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ORIGINAL ARTICLE

Reporting violence against the LGBTQIA+ population from the perspective of ESF/ NASF professionals in the municipality of Rio de Janeiro

Notificação de violência da população LGBTQIA+ na perspectiva dos profissionais da ESF/Nasf, município do Rio de Janeiro

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ABSTRACT The objective of the study was to analyze reports of violence against the LGBTQIA+ population from the perspective of professionals from the Family Health Strategy (ESF) and the Expanded Family Health and Primary Care Center in two clinics in the Planning Area (AP 5.1) in the municipality of Rio de Janeiro. Data on violence against the LGBTQIA+ population was collected from the municipality's information system from 2013 to 2022. The study characterized professionals' perceptions of what constitutes violence reporting and described facilitators and difficulties in identifying violence against the LGBTQIA+ population. Key factors among the facilitators include qualified listening and the use of a violence spreadsheet by the Programmatic Area Coordinator. Difficulties include failure to identify LGBTI-phobic violence as a significant demand, difficulty in the reception approach, professional prejudice against the LGBTQIA+ population, and failure to use the identity, sexual orientation, and social name requirements. The strategies identified to face the difficulties involve Permanent Health Education actions for the LGBTQIA+ population with the following themes: an approach to receptions, elucidation of concepts of gender identity, sexual orientation, and public policies and violence. The study suggests the need for the qualification of ESF professionals, interdisciplinary transversal assistance, and the creation of intersectoral thematic groups.

KEYWORDS Gender-based violence. Notification. Persons, LGBTQ. Family health.

RESUMO *Objetivou-se analisar as notificações de violência contra a população LGBTQIA+ na perspectiva dos profissionais da Estratégia Saúde da Família (ESF) e do Núcleo Ampliado de Saúde da Família e Atenção Básica em duas clínicas da Área Planejamento (AP 5.1), no município do Rio de Janeiro. Foram coletados dados sobre violência contra a população LGBTQIA+ no sistema de informação do município, no período de 2013 a 2022. Foram caracterizadas as percepções dos profissionais sobre o que entendem como notificação de violência e descritos os fatores facilitadores e dificultadores na identificação da violência contra a população LGBTQIA+. Dentre os facilitadores, destacam-se: escuta qualificada e utilização de planilha de violência da Coordenadora da Área Programática. Dentre dificultadores, evidenciam-se: não identificação da violência LGBTIfóbica como demanda, dificuldade na abordagem do acolhimento, preconceito (profissionais) com a população LGBTQIA+, não utilização dos quesitos de identidade, orientação sexual e nome social. As estratégias identificadas para enfrentar as dificuldades envolvem ações de Educação Permanente em Saúde sobre a população LGBTQIA+ com as seguintes temáticas: abordagem no acolhimento, elucidação de conceitos de identidade de gênero, orientação sexual e políticas públicas e violência. O estudo sugere a qualificação dos profissionais da ESF, a assistência transversal interdisciplinar e a criação de grupo temático intersetorial.*

PALAVRAS-CHAVE *Violência de gênero. Notificação. Pessoas LGBTQIA+. Saúde da família.*

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Introduction

In 2002, the World Health Assembly resolution (WHA 49.25) of the World Health Organization (WHO) became a milestone for the health sciences by declaring that violence is a significant public health problem. Brazil addresses violence as a public health problem based on the WHO guidelines[1].

According to Minayo[2], violence is a phenomenon that should be considered from a socio-historical analysis and related to power disputes. It is represented by violent acts such as threats, negligence, and omissions. It is also experienced subjectively and secretly, legitimized by ensuring the victim's shame in the certainty of the perpetrator's acquittal. An individually experienced phenomenon is addressed collectively by public policy[2].

In 2001, in response to the growing demand for care related to cases of violence in emergency units, Brazil established the National Policy for the Reduction of Morbidity and Mortality resulting from Accidents and Violence[3].

