

Health challenges in the LGBTI+ population in Brazil: a scenario analysis through the triangulation of methods

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Abstract *This article aims to reflect on the current health challenges of lesbians, gays, bisexuals, transgenders, intersex, and other sexual and gender minorities (LGBTI+) within the Brazilian scenario. This study adopted a triangulation approach, based on two studies developed in the Southeast and South of Brazil, which included policy analysis and qualitative research on the perceptions of key actors from the Brazilian Unified Health System (SUS) – LGBTI+ users, workers, and managers. All data were analyzed by an interdisciplinary team of researchers. The main problems faced by the LGBTI+ population were registered, indicating some of the necessary progress. Some of these challenges include: access of the LGBTI+ population to SUS; the need to train health professionals; the decentralization of health services sensitive to the LGBTI+ population; the distinct forms of violence and discrimination; the lack of research in health care conducted with specific groups, such as lesbians, bisexuals, intersex, and other sexual minorities. The results reinforce the urgency for the complete implementation of the “National Policy for the Comprehensive Health of LGBT”. The recognition of the LGBTI+ health needs will aid in achieving the principles which are the guiding principles of SUS.*

Key words *Sexual and gender minorities, LGBTI+ population, Minority health, Comprehensive health, Brazil*

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Introduction

The recognition of the social and health rights of lesbians, gays, bisexuals, *travestis* transgenders, intersex, and other sexual and gender minorities (LGBTI+) has been difficult to achieve both internationally¹, as well as in Brazil, where health is a constitutional and universal right. Since the end of the nineteenth century, these people have received pathologizing classifications based on the biomedical model². Throughout history, these people were considered to be sinners by the church, criminals by public security authorities, and sick by medical authorities³. As of the latter third of the twentieth century, this population began their struggle (which is still ongoing) for depathologization and for human rights, seeking the recognition for their healthcare needs⁴.

The acronym LGBTI+ is one of the recent variations that seeks to expand and recognize sexual diversity and contemporary gender. What is today called “LGBTI+ Health” originated from studies on male homosexuality at a moment in time in which this acronym did not exist, but which gradually began to recognize its internal diversity⁵⁻⁷. The acronym was initially expanded to include lesbians, and shortly thereafter bisexuals, *trans* people (*travestis* and transsexuals) and later, intersex. More recently, it has incorporated other forms of self-identification – present and future – which the sign “+” seeks to translate, keeping the acronym and the political demands of emerging identities open.

Addressing “LGBTI+ Health” as a question of the collective is urgent and involves recognizing that there are specific needs, but that the common demands of the group are essential and can generate more powerful political responses. It is not about a homogeneous group. Much to the contrary, each letter of the acronym contains specific health needs. The tensions are multiple, both inside and outside of the acronym, and include from the historical struggle against the HIV-AIDS epidemics to the implementation of the National Policy for the Comprehensive Health of LGBT (PNSI-LGBT, in Portuguese), the distinct modalities of violence that these people suffered, the gender-affirming procedures in SUS, the supposed “gay cure”, mutilating surgical procedures in intersex newborns, among other challenges⁸⁻¹¹. The specificities of the LGBTI+ Health still intersect with those of other segments, which share the fact of being historically marked by the stigma, by discrimination, and by violence: women, blacks, Indigenous, immigrants and refugees, the disabled, just to name a few^{4,12,13}.

It is important to recognize the pioneer role of social movements in the inclusion of a health agenda for the LGBTI+ population, but it is also necessary to pay attention to the current threats and setbacks, both nationally and internationally, as presented by McQueen¹. The Brazilian political arena has been the stage for internal disputes, and despite some achievements, more conservative and reactionary sectors of the three governmental powers have intensified their attempts to (re)pathologize and delegitimize the health needs of LGBTI+ people¹⁵. Pathologization occurs through the disregard for scientific evidence in favor of proposals grounded on prejudice. The terms used, such as “gay cure” and “therapeutic actions” seem to propose a counter-pedagogical approach that fights for space to counter the progress achieved regarding rights in the realm of LGBTI+ health.

