DOI 10.18471/rbe.v32.26475 Original Article

HEALTH CARE FOR LESBIAN, GAY, BISEXUAL, TRANSVESTITE AND TRANSGENDER INDIVIDUALS IN THE FAMILY HEALTH STRATEGY

ATENÇÃO À SAÚDE DE LÉSBICAS, GAYS, BISSEXUAIS, TRAVESTIS E TRANSEXUAIS NA ESTRATÉGIA SAÚDE DA FAMÍLIA

ATENCIÓN DE SALUD A LESBIANAS, GAYS, BISEXUALES, TRAVESTIS Y TRANSEXUALES EN LA ESTRATEGIA SALUD DE LA FAMILIA

Jameson Moreira Belém[1]
Maria Juscinaide Henrique Alves[2]
Emanuelly Vieira Pereira[2]
Felice Teles Lira dos Santos Moreira[3]
Glauberto da Silva Quirino[4]
Grayce Alencar Albuquerque[5]

How to cite this article: Belém JM, Alves MJH, Pereira EV, Moreira FTLS, Quirino GS, Albuquerque GA. Health care for Lesbians, Gays, Bisexuals, Transvestites and Transgenders in the Family Health Strategy. Rev baiana enferm (2018);32:e26475

Objective: analyze the health care provided to the lesbian, gay, bisexual, transvestite and transgender population in the Family Health Strategy. Method: qualitative study developed in June 2014 involving 12 nurses, in the interior of the state of Ceará, Brazil, through a semistructured interview. The data were organized and analyzed based on thematic categorical analysis and strategic axes of the Brazilian comprehensive health policy. Results: the health promotion and surveillance actions were reductionist, fragmented, biased in function of the sexual orientation and affected by the low attendance, stereotypes and barriers in care. Gaps in the academic background, in the professionals' qualification about sexuality and difficulties to implement, monitor and assess the health policy aggravated this context. Conclusion: the health care provided to the lesbian, gay, bisexual, transvestite and transgender population in the Family Health Strategy requires paradigmatic changes ranging from the theoretical-organizational sphere to the care relationships.

Descriptors: Sexual Minorities. Comprehensive Health Care. Health Status Disparities. Primary Care Nursing. Primary Health Care.

Objetivo: analisar a atenção à saúde prestada à população de Lésbicas, Gays, Bissexuais, Travestis e Transexuais na Estratégia Saúde da Família. Método: estudo qualitativo desenvolvido em junho de 2014 com 12 enfermeiros, no interior do Ceará, Brasil, por meio de entrevista semiestruturada. Os dados foram organizados e analisados

[1] RN. M.Sc. in Nursing. Substitute Professor at the Nursing Department of Universidade Regional do Cariri, Crato, Ceará, Brazil. jam.ex@hotmail.com
[2] RN. M.Sc. in Nursing. Temporary Professor at Universidade Regional do Cariri.. Crato, Ceará, Brazil.
[3] RN. Specialist in Health System Audit. Substitute Professor at Universidade Regional do Cariri. Crato, Ceará, Brazil.
[4] RN. Ph.D. in Science Education: Chemistry of Life and Health. Adjunct Professor at Universidade Regional do Cariri. Crato, Ceará, Brazil.
[5] RN. Ph.D. in Health Sciences. Assistant Professor at Universidade Regional do Cariri. Crato, Ceará, Brazil.

com base na análise categorial temática e eixos estratégicos da política nacional de saúde integral. Resultados: as ações de promoção e vigilância da saúde eram reducionistas, fragmentadas, enviesadas em função da orientação sexual e afetadas pela baixa assiduidade, estereótipos e barreiras nos atendimentos. Esse contexto era agravado por lacunas na formação acadêmica, qualificação dos profissionais sobre sexualidade e dificuldade de implementação, monitoramento e avaliação da política de saúde. Conclusão: a atenção à saúde prestada à população de Lésbicas, Gays, Bissexuais, Travestis e Transexuais na Estratégia Saúde da Família exige mudanças paradigmáticas desde o âmbito teórico-organizacional às relações de cuidado.

Descritores: Minorias Sexuais. Assistência Integral à Saúde. Desigualdades em Saúde. Enfermagem de Atenção Primária. Atenção Primária à Saúde.

