

# Between visibility and listening: access of the LGBTI+ population to primary healthcare<sup>i</sup>

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**Abstract:** This article aims to identify and analyze how health professionals working in primary care in the city of São Paulo understand LGBTI+ people access to health. The research covered the six administrative regions of the city and this paper analyses in depth interviews with specialists of the administrative regions, and also with managers, physicians, nurses and nursing technicians/assistants in Basic Health Clinics trying to understand how they see the access of this segment of people into primary care. The access of LGBTI+ people to primary care tends to prioritize those visually recognizable and whose health demands can be understood in the frame of health centered on illness. This keeps many segments and health demands without attention. The results of the investigation point toward the need of switching the visual frame for a listening strategy to promote access of LGBTI+ people to integral health.

**Key-words:** Sexual and reproductive health and rights. LGBTI people. Access to healthcare. Health professionals. Listening.

## *Entre a visibilidade e a escuta: o acesso da população LGBTI+ à atenção básica de saúde*

**Resumo:** Este artigo tem como objetivo identificar e analisar como os profissionais de saúde, que atuam na atenção básica na cidade de São Paulo, percebem o acesso à saúde de pessoas LGBTI+. A pesquisa abrangeu as seis regionais de saúde paulistanas e o artigo centra-se na análise das entrevistas em profundidade com especialistas nas regionais, além de gerentes, médicos, enfermeiros e técnicos/auxiliares de enfermagem nas Unidades Básicas de Saúde (UBSs) focando na forma como os profissionais veem a entrada desse segmento na atenção básica. Conclui-se que a forma atual de acolhimento tende a priorizar aquelas e aqueles reconhecíveis visualmente e cujas demandas envolvem uma concepção de saúde centrada na doença, o que mantém vários segmentos e demandas de saúde sem atenção. Sugere-se que a superação do enquadramento visual por uma estratégia de escuta poderia contribuir para o acesso das pessoas LGBTI+ à saúde integral.

**Palavras-chave:** Direitos sexuais e reprodutivos. Pessoas LGBTI. Acesso à saúde. Profissionais de saúde. Escuta.

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1. Throughout the text, both the acronyms LGBT and LGBTI+ will be used since the acronym has been expanded to include more social segments. The National LGBT Comprehensive Health Policy dates from the early 2010s, but currently the social movement has also given visibility to the intersex segment, which led us to incorporate it into the study.

2. In this article, Richard Miskolci, the first author, conducted the research, concept development and drafting of the article. Pedro Paulo Gomes Pereira participated in the theoretical conception, the general planning of the article, as well as its writing and final editing. However, first-person singular verbs and pronouns were used to emphasize the research experiences of the first author, which are important to the general composition of the article.

3. The names of all of the interlocutors have been changed to preserve their anonymity.

4. The Brazilian Institute of Geography and Statistics (IBGE in Portuguese) uses a skin color classification for “racial” self-

In December 2019, on a hot, sunny day, I was heading to a primary healthcare clinic [Unidade Básica de Saúde (UBS) in Portuguese] in the western zone of the city of São Paulo. It was one of the last interviews for the study on the access of the lesbian, gay, bisexual, *travesti*, transsexual, intersexual, and other (LGBTI+) population to primary health care<sup>1</sup>. I encountered a poor region, but surrounded by one of the richest neighborhoods in the city, which revealed to me yet another landscape of Brazilian contrasts and inequalities. Soon I saw a well-kept primary healthcare clinic, clean, organized and with new paint<sup>2</sup>.

After being greeted by the manager, who let me use her office, I received the first professional to interview, Inês<sup>3</sup>, a nurse, 43. She declared herself *parda* [racially mixed]<sup>4</sup>, heterosexual, divorced and the mother of two children. She said she was a Spiritist and had conducted graduate level studies. Inês was friendly and interested in the research subject. She said that there was a group at the clinic created by a psychologist that sought to improve access to healthcare for LGBTI+ people. This was the only initiative of its kind that I found in the twenty-four primary healthcare clinics visited in this city of more than ten million inhabitants. According to Inês:

They [LGBTI+ people] don't identify themselves when speaking, but they identify themselves by the way they dress, the way they act and, every once in a while, they say: "I don't have relations with men, but I'd like to have a Pap smear. I don't have relations with men, but I have a gynecological problem," that's how it appears. In the same way that, for example, men arrive who are homosexuals, homoaffectives, they show up with long hair, dressed as women, but they still do not have information on their social name<sup>5</sup>. So, this causes a certain amount of embarrassment when we call them by their name and they get up, the other people stare.

In her formulation, there is an effort to define gender and sexuality through a visual framing. Thus, the health professional observes clothing and gestures to also envision forms of care and specificities.

On the other side of the city, in May of the same year, I met Carla, at a primary healthcare clinic in a lower-income neighborhood in the eastern zone. She was thirty-seven years old at the time and described herself as *parda* [racially mixed]. She was hetero, married and the mother of three children. When asked, she said she practiced Umbanda [an Afro-diasporic religion]. She studied nursing at a Catholic university and, despite not having contact with gender issues, said she had taken courses on ethics and sociology that discussed the topic. At one point, when asked how she recognized the need for healthcare by LGBTI+ people, she pondered:

“When we don’t know, we treat them according to the image they show us, but normally those that we see are lesbians and gays.”

identification in the Census and people adopt it in everyday life as well.