In 2006, the Ministry of Health (MS) created the Surveillance System for Violence and Accidents (VIVA), which unified all the information systems for Notification Forms. This system addresses the types of violence: physical, sexual, psychological, deprivation, neglect, torture, human trafficking, financial, child labor, and legal intervention[4].

LGBTI-phobic violence stems from compulsory 'heteronormativity' imposed by gender binarism. This enforces an accepted and institutionalized norm regarding affection between people, determining that it is only possible between opposite genders, disregarding any possibility outside this framework[5].

For this article, the acronym LGBTQIA+ will be used: Lesbian, Gay, Bisexual, Transgender and Transvestite, Queer, Intersex, Asexual, and the + sign contemplates other diversities of gender/sexual orientation[5].

LGBTI-phobic violence is now identified as a hate crime, classified as a crime of racism. This term has been used to contextualize violence against the entire LGBTQIA+ community, in which transvestites and transgender individuals are the victims with the highest mortality rates, positioning Brazil as having the highest number of deaths of trans people in the world[6].

Reporting violence is one of the instruments of public health policy. Studies show that underreporting is an institutional fragility resulting from the unpreparedness of some health professionals – either by failing to identify the potential consequences of violence during treatment or by not considering situations of violence as a public health issue[7].

The violence Notification Form is used to display the epidemiological picture of diseases and illnesses, including violent events. It is intended to support planning, monitoring, evaluation, and enforcement of integrated and intersectoral public policies. It is also an instrument that guides health promotion and care. In this sense, it is up to federal authorities to invest in prevention and social protection policies. Regarding the LGBTQIA+ population, it is essential to give visibility to the data collected during the treatment of violence cases, especially concerning reporting them, since this data can be used to create public policies aimed at that population[3].

Then, a question arises: what is the perception of healthcare professionals about reporting violence? Furthermore, what factors facilitate or hinder the identification of violence in the healthcare of the LGBTQIA+ population? It is believed that answers to these questions could support the Permanent Health Education (EPS) actions promoted by the Expanded Family Health and Primary Care Center (NASF-AB), now renamed to eMulti (Multidisciplinary Team), mitigating the consequences of not completing the Notification Form for situations of violence against the LGBTQIA+ population.

This article seeks to analyze the process of reporting cases of violence against the LGBTQIA+ population from the perspective of senior professionals from the Family Health Strategy (ESF) and NASF-AB at two family health clinics in Planning Area (AP) 5.1 in the municipality of Rio de Janeiro.

Material and methods

This study is a descriptive, qualitative research project conducted in two family clinics in AP 5.1 in Rio de Janeiro. The qualitative research aimed to understand the social reality of individuals based on their experiences through social relations, focusing on the process of reporting cases of violence against the LGBTQIA+ population in the catchment area of two Family Health Clinics. The study was conducted from the perspective of senior professionals from the ESF and NASF-AB[8].

For data collection, a documentary analysis was conducted on notifications of violence against the LGBTQIA+ population, including the legal framework. An analysis of the violence information system from 2013 to 2022 was also carried out using TabNet, a tabulator developed by DataSUS. This system generates information from the Unified Health System (SUS) database[9].

A semi-structured, self-response questionnaire was administered to senior health professionals from the ESF of the two selected clinics: doctors, nurses, and dentists, as well as NASF-AB professionals from AP 5.1, including psychologists, social workers, physiotherapists, nutritionists, and physical education professionals. Formal consent was obtained from AP 5.1 for conducting the study at the two family clinics involved, with the responsible professional's signature and approval from the Research Ethics Committees of the Oswaldo Cruz Foundation (FIOCRUZ), Certificate of Ethical Appraisal (CAAE) No. 55708722.4.3002.5240 and Opinion No. 5.938.584; and of the Municipal Health Department of Rio de Janeiro (SMS-RJ), CAAE No. 55708722.4.3002.5279 and Opinion No. 5.894.967.

