



GENDER DIVERSITY AND ACCESS TO THE UNIFIED HEALTH SYSTEM

Diversidade de gênero e acesso ao sistema único de saúde

Diversidad de género y el acceso al Sistema Único de Salud

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ABSTRACT

Objective: To understand the dimensions of access to and comprehensive care in the Unified Health System (*Sistema Único de Saúde – SUS*) from the gender diversity perspective. **Methods:** Qualitative exploratory research carried out in Primary Health Care centers of the Primary Health Care network in Teresina, Piauí, Brazil, with (n=19) lesbians, gays, bisexuals, transvestites and transsexuals (LGBT). Data were collected in 2016 through four focus groups and a guiding question: “How would you like to see the access to, the quality and the organization of the actions and services offered to the LGBT population?”. Data underwent content analysis. **Results:** Four interpretative categories emerged, one for each group analyzed: Gynecological care for lesbians; The effeminate gay in the health services; In search of equity for transvestites; The assumed name for transsexual women in SUS. The lesbians said they face barrier to the access to health services and gynecological care; for gays, access is more difficult for those effeminate; for transvestites, the equity of care in specific outpatient clinics was pointed out as an important strategy; and for transsexual women, the use of the assumed name should be incorporated into the routine of health services. **Conclusion:** There is an urgent need for access to comprehensive health care networks by the LGBT people in order to promote their inclusion in the several social spaces, foster respect and facilitate equitable practices.

Descriptors: Sexual Minorities; Health Services Accessibility; Health Care.

RESUMO

Objetivo: Aprender as dimensões do acesso e da atenção integral na rede do Sistema Único de Saúde (SUS) na perspectiva da diversidade de gênero. **Métodos:** Pesquisa exploratória, com abordagem qualitativa, realizada em Unidades Básicas de Saúde vinculadas à rede de Atenção Básica, em Teresina, Piauí, Brasil, da qual participaram (n=19) lésbicas, gays, bissexuais, travestis e transexuais (LGBT). Os dados foram coletados no ano de 2016, através de quatro grupos focais e por meio da questão norteadora “Como vocês gostariam de ver o acesso, a qualidade e o modo de organização das ações e serviços de saúde a serem ofertados para a população LGBT?”, e foram analisados por meio da análise de conteúdo. **Resultados:** Emergiram quatro categorias interpretativas, uma para cada grupo estudado: Atendimento ginecológico às lésbicas; O gay afeminado nos serviços de saúde; Em busca da equidade para as travestis; O nome social para as mulheres transexuais no SUS. As lésbicas informaram que enfrentam barreiras no acesso aos serviços de saúde e no atendimento ginecológico; para os gays, o acesso é fragilizado para aqueles afeminados; já para as travestis, a equidade do cuidado, através de ambulatórios específicos, foi apontada como estratégia importante; e, para as mulheres transexuais, o uso do nome social deveria ser incorporado na rotina dos serviços de saúde. **Conclusão:** Há uma emergência no acesso às redes de atenção à saúde integral da população LGBT, com o intuito de promover a inclusão em seus diversos equipamentos sociais, promulgar o respeito e facilitar práticas de equidade.

Descritores: Minorias Sexuais; Acesso aos Serviços de Saúde; Assistência à Saúde.



