

## Opening the closets of access and quality: an integrative review on the health of LGBTT populations

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**Abstract** *The research aimed to study the situations that condition access and quality of health care to lesbians, gays, bisexuals, transvestites and transsexuals (LGBTT) in health services from an integrative review of national and international literature, whose sample of 41 papers was selected in PubMed, Lilacs and SciELO databases from 2007 to 2018. Access and health issues of LGBTT people were discussed in three dimensions: relational, concerning intersubjective relationships among users and professionals; organizational, concerning the organization of services and work processes; and contextual, which covers the effect of vulnerable situations enmeshed with social determinants on the conditions of satisfaction of health needs. The related data showed that LGBTT populations are the target of prejudice, violence, and discrimination, which, added to different social indicators, engender a context of vulnerabilities in access and healthcare. It is necessary to transform health institutions' practices and social relationships. Otherwise, there is a risk of increasingly warding off those populations from health services.*

**Key words** *Sexual and gender minorities, Health services accessibility, Health care, Quality health care, Integrative review*

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## Introduction

Access to health services is related to the ability of a group to seek and obtain health care, and accessibility conditions include political, economic, technical, and symbolic dimensions<sup>1</sup>. The quality of health services, on the other hand, is usually normatively assessed, and its theoretical framework consists of seven pillars: efficacy, effectiveness, efficiency, optimization, acceptability, legitimacy, and equity<sup>2</sup>. However, the idea of quality is also related to the subjectivity of health processes<sup>3</sup>.

In this context, inequalities in access and low quality of health care are issues pointed out in different health systems around the world, and primarily affect minority groups, such as lesbian, gay, bisexual, transvestite and transsexual (LGBTT) populations<sup>4,5</sup>. The social imaginary that institutes binary sexual patterns and promotes the alignments “woman-vagina-maternity-procreation-heterosexuality” and “man-penis-rationality-paternity-heterosexuality”<sup>6</sup> builds a non-place or a displaced place for those who fail to meet the standards. So, where and how would they be taken care of in their different health needs? In the closet?

The closet metaphor enacts how health services have been the scene of denials and concealments of the sociability of LGBTT populations. However, in this discussion, it is highlighted that the scientific literature on this topic has hardly had any visibility, thus the importance of underlining it as a large, expanded closet. Bringing this debate out of the closet is also promoting reflections, incursions, and criticisms in the field of knowledge.

Sexual orientation and gender identity are factors that must be considered in the debates on social determination in health. Subjects who escape sexual binarism are exposed to several situations of vulnerability, not only concerning health care but also employment, income, studies, safety, among others<sup>4</sup>.

The world of dissent from the heterosexual norm is very vast. Letters L, G, B, T, and T perceived only as an acronym can lead to the illusion of homogeneity. Each of these letters carries within itself an extensive and diverse set of experiences, as per situations and intersectional markers. However, the experiences of these communities are traversed by some common force lines, subjected to stigmas, prejudice, and violence that are also expressed in access and health care<sup>4-6</sup>. All of this pointed to a long path of political disputes, conflicts, and negotiations in the

field of fundamental rights and citizenship<sup>7</sup>. In modern times, laws, norms, policies, protocols, among others, are relevant instruments in the enactment of these rights<sup>8</sup>.

This paper, through an integrative review of national and international literature, discusses conditionants and challenges to accessing and quality of health care for lesbians, gays, bisexuals, transvestites, and transsexuals in health services.

## Methodological route

This is an integrative review of national and international literature, a research method that aims to gather, synthesize and critically evaluate results from previous studies on a given topic/issue, allowing the construction of an overview of the current state of knowledge and the identification of gaps and directions for future research<sup>9</sup>. The issue to be discussed in this study is situations that condition access and quality of health care for lesbians, gays, bisexuals, transvestites, and transsexuals in health services.

The survey of scientific publications was conducted in January 2019 in the following databases: U.S. National Library of Medicine (PubMed), Latin American and Caribbean Literature in Health Sciences (Lilacs), and Scientific Electronic Library Online (SciELO). Health Sciences Descriptors (DeCS) were used in both Portuguese and English, combined by the Boolean operator “and”. In the PubMed advanced search, descriptor “sexual and gender minorities” was combined with “access to health services”, “health care” and “quality of health care”, separately. The same combinations were performed in Lilacs and SciELO, resulting in a small number of papers. We also used the terms “homosexuality”, “transsexuality” and “transgender people”, in isolation, to broaden the search on these two databases, and new papers were compiled.

