10.18605/2175-7275/cereus.v16n1p469-485

<< Recebido em: 17/12/2023 Aceito em: 16/06/2024. >>

ARTIGO ORIGINAL

REVISTA CEREUS ISSN: 2175-7275

# Experiences of LGBTQIAPN+ patients in primary health care

## *Vivências de pacientes LGBTQIAPN+ na atenção primária à saúde*

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## ABSTRACT

This study aimed to explore the experiences of LGBTQIAPN+ patients in Primary Health Care. A qualitative approach was employed, conducted at the Research Laboratory of the Southern Maranhão Higher Education Institute. A semi-structured interview with trigger questions and inquiries regarding sociodemographic data and those aligned with the proposed objective was used. The snowball technique was employed for data collection. The narratives were transcribed in full and analyzed using Bardin's content analysis technique with the assistance of NVivo software. The results revealed that users had both satisfying experiences and situations that that impacted the continuity of care within the healthcare service. There still exist a range of barriers concerning the access and reception of the LGBTQIAPN+ population in Primary Health Care. The lack of qualification is one of the obstacles that hinder the access and provision of care for this population.

**Keywords**: Reception. Sexual and Gender Minorities. Primary Health Care. Nursing.

## RESUMO

Este estudo teve como objetivo explorar as experiências de pacientes LGBTQIAPN+ na Atenção Primária à Saúde. Foi empregada uma abordagem qualitativa, realizada no Laboratório de Pesquisa do Instituto Superior de Ensino do Sul do Maranhão. Utilizou-se entrevista semiestruturada com questões disparadoras e questionamentos referentes a dados sociodemográficos e alinhados ao objetivo proposto. A técnica bola de neve foi empregada para coleta de dados. As narrativas foram transcritas na íntegra e analisadas pela técnica de análise de conteúdo de Bardin com auxílio do software NVivo. Os resultados revelaram que os usuários vivenciaram experiências satisfatórias e situações que impactaram na continuidade do cuidado no serviço de saúde. Ainda existem uma série de barreiras relativas ao acesso e acolhimento da população LGBTQIAPN+ na Atenção Primária à Saúde. A falta de qualificação é um dos obstáculos que dificultam o acesso e a prestação de cuidados a esta população.

**Palavras-chave**: Recepção. Minorias Sexuais e de Gênero. Atenção Primária à Saúde. Enfermagem.

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## 1. INTRODUCTION

The sexual and gender diversity movement has undergone numerous changes and advancements over the years (Gomes & Zenaide, 2019), primarily through its social expressions (Santos et al., 2019). Today, the lesbian, gay, bisexual, transvestite, transsexual, transgender, queer, intersex, asexual, pansexual, non-binary and all the nuances in between (LGBTQIAPN+) community is fighting for the assurance of their rights, including equal access to healthcare. In response to this, the National Policy for Comprehensive Health Care for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals was established by Ordinance No. 2,836 on December 1, 2011. This policy aims to promote comprehensive health for individuals belonging to this social group, as well as contribute to the reduction of inequalities and recognize the demands of this vulnerable population (Brasil, 2013).

The LGBTQIAPN+ population is among the social minorities with low healthcare service utilization, primarily due to the judgments and discriminations they face. When combined with the lack of knowledge among healthcare providers, they often do not receive the necessary care, leading to the provision of poor-quality services (Santos et al., 2015).

In Brazil, Primary Health Care (PHC) was established as the main gateway to the Unified Health System (SUS), encompassing actions for promoting and protecting health, preventing diseases and/or illnesses, avoiding and/or minimizing risks, diagnosing, treating, and rehabilitating health (Almeida et al., 2018). Its objective is to provide the first point of contact for this population and, when necessary, refer them to more specialized care (Brasil, 2015).

It is essential to emphasize that the reception of the LGBTQIAPN+ population must address their individual needs, considering their demands holistically, while prioritizing trust and building relationships (Araújo et al., 2020).

Therefore, the reception of the LGBTQIAPN+ population in PHC must be based on ensuring the fundamental rights of the Unified Health System, such as universality, comprehensiveness, and equity, through ethical and professional commitment, aiming to reduce the social inequities faced by this population in healthcare services, especially in Primary Health Care (Guimarães, Lorenzo & Mendonça, 2020). This study aimed to explore the experiences of LGBTQIAPN+ patients in Primary Health Care.

