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Research Article

Integral approach to LGBTQIA+ health and its challenges in a municipality in southwest Minas Gerais

Abordagem integral à saúde LGBTQIA+ e seus desafios em um município do sudoeste mineiro

Enfoque integral de la salud LGBTQIA+ y sus desafíos en un municipio del suroeste mineiro

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Abstract

Introduction: The Federal Constitution and the principles of SUS (Unified Health System) establish health as a right for all, yet LGBTQIA+ individuals still face barriers to access. Discriminatory and heteronormative treatment often exacerbates their vulnerability. The health care needs of this population are frequently limited to sexually transmitted infections, highlighting a lack of professional preparation and the need for comprehensive care. **Objective:** To describe the stages and analyze the results of the research project "Characterization of Health Care for the LGBTQIA+ Population in a Municipality in Southwest Minas Gerais," conducted at the State University of Minas Gerais - Passos, MG. **Methods:** This was a quantitative, cross-sectional, exploratory, descriptive, and analytical study, conducted in 22 primary health care units in Passos/MG, between September and November 2022. The research included 136 professionals from Family Health Strategy (FHS). Data collection followed a defined schedule after approval by the UEMG Research Ethics Committee and was carried out through two self-administered questionnaires: one sociodemographic and another on the professionals' perception and knowledge regarding LGBTQIA+ health. The instrument was refined by eight specialists, who suggested adjustments to the questions for greater appropriateness. The responses were tabulated and analyzed using SPSS software. **Results:** Among the professionals interviewed, 80.1% reported not remembering or not having received training on LGBTQIA+ health, and 28.7% rated their knowledge of the National LGBT Health Policy (PNSI-LGBT) as "good," while 70.5% classified it as "average" or "poor." Nevertheless, 56.6% believed that their teams are prepared to care for this population. However, the discrepancy between the low level of training and the perceived preparedness for care revealed a significant gap in professional education. Most participants (75.7%) agreed that including content on sexual and gender diversity in educational curricula is essential, contrasting with 8.1% who saw no relevance. The majority of professionals recognized sexuality as a determinant of health (77.2%). **Conclusions:** The results, although limited by the sample size and region, align with the literature: there is a lag and a lack of professional preparation. It is recommended that regular training be implemented and strategies developed to reinforce inclusive public policies. The adoption of these practices may contribute to improving comprehensive care and reducing inequities in access to health care.

Keywords: Primary health care; Health status disparities; Sexual and gender minorities; Minority health.

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Resumo

Introdução: A Constituição Federal e os princípios do Sistema Único de Saúde (SUS) consolidam a saúde como direito de todos, mas pessoas LGBTQIA+ ainda encontram barreiras no acesso. O tratamento muitas vezes discriminatório e heteronormativo acentua essa vulnerabilidade. As demandas dessa população são frequentemente restritas a Infecções Sexualmente Transmissíveis (ISTs), evidenciando despreparo profissional e a necessidade de um atendimento integral. **Objetivo:** Descrever as etapas e analisar os resultados encontrados sobre o projeto de pesquisa "Caracterização da assistência em saúde à população LGBTQIA+ em um município do sudoeste mineiro", realizado na Universidade do Estado de Minas Gerais (UEMG), em Passos/MG. **Métodos:** Trata-se de um estudo quantitativo, transversal, exploratório, descritivo e analítico realizado em 22 unidades de Atenção Primária à Saúde (APS) em Passos/MG, entre setembro e novembro de 2022. A pesquisa incluiu 136 profissionais da Estratégia Saúde da Família (ESF). A coleta de dados seguiu um cronograma definido após a aprovação pelo Comitê de Ética em Pesquisa da UEMG e foi realizada por meio de dois questionários autopreenchidos: um sociodemográfico e outro sobre a percepção e o conhecimento dos profissionais em relação à saúde LGBTQIA+. O instrumento foi refinado por oito especialistas, que sugeriram ajustes nas perguntas para garantir maior adequação. As respostas foram tabuladas e analisadas no software SPSS. **Resultados:** Dos profissionais entrevistados, 80,1% relataram que não se lembram ou não receberam capacitação sobre saúde LGBTQIA+; 28,7% avaliaram seu conhecimento sobre a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Transexuais, Travestis e Transgêneros (PNSI-LGBT) como "bom", enquanto 70,5% classificaram como "mediano" ou "ruim". Ainda assim, 56,6% acreditam que suas equipes estão aptas para atender essa população. No entanto, a discrepância entre o baixo nível de capacitação e a percepção de aptidão para o atendimento revela uma lacuna significativa na formação profissional. A maioria dos participantes (75,7%) concorda que a inclusão de conteúdos sobre diversidade sexual e de gênero nos currículos de formação é essencial, em contraste com os 8,1% que não veem relevância. A maioria dos profissionais reconhece a sexualidade como determinante em saúde (77,2%). **Conclusões:** Os resultados, embora limitados em função da amostra e região, trazem dados que vão ao encontro da literatura: há uma defasagem e um despreparo profissional. Recomenda-se a implementação de capacitações regulares e a criação de estratégias que reforcem políticas públicas inclusivas. A adoção dessas práticas pode contribuir para melhorar o cuidado integral e reduzir as iniquidades no acesso à saúde.