Thus, in one more region of the city I encountered the formulation that the “figure shows itself to us”. In this way, these narratives indicated something about how healthcare professionals view LGBTI+ people who seek primary healthcare – the so-called entry point into Brazil’s Unified Healthcare System [Sistema Único de Saúde (SUS) in Portuguese] – in the city of São Paulo.

5. Social names are names trans people adopt for themselves. In Brazil, trans people have the right to use their social names in official administrative records.

These nurses were among the twenty-nine people interviewed who comprised the empirical body of the study of the perceptions of healthcare professionals regarding sexual and reproductive rights, conducted in 2019 and 2020. In my searches for bibliographic material about a similar topic, I discovered that this study was one of the few to include all the regions of the city, and one of the first to question different types of professionals. The studies I found addressed issues such as: the experience of implementing the Comprehensive Healthcare Policy for Lesbians, Gays, Bisexuals, *Travestis* and Transsexuals (LGBT) in the municipality of São Paulo (Calazans et al., 2019); advances and challenges in the implementation of the National Comprehensive LGBT Healthcare Policy (Sena & Souto, 2017); the history of public policies concerning the LGBTI+ population in Brazil (Mello et al., 2012) and of rights (Lionço, 2008); LGBTI+ health in primary healthcare (Santos et al., 2019); access to sex reassignment surgery in the Unified Healthcare System (Popadiuk et al., 2017); dialog between healthcare professionals and LGBTI+ people (Moscheta et al., 2016); humanization of care given to trans and *travesti* individuals (Ramos et al., 2020), and others.

One of the objectives of the study was to identify and analyze what professionals understood hindered these individuals’ access to healthcare, as well as what could offer stronger and more effective ways of receiving them. To this end, this article begins by discussing the research path. It then presents a brief history of the recent recognition and inclusion of the LGBTI+ population in the Brazilian healthcare system. Next the analysis focuses on the entrance of these people into primary care, seeking to understand how healthcare professionals view this delicate moment, and what strategies and measures they use and construct.

The entrance to a primary healthcare clinic is one of the most important moments in the care process, according to healthcare professionals, who see the moment as an opportunity to “create bonds”. In an effort to analyze the regime of visibility at play in the reception to primary healthcare clinics, the following section describes and analyzes how the current form of reception tends to prioritize those in the

LGBTI+ population, who are visibly recognizable and whose needs involve a disease-centered conception of health. The questions formulated throughout the text may serve to identify obstacles and possible solutions to achieve the comprehensiveness proposed in the National Comprehensive LGBT Healthcare Program.

## Research paths

The research encompassed the entire city of São Paulo, which was administratively divided into six regions by the Municipal Secretariat of Health. Semi-structured interviews were conducted with professionals specialized in issues of sexuality, gender and reproduction in the six São Paulo regional healthcare offices and with four different types of professionals from one primary healthcare clinic in each of the regions: administrators, doctors, nurses, and nursing technicians/assistants, none of whom had any special education or experience necessarily involving reproductive issues or the healthcare needs of LGBTI+ people.

At first, the regional coordinators indicated a professional to be interviewed from their offices based on the criteria that they have experience or familiarity with the research issues. This procedure was used to get to know the perception of the professionals who, in some manner, led or coordinated the regional clinics work in this field. The other interviewees were professionals from primary healthcare clinics – selected at random, one from each region – the administrator of the clinic was interviewed and in turn designated a doctor, a nurse and a nurse technician or assistant.

Health professionals' perceptions of sexual and reproductive rights involve their sociodemographic characteristics such as age, gender, and religious affiliation, as well as special education, sources of information and legal/professional regulations. These perceptions enable accessing relationships between subjectivity, intersubjectivity and objectivity (Merleau-Ponty, 1962; Ingold, 2000) in such a way that the concept of perception helps to comprehend how the agency of healthcare professionals is shaped by these professionals' situated perspectives regarding gender and sexuality (Butler, 2003; 2014).

The interviews were conducted between March 2019 and January 2020, in the professionals' work locations (regional headquarters or primary healthcare clinic), at a time agreed to by their superiors and administrators. They began with questions that allowed tracing the professional's sociodemographic profile including their gender identification and sexual orientation. They then addressed issues of health and sexual and reproductive rights in the healthcare service. All of the interviews

were recorded, lasted an average of thirty minutes and were transcribed for analysis. The group of interviewees was comprised predominantly of women from the city of São Paulo who were older than thirty (the average age was 45), white, middle class, with higher education; who, in general, had received a medical or nursing degree within the last two decades, and included a preponderance of married or divorced women who were also mothers<sup>6</sup>.

6. This data helps to explain the profile of the interviewees and provide elements for future analyses of the relationship between sociodemographic profile and perceptions.

The investigation, its methods, and techniques combined with years of experience by the researcher in the field of gender and sexuality (Miskolci, 2013; Pelúcio & Miskolci, 2009; Polidoro et al., 2020; Signorelli et al., 2020). The previous experience was internalized and facts experienced in the field over the years could be remembered or reinterpreted (Peirano, 2008; 2014) generating a sharp look at healthcare sites, reports on patient itineraries, as well as forms of interaction.

