

Gender and sexual rights: their implications on health and healthcare

Romeu Gomes¹
Daniela Murta²
Regina Facchini³
Stela Nazareth Meneghel⁴

Abstract *This article is an objective examination of aspects of gender and sexual rights, and their implications in the field of health field, using the methodology of an essay. The first part discusses femicide, highlighting that there are deaths of women due to the fact of being women, which constitute what could be described as the crimes of *lèse-humanité* or 'femi-genocide'. The second part discusses sexual and gender diversity, with an emphasis on the fragility of the 'right to have rights' expressed in the deterioration in health conditions of the population that is LGBTI (Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Intersex). Finally, the essay discusses recognition of gender plurality, and the limitations imposed on the rights of non-usual normativebodies bodies; criticism is directed at reiteration of the binary and cisgender normative ethos, which can exacerbate the health vulnerability of people with trans and other non-normative bodies and identities. It is concluded that, in the 30 years' existence of Brazil's Unified Health System (SUS), there have been advances in the political sphere, many of them created by or as a result of social movements, and initiatives that seek to confront femicide and the inadequate assistance available to LGBTI people. In the context of these challenges, it is reiterated that there is a necessary relationship between promotion of health and protection of human rights related to gender and sexuality.*

Key words Gender, Sexual rights, Health

¹ Instituto Nacional de Saúde da Criança, da Mulher e do Adolescente Fernandes Figueira, Fiocruz. Av. Rui Barbosa 716, Flamengo. 22250-020 Rio de Janeiro RJ Brasil. romeugo@gmail.com

² Superintendência de Promoção da Saúde, Secretaria Municipal de Saúde. Rio de Janeiro RJ Brasil.

³ Núcleo de Estudos de Gênero Pagu, Programa de Pós-Graduação em Ciências Sociais. Campinas SP Brasil.

⁴ Escola de Enfermagem, Universidade Federal do Rio Grande do Sul. Porto Alegre RS Brasil.

Initial considerations

Gender is defined as an element of social relations based on the differences perceived between the sexes, and is the first field in which power is articulated¹. Thus, it is related to the way in which societies deal with the perception of human bodies, and the consequences of this; this takes the form of arrangements that are changeable as new situations arise that are created by human practices².

According to Connell³, gender is “at the same time a source of creativity and a source of violence, in which bodies and cultures are both in play and are constantly transformed, sometimes even to the point of their destruction”. Thus, the gender arrangements can be a source of pleasure, recognition and identity, or a source of injustice and damage⁴.

It is also common to consider gender based on a static and categorical approach (feminine vs. masculine)³. In this article it is considered that as well as accepting gender as a dynamic category, its articulations with sexuality and its relationship with the various forms of transgender phenomena are important.

Included in the discussion are issues that relate to the experience of people who do not identify with the gender with which they were designated at birth (transvestite, transsexual, non-binary people or ‘queer’ identity), and to diversity of sexual orientation (straight, homo or bisexual). This implies considering that identity such as transvestite or transsexual does not refer directly to sexual orientation, since trans people may have their sexual desire directed toward people of the same sex, of the other sex, or even to other trans people⁵. This implies that ‘cisgender’ is another word which needs to be taken into account: in contrast to ‘transgender’, it refers to people whose gender identity and expression corresponds to the gender attributed at birth^{6,7}.

Feminism and the LGBTI movement – the movement of lesbians, gays, bisexuals, transvestites, transsexual women, trans men and intersex people – are fundamental actors in the defense of sexual rights and of plurality of gender identities. In Brazil, policies in the field of health^{8,9} reflect aspects of these movements.

Based on the essay format, this study examines aspects of gender and sexual rights in some detail, and their implications in health field, with a view to offering innovative contributions to this subject area¹⁰.

Women’s Right to Life

Slavery, rape and murder of women have been present over the whole history of humanity, making women’s right to life a fragile entity and concept. In the patriarchal societies, violence against women is an instrument of control that maintains masculine power¹¹. Although it has been present in all eras of history, the collective rape camps of the former Yugoslavia¹² turned sexual violence into a weapon of war.

The conquest of the Americas can also be seen as a white, male and patriarchal historiography, consisting of an uninterrupted history of appropriation and violation of racialized feminine bodies¹³.

Russel¹⁴ defines femicide as a form of sexual terrorism or genocide, expanding the concept to beyond the deaths committed by intimate partners, and showing that there are deaths of women that are in reality due to the fact of their being women – but these are deaths which were not perceived as such.