Palavras-chave: Atenção primária à saúde; Disparidades nos níveis de saúde; Minorias sexuais e de gênero; Saúde das minorias.

Resumen

Introducción: La Constitución Federal y los principios del SUS (Sistema Único de Salud) consolidan la salud como un derecho de todos, sin embargo, las personas LGBTQIA+ aún encuentran barreras en el acceso. El tratamiento a menudo discriminatorio y heteronormativo acentúa esta vulnerabilidad. Las demandas de esta población suelen estar restringidas a ITS, lo que evidencia la falta de preparación profesional y la necesidad de una atención integral. **Objetivo:** Describir las etapas y analizar los resultados del proyecto de investigación "Caracterización de la Atención en Salud a la Población LGBTQIA+ en un Municipio del Suroeste de Minas Gerais", realizado en la Universidad del Estado de Minas Gerais - Passos, MG. **Métodos:** Se trata de un estudio cuantitativo, transversal, exploratorio, descriptivo y analítico, realizado en 22 Unidades de Atención Primaria a la Salud en Passos/MG, entre septiembre y noviembre de 2022. La investigación incluyó a 136 profesionales de la Estrategia de Salud Familiar (ESF). La recolección de datos siguió un cronograma definido tras la aprobación del Comité de Ética en Investigación de la UEMG y se realizó mediante dos cuestionarios autoadministrados: uno sociodemográfico y otro sobre la percepción y el conocimiento de los profesionales en relación con la salud LGBTQIA+. El instrumento fue refinado por ocho especialistas, quienes sugirieron ajustes en las preguntas para garantizar una mayor adecuación. Las respuestas fueron tabuladas y analizadas en el software SPSS. **Resultados:** De los profesionales entrevistados, el 80,1% informó no recordar o no haber recibido capacitación sobre salud LGBTQIA+, el 28,7% evaluó su conocimiento sobre la Política Nacional de Salud Integral LGBT (PNSI-LGBT) como "bueno", mientras que el 70,5% lo clasificó como "regular" o "malo". Aun así, el 56,6% cree que sus equipos están preparados para atender a esta población. Sin embargo, la discrepancia entre el bajo nivel de capacitación y la percepción de aptitud para la atención revela una brecha significativa en la formación profesional. La mayoría de los participantes (75,7%) concuerda en que la inclusión de contenidos sobre diversidad sexual y de género en los currículos formativos es esencial, en contraste con el 8,1% que no ve relevancia. La mayoría de los profesionales reconoce la sexualidad como un determinante de la salud (77,2%). **Conclusiones:** Los resultados, aunque limitados por la muestra y la región, aportan datos que coinciden con la literatura: existe un desfase y una falta de preparación profesional. Se recomienda la implementación de capacitaciones regulares y la creación de estrategias que refuercen las políticas públicas inclusivas. La adopción de estas prácticas puede contribuir a mejorar la atención integral y reducir las inequidades en el acceso a la salud.

