The LGBT population's access to Primary Health Care services in a city in the inner state of Bahia, Brazil

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Abstract: Even with the creation of public policies aimed at improving the LGBT population's access to health services, inclusive strategies for this population remain very weak. This study analyzes the LGBT population's access to Basic Health Units in the city of Senhor do Bonfim, Bahia, Brazil, based on the dimensions of access theorized by Giovanella and Fleury and further developed by Assis and Almeida. This exploratory qualitative study used snowball sampling as its sample selection technique, in which participants indicate other participants. Semi-structured interviews were carried out and a thematic content analysis was organized into four analytical dimensions: in light of the symbolic dimension, in light of the technical dimension, in light of the political dimension, and in light of the economic dimension. The results showed weaknesses in the reception of the LGBT population in primary health care services. The LGBT people who took part pointed to experiences with professionals who are unqualified to meet their needs and desires, as well as the daily experience of prejudice, discrimination, stigma, and disrespect. Socially instituted social standards have a negative influence on the inclusion of LGBT people in health services.

➤ **Keywords:** Access to Health Services. Sexual and Gender Minorities. Primary Health Care.

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Introduction

The gay, lesbian, bisexual, transgender, and transvestite (LGBT) population around the world has historically fought for their guaranteed rights. Along the way, they face barriers in the family context, at school, at work, and in health services (Crenitte *et al.*, 2023; Melo *et al.*, 2022; Paiva *et al.*, 2023a). Discriminatory processes act on identities that deviate from the biologicist and binary norm, in other words, centered on reproduction and, in general, everything that deviates from the norm is violated and excluded (Paranhos; Willerding; Lapolli, 2021).

In Brazil, the struggles of the LGBT movement began to gain momentum in the mid-70s. The Homosexual Affirmation Group – Somos, in its Portuguese acronym, organized in São Paulo, is considered the forerunner in the struggle for homosexual rights. With the expansion of the debate on homosexuality, treating it as a political issue, the debate on dissident sexualities unfolded and strengthened other groups, which led to the formation of the LGBT movement. The movement proposes changes in values in Brazilian society, including those that include different groups, not just homosexuals (Morando, 2022).

In the 1980s, with the HIV/AIDS epidemic, mobilization groups were essential in driving forward movements in search of visibility and rights for the LGBT population. Based on the struggles of these movements, it was only on December 1, 2011, that the Brazilian Ministry of Health presented the National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals and Transsexuals (PNSI-LGBT, in its Portuguese acronym), established by Ordinance No. 2836. The document aims to "*Promote the integral health of lesbians, gays, bisexuals, transvestites and transsexuals, eliminating discrimination and institutional prejudice, as well as contributing to the reduction of inequalities and the consolidation of the SUS as a universal, integral and equitable system*" (Brasil, 2013, p. 18). It is important to note that even though the legal document exists, access to health services by the LGBT population is permeated by constraints, exclusion, helplessness, negligence, omission, and indifference (Crenitte *et al.*, 2023; Melo *et al.*, 2022; Paiva *et al.*, 2023a).

Studies show that LGBT people do not use public services, primarily because they do not feel welcome and, as a result, their needs are not met. The service is inaccessible and incapable of resolving their demands, which leads them to seek dignity through private institutions or other means of meeting their needs. The

Family Health Strategy (ESF, in its Portuguese acronym), which should be the gateway to the healthcare network, does not offer a caring and sensitive healthcare environment for this public, often exposing them to embarrassment. Professionals often do not provide a welcoming environment, contributing to the continuation of programmatic vulnerability within health services (Belém *et al.*, 2018; Melo *et al.*, 2022; Paiva *et al.*, 2023b).

Regarding the debate on the Brazilian population's access to health services, Assis and Almeida (2014) analyzed the weaknesses in access, clarifying what are among the main problems to be considered by Brazil's Unified Health System (SUS, in its Portuguese acronym). They state that even in the face of the harsh reality of access to health services and the compulsory nature of health needs, which incites the logic of induced demands, it is necessary to sensitize the population, break down social conformism and ensure universal and equitable access to guarantee that the real needs of the population are met. In terms of access for LGBT people, the challenge points to the intersection of different nuances of violence, which propagate stigma and tend to consolidate the chain of exclusions.

