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# The nursing perspective in the context of health care for the LGBTQIA+ population

## *O olhar da enfermagem no contexto do atendimento à saúde da população LGBTQIA+*

Daiana Mateus da Silva[1], Diádiney Helena de Almeida[2]

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**ABSTRACT** When seeking health care, the LGBTQIA+ population is constantly exposed to vulnerabilities evidenced by prejudiced practices resulting from assistance that reproduces discrimination. Considering the importance of the debate on sexual and gender diversity, and in opposition to care based on presumed cis-heteronormativity, which is discriminatory and disconnected from the needs of the people who use the service, this work was based on concerns arising from the field of nursing. How does the nurse perceive the body under her care? How do they relate to this individual in the context of the nursing process? Are nurses prepared to assist the LGBTQIA+ population? What best practices can be adopted? Are they aware of the risks of ineffective care for LGBTQIA+ people? This qualitative study was carried out using a semi-structured questionnaire applied to 17 nurses working at the Hospital Maternidade Theresa Sacchi de Moura/Hospital da Mulher, in Barra Mansa, countryside of Rio de Janeiro, in the municipality of Barra Mansa, in the interior of Rio de Janeiro. In the process of scientific research, the technique of discourse analysis was adopted based on the statements compiled, which pointed to a lack of preparation in relation to the specificities of the LGBTQIA+ community, resulting in the reproduction of violence and, consequently, becoming a barrier to access to health services.

**KEYWORDS** Gender identity. Cisgender persons. Gender norms. Sexual vulnerability. Nursing care.

**RESUMO** *A população LGBTQIA+, ao buscar assistência à saúde, é constantemente exposta a vulnerabilidades evidenciadas por práticas preconceituosas decorrentes de atendimentos que reproduzem discriminação. Considerando a importância do debate relativo à diversidade sexual e de gênero, e em contraposição ao atendimento baseado em uma cis-heteronormatividade presumida, discriminatória e desconectada das necessidades das pessoas usuárias, este trabalho partiu de inquietações advindas do campo de atuação da enfermagem. Como a enfermeira percebe o corpo sob seus cuidados? Como se relaciona com esse indivíduo no contexto do processo de enfermagem? A enfermeira está preparada para assistir à população LGBTQIA+? Quais as melhores práticas que podem ser adotadas? Essa profissional tem conhecimento sobre os riscos de uma assistência ineficaz para as pessoas LGBTQIA+? Este estudo qualitativo foi desenvolvido mediante questionário semiestruturado aplicado a 17 enfermeiras atuantes no Hospital Maternidade Theresa Sacchi de Moura/Hospital da Mulher, no município de Barra Mansa, interior do Rio de Janeiro. No processo de pesquisa científica, foi adotada a técnica de análise de discurso a partir das falas compiladas que apontaram despreparo em relação às especificidades da comunidade LGBTQIA+, resultando na reprodução de violências e, consequentemente, tornando-se uma barreira ao acesso dos serviços de saúde.*

**PALAVRAS-CHAVE** *Identidade de gênero. Pessoas cisgênero. Normas de gênero. Vulnerabilidade sexual. Cuidados de enfermagem.*

[1] Secretaria Municipal de Saúde, Hospital Maternidade Theresa Sacchi de Moura – Barra Mansa ( RJ), Brasil.
*daianamateus@hotmail.com*

[2] Universidade Estadual de Santa Cruz (Uesc) – Ilhéus (BA), Brasil.

## Introduction

The population of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals, Transgenders, Queers, Intersexuals, Asexuals and others (LGBTQIA+) encompasses multiple manifestations of sexuality, gender, and sexual orientation whose expectations and attitudes are shaped by social, economic, religious, and cultural factors[1,2]. These realities are permeated by the phases of discovery, challenges of the transsexualizing processes, fear, difficulties in finding work, coexisting with LGBTphobia, and other demands imposed in a context of social vulnerability. The search to ensure rights, to overcome stigmatized representations, to fight discrimination and violence and other forms of erasure of this reality is urgent. This group has specific health needs requiring a multi-professional approach along with global care such as the adoption of healthy habits, prevention, early detection of diseases, treatment and rehabilitation in a respectful and welcoming ways[3].

