

Primary Health Care in Brazil and the LGBTI+ population: An integrative review

A Atenção Primária à Saúde no Brasil e a população LGBTI+: uma revisão integrativa

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DOI: 10.1590/2358-28982023E19135I

ABSTRACT This article mainly focuses on the healthcare attention provided to the LGBTI+ population in Primary Healthcare within the Brazilian context. To achieve this, we sought to analyze the literature produced on the experiences of healthcare attention to the LGBTI+ population in Primary Healthcare in Brazil through an integrative literature review and thematic content analysis to identify, analyze, and report patterns within the researched data. The studies were classified and ordered according to the year of publication, region of the country, methodology used, and participant status. Although the researched period began in 2012, publications were only recorded in 2015. Between the years 2016 and 2019, there was an increase in the number of published studies related to the theme of this research. The decrease in publications in 2020 may be related to the reduction of activities due to the COVID-19 pandemic. It is also concluded that moral and religious factors have a strong impact on prejudice and discrimination, and there are reports in the literature of healthcare professionals being anchored in cultural teachings, family influence, and social groups that do not accept sexual and gender diversity, contributing to the distancing of the LGBTI+ population from the healthcare services offered by Unified Health System (SUS).

KEYWORDS Health services. Primary Health Care. Sexual and gender minorities.

RESUMO Este artigo tem como objeto principal a atenção à saúde oferecida à população LGBTI+ na Atenção Primária à Saúde (APS) no contexto brasileiro. Para isso, buscou-se analisar a literatura produzida sobre as experiências de atenção à população LGBTI+ na APS no Brasil mediante revisão integrativa da literatura e análise de conteúdo temática para identificar, analisar e relatar padrões dentro dos dados pesquisados. Os estudos foram classificados e ordenados de acordo com o ano de publicação, região do País, metodologia utilizada e status dos participantes. Embora o período pesquisado tenha se iniciado em 2012, apenas em 2015 foram registradas publicações. Entre os anos de 2016 e 2019, houve um aumento no número de estudos publicados relativos ao tema da pesquisa. A diminuição das publicações em 2020 pode estar relacionada com a redução de atividades em razão da pandemia de Covid-19. Conclui-se que fatores morais e religiosos têm forte impacto sobre o preconceito e a discriminação, e há relatos na literatura de profissionais de saúde que são ancorados em ensinamentos culturais, influência familiar e de grupos sociais que não aceitam a diversidade sexual e de gênero, o que contribui para o afastamento da população LGBTI+ dos serviços de saúde ofertados no SUS.

PALAVRAS-CHAVE Serviços de saúde. Atenção Primária à Saúde. Minorias sexuais e de gênero.

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Introduction

This article aims to analyze the main issues relating to healthcare offered to the population of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transgenders, Intersex and others (LGBTI+) in Primary Health Care (PHC), in the Brazilian context, especially from the implementation of the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (PNSI-LGBT), established by Ordinance No. 2,836, of December 1, 2011¹, as a result of the recognition of public policies on LGBTI+ human rights in the institutional sphere.

PHC is the preferred gateway to the Unified Health System (SUS) and, sometimes, the community's first contact with the health service, providing the possibility of better care for individuals, focusing on healthcare strategies and technologies for the individual and the community. However, this entry point is not always welcoming, and it is possible to identify several barriers to the provision of services that effectively consider the organizational, social, cultural and communication conditions that favor the LGBTI+ people with the team. Therefore, the quality of access must be questioned, as well as its effective existence for LGBTI+² populations.

In order to improve health services in PHC, policies that facilitate universalization and access were instituted, such as PNSI-LGBT². Despite existing access difficulties, PHC has the potential to improve care with empathy, acceptance and creation of bonds. As in other social groups, the LGBTI+ population has specificities to be understood and accepted in the context of health care, for example, the need for a trans man to undergo cytopathological examination as a way of preventing cervical cancer. This highlights the need to include the categories sexual orientation and gender identity as important variables at the intersection with access to health.

It can be stated that the construction of public policies for the health care of LGBTI+

people in an integral and continuous manner has been achieved through many demands and struggles for their rights. Historically, the LGBTI+ movement in Brazil was organized to combat the violence that was committed against this part of the population over the decades, as well as in the search for visibility in the affirmation of rights³⁻⁵. Despite several attempts to recognize rights through legislation in the post-redemocratization period, there is no law in the sphere of the Federal Legislative Power recognizing rights for LGBTI+⁶ people, a task that has been taken over by the Judiciary, especially in the context of neoliberalism and emergence of the extreme right, which had the direct consequences of moralizing and combating LGBTI+ rights as fundamental human rights⁷.

From the Fernando Henrique Cardoso government to the Dilma Rousseff government, several public policies for the LGBTI+ population emerged from dialogue and pressure from social movements in Brazil. Particularly during the governments of Luiz Inácio Lula da Silva and Dilma Rousseff the main public policies for the LGBTI+ population were developed, with emphasis on the Brazil without Homophobia program in 2004. In 2008, it is worth mentioning the holding of the 1st National Conference on Public Policies and LGBT Human Rights and the inclusion of the transsexualization process in the SUS. In 2009, the National Plan for the Promotion of LGBT Citizenship and Human Rights was drawn up; while in 2011, the creation of the LGBT module on 1-0-0 hotline, the preparation of the first report on homophobic violence in Brazil, the publication of the PNSI-LGBT and the holding of the II National Conference on LGBT Public Policies and Human Rights⁶.

The LGBTI+ population faces continuous challenges in relation to their fundamental rights and guarantees, expressed by various forms of prejudice and social violence. Unfortunately, these demonstrations often culminate in hate crimes, resulting in the extermination of people⁸. These events are evident in

the reports produced annually by the National Association of Transvestites and Transsexuals (ANTRA)⁹, the Institute of Applied Economic Research and the Brazilian Public Security Forum¹⁰, the National Council of Justice¹¹ and the Gay Group of Bahia (GGB)¹², which manifest the urgency and permanence of building public policies as state policies so that the citizenship of this social group is guaranteed.

