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LGBTQIA+ health in light of principlist bioethics

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Abstract

In light of principlist bioethics, this article analyzes the experiences of lesbian, gay, bisexual, travesti and transgender, queer, intersex, asexual and other gender identities and sexual orientations regarding access to health services. Conducted in 2018, in the municipality of Iguatu, Ceará, Brazil, this cross-sectional, qualitative research conducted semi-structured interviews with 26 lesbian, gay, bisexual and transgender individuals who participated in focus groups. Results reveal serious violations of basic bioethical principles, including institutional violence of psychological nature, disrespect to dignity, refusal of blood donation, non-acceptance of social name, lack of receptive and humanized care. The persistence and severity of the reported situations of discrimination show that, despite the progress and the existence of a specific health policy for this population, the measures to combat institutional prejudice have proven insufficient.

Keywords: Bioethics. Prejudice. Health services. Homophobia.

Resumo

Saúde LGBTQIA+ à luz da bioética principialista

O artigo analisa, à luz da bioética principialista, a experiência de lésbicas, gays, bissexuais, travestis e transexuais, queers, intersexuais, assexuais e outras identidades de gênero e orientações sexuais no acesso a serviços de saúde. Trata-se de pesquisa transversal, de abordagem qualitativa, realizada em 2018, no município de Iguatu/CE, Brasil, com 26 pessoas lésbicas, gays, bissexuais e transexuais, que participaram de grupos focais com entrevistas semiestruturadas. Os resultados apontam graves violações aos princípios básicos da corrente principialista, com violência institucional de cunho psicológico, desrespeito à dignidade, recusa de doação de sangue, não aceitação de nome social, falta de acolhimento e humanização do atendimento. A persistência e a gravidade das situações de discriminação relatadas mostram que, apesar dos avanços e da existência de uma política de saúde específica para essa população, as medidas de combate ao preconceito institucional têm se mostrado insuficientes.

Palavras-chave: Bioética. Preconceito. Serviços de saúde. Homofobia.

Resumen

Salud LGBTQIA+ a la luz de la bioética principialista

El artículo analiza, a la luz de la bioética principialista, la experiencia de lesbianas, gays, bisexuales, transexuales y travestis, queers intersexuales, asexuales y otras identidades de género y orientaciones sexuales en el acceso a los servicios de salud. Se trata de una investigación transversal, con enfoque cualitativo, realizada en 2018, en el municipio de Iguatu/CE, Brasil, con 26 personas lesbianas, gays, bisexuales y transexuales, que participaron en grupos focales con entrevistas semiestructuradas. Los resultados indican graves violaciones de los principios básicos de la corriente principialista, con violencia institucional de carácter psicológico, desprecio por la dignidad, negativa a donar sangre, no aceptación del nombre social, falta de recepción y humanización del cuidado. La persistencia y gravedad de las situaciones de discriminación denunciadas muestran que, a pesar de los avances y la existencia de una política de salud específica para esta población, las medidas para combatir el prejuicio institucional han resultado insuficientes.

Palabras clave: Bioética. Prejuicio. Servicios de salud. Homofobia.

Research

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The 1988 Brazilian Federal Constitution[1] established health as a right of all, without discrimination of race, color, or gender. Despite this achievement, for which the Health Reform movement was crucial, populations recognized as "minorities" still face barriers to access health services[2]. Such is the case for the LGBTQIA+ population: lesbian, gay, bisexual, travesti, transgender, queer, intersex, asexual, and other gender identities and sexual orientations.

Some milestones in addressing the barriers to access health care by the LGBTQIA+ population include the Program to Combat Violence and Discrimination against GLTB and to Promote Homosexual Citizenship, created in 2014, and Ordinance 2,836/2011, which established the National Policy for Integral Health of Lesbians, Gays, Bisexuals, Travestis, and Transsexuals. We also highlight the Ministry of Health Resolution 2/2011, which established the operational plan of this National Policy, recognizing a series of historical demands from the LGBTQIA+ population[3,4].

Despite such measures and the political and social advances, institutional prejudice persists in health services, harming not only the quality of care, but the very health of LGBTQIA+ people. LGBTphobia generally represents a whole set of attitudes that encompass aversion, prejudice, violence, or discrimination against the LGBTQIA+ community. Knowing this condition is fundamental, since, within the social construction of bodies, sexuality is not an isolated phenomenon, but participates in the dynamics of positions and oppositions that organize the whole society and dictate norms and rules to be followed[5].

