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Unidades Básicas de Saúde em Teresina-PI e o acesso da população LGB: o que pensam os médicos?

Basic Health Units in Teresina-PI and the access to the LGBT population: what do doctors think?

Unidades Básicas de Salud en Teresina-PI y el acceso de la población LGBT: ¿qué piensan los médicos?

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RESUMO: Este estudo teve como objetivo investigar a percepção de médicos de Unidades Básicas de Saúde de Teresina, considerada uma das mais homofóbicas capitais brasileiras, sobre o acesso e a qualidade da atenção à população LGBT. Trata-se de uma análise qualitativa de discurso sobre entrevistas semiestruturadas com profissionais médicos de sete unidades de saúde, selecionadas por sorteio, entre as 22 existentes na cidade, e fundamentada no método hermenêutico-dialético. Quatro principais categorias analíticas emergiram: 1. Percepção confusa entre universalidade e equidade, 2. Patologização e percepção de anormalidade na condição, 3. Negação de barreira ao acesso e imputabilidade da ausência de procura do serviço aos próprios sujeitos, e 4. Baixa demanda do grupo LGBT ou invisibilidade da condição. Conclui-se que um dos principais desafios à implementação da política nacional de saúde dirigida a esta população continua sendo os estigmas e preconceitos incorporados nas subjetividades dos profissionais, os quais dificultam a compreensão de direitos e as razões da existência de políticas compensatórias.

Palavras-chave: Identidade sexual. Políticas Públicas de Saúde. Equidade em saúde. Homossexualidade.

ABSTRACT: This study aimed to investigate the perception of physicians in Basic Health Units of Teresina, which is considered one of the most homophobic Brazilian capitals, regarding the

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access and quality of care to the LGBT population. We carried out a qualitative discourse analysis on semi-structured interviews with physicians of seven health units selected by lots from the 22 existing in the city, and based on the hermeneutic-dialectic method. Four key analytical categories have emerged: 1. Confused perception between universality and equity, 2. Pathologization and perception of abnormalities in the condition 3. Denial barrier denial of access and accountability of the lack of demand for the service to the subjects themselves, and 4. Low demand from the LGBT population or invisibility of their condition. We have come to the conclusion that a major challenge to the implementation of a national health policy aimed at this population remains; there are still stigmas and prejudices incorporated into the professional subjectivities, which hinder the understanding of the rights and reasons for the existence of compensatory policies.
Key word: Sexual identity. Public Healthcare. Policy Equity in Health. Homosexuality.

RESUMEN: Este estudio tuvo como objetivo investigar la percepción de médicos en Unidades Básicas de Salud de Teresina, considerada una de las capitales brasileñas más homofóbicas en relación al acceso y a la calidad de la atención a la población LGBT. Se trata de un análisis cualitativo del discurso en entrevistas semi-estructuradas con médicos de siete unidades de salud seleccionadas por sorteo, de entre las 22 existentes en la ciudad, y fundamentada en el método hermenéutico-dialéctico. Surgieron cuatro categorías analíticas clave: 1. Percepción confusa entre universalidad y equidad; 2. Patologización y percepción de anormalidad en la condición; 3. Negación de barrera de acceso y atribución de falta de busca por los servicios de los propios sujetos; y 4. Baja demanda del grupo LGBT o invisibilidad de la condición. La conclusión es que uno de los mayores desafíos para aplicar la política nacional de salud dirigida a esta población sigue siendo los estigmas y prejuicios incorporados en las subjetividades de los profesionales, las cuales dificultan la comprensión de los derechos y de las razones para la existencia de políticas compensatorias.
Palabras clave: identidad sexual; políticas públicas de salud; equidad en salud; homosexualidad.

INTRODUCTION

The attempt to reclaim health rights for the LGBT population emerges from the transition from the 20th century to the 21st century[1]. The initial demands came in the face of various forms of pressure from different social movements linked to the LGBT cause (Lesbian, Gay, Bisexual, Transvestite and Transsexual), with the focus being on coping with the HIV/AIDS epidemic that began in the period Such as «gay plague» or «gay cancer», given the higher incidence and prevalence in that population, which, as a striking consequence, reinforced the prejudice and discrimination against the LGBT social group[2].