In this light, this article seeks to reflect on the current health challenges of the LGBTI+ population in the Brazilian scenario. Based on the triangulation approach, which includes the analysis of public policies and qualitative research on perceptions from key actors (LGBTI+ people and SUS workers), together with an interdisciplinary analysis conducted by researchers, this study seeks to contribute to the discussion by identifying the main problems faced by this population, indicating some of the necessary advances. Recognizing the demands of this population is one way to aid in achieving the principles of universality, comprehensiveness, and equality of access to healthcare serves, which are guiding principles of SUS.

Methodology

This study adopted the triangulation approach^{16,17}, seeking to learn, through different lenses, about the complexity of LGBTI+ Health and its main challenges. The triangulation includes¹⁷: a) multiple qualitative methods, including semi-structured interviews, focus groups, and public policy document analysis; b) multiple participant profiles, including LGBTI+ users of SUS, LGBTI+ activists, and SUS workers and managers; c) theoretical triangulation, with inputs from gender, collective health, and social sciences theories; d) the triangulation of researchers, all with Ph.D.'s, from diverse fields (professionals in public health, sociologists, anthropologists, geographers, epidemiologists) and members of the Thematic Group (TG) on the Health of the LGBTI+ Population from the Brazilian Association of

Collective Health (ABRASCO, in Portuguese), who conducted an interdisciplinary analysis.

The data were collected through two umbrella projects:

1) Regarding sexual and reproductive rights of the LGBTI+ population¹⁸, which analyzed the perception of professionals from Basic Health Units (BHUs) and six headquarters of the regional health units of São Paulo (SP), regarding the health of the LGBTI+ population; it also provided a documental investigation of the history of the national LGBTI+ health policies and their implementation. In all, 29 professionals were interviewed, including managers, doctors, nurses, technicians, and nurse's aides in 2019. The project was approved by the Research Ethics Committee (CEP, in Portuguese) from the Federal University of São Paulo (UNIFESP), logged under protocol number 4.842.078.

2) Regarding the analysis of the implementation of the PNSI-LGBT in the three states of the South Region of Brazil^{19,20}, by means of 09 focus groups (FG), conducted with LGBTI+ users, activists, and SUS workers and managers, in the following capitals, with the respective number of participants and year in which the groups were conducted: Curitiba (n = 48 in 4 FG, 2018); Florianópolis (n = 36 in 3 FG, 2019), and Porto Alegre (n = 21 in 2 FG, 2018). The respective State Health Departments from the three states collaborated in the promotion, invitation, and engagement of participants from municipalities of the countryside of the states as well. The project was approved by the CEP from the Federal University of Rio Grande do Sul (UFRGS) (logged under protocol number 2.632.685/2018).

In both studies that make up this analysis, both interviews and FG were conducted by researchers with doctorate degrees, considering that post-graduate students also collaborated in the mediation of the FGs. The material was recorded, transcribed, and thematically analyzed by means of the emerging categories²¹. All of the participants agreed to participate and signed the Free and Informed Consent Form. For the triangulation^{16,17}, these different inputs (documental analysis, interviews, and FG), of different participants (users, professionals, managers, and activists), were discussed by the interdisciplinary research team, in turn producing the final analysis.

Results

The results were organized in two sections: 1) Health policies; 2) Challenges in SUS scenarios.

LGBTI+ health policies: a brief history of the Brazilian policies and the current challenges

The documental research revealed significant aspects about the implementation of health policies geared toward the LGBTI+ population, which are necessary to understand the current scenario. Only in 1985²² did the Federal Council of Medicine make an official announcement about the removal of the term “homosexuality” from the International Classification of Diseases (ICD), although in 1984²³ the stance of the Editorial Board of the *Revista de Saúde Pública* (Brazilian Journal of Public Health) defended the maintenance of the term in the ICD, delegitimizing the demand from the incipient Brazilian social movement and attributing the decision about the term to the field of psychiatry. In the same decade, during the peak of the HIV/AIDS epidemic, the National Program of STI/AIDS and its posterior consolidation was created. Therefore, it was during the “AIDS panic” that health policies for the LGBTI+ community began to be considered, much more in the sense of controlling the population, understood as agents of the transmission of disease, than in an attempt to protect or care for them²⁴. Nevertheless, the LGBTI+ health needs cannot be merely limited to the prevention and treatment of Sexually Transmitted Infections (STIs), although they are profoundly anchored in this context²⁵⁻²⁷.

