

DOI: <http://dx.doi.org/10.18569/tempus.v11i1.2327>

Assistência à saúde da população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários de Saúde?

Health assistance of LGBT people in a brazilian capital: what do Community Health Agents say?

Atención de la salud de la población LGBT en una capital brasileña: ¿qué dicen los Agentes Comunitarios de la Salud?

Rita de Cássia Passos Guimarães¹
Edu Trute Cavadinha²
Ana Valéria Machado Mendonça³
Maria Fátima Sousa⁴

RESUMO: Considerando-se a Atenção Básica como campo privilegiado para implementação de políticas de equidade e o agente comunitário de saúde, em virtude de sua função de elo entre comunidade e serviço, um ator estratégico para o seu sucesso, o presente artigo teve como objetivo investigar a percepção destes profissionais em cinco Unidades Básicas de Saúde da cidade de Goiânia, Brasil, quanto ao atendimento integral à saúde da população LGBT. O método utilizado

1 Doutoranda em Saúde Coletiva pela Universidade de Brasília (Departamento de Saúde Coletiva), graduada em enfermagem pela Universidade Católica de Salvador, tem especialização clínico-cirúrgica sob a forma de Residência. Seus estudos e pesquisas atuais concentram-se na área de Saúde Coletiva, Pesquisa Qualitativa, Gênero e Saúde e no uso da dramatização como ferramenta para potencializar programas de Comunicação e Educação em Saúde. UNB. Email: ritocapassos@gmail.com.

2Doutor em Ciências (Saúde Pública) pela Faculdade de Saúde Pública da Universidade de São Paulo - Faculdade de Saúde Pública, possui graduação em Enfermagem pela Universidade de Pernambuco. Mestrado em Enfermagem pela Universidade Federal do Paraná - UFPR em 2008. Atualmente é pesquisador do Núcleo de Estudos de Saúde Pública (NESP), coordenador do Observatório Nacional de Saúde LGBT e professor voluntário do Departamento de Saúde Coletiva da UNB.

3 Professora adjunta IV do Departamento de Saúde Coletiva, da Universidade de Brasília (UnB). Pós doutora em Comunicação em Saúde. Possui doutorado em Ciência da Informação pela UnB, mestrado em Comunicação e Cultura pela Universidade Federal do Rio de Janeiro, especialização em Administração da Comunicação Empresarial e graduação em Jornalismo e Relações Públicas. Atualmente é coordenadora do Mestrado Profissional em Saúde Coletiva e do Núcleo de Estudos em Saúde Pública da UnB (NESP/CEAM/UnB) e líder do Grupo de Estudos e Pesquisas em Informação em Comunicação em Saúde Coletiva (CNPq-Brasil).

4Doutora Honoris Causa pela Universidade Federal da Paraíba - UFPB (2014), com pós doutorado realizado em 2015 pelo Centre de Recherche sur la Communication et la Santé (ComSanté), da Université du Québec à Montréal (UQAM). Doutora em Ciências da Saúde pela Universidade de Brasília-UnB, mestre em Ciências Sociais pela UFPB, especialista em Saúde Coletiva e graduada em Enfermagem pela UFPB (1986). Professora adjunta IV do Departamento de Saúde Coletiva, da Faculdade de Ciências da Saúde, onde atualmente é diretora da Faculdade de Ciências da Saúde (2014-2018)

foi o Discurso do Sujeito Coletivo. Três discursos foram construídos relacionados a três ancoragens distintas que demonstram: 1. Minimização do problema, negação do preconceito e compreensão de barreiras como causadas pela própria população LGBT; 2. Negação da existência de barreiras ao acesso e à qualidade; e 3. Reconhecimento da existência de preconceitos que funcionam como barreiras e da necessidade de melhor capacitação das equipes. A partir destes resultados, foi possível inferir a negação do sexismo e das barreiras simbólicas, incompreensão do sentido de equidade, e o preconceito encarnado nas subjetividades destes profissionais, de forma semelhante ao que já foi encontrado em outros estudos envolvendo preconceitos e saúde, tais como de racismo institucional. No entanto, percebe-se também profissionais sensibilizados para a questão do respeito à diversidade e receptivos a processos formadores para melhor oferta de cuidado integral à população LGBT. Conclui-se que é preciso investir em metodologias ativas que permitam aos atores sociais expor e trabalhar seus valores e crenças, e reconhecer possíveis estigmas e preconceitos decorrentes deles, no sentido de oferecer uma atenção à saúde qualificada para a população LGBT.

Descritores: Equidade no Acesso; Política de Saúde; Sexismo; Atenção Primária à Saúde.

ABSTRACT: Considering Primary Healthcare as a privileged field for the implementation of equity policies and the community health agent, due to their role as a link between community and service, a strategic actor for its success, this article aimed to investigate the perception of these professionals in five Basic Health Units of the city of Goiânia, Brazil, regarding the integral healthcare of the LGBT population. The method used to analyze the interviews was the Discourse of the Collective Subject. Three discourses were constructed related to three distinct anchorages that demonstrate the following results: 1. Minimization of the problem, denial of prejudice and understanding of the barriers as caused by the LGBT population itself; 2. Denial of the existence of barriers to access and quality; and 3. Recognition of the existence of prejudices that act as barriers and of the need for better training of the teams. From these results it was possible to infer the denial of sexism and symbolic barriers, incomprehension of the sense of equity, and the incarnated prejudice in the subjectivities of these professionals, similar to what has already been found in other studies involving prejudices and health, such as the institutional racism. However, it is also possible to perceive professionals who are sensitive to the issue of respect for diversity and receptive to training processes to offer better integral care to the LGBT population. It is concluded that it is necessary to invest in active methodologies that allow the social actors to expose and work their values and beliefs and to recognize possible stigmas and prejudices arising from them in order to offer a qualified healthcare to the LGBT population.