Prejudice and discrimination extend to the care provided in health units, where this segment is still identified as deviating from the heteronormative standard¹³, which further enhances the stigmatizing social view and the need to include training actions for health workers in order to publicize the diversity and specificities of this group¹⁴. The LGBTI+ population, treated in a non-equitable way and sometimes segregated in this context, faces barriers to accessing health services¹⁵, being exposed to judgments from professionals in these services, as a result of structural LGBTIphobia, which have a negative impact on the production of care¹⁶.

PHC emerges as a crucial area in promoting health for this population segment, which demands an analysis from the perspective of the fundamental right to universal access to interventions and health care. It is imperative to guarantee individuals, in this context, not only treatment, but also resources for recovery, rehabilitation and, fundamentally, healing. In this context, APS must guarantee rights, such as use of social name, use of the bathroom according to gender identity and the offer of the transsexualization process, in addition to contributing to the dissemination of these rights¹⁷. Considering the Brazilian experience, especially based on how the SUS was organized, PHC is the central element of the universal health system¹⁸.

In contact with users – in reception, clinical care or any other type of health action – one can contribute to increasing equity, ensuring that knowledge about health rights reaches the greatest number of people of the LGBTI+ population. As PHC is one of the main gateways

to the SUS, it is necessary to promote health care practices, as well as demand managers of municipal health departments to organize strategies that promote attention and specific care for this public¹.

Material and methods

This article is based on bibliographical research, of the integrative literature review type, on the experiences of providing care to the LGBTI+ population in PHC in Brazil. It is a study of a qualitative nature – one capable of offering an understanding of complex social phenomena that are unable to be elucidated with quantitative research. Its use applies to the deep understanding of human behaviors, attitudes and motivations and produces meanings for what people think and feel¹⁹. In some models of scientific investigations, a prior consultation of the literature is carried out, to understand the panorama of productions on the topic and, subsequently, even to verify the feasibility, novelty and originality of the study. However, in some qualitative research, it can be the investigative method itself, using a sequence of systematic actions that follow methodological rigor. Research can be carried out exclusively with bibliographic data, and, therefore, the integrative review does not necessarily characterize a guiding strategy for research, but rather a full way of developing research as bibliographic²⁰. The objective of the integrative review is correlated with the state of the art, with the ability to identify trends and gaps in the literature²⁰.

Identifying the guiding question in the initial phase is extremely important for the review, as it provides information that determines the studies included, the identification strategies and the information to be investigated²¹. Taking into account the fulfillment of the research objective, in the first stage, the following question was determined: has Brazilian PHC offered comprehensive care with respect for human rights to the LGBTI+ population?

Based on the guiding question, a search was carried out in databases, according to sampling criteria capable of offering representativeness to the sample and reliability of the results²¹. A bibliographical survey was carried out in the electronic databases Biblioteca Virtual em Saúde (VHL) and in the Scientific Electronic Library Online (SciELO) from 2012 to 2022. This choice was due to the institution of the PNSI-LGBT carried out in December 2011 and considered an important milestone for health care for LGBTI+ people.

In the VHL, the following descriptors were used: *Minorias Sexuais e de Gênero* OR *LGBT** AND *Atenção Primária à Saúde* AND *Assistência Integral à Saúde* OR *prática integral de cuidados de saúde* OR *atenção à saúde* OR *acesso à saúde* OR *conhecimentos, atitudes e práticas em saúde*. In SciELO, the following were used: *Minorias sexuais e de gênero* OR *LGBT** OR *homossexualidade* OR *Transexualidade* OR *peças Transgênero* AND *Serviços de Saúde*. The Boolean operators AND and OR were used to unify the descriptors for the database search. Such operators constitute one of the resources used in advanced database searches and that help to build an effective search. The AND operator tracks articles that include all presented descriptors while the OR operator expands the results, being used to combine similar terms, based on the work of Toronto and Remington²².

In database research, controlled vocabulary was used, consisting of Health Sciences Descriptors (DeCS), which consists of a standardized set of terms used by a database to attribute a certain type of information. Medical Subject Headings (MeSH) is the English version of DeCS, developed by the National Library of Medicine and attributed to articles in Medline, PubMed, CINAHL, Cochrane and other databases²². It is important to highlight that DeCS was built in line with MeSH in order to adopt synchronization with international bases and offer a safe method of controlled vocabulary. Studies in databases with controlled vocabulary have variations in results when

compared to the use of natural language. In this sense, they generate fewer productions, however, they tend to present more relevant results²².

After the data search, the fundamental step of defining the inclusion and exclusion criteria²¹ was carried out, capable of delimiting the final research articles within all the articles found. In this study, the inclusion criteria were: Portuguese-language journals published since 2012, when the PNSI-LGBT was established; that addressed health care practices in PHC in caring for the LGBTI+ population. The exclusion criteria were: articles in English; over ten years; gray literature; citation of part of a work; letter to the editor; literature reviews; and those that did not meet the objectives proposed in the work.

Using the title, in the VHL database, 144 publications were selected, and in SciELO, 55, totaling 199 publications. Then, 20 publications were excluded because they were duplicates, and 161 after refinement by the inclusion and exclusion criteria. There were 18 publications left for full analysis and evaluation, 15 publications and 1 doctoral thesis. At this stage, 2 publications were excluded after analysis, as we met the inclusion and exclusion criteria. After careful analysis, 16 publications remained, which were included in the review.

