

Trem das Cores (Train of Colors), Valença/RJ Station: itinerary through LGBTQIA+ health in SUS and its meanings

Trem das cores, estação Valença/RJ: itinerário pela saúde LGBTQIA+ no SUS e seus significados

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ABSTRACT Even in the face of recent achievements, access to healthcare for the Lesbian, Gay, Bisexual, Transvestite, Transsexual and Transgender, Queer, Intersex, Asexual, and other (LGBTQIA+) population. Therefore, this article's objective is to shed light on aspects related to the health of these individuals based on their therapeutic itineraries and thereby contribute to the reorientation of care practices with a focus on the potential of Primary Health Care (PHC) as a health system device. This exploratory and descriptive study seeks to understand aspects of health and its meanings for the LGBTQIA+ population based on analyzing answers to a questionnaire and narratives obtained through semi-structured interviews. The analysis is in line with the findings of other authors with whom the study dialogued and highlighted primary care as fundamental equipment in the public network to guarantee the right to health for this population, considering the guiding principles of the SUS and the attributes of the primary care network.

KEYWORDS LGBTQIA+ persons. Integrality in health. Primary Health Care. Health policy.

RESUMO Mesmo diante de conquistas recentes, o acesso à saúde pela população de Lésbicas, Gays, Bissexuais, Travestis, Transexuais e Transgêneros, Queer, Intersexo, Assexuais e outras (LGBTQIA+) ainda é marcado por diversas barreiras, especialmente nos contextos interioranos, em que a oferta de serviços especializados é menor. O objetivo deste artigo, portanto, é trazer à luz aspectos relacionados com a saúde desses sujeitos fundamentado nos seus itinerários terapêuticos e, assim, contribuir para a reorientação das práticas de cuidado com enfoque nas potencialidades da Atenção Primária à Saúde (APS) como dispositivo do sistema de saúde. Baseado na análise de respostas a um questionário e de narrativas obtidas com entrevistas semiestruturadas, constitui-se então este trabalho exploratório e descritivo que busca compreender aspectos relativos à saúde e seus significados para a população LGBTQIA+. A análise vai ao encontro dos apontamentos de outros autores com os quais o estudo dialogou e destaca a APS como equipamento fundamental na rede pública para a garantia do direito à saúde dessa população, considerando os princípios norteadores do Sistema Único de Saúde e os atributos da rede de cuidados primários.

PALAVRAS-CHAVE Pessoas LGBTQIA+. Integralidade em saúde. Atenção Primária à Saúde. Política de saúde.

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Introduction

The discussion about the health of Lesbian, Gay, Bisexual, Transvestite, Transsexual and Transgender, Queer, Intersex, Asexuals and other (LGBTQIA+) people is relatively recent in the history of Brazilian public health. Despite the long journey undertaken by social movements, equity in healthcare for this population has still not been achieved in the Unified Health System (SUS), which is at odds with the doctrinal principles that govern SUS¹ and with what public health policies advocate for this population^{2,3}.

Despite the Transsexualizing Process in SUS, instituted in 2008, revised and expanded in 2013², and the National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (PNSI-LGBT) from 2011³, access to and the quality of care provided to this population are still considered exclusionary, leading to the vulnerability of these individuals⁴. The various obstacles they face make them distant from health facilities or result in the provision of poor-quality services^{5,6}.

Specifically in relation to transgender people, the lack of professionals and specialized units stands out. In Brazil, in 2023, there were only five hospitals qualified for outpatient and surgical care. In addition, many of the outpatient facilities are located in larger cities. It is also worth noting that the services offered only cover part of what is recommended by current regulations, putting this population segment at greater risk and vulnerability^{6,7}.

There are still approaches that link healthcare for the LGBTQIA+⁸ community to Sexually Transmitted Infections (STIs) and, in the case of transgender people, focus on gender reassignment as the only desirable objective⁸. Therefore, it is necessary and urgent to work towards the effective existence of a singularized and comprehensive care model.

Understanding the diversity and plurality of people's experiences implies the

construction of care to address specific demands – neglected and/or known – of the LGBTQIA+ population. However, this does not mean that their healthcare should be provided exclusively in specialized outpatient clinics, many of which were created in STI/HIV services or resulted from their transformation, perpetuating the venereal disease/abnormality correlation and recognizing the difficulty in welcoming this population into healthcare services open to the entire society^{5,8}.