RESUMEN

Objetivo: Aprender las dimensiones del acceso y de la atención integral de la red del Sistema Único de Salud (SUS) en la perspectiva de la diversidad de género. **Métodos:** Investigación exploratoria de abordaje cualitativo realizada en Unidades Básicas de Salud vinculadas a la red de Atención Básica de Teresina, Piauí, Brasil, en la cual participaron (n=19) lesbianas, gays, bisexuales, travestís y transexuales (LGBT). Se recogieron los datos en el año de 2016 a través de cuatro grupos focales con la pregunta guía “Cómo a vosotros les gustaría ver el acceso, la calidad y el modo de organización de las acciones y servicios ofrecidos a la población LGBT?” y fueron analizados a través del análisis de contenido. **Resultados:** Emergieron cuatro categorías interpretativas, una para cada grupo estudiado: Atención ginecológica a las lesbianas; El gay amariposado en los servicios de salud; Buscando la equidad para las travestís; El nombre social de las mujeres transexuales en el SUS. Las lesbianas informaron que afrontan barreras para el acceso a los servicios de salud y la atención ginecológica; para los gays el acceso es fragilizado para aquellos que son amariposados; para las travestís la equidad del cuidado a través de ambulatorios específicos ha sido apuntada como estrategia importante; y para las mujeres transexuales el uso del nombre social debería ser incorporado en la rutina de los servicios de salud. **Conclusión:** Hay emergencia para el acceso a las redes de atención a la salud integral de la población LGBT con el objetivo de promocionar la inclusión de sus diversos equipamientos sociales, promulgar el respeto y facilitar las prácticas de la equidad.

Descriptor: Minorías Sexuales; Accesibilidad a los Servicios de Salud; Prestación de Atención de Salud.

INTRODUCTION

Sexuality has been the central theme of the most diverse political, biomedical, social and anthropological debates. At the core of these discussions are the discriminatory and exclusionary processes generated throughout history⁽¹⁾. In the health field it is no different, especially with regard to health care and access to health services⁽²⁾.

Studies have shown that the lesbian, gay, bisexual, transvestite and transsexual (LGBT) population experiences difficulties in communicating with health professionals, fear of revealing their gender identity or sexual orientation, marginalization in health care practices, and other barriers to access to health services^(3,4).

The expressions of sexualities represented in groups of sexual minorities, when analyzed based on the concept of vulnerability in health – which leads to a broader view of public health in which there are predictors of susceptibility to illness –, include epidemiological issues and changes to favor inclusion in health services⁽⁵⁾.

The process of vulnerability in health can increase users' chances of exposure to illness through individual, collective and contextual conditions that cause, to a greater or lesser degree, susceptibility to physical and psychological illness. The individual determinant is the degree of information that individuals generate about themselves and their illness processes. The collective determinant is the access to health services and their adequacy to include users. The social determinant works as the social control of the emerging health and diversity demands⁽⁶⁾.

Based on the assumptions organized by the concept of vulnerability, in the present study, the social actors in the research process are represented by the group of sexual minorities, which is herein defined as the LGBT population. The failure to provide health care to this population gave rise to the need for specific health care policies. Thus, in 2011, the National Policy on Comprehensive Health Care for the LGBT Population emerged as a response to the demands and specificities historically stigmatized with the aim of promoting equity and implementing a State policy to guarantee human rights⁽⁷⁾.

However, despite the efforts to disseminate and discuss the theme, there is still something to be demystified. Regarding scientific production, there is a high prevalence of studies related to the LGBT population focusing on Sexually Transmitted Infections (STIs) and AIDS^(2,3,8,9).

Particularly with regard to access to health services, it should be noted that it is an essential part of the health care of LGBT. Access is indicated as a sine qua non condition in the structuring of any health service from the formal or informal admission to the health care facility to the use of services to the completion of care practices⁽¹⁰⁾. Access should not be limited to admission. Therefore, a broader concept of accessibility has been used to include the different potentialities of health territories in order to foster adaptations for the inclusion of users⁽¹¹⁾.

Access to SUS by LGBT has been hindered because this population does not follow a heteronormative pattern and that which makes them “different” can end up being used against them in the health services. Thus, the State ends up incorporating the LGBT population, based on the logic of the services that are offered, as a community of undesirable perverts. Therefore, they may have their right of access to health violated^(4,8), which naturalizes a “no space” in the SUS and reproduces failure to provide care.

Social institutions, such as religion or family, which are stratified in society, also influence sexuality and, consequently, the types of health care delivered by professionals in different fields of health sciences⁽¹⁾. Thus, LGBT can experience discrimination and stigmatization through barriers to access to health services which can influence the search for clandestine services, which,

because of their precariousness, can pose risks and, above all, raise the patterns of vulnerability, facts which indicate the importance of increasing the use of soft technologies in LGBT health care⁽³⁾ without disregarding the others.