### A brief history of LGBTI+ health: from the Aids epidemic to the implementation of the National Comprehensive LGBT Healthcare Policy

The LGBTI+ population has only a recent history of inclusion into Brazilian public healthcare policy. To a large degree, as analyzed by Gabriela Calazans (2020), this incorporation was realized thanks to pressure by the LGBTI+ social movement as well as its articulation with institutions such as the Federal Council of Medicine and the state. According to Calazans (2020: 463), seeking to understand public policies that deal with sexual and gender diversity lead us to recognize that these policies – and even the healthcare policies of the national Unified Healthcare System – are the product of the social movement's action and of its articulation with administration.

In 1985, the Federal Council of Medicine released a report affirming that homosexuality could not be considered a pathology, and at the deadly peak of the HIV/Aids epidemic, the National STD/Aids Program was created and was consolidated in the late 1990s. It was through the sexual panic of Aids that public policy for the LGBTI+ population was contemplated, more in the sense of understanding the group as agents of disease transmission, than to actually protect it (Pelúcio & Miskolci, 2009; Pereira, 2004). This dimension will be important to all healthcare, as the article will show.

LGBTI+ needs were more broadly introduced into the political agenda beginning with the mention of the category of homosexual in the First National Human Rights Plan (1996), during the Fernando Henrique Cardoso government. In 2004, during the first Lula administration, the *National Comprehensive Women's Healthcare Pol-*

*icy: principles and guidelines* was released which recognized the need, in health-care, to attend to the particularities of different segments of the female population – such as Blacks, the Indigenous and lesbians. Also in 2004, the federal government launched the *Brazil without Homophobia Program – Program to Combat Violence and Discrimination against GLTB and to Promote Homosexual Citizenship*. In the same period, the ministry of Health formed the “Technical Committee for Gay, Lesbian, Transgender and Bisexual Population Healthcare,” which was designated to establish a national healthcare policy for this group.

Another initiative that contemplated the LGBT population was the *Healthcare Users’ Charter of Rights*, approved under decree nº 675 of March 30, 2006, which detailed the right to care, treatment and service within the Unified Healthcare System free of discrimination by sexual orientation and gender identity. This Charter also affirmed that everyone has the right to be identified by the name they prefer, regardless of the name on their birth certificate and official identification card, creating an opportunity for the institutionalization in the Unified Healthcare System of a “social name,” a demand of trans people<sup>7</sup>.

7. For a critical analysis of the limits of the “social name”, see the article by Bento (2014).

In 2007, the 13th National Healthcare Conference was held, whose final report included proposals regarding the LGBT population, emphasizing: the recommendation to revoke the National Health Oversight Agency (Anvisa) decree that prohibited gays and other men who have sex with men from donating blood; encouraged research and the production of knowledge about this population; guaranteed access to the Unified Healthcare System, and promotion of a comprehensive national healthcare policy for the LGBT population.

A national healthcare policy began to materialize in 2008, with the release of the preliminary version of the document entitled National Comprehensive LGBT Healthcare Policy, whose final version was published in 2010. The centrality of healthcare among the demands by the Brazilian LGBT movement appeared in the annals of the First National LGBT Conference, held in 2008. In 2009, the federal government published the National Plan for the Promotion of Lesbian, Gay, Bisexual, *Travesti* and Transsexual Citizenship and Human Rights, whose objective was to systematize the proposals approved at the Conference.

Another key document, released in 2009, was the Third National Program on Human Rights, at which healthcare for the LGBT population was also present in the set of proposed actions including the expansion and consolidation of primary health-care services and home care services, as well as the recognition of “sexual orientation” as a specification to be contemplated in women’s comprehensive healthcare

programs. This was an historic demand of lesbian and bisexual women already covered in the *National Comprehensive Women's Healthcare Policy*.

Demands from transsexuals were included in decree nº 1.707, of August 18, 2008, through which the Health Ministry included sex reassignment surgery in the Unified Healthcare System. The right to use the chosen or "social name" in healthcare services was guaranteed in 2009 by Health ministry decree nº 1.820.

The *National Comprehensive LGBT Healthcare Policy* was approved in 2011. Its objective was to promote comprehensive healthcare for this segment, and eliminate discrimination and institutional prejudice. It also contributed to a reduction in inequalities and the consolidation of the Unified Healthcare System as a universal, integral and equitable system. According to Mônica Angonese and Mara Lago:

This initiative began with the recognition of the discrimination and exclusion of the LGBT population, and sought to prepare the Unified Healthcare System to respond to needs and guarantee their rights (Angonese & Lago, 2017: 260).

The *National Comprehensive LGBT Healthcare Policy* included specific objectives, implementation guidelines, as well as responsibilities and attributions for the Health Ministry, and state and municipal secretariats of health. It also included an operational plan for its implementation between 2012 and 2015.

Some studies have analyzed healthcare policies aimed at sexual and gender diversity in general, and the *National Comprehensive LGBT Healthcare Policy*, in particular (for example, Calazans, 2020; Paulino, Rasera & Teixeira 2019; Ferreira & Bonan, 2021). Calazans warns, however, that policies are only materialized in action (Calazans, 2020); the effectuation of rights established by the policy depends on its translation into concrete actions, and local administrators and healthcare professionals need to be engaged. This study sought to identify the perceptions of primary healthcare professionals as a means to comprehend their action and the healthcare provided to the LGBTI+ population to help determine how the *National Comprehensive Healthcare Policy* is implemented in practice in the largest city in the country.