Femicides have gender-based, racialized and social determinants. They are more frequent in places where the rules of society are ruptured by the conflict of war, or in territories dominated by trafficking^{15,16}, although they also happen in places where, for example, rules of honor are so rigid that a woman who may have infringed them may pay with her life.

For the patriarchal system, women are, in the last analysis, men’s property¹⁷. This does not mean all men behave in the same way, nor that the risk is the same for all women. The most vulnerable women are those that are migrants from peripheral countries; women who for ethnic, cultural or racial reasons are considered inferior; women that practice stigmatized occupations such as prostitutes; and those that are living in territories occupied by trafficking or paramilitary groups. To see femicides as arising from the hierarchical organization of society is important so as not to re-victimize the woman who has died, attributing to her the blame for her own death.

Somewhere around one-third of the murders of women are committed by the intimate partner. Five per cent of deaths of men are caused by women – the majority in situations of self-defense¹⁸. And between 60% and 70% of homicides of women are femicides^{19,20}.

At the beginning of the 2000s, there were 25 countries with a very high rate of feminine death by homicide (>6/100,000). Half of them were in the Caribbean, Central America and South

America; and this situation has remained similar in the subsequent years²¹.

In Brazil, feminine deaths by aggression grew from 2.3/100,000 to 4.8/100,000 over the period 1980–2013 – proportionally an increase of more than 100% in the period²². The frequencies are higher in regions where there is high masculine death by aggression, showing that places that are violent for men are also violent for women^{16,23}.

In the 2000s, various Latin American countries had prepared specific laws on homicide of women. Brazil passed a law on femicide in 2005, which specifically includes the issue of gender as a legally distinguished circumstance²⁴. This law has been in effect too short a time for a proper assessment, but the banalization of gender crimes indicates the need to monitor its application, so that there can be more efficient actions for prevention and punishment of these crimes²⁵.

Class-based legal systems, and those that seek to avoid the issue of gender, tend to carry with them the implication that having laws does not necessarily mean they will be obeyed¹³. In Brazil, the legal system has shown itself to be recalcitrant, placing difficulties in the way of classification of crimes as femicides, although it is known that the concept that “all are equal under the law”²³ is a myth, and that women, especially poor and black women, are not treated with equality, as a result of which many femicides are not even investigated²⁰. There is even a moral judgment, a re-victimization of the victim in the legal discourse, when justification is given for a crime of passion, using the disguise of “a state of violent emotion”.

Highlight theoretical terms to help in understanding and describing this phenomenon would include the concepts of necropolitics²⁶, social fascism²⁷, and femi-genocide¹³. ‘Necro-politics’ is associated with an ‘apartheid’ policy, in which certain groups are segmented, and confined into territories where life has no value, and thus, killing is allowed²⁶.

In Brazil, since the 1990s, there have been accusations of a state of lawlessness, in certain territories where the black population has suffered heavily from homicides. These deaths are due to conflicts created by mafia-type groups, but also action of the police²⁸, and the necro-politics that has applied to the male population has also affected the women who inhabit these territories ‘beyond the law’. Even so, little has been said, to date, in relation to the ‘lives with no value’ of racialized, poor, migrant women, exercising stigmatized occupation and living in these ‘apartheid’ regions.

In the countries where neoliberal policies have been put in place, with as their consequences authoritarianism, corruption, unlawful transactions and impunity, femicides have increased. In Central America and the northern frontier of Mexico, neoliberalism has created structural conditions for women to be discarded, as being no longer necessary for the army reserve, nor for the purpose of reproduction. Neoliberalism stimulates the emergence of a “toxic masculinity”, in which women are property, objects of pleasure or merchandise²⁷.

Femi-genocide constitutes a message to society to maintain the system of subjection/exploitation of women, expressing the mandate of masculinity. The conservative and fundamentalist backsliding brought about by racist capitalism acts on women’s bodies to eliminate them, in such a way that, hence, all femicide is political.

Societies that are more egalitarian in socio-economic, racial and gender terms have lower levels of violence, indicating that one of the ways forward is the struggle to reduce inequalities. Organized, women have achieved victories, some of them small, but definitely victories, and thus feminine militancy and the construction of solidarity networks should not be abandoned²⁹.

To deal with these crimes it is necessary to name, categorize and denounce these deaths³⁰, including the right to formulate the legal discourse. Segato¹³ proposes that femicides that take place in the public sphere are situations of *lèse-humanité* or ‘femi-genocides’. The use of this category of accusation would make it possible to make these crimes not subject to any statute of limitations, and able to be taken to international courts of human rights, where it may be possible, [perhaps], at least to see justice done.