According to research conducted by the Gay Group of Bahia (*Grupo Gay da Bahia – GGB*), published in Brazil's LGBT Homicide Report in 2014, the state of Piauí is one of the places that offers the most risk of death to this population. While LGBT Homicides in Brazil represents 1.6 in one million inhabitants, in Piauí this risk rises to 4.1, behind just Paraíba, with a risk of 4.6. The choice of this setting for the present research was related to its capital, Teresina, which represents one of the cities with an increased risk of “LGBTphobia”⁽¹²⁾.

The present study is also related to the research “Analysis of access to and quality of comprehensive health care for the LGBT population in SUS”, which was coordinated by the Department of Public Health Studies of the University of Brasília (*Núcleo de Estudos em Saúde Pública da Universidade de Brasília – NESP/UnB*) in partnership with several universities, including the Federal University of Piauí (*Universidade Federal do Piauí – UFPI*)⁽¹³⁾.

The inclusion of equity as a public health promotion policy underscores the differences based on the right to citizenship in access to health services and implies a commitment to cultural rights and collective assumptions⁽⁴⁾.

Gender diversity is expressed in the complexity of the context in which health care is provided to the LGBT population because sexual orientation and gender identity are social determinants of health, a fact that justifies the construction of interconnections to carry out actions to promote social inclusion, access, and improvement of the quality of health services in order to tackle inequities in the Unified Health System (SUS)^(3,10).

Given that, it is necessary to provide materials that can assist health professionals in identifying factors that can collaborate in the health process of the LGBT population in order to provide contributions to discussions and development of health practices focused on the needs of this population. The present study is relevant because if the needs of the study population are met they will directly influence the promotion of individual health and, consequently, public health.

Thus, this study aimed to understand the dimensions of access to and comprehensive care in the Unified Health System (*Sistema Único de Saúde – SUS*) from the gender diversity perspective.

METHODS

This is a qualitative exploratory research⁽¹⁴⁾ which facilitated access to the opinions, attitudes and meanings present in the experiences of the LGBT population in SUS. The research was carried out in Primary Health Care centers of the Primary Health Care Network⁽¹⁵⁾ located in the North, South and East/Southeast regions of Teresina, Piauí, Brazil, with lesbians, gays, bisexuals, transvestites and transsexuals (LGBT). These participants were recruited from non-governmental organizations, groups of activists, militants or representatives in the struggle for human rights. Thus, 19 people composed the sample: four lesbians, four gays, six transvestites and five transsexual women. The participants met the following inclusion criteria: to be living in Teresina for at least one year; to have had access to primary health care in medium- or high-complexity health care facilities; to be over eighteen years old. Those who did not meet these criteria did not participate. Sampling was finished after reaching saturation⁽¹⁴⁾.

Data collection took place in 2016 through the conduction of focus groups⁽¹⁶⁾, which allowed a broad problematization of the subject. Thus, four focus groups were held, one with each segment (lesbians, gays, transvestites and transsexual women) and each lasting an average of two hours. The groups aimed to identify and reflect on LGBT population's access to health services and the quality of care received through the guiding question: “How would you like to see the access to and the quality and organization of health care actions and services offered to lesbians/gays/transvestites/transsexuals in Teresina?”.

Regarding the method of analysis, a plan was developed following the content analysis method⁽¹⁷⁾. Therefore, four interpretive categories emerged, one for each studied group (lesbians, gays, transvestites and transsexuals): Gynecological care for lesbians; The effeminate gay in the health services; In search of equity for transvestites; The assumed name for transsexual women in SUS.

The present research was approved by the Research Ethics Committee of the School of Health Sciences of the University of Brasília (*Faculdade de Ciências da Saúde da Universidade de Brasília*) under Approval No. 652.643. All the participants signed the Free Informed Consent Form for Participation in Scientific Research. To maintain the anonymity of all the participants in the present study, the four women who declared themselves lesbians were identified as L1, L2, L3, L4; the four respondents who said they were gay were identified as G1, G2, G3, and G4; the six people who reported being transvestites were named T1, T2, T3, T4, T5 and T6; and the five women who said they were transsexuals were identified as TW1, TW2, TW3, TW4, TW5.

