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Research Article

Barriers to access to Primary Care for the LGBTQIA+ population: an integrative review

Barreiras no acesso à Atenção Básica pela população LGBTQIA+: uma revisão integrativa

Barreras de acceso a la Atención Primaria para la población LGBTQIA+: una revisión integradora

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Abstract

Introduction: The LGBT population is a group whose access to health care has historically been limited and is still crossed by complex issues ranging from the training of health professionals to the very organisational structure of the care system. Despite this, the scientific literature on the obstacles faced by these individuals in Primary Health Care, the gateway and coordinator of care, is particularly scarce. **Objective:** To characterize the barriers involved in the access of the LGBTQIA+ population to primary care**. Methods:** This is an integrative review of scientific studies selected from the PubMed and Virtual Health Library (VHL) Regional Portal search platforms, using as search descriptors the terms Sexual and Gender Minorities, LGBTQIA+, Primary Health Care, Health Services Accessibility. Complete articles were included without time restriction, in English, Portuguese and Spanish. Texts such as: literature reviews; editorials; study protocols; expert opinions and experience reports were excluded. **Results:** The review was composed by the selection of 14 studies, and their contents were assigned to three axes of discussion: physical/organizational barriers, social barriers, barriers related to education/training of health professionals. **Conclusions:** It is essential to expand the social discussions about the theme of sexual and gender diversity to deconstruct the established prejudices, moreover, it is essential to review the physical and organizational structure — as well as the training of health professionals — to create an inclusive care environment.

Keywords: Sexual and gender minorities; Primary Health Care; Health services accessibility.

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Resumo

Introdução: A população LGBT constitui um grupo cujo acesso à saúde é historicamente limitado e ainda hoje é atravessado por questões complexas que envolvem desde a formação dos profissionais de saúde à própria estrutura organizacional do sistema assistencial. Apesar disso, a literatura científica acerca dos entraves que estes indivíduos enfrentam na Atenção Primária à Saúde (APS), porta de entrada e coordenadora do cuidado, é particularmente escassa. **Objetivo:** Caracterizar as barreiras envolvidas no acesso da população LGBTQIA+ à APS. **Métodos:** Trata-se de uma revisão integrativa de estudos científicos selecionados nas plataformas de busca PubMed e Portal Regional da Biblioteca Virtual em Saúde (BVS), sendo utilizados como descritores de busca os termos Minorias Sexuais e de Gênero, LGBTQIA+, APS e Acesso aos Serviços de Saúde. Foram incluídos artigos completos sem restrição de período nos idiomas inglês, português e espanhol. Foram excluídos textos do tipo: revisão bibliográfica; editorial; protocolos de estudo; opinião de especialistas e relato de experiência. **Resultados:** Foram selecionados 14 artigos, sendo seus conteúdos atribuídos a três eixos de discussão: barreiras físicas/organizacionais, barreiras sociais e barreiras relacionadas à educação/formação dos profissionais da saúde. **Conclusões:** É essencial expandir as discussões sociais acerca da temática de diversidade sexual e de gênero de modo a desconstruir os preconceitos instituídos; ademais, faz-se fundamental a revisão da estrutura física e organizacional — bem como da formação dos profissionais da saúde — para criar um ambiente assistencial inclusivo na atenção básica à população LGBTQIA+.

Palavras-chave: Minorias sexuais e de gênero; Atenção Primária à Saúde; Acesso aos Serviços de Saúde.

Resumen

Introducción: La población LGTB es un colectivo cuyo acceso a la atención sanitaria ha estado históricamente limitado y sigue atravesado por complejas cuestiones que van desde la formación de los profesionales sanitarios hasta la propia estructura organizativa del sistema asistencial. A pesar de ello, la literatura científica sobre los obstáculos a los que se enfrentan estas personas en la Atención Primaria de Salud, puerta de entrada y coordinadora de la atención, es especialmente escasa. **Objetivo:** Caracterizar las barreras que supone el acceso de la población LGBT a la atención primaria. **Métodos:** Se trata de una revisión integradora de estudios científicos seleccionados de las plataformas de búsqueda PubMed y Portal Regional de la Biblioteca Virtual de Salud (BVS), utilizando como descriptores de búsqueda los términos Minorías Sexuales y de Género, LGBT, Atención Primaria de Salud, Accesibilidad a los Servicios de Salud. Se incluyeron artículos completos sin restriccíon de período, en inglés, portugués y español. Se excluyeron textos como revisiones bibliográficas, editoriales, protocolos de estudio, opiniones de expertos e informes de experiencias. **Resultados:** El corpus final de artículos se compuso de la selección de 14 artículos, y sus contenidos se asignaron a tres ejes de discusión: barreras físicas/organizativas, barreras sociales, barreras relacionadas con la educación/formación de los profesionales sanitarios. **Conclusiones:** Es esencial ampliar las discusiones sociales sobre el tema de la diversidad sexual y de género de manera que se deconstruyan los prejuicios institucionales, además, se hace fundamental la revisión de la estructura física y organizacional — así como la formación de los profesionales de la salud — para crear un ambiente asistencial inclusivo.