As Vitiritti, Andrade, and Peres[6] point out, health agents, before being professionals, are participants of social groups influenced by cultural models. These agents bear a cultural, historical, and social baggage built on the hegemonic model of heteronormativity and cissexism. Such baggage echoes in the exteriorization of negative feelings and attitudes towards the LGBTQIA+ population, which entails deficiencies in the care provided.

In this scenario, one must defend a theory that supports health care from a special perspective, as care has a direct relationship with immediate and long-term survival, with integral well-being and life as a right. In the present research, we adopted bioethical principlism as a referential, despite the criticism this approach has been receiving, mainly related to its epistemological homogeneity.

Beauchamp and Childress developed Principlism as a theory applied essentially to biomedical ethics. In *Principles of biomedical ethics*, the authors redefined the set of three principles presented in the *Belmont Report* and added non-maleficence as a subdivision of beneficence[7]. Principlism, therefore, establishes four basic principles as norms for biomedical practice: respect for autonomy, non-maleficence, beneficence, and justice.

Principlism is a key reference for ethics and deontology in health care; thus, as Santos and collaborators[8] remind us, ethical codes determine that health professionals, when exercising their role, must refrain from any value judgment in the relationship with users. This, however, is not the reality found in the care dispensed to the LGBTQIA+ population, who recurrently are given undue care and judged by health professionals[8].

Discrimination due to sexual orientation is widespread and manifests itself in various spheres of society, including institutionally, in spaces of care production[8]. Based on this finding and in light of principlist bioethics, this study analyzes the experience of LGBTQIA+ patients in health care services.

Method

This paper presents the results of a qualitative, descriptive, and exploratory study conducted in the municipality of Iguatu, Ceará, Brazil, with 26 LGBTQIA+ individuals. Participants were recruited in non-governmental organizations, activist groups, activists, and representatives of the struggle for human rights by using the snowball sampling technique – in which the first interviewee indicates the next one, and so on – until the theoretical saturation point is reached[9].

We established three inclusion criteria: being a LGBTQIA+ individual, having lived in the municipality of Iguatu for at least one year, and being 18 years of age or older. People who had never accessed any health service or who had any limitation to communicate, such as speech impairment, were excluded.

Data collection took place in 2018, by means of focus groups. In all, we had four groups, one for each segment (lesbian, gay, bisexual, and transgender) and the meetings lasted on average two hours. To ensure anonymity, interviewees are referred to by the name of the segment followed by a number.

The focus groups sought to identify and reflect on the easy or difficult accessibility of the LGBTQIA+ population to health services. Results were organized into categories and analyzed in light of principlist bioethics: respect for autonomy, non-maleficence, beneficence, and justice. The study followed all the guidelines established by the National Health Council in Resolution 466/2012[10].

Results

Most of the research participants defined themselves as a bisexual (7 participants) cisgender woman (11), aged between 20 and 29 years (17), mixed race (14), single with no partner (12), no religion/philosophy (12), with monthly income less than one minimum wage (13) and incomplete tertiary education (11). The selected fragments reveal and allow the analysis of common bioethical principlism violations committed by health professionals against the LGBTQIA+ population.

Respect for autonomy

Regarding the bioethical principle of autonomy, the most notable complaint among participants concerned an ongoing long, complex, and heated debate in Brazil and other countries: the restriction of blood donation by the LGBTQIA+ population. According to the respondents:

"We have cases of homosexuals who were even harassed. (...) The Hemoce [Ceará's Hematology and Hemotherapy Center] *didn't accept them because through anal intercourse some bacteria from the rectal canal could get to the heart valve, or to the heart's artery and end up spreading to the whole body. (...) So, these are health professionals saying that. (...) That's what they have as a reference and why they keep homosexuals from donating blood"* (Gay 4).

"When it comes to blood donation, I've always thought it an absurd health policy. For me, this confirms the prejudice against homosexuals. I went to a unit to donate blood once and the woman doing the screening said, with kind words, that I wasn't fit to donate blood. (...) Still, the SUS [Unified Health System] *talks about an integral health policy for the LGBT population. Does this policy include donation? Donating is a right of access for the LGBT population. (...) So, what hypocrisy is this?"* (Gay 5).