## 2. MATERIALS AND METHODS

This is a qualitative study addressing the experiences of LGBTQIAPN+ patients in primary health care. The study was conducted at the Research Laboratory of the *Instituto de Ensino Superior do Sul do Maranhão*, located in the city of Imperatriz, in the state of Maranhão, Brazil. It was approved by the Ethics Committee on Human Research at the *Unidade de Ensino Superior Dom Bosco* under approval number 5.732.080.

Inclusion criteria encompassed self-identified members of the LGBTQIAPN+ community, aged 18 or older, residing in Imperatriz, in Maranhão, who had at least one interaction with primary health care. Participants whose interviews contained incomplete information were excluded.

Initially, a search was conducted for potential participants who met the eligibility criteria. The snowball technique, which extended from December 1, 2022, to March 31, 2023, was employed for participant recruitment. Subsequently, verbal invitations were extended to potential participants, during which the study purpose was explained.

Recognizing that qualitative research aims to analyze the individual facts of the research subjects to understand their subjectivities, it assumes that there is a dynamic relationship between the real world and the individual's subjective experience. It focuses on the study of history, relationships, representations, beliefs, perceptions, and opinions, all of which are products of human interpretations of how they live, construct their artifacts, perceive themselves, feel, and think (Minayo, 2014).

Consequently, a total of 10 participants were included in the sample. Participants who agreed to take part in the research had interviews scheduled, and before commencement, they signed an Informed Consent Form (**Table 1**).

**Table 1.** Participant Profile

| Identification | Age | Orientation | Occupation | Education |
|---|---|---|---|---|
| P1 | 35 | Homosexual | Esthetician | Completed bachelor's degree |
| P2 | 22 | Bisexual | Student | Incomplete bachelor's degree |
| P3 | 50 | Lesbian | Writer | Completed bachelor's degree |
| P4 | 29 | Homosexual | Administrative technician | Incomplete bachelor's degree |
| P5 | 33 | Homosexual | Unemployed | Vocational technical high school |

| | | | | |
|---|---|---|---|---|
| P6 | 21 | Homosexual | Nurse aide | Incomplete bachelor's degree |
| P7 | 24 | Transgender woman | Student | Incomplete vocational technical high school |
| P8 | 19 | Homosexual | Student | Incomplete vocational technical high school |
| P9 | 23 | Bisexual | Nurse aide | Incomplete bachelor's degree |
| P10 | 30 | Bisexual | Nurse aide | Incomplete bachelor's degree |

A semi-structured interview script was used, comprising questions about sociodemographic data and trigger questions aligned with the research objective. The interview commenced with a warm-up phase, which served as a moment for the researcher to establish rapport with the participants. The interview began with trigger questions aimed at achieving the proposed objectives. These interviews were recorded using an audio recording device and transcribed in full (Szymanski, 2004).

To maintain impartiality in the study, two blind stages were conducted. In the one described earlier, one researcher conducted the interview with the participant, and the subsequent stage was guided by another researcher who performed the data analysis.

To identify the participants, the term "P" followed by a number corresponding to the interview order was used. The transcribed accounts of the interviews were analyzed using Microsoft Excel 2021 and NVivo software, employing Bardin (2011) content analysis technique, which consists of three stages: a) Pre-analysis; b) Material exploration; c) Treatment of results.