The National Health Survey reports that, in Brazil, 2.9 million people aged 18 or over declared themselves to be lesbian, gay or bisexual, and 1.8 million of these declared themselves to be homosexual. Also in this study, 1.1 million identified themselves as bisexual, and 1.7 million didn't know how to answer. It is also important to note that 3.6 million refused to answer and that 100,000 said they identified with other orientations. Among women, 0.9% said they were lesbian and 0.8% said they were bisexual. Among men, 1.4% said they were gay and 0.5% said they were bisexual. Among the two groups, 1.1% said they didn't know how to answer, and 2.3% refused to answer[3].

Considering this data and highlighting the existing omissions, this research shows the need for specialized training in LGBTQIA+ health for nursing professionals in order to rethink the assistance and care provided to this population. In this context, nursing plays a strategic role in adherence to services and in health promotion, as it acts from the first to the last stages in the health care service processes.

It is necessary to develop skills aimed at LGBTQIA+ care, considering ethical, qualified care that respects different sexualities and gender identities, providing welcoming and safe environments and fighting the obstacles that end up keeping this population away from health services. It is essential that nursing professionals understand and identify the pre-established and discriminatory conceptions that historically have created barriers to provide care to the LGBTQIA+ population[4].

These prejudices are reinforced by deficits in basic training, in which it is possible to note the unpreparedness of teachers and the absence of subjects that address sexual and gender diversity. In this way, understanding the need for specific processes and demands during assistance to women who are victims of violence, the demand for health guidance for sexual diversity, welcoming assistance to transvestites and transgender people, knowing their rights and guaranteeing the use of their social name are just some of the urgent needs regarding the role played by nursing professionals and which should be considered as part of their training.

The National Policy for the Integral Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (PNSI-LGBT)[5] concentrates guidelines for actions to promote, prevent, recover and rehabilitate health, encourage the production of knowledge, and strengthen popular participation. By confronting the binary idea of sexual orientation and gender, its main objective is to promote better understanding and ethics which, ultimately, will have an impact on the social determinants of health, reducing inequalities and ratifying the principles of universality, integrality and equity of the Unified Health System (SUS)[6,7].

Reports from coworkers about caring for LGBTQIA+ patients are constantly permeated by insecurity, surprise, embarrassment, and challenges due to a lack of guidance and training, which leads to a lack of knowledge about the best practice to adopt. Proud affirmation

and emphasis on the importance of nursing's role in assistance and care are common in this environment[8]. Discussing the best approach is part of these professionals' daily lives, but dealing with the LGBTQIA+ population remains a taboo. This work, in turn, reaffirms the need to raise the debate, to bring it out of invisibility in order to guarantee the health rights of this specific population, ensuring achievements already consolidated in the PNSI-LGBT.

Based on this study interest, the main questions that mobilized this research emerged: in the hospital context, how do nurses perceive the body under their care? How do they relate to the LGBTQIA+ population in the context of the nursing process? Are nurses prepared to assist the LGBTQIA+ population? What best practices can be adopted? Are they aware of the risks of ineffective care for these citizens?

Given these concerns, this work aimed to identify nursing knowledge about health care for the LGBTQIA+ population who use the health services offered in this field of study. Most nursing professionals have little or no knowledge about this population, consequently resulting in ineptitude and rights violations. In the presence of any sign of disrespect towards gender identity, there will immediately be an impediment to establishing a bond between the user and the nursing professional, which in the caregiving process, solidifies into marginalization[9].

## Material and methods

This is a qualitative study looking at the views of 17 nurses at the Hospital Maternidade Theresa Sacchi de Moura/Hospital da Mulher (HM), in the municipality of Barra Mansa, in the state of Rio de Janeiro, on sexual diversity and health care for the LGBTQIA+ population. Semi-structured interviews were conducted with nurses working in the Reception with Risk Classification (A&CR) units, the Internal Regulation Center (NIR), the Outpatient Clinic (AMB), the Joint Lodging (AC) and Obstetric Treatment, and the Obstetric Center (CO) of this institution.

The equivalent of 68% of the active workforce was interviewed, excluding 8 professionals, both men and women, who were unavailable and who refused to take part in the study. The sample consisted of 7 (41%) nurses from the CO, 4 (23.5%) from the AC, 4 (23.6%) from the A&CR, 1 (5.9%) from the AMB and 1 (5.9%) from the NIR.

As for the sociodemographic characteristics of the sample, the age range was 24 to 64, with an average age of 44. They were all heterosexual women, 35.4% of whom had been working in the unit for less than a year; 23.6%, for between 1 and 5 years; 5.9%, for between 6 and 10 years; 17.7%, for between 11 and 15 years; 17.7%, for between 16 and 20 years, making up a nursing team in which the youngest had been trained for 4 months and the oldest had been trained for 38 years.

