

Assessment of LGBTQIA+ access by health professionals at a Municipal Health Center of Rio de Janeiro

Avaliação do acesso ao acolhimento à população LGBTQIA+ por parte dos profissionais de saúde de um Centro Municipal de Saúde no Rio de Janeiro

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ABSTRACT The LGBTQIA+ population has different health demands, implying different actions. The National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites and Transgender ((PNSI-LGBT) reaffirms SUS commitment to universality, integrality and equity. The objective of this research was to evaluate the access to reception for the LGBTQIA+ population, by health professionals from a Municipal Health Center. A descriptive study with a qualitative method was carried out, in a participatory manner. To this end, 60 subjects participated in the research through face-to-face conversation circles and through online questionnaires. The majority (85%) of the participants consider the LGBTQIA+ population to be vulnerable. Although most do not report difficulties in welcoming this population, more than half consider that they do not have appropriate training. It was identified by the subjects that the greatest barriers to accessibility were not the geographic ones, but the professionals and users themselves, indicating the fragility of the bond. In order to improve access to reception, training processes are necessary for workers. The discussion about the health and disease process of the LGBTQIA+ population also requires an understanding of the concepts of sexual orientation and gender identity, in order to facilitate actions of acceptability and accessibility by health professionals.

KEYWORDS LGBTQIA+. Access. Reception. Primary Health Care. Health assessment.

RESUMO A população LGBTQIA+ tem demandas de saúde específicas, implicando ações diferenciadas. A Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (PNSI-LGBT) reafirma o compromisso do Sistema Único de Saúde com a universalidade, a integralidade e a equidade. Objetivou-se avaliar o acesso ao acolhimento à população LGBTQIA+ por parte dos profissionais de saúde de um Centro Municipal de Saúde na cidade do Rio de Janeiro. Foi realizado um estudo descritivo, de forma participativa, empregando o método qualitativo. Para tanto, 60 profissionais participaram de rodas de conversa presenciais e responderam a um questionário on-line. A maioria (85%) dos participantes considera a população LGBTQIA+ vulnerável. Apesar de a maior parte não relatar dificuldades no acolhimento dessa população, mais da metade considera que não há treinamento e/ou capacitação apropriados. Foi identificado pelos profissionais que as maiores barreiras de acesso não foram as geográficas, e sim as dos próprios profissionais e usuários, indicando a fragilidade do vínculo. Para a melhoria do acesso ao acolhimento, processos de treinamento/capacitação dos trabalhadores são necessários. A discussão sobre o processo de saúde e doença da população LGBTQIA+ também requer a compreensão dos conceitos de orientação sexual e identidade de gênero, de modo que facilite as ações de aceitabilidade e acessibilidade por parte dos profissionais de saúde.

PALAVRAS-CHAVE LGBTQIA+. Acesso. Acolhimento. Atenção Primária à Saúde. Avaliação em saúde.

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Introduction

The LGBTQIA+ population, which includes lesbians, gays, bisexuals, transsexuals, transvestites, queers, intersex, asexuals and more, has different health demands. This signals the need for new reception models for this population, especially at the gateway to the Unified Health System (SUS), mainly carried out in Primary Health Care (PHC). In Brazil, the LGBTQIA+ population is among the marginalized social minorities with less access to health services, thus not receiving due assistance in the face of judgments from health service professionals, whose discrimination exists both in different spaces of society and in the places where care is produced¹. This population remained helpless for a long time, in addition to being the target of a complex process of violation of autonomy, dignity and the right to health. It is noteworthy that, in a prejudiced society, non-heteronormative sexual orientation and gender non-compliance with biological sex establish violations of basic human rights and often provide a situation of vulnerability for these people¹.

The violation of rights often occurs due to issues of delegitimization of different sexual orientations and gender identities – also due to parental rejection and social rejection resulting from non-acceptance. It is important to highlight that, when it comes to teenagers, this favors contexts of loneliness, violence, sex work and death. Furthermore, it promotes anticipation of the possibility of discrimination against LGBTQIA+ people, which results in lower demand for services, as they already understand that they will be discriminated against, as well as difficulties on the part of health professionals in understanding the specificities of the LGBTQIA+ population and their demands, which can result in the promotion of precarious assistance and offensive treatment. There are many points of violation of human rights¹. According to Schadec and Zeifert², the greatest difficulties presented by this minority are basically linked to prejudice

and violation of human rights. Still, there are several movements to repudiate homophobia around the world, including the United Nations (UN), which has been making great efforts to combat these problems.