On the other hand, these discriminatory pressures have strengthened the participation of LGBT groups in the search for social rights, historically denied, including in the field of health[3]. The struggles over time culminated in the recognition of prejudice and discrimination as determinants

of health, and the need for health planning that contemplated the complexity of the offer of care, given the conditions of stigmatization and discrimination of this group.

Carvalho and Philippe[4] argue that the lack of adequate shelter in health facilities is one of the main problems faced by the LGBT population. Sousa and collaborators[5] point out that the process of humanization in the SUS depends on systematic and strategic changes that involve the thinking and acting of the community, managers and health professionals, to guarantee respect for the different manifestations of sexuality and different forms of family constitution.

The confluence of the efforts of social movements and Brazilian scientific production led the Ministry of Health to the elaboration of specific public policies and programs, as well as the inclusion of guidelines related to the LGBT population in other public health policies. The National Policy on Comprehensive LGBT Care (PNAILGBT), published in 2010, represented a culmination of this process, since its elaboration brings among its main objectives the reduction of inequalities related to the health of these social groups and the combating discrimination and institutional prejudice as obstacles to access, reception and quality of care[3]. The following year, the publication of the National Policy on Primary Care reaffirmed the Family Health Strategy (ESF) as the main gateway to the health system, and determined that the course of the patient should begin with the act of welcoming, listening and giving a resolutive answer to most of their health problems[6,7].

However, the achievement of policy guidelines at the various levels of complexity of care is not achieved by the simple elaboration and publication of their statements. This is a complex task, since hegemonic heteronormative patterns in society act directly in the generation and reproduction of discriminatory positions, which inevitably influence the conduct of professionals who will meet the demands of this group.

Overcoming the problem will undoubtedly entail processes of continuing education where issues involving prejudice, sexuality and health care are worked not only in the cognitive perspective of information and the norm but in the perspective of subjective self-understanding of the constitution of their own prejudices and values. It is fundamental, therefore, to know the different perspectives on the problem of the various professionals who work in the health system. In a country with continental dimensions and social structures as complex as Brazil, these factors can arise in intense forms, depending on the sociocultural context in which the health units are inserted. Hence the importance of investigations that include these diverse contexts.

According to data from the Basic Attention Information System[8], Teresina adopted the Family Health Strategy in practically all the districts of the municipality, covering a population of 759.000 people, which represented 95.6% of the general population of the municipality, with 72 Health Centers/Basic Health Units and 220 family health teams, distributed in urban and rural areas. On the other hand, the state of Piauí has been registering high homicide rates against the LGBT population. Its capital, Teresina, came to occupy the first place between 2010 and 2012 as the

capital that offered the greatest risk to the LGBT population. In 2013, it came to occupy fifth place as the country's most homophobic capital, and finally, in 2014, the second highest number of hate crimes, involving intolerance of sexual orientation, according to the annual reports of the Gay Group of Bahia.

The present article had as main objective to verify the perception of the medical professionals in the network of Basic Attention of the city of Teresina, Piauí, regarding the access of the LGBT population to the Unified Health System. The study was produced from a research cut, coordinated by the Nucleus of Studies in Public Health of the University of Brasília (Nesp/UnB), on accessibility and quality of care for the LGBT population throughout the country.

On the evils that beset the access of the LGBT population to the health systems in Brazil.

Regarding the field of health, the symbolic universe around sexual diversity was primarily constructed by the medical order, which for a long time identified and classified the LGBT segment as having, in particular, mental pathology and sexual misconduct. Many of these subjects underwent forced hospitalizations in asylum treatment institutions for mental disorder patients, to obtain a cure, where they were treated with electroshocks, intense medication, cold baths, isolation, among other tortures and explicit violations of the law Degenerates [9].

Although "homosexuality," used at the time, was extinguished from the 1973 American Psychiatric Association Mental Disorders Handbook and from the list of mental illnesses in the World Health Organization (WHO) International Classification of Diseases (ICD) , In 1985 there is still a strong relationship in the conservative environments of society and health institutions from sexual orientation to the pathologization of these people, since they understand that homoaffective relationships escape "natural" behavior and are capable of "correction"[10].