In terms of professional experience in other units, 76.4% worked or had worked in other units, while 23.6% had not had this experience. Among these professionals, 94.1% had a postgraduate degree and 5.9% had a specialization degree in the following areas: obstetrics and gynecology nursing, the Family Health Strategy, hospital management, occupational nursing, administration and auditing, medical-surgical nursing, surgical center nursing and central material and sterilization, urgent and emergency nursing, women's health, preceptorship in the SUS, hospital infection control, intensive care unit, etc.

Discourse analysis was the method used to access the meaning of both the said and the unsaid in the narratives of the interviews within the context of nursing professional experience. This was the chosen approach for interpreting the statements as a discourse that informs about a system of common and socially accepted values, which are determined by a specific social and historical context, as well as by the relationships established throughout life[10].

The study was submitted to the Research Ethics Committee of the National School of Public Health Sergio Arouca (CEP/ENSP), following the norms and resolutions of ethics, with a view to greater beneficence for the research participants than maleficence, so that the research took place with the permission and authorization of the aforementioned CEP, receiving approval CAAE 54879722.6.0000.5240 as well as the consent of the research institution.

## Results and discussions

The interviews allowed us to understand the nurses' professional careers and the meanings attributed to their care practices. In view of the research objectives, it was necessary to understand the dimensions of access and quality of services and compare them with the actions recommended by the PNSI-LGBT.

Among those interviewed, 21.2% answered that the role of the MH is limited to obstetric care. From this perspective, every LGBTQIA+ person is welcomed and cared for as a person in the pregnancy-puerperal period, showing an invisibility that prevents the development of good action strategies in favor of the universality, equity and integrality advocated by the SUS.

Standardizing and homogenizing bodies implies practices that, by not recognizing the complexity of health care in contexts of diversity, violate the rights of people who differ from socially established standards, favoring the erasure of these users and compromising the guarantee of adequate care. On the other hand, there were nurses who admitted being unprepared for the demands of LGBTQIA+ health care and who showed individual efforts towards a more welcoming attitude, marked by empathy and attentive listening, but which proved to be fragile and lacked the necessary support from current public health policies.

However, the nurses proved to be aware of the existence of LGBTQIA+ people when asked about the hospital's area of coverage, but it was clear that this access is still very low. Only one nurse reported not being able to answer this question. The others reported that they attended to a lesser extent to women with affective ties to other women who had demands relating to high-risk prenatal care, childbirth and puerperium care and some of the demands of the transsexualizing process. In online searches, the hospital also appears as a reference for HIV post-exposure prophylaxis care and, occasionally, for men who suffer violence.

Even after the approval of the PNSI-LGBT, there are many obstacles, such as the omission of rights, social stigma, invisibility, prejudice, intimidation, unethical practices, and the lack of preparation on the part of health professionals to attend to the specific needs of this population. As a result, many people omit their sexual orientation or gender identity due to fear of rejection and facing obstacles in their care.

The PNSI-LGBT sought to find out about the population's health situation, lifestyles, access to and use of health services, according to region of residence, sex, race, and color, revealing a small portrait of people who declare themselves LGBTQIA+, but we must pay attention to the lack of responses. This silence tells us the reasons why people continue to prefer not to answer questions that have been prepared to recognize their identities and indicates a refusal to accept them that is reinforced by discrimination. In this sense, we highlight the need to include lesbian in the health agenda, for example, with regard to gynecological care, where professionals assume that women's active sex lives are always heterosexual. This issue will be discussed further on.

Valuing the existence of diversity deconstructs a world divided into male and female which is daily reinforced in health institutions across the country. This invisibility is based on silence, discrimination and the violation of rights and can only be tackled with the

recognition of health policies and the production of specific academic knowledge aimed at this population, with the guarantee of rights that is consolidated in qualified listening and adequate care by all health professionals, and not just nurses.