In Brazil, the SUS must ensure that everyone is treated fairly, and even though there is a law that provides guarantees to these people, we live in a cis-heteronormative society, in which a standard is established for all individuals. In this way, those who do not comply with this normative standard would be on the margins of society. From this perspective, sex is also a sociocultural category, as it is constructed alongside gender, which is a category formed from individual practices, discourses and experiences in society. Butler³ seeks to launch the issue of hetero/bi/homosexuality into new lines of reflection; she criticizes some ontological and epistemological assumptions that have long been rooted in the human sciences, such as: what does it mean to be a woman, what does it mean to be a man? These questions increase the perception of the multiplicity of sexualities and ‘genders’, consequently, of differentiated demands.

In 2011, with the aim of promoting comprehensive health, equity and minimizing prejudice, the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (PNSI-LGBT) was sanctioned, with the purpose of meeting specific demands and repairing lack of health assistance for this group, including actions for LGBTQIA+⁴ visibility. The PNSI-LGBT was a decisive moment for public health policies in Brazil, as it guided and legitimized the needs and specificities, in accordance with the postulates of equity provided for in the Federal Constitution and the SUS Users Charter. It included strengthening the participation of representatives of the LGBTQIA+ population in health councils and conferences; guaranteeing the use of the social name of transvestites and transsexuals; the implementation of educational actions in health service routines aimed at promoting self-esteem; monitoring

and evaluating health and service indicators for the LGBTQIA+ population, including ethnic-racial and territorial aspects; offering health care and attention to adolescents and elderly people who are part of the LGBTQIA+ population; the qualification of SUS service networks for comprehensive care and attention; carrying out studies and research related to the development of services and technologies aimed at the population's health needs.

This legislation is a historic milestone in recognizing the demands of this vulnerable population. Health teams working in PHC must be open to understanding the demands and peculiarities of each situation that arises, seeking to organize the types of resources that help alleviate suffering, improve and prolong life, avoid or reduce damage, improve living conditions, favor the creation of positive bonds, reduce isolation and abandonment, increasing bonds and access. In relation to the demand for health care for the LGBTQIA+ group, sexual health is notoriously emphasized, failing to address other essential issues for this population, which is also affected by different health problems⁵.

Some studies have demonstrated the importance of the pathologizing process operated by biomedical rationality, precisely because of an imaginary that still relates homosexuality as a condition that in itself predisposes to diseases and the frequent association of the health of the LGBTQIA+ population with Sexually Transmitted Infections (STIs) and AIDS. The AIDS epidemic had caused new stigmas to this population due to the AIDS-homosexuality association, with the approach to the health of homosexual people only related to their sexuality, neglecting other causes of illness for these people. This process contributed to the development of affirmative actions and specific policies to combat discrimination⁶. In this sense, many articles point to promiscuity and the behavior attributed to gays, therefore, most of the demands offered by health professionals end up being related to this. As previously stated, this is nothing more than a

great stigma, which leads to the development of many other policies against discrimination.

Welcoming is a practice present in all care relationships, in real encounters between health workers and users, in the acts of receiving and listening to people, and can happen in different ways⁷. It is necessary to have a diverse reception, displaced from the cis-heteronormative model and qualified listening in order not to neglect the citizenship rights of users. It is understood that its implementation could have an impact on access and adequate care for this population, as well as proposing continuing and permanent education actions that enable health professionals to know how to deal with situations that arise in their daily practice related to health issues of the LGBTQIA+ population. Therefore, this article aims to evaluate access to care for the LGBTQIA+ population by health professionals at a Municipal Health Center (CMS) in Rio de Janeiro.