Results and discussion

The studies that constitute the basis of this article were classified and ordered according to the year of publication, region of the country, methodology used and status of the participants. To collect information pertinent to the study from journals, it is essential to use a previously prepared instrument that allows obtaining data to meet the research objectives, in addition to ensuring homogeneous checking of information and its recording²¹. In this sense, to compile scientific productions, an extraction form was used, containing: 1) main author, year; 2) title; 3) magazine; 4)

study region, state, city; 5) language; 6) objective; 7) methodology; 7.1) nature of the study; 7.2) number of participants; 7.3) location in PHC; 7.4) sample; 7.5) collection techniques; 7.6) analysis techniques; 8) results; 9) recommendations; 10) author's limitations; 11)

observations/limitations of the reviewers that were observed in the literature by Souza, Silva and Carvalho²¹. Based on the sheets, a table was created with the main information about each publication (*table 1*).

Table 1. Publications overview

Nº	Author	Year	Title	Periodic	Place of Study	Objectives
1	Araujo LM, et al. ²³	2019	O cuidado às mulheres lésbicas no campo da saúde sexual e reprodutiva	Rev enferm UERJ	Rio de Janeiro/RJ	Describe and analyze the care provided to lesbians by nurses and doctors in the field of sexual and reproductive health.
2	Araujo LM ²⁴	2015	Representações sociais de enfermeiras e médicos do campo da saúde sexual e reprodutiva sobre as mulheres lésbicas	Universidade do Estado do Rio de Janeiro	Rio de Janeiro/RJ	Describe the content of social representations of nurses and doctors, in the field of sexual and reproductive health, about lesbian women; identify the specificities of sexual and reproductive health recognized by professionals among lesbians; describe difficulties encountered by nurses and doctors in the daily practices of sexual and reproductive care for lesbians.
3	Belém JM, et al. ²⁵	2018	Atenção à Saúde de Lésbicas, Gays, Bissexuais, Travestis e Transsexuais na Estratégia Saúde da Família	Revista Baiana de Enfermagem	Juazeiro do Norte/CE	Analyze the health care provided to the Lesbian, Gay, Bisexual, Transvestite and Transsexual population in the Family Health Strategy.
4	Cabral KTF, et al. ²⁶	2019	Assistência de Enfermagem às mulheres lésbicas e bissexuais	Revista de Enfermagem UPFE online	João Pessoa/PB	To analyze, from the perspective of lesbian and bisexual women, nursing care in family health units.
5	Ferreira BO, et al. ²⁷	2019	"Não tem essas pessoas especiais na minha área": saúde e invisibilidade das populações LGBT na perspectiva de agentes comunitários de saúde	Revista Eletrônica de Comunicação, Informação e Inovação em Saúde	Nordeste brasileiro	Analyze the meanings attributed by community health agents regarding health care for LGBT populations.
6	Guimarães NP, et al. ²⁸	2020	Avaliação da implementação da Política Nacional de Saúde Integral à população LGBT em um município da região Sudeste do Brasil	Revista Eletrônica de Comunicação, Informação e Inovação em Saúde	Espírito Santo/ES	Evaluate the implementation of the National Policy for Comprehensive Health for the LGBT Population (PNAIPLGBT) in basic health care and understand the knowledge of nurses from the Family Health Strategy about sexual diversity and homophobia.
7	Guimarães RCP, et al. ²⁹	2017	Assistência à saúde da população LGBT em uma capital brasileira: o que dizem os agentes comunitários de saúde?	Actas de Saúde Coletiva	Goiânia/GO	Investigate the perception of Community Health Agents in 5 UBS.
8	Lima AM, et al. ³⁰	2019	Atributos da Atenção Primária a saúde e ferramentas de medicina de família no atendimento as diversidades sexual e de gênero: relato de caso	Revista Brasileira de Medicina de Família e Comunidade	Rio de Janeiro/ RJ	Present the family and community doctor as an important professional in the area of health for the lesbian, gay, bisexual and transsexual population

Table 1. Publications overview

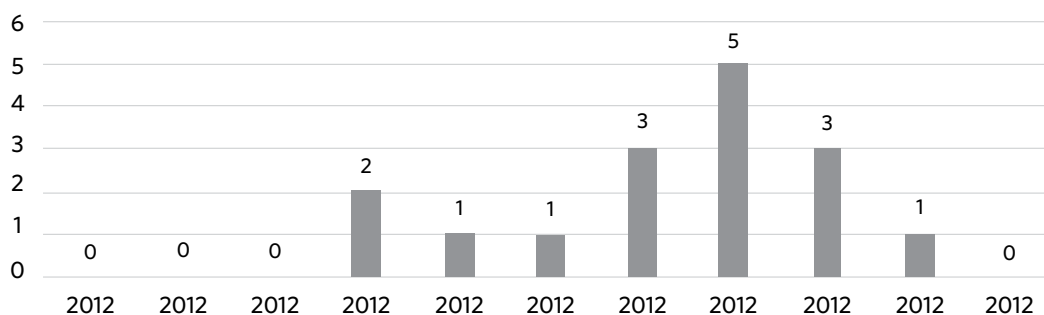
Nº	Author	Year	Title	Periodic	Place of Study	Objectives
9	Monteiro S e Brigeiro M ³¹	2019	Experiências de acesso de mulheres trans/travestis aos serviços de saúde: avanços, limites e tensões	Cadernos de Saúde Pública	Baixada Fluminense /RJ	Analyze the experiences of trans/transvestite women accessing health services and discuss sexual/gender discrimination and their demands for gender transition and AIDS prevention services.
10	Oliveira GS, et al. ¹⁷	2018	Serviços de saúde para lésbicas, gays, bissexuais travestis/transsexuais	Revista Enfermagem UERJ online	Cajazeiras/PB	Analyze, from the perspective of professionals from the Family Health Team, the access of Lesbians, Gays, Bisexuals, and Transvestites/ Transsexuals to basic Family Health Units.
11	Padilha VB, et al. ³²	2020	O cuidado integral de pessoas LGBTQs na atenção primária à saúde a partir das percepções de psicólogas/os de um serviço de saúde comunitária de Porto Alegre/RS	GHC	Porto Alegre/RS	Identify and map existing lines of care in health units of a community health service in the city of Porto Alegre/RS.
12	Paulino DG, et al. ³³	2020	"Pra mim, foi assim: homossexual, travesti e, hoje em dia, trans": performatividade trans, família e cuidado em saúde	Saúde & Sociedade	São Paulo/SP	Understand how a trans identity context mobilizes, in conjunction with family and health services, identity performances.
13	Rocon PC, et al. ³⁴	2016	Dificuldades vividas por pessoas trans no acesso ao Sistema Único de Saúde	Article in Ciencia & Saude Coletiva	Grande Vitória/ES	Discuss the difficulties of trans people living in the metropolitan region of Greater Vitória/ES in accessing health services in the SUS.
14	Silva AAC, et al. ³⁵	2021	Produção do cuidado de enfermagem à população LGBTQIA+ na atenção primária	REVISA	Bahia	Describe the production of nursing care for the health of Lesbians, Gays, Bisexuals, Transvestites and Trans Queers, Intersex, Asexual and other sexual and gender identities, based on reflections on the nurse's work.
15	Silva ALR, et al. ³⁶	2019	Representações sociais de trabalhadores da Atenção Básica à Saúde sobre pessoas LGBT	Trabalho, Educação e Saúde	Florianópolis/SC	Understand the social representations of Primary Health Care workers regarding these people, based on the premise that they can act as barriers to access actions and services.
16	Souza MHT, et al. ³⁷	2015	Cuidado com saúde: as travestis de Santa Maria, Rio Grande do Sul	Texto & Contexto Enfermagem	Santa Maria /RS	To present health care for transvestites in the city of Santa Maria, Rio Grande do Sul, Brazil. The field research was carried out from January to November 2012, with transvestites from different municipalities in Rio Grande do Sul, who lived in Santa Maria during the research.