From a different point of view, 69.2% of the women interviewed considered that the role of the MH is to offer 'humanized care', which responds to health demands in a comprehensive, welcoming manner, free of judgments, without exposure to embarrassment, guaranteeing the right to assistance to those who need it, providing a fertile space for freedom of expression of their sexuality and gender identity in accordance with the SUS principles. The PNSI-LGBT aims to expand and guarantee access to health services, respecting the SUS's commitment to its principles and recognizing the complexity and specificity of health care for this population[5,11]. From a different point of view, 69.2% of the women interviewed considered that the role of the MH is to offer 'humanized care', which responds to health demands in a comprehensive, welcoming manner, free of judgments, without exposure to embarrassment, guaranteeing the right to assistance to those who need it, providing a fertile space for freedom of expression of their sexuality and gender identity in accordance with the SUS principles. The PNSI-LGBT aims to expand and guarantee access to health services, respecting the SUS's commitment to its principles and recognizing the complexity and specificity of health care for this population[5,11]. This requires political training and ethical attitudes that are democratic and work for justice and to ensure rights on the part of managers and health professionals, to respect and recognize the importance of sexual health and sexual rights in all their diversity, overcoming simplistic conceptions of humanized healthcare. This requires a cross-cutting policy that aims to collectively build strategies uniting theory and practice[12].

As mentioned earlier, the reference to low access for the LGBTQIA+ population is reflected in the nurses' statements. According to 4.8% of the interviewees, care for this population is not common in the surveyed unit. This reinforces the perspective presented here of increased vulnerability in terms of guaranteeing basic human rights, such as health, reproductive, and sexual rights. On the other hand, 4.8% of the professionals answered that they act based on their experience to meet the needs emerged in the unit. Considering an environment in which the specificities of health care for the LGBTQIA+ population are constantly silenced; these professionals generally rely on individualized attitudes to associate technical-scientific knowledge with their own practice of assistance and care. Thus, it is urgent and indispensable to broaden the political and ethical debate on sexuality, diversity, and the safeguards for this segment's right to health.

In this process, it is necessary to understand how this group accesses the services offered at this unit, and how well this service is provided.10 In general, it was found that the LGBTQIA+ population takes a long time to access the service or doesn't access it as they should. Out of the nurses interviewed, 5.8% believed that access is associated with a physical or geographical space that favors privacy and freedom to express their demands, thus facilitating their entry into the health service. On the other hand, 82.6% of them related the way this service is provided as being guided by qualified, welcoming, effective, and discrimination-free listening.

Studies show the prevalence of precarious access to healthcare for the Black population due to the prevailing structural racism in Brazilian society, as well as the weight of socio-economic inequalities. It is important to highlight the analysis considering the lack of access to healthcare for smokers who, due to stigma, end up marginalized and imbued with a sense of not belonging to the healthcare services increasing difficulties in access and adherence to healthcare services[13].

When talking about the Brazilian population's health, great traces of inequity are still observed despite the current legislation directly impacting socially vulnerable groups and resulting in regrettable consequences in the morbidity and mortality profile when compared to others. As an example, the National Policy for Women's Health Care[10] mentions lesbian and bisexual women in just one topic of the text, without any allusion to the concrete operationalization of actions related to their health[14,15].

As for their relationship with the unit, pregnant women give birth there, and those people who have undergone the transsexualization process, whenever they need some assistance or guidance, they contact the unit again and continue to use the service. The discourse shows that professionals don't feel prepared for technical issues, as they have difficulties with concepts. Among other actions, the Charter of the Rights of Health Users[16] proposes humanized healthcare, with the use of social names as a way of welcoming this population. Although there is a theoretical guarantee that the social name will be used in the institution researched, it was found that the medical records are not adjusted. According to the legislation in force, it is essential to defend and guarantee the rights advocated for fair and democratic care and to combat discrimination, be it racial, generational or religious, including sexual orientation and gender identity as priorities[17].

In the context of the speeches, it is observed that there is a view on access that understands it as a work practice in which the individual organizes themselves within a physical or geographic space that favors privacy and freedom to present their demands and thus favor their entry into the health service. The PNSI-LGBT refers to access as being related to the availability of assistance, social development as health indicators and, finally, qualified treatment. Other interviewees believe that access refers to the way in which this care takes place, through qualified and welcoming listening, in order to provide universal, equal and orderly care in SUS health actions and services[14].

The speeches implicitly deny prejudice and reaffirm access to the unit. The constitutional directive in the Organic Health Law[14] is structured around the three principles of the SUS, these being: universality, which establishes access for all to actions and services; comprehensiveness, which implies the obligation to offer quality health care, ranging from protection and prevention to all levels of complex care; and equity, which seeks to reduce inequalities in health. The question remains as to what the limits are between knowledge of the laws and rights aimed at this population and the actual omission and negligence.

