"May I Help?": Care for the LGBT Population at a Basic Health Unit in in Rio de Janeiro from the Community Health Agents' Perspective

"Posso Ajudar?": O Cuidado à População LGBT de uma Unidade Básica de Saúde do Rio de Janeiro na Perspectiva dos Agentes Comunitários de Saúde

"¿Puedo Ayudar?": El Cuidado a la Población LGBT de una Unidad Básica de Salud de Rio de Janeiro Desde la Perspectiva de los Agentes Comunitarios de Salud

RESUMO
A Atenção Primária à Saúde é a principal porta de entrada dos usuários ao Sistema Único de Saúde e deve ser pautada, dentre alguns princípios, pela equidade, tendo em vista as barreiras encontradas por determinados grupos, como a população LGBT (Lésbicas, Gays, Bissexuais, Travestis e Transexuais). A partir disso, este estudo objetivou avaliar estratégias de acolhimento à população LGBT e verificar o nível de conhecimento de questões de saúde LGBT de um grupo de Agentes Comunitários de Saúde (ACS) de uma Unidade Básica de Saúde do município do Rio de Janeiro. Trata-se de estudo transversal realizado em 2023 com 31 ACS a partir de questionários semiestruturados respondidos presencialmente. Evidenciou-se que a maioria (54,8%) não aborda questões de gênero e sexualidade no cotidiano de trabalho, 87,1% nunca teve capacitações sobre a temática e a maioria (77,4%) acredita que treinamentos poderiam contribuir para a melhoria do acolhimento dos ACS.
DESCRITORES: Agente Comunitário de Saúde. LGBT. Atenção Primária à Saúde. Acesso.

ABSTRACT
Primary Health Care is the main gateway for users to the Unified Health System and should be guided, among some principles, by equity, given the barriers faced by certain groups, such as the LGBT population (Lesbians, Gays, Bisexuals, Transvestites and Transgenders). Based on this, this study aimed to evaluate strategies for welcoming the LGBT population and to verify the level of knowledge of LGBT health issues of a group of Community Health Agents (CHAs) from a Basic Health Unit in the city of Rio de Janeiro. This is a cross-sectional study carried out in 2023 with 31 CHA based on semi-structured questionnaires answered personally. It was evident that the majority (54.8%) do not address gender and sexuality issues in everyday work, 87.1% have never received training on the subject and the majority (77.4%) believe that training will contribute to improving the reception of CHAs.
DESCRIPTORS: Community Health Agent. LGBT. Primary Health Care. Access.

RESUMEN
La Atención Primaria de Salud es la principal puerta de entrada de los usuarios al Sistema Único de Salud y debe basarse, entre algunos principios, en la equidad, considerando las barreras encontradas por determinados grupos, como la población LGBT (Lesbianas, Gays, Bisexuales, Travestis y Transexuales). A partir de ello, este estudio tuvo como objetivo evaluar estrategias de acogida a la población LGBT y verificar el nivel de conocimiento sobre cuestiones de salud LGBT de un grupo de Agentes Comunitarios de Salud (ACS) de una Unidad Básica de Salud del municipio de Rio de Janeiro. Se trata de un estudio transversal realizado en 2023 con 31 ACS a partir de cuestionarios semiestructurados respondidos presencialmente. Se evidenció que la mayoría (54,8%) no aborda cuestiones de género y sexualidad en su rutina laboral, el 87,1% nunca recibió capacitaciones sobre la temática y la mayoría (77,4%) considera que los entrenamientos podrían contribuir a mejorar la acogida realizada por los ACS.
DESCRIPTORES: Agente Comunitario de Salud. LGBT. Atención Primaria de Salud. Acceso.

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INTRODUCTION

Based on an understanding of gender and sexual diversity markers as social determinants of health and disease, the Ministry of Health instituted the National Policy for Comprehensive LGBT Health (PNSILGBT) (a term that will be used throughout the text and refers to the groups of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals) in 2013, as an attempt to repair the history of neglect of this population and respond to the demands of social movements[1].

Although the PNSILGBT does not include organizational specifications within the levels of health care in its scope, it is considered an important milestone for states and municipalities to begin their work processes focused on this group, especially in Primary Health Care (PHC), as the preferred gateway to the Unified Health System (SUS)[2,3].

According to the provisions of the National Primary Care Policy[4,5], municipalities that use the Family Health Strategy (ESF) model to guide the PHC work process will have as minimum team components a nurse, doctor, nursing technician or assistant, dental surgeon, oral health technician or assistant, and Community Health Agents (ACS).

The professional category of CHWs under the ESF model was established in 2002[6] and, in practice, CHWs act as a link between the community and the health service, performing functions of health promotion, disease prevention, surveillance, and support in monitoring families in their territory, developing activities through individual, family, and community approaches[7,8] .

Given their relevance in the social and dynamic context of the territory, CHWs play a fundamental role in guaranteeing the rights and engagement of the population, becoming a strategic figure in the provision of services and in the dialogue with users in order to resolve their demands[8].

