

Construction of LGBT health policies in Brazil: a historical perspective and contemporary challenges

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Abstract *This essay presents a timeline of the construction of health policies for lesbians, gays, bisexuals, transvestites and transsexuals (LGBT) in Brazil drawing on the concepts of sexual politics. Beginning with the creation of the Unified Health System, we outline the first health care policies developed in response to the AIDS epidemic in the 1990s. We then go on to show how, the fruit of dialogue between the government and the gay rights movement, LGBT health became the object of public policies focusing on human rights, comprehensive care, and strengthening the citizenship for people who deviate from hetero-cis-normativity. Against the backdrop of the rising tide of conservatism and dismantling of progress on LGBT rights, we highlight current challenges for achieving comprehensive health care that takes into account sexual and gender diversity.*

Key words *LGBT, Comprehensive health care, Public policy, Sexual politics, Diversity*

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Introduction

This article in the form of an essay aims to promote reflection on issues related to the health of lesbians, gays, bisexuals, transvestites and transsexuals (LGBT). Studies in Brazil have shown that LGBT populations has suffered discrimination, negation, prohibition, constraint and violence in health services due to their sexual orientation and non-normative gender identity¹.

Sexual politics can help us understand the social, cultural and political dynamics that permeate these issues. Sexual politics can be defined as interventions that use laws, resolutions, campaigns, actions and programs implemented by the state to regulate sexuality². Through systems of power, certain groups with given practices, desires, identities and expressions are rewarded to the detriment of others, who are punished, discriminated and marginalized. The product of negotiations and agreements, commonly influenced by varying interests – ideological standpoints, religious beliefs, cultural values, scientific evidence – sexual politics translate “truths” and “moralities”, constraining people with regulatory lines of force and creating repertoires based on a cis-heteronormative matrix³.

Thus, sexual politics and forms of moral regulation tend to delineate the life of “others”, insofar as their expressions, practices and desires are either discriminated against or considered subjects of rights. An example is the National Policy on Comprehensive Healthcare for Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transvestites created within Brazil’s national health service, the *Sistema Único de Saúde* (SUS) or Unified Health System, in 2011. The gains from these and other policies are the product of struggles spanning more than 40 years, since the emergence of the LGBT movement.

As a theme on the political agenda of modern democracies, especially Latin American countries, social inclusion has always been a contentious matter, particularly when it comes to issues like gender and sexuality. While researchers, professionals and policymakers have attempted to formulate and implement LGBT health policies and programs, the materialization of effective policies faces multiple barriers⁴.

This article presents a timeline of LGBT health programs, actions and interventions in Brazil and reflects specifically on the ten years that have passed since the creation of the National Policy on Comprehensive Healthcare for Lesbians, Gays, Bisexuals, Transvestites, Transsexu-

als and Transvestites (hereafter referred to as the national LGBT health policy).

Landmarks in the LGBT health debate

Studies assessing the effectiveness of government plans, programs and conferences implemented during the process that has shaped LGBT policies identified that some actions developed in response to the AIDS epidemic were strictly linked to LGBT sociability⁵. At the time, scientists were calling AIDS “gay-related immunodeficiency” (GRID) and the press and media often referred to the disease as “the gay cancer”⁶.

With the rise in the number of AIDS cases and absence of a timely response to this public and moral problem, the Brazilian government drew on the experiences of other countries to formulate its AIDS policies. It is worth highlighting, however, that non-governmental initiatives played a fundamental role in the response to the epidemic, with the creation of the AIDS Prevention Support Group (GAPA) in São Paulo in 1985, and the Brazilian Interdisciplinary AIDS Association (ABIA) and *Grupo pela VIDA*, both in Rio de Janeiro in 1986 and 1989, respectively.

Government initiatives included the creation of the National Sexually Transmitted Diseases and AIDS Control Program in 1987, linked to the Ministry of Health. This program gave rise to discussions about ethical issues related to AIDS, prevention, conventional and alternative treatments, vaccines and drugs, counselling, sexuality and HIV status⁵⁻⁷.

The struggle to democratize health care gained significant momentum during this period. This political movement raised the issue of social determinants of health and the need for social policies and projects to democratize the state apparatus and decentralize power, respecting public participation and ethical values in the promotion of social change⁸.