RESULTS AND DISCUSSION

In the present study, an interpretative synthesis was carried out, and the data found in the participants' statements were consistent with the health context of the LGBT population. This section presents the analyses of the four thematic categories

that emerged from the study: Gynecological care for lesbians; The effeminate gay in the health services; In search of equity for transvestites; The assumed name for transsexual women in SUS.

Gynecological care for lesbians

The category Gynecological care for lesbians highlighted the failure to provide gynecological care to these women. Changes in the female body (such as menarche, suspected pregnancy or menopause) are events that lead women to seek a gynecologist. The visits to the facilities are mostly induced by socially recognized events that biologically alter the female body⁽¹⁸⁾.

The gynecological consultation may trigger anxiogenic behaviors in many women, and such care may be even more complex considering the specificities of lesbians. Lesbianism is a theme that is still left aside in the whole health-disease-care process of lesbian or bisexual women, demonstrating invisibility, ignorance, prejudice, stigma and repression of female sexuality⁽¹⁹⁾, which implicitly or explicitly denote normative models of health technologies⁽⁴⁾.

Gynecology, as a health sciences specialty, has emerged to assist in the preparation, exercise and loss of reproductive capacity during the passage from the nineteenth century to the twentieth century. However, such a purely reproductive approach excluded women from the right to their own body and emphasized their reproductive role, placing them in an underprivileged and normative position⁽²⁰⁾.

Thus, women's health care is still based on a biological model of care and, therefore, issues related to sexual orientation have not been incorporated into the gynecological care practice. This gap makes lesbians and their sexual practices invisible and can reinforce the heteronormative pattern in health care, as reported by the following participant:

“When I get to talk to the gynecologist, she does not even ask what my sexual orientation is... if I am a lesbian, what my sexual practices are, she treats me as if I were one of her patients out there who have five children and who have an active life with a man. (L2)”

In general, studies that address lesbianism have shown that these women are not encouraged by health professionals to reveal their sexual orientation when accessing health services⁽¹⁸⁻²⁰⁾. In this regard, health professionals are considered a barrier to access to health services by the study participants. This fragility obliterates the provision of trustful care and, therefore, increases exclusion and symbolic violence, unlike what public health care policies advocate for women^(17,18). L1 highlighted this experience:

Actually, the first time I was served by SUS I felt violated. I felt this way I am saying: violated. They did not ask me anything. They simply went on to perform the exam on me. I cried so much that I got traumatized. (L1)

The L1's statements showed how health services may be far from embracing and promoting relationships with lesbian or bisexual users. Studies^(19,20) have shown the need for gynecological care to promote care strategies to address the health-disease process of lesbians. Soft health care technologies need to adjust to lesbians' lifestyle, which includes quality listening on the part of professionals from the very first consultation^(2,3).

Biologically speaking, the female body is distant from the social and affective practices of a woman's life; therefore, there is a sort of division between a woman's sexual expressions and the biological sex, which explains the invisibility of sexual orientation in health promotion actions^(19,20).

For bisexual or lesbian women, the presumption of heterosexuality, coupled with health professionals' failure to establish a relationship with the patient, may be related to the non-disclosure of sexual orientation in the gynecological consultation; in addition, intimate relationship practices and the silence surrounding them may prevent the patient from disclosing it⁽²⁰⁾. Thus, it is necessary to disseminate information about the different nuances of women's sexual practices and their corresponding care while practicing them as a health promotion practice, with the gynecological consultation standing out as a privileged space for doing so^(2,20).

The weaknesses revealed in the aforementioned statements point to the need for the creation of protocols, guidelines and instruments for lesbians' health care⁽²¹⁾, as well as the construction of a new health-teaching paradigm to provide academic training to discuss sexuality as a relevant issue in health care⁽²²⁾.