LGBTQIA+ people who access the system face an additional challenge: guaranteeing their rights and the quality of healthcare actions. The PNSI-LGBT establishes guidelines and objectives to ensure that this group is better served in the public health network, but the policy still lacks greater dissemination and adequate training for its implementation.

The quality of health services is related to the sum of conditions necessary to meet the demands put forward, mobilizing resources to deal with health problems in a way to maximize the well-being of users, after taking into account the balance between gains and losses at all stages of the process. Quality must be a constant search for health practices based on evidence, humanized assistance, and the responsibility of professionals and managers in order to respect the SUS guidelines[17,18].

The quality of care received by the population depends on the particular characteristics of the healthcare system, the infrastructure, the profile of the professional team, and the organization of the services. However, the historical context in which the population and health services are inserted shapes health quality by expressing the intentionality of health policies and professional practices. Good quality services can change structural inequalities in healthcare through more equitable responses during the provision of

care. With comprehensive actions of good quality, services can effectively contribute to overcoming historical disadvantages in the health indicators of vulnerable regions and populations in the country[18-20].

Therefore, promoting equity for this public means recognizing their specific vulnerabilities, identifying the political and operational initiatives that protect the human and social rights of this group and outlining strategies for their implementation. There is a consensus on the need to tackle homophobia and LGBTphobia in the SUS, and on the need to protect the right to free sexual orientation and gender identity as a fundamental and structuring strategy for guaranteeing access to services and quality of healthcare[21-23]. In order to put an end to the invisibility of this debate, a new social, educational and cultural order would have to be adopted that is not fixed by a biological or cultural determination.

Periodic cytopathological examinations continue to be the most widely adopted strategy for cervical cancer screening. Achieving high coverage of the population defined as the target is the most important component in primary care in order to achieve a significant reduction in incidence and mortality from this disease. The natural history of cervical cancer usually involves a long period of precursor lesions, which are asymptomatic and can be cured in almost all cases when properly treated. Countries with more than 50% coverage of cytopathological exams carried out every 3 to 5 years have rates of less than 3 deaths per 100,000 women per year; and for those with more than 70% coverage, this rate is equal to or less than 2 deaths per 100,000 women per year[24,25].

Lesbian and bisexual women should have a Pap smear to prevent cervical cancer, following the same guidelines as women in heterosexual relationships. The first Pap smear should be taken from the age of 25. If the test is negative, it can be taken every 3 years. The prevalence of infection by the HPV virus, which is directly related to the incidence of cervical cancer, is relatively lower in women who identify as lesbians if they have not had penile sexual intercourse throughout their lives. However, they are not free from the possibility of having the oncogenic type of virus (which can develop into cervical cancer), so it is necessary to follow screening as well. A welcoming environment in which women feel comfortable sharing their sexual habits is important, so that the team of health professionals can seek comprehensive guidance and approaches during the healthcare process. Not knowing how to provide specific care for these women reveals conduct and guidelines that are not in line with scientific evidence[10,15,24].

In the context of birth, the Declaration of Live Birth (DNV) is an instrument that has been standardized by the Ministry of Health since 1990 and is mandatory throughout the national territory. It becomes a provisional identity document that guarantees access to public services until the birth certificate is issued and it helps to plan actions for improvement[20,26].

In 2017, the National Council of Justice ordered changes to the layout of the DNV and the Live Birth Information System (SINASC), so that the certificates issued include parentage, regardless of gender identity, such as in cases of assisted reproduction, transgender couples, same-sex unions, and other similar situations. Therefore, the terms 'father' and 'mother' should not be used, only the name(s) of the parent(s) should appear in the 'Legal Guardian' field, as well as not referring to the complements 'maternal' and 'paternal' with regard to ascendants, precisely to include LGBTQIA+ families. Thus, all the professionals responsible for filling it out must be trained on the changes, and the registry offices must make the record based on these changes, and failure to comply with the law is characterized as institutional LGBTphobia[2,27,28].

The interviewed nurses reported not having any guidance and claimed to be unaware of

the guidelines mentioned above when filling out the DNVs. These are structural problems that require constant qualified training so that rights are guaranteed and professional practices are transformed. Not knowing and, consequently, neglecting this right affects the quality of life of this population and produces violence rather than assistance and care.