The following methodologies were employed for data collection: a) documentary analysis, b) information system analysis, and c) semi-structured questionnaire. The questionnaire explored the following topics: a social profile (gender, age, profession, and years of experience in ESF); knowledge about the protocol for handling cases of violence against the LGBTQIA+ population; implementation of reception and care actions for identified cases of violence; reporting of violence; and utilization of intersectoral network flows for referrals.

The questionnaire asked health professionals about their work with the LGBTQIA+ population, such as identification of their attributions and demands related to assistance for LGBTI-phobic violence, knowledge of the protocol for providing care regarding situations of violence, knowledge of fields in the Notifiable Diseases Information System (SINAN), in particular, questions relating to social name, gender identity, sexual orientation, and motivation for violence, understanding of how to carry out actions to notify the LGBTQIA+ population of violence, as well as assessing whether professionals identify violence situations within this population and what follow-up actions should be taken[9].

The research aimed to identify what aspects facilitated or hindered professionals in dealing with LGBTI-phobic violence in their work. It also looked at the appropriation of and links with the intersectoral network comprising the Guardianship Council (CT), Social Assistance Reference Center (CRAS) and Specialized Reference Center for Social Assistance (CREAS), and intersectoral; Adult and Child Psychosocial Care Centers (CAPS, CAPSI); Mental Health and Psychiatry Outpatient Clinic, all components of the Psychosocial Care Network

(RAPS). Finally, the guidelines suggested topics for EPS actions to promote knowledge of LGBTQIA+ issues among health professionals.

A thematic content analysis of the topics covered in the questionnaire and the documents was conducted to identify analytical categories for violence cases, welcoming, handling, following up on violent situations, and liaison with the network[9].

The methodological analysis was carried out through triangulation of techniques and sources of evidence, which involved analyzing the actions of reporting violence against the LGBTQIA+ population from the perspective of different interviewed actors and the analyzed documents[9].

Results e discussion

Data reported on violence against the LGBTQIA+ population in Primary Care in the municipality of Rio de Janeiro from 2013 to 2022

The data on reported violence were accessed through TabNet, in the professionals' exclusive area on the website of the Secretary of Health Promotion, Primary Care, and Health Surveillance (SUBPAV). Various filters were applied, including year of report, all months of notification, frequency, areas of occurrence and planning area, neighborhood of occurrence, sexual orientation, motivation for violence (homophobia/transphobia), and type of violence. The data found is shown in *tables 1 and 2*.

Table 1. Notification of interpersonal/self-inflicted violence in AP 5.1 according to motivation, from 2013 to 2022

	Year										
Motivation	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
Homophobia / transphobia	0	0	0	5	5	1	2	3	11	3	30

Source: Own elaboration based on data extracted from Tabnet[10].

Table 1 shows that 30 cases of homophobic violence were reported between 2013 and 2022. In 2021, there was an exponential increase in the cases that occurred in 2020. According to the Grupo Gay da Bahia (GGB) in its 2021 Report[11], this increase is due to the government's failure to legitimize the markers of violence directed at the LGBTQIA+ population as a source of data for monitoring and addressing cases of violence. The National Association of Transvestites and Transsexuals (ANTRA) notes that the increase was fueled by the government's ideology at the time[6].

The denial of the reality of specific LGBTI-phobic violence rooted in society through ideological and prejudiced discourse, coupled with the absence of epidemiological data on violence against the LGBTQIA+ population, such as sexual orientation and gender identity, decontextualizes the violence. It then becomes seen as intentional acts, traffic accidents, or thefts followed by death rather than as a source of LGBTI-phobic violence. The same document emphasizes underreporting as a reality that revictimizes and strips fundamental rights from this population. Criteria such as social name, gender identity, sexual orientation, and motivation for the violence are underreported or answered by health professionals without consulting the user[6].