It is understood that ensuring singularized and comprehensive approaches to health is a constitutive part of Primary Health Care (PHC), which is envisioned as a conducive environment for some of the affirmative actions regarding the rights of the LGBTQIA+ population. Seeking to ensure greater access and better resolution while respecting the specificities of each patient, PHC emerges as an important player in minimizing inequalities and exclusion of this social group, effectively aiming for equity in health, one of the principles on which the SUS is structured^{9,10}.

However, it is recognized that there are still unprepared teams and units that fail to provide a welcoming and respectful environment, which recognizes this population as a vulnerable group with specific health needs compared to the general population⁹. Thus, it is important that LGBTQIA+ individuals are heard on aspects relating to their healthcare based on their therapeutic itineraries, contributing to comprehensive care in PHC.

Accordingly, here is an extract from the study 'Health of the LGBTQIA+ population in primary healthcare in Valença/RJ: barriers and potential for comprehensive care', registered with the CEP/CONEP system under CAAE 54947222.9.0000.5240, Opinion number 5.335.681, as provided for in Resolution 466/2012 of the National Health Council, and carried out with the author's own resources, in which LGBTQIA+ residents of the municipality in the interior of the state of Rio de Janeiro were interviewed.

Material and methods

This work gives voice to and details aspects related to the health experiences of some LGBTQIA+ individuals in the city of Valença, a municipality in southern Rio de Janeiro with a rural and agricultural heritage. Valença experienced its economic peak during the coffee plantation agriculture and the textile industry¹¹. It currently has a population of 68,088 people living in its central area and six districts¹². Like many other regions in Brazil, Valença bears deep marks from its colonial past, which involved the domination of Indigenous people and slavery¹¹.

During the research period, the service sector was the main economic activity, and the Dom André Arcoverde Foundation (FAA), which sponsors the Valença University Center, was one of the city's leading employers. One of its most outstanding undergraduate programs is Medicine, with approximately 200 new students annually. These students occupy the entire health services structure directly managed by the Foundation, in the case of the Valença School Hospital (HEV) and by the Organizational Contract for Public Education/Health Action (COAPES). This contract, signed in 2018 with the Municipal Health Department, integrates teaching, service, and community in the 27 PHC units, reaching 90% of the population^{11,13}.

According to the 'Mosaico Brasil' survey in Valença, around 9% of men define themselves as gay, 3% as bisexual, and the remaining 88% as heterosexual. Among women, 6% said they were lesbians; 4%, bisexuals; and 90%, heterosexuals¹⁴. Considering the municipality's population, there are around 7,000 people who declared themselves LGBTQIA+ and would benefit from qualified and comprehensive care in PHC, capable of addressing their specific needs. Additionally, the municipal health plan should include their rights and specificities, which was not the case in the document valid between 2018 and 2021¹¹.

This research emerged from that scenario as a cross-sectional, exploratory, descriptive study with a qualitative approach, which was conducted in two phases: 1) dissemination on digital platforms of a self-administered questionnaire developed using Google Forms software – the objective was to identify the socio-educational profile, health needs, search for and knowledge of health services, perception of health care and the LGBT Municipal Council; and 2) conducting semi-structured interviews aimed at accessing the perceptions and experiences of the LGBTQIA+ population in their search for health care in the municipality of Valença, Rio de Janeiro, especially in PHC.

In the first phase, an invitation to participate in the survey was sent out with a link to the questionnaire. The message was sent to seed members of the LGBTQIA+ social movement chosen for convenience, who would then disseminate it using the snowball technique¹⁶ to reach as many respondents as possible during the 90-day period in which the questionnaire was available. The instrument consisted of 34 closed questions to choose one of the provided alternatives.