Palabras clave: Minorías sexuales y de género; Atención Primaria de Salud, Accesibilidad a los servicios de salud.

INTRODUCTION

Health care models have evolved significantly in response to societal development. With Brazil and other developing countries experiencing a notable increase in chronic conditions, there has been a pressing need to rethink health care approaches. Traditionally, these models were, and in some cases still are, fragmented, reactive, and episodic. Primary Health Care (PHC) and the integration of care services emerged as strategies to address this critical transition. According to the World Health Organization, PHC represents the primary level of care and serves as the entry point to the health system and its various levels.[1] In Brazil, PHC is a key component of the Health Care Network (HCN), which aims to integrate different levels of care — HCN also includes the population it serves and its operational structure.[2] Given this context, it is crucial to consider which populations the health services aim to serve. Each population has unique needs and individual and collective factors that influence their health and access to the health system.

Historically, the national health system was guided by discriminatory policies that marginalized expressions of sexuality and gender identity outside heterosexual and cisnormative standards. For instance, such policies categorized these identities as diseases requiring psychiatric treatment,

resulting in compulsory hospitalization and significant physical and psychological harm for many individuals. For an extended period, the healthcare system failed to recognize and adequately address the genuine needs of the Lesbian, Gay, Bisexual, *Travestis*, Transsexual, Queer, Intersex, and Asexual (LGBTQIA+) community.

Currently, however, […] the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, *Travestis*, and Transsexuals (*Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais* – PNSILGBT) serves as a crucial tool for fostering inclusion and revising past practices in health services for the LGBTQIA+ population. However, the effective implementation of PNSILGBT remains constrained by challenges related to acceptance and dissemination. These difficulties often stem from discriminatory attitudes that are ingrained in health professionals and the structure and organization of the care network. Such attitudes act as barriers to health and contribute to the perpetuation of illness.[2,3]

Much of the scientific literature exploring the relationship between the LGBTQIA+ population and the health system focuses on describing the experiences of users and healthcare employees, often through anecdotal reports, and analyzing specific aspects within this population. For instance, Gomes and Junior[4] analyze the experiences of family doctors in caring for the LGBTQIA+ community and find that professionals generally lack knowledge about the specific needs of this population. While the growth in research on this topic is highly valuable, especially given the marginalization of this group, there remains a scarcity of studies focusing specifically on PHC. Few studies thoroughly examine how the LGBTQIA+ population currently engages with primary care services.[4]

In this context, the study examines access to PHC services by the LGBTQIA+ population. The research had two primary objectives: i. to identify the barriers that impede this population's access to PHC, including physical and structural obstacles; and ii. to explore the various factors involved in this process, aiming to contribute to the development of a comprehensive understanding of individual and collective health.

METHODS

Study design

This study is an integrative review, characterized as qualitative, descriptive, and exploratory. This research method was selected because it enables the synthesis of existing studies, identifies potential gaps in the literature, and provides direction for future research in the area. The review is guided by the following research question: What are the main barriers affecting the LGBTQIA+ population's access to PHC?

Data collection

Data collection occurred from December 2021 to February 2022, while data selection and analysis were conducted in March 2022. Scientific articles were retrieved from the PubMed and Virtual Health Library (VHL) portals, which include the Medical Literature Analysis and Retrieval System Online (MEDLINE), Latin American and Caribbean Literature in Health Sciences (LILACS), and the Nursing Database (*Base de Dados de Enfermagem* –BDENF). Inclusion criteria were: scientific articles available in full online,

written in Portuguese, English, or Spanish, and relevant to the proposed topic. Articles excluded from the review were those with methodological designs such as bibliographic reviews, editorials, study protocols, expert opinions, and experience reports.