Keywords: Equity in Access, Health Policy, Sexism, Primary Healthcare.

RESUMEN: Se considera a la atención básica como un campo privilegiado para implementar políticas de equidad y al agente comunitario de la salud, en virtud de su función de conector entre la comunidad y el servicio, como un actor estratégico para el éxito, el presente artículo tuvo como

objetivo investigar la percepción de estos profesionales en cinco unidades básicas de la salud, de la ciudad de Goiânia, Brasil, en relación a la atención integral de la salud de la población LGBT. Se utilizó el método discurso del sujeto colectivo. Se construyeron tres discursos relacionados a tres anclajes distintos que demuestran lo siguiente: 1. Minimización del problema; negación del preconcepto; y comprensión de barreras, generadas por la propia población LGBT; 2. Negación de la existencia de barreras al acceso y a la calidad del servicio; y 3. Reconocimiento de la existencia de prejuicios que funcionan como barreras, y necesidad de mejorar la capacitación de los equipos. A partir de estos resultados, se pudo deducir la negación del sexismo y de las barreras simbólicas, la incompreensión del sentido de equidad, y el preconcepto encarnado en las subjetividades de estos profesionales, de forma semejante al que ya se encontró en otros estudios que implican prejuicios y salud, tales como el racismo institucional. Sin embargo, también se perciben profesionales sensibilizados con la cuestión del respeto a la diversidad, y receptivos a procesos formadores para mejorar la oferta del cuidado integral a la población LGBT. Se concluyó que es necesario invertir en metodologías activas, que permitan a los actores sociales exponer y trabajar sus valores y creencias, y reconocer posibles estigmas y prejuicios derivados de ellos, en el sentido de ofrecer una atención a la salud calificada para la población LGBT.

Descriptor: equidad en el acceso; políticas de salud; sexismo; atención primaria de la salud.

INTRODUCTION

Prejudice and discrimination regarding divergent sexual behaviors of the heteronormatized pattern are consensually recognized in the literature as determinants of health, since they provoke specific vulnerabilities, constitute symbolic barriers to access, influence the quality of attention, and carry a strong potential to trigger processes of suffering, illness, and premature death of this population¹⁻².

The article 196 of the Constitution establishes health as the right of everyone and the duty of the State. This constitutional requirement arises in the organic health Law 8080/90 in the form of three guiding principles of SUS: the *universality* that establishes universal access to health services and actions, without restrictions of origin, race, gender, class, religion or any other form of discrimination; the *integrality* that implies the obligation to offer a quality healthcare that goes from protection and prevention to all levels of complexity of care, involving not only the biological aspects, but also the psychosocial and cultural aspects of care, and, therefore, need intersectoral actions; and *equity* that seeks to correct injustices with historically vulnerable populations through specific policies and actions to reduce health inequalities. In this way, the symbolic barriers to access that are imposed by prejudice and stigma obscure the fulfillment of the principle of universality; the lack of knowledge and/or negligence on the part of managers and health professionals of the psychosocial aspects and specific needs of the LGBT population prevents an integral care, and the

heteronormative pattern of health practices, the pathologization process of the behavioral variants, the incarnated prejudice of the subjectivities of users and professionals, and the institutional sexism, make it difficult to comply with the actions foreseen by the equity policies.

In 2008, the 13th National Health Conference³ established, for the first time, that sexual orientation and gender identity should be included in the analysis of the social determination of health, with a view to the construction of public policies, thus, confirming both the scientific production on the subject and the demands of social movements defending the interests of the lesbian, gay, bisexual, transvestite and transsexual (LGBT) population.

In 2011, through the Ministry No. 2836/2011, the Ministry of Health (MH) launched the National LGBT Comprehensive Health Policy (NLGBTCHP)⁴, built in partnership with the civil society and aiming at establishing guidelines and actions for the three spheres of the government, with regard to promotion, prevention and recovery in healthcare, emphasizing the importance of reducing the inequities resulting from gender identity and sexual orientation. It thus becomes a valuable instrument for the fight against homophobia, lesbophobia and transphobia in the field of health, and against institutional prejudice in the Unified Health System (SUS).

The main objective of the policy is to promote the integral health of lesbians, gays, bisexuals, transvestites and transsexuals, eliminating discrimination and institutional prejudice, as well as contributing to the reduction of inequalities and the consolidation of SUS as a universal, integral and equitable system. When referring to institutional prejudice, the policy explicitly recognizes the vulnerability of the LGBT population, when exposed to prejudice and discrimination of health professionals in service, which disqualifies the attention given, and compromises the efficiency of the health system as a whole. Having less than four full years, although already established in almost all regions of the country, it is still little known by health professionals.

Conceived as entry doors by the model of care used in SUS, the Basic Health Units (BHUs), especially when they have the Family Health Strategy (FHS), represent the spaces for the implementation of actions from public policies aimed at equity⁵. However, there are many challenges for the reorganization of the services, protocols and routines in Primary Care under the perspective of overcoming discrimination and prejudice and the practice of integrality and equity, which requires of individuals, collectivity and institutions, changes based on respect for diversity, which is still an obstacle.

A prominent professional for the FHS is the Community Health Agent (CHA). It is inside the link between the community and the health system itself, it conducts disease prevention activities and health promotion, through collective or individual actions, under the supervision of the manager and as SUS guidelines, in addition to having access to households, and, consequently, to the families' privacy⁶⁻⁷. Therefore, it becomes a key player to address the issues surrounding current prejudices and stigmas both in the community and in the healthcare facilities.