"I know that if, at the time of screening, I declare that I'm gay, I will not be allowed to donate blood. (...) So, I won't say it. Because they will run all the tests on my blood and the results will be as good as when I was 16 [when the participant donated blood, before discovering himself gay], *it will be ok to donate. But saying I'm gay could change everything"* (Gay 6).

Non-maleficence

The testimonies revealed that institutional violence in health services is the main factor related to violations of the principle of non-maleficence. Such violence is materialized by inadequate assistance, ridicule, non-adoption of social name, and mockeries that cause emotional instability in patients:

"I went to my first doctor's appointment with my partner in the private [service]. *My partner went into the office with me, and at first the doctor treated me fine. When the doctor asked, I said I was a lesbian and her* [the doctor] *attitude changed completely. (...) I noticed it, and from then on it was over. (...) The way she started treating me was totally different from before she knew my sexual orientation (...). I didn't like it and never went back, no way. (...) I felt terrible. (...) She* [the doctor] *treated me in a way that I felt awful and didn't return. It is horrible to be treated like that, where the person keeps shying away from you, as if you have some kind of disease. I am as normal as anyone else, as the doctor who treated me"* (Lesbian 1).

"It was horrible. I was a teenager, I felt raped, I really did. It hurt; I didn't feel comfortable at all. I think the doctor herself noticed and I was forced to speak. 'So that's it, you are a lesbian.' Like, I didn't have to lie, but I also didn't feel comfortable at any point. I'm talking about the first time. (…) This happened in the SUS" (Lesbian 2).

"I haven't done [exams] *out of shame. Shame and fear. Fear of arriving at the clinic and being mocked if I ask for a blood test. (…) If I go the clinic and ask for a blood test, the professional might look at me and say… she won't ask if it's a complete blood count or another type of blood test, she'd ask: 'Is it for HIV?' That'd be the question. And she won't ask it directly to you; no, she'll ask in a way that everyone at the health center or in the hospital know you're there getting a blood test for whatever reason. But her first question would be: 'Is it for HIV?' Loud and clear. I think that's ridiculous"* (Gay 4).

"I have a friend (…) who went to the dermatologist in the public service and the doctor asked him for an HIV test. Then he said: 'But I came here for another reason.' And the doctor replied: 'No, let's do it, I think there's something fishy about it.' (…) He went to the dermatologist and the first thing the doctor asked was an HIV test. And that wasn't the worst thing. He did the test and took it to the doctor, who said: 'Oh, wow, it is negative' and kept on mocking, in disbelief, [suggesting] *that because he was gay, he obviously must have* [HIV]. *(…) It's a dehumanized care, and the main point is the discrimination and prejudice against the LGBT population"* (Gay 5).

"I faced discrimination even here in the regional hospital, because he [the doctor] *did not want to address me with the name that I wanted. He said: 'No, I will address you by the name written here, your name is this one.' I said: 'No, I want to be called Sabrina, it's the name I like.' But he insisted on not using my chosen name. (…) He said: 'I don't even refer to transsexuals who had the surgery as 'she'' (…). Then he immediately embarrassed me: 'What do you feel, sir?'"* (Transgender 1).

Beneficence

Few interviewees reported experiences of humanized and welcoming care, capable of evoking feelings of satisfaction, importance, and zeal. Such care, when it occurs, results from a professional attitude free from prejudices and imposed cultural standards:

"[I was well] *treated only when I went for an STI* [sexually transmitted infection] *test at Cemear* [Specialized Microregional Center for Reproductive and Sexual Health Care], *the only place where they asked me about my sexual orientation. But I was never asked this in any other health service, only at Cemear. (…) I said I was bisexual, filled a questionnaire, and was very well treated by their staff"* (Bisexual 3).

"I was well treated by a younger professional and she was from another country. I don't know if it is due to cultural issues, but Brazil is a very sexist and conservative country. She was Cuban and, from my perspective, very open minded. We talked a lot and even developed a friendship. She was very kind and always gave me advice and so on. (…) When the professional rids themself of religious and cultural aspects and beliefs, it facilitates the access itself. (…) In other words, the care has to be welcoming" (Bisexual 4).

"I went to both male and female gynecologists and I felt the difference regarding empathy, you know? I had very bad cramps and when I talked to the man, he said: 'Okay, then take this medicine,' he gave it to me and I left. But when I told the woman about it, she said: 'Well, let's do some tests so I get a real sense of what is going on, because it could be anything from a minor thing to something more serious.' So, it was different; It was a small thing, but different. Just the fact that she was interested in seeing the exams show a different approach" (Bisexual 6).