Considering these problems, this study aims to analyze the access of the LGBT population to Primary Health Care (PHC) in the municipality of Senhor do Bonfim, Bahia, Brazil.

Methodology

This is an exploratory qualitative study, carried out in the city of Senhor do Bonfim - BA, Brazil, located in the northern region of the state, 375 km from the state capital Salvador. The data was collected between December 2021 and March 2022. The study participants were 10 LGBT people registered with the municipal PHC services. The data collection technique used was snowball sampling, a non-probabilistic sampling tactic in which participants indicate other participants, who are part of specific groups and, given the context of vulnerability, are often difficult to approach (Dewes, 2013).

The inclusion criteria were LGBT people who were over 18 years old and lived in the area where the research was carried out, as well as being covered by a Family Health Unit. The exclusion criteria were refusal to sign the informed consent form (ICF) and the participants' unavailability for virtual interviews. The study began

with invitations to the LGBT population of Universidade do Estado da Bahia, campus VII. Those interested in participating voluntarily allowed us to start collecting the data.

A semi-structured script was used for the interviews, which were conducted using Microsoft Teams, phone, and Skype calls and recorded with the permission of the interviewees. The reason for conducting the interviews virtually was due to the Covid-19 pandemic. The definition of the number of participants for the interviews was based on the criterion of theoretical and empirical saturation of the data collected (Minayo, 2010).

The data produced was analyzed using Thematic Content Analysis (Bardin, 2015), systematized using the proposal by Oliveira (2008) based on the following steps: after transcribing the interviews in full, a floating reading was made of the texts produced with the creation of provisional hypotheses about the object studied (Oliveira, 2008). Next, recording units were identified by theme, which enabled a thematic analysis of the text to be carried out, defining the dimensions of LGBT access to PHC services according to theoretical dimensions: symbolic, technical, political, and economic.

The theoretical approach used to analyze the access of the population studied to PHC services was based on Giovanella and Fleury (1995). The authors pointed out the need for a comprehensive view of accessibility to health services that considers the economic dimension, which refers to the relationship between supply and demand; the technical dimension, which refers to the organization and planning of the service network; the political dimension, which considers the development of popular organization and health awareness; and the symbolic dimension, which addresses social representations about health care and the health system (Giovanella; Franco; Almeida, 2020).

Data production began after authorization from the municipality and approval by the Research Ethics Committee of the State University of Bahia (UNEB) (Decision nº 4,840,544). Confidentiality of the information shared was ensured and the signing of the ICF was requested. To identify the people interviewed, while respecting their anonymity, their real names were replaced in their testimonies by the term Participant followed by a number to identify them from 1 to 10, e.g., Participant 10.

Results and Discussion

Characterization

Table 1 shows the profile of the LGBT people taking part in the study, in Senhor do Bonfim, Bahia, Brazil.

Table 1. Sociodemographic profile of LGBT people interviewed, Senhor do Bonfim-BA, Brazil, 2021-2022

Variables	n	LGBT Population (n=10) %
Age (years old)		
18 to 24	4	40
25 to 29	4	40
30 to 36	2	20
Biological sex		
Female	3	30
Male	7	70
Education		
High school incomplete	1	10
Higher education complete	1	10
Higher education incomplete	5	50
High school complete	2	20
Postgraduate	1	10
Sexual Orientation		
Homosexual	8	80
Bisexual	1	10
Pansexual	1	10
Gender identity		
Cisgender	9	90
Nonbinary	1	10

continue...

Variables	n	LGBT Population (n=10) %
Has private health insurance		
No	10	100
Yes	-	-
Employed		
No	5	50
Yes	5	50
Registration unit		
ESF Centro I	4	40
ESF São Jorge	2	20
ESF Monte Alegre	1	10
ESF Mamedio Pereira de Souza	2	20
PSF Alto da Maravilha II	1	10

ESF: Health Family Strategy (*Estratégia de Saúde da Família*); PSF: Health Family Program (*Programa de Saúde da Família*).
Source: The authors.