Material and methods

A qualitative, descriptive study was carried out, with a participatory approach. The research was divided into two stages: the first, in May 2023, involved collecting information about what the subjects understood about welcoming the LGBTQIA+ population through a questionnaire sent by email to health agents, nursing technicians, nurses, dentists and doctors; and the second, in June of the same year, to hold conversation circles with these professionals, aiming for a richer and more in-depth discussion on the topic.

The research was carried out in a CMS in the North Zone of Rio de Janeiro that works with 8 Family Health teams with approximately 35 thousand registered patients. The teams are made up of 5 Community Health Agents (ACS), 2 nursing technicians, 1 nurse, 1 doctor and 1 dentist (according to the Family Health Strategy – ESF, a dentist can make up more than one team), totaling approximately

72 members. The CMS offers primary care services, as well as those offered by Family Clinics, such as free on-demand care (acute complaints) and appointment scheduling for care lines (prenatal care, childcare, hypertension, diabetes, tuberculosis, among others), and its area of operation is two neighborhoods in the North Zone (Bonsucesso and Ramos) in the city of Rio de Janeiro.

The unit has 8 workstations (windows), where 1 ACS per team remains throughout the unit's operation (07:00-18:00), totaling 8 ACS during the work period. If the patient is in the unit due to acute demand, he or she will be directed to an office so that the nurse can carry out a qualified listening session, in order to identify the problems and forward them with resolution. This nurse meets all acute demands that arrive at the unit and distributes them equally to the medical or nursing demand, according to what is necessary.

The participants of the research were professionals from the ESF team, including 8 doctors, 8 nurses, 16 nursing technicians, 37 ACS and 3 dentists, totaling 72 participants. The research inclusion criteria were: being an ESF health professional working in the selected health unit for at least one year. The exclusion criteria were: professionals on leave/vacation or with less than a year of experience.

The subjects were contacted via email to carry out the two stages. In the first stage (May 2023), they could choose to answer the questionnaire at the unit itself, as time and a computer were reserved for this, via cell phone or at home. Of the planned total, 60 actually participated. Some professionals were on vacation or on leave, so they were unable to contribute. The second stage (June 2023) was carried out over a few weeks, in accordance with team meetings that took place regularly in the unit itself. Therefore, neither of the two stages had costs or losses for the interviewees. Team conversations were scheduled and held, all recorded to be transcribed in full for later analysis. All eight teams participated.

The questionnaire and conversation guide aimed to explore questions about the access and vulnerability of the LGBTQIA+ population, the meaning and way of carrying out reception and the training/qualification processes in service to serve this population.

Access and reception were analyzed based on the dimensions of accessibility and acceptability, main factors that influence issues of barriers and the creation of bonds. Accessibility is linked to geographic location, including the method of travel, travel time and distance between the user's home and the institution. It refers to the relationship between users' power resources and the obstacles placed by the institution. Acceptability refers to users' attitudes regarding acceptance of the care provided at the health unit and the bond. These will be evaluated by health professionals and their experiences with users in the unit⁸.

Thematic content analysis⁹ was carried out, which involves a systematic procedure, to create valid inferences about certain verbal, visual or written content, seeking to describe, quantify or interpret a certain phenomenon in terms of its meanings, intentions, consequences or contexts and simple frequency analysis of the answers to direct the questions explored.

The research was approved by the Research Ethics Committee (CEP) of the Sergio Arouca National School of Public Health with Certificate of Presentation of Ethical Appreciation (CAAE) n° 55375222.0.0000.5240 and opinion n° 5.282.993 and by the CEP of the Municipal Health Secretariat of Rio de Janeiro with CAAE n° 55375222.0.3001.5279 and opinion n° 5,387,995.

Results and discussion

The majority (83%) of professionals invited to the research responded to the questionnaire sent, consisting of: 8 doctors, 8 nurses, 3 dentists, 14 nursing technicians and 27 ACS, totaling 60 participants. The age range of 25 to 44

years corresponded to approximately 57% of those interviewed. Around 50% of participants had superior education or above. Regarding working time at CMS, 51.6% of professionals had worked at the unit for at least 5 years.

The majority (85%) of participants consider the LGBTQIA+ population to be vulnerable. They believe that vulnerability does not only arise from the financial context, but also from the social and health context. They also identify difficulties for this population to access free-demand care.