Article 196 of the 1988 Federal Constitution⁹ states that “health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards, and at the universal and equal access to actions and services for its promotion, protection and recovery.” This notable step forward was propelled by social movements and civil society organizations calling for one single common right: universal, comprehensive and equal health care.

LGBT movements gained strength in the 1990s. This process was characterized by ini-

tiatives to strengthen organization and mobilization focused on the struggle for rights and establishing partnerships with federal, state and municipal bodies to promote AIDS prevention and control. Notable advances during this period include: making treatment for AIDS available on the SUS in 1991 and the accreditation of hospitals for the monitoring and follow-up of people living with HIV; the systematization of the notification of new AIDS cases in 1993, via Brazil's national notifiable diseases information system (SINAN); the creation of the National Laboratory Network in 1997, enabling the monitoring of people living with HIV undergoing antiretroviral therapy; and the launch of national sexually transmitted diseases and AIDS programs throughout the 1990s, culminating in a ruling issued by the Ministry of Health in 1998 providing that people with HIV have the right to receive medication free of charge from the SUS¹⁰. While these initiatives made public health services more accessible to LGBT populations, the care provided to these groups tended to focus on AIDS prevention and treatment to the detriment of other health problems.

In 1996, Brazil adopted the National Human Rights Program I, being one of the first countries to comply with the specific recommendation made by the World Conference on Human Rights and taking the unprecedented step of assigning human rights the status of government policy. In the following year, the government created the National Secretariat for Human Rights within the Justice Ministry, which later had its name changed to the Secretary of State for Human Rights, gaining the status of ministry. In 2002, despite its neoliberal agenda, president Fernando Henrique Cardoso's government made some advances in LGBT policies, approving the II National Plan for Human Rights (PNDH 2). With regard to health, proposal 248 of the plan opened the possibility of promoting campaigns directed at health and legal professionals to raise awareness of scientific and ethical concepts concerning LGBT populations¹¹.

In 2003, the Lula government allocated more funds and strengthened the organizational structure of the Special Secretariat for Human Rights. From then on, the LGBT agenda fell under the wing of human rights policy¹². Lula's first term (2003 to 2006) was marked by intense dialogue with LGBT movements. In 2004, the government launched the Program to Combat Violence and Discrimination against the LGBT population and Promote the Citizenship of Homosexuals, commonly known as the "Brazil without Homopho-

bia" program, strengthening dialogue on the protection of LGBT rights between civil society and the state. The Program consisted of actions covering a range of areas: articulation of government policy aimed at advancing the rights of homosexuals; legislation and justice; international cooperation; the right to safety; the right to education; *the right to health*; the right to work; the right to culture; youth policy; *women's policies*; *policies against racism and homophobia*¹³. The participation of groups from the LGBT movement in the formulation of the program is evident from the wording used in the document, which contains real-life narratives from LGBT populations, explanations of LGBT terms, and short, medium and long-term actions in various sectors of society, including funding for the creation of LGBT referral centers run by non-governmental organizations.

The ideal of a society without sexism, machismo and LGBTphobia envisioned by the Brazil without Homophobia program emphasizes the social inclusion of people with nonconforming sexual orientations and gender identities. However, it also has its contradictions, including the potential decharacterization or (dis)integration of the wide range of gender expressions within the LGBT community. As Facchini¹⁴ highlights, the "alphabet soup" is not a homogenous group, but rather one that, despite points in common, extol their specificities and singularities.

The construction of sexual politics requires the articulation, mobilization and activation of social and political change^{4,12}. In this regard, the Ministry of Health created a technical committee to promote dialogue between the different actors involved in implementing the Brazil without Homophobia program, especially those engaged in actions linked to the right to health. Later formalized by Ministerial Order 2227/2004 and made up of members of LGBT groups and officials from the ministry's technical departments, the committee was tasked with formulating a policy to promote comprehensive healthcare for LGBT populations¹³.

In the same year, the government launched the National Policy for Comprehensive Women's Health Care. The fruit of discussions with a diverse range of civil society groups, the policy was aimed at advancing women's right to health. It proposed improvements in obstetric care, measures to tackle sexual and domestic violence, and general actions designed to promote women's health, as well as initiatives targeting vulnerable groups such as lesbian women¹⁵.