The following inclusion criteria were defined: original papers, available in full in electronic format, in Portuguese, English or Spanish, and published from January 2007 to December 2018. Exclusion criteria were: editorials, letters to the editor, dissertations and theses, papers with an exclusively clinical-epidemiological focus, review papers, essays, and experience reports. The Yogyakarta Principles<sup>10</sup> were launched in late 2006. They are a fundamental document for the fight against prejudice and discrimination against LGBTT populations in the world. Thus, the starting date considered in this search was 2007.

The first survey returned 3,428 papers. After reading the titles or abstracts, 448 studies were eliminated as they were duplicates, and 2,916 due to the exclusion criteria. As a result, 64 publications were left out for full-text reading. Of these, 23 were excluded because they did not discuss issues related to access or the quality of health care for LGBTT populations. In the end, 41 papers were included in the study and identified by an alphanumeric code. We present the search strategies schematically by the specificity of each database in Figure 1.

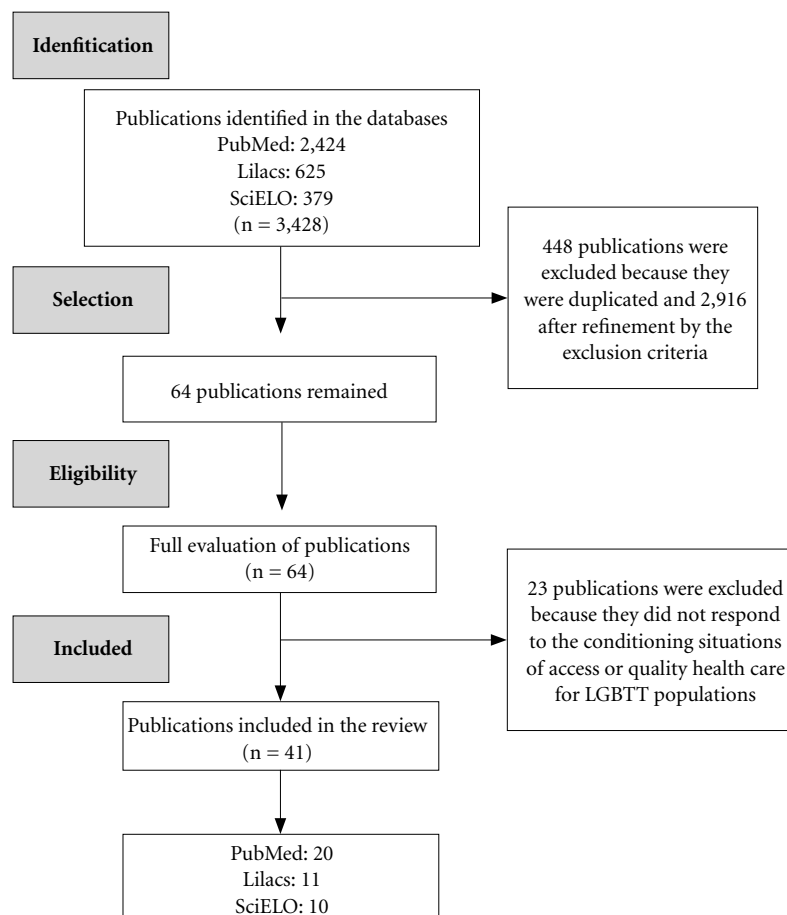
A more descriptive analysis of the material found was carried out after some reading sessions. Some of this information was synthesized in a synoptic table (Chart 1) containing the following items: code accompanied by the reference number, title, first author, journal, and year. Then, we conducted a content analysis guided by the discussion of the integrative review, where

the categories access and health care of LGBTT populations were discussed in three dimensions: relational, which concerns the intersubjective relationships between users and professionals; organizational, which refers to ways of organizing services and work processes; and contextual, which encompasses how situations of vulnerability interwoven with social determinants affect the conditions for satisfying health needs.

## Results and discussion

### What did we find in the closets?

The issue of access and quality of health care for LGBTT populations has been the subject of growing interest in national and international literature. From 2009 to 2014, five publications on the theme were identified, and 36 were found



**Figure 1.** Flow of the article selection process for the integrative review.

Chart 1. Summary table of selected papers.

