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Access to Health Care by Minorities: Men who establish Homoaffective Relationships

Celso Pasadas[1]& Francisca Manso[2]

Abstract

Context: Access to adequate and competente healthcare is a fundamental and universal right for all people and must be enjoyed without any kind of discrimination based on ethnicity, religion, age, gender or any other condition. **Objective:** to critically evaluate the results of the studies on access to health care by sexual minorities, namely homosexuals or homoaffectives. **Method:** Integrative review based on the search for full-text articles written in English or Portuguese in the data base of the Academic Search Complete, CINAHL Complete, PubMed, Cochrane Central Register of Controlled Trials, Cochrane Clinical Answer database, ERIC, MedicLatina, MEDLINE Complete, Psychology and Behavioral Sciences Collection and SciELO. Studies were evaluated according to predefined inclusion and exclusion criteria. **Results:** From a total of 447 studies/articles from the last ten years 284 were selected; of these, 17 articles fulfilled all the inclusion criteria with content relevant to the theme. **Conclusion:** The results of the articles found at national and international level highlight factors related to the organization of services and negative discriminatory attitudes by professionals towards sexual minorities in accessing services. It is essential to continue to educate and sensitize health professionals to the specific health needs of these minorities, promoting competence and cultural sensitivity.

Keywords: Prejudice; Homoaffectivity; Minorities; LGBTQ+; Health Care; Access to Health Services.

1. INTRODUCTION

The Portuguese Constitution defends that according to the principle of equality, all citizens have the same social dignity and are equal before the law. It is also clear in its 64thArticle when it states that everyone has the right to health protection and the duty to defend and promote it. Having good sexual health is an important indicator of one's overall health. It is unquestionable that belonging to a sexual minority cannot in itself constitute a barrier for accessing healthcare. Historically, the topic of sexuality has always been surrounded by myths and taboos. Secular repression marked, with great prominence, the different dimensions of sexuality often guided by discrimination, stigma and even social exclusion. These can also be important determinants of health. The topic of sexuality is broad and complex, comprising several dimensions: sexual orientation, sexual identity, gender-related roles, the practice of the sexual act itself and also other aspects: biological, psychological, psycho-emotional and cultural.

Human sexuality can be defined as an energy that motivates us to seek love, contact, tenderness and intimacy. The approach to the topic of sexuality has gone through different stages along the cultural and biological evolution of the human being. It is integrated into the way we feel, move, touch and are touched. It influences thoughts, feelings, actions and interactions and therefore also influences our physical and mental health (Matoso, 2014). It is an integral and crucial part of one's identity that defines and distinguishes individuals. Sexual orientation and sexual act allow individuals to connect at various levels of intimacy. Sexual orientation must be distinguished from sexual act or sexual behavior and also from sexual fantasy (Kalra et al., 2015). Sexuality is of enormous importance throughout our existence as it is an essential part of our personality and our lives (Paiva et al., 2008; Matoso, 2014; D'Avanzo et al., 2017; Lippa, 2020). It is a fundamental dimension in human life, present at all stages of the life process, that is influenced by culture, moral and ideological values, motivations, affectivity, desires and discoveries (Almeida et al., 2011; Allen &Desille, 2017; Zanatta et al., 2018).

[1]MSc,RN, Specialist Nurse, CHULN – HSM, Av. Prof. Egas Moniz, 1600-190, Lisbon, Portugal. Tel.: (351) 217805140/3. E-mail: thehunter1630@hotmail.com.
[2] PhD, MSc, RN, Nursing Teacher.

The practice of sexuality is linked to a healthy life and well-being of every individual, being important for the maintenance of the person's health conditions. The social stigma of homosexuality or any other form of sexual orientation not only interferes with the way the person belonging to the sexual minority is treated, but also how the person perceives himself due to this stigma (Pachankis et al., 2015). Currently in Portugal, homosexuality has gained the attention of the media and society in general; people are more likely now to understand the importance of sexuality throughout life as well as sexual relationships and the benefits and the different sexual needs that men and women have. However, negative attitudes and social representations about this theme still persist as a result of many years of conservatism.