The spreadsheet was consolidated with the 58 responses obtained. Participants who did not agree to the Informed Consent Form, those under the age of 18, self-declared cisgender, and heterosexuals were excluded. Among the 53 validated questionnaires, there were no self-declared intersex or queer individuals, but some participants stated that they fell within the non-binary gender spectrum. Based on the information in the questionnaire and to ensure that each LGBTQIA+ group was properly represented, the following were considered: self-declared gender identity and sexual orientation; use of public health services, especially PHC; the social markers of difference (skin color or ethnicity, age, and schooling); willingness to take part in the research; and having provided contact information (telephone, cell phone or e-mail) to select participants for the second phase

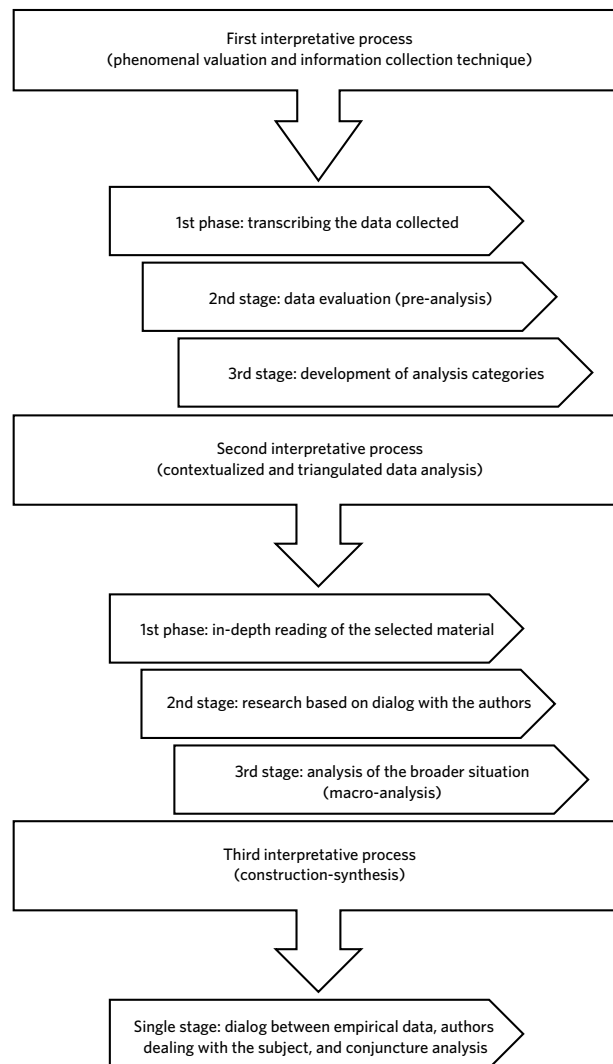
of the study. These inclusion criteria meant a total of 29 possible interviewees, of whom nine took part in the second phase.

In this phase, nine interviews were conducted based on a semi-structured script, which allowed the narratives and a process of constructing meanings to emerge, in which the told stories opened up space for other stories in a sequence in which the storyline was not modified and various paths were opened up for unforeseen subjects in connection with the research and the researcher's interest in

composing the narrative. The interviews were recorded and transcribed. Throughout the process, ethical aspects were respected, and the project was approved according to the Consubstantiated Opinion of the Research Ethics Committee (CEP) of the National School of Public Health Sergio Arouca of the Oswaldo Cruz Foundation (ENSP/FIOCRUZ), under number 5.335.681.

The material's analysis process was guided by the proposal outlined in *figure 1*, summarized by Marcondes and Brisola¹⁷.

Figure 1. Analytical diagram



Source: Own elaboration based on Marcondes e Brisola¹⁷.

To comply with the commitment to confidentiality and anonymity, the interviewees were identified with the colors of the LGBTQIA+ flag proposed in 2018¹⁸. Therefore,

the intention was also to highlight the relevance of the symbols representing the fight for rights (*table 1*).

Table 1. Research participants

Color of the LGBTQIA+ flag	Identificaton	Profile
Pink	Pink	Young, self-declared trans woman and transvestite indiscriminately in the interview. She was born and lives in Valença
Blue	Blue	Young, trans man
Brown	Brown	Young, trans woman who declares herself dark-skinned
Black	Black	Young, cis man who declares himself gay and black
Violet	Violet	Young, cis woman who declares herself bisexual
Indigo	Indigo	Cis man, self-declared gay and white
Green	Green	Participant self-declared non-binary
Yellow	Yellow	Young, cis woman, lesbian, white, and blonde
Gray	Gray	Participant self-declared asexual

Source: Own elaboration.

