliminate discrimination and institutional prejudice and reduce inequalities and the consolidation of SUS as a universal, comprehensive, and equitable system across the country[8].

In Teresina, health coverage services started in mid-1994, when the city restructured its care model to meet SUS doctrinal principles, which resulted in the incorporation of the Community Health Workers Program (PACS). Two years later, the Municipal Health Council approved the Family Health Program (PSF) implementation, which initially started to be developed by three teams. In 1998, the program had 40 teams and covered one-third of the municipality's population[9].

Currently, Teresina has full ESF coverage, with a network of 90 PHC rural and urban units (UBS), and 37 teams adhering to the Program for Improving Access and Quality of Primary Care (PMAQ-AB). It also has three Extended Family Health and Primary Care Center (NASF-AB) teams and one Street Clinic (eCR) team[9]. However, the high population coverage and a typically shared health responsibility in the operationalization of the ESF do not ensure that the strategies designed and agreed in the policies and programs will be effective in the care of LGBTT people in the UBS.

Also, primary care work has technical, economic, political, and ideological dimensions and involves an essential ethical component linked to the emancipation of people and families[10]. If the user-professional bond is strengthened, for example, the disclosure of sexual orientation or gender identity becomes natural during the visits[3].

However, we know that the positive transformations over the years incorporated in the construction of the ESF do not directly imply a change in the practice of health professionals, which requires a debate on health practice as a whole, especially in the face of the setbacks in the latest update of the 2017 National Primary Care Policy[11]. Thus, this paper aimed to analyze expe-

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riences narrated by primary care professionals in health care for LGBTT people in Teresina, the capital of Piauí.

Methodological route

This is a qualitative, narrative study research[12]. To this end, we selected a UBS located in the central region of Teresina equipped with six family health teams (eSF) and one Street Clinic team (eCR), besides an articulation with teams from the Extended Family Health and Primary Care Center (NASF-AB). Due to its dimensionality, it is considered Type II by the Ministry of Health and has local coordination.

Thirty-two health professionals participated in the research. As inclusion criteria, we selected doctors, nurses, dental-surgeons, oral health technicians or assistants, nursing technicians or assistants, community health workers (ACS), and a coordinator, and professionals of the NASF-AB teams (psychologist, physiotherapist, and nutritionist) and those from the eCR (nurse, social worker, doctor, and social worker). All had been working for at least six months in primary care. Those who were removed due to leave, qualification, or training were excluded. We also adopted the debate on Minayo[13] sampling and saturation and data collection, which took place between August and October 2019 and was interrupted when the narratives proved to be repetitive.

We used the individual narrative interview[12] to access the professionals' narratives, which aimed to encourage twenty-six participants to tell stories about events and professional experiences through elementary communication. A focus group[14] was also held with six more participants to understand everyday practices, representations, and symbolisms within the group of professionals. We followed the proposal of Gomes and Mendonça[15] for the construction of the plot, which outlines some essential stages concerning analytical-interpretative sequence: (1) understanding of the context of the narratives; (2) unveiling the structural aspects of the narratives; (3) interpretative synthesis of the narratives. The qualitative analysis was based on three dimensions – relational, organizational, and contextual – inspired by the theoretical discussion by Giovanella and Fleury[16].

The Research Ethics Committee of the Fernandes Figueira National Institute of Women, Children and Adolescent Health (IFF), the Oswaldo Cruz Foundation (Fiocruz), approved the research, July 2019. All subjects involved were instructed to sign the Informed Consent Form (ICF), and fictitious names replaced the participants' real names.

Results and discussion

Most of the subjects were women (83%). From this point on, we wrote this paper in the political grammar of feminism, generalizing and expanding to the feminine-plural. Forty-eight percent were aged 40-60 years, with a mean of 16 years seniority in the professional category and 19 years work in primary care. Forty-two percent had a *latu sensu* course, preferably in public health, family health, or mental health, and 3% had a master's or doctorate. Thirty percent of those working in mid-level positions already had an undergraduate degree or were studying. Cisgenerity was a common point for all participants, and 94% identified themselves as heterosexual, dividing themselves between single (50%) or married (50%), with 60% self-declared black, and 65% were catholic.

