

Access barriers for Men who have Sex with Men for HIV testing and treatment in Curitiba (PR)

Barreiras de acesso para Homens que fazem Sexo com Homens à testagem e tratamento do HIV no município de Curitiba (PR)

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ABSTRACT More than half of new HIV infections in 2018 were among key populations, including gay men and other Men who have Sex with Men (MSM). Stigma can have several behavioral consequences, adversely reflecting on the lives of individuals and can be translated into barriers to access to public health services. This paper aimed to analyze the main barriers to accessing HIV testing at a Curitiba Testing and Counseling Center and the linkage of gay men and other MSM with the health service for early HIV treatment. Primary data were collected following the qualitative method, triangulating field observations, document analysis, and interviews. The results pointed to the lack of trained professionals, difficulty receiving health services, acceptance of sexuality, fear of results, and lack of information as the main barriers to testing. Difficulty in accepting the diagnosis, prejudice, and discrimination were some barriers identified to start treatment. We can conclude that the expansion of access to guarantee the rights of those who have more difficulty entering the Unified Health System (SUS) is still a significant challenge.

KEYWORDS HIV. Homosexuality, Male. Health evaluation.

RESUMO Mais da metade das novas infecções por HIV em 2018 ocorreu entre populações-chave, incluindo homens gays e outros Homens que fazem Sexo com Homens (HSH). O estigma pode trazer uma série de consequências comportamentais, refletindo negativamente na vida dos indivíduos, e pode ser traduzido em barreiras para o acesso aos serviços públicos de saúde. O objetivo deste artigo é o de analisar as principais barreiras para o acesso à testagem do HIV em um Centro de Orientação e Aconselhamento de Curitiba e a vinculação dos homens gays e outros HSH ao serviço de saúde para o tratamento precoce. Realizou-se a coleta de dados primários seguindo método qualitativo, triangulando as técnicas de observações de campo, análise documental e entrevistas. Os resultados revelam falta de profissionais capacitados, dificuldade de acolhimento nos serviços de saúde, aceitação da sexualidade, medo do resultado e falta de informação como principais barreiras para se testar. Dificuldade na aceitação do diagnóstico, preconceito e discriminação foram algumas barreiras encontradas para o início do tratamento. Pode-se concluir que a ampliação do acesso para a garantia dos direitos daqueles que efetivamente têm mais dificuldade de entrada nos serviços de saúde do Sistema Único de Saúde (SUS) permanece um grande desafio.

PALAVRAS-CHAVE HIV. Homossexualidade masculina. Avaliação em saúde.

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Introduction

In Brazil, more than half of the new Human Immunodeficiency Virus (HIV) infections in 2018 occurred among the most vulnerable populations: sex workers, drug users, gay men and other Men who have Sex with Men (MSM), transgender people, people deprived of liberty, and their partners¹. Gay men and other MSM accounted for 17% of new infections globally. Also, according to estimates by Unaid¹ from 2010 to 2018, Brazil experienced a 21% increase in new HIV infections, which corresponds to more than eight thousand cases.

One of the population groups most vulnerable to HIV infection^{2,3}, MSM are up to 22 times more likely to acquire HIV than adults in the general population¹. MSM are defined as men who have sex with other men, regardless of whether they have sex with women or have a personal or social identity associated with this behavior, such as those who fall into the 'gay' or 'bisexual' categories¹. The MSM category is defined by sexual activity and not sexual orientation or gender identity.

As at the onset of the HIV epidemic, a predominance of cases is again observed among MSM in Brazil, which is also found in other countries^{4,5}. The survey carried out in ten Brazilian cities in 2009 using the Respondent Driven Sample (RDS) method to recruit MSM, considered to be a difficult-to-access population, had an HIV prevalence of 12.1%, but only 49% had been tested for HIV at least once⁶. The results of a second national survey that used the same RDS method in twelve Brazilian cities in 2016 showed a prevalence of 17.5% in MSM⁷, a considerable increase if also compared with the first survey.

