Rev Rene. 2023;24:e83152.
DOI: 10.15253/2175-6783.20232483152
www.periodicos.ufc.br/rene

Original Article

Knowledge and practice of primary care nurses about gender and care for LGBTQIA+ people

Conhecimento e prática de enfermeiros da Atenção Primária sobre gênero e assistência às pessoas LGBTQIA+

How to cite this article:
Paiva EF, Freitas RJM, Bessa MM, Araújo JL, Fernandes SF, Góis PS. Knowledge and practice of primary care nurses about gender and care for LGBTQIA+ people. Rev Rene. 2023;24:e83152. DOI: https://doi.org/10.15253/2175-6783.20232483152

Elisama Ferreira Paiva[1]
Rodrigo Jácob Moreira de Freitas[1]
Marcelino Maia Bessa[1]
Janieiry Lima de Araújo[1]
Sâmara Fontes Fernandes[2]
Palmyra Sayonara Góis[1]

[1]Universidade do Estado do Rio Grande do Norte. Pau dos Ferros, RN, Brazil.
[2]Universidade Estadual do Ceará. Fortaleza, CE, Brazil.

Corresponding author:
Marcelino Maia Bessa
Rua Miguel Antônio da Silva Neto, s/n,
Aeroporto. CEP: 59607-360. Mossoró, RN, Brazil.
E-mail: marcelino.maia.18@outlook.com

Conflict of interest: the authors have declared that there is no conflict of interest.

Special Call - Promoting the health of vunerable populations

EDITOR IN CHIEF: Ana Fatima Carvalho Fernandes
ASSOCIATE EDITOR: Luciano Marques dos Santos

ABSTRACT
Objective: to understand the knowledge and practice of Primary Health Care nurses about gender and assistance to LGBTQIA+ people. **Methods:** qualitative study, conducted with nine nurses from Primary Health Care. Data were collected through semi-structured interviews and submitted to Thematic Content Analysis. **Results:** three categories emerged: knowledge about gender and the LGBTQIA+ population; perception of the National LGBT Comprehensive Health Policy; and demand for services and nursing care for the LGBTQIA+ public. **Conclusion:** it was evidenced deficient knowledge about gender and health of the LGBTQIA+ population. There is a lack of preparation of the professionals who assist these users, which causes barriers to access to care and services, due to the lack of knowledge about the existence of the national policy of integral health of this population. Nurses focus on punctual and biologist actions. **Contributions to practice:** the findings contribute to subsidize the thinking/doing of nursing regarding vulnerable populations, who need an equitable, integral, and humanized look. It is necessary to strengthen discussions in health training and continuing education to expand knowledge about gender, the access of the LGBTQIA+ population to services and the consolidation of the actions of the national health policy aimed at this population group.
Descriptors: Sexual and Gender Minorities; Comprehensive Health Care; Nursing; Primary Health Care.

RESUMO
Objetivo: compreender o conhecimento e a prática de enfermeiros da Atenção Primária à Saúde sobre gênero e assistência às pessoas LGBTQIA+. **Métodos:** estudo qualitativo, realizado com nove enfermeiros da Atenção Primária à Saúde. Os dados foram coletados mediante entrevista semiestruturada e submetidos à Análise de Conteúdo Temática. **Resultados:** emergiram três categorias: conhecimento sobre gênero e população LGBTQIA+; percepção sobre a Política Nacional de Saúde Integral LGBT; e procura pelos serviços e assistência de enfermagem ao público LGBTQIA+. **Conclusão**: evidenciou-se um conhecimento deficiente sobre gênero e saúde da população LGBTQIA+. Há um despreparo dos profissionais que assistem esses usuários, o que provoca barreiras de acesso à assistência e aos serviços, devido ao desconhecimento da existência da política nacional de saúde integral dessa população. Os enfermeiros se centram em ações pontuais e biologicistas. **Contribuições para a prática**: os achados contribuem para subsidiar o pensar/fazer da enfermagem a respeito das populações vulneráveis, que necessitam de um olhar equânime, integral e humanizado. É necessário fortalecer as discussões na formação em saúde e na educação permanente, para ampliar o conhecimento sobre gênero, o acesso da população LGBTQIA+ aos serviços e a consolidação das ações da política nacional de saúde destinadas a esse grupo populacional.
Descritores: Minorias Sexuais e de Gênero; Assistência Integral à Saúde; Enfermagem; Atenção Primária à Saúde.

Received: Dec. 27th 2022; Accepted: Mar. 9th 2023.