Palabras clave: Atención primaria de salud; Disparidades en el estado de salud; Minorías sexuales y de género; Salud de las minorías.

INTRODUCTION

According to the doctrinal principles of the Unified Health System (SUS) — universality, equity, and comprehensiveness in health services and actions — we have the basic concept of public health care in Brazil.[1] On the basis of this, it is understood that health is a right of all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems,

without any discrimination. Furthermore, it guarantees universal and equal access to actions and services for its promotion, protection, and recovery,[2] respecting the principle of equity, which states that equality must be linked to social justice, aiming to reduce existing social disparities in our country through health actions and services.[3]

Regarding the lesbian, gay, bisexual, transvestite and transgender, queer, intersex, asexual population and those belonging to other groups and variations of sexuality and gender (LGBTQIA+), what has been observed is a difficulty in accessing health services and a distancing from care units, including primary health care (PHC), motivated by various obstacles whose basis is institutional heteronormativity (presumption of heterosexuality as the rule).[4] This means that individuals experience, in these environments that should be welcoming to them, situations of discrimination, prejudice, and embarrassment, in addition to the lack of professional preparation resulting from the absence of training on LGBTQIA+ health during undergraduate studies, technical courses, and programs of medical and multiprofessional residency.[5]

To clarify the adoption of the LGBTQIA+ acronym, the first letters refer to sexual orientation, that is, to whom affection and sexual desire are directed: Gay men are men who feel sexual and affective attraction to other men, Lesbians are women who feel sexual and affective attraction to other women, Bisexuals are people who feel sexual and affective attraction to both men and women. Transsexuals, in turn, are people who assume the gender opposite to that of their birth; an identity linked to the psychological, and not the physical, since in these cases there may or may not be a physiological change for adaptation. Queer is a term to designate any person who deviates from cis-heteronormativity, whether due to their sexual or gender identities. Intersexuality describes people who may be born with genitals corresponding to one sex, but have the reproductive system and hormones of the other. Asexuals are people who have no sexual interest. The rest serve to encompass the other people in the flag and the plurality of sexual orientations and gender variations.

Clarifying the acronym LGBTQIA+ is necessary, since sexual orientation and non-normative gender identity are social markers directly related to access to health care[6] and also because it is an acronym unknown to many—which can directly affect health care management for this population. In this context, it is noted that the health care system and its professionals are, for the most part, not equipped to provide adequate support and treatment to this population.[7]

Health indicators reflect the state of health care in a given location, highlighting existing shortcomings in health promotion and protection, as well as violations of human rights.[8] Access to health services involves multiple aspects, such as the political, economic, social, organizational, technical, and symbolic fields.[9] Thus, when these contexts intersect with markers of gender, race/color, and class, the problems involving access to and quality of health services accessed, for example, by the LGBTQIA+ population, intensify, culminating in greater invisibility and vulnerabilities for these individuals.

Despite the existence of public policies and state actions, such as the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Transsexuals, Transvestites and Transgenders (PNSI-LGBT) of 2013, these policies are still unknown to health professionals,[7] causing assistance to the LGBTQIA+ population to be associated for the most part with sexually transmitted infections (STIs) — neglecting all the specific risks and needs of each LGBTQIA+ segment.

That said, we have a scenario that demonstrates the need to understand the limitations of the qualification of PHC+ professionals for the care of the LGBTQIA+ population and their knowledge of the PNSI-LGBT, as well as to analyze the quality of accessibility of this service for the aforementioned population, seeking to understand the existing obstacles to the effective fulfillment of the right to health established in the Federal Constitution.

METHODS

We conducted a quantitative, cross-sectional, exploratory, descriptive, and analytical study, conducted with data collected from 22 primary health care units (PHCUs) in the municipality of Passos/MG, between September and November 2022. The study involved 136 professionals from the Family Health Strategy (FHS), including community health agents (CHAs), nursing assistants, dentists, nurses, pharmacists, doctors, nutritionists, and nursing technicians.