The difficulty in obtaining official data has historically been imposed by government agencies, continuously denying LGBTI-phobic violence and reinforcing the invisibility of the LGBTQIA+ population. In this context, the provision of assistance to the LGBTQIA+ population becomes fragile, as professionals do not integrate care according to the demands of this population. As a result, labels strengthen the stigma of discrimination based on sexual orientation and gender, worsening mental suffering[12].

In May 2022, the Municipal Secretary of Health (SMS)-RJ released monitoring data on interpersonal/self-inflicted violence and sexual violence between 2012 and 2022. It used the following violence notification markers: month, year, residents of Rio de Janeiro, life cycle, biological sex, race/color, by year, and AP. This report did not include markers for sexual orientation, gender identity, and motivation for violence, corroborating the premise that events of violence against the LGBTQIA+[13] population were ignored. It should be noted that interpersonal violence occurs in the family by intimate partners or within the community, while self-inflicted violence is directed at oneself[4].

The VIVA instruction manual highlights that the items gender identity, sexual orientation, and motivation of violence due to homo/transphobia were included in the Violence Notification Form as a health condition in 2014. Still, their implementation took place in version 5.0 in 2015[4].

When seeking comparative data, there were 185 reports of violence against the LGBTQIA+ population in the city of Rio de Janeiro. According to the GGB, in 2014, there were 12 murders, making this municipality the third highest in the number of LGBTI-phobic violence events, with 12.12% of the cases in the region. There was no change in the following year[11].

Regarding the records of violence, in 2022, the SMS-RJ presented data on violence motivated by homo/transphobia that occurred in 2021. In this context, the data concerning the motivation for violence due to homophobia were 315 cases; biphobia, 139 cases; violence motivated by gender identity against transvestites, 13 cases; and transsexuals, 47 cases. It is noteworthy that the data indicate at least one notification per day[13].

Physical violence leads the indicators, followed by psychological and sexual violence. Sexual violence is most commonly reported among adolescents[14].

Table 2 shows the number of occurrences of the different types of violence.

Table 2. Notification of Interpersonal/Self-Inflicted violence due to Homophobia/Transphobia and Sexual Orientation (homosexual), in AP 5.1, by residents of Realengo Neighborhood, by type, from 2013 to 2022

	Year										
Nature	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
Physical	0	0	0	2	1	1	2	2	5	1	14
Psychological	0	0	0	1	1	0	0	0	2	1	5
Self-inflicted	0	0	0	1	1	0	0	0	1	0	3
Sexual	0	0	0	0	1	0	0	1	2	1	5
Other	0	0	0	1	1	0	0	0	1	0	3
Total	**0**	**0**	**0**	**5**	**5**	**1**	**2**	**3**	**11**	**3**	**30**

Source: Own elaboration based on data extracted from Tabnet[10].

In line with the findings, the ANTRA Dossier states that most violent events registered as hate crimes are physical and often lead to the victim's death. These acts are committed with cruelty and the intent to dehumanize the victims, including stoning, beatings, intentional run-overs, burning, shootings, premeditated murder, and concealment of the body[6].

The 2021 report presented by GGB indicates that the home is the most unsafe place for the LGBTQIA+ population in Brazil, as it is the location with the highest incidence of violence, accounting for 110 cases, or 36.67% out of the 300 reported cases[11].

Given this, it is essential to consider the role of the ESF's intervention as a healthcare organizer. Studies show that LGBTI-phobic violence occurs more frequently at home. This reality is present in all territories covered by the ESF. However, how can the occurrence of violence be identified, given that professionals do not recognize the signs of this violence in users belonging to the LGBTQIA+ population?[15].

Characterization of Health Professionals' perception of what they understand as reporting violence

The field research was conducted in 2022. Thirteen professionals responded to the questionnaire, including five from the NASF-AB team: a physiotherapist, a social worker, a nutritionist, a psychologist, and a physical education professional. Four nurses and three doctors were also interviewed, and a dentist also participated. The professional experience in ESF and NASF-AB ranged from 6 months to 17 years of practice.

