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ACCESS TO HEALTH CARE FOR THE LGBTQ+ POPULATION

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Abstract: In accessing health care, discrimination, stigma, invisibility and other barriers related to sexual orientation and gender identity can result in serious damage to the health of the LGBTQ+ population. Health professionals can contribute to these barriers or, on the other hand, to equitable and quality health care. Faced with this problem, we were faced with the need to study the situation of vulnerability of the LGBTQ+ community in terms of access to health care.

Through an integrative literature review, we explored the question "What are the factors that influence access to health care for the LGBTQ+ population between 15 and 30 years old?". The outlined objectives consisted of identifying the factors that influence access to health care for the LGBTQ+ population, identifying the health specificities of the LGBTQ+ population; understand the barriers in accessing health care and their consequences.

Nine primary studies of a quantitative and qualitative nature, carried out in different countries whose health system and social environment are similar to Portugal, were selected. As search criteria, we included articles in Portuguese and/or English, and published within a period of 5 years (2018 to 2023), through the EBSCO platform with access to the CINHAL Complete and Medline Complete databases.

The analysis and discussion of the documentary corpus revealed that the main barriers center on discrimination and invisibility in health care, the lack of competence of health professionals, health literacy and attitudes of the LGBTQ+ population and the transition phase in which trans individuals meet.

A direct relationship was established with the postponement and/or lack of seeking care by this population and discrimination in health contexts. Heterosexuality and cisnormativity and consequent invisibility were another factor related to the eviction of health care. Health professionals often assume the client's sexual orientation/gender identity, resulting in a barrier to providing individualized care that meets the client's needs. These factors are often motivated by the lack of cultural and professional competence of caregivers, not having the necessary training and knowledge to provide quality care to this population. We also verified a wrong perception of the severity of the symptoms by LGBTQ+ individuals, which results in a postponement of the search for health care.

Knowing the disparities in health and existing barriers in accessing health care for this population in a context of vulnerability is essential to contribute to equitable health care.

Keywords: LGBTQ+, Health Literacy, Nursing, Access to Health Care

INTRODUCTION

There are several acronyms used to identify people of sexual and gender minorities. Throughout this review we will use the acronym LGBTQ+, with the letter "L" referring to Lesbian, "G" to Gay, "B" to Bisexual, "T" to Trans, "Q" to Queer and the sign "+ " represents all the people and groups that are part of this community but do not fit or identify with the letters mentioned (Safe. To.Be, n.d.).

This population is described as being in a context of vulnerability due to a set of factors. LGBTQ+ people are part of a historically discriminated, marginalized and abused group, which has consequences in terms of health determinants (Ekmekci, P. E., 2017). According to the DGS (2022), health determinants are factors that have an impact on the current state of health of a person or population, resulting in an increase or decrease in the probability of disease occurrence. Thus, social exclusion, lack of literacy and marginalization results in limited

access to health services, health information and has an impact on these determinants (Ekmekci, P. E., 2017).

The right to health is a fundamental human right and must be enjoyed without any discrimination based on race, age, ethnicity or any other factor (WHO, 2022).

Several factors that influence access to health care by the LGBTQ+ population have been described in the literature. According to Associação ILGA Portugal (2019) some of these factors are the invisibility of sexual orientation in health contexts, the existing discrimination in these contexts and the lack of knowledge on the part of health professionals about LGBTQ+ health.

As a methodology, the first stage of this Integrative Literature Review consisted of formulating the research question "What are the factors that influence access to health care for the LGBTQ+ population between 15 and 30 years old?", to which we intend to answer with the realization thereof. In view of this, we established the main objective of identifying the factors that influence access to health care for the LGBTQ+ population.

THEORETICAL CONCEPTUALIZATION

People from the LGBTQ+ population use different terms to identify themselves. It is important to note that some people choose not to use names to describe their sexual orientation or gender identity and that although there are definitions for each concept these may not mean the same for all (safe.to.be, n.d.). The presentation of the meaning of the concepts that will be used throughout this article aims to clarify them for a better understanding of the topic addressed. In addition, as health professionals, it is essential to know some terms and respect the identity of each one in order to facilitate and make the conversation with people from the LGBTQ+ population more respectful (Human Rights Campaign, 2011).

Bisexual (Bi): Person who is attracted to two or more genders (Ex Aequo Network, 2020).

Pansexual: Refers to people who are attracted to all genders or to people regardless of their gender (Ex Aequo Network, 2020).