Having already approved this national policy, it is important to recall that, in May 2013, the Federal Council of Medicine approved a resolution that guaranteed same-sex couples access to assisted reproduction to have children, prohibiting so-called surrogate motherhood and restricting the "substitute uterus" within the family, to the fourth degree of kinship. In relation to the trans population, decree nº 2.803,

of November 19, 2013, revoked the 2008 decree, with the result that the Health Ministry included sex reassignment procedures in the Unified Healthcare System to be carried out in qualified established services. The decree regulated the guidelines which cover transsexuals from pre-operational clinical and outpatient care to surgery, assistance, and post-operative care.

The investigation that gave rise to this article took place during a historic moment, in which healthcare activities aimed at homosexual men, lesbian women, bisexuals, intersexuals, *travestis* and trans persons remained incipient, and thus required identification and analysis to evaluate their effectiveness and reflect on how to improve them. The next section will address this aspect, beginning with a look at entry into primary care.

### Entry into primary care

In the winter of 2019, I was in front of a primary healthcare clinic in a poor neighborhood in São Paulo's southern zone. At the appointed time, I met Joana: a nurse, graduate of the Universidade de São Paulo, thirty-four years old, white, heterosexual, married without children, whose mother was a small business owner and father an automotive welder. Joana lived in a small house behind the home of her now retired parents.

In considering who were the LGBTI+ users who came to the primary care clinic, Joana stated: "Usually, they come from outside their coverage area. They are not registered here, it's very rare for them to come here with a record. They come from other places, outside of their region, outside of the coverage area." Thus, Joana maintained that LGBTI+ people sought out primary healthcare clinics far from where they lived. Inês, the nurse who works in the western zone whose narrative opened this article, when reflecting upon the entries into primary healthcare clinics, commented: "*These people, when they come to us, it is usually because of some sexually transmitted disease that they observe, that they notice.*"

Thus, LGBTI+ people do not enter these clinics for preventive care, as healthcare professionals assume and work towards. The chosen paths (for example, opting for a clinic far from their residence) seem to be guided by an attempt to respond to a heterosexist visibility regime marked by family disapproval and prying neighbors. This regime emerged during the analysis of interviews and proved to be central to understanding the performance of primary care health professionals. Everything seems to converge into a regime of visibility of difference that is inseparable from the role that the healthcare system performed historically, which Michel Foucault



(2020), more than four decades ago, defined as an apparatus of sexuality. One of its elements was to identify as pathological behaviors those that are outside the heterosexual reproductive standard.

Sérgio Carrara (2015) analyzes the emergence of the notion of sexual rights as an aspect that is central to the transformation of sexual policies and which influences the apparatus of sexuality. Carrara affirms that these rights indicate an emergence of changes in the secular regime of sexuality that is accompanied by a kind of moral regulation. Carrara indicates the possibility that biopolitical effects are now felt in more subtle and indirect ways, for example, over the control of the vulnerable.

In the case under analysis, according to the professionals interviewed, entry into a primary healthcare clinic doesn't occur because of an alteration in blood pressure or other chronic diseases, but mainly because of sexually transmitted infections (STIs). This fact suggests that the health needs of this segment of the population are only specifically recognized by professionals when they bring their sexual orientation into the discussion – which appears to be more common in relation to STIs than in the case of other needs.

The review study by Elizabeth Prado and Maria Fátima de Souza (2017) – conducted between 2011 and 2016, and, therefore, when the National Comprehensive LGBT Healthcare program was already in effect – indicated that this history of care for this population continued to be associated with the issue of STIs. In addition, other issues arose that have challenged healthcare professionals. The interviews conducted during the present study permit recognizing that, at least in the context of São Paulo in the mid-2010s, an inflection took place that brought healthcare professionals' focus to the issue of recognition of the "social name" and to the requests for hormone therapy and sex reassignment procedures.

In another primary healthcare clinic in São Paulo's western zone, Andreia – a forty-six-year-old nurse, racially mixed, hetero, married with two children and graduate studies in family health – commented that the LGBTI+ people who come to the clinic do not always identify themselves: "It's very difficult, because usually someone else from the community is here. These needier people are more oppressed. I still feel this. She feels cornered, right?! Not by the professional, but by the neighbors."

The search for a healthcare clinic far from home and the practice of not identifying themselves were important issues in the care given to LGBTI+ people during the study. In this case, the access to healthcare required recognition and reflection about what restricts the healthcare professionals' visibility (such as the lack of ed-

ucation and/or information about this population segment). Although the heterosexism of family and neighbors seems to reside outside the healthcare system, it can actually be understood to be internal as well, since it has been revealed to be a barrier for access to primary care.

In the view of Antônio, a doctor at a primary healthcare clinic in the southern zone, who is forty-three, white, a Spiritist and a separated father of two sons, who currently self-identifies as gay: “I think that primary care is the entryway for these patients and we need to train the clinics to receive them. They are not trained, there are no professionals trained [in this field], and there is no real, current influx of these patients, in my opinion”. In addition to indicating the importance of the clinics and criticizing the care given to LGBTI+ people, Antônio also describes how the typical itinerary of an LGBTI+ patient, before arriving at the doctor, involves three people: the community healthcare worker, the administrative representative and the healthcare professional. According to him “we should all be trained and have this understanding of this public”.