Code/ Ref.	Title	First Author	Journal	Year
A01 (30)	Acesso a cuidados relativos à saúde sexual entre mulheres que fazem sexo com mulheres em São Paulo, Brasil	Barbosa RM	Cadernos de Saúde Pública	2009
A02 (14)	As experiências dos cuidados de saúde de pessoas transexuais em Portugal: perspectivas de profissionais de saúde e utentes	Pinto N	Revista de Psicologia	2012
A03 (26)	Estudo descritivo da homofobia e vulnerabilidade ao HIV/Aids das travestis da Região Metropolitana do Recife	Sousa OS	Ciência & Saúde Coletiva	2013
A04 (15)	Processo de formação das representações sociais sobre transexualidade dos profissionais de saúde: possíveis caminhos para superação do preconceito	Santos AB	Ciência & Saúde Coletiva	2014
A05 (50)	<i>Estigma y discriminación a profesional de la salud transgénero</i>	Campo-Arias A	<i>Revista de la Facultad de Medicina</i>	2014
A06 (18)	<i>Experiences of homosexual patients' access to primary health care services in Umlazi, KwaZulu-Natal</i>	Cele NH	<i>Curationis</i>	2015
A07 (38)	Violência e sofrimento social no itinerário de travestis de Santa Maria, Rio Grande do Sul, Brasil	Souza MHT	Cadernos de Saúde Pública	2015
A08 (34)	<i>Stigma, sexual health, and human rights among women who have sex with women in Lesotho</i>	Poteat TC	<i>Reproductive Health Matters</i>	2015
A09 (41)	Experiências homossexuais de adolescentes: considerações para o atendimento em saúde	Taquette SR	Interface - Comunicação, Saúde, Educação	2015
A10 (49)	<i>That would have been beneficial: LGBTQ education for home-care service providers</i>	Daley A	<i>Health &amp; Social Care in the Community</i>	2015
A11 (27)	<i>Outness, stigma, and primary health care utilization among rural LGBT populations</i>	Whitehead J	<i>PLoS One</i>	2016
A12 (28)	Dificuldades vividas por pessoas trans no acesso ao Sistema Único de Saúde	Rocon PC	Ciência & Saúde Coletiva	2016
A13 (47)	<i>Perceived health concerns among sexual minority women in Mumbai, India: an exploratory qualitative study</i>	Bowling J	<i>Culture, Health &amp; Sexuality</i>	2016
A14 (46)	<i>Health care provision in Brazil: A dialogue between health professionals and lesbian, gay, bisexual and transgender service users</i>	Moscheta MS	<i>Journal of Health Psychology</i>	2016
A15 (31)	<i>Lesbian women's access to healthcare, experiences with and expectations towards GPs in German primary care</i>	Hirsch O	<i>BMC Family Practice</i>	2016
A16 (40)	<i>Barreras en la atención de la salud sexual en Argentina: percepción de las mujeres que tienen sexo con mujeres</i>	Silberman P	<i>Revista de Salud Pública</i>	2016
A17 (33)	<i>Lesbian and bisexual women's sexual healthcare experiences</i>	Munson S	<i>Journal of Clinical Nursing</i>	2016
A18 (42)	<i>'Competent persons who can treat you with competence, as simple as that' – an interview study with transgender people on their experiences of meeting health care professionals</i>	Lindroth M	<i>Journal of Clinical Nursing</i>	2016
A19 (48)	Sentidos atribuídos aos cuidados de saúde e à prevenção de DST/Aids em específico por jovens gays	Cunha RBB	Physis: Revista de Saúde Coletiva	2016
A20 (51)	Da (im)possibilidade do diálogo: conversações públicas e os direitos LGBTs	Moscheta MS	Psicologia & Sociedade	2016
A21 (35)	<i>Obstáculos y facilitadores para garantizar el derecho a la salud integral trans en el Gran Buenos Aires y La Plata</i>	Neer AF	<i>Revista Argentina de Salud Pública</i>	2016
A22 (22)	Unidades Básicas de Saúde em Teresina-PI e o acesso da população LGB: o que pensam os médicos?	Pereira EO	Tempus Actas de Saúde Coletiva	2017

it continues

Chart 1. Summary table of selected papers.