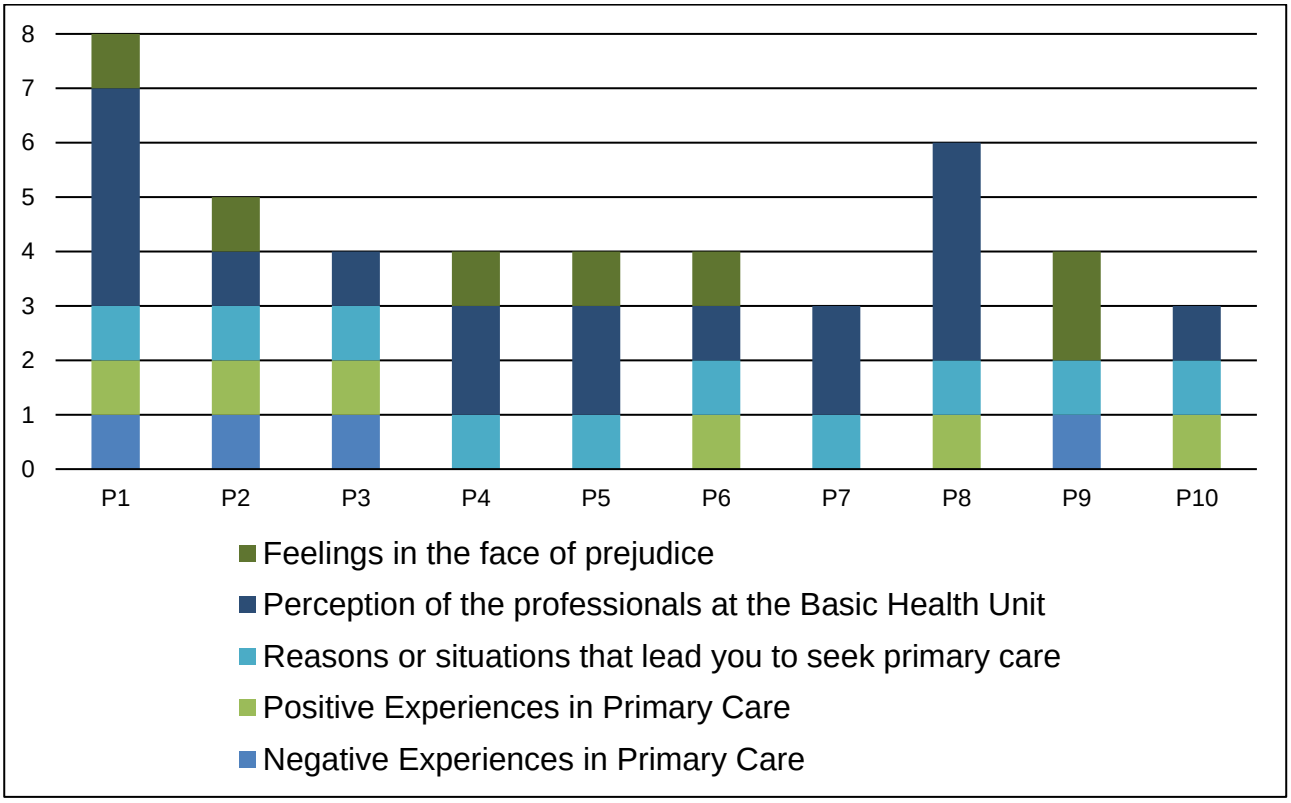
In the pre-analysis, there were initial readings of the interviews. During the material exploration stage, registration units were organized based on the relevance of words, through counting and weighted percentages, as presented in Table 2.

**Table 2.** Units of record based on word relevance

| **Units of record** | **Relevance of words** | |
|---|---|---|
| | **Count** | **Weighted percentage (%)** |
| Relationship with unit professionals | 43 | 4.33 |
| Barrier to professional care due to prejudice and discrimination | 22 | 2.21 |
| Consultations and prevention | 16 | 2.13 |
| Feelings during the service | 12 | 1.60 |

| | | |
|---|---|---|
| Community difficulties in seeking help | 12 | 1.59 |
| Attention and respect | 11 | 1.32 |
| Reception, empathy, and humanization in care | 08 | 1.08 |
| Existence of experiences of vulnerability | 07 | 0.63 |

From the units of record emerged the units of context, which were identified based on the relevance of the theme in the texts and can be seen in Graph 1 and Table 3.




**Graph 1.** Quantitative representation of theme relevance

**Table 3.** Record units that led to context units based on theme relevance

| Record units | Context units | Relevance of themes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Barrier to professional care due to prejudice and discrimination<br>Feelings during the service<br>Community difficulties in seeking help<br>Feelings during the service | Negative experiences in primary health care | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Attention and respect<br>Reception, empathy, and humanization in care | Positive experiences in primary health care | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| Consultations and prevention | Reasons or situations that lead you to seek primary health care | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Relationship with unit professionals | Perception of the professionals at the basic health unit | 4 | 1 | 1 | 2 | 2 | 1 | 2 | 4 | 0 | 1 |
| Existence of vulnerability experiences | Feelings in the face of prejudice | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 2 | 0 |

Finally, the third stage defined for treatment of results, analysis categories emerged, as presented in Table 4. Leading to the results that will be presented later.