However, in the itinerary outlined by Antônio, I identified during this study an educational inequality among healthcare professionals in terms of comprehension of the specificities of LGBTI+ people. This prevents them from facing the challenge of limiting their exposure to prejudice and discrimination, towards access to a primary healthcare clinic. This fact helps to explain why many seek primary healthcare clinics far from where they live, or those which have a reputation for caring for this segment, even if they aren't officially reference centers [as clinics offering specialized care for complex issues are known]. Carlos is a doctor who works in one of the few clinics regarded by users as a reference center. He is gay, white, forty years old, single, childless, and a non-practicing Catholic. He commented that this population segment needs to have access to the Unified Healthcare System from any point within the system: “If the person is there in the extreme periphery, then they need to receive care in the extreme periphery. She comes to a reference center, if she has a specific health condition that warrants the reference center, whether a sexually transmitted disease, or any other issue.”

The formulations of healthcare professionals seem to be directed at the forms of access, the lack of preparedness (or unequal access to knowledge) of professionals, the forms of perception and to the ways of framing. This refers to what I have called the visibility regime, which will be discussed in more depth later. First I will present how administrators, nursing technicians and assistants, nurses and doctors describe the reception of the LGBTI+ segment in primary care, especially at primary healthcare clinics.

## Professionals' perceptions about the LGBTI+ population's access to healthcare

As previously mentioned, since the 1980s, the Aids epidemic increased attention by the healthcare field to the LGBTI+ segment, especially, at the time, to gay men who were seen as more vulnerable to HIV infection. Regina is a sixty-year-old doctor. She is white, Catholic, hetero, married with two children and works in the eastern region. Reflecting on the above, she emphasized that her work during the most dramatic period of the Aids pandemic was what made her better informed and prepared to deal with this population: "For a long time, for eight years, I participated in a specific service, which was in the AIDs and HIV testing center. This was at the height of the epidemic." Her statement suggests that this experience contributed to her getting to know the LGBTI+ public, especially the homosexual segment, which contrasts with interviews with recently graduated and active professionals, who emphasized a change of focus to the "T segment" (that is, *travestis* and transsexuals).

Aline is a forty-two-year-old psychologist. She is white, non-religious, hetero, married, and a mother with one daughter whose work focuses on the LGBTI+ population at a regional office. She commented on this focus: "I think that in the case of *travestis* and transsexuals there was a political issue at the time that encouraged us to pay more attention to them." According to her, this began around the middle of the 2010s. However, Antonio – who was cited earlier – stressed that "today LGBTI+ may be thought of as being synonymous with trans" because of the nature of their needs:

I think it is because this trans issue had something very specific in its need for hormone therapy and to have a specific treatment. Homosexual issues don't present demands as specific as the trans issue that requires a specific treatment.

Both narratives help to explain a certain equivalency in the perception of the LGBTI+ population as transsexual and *travesti* people but keep open the issue of the consequences for the other segments regarding their access to primary healthcare and if, and how, they are being effectively received. The current regime of visibility of the healthcare system regarding LGBTI+ people seems to be based on a form of visual identification and demands that relegate gays, lesbians, bisexuals and intersex people to invisibility or to being squeezed into the T category, as the first narratives by professionals in this article indicated.

Addressing this issue of invisibility that undermines care, Aline commented "I think there are lesbians that leave with birth control prescribed by the doctor." Her narrative aligns with information from international literature which indicates that les-

bian women have a lower frequency of gynecological exams, Pap smears and breast cancer prevention tests (Aaron et al., 2001; Almeida, 2009; Marrazzo et al., 2000). They also indicate that these women do not always seek care when necessary or only do so when serious problems emerge and in periods of worsened health (and that healthcare professionals request fewer of these exams for these women). Research has shown that healthcare is limited to the dimensions of reproduction, despite the Comprehensive Women's Healthcare Assistance Program.

In addition, a lack of awareness of the existence of intersex people predominated among interviewees. This lack of knowledge attests to the lack of preparation for meeting the healthcare needs of these people. Investigators such as Lima and team (2017) have shown that, when an intersex person decides to go to a health service (for example, to question the sexual designation they were given at birth), they pass through different sectors and paths. All routes present difficulties and violence. In the healthcare apparatus, the interventions available are almost exclusively surgical or drug-based. In this way, intersexuality tends to become invisible and, when recognized, encompassed in the sphere of disease.

In general, the perceptions of the professionals indicate the persistence of a binary understanding of gender in the healthcare field. Physical and subjective ambiguities tend to be ignored or read only in the light of transsexuality (a regime of visibility is in operation here in which visible diacritical signals are evaluated and indicate the need for attention), or, in the case of intersex people, treated as pathological. This fact contrasts with the need, for LGBTI+ people's access to healthcare, to recognize specificities, which cannot be substituted by syntheses or stereotypes.

The current focus of care, regarding the trans segment and its demands, operates through a reification of presumed trans and *travesti* characteristics. That is, the visibility regime precedes the encounter and implies certain options (such as focus on STIs). Thus, even with the T group, the access is inadequate, since there isn't a relationship in which the trans people and *travestis* are listened to, in order to know who they really are.