Objetivo: analizar la atención de salud prestada a la población de lesbianas, gays, bisexuales, travestis y transexuales en la estrategia Salud de la Familia. Método: estudio cualitativo desarrollado en junio de 2014 con 12 enfermeros, en el interior del estado de Ceará, Brasil, mediante entrevista semiestructurada. Los datos fueron organizados y analizados con base en el análisis categorial temático y ejes estratégicos de la política nacional de salud integral. Resultados: las acciones de promoción y vigilancia de salud eran reduccionistas, fragmentadas, sesgadas en función de la orientación sexual y perjudicadas por la baja asistencia, estereotipos y barreras en las atenciones. Ese contexto era agravado por deficiencias en la formación académica, cualificación de los profesionales sobre sexualidad y dificultad de implementación, monitoreo y evaluación de la política de salud. Conclusión: la atención de salud prestada a la población de lesbianas, gays, bisexuales, travestis y transexuales en la estrategia Salud de la Familia demanda cambios paradigmáticos desde el ámbito teórico-organizacional hasta las relaciones de cuidado.

Descriptores: Minorías Sexuales. Atención Integral de Salud. Disparidades en el Estado de Salud. Enfermería de Atención Primaria. Atención Primaria de Salud.

Introduction

The right to universal access to health care and services in Brazil has been constitutionally established since 1988, with the creation of a Unified Health System (SUS), which assures users of care aimed at the promotion, prevention, diagnosis, treatment, cure, rehabilitation and rehabilitation of health at all levels and instances of the care networks[1].

In this context, the Family Health Strategy (FHS), as the main structuring axis of the SUS, is used to strengthen Primary Health Care (PHC) as the first level of care, the gateway into the system and the collator of care in the SUS, aiming to ensure the integrality of care to individuals, families, and groups[1].

Accessibility and timely access to primary health care are still a problem in many countries though[2], especially among vulnerable populations experiencing inequalities, inequities, and violations of rights[3]. Lesbian, gay, bisexual, transvestite and transgender (LGBT) individuals commonly experience this reality in the context of Latin America[4] though, due to the non-adaptation of the gender identity to the biological sex or the non-heteronormative sexual orientation[5-6]. This population, when compared to heterosexual individuals, faces structural, cultural and organizational obstacles when faced with symbolic, moral and aesthetic barriers articulated to social markers of difference, logics of exclusion and/or non-social acceptance[7].

In this scenario of discrimination, negative experiences can be observed in health services in the form of improper professional conduct, constraints, verbal offenses with prejudiced and stigmatizing connotations[8], as well as non-humanized care, lack of care, neglect of actions and/or omission of care[9]. These acts, which violate human rights, contribute to reduced attendance, lack of health services visits and a deficit in self-care, which increases the vulnerability of the LGBT population to health problems[8].

Indicators of the health-disease situation of this population in the country point to high rates of homophobic violence, despite the sub-registries (denunciations and notifications) in official data[10], individual, social and programmatic vulnerability

to Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (AIDS), especially among men who have sex with men (MSM)[11] and transvestites[12], vulnerability to depressive behaviors, anxieties, excessive fears, ideations and suicide attempts since the adolescent age[13] until adulthood and old age[14], associated with an increased risk of abuse of alcohol and other drugs[6].

Thus, in recognition of the unfavorable health conditions affecting the LGBT audience, countless governmental actions and strategies have been formulated and implemented to reduce inequities and inequalities in health in this population group. The National Council for Combating Discrimination (2001), the Brazil Without Homophobia Program (2004), the Technical Committee for the Health of the LGBT Population (2004), the National Plan to Combat the Epidemic of AIDS and Sexually Transmitted Diseases (STD) (2007), National Plan to Combat the Epidemic of AIDS and STD among Gay people, MSM and Transvestites (2007), the Transgender Process (2008), National LGBT Conference (2008), National Plan for the Promotion of Citizenship and LGBT Human Rights (2009), National Human Rights Program (2009) and the National LGBT Comprehensive Health Policy (2011)[15].

The National LGBT Comprehensive Health Policy, set out in four strategic activity axes, constitutes an important marker that recognizes sexual orientation and gender identity as determinants of health. The policy also serves as a guiding tool for the care practices to respond to the health needs of this group, in a timely, problem-solving and integral manner, with emphasis on promotion, surveillance, health education, monitoring, and accessibility, as fundamental and strategic pillars of the FHS[16].