Introduction

The National Policy for Comprehensive Health to Lesbian, Gay, Bisexual, Transvestite, and Transgender (LGBT) was created to mitigate the effects of discrimination, institutional violence, and exclusion related to the health-disease process of subjects with "non-hegemonic" identity, aiming to establish management mechanisms to encompass greater equity in the Brazilian Unified Health System (SUS), with special attention to the demands and health needs of the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and more (LGBTQIA+) population[1].

In this study, we chose to use the acronym LGBTQIA+, instead of LGBT, as stated in the policy because it was understood that, at the time of the policy's construction, this nomenclature did not involve other identities, which were being presented and discussed.

The LGBT health policy can be considered an advance in the field of public health care policies for this population, but its effectiveness and design have been the subject of discussion and questioning. Its goal is to reduce the inequities and vulnerabilities suffered by this population, as well as the difficulties of health professionals, including nurses, to effectively intervene in the health needs of this group, which, often due to lack of knowledge of the specificities of the public in question, weakens the effectiveness of the principles of equity, universality, and integrality in SUS[2].

Among the obstacles to the effectiveness of the policy is the difficulty of nurses in knowing the rights and health needs of this population. Thus, nurses' practice has contributed to the desubjectivation of the LGBTQIA+ user, due to the objectivity with which they conduct care and to cis-heteronormative stigmas and attitudes[3]. As well as the unpreparedness of health professionals and services to work with the transgender and transvestite population, considering the gender diversity of users[4], although many have some knowledge about the approach to the LGBTQIA+ population, there is no effective engagement in the forms of care built so that they can, in fact, welcome the differences[5].

As a proposal to deepen the understanding of this scenario of difficulties mentioned, the World Health Organization (WHO) points to knowledge about gender and health as essential to professional training[6]. Gaps in how curricula are structured and in the approach to issues related to gender and sexuality contribute to the fragmentation of training and care practices of nurses[7]. Therefore, the naturalization of prejudice and the social construction of the roles of men and women in society reverberate the hegemony of heterosexuality, harassing any expressions of identities and subjectivities that deviate from this matrix[8].

Thus, gender constitutes an important analytical category that should be present in nurses' education, to provide them with the tools for the daily care of the LGBTQIA+ population. Gender is understood as a field of sociology, arising from feminist studies, which analyzes the social construction of men and women in a society/culture[9]. In this context, the present study is based on the following question: What is the knowledge, and how do Primary Health Care nurses practice about gender and care for LGBTQIA+ people?

The present study is justified by the need to analyze nurses' knowledge about gender and assistance to LGBTQIA+ people, since poor knowledge contributes to unqualified practice, making it necessary to strengthen reflections on the thinking/doing of nurses in health care[10].

In addition, it is necessary to strengthen discussions about public health policies and the specific demands of a group as diverse and heterogeneous as the LGBTQIA+ population, specifically in the countryside of the Brazilian northeastern region, where this population is victim of high rates of violence and homicides[11]. The study is also justified by the lack of scientific research that addresses the sociocultural context of the northeastern semi-arid hinterland, with a view to understanding issues such as gender, diversity, and sexuality in the field of health care and nursing.

Thus, this study aimed to understand the knowledge and practice of Primary Health Care nurses about gender and assistance to LGBTQIA+ people.

Methods

This is a qualitative research[12]. The report of this study follows the guidelines contained in the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The investigation was conducted in a small countryside town of Rio Grande do Norte, located in northeastern Brazil, and the locus for the development of the research were the nine Basic Health Units located in the urban area of the city. It is noteworthy that the semi-arid hinterland region of the Northeast presents distinct and determining sociocultural specificities of identity construction regarding sexuality, strongly based on patriarchy, cis heteronormativity, with rigid ways of defining the roles that men/women should assume, thus determining a preconception about gender and sexuality[13].

The research participants were nurses who worked in Primary Health Care (PHC), specifically in nine Basic Health Units. As inclusion criteria, we chose nurses who worked in direct user care and had been working for at least six months in the health service. On the other hand, the non-inclusion criteria were as follows: nurses on vacation, on leave of absence or on leave of absence; and nurses who, after three attempts at searching the units, could not be successfully contacted for the interview. After applying the criteria, nine nurses participated in the research. It is noteworthy that two nurses refused to participate in the research, a guaranteed ethical right of the participant.

For data collection, we used the interview technique guided by a semi-structured script. The initial approach to the participants took place in person and in the respective basic health units where the nurses worked. After applying the eligibility criteria and getting the agreement to participate in the study, an individual interview was scheduled, according to the availability of the professional. This interview was conducted by a previously trained undergraduate, who had no professional link with the health services and the interviewees.