The timeline of the creation of LGBT health policies and programs also includes the establishment of the National Commission on Social Determinants of Health in 2006. Following recommendations issued by the World Health Organisation, which established its Commission on Social Determinants of Health in March 2005, the commission was composed of experts from the fields of culture, economics, politics and science. The Commission prioritized the following social determinants of health: 1) social, regional, racial/ethnic, and *gender* inequalities in morbidity and mortality and risk factors; 2) inequality in access to and the quality of health services and social interventions; and 3) methodological aspects of studies of the social determinants of health¹⁶.

Also in 2006, LGBT groups were provided a seat on the National Health Council, giving greater prominence to LGBT issues on the social agenda and strengthening the movement's role participation of in the formulation of health policies for sexual and gender minorities⁵. Since then, initiatives designed to strengthen dialogue between different actors, including those engaged in the field of health, have attempted to involve LGBT populations as subjects of rights. This is evidenced by Ministerial Order 675/2006, which introduces the Healthcare Rights Charter¹⁷, underpinned by six principles of citizenship, the third of which states “[...] all citizens are entitled to the right to humane treatment, without discrimination”.

The Charter¹⁷ states that SUS users should receive care free from any form of discrimination, restriction or negation due to sexual orientation and/or gender identity that deviates from hetero-cis-normativity. The document legitimizes the humanization of the SUS as opposed to the “consumption of health care”. Health services should not be understood as a mere “basket of services” or “consumable product”, but rather a product of the health system aligned with the principles of human rights, quality, and chiefly, universal, comprehensive and equal health care.

In this regard, it is worth highlighting the 13th National Health Conference, held in 2007. The final conference report contains the discussions and deliberations specifically concerning LGBT populations, namely: equal access to respectful quality care in the SUS; raising health professional awareness about LGBT rights and the creation of LGBT health promotion groups; the right to intimacy and individuality; the recommendation to revoke the order issued by Brazil's health surveillance agency, ANVISA, banning blood

donation by LGBT people; and support for the approval of Bill 122/06 proposing to criminalize LGBTphobia¹⁸.

In 2008, the Ministry of Health launched the “More Health: Everybody's Right” program, which was part of the government's development policy at the time. The program outlines the guidelines and strategies underpinning each core area, the measures adopted, meta-syntheses and investments in health. It is worth highlighting Core Area I – Health Promotion, which sets out actions to tackle health inequities and inequalities affecting black people, *quilombolas*, the LGBT community, gypsies, and the homeless, among others. One of the goals of the program was to train 5,000 social movement leaders and support 27 state teams working in municipalities with more than 100,000 inhabitants in planning and implementing actions to address health inequities¹⁹.

In the same year, the government held the I National GLBT Conference (GLBT was still the term used at the time) in Brasília, attended by President Lula and bringing together representatives of civil society organizations and the government. The conference – which discussed a wide range of topics, including LGBT health – constituted another landmark in the struggle for LGBT rights in Brazil. Debates were held on the recognition of gender identities in health services and the then Health Minister, José Gomes Temporão, announced the publication of Ministerial Order 457/2008, providing that gender reassignment surgery shall be made available on the SUS in some capitals. There were also calls to change the terminology used in the Conference, adopting the term LGBT instead of GLBT. The event culminated with the approval of the Brasília Charter, bringing hope to the country and spurring political mobilization²⁰.

The theme of the II National LGBT Conference in 2009 was “For a country free of poverty and discrimination: promoting citizenship among lesbians, gays, bisexuals, transvestites and transsexuals”. The aims of the conference were to propose guidelines for the implementation of policies to combat discrimination, evaluate the implementation of the National Plan for the Promotion of the Citizenship and Rights of LGBT People, strengthen strategies to increase visibility, and define guidelines for implementing policies to end poverty and combat discrimination against LGBT populations²¹.

At the time, sexual and reproductive health care was a priority area of primary health care. Actions designed to tackle gender inequalities

focused on cementing the principle of equity in the SUS. In 2010, for example, Guide 26 – Sexual and reproductive health, providing technical guidance for primary care workers, specifically discusses LGBT health care²².