Sexual and gender diversity: how fragile is ‘the right to have rights’

One of the models through which hierarchies and norms relating to gender are articulated with questions of health derives from taking the anatomical differences between men and women, especially the genitals, as the basis for a sexual dimorphism which argues incommensurability³¹, which is articulated to sexuality, in such a way as to demand coherence and continuity between sex, gender and desire³². Such cultural constructs, which have become embedded in the very process, itself, of constitution of western Modernity, can determine conditions of health, relegating people and populations marked by variations of gender

and sexuality to a place of unintelligibility, in which their status as humans is not recognized³³.

The literature has reported interpersonal violence, discrimination and its effects in disparities in health, with an increasing incidence of problems, especially those who are more sensitive to social and individual vulnerability, such as: issues of mental health and those connected with HIV and Aids; difficulties in access to services and care; inadequacy of services and vulnerability of programs; and, at the limit, fragile recognition of people and populations as holders of rights³³⁻³⁸.

Brazilian scientific output on health and LGBTI focuses mostly on HIV and Aids (the only subject on which there is systematic and regular production of epidemiological data); followed by the subject of violence (which appears articulated with individual and social vulnerability for infection by HIV); other adversities including depression, suicidal tendencies and suicide attempts; substance abuse; and difficulties of access to health care and services³⁹⁻⁴⁸. In spite of important research efforts that have accompanied and made possible the construction of public policies to combat violence against LGBTI people, there is no systematic and regular production and publication of data on discrimination and aggression against LGBTI people.

The very creation, itself, of the category “homosexual”, and its identification as a “condition”, is, historically, a reaction in contexts of criminalization of sexual relationship between people of ‘the same sex’⁴⁴. Over the second half of the twentieth century two processes took place in parallel: (i) the separation between what was called “gender identity” and homosexuality; and, later, (ii) removal of the characterization of homosexuality as a pathology⁴⁵.

Homosexuality ceased to be treated as a mental disorder in 1973, when it was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatry Association. However, it remained on the list of mental illnesses until May 17, 1990, when the 43rd World Health Assembly decided to remove it in the 10th version of the International Classification of Diseases (ICD10). That version, however, still conserves categories that articulate a connection between homosexuality and mental disorders^{45,46}. Because of this, there is a recommendation for elimination of any connection between sexual orientation and disease, in the preparation of the 11th ICD, which is to be published⁴⁶.

In the Brazil of the 1970s, the first actions of the nascent homosexual movement included

mobilization of a widespread campaign in favor of review of the classification of homosexuality as a pathological condition. The Federal Medical Council issued an opinion in 1985 considering that homosexuality *per se* is not a pathological condition⁴⁷. Demands for anti-discrimination legislation, recognition of homo-affectionate unions, public safety and education policies have been part of the Brazilian movement since it began⁴⁸.

Insertion of LGBT into the political agenda begins in the 1990s, through actions focused on prevention of HIV and Aids, and inclusion of the category ‘homosexual’ in Brazil’s First National Plan for Human Rights (1996). The 2000s decade was the high point of this process of recognition, with the following events as landmarks: creation of the Brazil Without Homophobia program (2004); the First LGBT Conference (2008); adoption of regulations for combat of discrimination and to guarantee the civil use of a ‘social name’ by trans people; and recognition by the Federal Supreme Court, in 2011, of a stable homo-affective union as a family entity^{48,49}. In the field of public policies, two highlights have been: (i) institution, in 2008, of the Transsexualization Procedure in the Unified Health System; and (ii), in 2010, the National Integrated LGBT Health Policy^{9-50,51}.

An important point in the 2010s was the halting of this agenda at the federal level, and intensification of investments in efforts at reversal of rights. There was a multiplication of draft laws, such as for example, (i) the ‘Family Statute’ (Draft Law 6583/13), which excluded homo-affected unions from the list of family entities recognized by the Brazilian State, and (ii) laws seeking to restrict the possibility of use of a ‘social name’ by trans people.

There are also initiatives that point in the direction of once again making homosexuality a pathology, attacking the conditions that make it possible to regard these populations as the subjects of rights. An interim judgment given in September 2017 by the Federal Courts in the region of the Federal District partially accepted the claim in a class action against Resolution 01/99 of the Federal Psychology Council⁵², which orients professionals of the area on how to act in issues relating to sexual orientation. The case was based on one of the remaining labels, as a pathology, that remained in ICD-10^{45,47} – the notion of “ego-dystonic sexual orientation” – and the court decision makes it possible for sexual reversal therapies once again to be legitimately used in Brazil.