Stigma was defined as an attribute that profoundly discredits a person, labeling the individual with a tarnished identity in the face of society⁸. According to a study by Genberg et al.⁹, from a relational

perspective, the association of the stigma of living with HIV can lead to adverse effects on prevention and treatment adherence due to the fear of isolation or social rejection. Parker¹⁰ believes that discrimination is a behavioral response to negative attitudes and a materialized stigma. Discrimination actions can have several behavioral consequences, reflecting negatively on the lives of stigmatized individuals¹⁰.

Several forms of discrimination generated by the stigmatization of homosexuality increase individual vulnerability, decrease self-esteem and the perception of their rights. They hinder the structuring of full identity, leading to internalized homophobia¹¹. Different forms of discrimination can be translated into barriers to access public health services. According to Obrist et al.¹², access to health services can be determined by situations of the population's vulnerability, which depends on human, physical, financial, and social capital.

A study by Assis and Jesus¹³ identifies advances in reducing inequalities and expanding access to the Unified Health System (SUS) network, especially in PHC, since the publication of the 1988 Brazilian Magna Carta, which ensured health as a universal right guaranteed by the State.

However, there were also limits related to accessibility, fragmentation, decentralization, and regionalization of the care network, with inadequacy in receiving and caring for specific groups, besides regional asymmetries. Social inequalities emerge in other studies, even in developed countries such as Canada and some European countries¹⁴⁻¹⁶. According to Travassos et al.¹⁷⁽⁹⁷⁶⁾, access

expresses characteristics of the supply that facilitate or obstruct people's ability to use health services when they need them. Barriers to access originate from the characteristics of health systems and services.

The analysis proposed in this paper is nested in broader research called 'Assessment of access by Men who have Sex with Men to the Curitiba Guidance and Counseling Center', where a single case study was carried out using quantitative and qualitative approaches. The assessment was based on an interventional research project at the Guidance and Counseling Center (COA) called 'A Hora é Agora (AHA, in English, The Time is Now)'. The question that motivated the study was whether the AHA project developed at the COA in Curitiba changed MSM access to HIV testing and the linkage of diagnosed HIV+ users to health services to provide the early HIV/Aids treatment.

The AHA aimed to prevent and control HIV among gay men and other MSM, especially among young people aged 14 to 29, which began in December 2014 and ended in December 2017. The project aimed to increase access to testing, offering finger-prick rapid tests at a mobile unit or trailer parked in a strategic location, i.e., near socially interactive areas visited by the target audience; in the Non-Governmental Organization (NGO) Grupo Dignidade, serving lesbians, gays, bisexuals, transvestites and transsexuals (LGBT); at the public health unit (COA); and by incorporating HIV testing into the Curitiba Street Clinic.

Also, with the support of the virtual platform (<https://www.ahoraegora.org/>) called e-Testing, the key population of the project (MSM) could receive the oral fluid test at home or collect it at the popular pharmacy of the Ministry of Health to carry out the self-test. The project also aimed to strengthen the link of HIV+ cases with HIV care health services in Curitiba by 'linkage', facilitating access to ART and ensuring the monitoring of users through the 'linker' – neologism derived from the English word linkage.

The linker was a member of the AHA team that assisted users with HIV+ results to initiate treatment in public health services in primary health care (PHC). The linker is a professional selected and trained to support users when they discovered they were HIV+, facilitating

their access to health services, and answering any questions about HIV/Aids, always encouraging their autonomy.

The COA was implemented in Curitiba in 1992 by the state administration. In 1995, it shifted to the municipal administration of Curitiba. When the Ministry of Health changed the name of the COA to Testing and Counseling Center (CTA), Curitiba opted to keep 'COA', understanding that its users had already created a service identity. It is currently considered a Specialized Care Service that provides testing for HIV, syphilis, hepatitis B and C, counseling, outpatient medical care for People Living with HIV/Aids (PLWHA), and a Drug Dispensing Unit. The COA is staffed with advising psychologists, nurses, pharmacists, doctors, and administrative assistants.