Regarding the flow of care in cases of intrafamily/self-inflicted violence, the SMS-RJ follows the workflow established by the Ministry of Health using a protocol to attend to suspected or confirmed cases of violence. Most respondents declared knowing the protocol, but the type of description varied. The central answers revolved around welcoming, registration, and referral to the intersectoral network (CRAS, CREAS, Public Defender's Office, CT) and RAPS via NASF-AB professionals. The word 'welcoming' was the most mentioned by the respondents, as shown below:

The psychologist stated: "*In cases of sexual violence with penetration, procedures for prophylaxis and rapid testing are carried out within 48 hours*".

The social work professional said they proceeded: "*Welcoming, qualified and confidential care, prophylaxis, and SINAN*".

According to the Ministry of Health, it is recommended to request laboratory tests for emergency contraception, as well as to perform prophylaxis for Sexually Transmitted Infections (STIs)/AIDS and hepatitis B, with specific measures in the first 72 hours, and not within 48 hours as stated by the psychologist[16].

The medical and nursing professionals declared: "*Knowledge of welcoming, prophylaxis, filling in the SINAN form, and the need to call in the NASF-BA*". Only one professional, the dentist, reported not knowing the protocol-related activities.

On this issue, the NASF-AB professionals said that they handled violence cases according to the protocol required by the Ministry of Health. Although this topic is linked to social work and psychology, in the absence of these professionals on the team, others must be able to deal with cases in the Family Health teams[17].

Approximately half of the interviewees expressed familiarity with the prophylaxis procedure, specifically post-exposure prevention actions for STIs. NASF-AB professionals emphasized that when care is provided in an integrated and multidisciplinary way by the Family Health and NASF-AB teams, it is easier to identify and deal with a situation of violence.

In the Family Health teams, the matrix support offered by NASF-AB in cases of violence is a strategy to ensure discussion and support. As Patrocínio et al.[17] pointed out, the NASF-AB is a tool implemented by the federal government to expand the scope of

care provided by the Basic Unit (UB), to offer matrix support and direct solutions based on the assistance and pedagogical dimensions of healthcare interventions offered by the teams.

Networking remains a challenge: although the ESF teams handle the protocols, comply with the workflow, and claim to fill in the Notification Form, they indicated that they leave networking to the NASF-AB team[17].

Between 2020 and 2021, the NASF-AB team prioritized permanent education in health (EPS) in the units' activities. It was noted that the Family Health Teams experience high turnover rates, with employees without experience working in the ESF. The EPS involved the topics of Violence and the Notification Form.

Silveira et al.15 point out that Primary Care (PC) is the healthcare coordinator. It is responsible for health promotion, prevention, and rehabilitation with its professionals. It actively articulates the network and civil society and is responsible for discussing and proposing joint actions to reflect on the impact of violence[15].

The participants listed thematic suggestions for continuing education in health (EPS) regarding the LGBTQIA+ population, such as approaches to welcoming, clarification of concepts related to gender identity and sexual orientation, and better understanding of public policies and the issue of violence.

EPS is a powerful tool for healthcare professionals, directly impacting health promotion. It facilitates the construction of intra- and intersectoral knowledge, promoting a collective and horizontal interdisciplinary approach. EPS also drives intersectoral actions with public and private organizations, all working towards health promotion. The changes in the AP health policy have elevated the Family Health Strategy (ESF) to a powerful place for EPS, creating a space characterized by interdisciplinarity[18].

Regarding completing the Notification Form, it was observed that out of all 13 participants, eight said they had filled it in, three had never dealt with cases of violence in general, and one said they sometimes completed it. The NASF-AB team, whose premise is to matrix the Family Health teams, reported instances of not filling in the form. In contrast, professionals from the Family Health teams said they filled it in, except a nurse and a dentist who said they had never attended to situations of violence. However, the Notification Form for violence has been a standardized and qualifying instrument for violence situations since 2009 by the Ministry of Health. Its completion is mandatory in cases of suspected or confirmed violence by healthcare professionals[4].