Vulnerability seems to refer to the sense of fragility, and may be linked to different thematic fields. According to Ayres¹⁰, the concept of vulnerability is linked to guaranteeing the citizenship of politically fragile populations from the perspective of human rights. For Kowarik¹¹, vulnerability refers to the deterioration of civil rights, the loss of acquired guarantees, and the weakening of citizenship. What stands out is the inequality before the law and subjection to violence; the difficulty in accessing housing, health services, social assistance and employment; the coexistence of archaic and modern forms of work with an important participation of informality that is not legally protected, with social apartheid being notable in urban environments.

Two of the teams that work in places called 'scene of use' (open scene of drug consumption and homeless population) report that it is one of the places very frequented by the LGBTQIA+ population, mainly by transvestites and transgender people. One of the ACS reported that 'the girls' (referring to transvestites) were 'very aggressive' and that this made bonding difficult. She realized, however, that they had low self-esteem, so she managed to get donations of bags, earrings, lipsticks and other makeup, carrying out a social action in this part of the territory. In addition, she also organized the distribution of warm food to help with nourishment.

Low self-esteem in the LGBTQIA+ population, often resulting from social prejudice, is considered a trigger for depressive episodes,

feelings of guilt, fear, distrust, confusion, insecurity, anxiety, shame, social isolation, difficulties in establishing and maintaining romantic relationships, sexual dysfunctions, hostility, eating disorders and alcohol and drug abuse⁴. It is believed that the abusive use of psychoactive substances in the LGBTQIA+ group, although it is an exclusive and individualized process, could be a way of coping with various negative feelings, such as insecurity and anxiety regarding the acceptance of sexual orientation¹². The findings of this study point in this direction.

Unanimously, the subjects interviewed in the conversation circles and interviews indicated that they did not experience difficulties in calling patients by their social name, but reported that the medical record system does not always offer this option for registration, causing embarrassment for both parties. According to Hannauer and Hemmi¹³, the registered name has an important weight for transgender people, and some of them want to change it. In addition to some people demanding body changes, changing their name in court is a frequent demand by the transsexual population. Furthermore, they report that calling a patient by a male name and a female patient appearing would not be appropriate, as they end up exposing this patient in a negative way. They also highlight that some patients complain about the ACS, as if they didn't want to call them by the correct name. However, the problem would be with the system registration option, or, in this case, the lack of this option, as shown in the following reports:

I have difficulty seeing the person and knowing that the name in the system does not match the gender presented and not being able to change it, as the system itself does not have this option. (ACS).

[...] The system used today does not facilitate or offer basic options such as social name and gender upon first access. Difficulties in knowing the health protocols of the LGBTQIA+ population in general, prejudice, lack of empathy, respect and labels. (Nurse).

According to the authors Penchansky and Thomas⁸, acceptability depends on the bond that the health professional will be able to create with the patient. However, health agents say that many patients do not return for care because they do not create this type of bond and trust.

The Technical Note from the State Department of Health of Rio de Janeiro (SES-RJ), published on International Trans Visibility Day, on March 31, 2009, instituted the use of the social name in all health units in the state, in addition to guide managers, employees, contractors and service providers to observe the guarantee of this right in their units. Transvestites, women and transgender men have the right to be identified as they wish to be known in all direct and indirect administration bodies and service providers of SES-RJ¹⁴.

The main complaints that professionals reported about reception by social name are highlighted in the sentences said by health professionals, below, highlighting that the electronic medical record has flaws in displaying social name and that often the patient himself does not identify the pronouns of how you want to be called and registered.

Acceptance of welcoming agents to learn to call by social names, being careful with the pronouns used as they do not always appear in the medical records. (ACS).

Difficulties when the patient does not make their gender or even their social name explicit so that the care is the way the person wants. It is difficult to use a name that does not appear in the medical record. (Doctor).

It is interesting to observe how professionals might have difficulty confronting their own prejudice, which is often already deep-rooted. At some points in the research, it is not clear whether the professional realizes this, as it would seem to hold the system responsible or even blame the patient himself.