***Queer*:** It concerns how some people express their sexuality or gender orientation. It is sometimes used as a synonym for the LGBT community (Ex Aequo Network, 2020).

Lesbian: "A person who identifies as a woman and who is romantically and/or sexually attracted to another woman" (safe.to.be, n.d.).

Gay: "A person who identifies as male and who is romantically or sexually attracted only to people of the same sex" (safe.to.be, n.d.).

Biological sex: Classification system based on the geno or phenotypic characteristics of an individual. Individuals are generally classified as female, male, or intersex. The factors that contribute to this classification are chromosomes, genials, gonads, hormones, among others (Ex Aequo Network, 2020).

Sex assigned at birth: Expression used to refer to the biological sex that health professionals assign to babies at birth. It is usually accompanied by a gender that is also assigned at birth since sex is associated with gender in society. This does not define the future gender identity that is self-determined by the person (Ex Aequo Network, 2020).

Gender identity: It refers to the internal and individual experience of gender, how each person feels and self-determines. It is related to people's identification with the role socially assigned to men and women and may or may not coincide with the person's biological sex (safe.to.be, n.d.).

Gender expression: It is important not to confuse it with gender identity (which is related to an internal feeling). This relates

to the way people express themselves to the outside world. A person can express himself through clothes, makeup, certain body language or way of speaking (safe.to.be, s.d.).

Gender Transition: The period through which a trans person can decide to change certain aspects of their life in order to better reflect their gender identity: some people choose to change aspects of their gender expression (clothing or hairstyle), others submit for aesthetic procedures and others may still need body modifications through surgery (safe.to.be, s.d.).

Cisgender: Someone whose gender identity corresponds to the gender they were assigned at birth (safe.to.be, s.d.).

Trans: Refers to those who identify with a gender that differs from the one assigned to them at birth (safe.to.be, s.d.).

Non-binary: People who are not in the gender binary division (male – female) (safe.to.be, s.d.).

Genderqueer: Within the realm of non-binary. Refers to a person who identifies with neither, both, or a combination of genders, but who does not recognize conventional gender distinctions (safe.to.be, s.d.).

Social name: Name that trans people use when their legal name on identification documents does not match the gender they identify with (Ex Aequo Network, 2020).

THE LGBTQ+ POPULATION IN A SITUATION OF VULNERABILITY, THE RIGHT TO HEALTH AND ACCESS TO HEALTHCARE

The term "vulnerability", in a health context, refers to the susceptibility to risk and health damage due to social disadvantages that some individuals and groups face, not referring to an intrinsic characteristic of the person, as it is the result of several factors. external factors. In this sense, populations or groups in a context of vulnerability are those who are most susceptible to damage to their health due to social conditions and lack of material or personal resources that allow them to deal with risks (Ferreira, Santos, Ribeiro, Fracon & Wong, 2021).

These populations or groups demonstrate greater difficulty in accessing equitable health care, constituting a barrier to their quality of life. In order to overcome these disadvantages, health institutions must provide accessible care adapted to their specific needs, promoting equity and access to health care (Smithman, Descôteaux, Dionne Richardm Breton, Khanassov, Haggerty, 2020).

Congruently, the LGBTQ+ population is particularly susceptible to social exclusion, stigmatization and discrimination, including in health contexts. These factors hinder their access to health care, resulting in damage to their health. In addition, evidence of heterosexism and heteronormativity in health care is also reported (Mendes, 2022).

Heteronormativity is the term that refers to the marginalization of other sexual orientations, to the normalization of the assumption of heterosexuality, considering heterosexuality as the norm. Cisnormativity concerns the normalization of the cisgender assumption, considering that all people identify with the gender assigned to them at birth (Ericsson, 2021).

The right to health, a fundamental human right, implies access to health services by all people, whenever and wherever they need it. (WHO, 2017). Access to health care encompasses a series of opportunities: identifying health needs, seeking services, accessing these resources, obtaining or using health services and being offered services that are adequate to health needs, which may be a definition for the term (Mendes, 2022).

The LGBTQ+ population is attributed higher rates of stress, avoidance of health care and irregular access to it (Gahagan &

Subirana-Malaret, 2018). In fact, perceived and real discrimination in health contexts hinders health-seeking behaviors, having a negative impact on the mental and physical health of this population (Mendes, 2022).