National⁽²³⁾ and international^(24,25) studies on female homosexuality in the health field have demonstrated the need to adjust health services to improve their access by this population. The services should foster embracement of all users' needs in addition to bonding and care so that their particularities are rethought based on the needs of each woman attending the gynecological consultation.

The gynecological consultation of lesbian and bisexual women, or women who have sex with other women, should not necessarily be different from that offered to women in general. However, it is important that the health professional is aware of the sexual orientation of each woman as it is key to reduce the heteronormative emphasis placed on gynecological care and necessary to understand the risks related to certain sexual practices⁽²⁵⁾.

The effeminate gay in the health services

This category shows the weaknesses in access to SUS by individuals who have behaviors socially instituted by the female universe. The participants G3 and G4 reported experiences of tension in public health services:

“Why am I underserved? As I am a more effeminate person they start to laugh. Even the person who is serving you “frowns” on you. I have this difficulty in the Emergency Care Room, in the primary health care center, and in the hospital too. (G3)

The gay who is effeminate suffers a lot more. He is not the transvestite. But the person who is the most effeminate, the “fag” (G4)”

The term gay has brought in its bulge traces of American culture and has assumed an elitist pattern. In this context, empowerment regarding the reinforcement of the expression “fag” is a result of the deconstructive and political dimension of affirmation of the different markers of identity, especially to individuals whose repertoire includes notorious artifacts of the feminine⁽²⁶⁾.

The social construct of the association of women with the place of subservience in society repeats the paradoxical logic of male domination, in which machismo is maintained through asymmetrical relationships between men and women⁽²⁷⁾. The effeminate gay visibly identifies with the feminine; therefore, society reserves for him a double judgment: one for not following the heteronormative pattern and the other for becoming close to those who are violently subjugated, i.e., women⁽²⁶⁾.

Thus, the culture of homophobia towards effeminate gays remains parallel to social standards and is expected by culture. This oppression can also be perpetuated in health spaces, which should be equipment of inclusion, tolerance and respect for sexual minorities. Health professionals must therefore work against homophobia, against machismo, and in favor of gays' access to comprehensive care in SUS^(2,3,8). G1 reported his experience of barriers in health services:

“I have seen many of my “fag” friends suffer in health care centers. Sometimes they experience violence as they get beaten by a – I will use our language – a “bofe”, a “boy”. So, we look for a boy and everything else. Then he beats us and when we get to the health care center people judge us: “He deserved it!” (G1)”

The G1's accounts of the professional's behavior during the consultation demonstrates a sort of blame on the user, highlighting the place of abjection and oppression for effeminate gays, which is close to the violence experienced by women. In addition, alterity is returned to the user, i.e., a male body with female behavior. Thus, it is important to address work processes and humanization in SUS to broaden this discussion, demystify moral standards and promote health care for effeminate gays⁽⁷⁾. This is not a mere dispute between the masculine and the feminine, or vice versa, but the necessity of provoking the liberation of the bodies that are still imprisoned in their social image.

An analysis of young gay men and their health revealed the importance of proposing health promotion and disease prevention initiatives to reinforce the guarantee of rights and shed light on concerns such as discrimination, the symbolic assumption of masculinity, the scarcity of quality information and the limited number of trained professionals, in both health and education sectors, to sensitize these young people and their families⁽²⁷⁾.

In another qualitative study conducted in the state of São Paulo, the relevant aspect observed in the analysis refers to the influence of homophobia on gay teenagers' health, especially regarding their psychological health, as it corroborates the manifestation of depressive behavior, anxiety and excessive fear, and even suicidal thoughts and ideations, states that highlight mental suffering whose origin is intertwined with the scenes of violence experienced⁽²⁸⁾.

This finding reveals one of the perverse effects of homophobia and it may be reinforced by health services, an issue that has also been addressed in another study⁽²⁹⁾ that pointed out that homophobia, especially towards effeminate gays, is a historical process and its confrontation depends on the strengthening of inter-sectoral actions that seek to match what is predicted in policies and what in fact happens in the access to prevention and care by effeminate gays in SUS.