In order to verify the implementation of the BHUs actions resulting from the NLGBTCHP, and considering the importance of the CHAs as links between the community and the BHUs, this qualitative research involving five family health units in the city of Goiania has been held, and with the main objective to understanding the social representations of the CHAs on the comprehensive healthcare of LGBT people, seeking to verify discriminatory processes that act as barriers to access and, or as causes of the reduced quality of care offered to the LGBT population.

Prejudice and discrimination against the LGBT population in the context of health services

The literature has shown that in the policy development stage, the dialogue with the leaders and with the social movements facilitated the construction of a quality text, able to provide coverage to the main demands of the target population⁸⁻⁹. However, the effective implementation of actions is faced with local political resistance, motivated by moral positions, often of religious order, and the subjectivities involving workers and health professionals, reflected in discriminatory behavior, which are often stigmatizing¹⁰⁻¹¹.

In a study carried out in the media about Christian religions and homophobia in Brazil, the authors reveal a hate scenario, disgust and repression to any manifestation of sexual diversity. Some parts of the Bible are cited by religious to emphasize such speeches, as the passage of the Sodom city, that would have been destroyed because of the “sin” of “homosexuality” and that it could befall on the country if there were no mobilization against the advance of the LGBT citizenship¹².

Borrilo¹³ demonstrates that the concept of homophobia covers two important aspects that should be considered in the analysis of reality. The first aspect refers to the affective dimension, namely the rejection of homosexuality, and the other is about the cultural and cognitive dimensions, in which, in addition to the outright rejection, there is a lack of tolerance for any political action to ensure rights and equality this population. In every way, homophobia resembles other discriminatory behaviors, in which the other is considered inferior, abnormal, and, therefore, excluded from rights of their own humanity and affection. Thus, homophobia is beyond the interpersonal relationships issues, occupying institutional spaces such as schools, churches, health services, among others¹⁴⁻¹⁵, and it ends up invading subjectivities in a deep way, which makes it even more difficult to combat.

At the present time, the term has been expanded to LGBTophobia, as a claim to the LGBT movement, or more precisely to lesbophobia, homophobia, biphobia and transphobia, which carries the same sense of aversion, intolerance and phobia to any pattern that diverges from heteronormativity. The intention of the movement was to give greater visibility to lesbophobia, which involves sexist forms of violence, such as the common occurrence of “corrective” rape of lesbian women¹⁶. The transphobia, also for the same reason of visibility, and the highest percentage of lethal violence. According to the Transgender Europe NGO, we live in the country that most kills transsexuals in the world¹⁷.

It is historically understood that the LGBT population is discriminated and persecuted for their sexual orientation and gender identity, and, more recently, primarily as a result of the AIDS stigma; thus, distancing it from the healthcare environments, because its members consider that professionals are reproducers of homophobic discourses. A document from UNAIDS¹⁸ (p. 25) reveals that less than 10% of the LGBT people on the planet have access to prevention and care, and with regard to the transgender person, the same document points to the denial of their identity, hindering their accessibility to the health system. In addition to the stigma of AIDS, there has been described discriminatory attention in the units, constraints, inadequate behaviors, prejudiced connotations or even verbal offenses by professionals¹⁹.

A dossier presented by the health policy itself for the LGBT population shows that about 40% of lesbian or bisexual women do not reveal their sexual orientation in the consultations. Among those who reveal, 28% report to consider the service faster, and 17% the lack of test requests considered by them as necessary²⁰. The report also shows that the coverage in the realization of the pap smear screening test among heterosexual women in an interval of three years was 89.7%, while among lesbian and bisexual the coverage falls to 66.7%. It has been also shown that the lack of preparation of the professionals to deal with specific issues such as the difficulty of these women to assume themselves as homo or bisexual, and the denial of the risk of contracting sexually transmitted diseases are among the main reasons that lead to a lower demand of the homosexual women for health services.

With respect to male homosexuals (and male bisexuals?), besides being the main victims of violence and homophobic homicides, according to official and hemerographic data of the last Report of Homophobic Violence in Brazil²¹, it is well established that discriminatory experiences in society in general, and in the health services, cause from low self-esteem, feelings of guilt, insecurity to social isolation, difficulties in establishing and maintaining romantic relationships, sexual dysfunction and depressive episodes of lesser and greater severity, including the increased risk of suicide²².

Lionço²³ when referring to the transgender group, while recognizing the gain for this population segment regarding the regulation of the transsexualizer process in SUS, draws attention to the fact that this process does not solve the problem of poor access to primary care and quality care at all levels of the system. Arán²⁴ points out to the severity of the condition of the female transsexuality, due to ignorance, inexperience and unpreparedness of health services to deal with the intense suffering of these people.

These are some of the reasons why some studies indicate that the LGBT population is resistant to the demand for health services, which, shows the existing discriminatory context, based on the heteronormative pattern, the lack of qualification and the prejudice of the professionals to meet this demand.

In an attempt to try to reduce this discriminatory framework, state agencies, with decisive participation of social movements, have launched some campaigns and programs in the last two decades. In 2002, the National STD / AIDS Program of the Ministry of Health launched the campaign “Health Professional: every homosexual has the right to a treatment of equality and respect”. In 2004, the Special Secretary for Human Rights of the Presidency launched the *Brazil without Homophobia* program²⁵, and in 2009 the National Plan for the Promotion of Citizenship and Human Rights of Lesbian, Gay, Bisexual, Transvestite and Transsexual²⁶, and, finally, in 2011 the MH published the National Policy on Integral Health of the LGBT Population.