The consequences of barriers to accessing health care and a lower rate of use include a decrease in average life expectancy, lower quality of life and a higher rate of chronic and acute illnesses, which the LGBTQ+ population falls into (Gahagan & Subirana-Malaret, 2018).

For the promotion of access to health care, it is important to analyze the existing barriers and how they affect vulnerable people or groups (WHO, 2022).

As caregivers, nurses have the potential to recognize barriers and inequalities in equitable access, a skill that can improve care provided to this community and lead to better health outcomes (Manzer, O'Sullivan & Doucet, 2018). These take on a decision-making role, educating and protecting the interests of the user. The lack of preparation and knowledge, when it comes to planning care for the LGBTQ+ community, is a precedent for the lack of quality and equitable access to health care (Carabez & Scott, 2016).

According to Farias et al. (2018), nurses play an important role in care and must seek to improve their practices to promote greater comfort for LGBTQ+ people. Since these professionals are more present in health care, they are in a favorable position to promote health education.

METHODOLOGY

Regarding the methodology, we started by formulating the research question "What are the factors that influence access to health care for the LGBTQ+ population between 15 and 30 years old?", intending to answer this question. Its construction was based on the P[I][C] OD method (Participants, Interventions, Comparisons, Results and Study Design).

The selected participants are the LGBTQ+ population between 15 and 30 years old, the results are the factors that influence access to health care and the study design are both quantitative and qualitative primary studies. As for interventions and comparisons, these do not apply to the research question presented.

As for the inclusion criteria, we established: articles whose target population includes people from the LGBTQ+ community between 15 and 30 years old, which address barriers and disparities in access to health care and access to them by the target population. Finally, primary studies of a quantitative or qualitative nature, published less than 5 years ago, in English or Portuguese and whose countries of origin are comparable to Portugal in terms of human rights and quality of the health service. Exclusion criteria include: studies whose target population is people from the LGBTQ+ community who are only under 15 years old or only over 30 years old, or that include only heterosexual and cisgender population. In addition, gray literature and systematic and integrative literature reviews published more than 5 years ago and, in a language, other than Portuguese or English are excluded.

The main objective of this study is to identify the factors that influence access to health care for the LGBTQ+ population. As specific objectives we built: to identify the health specificities of the LGBTQ+ population; to determine what are the barriers in accessing health care for this population; and what are the consequences of barriers to accessing health care.

To search for quantitative or qualitative primary articles, we used the EBSCO platform with access to the CINHAL Complete and Medline Complete databases for the selection of articles, during April 30th and May 1st,

2023. We started by building a framework of concepts with keywords and MeSH descriptors according to the research question and the P[I][C] OD. Then we select some of these and combine them with Boolean descriptors to form search expressions. In order to restrict research, we selected a time horizon of 5 years (articles published between 2018 and 2023), and published in English and Portuguese.

In all, the sum of the seven searches with the different search expressions resulted in a total of 8,172 identified articles. Of these, by reading the title and abstract, we selected 49 articles, of which 18 were excluded because it was not possible to access their full text. Thus, 31 articles were selected for their full analysis. For the analysis of these 31 articles, we took into consideration, the inclusion and exclusion criteria presented above, and only nine of these fulfilled the criteria and were selected.

We also carried out a quality assessment using the Joanna Briggs Institute (JBI) critical assessment instruments. All nine selected articles were included after this evaluation according to the priority criteria. The six qualitative articles included important criteria present such as: congruence between the research methodology and the methods used to collect the data, there is a relationship between the conclusions and the analysis and interpretation of the data and a congruence between the research methodology and the methods used to collect the data. Regarding the three studies of a quantitative nature, the criteria for inclusion in the sample are clearly defined, the study subjects are described in detail and the context and exposure were measured in a valid and reliable way.

In Image 1, the PRISMA flowchart of the article selection process.

RESULTS AND DISCUSSION

Nine primary studies were analyzed (Table 1), six of a qualitative nature (E1, E2, E3, E4, E6 and E9) and three of a quantitative nature (E5, E7 and E8). The sample size of the selected articles varies between 22 and 31,172 participants, constituting a total of 33,149 participants.