Source: Own elaboration based on research data.

Although the research period began in 2012, publications were only recorded in 2015. Between 2016 and 2019, there was an increase in the number of published studies related to the topic of this research. The visibility of the LGBTI+ population has been growing, and, with the dissemination of their demand for rights, including health, it is possible that the subject is gaining more space in health

studies. The decrease in publications in 2020 may be related to the reduction in activities due to the COVID-19 pandemic, but also to a reification of morality and religiosity, which has permeated government discourse in recent years. However, the number of studies is insufficient to advance the understanding of this phenomenon (*graph 1*).

Graph 1. Studies by year of publication

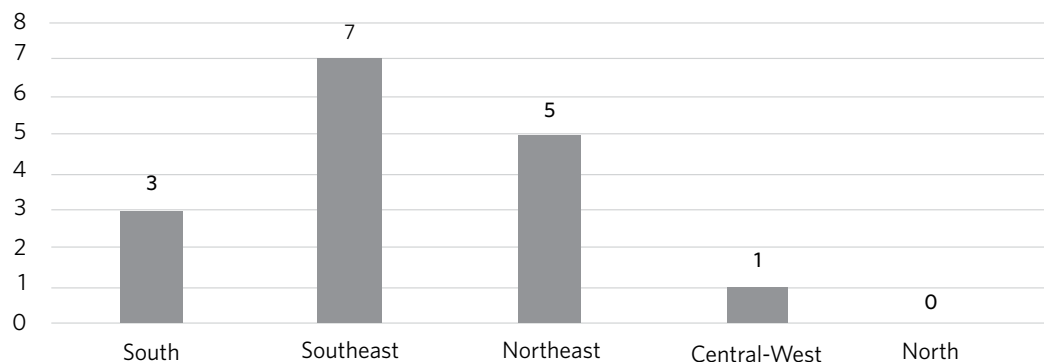


Source: Own elaboration.

The Southeast region presents a greater number of articles, a result similar to that of other studies, which indicate a concentration

of research on the topic in large cities in Brazil. No work was carried out in the North region (*graph 2*).

Graph 2. Studies by Brazilian region

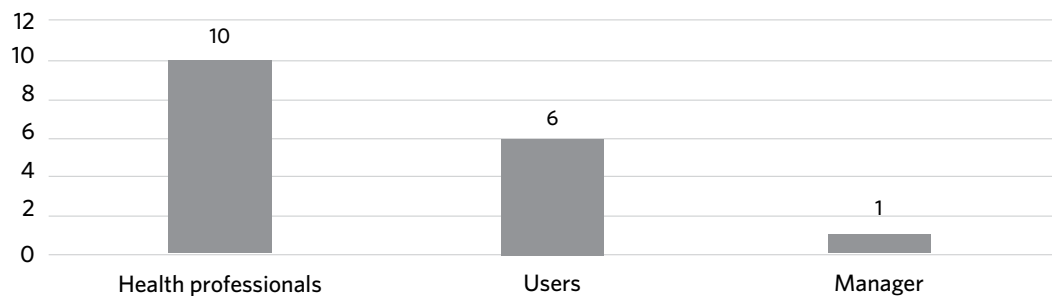


Source: Own elaboration.

Regarding the methodological nature of the studies, 15 qualitative studies and only 1 quantitative were found. Qualitative research employed varied data collection techniques, such as semi-structured interviews, open interviews, focus groups, participant observation, questionnaires and case reports. The analysis approaches found were content analysis, dialectical hermeneutics and discourse analysis.

When quantifying the studies by category of subjects researched, one of them includes both the presence of health professionals and managers, which is why the total number of publications is 17 (*graph 3*). It is clear that the majority of studies are carried out with health professionals, due to the ease of access to research subjects, as, in general, these studies are carried out by health professionals, within health units.

Graph 3. Studies by category of researched subjects



Source: Own elaboration.