Although it is possible to notice a greater commitment of the State and the civil society in order to guarantee rights and to combat discrimination and prejudice, and even if it possible to recognize the advances as the legalization of homosexual marriage, the mandatory use of the social name for transvestites and transsexuals in the health services, and the regulation of the transsexualizer process in SUS, there is still too much distance between the planned actions and their implementation, especially in terms of resistance created by aspects that are rooted in our society, marked by a socio-historical Christian construction, patriarchal and sexist.

The Implementation of the National Policy of Integral Health to the LGBT population as a goal for Equity: The Role of Primary Care and of the CHA

It is interesting to observe that the term *equity* does not appear explicitly in the Constitution nor in the Organic Health Law 8080/90. The concepts outlined in the SUS constitution are the universal and egalitarian access to actions and health services²⁷. However, the notion of equity has become one of the pillars of the SUS, to the extent that the Brazilian health legislation incorporates this concept on two axes: “universal and equal access (equity of opportunity) and action on the determinants of health levels (equity of conditions)”²⁸.

Thus, this principle guides that programs and services are offered regardless of the level of complexity, without privileges or barriers, respecting needs and justice criteria, considering the prioritization of those who most need it. The principle of equity is, therefore, of “a political and ethical dimension by reducing avoidable and unfair differences that attack the human dignity”²⁹.

Mello³⁰ points out that the principle of equity is also structuring of SUS, and he highlights that the recognition that different social groups may have different health needs, also implying demands for different actions. Thus, the formulation and implementation of health policies geared to specific social segments need to be designed in an articulated way with SUS policies, ideally based on the principles of universality, integrality and equity.

In this scenario emerges the National Policy of Integral Health of the LGBT Population, having among its explicit objectives the search for greater equity in SUS, and specifically seeking the widening of LGBT population access to SUS health services, special attention to the demands and

health needs of the LGBT population, the qualification of the service network, the elimination of prejudice, discrimination, violence and exclusion in health services, and the guarantee of the use of the social name of transvestites and transsexuals.

In 2006, the National Primary Care Policy (NPCP) was approved. Its main pillars are the process of decentralization and social control of the management and has as a basis the organizational and care guidelines of SUS, focusing on redesigning the work processes from the FHC, considering the priority strategy of PHC, given its potential to apply the principles of universality, integrality and equity of SUS. In the same year, the Pact for Health, processed by the Tripartite Interagency Committee (TIC), determined three dimensions of action: Pact for Life, Pact in Defense of SUS and the Management Pact. The priority of the Pact for Life is “to consolidate and qualify the Family Health Care model strategy as Basic and center originator of healthcare networks in SUS” (Brazil, 2006).

Considered as the gateway to SUS, the PHC and within it the FHS are of fundamental importance for the implementation of any and all public policy of seeking equity, constituting a privileged arena for the implementation, evaluation and monitoring of these policies. According to Starfield³¹ PHC is the basis that determines the work of all the other levels of health systems and promotes the organization and rationalization of the use of resources, both basic and specialized, targeted at the promotion, maintenance and improvement of health.

In the FHS, the CHA is an important professional, with the primary function to act as a link between the enrolled population in their area and the health team. Being resident of the community and being in permanent contact with the families facilitates the surveillance work, the prevention and health promotion, accounting for the health system an element with great contribution potential to the reorganization of services. Studies have shown that there is consensus on the recognition of their importance as a channel of communication between the community and professionals, as they reflect the perceptions, knowledge and feelings of the community and establish new ways of practicing healthcare³².

It is evident, therefore, the importance of knowing, in the phases of implementation of the policy, the perception of these professionals about the service to the LGBT population in their communities, about their access to services, and the quality of care offered, as well as the progress of the implementation of specific policy actions in the BHUs.

This article presents a first exploratory study about the perception of these professionals, without the pretension to draw a national framework at this moment. The city of Goiânia has been chosen for this study. It is a particularly interesting field because it has strong conservative characteristics in its society and, on the other hand, it has a strong social movement for the defense of the LGBT population³³; it already has the policy considered as being implemented in the city since 2013, with the Special Advisory on Sexual Diversity, among other functions, to support and monitor

diagnoses of the situation of the lesbian, gay, bisexual, transvestite and transsexual population in the city and to elaborate projects or programs aimed at these groups.

METHOD

This is a qualitative research, based on the analysis of speeches collected from semi-structured interviews with community health agents. The calculation of the number of BHUs that should be included in the research used the total number of BHUs in the region (DAB / MS - 2014), the total population coverage, and the LGBT segment⁵. Considering that the probability of an LGBT individual in the general population is 10%, it has been defined that five BHUs would be randomly selected, and, for each of these, two to three CHAs would be interviewed, totaling for this study 11 interviews, which were collected in November 2014, and are subsequently transcribed and analyzed.

For the data analysis, the Collective Subject Discourse (CSD) method of Lefèvre and Lefèvre³⁴ has been used. It is a method that constructs a first-person synthesis discourse, organized with parts of discourses of similar meaning, through standardized and systematic procedures. Through these procedures, the CSD allows the knowledge of thoughts, beliefs and values of a community on a particular topic at a particular time. The method is based on the theory of Social Representation of authors such as Moscovici³⁵ and Jodelet³⁶, even if this concept is not applied in all the analysis applying the methodology.

Thus, the authors define as basic tools to work the speeches: Expression Key (ECH), Central Idea (IC) and Anchorage (AC). The Key Expressions are literal transcriptions of the speech or excerpts, which should be highlighted by the researcher, and which reveal the essence of the statement or the theory implicit in it. The Central Idea is a name or linguistic expression that reveals and describes in the most synthetic, precise and reliable way possible the meaning of the specific affirmations present in each of the analyzed discourses, and Anchorage is the expression of a given ideology that the subject of discourse professes and which is embedded in its discourse as if it were any statement.