Nevertheless, the health services and professionals in PHS face challenges in order to understand, incorporate, and meet the demands and specificities in the organization and provision of care and attention to the LGBT audience, with a view to implementing health promotion actions[17] that, when not incorporated into the daily work of the FHS, imply the search for secondary care services, reinforcing the hospital-centered logic of the LGBT audience[8].

Thus, the objective was to analyze the health care provided to the lesbian, gay, bisexual, transvestite and transgender population (LGBT) in the Family Health Strategy (FHS).

Method

Exploratory and descriptive study with a qualitative approach, developed with nurses working in the FHS in the city of Juazeiro do Norte, located in the Cariri Microregion, South Meso-region of the state of Ceará, in the Northeast of Brazil.

The research complied with the ethical and scientific requirements for research involving human beings, defined in Resolution No. 466/12 of the National Health Council/Ministry of Health, and received approval from the Research Ethics Committee under Opinion No. 458.757.

In order to include the study participants, the following criteria were established: being a nurse of a Family Health Team (FHT) in the city and presenting at least one year of professional practice in the team the nurse was professionally affiliated with during the research period. The researchers established this last criterion because they consider that this period offers more contact with the health reality of the care community and the knowledge of their health profile.

The choice of these professionals is justified by their insertion, coordination, and participation in PHC actions and services. In addition, the work processes and the way in which these professionals perceive the contexts of vulnerability, individual and collective needs, determinants and health determinants of the vulnerable populations can serve as characteristics of the health practices offered to this audience in this care scenario.

Initially, approval was requested from the Primary Care Department, a management entity of PHC, linked to the Municipal Health Department of the city, by means of an authorization document to carry out the research.

After authorization had been granted, the health districts were surveyed that possessed the largest number of FHT and were located in urban areas. In its care configuration, PHC in Juazeiro do Norte (CE) was subdivided into six health districts (political-administrative delimitation of the territory used for the organization of the care system that joints a variable number of FHT). In total, during the data collection period, 66 FHT were distributed across the six districts, accounting for 87.14% of the PHC coverage. After obtaining the values, data were collected in health districts II and V, selected because they possess the largest number of FHT allocated in the urban area.

After selecting the health teams, we randomly and personally contacted the nurses participating in the study. At that moment, these received further information on the development of the research, their compliance with the inclusion criteria was evaluated and they were invited to participate. The information was collected in June 2014, on of preset data, place and time, respecting the availability of the interviewee and analyzing the local conditions for the proper development of the interview.

The study sample consisted of 12 nurses working in FHT, in the age group between 24 and 39 years of age (mean of 30.3 years), predominantly female. Most respondents were married, Catholic, with a monthly income ranging from two to six minimum wages, with an average of 4.2 wages (to calculate the monthly income, the minimum wage of R$ 678.00 valid during the period of the research was considered).

Regarding training and qualifications, eight professionals held a specialization degree in family health, although most of them reported never having participated in training for care to the LGBT audience. As for the time of professional practice, seven nurses had less than five years of experience, and the other participants had between five and ten years of experience in the FHS.

To collect the information, a semistructured interview was used. During its application, procedures or measures were adopted to minimize the discomforts and predictable risks, guaranteeing the confidentiality of the personal information obtained and the participants' anonymity, through the adoption of codes to omit data that would permit identification.

The statements were audio-recorded with the participants' authorization, expressed by signing the Free and Informed Consent Form (TCLE), and later transcribed in full. The data collection process ended after the theoretical saturation of the discourse was identified[18].

The information obtained was organized using thematic categorical analysis. The phases of pre-analysis, material exploration, and treatment of results were followed, using systematic procedures and objectives to describe the content of the messages[19]. Nevertheless, the researchers' flexibility and sensitivity to allocate the discourses in categories and subcategories were taken into account.

The results were presented citing excerpts from the answers, identified through the use of codes consisting of the word nurse, followed by a number that represents the order of the interviews. Subsequently, they were discussed in association with the relevant literature and analyzed in an interpretive manner based on the four strategic axes contained in the operational plan of the National LGBT Comprehensive Health Policy[16].