2. METHOD

Integrative review is a method that aims to analyze the knowledge of a given phenomenon, by critically analyzing the results of studies carried out in a systematic, broad and orderly manner. It allows the combination of empirical and theoretical data that can be directed to the definition of concepts, identification of gaps in areas of studies, review of theories and methodological analysis of studies on a given topic. This integrative review was carried out from electronic bibliography and by the consultation of other work references that helped structurize the research. Data collection in full-text articles were carried out in the Academic Search Complete, CINAHL Complete, Cochrane Central Register of Controlled Trials, Cochrane Clinical Answer Database; Cochrane Database of Systematic Reviews, Cochrane Methodology Register, ERIC, MedicLatina, MEDLINE Complete, Psychology and Behavioral Sciences Collection, PubMed and SciELO.

Theresearch was based on the following question: "What are the implications of sexual orientation for sexual minorities in accessing health services?" In line with this question were identified articles that studied homosexuality and the access to health services. The inclusion criteria: articles from the last 10 years in Portuguese and English addressing the theme of access to health services by sexual minorities. Regarding the exclusion criteria: studies not related to the context and outside the time limit. The choosing of the articles was performed according to the inclusion criteria, using the Boolean operators AND and OR as an auxiliary. A total of 447 articles were obtained, being selected 17.

The research involved the following phases: a) identification of the topic, b) definition of the problem and the research question, c) definition of the descriptors, d) definition of the inclusion and exclusion criteria, d) definition of the sources and strategies in data collection, e) evaluation of articles, f) analysis and categorization of contents and g) synthesis of results.

3. RESULTS AND DISCUSSION

The themes presented are part of the categorization of previously selected articles.

3.1. Homoaffectivity at the Root of Prejudice

The word 'homosexual' was created in 1868 and although the word 'heterosexual' was created and used only in 1930, heteronormative behaviors overlapped with homosexual forms of expression (Melo et al., 2011; Albuquerque, 2016). Some authors refer that it becomes more relevant to mention homoaffective or heteroaffective relationships than homosexual or heterosexual relationships. Designating the homosexual as homoaffective represents the allocation of the latter on the frontier of greater respectability. It is a way of reducing stigmaassociated with promiscuous sexual behavior, bringing it closer to a heteronormative, marital and monogamous model of sexual conduct (Miskolci, 2009; Mendes & Pereira, 2013; Filho & Rinaldi, 2018).

The identity or diversity of the sex of the pair generates different kinds of relationships. Same-sex affection remains the biggest and most stigmatized taboo in the modern world, leading homoaffectives to their condemnation for their sexual orientation (Frigo et al., 2014). In a conjugal life, if two people of the same sex fulfill the duties of mutual assistance, in a true stable coexistence characterized by love and respect, then the law cannot ignore the rights and obligations that arise (Dias, 2010; Barcellos&França, 2016). Homoaffective marital relationships are defined as family and have the right to individual citizenship and to constitute a family,being sociallyresponsible for the education and socialization of children, whether biological or adoptive (Mello, 2005; Costa et al., 2012; Maciel& Pereira, 2018). Affection becomes more than a feeling that nourishes a relationship between two people that form a family, it becomes a legal category (Filho & Rinaldi, 2018).

The study of interpersonal attraction, initiated in the late 1950s, relates the concept of attitude to the concept of attraction. The first concept allocates the "object of thought" in an evaluative dimension (cognitive, affective/emotional and behavioral dimensions). The conceptualization of interpersonal attraction includes two categories of theories: the c*ognitive organizationtheories* and the *social exchange and reinforcement theories*. *Cognitive organization theories* state that attraction is explained by the internal consistency between cognitions and feelings. This group includes the *equilibrium theory* (Heider), the *cognitive dissonance theory* (Festinger) and the *congruence theory*

(Osgood and Tannenbaum). Heider's (1958) *equilibrium theory* constitutes the paradigm of cognitive explanations of interpersonal attraction. Like Heider, Newcomb (1961, 1968) and Festinger (1957) also developed *theories of cognitive consistency* with direct implications for the study of interpersonal attraction. The *social exchange and reinforcement theories*, explained by various models such as Lott & Lott (1968, 1974) and Byrne (1971; Clore& Byrne, 1974) place emphasis on the relationship between the evaluative and behavioral components with attraction being explained by the behavioral and affective interdependence that characterizes interpersonal relationships. According to Byrne (1971) a person's attraction is related to the proportion of similar attitudes associated to others. Several studies suggest that the complementary relationship between two partners increases attraction to each other. In fact, there are a number of factors that, to a greater or lesser extent, are responsible for "relational preferences" that explain the generality of the attraction phenomena. Among these factors are interpersonal similarities or complementarities, positive evaluations (appreciations) and personal physical attributes. The *social identity theory* seeks to understand which psychological aspects unite a group and what makes them recognizable by others. Discriminatory behaviors are essentially social in nature and derive from processes that, although cognitive, are based on intra- and inter-group relationships and are definable on a continuum that varies between interpersonal behavior and intergroup behavior (Tajfel & Turner, 2001).