Code/ Ref.	Title	First Author	Journal	Year
A23 (25)	Assistência à saúde da população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários de Saúde?	Guimarães RCP	Tempus Actas de Saúde Coletiva	2017
A24 (37)	Vivências de travestis no acesso ao SUS	Ferreira BO	Physis: Revista de Saúde Coletiva	2017
A25 (36)	<i>Contemporalis homo sacer: obstáculos para acceder a los servicios de salud para las poblaciones trans</i>	Caravaca-Morera JÁ	Texto & Contexto – Enfermagem	2017
A26 (20)	<i>What lesbian, gay, bisexual, transgender, queer, and intersex patients say doctors should know and do: a qualitative study</i>	Alpert AB	<i>Journal of Homosexuality</i>	2017
A27 (21)	<i>Health care needs and care utilization among lesbian, gay, bisexual, and transgender populations in New Jersey</i>	Qureshi RI	<i>Journal of Homosexuality</i>	2017
A28 (43)	<i>Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa</i>	Müller A	<i>BMC International Health and Human Rights.</i>	2017
A29 (17)	<i>A qualitative study examining young adults' experiences of disclosure and nondisclosure of LGBTQ identity to health care providers</i>	Rossmann K	<i>Journal of Homosexuality</i>	2017
A30 (13)	<i>Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada</i>	Giblon R	<i>BMC Health Services Research</i>	2017
A31 (44)	<i>LGBTQ Youth's Perceptions of Primary Care</i>	Snyder BK	<i>Clinical Pediatrics</i>	2017
A32 (51)	<i>The importance of health(ism): A focus group study of lesbian, gay, bisexual, pansexual, queer and transgender individuals' understandings of health</i>	Graham K	<i>Journal of Health Psychology</i>	2017
A33 (11)	<i>Health for All? Sexual Orientation, Gender Identity, and the Implementation of the Right to Access to Health Care in South Africa</i>	Müller A	<i>Medical Education</i>	2017
A34 (12)	A Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais e Transgêneros (LGBT) e o acesso ao Processo Transexualizador no Sistema Único de Saúde (SUS): avanços e desafios	Popadiuk GS	Ciência & Saúde Coletiva	2017
A35 (39)	O que esperam pessoas trans do Sistema Único de Saúde?	Rocon PC	Interface - Comunicação, Saúde, Educação	2017
A36 (29)	<i>Disclosure of sexual orientation among women who have sex with women during gynecological care: a qualitative study in Brazil.</i>	Rufino AC	<i>The Journal of Sexual Medicine</i>	2018
A37 (32)	Práticas sexuais e cuidados em saúde de mulheres que fazem sexo com mulheres: 2013-2014	Rufino AC	Epidemiologia e Serviços de Saúde	2018
A38 (16)	<i>"Like finding a unicorn": healthcare preferences among lesbian, gay, and bisexual people in the United States</i>	Martos AJ	<i>Social Science &amp; Medicine</i>	2018
A39 (24)	Diversidade de gênero e acesso ao Sistema Único de Saúde	Ferreira BO	Revista Brasileira de Promoção da Saúde	2018
A40 (23)	Acesso de lésbicas, gays, bissexuais e travestis/ transexuais às Unidades Básicas de Saúde da Família	Oliveira GS	Revista Rene	2018
A41 (19)	<i>The no-go zone: a qualitative study of access to sexual and reproductive health services for sexual and gender minority adolescents in Southern Africa</i>	Müller A	<i>Reproductive Health</i>	2018

from 2015 to 2018. Regarding the language, 21 papers were in English, seventeen in Portuguese, and three in Spanish. About half of the works found were from PubMed and the rest from Lilacs and SciELO. The studies were developed in Brazil (16), United States (7), South Africa (5), Canada (4), New Zealand (2), Argentina (2), Portugal (1), Sweden (1), Colombia (1), India (1) and Germany (1).

The 41 works were published in 30 journals, sixteen of which were from the U.S., ten Brazilian, two Colombian, one Argentine and one Portuguese. Among Brazilian journals, *Ciência & Saúde Coletiva* had a higher frequency of papers (4), followed by *Physis* (2), *Interface* (2), *Cadernos de Saúde Pública* (2), *Tempus Actas* (2), and the remaining ones appeared with a single publication. In Brazil, this scientific production has found space in indexed journals of national circulation that stand out in the dissemination of social sciences and humanities in health studies. Almost all national publications were from journals rated A2, B1 or B2, in the area of collective health by the periodical evaluation system of the Coordination for the Improvement of Higher Education Personnel (Qualis/CAPES). Most foreign journals were rated A1, A2, and B2 for the same area of knowledge.

The professional background of the first authors of the papers was, mainly, in Psychology (12), Nursing (10), and Medicine (9). Four papers had a single author, and a large contingent of three or more authors, expressing strong interaction between different research centers and interdisciplinary dialogues.

Twenty-nine papers used a qualitative approach, nine were quantitative, and three were quantitative-qualitative studies. Previous reviews<sup>4,5</sup> also pointed out the predominant qualitative approach in studies on LGBTTT health, perhaps because they are more conducive to understanding complex issues, such as gender, sexuality, production of subjectivity and human rights relationships in the area of health. Many used techniques of content analysis or analyses based on hermeneutic-dialectic assumptions in the interpretative process. In quantitative publications, descriptive studies with sociodemographic and clinical information from LGBTTT populations prevailed.