While the COA is a vital reference for the most vulnerable populations and serving a good number of MSM, this population struggles to access health services due to this social group's stigma^{6,18}. Most MSM want privacy and secrecy regarding their sexual orientation or activity, which is not always respected. There is also a need for an adequate approach to these groups vulnerable to HIV infection so that there is a more significant link and adherence to treatment, which have been lower.

This is an original study in Brazil because it reveals the barriers and facilitators of users at the time of HIV+ diagnosis at a SUS health service, based on an intervention and research project – the AHA. Given the above, it is fundamental to deepen the understanding of the different barriers of access to HIV prevention, diagnosis, and treatment by young gay men and other MSM at a SUS service in Curitiba, in a context of introducing new technologies for improving care management. In this sense, this paper aims to analyze the main barriers for access to HIV testing at a COA in Curitiba and the linkage of gay men and other MSM to the health service for the early treatment of HIV based on the AHA project.

Material and methods

Primary data was collected following a qualitative method, triangulation of field observation techniques, document analysis, and interviews with users, managers, and health professionals to achieve the objective of the analysis. According to Denzin¹⁹, triangulation uses different data sources or different data from the same source to examine the same object. This study sought convergence and confirmation through these different techniques used to strengthen the internal validity of the analysis. Such data provided context and depth, providing a denser view of the intervention in the COA.

Field observations were necessary so that the researcher could make a field mapping, that is, previous interaction with the subjects' reality before the interviews. We observed the

busiest times of the research target population (the MSM), service to users, access for people with disabilities, team integration, and waiting time for assistance. The observations were made at three stages from February to April 2018, on all weekdays, during COA's entire opening hours.

After the free-floating reading of the available documents of the AHA project, we selected for analysis the project protocol; minutes of meetings between linkers and linkage coordination; the user and linker contact information forms; half-yearly and annual reports on the cooperation agreement; the reports of the supervisory visits at the COA; and the AHA project evaluation report. We identified and organized the type of document, its nature, the number, and characterization of its contents to analyze these documents, as per *table 1*.

Table 1. Document analysis of the AHA assessment in the COA

Document	Nature of document	Number of documents analyzed	Characterization of the document's content
Project Protocol	AHA Project official document	1	Justification for the AHA project, objectives, methodology used, participants, instruments used in data collection, and time for carrying out the research.
Minutes/aide-mémoire of meetings between the linkers and the linking coordination	Details of the issues addressed in the meetings on the linking strategy	29	Barriers encountered by users in the Basic Health Units (UBS) in Curitiba; barriers found in the COA; difficulties identified by linkers in the linking process.
Cooperation Agreement interim and annual reports	Information on the development/progress of the AHA project	5	Data from the testing and linking process, communication and information materials used, results achieved, progress and challenges of the AHA project.
User/Linker Registration Forms	Record of each contact made between the linker and the user	73	Barriers encountered by users in each process: registration at the UBS, appointment, test scheduling, medication pick-up, among others.

Table 1. (cont.)

Document	Nature of document	Number of documents analyzed	Characterization of the document's content
Supervisory visit reports	Details of the situations observed in the COA	8	Relationships between COA professionals and project professionals, service to users, and COA structure.
Project 'Agora é a Hora' (The Time is Now) evaluation report	Project implementation assessment report	1	Satisfaction survey with COA users carried out in 2016; positive and negative points of the COA from users' perspective (interviews conducted in 2016), main findings according to the critical variables of implementing the AHA project.

Source: Own elaboration.