Another factor that has been considered as a contributor to the construction of a symbolic universe of negativity in relation to the diversity of sexual behaviors is the use of the "risk factor" as an analytical category of epidemiological discourse, which according to Ayres[11] produced secondary notions of "risk groups" and "practices of risk" leading to a process of stigmatization and discrimination of adolescents, homosexuals, sex workers, among others.

It was also based on the observation of the stigmatizing process that the notion of a symbolic dimension of the service organization was developed in the health field, which would involve not only the geographical, economic and functional objective aspects, but also the subjectivities and, consequently, relational dynamics, influenced by the beliefs and values of the various subjects and groups interacting around health care[12].

Symbolic barriers to LGBT population access to services have often been denounced and discussed, not only in relation to male homosexuals[13], but for all groups that make up the diversity of orientation. For lesbians and bisexual women, for example, discrimination associated with unpre-

pared health professionals is the main barrier for them to assume their sexual orientation during care[14]. About transvestites and transsexuals, symbolic barriers to access and quality of care have been reported as being even more intense, ranging from the difficulty in complying with the determination of the use of the social name in medical records[15] and the still persistent process of psychiatry of the condition of transsexuality, for the guarantee to the surgery of redefinition of sex[16].

In addition to the recognition by health programs and public policies of discrimination, as determinants of health and institutional prejudice as a symbolic barrier to access and excellent quality of care as a whole, inter ministry mechanisms were also adopted in order to strengthen the promotion of respect for diversity. In 2007, the Ministry of Education's "Education as Exercise of Diversity" document recognized that the social construction of the notion of the epidemic of sexually transmitted diseases associated with same-sex sexual practices was centered on a prejudiced and exclusionary approach[17].

On the other hand, the social movements provided better spaces of participation, through which they could make more visible their main demands, which Carrara[18] summed up as: Free expression of sexual orientation; Change to the social name in identity documents; Access to quality health; And protection by the State against violence motivated by the intolerance of diversity.

If, on the one hand, the confrontation so far carried out does not seem to have been enough to dissolve the subjectivities of stigmata, profoundly embodied in culture, on the other hand, they can function as mediators of discourse, producing, above all, embarrassment of professionals in explicitly assuming their prejudices, and provoking, at first, a tendency to a performative discourse, aligned with the politically correct, which means the negation of prejudice.

Thus, it seems fundamental to study hermeneutically the discourse of doctors and other professionals, seeking to reveal underlying ideologies and moralities regarding the LGBT population's access to health care. This type of study, however, is practically non-existent in Brazilian literature. The context of Teresina, characterized by a society with strong religious influence, and considered as one of the most discriminatory of the country in relation to the LGBT group, can help to better understand how these discourses are structured, contributing to the future planning of strategies of continuing formation and capacity building.

METHODOLOGY

This is a qualitative study of discourse analysis by the dialectical hermeneutic method. For Minayo[19], in social research there is an identity between subject and object, revealing a common substratum of identity with the researcher, making subjects and researchers imbricated and engaged in the same science. The qualitative approach brings about a fundamental and intimate approximation between subject and object, since both are of close nature.

Seven Family Health Units were selected by lot, among the 22 existing ones in the city, and the

medical professionals who participated in the study. The criteria for exclusion of the participants were: not to be included in a complete family health team, to have less than three years of primary care, and not to be registered in the National Registry of Health Establishments.

If the requirements were not fulfilled a new lottery was carried out. For the collection of data, individual semi-structured interviews were recorded and later transcribed for the hermeneutic-dialectic examination, proposed by Minayo[19], following data ordering; classification of the data and final report.

The data ordering stage is a hermeneutical procedure in which the empirical material presented as a corpus was technically analyzed. This was done through a horizontal map, formatted from the integral transcription of the lines, the reading of the material, the ordering of these, as well as the adequate arrangement of the facts observed.

The classification of the data was established through a horizontal and exhaustive reading of each data, which allowed to emerge the units of inference, which can be expressed in unit elements of content that were submitted to classification and aggregation. In the study, they were words and/or phrases of the dialectical subjects in action. Inference units, in the light of the theoretical framework, were grouped into four categories of analysis. At the end, the final report was a production of the categories rationale, discussion of data and final scores.