LGBTI+ health needs were introduced in the political agenda in a broader form, through the mention of the homosexual category in the *National Program of Human Rights* (1996)²⁸. In 2004, the *National Policy of Comprehensive Healthcare for Women*, recognized the need for health care to be provided for many segments of women, including lesbians²⁹. In the same year, the federal government launched the *Brazil without Homophobia – Program to Combat Violence and Discrimination against LGBT and Promote Homosexual Citizenship*³⁰. The Ministry of Health (MH) created the working group that would later lead to the “Technical Committee for the Health of the Gay, Lesbian, Transsexual, and Bisexual Population”³¹. In a dialogue with other policies for the promotion of equality, a set of guidelines was formulated which served as the foundation

for the PNSI-LGBT³², whose final version was disclosed in 2010, approved in 2011, and agreed upon in the Tripartite Commission in 2013.

Before the PNSI-LGBT was created, other initiatives contemplated the LGBTI+ population, such as the *Charter of the Rights of the Healthcare User*³³, which described the right to healthcare at SUS, free of discrimination by sexual orientation and gender identity, opening space for the institutionalization of people's social names in SUS. In addition, the centrality of healthcare as a demand of the LGBTI+ movement is described in other documents, such as the Annals of the I National LGBT Conference, given that of the 559 proposals approved by the Final Plenary, 167 concerned health, which corresponds to nearly 30% of the total³⁴.

The PNSI-LGBT³² is based on the principles and guidelines of SUS, giving priority to equality, comprehensiveness, and social participation, which involve the recognition of the right to health as a basic right and principle of citizenship. It recognizes that the institutional discrimination and prejudice are barriers to the access and quality of health care; shifts the logic that attributes to the individual the sole responsibility for the process and condition of being healthy and places the State as a co-responsible partner in the production of health care; and points out guidelines, responsibilities, and functions attributed to the MH, as well as to the State and Municipal Health Departments.

Nevertheless, the implementation of the PNSI-LGBT in healthcare services does not always run in line with user needs, with studies on its application being rather scarce in the literature^{10,19,35}. Its effective implementation depends on a number of factors, including the commitment of local managers, engaged healthcare professionals, and interaction with social movements. Some key actions relevant to this implementation can be highlighted^{10,19,36-38}: the inclusion of social names on the SUS cards; the expansion of the gender-affirming procedures in SUS, enabling specialized healthcare services in the states of RS, RJ, SP, GO, PE, RJ, MG, SP, and PR; online-based courses on the PNSI-LGBT for SUS workers, offered by universities and by the Open University of SUS (UNASUS, in Portuguese); the inclusion of the "social name", "sexual orientation", and "gender identity" fields on individual registration forms of the e-SUS electronic system of primary care (SISAB) and of the notification of violence from the National Disease Notification System (SINAN), and the field "motive

of violence" by "homo/lesbo/bi/transphobia"; as well as support provided to the LGBTI+ technical health committees in the states, together with the State Health Departments and social movements, creating dialogue advisory spaces, and social control for the implementation of the policy at the local levels.

Although some progress has been noted, there is still much to be developed. Researchers point out the need to rethink the education of healthcare professionals^{18,39}, whose content on LGBTI+ health are poorly treated. The health actions geared toward lesbian women, bisexual and intersex people, and other identity minorities, are still in their initial stages^{35,40}. It is important to emphasize that the PNSI-LGBT barely mentions intersex or other sexual minorities. In addition to not being listed in the title (LGBT), there is also no reference in the text of the policy formulated for these groups. The PNSI-LGBT, therefore, needs to be updated.