As for the participants, the surveys include both LGBTTT groups and health professionals, especially doctors. Most of the studies use the recruitment of LGBTTT participants through convenience sampling, using the Snowball technique.

Noteworthy is the incorporation of participants through online recruitment or with the support of crucial informants from LGBTTT social movements. The main advantage of methods that use chains of reference is that, in complex, difficult access social networks, such as LGBTTT populations, it is easier for a group member to know another member than researchers to identify them.

Nineteen papers discuss LGBTTT populations as a single group, considering the nuances in their analysis. Twelve studies use only the categories transvestite, transsexual, or transgender man/woman or trans people. They discuss the biomedical conditions arising from the process of body transformation, such as the use of hormones, plastic surgery, silicone applications, and even sexual reassignment.

Nevertheless, these analyses transcend the hegemonic and pathological perspective, and the authors seek to unveil the challenges for health promotion, legal assurance of these processes, the strengthening of rights, recognition, and autonomy of these subjects in health services. Eight papers address the quality of health care for lesbians and bisexual women in public and private services. Exclusive gay men studies were found only in two publications, one national and the other international. No paper analyzed only the bisexual condition.

The theme has been concealed in the different studies, suggesting that bisexuality holds a vulnerable place socially, politically and scientifically, and is still perceived as “questionable” sexuality, which hinders the possibility of real inclusion of these subjects. A review of papers published in the United Kingdom also noticed the limited production concerning bisexuals<sup>5</sup>. Despite the importance of the topic, issues related to the health needs of adolescent and young LGBTTT were discussed in only three papers. In some studies (5), the researchers – gays, lesbians, and a trans man – explained, in the paper, their sexual orientation or gender identity.

### **Are the rights recognized to LGBTTT populations on the shelves of closets?**

Human rights are born as universal natural rights. They develop as positive private rights, to finally find their full fulfillment as universal positive rights<sup>8</sup>. In the revised papers, reflections on LGBTTT rights claim legitimacy in a set of normative documents, from the 1948 Universal Declaration of Human Rights to the 1994 International Conference on Population and Development

in Cairo. The 2007 Yogyakarta Principles – a document that synthesizes a set of principles for the application of international human rights legislation concerning sexual orientation and gender identity – were fundamental to guide States in adopting measures to protect LGBTTT populations. The analyses on access conditions and the quality of health care, in most cases, were included in these milestones<sup>11-14</sup>.

Removing homosexuality from the section of pathology was a relevant fact to address abuse, restrictions, and denials of rights to LGBTTT populations. However, the process of deconstructing the pathological perspective has been long and non-linear. The papers<sup>12-15</sup> mentioned the role of international normative frameworks when, in the mid-1970s, bodies such as the American Psychiatric Association and the American Psychological Association stopped classifying homosexuality as a disease and, in 1990, the World Health Organization followed the same path, removing it from the list of mental illnesses.

The approval of laws that prohibit crimes against sexual orientation and gender identity – such as U.S. Matthew Shepard Law and the law regulating LGBT marriage in Canada – are taken as examples of legal initiatives that enhance the enforcement of rights<sup>13,16,17</sup>. The papers discuss the case of South Africa, which, despite being surrounded by countries averse to LGBTTT rights, opened space for the consolidation of one of the most “progressive” laws in the world; its Constitution was the first to prohibit sexual, and gender discrimination and, currently also protects LGBTTT refugees, which is why it concentrates a large number of “sexual asylum seekers” of the continent<sup>11,18,19</sup>. In Portugal, the Gender Identity Law allows and assists body changes and modification of civil records since 2011, and is a reference for discussing LGBTTT rights<sup>14</sup>.

In discussing LGBTTT health care aspects, many papers<sup>17,20,21</sup>, mainly from the U.S., refer to documents such as protocols, technical manuals, conduct guidelines, recommendations, and others. Mostly, they point out gaps between the theoretical-logical models of policies and programs and the reality of clinical practice.

In the Brazilian scenario, many publications mention the 1988 Federal Constitution that established the universal right to health<sup>15,22,23</sup>, the 2004 “*Brasil sem Homofobia*” (Brazil without homophobia) program, and the 2008 First National Conference of LGBT Public Policies and Human Rights<sup>12,15,24</sup>. In the discussion on depathologization, Resolution 001/99 of the Federal Council of

Psychology, which prohibits psychologists from participating or proposing events and services that aim to “treat” and “cure” LGBTTT people<sup>15,23</sup>, is often cited. In the discussion about the transsexualizing process in the SUS, the landmark is Ordinance N° 2803/13, from the Ministry of Health, pointed out as a watershed in the perspective of health equity<sup>4,25</sup>. Ministerial Ordinance N° 2.836/11 that launched the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals is a reference for discussions on access and quality of health care for these populations<sup>12,23,24</sup>.