The data shows that the age of the participants ranged from 18 to 36 years. The male biological sex stood out among the people interviewed, represented by a total of 70% of the participants. Regarding education, 50% of the participants had incomplete higher education, and about sexual orientation, 80% declared themselves to be homosexuals, i.e., people who are physically or emotionally attracted to people of the same gender, 10% bisexuals, i.e., people who are physically or emotionally attracted to people of either the male or female gender, and 10% pansexuals, who are attracted to people regardless of gender. As for gender identity, 90% of the people interviewed declared themselves to be cisgender, i.e., people whose gender identity corresponds to the sex they were assigned at birth, and 10% non-binary, i.e., people who do not fit into the social roles defined as female or male.

All the people who took part in the study declared they did not have private health insurance. Regarding employment, 50% reported having some kind of employment. As for registration with the municipality's PHC service, 40% of those

interviewed reported being linked to the ESF Centro I, located in the central part of the municipality, while the rest were distributed in other neighborhoods.

The dimensions of access and the experience of LGBT people in Primary Health Care services in the municipality of Senhor do Bonfim - BA, Brazil

Based on the assumption that PHC encompasses a set of actions aimed at preventing diseases and illnesses, which aims to be the first gateway for users to health services and, consequently, must ensure universal, equitable, comprehensive, and equal access, it essentially presupposes the discontinuation of any type of exclusion based on race/color, age, health status, sex, gender identity, and sexual orientation, among other characteristics (Brasil, 2017).

It is important to clarify that the supply of services, as well as their quality, is affected by different forces. Funding, for example, has been shown to have a direct impact on the practices implemented and the organization of services. This is confirmed by the implementation, in 2019, of the government program *Previne Brasil* (Brasil, 2022). It deals with the new PHC financing model, which is at odds with what is set out in the PHC proposal and seems to have a restrictive objective, limiting universality, increasing distortions in financing, it seems to reverse the reduction in health inequalities and also induces the targeting of PHC actions (Harzheim, 2020). This is confirmed by the fact that its central proposal encourages the development of work centered on the logic of indicators, which establish action strategies focused only on prenatal care, women's health, children's health, and chronic conditions, excluding other populations that need health services.

Based on the understanding that there are several dimensions to access, as already mentioned, the data in this study will be presented according to the dimensions of access adopted by Giovanella and Fleury (1995), further developed by Assis and Almeida (2014), i.e., symbolic, technical, political, and economic dimensions.

LGBT access to Primary Health Care services: an analysis in the light of the symbolic dimension

The symbolic dimension highlighted here includes perceptions related to different social representations and how the system is organized to meet the specific needs of each user. Through experiences and interactions, people build up knowledge

that allows them to have a symbolic dimension of objects, which are expressed or manifested in events, ideas, people, notions, and feelings (Jesus; Assis, 2010).

Regarding this issue, the vast majority of people interviewed pointed out that their autonomy during consultations was not ensured or was weak. They show that the LGBT population's access to this service is often surrounded by prejudices and that there is no concern by professionals about issues related to gender and sexuality. These aspects are revealed in the following statement:

> [...] Most of the time when LGBT people seek care, there is already a certain prejudice from the medical staff, from the people who are there [...], people already prejudge, look if there is a transvestite at the health center, they already start looking, they think it is some kind of disease and send them to the CTA (testing and counseling center), in short, people end up thinking that LGBT people [...] only seek health care under these conditions. (Participant 07)

The fragility of reception services can undoubtedly be associated with different factors, but it is important to clarify that the vulnerability of LGBT people is further intensified by this problem. Prejudice, discrimination, and stigmatization become a barrier to access, which contribute negatively to not seeking health services (Ferreira; Pedrosa; Nascimento, 2018).

Socially imposed standards have a negative influence on the inclusion of LGBT people, as well as on the creation of bonds and acceptance. This is confirmed by the accounts of the experiences of the study participants in the services.