As for the ethical aspects, it should be noted that each participant received an identification through the professional category "Med" followed by the number 1 to 7. The work was approved by the Research Ethics Committee of the Faculty of Health of the University of Brasília, under the opinion of CAAE 25856613.9.0000.0030. All the participants signed the Term of Consent and Free Clarified.

RESULTS AND DISCUSSION

"They must be inserted in the normal population to

be seen naturally "(MED1).

From the analysis in the inference units, four main categories emerge: 1. Confused perception between universality and equity; 2. Pathologization and perception of abnormality in the condition; 3. Denial of access barriers and imputability of the lack of service demand to the subjects themselves; 4. Low demand from the LGBT group or invisibility of the condition.

Confused Perception between Universality and Equity.

In the relationship between doctors and clients, it can be seen from the material collected that the discourse of universalization strongly implies the exercise of equity:

"There is nothing special for them, precisely because we stand for the idea that they must be inserted within the community and without cause for them to be segregated in one way or another" (MED 1).

"They enter into universality, have no services and actions specifically directed at them yet. [...] One problem the overvaluation of this gro*up, weakening others, is not it?!* (MED3).

"Here in the office, anyone has access, regardless of whether or not that group. Priority is given to those already officially standardized: the elderly, people with special needs, pregnant women and infants "(MED4).

"We have nothing specific for LGBTT. It's like I'm telling you, it's a universal access, regardless of gender, race, age ... it has no specific program. It's the same for everyone. The ease or difficulty is the same "(MED5).

The lack of consideration of what is prescribed in the records of the National Policy for Integral Attention to LGBT Population, the conceptual confusion and practice between equality and equity, and the symbolic violence on the part of the professional are diverse faces of the same phenomenon. The fragments of dialogues extracted from the speeches of the medical professionals, inserted in the public health network of the Piauí capital, suggest some distance from a model of integral and equanimous care, proposed by the Unified Health System (SUS).

The efforts of the three spheres of government and organized civil society to promote, care and care in health, prioritizing the reduction of inequalities due to sexual orientation and gender identity, as well as the fight against homophobia, lesbophobia and transphobia, and discrimination in Institutions and services of the Unified Health System, will be small if there is no change in the current paradigms in the field of discourse and medical actions.

It is necessary to affirm that the concept of gender equality given by professionals does not respect the freedom that all human beings, both women and men, possess to develop their personal capacities and make choices, without the limitations imposed by stereotypes, thus imposing , based on a conceptual chain in which gender equality is marked by the obligation of women and men to be identical, different from the approach in which their rights, responsibilities and opportunities do not depend on whether they were born with the female or male sex.

Regarding how the actions and services directed to the LGBT population are organized in the health unit where the medical professionals interviewed perform their functions, there is unanimity in the speech, in which he claims that there is "nothing specific for them" (MED5). However, it is observed that the justification is basically based on the ingrained concept of equality, focused on

the universalization of rights. The point of view of the medical class cannot always be guarded, so that the discourse, although careful, evidences the medical nonobservance to the National Policy of Integral Health of LGBT.

In this sense, the importance of a look that contemplates the interaction of several difference markers is necessary. It is also possible that the LGBT population served by these interviewed professionals may be conditioned to other forms of oppression by numerous factors, such as the statements of Parker and Camargo Jr.[20] that links to the oppressions of sexual orientation, poverty, racism, gender inequality and homophobia, and when correlated, systematically, provides subjects with a situation of marked vulnerability.

The perception that sexual orientation and gender need for comprehensive health care is related not only to determinants in the health/disease process, but also to its negative products, such as prejudice, violence, stigma, discrimination, among others, but with economic factors, as highlighted by the speeches of the medical professionals interviewed. The confusion of the concept of universality, to justify the absence of specific actions for the LGBT population, is evident and clear, and it damages the guarantee of men and women being treated fairly, according to their needs. It is important to highlight that within this concept the importance of the treatment that must consider, value and favor, in an equivalent way, rights, benefits, obligations and opportunities between the genders is addressed.

Pathologization and Perception of Abnormality in Condition.