In search of equity for transvestites

This category shows that equity, as a SUS principle, challenges the different social, cultural and economic inequalities underlying individuals' vulnerabilities. This principle is associated with minorities and acknowledges the notion of justice as the basis for building a universal public health system⁽³⁾. But how has equity been implemented in policies aimed at guaranteeing rights? How have equity policies ensured the access of transvestites to SUS? These concerns reveal the need to operationalize strategies for the inclusion of transvestites in health services.

Gender identity is a determinant of health that, in view of the social stigma experienced by transvestites, can maximize physical and mental suffering in addition to favoring vulnerability issues in general⁽⁷⁾. In addition to prejudice, “travestiphobia” can be replicated in social health facilities by the different professionals who work there – from doormen to physicians^(8,10).

Thus, equitable strategies need to be activated to guarantee the access of transvestites to SUS so that care is effective in the daily practice of health. The accounts of T2 outline one of these strategies:

“Have you seen the news about a hospital that wanted to create a third ward because the women were not willing to accept transvestites in their ward? (T2)”

Because they require specific care due to hormone therapy and body changes, trans people (transvestites/transsexual women and men) have access to outpatient services that have been created for specific purposes. These spaces have multidisciplinary teams composed of social workers, speech therapists, physical therapists, psychologists, gynecologists, proctologists, endocrinologists, plastic surgeons, and others^(30,31).

The T2's accounts show that the creation of a “third ward” is the fulfillment of the proposal of these peculiar centers for the care of trans people, which contributes to the specialized care and guarantees more respect and dignity to the users. The creation of this first outpatient clinic took place in 2009 in the state of São Paulo, and today these clinics are found in several capitals in Brazil⁽³¹⁾.

An ethnographic study of transvestites from Santa Maria, Rio Grande do Sul, Brazil, has shown that they feel disturbed by the way they are treated in health services, especially because of the moral and social judgment and the distance kept by SUS health professionals through gestures, looks and conversations, which corroborates the intensification of transvestites' social suffering⁽³²⁾.

Since there are still no specific outpatient services in the region where the present research was carried out, transvestites, in attempts to access basic and specialized SUS services, experience vexatious experiences like those reported in the aforementioned study, as reported by T4:

“I feel embarrassed to seek a urologist. I am a woman, a urologist does not suit me, but I know it is important, and I even wanted to go because I have had some serious problems. One day I also went to see a proctologist and his assistant kept looking at me in a way that I made me want to get out of there (T4).”

There is a tenuous relationship between expanding the access of transvestites through specific services and, at the same time, delimiting spaces of use⁽³¹⁾. The proposal to specialize in care also deceits the inclusion of transvestites in the health care network open to the general public. Because of that, respect for diversity is treated as an equitable policy that delimits spaces for the access of transvestites⁽³³⁾.

In public health, the LGBT care network has been strengthened since the implementation of the National Policy on Comprehensive Health Care for the LGBT Population in 2011. Nevertheless, there is still failure to embrace users, especially transvestites^(3,4,7). It should be noted that this model of care “confines” transvestites to specific outpatient clinics which sometimes see them as infectious agents as these services are usually linked to STIs and AIDS demands⁽³²⁾.

A study on existential gender dissents has shown that resistance to biopower and its biopolitics has always been expressed in the lives of transvestites, in which the desires to build their lives are expressed in the body. They struggle to be accepted in society and insist on achieving their goals despite the weaknesses along the path, and, through specific care outpatient clinics, one can see the interlocution with subjects who resemble their lives, who establish feelings of belonging and construction of an expression of being, creating connivances and producing strategies for the allocation of their specificities⁽³³⁾. Another study showed that transvestites saw the outpatient clinic as a means of social support and, therefore, a protective factor in health promotion and disease prevention⁽³⁴⁾.

There is, therefore, a need to work towards health equity for transvestites as a permanent and changing process which should allow for changing its main goal as improvements are achieved⁽³¹⁾.