Subsequently, semi-structured interviews were carried out to identify the barriers to MSM access to the COA and other services in Curitiba. The interviews were recorded and later transcribed for analysis. Three categories

were created according to each question asked in the interview, grouped according to access barriers: barriers for MSM, MSM testing barriers, and MSM treatment onset barriers (*table 2*).

Table 2. Categories of analysis and questions related to access barriers

Categories of analysis	Questions	Informants
Barriers for MSM	What are the main barriers MSM users may encounter when looking for the COA? In your opinion, what is the most significant barrier to reaching MSM in Curitiba?	All users and health professionals
Testing barriers	Can you describe some of the reasons why MSM may choose not to be tested for HIV?	All users; health professionals and managers
Treatment barriers	What do you consider the main barrier for a user (MSM) diagnosed with HIV+ not to start treatment?	HIV+ users and health professionals

Source: Own elaboration.

The selection of participants for the interviews with the informants was intentional to obtain the specific categories of participants relevant to the research objectives. The linkers played a vital role in the selection, as they were responsible for inviting and scheduling

interviews with HIV+ users followed-up or those who had already ended the linkage. Users who went to the COA to test themselves were approached in the waiting room during the days and hours of highest attendance at the service while waiting to take the test.

Regarding health professionals and managers, the interviews were previously scheduled by the researcher and carried out at the COA in a private room.

The number of informants was based on the saturation criterion²⁰, or the point at which the themes started to be repeated and new

information ceased to appear. Twenty-two interviews were conducted per the inclusion and exclusion criteria detailed in *table 3*, and all managers, health professionals, and users invited for interviews were directly or indirectly involved with the COA.

Table 3. Criteria for inclusion and exclusion of research participants

	Managers and COA professionals	Users
Intentional selection characteristics	COA health professionals (including superintendence, district management, and local coordination)	Took the test in the last six months at the COA
	Professionals hired by the AHA Project	Never took the test
Inclusion criteria	Held current position for at least six months	Self-identifies as MSM Lives in Curitiba
	Accepting to participate in the research (Informed Consent Form)	Above 18 years Accepted to participate in the research (Informed Consent Form)
Exclusion criteria	COA professional who does not serve the project population (e.g., doctors and administrative staff)	Does not self-declare as MSM Transvestite/transsexual
Interviews realized	Two managers	Seven HIV+ users
	Seven professionals	Six HIV- users
	Total: 9	Total: 13

Source: Own elaboration.

A thematic content analysis was performed, a data treatment method, which aims to interpret qualitative material, ensuring an objective, systematic description and richness manifested at the time of collection²¹. This analysis included the exploration of the material, which consisted of coding and categorizing, thus building thematic categories according to the barriers, and the treatment of results, which was the phase of reflection and intuition based on empirical materials, comparing accumulated and acquired knowledge²¹.

This research was submitted and approved by the Research Ethics Committees of the

National School of Public Health Sergio Arouca/Fundação Oswaldo Cruz (Ensp/Fiocruz), under Opinion 2.539.927 of March 12, 2018, and the Municipal Health Department of Curitiba, under Opinion 2.609.994 of April 19, 2018.

Results and discussion

The main barriers of MSM access to the COA, the barriers to reaching the MSM in Curitiba, the barriers that prevent MSM from testing themselves, and MSM diagnosed with HIV+

from starting treatment were analyzed according to the views of users, health professionals, and managers.

The main barrier mentioned by MSM for access to the COA was the opening hours, which is not a specific barrier of the COA but of most public services that operate during business hours. The professionals also mentioned the reduced number of the COA team, which cannot meet the demand and often must ask the user to return the next day.

If the user arrives a little later, say at 4 p.m., for a service he wants... the internet says he is staying until 6 p.m.; if he gets in at 4 p.m., he won't be able to take the test if we're not here. So, maybe it's a door in the face; that's what he's going to get, and no listening to what it is or what happened. (Professional 6).

The barriers to reaching the MSM in Curitiba mentioned by health professionals and managers were access, location, humanization, lack of trained human resources in services, and prejudice.