In this research, thematic content analysis was used, a flexible and widely used technique for identifying, analyzing and reporting patterns within data. The process occurred in three phases: data pre-analysis, material exploration and data processing³⁸. Three categories of analysis emerged from the analyzed

material, which were: the relational sphere between health professionals and LGBTI+ users; the service organization and LGBTI+ health care; and, finally, the guarantee of user rights. *Table 2* displays the categories formulated according to the order number defined in *table 1*.

Table 2. Formulation process and order number of categories

Category	Subcategory	Units of meaning	Order number of publications (as shown in <i>table 1</i>)
The relational sphere between health professionals and LGBTI+ users	Reception and bonding	Lack of welcome and lack of interest from workers	4, 8, 11 and 16
		Lesbians with masculine appearances and bisexuals said they were not welcomed and cared for	
		Family and community doctor capable of establishing rapport and providing care	
		Transvestites seek care in other spaces outside of healthcare where they experience welcoming	
		LGBTI+ professional on the team facilitates reception	

Table 2. Formulation process and order number of categories

Category	Subcategory	Units of meaning	Order number of publications (as shown in table 1)
	Prejudice and discrimination	Minimization of the problem, lack of respect and prejudice as a barrier Recognition of the existence of prejudice and discrimination as elements that hinder interaction Social representations of workers anchored in moral and religious precepts Perception of sexuality and gender identity as incorrect LGBTI+ users do not reveal sexual orientation and gender identity out of shame and fear of discrimination, especially lesbians	3, 4, 7, 10, 15 and 16
Service organization and LGBTI+ health care	Training of health workers	Lack of information and preparation of professionals to meet the specificities and health needs of LGBTI+ users Even greater lack of preparation among lesbians, bisexuals, trans and transvestites Difficulties in discriminating between sexual orientation and gender identity Inability to communicate (inappropriate questions and statements) Stereotypes of health needs (centered on STIs) and the permanence of the conception of promiscuity and risk group Lack of information from professionals about STIs when necessary and timely Family and community doctor capable of providing adequate care Training as being inefficient in changing values, attitudes and social representations Professional training depends on individual and not institutional initiative Need for more investment in research to provide subsidies to improve professional training	1, 2, 3, 4, 5, 6, 8, 10, 11, 14 and 15
Service organization and LGBTI+ health care	Access and quality of care	Access barriers, dissatisfaction, low attendance and adherence Transvestites face even greater barriers and rarely seek health services Low supply of specific actions for gender transition, STI/AIDS are not the main reason for LGBTI+ population to look for care. Organization of the health service network	3, 5, 7, 9, 11, 13 and 16
Guarantee of user rights	Observance of policies and regulations designed to ensure these rights	Misunderstanding of the meaning of equity Lack of knowledge of PNSI-LGBT and other health policies Failure to comply with legal standards guaranteeing rights (for example, social name) Recognition of Trans identity expression to establish bonds, effective reception and comprehensive care Psychological suffering caused by rights violations	2, 3, 6, 7, 9, 10, 12 and 13

Source: Own elaboration based on research data.

Next, the three formulated analytical categories will be examined, subdivided into their subcategories.

In the analysis of the categories, we highlight the ‘relational sphere between health professionals and LGBTI+ users’ category,

especially the subcategory ‘reception and bonding’. During reception, a bond is established based on trust and responsibility of the healthcare team in caring for and promoting the health of users³⁹. Welcoming involves listening, validating needs and being available to

assist. It is an action of rapprochement and inclusion, aligned with the SUS⁴⁰ National Humanization Policy.

Access and reception go hand in hand, in the same direction and with often similar objectives, which are the search for health services, and are related to the ability of a group to seek and obtain health care and the conditions of accessibility to include economic, technical and symbolic dimensions³⁹. Access and reception permeate the quality of health services, which are usually evaluated, taking seven pillars as a theoretical framework: efficacy, effectiveness, efficiency, optimization, acceptability, legitimacy and equity. However, the idea of quality is also related to the subjectivity of health processes⁴¹.

In this sense, inequalities in access and reception and the low quality of health care are interconnected problems, which especially affect minority groups, such as LGBTI+ populations, and interfere with the inclusion of these individuals in the health system⁴². It is worth noting that, in everyday care, there is still a persistence of pathologization of sexual identities and gender expressions outside cis-heteronormativity – despite the Federal Council of Medicine in Brazil having removed homosexuality from the International Classification of Diseases (ICD-9, code 302.0) in 1985 and the World Health Organization having excluded trans identities from the ICD in 1994. This issue permeates the entire health field, and not just PHC.

LGBTI+ people may not fit into binary standards, which makes it challenging to adapt health policies such as those for men's or women's health. The inclusion of plural identities and diverse bodies in healthcare requires preparation from professionals. This differentiates individuals within the LGBTI+⁴³ population group. When health services are not prepared to meet these needs, there is poor access to PHC. Those who do not fit into the sexual binary face vulnerabilities in several areas, including health, employment, income, culture and public safety, among others⁴⁴. In

this context, access to healthcare varies even within the LGBTI+ population.

Welcoming promotes a phenomenon called bonding, a connection between people with common interests or feelings²⁶. This bond between user and healthcare team develops over time, based on the team's trust and responsibility for care and health promotion³⁹. Comprehensive care establishes links between the LGBTI+ public and health professionals³⁰. One of the studies³⁸ reports that transvestites, as they do not find receptiveness in Basic Health Units (UBS), seek care in other spaces outside of healthcare, such as prostitution spots, gay nightclubs, police stations, family homes, LGBTI+ parades and excursions.

The lack of interest on the part of health professionals is one of the main gaps to be filled in relation to the arrival of the LGBTI+ population in PHC services. These users frequently report difficulties in communicating due to their sexual orientation. The inefficiency of health professionals in creating bonds that facilitate access to the services offered, the inability to welcome, listen and, above all, solve problems linked to the specificities of this public keep this population away from the services offered by PHC³².