By contrast, despite the progress, in recent years there has been a large gap in the progress of nationwide actions toward LGBTI+ health, which is a reflection of conservative governments and austerity measures, with cuts in SUS funding. The report from the 16th National Health Conference (2019)⁴¹ points to challenges regarding the health of the LGBTI+ population, the need for policies that promote equality from intersectional and intersectoral perspectives, and the need for interventions to curb violence, which require effective action on the part of the State.

Challenges for the health of the LGBTI+ population in SUS scenarios

The two field studies conducted herein and whose triangulated analysis was the basis for this article, revealed common narratives, which include such aspects as¹⁸⁻²⁰: the stigma and discrimination of LGBTI+ users by healthcare workers; the need to educate/train professionals on the theme; problems in access to the healthcare networks; the limitations in the SUS information systems, which end up contributing to the lack of information of this population; concern about the management of the feeding of data into the systems and not necessarily with the demands of LGBTI+ users; idealized views of primary care but that do not necessarily run in line with the true reality. One common complaint was that the health information systems did not adapt to the existence of trans, *travesti*, or non-binary people, even though this demand is not recent. One ex-

ample that emerged from the field was related to the difficulty to perform gynecological exams, such as the pap smear in trans men and prostate exams in trans women, because the IT system did not allow it. As Berenice Bento claims⁴², the maintenance of situations in which people should be remembered for their supposed inadequacies or extraordinary condition forces them to depend on favors or benevolence from someone to “adjust the system”, that is, it reiterates the mechanism of minimal citizenship to which the government controls and segregates trans people.

Nevertheless, the lack of knowledge and the need for training are rhetorical arguments that seem to justify the unwillingness and non-accountability of the healthcare workers and managers in the implementation of the policy, as defends Paulino et al.⁴³ The problems related to the health of *travestis* and transsexuals must also not be decontextualized from everyday violence, from the relevant harm to mental health, such as depression, suicide attempts, and HIV vulnerability^{25,44}. The data, though scarce, make it possible to highlight that the combination of the effects of stigma, violence, discrimination, and transphobia are elements of the everyday routine of the violation of the rights of trans people⁴⁴⁻⁴⁶. In health services, in spite of the existing norms, discrimination still appears as an obstacle to the access to healthcare services. Improvements in the quality of life of the transvestite and transsexual population requires a deep debate concerning the biomedical model. In the meantime, internationally, yet another step has been taken toward depathologization for trans people. Although the WHO still maintains transsexuality as a “gender incongruence”, in the new edition of the ICD-11, in effect since 2022, it has been removed from the category of “Mental, behavioral, and neurodevelopment disorders” and included in the “Conditions related to sexual health”.

The access to healthcare services is still a major challenge for the LGBTI+ and, perhaps, the first to be combatted. In a study¹⁸ conducted in São Paulo, whose analysis is included in this triangulation, healthcare workers revealed barriers in the access of LGBTI+ people to health services, related, among other things, to the lack of proper training of the staff responsible for embracement at the BHUs, the lack of professional development courses on LGBTI+ health, and, above all, of a plan that integrates this type of action in a strategic and interconnected view within basic health care, which is the entry way for people to SUS. BHU managers tend to agree

that specialized healthcare units are insufficient, first, because the majority focus only on STIs, but also because they are few and far between, given that the LGBTI+ demands are ramified and the people tend to receive better medical care when there are health services near their homes¹⁸. This question of the proximity of the health services was even more prominent with the researchers from the study from the South of the country¹⁹, which denounced that the health services for LGBTI+ people (such as trans outpatient clinics) are concentrated only in capital cities and large urban centers. Therefore, one of the proposed challenges is the need for de-centralization (from the center to the peripheral regions) and the inland spread (from the large cities to the countryside) of the health services for LGBTI+ people.