Data collection was carried out in the aforementioned months, according to the schedule established for the development of the project, which began in May 2022 after approval in a public notice and release by the Research Ethics Committee (CEP) of the State University of Minas Gerais (UEMG) — Passos Unit (CAAE: 60383722.2.0000.5112), as per Opinion No. 5.567.795, issued in August 2022.

Participant recruitment was carried out by invitation in the PHCUs with all professionals who wished to participate in the research through an explanation of the objectives, methodological procedures, and the signing of an informed consent form. Professionals who were not part of the PHC teams, those who were absent from work or unable to answer the questionnaire on the scheduled day, as well as professionals who refused to participate in the research and sign the informed consent form, were excluded from the study.

Data collection was based on two self-administered questionnaires:

1. A sociodemographic questionnaire developed by the researchers, containing the variables: name, age range, race/ethnicity, gender identity, sexual orientation, profession, years of experience, and religion;
2. A questionnaire on the individual perception of the target audience regarding their level of knowledge (Tables 1 and 2), as well as a direct analysis of knowledge (Tables 3 and 4) aimed at evaluating the team's preparedness to welcome the LGBTQIA+ population, also developed by the researchers and refined by professionals working in centers specializing in services for LGBTQIA+ people and/or who are part of spaces (working groups, committees, associations, etc.) that discuss gender, sexuality, and diversity, to better adapt the questions to the research objectives. This section also included an open section for comments.

Table 1. Sexuality as a determinant of health.

	Frequency	Valid percentage
Agrees	105	77.2
Neither agrees, nor disagrees	14	10.3
Valid		
Disagrees	17	12.5
Total	136	100.0

Table 2. Perception of health vulnerabilities in the LGBTQIA+ population.

	Frequency	Valid percentage
Does not have any	7	5.1
Has few	31	22.8
Valid		
Has many	82	60.3
Does not know	16	11.8
Total	136	100.0

Table 3. Notification of an LGBTQIA+phobia incident.

	Frequency	Percentage	Valid percentage
Agrees	79	58.1	59.4
Neither agrees, nor disagrees	31	22.8	23.3
Valid			
Disagrees	23	16.9	17.3
Total	133	97.8	100.0
Blank responses	3	2.2	
Total	136	100.0	

Table 4. Health care initiatives focused on providing comprehensive care for LGBTQIA+ individuals.

	Frequency	Percentage	Valid percentage
Agrees	107	78.7	78.9
Neither agrees, nor disagrees	10	10	7.5
Valid			
Disagrees	17	17	12,7
Total	134	134	100
Blank responses	2	2	
Total	136	136	

Eight professionals participated in the refinement phase, including five doctors, one nurse, one physiotherapist, and one clinical pharmacist. The invitation to participate was made by email, allowing participants to access a preview of the questionnaire through a Google Forms form, where they could leave contributions and comments on each question that could be improved, whether in the formulation of the sentences or in the choice of more inclusive terms and appropriate to the target audience. The changes considered pertinent were implemented to increase the applicability of the instrument.

In its first part, regarding the identification of the research participants, the use of the race/color question was suggested, as recommended by the Brazilian Institute of Geography and Statistics (IBGE). The option of “Stable Union” was included in the Marital Status field, and the option “I don’t know/I don’t want to answer” was added to the Religion field, providing greater freedom of response and avoiding possible discomfort. The “Other” field was added to the Marital Status, Gender Identity, and Profession categories, making the identification more inclusive.

The second part of the instrument sought to analyze the perception and knowledge of health care professionals regarding the health demands and specificities of the LGBTQIA+ population. The questions addressed knowledge about the PNSI-LGBT, the vulnerabilities and specificities of this population, respect for social names, reporting of LGBTQIA+phobia, the team’s aptitude in addressing these specificities, and training.

Considering the professionals’ observations, the question about the existence of training during the period of professional practice was adapted to better understand when the training was received — whether during, after, or in both moments of training and professional practice.