This focus also leads to inattention to the general or specific problems of the other segments, such as segments B (bisexuals) and G (gays). This inattention, however, encounters an increasing number of gays who are seropositive for HIV. In a recent study, Kerr and team (Colucci, 2018) showed that the prevalence of positive HIV tests in men who have sex with men was higher in 2016 than in 2009. These authors attribute the increase in HIV prevalence among men who have sex with men to the reduction in public campaigns.

In reality, a context exists that involves the entire LGBTI+ population. Many researchers believe that the main health problem of the LGBTI+ population is the violence to which it is subjected and its consequences. Studies recognize that this social segment frequently has its mental health shaken by the effects of continuous exposure to prejudice and discrimination. Some denominate this as “minority stress” (Freitas et al., 2017). This condition explains the greater vulnerability of LGBTI+ people to depression and, ultimately, suicide (Russel & Joyner, 2001). This is associated with a greater vulnerability to physical attacks that range from family violence – related to the refusal of family members to accept the person’s sexual orientation and/or gender identification – to beatings and attacks by strangers, which sadly often culminate in homicides (Pinto et al., 2020).

The pressure of “minority stress” associated to few structural sources of support that would help develop forms of resilience, increases the propensity for chemical dependence (Bryan et al., 2017), both on legal drugs, such as antidepressants, and on illegal ones. Without proper assistance and support, individuals left to their own devices have a limited range of alternatives to bear the accumulated emotional pain. According to the interviews, there is little or no perception that the needs of LGBTI+ people involve the psychosocial consequences of prejudice and discrimination.

During the interviews, I noted that prejudice and discrimination tend to appear in the narratives of healthcare professionals as something “external” to the health system, or located in the neighborhood, or in mediations before the patient reaches the doctor. According to Regina (a doctor with broad professional experience in the eastern zone), dealing with this involves much more than just the healthcare service itself: “The doctor alone is not enough, if the person won’t come here, it’s useless. There must be a response, there must be a change in overall behavior.” To which the positions of other doctors are added, like Antônio, who identified barriers in primary care itself to the reception of LGBTI+ people: “A small complication exists in relation to community healthcare workers, because, at times, they [LGBTI+ people] feel constrained, mainly those who are not openly gay, to seek this access.” At the primary healthcare clinic Antônio affirmed:

The big difficulty is that the arrival of this patient generates a murmur inside the clinic, involving the community healthcare worker, involving the administrative representative, involving the nursing assistant. When a chart arrives either they report that the patient is trans, or any LGBT, so the whole stereotyping about this patient begins.

In summary, in the doctor’s view, what predominates is the recognition, identification and insertion of the patient into a stereotype, from the contact in the community with the healthcare worker<sup>8</sup>, to arrival at the primary healthcare clinic under the

8. Due to the territorial scope of the research, it was decided to divide the data collection into four professional profiles. In future studies, we plan to focus the analysis on community healthcare workers because of our interests in comprehensiveness and in the care.

9. The professionals showed an ability to search for protocols when necessary, such as those they (directly or indirectly) mentioned most, the Protocol for the Care of Transsexual and Travesti People in the Municipality of São Paulo.

gaze of the security guard and the evaluation of the person who fills in the admission form, until reception by a nursing assistant or technician. In fact, the doctors' interviews also revealed that, though with possibly less prejudice or stereotype, their consultations and referrals seem to fit the framing in the protocols<sup>9</sup> established for this population. As a result, and always according to the interviewer's formulations, it is worth asking about obstacles and solutions in primary healthcare.

## Obstacles to entry into primary care and possible solutions

There are many obstacles to entry into primary care for the LGBTI+ population, and, therefore, to their access to the comprehensive healthcare proposed in the National Comprehensive LGBT Healthcare Program. The investigation identified an inequality of education and information among different healthcare professionals. It also identified that mid-level professionals – such as community healthcare workers, nursing assistants and technicians – are simultaneously those most involved with admissions but the least prepared to receive patients. Although higher level professionals have declared an interest in welcoming the segments that comprise the LGBTI+ collective, they had, as mentioned, a predominant tendency to synthesize them with the T segment. Additionally, a consensus existed that the problem was basically to get the person to the primary healthcare clinic, that is – in the view of healthcare professionals – the obstacles to healthcare access can be summed up to getting this population into the system to provide them with what, in theory, would be at their disposition.

From a historical perspective, what stands out among the findings provided by discussions with healthcare professionals is that, in fulfilling the needs of the LGBTI+ population, there has been a focus on one segment or another, instead of advancing the inclusion of the population's entire internal diversity. If the concern about STIs led to a broader perspective that involves the needs of the trans and *travesti* segment, which could be seen as progress, this wound up taking place with a reification of trans people (which distances them from healthcare access, since it is far from their reality) and, also, in detriment to recognizing specific needs of the other segments that compose this population. If there is continuity in the way care is given to the LGBTI+ population, beyond the healthcare system addressing what each era defines as urgent, it also continues to only recognize needs that are based on a disease-centered conception of health, on its physical aspects, with little or no attention paid to psychological or social aspects.