If the access to healthcare is essential, it is also important to recognize that violence and its consequences figure as the main health challenges for the LGBTI+ population^{8,37,44}. Studies^{46,47} recognize that this collective often has its mental health impacted by the effects of the continuous exposure to prejudice and discrimination, which some researchers call “minority stress”. Such a condition explains the greater vulnerability of LGBTI+ people to depression and, in the worst-case scenario, to suicide. The violence surpasses the life cycles of the LGBTI+⁴⁴: it begins with family violence, related to the refusal of the family members to accept the person’s sexual orientation and/or gender identification; it continues with bullying in schools; and it continues with acts of interpersonal violence in adulthood, which can even culminate in homicide practiced due to the simple fact of being LGBTI+, which we can call “LGBTicides”. In another study developed in our TG on LGBTI+ health, we identified that the violence continued even after death, in the case of trans people, a fact which we called “post-mortem violence”: their identified genders are not respected by the families or by the coroners; bodies are dressed for the funeral with clothes representative of their birth sex; the hair is cut; names are “de-rectified” on the tombstones and death certificates; among other violent acts⁴⁸.

Under the pressure of the “minority stress” and the lack of structural sources of support to develop means of resilience, future studies should identify the ways to face inequalities and that could generate a greater probability of chemical dependence on legal drugs, alcohol, and antidepressants, as well as on illegal drugs. Without the proper care and support, subjects whose lives are left up to luck have a minimal realm of

alternatives to support the emotional pain that they accumulate. In synthesis, as regards mental health, it is of utmost importance to implement studies that explore the psycho-social consequences of the stigma and of the discrimination, together with the creation of collective and structural means, as well as intersectoral approaches, through which to combat the problem.

As regards the health of lesbian and bisexual women, what has emerged are recurrent questions related to the limitations of healthcare workers in the embracement of this group. The phenomenon of lesbian invisibility has been described in the literature⁴⁰ and has been observed in the field of collective health. Scientific publications on the theme are still rare and efforts to better understand the wide range of specificities of this group will be necessary. The literature^{40,49–53} on lesbian and bisexual women indicates a lower frequency of doing gynecological exams and breast cancer check-up exams; they search too late for care, only after the disease has worsened; less requests for exams by the healthcare professionals who attend to the patients; and limited care provided to reproductive dimensions.

Another challenge is to give incentive to research on the health of intersex people. Investigators have shown that, when an intersex person decides to go to a healthcare service, the person must go through many different services that question the person as to the sexual designation that was attributed to them upon birth^{54,55}. In this journey, the intersex person comes into contact with distinct professionals, in routes marked by difficulties and violence. The interventions are almost always surgical and drug-based. In this sense, intersexuality is understood within the realm of the disease. There is a persistence to formulate a binary construction of gender and the body, and subjective ambiguities are treated as pathological. To progress in the debates on healthcare for intersexuality, it is necessary to invest in the qualification of the healthcare teams who work with the intersex question.

As regards homosexual men, Kerr et al.⁵⁶ showed that the prevalence of HIV in gays and other men who have sex with men (MSM) increased from 12.1% in 2009 to 18.4% in 2016. For the authors, this was due to the gaps in preventive actions, conservative religious movements in the government, and an insufficient allocation of resources⁵⁶. The prevention campaigns are sometimes geared toward individual attitudes, failing to give emphasis to the structural bases (such as the Pre-Exposure Prophylaxis – PrEP), and

sometimes simply avoid the new realms of the epidemic, ignoring practices, such as *ChemSex*⁵⁷, a phenomenon in which mobile phone applications facilitate sexual encounters with the use of drugs, creating a context of vulnerability to health problems. Unprecedented scenarios such as these require research, new strategies for prevention, debate, and public clarification.

In the end, there is no way to ignore the challenges that the COVID-19 pandemic has brought to the LGBTI+ population. Non-hegemonic gender identity and sexual orientation are sources of inequality and need to be considered in healthcare planning. The pandemic, however, exacerbated these inequalities, which, when added to invisibility in the production of indicators regarding the impacts of COVID-19 in this population, only reinforce their marginalization. It is a group that has already been submitted to “ghettoization”, and whose measures of social isolation ended up confining, in the same space, LGBTI+ people (mainly young people) with family members, who often disrespect their sexual orientation/gender identity, leading to situations of domestic violence⁵⁸. The stress of living with family members who do not respect them leads them to a series of mental health problems, increasing the risk of depression, anxiety self-mutilation, suicide attempts, among others^{59,60}.