In this summary table of the characters, we have chosen to include in the article only how the individuals declared themselves, which refers to what each one prioritizes when presenting themselves. It is important to emphasize that sexual and gender identities develop through numerous mechanisms and various intersections. Identity differentiates people as individuals in specific cultural, political, and economic positions within each society; among the various identities, sexual or gender identities are also integrated¹⁹, representing the people categorized under the acronym LGBTQIA+.

Gender identity is therefore defined as a person's perception of themselves as male, female, or some combination of the two, regardless of their biological sex²⁰. The interviewees made the following statements:

I'm a very feminine person, but my girlfriend isn't so feminine... (Yellow).

[...] I identify myself as an LGBTQIA+ person, right? A cis gay man. (Indigo).

I look at G, which is the letter I belong to within the acronym... (Black).

I'm a cis bisexual woman. (Violet).

Now no one can call me a faggot, I'm a transvestite! (Pink).

I am a transvestite woman. (Brown).

I felt that I wasn't part of reality, and then I discovered that there were trans people, and I began to identify myself with them. (Blue).

I'm a demisexual gay man; there's a branch of my sexuality. (Gray).

When someone asks me about my sexuality, I say it's more like pansexual. As for gender, I don't fully identify myself as a man, but I don't identify myself as a woman either, I'm in the process of learning more about non-binarity. (Green).

In these statements, in addition to their perception of themselves about gender, those

individuals also identified their sexual orientation, represented in the acronym that also seeks to represent them by their characteristics, thus including lesbianism, homosexuality, and multisexuality, as well as other possibilities of identification about gender and sexuality^{19,20}.

This is a critical moment to engage with the strategy of implementing identity policies resulting from the struggle of organized civil movements in dialogue with the State, especially the PNSI-LGBT. Therefore, it is necessary to articulate this dialogue between established policy and practical achievements to improve the healthcare everyone, regardless of gender identity, is entitled to, as guaranteed by the 1988 Federal Constitution (CF/88), by

the SUS normative and organizational structure, in the programmatic framework of PNSI-LGBT, and other identity policies or actions to assert rights^{2,3,21}.

Results and discussion – What does having health mean to you?

The analysis of the concept of health for the research participants begins by examining what emerged in response to the question: ‘What does having health mean to you?’ Some responses were selected and organized according to their meanings in *table 2*, which follows:

Table 2. Meanings of health

The body	<p>Absence of illness.</p> <p>Taking responsibility for one's own body and obtaining the means to do so.</p> <p>Having good immunity and not getting sick very often.</p> <p>Free access to the public health system for routine check-ups so the body stays in full working order, free from infections, illnesses, or anything that doesn't allow it to function properly.</p> <p>Being able to access health professionals and medication.</p> <p>To be healthy.</p> <p>To be well and have nothing to restrain me.</p>
The body and mind	<p>Mentally at peace.</p> <p>Health for me means being physically and mentally well.</p> <p>Having a healthy body, not just physically but mentally, in balance.</p> <p>Enjoying physical and mental well-being as far as possible. Physical and mental well-being.</p> <p>Physical and mental well-being.</p> <p>To be well both physically and mentally. Being physically and psychologically well.</p> <p>Physical and mental well-being.</p> <p>Being well organically, physically, and mentally. Taking care of your body and mind.</p> <p>Health is physical and psychological well-being.</p> <p>It's a combination of being physically and mentally healthy.</p> <p>Feeling well enough to do what one wants to do, mentally and physically. Balance and fullness.</p>
Body, mind, and social contexts	<p>Biopsychosocial well-being.</p> <p>Not being biopsychosocial ill. Physical, emotional, and social well-being.</p> <p>Physical and emotional well-being and good quality of life. It is the state of physical and biopsychosocial well-being.</p> <p>Complete physical, mental, and social well-being.</p> <p>Being well with myself and my environment.</p> <p>Peace of mind, mental tranquility, and acceptance of everything and everyone, including myself, at all times.</p> <p>Quality of life is related to physical, mental, and social aspects. Being healthy is more than the absence of illness; it's having a quality of life—a dignified life and access to quality public healthcare.</p> <p>Being well with one's body, having basic access to health, education, leisure, etc.</p> <p>Health is having a good physical, mental, and spiritual state, access to housing, comfort, work, education, guidance on lifestyle habits, leisure, and socio-economic support.</p>