> [...] It is up to the training of professionals [...], because it is uncomfortable to arrive at a place and just because you are wearing clothes that are not usual for some people, like some trans people, gays, lesbians, everyone has their own style and everyone is free to use it and to be stared at or to realize that someone is whispering about them is embarrassing, I have seen stares, but they have been very discreet, so I think it would be very nice if professionals could treat people better, give them better care, because often people do not want to be seen with a certain style of gender and then you know, you have to do it in a way that makes everyone feel comfortable. (Participant 09)

Gender expression, which refers to the way a person expresses their gender identity and involves aspects such as clothing, behavior, verbal and even bodily expression, is a problem faced by the LGBT population. The report above expresses the feeling of repression and judgment of people who deviate from cis-heteronormative standards (Oliveira, 2020). Moreover, the statements also point to the marked confusion between gender identity and sexual orientation in health services and other factors that contribute to the invisibility and distancing of this public from health services.

Despite the contexts mentioned above, the people interviewed also point to possible paths and understanding of the specificities of their existence, as in the following testimonies, which even provides aspects of an awareness of the existing intersectional aspects.

> [...] The professionals at the basic health unit confuse, for example, equality with equity [...] I am black and, because I am black, do I have to get the same service as a white person? Because for the health worker, the doctor and even often the nurse, we are all people, we are all equal, regardless, and we know that is not the case. There are specific characteristics of the black race and characteristics of the white race that we need to align depending on the type of care we provide. (Participant 01)

When discussing the health of LGBT people, it is necessary to emphasize the need for more dialogue on the subject. The PNSI (National Policy for the Comprehensive Health) includes objectives, guidelines, and responsibilities for the spheres of government, including the Operational Plan, which serves as a guiding principle for implementing the policy, welcoming and caring for LGBT people, among other actions necessary for inclusion and ensuring more equitable access, with a view to ensuring care based on the demands and specificities that encompass this population (Gouvêa; Souza, 2021).

The reports of the research participants reinforce the need for awareness-raising and professional training in order to provide comprehensive and equitable care that considers the specificities of LGBT people.

LGBT access to Primary Health Care services: an analysis in the light of the technical dimension

This dimension refers to the planning and organization of services, which contribute to enabling the population to access health services. The basic and guiding documents of the Brazilian health system have as their fundamental principles the regionalization and hierarchization of the health services network, to establish universality, equity, and comprehensiveness (Jesus; Assis, 2010).

Regarding this dimension, the participants pointed to contexts which are common to the entire population that uses health services and are therefore not directly associated with aspects related to gender or sexuality. They pointed to difficulties in accessing health services at night and at weekends. They also say that the service is only available by appointment.

> [...] not at weekends and at night, only during the day. At weekends and at night we usually have to go to the UPA (emergency unit). (Participant 04)
>
> Appointments must be scheduled, you schedule them today to be seen next week, if you are unwell you have to go to the UPA (emergency unit) [...]. (Participant 05)

Some Brazilian cities are adopting the method of extended opening hours for PHC services, which are now open 24 h a day, such as Boa Vista and Mogi das Cruzes, in Recife. In these places, a new care standard has been implemented in some ESFs (Family Health Strategy) since 2014. These units have extended hours for consultations, 7 am to 7 pm and 24 h for minor emergencies, as well as an observation room (Pessoa; Gouveia; Correia, 2017). Along these lines, in 2020, the Health on Time Program was instituted by the Ministry of Health and is also another strategy that proposes expanding access to PHC actions and services through extended hours (Brasil, 2019; Giovanella; Franco; Almeida, 2020).

What justifies extending opening hours is the fact that PHC seems to be the population's preferred access route and the fact that after 5 pm there is a high demand for emergency services for non-urgent conditions, which ends up contributing to overcrowding.

It is worth recognizing, as pointed out by Pessoa, Gouveia and Correia (2017) and Giovanella *et al.* (2020), that although this model shows a greater tendency to guarantee attendance by a health professional, it can favor discontinuity of treatment, as it tends to turn the ESF into an emergency room (Pessoa; Gouveia; Correia, 2017). Moreover, the extended hours are most often carried out by on-call doctors, who, due to their training, tend to have a different approach than family health doctors, which can compromise PHC attributes such as longitudinality and healthcare coordination.