Data collection occurred in October 2019. The nine interviews were conducted in the meeting rooms of the respective Basic Health Units, only with the presence of the interviewer and the participant, recorded using a cell phone with a voice recorder application, transcribed in full by an undergraduate and reviewed by the advisor. Lasting approximately 40 minutes, the interviews were guided with a semi-structured script, aiming to capture some results guided by questions related to sociodemographic, cultural, health and nursing care aspects, namely: knowledge about gender; health of the LGBTQIA+ population; experiences in serving the public; actions of the LGBT health policy developed in the unit; demand for this public to the service; services offered to this population; services offered by the unit; existence of any specific service for this population; knowledge of any transgender in their area; and search for these subjects by the unit. Moreover, it is noteworthy that the collection script was built by the research members themselves, based on the axes of the LGBT Policy[1].

A pilot test was conducted with a nurse who did not fit the inclusion criteria, to verify that the questions were clear and met the research objective. After the test, the instrument was revised. As soon as the interviews were carried out, the student made the transcription and the pertinent field notes. It was not possible to repeat the interviews, and the transcripts were not returned to the participants due to the time for research closure. In addition, there was no feedback of the results to the participants, but there is a proposal to present the research results in seminar and course formats to nurses in the municipality.

After having contemplated all the research subjects, according to the inclusion criteria, the interviews were closed; however, it was noticed that the answers were already repeated, pointing to a tendency of theoretical saturation. The themes were pre-established by the script, which generated ten codes, which were later analyzed and grouped.

The Thematic Content Analysis method[14] was used for data analysis, according to the following sta-

ges: pre-analysis, with the performance of a floating reading of the interview transcripts; exploration of the material, which refers to the identification of the nuclei of meaning, that is, of the meaning expressed in the speeches of the interviewees through codification, generating level 1 codes, so that, then, through inferences made by the researchers, subcategories or level 2 codes emerged, grouped by similarity in significant thematic categories; and, finally, treatment of the results, inferences and interpretation, in which the findings are discussed. The discussion of the results was anchored in the pertinent scientific literature and in the referential of feminist and queer theories[9], which subsidize the LGBT Policy[1], regarding the concepts of gender, sex, sexuality, and gender identity.

As provided in Resolution No. 466/12, of the National Health Council, the research followed the ethical precepts and was approved by the Research Ethics Committee of the State University of Rio Grande do Norte, under Opinion No. 3,347,075/2019, with Certificate of Ethical Appreciation Submission: 09002319.8,0000,5294. To maintain the anonymity of the interviewees, fictitious names were assigned, with the code name "Participant" added to a number ranging from 01 to 09, which is the number of subjects.

Results

Regarding sociodemographic aspects, among the nine nurses interviewed, regarding gender, eight are women. Regarding the age range, the age of the subjects varies from 30 years or more. As for the time of training, five of the investigated subjects said they had 16 to 20 years of training, and two had 6 to 10 years of training.

As for the time of work in PHC, five have 16 to 20 years of experience. Furthermore, in the family health strategy, five nurses with < 5 years of experience predominated. And finally, regarding professional qualifications, eight reported having at least one specialization, while one had only an undergraduate degree.

From the analysis of the interviews, three categories were noted: knowledge about gender and the LGBTQIA+ population; perception of the National LGBT Comprehensive Health Policy; and demand for services and nursing care for the LGBTQIA+ public. The categories were constructed and discussed by researchers linked to the Knowledge, Nursing and Population Health Research Group.

Knowledge on gender and LGBTQIA+ population

In the perception of some participants of the study, it was evident a deficient and little explored knowledge about gender and health of LGBTQIA+ people. They also emphasized the inexistence of this thematic discussion in their training process, as evidenced in the following statements: *I only know this information from television because even at the time of my training this discussion of gender was not present, transgender, sexuality only of men and women* (Participant 01). *Well, in the old days gender was masculine and feminine, today it is more how the person feels, at least from what I read* (Participant 09).

Still, in this sense, the interviewees center and restrict their speeches on the feminine and masculine dichotomy. In addition, they present a confusion between concepts in their speeches, showing little knowledge about the theme, both in theory and in their daily health care practice, as can be seen in the following reports: *What defines and distinguishes through characteristics, the masculine and the feminine* (Participant 03). *Masculine, feminine and today there are those transgender people, who have a sex, let's say masculine, but see themselves as if they were feminine* (Participant 02). *Gender is what is differentiated, the subject male and female* (Participant 04). *Gender is a term used to designate and differentiate between male and female characteristics* (Participant 06). *Gender is the masculine and feminine and, today, we already have the gender option, right? You decide to be male or female* (Participant 07). *Gender is how the person sees himself, how he sees and recognizes himself, is the social role* (Participant 05).