Studies show how historical and structural problems in health services and systems, linked to political, economic, and cultural contexts, affect the health production of individuals with multiple stigmatizations – by gender, skin color/ethnicity, socioeconomic status, among others<sup>11,16,26,27</sup>. In the Brazilian reality, despite the existence of health policies for LGBTTT populations, health managers face difficulties in operationalizing, monitoring, and evaluating them, and weaknesses are identified in the coordination and dialogue between representatives of the federal, state, and municipal governments<sup>12,23</sup>.

If national and international literature shows how normative and legal instruments are essential for the guarantee of LGBTTT rights, it also reveals that they are not sufficient for changes. For its actual effectiveness, other pacts that are not normative and legal and traverse circuits other than those macro-political and macro-institutional must be established. The political struggles that cross the authorities that design, implement and manage public policies are translated and re-enacted in the health services, in the corridors of the units, within offices, in meetings, and in the sociabilities that are woven there daily.

### **Dismantling the closets of access and quality of LGBTTT health care**

In this topic, we analyze the discussions in the literature on the conditions that influence access and quality of health care for LGBTTT populations. A vast national and international theoretical production has invested in categories and models of analysis for the study of access and quality in health, under varied perspectives, ranging from normative evaluative to more sociological studies. Without intending to delve into more technical issues in the area of health assessment, in this review, the themes and discussions found in the papers were organized into three main dimen-

sions: relational, which concerns inter-subjective relationships between users and health professionals; organizational, which refers to strategies for organizing services and work processes; and, finally, contextual, which shows how different issues of vulnerability affect health situations. The distinction between these dimensions is merely to operationalize the analysis; in publications – as well as in real-life interaction flows – they are complex and interwoven.

### **The relational dimension**

In the dimension called here “relational”, the relationships between LGBTTT people and health professionals were identified as a central condition to the quality of care, like reception, which implies building bonds, respect, non-discrimination, and non-judgment, that is, the practice of a clinic committed to citizenship<sup>25,28</sup>, depends on them.

The literature on conditions of access to health services shows that a good user-professional relationship requires active and qualified listening<sup>1,3</sup>. In the reviewed papers, this qualification of the relationship was pointed out as a condition for the disclosure of sexual orientation or gender identity in health services – an indispensable condition for resolute care and the establishment of care lines<sup>22,29</sup>. The LGBTTT populations showed different concerns regarding whether or not to reveal themselves to health professionals<sup>29-31</sup>.

Research with lesbians in São Paulo showed that the main barrier in the search for health services is related to the fear of revealing their sexual orientation and homoerotic practices, and the expectation of suffering prejudice<sup>30</sup>. In a study carried out in Germany with 766 lesbians, only 40% revealed their sexual orientation to health professionals, although 89% of them had a referral doctor for PHC<sup>31</sup>. Non-disclosure can make lesbian more vulnerable to sexually transmitted infections (STIs) and AIDS, because, despite their varied sexual practices, they hardly use condoms<sup>32</sup>.

In South Africa, LGBTTT populations described experiences of disrespect by health professionals or administrators, when revealing sexual orientation or gender identity in health services, with scenes of verbal and sexual harassment<sup>19,20</sup>. In expressing their desire for pregnancy, lesbian in New Zealand felt harassed through pejorative reactions by health professionals<sup>33</sup>. Another study showed that users who revealed themselves were 2.5 times more likely to suffer prejudice<sup>34</sup>.

The disclosure of sexual orientation or gender identity can cause embarrassment in health professionals who are barely sensitized or trained to serve these populations. Research<sup>29,33</sup> showed that after the verbalization of LGBTTT identity, users realized that the professionals became uncomfortable, with a rapid change of subject, not knowing how to continue the communication, or else, incredulous at the revelation of sexual orientation or gender identity. In the visits, some users also noted inadequate curiosity from health professionals, where issues and details of sexual practices were questioned, without these concerns being relevant to the historical revival, diagnosis, or treatment in health<sup>19,20</sup>. They also highlighted that the professionals’ religious beliefs, when imposed, weakened the bond<sup>18,22</sup>.

The violation of information confidentiality in LGBTTT health care was a topic widely addressed in the investigated literature and other reviews<sup>4,5</sup>. Users reported that their sexual orientation or gender identity was shared with other professionals, indiscriminately and unnecessarily, as well as with other people in the community<sup>35,36</sup>. In the U.S., users reported fear that their information would be passed on to health insurers, and higher fees would be charged, associating LGBTTT identity with the risk of contracting HIV<sup>17</sup>. Canadian trans people had difficulties in adhering to health insurance, being on separate lists waiting for more than a year to take out insurance<sup>13</sup>.