This scenario refers to critical points of view that were constructed around or before 2010, on the difficulties of converting public policies into legislation⁵³, and on the scope actually achieved by policies addressing LGBT people, seen as fragmentary, one-off and peripheral⁴⁹. These advantages, anchored in a context of recognition of sexual and reproductive rights and combat of intolerance under the aegis of the United Nations⁵⁴, became significantly more fragile as a result of transnational processes of reactive politicization of morality and the area of religions^{55,56}. In Brazil, as in several countries, such processes, which have been described as a 'wave of conservatism', come together based on lines of force that articulate manifestations of social intolerance, celebration of meritocracy and entrepreneurship, imposition of restrictions on activity by the state, and demands for more punitive and repressive public safety policies⁵⁷.

The effects of this political context are already making themselves felt in the epidemic of HIV and Aids, with growth in rates of incidence, strongly concentrated in specific social segments and with already high mortality rates. Currently, the prevalence of HIV among men who have sex with men is 19.8% for those aged 25 or over; and the proportion of cases of Aids among homosexuals and bisexuals has grown by 32.9% in the last decade⁵⁸. A survey among transvestites and transsexual women in Rio de Janeiro indicates prevalence of 31.2% for HIV³⁸.

As the only aspect of LGBTI health that is systematically monitored over time in Brazil, the data on HIV and Aids are an alert on the deterioration and the severity of the health conditions of LGBTI people. They further indicate the urgency of reaffirming the necessary relationship between the promotion of health and protection/promotion of the human and fundamental rights of these populations.

Recognition of gender plurality, and the limit of rights for non-usual bodies

The conceptual separation between sex and gender was forged in the context of formalization of the procedures for bodily sex modification in trans and intersex people, was materialized by the notion of gender identity, and was essential for incorporation of the health needs of transvestites and transsexuals. Widely used, this concept, which is linked to the recontextualization of sex achieved in the 20th century, and to the technical feasibility of carrying out bodily modifications of

sex in trans people, has become the main reference for access to this type of care and has contributed to recognition of trans life choices, especially transsexuality, as a psychiatric category⁵⁹.

The notion of gender as a differentiated component of biological sex, modelled by education, fixed in the first years of life, irreversible and prevalent in relation to the physical characteristics in sexual maturity⁶⁰, was introduced in the 1950s when researchers investigated the relationships between an individual's nuclear identity, anatomy, chromosomes and hormones. In this context, they recommended that in intersex babies the sex should be defined based on biological markers, and in older children and adults the reference would be the gender manifested^{42,61}.

In 1964, Stoller⁶² presented the term 'gender identity' to refer to the feeling of belonging to a given sex. Based on the life experience of a trans person, he considered that, by dissociating the perception of one's self from sexual activities and fantasies, this term would better signify the sensation of belonging to a given sex than the idea of 'gender role' introduced by Money and his colleagues⁶³.

With this, the medical discourse was re-figured, to guide for intervention on non-usual bodies, and the organization of services. The conceptualization of gender identity and its immutable character became a reference for medical protocols for management of intersexuality and other conditions of mismatch between gender identity and anatomy, such as transsexuality⁶², this being the clinical signal for bodily modification of sex and a criterion for access to care⁶⁰ to be verified based on a process of psychological evaluation⁶⁴.

Although the present international clinical guideline is more flexible and de-pathologized⁶⁵; although it tries to escape the binary approach to gender; and takes into account the multiplicity of paths and needs of trans people; the access to bodily modification of sex still follows a model based on evaluation and psychiatry, which understands trans people to be suffering from 'Gender Dysphoria'. In Brazil, similarly, and in spite of the position taken by the Federal Psychology Council through its Resolution 01/2018⁶⁶, care is pathologized, and centered on diagnosis of 'Sexual Identity Disorder', with a highlight for the self-attributed gender identity test, which denotes a purpose of regulation of identities and normalization of trans bodies.

If on the one hand the constitution of the concept of gender identity has been fundamen-

tal for recognition of trans living conditions and acceptance of their demands, on the other it is noted that, across the field there is a cis-hetero-normal matrix, which reiterates a normative context which presupposes a coherence between sex and gender, which attributes the status of pathology to identities and bodies that are outside the norm, while it regards cis and binary lifestyles as natural. At the same time as it makes the specificity of trans people visible, paradoxically it 'naturalizes' the cis-gender and binary model of the sexes in the health system. This not only limits and/or excludes a trans subject, but gives agency to interpretation of these life patterns as a gender identity *per se*, which because it is outside the norm needs to be named.