More than half of the subjects responded that they do not feel qualified to provide differentiated and specific care for the LGBTQIA+ population, making themselves available for possible training. Ten professionals said that they took extension courses offered by the Open University Network of SUS (UNA-SUS)¹⁵, whose objective is to contribute to the performance of health professionals, so that they carry out their care, promotion and prevention actions for the population with quality and in an equitable manner, guaranteeing to this population access to comprehensive healthcare. Below are some answers:

The lack of training and preparation of professionals is the dominant factor in providing adequate care/reception. There is no knowledge of health programs aimed at this population, making quality care difficult. (Nurse).

The UNA-SUS courses are good and easy to take, in addition to generating certification at the end. As soon as I joined the Unit, as I was a recent graduate, I completed some training on this platform, including assistance to the LGBT population. (Nurse).

In relation to women's health, all interviewees said they would welcome a lesbian woman to undergo a preventive exam (cytology). Some studies describe the challenges reported by a group of lesbian women during care and reception, for example, the mistaken belief of health professionals that lesbians and bisexuals are not at risk of developing breast and cervical cancer¹⁶.

Periodic evaluation of the cervix has been neglected in these women due to the frequent judgment by health professionals that their sexual practices do not lead to the risk of cancer. Since there is no true scientific support for this judgment, the conduct only reveals a stigmatizing rationality that, nevertheless, feels scientifically supported⁶.

In relation to trans men, the majority (90%) of those interviewed reported that they would welcome the patient to undergo

the exam. This question has become relevant since transgender men are more likely to have an inadequate cytopathological exam, in addition to a lower propensity to have screening as recommended, when compared to cisgender women (who identify with the female gender assigned at birth), making so that this public must always be reminded of the need to carry out this exam¹⁷. It should be noted that reception needs to guarantee equity, and it is appropriate for the professional that there is no prejudice or distinction at the time of care. This should explain the importance of the exam and other questions about sexual and reproductive planning during the consultation. It is worth highlighting that in-service training should never cease to exist, mainly because it is a service that needs to be comprehensive. Furthermore, health units must make an effort to combat prejudice that may exist on the part of some professionals. In this context, the desire to ignore your reproductive organs, the anxiety about having to undergo examinations of the genital region, the use of androgenic therapy which, over time, ends up atrophying the vaginal canal, as well as other psychological and social factors, make challenges in carrying out the Pap smear in transgender men¹⁸.

Regarding the transsexualization and hormoneization process, the places that offer this type of care in the city of Rio de Janeiro are the Pedro Ernesto University Hospital and the State Institute of Diabetes and Endocrinology. The majority of participants (60%) are unaware of the services as they are not part of primary care, and report that they have heard about them, but do not know in depth what they mean or how the type of reception or care would be provided, even though it is offered by the SUS. In other words, most respond that they do not know the referral flow to secondary care or that primary care is also part of one of the flows to be followed. The hormoneization flow is fully explained in PHC.

Professionals are not sufficiently trained and existing flows do not absorb this entire population in a timely manner. We don't even know how to inform the waiting time for the Transsexualization Process. This ends up increasing the chance of this population starting this process independently and putting their health at risk. (Doctor).

I understand the basics of the subject, I don't know in depth about the process as a whole, how it works. (Nurse).

A guy came to get an injection to avoid getting pregnant, I was embarrassed and accepted the procedure. (ACS).

Sometimes I receive male patients with prescribed contraceptives, and I don't understand why. (Nursing Technician).

As Carvalho and Phillipi¹⁹ point out, it is important that users of health services are aware of their rights as Brazilian citizens in order to better exercise them, as they are main parts of several movements. Therefore, it is extremely important to be aware of some programs developed, which fight for the rights to equality of this population. After all, there are rights, but also duties on both sides, both the service provider and the user, and being aware of this is something extremely relevant, even more so because it is health, a main and determining factor in the life of a human being.

Trans patients are among the portion of LGBTQIA+ people who are most socially stigmatized; additionally, few employees or providers have knowledge about trans health or are trained to respect the gender identity of users of this group, as well as their special confidentiality needs^{20,21}. According to the interviewees, this ends up reflecting on patients' accessibility to a specific service, being a complicating factor, since, according to Penchansky and Thomas⁸, accessibility concerns geographic location and travel, the distance between the user's residence and unit, round trip time, among other features.