Results

Under axis 1 of the National LGBT Comprehensive Health Policy, titled "access of the LGBT population to comprehensive health care", the participants expressed this group's low adherence to the actions and reduced attendance to health services, related to the fear of suffering discrimination and prejudice by FHS users and professionals. The members of the LGBT group are perceived as not belonging to the spaces of the primary health care units, as evidenced in the fragment "*The primary care unit is not a place for them*. (Nurse 5)", mainly due to their anxious behavior, mental problems and Sexually Transmitted Infections (STI). In

addition, regardless of whether or not it is expressed, sexual orientation is referred to as an impediment to communication between LGBT users and nurses.

Chart 1 – Thematic categories for the axis "access of the lesbian, gay, bisexual, transvestite and transgender population to comprehensive health care". Juazeiro do Norte, Ceará, Brazil – 2018

Categories	Interview excerpts
Reasons appointed for low attendance to health services and adherence to actions by the LGBT population	*Adherence essentially happens upon spontaneous demand, however, these populations hardly visit the service and probably imagine how the professionals and other users will receive them.* (Nurse 10). *I believe that there is a lack of demand really, or because this user does not want express what he is.* (Nurse 3). *There is no actual demand or even bonding dynamics. Most of the demand is punctual and there is no relationship of continuity, due to the marginalization the people in the group experience and the marginalization due to the fact that the professional are involved in other priority activities from the epidemiological perspective. That creates distancing.* (Nurse 8). *Do these people judge that the service can guarantee the safety, welcoming and respond to their needs? Today, this doubt remains for me as well as for them, because I am unable to guarantee that the other service users will respect them as they should be.* (Nurse 6).
Stereotypes related to health needs	*Not everyone at the health service is obliged to support anyone, of course. There needs to exist tolerance, but frantically getting to a public service, where there are different people, including children and elderly people, that's annoying, bad.* (Nurse 11). *They do not come to the service because their main need is monitoring with a specialist. The primary health care service is no place for them. Cases of condyloma, herpes, HPV, here* [at the health unit] *this service is not offered. They go straight to the infectology center.* (Nurse 5). *They have a lot of inquiries and often need to seek psychological support and social services, for the emotional problems due to the prejudice or because they are going through difficult situations.* (Nurse 2).
Barriers imposed on welcoming and communication between professional and LGBT users	*They feel marginalized. They feel uncomfortable to dialogue in function of their sexual orientation, because some are badly solved, still going through the acceptance process, they suffer.* (Nurse 12). *Even those who are self-disclosed, they feel uncomfortable or face that barrier to come to express an opinion, because it is something complicated and which most of society frowns upon.* (Nurse 4). *I believe that there is no difficulty to approach, it depends on the professional. As soon as these people tend to trust the health professional, to dialogue, to open up, you give the opportunity to express themselves, to feel better. So you gradually capture information that he wasn't even considering giving you at first.* (Nurse 1).

Source: Created by the authors.

In axis 2 of the National LGBT Comprehensive Health Policy, related to "health promotion and surveillance actions for the LGBT population", there was a focus on risk behaviors based on a comparative conception between heterosexuals and homosexuals. According to the professionals, the actions should be focused on vulnerabilities, STIs and psychological aspects. The non-heterosexual sexual orientation is determinant for the development of strategies aimed at this audience. As a result, the professionals highlighted the need for active search with the help of the Community Health Agents (CHA) and the constitution of specific groups for health education with the support of other services.

Chart 2 – Thematic categories for the axis "health promotion and surveillance actions for the lesbian, gay, bisexual, transvestite and transgender population". Juazeiro do Norte, Ceará, Brazil – 2018