An example of this is the superimposition, over the notion of gender identity, of the trans life experience. This denotes the concern to identify the 'true' gender identity of these subjects and the idea that this is an exclusive attribute of trans people. The idea that cis-gender life experiences are normal and unquestionable, and not the result of subjection to the regulations of gender and reiterated repetition of the norms⁶⁷, leads to the view that attribution of gender and identity construction are a particularity of those that are outside the norm.

This can be clearly observed in Brazil's Interpersonal or Self-Provoked Violence Incident Reporting Information System (SINAN). The reporting / investigation / instruction format of this system shows a naturalization of cis-gender attitude and interpretation of trans life experience as a synonym of gender identity. Not only is there no clarification, in the 'sex' field on the form, as to whether this item refers to biological sex or civil registry; there is also a recommendation from the instructions⁶⁸ that for trans people the "gender identity" field on the form should be filled in – this has the option 'transvestite', 'transsexual woman', 'transsexual man', 'not applicable' and 'unknown' – revealing the interpretation of trans life experience, precisely, as gender identities which, because they are outside the norm, need to be formally identified.

There is also the question of comprehension of gender identity as a social determinant of health. Even though the understanding that this component has an effect on the health conditions of those who have non-normative identities is extremely positive, this reveals the insufficiency of the health system which, cis-normative and binary, excludes and imposes limits on trans people in the exercise of this right – in spite of some

efforts by the public authority to face up to these subjects' vulnerability, such as recognition of the use of social name, and formalization of the Transsexualization Process in the SUS. Whether it is by making other needs than corporal modification effectively invisible, or whether it is due to the concrete or bureaucratic impossibility of accessing services, made worse by transphobia, the fact is that the health system frequently violates rights and neglects those that are not cis-gender.

In this panorama, something that stands out is the acceptance of trans people in contexts that are not related to bodily modifications of sex. As a consequence of the binary and cis-gender logic that orients the health system, and the violation of their rights (– to secrecy, privacy and the right to use of a social name: all guaranteed by the SUS Users' Charter, of 2007), often they are effectively prevented from accessing services and procedures by bureaucratic and operational issues of a system that does not provide for giving care to non-normative identities and bodies, or their health needs.

In the hospital context, for example, there are cases of allocation of trans people in emergency rooms and nursing wards contrary to their gender identity, outside the Transsexualization Process. Frequently allocation in sectors compatible with their gender identity is negated to people who do not carry out civil re-qualification, which as well as being a violation, in that it does not recognize gender self-determination, violates the right to privacy and secrecy.

Outside the hospital context, a highlight is the limitation or impossibility of offer of lines of care linked to gender for trans people, such as, for example, gynecological and obstetric care, and access to legal abortion. The fact that this type of care is genderized and exclusive for users of the feminine gender, makes it impossible to give this care to trans men as a result of the non-conformity that they live with between sex and gender. Thus, if for those that do not carry out civil requalification the recognition of their gender identity paradoxically may make their need for these modalities of attention invisible, for those that have gone through this process, this is a bureaucratic problem, since in Brazil the supply of this care is not specified for people designated as being of masculine gender.

Thus, in spite of the importance of the concept of gender identity, the acritical use of the reiterative character of cis-gender and binary normativity of this notion can increase the health vulnerability of trans people, and the neglect of

these and other people whose bodies and identities are outside the norm. In spite of its importance it is fundamental to examine the details of this problem with care and in detail, so that it may effectively be possible to put in practice the exercise of the right to gender plurality outside the bonds of the system (the 'CIS-tem').

Final consideration

As well as dealing with questions of the health of specific populations – women and LGBTI – this article has evidenced cultural constructs that are at the basis of modern western societies and which characterize gender as a social power relationship. Thus, the reading of the bodies of men and women based on an incommensurable sexual di-morphism appears to be articulated with three trends or factors: (i) the social devaluation of women; (ii) separation between sex and gender, which maintains sex as an expected reference for expression and identity of gender; and (iii) an expectation of continuity between sex, gender

and desire.

In the 30 years of the SUS's existence one cannot leave out of account, on the one hand, progress in the political field – much of it created by social movements in defense of human rights; and on the other, initiatives that seek to confront femicide and the absence of adequate care for people who are not cis-gender. But there is still much to be done to guarantee the rights to health and life of women and LGBTI people, in their status as subjects with full humanity, who are thus fully entitled to exercise rights.