What to expect from this universe of cis women, heterosexual, middle-aged, with several training courses, married or single, predominantly black, and with a Catholic base? Based on theoretical debates consolidated by Giovanella and Fleury[16], this paper will present the experiences of the professionals in three main dimensions: relational, which concerns the intersubjective relationships between users and professionals; organizational, which refers to ways of organizing services and work processes; and, finally, contextual, which encompasses how situations of vulnerability and social determinants affect the conditions of satisfaction of health needs. Distinguishing between these dimensions merely aims to operationalize the analysis. However, they are interwoven in the real-life interaction flows.

Relational dimension

Knowing/learning about gender identity or sexual orientation was pointed out in the rhetoric of the professionals as something "irrelevant" to health care. With this discourse, the process of disclosure itself is somehow denied, interdicted, or hindered, either spontaneously, as self-disclosure, or from the health professional's question. The user-professional communication course should be a trust-building moment, exchanging knowledge, compassion, solidarity, and recog-

nition of the subjects and their singularities[6,17]. However, if users are not allowed to leave the closet in the flow of their interactions in the service crookedly or through doorways, the professionals seem interested in locating and reiterating the place of LGBTT people there, in the closet. Rather than asking or speaking, the trail seems to follow another chain of discovery. It looks like a puzzle to us, with some pieces assembled, others hidden, until something is concluded about the issue:

I will define Teresina as a province. People are terrified to come out, so much that as I work in the same area where I live, some people I know are LGBTT, but they don't speak. I only know because I live there. (Manuela, ACS).

Often, people close to them inform us. They are often a neighbor, a person who lives on the street, or an acquaintance of theirs. (Josefa, nursing technician).

No, I don't think [you should ask about sexual orientation and gender identity]. I think it's irrelevant. I think the issue of this category is essential. However, no, I don't think it's relevant to ask. It is often the ACS who brings the information. I do not usually ask this type of question, and everything is fine. (Marta, nurse).

Manuela, a community health worker (ACS) living in the region where she works, uses informal and daily networks to learn about the users' sexual orientation and gender identity issues. Sometimes, as Josefa recalled, this information traverses the network of clinics and can reach a neighbor. Opening the door that allows you to glimpse the interior of the cabinet is, once again, intermediated by a third party in the relationship.

One can observe a tendency to keep LGBTT populations within suspicion, doubt, and curiosity. Professionals create "off-limits" restrictions on the subject, especially when they avoid asking about these issues and blame the user for not verbalizing their sexual orientation or gender identity during the service - "but he also doesn't tell me!" (Marcos, doctor). Thus, the professionals deny any discrimination (in the style of thinking that promotes the idea that not recognizing differences directly means not discriminating) and reaffirm the ethics of "servicing everyone equally" (Cristiane, nurse).

The prospect of coming out of the closet was also associated mainly with effeminate gays, those who notably have, in the eyes of health professionals, some performance deviating somehow from what is expected from a male performance, for example. Some elements enter this puzzle, like the "way" they act, and their clothes and voice. Nurse Camila narrated that "the behavior, the way they act, and the voice say it all. You don't even have to ask".

This strategy of peering into the closet of subjects who escape the ways of conceiving femininities and masculinities, especially among gays and lesbians, seems to have a different rationale than transvestites and transsexuals. From the perspective of health professionals, gays and lesbians believe there is a search for a classifying sexual orientation based on stereotypes, moralities, and own judgments, impregnated with common sense. This device that does not allow either an affirmative view or defensive concealment can still be a strategy for the regulation and social control of dissident bodies[18]. These subjects – L, G, and B people – possibly often try to match standards so that they are better received and cared for in health services, as pointed out by some studies[3,6,19].

Transvestites and transsexuals who already have other forms of expressing their bodies believe the puzzle seems to be already assembled. Nurse Clara reported using the social name by transvestites and transsexuals as a critical element in shaping dissident identities and removing these subjects from suspicion and curiosity, as is the case with lesbians and gays, naming them as transvestites and transsexuals:

Who is a transvestite? You can see it quickly. We have the issue of the social name. I have more doubts regarding others, but not about these. (Clara, dental surgeon).