The COA is located in a central region of Curitiba, with easy access to the bus terminals, although some people have difficulty paying for transportation from the suburbs to downtown.

We also have to think that there are also MSM in the suburbs, who, somehow, may not be able to access this offer that the project or COA can provide; that issues of rapid tests are not in the suburban units. Anyway... (Professional 6).

According to health professionals, there was also a concern about the lack of humanization in the service and people trained to care for MSM and other vulnerable populations, including prejudiced employees. A study conducted with MSM in Brasília revealed that access to public health services is limited, and there is no privacy. As a result, individuals are subjected to stigma, to

the very least symbolic violence, or a service geared to the heterosexual public²². In other words, these services are less humanized and receptive because they disrespect the social and sexual diversity of the most vulnerable groups.

The interviewed users mentioned the lack of information, fear, shame, and homophobia as barriers to reach MSM in Curitiba. The interviews highlighted the need for communication and information on HIV/Aids for MSM and other key populations, the relevant lack of information materials, and the few existing media campaigns.

I had stopped at the time of Renato Russo and Cazuza. Yes, I don't really see much. There have to be more educational campaigns. (User 3 HIV+).

Fear, shame, and homophobia arise in all issues, from the idea of a conversation on the topic, lead people to agree with the need to perform the test and start treatment if the result is positive.

[...] homophobia concerning the disease because diseases have a social issue, don't they? I had a seropositive friend who always said, 'Is the problem more social than it really is in the physical?'. (User 5).

Regarding testing barriers, professionals and managers mentioned prejudice, lack of suburban access, reception difficulty in health services, the sexuality acceptance issue, and COA's opening hours and lack of staff. According to Lippman et al.²³, despite evidence of increased risk among MSM, the coverage of periodic HIV testing in this population subgroup is still low, which is probably due to access barriers that make this social group even more vulnerable.

Some MSM are very withdrawn. Treatment is difficult with them; conversation is difficult. It is necessary to have a much closer approach

and use tricks not to lose the patient. So, it's a hardship we try to circumvent every day. (Professional 1).

Users list the lack of trained professionals, the difficulty of access, time to take the test, the fear of suffering prejudice, exposure, fear of the result, lack of information, stigma, and shame as testing barriers. These barriers can be divided into organizational and subjective, which denotes an overlapping of barriers and, consequently, vulnerabilities.

According to some health professionals interviewed, the need for training the network of professionals in Curitiba was evident in some issues addressed, as was the difficult access to services by people living farther from the center. Concerning working people, the time to take the test was also mentioned by some interviewed users, as the opening hours of public services are limited and coincide with the business hours of most workers. While the location is close, there is not enough time at lunch to perform the test, result, and post-test counseling. Fear emerges through prejudice, exposure, and the test result.

Fear of being exposed. Exposure, for sure. 'Nobody likes to be seen taking a blood test for...', do they? (User 5 HIV-).

People have a very wrong preconception of HIV. I had this prejudice, and today I suffer from it. Today I am on the other side. I think that's precisely what it is: people's prejudice. (User 5 HIV+).

[...] although he is a person, let's say, assumed, who has sex with men, he still has a stigma of 'people have HIV because they don't take care of themselves'. There is a lot like that... I even see among people living with HIV that there is a specific thing: '... you have it because you didn't take care of yourself'. So, this is sort of a moral thing... (User 3 HIV+).

Concerning the lack of information, the need for the media to influence more was answered to try to reduce prejudice and make people have more courage to go and test themselves. Studies carried out with MSM in Germany and Malawi have confirmed shame and fear of stigma as the most daunting barriers for MSM to test themselves^{24,25}. In Curitiba, stigma, and shame were barriers mentioned by all respondents.