Regarding the resolvability and quality of health services, some of the people interviewed mentioned that their concerns were not addressed during consultations and that they were very superficial and mechanical: they treated the pain but did not investigate its cause. These statements are evident in the following accounts:

> [...] I would like them to treat us better, we spend a lot of time there waiting to be seen and when we are seen, we are not seen well, as I said, they barely look us in the face, they give us a medication and that is it. (Participant 08)
>
> [...] We do not have autonomy in the consultation, autonomy over what we are feeling, like saying we have a headache and automatically being prescribed dipyrone. [...] I am not generalizing, but most consultations are very automatic, that is the word. (Participant 01)

Qualified listening and the patient's involvement in their own care help to create a bond with the health team. PHC is users' first port of call to health services, but as we can see from the above, several barriers hinder this access. These range from opening hours, the teams' work process, especially those who work by appointment and do not leave a percentage for spontaneous demand, to health professionals who are unprepared or overworked and do not provide an adequate service to the population. All of this is undoubtedly reflected in the lack of a bond and the poor reception of service users. Isolated proposals, such as extending opening hours, without creating bonds with the emergency network, or without valuing the individual, tend to focus on acute care and disease management, with observation of serious cases awaiting transfer.

LGBT access to Primary Health Care services: an analysis in the light of the political dimension

The political dimension is related to public health policies, the historical shape of the healthcare model and community participation. This dimension is concerned with the development and strengthening of health awareness and popular organization (Jesus; Assis, 2012). In this regard, it is important to recognize that society's effective participation in the actions of the state in the development of projects to be implemented in the Unified Health System (SUS) can help build more equitable, comprehensive, and universal access to health services. This is because it will be based on the desires and needs pointed out by society.

Regarding the reality delimitated by the people who took part in the survey, the majority reported that they had no knowledge, for example, of the meetings of the municipality's Municipal Health Council and that they were unaware of any assistance or education activities aimed at the LGBT population.

> No, I have never taken part. I have never heard of it [Municipal Health Council]. (Participant 03)

> I never took part, I did not even know it existed and if it did, it was not well publicized. (Participant 09)

Other participants mentioned they were aware of the existence of the Municipal Health Council, but claimed they did not take part due to a lack of information about the time and place of meetings, as well as because they understood that it

was an activity restricted to employees of the Municipal Health Department, who, according to these interviewees, were not open to popular participation.

> As well as being exclusive to people who work in the health department, I will tell you straight away that no, I have never taken part [...] it is also exclusive to people linked to the government, the current municipal management. (Participant 01)

> [...] I have a knowledge base of how it works and how it should be, but this health council I do not have that knowledge, but I know it exists, I know it is operational because there are meetings, the scheduling of meetings [...] it is a point to discuss defined topics, it is there to provide the social outline and actually ensure that public policies exist, it has to ensure transparency, so it has to seek out society, for example, on such and such a day there is going to be a meeting and invite everyone to take part and be aware of the approvals, publish them in the Official Gazette, put them on official websites, in short, all the decisions are to be made public, but in a way, this does not happen. (Participant 07)

Regarding the above, it is worth pointing out that Law nº 8 142/90 regulates social participation through the creation of Health Councils and Health Conferences. It deals with the composition of the Health Council, which must be made up of government representatives, service providers, health professionals, and users (Brasil, 1990). However, as we can see from the declarations, the Municipal Health Council of the municipality of Senhor do Bonfim, in Bahia, does not seem to be complying with the provisions of this law, after all, the people interviewed are not aware of the meetings and understand that they are restricted to people linked to management.

The active participation of the community in the development of the local Unified Health System (SUS) helps to build politicized, critical, militant and non-alienated subjects. Social participation contributes to monitoring the projects implemented and their operation in accordance with the demands presented by society.

Regarding the effects of the implementation of projects and policies aimed at the LGBT population to date, the participants reported that there had not been many changes and that these policies were not being complied; they said that managers did not give them the necessary consideration.

> No, for me it does not work, it is not right, the policies are not enforced, the actions taken on behalf of the LGBT population are not being upheld, they are not done effectively, everything is too much concealed, it is very dangerous to talk about [...] they believe that the CTA (testing and reception center) is the place of shelter for the LGBT population. (Participant 01)

> [...] no, because of the government's lack of commitment, right? I mean, the government and the individual administrations are really focusing on this community, you know? So much so that, when we see Blue November, and all these celebration months, Yellow

> September, and everything else, we see a certain mobilization aimed at meeting these demands, of men, women, in short, psychological issues, but then we do not see anything focused or directed in any month at the LGBTQIA+[1] community, so I believe that the policy is there, it was made, but it is not implemented to the letter, you know, it has not been fulfilled. (Participant 02)