A free-circulation space, the health unit comprises different relationships between the various subjects of the alphabet soup, which gives rise to an experience of spatiality marked by very different rules and norms. Acceptable corporealities are those that "pass" without being recognized by non-cisgenerity and non-heteronormativity. Not being identified as LGBTT in service makes us think of the idea of "passability", which can be an avoidance strategy in the face of discrimination and violence in health services. Some subjects "pass" more easily than others, that is, inside the alphabet soup. Some subjects, more than others, have the privilege of going unnoticed in their sexual orientation or gender identity.

The organizational dimension

The principle of equity is contemporary and promotes associations to the rights of minorities. It aims to introduce a difference in the public

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space of citizenship, which acts at the heart of the struggle for different equities. Thus, the recognition of difference clashes with the classic legal thought that perceives citizenship as standard and undifferentiated. However, given the diversity of modern societies, equality is only complete when shared with the very notion of equity. A universal standard is insufficient if it does not include the right to difference. It is no longer a homogeneous pattern but an equal pattern[10,20]. The health professionals interviewed argue that the idea of equity that should govern the organization of work with LGBTT populations seemed distorted, as reported below:

I care for all patients in the same way, with the same equity, the same friendliness. I try to give my all, and I do it with love. Did you see the patients here in the office? Everyone left satisfied. Did someone leave here cursing me? Nobody called me a bad nurse. (Cristiane, nurse).

Regarding specific groups, I think of pathologies. For example, a group of hypertensive patients. Some are people with diabetes and will be treated for that specific disease. Then, you treat a specific group differently just because it is that group there. No, I think that there must be equity, regardless of sexual condition. (Conceição, doctor).

The clinic's service was performed in the same way as with another patient, without any differentiation, following the same equity. (Pedro, oral health assistant).

Cristiane, Conceição, and Pedro's selected statements exemplify how the concept of equity seems to be subsumed to that of universality, another principle of the SUS. It is not because the system belongs to everyone that everyone has the exact health care needs and demands[10]. That is why the concept of equity was proposed, precisely to include differences in health care[20]. Cristiane distorts this concept and evaluates her service by the user's lack of "explosiveness". In her statement, there seems to be a humanitarian, love-based project, as she mentions. However, it ends up making the specifics of care for the other invisible. The other, which is evoked by love, when it does not seem to rebel, is mentioned, quoted, and remembered. For this reason, many LGBTT users struggle to reveal their dissenting identities due to the standardization of care that should be unique and built from bonds, exchange of knowledge, and respect[4,6]. Conceição was very objective, framing pathology as essential in the medical routine, perhaps in an attempt to move away from other content that she does not consider necessary for health work. This is also what Pedro believes: everyone should receive the same care. Since work continues as a team, the conceptions seem to remain shared.

We reiterate how much the primary care clinic still seems to be firmly centered on the biomedical approach[10], which hinders moving to longitudinal work in an expanded network and comprehends the subjects among the biopsychosocial spheres of life, corroborating the findings of other studies[5,6].

When asked about legislation, policies, or resolutions in the field of health of LGBTT populations, the refusal came in unison: "No, I don't know. The protocol that we use only talks about sexually transmitted diseases" (Marta, nurse); "The question mark remained" (Clara, oral health assistant); "No, do you believe it isn't so?" (Manuela, ACS).

During the focus group, the ACS stated that they did not ask about these questions when completing the E-SUS form, as they did not believe they were so crucial for the work routine, according to transcripts: "I select that all are straight!" (Leticia, ACS); "The point is that we don't take these two questions from the individual registry *literally*. Now, I believe it is a mistake because if it's there, we have to ask, right?" (Flávia, ACS - our emphasis).

The E-SUS form includes two questions about sexual orientation and gender identity, which are not deemed mandatory by the system: "Do you want to inform your sexual orientation/gender identity?" To which users can answer "yes" or "no". If positive for sexual orientation, one can choose between "heterosexual, bisexual, homosexual (gay or lesbian), or other". If positive for gender identity, one can choose "a transsexual man, a transsexual woman, a transvestite, or other".