In this sense, these are obstacles for the CMS itself, since it is located in Ramos, where the patients live, an area covered by the North Zone. The hospitals that offer the services are located in Vila Isabel and in the City Center of Rio de Janeiro, respectively 20 minutes by car and 50 minutes by public transport, and 18 minutes by car and 40 minutes by public transport, considering the distance from CMS. The ACS report that not all patients have a car or are able to pay for tickets. As for service at the basic unit, they can access it by walking or cycling.

To corroborate the information above, among the specific problems frequently observed in the trans population, the unavailability of basic supplies necessary for hormonal therapy stands out, as the recommended medications are not incorporated into the SUS. Difficulty in accessing surgical treatments, especially sexual reassignment, was also noted. Consequently, transgender-specific healthcare is scarce, limiting their choices in accessing the healthcare they need in a timely manner. This makes the few services available even more critical and of limited access regarding the transsexualization process²². Furthermore, prejudice and lack of technical training of the professionals involved end up making reception and care often inhumane and traumatic, limiting adherence to multidisciplinary follow-up^{21,23}.

Regarding the conversation circles, these were important to deepen and complement some of the information previously obtained through the questionnaires. All participants reported feeling comfortable and important in contributing to the study. Furthermore, they reported that they had some difficulties with the new electronic medical record system (Vita Care) and with the way of welcoming patients from the LGBTQIA+ population. They confessed that, in addition to the difficulty of this new medical record, they were afraid of asking for help when accepting a patient who deviated from the heteronormative standard and being labeled

prejudiced, since the difficulty of filling out the record and the lack of knowledge in all areas limited the process of welcoming and registering users.

The moments shared in the conversation circles were very powerful, and participants were able to express their perceptions based on the triggering questions. One of the issues raised in the questionnaire was the vulnerability of the population, in which the majority indicated that it existed. As the topic was explored in the conversation, it was possible to realize that the vulnerability they believed to be due to lack of money was not just that, and that other factors such as mental health and lack of security were also important. According to the base text of the National Conference of Gays, Lesbians, Bisexuals, Transvestites and Transsexuals: the protection of the right to free sexual orientation and gender identity is not only a matter of public security, but also involves, in a significant way, issues pertinent to mental health and attention to other vulnerabilities relating to these segments⁴.

It is important to highlight that the ACS are the first to be called for any type of reception or care, and nurses are responsible for all spontaneous demand in the unit, that is, any spontaneous demand goes through the ACS who forwards it to the nurse for assistance or guidance. As identified in the questionnaires, some professionals report difficulties in welcoming people due to the difficulty of creating a bond with this population. They report that some patients took months to request a first consultation. The CMS is geographically close to the residence of users who are part of the assigned area of the territory, with no major geographic barriers, as everyone can access the unit without needing to drive. This leads us to believe that one of the biggest difficulties is acceptability, as it is what defines whether patients and health agents are maintaining a good enough relationship to characterize attention for welcoming and care, as described below.

I went to the territory, I always saw a hairdresser who kept looking at me, but she didn't say anything, this happened a few times until I approached her and asked if she needed any help. She said: I need to schedule a preventive collection appointment for my wife. I took the case to my nurse, and soon after went to deliver the appointment date. The patient was very happy, as she felt welcomed, and said that in the other place where she lived, no one in the unit had asked this question about her health. (ACS).

Acceptability begins with the acceptance of the health professional, normally by the ACS; and when they encounter any difficulty, they usually seek out doctors or nurses to help resolve the user's demand.

I saw a guy sitting in reception for almost an hour. I noticed that he started to stare at me and I went to approach him, when I got close, he asked if he could speak to me at the door of the unit because it was very crowded there. Arriving at the door, he requests rapid tests for syphilis, HIV and hepatitis because he had an unprotected relationship with his partner, but was embarrassed to talk about it around other people. I said it was ok, that I would welcome him for the procedure and that he would just wait to be called by name, that the nurse would be aware and would take him to an office so that he would be more comfortable. (ACS).