**Table 4.** Context units that led to analysis categories

| Context units | Analysis categories |
|---|---|
| Negative experiences in primary health care<br>Reasons or situations that lead you to seek primary health care | Satisfaction with consultations and examinations received in primary health care |
| Negative experiences in primary health care<br>Feelings in the face of prejudice | Situations directly impacting user retention in primary health care |
| Positive experiences in primary health care<br>Perception of the professionals at the basic health unit | Reception, humanization, and training in primary health care |

## 3. RESULTS

Based on the analysis categories, it was possible to perceive that user had satisfactory experiences at some point during consultations and examinations received in

primary health care. However, in other instances, there were experiences that impacted the continuity of care within the primary health care. It is also evident from the participants expressions that there is a lack of reception, humanization, and training of health care professionals to serve the LGBTQIAPN+ community, as discussed in the following accounts.

***Satisfaction with consultations and examinations received in primary health care***

It was observed from the statements of participants P1 and P2 that they had positive experiences in medical care. They felt welcomed during the consultation, received the necessary assistance, and felt comfortable sharing their health situation. Participant P6 stated that every time they visited the Basic Health Unit, they were well received, from the doorman to the doctor.

> *"[...] the doctor was a dream; I congratulated and praised her and told her, 'You are in the right place; you welcomed me well, and I am comfortable talking to you. Good service is rare to find' (P1).*
>
> *"I was well attended, and the doctor was attentive and welcoming. I received all the assistance I needed" (P2).*
>
> *"[...] every time I visited the basic health unit, I was well attended, from the doorman to the doctor" (P6).*

Regarding gender, a transgender woman was part of this study (P7). She reported that she is known in the neighborhood where she lives and has been assisted by the Basic Health Unit, always being treated with respect.

> *"I am known as a transgender woman, and they (the professionals at the Basic Health Unit) always treat me with respect" (P7).*

It was observed that not only in medical consultations but also in dental treatments, participant P8 did not encounter difficulties and was always well received. This experience was also reflected in the statements of participant P10.

> *"Once, I needed dental care, and I had no difficulty finding this care, and I was well received" (P8).*
>
> *"Whenever I went to seek help, I found it and was well attended" (P10).*

In this category, it was noticed that some professionals provided welcoming care to the LGBTQIAPN+ community. Regardless of sexual orientation or gender, the care was patient focused. However, in the following category, the participants in this study experienced unwelcome moments that could influence their continued engagement with primary health care.

***Situations that directly impacted the user continued engagement with primary health care***

It was noted in the statement of P1 that when seeking care at the Basic Health Unit, he did not like the rude way he was treated. The report showed that during the appointment, he was afraid of encountering prejudice in the professional gaze, a fact that could lead to the user withdrawal. Between the lines of his speech, there is the possibility of seeking care in the private health care sector due to the fear of prejudice and an overestimation of his sexual orientation.

> *"[...] one doctor, I didn't like her, she treated me very poorly and was rude, she didn't welcome me [...] it drives people away from the basic unit! And it can lead to expenses, people spend money they don't have to go private because they don't want to expose themselves to prejudice [...] Fear, fear of prejudice in the eyes of these people and them thinking they are better because they are heterosexuals [...] (P1)."*

It became evident from P3 statement that the feeling of indifference they experienced in the doctor watch during the appointment is a factor that contributes to distancing themselves from the unit. This same view was reported by P4 when mentioning the fear of experiencing discrimination from these professionals. Another participant, P2, reported that when they needed to seek the unit, they were not treated in a humane manner.