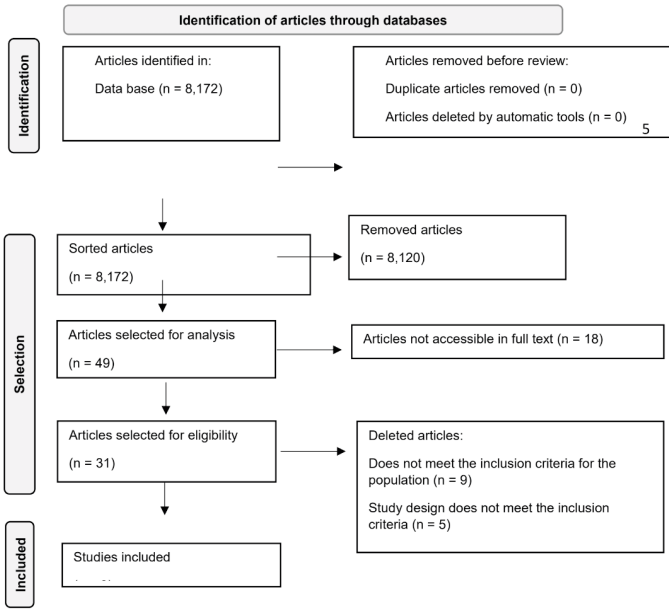
The analysis of the mentioned articles allowed identifying several factors that influence access to health care, namely: discrimination and invisibility present in health care; the professional and cultural competences of health professionals regarding the health issues of the LGBTQ+ population; health literacy and attitudes of the LGBTQ+ population; gender transition phase; and the predisposing and facilitating factors associated with the use of health services.

THE DISCRIMINATION AND INVISIBILITY PRESENT IN HEALTH CARE

Six of the nine articles (E1, E2, E3, E4, E5 and E7) referred to existing discrimination and invisibility of health care as a factor that influences access to it.

In the study carried out by Wingo, Ingraham & Roberts (2018), participants reported having experienced homophobia and/or transphobia in health services. We highlight the use of incorrect pronouns in trans users, the approach to aspects related to their identity that are irrelevant at the time, and inappropriate treatment after revealing their identity. Discriminatory attitudes are also described in the context of health care related to gender transition, making the places of care an environment where users feel neglected (Wingo, Ingraham & Roberts, 2018).

The existence of discrimination towards bisexual people is also evident where, according to Rahman, Li & Moskowitz



Picture 1 – PRISMA flowchart of the article selection process

Code	Title	Author	Year	Country
E1	Improving pathways to primary health care among LGBTQ populations and health care providers: Key findings from Nova Scotia, Canada	Gahagan & Subirana-Malaret	2018	Canada
E2	Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study	Wingo, Ingraham & Roberts	2018	USA
E3	Comparing the Healthcare Utilization and Engagement in a Sample of Transgender and Cisgender Bisexual+ Persons	Rahman, Li & Moskowitz	2018	USA
E4	Lesbian and bisexual women's experiences of health care: "Do not say, 'husband', say, 'spouse'"	Soinio, Paavilainen & Kylmä	2019	Finland
E5	Sexual orientation-related disparities in healthcare access in three cohorts of U.S. adults	Tabaac, Solazzo, Gordon, Austin, Guss & Charlton	2020	USA
E6	Adolescent Pride Festival. Their Interactions with Primary Care Doctors	Cafferty, Desai, Alfath, Davey & Schneider	2020	USA
E7	Experiences of Transgender Participants in Emergency Departments: Findings from the Outlook Study	Thompson-Blum, Coleman, Philips, Richardson, Travers, Coulombe, Wilson, Woodford, Cameron & Davis	2021	Canada
E8	Predictors of Past-Year Health Care Utilization Among Young Men Who Have Sex with Men Using Andersen's Behavioral Model of Health Service Use	Diaz, Sandh, Schnall, Garofalo, Juhns, Pearson, Bruce, Batey, Radix, Belkind, Hidalgo & Hirshfield	2022	USA
E9	Cisnormativity as a structural barrier to STI testing for trans masculine, two-spirit, and non-binary people who are gay, bisexual, or have sex with men	Stewart, Ryu, Blaque, Hassan, Anand, Gómez-Ramirez, McKinnon, Worthington, Gilbert & Grace	2022	Canada

Table 1: Identification of articles selected for the documentary corpus

(2019), these people experience more health disparities compared to heterosexuals.

With regard to sexual and reproductive health care, these often lead to the need to disclose sexual orientation and gender identity to the care provider, since it involves topics such as sexual activity and the anatomy of the reproductive system. Congruently, cisgender queer women and genderqueer individuals revealed their sexual orientation/ gender identity for the first time in these contexts. Although this factor can lead to greater user satisfaction, it also constitutes a risk for discrimination (Wingo, Ingraham & Roberts, 2018).