Another modification involved vulnerabilities, which were initially limited to clinical situations. It was suggested to replace the term “clinical” with “in health,” broadening the concept to include social, psychological, and other aspects. In addition, terms such as “drug addiction” and “alcoholism,” considered pejorative by the evaluators, were replaced by “substance/tobacco/alcohol abuse and dependence.”

The question addressing responsibility for creating actions to reduce these problems, previously attributed only to the PHC team, was expanded to include the municipality, promoting co-responsibility.

At the end of the data collection instrument, an open section was included for participants' comments, aiming to better understand the perceptions and barriers faced regarding the topic. This space seeks to corroborate, through the professionals' statements, the vulnerabilities and obstacles to access to health care for the LGBTQIA+ population identified in the literature.

The questionnaire responses were tabulated and stored in a Microsoft Excel spreadsheet, restricted only to the researchers. Subsequently, the collected data were processed using the SPSS software platform for statistical analysis, resulting in frequency and percentage tables. In detail, each table contains the frequency, which corresponds to the number of times this variable was repeated, with the percentage referring to the total value.

RESULTS AND DISCUSSION

Participant profile

The most prevalent age range among participants was 36 to 45 years (45.6%), with a predominance of women (83.9%) and cis-heterosexual individuals (87.5%). CHAs were the most represented group in the sample, reflecting the typical composition of FHS teams. Considering the participants' profile, there was a predominance of cis-heterosexual individuals, which highlights the lack of representation in the team in terms of sexual orientation and gender identity. Furthermore, the predominantly female composition, as expected, is in line with the trend of greater presence of women in care professions, such as those in the health field, as indicated by IBGE gender statistics.[10]

Although CHAs represent the majority of professionals in a FHS, the reduced participation of physicians was a limiting factor, as there was less availability and greater resistance from these professionals to participate in the research. This less diverse profile among participants contributes to a generalization of the results, since a homogeneous audience makes it difficult to analyze different segments separately, limiting the understanding of the diverse needs and perceptions within health care teams.

Training and knowledge

One of the aspects analyzed by the questionnaire was the training of health care professionals on topics related to LGBTQIA+ health. Among the participants, the majority do not remember or have never received training during their professional careers (80.1%), while only 19.2% reported having received some type of training, either during their undergraduate studies, after graduation, or both. It is observed, therefore, that the approach to gender and sexual diversity is not formally included in academic or technical curricula. Even those who have had some training consider it insufficient for adequate preparation, highlighting a significant deficiency in both initial training and Continuing Education in Health (CEH).[11]

This lack of training reflects the heteronormative factors that permeate training and education in health courses. Currently, LGBTQIA+ themes are excluded or practically non-existent in curricula, especially in courses such as Nursing and Medicine. The insufficient approach to these issues is consistent with the institutionalized conservative and heteronormative character of Brazilian society, contributing to frequent complaints of indifference and prejudice in places that should be safe, such as health care services.[11,12]

The lack of knowledge about gender and sexual diversity issues is reflected, in practice, in discriminatory care and inappropriate conduct, resulting in inefficient approaches and reports of repression in health services, fear of suffering violence, lack of effective follow-up in PHC, anxiety, and embarrassment when seeking care in the public health system. This context also highlights the non-compliance with the fundamental principles that govern SUS, such as universality, comprehensiveness, and equity.[12]

Furthermore, this reality reveals a deficiency in the understanding of the social determinants of health and disease, ignoring how social, economic, cultural, and political markers affect people's health. The literature and the results of current research show a lack of effectiveness in the care provided, highlighting the need for a more in-depth study of these issues during undergraduate studies.[12]

It therefore becomes evident that there is a need to broaden the inclusion of subjects that address equity and respect, focusing on gender and sexual diversity, ensuring universal knowledge about PNSI-LGBT. The mandatory and cross-cutting inclusion of these themes in undergraduate subjects, as well as the provision of practical courses and ongoing training for all health professionals as part of the CEH, are strategies that can help mitigate inequalities arising from the lack of knowledge and preparedness of professionals.