Finally, it is reaffirmed, based on the specialized literature, that gender and sexuality are social determinants of health, articulated with other determinants, such as racial or socio-economic issues. All this underlines the need for full recognition and promotion/guarantee of the human and fundamental rights of women and LGBTI people, as a necessary condition for achievement of better conditions of life and health for these populations, above all in the Brazilian and international policies in which such rights are particularly affected.

Collaborations

R Gomes, D Murta, R Facchini and SN Meneghel worked together, collaboratively, with equal status.

References

1. Scott J. Gênero: uma categoria útil de análise histórica. *Educação e Realidade* 1990; 16(2):5-22.
2. Gomes R. *Sexualidade masculina, gênero e saúde*. Rio de Janeiro: Editora Fiocruz; 2008.
3. Connell R. *Gênero em termos reais*. São Paulo: nVersons; 2016.
4. Connell R, Pearse R. *Gênero: uma perspectiva global*. São Paulo: nVersons; 2015.
5. Giammattei SV. Beyond the Binary: Trans-Negotiations in Couple and Family Therapy. *Fam Process* 2015; 54(3):418-434.
6. Reisner SL, Biello K, Rosenberger JG, Bryn Austin BA, Haneuse S, Perez-Brumer A, Novak DS, Mimiaga MJ. Using a two-step method to measure transgender identity in Latin America/the Caribbean, Portugal, and Spain. *Arch Sex Behav* 2014; 43(8):1503-1514.
7. Tebbe EA, Moradi B, Ege E. Revised and abbreviated forms of the genderism and transphobia scale: tools for assessing anti-trans prejudice. *Journal of Counseling Psychology* 2014; 61(4):581-592.
8. Brasil. Ministério da Saúde (MS). *Política nacional de atenção integral à saúde da mulher: princípios e diretrizes*. Brasília: MS; 2004.
9. Brasil. Ministério da Saúde (MS). *Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais*. Brasília: MS; 2013.
10. Tobar F, Yalour MR. *Como fazer teses em saúde pública: conselhos e ideias para formular projetos e redigir teses e informes de pesquisas*. Rio de Janeiro: Fiocruz; 2002.
11. Biglia B, San Martin C. *Estado de wonderbra: entretejendo narraciones feministas sobre las violencias de género*. Barcelona: Virus Editorial; 2007.
12. Peres ACS. Campos de estupro: as mulheres e a guerra na Bósnia. *Cad. Pagu* 2011; (37):117-162.
13. Segato R. *La guerra contra las mujeres*. Madrid: Traficante de Sueños; 2016.
14. Russel D, Caputti J. *Femicide: the politics of women killing*. New York: Twayne Publisher; 1992.
15. Carcedo A. *No olvidamos ni aceptamos: Femicidio en Centroamérica 2000-2006*. San José: Asociación Centro Feminista de Información y Acción (CEFEMINA); 2010.
16. Meneghel SN, Hirakata VN. Femicídios: assassinatos de mulheres no Brasil. *Rev Saude Publica* 2011; 45(3):564-574.
17. Pateman C. *O Contrato Sexual*. Rio de Janeiro: Paz e Terra; 1993.
18. World Health Organization (WHO). *Understanding and addressing violence against women. Femicide*. Geneva: WHO; 2012.
19. Carcedo A, Sagot M. *Femicídio en Costa Rica 1990-1999*. Washington: Organización Panamericana de la Salud; 2000. (Colección Teórica, 1).