Qualiquantisoft software to support qualitative research, based on the CSD theory, has been used to process the analysis.

5 Calculated by Ana Maria de Brito (PhD in epidemiology, researcher at Fiocruz, in Pernambuco and professor at the Universidade de Pernambuco) for multicentric national research: "Analysis of the access and quality of the Integral Healthcare for the LGBT population in the Unified Health System" under the coordination of the Nucleus of Public Health Studies/ NPHS/CEAM/UNB.

Ethical considerations

The Free and Informed Consent Term (FICT) has been properly applied. This research has been conducted fulfilling the ethical imperatives of the Resolution No. 466/12 of the National Health Council on research on human beings and it has been duly authorized by the National Council of Municipal Health Secretary (NACOMUHS) through the external letter 045/14 and by the Ethics Committee of the Universidade de Brasília (CEP-FS/Opinion No. 652.643), as part of a multi-entitled “Analysis of access and quality of integral healthcare for the LGBT population in the Unified Health System” under the coordination of the Nucleus of Public Health Studies/NPHS/CEAM/UNB.

RESULTS AND DISCUSSION

In the methodology section, we describe the instruments necessary for CSD analysis, such as Key Expression (KE), Central Idea (CI) and Anchorage (CA). The results were obtained by inferring the KE of each interview, categorizing them in CI and grouping the latter as similarities and complementarities in CA. The speeches are presented in the form of speech-synthesis (CSD) written in the first person as if it were a reunion of the testimony of the contents of a community in the speech of a fictional subject. The option to present the speeches in anchorage rather than central ideas, is part of the authors’ model of analysis³⁷ for which the collective discourse may contain several central ideas, but their reunion in anchorages allows to analyze the linguistic manifestation in a deeper way, allowing to capture the motivations, beliefs, values or ideologies associated with the specific topic researched. In our case, the anchorages allowed us to unveil the conceptual and ideological assumptions that will set, or not, prejudice, stigma and discrimination in speeches.

Three Anchors found in the survey will be presented next, along with the corresponding Collective Subject Discourses (CSDs).

ANCHORAGE 1

Considers that the LGBT population seeks the BHUs very little, they deny prejudices in the service and thinks that the barriers of access, if they exist, are caused by the population itself.

CSD 1

I do not have much idea of the needs of this group, because the demand is too small, we work more with other things such as dengue fever, pregnant women, nothing on that side. Also... they do not assume it, right? Few assume that, generally those who assume are younger, the younger generation. We do not even keep asking much, no. Sometimes, since we live in the community, you might even suspect. As well as there is a case in my area of two women... For years they live together, and what are they? sisters? I have also seen colleagues commenting... They talk like this: "Oh, that one has now decided to be a dyke, got herself a woman", but as there was no one who came and checked, so we do not fit them in this group. If they come to the unit they are welcome, they are treated as normal patients. We treat them as ordinary people, by name, as in the document. I think people are not discriminated like that. Now... I see that they are people who look little for the unit, and if they do not come it is not because there is anything here hindering, it is not that. It is not because of the professional, I see that it is fear. We have to work the psychological side of that people, for them to accept themselves, to see themselves as normal people.

The demand of the LGBT group is seen as small, unrepresentative in the face of other major problems such as dengue fever or the monitoring of pregnant women. There is a tendency to keep the LGBT population with little visibility; with some suspect ("what are they? Sisters?"). In part this happens because of the users ("Also... They do not assume, right?") and partly by a some sort of interdict on the subject ("We do not even keep asking much, no." ou "but as there was no one who came and checked"). Discrimination is denied, and good care is reaffirmed, while comments of assertions attributed to other CHAs with pimp definitions of behavior in the community and without any criticism ("Oh, that one has now decided to be a dyke...").

The user is welcome and "treated as a normal patient" remains, therefore imperceptible by the agent of the speech that there is some abnormality that there, in the scope of healthcare, is not considered. However, the possible difficulties of access are not caused by possible discriminations by the professionals, but by the withdrawal of the own group, the shame of the person that is not well accepted. It would be necessary to work towards the members of the population themselves, not just the professional training.

The CSD 1 Anchorage synthesizes a perception problem minimization and denial of discriminatory practices in the field of health services, already mentioned in the literature^(1,2,7,9), maintaining, however, the trend of pathologizing that is found in key expressions such as: "We have to work the psychological side of that people, for them to accept themselves".

This CSD illustrates well the problem of the deep invasion of the subjectivities of historically

constructed stigmata. The subject does not recognize in himself the elements of prejudice, not their discriminatory actions, and shows no sensitivity to perceive it in the world around them. Since the problem is not in the professionals but in the population itself, one can deduce the resistance in relation to formative processes to combat prejudice. This also points to the need of thinking of formative methodologies that are not only expositive, cognitive content, but which use active processes, where values, beliefs, emotions and perspectives can be exposed and problematized.

ANCHORAGE 2

Recognizes the existence of demands, denies access difficulties, but does not accept specific actions, considering them to be discriminatory.

CSD 2

Here is this group, yes. There are several in the area, even in my area there are those who are assumed. They have no restrictions, come to normal service, access is free for them. If it was about ten, fifteen years ago, I think it would be much more critical, not now, now there are no restrictions... I've never seen anyone with difficulty due to this, no. To tell you the truth, they are the ones who least need care. Mine, my areas, hardly ever need it, when they need it, it is a routine visit, show some tests, to order some tests, nothing further than normal. They are well attended, what is within our reach. People complain that they are being underserved, but it is not because they are gay or lesbian, it is because it is one of SUS' problems. We do not do anything specific, because if you are doing something specific, we will be discriminating. The service is extended to all, there is no inequality. Just as they have their barriers, others also have it... we also have special patients, deaf, dumb and it is like I told you... It is like anyone else. If they are normal people, they have normal service... Should it be different from us? I do not think so, I think it would be the same as us... do not they need the service, medicine?... It is a normal person. They should not have a specific group. In relation to lesbian and gay, it is hard to say that will do a specific job for them, you can do a job, and then some of them may say: "wow, that is good", then someone who is not may say: "instead of the government to invest in other things, they will invest in it".