Table 2. Meanings of health

	I believe that being healthy is about feeling good, having a quality of life, and having a healthy body and mind without any limiting factors or factors that prevent me from having a long, productive, and happy life. Complete well-being.
A political dimension	It is having easy access to the minimum that I, as a citizen, deserve in cases of illness. It means having access to the medication I need for my transition and being well taken care of and respected in the healthcare establishments. It is about having universal access to public health policies at all levels of government. Being healthy is linked to quality of life, which will depend on each individual's particularities. I believe that being healthy is also linked with access to health and public health policies

Source: Own elaboration.

Given the vast array of interpretations and references regarding the concept of health, the first block represents some answers associated with the concept of health centered on the biological body²². In Gray's words, health means being in "full health, enjoying how I sleep and wake up, how I eat, everything, it's all very good". Therefore, to be in balance, the body would be the object of action to maintain and restore its functions²².

The second block represents those answers in which health is expressed as related to physical and mental well-being, adopting a perspective of continuity between the somatic and the psychic, in which body and mind are interrelated^{22,23}. From this perspective, it emerges how important mental health has become, both due to the shift in concepts and the re-signification of psychological suffering as legitimate and amenable to a therapeutic approach²³.

My parents took me to a psychiatrist, but I didn't get a consultation because she didn't treat children, and my parents are very prejudiced against psychiatrists. They are well aware that I have a disorder and take medication, but they think it's my choice. Since I was very young, they had to agree, but they only agreed to consult a psychologist, who is also a health professional. (Violet).

This fact deserves to be analyzed concerning statistics, in which the LGBTQIA+ population is one of the groups with the highest prevalence of psychological suffering, more

significant disability caused by suffering, and, consequently, worse health conditions in direct relation to the discrimination they face. The primary psychiatric diagnoses among this population include depression, anxiety disorders, substance use problems, eating disorders, and body image disorders²⁴.

In addition to these statistics, it is essential to mention the stories reflecting the suffering these people are subjected to:

In high school, I was already sure of who I was, but still, as it's something that is engraved in us, I still had a certain prejudice about my sexuality. That was when I had a depressive episode, and it all collapsed: school, family, work, relationships... (Green).

Mental health... I could be less anxious, but the volume of workouts I've been doing has helped me; I've been very calm, and I've felt very little anxiety. (Gray).

I knew X, so she asked me for several tips and told me about things that were happening. I see myself in her situation so much; I feel if I didn't have the privileges I have today, I would be in her place. I don't want anyone to do this ever again; I don't want any transvestite dying, killing themselves. It hurts me! (Pink).

Unfortunately, suicide is one of the expected outcomes when talking about these dissident identities as a result of the oppressions they

face, correlating this with data showing their higher prevalence in this identity category²⁴. Linked to mental health issues comes the idea of constant vigilance over LGBTQIA+ lives and the resulting oppressions, reinforced in rural contexts, resulting directly from discrimination and the prohibition of their experiences, as these

[...] people are at the forefront, the transgender and transvestite population, who are beaten to death, then there's a whole judgment from society on that people because they did it, people start questioning, raising possibilities as if they had the power to question someone else's life. (Black).

The next analytical block considers health from a biopsychosocial perspective. It is interesting to note that such an understanding, by considering social issues in the definition of health, innovates by incorporating this dimension of people's lives into the health-disease process, reinforcing the idea that there is no separation between mind and body and, simultaneously, placing the whole human being as affected and constituted by the society in which they live²². To be healthy is to have “*peace of mind, mental tranquility, and acceptance of everything and everyone, including myself, at every moment*” (Brown).