Taking into consideration, the frequent episodes of discrimination, the experiences experienced influence access to health care, so it appears that a postponement or even eviction of health care by individuals from the LGBTQ+ community (Tabaac, Solazzo, Gordon, Austin, Guss & Charlton, 2020; Wingo, Ingraham & Roberts, 2018). In line with the aforementioned studies, also in the one by Tabaac, Solazzo, Gordon, Austin, Guss & Charlton (2020) it was found that sexual minorities were much more likely than heterosexual people to postpone health care for this reason.

Regarding the trans population, according to Thompson-Blum et al. (2021), experiences of transphobia were a significant determinant of eviction from the emergency department. Evidence suggests that people who have their trans identity disclosed to health professionals may be subject to health care avoidance, likely due to past negative experiences. Thus, trans men and women feel less comfortable with caregivers than bisexual and cisgender women (Rahman, Li & Moskowitz, 2019).

Several (E1, E2 and E4) of the nine studies analyzed also addressed invisibility, cisnormativity and heteronormativity in health care as a barrier to accessing it.

The use of inclusive terms when providing care is critical, helping sexual minorities to reveal their identity. However, health care is often described as heteronormative, so that the questions asked by health professionals, as well as the health education information transmitted, are not suited to the needs of people of sexual or gender minorities (Soinio, Paavilainen & Kylmä, 2019).

The assumption of sexual orientation by health professionals also impacts access to mental health care, with some lesbian and bisexual women evicting them, who reported that they stopped resorting to this type of care after experiencing negative experiences (Soinio, Paavilainen & Kylmä, 2019).

The same was true in relation to primary health care where, according to Gahagan & Malaret (2018), situations of exclusion and disparities in this context can result from a cis and heteronormative structure.

From a cisnormative perspective, sexual and reproductive health care is often described as women's health, which may constitute a barrier to access by trans men and genderqueer individuals (Wingo, Ingraham & Roberts, 2018).

According to Wingo, Ingraham & Roberts (2018), trans men and genderqueer individuals encountered barriers in accessing healthcare related to gender transition. These experienced situations where health professionals considered their trans identity to be a result of internalized misogyny, not getting the health care they needed.

PROFESSIONAL AND CULTURAL COMPETENCES OF HEALTH PROFESSIONALS REGARDING THE HEALTH ISSUES OF THE LGBTQ+ POPULATION

Studies E1, E2, E4 and E6 addressed the lack of competence of health professionals regarding health issues of the LGBTQ+

population.

According to Gahagan & Malaret (2018), several evidences in the literature demonstrate the existence of a large number of health professionals and trainees who lack knowledge, cultural competence and even comfort in approaching a variety of health problems faced by the population. LGBTQ+. Lack of access to culturally competent health care providers can result in social costs such as reduced average life expectancy, lower quality of life and higher incidence of acute and chronic illnesses in the LGBTQ+ population.

In the study by Wingo, Ingraham & Roberts (2018), participants described experiences that demonstrated a lack of competence on the part of health professionals to address certain health issues. These revealed that they were asked imprecisely about their sexual activity and did not receive practical health information, which left them confused about their sexual and reproductive health needs. In addition, when cisgender participants questioned the caregiver about information regarding homosexual relationships, they were unable to respond.

Trans participants described health professionals as incapable of transmitting useful information, resulting in the postponement of health care, with a consequent impact on the quality of life of these users. Although gender-affirming surgeries and hormone therapy are considered sexual and reproductive health care, most professionals were described as ignorant of their health specificities, with even reports of professionals who refused to support care related to the gender transition (Wingo, Ingraham & Roberts, 2018).

Also, according to Soinio, Paavilainen & Kylmä (2019), lesbian and bisexual women considered that the health system was not able to provide the follow-up they needed, so they needed to seek health information autonomously. Additionally, there were also situations in which the sexual orientation of these women was undervalued and health professionals did not believe that they did not have sexual relations with men.

With regard to sex education, participants also felt that caregivers lacked the necessary knowledge and understanding. For example, lesbian women reported having experiences in which doctors, due to their sexual orientation, did not consider it necessary to carry out STI (Sexually Transmitted Infections) screening when requested by them (Soinio, Paavilainen & Kylmä, 2019). However, the risk of contracting an STI is multifactorial and independent of sexual orientation, so anyone who does not use barrier methods can acquire an infection. Furthermore, the incidence of some STIs among women who have sex with women is identical to the reported incidence in women who only have sex wím men (Gil-Llario, Morell-Mengual, García-Barba, Nebor-García & Ballester-Arnal, 2023).