Descriptors were obtained from the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH) vocabularies, including: Sexual and Gender Minorities; LGBTQIA+; Primary Health Care (PHC); and Access to Health Services. The search strategy utilized Boolean operators OR and AND, resulting in the following search string for the Virtual Health Library (VHL): ((“Sexual and Gender Minorities” OR “LGBT”)) AND ((“APS” OR “Primary Care”)) AND ((“Access to Health Services” OR “Accessibility to Health Services”)). For PubMed, the search strategy employed equivalent English terms: (((“Sexual and Gender Minorities”[Mesh]) OR “LGBT”) AND “Primary Health Care”[Mesh]) AND “Health Services Accessibility”[Mesh].

The descriptors were obtained from the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MESH) vocabularies, namely: Sexual and Gender Minorities; LGBTQIA+; PHC and Access

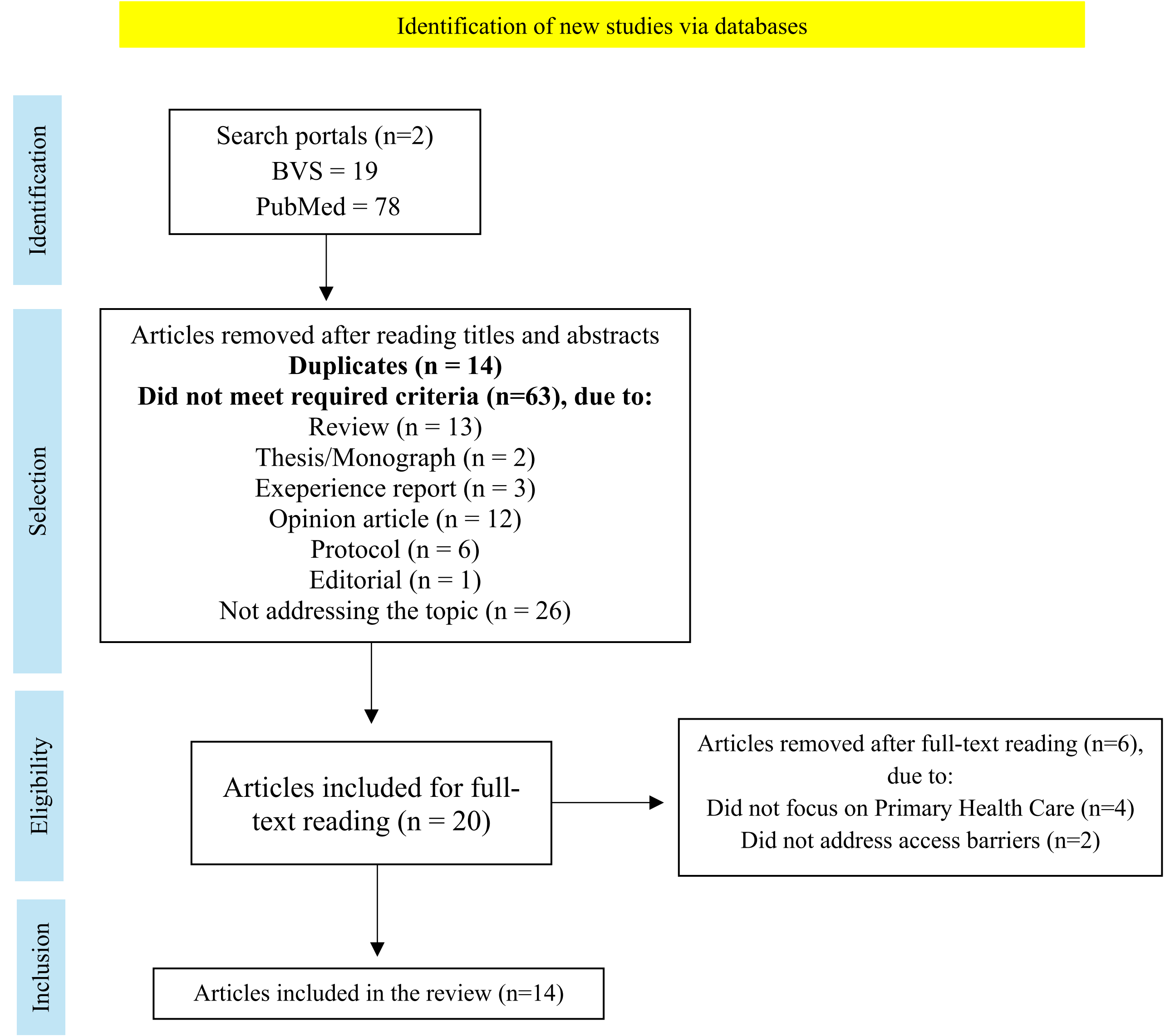

Figure 1. PRISMA flow diagram for article selection.