Categories	Interview excerpts
Health actions constructed based on the conception of risk group	*We cannot untie the notion of risk. Although the epidemiological profile of sexually transmitted diseases has changed a lot, there's still a pattern, because these are people who drink a lot, they circulate in festive atmospheres, alternative places that are vulnerable to sexually transmitted diseases due to the association with alcohol and, because of the prejudice, some conform to unprotected sex, because they feel minimized or inferior. So, because of this environment they are obliged to live with, sometimes being more excluded, they remain a risk group, being a population exposed to social vulnerability, violence and sexual crimes.* (Nurse 9). *Independently of whether the person is homosexual or heterosexual, if you have many partners, the probability of you getting a sexually transmitted infection is huge. So everyone is part of the risk group today.* (Nurse 3). *These people have the same needs as the general population, but in addition to other specific things, such as the urologist, more frequent HIV test, if he is submitted to frequent risk behaviors.* (Nurse 7).
Biased health surveillance for the LGBT population	*People have to come to the service and you perform an active search movement, to capture them, because these people suffer from sexual infections and are potential sources of transmission. You need to sensitize them.* (Nurse 10). *I don't know how to capture them because, especially in my area, this group is very closed, and those people whose sexuality has been most outed, they are reluctant to participate in the activities at the service. I would need a strategy to create a specific group or an interdisciplinary action, joining with the psychologist and the social worker to be able to capture this population.* (Nurse 2). *You need to actively search for this population, to know if they truly want to participate in the actions, expose their "I" or their opinion to other people. Doing this work with the Community Health Agent, aiming to constitute a group for health education in the same way as with the pregnant women, postpartum women, hypertensive patients, diabetics, family planning, with the support of the psychologist and the social worker.* (Nurse 8). *I need help from the health agents, because for those I know who are incubated it's fine. But there are some who don't visit the service. I would need a non-specific strategy for the people in that group, because there are many who do not want to come forward. I'd need to offer health education, addressing sexuality, and extend an invitation without addressing those people.* (Nurse 12).
Biased care actions in function of non-heterosexual sexual orientation	*When they come to the service it's because they have some clinical symptom, and our role is to identify the problem and provide them with condoms and health education during the consultation.* (Nurse 11). *I would not like to work with that group, because it's so complex. It does not only involve sexual illnesses, but feelings, love triangles, so many things that it's the last thing I would like to work with. I don't like it, I won't lie.* (Nurse 1). *If they have self-declared, I cannot treat the sexuality of a heterosexual woman in the same way as I address the sexuality of a lesbian woman. These are different worlds.* (Nurse 9). *The homosexual patients I treated were HIV and tuberculosis patients, because they practiced unsafe sex, so as not to lose their partner, because they are very needy individuals, due to a life of exclusion, prejudice, psychological and physical violence. So my actions would practically focus on welcoming, strengthening issues like the rights to citizenship, prevention of STI, reduction of alcoholism incidence rates and its association with the use of other drugs, emphasizing self-esteem, the overcoming of violence and the promotion of a peace culture.* (Nurse 6). *The large majority of attendances involve people with characteristic symptoms of STI, such as Aids, syphilis, hepatitis caught due to lack of information or cultural issues.* (Nurse 4). *They are vulnerable to STI, Aids, and then to tuberculosis and so forth, because the majority does not take care as they should yet.* (Nurse 10). *Cases of forwarding depend. They may need specialties in urology, gynecology, infectology or psychology to treat some problem, because they are not accepted in society and are victims of various types of prejudice that end up triggering a mental disorder.* (Nurse 5).

Source: Created by the authors.

In axis 3 of the National LGBT Comprehensive Health Policy regarding "continuing education and popular education in health with a focus on the LGBT population," the professionals reported difficulties in addressing aspects related to the health of this population due to gaps in vocational training, although value aspects are regarded as necessary to ensure respect. In addition, the professionals were unaware of the existence and/or guidelines of a policy for LGBT, with actions included in other programs and strategies. In this way, skills were identified as essential to qualify the care for the LGBT audience.

Chart 3 – Thematic categories for the axis "continuing education and popular education in health focused on the lesbian, gay, bisexual, transvestite and transgender population te". Juazeiro do Norte, Ceará, Brazil – 2018