The articles reviewed for the preparation of this research showed that lesbians of masculine appearance and bisexual women reported not being welcomed, cared for and assisted in their specificities, compromising accessibility to the health services offered²⁶. There is a complaint from this public regarding the lack of reception and the unpreparedness of the teams during the service. Lesbian and bisexual women reported that care professionals, despite being trained and having the technique to practice their profession, did not have the necessary empathy to build the bond between user, professional and, consequently, with the health unit²⁶.

There are also reports of lesbian women who faced discomfort when carrying out cytopathological examination with an inadequately sized speculum, as they felt uncomfortable

with penetration. As a result, they left the consultation dissatisfied with not having been attended to in their specificities. It is also noteworthy that lesbian women also stop looking for health facilities to obtain information and care for their health, as is the case with the prevention of Sexually Transmitted Infections (STIs). Lesbians believed they were immune to STIs, as they only had sexual relations with women, however, without adequate protection during sexual relations. These situations could have been minimized by the existence of a bond between professionals and users, which would provide a more sensitive attitude on the part of professionals and allow for a greater exchange of knowledge to reduce health risks. This lack of agreement occurs when health professionals do not have the qualifications, preparation and interest in caring for and welcoming this population²⁶. One of the studies showed that the creation of bonds between users and the health unit increases when one of the team members is openly part of the LGBTI+ population, which facilitates reception, understanding and meeting specific demands of this population³².

With regard to 'prejudice and discrimination' as subcategories, it is worth highlighting that, in the analysis of the articles, many statements were found about acts of prejudice suffered by people from the LGBTI+ public. Exceptions are rare, excluding some professionals who are part of this population and few sensitive professionals who are interested in providing dignified care to any citizen who seeks care in health units^{25,29}.

As of 2019, LGBTIphobia was recognized as a crime following a decision by the Federal Supreme Court⁴⁵. Prejudice and discrimination on the part of health professionals are not recognized and are denied. The lack of recognition makes it difficult to modify behaviors and routines, which maintains access barriers and makes it difficult for users to interact with the services offered^{25,28}.

Moral and religious factors fuel prejudice and discrimination. Health professionals often

internalize social representations influenced by cultural teachings and pressure from groups that reject sexual diversity. For these people, those who do not follow cis-heteronormativity are seen as incorrect and unacceptable based on moral and religious values, which alienates users from health services³⁵. This prejudice also leads members of the LGBTI+ community to hide their sexual orientation and gender identity for fear of discrimination¹⁷.

Furthermore, the lack of understanding regarding non-normative behaviors increases the vulnerability of this population, causing physical, psychological and social suffering³². Additionally, the feeling of exclusion from healthcare spaces further distances this community from available services, also depriving them of social interactions²⁵. In this scenario, full access to health services is fundamental for the use of these services, as well as being the result of individual factors related to the quality of care⁴⁶. Thus, discriminatory practices based on sexual orientation and gender identity are one of the main obstacles to actualize the right to health for LGBTI+ people.

When analyzing the categories, it is also worth highlighting the category 'service organization and LGBTI+ health care', focusing on the subcategory 'training of health workers'. In the graduation of higher education professionals, topics such as gender identity and sexual orientation are limited to addressing issues related to sexually transmitted infections, with no greater concern with the demands and specificities of the LGBTI+ population²⁸. Such courses barely address issues related to gender and sexuality and health issues among lesbian, gay, bisexual, transvestite and transsexual people, nor is there emphasis on issues related to discrimination, inequities and violence among this public, which could contribute to a more humanized, ethical and respectful posture on the part of professionals²³. A point to highlight is that one of the studies reveals that the training offered to workers proved to be inefficient in changing values, attitudes and social representations;

also, that the various types of training should also address beliefs and moral values.

In relation to professional training, there is silence on health issues related to lesbians, mainly in support materials aimed at health professionals and service users, such as: publicity materials for health campaigns; educational materials; field research related to women's health; and in investments for the development of technological resources, which, in some way, can contribute to the quality of healthcare for lesbians²⁴. The studies also showed that the training of health professionals depends on individual initiative, while training through institutional initiatives would be desirable³².

Health professionals highlighted numerous gaps, such as knowledge gaps, inability to communicate and omission in relation to demands related to the health of lesbian women. The inability in relation to the necessary skills in communication is accentuated, which is so important when approaching topics such as sexual practices and sexualities²³. Due to the deficit in health professional training, there are reports of difficulties in addressing aspects related to the health of the LGBTI+ population, with training being identified as a key factor in improving care for this public²⁵.

There is a need to put on the agenda, in health professional training institutions, issues related to the LGBTI+ public, for a better connection between health professionals and sexual diversity, as, throughout training, there is no preparation for the discussion of topics related to sexuality openly and without prejudice²⁸. The lack of preparation of professionals in relation to caring for this population is also seen in the persistence of the stereotype of 'risk groups', which links LGBTI+ people to STIs, and in the conception of sexual promiscuity, showing the persistence of prejudiced and inadequate views³⁶.

Adequate training of health professionals is a fundamental part of attracting the LGBTI+ public to carry out preventive exams, necessary for the early detection of diseases in PHC

units, such as the preventive exam for cervical cancer (cytopathological exam). The still limited communication between this public and the health professional, which does not adequately address women's sexual orientation during nursing consultations, leads to patients' reluctance to reveal their orientation due to the lack of comfort and the absence of established bonds²⁶.

The difficulties identified in government proposals related to the LGBTI+ public arise from the lack of investment in the professional training of health workers. This training must be focused on competence and the development of communication skills, enabling health professionals to use non-discriminatory language to ensure more effective and inclusive care for the LGBTI+³⁵ population.