The research revealed a challenge in understanding the need to fill in the Notification Form as a working tool for all NASF-AB members. It should be emphasized that the target of notification of violence is the vulnerable populations such as children and adolescents, older people, and women. For these segments, legal frameworks establish compulsory reporting of violence cases by health, education, and security professionals. It stands out that this requirement is the result of social movements, including the LGBTQIA+ population, the subject of this research, as well as quilombolas, Indigenous people, and people with disabilities[4].

It is up to the professionals who work with violence to learn and incorporate into their practices the importance of completing the Notification Form and encouraging the establishment of public policies to deal with situations of violence. The Notification Form enables data to be entered into the system. Its monitoring shows the epidemiological reality fundamental to generating public policies and creating support services for victims and their families. This enables the mapping of the characteristics of such events[19].

Ribeiro and Silva[19] argue that how work is managed and organized can lead to fragmentation due to individualized management. In addition, this can lead to underreporting. When observing the work of NASF-AB's team, this reality becomes apparent as it divides its work into thematic axes linked to its function:

violence and psychosocial, led by social workers and psychologists; nutrition, led by nutritionists and speech therapists; and rehabilitation, led by physiotherapists and physical education professionals. This division does not fully understand the Notification Form for epidemiological reporting of violence, which affects the continuity of transversal care for all professionals[19].

Therefore, NASF-AB, as a strategy for matrix support and network articulation, must focus on addressing and fighting violent situations to legitimize matrix support, a technical support tool in shared or individual clinical healthcare and a pedagogical dimension through EPS[19].

Considering the available data, it is clear that professionals do not commonly complete the Notification Form. Violence is a recognized public health issue, so it should be part of the AP's health professionals' duties. Ribeiro and Silva[19] reinforce the contradiction between the legal obligation for health professionals to fill in the compulsory Notification Form in cases of suspected or confirmed violence and the fact that health professionals do not use the notification form as a tool.

Most survey participants reported knowing and using all the fields when asked about their knowledge of the Notification Form. Only two interviewees, one from the NASF-AB team (a physiotherapist) and the other from the ESF team (a dentist), reported not knowing all the fields.

Regarding the intersectoral network and RAPS, both social work and psychology professionals demonstrated in-depth knowledge of the intersectoral network, given that these categories are considered references for intersectoriality. Furthermore, these pillars are established by the central coordination at SMS-RJ and followed by the local program areas.

Analysis of the data collected in the questionnaire showed that most of the NASF-AB team referred to knowledge, protocol management, and networking. It should be emphasized that the premise of interlocution with support networks is not restricted to the NASF-AB. Even though it is set up to do this, the Family Health teams are also relevant as they are references in the territory, care coordinators, and responsible for interacting between the networks and establishing the link between the facilities[20].

According to Melo et al.[21], the premise of primary care as a healthcare coordinator is to draw up the Singular Therapeutic Project (PTS), aligning the flow of the Health Care Network (RAS). Primary care is the point of articulation between secondary and tertiary levels of care in terms of referral and counter-referral, i.e., it directs users to other levels of care and facilities and ensures their return to their UB of reference – to avoid possible communication breakdowns, facilitates care continuity, and guarantees users rights. As well as being an articulator between the Family Health teams, the NASF-AB becomes a reference and counter-reference in inter- and intra-sectoral articulation for discussion cases requiring multi-sectoral and multidisciplinary intervention[21].

Description of the factors that facilitate or hinder the identification of violence by health professionals in the LGBTQIA+ population

Health professionals identified five facilitating factors: qualified listening, use of the violence spreadsheet from the Programmatic Area Coordination (CAP), provision of comprehensive health services, the occurrence of Debate Cycles with the LGBTQIA+ theme for Primary Health Care (PHC) professionals in the SMS-RJ; and guidelines for the scope of healthcare for the LGBTQIA+ population available in the Primary Care Services Portfolio-SMS-RJ.