In their speeches, the nurses put gender as an option, always within the masculine/feminine duality. Only one of the participants points to the perspective of gender as an identity and social construction.

Perception about the National Policy for Comprehensive Health LGBT

It was identified a lack of knowledge of the existence of this policy by the study participants. Those who know only know of its existence, but do not see its applicability in practice, only in theory: *I have no knowledge about the policy* (Participant 01). *Despite the demand of this population for health services, we don't have policies aimed exclusively at this public. Although I have already served this population* (Participant 04). *The policy is beautiful there on paper, nothing ever came of it* (Participant 07).

In addition, a fact that called attention concerns the invisibility and the application of the LGBT Policy in the municipality and region of insertion of the research subjects. According to one report, the policy is more effective in other regions of the country, where there are groups that claim for rights, not only in health, but also in various aspects of human life, as perceived in the following report: *There is the policy for more than five years, from what I saw, in the policy, it deals with issues of violence, of STIs [Sexually Transmitted Infections], but this policy did not reach the municipality, it was never implemented here, and it is much more present and effective in the South and Southeast regions, because they are more developed parts of the country* (Participant 05).

The demand for nursing care and services for the LGBTQIA+ public

From the analysis of the speeches of the study participants, it was evident a low demand for health services by the population in question, as well as a lack of active search by professionals for these users to help. When they appear in the health services, the professionals, in their speeches, showed that these subjects go to very specific and punctual activities related to sexually transmitted infections, to medical appointments, and to the renewal of prescriptions, as evidenced in the following speeches: *They rarely seek the health service* (Participant 03). *Sporadically! Unless they already have some kind of pathology. Right? Then they seek more* (Participant 05). *What I know is that, for correlation to basic attention, we are little sought after, they only look for us regarding the rapid test, right?* (Participant 01). *There is no demand, when they look for us, it is when they really look for us, you know? Some pathology already well advanced, right?* (Participant 02). *They come and say: I want to do the rapid test! Because they only come when they are in a situation of distress. Like, they had an unprotected sexual intercourse, the condom broke, they only come in those moments* (Participant 07). *The little they look for is to get a condom (Participant 04). Only in the issue of rapid tests, if they have chronic diseases, they are part of specific groups...* (Participant 08).

Furthermore, it is worth mentioning the lack of knowledge about the health needs and the specificities in relation to the epidemiological profile of this public, as well as the unpreparedness of health professionals regarding the assistance to these users, if there is a demand for services. This concern was made explicit in the speeches of the participants: *They come for basic medical consultations, they attend for that, a curiosity is... a person appeared here that he was homosexual and wanted to do hormonal feminization, then he came to me. I answered, look, I have no data for this, nor much less can I do it, now we have a gynecologist, who is a doctor at the Family Health Program, I think the most suitable person than I am to tell you, but it didn't help much, no, because the doctor also said that it was not his area, that he didn't work with this, and asked to look for a specialist who worked with this, that is, he wasn't served because the professional had no experience whatsoever, he had never read anything about this, but it was also only this case that appeared here* (Participant 05). *Presently that you are actively searching, it is as if he was different from the rest, and they are not different! So, they must search, and it is their right, right? This business of active search is very archaic, as if they were something different that the unit had to take them there. They are the same* (Participant 02). *In the basic health care booklets, there is nothing about this. It is difficult. As the demand doesn't disturb me, doesn't look for me, I don't look for them either* (Participant 1).

In addition, the statements of the study participants referred to nursing care based on the biomedical care model, with specific clinical actions aimed at solving the individual complaints of the LGBTQIA+ population, besides the delivery of condoms, rapid tests and directions to medical appointments, which sporadically carry out services related to health promotion

and disease prevention, such as, for example, cytology and participation in specific groups for chronic diseases, for example, hypertension and diabetes mellitus: *No, none. They don't look for it. I don't know where they are, but they don't look!* (Participant 01). *Once a guy came to do a rapid test, the test was positive, I referred him to the specialized assistance service, and then, as he is from my area, he always comes for some kind of service, then, only after the test was positive, he declared that he was homosexual* (Participant 03). *I have, yes, when doing rapid tests, I have also done cervical cytopathological prevention exams, when the person, presently, has already reported his or her option, and we, who are professionals, cannot show any surprise or difference, we attend like any other person* (Participant 07).