> [...] I think what is really missing is the knowledge issue, in fact, projects are approved, laws are approved and maybe these projects and laws do not end up going where they should, right, [...] in order for us to be able to do this social council, we need to know what is going on. (Participant 07)

The statements highlighted above reiterate the fragility that surrounds the social participation agenda and, as a result, the stigma that pervades the LGBT population. Participant 07's comments, for example, reaffirm the importance of community participation in the Municipal Health Councils. After all, it is during these meetings that the population will learn about the projects and laws that have been implemented and what the government is planning to do for that community. The knowledge of the population and the health team about the PNSI-LGBT (National Policy for the Comprehensive Health for the LGBT population), for example, which is the guiding principle for the assistance of this population, after all, aims to provide access to comprehensive health carefree from discrimination and institutional prejudice, as well as reducing inequalities and consolidating the Unified Health System - SUS (Brasil, 2013).

Despite the weaknesses described so far, one participant reports the existence of a potentially positive initiative in the municipality:

> [...] at the Secretariat of Social Assistance, there is a group that is being started [...] I think in the district of Igara, they are holding meetings, right, with young LGBT people from the community, from the district and they are discussing public policies and seeing what these people's wishes are and I think this group is growing, it is getting stronger and it was an initiative, I think, of the people from CRAS (Social Assistance Reference Center) itself to attend to this public, to bring knowledge, to bring discussions, to try to meet their wishes, to know what their realities are and where this reality permeates, but other inclusive actions and even education I don't see happening. (Participant 07)

Discussing the political dimension makes it possible to build politicized, critical, militant, and active subjects within the community and municipal management. Social awareness and the creation of autonomy are essential links for building a Unified Health System - SUS based on the principles of universality, equity, and comprehensiveness. The population needs to be more active, to be included in

management demands and, consequently, to demand actions from managers aimed at improving the strategies implemented to date, as well as opening the way for the implementation of laws and projects that are still inoperative in the municipality. One cannot fail to consider that the LGBT population, in an intersectional way, lives with a series of issues such as patriarchal logic, socially imposed binary social roles, homo/trans/lesbophobia, health-related stigmas and others that are difficult to deal with and, consequently, can contribute to a standstill in the demand for basic rights such as those mentioned above. The dimensions addressed here, involving vulnerable groups such as women, blacks and LGBT people, need to be engaged with by society as a whole, and not just those directly affected. Political party groups have an obligation to ensure safety and health for all people.

LGBT access to Primary Health Care services: an analysis in the light of the economic dimension

The economic dimension highlighted here is based on the principle of equity and rationalization between supply and demand, aiming at maintaining a balance between what is offered in health services and the demand. In this way, it aims to offer access to health with availability, accessibility, functional, and financial adequacy (Jesus; Assis, 2010).

It is indisputable that the SUS faces challenges in ensuring quality access. The underfunding of the health system, for example, is one of the biggest challenges. Following the approval of Constitutional Amendment 95 (EC 95/2016), which froze spending on health and education for 20 years, its situation has worsened, culminating in a widening discrepancy between the provisions of the law and the actual provision of services, which reflects on the prerogative of the population's right to equal, comprehensive, and egalitarian access to health. Besides EC 95, there is the new funding model for primary care through the creation of the "*Previne Brasil"* program, as already mentioned, which increases the invisibility of minorities in particular. Moreover, it is worth recognizing that the Cartesian logic, which values the strong fragmentation of health initiatives and the medical-centered logic, tends to strongly demarcate the subjective construction of the access concept for people who use health services.