The CSD 2 also presents the negation of prejudice by considering actions specific to the LGBT population as "discriminatory", and reveals the lack of awareness and invisibility of equitable care for the population of recognized historical vulnerability, confusing affirmative actions as a form or privilege and showing that they do not understand the difference between positive and negative discrimination. In this case, there does not seem to be an understanding of equity as the guiding principle of health actions and services, aimed at meeting specific needs and complying with justice, considering the prioritization of those who need it the most, and achieving a political and ethical dimension of the inequality as avoidable fruits of injustice.

The CSD 2 has some prospects that are similar to the CSD 1, with regard to the denial of prejudice and the reassurance of a good service in the units, but here the group's visibility is affirmed, although it is considered that they need some special attention ("they are the ones who

least need care”). Access difficulties are flatly denied (“*access is free for them*” e “*I’ve never seen anyone with difficulty due to this, no*”), prejudice by barriers are gone and when they arise, complaints are caused by problems that affect users as a whole and it is not specifically related to the condition of LGBT.

What draws most attention, however, in the perceptions and representations gathered in this CSD is the lack of understanding of equity actions, comprising them as discriminatory behavior, in the negative sense of the term (“*We do not do anything specific, because if you are doing something specific, we will be discriminating*”), and the affirmation that specific actions would bring a character to the condition of abnormality (“*Should it be different from us? I do not think so, I think it would be the same as us... do not they need the service, medicine?... It is a normal person*”). Interestingly, as in CSD 1, the stigma arises again without being noticed, when in the attempt to reaffirm equality, the homosexual behavior is compared with illnesses or disabilities (“*Just as they have their barriers, others also have it... we also have special patients, deaf, dumb and it is like I told you... It is like anyone else*”).

In this speech, the absence of the notion of minority rights is completely ignored, since an obstacle uncritically presented for the implementation of specific actions is the consideration that the heterosexual majority judge that the government spend money on something of little importance (“*instead of the government to invest in other things, they will invest in it*”).

Despite representing perceptions and representations of a small contingent of CHAs and coming from a single region of the country, this second CSD, along the first, illustrates some of the difficulties that are faced in implementing equity policies in the system end. The very notion of equity, as shown, which is critical for the system organization and delivery of services, it seems understood in a city where politics is considered to be implanted and has its own advice to follow. As discussed in the presentation of the problem surrounding this research, there is still a gap between the quality of policy formulation and effective implementation of actions. It is observed that, from the point of view of training, for example, or they are not there, or if they have not been able to sensitize a significant portion of CHAs to the importance of policies like this. This will become even clearer when we analyze the perceptions and representations gathered in the CSD 3.

ANCHORAGE 3

Recognizes the prejudice in the units, the need for special actions for the LGBT population and demands better dissemination of the problem and training for staff.

CSD 3

I think their access is complicated because they face prejudice. It is not easy... many of them feel embarrassed to seek the unit and fear being discriminated in attendance, you know? Once one of them told me that they do not come because they are afraid of not being attended... they are afraid to expose what is going on and the person does not understand. So I do not feel that they have support in the unit. I think we have little capacity to deal with situations, you understand? I guess I never had anything specific to this. There is little offered to this population in the overall system. Because things here take too long to arrive, sometimes it is coming, but it goes through the manager and delays, because he is waiting to bring together the unit to pass it on. There are many flyers... but direction very, very little. Wow, I think it would be great if there was this exchange right? I think that this policy would grow! I think it is really necessary more programs to encourage. Sometimes even in the media, on television, to show certain normality... I think there would have to be more openness, more lectures, call people back here, talk more about the subject. I have a neighbor who is the national president of a movement. He was born a boy, and it seems he has changed... he is very important; I think he does such a nice service... It was through him that I learned, you know?

The CSD 3 shows a perspective that is opposed to the previous two speeches. Here the symbolic barriers caused by prejudice and discrimination are recognized and the BHU is seen as an unwelcoming place for the LGBT population (“*I do not feel that they have support in the unit*”). Specific demands are also recognized, as well as the need for training to fight against prejudice and for the professionals to know how to deal with the particularities of the group. It is also interesting to note that aspects already concerned about the difficulties for the practical implementation of actions in the BHUs are clearly cited (“*things here take too long to arrive, sometimes it is coming, but it goes through the manager and delays, because he is waiting to bring together the unit to pass it on*”).

Another important point is the perception of inadequacy, as discussed in the literature; of some strategies to empower professionals and inform the public (“*There are many flyers... but direction very, very little*”). That is, it is being perceived that the necessary transformations for an equitable access in quality and access cannot be reached by information gathered in flyers, that this practice contributes very little for a re-adaptation of the professional conducts. In the same way it is necessary to draw attention to the perception of the importance of a greater involvement of other social sectors in the fight against prejudice (“*... I think it is really necessary more programs to encourage. Sometimes even in the media, on television, to show certain normality... I think there would have to be more openness, more lectures, call people back here, talk more about the subject*”). It should also be highlighted the understanding of the importance of social movements within the communities for social change in relation to stigma, prejudice and discrimination (“*I have a neighbor who is the national president of a movement. He was born a boy, and it seems he has changed... he is very important, I think he does such a nice service... It was through him that I learned, you know?*”).