Another subcategory that emerged in the research was 'access and quality of care'. Access can be defined as the ability and freedom to obtain something or make use of something. In health, it is defined as the set of natures and circumstances that facilitate the entry of users into the public health network and the different services offered. Access is a determining concept for understanding disparities in the provision of health services to the population, presenting dimensions that influence equity in access to these services. Furthermore, it is understood as people's perception of accessibility, while the latter concerns the way in which health services are accessed².

From the perspective of the LGBTI+ population, the health service network does not adequately meet their needs. Symbolic barriers to access, resulting from intolerance to sexual behaviors that deviate from the heteronormative standard, trigger processes of suffering, dissatisfaction, lack of regularity in consultations, low adherence to treatment, illness and early mortality within this group. Consequently, the quality of healthcare offered to the LGBTI+ community is insufficient²⁸. Finally, two studies suggest that access barriers are not recognized by professionals, which makes action on them even more difficult^{25,28}.

Frequent difficulties in access end up discouraging the search for health services, which are often prematurely perceived as inaccessible and ineffective in meeting users' demands and expectations, including consultations and exams. One of the studies shows that a portion of this population seeks to use the private network to resolve complaints not addressed in the public network. Welcoming the health service and building bonds, mentioned in the previous topic, are crucial for improving access and adherence to health care by the LGBTI+ public²⁵.

Transvestites face even more significant obstacles due to body modifications that are often misunderstood by health professionals, which discourages them from seeking public health services. Furthermore, they report feeling deprived of acceptance, respect and appreciation, as they are constantly questioned about their lifestyles. This difficulty causes many transvestites to look for other forms of care to meet their health needs, such as religious houses of African origin, for example³⁸.

Some health professionals believe that the trans population should not even be treated in PHC, but only in specialized care, even if their complaints refer to health issues pertinent to PHC³². The author highlights, in addition to the need for worker qualifications, the establishment of lines of care designed for this population.

If, on the one hand, there is a perception that trans people should not be treated in PHC, on the other hand, gaps in specialized care persist. Trans people seek specialized services in the transsexualization process in the public health network, however, studies show a low supply of specific actions for gender transition, as these services are not yet provided by all Brazilian states, despite the Ministry of Health launching, in 2008, the transsexualization process in SUS³⁴.

Although many professionals believe that the main reason why the LGBTI+ population seeks care is related to STIs, this group seeks interdisciplinary continuing education

initiatives on human rights within the SUS. This includes issues related to gender identity and sexual orientation, guaranteeing sexual and reproductive rights, increasing participation in health councils and the right to use one's social name in the system's records, as will be discussed in the next topic²⁷.

In the context of the research, we examined the category referring to 'Guarantee of user rights', with special attention to the subcategory that addresses 'observance of policies and regulations designed to ensure these rights'. The Federal Constitution of 1988, in its article 196, guarantees health as a right for all and a duty of the State. Organic Law No. 8,080/1990 establishes the guiding principles of the SUS, including universality, which ensures universal access to health services without restrictions, and comprehensiveness, which encompasses complete health care, from prevention to more complex care, considering biological, psychosocial and cultural aspects²⁹.

There is no doubt that health is a fundamental human right. Therefore, it is crucial to recognize that life depends on equitable and quality access to health services, through a public system that adequately meets diverse human needs, without discrimination, and based on the inalienable right of each person. Therefore, health becomes a fundamental right so that other rights can also exist⁴⁷. This perception aligns with a critical perspective on human rights, taking into account that they must be considered as a starting point⁴⁸, and not as a simple point of arrival. Particularly, the importance of reflecting on democracy must be considered, pondering exclusion and inequality through forms of social emancipation⁴⁹ that directly impact the realization of human rights.

In the Federal Constitution, equality of rights is linked to equity, especially in matters of social rights. Equity can be understood in two ways: first, as a principle of justice that establishes fair rules for social coexistence, often associated with the principle of equality; second, as the adaptation of the general norm

to specific situations to avoid injustices, taking into account the particularities of each group⁵⁰.

A recurring vision among health professionals is the idea of equality in the care of LGBTI+ people, without taking into account the principle of equity due to the specific demands of each individual in this population. In a survey carried out with female health professionals, it was found that there was a lack of knowledge about the needs and specificities of this public in relation to health, with an idea of generalization, that is, that everyone should receive the same reception and treatment, which contributes to vulnerability and exclusion¹⁷.

In order for there to be greater equity related to users' rights, it is necessary for health professionals to improve knowledge regarding public policies and specificities regarding LGBTI+ people, promoting greater qualification of the services provided, contributing to the principles of universality, integrality and equity, helping to confront the exclusionary consequences of cis-heteronormativity and LGBTIphobia¹⁷.

Regarding human rights guarantees, one of the examined articles highlighted the non-existence and insufficiency of institutionalized care guidelines and policies for the LGBTI+ population. Research participants, when asked about health care aimed at this group, revealed embarrassment and uncertainty regarding the topic³².

In this context, the violation of the rights of the LGBTI+ population is explained by the inability of health service professionals to promote access, welcome and build bonds with this public, adopting an exclusionary stance based on sexual orientation, contributing to the distancing of this population from services health services. These factors associated with vulnerability contribute to an increase in psychological suffering in this group²⁵.

In the field of regulations aimed at comprehensive health, the PNSI-LGBT was established in December 2011, however, studies show that this policy remains little known among health workers. A survey evaluating the

implementation of the PNSI-LGBT indicated that 70% of professionals, when asked about their knowledge regarding the policy, reported having no knowledge on the subject²⁸.

There is a concern to demonstrate a good relationship between the health professional and the LGBTI+ population, indicating that there are demands and censorship imposed in their workplace, where subjectively public policies should be respected, as well as the PNSI-LGBT, which exerts pressure for the positioning of health professionals²⁴. Although this policy is still insufficiently known and adopted, regulations are necessary as a condition for guaranteeing rights and serve to guide actions and inhibit abusive or illegal behavior. However, one of the studies highlights that they are not enough to change the social representations and moral values that are related to this population¹⁷.