From this dialogue in the group, we realized that the act of completing the form with the heterosexual orientation for everyone, as brought by Leticia, mainly without prior consultation, reinforces the heteronormative standards within the health services and reveals the unpreparedness of the professional community workers and the team as a whole. Flávia also points out that these issues are not taken *literally*. In this plot, the LGBTT populations continue to be hidden, impeded, and denied within the services of the unit studied. Therefore, we wondered whether any qualification or training initiative had been provided by management or by the professionals themselves. The answer also was a "NO" cascade: "No. They do not provide any clarification

on this. There was only an AIDS test." (Catarina, nursing technician); "I don't know, I don't remember." (Suzana, ACS). "No, at least in this unit here, I have never seen these things concerning tuberculosis, leprosy, vaccines, these things." (Josefa, nursing technician).

Throughout the narratives, no health professional listed any course focusing on the health of LGBTT populations, either before or after the implementation of the policy. They believed that training and qualification and refresher courses seemed to be part of biomedical knowledge (tuberculosis, leprosy, and vaccines) or when, incidentally, they touch the LGBTT issue, they turn to the old and so constant discussion of AIDS. Among the many "NO" – "I didn't have", "I am not aware", "I don't know" – is "I don't remember", that absence that not even memory can register. We also highlight no courses with themes such as human rights, sexual diversity, violence, and gender, and others, which makes us think that courses focused on LGBTT health do not generate interest by different actors in this scenario.

The contextual dimension

Violent events are not themselves an entity, a uniform, monolithic phenomenon, which falls on society as something external to it and can be explained through relationships of the cause and effect[21] type. On the contrary, the narratives of health professionals showed how structural violence is masked, multifaceted, and diluted amid society under the mists of the most diverse manifestations, which interconnect, interact, (re) feed, and become stronger. Patrícia preferred to call the intermingled elements in the context of vulnerabilities that enhance violence "combos": "When the patient comes to us, he comes with a *combo*. They are homeless, with HIV, black, tuberculosis, poverty, and difficulty. It is so much that it is challenging: violence is wide open" (Patrícia, social worker - emphasis added by the authors).

Patrícia's account shows how we have marks of a society in crisis: economic, ethical, cultural, identity, belonging, health, education, and many others[2]. The countless differences and asymmetries of power generated amid these crises are reenacted in inequalities that reinforce the oppressive societal relationships. The other, who carries a "combo" here, is not recognized as a subject, not even as a subject of rights. How to think about the subjectivities and alterities of these subjects amid such an unequal context? Although this question seems obvious, the socioeconomic situations and conditions inspiring structural violence must be found in the very structure of society. If the crisis is multiple, Arruza et al.[22] affirm that we need a "combo" of confrontations, appropriate for each culture, generated from solidary, collaborative, collective, and complementary practices. These practices may structure the ideas of power and lead to political, social, and economic equality. Caio, who is gay, seems to have a critical eye on what he sees and perceives and includes specific elements of Northeastern culture in this production of inequalities.

Many people from the South don't like people from the Northeast because they think we eat lizards, are poor, hungry, and black. It is segregation within the segregation, and all this will be linked when it comes to LGBTT. (Caio, Nursing Technician).

The Northeastern people's imagery constructions have always been drawn in Brazilian history, in books, myths, and legends. They show disputes over land, misery, hunger, and desire for justice (told by the group of Lampião and the followers of the messianic Antônio Conselheiro, who affronted local power). Consequently, the construction of stereotypes of the miserable, the poor, the landless, the vigilante, and several others was left to the Northeasterns[23]. These have been and are perpetuated to this day in the imagination of some, especially those living in the South and Southeast of the country. Other segregations, other networks circulate through asymmetric power relationships within the same geographic and cultural territory, even within the different northeastern regions. They cannot go unnoticed, as Caio brought in his account.

In this scenario of social and cultural elements, it is also vital to discuss religious beliefs as issues that reach the unit and influence the work processes of health professionals with LGBTT populations. Therefore, we seek to understand how these professionals conceive, interpret, and act on care dynamics.

However, you know how it's like, here in Piauí: religion is powerful. The pressure of being from one religion and another influences a lot (...) I have seen many scenes here at the unit. Many statements by coworkers. I never forget a woman who was forcing a church pamphlet to be handed over to a person dressed like that. (Joana, dental surgeon).

The wave of religious fundamentalism has plagued Brazil and other Latin American countries. It has produced denial, discrimination, erasure, and setback in the field of human rights. A study[24] shows that many PHC professionals de-

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scribe cisgenerity and heterosexuality as actual "divine wills", and, thus, LGBTT populations are failing to fulfill a sacred determination. The social representations of these professionals seem to frame all types of identity that subvert cis-heteronormativity as a sin and can lead to discriminatory behavior in different areas, even without the conscious perception of perpetrators[24].