It was only in 2015, during President Dilma Rousseff's government, that abuse based on sexual orientation and gender identity was included on the Notification/Individual Investigation Form for Domestic, Sexual and other Types of Violence, part of the country's national notifiable diseases information system (SINAN), ensuring that violence against LGBT patients is recorded upon admission to public health services²³.

Spurred by these political processes and the organizational arrangements introduced to the SUS, the Ministry of Health formulated the national LGBT health policy in partnership with representatives of the LGBT movement. The policy aimed, among other things, to eliminate institutional discrimination, contribute to reducing inequalities and consolidate the SUS as a universal, comprehensive and equitable health system⁴. The Policy was approved by the National Health Council in 2009, published via Ministerial Order 2836/2011 and signed during the 14th National Health Conference. On the same day as the signing, Tripartite Interagency Committee (TIC) Resolution 02/2011 was also signed, approving the Policy's operational plan.

Ten years of the national LGBT health policy

The launch of the first comprehensive health policy for LGBT populations in was a milestone for Brazil. To gain a more depth understanding the policy and the politics behind the policy, we draw inspiration from Baptista and Mattos²⁵, who propose the following cycles of public policy making: 1) placement on the agenda; 2) policy formulation; 3) decision-making; 4) policy implementation; and 5) policy evaluation.

The first questions we considered were: How did LGBT health find its way onto the health policy agenda? Which interest groups were involved in this process? Who were the main actors? To commence the discussion, it is important to remember that the sexual orientation and gender identity of those who deviate from hetero-cis-normativity are markers that act in the dynamics of the determinants of health, causing constraint, discrimination and violence in health services and engendering multiple vulnerabilities among LGBT populations^{26,27}.

These markers of sex and gender lie at the root of the concept of vulnerability. This concept began to be used in the field of public health in the 1990s, especially in discussions concerning the AIDS epidemic in different countries around the globe^{6,10}. Identifying when the concept of vulnerability began to emerge within the field of health by drawing on the discussions surrounding AIDS therefore seems to be an important basis for analysis of this theme.

The understanding of vulnerability proposed since the introduction of The Brazil without Homophobia program – in the health policies outlined above and within the LGBT movement – placed LGBT health on the health equity agenda in the SUS. It is worth highlighting that the discussions surrounding LGBT health were reinforced by various health and human rights conferences over the years since the creation of the 1988 Federal Constitution.

But who were the “policy makers”? We mentioned above that the technical committee was created in 2004, comprising health professionals, health managers, patient representatives, and representatives of LGBT movements, among others. These groups were the main agents involved in the discussion and formulation of the policy. However, the author cited in the official document is *Brazil*, as is the case with most government documents, especially health policies. We know that the committee was behind the debate, but who made up the materiality of the policy? What are their backgrounds? What are their dialogues? As Gomes points out²⁸, the materialization of such policies involves the hard work of numerous anonymous characters.

The policy formulation process was arduous, evolving into a fraught debate, bargaining, hold ups and silence. After being approved by the National Health Council in 2009, the process between appraisal by the Health Minister and endorsement by the TIC was lengthy conflict-ridden²⁷. The backdrop was the 2010 presidential elections, during which the congressional evangelical caucus waged war against sexual diversity and gender. It was only in the first semester of 2011, after the Health Minister Alexandre Padilha (2011-2014) took office, that the draft policy was fully approved and referred to the TIC in the form of an operational plan to be agreed between the three levels of government (federal, state and municipal) and turned into policy. The operational plan was of fundamental importance as its design was articulated by the now defunct Participatory Management Support

Department (DAGEP), members of the National Health Council, the technical committee and some members of the National Council of Health Secretaries (CONASS) and National Council of Municipal Health Departments (CONASEMS)²⁸.

The operational plan, which defines the decision-making process, is structured around four core areas and comprises actions that address the following social determinants of LGBT health: Core Area 1: Access to Comprehensive Health Care for the LGBT population; Core Area 2: Health Promotion and Surveillance Actions geared towards the LGBT population; Core Area 3: Permanent education and popular health education; and Core Area 4: Monitoring and evaluation of health actions geared towards the LGBT population²⁴. Many advances have been made over the last ten years, especially in promoting health equity and the creation of state LGBT health committees. Examples include the introduction of state LGBT health policies, creation of coordinating offices, accreditation of hospitals to perform gender reassignment surgery, and other successful experiences²³.