From the point of view of health professionals, it is important to note that their concerns related to the health of LGBTQ+ users do not always fully coincide with those expressed by LGBTQ+ individuals themselves. Many health professionals do not feel informed, comfortable or culturally competent to provide care or meet the needs of this community (Gahagan and Malaret, 2018).

HEALTH LITERACY AND LGBTQ+ POPULATION ATTITUDES

According to Tabaac, Solazzo, Gordon, Austin, Guss & Charlton (2020), the wrong perception of the severity of symptoms leads to a delay in health care. It was found that women of sexual minorities were more likely to have passed more than a year since the last physical examination. Additionally, mostly heterosexual or bisexual individuals were more likely to postpone care believing that

there was no solution to their health problem, compared to heterosexual individuals.

LGBTQ people identify reproductive health and family planning, substance abuse, and access to methods to prevent risky behavior as important topics. The trans population is also concerned with educational content on gender transition processes, body image, self-esteem and coping strategies, and mental health issues (Gahagan and Malaret, 2018).

With regard to the younger population, the study by Cafferty, Desai, Alfath, Davey & Schneider (2020) demonstrated that there was a perception of a greater need for STI screening by LGBT adolescents compared to heterosexual young people, which may represent an increase in perception of risk factors and the need for regular STI screening tests. However, the study was carried out with young people who were visiting the Pride festival, which may suggest that it has an influence on the health education of this population.

GENDER TRANSITION PHASE

Now addressing a factor related to the trans population, articles E1, E7 and E9 addressed the gender transition phase in which the individual is.

According to Stewart et al., 2022, the trans gay and bisexual male population faces unique structural and individual challenges when accessing health care compared to the cisgender population. Spaces segregated by gender, lack of competence of the care provider and barriers in the legal documentation that often does not represent the correct gender identity stand out.

In the study carried out by Gahagan and Malaret (2018), health professionals also identified concerns regarding legal documentation, noting that many trans users do not have their gender identity represented in legal identification documents. This incongruity often leads to poor evaluation of these people's sexual risk behaviors (Stewart et al., 2022).

Living according to gender identity, assuming trans identity and seeking health care related to gender transition is associated with a greater likelihood of experiencing transphobia. This way, the unpredictability of the reactions of others makes the disclosure of gender identity a risk and contributes to the avoidance of health care (Thompson-Blum et al., 2021).

The results of the study by Thompson-Blum et al. (2021), people who had already completed the transition fully or completely or were planning to do so were more likely to avoid the emergency department compared to those who did not plan to do so. The results also suggest that the avoidance of the emergency service may depend on the person's comfort in revealing their gender identity.

The medical transition changes the appearance of the individual making them easier to be identified by others by the gender they identify with. However, evidence suggests that people who are known to health professionals as trans are more likely to avoid health services (Thompson-Blum et al., 2021).

The fact that the person is perceived by others by the gender they identify with can be considered a conditional privilege, so this privilege ceases to exist when the person reveals that he is trans. This may explain how the possibility of disclosing one's identity or transition phase leads to emergency department avoidance due to fear of anticipated discrimination (Thompson-Blum et al., 2021).

PREDISPOSING AND FACILITATING FACTORS ASSOCIATED WITH THE USE OF HEALTH SERVICES

According to Diaz et al. (2022), predisposing factors are antecedents that have

a negative impact on health outcomes and may be indicative of structural disadvantage, including educational disparities. Enabling factors represent the logistical aspects of getting care, which include having access to a healthcare provider, health insurance, and geographic region. The authors found that social and structural factors provide a solid basis for assessing multiple layers of influence on health care utilization.

The study sample (Diaz et al., 2022), consisted of adolescent and young adult men who had sex with men. The results admit that factors such as education, parents' education level, participants' ages and geographic regions are associated with the use of a variety of health services. According to these authors, when evaluating the predisposing factors, it was found that lower levels of parental education were associated with a lower probability of using health services, classifying it as a structural barrier.

CONCLUSION

The right to health is a fundamental human right, implying access to health services by all people. This way, it is essential to guarantee access to equitable health services, especially with regard to populations or groups in a context of vulnerability. In order to overcome the existing disadvantages, it is crucial that institutions are active in promoting equity and access to health care.