Regarding the economic dimension, the participants pointed out that the demand from local SUS users is greater than what is actually offered. The agenda of

services offered on a daily basis in PHC services is insufficient and in order to have access to the services, they need to arrive at the units very early in the morning, since the criterion for appointments is the order of arrival, and vacancies are limited. This is confirmed by the need to stand in queues at dawn to make these appointments, as we can perceive from the following statement:

> [...] here is how it works, you go on a Friday morning, and they tell you do not have to go at 5 am, the passwords are only released at 6 am, but if you get there at 6 or 7 am, you can no longer get passwords [...] you have to arrive early, you have to commit to almost dawn at the door of the health center so you can get a vacancy. (Participant 01)

Besides the shortage of doctors in PHC services, participants also reported a shortage of medical specialties to meet their needs. Participants often mentioned having to wait months for an appointment with a specialist. It is important to clarify that one of the municipality's health units, to which most of the people interviewed were affiliated, not only functions as an ESF, but also as a medical specialty center, in the same physical structure, which confuses the population about the basic proposal for PHC and contributes to reinforcing the logic of strong specialization. This can be seen in the following statements:

> [...] it takes so long. There is someone in my family who is been trying to get an appointment with an ophthalmologist for a few months now and has not been able to, so much so that they have to stand in queues at dawn to try and get an appointment. (Participant 03)

> Usually, when I need something, I have to look elsewhere (privately), when there is not what I need at the clinic here, it takes a while, it is not easy to get an appointment, you know? (Participant 04)

> The appointment center also needs to be changed, they do not publicize when there is an appointment, it is the clinic that releases it and they announce it half an hour before and then, when you get there, the appointments are over, there are no more vacancies, there are no vacancies for everyone, so these are my reservations, the number of professionals needs to be increased. (Participant 10)

From people's testimonies, we can infer that PHC, which should be the gateway for users to SUS health services, does not seem to be working effectively, either because of users' poor understanding of the initial proposal for PHC services or because of the lack of resources to ensure provision. All of this hinders the ideal approach to managing the process of health and disease, in the promotion and prevention of illnesses and certainly reflects on the overload of secondary and tertiary health services.

Confirming the aspects described in this study on the difficulty of access to medical specialty services, Silva et al. (2017) pointed out that the insufficient supply of medical specialties makes it very difficult for managers to guarantee the population's access to these types of assistance. (Silva *et al.*, 2017). Furthermore, given this access problem, users' health needs or their demands for health services are not met. We return to the understanding that this idea of health demands focused on the specialization of medical actions is often reaffirmed and does not reflect the real needs of the population.

As already mentioned, there are many reasons why people stay away from health services. Regarding the reasons specific to LGBT people, the following statement highlights the need for respect, not just in health units, but in all social spheres, and the impact that prejudice has on their daily lives:

> [...] no one has anything to do with another's sexuality, many people think that the person is like that because they want to be, like I was born and chose to suffer prejudice, to be mistreated [...] until we look at ourselves and say that we do not want to listen to so--and-so, we suffer, until the day we stand up and say no, what they say to me now is of no use to me, so it takes a while, but imagine, you know yourself like that, you call yourself that, you will not listen to that anymore and it does not suit you, it takes a while, right? So, that is why I say that respect is one of the things that has to come first, not just in health, but everywhere, really everywhere. (Participant 10).

There are many responsibilities. In one plan, it is up to managers to articulate ways of increasing the population's accessibility to health services and to create demand management strategies. Strengthening social participation, for example, could enable the creation of possible pathways. In their study, Camargo and Castanheira (2020) discussed a strategy created by professionals at a Basic Health Unit in São Bernardo do Campo, São Paulo, Brazil, called Welcoming Team (AE, in its Portuguese acronym), which aims to welcome users and listen to their demands. If the patient comes to the unit and does not have a scheduled appointment, they will be referred to AE, if it is outside opening hours, the user will be referred to general welcoming. (Camargo; Castanheira, 2020). In this reception methodology, professionals organize their appointment schedules, with the aim of increasing the supply of appointments for the day through the AE.

The exercise of social participation removes the population from the position of passivity in this relationship. By fully participating in the Municipal Health Councils, which must be open and disclosed to society, it is possible to dialogue,

understand and inquire about their desires and needs regarding health services, with the aim of improving access to the services offered, giving meaning to the principles of equality, freedom, diversity, and solidarity (Brasil, 2013). Local management has the duty to present a health plan every four years, which should contain the actions and objectives that must be achieved during this period. In this plan, it is important to encourage social participation in the discussion and drafting of this plan. After all, it is a time when the needs, specificities, and desires of the public health policies that will be drawn up can be listed, and more than just participating, the population must be aware of their rights.