> *"[...] I felt indifference in the doctor's gaze" (P3).*
>
> *"[...] if we go there and are not well received and there is no focus on human health, it drives us away from health care" (P2).*
>
> *"These are things that, whether we want it or not, affect our lives, and I end up distancing myself when this situation occurs" (P4).*
>
> *"People are afraid to seek help and face discrimination from health care professionals" (P4).*

The national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals emerged with the aim of considering health in its comprehensive aspect and from various perspectives to improve the health of this vulnerable group. However, regarding the comprehensiveness of care, P5 states that they do not always receive the assistance they need, and the lack of empathy from health care professionals interferes with the understanding of the demands of this population, leaving them vulnerable.

> *"Lack of empathy from the professionals working in Basic Health Units. I do not always receive the assistance I need" (P5).*
>
> *"Lack of understanding and exclusion by these professionals make us vulnerable" (P5).*

In addition to difficulties with receptiveness at the unit, P6 mentions that psychological problems such as depression and anxiety are common within the LGBTQIAPN+ community. In this perspective, it was observed in P7 statement that many professionals do not tolerate the LGBTQIAPN+ community, especially transgender or homosexual individuals, and therefore fail to provide adequate care considering each individual needs.

An important point raised revolves around the trust that users place in primary health care professionals. In the reports, it was observed that participants often face situations of prejudice and disdain from these professionals when seeking information about their sexual lives, as the image of the LGBTQIAPN+ community is culturally linked to prejudice.

These are situations that can sometimes distance LGBTQIAPN+ users from primary health care professionals, as evidenced in P10 statement, where they assert that the system itself lacks specific and targeted care for the community.

> *"[...] nowadays, these are the problems that most cause psychological distress, such as depression, anxiety, and various other disorders" (P6).*
>
> *"[...] many professionals do not like our population and end up treating us incorrectly. People do not tolerate trans or homosexuals as much and feel uncomfortable with our presence" (P7).*
>
> *"[...] There is a lack of attention when we seek information. Indifferent looks make me somewhat embarrassed. Some professionals treat us differently; it seems like they don't like our presence" (P8).*
>
> *"[...] Those who have an active sex life seek prevention. It is very embarrassing because there are many people in the unit, and I feel shy because many professionals do not know how to deal with the LGBTQ+ public and think derogatory things about us. I have seen a lot of discrimination. You are going to the unit to have more security about your*

> *physical health, and if you encounter prejudice, it distances me a lot. I have felt a certain mockery in the professionals' speech and felt bad" (P9).*
>
> *"[...] Lack of care by the system itself because there are no directed cares for the* LGBTQIAPN+ *community" (P10).*

### *Reception, humanization, and training in primary health care*

Health care professionals should embrace welcoming and humanized practices and be well-prepared. Regarding this, P1 and P2 stated that when professionals put on their "uniform" (lab coat), they believe they assume an authoritarian posture, which is reflected in their professional practices. They also report that when they arrive for care, they are already in need of attention, and what they often encounter are unpleasant situations.

> *Professionals believe they are qualified, but when they put on the "uniform" (lab coat), they change. Patients arrive in a vulnerable state, and when someone is sick and comes to the unit, they are given judgmental looks and are not treated kindly, with little regard (P1).*
>
> *It requires a humanized approach and love for others to serve the population. I don't know why they are like this; if they don't like their profession, all I know is that you have to love what you do (P1).*
>
> *"[...] In the last appointment, the doctor did not give proper attention; it's as if I were an object and not a human being" (P2).*

Based on the first two categories, there are professionals who are showing more respect and being less prejudiced towards the LGBTQIAPN+ community. However, some still tend to demonize the community. In the perception of P4 and P5, issues such as a lack of reception and humanization lead to undesirable feelings.

> *"They are respecting people more; I see these professionals as less prejudiced" (P3).*
>
> *"Nowadays, I believe this barrier is being broken because people are gaining more understanding and seeking more information. But until a few years ago, I believe there was a significant barrier that prevented LGBTQIAPN+ people from seeking health care and many other sectors" (P6).*
>
> *"[...] because not everyone has the empathy to deal with these people or the community. In other words, the professional must be friendly and treat them as a real and genuine human being. Most people who are not part of our community tend to demonize our existence and end up treating us differently" (P4).*

> *"Feelings of neglect and lack of respect for the patient" (P5).*

In conclusion, it is possible to understand that for the LGBTQIAPN+ community, there is a lack of training for qualified professionals to understand the spectrum of sexuality and gender. This training should provide a sense of security for patients, proper reception, and be in accordance with their gender identity, thereby enabling the realization of the doctrinal principles of the health system.