Perception and aptitude for care

Since the PNSI-LGBT is a public policy developed to recognize the demands of this population, it was considered important to address the self-assessment of professionals regarding their knowledge of this policy. Many were unaware of its existence, which is consistent with the data regarding the lack of training. The self-assessments indicated that 28.7% of professionals considered their knowledge "good," 40.4% "average," and 30.1% "poor."

Our study also sought to assess whether participants considered themselves capable of meeting the specific health needs of the LGBTQIA+ population. Among the valid responses, 56.6% of professionals "agree" that the team is prepared, 14% "neither agree nor disagree", and 28.7% "disagree."

Despite a large proportion (70.5%) of participants acknowledging that their knowledge of the PNSI-LGBT was "average" or "poor," as well as the lack of training in technical training environments, the majority still considered the teams capable of providing specific care to this population. This suggests a possible contradiction in the responses, indicating that the way the questions were formulated and organized may have led participants to inconsistent answers.

This contradiction highlights the impact of response bias, since the lack of knowledge about the PNSI-LGBT and the lack of training during undergraduate studies and professional practice are real, but do not seem to be sufficiently recognized in terms of their impact on professional practice. The lack of theoretical grounding leads participants to believe that serving everyone equally is sufficient to guarantee a qualified team, which does not correspond to reality. This creates a false sense of fulfilling the social role or what is expected in the responses.

To mitigate this bias in future research, it is recommended that the questionnaire questions be more objective and that it be made explicit that knowledge about the PNSI-LGBT should be considered when assessing whether or not the team is able to meet the specific needs of the LGBTQIA+ population. It is also essential to emphasize that there is no expected response pattern and that participants should feel comfortable expressing their real perceptions.

Regarding the understanding of sexuality as a determining factor in the health of individuals and the perception of the specific vulnerabilities of the LGBTQIA+ population, the answers are found in Tables 1

and 2. These data highlight the need for critical, comprehensive, and humanized training that incorporates a broad understanding of the social determinants of the health-disease process.

For more health professionals to understand the specificities of LGBTQIA+ health and the importance of adequately serving this population, it is essential that health education continuously and regularly address issues related to gender identity, sexual orientation, and the barriers faced by these communities. The training of professionals must transcend the mere transmission of technical knowledge, incorporating an effective commitment to citizenship, human dignity, and the reduction of social inequities. Only in this way will it be possible to prepare professionals capable of understanding how social markers—such as gender, sexual orientation, race, and social class—directly influence health conditions and access to services, promoting a more equitable practice committed to social justice.

Finally, questions directly related to the PNSI-LGBT were asked to superficially assess knowledge about some important aspects of addressing the specific health needs of this population.

It is the responsibility of the health professional to complete the Individual Notification Form for Interpersonal and Self-Inflicted Violence; and, according to the PNSI-LGBT, it is necessary that the questions of sexual orientation and gender identity be included in clinical records, in the violence notification documents of the Health Surveillance Secretariat of the Ministry of Health (SVS/MS), as well as in other identification and notification documents of the SUS, so that the Ministry of Health can qualify the data and information received to strengthen the policies aimed at each case.[13]

Considering that, of the valid responses, 23.3% of professionals expressed doubts about the need for this completion and 17.3% disagreed with its importance, it becomes essential to expand knowledge about these practices in health institutions. It is fundamental to guarantee easy and immediate access to all the documents necessary for notification, promoting awareness and continuous training of professionals so that they recognize the relevance of documenting this information and contribute to the improvement of health policies.

Importance of including content

The inclusion of content about the sexuality of LGBTQIA+ people and health policies aimed at this population in undergraduate and postgraduate programs is widely considered important by the research participants (75.7%), in contrast to the 8.1% who do not see these topics as relevant. However, many health professionals demonstrated a lack of knowledge about the concept of equity, one of the fundamental principles of SUS, arguing that all patients should be treated the same way, without taking into account the specific needs of different groups. This view, which suggests that “no one is different from anyone else,” ignores forms of discrimination, such as LGBTQIA+phobia, that can occur in health services.