Discussion

Regarding the gender category, the results show a lack of knowledge of conceptions of gender and identities that go beyond the binary man-woman, male-female, heterosexuality-homosexuality, anchored in the historical naturalization of cisgender experience, expressing subtle violence in their speeches, when they ignore health needs, strengthening inequities in health and increasing barriers to access health services. Another important finding is the predominance of the conception of sexual orientation or gender identity as a user's choice, as if the user chose to experience pain, inequities, and hostility to compose a group historically harassed in this society and, especially, in health services.

The inclusion of the category gender and health in health training is necessary regarding the discussion oriented to demystify knowledge and the imposition of prejudiced behaviors anchored in moral value judgments, recognizing the various expressions of identity: transvestitility, trans masculinities and trans femininities, non-binary manifestations and the diversity of bodies and orientation of desire[7].

A study showed a lack of knowledge, for nurses, about the differentiation between sexual orientation and gender identity. Although most of the interviewees in the research considered sexual orientation and gender identity as determinants and conditioning factors in the health situation of the LGBTQIA+ public, some participants still disregarded these aspects[15].

The Brazilian society is marked by gender binarism, in which one is recognized as male or female, that is, people who diverge from this cis-heteronormative standard are understood as abject beings[16]. For health professionals, there is no escape from these concepts and reflections, in fact, there is the unpreparedness and difficulty of health professionals to work with sexual and gender diversity - one of the problems pointed out in the scientific production in the health field. The problematic interaction between health professionals and members of the LGBTQIA+ community is related to the way individuals use health care spaces, often limited and with access barriers[17].

Thus, it should be emphasized that changes in this context require transformations in beliefs and values that cut across social relations and place subjects and populations whose vulnerabilities are associated with gender and sexuality in a place of exclusion and misunderstanding[18].

From this perspective, gender has a biological character, in other words, it is determined by parental chromosomes and genital organs at birth. Thus, it is understood that several behaviors are expected from what the family and/or society considers to be more appropriate to a person's biological sex, since conception/birth. Gender is a category used to understand how historically occurred the social construction about what it is to be a man and a woman in each society/culture and the roles they play[9].

Thus, gender is opposed to Gender Identity, which refers to the way one feels and presents oneself as male, female, genderless, or a mix of both, to oneself and to society, which is independent of biological sex and sexual orientation. The identity is self-determined, being in conformity with the sex at birth (cis) or not (trans), while sexual orientation is the manifestation of affective/sexual desire and may be for people of the same sex (gays, lesbians), different (heterosexual), both sexes (bisexual) or none (asexual)[1,9].

It is necessary to grasp the definition of these concepts to approach this population, avoid prejudices and be able to meet the demands so that they are consistent with their needs. In the process of nursing education, this apprehension needs to be effective, to take place while still undergraduate, and to be inserted, as a conceptual basis, in the curricular models of teaching and in the National Curriculum Guidelines that govern health education in Brazil, on a mandatory basis.

Although the LGBTQIA+ policy has existed for more than 11 years, these findings echo the results of other studies that evidenced the lack of knowledge of the policy by professionals and, consequently, its non-materialization in health services[19]. It is also noteworthy the transfer of responsibility to management and to the users themselves, to build knowledge about the LGBT health policy.

The demand for local health management is evident, since its effectiveness should occur universally, since the health reality of the LGBTQIA+ population is not limited to the more developed regions, as the results show. On the contrary, in interiorized contexts, the inequities are more evident and likely to cause damage to health and risk of death, motivated by the preservation of so-called conservative customs in these realities[20].

Indeed, it is necessary to understand the LGBTQIA+ community in all its complexity and plurality, respecting the autonomy and diversity of each population segment that makes up the acronym. It is noteworthy that the pluralism of acronyms tries to encompass groups of individuals that, despite being moved by similar discourses and agendas, delimit their differences and specificities, which are little or not understood by society. Therefore, it is indispensable to reflect on LGBTQIA+ subjectivities[21].

Nevertheless, this study still reveals the lack of knowledge about the health needs of this group, as well as the distance between professionals and the LGBTQIA+ population, characterized by the statement that these users rarely seek Primary Health Care services, as well as the service, via professionals, does not seek this public.

Despite these statements, the identification of health needs should not be listed only by the spontaneous demand that seeks health services. Therefore, it is essential to record data, use indicators, and build epidemiological profiles of this population, identifying their specific social demands in the territory of insertion, where they are socially produced and reproduced, and where they experience the inequities of minority groups[22].