The CSD 3 demonstrates that already exist at this time, professional groups aware of the issue and seeking to have better training to deal with these issues in their health practices. Identifying these individuals in the general environment of a set of professionals can also be a strategy for a deeper training, without ignoring the general training processes, but seeking to make them more aware of the multiplier agents from a perspective of respect for dignity and the reaffirmation of the importance of equity policies.

FINAL CONSIDERATIONS

Considering the Basic Health Units and, within them, the Family Health Strategy as privileged arenas for the implementation, monitoring and evaluation of the effectiveness of public health policies aimed at equity, one must also consider the community health agent as a strategic actor for the success of these policies. Integrated to the community and serving as a link between the local people and teams, this professional reflects both the prevailing morals in the community, as they may prove to be transformed into multipliers of a care perspective that respects the dignity of every human being within the richness of its diversity of ways of being and loving.

The results of this study, although limited due to the contingent and region, were able to present perceptions and representations, which are sure to be repeated in other contingents and regions in the country, although the expansion of research, already foreseen, may present even more enlightening perspectives on the problem.

It was possible to demonstrate the denial of sexism and barriers created, similar to what has been found in other studies involving prejudices and health, such as the institutional racism. At the same time, the hermeneutical analysis of the speeches in the construction process of the collective discourses has helped visualize clearly the prejudice that lies in the subjectivities. Similarly, it draws attention to the lack of understanding of what are, in health, actions to comply with equity, a structuring principle for SUS, as defined by the Health Reform. Fortunately, it was possible to present too, although in the restricted universe of this stage of the research, the presence of CHAs who were sensitized to the issue of respect for the diversity and receptive to forming processes of a better and more open care offer.

The implementation of actions at the end of the health systems is a much more difficult process than the policy making in the center. Therefore, it is necessary to invest in active methodologies that enable social actors to expose and work their values and beliefs and recognize possible stigma and prejudice arising from them, so that they can deconstruct them. Only then will it be possible to offer qualified healthcare to the LGBT population and other minority and/or diverse population groups, contributing to the training of technically and ethically prepared professionals.

REFERENCES

1. Carrara S. Discriminação, políticas e direitos sexuais no Brasil. *Cad Saúde Pública* 2012; 28(1):184-189.
2. Lionço T. Que direito à saúde para a população GLBT? Considerando direitos humanos, sexuais e reprodutivos em busca da integralidade e da equidade. *Saúde Soc* 2008; 17(2): 11-21.
3. Brasil. Relatório Final da 13ª Conferência Nacional de Saúde: Saúde e Qualidade de vida: políticas de estado e desenvolvimento/Ministério da Saúde, Conselho Nacional de Saúde. Editora do Ministério da Saúde 2008.
4. _____. Portaria n. 2.836, de 01 de Dezembro de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (Política Nacional de Saúde Integral LGBT). *Diário Oficial da União* 2011; 01 dez.
5. Carvalho DM, Santos MAS, Stopa SR, Vieira JSB, Melo EA, Reis AAC. A Cobertura da Estratégia de Saúde da Família (ESF) no Brasil, segundo a Pesquisa Nacional de Saúde, 2013. *Ciênc. saúde coletiva* [Internet]. 2016 Fev [Citado 2016 Nov 09]; 21(2): 327-338. Disponível em: <http://www.scielosp.org/scielo.php?>
6. Costa SM, Araújo FF, Martins LV, Nobre LLR, Araújo FM, Rodrigues CAQ. Agente Comunitário de Saúde: elemento nuclear das ações em saúde. *Cien Saude Colet*. 2013; 18 (7): 2147-2156.
7. Nunes MO, Trad LB, Almeida BA, Homem CR, Melo MCI. O agente comunitário de saúde: construção da identidade desse personagem híbrido e polifônico. *Cad Saude Publica* 2002; 18(6): 1639-1646.
8. Silva, JL. Como os serviços acolhem a população LGBT? II Seminário Nacional Gênero e Práticas Culturais: Cultura, Leitura e Representação. João Pessoa, Paraíba; 2009 Out 28-30. Disponível em: <http://www.itaporanga.net/genero/gt8/10.pdf>. Acesso em 29 de Abr de 2014.
9. Cavalcante, SJ. Formas de Acolhimento e Atendimento nos Serviços Públicos de Saúde a População LGBT. II Seminário Nacional Gênero e Práticas Culturais: Cultura, Leitura e Representação. João Pessoa, Paraíba; 2009 Out 28-30. Disponível em: <http://www.itaporanga.net/genero/gt8/18.pdf>. Acesso em 29 de Abr de 2014.
10. Ferraz D, Kraiczuk J. Gênero e Políticas Públicas de Saúde – construindo respostas para

o enfrentamento das desigualdades no âmbito do SUS. Rev de Psicologia da UNESP 2010; 9(1): 71-82.

11. Cardoso MR, Ferro LP. Saúde e população LGBT: demandas e especificidades em questão. Psicol cien prof 2012; 32 (3): 552-63.

12. Natividade M, Oliveira L. Sexualidades ameaçadoras: religião e homofobia(s) em discursos evangélicos conservadores. Sex, Salud y Soc: Revista Latinoamericana. [periódico na Internet] 2009. [Acesso 2015 jun 23];(2):[cerca de 20 p.] Disponível em: www.sexualidadsaludysociedad.org.

13. Borrilo DA. Homofobia. In: Lionço T, Diniz D, organizadoras. Homofobia e Educação: Um desafio ao silêncio. Brasília: Letras Livres - Ed UNB; 2009. p. 15-46..