Homophobia is the irrational fear and hatred of people who are attracted to others of the same sex which can lead to social exclusion, discriminatory experiences, stigma and in more serious cases, violence (Pega, 2015; Müller, 2017). LGBTQ+ sexual minorities represent groups of people of different ethnicities, classes, ages, genders and socioeconomic status. What unites them as minorities, in sexual and gender terms, are their shared experiences of stigma and discrimination (Müller, 2017).

Violence based on sexual orientation is one of the ways in which sexual stigma is expressed. Sexual stigma based on the perception of sexual orientation emerges from a set of beliefs shared in society in which homosexuality is denigrated and socially reprehensible in relation to heterosexuality (Herek et al., 2012; Davis-Delano et al., 2020). 'Heterosexism' is a term coined as an alternative to the term 'homophobia' in order to highlight the similarities between the oppression of lesbian, gay, bisexual, transgender people and the oppression of women and people of color (Ritter &Turndrup, 2002; McGeorge & Carlson, 2009; Calabrese et al., 2018; Watson et al., 2019). It refers to an internal process that simultaneously gives privileges to heterosexuals while oppressing homosexuals (Hereck, 1990; Ritter &Turndrup, 2002; McGeorge & Carlson, 2009; Singh & Moss, 2016). The homophobic prejudice towards homosexuals, by heterosexual people, contributes to increase the group boundaries ("us" as opposed to "others" or "them"), ensuring intergroup distinctiveness, contributing to fostering the positivity of social identity of the members of the dominant heterosexual group (Gomes &Serôdio, 2014).

According to the *theory of self-categorization*, group identity can be threatened by the lack of clarity of boundaries between in-group and out-group. Intergroup distinctiveness is defined by establishing relevant differentiating criteria between groups. Regarding the criteria of sexual identity, homosexual people are a relevant comparison group for heterosexual people and can be perceived as a threat to intergroup distinctiveness since they violate expectations indexed to traditional gender roles (Gomes &Serôdio, 2014). Thus, any sexual identity that varies from full heterosexuality is seen as deviant, morally wrong and unnatural (McGeorge & Carlson, 2009). The construction of the masculine identity is reinforced by the refusal of emotions or delicacy, roles attributed to the female sex, where it is assumed as a psychological mechanism the insult and the humiliation to any heterosexual man who flees or violates this premise, being labeled as non-masculine (Matoso, 2014). Homoaffectives grow up in a homophobic environment and internalize heterosexist stereotypes (Maia, 2012; Pakula et al., 2016; Smith et al., 2016; Puckett et al., 2018), that consider homoaffectives as incapable of valid relationships and social adjustment as good as heteroaffectives (Graham et al., 1984; Quintas, 2008; Wirtz et al., 2014). Homoaffective people change their perception and understanding of the problem, which is no longer linked to an individual or relational pathology, but rather to a pathology that exists in the broad structure of society. Members of marginalized groups often internalize discrimination and abuse as a problem that exist within themselves (internalized homophobia), making the process of oppression invisible (McGeorge & Carlson, 2009; Beusekom, G.; Bos, H., Kuyper, 2009; Overbeek, G. &Sandfort, T., 2016).

Internalized homophobia is related to the internalization of insult and stigma by LGBTQ+ people and can be an intervening factor in the marital relationship in homoaffective couples, in cases of abuse and conjugal violence, resulting in a lesser demand for help (McClellen, 2005; Bornstein, Fawcett, Sullivan, Senturia&Shiu-Thorton, 2006; Lorenzetti et al., 2017). Greater exposure to discrimination and perceptions of stigma have been associated with poorer mental health in sexual minorities (Fingerhut et al., 2010; Yi et al., 2016; Russell & Fish, 2016; Plöderl et al., 2017). LGBTQ+ people who are victims of discrimination tend to use a series of psychic defenses to deal with their inner conflict and the resulting chronic anxietybeing more common the denial, reaction formation, rationalization and the cover-up (Borrillo, 2010; Frigo et al., 2014; Camp et al., 2020).