Make it more common to take this shame out of people, such as entering a building where I know that there is an HIV test being performed there. People looking at me out there walking on the street know that tests are being carried out there. They will look and think: 'He has Aids!'. So, this ends up causing us a particular fear, especially with homosexuals, that they have to enter a place like this. (User 6 HIV-).

The health professionals interviewed spoke about the barriers that prevent HIV+ users from starting treatment: denial of diagnosis, accepting their sexuality, prejudice, religious issue, lack of financial resources, such as money for transportation.

Because we serve here, and we have already seen many people who were unable to go to an appointment because they did not have a bus ticket. (Professional 1).

[...] I have already lost a user because of religion; as the family said that Jesus would heal, he did not want to undergo the treatment. Regarding the family, fear of showing it to the family for... fear of identifying with the medication and taking the medication home. (Professional 4).

The widely recognized benefits of the early introduction of ART, according to Marsicano et al.²⁶, seem to be neglected by the stigma and fear of being positive. The HIV+ users interviewed mentioned fear of medication and its side effects, lack of information, and shame as barriers to starting treatment.

In line with a study by Silva et al.²⁷, people are usually afraid of what they don't know; that is why information and communication are so important. All respondents mentioned the fear of medication and side effects as the main barrier, so pharmacists appeared as essential mediators in guaranteeing access to UDMs. *“Fear of medication and medication side effects. Some people report suffering from diarrhea all day”* (User 1 HIV+).

Despite the significant benefits of early treatment in high- and low-income countries, people continue to test late for HIV infection²⁸ due to HIV testing barriers, many of which are shared across settings and populations²⁹.

All users interviewed were successful in their process to start treatment, but, according to the minutes of the meetings and records forms analyzed, some users faced some barriers during the process even when managing to start treatment:

a) Difficulty in accepting the diagnosis – some users who accepted the linkage did not want to talk about the linkage process right after the quick test; they asked for time to ‘digest’ the diagnosis, which caused some delay in the whole process. One user revealed that he wanted to commit suicide after diagnosis, besides other cases where partners were deemed guilty of transmitting the virus.

b) Registration at the Basic Health Unit (UBS) – users must register at the UBS to start treatment, although this was a significant barrier for users who chose a unit further away from their place of residence. Even decentralizing the public health network in Curitiba to care for people living with HIV/Aids, users' dwelling territory was an important issue for some UBS, for example, Mãe Curitibana, Vila Guáira, Campina do Siqueira, and Iperotiga. Thus, users who chose care away from their homes, especially so as not to be recognized by their neighbors in the service or so that the UBS where they were already registered did not know about the diagnosis, were prevented

because they lived in a region that did not correspond to the area attended by the health service. Linkers reversed the situation in some cases, and in others, users were directed to the COA, which demotivated some users, requiring more significant intervention by the linkers.

c) Waiting time to schedule appointments and exams – in some of the reported cases, the first appointment was difficult to schedule, taking up to two months and generating the transfer of UBS. Also, a linker was prevented from entering the medical visit with the user in one UBS, and, in another UBS, the unpreparedness of one of the teams to observe PLWHA was observed. There was also a delay in scheduling necessary tests for ART prescription, such as CD4, viral load, and chest x-ray exams for users with suspected tuberculosis. According to the final report of the linkage, 22 users had difficulty scheduling the visit, and 30 found difficulties with laboratory tests.

d) Prejudice and discrimination – some of these cases are reported in the minutes of the meetings, such as the referral of a user to another service, given that PLWHA can be assisted in any health unit; stigma/discrimination during medical visits at the UBS of Bacacheri, Ouvidor Pardo, and Mãe Curitibana; a user was kicked out of his home after the father found out he was infected with HIV; a user reported the number of a friend to the linker, fearing that the family would discover his diagnosis.

The study carried out in Brasília (DF) by Pimenta and Merchan-Hamann²² draws attention to the need for reformulation in the education and teaching of health professionals to reduce the vulnerabilities of homosexual citizens. Also, Gomes et al.¹⁸ show how fundamental the role of civil society is in occupying social control spaces to eliminate barriers that compromise access to health services.