The medical view of homosexuality, as a detour, continues to be present in the medical discourse, impacting the daily search for the health service:

> *"I talked to them a lot (...): it's not because you're that way you're going to play no. You can have a good behavior and be a normal person as I am [...] They have problems, but we will not hide, right? Let's put it out, tell the truth, they have trouble, they have! You need to, you have to listen"*(MED2).
>
> *"Access ... is what is offered to all, without distinction, to the normal and to the gay"* (MED2).
>
> *"I believe that there are no specific actions for this group here, it is attended to as everyone. There is control of hypertension, diabetes, tuberculosis, leprosy, other pathologies, but LGBT does not!"(*MED4).
>
> *"There is no specific routine for them here in the unit (...) Sometimes campaigns, diseases, that they have a higher risk profile"* (MED 6).

> *"(...) no specific demand on this. The issue of exposure to sexually transmitted disease remains the same. "(MED 3). "Worried about taking the HIV test. (...) They are very worried about this point, right? (...), then it is, I already knew by heart, HIV, X-ray of the chest and the blood count.* "(MED 2).

The present study demonstrates that there are professionals who still preserve the vision, considered by Caponi[19] as archaic, of the medical order of the twentieth century, who for a long time identified and classified the LGBT segment as having mental pathology and sexual misconduct. Failure to comply with the specificities of the LGBT population is reinforced by medical professionals because of the lack of knowledge about the concept and effect of Positive Discrimination given by Reimers[21], which shows it as a real redistribution of social opportunities and as a powerful weapon to respond to the democratic aspiration of equal opportunities.

The studies corroborate with the findings of Ayres[22], which affirms that vulnerability still prevails in health scenarios. In times when the LGBT population was strongly criticized in the history of the Acquired Immune Deficiency Syndrome epidemic, where the vulnerability to which they were exposed made them eligible for exclusion and abuse, such as stigmatization and discrimination, the idea of groups protagonists in the dissemination of the disease, and the narratives of this study point to this repercussion in the medical practice in the present day.

It is indisputable, therefore, that the influence of established heteronormative social patterns of character has within the health spaces investigated its space of action. It is also true, according to Sousa et al.[5], that this influence strongly influences professional conduct, increasing the risk of some not having their rights respected and moving them away from health services, just as in places where LGBT demand does not have the Basic Health Unit as a reference for its integral needs, like the Teresina model of this study.

The pathologization of the LGBT population is also evidenced in the discourse of the professionals surveyed, where the relation of specific actions of integral attention to the health of the LGBT population to programs of chronic pathologies accompanying treatment denotes an evident match between the individual LGBT and the patient affected by these diseases.

Another factor to consider is the strong stigmatizing relationship of the LGBT population with Sexually Transmitted Diseases (STD), which is still present in medical practices today. Proof of this is the finding in the medical discourse when affirming that the demand of the segments is restricted by the preoccupation and the accomplishment of examinations for the diagnosis of diseases considered predominant of the LGBT segments, being their conduct replicated by means of a standardized routine, evidenced in the study by means of requesting specific exams.

The reports extracted in the speech, collected in the interview, reveal that the association

between the LGBT population and STD is still reinforced by medical professionals, where there is condemnation of sexual orientation to contact with factors causing illness, especially HIV, evidence compatible with the stigmas which this population has been facing since ancient times. Affirmations in this sense do not promote the health of LGBT individuals, but they can influence them in a negative way for denial or, also, deprivation of the full enjoyment of their sexual orientation, by the psychological fear instigated by the health professional.

It is clear how the health professional sees and assists LGBT users in the units surveyed. It is necessary, in this context, that the National Plan to Combat the AIDS Epidemic and STDs among Gays, MSM (Men Who Have Sex with Men) and Travestis[17] be observed, especially in the prescription dealing with homophobia and transphobia, initiated since the family life, where it triggers sequenced barriers that need to be overcome by the affected individual, and its negative effects in several aspects, such as "self-esteem, difficulties in sociability, exclusion from family life and discontinuation of formal education"[17], among others difficulties that end up leading to several other losses.

On the other hand, we find in a single speech the perception that the LGBT population has advanced regarding the adoption of adequate safety measures to prevent STDs:

> "*Amazingly, it is a group that has some clarification regarding protection against sexually transmitted diseases"* (MED1)

Denial of access barrier and imputability of the absence of service demand to the subjects themselves.