Discriminatory behaviors can be a factor that increases insecurity, self-esteem and the likelihood of consuming psychoactive substances (Pakula et al., 2016; Smith et al., 2016). In a Portuguese study with a sample of 385 higher education students, 20% reported having unfavorable attitudes towards homosexual people. These people, mostly male, had low familiarity with homosexual people and marked conservative social values and self-promotion as opposed to social values of self-transcendence and openness to change (Gomes &Serôdio, 2014).

3.2. Sexual minorities, health/disease process and access to care

The diagnosis of homosexuality as a mental illness was removed from the DSM in 1973 and from the International Classification of Diseases (ICD) in 1991. Experiences of social exclusion, discrimination and prejudice are linked to pathologizing theories of sexuality in medical and social speech with a strong impact on mental health. Despite this formal depathologization, the negative effects are still visible in the discriminatory attitudes of some people and professionals (Müller, 2017; Mahler, Mundle&Plöderl, 2018; Balik et al., 2020).

Several studies conducted in Europe and in the United States have shown that homosexuals have increased rates of depression, suicide and anxiety when compared to their heterosexual peers (King et al., 2008; Bockting, 2013; Collier et al., 2013; Müller, 2008, 2013; Bockting, 2013, 2017). Data show that gay youth experience high rates of physical and sexual violence, bullying, risky behavior and substance use (U.S Department of Health and Human Services, 2016). The 'coming out' process for homosexual individuals occurs at a highly critical time in their lives and is often associated with increased drug and alcohol use, unprotected sexual practices, self-harm, suicide attempts and suicide (Kalra et al., 2015). As they grow up, these individuals realize that they are part of a group that is not valued by society and that is vulnerable to prejudice and discrimination. These negative experiences are internalized, leading to future negative expectations of identity and sexuality often increasing vulnerability and risk (Kalra et al., 2015).

Several explanatory models have been used to explain the increased risk in the LGBTQ+ group of developing mental disorders. These focus on stigma-related stressors, experiences of fear, discrimination, violence, internalized homophobia, concealment of sexual orientation and lack of social support (Meyer, 2003; Stall, 2008; Hatzenbuehler, 2009; Pachankis, 2015; Plöderl, 2017). Sexuality-related stress appears to be the cause of the increased prevalence of depressive symptoms experienced by homosexual individuals. It is important for practitioners to interpret the high prevalence of stress, anxiety, depression and drug use among these individuals as a direct result of heterosexism rather than a personal 'disability' (Lewis et al., 2003; McGeorge & Carlson, 2009; Pakula et al., 2016; Ding et al., 2020). People of sexual minorities are exposed to verbal abuse, rejection, violence and discrimination (Fingerhut et al., 2010; Pega, 2015; Müller, 2017; Blondeel et al., 2018) that can lead to a state of hypervigilance in their social environment, putting them in a chronic state of stress (Meyer, 1995; Fingerhut et al., 2010; Camp et al., 2020; Shangani et al., 2020). These people are subjected to internal and external stressors. External stressors are consisted of deliberate and overt acts of discriminationwhile internal stressors emerge within the individual such as stigma and internalized homophobia as well as an internalization of society's negative evaluation of homosexuals (Meyer, 1995; Fingerhut et al., 2010; Perez-Brumer et al., 2019). The therapeutic goals are not to change the sexual orientation of homosexual people but to deal with problems that may arise from experiences related to prejudice, stigma, discrimination, conflicts in the workplace, depression or the search for personal development (Sorensen & Roberts, 1997; Moleiro& Pinto, 2009; Hatzenbuehler, 2017).

Gay people have specific health care needs, in several areas, such as the risk of chronic illness, mental health problems, violence and sexually transmitted diseases (Mayer et al., 2008; Holley et al., 2016; Müller, 2017; Lin et al., 2021). An investigation conducted in the United States with 116 students in the health area, 75% of the female sex, showed that between 8 to 12% believed that homosexuality should be punished; 5 to 12% of students did not like sexual minorities and between 51 to 53% stated that homosexuality was against their religious beliefs (US Institute of Medicine, 2011).