On the other hand, these processes appear to have been stifled by federal, state and municipal management. When we take a closer look at the ideology coupled with the power of management, it is evident that sexuality in western societies has been structured within a “punitive” social framework and power relations are ingrained in this construction^{2,3}. There is a need to break with “sexual hierarchy”, where the institutions that perform social control tend to draw a line between “good and bad” sexuality³. These concepts, particularly the orchestration of an anti-gender offensive by conservative groups against LGBT rights and policies, puts the whole human rights project at risk²⁹.

Considering that, despite the efforts of previous governments, there remains a lack of regional LGBT health policies, how can we formulate, implement and monitor health policies that take into consideration social, economic and cultural elements within the current political conjuncture in Brazil?

Brazil’s socioeconomic and cultural inequalities present a challenge for the effective implementation of social policies. Brazil is a country of regional difference⁸. The social inequality dilemma, lack of technical capacity of local managers and vicissitudes of Brazil’s municipalities are just some of the difficulties faced in decentralizing health policies¹². In addition to the political and administrative dimension of structural determi-

nants of health, there is a need to broaden our vision to include the concept of territory, where each region and area are seen as a space of collective production permeated by historical and social materiality where singular spatial configurations are weaved¹⁶.

Thus, the creation of a national LGBT health policy²⁴ does not necessarily guarantee its effective implementation, because a mixture of forces come into play as part of the social and political dynamics behind the policy. Another important factor affecting the *governability* of the policy is funding. To meet the policy’s objectives, sufficient funding is needed to develop, structure and maintain actions and services. Investment in health is related to some extent to the quality of care delivered to LGBT people. In turn, care quality can also reveal health workers’ and managers’ understanding of sexual and gender diversity²⁶.

The recruitment of qualified health professionals for the SUS inevitably depends on the training and education they receive in education institutions. This highlights the need for changes to health course curricula, promoting the inclusion of issues of gender and sexuality at undergraduate degree level in order to promote changes in the workplace. This debate is a vital first step on the future path to change in both education institutions and health services^{1,23,27}.

Another important concern when it comes to training related to the national LGBT health policy are permanent health education strategies. These strategies seek to promote collective reflection about work, provide transformational tools and build the capacity of social leaders, municipal and state health managers, health workers, and members of councils and other different groups^{24,27}.

Recognizing weaknesses in this area, the Ministry of Health created the distance-learning course “the National Policy on Comprehensive Healthcare for LGBT People”. Offered via the SUS Open University Network (UNA-SUS), the course was developed via an intersectoral partnership and participatory design process involving the defunct Secretariat for Participatory Strategic Management (SGEP), Secretariat for Health Work Management and Education (SGETS), Rio de Janeiro State University, and LGBT Health Technical Committee. It targeted health students, managers and professionals, and others interested in the topic. In April 2019, a partnership between the Federal University of Rio Grande do Sul and Federal Institute of Rio Grande do Sul, with support from the Rio Grande do Sul State

Department of Health, Federal University of Paraná and Ministry of Health, resulted in the creation of another distance-learning course on LGBT health. Along the same lines as the course offered by the UNA-SUS, the course is hosted on an online learning platform and awards a certificate. Despite the success of these high quality courses, the use and availability of these types of technologies is still limited in Brazil^{23,27,30}.

In addition to training, it is necessary to promote dialogue with and between the leaders and health managers involved in the policy implementation process. Different strategies are needed to promote the adherence of state and municipal health secretaries to ensure effective policy implementation at local and regional level. In addition, the Ministry of Health should seek to strengthen relations with the organizations that support the CONASS and CONASEMS²⁷.

In the social and political sphere, it is important to highlight the importance of strengthening relations between different social groups and joining forces to counter the retrograde conservatism. The latter is seeking to dominate Brazil's National Congress and attempting to deny recognition of LGBT populations as subjects of rights under the banner of defense of "family" and "moralism". Secularism has become a disputed category, both by religious groups and LGBT movements^{4,29}.