The lack of theoretical preparation and discussions in the training of health professionals endorsed the evidence about the unpreparedness of health professionals to welcome and care for the LGBTQIA+ population, especially the transgender population. The literature also problematizes the training process of these professionals, pointing out that the discussion about gender and sexuality is still incipient or optional in health courses[4,7].

By stating that this user is like any other, the professional denies the specificities of care and assistance to trans men, who may need gynecological, prenatal, and family planning monitoring, for example, as trans women and transvestites may need prostate cancer monitoring, thinking about sexual/reproductive health[23]. In addition to the guarantee of sexual and reproductive rights, it is pointed out the respect for the right to intimacy and individuality and the implementation of care protocols against violence, considering gender identity and sexual orientation in the health services themselves[11,20].

It is also considered the issues related to cultural barriers to access, such as prejudice and hostile relations with these users, who seek health services and encounter approaches and care practices based on reproductive health, heterosexual, cisgender, binary and biologicist, emphasized by the interviewed professionals. At this point, we highlight the few care actions performed, reduced to the performance of ra-

pid tests for qualitative detection of human immunodeficiency virus (HIV) antibodies and the delivery of condoms[24-25].

This highlights the lack of knowledge of the territory by PHC professionals, since none of the speeches pointed to any approach, bond, or identification of the health needs of the LGBTQIA+ population. These statements are worrisome, since, without the necessary knowledge to deal with the demands of this population group, nurses, in their daily work, contribute to the marginalization of this population and its invisibility in health services.

Other studies are similar, when they affirm the existence of health practices that are fragmented, insufficient, and based on judgments originating from the professionals themselves, which hinders the resoluteness and applicability of care. These studies also evidence that the (pre)conceptions of professionals are barriers to the embracement of LGBTQIA+ people, for they feel uncomfortable when asked about their sexuality and conclude that health services are unable to welcome and solve their specificities[3,26].

Besides, by not knowing the health needs of this public, nurses weaken the possibility of bonds and the potential of solving primary health care problems, despite having two important instruments to intervene in this reality: the nursing consultation and the construction of groups for health education, either in the physical space of the health service, or in the social instruments of the territory, such as churches, associations, and schools.

This situation allows us to think about the problems existing in the formation of professionals during their undergraduate studies, the ideal moment to acquire the ethical, political, and scientific competences adequate to the health realities of the LGBTQIA+ population. Added to this is the absence, in the Permanent Education in Primary Health Care, of any movement or initiative to face this reality to minimize the health inequities of these users[27].

Certainly, there is a need for changes in the training processes of health professionals, especially nurses, to build skills and abilities and make them able to address issues related to gender and sexual orientation, contributing with strategies to combat discrimination, prejudice, and institutional stigma[28-29].

Nurses should develop their duties and functions in the perspective of a quality health care process that includes all subjects, which implies care focused on empathy and humanization. Nurses have always been present in care, from primary care to high complexity, hence being the main responsible for providing care and maintaining quality of life, practices that are primordial to their work process[30].

Finally, training in health and the continuity of the educational process in the exercise of the profession should be primordial to the instrumentalization of qualified professionals to care for the health of subjects and their specificities. It is certain, then, that it is increasingly necessary to hold discussions about cross-cutting issues to improve care, namely: gender, sexuality and LGBTQIA+ population. Therefore, it is up to universities to bring the discussion of gender to the center of their curricula as a possibility to train critical and reflective nurses, who understand the category gender as important and structuring of the social order, in the constitution of diverse and complex subjects.

Study limitations

The limitations relate to the method, since the interview technique, carried out in a single meeting, often does not allow us to go deeper into the questions and because it is applied in the service, it can rush the answers and lead them to be superficial. Therefore, it is necessary that new interviews be conducted and repeated, and that the transcribed material be returned to the participants so that they can provide feedback on their statements and results.

Contributions to practice

This study contributes to reflections about the thinking/doing of nursing for vulnerable populations, who need an equitable, integral, and humanized look. Furthermore, by pointing out the need to strengthen discussions of gender in health training and continuing education, the research contributes to the expansion of knowledge about gender, the access of the LGBTQIA+ population to services and the strengthening of the actions of the national health policy for this population group.

In summary, it is suggested that professionals deepen the discussion of gender and health practices to LGBTQIA+ people, through meetings propitiated by continuing education and by strengthening the teaching-service relationship with Universities, which, through extension projects and changes in their curricula, can provide changes in professional practice regarding gender and LGBT health policy.