A case was reported of a patient requesting hormone treatment, in which the professional was a little uncomfortable as he did not know the correct flow of care.

I know that SUS provides hormone treatment, but I don't know where I would send it, no matter how much we study and try, the flows are very complex and there is a lack of organization. The patient was referred after a few calls, but I was unable to provide guidance regarding the waiting time. (Doctor).

In 2017, Guimarães²⁴, through a qualitative study, identified the existence of prejudices among ACS that act as barriers and the need

for better training of teams. In this study, professionals did not demonstrate any type of prejudice when answering the questionnaires or participating in conversation circles. However, the first author of this study works as the unit's technical responsible nurse, and perhaps this limited the speeches of some subjects due to the unequal hierarchical relationship.

All subjects reported difficulty in putting into practice an effective active search prioritizing health promotion, as patients only appear when they already have any symptoms of illness, which, even though they visit the territory to offer consultations, the majority of the LGBTQIA+ population only goes to the unit in emergency cases. This corroborates what Mello et al.²⁵ argue: because there are difficulties in implementing health actions for the LGBTQIA+ population, this social group ends up seeking health services only in emergency situations. Even so, professionals are interested in carrying out an active search for health promotion, requesting training for health services for the public, in order to stay informed and be able to pass this information on.

Final considerations

This study aimed to evaluate access to care for the LGBTQIA+ population from the perspective of health professionals, in order to contribute to improving the work process in a primary care unit. Acceptability and accessibility were used as criteria. It was identified by the subjects that the biggest access barriers were not geographical, but rather those related to the actions of the professionals and users themselves, indicating the fragility of the bond, of the professional reception capacity and the difficulty in implementing the guidelines and standards that govern comprehensive care for the LGBTQIA+ population in the SUS. There are still many stigmas, especially regarding the issue of reception being based mainly on sexual practices, which was previously mentioned as

not the only demand to be analyzed. This population cannot be made invisible or neglected.

Carrying out the research allowed professionals who work in the ESF of this CMS to speak out and express themselves on how they experience access to care for the LGBTQIA+ population, generating an important exchange of knowledge and information between all participants. Initially, it was believed that it would not be possible to carry out everything in such a short time, however, the participants were available and interested, making the development of the study viable.

Based on the results, the following can be considered as facilitators of the reception process: the availability of professionals for reception despite the lack of specific educational processes; the ability to carry out consultations with LGBTQIA+ people to collect preventive exams; carrying out actions aimed at the LGBTQIA+ population in the territory, educating the population about what services are offered in the primary care unit.

The main barriers to the reception process were the electronic medical record, which does not allow the insertion of the social name; the lack of knowledge/disclosure of the flows of the transsexualization process; the difficulty in forming bonds between users, ACS and other health professionals; and the deficit in continuing health education processes on the specific topic.

As recommendations for CMS management, it is proposed to increase the frequency of the management committee, which is a place with the participation of the population and territory leaders to validate the unit's flows. As a strategy to address the team's difficulties, it would be appropriate to provide more spaces

for discussing cases and continuing education. In relation to electronic medical records, new training must be requested from the electronic medical record company, aiming to provide reliable assistance to issues of gender, sexuality, social name, among others. With regard to the reception of the LGBTQIA+ population, the need to prioritize reception as a team, and not just by just one nurse as the center of the unit's demands, stands out. This can make the bond easier to create, as the patient will be able to verbalize their demand directly to the team itself. Finally, it is necessary to create more spaces in the territory, using support networks to provide spaces for health promotion and disease prevention and health education also focused on the LGBTQIA+ population.

Collaborators

Lopes R (0000-0001-9066-8626)* contributed to the conception and design of the manuscript; acquisition, analysis and interpretation of data; writing, critical review of intellectual and spelling content; final approval of the version to be published, being responsible for all aspects of the work, ensuring that questions regarding the accuracy and integrity of any part are appropriately investigated and resolved. Cardoso GCP (0000-0002-4014-0951)*, Amorim TR (0000-0002-6022-7106)* and Santos JB (0000-0001-6546-1965)* contributed equally and substantially to the manuscript design, analysis and interpretation data, critical review for intellectual and spelling content and final approval of the version to be published. ■

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