It has therefore become a challenge to tackle this issue and broaden its discussion in classrooms and workplaces through continuing education, as well as expanding scientific dissemination in order to tackle violence that is reified on a daily basis. In this context, recognizing deficiencies in care and seeking to mitigate them is a task that requires effort and dedication – and one that needs to be seen as a political and ethical stance. On the other hand, according to the nurses' reports in this study, this request is not perceived and is therefore seen as unnecessary.

For the field of nursing, caring in the reception process is always emphazised[29]. Being able to listen to others is as important as understanding them, as such an ability is essential for satisfactory attendance. In the same way that the ability to listen to others implies a propensity to silence[30].

From there, a relationship of dialogue and trust is established in nursing, always related to the users, but also involving good communication with the entire multidisciplinary healthcare team. Therefore, it is about reaffirming humanized care as a policy that can guide healthcare in the direction of respecting and ensuring health rights[30]. This establishes a dialogic and trusting relationship with nursing, always related to users, but which also involves good communication with the entire multidisciplinary health team. This means reaffirming humanized care as a policy that can guide healthcare to ensure respect and guarantee the rights to health.

The invisibility of various groups of the LGBTQIA+ population must be taken into account. In this context, according to the reports gathered in the interviews, this population arrives at the unit, seeking medical care; some professionals have more or less contact with them, and some haven't even been through this experience. This can be observed among nurses who have been working for less time at the researched unit.

Waiting rooms are seen as strategic places to democratize information, learning and exchange experiences, but this space is still little used[31]. Qualified listening, dialogue, attitude and reorganization of the health service result in successful care in the sense of listening, identifying demands, establishing a bond and achieving adherence to care. This dimension also affects relations between teams, and it is essential to create democratic spaces for dialog and collective proposals. Listening is a crucial tool for promoting care as an integral action, establishing fair and ethical bonds, producing welcoming relationships, and respect for diversity and uniqueness in the encounter between those who provide care and those who receive it[30].

Training nursing professionals through continuous health education is fundamental to improving health service quality to guarantee that the population's needs are met[31]. From this point of view, and considering daily work experiences, continuing education can help formulate strategies to solve problems identified in this study, adopting more effective measures to eliminate institutional discrimination with routines and protocols that comply with current legislation.

Knowledge of the specific needs of the LGBTQIA+ population was one of the main elements identified to improve nursing practice in health care[2]. While it is up to this group of professionals to guarantee integral care for human beings in all their life cycles, with a perspective of respect for diversity, it is also their political, ethical and legal responsibility to develop constant debates and reflections in favour of minorities so as to personalize care, contemplating diversity, and broadening the scope of care in the provision of health services to society as a whole[31].

## Final considerations

Based on the interviews, we can see that the nurses at Barra Mansa's MH partially recognize the LGBTQIA+ population as a public subject to their care. They use subjective terms, such as empathy and respect, but are unaware of the public policies aimed at this population, as well as the particularities related to health care for these groups. Indifference to the issue of LGBTQIA+ healthcare was also observed in the speeches of some professionals. In addition, there was an overlap of personal values and a lack of critical knowledge considering the prejudice and rates of violence with which this population is associated.

The interviewed group recognizes the importance of continuing education, and is involved in specializations, but none of which address the issue of gender and sexuality. Considering the institution's responsibility to promote training, no initiative was taken. By ignoring this reality, nursing professionals conduct their practices based on common sense and, therefore, on conceptions based on cis-heteronormativity, reproducing discrimination and negligence. In general, nurses admit that they don't feel prepared to work in LGBTQIA+ healthcare. However, they did not demonstrate an understanding that this situation generates violence, deepening the marginalization, psychological suffering, and exclusion of this population.

This research, based on the experience of a group of nurses from the MH in Barra Mansa, contributed to reflecting on the training needs surrounding nursing care for the LGBTQIA+ population, pointing to urgencies within the health services. During the interviews, it was possible to realize that, for some professionals, these realities were never even considered as demands of their work. In other words, the health service didn't make any requests of them, reinforcing structural prejudices. Finally, it is necessary to emphasize the critical debate around the concept of 'humanization' of care, which has always referred to nursing care. It is a question of mobilizing nursing professionals to redefine, in their practices, the demands posed by the diversity of life and, therefore, the importance of considering existing representations of gender and sexuality.

## Collaborators

Silva DM (0000-0002-5981-424X)* and Almeida DH (0000-0002-7151-0564)* equally contributed to the preparation of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

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