Categories	Interview excerpts
Deficient personal and professional education for care to the LGBT clients	*Many professionals do not know how to deal with people, address them, treat them with character and dignity. There are things we don't learn in college; it's life that teaches us. It is not because you've studied or something like that; it's the education from home that shapes people's character. So I believe it does not depend on the qualification, training or years of study.* (Nurse 1). *Today, the higher education institutions do not train the future professionals with regard to the LGBT group, because there's difficulty to address cross-sectional themes and it depends on the teacher training. The graduates reflect their teaching staff. If the teachers are prejudiced in certain respects, they will tend to reproduce the model they have learned.* (Nurse 7).
Ignorance on the policy and/or its guidelines	*We call upon the users to adhere to the programs, to the cervical prevention campaigns, vaccination campaigns, but the LGBT population is not being summoned because the Health Department is not currently developing a campaign, program or specific project focused on that group.* (Nurse 9). *I know there is an LGBT policy, but I've never studied and looked into that in further depth. I do what there is to do in STI prevention, in welcoming, but not because I know the policy. I do it because it's part of other policies.* (Nurse 4). *Just like there's the man's health, woman's health, child health policy, there should be one for LGBT as well. As there are that many people and couples like that, they are also entitled to a policy that favors them.* (Nurse 12). *No, I don't know. I believe there should be an LGBT policy, but which is not considered a priority.* (Nurse 8). *The Family Health Strategy and the health care programs are for heterosexuals and not for homosexuals. To the extent that there is no health policy for LGBT.* (Nurse 3).
Continuing education as a need for qualified care to the LGBT clients	*I think it starts with the health professionals' lack of qualification to attend to this population. The entire FHS team should be trained on the health of the LGBT population.* (Nurse 2). *It needs to start with the base of the FHS, offer training to the community health agents, for them to know how to address this audience, identify the needs, do an active search and survey information through a basic questionnaire, to drive the health promotion actions.* (Nurse 11). *As the professionals learn something very superficial in college, there's a need for training, continuing education, not only for the nurse, but for the entire team.* (Nurse 5).

Source: Created by the authors.

In axis 4 of the National LGBT Comprehensive Health Policy concerning the "monitoring and evaluation of health actions for the LGBT population", the professionals reported that the development of health actions is influenced by a lack of resources and support from managers, discontinuity of actions, overload of duties and centralization in the nurse. These processes are hampered by the lack of participation of different social segments in the formulation of strategies and the decentralization of actions.

Chart 4 – Thematic categories for the axis "monitoring and assessment of health actions for the lesbian, gay, bisexual, transvestite and transgender population". Juazeiro do Norte, Ceará, Brazil – 2018

Categories	Interview excerpts
Lack of support for the development of actions	*There needs to be the base of the federal, state, municipal governments and the agreement with the professionals in an ongoing and cohesive manner. It's not just the professional's good will. There's a need for support and resources to function properly, do a high-quality job and keep it up.* (Nurse 1). *Another great challenge is to monitor and analyze the actions that take place. Therefore, we need support from the managers in structural, material and staff terms. This process should not be centered in the nurse. The entire team needs to be involved.* (Nurse 7). *Unfortunately, in the reality of the family health teams, they are being pulverized by a range of demands, actions and services that need to be offered in the Ministry of Health programs, and cope with limitations with regard to the hour load and the number of professionals. These requirements prevent the professionals from dedicating themselves more to the epidemiological actions, although some avoid this, due to issues involving prejudice and marginalization. Hence, the actions end up not existing.* (Nurse 10).
Lack of social control by LGBT audience in participation entities	*We need to start the debate before the "superiors", the managers responsible for the formulation, so that we can participate in the planning process of the strategies that are to be developed according to the local health realities, which they are unaware of. In addition, the people who are the target of these actions are not consulted at any time; nothing takes place in a decentralized manner.* (Nurse 8). *Overall, the governments, as these are minority groups, end up not giving the necessary room for debate and to address such important and specific matters to guarantee these groups' rights.* (Nurse 11).

Source: Created by the authors.

Discussion

The results indicated a low level of attendance to health services and low adherence to the actions by the LGBT group, due to the absence of a care agenda and the involvement of professionals with the demands and reception of this audience. This is a result of social stigmatization, stereotypes about health needs and the professionals' socially mistaken ideas about LGBT.

Prejudice against non-heterosexual sexual orientation, discriminatory situations or perceived homophobia in health care represent the main barriers that delay or prevent the demand for services when LGBT people need care. Thus, the professionals end up not knowing the problems and health needs of populations with different sexual orientations, which implies that they remain in a situation of vulnerability[20]. This dimension corroborates the content of the professionals' discourse, which is based on stereotyped social representations about the group and presents a prejudiced, stigmatizing, discriminatory and excluding content, contributing to a lack of interest in developing specific actions for this population, despite the existence of a National LGBT Comprehensive Health Policy.

