# Health Care on Lesbian, Gay, Bisexual, and Transgender People in Primary Health Care

**Cuidado em Saúde de Lésbicas, Gays, Bissexuais, Travestis e Transexuais na Atenção Primária à Saúde**
**Atención de Salud de Lesbianas, Gays, Bisexuales, Travestis y Transgénero en la Atención Primaria de Salud**

**RESUMO**
A pesquisa analisa como se organiza o cuidado à população LGBT diante dos desafios impostos pela interiorização das políticas de equidade. Com abordagem qualitativa, foi realizada em nove Unidades de Saúde da Família de um município de pequeno porte no semiárido nordestino. Foram entrevistados 27 profissionais, entre Médicos(as), Enfermeiros(as), Odontólogos(as) e Agentes Comunitários de Saúde, seguido de análise de conteúdo. Três categorias emergiram: Perspectivas em disputas: reconhecimento de direitos e movimentos anti gênero; Zonas de objetificação dos corpos LGBT na ótica dos(as) profissionais e A incompletude da Política Nacional de Saúde Integral LGBT. Corpos LGBTs são ininteligíveis para a maioria dos profissionais de saúde, os quais relatam reduzir a prática do cuidado ao HIV. A implementação da PNSI-LGBT em nível municipal deve considerar os fatores culturais e históricos do contexto em que os profissionais estão inseridos.
**DESCRITORES:** Atenção Primária à Saúde; Minorias Sexuais e de Gênero; Equidade em saúde.

**ABSTRACT**
The research analyzes how care for the LGBT population is organized in the face of the challenges imposed by the internalization of equity policies. With a qualitative approach, it was carried out in nine Family Health Units in a small municipality in the northeastern semiarid. 27 professionals were interviewed, including Doctors, Nurses, Dentists and Community Health Agents, followed by content analysis. Three categories emerged: Perspectives in disputes: recognition of rights and anti-gender movements; Areas of objectification of LGBT bodies from the perspective of professionals and The incompleteness of the National Policy for Integral Health LGBT. LGBT bodies are unintelligible to most health professionals, who report reducing the practice of HIV care. The implementation of PNSI-LGBT at the municipal level must consider the cultural and historical factors of the context in which the professionals are inserted.
**DESCRIPTORS:** Primary Health Care; Sexual and Gender Minorities; Health Equity.

**RESUMEN**
La investigación analiza cómo se organiza el cuidado hacia la población LGBT frente a los desafíos impuestos por la interiorización de las políticas de equidad. Con un enfoque cualitativo, se llevó a cabo en nueve Unidades de Salud de la Familia de un municipio de pequeño porte en el semiárido del noreste brasileño. Se entrevistaron 27 profesionales, entre médicos(as), enfermeros(as), odontólogos(as) y agentes comunitarios de salud, seguido de un análisis de contenido. Emergieron tres categorías: Perspectivas en disputa: reconocimiento de derechos y movimientos antigénero; Zonas de abyección de los cuerpos LGBT en la mirada de los profesionales; e Incompletitud de la Política Nacional de Salud Integral LGBT. Los cuerpos LGBT resultan ininteligibles para la mayoría de los profesionales de salud, quienes reportan reducir la práctica del cuidado al VIH. La implementación de la PNSI-LGBT a nivel municipal debe considerar los factores culturales e históricos del contexto en que los profesionales están insertos.
**DESCRIPTORES:** Atención Primaria de Salud; Minorías Sexuales y de Género; Equidad en salud.

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## INTRODUCTION

By breaking with the norm of supposed continuity between sex, gender, and desire, lesbian, gay, bisexual, transvestite, and transgender (LGBT) people have been victims of control over their bodies based on gender and sexuality, intersecting with other social determinants such as race and class. They are victims of a stigmatizing imaginary constructed throughout history by various dominant actors, supported by biomedical, legal, and religious discourses [1,2].

Stigma is considered one of the main causes of health damage in the LGBT population and must be combated to improve the health levels of this population. Stigma acts to induce stress as a factor in the development of morbidity and mortality, while restricting access to health protection resources. Combating stigma requires multilevel interventions that simultaneously address individual responses (such as stigma management and coping), interpersonal prejudice (such as the various forms of violence experienced), and systems that restrict access to basic rights at the structural level [3–5].

In the field of health, Primary Health Care (PHC) has proven to be a powerful intervention for expanding access and promoting equity among different groups [6]. In Brazil, PHC is guided by the Family Health Strategy (ESF), implemented with the aim of deepening structural changes in the concepts of the process of illness and health promotion in communities, with important results in health levels [7,8].

The PNSI-LGBT, however, has weaknesses such as a lack of funding for implementation and the absence of a legal framework to support it, making its implementation particularly challenging in different contexts [10,11].

Thus, the objective of the research was to analyze how care for the LGBT population is organized in the challenges imposed by scale, that is, a small municipality in the northeastern semi-arid region, considering PHC and the professionals who guarantee its materiality, seeking to identify the intersections, particularities, potentialities, and challenges for the implementation of the PNSI-LGBT.