An important aspect that has gained prominence recently is the emergence of LGBT cyber-activism. LGBT health and HIV/AIDS activism have been constant themes in this sphere. Up to the middle of the 2010s, LGBT movements were largely made up of long-standing members of groups and organizations and characterized by a generally low level of education. Political mobilization was more focused on forums, commissions, conferences and councils, considering that the progress of the collective struggle depended on in-depth analyses of policies in situ. In contrast, younger activists communicate within the movement in a more engaging and attractive manner, creating a new network of militants who follow the progress of policies using online platforms³¹.

The 2018 presidential election was a milestone in disputes, activism and confrontations involving LGBT populations. On 11 April 2019, President Bolsonaro signed Decree 9759/2019, extinguishing various councils, committees, commissions, groups and other types of federal collegial bodies, including various bodies directly linked to LGBT populations, for example, the

National Council for Combating Discrimination and Promoting LGBT Rights. Various groups have lost their voice in government bodies, reinforcing the importance of bringing together different groups and social movements to join forces.

A major step forward in the struggle for human rights was the criminalization of LGBTphobia by Brazil's Supreme Court in 2019, putting it on an equal footing with racism. Yet, given the range of social and cultural complexities coupled with criminalization, the ruling does not resolve the numerous issues associated with LGBT health.

Over more than three decades of the HIV/AIDS epidemic, we have not been able to give due consideration to the processes of social, economic and cultural determinants of health and of gender of LGBT populations. While significant advances have been made in drug development, little has been invested in education-based prevention initiatives, especially community-based and popular programs³².

In the ten years since the creation of the national LGBT health policy, pre- and post-exposure prophylaxis (PrEP and PEP, respectively) have become important combination prevention methods; however, a number of challenges must be addressed to make these methods available to the most vulnerable groups. *Deteriorating living conditions* and barriers to access to goods and services experienced by LGBT populations – in their geographical, financial, symbolic and organizational dimensions – are part of this story of struggles and disputes over the public health agenda^{6,10,32}.

It is worth mentioning that the difficulties faced in implementing the Policy are also related to the approval of Constitutional Amendment 95/2016, which established a 20-year ceiling on health spending, creating funding shortages and, perversely, stifling LGBT health actions⁸.

The global health emergency cause by Covid-19 has had an immeasurable impact on people's health. LGBT populations – marked by gender, race, class, ethnic, territorial and generational relations – have suffered from LGBT-phobia, a lack of institutional protection, family violence exacerbated by social isolation, mental illness, and difficulties in accessing health services and ensuring continuity of care. This situation increases the fragility and vulnerability of LGBT populations³³.

The pandemic has intensified Brazil's deeply entrenched social inequalities on various levels,

exacerbated even further by public governance underpinned by neoliberalism, government neglect, denialism and widespread dissemination of disinformation.

Final considerations

The timeline outlined above shows how LGBT policies and rights have stoked discussions of key issues, marking a thorough break with the conventional vision of issues of sexuality and gender in the field of health. This inflection point is the fruit of intense dialogue between social movements, policy makers, health professionals and others who have attempted to produce a new politics of sexuality. However, this path has also presented ambiguities, silence and gaps.

It is also worth highlighting changing health needs beyond HIV prevention and treatment, respecting the singularities of each identity and strengthening the citizenship of sexual and gender minorities.

For the implementation of the national LGBT health policy to be effective, it is necessary to address the structural distortions inherent in the SUS, where the primary challenge is overcoming Brazil's numerous health inequalities. This requires a broad shift in the model of development and society, combining the strengthening of democratic values and social progress.

In this way, LGBT health policies, programs and actions also become an exercise in resistance in these times of countless attacks on LGBT rights. Although the struggle to implement the Policy is just beginning, the macro-political and macro-institutional apparatus of LGBT achievements instill new hope for the future of the SUS. Conjugating the verb hope should be one of the greatest banners in health; learning from the past, reflecting on the present and hoping for a tomorrow with tremendous resistance. Finally, it is important to design a range of creative organizational, moral, political and geographic arrangements in order to build other ways of producing health for LGBT populations.

Collaborations

BO Ferreira and M Nascimento contributed to all stages of the article's construction.

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