In the medical view, access is marked by the absence of barriers, and the LGBT user himself is responsible for his absence in the Basic Health Unit:

> *"There is no difficulty, there is always a way for the patient to be treated, if he cannot come, we go to his residence ... I do not understand if there is discrimination between LGBT and other patients of the population"* (MED2).

> *"Nowadays, the difficulty they have is the same difficulty as any ordinary person has [...]"* (MED6).

> *"No, there is no impediment, it is on their part, they are ashamed, it is still the taboo, which has improved a lot, right? Improved 60%. Formerly, they were hidden, today it has improved a lot. There in my interior I am worried, already they are all loose already, they make question" (*MED2).

"They themselves, LGBT, do not seek unity as a formed group. If they do not seek unity, they mobilize, then we also do not have the opportunity of this relationship ... But we have no contact with this group, this group at no time sought us" (MED4).

*"Except for their own prejudice, if I have, but not for the team, for UBS, not at all! If you have, it's by themselves, you suddenly get here. But for the team, for the unit, no!" (*MED5).

It is not only the discriminatory practices that block access to the health system for the LGBT population, but also, and perhaps imperatively, the impropriety of the provision of attention and care. The common narrative discourse, which alleges the absence of the LGBT population in the health services, does not show a good health condition for lesbians, gays, bisexuals, transvestites or transsexuals, but a lack of attention to issues related to sexual orientation or, assistance, since access to the LGBT segments is conditioned to the understanding of the demands of these groups, in order to comply with the principles of universality and integrality of the Unified Health System.

The Brazilian Center for Health Studies points out that the health sector has been permeable to the debate and the incorporation of challenges and innovations of various natures, which gives rise to a positive expectation regarding the changes. However, there is a broad realization that the human rights of LGBT groups are violated or neglected[23]. Corroborating with the last statement, it was verified in the study that the understanding of specific demands to the LGBT segments are absent in all the Basic Health Units surveyed, marked by the lack of specific actions.

Faced with the factors that impute the LGBT user to the lack of demand for health services, where the professionals interviewed are, the Humanization Campaign of the Ministry of Health shows that the violence suffered by the client within the space included as a health facility leads to blockages and traumas that are difficult to repair, and it is not the professional's role to accelerate this process or try to influence the decisions of their clients, much less to "blame them for remaining, but to trust and invest in their capacity to face obstacles"[24].

Thus, it is possible to observe that a health model whose service is compatible with the needs of the community, including the LGBT population, is necessary in the health institutions surveyed. The issues raised by Adami[25] and Unglert[26], which consider the format of services offered, the timing and improvement of care, should be reconsidered for a more inclusive picture, and for issues such as agendas for participation and involvement for the integration of the entire attached community , campaigns to integrate populations historically excluded from services by means of prejudices and discriminations, as well as the reinforcement of services that consider and respect the peculiarities, choices and way of life of each one.

The present study reinforces, in the logic of integrality to health, some issues that must be

carefully observed, especially those inserted in the field of damages and health problems, arising from continuous and repetitive processes of stigmas, discrimination and social exclusion, only the physical, but also the psychological, whose amplitude and magnitude are of a large scale from the negative and irreversible point of view, corroborating with the findings of Sousa et al[5] regarding these types of violence in the field of health.

The guidelines and objectives of the National LGBT Comprehensive Care Policy are therefore focused on changes in the social determination of health, with a view to reducing the inequalities related to the health of these social groups. The Unified Health System guidelines reaffirm the commitment to universality, to integrality and to the effective participation of the community. With the implementation of the Policy, the Ministry of Health[27] itself recognizes that sexual identity and gender identity are constituents of a complex process of discrimination and exclusion, from which the vulnerability factors derive.

Low demand from the LGBT group or invisibility of the condition

> *"We do not have that kind of patient here, I never attended, never came here for us. [...] There is still a complex, right? For some, some not, right? They make a point of being [...] some make a point of appearing and others do not, make a point of hiding"* (MED2).
>
> *"As the community is reduced, at least those that are known, that are well exposed, that has some degree of revelation, the demand is small, it is short"* (MED3).
>
> *"In fact, when the patient looks for our team [...], we do not try to identify their sexual choice ... regardless of their choice, we serve everyone"* (MED4).
>
> *"Also, it's that thing, that we know it's LGBTT, it does not! For example, I am LGBTT and I want a consultation, no, it does not! It's somebody who comes for an appointment here at the station and will be taken care of anyway"* (MED5).
>
> *"Demand is small, and there is still a lot of prejudice, especially from family members*" (MED6).
>
> *"Not too little. If I have three, I have plenty. Very little demand. And it's because we attend well, it gets well. If I have three, I have a lot, that I follow up"* (MED7).