The assumed name for transsexual women in SUS

This category addresses the definition of assumed name, which is the name by which trans people like to be called and which contrasts with the legal name of these subjects⁽³¹⁾. The assumed name allows the guarantee of the subjectivity and particularity of each person in their own recognition. According to the transsexual women participating in this research, it is essential to live by an assumed name, either in the use of the toilet for the gender that is expressed or in the recognition of their gender identity in health services^(35,36).

In SUS, the health care users' rights charter is one of the basic instruments for strengthening humanization in health care⁽⁸⁾. The scope and aims of the charter address the right to care free of any kind of prejudice and guarantees identification through the assumed name⁽⁸⁾. However, the transsexual women interviewed reported discriminatory episodes in the services:

“They do not go to these health care facilities because they do not feel welcome there. At least I avoid it to the max because I know I will have some discussion about the assumed name and I will have to say to the physician or to the assistant what gender identity is. So, it is a space of conflict. Then we avoid it to the maximum. (TW1)”

“I think the biggest problem is the name itself, the assumed name id card. (TW3)”

The importance of fostering the culture of humanization and respect for the assumed name requires, above all, the recognition of and respect for the human being and permeates health professionals' practice, the subjectivities of users and,

finally, collective actions⁽³⁴⁾. The transphobia materialized in the resistance to the use of the assumed name can generate obstacles in the health-disease-care process of transsexual women⁽³⁵⁾.

A study carried out with transsexual women revealed that the use of the assumed name, according to their perceptions, works as a tool for the access of the trans population to health services and favors adherence to the services offered and their embracement from their arrival in health care facilities, where professionals carefully listen to their demands, deliver comprehensive care, and foster the articulation with the other services of the network. Initial care through the assumed name may lead users to continue health promotion practices⁽³⁷⁻³⁹⁾.

Another documentary study on the use of the assumed name questioned the reason for the obstacles to perform a simple, low-cost and highly effective action such as the use of the assumed name. The study discussed other things that go beyond SUS and are configured in the scopes of religion, educational training, social construction of gender, which must be demystified in debates in the media and in society in general⁽³⁹⁾.

The participants described these barriers experienced in SUS and highlighted the importance of knowledge about this right by all the people who work in the services. TW5 lists the feelings and sensations associated with the embarrassment:

“One day I felt terrible at the primary health care center. They called me by my male name. I was so embarrassed, but so embarrassed, that I never went back there (...) Now I do not go there anymore. Well... [I will just go] if there is no other option. (TW5)”

Censorship has been increasingly present in cases involving sexual minorities⁽¹⁾. However, sexualities still need to be understood in the light of human relationships, especially in the field of health. The struggle for the use of the assumed name is not only related to a new nominal inscription, but to the representations and meanings implied in that process. The name is only a metaphor to characterize the new baptism of transvestites and transsexuals⁽³⁷⁾.

The results found in the present study need to be analyzed in light of some limitations, such as the type of recruitment that was used in the research, which may favor the selection of groups of related vulnerabilities. Therefore, it may not represent the community at large. Participants in this research are mostly involved in LGBT activism and militancy and, therefore, may bring more politicized data into the study, eventually moving away from the more marginalized individuals.

Therefore, further research should be carried out using different designs to explore these and other aspects pertinent to LGBT population's access to health services.

FINAL CONSIDERATIONS

First, the limits imposed by the LGBT acronym used in this study should be highlighted as a great challenge to be overcome, both for in SUS and in society in general. The main barrier to access to health services is the failure to embrace people as subjects who have very particular rights, desires and possibilities. They are users who reinvent themselves in the kaleidoscope of life. Therefore, it is SUS should be attentive to promote user embracement and create intervention strategies for the provision of health services.

In view of the scenarios of iniquities pointed out by the investigated participants, the study showed the urgent need for the organization of health care networks to promote the inclusion of the LGBT population in its various social facilities, ensure respect and valorization of life, facilitate equitable practices and demystify myths about sexual minorities. Given that, there is an ultimate need to know the specificities of care for each group of the LGBT community and emphasize SUS as a privileged social, political and ethical equipment for tackling LGBTophobia.

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