> *"At times, you don't feel safe seeking out that professional, and in some way, we would like to feel comfortable discussing our issues" (P9).*
>
> *"Some professionals do not know how to provide reception as simple as with any other ordinary citizen" (P8).*
>
> *"[...] It doesn't affect me, but it does affect many others because many don't know how to deal with this feeling of indifference and lack of professionalism from these professionals, regardless of who they are, whether it's a doctor, nurse, or receptionist" (P5).*
>
> *"[...] Every group you attend to that falls outside the normative, what they call 'normal,' they need to have that attention focused on them. If I am treated within a norm, you will only know what is there, what was deemed normal. But when you have this attention focused on transgender people, for example, a urologist treating a transgender woman or a gynecologist treating a transgender man, they need to have this focus on this population to be treated as human beings with respect" (P2).*
>
> *"Many professionals graduate and treat people however they want. They need to be prepared to treat people well during the appointment with equality" (P7).*

## 4. DISCUSSION

In the present study, the participants self-identified their sexual orientation as homosexual, bisexual, with only one identifying as a transgender woman. In the study by Sene et al., (2022), the sample included cisgender individuals, homosexuals, and bisexuals.

The national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals considers that LGBTQIAPN+ individuals should have access to Unified Health System, with quality and resolution of their demands and needs. Thus, all professionals in primary health care have the responsibility to provide comprehensive and specific care to this population (Brazil, 2011).

It was observed in this study that some professionals provided welcoming care to the LGBTQIAPN+ community. Regardless of sexual orientation or gender, the care provided focused on patient attention. The interviewees reported a good reception from the moment

they arrive, ensuring them comfort and well-being. As a result, it was possible to perceive in the interviewees statements the positive impact of the care provided by the professionals who make up primary health care.

A study points out that common supportive experiences involve primary care physicians treating transgender individuals with equality, competence, and respect. When patients receive support from physicians, they tend to feel more welcomed and experience fewer mental health issues (Treharne et al., 2022), as well as promoting promising intervention points to improve the health of men who have sex with men (Stults et al., 2020).

With the increasing visibility of sexual minority groups, there is a need to ensure that primary health care professionals provide comprehensive and equitable health care, aiming to improve the overall health and well-being of the LGBTQIAPN+ community. Integrating the needs of sexual and gender minority groups into nursing care and health promotion programs directly impacts patient access and adherence to strategies (Mccann & Brown, 2020).

Silva et al., (2021) argue that the inclusion of the LGBTQIAPN+ population in health care requires transformations on the part of health care professionals, both in terms of thinking and acting. Even with significant progress following the implementation of the national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals, it is evident that the unique aspects of this population are still rooted in stigma and prejudice.

Therefore, it is necessary for actions aimed at this population to not be momentary but to encompass the reality in which they are embedded (De Matos Leal et al., 2018). In this category, it was possible to observe, in the interviewees statements, that when seeking care at the basic unit, they did not like the rude way they were treated. One account demonstrated that during the care, he was afraid of the prejudice in the health care provider's gaze, which can lead to distancing from the unit.

In adverse situations, there is a noticeable distancing of the LGBTQIAPN+ population from primary health care, taking into account the way they are treated by professionals, often stemming from the fear of embarrassment, which goes against the principles of the national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals. Hetero-cis-normative situations can encourage users to self-medicate and seek other primary health care (Shihadeh et al., 2021), as mentioned by P1 in this research.

Heterocentrism and the masculinity of primary health care have contributed to feelings of exclusion among LGBTQIAPN+ adults (Conyers et al., 2023).

The LGBTQIAPN+ population faces many difficulties and barriers that hinder access to primary health care. The professionals are aware of the issue; however, in the undertones of some, prejudices and resistance are evident (Costa-Val et al., 2022). According to Lionço (2008), the lack of sensitization among professionals is one of the main obstacles to access to care for LGBTQIAPN+ individuals. Therefore, it is crucial that the topic be addressed in both academic programs and everyday health care practices through ongoing education strategies.