In the interviews, the criticism of an incipient professional education was almost unanimous for its failure to provide information about the LGBTI+ segment or about

gender and sexuality issues in general. “I don’t remember having anything, not a single conversation about this specific subject,” said one forty-one-year-old doctor who worked in [São Paulo’s] western region. She was white, hetero, a Spiritist, and married with two children. A thirty-nine-year-old nursing graduate and manager of a primary healthcare clinic – who was white, Catholic, hetero, and a divorced mother of one – said: “At nursing college, zero. I tell you, at college it was zero. I graduated a while ago, but there were no classes, nothing specific. I ended up having training when I worked there, in downtown.”

The few people who reported having any training or information about the topic said that it was addressed in a contingent way, or secondarily in a class or specialization course. This corroborates studies about curricula, such as that mentioned by Adriana Lemos (2014), which found few courses with a bibliography about gender and sexuality in healthcare education in Rio de Janeiro. This tends to be corroborated in contexts such as São Paulo, which is discussed here.

Most of the professionals interviewed, in addition to describing their education as deficient, believed that college courses could incorporate this content. Antônio commented, “A discipline involving either psychology or even the field of psychiatry.” He also suggested that improving primary healthcare services would require “technical training, so that we can absorb these patients and bring them to us. It’s no use being trained if we can’t manage to actively seek them out and bring them into our midst.”

While doctors and nurses emphasized educational deficiencies as something to correct to improve care, most of the administrators said in the interviews that services also need to be improved. Asked by the researcher whether they believed the LGBTI+ segment should be treated in reference centers, or in any health clinic, the responses tended to recognize the importance of reference centers, but, that ideally the entire healthcare system would be able to treat LGBTI+ people. One administrator of a primary healthcare clinic that is considered a kind of reference center for the trans and *travesti* population, a forty-two-year-old white male, with a degree in business administration and a graduate degree in health administration, with no religion, hetero, and a married father of two affirmed:

I think that the reference center is important, it’s empowering, but I think that it should be instituted in the clinics, because the population will be throughout the territory in all of the municipality [...]. This is the only reference center. We receive patients from everywhere. So, the patient comes from the eastern zone, comes from the southern zone, and they come here because it’s the only

reference center. Perhaps this exclusive empowerment could happen in their own region, if this possibility existed, this entry point.

In other words, improvements to the healthcare system for LGBTI+ healthcare imply, in the view of the workers themselves, improvements in the education of professionals and in the organization of the reception system. There is a clear openness among most of the professionals interviewed to the issue of LGBTI+ healthcare, and a comprehension of healthcare related to sexual and reproductive rights among those with higher education<sup>10</sup>. A continuing education policy on these topics is still lacking and their inclusion in curricula for courses such as medicine and nursing would possibly be more effective in the long run. Without this educational foundation, and without specialization or similar courses, there are few spontaneous initiatives to improve the care given to the LGBTI+ population within the primary care network. As stated at the beginning of this article, of the twenty-four primary healthcare clinics visited, only one had its own initiative – a group for reflection and education to improve this segment’s access to the clinic and improve its care.

Ultimately, the perceptions of healthcare professionals – as well as the obstacles they mentioned, the paths they indicated – highlight a regime of visibility. What does the research reveal about this regime of visibility? How is it constituted and how does it operate in healthcare services? Does the conception of health and care that shapes it inhibit access, or allow it only according to certain standards?

### Regime of visibility and healthcare: debating the research findings

Despite the changes that have led to what is now known as LGBTI+ healthcare, the visibility regime that I found during the research indicated the maintenance of the historical medical classification of peripheral sexualities, which Foucault (2020) described as part of the sexuality apparatus. Identified by gender, they were described by classical sexology as escaping the heterosexual-reproductive standard and are now presented new techniques and therapies that signal possible bodily changes<sup>11</sup>.

In the field, “LGBT people” was a term that emerged from professional experiences that combine knowledge, protocols, and information in the identification of these individuals based on their gender, displayed in the way they present themselves publicly. This recognition process makes it possible to recognize them, always in contrast to the model of “normality”, as people who veer away from this model. In this process, people who displayed visual characteristics (mainly *travestis* and trans people) were designated as LGBT. It is a visibility regime accustomed to the hyper

10. According to the analysis of the transcribed interviews using R software, it is possible to assert that the professionals’ responses are made in terms of the law and not morality or religion.

11. Historically, medicine identified sexualities outside the heterosexual and reproductive standard, associating them with gender. According to historians of sexuality, the article by the German psychiatrist Carl Westphal [“Contrary sexual feeling” (1870)] can be seen as consolidating a linear association between desire and gender that classifies desire for people of the same sex as a type of “inversion”. The association between gender and desire within a heterosexual matrix (Butler, 2003) has continued since then as a presupposition that shapes medical thought and psychiatric and psychological analyses, as well as forms of self-understanding and demands for recognition (Sedgwick, 2007).



visibility of gender identifications that differ from socially expected ones. This visibility regime maintains the apparatus of sexuality that is based on treating dissident sexualities as pathologies.

Thus, in this regime based on hypervisibility, intersex people are unknown and invisible but when, for example, I described or mentioned them in primary healthcare clinics, they generated a positive reaction that tended towards reception that would route them to procedures viewed as similar to those made available to trans people. The healthcare professionals rarely spontaneously mentioned bisexuals, gays and lesbians. When asked, most responded that “they were received like everyone else.” This affirmation revealed that, when the way the patient presents themselves publicly does not clearly contrast with a socially expected and standardized category of gender, they are no longer recognized as needing special attention. Only if their health need involves a sexually transmitted infection and, therefore, if their desire is expressed, will the person come to be recognized.