20. Margarites AF, Meneghel SN, Cecon RF. Femicídios na cidade de Porto Alegre: Quantos são? Quem são? *Rev Bras Epidemiol* 2017; 20(2):225-236.
21. Geneva Declaration of Armed Violence. Global Burden of Armed Violence: Every Body Counts. 2015. *Chapter three: Lethal violence against women and girls*. p.87-119. [acessado 2017 Nov 8]. In: <http://www.genevadeclaration.org/measurability/global-burden-of-armed-violence/global-burden-of-armed-violence-2015.htm>
22. Wailsselfsz JJ. *O mapa da violência 2015. Homicídios de mulheres no Brasil*. Rio de Janeiro: CEBELA, FLACSO; 2015.
23. Rattón JL. Mulheres, violência e percepção da violência em Pernambuco. In: Sento-Sé JT, organizador. *Segurança Pública: Outros Olhares, Novas Possibilidades*. Brasília: Presidência da República; 2009. p. 88-103.
24. Brasil. Lei 13.104, de 9 de março de 2015. Prevê o feminicídio como circunstância qualificadora do crime de homicídio e inclui o feminicídios no rol dos crimes hediondos. *Diário Oficial da União* 2015; 10 mar.
25. Pasinato W, coordenador. *Diretrizes nacionais Femicídio. Investigar, processar e julgar com a perspectiva de gênero. As mortes violentas de mulheres*. Brasília: ONU Mulheres, Secretaria de Política para as Mulheres, Secretaria Nacional de Segurança Pública; 2016.
26. Mbembe A. *Necropolítica seguido de Sobre El Gobierno Privado Indirecto*. Santa Cruz de Tenerife: Editorial Melusina; 2011.
27. Sagot M. Un mundo sin femicídios? Las propuestas del feminismo para erradicar la violencia contra las mujeres In: Sagot M, coordenador. *Feminismos, pensamiento crítico y propuestas alternativas en América Latina*. Buenos Aires: CLACSO; 2017. p. 61-78.
28. Anistia Internacional. *Relatório 2016/2017. O estado dos direitos humanos no mundo*. Rio de Janeiro: Anistia Internacional do Brasil; 2017.
29. Meneghel SN, Lerma BRL. Femicídios em grupos étnicos e racializados: síntese. *Cien Saude Colet* 2017; 22(1):117-122.
30. Munevar D. Delito de femicidio. Muerte violenta de mujeres por razones de género. *Revista Estudios Socio-Jurídicos* 2012; 14(1):135-175.
31. Laqueur T. *Inventando o sexo: corpo e gênero dos gregos a Freud*. Rio de Janeiro: Relume Dumará; 2001.
32. Butler J. *Problemas de gênero: feminismo e subversão da identidade*. Rio de Janeiro: Civilização Brasileira; 2003.
33. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. *Lancet* 2016; 388(10042):390-400.
34. Plöderl M, Tremblay P. Mental health of sexual minorities. A systematic review. *Int Rev Psychiatry* 2015; 27(5):367-385.
35. Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, Holland CE, Max R, Baral SD. Global health burden and needs of transgender populations: A review. *Lancet* 2016; 388(10042):412-436.
36. Conron KJ, Mimiaga MJ, Landers SJ. A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health. *Am J Public Health* 2010; 100(10):1953-1960.
37. Veras MASM, Calazans GJ, Almeida Ribeiro MCS, Freitas Oliveira CA, Giovanetti MR, Facchini R, França IL, McFarland W. High HIV Prevalence among Men who have Sex with Men in a Time-Location Sampling Survey, São Paulo, Brazil. *AIDS Behav* 2015; 19(9):1589-1598.