The LGBTQ+ population is described as a vulnerable group that faces several barriers in accessing health care. The analyzed studies and their discussion made it possible to know some of the factors that influence access to health care by the target population, thereby contributing to achieving the initially proposed objectives.

Discrimination and invisibility are factors still present in health care. Episodes of discrimination were described in the analyzed literature, with a positive relationship between these and the postponement of care or avoidance of health care. In addition, it was found that health care follows a straight and cisnormative structure, which may result in obstacles in accessing health care, health education, difficulty in collecting information to be able to provide individualized health care adapted to the needs of each user.

The cultural competence, training and knowledge of health professionals regarding the health issues of the LGBTQ+ population are also important in order to be able to provide adequate health care adapted to the needs of each user. However, there is evidence of a lack of these skills, constituting not only a contribution to the avoidance of health care by the LGBTQ+ population, but also an obstacle to obtaining effective health care.

Health literacy and attitudes on the part of this population also contribute to a delay in health care. The wrong perception of symptoms as not being serious enough to resort to health services results in a delay in receiving health care. In addition, a perception of greater need for health care and risk factors also contributes to individuals taking the initiative to use them.

With regard to the trans population in particular, the gender transition phase in which the person is found to be another element, as well as the congruence between the gender identity with which they identify and the legal identification documents presented in the access to health care.

There are also other social and structural factors that constitute the multiple layers of influence in the use of health care, such as education, parental education, age and geographic region.

Health professionals, including nurses, can contribute to reducing some of these factors and ensuring more equitable access to health care. In addition, it is the nurse's duty to

provide individualized care, free of prejudice and taking into consideration, the equity and universality of health care, and for this it is necessary to know the specific needs of this population.

The study and evaluation of the existing barriers in the accessibility of health care and the way in which they affect people or groups in vulnerable situations is crucial to be able to act on them and reduce health disparities, hence the importance of developing studies around this theme. Therefore, we consider it essential to continue research in this area. Given the training needs of health professionals, it is still crucial to translate evidence into practice.

REFERENCES

Associação ILGA Portugal. (2019). *Saúde em Igualdade. Pelo acesso a cuidados de saúde adequados e competentes para pessoas lésbicas, gays, bissexuais e trans*. https://ilga-portugal.pt/ficheiros/pdfs/igualdadenasaude.pdf

Cafferty, R., Desai, B., Alfath, Z., Davey, C., & Schneider, K. (2020). Adolescent Pride Festival Attendees—Assessing Their Interactions With Primary Care Physicians. *Journal of Adolescent Health*, *66*(6), 666–671. https://doi.org/10.1016/j.jadohealth.2019.11.305

Carabez, R., Scott, M. (2016). "Nurses don't deal with these issues": nurses' role in advance care planning for lesbian, gay, bisexual and transgender patients. *Journal of Clinical Nursing, 25*(23-24), 3707–3715. https://doi.org/10.1111/jocn.13336

Diaz, J. E., Sandh, S., Schnall, R., Garofalo, R., Kuhns, L. M., Pearson, C. R., Bruce, J., Batey, D. S., Radix, A., Belkind, U., Hidalgo, M. A., & Hirshfield, S. (2022). Predictors of Past-Year Health Care Utilization Among Young Men Who Have Sex with Men Using Andersen's Behavioral Model of Health Service Use. LGBT Health, 9(7), 471–478. https://doi.org/10.1089/lgbt.2021.0488

Direção-Geral da Saúde (2022). Determinantes de saúde. Plano Nacional de Saúde 2030. https://pns.dgs.pt/pns-em-acao/determinantes-de-saude/

Ekmekci, P. E. (2017). Do we have a moral responsibility to compensate for vulnerable groups? A discussion on the right to health for LGBT people. *Medicine, Health Care and Philosophy*, *20*(3), 335–341. https://doi.org/10.1007/s11019-016-9750-1

Ericsson, S. (2021). Gender and sexuality normativities: using conversation analysis to investigate heteronormativity and cisnormativity in interaction. In J. Angouri & J. Baxter (Eds.), *The Routledge Handbook of Language, Gender, and Sexuality* (pp. 289-303). Routledge.