to Health Services. The organization of the search strategy used the Boolean operators OR and AND, resulting in the search result in the VHL: ((“Sexual and Gender Minorities” OR “LGBT”)) AND ((“ APS” OR “Primary Care”)) AND ((“Access to Health Services” OR “Accessibility to Health Services”)). For PubMed, the search strategy used was based on equivalent terms in the English language: (((“Sexual and Gender Minorities”[Mesh]) OR “LGBT”) AND “Primary Health Care”[Mesh]) AND “Health Services Accessibility”[Mesh].

Os descritores foram obtidos a partir dos vocabulários Descritores em Ciências da Saúde (DeCS) e Medical Subject Headings (MESH), sendo eles: Minorias Sexuais e de Gênero; LGBTQIA+; APS e Acesso aos Serviços de Saúde. A organização da estratégia de busca utilizou os operadores booleanos OR e AND, tendo como resultado para a busca na BVS: ((“Minorias Sexuais e de Gênero” OR “LGBT”)) AND ((“APS” OR “Atenção Básica”)) AND ((“Acesso aos Serviços de Saúde” OR “Acessibilidade aos Serviços de Saúde”)). Para PubMed, a estratégia de busca utilizada foi feita a partir dos termos equivalentes no idioma inglês: (((“Sexual and Gender Minorities”[Mesh]) OR “LGBT”) AND “Primary Health Care”[Mesh]) AND “Health Services Accessibility”[Mesh].

The articles selected, following the PRISMA flowchart (Figure 1), were synthesized using a data collection instrument that recorded the article title, year of publication, author, and main findings, as detailed in Chart 1.

From the data summarized in Chart 1, the objectives, methodologies, and results of the selected articles were integrated. A thematic analysis was conducted following the six steps proposed by Braun and Clarke (insert year): familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. This process identified three main thematic axes relevant to the issues addressed in this review[5]: physical/organizational barriers, social barriers, and barriers related to the education/training of health professionals.

RESULTS AND DISCUSSION

Physical/organizational barriers

In the characterization of access to healthcare, barriers, whether structural, organizational, or related to infrastructure, directly affect the quality of services provided to the population. When examining access to primary care for the LGBTQIA+ population, the impact is heightened by the fact that many prominent physical barriers often reflect the manifestation of prejudice experienced both outside and within healthcare settings.

Chart 1. Distribution of articles by title, authors, publication years, journal, database, and main findings.

Title	Authors and year of publication	Type of study	Main finding
Avaliação da implementação da Política Nacional de Saúde Integral à população LGBT em um município da região Sudeste do Brasil	Guimarães et al. (2020)[6]	Descriptive, exploratory, and qualitative	There is limited knowledge among professionals about the LGBT population and the National Policy on Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (*Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais* – PNSILGBT), which restricts access to healthcare for this population

Continue...

Chart 1. Continuation.