### **The organizational dimension**

How the services are organized, the work processes and the effects concerning access and quality of health care for LGBTTT populations have been debated in the literature. The inadequate reception was evidenced in several situations, such as the non-recognition of the social name in the medical records and the communications at the counters, in the waiting rooms and the offices, reported by Brazilian transvestites<sup>37-39</sup> the routine dispensing of male condoms to lesbian, without considering their sexual practices<sup>40</sup>; the confusion between transsexuality and homosexuality<sup>15</sup>; exposing LGBTTT teenagers to vexatious situations or breach of privacy before parents or guardians<sup>20,41</sup>.

The heteronormative organizational logic and its effects on the work and communication processes in health services were perceived by the subjects participating in the reviewed studies, as well as they were highlighted in other previous reviews<sup>4,5</sup>. In the ambiance of the services, espe-



cially in the waiting rooms, users highlighted the lack of activities and informative and educational resources – posters, leaflets, booklets, lectures – regarding the health of LGBTT populations<sup>12,42-44</sup>. The creation of a favorable environment for these populations in services requires, among other things, the institutional promotion of educational processes that include respect for sexual and gender diversity and fosters a culture of valuing human rights. Thus, some essential weaknesses are identified in health institutions regarding this educational role<sup>23</sup>. One work showed that the educational materials used in the services had a very technical language, not LGBTT-friendly, which did not come close to the communities' dialects and slang<sup>33</sup>. LGBTT people also realized that they were being judged by workers in the cleaning, security, and administration services of health institutions, due to their way of speaking, their clothing, or ways of expressing themselves<sup>24</sup>. Others reported that they felt rejected by other users of services in the waiting room<sup>23</sup>. In several works<sup>18,43</sup>, users suggested carrying out educational actions for managers, administrators, health professionals, and others working in support services, as well as for the community in general, in order to demystify historically constructed concepts – which could have positive effects on both the relational and organizational dimensions.

The transformation of work processes in health institutions requires professionals to be more sensitive and understand the rights and specificities of care to LGBTT populations, especially transgender people<sup>12</sup>. In the United States, LGBTT populations in rural areas report difficulties in finding available and trained health providers<sup>27</sup>. In Portugal, these populations were better assisted by professionals who had LGBTT relatives, indicating a sensitivity generated from the systemic experience itself<sup>14</sup>.

Besides its pedagogical dimension, permanent education – capacity building and training, the most discussed modalities in the literature – focused on LGBTT health was mentioned as an essential strategy for changing the operational logic of services<sup>23,44</sup>. Initiatives promoting this debate, such as that of the Association of American Medical Colleges, which has made videos, guides, and informative manuals available to health professionals, were discussed<sup>17</sup>. Likewise, initiatives by the Ministry of Health of Brazil were discussed, which, in partnerships with public universities, have promoted courses and training on the LGBTT theme, in the distance mo-

dality<sup>22,25</sup>. The inclusion of the issue of LGBTT rights in academic education was another theme highlighted. Health professionals interviewed pointed out weaknesses in the teaching offered at colleges; considered that the curricular contents referring to LGBTT health convey an exclusively technical and biomedical conception, focusing on STIs and associated risks<sup>12,25,31</sup>.

The meanings assigned to the needs and health care of LGBTT populations are immersed in a continuous network of confrontations, negotiations, legitimations, and transformations, which can bring these subjects closer to or move them away from services, and that is why a broader and permanent discussion on the training devices and in-service education processes is necessary.

### The contextual dimension

In a series of studies, situations of vulnerability and social determinants that affect the conditions of satisfaction of the health needs of LGBTT populations are discussed. The ideas of vulnerability and social determination in health refer to the intertwining of material, psychological, cultural, moral, legal and political conditions that strip rights, autonomy, recognition, and participation from people in varying degrees, exposing them to situations of illness and exclude them from the resources available to health<sup>41-48</sup>. What is called the LGBTT universe here is a heterogeneous cluster of people, who are distinguished not only by their sexual or gender identities but by class, skin color/ethnicity, origin, and other markers.

The situations of poverty, violence, discrimination, and stigmatization are essential components of contexts that make vulnerable and precarious the health conditions of LGBTT people, although not always in the same way<sup>15,26</sup>. Some studies have shown that immigrants, indigenous people, people deprived of their liberty, blacks, and rural residents suffer even more pronounced vulnerabilities in their attempt to access health services<sup>27,43</sup>.