Finally, the inseparability between health and politics emerges, bringing people closer to what is known as the expanded concept of health, a process that involves social, political, and economic aspects under the significant influence of the context in which the subjects are inserted. Finally, the inseparability between health and politics emerges, bringing people closer to what is known as the expanded concept of health. This process involves social, political, and economic aspects under the significant influence of the context in which the subjects are inserted. Therefore, health results from conditions such as nutrition, housing, education, income, the environment, work, transport, employment, leisure, freedom, access to and ownership of land as well as access to health services^{2,11,25}.

In general, my health is fine; apart from that [hormone monitoring], there is no other need. The mind is unstable from time to time, but nothing that I can't straighten out and say: 'Look girl, that's not how things work, you're too anxious, control your nerves' - I think that's just everyday stuff that everyone goes through, after all, we're at a time when it's hard to get a job, it's hard to eat well too, so there are everyday worries that affect the mind. (Brown).

It can be seen, then, that when talking about comprehensive health, it is necessary to pay attention to the needs beyond the concept of health in the logic of organic disease or dysfunction. In line with the expanded concept of health, providing healthcare requires articulation between different types of knowledge and institutions to guarantee this right provided for in the 1988 Federal Constitution^{3,21,22}. It also points to possible ways in which PHC should be central to implementing the leading public health policies^{4,8}.

Towards comprehensive care: PHC in the spotlight

Healthcare for the LGBTQIA+ population is still fragmented, organized in specialized centers in larger cities and mainly linked to university hospitals^{5,7,9}. This makes it necessary to rethink care practices and networks in line with their population's needs. In this sense, reaching the most diverse territories, PHC stands out as the place to implement the proposals listed in the guidelines and the policies conceived to correct the inequities to which these people are subjected^{3,8}.

Given the importance of this structure in the health system, we will analyze some of the PHC attributes²⁶ that emerged from the interviews, as shown in *table 3*. From the perspective of this study, comprehensiveness will only be achieved by ensuring that PHC attributes are operated in such a way that the analysis of their presence and functioning is transversal to the entire research process.

Table 3. Attributes and responsibilities of PHC

Attributes and responsibilities of PHC in LGBTQIA+ healthcare	
Comprehensive Care	Access at first contact (dimensions of access)
	Coordination of care
	Longitudinality of care
	Problem-solving capacity
	Family and community orientation
	Health education
	Barriers and potential

Source: Own elaboration.

PHC should be the gateway for users into the health system, and therefore, services should be easily and timely accessible to achieve the best possible results in comprehensive health²⁶. When access is compromised, all healthcare flows become unfeasible because “if I don’t have access to health, how can I try to seek help, even if it’s in public health? That’s where I’ve always had access” (Black).

It is therefore necessary to shed light on LGBTQIA+ people’s access to health services⁴. Based on the principle of comprehensive care, it is urgent to give them the attention they need to repair inequities and

to discuss the details of this population’s health, access, and reception, as well as how SUS works with them and their specific demands. (Indigo).

Otherwise, the same situation that occurred to Brown will happen to several other people.

[...] I have been trying to get [hormone therapy] for almost two years now; I started in Bahia, and it was extremely difficult because my city didn’t offer any accessibility, so I had to go to the capital. (Brown).

The first dimension of access is impaired, which is characterized by the physical absence of human resources, services, and equipment in the appropriate place and when they are needed²⁷.

Thus, both for geographical reasons and as a result of the protocol requirements for the

process of transsexualization, the expansion of access provided for the PNSI-LGBT has not yet been achieved because, even in the capital,

[...] they told me that I would need a psychologist’s report, but they didn’t have a psychologist available because I wasn’t from the capital. It was tough to find a psychologist through the SUS; I couldn’t afford a private one at the time. (Brown).

Here emerges another dimension of access emerges: the ability to pay, which comprises the relationship between the cost of using health services and the ability of individuals to pay²⁷. It encompasses the debate on financing the health system and relates to some social determinants of health, such as income and employability^{25,27}.

Acceptability, on the other hand, is the dimension of access that encompasses the nature of the services provided and how individuals and communities perceive them. It is the least tangible and most challenging dimension to assess, as it relates to many subjective, social, and cultural factors in the relationship between users and services. In addition, its key point is the mutual respect between health professionals and service users²⁷, which is not the case in relation to diversity, as Yellow says:

The experience that affected me the most was a gynecologist’s consultation. She asked me some basic questions during the interview, and I told her that I wasn’t hetero. Then, the consultation changed

completely; it made me feel uncomfortable the whole time and was terrible. (Yellow).