Conclusion

The study showed a deficient and little explored knowledge about gender and health of the LGBTQIA+ population, as well as a lack of knowledge and interest in the health needs and specificities of this public. There is a lack of preparation of professionals to assist these users, which causes barriers to access to care and services, due to the lack of knowledge about the existence of the national policy of integral health of the LGBTQIA+ population and for focusing on punctual and biologicist actions.

Authors' contribution

Conception and design, data analysis and interpretation, article writing, critical and relevant revision of the intellectual content: Paiva EF, Freitas RJM.
Writing of the article, critical relevant revision of the intellectual content: Bessa MM, Araújo JL.
Final approval of the version to be published: Paiva EF, Freitas RJM, Bessa MM, Araújo JL, Fernandes SF, Góis PS.
Agreement to be responsible that all aspects of the manuscript related to the accuracy or completeness of any part of the manuscript are properly investigated and resolved: Paiva EF, Freitas RJM, Bessa MM, Araújo JL, Fernandes SF, Góis PS.

References

1. Ministério da Saúde (BR). Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais – LGBT [Internet]. 2013 [cited Jan 10, 2023]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_lesbicas_gays.pdf
2. Oliveira DC. Representativeness of the LGBTQIA+ population in epidemiological research in the context of the National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals in Brazil: expanding the production of knowledge within the SUS for social justice. Epidemiol Serv Saúde. 2022;31(1):e2022020. doi:https://doi.org/10.1590/S1679-49742022000100030
3. Melo LS, Bonelli MA, Ayres JRCM, Silva GWS, Borges FA, Wernet M. Nurses and health care for gay adolescents. Rev Latino-Am Enfermagem. 2022;30(spe):e3792. doi: https://dx.doi.org/10.1590/1518-8345.6293
4. Rosa DF, Carvalho MVF, Pereira NR, Rocha NT, Neves VR, Rosa AS. Nursing care for the transgender population: genders from the perspective of professional practice. Rev Bras Enferm. 2019;72(suppl 1):299-306. doi: https://doi.org/10.1590/0034-7167-2017-0644
5. Costa-Val A, Manganelli MS, Moraes VMF, Cano-Prais HA, Ribeiro GM. The care of the LGBT population from the perspective of Primary Health Care professional. Physis. 2022;32(2):e320207. doi:https://doi.org/10.1590/S0103-73312022320207
6. World Health Organization (WHO). CD52/18: addressing the causes of disparities in health service access and utilization for lesbian, gay, bisexual and trans (LGBT) persons [Internet].

2013 [cited Jan 10, 2023]. Available from: https://iris.paho.org/handle/10665.2/4411

7. Lima ACS, Alves MJH, Pereira EV, Pereira AP, Albuquerque GA, Belém JM. Gender and sexuality in the training of nurses in brazilian public higher education: a documentary study. Rev Enferm Centro-O Min. 2021;11:e3877. doi: http://doi.org/10.19175/recom.v11i0.3877

8. Almeida LE, Oliveira JM, Oliveira V, Mialhe FL. Scientific production on LGBTQIA+ health: a critical analysis of the literature. Saúde Soc. 2022;31(4):e210836. doi: https://dx.doi.org/10.1590/S0104-12902022210836pt

9. Miskolci R. Teoria Queer: um aprendizado pelas diferenças. Belo Horizonte: Autêntica; 2017.

10. Parente JS, Moreira FTLS, Albuquerque GA. Physical violence against lesbian, gay, bisexual, transvestite and transgender individuals from Brazil. Rev Salud Pública. 2018;20(4):445-52. doi: https://doi.org/10.15446/rsap.V20n4.62942

11. Bezerra MVR, Magno L, Prado NMB, Santos AM. Historical conditions for emergence of the National Policy for Comprehensive LGBT Health in the social space of health in the State of Bahia, Brazil. Cad Saúde Pública. 2021;37(8):e00221420. doi: https://doi.org/10.1590/0102-311X00221420

12. Flick U. Qualidade na pesquisa qualitativa. Porto Alegre: Bookman Artmed; 2011.

13. Oliveira ALA, Souza BJ. Public health policies for rural men in the Northeastern semi-arid region. Est Soc Agric. 2020;28(3):644-75. doi: https://doi.org/10.36920/esa-v28n3-7

14. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.