A study with the LGBTT populations of New Jersey showed that, among the difficulties of access to health services, is the cost of private insurance<sup>21</sup>. In the Brazilian and South African realities, LGBTT populations in situations of poverty face weaknesses in accessing health services and actions due to the difficulty, for example, of paying for transportation to travel to health units<sup>11,28</sup>. In the case of trans people, in an attempt to become intelligible, the scarcity or lack of provision

of specific technologies and specialized procedures in public services causes them, many times, to undergo the processes of forging their bodies in clandestine, unsafe services and end up experiencing near-death experiences constantly<sup>37-39</sup>.

LGBTT-phobia, a term that denotes discrimination and the most varied forms of violence suffered by LGBTT populations, extends and reproduces in the chain of events ranging from abuse and battering within families, on the streets or at work, and even the institutions where they seek support, such as police stations and health services<sup>16</sup>. Trans people, a group for which the search for health services is often associated with these events, reported the non-purposeful use of the social name, teasing, and vexing games in emergency rooms<sup>12,14,19</sup>. Institutional violence generates mistrust of professionals, hinders bonds, and produces the stance of avoiding health services in other situations<sup>38</sup>.

Another aspect discussed is how discrimination and violence condition access and the quality of health care, and are also factors of illness. These situations are associated with anxiety, depression, suicide attempts, abuse of psychoactive substances, and must be considered by health services<sup>17,47</sup>.

With the AIDS epidemic, homosexuality and other sexualities and genders diverging from the norm became perverse to illness, transforming one's sexual identity into a synonym for AIDS. Some papers discussed how the dual stigma – transgressing heteronormativity and AIDS – in their various crossings, also traversed health services in Latin America<sup>48</sup>, Canada<sup>49</sup>, and the United States<sup>25</sup>, operating in both primary and specialized care. In India, with the increased HIV incidence among transgender people, this dual stigmatization has been further reinforced<sup>47</sup>. An Argentine study showed another way of stigma: users assessed transgender health professionals as HIV-infected, pedophiles or sex offenders, unethical or not very competent in their profession<sup>50</sup>.

The recognition and protection of human rights are the supporting pillars of democracy<sup>8</sup>. In the reviewed publications, the importance of LGBTT activism was discussed in the struggles for human rights in the health field and, therefore, in the struggles to transform positively the very contextual conditions and intrinsic to the services and professional practices that influence access and quality of LGBTT health care<sup>45,46,51</sup>.

## Final considerations

The instituting imaginary of society is not a mere mental image of something. It is an unceasing “social-historical and psychic” creation of ways of relating, acting, and thinking that produce realities and rationalities<sup>7</sup>. National and international literature shows us how the imaginary that created heteronormativity has permeated, especially, practices in health services – whether in waiting rooms or inside offices – and affected the conditions of access and quality of health care for LGBTT populations. People whose gender identity and sexual orientation are different from what sexual binarism proposes are subject to prejudice, violence, and discrimination, which, added to class, skin color/ethnicity and origin markers, generate a context of vulnerabilities in the health field.

Advances in human rights laws, norms, policies, and programs, and especially concerning the health of LGBTT people, are recognized. However, besides these essential regulatory frameworks, there is a need to think about strategies for transforming practices and face-to-face interactions that occur in the interstices and the daily lives of health services. Otherwise, there is a growing risk that LGBTT populations will be increasingly removed from these institutions. Legal regulations are only realized when translated into local dynamics, that is, incorporated and shared by managers, professionals, and users of the services.

It is necessary to link, within the same principle of justice, the space for the recognition of gender injustices (social and cultural field) and the space for inequalities linked to the exploitation and redistribution of resources (economic field)<sup>52</sup>. This perspective imposes the reflection that the barriers faced by LGBTT populations in health services are the product of the devaluation or lack of recognition of their identities that, in a circular logic, produce or enhance restrictions regarding access to social goods and resources, including health care.

The fact of whether or not to reveal themselves to be LGBTT in interactions with health services emerged in the literature as a matter of high relevance in the health production processes of LGBTT populations. We could ask ourselves here about the “place of speech”<sup>53</sup> of sex-gender dissidents and the power hierarchies established in the field of health. The word “place” comes in handy. We can derive from the literature that

health services have been extensions – drawers and shelves – of that invisibility and denial that has been referred to with the closet metaphor. Therefore, revealing oneself is an unavoidable part of the break with this logic. It is an operation necessary to open the “lockers”, so that LGBTT people’s rights are recognized, accessed, and realized.

### **Collaborations**

BO Ferreira and C Bonan contributed equally to all stages of the construction of the manuscript.

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