Discomfort, distrust of confidentiality, and fear of prejudice also arise when deciding to seek health services far from where they live, which is even more critical in a small town. Green refers to this dimension of access when narrating his relationship with the healthcare unit in the neighborhood where he has always lived in Valença and the motivation for not going to that service for sexual healthcare, instead using another facility in the health network.

I've always been very well assisted, but I've never talked about sexuality, gender, or anything; it's a neighborhood where everyone knows each other, knows all my family, and so on... So, I suspected it could be HPV, and I wanted to talk to someone who had no connection with my family, so I went to the Casa Coletiva (Collective House). (Green).

Finally, information is an essential dimension for understanding the other dimensions analyzed. Information asymmetry, when one part of the system possesses the knowledge and the other parts don't, prevents adequate access and undermines the effectiveness of care²⁷. Despite the provisions of the PNSI-LGBT and the principles of SUS^{3,21}, information on health rights, policies, and services circulates poorly and scarcely, leading to the invisibility of this population group.

I've been in the city of Valença for almost five years, and I've been able to meet a lot of LGBTQIA+ people and have more contact with gay men; I've been able to see the lack of information about STIs and PrEP, and PEP. I believe that solutions could be considered to ensure that information reaches everyone; now, I even talk about it with people who are not LGBTQIA+. (Black).

Many of these access characteristics reveal the inequalities perpetuated in our social structure. So, from the perspective of access,

it can be said that the narratives in this research are connected to the general situation of the health system, which, despite advances, remains inequitable²⁸. Those most in need of public healthcare services are precisely those concentrated in the least privileged social groups in society, such as the LGBTQIA+ population, and they are the ones least likely to use these services due to the numerous existing barriers^{3,28}.

Another essential attribute of PHC is the coordination of care²⁶, understood from the broader concept of health, as it emerges in the words of Indigo:

[It is needed] to think about vulnerability issues; we need intersectoral work with [social] assistance. Some people don't have a home, trans people and homosexuals are going to be thrown out of their homes, and I think intersectoral work is critical to thinking about these issues of social vulnerability and family violence. That's why I believe that perhaps if we had some training, we would at least be able to play our part in coordinating the care of these people. (Indigo).

In this sense, and in accordance with the PHC attributions, it is about organizing and reorienting the healthcare model, both in terms of strict clinical care and in terms of health promotion and comprehensive health²⁶.

Many health conditions of the LGBTQIA+ population could be addressed in PHC, as is already the case in some Brazilian municipalities that have organized LGBTQIA+ healthcare lines, with longitudinal and structured follow-ups in PHC^{29,30}. One criticism of the transsexualizing process instituted by SUS is precisely the lack of provision for hormone therapy to also be carried out in PHC with trained professionals for this type of care^{9,29,30}.

Offering comprehensive healthcare requires knowing all those who come to the service. According to Pink, "we can't go to a health center and say: 'Look, will you help me get my hormone treatment?' because that's not possible nowadays". This illustrates the need

to expand access and, above all, the possibility of a clear dialog about what facilitates and hinders the guarantee of the right to health in PHC, not only at this level of care^{4,31}.

In this sense, Indigo expresses their motivation to acquire new skills about the care they provide to LGBTQIA+ users in PHC, as well as reflections on the institutionalized healthcare practices that result from this:

I've learned a lot from the cases of trans people I'm currently supporting. I've learned a lot from the cases of trans people I'm currently supporting. I've learned that needs arise, and now I know I have to be aware of them, such as the need for a medical report to get breast removal surgery or breast implants and then refer them to psychiatry; maybe this will fall away. Hopefully, it won't be necessary anymore. In short, you need to know how to organize it beforehand to provide it for the patient. (Indigo).

Indigo perceives the importance of assuming the role of a facilitator for the continuity of care, expanding its problem-solving capacity, and coordinating the process^{4,26}. However, the limits of Primary Health Care (PHC) are clear given the rigid protocols established to ensure that some individuals have access to the interventions they need, such as the 'psychiatrization' of transsexuality expressed in the requirement of medical and/or psychological reports, which condition the possibility of bodily modifications^{9,31}.