In a systematic review on homophobic attitudes of nursing students in Latin America, it was reported that homophobia was more common in students who had conservative religious values (Aynur et al., 2020). In England, a study carried out with a group of 137 students, highlights that of the 83% of heterosexual women, 16% felt uncomfortable if they were to be responsible for caring for a homosexual person (US Institute of Medicine, 2011). A study carried out in South Africa highlights that people who identify as homosexual experience discrimination from doctors, psychologists, nurses, administrative and security staff in health institutions in the form of insults, ridicule or social exclusion (Rispel et al., 2011; Müller, 2017).

Another study carried out in 2018 in South Africa and in Southern African countries (Mozambique, Zambia, Malawi and Zimbabwe) analyzed data from fifty in-depth qualitative interviews with representatives of organizations working with adolescents, sexual and gender minorities and/or sexual and reproductive health.

The results highlight that sexual and gender minority adolescents in these countries experience double marginalization in accessing general and reproductive health care. In Mozambique, sexual activity between people of the same sex was decriminalized in 2015, however, in the remaining countries there are still different levels of criminalization. In many Southern African countries, these laws originate from old penal codes introduced during the British colonial period (Müller, A. Spencer, S. Meer, T & Daskilewicz, K., 2018).

A study that reviewed homophobic attitudes of nurses in Switzerland showed that while 62% expressed positive attitudes, 30% expressed neither positive nor negative attitudes (Rondahl et al., 2004; Aynur et al., 2020). In the US, a study (2008) conducted by nurses working in polyclinics and other health services showed that 22% of nurses were quite homophobic (Blackwell, 2008; Aynur et al., 2020). In the European Union, a study was carried out (2008) on sexual discrimination, covering 27 state members, which revealed that in the health area, about 14% of the European population had already felt discriminated against due to their sexual orientation, increasing to 25% when analyzing data only concerning Portugal (European Commission, 2008). A study conducted in Portugal (2006) showed that 14% of the respondents felt discriminated against once and 44% reported having been discriminated against more than once (Silva et al., 2007).

A survey carried out with 124 nursing professionals (2008), regarding the attitudes of professionals about the patient's sexual orientation in Portugal, found that 23% of nurses participated in situations of discrimination based on sexual orientation, with verbal expressions being the most common highlighted (69%), 48.3% in health services. 67.5% of professionals state that they assume that their patients are heterosexual when providing care (Quintas, 2008); still in this study, around 73.8% of nurses do not ask their patients about their sexual orientation, even though it is an important information for providing care. 84.9% of nurses who participated reported having little or no knowledge about the LGBTQ+ community; about 8.7% of professionals consider that AIDS exists mainly among LGBTQ+ people; 92.1% of professionals do not agree with the fact that LGBTQ+ patients need specific care (Quintas, 2008). Regarding nursing professionals, 60.3% reported not having had academic training on issues related to sexual orientation and 48% of professionals who received training said that it was insufficient. These professionals agree (76.2%) that their academic curriculum should include subjects on the LGBTQ+ theme, while 45.2% of the professionals consider the quality of our national health service to be insufficient or very insufficient in terms of the care provided to these patients (Quintas, 2008).

Several studies confirm that negative experiences with health care professionals contribute to the erosion of trust and security in the health system, causing these sexual minorities not to seek the services they need (Müller, 2017; Balik et al., 2020). These people are alienated from health services, reducing their use, presenting greater morbidity and mortality from infections, cancer and heart diseases (O'Hanlan et al., 1997; Müller, 2013; Chard et al., 2015; Whitehead et al., 2016). When they seek health services, they hide their sexual orientation from the health professional or end up having to "educate" them about their sexual orientation or gender identity (Wilton, 2000; Müller, 2013; He et al., 2020). When health professionals neglect this information, they overlook an important dimension of the patient's life that can affect their sexual and general health (Krnel&Skela-Savič, 2020).

Homosexuals believe that healthcare professionals lack an understanding of their psychosocial problems, vulnerabilities to specific infections or preventive health needs (Kushwaha et al., 2017). Oppressive norms, in the form of heteronormativity, both in structural aspects and in the health system (approaches of service managers) combined with subtle and camouflaged homophobia, contributes significantly to the experiences of exclusion of homosexual individuals from health services (Nhamo-Murire& Macleod, 2018). These end up finding subversive ways of exercising their autonomy to the detriment of the lack of health support. They end up looking for information and mobilizing resources using the internet, pharmacies or colleagues in order to live healthier.