The scenes of violence are face-to-face with the unit's daily work. The professionals reported several other situations with colleagues from the unit who have severely denied service to LGBTT populations. Professional moralism seems to have a refusal, breach of ethical codes, disrespect for the Federal Constitution, carelessness, and negligence. However, isn't the SUS for all? It depends mainly on sexual orientation and gender identity. These showed that gender markers weaken access and quality of health care, further alienating LGBTT populations from the ESF. Where will these people find care? Do they return to the unit? Recent studies[5,6] have shown that LGBTT populations end up having their right to access to health violated, naturalizing a "no place" in the SUS, leading to other precarious health care routes.

These forms of violence also occur among others, such as symbolic violence, discussed by Bourdieu[25]. The author believes it is "censored and euphemized, that is, unknown and recognized"[25](p.211). In the accounts, it appears as domination in contexts in which control is not directly exercised. Unlike the cases in which one fails to serve the LGBTT user – "I don't serve gay people here, I already said that. Period." (Antônio, doctor) – symbolic violence is established, for example, with "jokes", as Pedro quotes: "we see some sideways laughter, jokes, right here in the waiting room" (Pedro, oral health assistant). The idea that LGBT-phobia is related to the social control of bodies is like daily patrolling of gender (in) conformities. The violence types include a tangle of discourses and produced cultural, social, and political practices[18].

Gender inequities have become even more potent amid the country's economic, geographical, political, and social inequalities. The Brazilian, northeastern, and Piaui's contexts were permeated by triggers of violence, denial, and erasure when in themselves they no longer represent naked violence. When we turn our lenses to the unit, from the most "smiling" way of talking to the user to the denial of care, the violence that occurs there directly interferes with the quality of care provided to LGBTT populations. The professionals' discourse showed how much violence happens in this area that should protect and care and how much these scenes are shared. In other words, the process of social determination in health is translated into the material, psychological, cultural, moral, legal, and political conditions that deprive LGBTT populations of rights, autonomy, and participation in different levels and exclude them from the different resources available in health network[4-6].

Final considerations

These clarifications state that LGBTT populations are not recognized as a "general population" – as prescribed by the 2017 National Primary Care Policy itself – nor are they recognized as populations requiring specific health care. Therefore, it is not a question of reflections so that these people "feel normal" in the care provided at the ESF, as attested by some reports, but, on the contrary, that they are recognized in their differences, and that their expressions, desires, identities, and corporealities are accepted and respected in the territories. These differences have been erased, hidden, and obstructed by the normative discourse in favor of supposed equality, which operates even more in the lines of discrimination and violence in health.

In the relational dimension, we perceived how much the revelation of sexual orientation/gender identity is at the same time stalked by health professionals, when it is within suspicion, prohibited, when nobody asks, wants to ask, and nor is it recorded, either in the communication with users, or forms, records, and work registers. In the organizational dimension, most professionals do not know the National LGBTT Health Policy. Of course, knowing about the policy does not ensure the quality of care. However, it calls our attention that some justifications are set in the order of not knowing, non-contact in training, and non-initiative management. When analyzing some contextual elements that could interfere in the unit's work dynamics and health practices, the professionals narrated cases of negligence, breach of secrecy and confidentiality, refusal to attend, and symbolic violence, expressed in smiles, jokes, and moral and religious judgments. In the ESF, sexual and gender "abnormalities" have also been patrolled in their own right to exist as such.

That is why we embrace listening as one of the keys to respecting sexual and gender diversity in primary care, and LGBTT bodies must

be recognized as active ESF users. We are talking about that we have not managed to ensure that LGBTT populations were effectively assisted in health services, mainly by health professionals, in more than three years of health reorganization in the territories and expansion of the ESF. The statements showed how LGBTT populations are invisible in their potential expressions, appearances, and participation, and, since they escape the normalities of sex and gender, they stay in the place of "control", "verification", and "examination" of their abjections. White coats seem to be like a shield, used to move away from those bodies that carry flags, stigmas, and prohibitions.

Collaborations

All authors equally contributed in all stages of the construction of the manuscript.

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