It is noteworthy, however, that there is an urgent need for awareness-raising processes and for permanent education for healthcare professionals in an institutionalized and continuous manner for comprehensive LGBTQIA+ healthcare, as Indigo himself demonstrates a certain unpreparedness in addressing lesbian women.

The majority of SUS users who come to mind with this question are lesbian women. [...] the fact that one of them has never had penetrative sex; and then the issue of Pap smear collection test, which

is not necessary. [...] we need to guide them on another way of preventing STIs, which has some particularities; on the other hand, they have a lower risk of various STIs because they have sex with fewer contaminated fluids. (Indigo).

With information that is partially based on evidence and difficulties in understanding the healthcare needs of lesbian women, which is also the case for bisexual women, there is a high chance that the result will be poor-quality care and the alienation of these people from healthcare services.

Despite what is recommended in public health policies, there is still a lack of action on the part of those responsible for implementing actions to ensure better healthcare quality for this population. This is contrary to what is established in the PNSI-LGBT operational plan, one of the main instruments for providing the comprehensive health of LGBTQIA+³ people, which is stated in its text:

The plan is part of the dynamics of SUS through strategies of participatory and collaborative management, considering that the comprehensiveness of actions depends on the performance of interdisciplinary teams, providing continuous services to people in their context, and working on the quality of life, health promotion, prevention, health surveillance, primary care, and specialized care³⁽²⁸⁾.

Such omission, in addition to violating programmatic guidelines, hinders access to comprehensive health care for this population group, resulting in worse health outcomes. As a consequence, common problems that could be managed by PHC in its traditional and implemented lines of care fail to receive adequate care; therefore, neglected, they contribute to a greater burden of suffering and poorer health indicators in this population^{6,31}.

Despite the violence, invisibility, and oppression, LGBTQIA+ people insist on the power of living, as Indigo points out when talking about the experience of X, which he

considers a synthesis of the identity force that drives being and the little-explored existence in the rural scene:

[...] in the situation of poor people who have a different socio-cultural level, the forces of being bring this about. They wear dresses and prepare themselves, even though living in poor houses on farms. This emerges, and it finds ways. (Indigo).

Conclusions

PHC is an important state strategy for enforcing the right to health, as it was established in the 1988 Federal Constitution. It is also one of the main components of the public health network. Therefore, it is essential to understand its role in consolidating the SUS as state policy, considering its principles and guidelines.

At this level of care, several actions can be adopted to truly achieve comprehensive healthcare. Despite this, little has been invested in the PHC's capacity to accommodate the LGBTQIA+ population. There are some interesting experiences in cities like Rio de Janeiro and São Paulo, and some professionals working at this level of care who develop care for the LGBTQIA+ population in a unique way. However, there is still much to be done to ensure the universality and quality of care for all those who rely on PHC as their main healthcare reference.

PHC has the necessary capillarity to reach the vast majority of people, regardless of the

territories in which they live, unlike the strategy centered on specialized healthcare services for the LGBTQIA+ population located in large cities. Access to such services, concentrated in a few municipalities, constitutes a major barrier to the realization of comprehensive healthcare for LGBTQIA+ people.

Throughout the course of the study, various obstacles to healthcare for these individuals were encountered. However, clues indicating a paradigm shift in healthcare for the LGBTQIA+ population were also found in the practices of professionals committed to comprehensive care despite the limitations of the public health system.

The challenges are resized, especially in the scenario researched, due to the social markers and their *modus operandi* in a rural context. There are still many challenges to overcome, so it is necessary to empower the LGBTQIA+ population in the pursuit of their rights. Furthermore, it is important to demand the effective implementation of the PNSI-LGBT and thus move towards universal care and comprehensive healthcare.

Collaborators

Magalhães CRS (0000-0003-3473-6596)* contributed to the conception and design, data collection, analysis and interpretation, and textual production of the manuscript. Castro AM (0000-0003-1190-5828)* contributed to the critical analysis of the information, textual production, and final revision of the manuscript. ■

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