Prejudice, discrimination, and stigma are the main barriers to accessing healthcare faced by the LGBT population on a daily basis, culminating in these people being turned away from health services and/or when they do seek them out. As a result, they omit information about their sexual orientation for fear of not being welcomed and attended to within the services. In addition, barriers predispose these people to mental illness, drug abuse and/or disordered medication use, putting their lives at risk. Given all the above, there is still a need for greater awareness among a large part of the population about the demands involving the LGBT population.

Concluding remarks

Access to health services is an obstacle for the Brazilian population. In relation to the access of the LGBT population to Primary Health Care services in the municipality of Senhor do Bonfim, Bahia, Brazil, the analytical dimensions adopted show that access is permeated by prejudice, discrimination, stigma, and a marked weakness in the approach of professionals to issues related to gender and sexuality. This contributes to the population turning away from health services.

In the symbolic dimension, it is quite clear how social standards, especially heteronormative and cisnormative ones, interfere in the assistance provided and, consequently, in LGBT people's access to services. In the technical dimension, the people interviewed reported difficulties regarding the opening hours of the services, which also influences the degree of access to the service to which the person is linked, as well as pointing out the action of the stigma associated with LGBT people and how this is reflected in the access to services. In the political dimension, the nuances related to popular participation stand out, from the perception that there is

no government incentive, to the difficulty of engagement and even the recognition of the lack of proactivity by the population itself. The economic dimension, in turn, strongly demarcates problems relating to supply and demand and how they interfere with LGBT people's access to services.

Based on the dimensions adopted in the analysis, the feeling of exclusion, a lack of a welcoming atmosphere, a sense of disrespect, omission and indifference on the part of healthcare professionals is quite clear.

Besides the above-mentioned factors, which are also related to the fragile access of the LGBT population to the SUS, there is the precariousness of actions related to the continuing education of professionals, which consequently contributes to a lack of respect for the principles and guidelines of the health system. It also diverges from the objectives and premises of other programs and policies, such as "Brazil without homophobia" and "PNSI-LGBT", which interferes with the enforcement of rights in several Brazilian municipalities.

From the situation researched, it is also clear that even though there are specific public policies aimed at ensuring access free from any form of prejudice and stigma, this is not effectively safeguarded. The social logic that exists in our society also interferes with the professional practices implemented[2].

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Notes

[1] It became an acronym for lesbian, gay, bisexual, transgender, and queer, with a "+" sign to recognize the unlimited sexual orientations and gender identities used by members of this community.

[2] J. F. dos Santos and S. S. da Silva: conception and design of the research, obtaining, analyzing, and interpreting the data and writing the manuscript. E. A. Santos and A. A. da Silva: critical revision of the manuscript regarding its intellectual content.

Abstract

Acesso da população LGBT aos serviços de Atenção Primária à Saúde em uma cidade do interior baiano

Mesmo com a criação de políticas públicas voltadas para melhoria do acesso da população LGBT aos serviços de saúde, persiste muita fragilidade nas estratégias inclusivas para esta população. O estudo analisa o acesso da população LGBT às Unidades Básicas de Saúde do município de Senhor do Bonfim, Bahia, a partir de dimensões de acesso teorizadas por Giovanella e Fleury e aprofundados por Assis e Almeida. Trata-se de um estudo de abordagem qualitativa exploratória que utilizou como técnica de seleção da amostra a *snowball sampling*, na qual os participantes indicam outros participantes. Foram realizadas entrevistas semiestruturadas e uma análise de conteúdo temática organizada em quatro dimensões analíticas: à luz da dimensão simbólica, à luz da dimensão técnica, à luz da dimensão política e à luz da dimensão econômica. Os resultados apontaram fragilidades no acolhimento da população LGBT nos serviços de atenção básica à saúde. As pessoas LGBT participantes apontam experiências com profissionais desqualificados para atender suas necessidades e seus anseios, além do convívio cotidiano com preconceito, discriminação, estigma e desrespeito. Os padrões sociais instituídos socialmente influenciam negativamente na inclusão das pessoas LGBT nos serviços.

➤ **Palavras-chave:** Acesso aos serviços de saúde. Minorias sexuais e de gênero. Atenção Primária à Saúde.