Title	Authors and year of publication	Type of study	Main finding
Barries to primary and emergency healthcare for trans adults	Vermeir et al. (2017)[7]	Descriptive, exploratory, and qualitative	Trans adults generally feel discriminated against and excluded in PHC services due to physical and socio-environmental barriers and limited knowledge among healthcare professionals
Diversidade de gênero e acesso ao Sistema Único de Saúde	Ferreira et al. (2018)[8]	Descriptive, exploratory, and qualitative	Healthcare services are generally structured according to heterosexual and cisgender norms, excluding LGBT patients
Experiences of homosexual patients' access to primary health care services in Umlazi, KwaZulu-Natal	Cele et al. (2015)[9]	Descriptive, exploratory, and qualitative	"Healthcare professionals have limited knowledge about homosexuality, influenced by cultural and religious beliefs in their treatment of homosexuals
Improving pathways to primary health care among LGBTQ populations and health care providers: key findings from Nova Scotia, Canada	Gahagan e Subirina-Malaret (2018)[10]	Descriptive, quantitative, and cross-sectional	Doctors and patients have differing views on key topics related to their health
Lesbians women's access to healthcare, experiences with expectations towards GPs in German primary care	Hirsch et al. (2016)[11]	Descriptive, quantitative, and cross-sectional	Lesbian women report low levels of knowledge among professionals regarding issues related to lesbian identity, as well as prejudice and discrimination
Outness, stigma, and primary health care utilization among rural LGBT populations	Whitehead et al. (2016)[12]	Descriptive, quantitative, and cross-sectional	Trans individuals have less access to healthcare and often need to travel longer distances to reach healthcare centers
Primary care access and foregone care: a survey of transgender adolescents and young adults	Clark et al. (2017)[13]	Descriptive, exploratory, and qualitative	Patients report feeling more comfortable discussing issues related to sexuality and gender identity with family doctors and within their community
Primary care clinician's willingness to care for transgender patients	Shires et al. (2018)[14]	Descriptive, quantitative, and cross-sectional	Transphobia is identified as a major factor limiting PHC doctors' willingness to provide care for trans individuals
Serviços de saúde para lésbicas, gays, bissexuais e travestis/transexuais	Oliveira et al. (2018)[15]	Descriptive, exploratory, and qualitative	Healthcare services tend to be standardized according to heterosexual protocols, with a lack of cultural competence in LGBTQIA+ issues
Stigma, gender affirmation, and primary healthcare use among black transgender youth	Goldenberg et al. (2019)[16]	Descriptive, quantitative, and cross-sectional	The absence of affirmative gender policies has been correlated with limited access to healthcare services
Transgender and gender nonconforming patient experiences at a family medicine clinic	Hinrichs et al. (2017)[17]	Descriptive, exploratory, and qualitative	Quality care for trans individuals involves respecting their self-identification and focusing on their overall health, not just on gender diversity issues such as transition therapies
Transphobia rather than education predicts provider knowledge of transgender health care	Stroumsa et al. (2019)[18]	Descriptive, quantitative, and cross-sectional	Transphobia is the main factor limiting healthcare professionals' knowledge about caring for the transgender population
Health care access among transgender and nonbinary people in Canada, 2019: a cross-sectional survey	Scheim et al (2021)[19]	Descriptive, quantitative, and cross-sectional.	Wait times for accessing healthcare services and PHC act as a significant barrier for transgender and non-binary individuals

Source: elaborated by the authors (2022).

Among the main limitations in this context is the invisibility of LGBTQIA+ individuals within physical environments, exemplified by the lack of neutral bathrooms and spaces providing basic privacy.[7] The absence of such fundamental amenities highlights the disparity in accessibility between the cisgender heterosexual population and the LGBTQIA+ population, particularly for transgender individuals. The need for transgender individuals to choose between male or female bathrooms or to change in public can lead to significant anxiety and social withdrawal. Creating a welcoming and safe environment for the LGBTQIA+ community through low-cost measures, such as the installation of flags and posters, has been identified as a factor that promotes increased demand for healthcare.[7]

Regarding the transgender population, it is essential to address the issue of using their social name when discussing physical barriers to accessing primary care or any health services. PNSILGBT has stipulated since 2013 that the use of social names in medical records and care is a key objective.[20] However, this practice is not consistently implemented in actual care settings, including primary care. The use of a social name is crucial for the transgender population's access to health services, and its omission from forms can severely disrupt the doctor-patient relationship early on.[6,8] Indeed, a study conducted in Nova Scotia (Canada) identified binary medical records as a significant physical barrier to care for this population.[7]

Another barrier identified in studies involving transgender patients is the tendency for their care to be concentrated in specialized settings — such as outpatient clinics focused on gender transition —, a fact that excludes them from PHC.[6,8,18] While the establishment of specialized environments represents a significant advancement for providing complex consultations and services — mainly related to issues such as transition and hormone therapy —, it inadvertently separates transgender patients from PHC. As a result, their access to integrated care, which addresses various aspects of their health and provides continuous and longitudinal monitoring, is hindered.[8]

The absence of adequate tools for collecting health indicators specific to the LGBTQIA+ population in Brazil represents a significant structural and organizational barrier.[6] This lack of data hinders the provision of appropriate services and the development of targeted strategies, as well as the identification of factors and situations of vulnerability and prevalent illnesses.[6] It suggests that the health concerns of this population are considered negligible by the Brazilian Unified Health System (*Sistema Único de Saúde* – SUS), despite SUS's principles of providing universal, equitable, and comprehensive healthcare access. Additionally, the service region itself can be a complicating factor, particularly in rural areas where prejudice against the LGBTQIA+ population may be more pronounced.[12] In these less populated regions, healthcare professionals are often more integrated into the community, which can lead to fears among LGBTQIA+ patients about disclosing their sexuality during consultations and potentially facing repercussions.[7,12] As a result, LGBTQIA+ individuals living in rural areas may experience their physical environment as a barrier to accessing basic health services. The need to travel to locations offering specialized services, coupled with long waiting times and associated costs, further complicates access to healthcare for this population.[13,19]