However, these sources do not provide evidence-based information and can lead to ill-informed decisions (Kushwaha et al., 2017). It is essential that health care professionals develop specific knowledge and skills about orientation, sexual identities, stress, practices and stigmatization processes to which minority groups are subject. A good therapeutic alliance is crucial to create trust and positive expectations in the health care professional-patient relationship allowing a more effective intervention to promote better care (Plöderl, 2017).

The professional assistance of nurses in men's health must be based on a holistic and relevant approach to the experiences of sexuality, body self-perception, meaningful human affective relationships, flexibility to deal with vulnerability, potentialities and needs and/or related problems (Mandú, 2004; Moleiro& Pinto, 2009; Matoso, 2014). Nurses must provide care using strategies based on respect for human dignity and self-determination (Zuzelo, 2014; Terrazas et al., 2018; Aynur et al., 2020). Health care does not only extend life but also improves its quality (Stonewall, 2015; Peate, 2015). Homosexuals often experience social exclusion, violence and different forms of stigmatization and discrimination. Research shows that homoaffective relationships are considered to be criminal offenses in 75 countries worldwide, punishable by fines or imprisonment (Stojisavljevic et al., 2017).

A study carried out in the United Kingdom, involving male homosexuals, concluded that half of the respondents had not revealed their sexual orientation to their treating physician and, of this half, about 39% had no intention of doing so. The study suggests that this is because homosexuals feel anxious that their treating physician will not keep this information confidential and that the quality of care they would receive would be inferior (Dodds et al., 2005). The fear of experiencing homophobic discrimination or secondary victimization, coupled with the knowledge that public institutions do not provide specific health care, constitute significant barriers on accessing care (Müller, 2017). As a consequence of prejudices and ignorance within the health care professions, these people often receive substandard health care. Knowledge of sexual orientation, behavior and training as well as specific supervision are essential to promote prevention, correct diagnoses and quality of care for each patient.

Experience in dealing with LGBTQ+ individuals is an important factor in changing homophobic attitudes in favor of these patients (Rondahl et al., 2004; Chard et al., 2015; Aynur et al., 2020). Regarding the homophobic attitudes of professionals, there is no consensus. A study with 192 Turkish nurses (2014) highlighted that the scores of homophobic attitudes of those who had contact with other homosexuals (33.9%) were lower than nurses who had no contact with these patients (Aynur et al., 2020). In a study conducted in Southern Taiwan (2007), it was determined that of 1824 nurses who had friends or close relationships with LGBTQ+ individuals, showed a more positive attitude towards homosexuality (Yen et al., 2007; Aynur et al., 2020).

According to the *theory of self-determination*, 3 components are needed to optimize health behavior: autonomy, competence and identification. Autonomy refers to aspects of the health system that make patients feel comfortable describing their medical history and social environment, allowing them to have control over their own health decisions. Competence helps to empower the patient to achieve their health and well-being goals through the necessary resources and skills (Kushwaha et al., 2017; Heggdal et al., 2021) Identification refers to empathy and kindness towards the patient (Ryan, 2000; Kushwaha et al., 2017; Lataillade& Chabal, 2020).

In order for health professionals to provide competent care to sexual minorities, namely homoaffectivepatients, it is necessary to ensure that specific content is systematically integrated into academic curriculum, meeting specific needs, training communication and other skills (Obedin-Maliver et al., 2011; Müller, 2013; Carvalho et al., 2017; Aynur et al., 2020). Professionals should be trained in communication standards in order to understand the relationship between health, illness and gender issues using a comprehensive approach for solving the most frequent health problems (US Institute of Medicine, 2011). Psychoeducation and counseling are tools used to change the quality of care. In accessing health services, it is important that nurses provide comprehensive and humanized care, based on public policies, contributing to the reduction/elimination of inequalities. Health professionals in the initial assessment should avoid heteronormative language when referring to their patients' affective relationships (Matthews, 2007; McGeorge & Carlson, 2009; Lorenzetti et al., 2017; Zeeman et al., 2019).