Farias, G., Lima, V., Silva, A., Chaves, A., Gomes, V., Silva, A., & Paixão, V. (2018). Os cuidados do enfermeiro às lésbicas. *Revista de Enfermagem UFPE online*, 12(10), 2825-2835. https://doi.org/10.5205/1981-8963- v12i10a236414p2825-2835-2018

Ferreira, J., Fracon, B., Ribeiro, L., Santos, L. & Wong, S. (2021). Vulnerability and Primary Health Care: An Integrative Literature Review. *Journal of Primary Care & Community Health* (12), 1–13. https://doi.org/10.1177/21501327211049705

Gahagan, J., Subirana-Malaret, M. (2018). Improving pathways to primary health care among LGBTQ populations and health care providers: Key findings from Nova Scotia, Canada. *International Journal for Equity in Health*, *17*(1), 1–9. https://doi.org/10.1186/s12939-018-0786-0

Gil-Llario, M. D., Morell-Mengual, V., García-Barba, M., Nebot-García, J. E. & Ballester-Arnal, R. (2023). HIV and STI Prevention Among Spanish Women Who have Sex with Women: Factors Associated with Dental Dam and Condom Use. *AIDS and Behavior*, *27*(1), 161–170. https://doi.org/10.1007/s10461-022-03752-z

Human Rights Campaign. (2011) Glossary of Terms. https://www.hrc.org/resources/glossary-of-terms

Manzer, D., O'Sullivan, L. & Doucet, S. (2018). Myths, misunderstandings, and missing information: Experiences of nurse practitioners providing primary care to lesbian, gay, bisexual, and transgender patients. *The Canadian journal of human sexuality 27*(2):1-14. DOI:10.3138/cjhs.2018-0017

Mendes, R. (2022). *A Saúde da Comunidade LGBTQ+: Especificidades e Disparidades nos Cuidados de Saúde*. [Master's thesis, Universidade Beira Interior]. Repositório Digital da UBI. https://ubibliorum.ubi.pt/bitstream/10400.6/12885/1/8989_19328.pdf

Rahman, M., Li, D. H., & Moskowitz, D. A. (2019). Comparing the Healthcare Utilization and Engagement in a Sample of Transgender and Cisgender Bisexual+Persons. Archives of Sexual Behavior, 48(1), 255–260. https://doi.org/10.1007/s10508-018-1164-0

Rede Ex Aequo. (2020). Glossário LGBTI. www.rea.pt/glossario-lgbt/

Safe.To.Be. (s.d). Terminologia. https://safetobe.eu/pt/fact-checking/

Smithman, M. A., Descôteaux, S., Dionne, É., Richard, L., Breton, M., Khanassov, V. & Haggerty, J. L. (2020). Typology of organizational innovation components: Building blocks to improve access to primary healthcare for vulnerable populations. *International Journal for Equity in Health*, *19*(1). https://doi.org/10.1186/s12939-020-01263-8

Soinio, J., Paavilainen, E. & Kylmä, J. (2020). Lesbian and bisexual women's experiences of health care: "Do not say, 'husband', say, 'spouse.'" *Journal of Clinical Nursing*, *29*(1–2), 94–106. https://doi.org/10.1111/jocn.15062

Stewart, M., Ryu, H., Blaque, E., Hassan, A., Anand, P., Gómez-Ramirez, O., MacKinnon, K. R., Worthington, C., Gilbert, M., & Grace, D. (2022). Cisnormativity as a structural barrier to STI testing for trans masculine, two-spirit, and non-binary people who are gay, bisexual, or have sex with men. PLoS ONE, 17(11 November), 1–22. https://doi.org/10.1371/journal.pone.0277315

Tabaac, A. R., Solazzo, A. L., Gordon, A. R., Austin, S. B., Guss, C., & Charlton, B. M. (2020). Sexual orientation-related disparities in healthcare access in three cohorts of U.S. adults. Preventive Medicine, 132, 105999. https://doi.org/10.1016/j.ypmed.2020.105999

Thompson-Blum, D. N., Coleman, T. A., Phillips, N. E., Richardson, S., Travers, R., Coulombe, S., Wilson, C., Woodford, M., Cameron, R., & Davis, C. (2021). Experiences of Transgender Participants in Emergency Departments: Findings from the OutLook Study. Transgender Health, 6(6), 358–368. https://doi.org/10.1089/trgh.2020.0112

Wingo, E., Ingraham, N., & Roberts, S. C. M. (2018). Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study. *Women's Health Issues*, *28*(4), 350–357. https://doi.org/10.1016/j.whi.2018.03.002

World Health Organization (2017). Health is a fundamental human right. https://www.who.int/news-room/commentaries/detail/health-is-a-fundamental- human-right

World Health Organization (2022). Human Rights. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health