Social barriers

The LGBTQIA+ population's access to PHC is often hindered by deeply ingrained prejudices, rooted in a society characterized by conservatism and the stigmatization of gender and sexuality that deviate from the cisgender heterosexual norm. This has resulted in healthcare systems that frequently operate based

on a segregating perspective, failing to acknowledge the unique aspects of the health-disease process for sexual and gender minorities and attempting to conform them to models designed for the cisgender heterosexual population.[10] Additionally, there is a tendency to exotify LGBTQIA+ bodies and existences, often reducing their healthcare needs to issues related to Sexually Transmitted Infections (STIs) and gender transition processes. This focus neglects basic PHC topics such as prevention and care — non-communicable chronic diseases, prenatal care, and mental health support.[15] This underscores the critical need to overcome and dismantle prejudices, allowing for the development of an LGBTQIA+ care network that recognizes and addresses individuals' comprehensive needs without rendering their unique nuances invisible or relying on stereotypes.[8,10,17]

The LGBTQIA+ community frequently encounters a spectrum of prejudice, from subtle discrimination to severe physical violence. Many individuals report traumatic experiences and negative encounters in PHC settings — leading to a reluctance to seek these services and distancing them from the entry point of SUS.[7] Additionally, the persistent exposure to prejudice in healthcare environments can result in internalized stigma among LGBTQIA+ individuals. This internalization, often accompanied by a strong sense of guilt, can lead to the normalization of inadequate care and exclusionary behavior from healthcare professionals.[7,12]

The fear of encountering prejudice again negatively impacts the doctor-patient relationship. Some individuals feel uncomfortable discussing topics related to sexual orientation and gender identity with medical professionals — leading to less frequent medical consultations and poorer general and mental health indicators.[6,10] However, family and community doctors are generally perceived as more receptive to the LGBTQIA+ population and are considered more capable of providing comprehensive, tolerant, and inclusive care. This perception underscores the crucial role these professionals play in increasing access to PHC for individuals who do not conform to the cisgender heterosexual norm.[13,11]

It is important to recognize that while violence permeates society broadly, the various groups within the LGBTQIA+ community experience different forms and intensities of prejudice. The most severe and violent incidents disproportionately affect non-white individuals who deviate most from the cisgender heterosexual norm and have less passing in the eyes of others.[15]

In this context, trans and non-binary individuals are generally the primary targets of discriminatory actions. They frequently report experiences such as the inappropriate use of pronouns, intentional use of dead names, and the mischaracterization of their gender identity as "confusion" or the result of previous trauma. Additionally, transphobic healthcare professionals are often less inclined to provide attentive care to this population, with instances of outright refusal of care also being reported.[21,14]

Gay men often experience an ambiguous process within the scope of PHC care. Despite recent advances in social rights and efforts to deconstruct prejudices, these improvements seem predominantly associated with the figure of the "restrained gay", tipically white and affluent. In contrast, those who are Black, poor, and/or perceived as effeminate continue to be marginalized and face serious violence within PHC settings.[8] Reports of prejudice against this population commonly include discrimination based on appearance and way of dressing, rejection and threats from other patients in waiting rooms; the influence of cultural and religious beliefs on medical care; and inappropriate personal involvement from healthcare professionals, sometimes leading to moral and sexual harassment.[15,9]

For lesbian women, some PHC professionals base their care on sexist and heterocentric beliefs, often assuming that female sexuality is inherently tied to motherhood and that lesbianism is linked to promiscuity and classified as a risk behavior for STIs.[11] Consequently, many lesbians feel anxiety and

discomfort, fearing discrimination in healthcare settings that should provide receptivity and acceptance. Even in countries with high accessibility to PHC, such as Germany, a significant number of patients (60%) choose not to disclose their sexual orientation to their doctor, fearing the potential negative impacts on the doctor-patient relationship.[15,11]