Finally, we register aspects that arise as guiding questions for improving access and

quality of care for MSM and other vulnerable groups to provide a synthesis of the access barriers (*table 4*) announced by the

different subjects.

Table 4. Summary of access barriers

ACCESS BARRIERS	
Barriers for MSM	<p>Professionals and managers mentioned the opening hours as the main barrier for MSM in the COA, besides lack of staff</p> <p>To reach the MSM in Curitiba, professionals and managers mentioned: access, humanization, lack of trained human resources in services, prejudice</p> <p>To reach the MSM in Curitiba, users mentioned: lack of information, fear, homophobia, shame. Reagent users cited: fear, prejudice, shame</p>
Testing barriers	<p>Per the view of professionals and managers: prejudice, lack of access (suburbs), reception difficulty in health services, accepting sexuality, opening hours of the COA, lack of trained staff at the COA</p> <p>Users pointed out as barriers: lack of trained professionals; time to take the test; difficult access; fear of suffering prejudice; fear of exposure; fear of the result; shame</p> <p>HIV+ users cited: fear, prejudice, stigma, lack of information</p>
Treatment barriers	<p>The professionals mentioned: denial of the diagnosis, issue of accepting their sexuality, prejudice, religious issue, lack of financial resources (money for transportation, for example)</p> <p>HIV+ users mentioned as barriers: fear of medication, side effects; lack of information, shame and when someone wants to 'give up on life'</p>

Source: Own elaboration.

Final considerations

This research addressed the access of Men who have Sex with Men, one of the most vulnerable populations to HIV infection, in an intervention that aimed to expand access to early diagnosis and treatment for HIV to prioritize this population.

The results revealed that the AHA strategies converged to increase the visibility of the COA among MSM and that the entry of the AHA project also provided increased

testing at the COA, a more appropriate approach to counseling and care.

The COA's opening hours were the main barrier found and the most easily perceived access barrier. Moreover, the need to expand the COA team became evident as the AHA project changed MSM access in the COA, but the demand was only absorbed due to the team recruited by the project. It is worth emphasizing the importance of this team of trained professionals who helped reduce the time between diagnosis and treatment

and introduce a new organizational culture.

The barriers mentioned to reach MSM, test them and start their treatment immediately led us to conclude that there is a need for more information on HIV/Aids and prevention for the entire population, not just for the key populations. Information about treatment is also essential for people even before a possible diagnosis. We recommend that the Ministry of Health and health departments develop more actions in this area for the general population without focusing on key populations to reduce stigma. Actions with the Ministry of Education, such as the extinct School Health and Prevention project, could affect, as they will focus precisely on the young population, where the epidemic predominates.

This study brought the need for greater depth on stigma, given an overlap found. Stigma is found in the disease, MSM categories, transgender/transvestite people, and the individual vulnerable situation of MSM, such as their socioeconomic condition and the barriers to access and treatment brought about by these conditions. It is important to have continuing education and conversation circles with the primary care network, including sex, sexuality, gender, and vulnerabilities. Also, better mediation and interaction with civil society organizations and communication channels are required to address sensitive issues for young gay men and other MSM who need to improve access and care for healthier sex life.

Finally, it should be emphasized that most respondents and users of this research have completed high school or above and are therefore privileged concerning access, given that access is directly linked to the individual level of knowledge and education. In this sense, expanding access to ensure the rights of those who effectively have more difficulty entering SUS health services is still a significant challenge.

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Collaborators

Cota VL (0000-0002-6823-9304)* contributed to the design, planning, analysis, interpretation of data, elaboration of the draft, critical review of the content, and approval of the final version of the manuscript. Cruz MM (0000-0002-4061-474X)* contributed to the design and planning, critical review of the content, and approval of the final version of the manuscript. ■

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