The nurse's role in the sexual health consultation is to appreciate relevant subjective biological, social and communicational aspects related to experiences and significant affective and relational exchanges. It's important to assess self-esteem, body self-perception and needs and/or problems related to sexual health. Promotion of sexual health should consider potential processes that generate vulnerabilities, coping and resolution capacities (autonomy, body self-control, responsibility for sexual life and health, recognition of sexual rights and prevention and control of related psycho-emotional aspects) and specific socio-epidemiological profiles: social and health resources availability, guidelines, public policies and the place for the provision of care. It is important to establish a secure psychological environmentwhen approaching sexual health and its referral, promoting active participation and educational measures (Mandú, 2004; Carvalho et al., 2017; Chambers et al., 2021). Support for people's access to mental health nursing consultations should be complemented by other care modalities/interventions that allow comprehensive responses, allowing access to services, with an integrated and capable team to identify the specific needs of individuals (Mandú, 2004; Plöderl, 2017; Müller, 2017).

The nurse's intervention, by promoting a space for free expression and active participation of the patients,allows the expression of feelings, the identification of knowledge and needs, values and dilemmas experienced by them. In the establishment of a therapeutic relationship, judgments of value, censorship, impositions or discriminatory practices should not exist (Mandú, 2004; Plöderl, 2017; Lataillade& Chabal, 2020). The practice of positive 'gay affirmative' health care has been suggested as a paradigm that can guide the work of mental health professionals with the homosexual population (Crisp, 2006; Kalra et al., 2015; Moradi & Budge, 2018; Pereira et al., 2019). This paradigm helps to affirm the identity of the homoaffective as a positive human experience (Kalra et al., 2015).

The multi-professional team may integrate homaffectives into its staff. These can provide valuable knowledge and insightin care, helping patients feeling comfortable, welcomed and represented. It is also important to create a safe environment and training of all staff (U.S Department of Health and Human Services, 2016). The staff must understand that discrimination against homoaffectivepatients, whether subtle or covert, is unacceptable and unethical and like any other type of discrimination, must not be tolerated. It is important to create mechanisms and monitor any disrespectful behavior. Some staff members may have ingrained prejudices or negative feelings about these patients due to ignorance or lack of familiarity with this people. Others may consider that their religious beliefs go against homosexual representation, making it necessary to work with these individual's beliefs and representations (U.S Department of Health and Human Services, 2016).

4. CONCLUSIONS

Scientific and social progress contributed to the depathologization of homosexuality. The social stigmatization imposed on sexual minorities has encouraged the recent increase in scientific studies around homosexuality and its relationship with the health and disease process. Despite advances in anti-discrimination laws related to sexual orientation around the world, there are some countries in Southern Africa, with the exception of Mozambique (Change of the penal code in 2015), which still criminalize sexual activity at different levels, between people of the same sex. These discriminatory laws undermine human rights and perpetuate violence, hate crimes and threaten individual health. Individuals who identify themselves as homosexuals or homoaffectives still face a set of challenges and discriminatory practices in accessing health care.

Facing difference, accepting and respecting people's freedom is a proof of maturity. Hasty judgments always accompany situations of mistrust, resistance to communication or encourage conflict. Some attitudes of social discrimination by professionals stem from homophobia. Heteronormativity makes the equity and quality of care for these people unfeasible. Several studies reveal that members of sexual minorities are more susceptible to health problems such as alcohol, tobacco and illicit drug abuse, unprotected sex, mental disorders, bullying and Sexually Transmitted Diseases (STDs) such as HIV/AIDS, among others. In this context, although there are several studies in Europe, Asia and Africa, most studies come from the United States. In Portugal, these studies need further development, larger samples, reliable instruments and qualitative studies.

The development of competent, specific and certified professional practices values:the acceptance of difference, understanding, verbal and non-verbal communication, assessment of the ability to ask for help, identification of signs and symptoms related to abuse and/or violence (by partners) or other mental health conditions. Promoting 'friendly' spaces with empathetic care in a safe environment is essential.

It is fundamental that this specific themeis included in the academic curriculum of future health professionals andtransversally to all education, addressing the sexual health of sexual minorities in all cycles of life and in the various contexts (family, institutional, prison). It is extremely important to have reference manuals and specific guidelines on LGBTQ+ health for consultation in libraries and health institutions. The broad debate on these issues in teams and in society are essential contributions for changing attitudes and social representations. The allocation of resources and greater investment in public policies are some of the fundamental dimensions for the inclusion of minorities in accessing services and improving the continuity of health care.

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