The bisexual population frequently faces invalidation of their sexuality, with bisexuality often being dismissed as indecision or debauchery. This group is frequently overlooked, even in environments that are generally receptive to the LGBTQIA+ community. The present review did not identify studies in the analyzed scientific literature that specifically address barriers to access for bisexual individuals within PHC. This absence underscores the persistent invisibility to which this group is systematically subjected.[22]

Barriers related to the education/training of health professionals

A significant portion of the inadequate training of health professionals on comprehensive care for sexual and gender minorities stems from the lack of a systematic approach to LGBTQIA+ health in educational settings. This gap contributes to the exacerbation and perpetuation of historical prejudices.[6] When the topic is addressed, it is often limited to discussions of STIs, reinforcing a pathologizing perspective that views non-cisgender and non-heterosexual individuals as a risk group.[6]

Teaching deficiencies are also evident in continuing education for health professionals. Many transgender patients report that their doctors lack knowledge about sexuality and gender issues and often rely on unreliable sources of information found online. This can lead to embarrassing and inappropriate statements and questions, which hinder the establishment of a positive doctor-patient relationship.[6,7]

Due to a lack of knowledge about the LGBTQIA+ population, many professionals place the responsibility of educating them on patients regarding sexuality and gender issues. This not only undermines patients' trust in the therapeutic guidance and decisions made by these professionals but also adds stress for patients who are unfairly positioned as educators in an environment that should focus on their care.[7,9]

A survey conducted in Canada revealed that 54.7% of non-LGBTQIA+ health professionals have never received training in cultural competence related to the LGBTQIA+ population, and only 9.4% felt confident in providing care to sexual and gender minority patients; in contrast, LGBTQIA+ professionals generally report greater sensitivity and security when caring for these populations, though approximately 75% still experience insecurity.[10] This lack of training and confidence among non-LGBTQIA+ professionals creates a conducive environment for inappropriate practices and prejudiced behaviors, such as the unnecessary exposure of LGBTQIA+ bodies to satisfy the curiosity of medical staff.[10]

In the national context, although PNSILGBT has contributed to gradual improvements in the LGBTQIA+ population's access to PHC and SUS, significant barriers remain to the effective implementation of this access. Many professionals still exhibit limited cultural competence regarding the LGBTQIA+ population and have insufficient knowledge about the objectives, guidelines, and implications of PNSILGBT. Consequently, many professionals are only familiar with general aspects of the topic, often limiting their practice to the use of social names.[6]

Family practice physicians generally show greater knowledge and cultural competence when dealing with the LGBTQIA+ population. This is likely due to the training they receive during medical residency and their role as primary care providers within the community. LGBTQIA+ patients report higher levels of acceptance and fewer uncomfortable situations during consultations with these professionals, highlighting their crucial role in improving access to healthcare for this population.[18]

Therefore, there is a need to introduce a systematic approach to LGBTQIA+ health in both professional training and continuing education programs. This approach should focus on developing the cultural competencies necessary to provide quality and comprehensive care to this group. However, it is important to note that merely increasing the amount of technical and scientific teaching on LGBTQIA+ issues is insufficient to enhance the knowledge and receptivity of health professionals. It is also crucial to address and dismantle prejudiced and discriminatory attitudes, which are identified as primary factors that hinder a positive professional-patient relationship.[18]

CONCLUSION

Building a genuinely inclusive health system that provides effective and comprehensive care for the LGBTQIA+ population requires the development of public policies that address social, physical, organizational, and professional training barriers. To achieve this, it is essential to broaden the discussion on sexual and gender diversity across various public spheres. This will help normalize the conversation and work toward dismantling prejudices, which are central obstacles to ensuring full access to PHC for the LGBTQIA+ population.

Moreover, it is crucial to move beyond public debate and address practical implementation. This involves reviewing the physical and organizational structures of PHC services to mitigate subtle and often imperceptible manifestations of segregation that may be overlooked by a cis-heteronormative perspective.

Finally, efforts must be significantly increased to develop a health education model that effectively integrates sexual and gender diversity into the training of health professionals. This model should also focus on combating prejudice against LGBTQIA+ individuals in a comprehensive and assertive manner.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

LEMB: Conceptualization, Data Curation, Formal Analysis, Methodology, Project administration, Visualization, Writing – Original Draft, Writing – Review & Editing, Supervision. LMF: Formal Analysis, Writing – Original Draft, Writing – Review & Editing. GGB: Formal Analysis, Writing – Original Draft, Writing – Review & Editing.

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