Justice

Participants, especially those with mannerisms considered feminine or feminine-presenting, such as travestis, also reported violations to the principle of justice. The interviewees point to the need for public health policies directed to the specificities of each group and greater qualification of professionals to care for the LGBTQIA+ population:

"There is no easy accessibility. There are laws, you know. We've got all the rights, but we can't exercise

them. The professionals of any area prevent us from that. They should be better prepared. In fact, they have to be better prepared, as prejudice will always exist" (Transgender 4).

"We know, we are aware of our rights; but sometimes it seems that the employees of public health entities and agencies, who are there to provide us care, don't understand that. (...) I am not putting the blame on them; this is a cultural issue" (Gay 6).

"The biggest difficulty today are public policies. There has to be an extension, university, school, society. If you don't start from the smallest to the biggest, nothing is solved. Law courses fighting violence against women, nursing courses addressing teenage pregnancy, so why not look at gay health?" (Gay 1).

"We are breathing through respirators, it is not easy for anyone and when you are gay, especially if you are a travesti or trans, the difficulty is even greater" (Gay 1).

"The more we try to be polite – we gays or travestis – in a health unit, the more we try not to show it, not to attract attention, the professionals themselves ridicule us due to our appearance, our high-pitched voice, our mannerisms. Because, culturally, the more effeminate, the more people mock you" (Gay 4).

Discussion

The term "bioethics" was introduced in the 1970s by biologist and oncologist Van Rensselaer Potter, who argued that ethical values cannot be separated from biological facts. With the advance of medicine, especially biomedical technology, new problems arose and Potter started advocating for an ethics of life that should exist beyond universities, bringing the scientific achievements closer to people's daily lives[7].

Since then, bioethics has been developing as a field of applied ethics, ensuring its space within science, academia, and society. Some specific demands, such as those related to ethical issues in research with human subjects, led the US government to create the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, responsible for publishing the *Belmont Report*, which proposed three fundamental principles: respect for autonomy, beneficence, and justice[11].

In the same period, the perception that ethical discussions needed to go beyond research with human beings and include clinical and care practice increased. Considering this need, in 1979 Beauchamp and Childress published the book *Principles of biomedical ethics*, in which they add a fourth element – non-maleficence – to the three principles of the *Belmont Report*. This work cemented the so-called "principlist bioethics"[12].

Considering the four principles highlighted by Beauchamp and Childress, which must be included in health care practices and are currently mentioned in deontological codes, the present study identified several violations to these fundamentals, resulting in a dehumanized care to the LGBTQIA+ population.

Autonomy is defined as the human being's right to self-government, exercising protagonism in the health-disease process[13]. Based on this definition, we observe that the LGBTQIA+ population does not have their autonomy respected in health services, especially blood centers, where they are barred from donating blood, even without presenting factors of unfitness according to the Ministry of Health guidelines and protocols.

Regarding hemotherapeutic technical procedures, the Ministry of Health issued Ordinance 158/2016[14], and Anvisa issued Collegiate Board Resolution 34/2014[15]. These documents establish guidelines for screening, blood collection and transfusion. Article 64, item IV, of the Ordinance and article 25, item XXX, of the Resolution stipulates hypotheses of temporary and definitive inaptitude. Both regulations manifest similar content, preventing men who have had sex with other men from donating for a period of 12 months, and extending the prohibition to the partners of these men, in case of unsafe sex.

When asked about the reasons for this prohibition to a specific group, public agencies resort to the transfusion safety argument and the maxim of protecting the collective interest. But such prohibition unequally restricts individual rights, revealing a prejudiced bias when associating risk factors to a specific group, based on their sexual practice [16].

Precautionary procedures in blood transfusion thus segregate the homosexual population already during screening. While the only requirement made to a heterosexual person is to have had sexual intercourse with a sole partner in the last 12 months, even without using condoms, this possibility is not even considered for homosexual people, thus making sexual orientation an excluding factor for donation, provided by the legislation itself [14,16].

In Ordinance 1,353/2011 [17], previous to the norm currently in force, the Ministry of Health recognized that sexual orientation itself should not be used as a criterion to select blood donors. Ordinance 158/2016 [14] kept this recommendation in Article 2, Paragraph 3, which states that the services provided by blood centers should be free of any discrimination due to sexual orientation. Further on, however, the same ordinance provides for the exclusion of those who have same-sex relationships.