14. Ministério da Educação. Secretaria de Educação Continuada, Alfabetização e Diversidade (SECAD). Gênero e Diversidade Sexual na Escola: reconhecer diferenças e superar preconceitos. Caderno SECAD 2007. (4).

15. Santos FE, Junior H, Carvalho RN, Ramalho TMM. Homofobia nas instituições públicas e negação dos direitos das travestis. Rev Tema 2013; [Acessado 2015 jun 28];14(20-21) :[cerca de 23 p.] Disponível em: <http://revistatema.facisa.edu.br/index.php/revistatema/article/viewFile/168/pdf>.

16. Barbosa BRSN, Nascimento ET, Carvalho IAF, Cavalcante JCD. Invisibilidade lésbica e a interseccionalidade de opressões. Perspectiva feminina de gênero: Desafio no campo das militâncias e das praticas. 18º REDOR – UFRP. Nov/14. Disponível em: <http://www.ufpb.br/evento/lti/ocs/index.php/18redor/18redor/paper/view/2269/821>.

17. Fernandes, FBM. Assassinatos de travestis e “pais de santo” no Brasil: homofobia, transfobia e intolerância religiosa. Saúde debate, Rio de Janeiro , v. 37, n. 98, p. 485-492, Set. 2013. Disponível em: <http://www.scielo.br>

18. UNAIDS. Direitos Humanos, Saúde e HIV: Guia de ações estratégicas para prevenir e combater a discriminação por orientação sexual e identidade de gênero. Grupo de Cooperação Técnica da América Latina (GCTH) e Centro Internacional de Cooperação Técnica HIV/AIDS, 2007.

19. Albuquerque GA, Garcia CL Alves, MJH Queiroz CMH, Adami F. Homossexualidade e o direito à saúde: um desafio para as políticas públicas de saúde no Brasil. *Rev Saúde em Debate* 2013; 37 (98): 516-524.
20. Facchini R, Barbosa, Regina M. Dossiê saúde das mulheres lésbicas: promoção da equidade e da integralidade. Belo Horizonte; s.n; 2006. 43 p.
21. Brasil. 2013. Relatório sobre Violência Homofóbica no Brasil: ano de 2013. Brasília: Secretaria de Direitos Humanos da Presidência da República.
22. Cardoso MR, Ferro LF. Saúde e população LGBT: demandas e especificidades em questão. *Psicol Cienc Prof* 2012. 32 (3): 552-563.
23. Lionço T. Atenção integral à saúde e diversidade sexual no Processo Transexualizador do SUS: avanços, impasses, desafios. *Physis Rev de Saúde Colet* 2009; 19 (1): 43-63
24. Arán M. A transexualidade e a gramática normativa do sistema sexo gênero. *Ágora: Estudos em Teoria Psicanalítica*. 2006; 9 (1): 49-63.
25. Conselho Nacional de Combate à Discriminação. Brasil Sem Homofobia: Programa de combate à violência e à discriminação contra GLTB e promoção da cidadania homossexual. Brasília: Ministério da Saúde; 2004.
26. Comissão Técnica Interministerial e Programa das Nações Unidas para o Desenvolvimento (PNUD). Secretaria Especial dos Direitos Humanos da Presidência da República (SEDH/PR). Plano Nacional de Promoção da Cidadania e Direitos Humanos de Lésbicas, Gays, Bissexuais, Travestis e Transexuais; 2009.
27. Brasil. Lei nº 8.080 de 19 de Setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 19 set.
28. Duarte CMR. Equidade na legislação: um princípio do sistema de saúde brasileiro? *Cien Saude Colet* 2002; 5(2): 443-463.

29. Granja GF, Zobolib ELCP, Fortes PAC, Fracolli LA. Equidade no sistema de saúde brasileiro: uma teoria fundamentada em dados. *Rev Baiana de Saúde Pública* 2010; 34(1):72-86.
30. Mello L, Perilo M, Braz CA, Pedrosa C. Políticas de saúde para lésbicas, gays, bissexuais, travestis e transexuais no Brasil: em busca de universalidade, integralidade e equidade. *Sex, Salud y Soc - Revista Latinoamericana*. 2011; 9: 7-28.
31. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO/Ministério da Saúde; 2002.
32. Cardoso AS, Nascimento MC. Comunicação no Programa Saúde da Família: o agente de saúde como elo integrador entre a equipe e a comunidade. *Cien Saude Colet* 2010; 15(1): 1509-1520.
33. Braz C, Mello L, Perilo M, Maroja D. Para além das fronteiras: parcerias e tensões em torno da construção da cidadania na perspectiva do movimento LGBT em Goiás. 2011[acesso em 6 de julho de 2015]; 2(17). Disponível em <http://www.revista.ufpe.br/revsocio/index.php/revista/article/view/44/39>
34. Lefèvre F, Lefèvre AMC. O discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa. Caxias do Sul: Educs; 2003.
35. Moscovisi S. A representação social da psicanálise. Tradução de Cabral. Rio de Janeiro: Zahar, 1978.
36. Jodelet D. Representações sociais: Um domínio em expansão(L. Ulup, Trad.). In D. Jodelet (Ed.), *As representações sociais* (pp.187-203). Rio de Janeiro, RJ: Editora da Universidade do Estado do Rio de Janeiro, 2001.
37. Lefèvre AMC, Lefevre F, Cardoso MRL, Mazza MMPR. Assistência Pública a Saúde no Brasil: Estudo de seis ancoragens. *Saúde e Sociedade*. 11 (2): 35-47, 2002.

Article submitted on 17/04/2017

Article approved on 31/05/2017

Article posted in the system on 20/09/2017