The distancing of LGBT persons from the public health network occurs due to dissatisfaction because they consider these services inaccessible and incapable of solving their demands, making a significant portion of them use the private network to have access to medical consultations and examinations[21]. This perspective is reinforced, as the interviewees point out that the FHS does not constitute a space for health care for LGBT people. Therefore, the professionals, by not accepting the demands of these users and adopting non-receptive behaviors and postures, reinforce the logic and contribute to the maintenance of programmatic vulnerability within the health services.

The way the service welcomes and builds links with the user is determinant for the adherence to care actions. Along the health itineraries, however, barriers imposed in the relationship between professionals and LGBT

users are evident. The communication difficulty due to the sexual orientation, the inability of services and professionals to guarantee access, welcome, listen, solve basic problems or refer to specialized services and build bonds[22] contribute to the distancing of this population from the health promotion services. This distancing, in combination with the situations of vulnerability and violations of human rights, has been identified in the social process as a catalyst for illness and the need for hospitalization, in which personal trajectories become central in the hospital-centered logic[23].

In the context of primary care, the care actions the interviewed professionals reported were skewed in function of the user's non-heterosexual sexual orientation, as they were restricted to the sexual aspects with a focus on STIs, vulnerabilities and psychological aspects. This reductionist logic is based on the conception of risk groups, the FHS as a heteronormative care scenario and on discriminatory and marginalized social representations[8,24]. The members of the group internalize this aspect and reproduce it in the self-care behaviors adopted and in the search for care, which are conditioned by the presence of pathological symptoms or symptoms for STI screening and treatment[8].

As a result of this condition, the health strategies the professionals pointed out were centered on a curative, biomedical and epidemiological logic, which considers homosexuality under the pathologization bias that needs to be subject to active search and capturing mechanisms to be the target of intervention. This finding does not only indicate the predominance of the biomedical model in Brazilian health, but also evidences the use of strategies that do not conform to the principles of PHC and the LGBT policy, which are focused on health promotion through the recognition of the determinants and conditioning factors of health and the timely access to comprehensive and qualified care to reduce the inequalities in health[1].

The nursing practices in the field of sexuality show little relation to health promotion and are concretized through guidelines on the prevention of STIs and the use of contraceptive methods[25]. The professional education is still centered on a biological view, with reductionism to genitality, emphasis on disease and the technique of care, highlighting hard technologies, disregarding the determinants of health and social relations imbricated in the health-disease process.

This finding materializes in the professionals' practice, in the care and in the consultations, in which there is evidence of difficulties in addressing the users' sexual orientation. Experiences reported by LGBT individuals describe that the lower demand for health services is associated with the existence of discrimination and unprepared professionals to deal with their specificities, as well as difficulties in revealing their sexual identity to the health professionals[6].

During the nurse's academic education, the approach of sexuality in the curricular subjects and contents is limited to biological or reproductive aspects with pathological bias and is marked by the neutralization of the sexed bodies, the asexualization of the subject receiving care and of the care provided and the concealment of the theme. The eventual and informal nature throughout the training are mechanisms that generate feelings such as insecurity, anguish and embarrassment at the moment of nursing care, as well as negative or unwanted reactions that refer to the issue of students' unpreparedness to deal with sexuality[26], especially if it differs from the existing heteronormative patterns.

In view of this gap, the nurses, in their care and teaching activities, reproduce the heteronormative model[24] - most significant during their training - and their care and/or pedagogical practices tend to rest on personal beliefs and values[27].

This fragile educational context is aggravated by the lack of awareness on LGBT policies and/or their guidelines and the lack of continuous professional qualification that together reinforce the invisibility and marginalization of the LGBT audience's health demands. These are perceived as non-priority, as there is a care profile that is restricted to a programmed demand based on

rigid and convenient routines, focused on specific populations and epidemiological contexts. Although content related to LGBT health care is being discussed, the teaching of specific policies for this audience is basically non-existent[28].

In order to provide comprehensive care to users, there is a need for insertion and standardization of content about sexuality in the nursing curricula[29]. When it comes to sexual diversity, the nurses' lack of understanding can negatively affect the type and quality of care received, as culturally sensitive care is not provided to LGBT users[30-31].