The principle of non-maleficence can be defined by the maxim *primum non nocere:* first of all, do no harm [7]. What we verified in the participants' testimonies is, however, the report of experiences that cause damage to the emotional health of LGBT people through prejudice, discrimination and mocking attitudes that characterize institutional violence of psychological nature.

According to the Ministry of Health [18], psychological violence involves verbal or gestural aggressions aimed at terrorizing, humiliating, rejecting and restricting someone's freedom, as well as situations of blackmail, discrimination, exploitation and prohibition of socialization, among others. In a study conducted in the countryside of Ceará, 1.2% of 249 LGBTQIA+ people who reported having suffered psychological violence pointed to aggressions perpetrated by health professionals [19].

Such violence has harmful consequences on health. When it comes to the homosexual population, the impacts are extremely worrying: higher incidence of mental disorders, suicide attempts, and use of illicit psychoactive substances [20-22]. A number of vulnerability factors increase the health risks of this population, such as social exclusion, homophobia, and invisibility in institutions (especially health services), which result in high levels of discrimination and rejection [21,22].

Despite government programs advocating inclusion, at least in theory, health care for the LGBTQIA+ population is marked by assumed heterosexuality, lack of space for patients to verbalize their sexual orientation, professionals unprepared to deal with the specific demands of this population, and serious human rights violations [23-25]. All these elements result in difficulty or impediment in accessing health services.

One of the most reported violations is the disrespect to the social name. Decree 8,727/2016 [4], which enforces the right to use the social name and gender identity in all areas of federal public administration, prohibits the use of pejorative and discriminatory terms. Name changes do not require court decisions, but even so, being addressed by one's social name has been a much-desired and unattained goal. Society's difficulty in breaking with the binary barriers male/female, masculine/feminine, man/woman is notorious [26].

The issue of LGBTphobia in health services is not an isolated phenomenon, but just another manifestation of an exclusionary model of culture and thought. Strategies to change, overcome, and combat prejudice, discrimination, and violence against the LGBTQIA+ population must thus be designed. The National Plan for the Promotion of Citizenship and Human Rights of LGBT, from the Special Department for Human Rights, goes in this direction by promoting LGBT citizenship by network actions. The plan advocates a systemic action through articulation in all spheres of government, in the three branches of government and between public authorities, the private sector and organized civil society, as well as intersectoriality and transversality when proposing and implementing public policies. This plan recognizes that the fight against homophobia requires integrated actions between the areas of education, health, safety, and several others [3].

Another important initiative is the National Policy for Integral Health of Lesbians, Gays, Bisexuals, Travestis and Transsexuals, considered a milestone in the struggle for LGBTQIA+ rights. Implemented in 2013, the policy points out the attributions of each governmental sphere within the national territory, fulfilling a guiding role and ensuring, at least theoretically, the integral access to health by this population, regarding gender specificities and the diversity of sexual practices[3].

Beneficence, in turn, can be defined as actions that do some good to one or more individuals. The principle of beneficence expresses a moral obligation to act for the benefit of people[7]. In the participants' discourse, however, few reports of beneficent actions in health services emerged. These situations, when experienced, involved appropriate interpersonal treatment, which resulted in the patient's well-being and harm reduction by actions of welcoming, reception, and friendliness.

In this context, it is worth highlighting the National Humanization Policy (PNH) as a possibility for ensuring beneficence and its relation with the National Integral Health Policy. According to the PNH, the act of humanizing care is translated into including differences in the processes of management and care. This change, however, is not built individually or by isolated groups, but in a collective and shared manner[3].

Research on the care provided to lesbians and bisexuals in health units in the city of João Pessoa, Paraíba, Brazil, revealed this public's dissatisfaction with the professional team's approach[27]. This unwelcoming approach, combined with professional unpreparedness, was the main reason cited by participants for avoiding health services.

To curb non-adherence and the population's disengagement from health services, a welcoming environment is essential. Thus, when seeking assistance, the LGBTQIA+ population must be treated in an comprehensive and humanized manner. When a person's needs are met, their bond with the health unit is strengthened, which leads them to seek the services again. Accordingly, the subject's satisfaction with the care received improves the quality of care and encourages them to seek assistance whenever necessary[28].

Humanizing the SUS requires changes in how the community, managers, and professionals think and act. Such changes must start by recognizing LGBTQIA+ people's sexuality and the diverse new forms of family constitution. Health protection strategies must respect the specific vulnerabilities of this population to promote not only access, but also quality of care, empowering subjects to develop their own citizenship.