38. Grinsztejn B, Jalil EM, Monteiro L, Velasque L, Moreira RI, Garcia AC, Castro CV, Krüger A, Luz PM, Liu AY, McFarland W, Buchbinder S, Veloso VG, Wilson EC; Transcender Study Team. Unveiling of HIV dynamics among transgender women: a respondent-driven sampling in Rio de Janeiro, Brazil. *Lancet HIV* 2017; 4(4):e169-e176.
39. Perucchi J, Brandão BC, Vieira HIS. Aspectos psicossociais da homofobia intrafamiliar e saúde de jovens lésbicas e gays. *Estud. psicol.* 2014; 19(1):67-76.
40. Barbosa RM, Facchini R. Acesso a cuidados relativos à saúde sexual entre mulheres que fazem sexo com mulheres em São Paulo, Brasil. *Cad Saude Publica* 2009; sup 2:S291-S300.
41. Valadão RC, Gomes R. A homossexualidade feminina no campo da saúde: Da invisibilidade à violência. *Physis* 2011; 21(4):1451-1467.
42. Arán M, Murta D, Lionço T. Transexualidade e saúde pública no Brasil. *Physis*. 2009; 14(4):1141-1149.
43. Teixeira-Filho FS, Rondini CA. Ideações e tentativas de suicídio em adolescentes com práticas sexuais hetero e homoeróticas. *Saúde Soc* 2012; 21(3):651-667.
44. Weeks J. *Sex, politics and society: the regulation of sexuality since 1800*. New York: Longman Inc.; 1989.
45. Drescher J. Queer diagnoses revisited: the past and future of homosexuality and gender diagnoses in DSM and ICD. *Int Rev Psychiatry* 2015; 27(5):386-395.
46. Cochran SD, Drescher J, Kismödi E, Giami A, García-Moreno C, Atalla E, Marais A, Vieira EM, Reedi GM. Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11). *Bull World Health Organ* 2014; 92:672-679. [acessado 2017 Fev 8]. Disponível em: <http://www.who.int/bulletin/volumes/92/9/14-135541.pdf>
47. Conselho Federal de Medicina. PC/CFM/Nº05/1985. [acessado 2017 Dez 1]. Disponível em: http://www.portalmedico.org.br/pareceres/cfm/1985/5_1985.htm
48. Simões JA, Facchini R. *Na trilha do arco-íris: do homossexual ao movimento LGBT*. São Paulo: Editora Fundação Perseu Abramo; 2009.
49. Aguião S, Vianna A, Gutterres A. Limites, espaços e estratégias de participação do movimento LGBT nas políticas governamentais. In: Lopes JSL, Heredia B, organizadores. *Movimentos sociais e esfera pública: burocracias, confrontos, aprendizados inesperados*. Rio de Janeiro: CBAE; 2014. p. 239-270.
50. Brasil. Ministério da Saúde (MS). Portaria nº 457, de 19 de agosto de 2008. Aprova a regulamentação do Processo Transexualizador no âmbito do Sistema Único de Saúde (SUS). *Diário Oficial da União* 2008; 20 ago.
51. Brasil. Ministério da Saúde (MS). Portaria nº 2803, de 19 de novembro de 2013. Redefine e amplia o Processo Transexualizador no Sistema Único de Saúde (SUS). *Diário Oficial da União* 2013; 20 nov.
52. Conselho Federal de Psicologia. Resolução CFP nº 01/99. [acessado 2017 Dez 5]. Disponível em: http://site.cfp.org.br/wp-content/uploads/1999/03/resolucao1999_1.pdf
53. Mello L, Avelar RB, Maroja D. Por onde andam as políticas públicas para a população LGBT no Brasil. *Soc Estado* 2012; 27(2):289-312.
54. Correa S. O percurso global dos direitos sexuais: entre “margens” e “centros”. *Bagoas* 2009; 4:17-42.
55. Vaggione JM. La Iglesia Católica frente a la política sexual: la configuración de una ciudadanía religiosa. *Cad. Pagu* 2017; 50:e175002.
56. Cornejo-Valle M, Pichardo JI. La “ideología de género” frente a los derechos sexuales y reproductivos. El escenario español. *Cad. Pagu* 2017; 50:e175009.
57. Almeida R. A onda quebrada - evangélicos e conservadorismo. *Cad. Pagu* 2017; 50:e175001.
58. Brasil. Ministério da Saúde (MS). *Boletim Epidemiológico - Aids e IST*. Brasília: MS; 2017. Ano V - nº 1.
59. Meyerowitz J. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge: Harvard University Press; 2002.
60. Murta D. *A psiquiatria da transexualidade: análise dos efeitos do diagnóstico de Transtorno de Identidade de Gênero sobre as práticas de saúde* [dissertação]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2007.
61. Hausman B. *Changing Sex: transsexualism, thechnology and the idea of gender*. Durham: Duke University Press; 1995.
62. Stoller R. *Sex and Gender*. Nova York: Science House; 1968. v.1.
63. Money J. Sex reassignment as related to hermaphroditism and transsexualism. In: Green R, Money J. *Transsexualism and sex reassignment*. Baltimore: The Johns Hopkins Press; 1969. p. 91-114.
64. Murta D. *Os desafios da despatologização da transexualidade: Reflexões sobre a assistência a transexuais no Brasil* [tese]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2011.
65. Red Internacional por la Despatologización Trans. *Manifiesto* [homepage na internet]. 2009. [acessado 2017 Nov 8]. Disponível em: <http://www.stp2012.info/old/pt/manifiesto>
66. Conselho Federal de Psicologia. Resolução 01/2018. *Estabelece normas de atuação para as psicólogas e os psicólogos em relação às pessoas transexuais e travestis*. [acessado 2017 Nov 8]. Disponível em: <http://site.cfp.org.br/wp-content/uploads/2018/01/Resolu%C3%A7%C3%A3o-CFP-01-2018.pdf>
67. Buttler J. *Bodies that Matter. On the discursive limits of “sex”*. New York, Routledge; 1993.
68. Brasil. Ministério da Saúde (MS). *Viva: instrutivo: notificação de violência interpessoal e autoprovocada* [recurso eletrônico]. Brasília: MS; 2016. [acessado 2017 Nov 8]. Disponível em: http://bvsmms.saude.gov.br/bvs/publicacoes/viva_instrutivo_violencia_interpessoal_autoprovocada_2ed.pdf

Article submitted 05/01/2018

Approved 30/01/2018

Final version submitted 26/02/2018