Lesbians, bisexuals, gays, *travestis*, trans and intersex people are only perceived, and simultaneously seen and understood through a visibility regime that revises the historical association between what Foucault defined as peripheral sexualities and a perceptible gender “inadequacy” (Butler, 2014). STIs are added to this gendering perspective which brings sexual orientation to the discourse, to corroborate an anatomicopathological understanding of this population segment that is rarely recognized in any other way, nor seen as having other health needs (Brasil, 2010; Ferreira & Miskolci, 2020).

The result is that, when lacking or seeking to shed prejudices, professionals tend to contribute to universality of access and, to a lesser extent, to equity, but this does little or nothing to approach the comprehensiveness that governs the National Comprehensive LGBT Healthcare Program which is one of the principles of the Unified Healthcare System. According to the interviews, the visibility regime active in primary healthcare maintains an understanding of LGBTI+ healthcare based on pathologies, on needs that involve diagnosis, care and treatment, which is materialized in interventions using medicine and surgery. Thus, it tends to erase differences between segments of the LGBTI+ population, failing to recognize their specificities and range of needs. It also doesn't help the care, attention and bonding process because it is anchored in visual recognition, in the re-updating of the anatomicopathological clinical gaze which, according to Foucault (1977), founded contemporary medicine.

In a manner only apparently contradictory, this visibility regime associates itself, even with mixed signals at the primary healthcare clinic, to that which generates

fears in subjects in relation to their families and neighbors, leading some to seek care in another neighborhood. In the primary clinic, wherever it may be, the treatable bodies tend to be recognized solely by a visual contrast to the apparent norm. In other words, it is more likely that the feminine boy, the masculine lesbian, trans individuals and *travestis* will receive care, while the “discreet” (possible bisexuals, gays or lesbians) or the “invisible” (such as intersex people) will not. Many are excluded or receive care only when their needs fit the system’s expectations, meaning that their right to equity and comprehensive care is denied.

The professionals interviewed in primary healthcare clinics are trying to find and take in this population, but haven’t received education or ongoing training; they work in less than ideal circumstances and are led by the protocols to use stereotypes and fixed identities to identify those who enter the public health system. The result is an admission into the Unified Healthcare System structured around a narrow conception of health, based on an updated version of the clinical gaze capable of recognizing only certain patients, diseases and conditions. The promotion of healthcare is compromised by the reifications engendered by this visibility regime, briefly outlined here, such as guiding professionals to read diverse gender identities as if they were fixed, perhaps capable of being consolidated anatomically.

Thus, healthcare that wants to promote itself stops being preventative and ends up limited to the needs of treating STIs, or therapeutic or surgical procedures. A partial (non-integral) notion of healthcare is preserved, centered on disease and illness, which also fails to incorporate all of the segments of the LGBTI+ population. Therefore, from a historical perspective, the shift in focus from STIs to hormonal therapy and other procedures for trans people, not only indicates a prioritization of one segment over another in the LGBTI+ population – or attention to one to the detriment of another – but, also, a focus on healthcare needs emerging from an understanding invariably based on pathology and/or needs which involve interventions with drugs or surgery. So that, in addition to distancing itself from the principle of equity, it is also far from comprehensive, because it erases the psychic and social aspects of health, such as the phenomena of stress felt by minorities mentioned previously or greater vulnerability to everyday violence.

## Final notes

During the study, the healthcare professionals themselves indicated the need for information for education and improvement, as well as the establishment of more effective protocols and practices. Additionally, the interviews showed an unequal distribution of knowledge in the primary healthcare clinics. A visibility regime was

also encountered that maintained an anatomicopathological clinical gaze towards primary healthcare. I hope to have demonstrated that this visibility regime acts against the reception and care of LGBTI+ people. Moreover, despite good intentions and a goal of following the National Comprehensive LGBT Healthcare Program, it is important to insist on the persistence of a visibility regime that is part of the historic apparatus of sexuality, which treats as pathological those who differ from the heterosexual reproductive model.

Admission into primary healthcare clinics and the perceptions of healthcare professionals are based on this visibility regime. This framework leads to thinking about alternatives that escape the visibility regime, which undermines universal and comprehensive healthcare for the LGBTI+ population. This is because comprehensive care will only be achieved if there is an effort to overcome external classifications of individuals that reify their forms of self-understanding and identification, squeezing them into fixed identities and known necessities.

The results of the study warn of the need for more listening and less anticipated visual framing, because, as Foucault previously warned, visibility is a trap. Listening must be well developed, offering opportunities for people to speak, without expecting them to confess (for example, when an individual is only heard through the report of an STI, which returns to confessions of the flesh and, once again, to pathology). Replacing this flawed and damaging visibility regime with a pedagogy of listening can enable practices that offer universal, equitable and comprehensive healthcare to the LGBTI+ segment.

The “pedagogy of listening” is a proposal to think and act in conversation, making oneself available to Others. This movement would be realized through the construction of pedagogical situations, quite different from those that establish a superiority of the healthcare professional. That is, the goal would be to elide the dissymmetry between those seeking care and the caregiver. As such, it is a pedagogy of bonds, with a stake in the community (Segato, 2018; Freire, 2010).

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