## METHOD

The research is exploratory in nature, with a qualitative approach, based on Content Analysis and focused on the case study of the municipality of Cuité, in Paraíba. Approved by the Research Ethics Committee (CAAE No. 68929417.6.0000.5182), it respected the integrity and anonymity of the participants. The field of study covered nine Family Health Units (USFs) — five urban and four rural. Cuité, headquarters of the 4th Health Region of Paraíba, has an area of 747.84 km², an estimated population of 20,338 inhabitants, a GDP of approximately R$ 157.1 million, a per capita GDP of R$ 7,735.40, and an HDI of 0.591 (low).

Twenty-seven primary health care professionals participated (three physicians, five nurses, five dentists, and 14 community health workers), selected based on the following criteria: working at the ESF in Cuité-PB and a minimum of six months of experience. Those who were absent from work during the data collection period were excluded. To maintain anonymity, participants were identified by pseudonyms: M, E, D, and ACS followed by numbers.

Data collection was performed through semi-structured interviews, conducted in person by researchers PRF and DALS, with a digital recorder and field diary, following the following axes: 1) knowledge about the PNSI-LGBT; 2) needs of the LGBT population; 3) difficulties in care; 4) care actions; 5) perception of care; 6) strategies to expand access; 7) strategies to raise awareness among professionals. The saturation criterion guided the end of data collection.

The analysis followed the three stages of Bardin's technique: pre-analysis (organization, transcription, and reading of interviews), exploration of the material (coding into recording units and thematic categorization), and interpretation/inference. Three categories emerged from this analysis: 1) Perspectives in disputes: recognition of rights and anti-gender movements; 2) Zones of abjection of LGBT bodies from the


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perspective of professionals; and 3) The incompleteness of the National Policy for Comprehensive LGBT Health.

## RESULTS

The majority of the research participants are women with up to 27 years of experience in primary care services. Most professionals with higher education did not pursue postgraduate studies. As for Community Health Agents (ACS), most have only completed high school. None of the interviewees reported having participated in training focused on the National LGBT Comprehensive Health Policy (PNSI-LGBT).

### Areas of stigmatization of LGBT bodies from the perspective of professionals

Some professionals denied the specific needs of the LGBT population:

*I can't see any needs, because in my area there are only two, one who is openly gay and another who is not. We know who they are because we know them, although there are others who we know are not openly gay. (AC9)*

*"No! No needs! Because I treat everyone as normal, I don't see any needs. It doesn't seem like it! I don't see anyone complaining, no gay people... no one from the LGBT community. I don't see anyone complaining about treatment." (D5)*

### Other responses reinforce stigmas associated with LGBT bodies:

*[...] I also think it's a vulnerable population for drug use. Even because of their own lifestyle choices. They exclude themselves from society and end up opening the door to this kind of thing. (E2)*

### The incompleteness of the PNSI-LGBT in municipal practice

The absence of strategies in the municipality was justified by an alleged low demand:

*[...] In terms of health, we are on our own, it is up to them to seek help. (D4)*

*[...] we don't have groups at the unit and we don't work precisely because of the lack of demand from this group. (E4)*

In addition, there is evidence of stigmatizing associations between the LGBT population and sexually transmitted diseases:

*[...] They need to improve their hygiene and health, because sometimes they (lesbians) don't get tested. Sometimes when they go to get checked, they have AIDS or some other sexually transmitted disease, right? (AC3)*

*So much so that we offer rapid testing not only to heterosexuals, but also to the entire community that is interested, because we know that many have promiscuous lifestyles, right? [...] and also use drugs. (E2)*

*[...] to tell you the truth, no. I don't know. [...] I think mainly STD prevention. (E2)*

## DISCUSSION

The results show that even in contexts with a history of state public policies aimed at the LGBT population, as is the case in Paraíba, there is a mismatch between institutional regulations and everyday practice in small municipalities. The statements of professionals reveal a limited or stigmatized understanding of LGBT identities, with low appropriation of the PNSI-LGBT and a lack of local strategies for continuing education.

The literature also points to the prevalence of closet culture as a regulatory device for manifestations of gender and sexuality in services, as argued by Foucault [34] and Butler [35], reinforcing the institutionalized invisibility of dissident bodies. The historical pathologization of LGBT subjects, as observed in the statements of professionals, perpetuates a cycle of exclusion that distances this population from primary care services and challenges the principles of equity in primary care.

Another important point concerns the role of local cultures in resisting the implementation of inclusive health policies. As pointed out by Soliva and Silva Junior (2014), and studies of the Brazilian semi-arid region [26], there is a tendency to naturalize social problems and maintain clientelistic practices, which overlap with human rights-oriented initiatives.

Despite the limitations of this study regarding intersectionality with other social markers of difference (such as race, class, and disability), the findings offer important clues about how gender and sexuality are treated in public health services, which may support future intersectional analyses. The discussion presented here emphasizes that the advancement of the PNSI-LGBT depends not only on legal and regulatory frameworks, but also on cultural and educational transformation in the territories.

## CONCLUSION

Despite advances in public policies for the LGBT population at the national and state levels, there are deficiencies in communication with municipalities, which compromises care processes in the SUS. In local practice, care ends up being guided by common sense and the individual views of professionals, often permeated by stigma and prejudice. This reality reflects the influence of the cultural context of professionals, which can be understood in light of intercultural theory, which points to the relationship between cultural factors and health and illness processes. The study also highlights that, in health management, especially in people management, it is essential to focus on the social aspects of organizations. For policies aimed at the LGBT population in Primary Health Care (PHC) to be effective, it is necessary to promote cultural changes among health professionals at various levels of the system.

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