It is important to highlight that the panorama presented in this article focuses directly on the discussion about recognition, insofar as the “non-recognition [...] means social subordination in the sense of being deprived of participating as an equal in social life”, as proposes Nancy Fraser⁶¹ (p. 107). For this author⁶¹, the institutions will structure themselves specifically based on that which is recognized, in such a way that the non-recognition implies norms that regulate the valuation and disparate opportunities “[...] that constitute some categories of social actors as normative and others as deficient or inferior” (p. 108). However, there is no parity of opportunities and valuation in institutions that do not recognize the characteristics that socially place the people within political and social minorities, be they in health or not.

Also important are the reflections from McQueen¹, who claims that the questions of the recognition of the LGBTI+ population refer to the strategic drafting of regulations that govern the social relations in processes through which specific groups are constructed, regulated, censured, and even erased. The author also points out that what is considered deviant from the established

set of norms positions these people as marginal and “exception”, which justifies the omission or exclusion. McQueen¹ adds that the struggle for recognition of the LGBTI+ people is not only a struggle to obtain recognition, but rather an ontologically based struggle in relation to that which is recognizable.

Final considerations

The triangulation conducted in this study leads one to consider that the very notion of LGBTI+ health is new in Brazil and, therefore, a field of studies that warrants deeper study. Many studies focus only on one of the segments of the acronym. From the perspective of collective health, we give priority to the recognition that it deals with a group whose diversity is broad and whose demands surpass those that are only articulated through identity and segments. Triangulation was an attempt to search for connections between such diverse identities but who share common goals for the field of collective health. We do recognize the limitations of this study, which include a field study conducted only in the South and Southeast regions of Brazil, failing to hear interlocutors from other regions of the country; or the fact that we are not able to do go deeper into the segments, since the intention was to approach the collective that makes up the acronym; as well as the failure to embrace the discussion on the other sexual and gender minorities.

As members of a TG of Health for the LGBTI+ Population of ABRASCO, we aim to contribute to a broad research agenda on the recognition of this population, in the sense of the intersectionality of the markers. Likewise, it is from the need

to create forms of inclusive care and grounded on equality that one can reinvent the trajectories and therapeutic itineraries, as well as reconfigure the spaces for the development of life. Such creations and inventions can be investigated and incorporated as intersectoral public policies.

The challenges of health interlink with the need to advance theoretical and conceptual reflections, involving the human rights of those who are still not covered and recognized by healthcare services, in such a way that the identification of the health demands of the LGBTI+ population are related to and expand our comprehension of this population. After decades of the incorporation of the concept of gender and the development of studies on sexualities, today it is possible to affirm that the frontiers have been modified in such a way that, rather than representing one closed segment, the LGBTI can now be understood as the most visible part of the group, the tip of the iceberg, but that it includes an incalculable population of “submersed” people in the eyes of the majority, and who wish to be encompassed within the sign of “+”. This includes from emerging identifications, such as asexuals, pansexuals, or those that do not identify themselves within any gender binarism (non-binaries).

The difficulties faced by the LGBTI+ population are more and more an integral part of the collective and structural interest for public policies, especially in the area of health. Likewise, both SUS and the healthcare network call for change, demanding an attentive and sensitive eye from both the scientific world and healthcare network workers/managers, striving not only for the development of concepts and theories, but also for the qualification of healthcare practices that meet the needs of the emerging reality.

Collaborations

The authors declare that they collaboratively participated in the construction of the article. They conceived the proposal together, within the Thematic Group (GT) on “LGBTI+ Health” of the Associação Brasileira de Saúde Coletiva (ABRASCO); they conducted the field research, tabulating the results, performing the analysis and systematizing the draft version of the text. All authors reviewed the text equally, suggesting improvements, and approved the final version of the article.

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