15. Gonçalves JR, Lutosa GR. Analysis of nurses knowledge related to assistance to the LGBT population. Rev JRG Estud Acad [Internet]. 2019 [cited Jan 10, 2023];2(5):226-39. Available from: http://revistajrg.com/index.php/jrg/article/view/314/398

16. Melo IR, Amorim TH, Garcia RB, Polejack L, Seidl EMF. LGBT population's right to health: contemporary challenges in the context of Brazilian national health service (SUS). Rev Psicol Saúde. 2020;12(3):63-78. doi: https://dx.doi.org/10.20435/pssa.vi.1047

17. Nogueira FJS, Aragão TAP. Brazilian policy of LGBT integral health: what actually happens from the point of view of agents and health professionals. Saúde Pesqu. 2019;12(3):463-70. doi: https://doi.org/10.17765/2176-9206.2019v12n3p463-470

18. Silva JF, Costa GMC. Health care of sexual and gender minorities: an integrative literature review. Rev Bras Enferm. 2020;73(Suppl 6):e20190192. doi: https://doi.org/10.1590/0034-7167-2019-0192

19. Guimarães NP, Sotero RL, Cola, JP, Antonio S, Galavote HS. Avaliação da implementação da Política Nacional de Saúde Integral à população LGBT em um município da região Sudeste do Brasil. Rev Eletron Comun Inf Inov Saúde. 2020;14(2):372-85. doi: https://doi.org/10.29397/reciis.v14i2.1712

20. Ferreira BO, Bonan C. Where are LGBTT populations in the Family Health Strategy? narratives of health professionals in Teresina, Piauí, Brazil. Ciênc Saúde Coletiva. 2021;26(5):1669-78. doi: https://doi.org/10.1590/1413-81232021265.04752021

21. Abade EAF, Chaves SCL, Silva GCO. Saúde da população LGBT: uma análise dos agentes, dos objetos de interesse e das disputas de um espaço de produção científica emergente. Physis Rev Saúde Coletiva. 2020;30(4):e300418. doi: https://doi.org/10.1590/S0103-73312020300418

22. Bezerra MVR, Moreno CA, Prado NMBL, Santos AM. LGBT health policy and its invisibility in public health publications. Saúde Debate. 2020;43(spe8):305-23. doi: http://doi.org/10.1590/0103-11042019S822

23. Rocon PC, Wandekoken KD, Barros MEB de, Duarte MJO, Sodré F. Acesso à saúde pela população trans no Brasil: nas entrelinhas da revisão integrativa. Trab Educ Saúde. 2020;18(1):e0023469. doi: https://doi.org/10.1590/1981-7746-sol00234

24. Cavalcante DR, Ribeiro SG, Pinheiro AKB, Soares PRAL, Aquino PS, Chaves AFL. Sexual practices of women who have sex with women and condom use. Rev Rene. 2022;23:e71297. doi: https://doi.org/10.15253/2175-6783.20222371297

25. Abreu PD, Araújo EC, Vasconcelos EMR, Moura JWS, Sousa JC, Santos CB. Transexual "womanhood" and the emergence of transfeminism: rhetorics of HIV/aids in the light of the queer theory. Texto Contexto Enferm. 2019;28:e20180294. doi: http://dx.doi.org/10.1590/1980-265X-TCE-2018-0294

26. Santos LES, Fontes WS, Oliveira AKS, Lima LHO, Silva ARV, Machado ALG. Access to the Unified Health System in the perspective of male homosexuals. Rev Bras Enferm. 2020;73(2):e20180688. doi: http://dx.doi.org/10.1590/0034-7167-2018-0688

27. Ferreira BO, Nascimento O. Construction of LGBT health policies in Brazil: a historical perspective and contemporary challenges. Ciênc Saúde Coletiva. 2022;27(10):3825-34. doi: https://dx.doi.org/10.1590/1413-812320222710.06422022

28. Lopes LP, Carvalho MGF, Araújo LMB. Gender diversity and health access: perceptions of the students of nursing and medicine of Centro Universitário Patos de Minas. Braz J Hea Rev. 2019;2(4):3286-302. doi: http://doi.org/10.34119/bjhrv2n4-092

29. Oliveira GS, Nogueira JA, Costa GPO, Silva FV, Almeida AS. Access by lesbians, gays, bisexuals and transvestites/transsexuals to the Basic Family Health Units. Rev Rene. 2018;19:e3295. doi: https://doi.org/10.15253/2175-6783.2018193295

30. Santos JS, Silva RN, Ferreira MA. Health of the LGBTI+ population in primary health care and the insertion of nursing. Esc Anna Nery. 2019;23(4):e20190162. doi: https://dx.doi.org/10.1590/2177-9465-EAN-2019-0162