The curriculum should include not only technical skills, but also ethical and political issues.[14] Training should address the sexuality of LGBTQIA+ people, aligned with the person-centered clinical method, which promotes comprehensive and individualized care. This method considers the patient’s social, cultural, and historical context, allowing health professionals to offer more equitable and inclusive care. The view that specific health care for the LGBTQIA+ population is not necessary in training may reflect an overly technical and limited approach. Training should integrate both technical and political aspects. Focusing solely on equal treatment, without considering the specificities of individuals, compromises a full understanding of the concept of promoting health.[15] This restricted focus can lead to inadequate practices that do not meet the diverse needs of patients. Therefore, it is crucial that training includes a critical analysis of the social and political dimensions of health care.[15] Empowering professionals to

recognize and address these differences effectively is essential to improve care and reduce the spread of violence and discriminatory conduct.

Dissemination of policies and strategies

Regarding the municipality's performance in objectively and accessibly disseminating strategies, such as care flows and public policies aimed at the community, 32.4% of respondents agreed that this dissemination occurs satisfactorily, 10.3% stated they did not know how to answer, and 55.1% considered that the municipality does not carry out this dissemination in a way that is accessible to professionals and the target audience. This scenario reflects a lack of knowledge of the LGBTQIA+ health care network and shows that the city of Passos fails in its performance aimed at the health of this population, demonstrating a lack of implementation and dissemination of information on the subject. This perception is aligned with the participants' assessment of the preparedness of PHC to serve the LGBTQIA+ population, in which only 44% agreed that this level of care is adequately prepared.

This data is consistent with the perception that the municipality does not offer adequate preparation for primary health care in relation to the LGBTQIA+ population. The minority that considers the dissemination effective may have a perception influenced by actions focused on the prevention of STIs, or by fears of criticizing the local administration.[16]

Almost 80% of professionals agree that the primary health care team, in conjunction with the municipality, is responsible for creating actions aimed at reducing problems related to mental health, substance abuse and dependence/tobacco/alcohol, depression, and suicide among LGBTQIA+ individuals. Given the data, the importance of the municipality's role in addressing the community's risk is highlighted, since recognizing this responsibility contributes to the involvement and engagement of teams in policies and projects that effectively impact the comprehensive care of the LGBTQIA+ population.

The low dissemination of specific policies for this population among health professionals is a recurring problem. The scarcity of studies on the implementation of the PNSI-LGBT (National Policy for Comprehensive Health of the LGBTQIA+ Community) and the adequacy of legislation to the needs of patients, in addition to the lack of official data on LGBTQIA+ health as a whole, undermines the effectiveness of public policies and strategic actions aimed at this population.[16]

To improve training and assistance offered, the municipality should implement comprehensive awareness campaigns, such as lectures and discussion groups, that promote PNSI-LGBT and empower professionals to adequately meet the needs of the LGBTQIA+ population. Creating more accessible communication channels that offer guidance on rights, services, and assistance—especially for victims of LGBTQIA+phobia—and implementing referral centers similar to those in Belo Horizonte and Uberlândia are essential to facilitate support and improve assistance. These actions would not only improve local health practice and policy but also strengthen the municipality's commitment to an inclusive and effective approach to the health of the LGBTQIA+ population.

Respect for identity

When asked whether respecting social names allows users to receive more welcoming and humane care in health services, in addition to guaranteeing trans and transvestite people the right to identity, 88.2% "agree," while 6.6% "disagree." It is worth noting that the collection of information, such as the registered

name, social name, and the pronoun by which the individual would like to be called, must be included in the forms. Similarly, information such as gender identity, sexual orientation, and marital status should be included in medical records and better explored during the consultation, ensuring confidentiality.

In this sense, regarding the barriers faced, the admission form or the regulation itself limits access to procedures and consultations based on gender[17] ("We have had a case of a trans man coming to the unit for a Pap smear and giving his social name, but the system does not accept it, only the female name. We had to put his registered name on the form"). This reality reinforces a heteronormative practice, violates the right to identity, and intensifies the vulnerability of these individuals.