One of the most important rights for the LGBTI+ public, guaranteed by Ordinance n° 1,820/2009 of the Ministry of Health, is the observance of the use of social names in public health units. The use of the social name contributes to the SUS principle of equity and encourages respect for diversity, however, compliance with its use still depends on the acceptance by health professionals to abandon prejudices and dogmas²⁸. Non-compliance with its use makes it difficult for trans and transvestite people to remain in the services offered by the SUS and increases abandonment of health treatments. Furthermore, disrespect for the social name on the part of health professionals has been indicated as one of the main access barriers faced by this public³⁴.

Monteiro and Brigeiro³¹ observed that the non-use of social names in consultations by health professionals leads to a feeling of embarrassment in trans users. The majority of those interviewed in their research were aware of their right to use their social name and express their gender identity. The non-use of social names in health services was recognized as a discriminatory act against trans/transvestite women. Oliveira et al.¹⁷ also

highlight the importance of access to the women's bathroom for transvestites and transsexuals, but recognize that there is still much progress in terms of equity to be done. Other actions, especially in strengthening trust, are necessary to capture health information, as well as the use of sympathy and cordiality that facilitate the strengthening of bonds and ties that are so important for the mental health of this population¹⁷.

It is essential to expand knowledge of public policies for the health of the LGBTI+ population and reduce the gap caused by cis-heteronormativity. In addition to constitutional rights to health, documents such as the National Primary Care Policy (PNAB) and the SUS Users' Rights Charter contribute to guaranteeing these rights. The latest revision of the PNAB prohibits any exclusion based on age, gender, race, ethnicity, belief, nationality, sexual orientation or gender identity⁵¹. Likewise, the SUS Users' Rights Charter establishes the right to access health services for the promotion, prevention, protection, treatment and recovery of health⁵². Therefore, it is essential that health services and professionals recognize the importance of users' expression of identity and their relationship with family ties, ensuring a reception that considers the completeness of the subjects³³.

Final considerations

The objectives of this study were to analyze the literature on the experiences of providing care to the LGBTI+ population in PHC in Brazil. We seek to understand how such experiences unfold in the daily lives of UBS, identifying the aspects that hinder or facilitate access to health care for this population. Furthermore, we seek to determine whether existing practices are aligned with human rights aimed at this group.

The literature examined in this study indicates that actions aimed at the LGBTI+ population are still incipient, fragmented and

ineffective in dealing with the needs of this group. This problem is exacerbated by the fact that PHC serves as one of the main gateways to the SUS, being the community's first point of contact with health services, despite formal regulations being established. As mentioned previously, there are public policies aimed at promoting gender equity and ensuring comprehensive health care, as well as norms that aim to protect the rights of the LGBTI+ population.

Analysis of the reviewed articles indicates that this population faces significant reception difficulties, which compromises access to available health services. Much of the literature examined highlights the lack of preparation of health teams to deal with this population and the lack of reception necessary to establish an effective bond between user and health professional, resulting in a lower frequency of visits to health units. Personal barriers, influenced by beliefs and moral values, should not prevail over the professional's commitment to users' rights. Furthermore, the LGBTI+ population continues to have little visibility in terms of its particularities, including with regard to the most common health problems that should be addressed by PHC.

It is concluded that moral and religious factors have a strong impact on prejudice and discrimination and often predominate over equity and inclusion policies. In the literature analyzed, no other social markers of difference were found, such as age, color, occupation or social class, which could explain some exclusionary attitudes, in addition to sexual orientation and gender identity. There are reports in the literature of health professionals who anchor their health actions in social representations that do not accept sexual diversity, and who believe that people outside the cis-heteronormativity are considered incorrect and even unacceptable, contributing to the distancing of this population from health services offered in the SUS.

The analysis of the studies also points out that, despite the existence of themes such as

gender identity and sexual orientation in the training of higher education health professionals, these themes are limited to approaches to issues related to STIs, with no greater concern with other demands, and specificities inherent to each segment of this population.

In relation to the training of health workers, regardless of their level of education, a point to highlight is that few actions delve into topics linked to gender and sexuality and health issues among lesbian, gay, bisexual, transvestite and transsexual people; Nor is there any emphasis on issues related to discrimination, inequities and violence directed at this public, which could contribute to a more humanized, ethical and respectful attitude on the part of professionals.

We emphasize that PHC must guarantee social rights, such as the use of social names, use of the bathroom on the premises of health units, according to their sexual orientation and gender identity, offering the transsexualization process, in addition to contributing to the dissemination of these rights. We highlight, based on the analysis of the texts that served to prepare this work, that PHC can contribute to improving the health of this population group in defense of the right to universal access to health actions and services, so that users are

assured the treatment, recovery, rehabilitation and healing.

There are numerous resources available free of charge for the training of health workers, such as courses, publications, specialized websites, explanatory folders and other various literature that could help in offering good health care to this population. PHC has the capacity to stimulate its health professionals, training them through courses, mentoring, debate cycles, development, matrix support and soft skills, among other forms of technical development of human potential, creating the necessary conditions for the generating equity, minimizing vulnerability and contributing to a fairer society.

Collaborators

Reis AA (0000-0002-1141-0473)* contributed to the conception and design of the research, preparation, standardization, and all processes for delivery and publication of the manuscript. Carvalho HR (0000-0001-6366-1971)* contributed to complementing the bibliographic research, critical review, standardization and technical standards of the file and editing the final version of the manuscript for publication. ■

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Received on 11/24/2023

Approved on 12/23/2023

Conflict of interests: non-existent

Financial support: non-existent

Responsible editor: Élide Azevedo Hennington