Catering to the LGBTQIA+ population involves possible ethical conflicts, and bioethics is a useful tool to seek solutions to such conflicts[4]. Importantly, however, when the principlist model – autonomy, justice, beneficence, and non-maleficence – is applied uncritically in primary care it generates limitations, since this theoretical approach tends to be better suited to threshold situations in the hospital setting.

Before being the main premise of the LGBT health policy, an equitable and prejudice-free health care responds to the principle of justice of the principlist approach, interpreted as the equal, equitable, and appropriate distribution of resources, determined by justified norms that structure the terms of social cooperation[7]. In this respect, to guarantee justice is to ensure the achievement of SUS's doctrinal principles, constitutionally provided. On the other hand, when LGBTQIA+ people report exclusion and violation of rights, they are denouncing social injustice.

Inequality in the care of the LGBTQIA+ population and the influence of heteronormativity mark the care provided in the public health system. Excepting the testimonials linked to the principle of beneficence, all participants reported violations of the principle of justice, pointing to unequal care and denial of rights.

Declared homosexuals, especially travestis, reported situations where they were purposely humiliated in health services. This type of care can be understood as a strategy employed by professionals to discharge LGBT patients more quickly. Situations like this, besides characterizing clear violation of the principle of justice, violate the constitutional principle of isonomy and the SUS's precept of universality.

Receiving care free of prejudice and discrimination is a right of the LGBTBQIA+ population. But besides having their rights respected, these people should be treated humanely by professionals prepared to address their specific demands, ensuring that they feel welcome and accepted in care spaces. To this end, actions aimed at the qualification of health professionals are necessary.

This preparation must occur during academic training, building theoretical and practical bases on the topic. In a study conducted in Northeast Brazil, none of the professionals interviewed had taken specific courses on gender and sexuality issues, and the topic was only addressed when related to infectious and contagious diseases[2]. In another study, with medical students in Piauí, Brazil, 97.5% of the interviewees said they had not taken specific courses on sexuality[29].

In a study conducted in the municipality of Cajazeiras, Paraíba, Brazil, 55% of the professionals interviewed had participated in training or qualifications regarding sexuality, and 65% on the LGBTQIA+ population[30]. However, the same research revealed the unpreparedness of professionals when questioned about these issues. Results showed that training professionals to merely reproduce knowledge does not give new meaning to health care. Human sexuality is complex; therefore we must train professionals capable of recognizing the various nuances related to the topic and the specificity of care for vulnerable groups[2,27,30].

It is urgent that contents related to the care of the LGBTQIA+ population be constantly discussed during the training of future health professionals. Such discussions should occur in all social spaces, thus reducing prejudiced and discriminatory attitudes that perpetuate social exclusion and the denial of citizenship.

Final considerations

In the situations reported by the research participants, we identified severe violations to principlist bioethics. The testimonies revealed situations of personal insults, embarrassment and ridicule, attack on dignity, psychological institutional violence, refusal of care in some services (such as blood donation), disrespect for the use of the social name, and lack of a welcoming environment.

Although the research addresses prejudice and discrimination specifically in health services, LGBTphobia is not restricted to this field. It is part of a normative, structuring, and exclusionary worldview. Results show that government strategies – including the National Policy of Integral Health of Lesbians, Gays, Bisexuals, Travestis and Transsexuals – and the political and social advances achieved, although important, have proved insufficient in the face of the systemic nature of LGBTphobia. Thus, we must develop combat strategies that consider prejudice and discrimination against the LGBTQIA+ population as a historical, social, and cultural phenomenon.

Actions to fight and overcome institutional prejudice and LGBTphobia in health care must exceed the academic, scientific and theoretical limits of health policies and programs. We must raise awareness and political action in practice and at all levels, at the individual and community scope, in interpersonal everyday relationships of family, social, and professional life. The need for laws that criminalize discrimination based on sexual orientation and gender identity, and ensure the inclusion of gender, sexuality, and sexual diversity discussions in school and university education is particularly noteworthy.

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Jeanderson Soares Parente and Caik Ferreira Silva outlined and designed the study and, together with Beatriz de Castro Magalhães and Mauro McCarthy de Oliveira Silva, analyzed the data and wrote the article. Grayce Alencar Albuquerque contributed significantly to the manuscript writing and critical revision of the content.

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