Regarding qualified listening, the NASF-AB team reported that they carried out this procedure and highlighted the importance of a more in-depth look at this population. The

nursing team stated that qualified listening contributes to welcoming, making it possible to understand their difficulties and needs.

Another facilitator reported by nurses is the active search for cases included in the CAP violence spreadsheet shared between the ESF/NASF-AB teams. This spreadsheet refers to consolidated instances of violence occurring in the municipality of Rio de Janeiro and attended to by public and private health units and facilities providing care for victims of violence, such as the Lilac Rooms.

Notification forms are forwarded to the Health Surveillance sector and sent to the Family Health teams and NASF-AB to monitor and follow up with users in their places of residence.

Regarding service provision, the nursing team referred to the availability of rapid tests, condoms, and other care services as being in the logic of comprehensive healthcare, as opposed to the logic of labels.

At SMS-RJ, debate cycles bring together professionals from all areas of activity and APs for an expanded discussion on various health segments, including the LGBTQIA+ population. This acts as a facilitator for the identification of violence[22].

In the research, eight obstacles were identified: failure to identify LGBTI-phobic violence as a representative demand; difficulty in the welcoming approach; professionals' prejudice towards the LGBTQIA+ population; inability to use the LGBTQIA+ questions (social name, gender identity, sexual orientation); long waiting list for hormone therapy, gender reassignment, and mastectomy procedures at the secondary level; the lack of knowledge about public health policies for the LGBTQIA+ population; the difficulty professionals have in identifying this population, given their gender identity and sexual orientation; and the low professional qualifications for specific assistance with LGBTQIA+ demands.

Regarding the failure to identify LGBTI-phobic violence as a representative demand, only one NASF-AB professional reported having attended to cases of LGBTI-phobic violence: "*I attend to cases of LGBTI-phobic violence, but not very frequently. The demand that comes in is still deficient*".

Among the ESF nursing and medical teams, three reported having attended to cases of LGBTI-phobic violence. In this respect, Silveira et al.[15] consider that the UBs are in a position to provide the first care because they are located in the user's home territory. PHC has professionals who are integrated and trained in the technical, practical, and strategic dimensions of dealing with situations of violence and recognizing violence to avoid underreporting[15].

As the last complicating factor, the low professional qualification stands out, as corroborated by Guimarães et al.[23], who pointed out that professionals have difficulty distinguishing between the concepts of sexual orientation and gender identity. During the fieldwork, it was possible to observe some professionals' difficulty in understanding the terms mentioned by the author[23].

Final considerations

The survey of senior health professionals from the ESF and NASF-AB revealed that the issue of LGBTI-phobic violence is still unrecognized by some professionals. Whether it is the difficulty of not noticing its signs in the user during assistance or witnessing a situation of violence and not identifying it. For some professionals, violence does not yet represent a demand related to their duties. Thus, it was observed that reporting violence is not a practice that health professionals have fully internalized.

The issue of violence demands comprehensive care, meaning multidisciplinary and interdisciplinary work. The teams of ESF and NASF-AB become jointly responsible for the health surveillance of the assisted families. Regarding the act of reporting violence, it is understood that by reporting, care is expanded, and a network is established, affirming some

of the attributes of PHC, such as coordination of care and longitudinally.

Regarding assistance to the LGBTQIA+ population, factors that facilitate and hinder the identification of violence by professionals were identified. It was possible to determine that knowledge of the care protocol, multidisciplinary welcoming, and referral to the intersectoral network was explicit among professionals. However, there was not unanimous adherence to the complete practice of these procedures.

Despite its power in the ESF to provide information and training to professionals concerning issues relating to the LGBTQIA+ population, the NASF-AB needs to exploit EPS actions sufficiently. These could boost and improve professional actions following the workflow of care for violence: identifying situations of violence, welcoming people, intersectoral work, and maintaining care.

Collaborators

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