Such situations end up driving patients away and conveying a sense of insecurity in terms of reliability, failing to ensure comprehensive and universal health care. Improving the care provided to the LGBTQIAPN+ community depends on changes in the behavior of health care professionals, requiring training and qualification for a comprehensive, universal, and equitable approach (Paulino, Rasera & Teixeira, 2019).

he interviewees in this study stated that when professionals put on their "uniform" (lab coat), they believe they adopt an authoritarian posture, which reflects in their professional practices. They also report that when they arrive seeking care, they are already in need of assistance, and what they often encounter are unpleasant situations.

In the view of the LGBTQIAPN+ community, what is lacking is a humanized approach and training for professionals on the topics of gender, sexuality, and LGBTQIAPN+ health care (Shihadeh et al., 2021). Medical professionals considered the topic of health care for lesbians, gays, bisexuals, transvestites, and transsexuals in primary care important, although it has been underexplored in their undergraduate courses (Gomes, Tesser & Carlos, 2022; Negreiros et al., 2019), as have nursing professionals (Mcewing et al., 2022).

Training for professionals should begin with a dialogue primarily focused on the process of humanization and welcoming the LGBTQIAPN+ community into primary health care (Miskolci et al., 2022). According to Lionço (2009), it is essential for health care professionals to have a closer connection with public policies and the specific issues faced by the LGBTQIAPN+ population to enhance the quality of services across various sectors. Therefore, health care professionals should be attentive to situations that lead to the vulnerability and illness of this population, as well as to public policies that facilitate access to the primary health care.

In this regard, Bezerra et al., (2019) conducted a study to investigate how to improve the reception and care of the LGBTQIAPN+ population in primary health care. Many of the interviewees highlighted "training" and "capacity-building" as key pillars for providing humanized care. The lack of preparedness among health care managers and professionals to address issues related to sexual and gender diversity constitutes a significant barrier to both access to services and comprehensive health care.

However, this discussion circles back to its beginning with the national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals. All the issues highlighted in this study could be reinforced and prevented if the policy were strictly followed. Nevertheless, as exemplified by the Health Department of the State of Bahia, which does not clearly assume responsibility for a state LGBTQIAPN+ policy (Bezerra et al., 2021), as well as the Health Department of the State of Paraná, which points out that there are still gaps in the implementation of the policy across the three levels of health care for the LGBTQIAPN+ population (Silva et al., 2020).

In the current study, although we observed professionals who ensure equal and welcoming care, we noticed that in some cases, the LGBTQIAPN+ community remains invisible in the implementation of public policies. In the context of primary health care, it is primarily the responsibility of nursing professionals and physicians to guarantee comprehensive care while minimizing potential sexual and gender inequalities (Santos et al., 2019).

Universality, equity, and comprehensiveness are enshrined in the Federal Constitution and are guaranteed to everyone by the State, "without prejudice and privileges of any kind" (Brazil, 1988). However, in some cases, such principles are not put into practice. Effectively applying these principles, and consequently the national policy for whole health care for lesbians, gays, bisexuals, transvestites, and transsexuals, is a democratic practice. Health care should be directly linked to welcoming, with its logic considering human diversity in all its forms. Understanding the vulnerability of this population and providing care based on the fundamental principles of the Unified Health System is what is expected of health care professionals.

## 5. CONCLUSION

Concurrently with the objective of this present study, which aimed to understand the experiences of LGBTQIAPN+ patients in primary health care; even though there are

situations that favor user reception and retention, there are still a range of obstacles regarding the access and reception of the LGBTQIAPN+ population in primary health care. As a result, it was possible to identify that they end up feeling embarrassed and, out of fear, withdraw due to the indifferent gaze and the way they are received by health care professionals.

Furthermore, it was found that a significant portion of health care professionals is not adequately trained to serve this population. Lack of qualification is one of the barriers that hinder health care delivery, as professionals create an unsafe environment due to their lack of understanding of the spectrum of sexuality and gender.

Therefore, we suggest that the development of health promotion actions is necessary, aiming to protect, receive, and provide humanized care to the LGBTQIAPN+ population. Thus, raising awareness among the LGBTQIAPN+ population about their rights to access health care in search of reception and comprehensive health care is important.

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