In the face of symbolic violence, as well as the aggressions committed by disrespect, the

revelation to the other of sexual orientation, becomes an arduous and challenging task, evidenced by Foucault as a silencing of sexuality. In this context, this complexity is identified in this study by which the individual expresses his sexuality, corroborating with the studies of Abdo[28], who claims that such a factor may be related by relationships, life circumstances or culture, which presupposes to be something gradually constructed and for characterizing gender performance and identity.

The National LGBT Integral Health Policy also recognizes the complexity involved in the denaturalization process of heteronormative precepts that lead to discriminatory actions, since it predicts a long and difficult path to be followed, warning that the greatest difficulty "will be to overcome the prejudice and the discrimination that requires, from each and the collective, changes in values based on respect for differences"[27].

The exposed conditions report the absence of the LGBT population in the health units and a service to the individual whose sexual orientation, yearnings and problems are veiled to the professional and restricted to the patient. The Brazil Without Homophobia Program prescribes, since 2002, that the integral care by the health system is only possible through a relationship of established agreement when the respect of both parties is evidenced in a reciprocal way. Therefore, the role of the health professional is to facilitate the dialogue, "acting with tact and diplomacy in the search for the most appropriate orientation or direction in each case"[24].

Medical professionals report the LGBT population's lack of demand for health services. Although they do not offer any particular care to this population, some claim never to have had contact with any segment. Access, besides open gates, is fundamental for the implementation of the National LGBT Comprehensive Health Policy, so that the symbolic barriers between the health service and the user can be transformed into a process of mutual bonding by the establishment of trust, leading to the construction of more health for a population so neglected over time and still living in conditions of vulnerability.

With the universality of the right to health, it is necessary to propose specific reception and attention strategies, according to the singularities of the individuals seeking assistance. Thus, it is necessary for the Brazilian state to define, in a more objective way, the recognition of the perspectives of equity, as Leonço[29] reinforces, which considers primordial the design of equity in systems, since beyond the universality of human and social rights, guarantees the recognition and differences between social groups, which often, like the LGBT population, are in a situation of inequality.

Thus, in order for the desired change in the LGBT population's health access scenario to occur, it is essential that health professionals and managers invest in the idea that factors related to sexual orientation and gender identity are important determinants of the processes of cure and illness, as Buss[30] states, which also relates to other factors that directly interfere with the epidemiological profile and, consequently, of the pathological profile and mortality, such as social class, schooling,

among others.

FINAL CONSIDERATIONS

Implementing the National Policy of Integral Care for the LGBT population continues to be a challenge, since it is imperative to broaden the perception of what is understood by social and reproductive rights and the recognition of the diverse possibilities of human constitution and, the exercise of sexuality.

It urges to point out that, although several actions to promote respect for diversity have already progressed in different sectors, including in the health field, this study demonstrates that it is necessary to change the conceptions and practices of health professionals, besides knowing and appropriating the causes prescribed in the policy, can construct a new scenario in Primary Health Care.

Great were the victories of the LGBT population to positivize, in the juridical order, fundamental rights for the exercise of citizenship and, also, to guarantee their health, as a humanized service and free of prejudice and discrimination based on sexual orientation and gender identity, including ensuring the use of the social name for transvestites and transsexuals as a strategy to promote access to the system through the Charter of Rights of Health Users. However, no less complex actions need to be adopted so that these rights can be incorporated and recognized as such by health workers, which requires changes of values based on respect for differences, being not different from the Teresina reality addressed in this study.

Obviously, the findings of the present study cannot be generalized to Brazil, and the results of the study in other regions will allow a broader understanding of the phenomenon. However, we do not expect results that differ from those presented by the Teresina context, marked by strong traditional religiosity and homophobia.

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