The barriers faced by transgender and transvestite people in the health care system are widely documented, especially regarding respect for their chosen name and gender identity. Furthermore, the discrepancy in the data, where a high percentage recognizes the importance of respecting chosen names but institutional failures exist, can be explained by a lack of training and inadequate institutional policies.[11,12]

Therefore, it is urgent that healthcare institutions adopt objective policies and practices to ensure respect for social name and gender identity in medical records and files, including updating IT systems to support these changes and prevent embarrassment and violence suffered by this community.

Limitations of study

Some limitations and areas for improvement were found during the application of the research, such as the difficulty health professionals had in answering the proposed questionnaire, as well as the refusal of many. Therefore, it is suggested that the questionnaires be simple and objective, to avoid response bias, facilitate interpretation, and ensure the participation of more professionals.

Regarding the applicability of the instrument, because of the small sample size and the p-value not being statistically significant, it was not possible to relate these responses to some sociodemographic data, such as age, gender, sexuality, and profession. Despite this, many of the participants contacted us after the application to clarify doubts, which provoked an interesting reflection on the topic, mainly regarding professional practices.

The main strengths of the project include the introduction and, in many cases, the first contact of professionals with the theme of LGBTQIA+ health, since, in these exchanges, many expressed their feelings and demonstrated interest. It was also possible to identify strategic points that need more attention for health education, such as the need to include the theme of LGBTQIA+ health during undergraduate studies; Adjustments to the information systems of health units to increase the inclusion of transgender and transvestite people, respecting their chosen name; as well as the expansion of CEH in health institutions.

Thus, to achieve more comprehensive care in PHC and equity in practice, the results obtained can be used to promote public policies in the municipality, in addition to expanding discussions on the subject through CEH, enabling updates to health practices and improvements in reception.

CONCLUSION

The results of this research, despite limitations related to sample size and regional scope, reveal a reality consistent with existing literature: there is a significant lack of preparation and knowledge among health professionals regarding LGBTQIA+ health. In addition, a denial of prejudice and barriers imposed by these professionals was observed. The lack of familiarity with terms, especially those related to sexual

orientation, even with explanations provided during the questionnaire, highlights an educational gap. Professionals more familiar with the topic generally belong to the LGBTQIA+ community.

The research also revealed the absence of a consolidated network for comprehensive care for the LGBTQIA+ population in the municipality. Many professionals face difficulties in directing demands and meeting the specific needs of these individuals within SUS. This challenge reflects not only professional unpreparedness but also the lack of care flow and actions that address sexual and gender diversity locally.

The lack of representation and insufficient integration of LGBTQIA+ issues into health practices and policies are factors that directly influence the effectiveness of care. Social determination of the health-disease process highlights how social conditions, discrimination, and lack of access to adequate information and services affect the health of the population.

Given this scenario, it is crucial that health professionals assume the role of agents of social transformation. They have the potential to promote significant improvements in the quality of life of the LGBTQIA+ population by offering more inclusive and sensitive care to their needs. Investing in CEH for professionals, especially in PHC, is fundamental to expanding knowledge about the PNSI-LGBT and to promoting a comprehensive, equitable, and non-limiting approach to a cis-heteronormative and exclusionary system. This effort will contribute to identifying inequities in access to health services, reducing discriminatory behaviors, and improving illness conditions, resulting in a more inclusive and fair health system.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

SPG: Conceptualization; Methodology; Investigation; Data curation; Formal analysis; Writing – original draft; Writing – review & editing. DFES: Methodology; Investigation; Data curation; Formal analysis; Writing – original draft; Writing – review & editing. LSP: Methodology; Investigation; Data curation; Formal analysis; Writing – original draft; Writing – review & editing. TMNB: Methodology; Investigation; Data curation; Formal analysis; Writing – original draft; Writing – review & editing. PGS: Supervision; Methodology; Writing – review & editing.

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