In this way, teaching strategies and training programs for health care focused on the LGBT can have positive and beneficial effects by raising the knowledge, skills, and attitudes of students and professionals, promoting cultural competence, sensitivity and reducing approach difficulties in care[32-34].

The interviewees also revealed that the health actions for the LGBT population are scarce in PHC, due to the difficulty of prioritizing, operationalizing, supporting and implementing a care agenda that imposes itself as a challenge to the work process in the FHS. As a result of these aspects, the logic prevails that groups considered as minorities and as marginalized receive little attention and that access to health should be conditioned to a profile of morbidity and mortality.

The practice of policies to promote equity depends on the ability of the federal government to sensitize managers at the subnational levels; the provision of objective conditions for the three spheres of government in the agreement on responsibilities and financing; the degree of organization of the social movement to pressure those in power to implement these policies; as well as on raising the professionals' awareness and qualification to act in accordance with the policies to promote equity[35].

Finally, the monitoring and evaluation of the actions, as the interviewees pointed out, are dimensions that do not take place, because the vertical policies do not meet the actual local needs and the social control of the LGBT audience is non-existent. Popular participation is an important management tool due to its ability to contribute to the development and improvement of actions. Effective participation is a permanent challenge for the operationalization of public policies within the SUS though[35].

Given this framework of institutional weaknesses and structural deficiencies that permeate actions to promote equity, they are at risk of constituting mere occasional events at the expense of a permanent policy[35]. This demonstrates the need for a paradigm shift in health care to achieve a new vision of social justice, in which all people have fair opportunities to reach their full health potential[1,15].

Hence, the constituent principles of the SUS, i.e. universality, comprehensiveness and equity, which are materialized in the National LGBT Comprehensive Care Policy, can truly promote the confrontation of exclusionary conditions in health services, especially in PHC, as a result of homophobia and of heteronormativity, which persists in society. Otherwise, symbolic, moral and aesthetic barriers will continue to exist, which prevent LGBT people from accessing and getting care in health services.

As a result of the research being conducted with a small sample, composed of only one professional category of the multidisciplinary team working in the FHS, and the intentionality in the way the participants were recruited, as well as limitations associated with the study, may compromise the interpretation and generalization of the results. The findings provide important data on the care provided to the LGBT audience in the FHS and contribute to filling gaps related to the subject.

Conclusion

Despite the existence of an operational plan that provides support for the implementation of the National LGBT Comprehensive Care Policy at all levels of health care, primary care for this audience is scarce in the context of the FHS.

In this care setting, the nurses' activities involving LGBT users is fragile due to low

attendance, stereotypes related to health needs, barriers for welcoming and communication. Therefore, the health promotion and surveillance actions and strategies are biased due to the non-heterosexual sexual orientation and influence of the biomedical model, as well as aggravated by gaps in academic training and professional qualification, ignorance of the policy and its guidelines, lack of support for the development of actions, absence of social control in the instances of participation, monitoring and evaluation of health actions.

Thus, great advances are needed so that the axes of the policy situated on a theoretical-organizational level are not only perceived and incorporated in the practice but also understood as dimensions essential to the transformation of inequities, inequalities and health disparities experienced by LGBT. In PHC, this process involves the need for paradigmatic changes that anchor the expanded conception of health and transcend socio-historical and cultural aspects rooted in the health-disease process and in the relationships and attitudes among the subjects involved in the production of health care and in the development of health promotion actions and strategies.

Collaborations:

1. design, project, data analysis and interpretation: Jameson Moreira Belém and Grayce Alencar Albuquerque;

2. writing of the article and relevant critical review of the intellectual content: Jameson Moreira Belém, Maria Juscinaide Henrique Alves, Emanuelly Vieira Pereira, Felice Teles Lira dos Santos Moreira, Glauberto da Silva Quirino and Grayce Alencar Albuquerque;

3. final approval of the version for publication: Jameson Moreira Belém, Maria Juscinaide Henrique Alves, Emanuelly Vieira Pereira, Felice Teles Lira dos Santos Moreira, Glauberto da Silva Quirino and Grayce Alencar Albuquerque.

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Received: May 15, 2018

Approved: November 13, 2018

Published: December 28, 2018