Thus, considering the daily work routine in which CHWs need to have direct contact with users during registration and throughout their use of the FHS, it is important to reflect on the preparation of these professionals regarding the comprehensiveness and specificities that the LGBT population may demand of them[9] .

There are few studies that seek to identify the perspective of CHWs in this context of the demands of the LGBT population, and this study contributes to revealing the perception of these professionals who are so necessary in the construction of the ESF, PHC, and SUS.

Based on this introduction, this research aims to: evaluate strategies for welcoming the LGBT population by a group of CHWs from an ESF unit in the municipality of Rio de Janeiro (RJ) and verify the level of knowledge about health issues relevant to the LGBT population by a group of CHWs from an ESF unit in the municipality of Rio de Janeiro.

METHODOLOGY

This is a cross-sectional, descriptive, and exploratory study that took place in October 2023 at a UBS with six ESF teams, located in Rio de Janeiro.

The inclusion criteria were: being an ACS in the same team for at least 6 months and agreeing to participate in the research by signing the Free and Informed Consent Form (FICF). There were no exclusion criteria, except for

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withdrawal from participation at any time during the interview.

After accepting participation, the TCLE was made available and signed by both parties in two copies (one for the interviewee, the other for the interviewer), and data collection took place through face-to-face interviews. A semi-structured questionnaire containing 16 objective questions and two open questions prepared by the researchers was used.

The objective questions were designed to outline a brief sociodemographic profile of the participants and measure their level of knowledge about some issues related to the acceptance and health of the LGBT population, while the open-ended questions focused on qualitative aspects of acceptance, the central issue of this research.

The interviews took place at the workplace in a private room chosen in advance at a pre-scheduled time and date, favoring a comfortable and safe environment. The interviews lasted an average of 20 minutes.

The data were grouped into tables and charts and analyzed and divided in order to support the discussion.

Tables 1, 2, and 3 present the variables collected and their respective prevalence (n) and proportional percentage (%).

The participants were 31 CHWs from a ESF unit of the MRJ. Of the 31 eligible CHWs, all participated in the study.

Based on their responses, we sought to group the results into categories that made sense in order to structure a discussion, and the excerpts from the narrative presented were cataloged using the codes CHW1, CHW2, CHW3... up to CHW31 for the purposes of a brief content analysis and also to ensure the privacy of the participants.

The research was conducted in accordance with the Research Ethics Committee (CEP) of the Municipal Health Secretariat of NN, in compliance with the ethical principles of the National Health Council, approved with the Certificate of Ethical Appraisal (CAAE) No. 71740823.0.0000.5279 and opinion No. 6,284,025.

RESULTS AND DISCUSSION

Table 1 shows the sociodemographic characteristics of the sample of community agents who participated in the interview.

Table 1. Sociodemographic profile of participants (N=31)

Variables	n	%
Gender		
Female	27	87,1
Male	4	12,9
Sexual orientation		
Heterosexual	31	100
Homosexual	0	-
Other	0	-
Age		
18 to 25 years old	1	3,2
26 to 35	7	22,6
35 to 45 years old	8	25,8
46 to 55 years old	13	41,9
56 to 65 years old	2	6,5
Religion		
Catholic	17	54,8
Christian	1	3,2
Evangelical	12	38,8
Other	1	3,2
Length of service at UBS		
6 months to 1 year	1	3,2
1 to 3 years	10	32,3
3 to 5 years	2	6,5
5 to 10 years	9	29
> 10 years	9	29
Education		
High school graduate	20	64,5
Incomplete higher education	2	6,5
Complete higher education	9	29

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Among the interviewees, 27 were women (87.1%) and 4 were men (12.9%), the majority (67.7%) were between 35 and 55 years old, had completed secondary education (64.5%) and declared themselves to be Catholic (54.8%) and heterosexual (100%). Regarding the length of service at the UBS, the majority (58%) had more than 5 years of experience as CHWs.

No national surveys were found that surveyed the sociodemographic profile of CHWs; however, the predominance of females, the age group of prevalence, and the long time in the role are corroborated by data found in other studies[10,11] .

It is important to note that all CHWs were heterosexual, meaning there were no LGBT CHWs in the category, which could be a facilitator in representation among peers, and the majority were Catholic, a religion with ideals and beliefs that clash with LGBT experiences, creating an atmosphere of judgment and prejudice and consequent alienation of users from these professionals due to feelings of rejection and unwelcome[12]

Table 2 shows the results regarding prior knowledge about sexual diversity.

Table 2. Prior knowledge about sexual diversity (N=31)

Variables	n	%
Are you familiar with the acronym LGBT?		
Yes	18	58
No	13	42
Can you identify which group each letter of the acronym LGBT belongs to?		
Yes	1	3,2
No	29	93,6
Did not want to answer	1	3,2
Have you had any previous contact with the topic of sexual diversity?		
Yes	11	35,5
No	20	64,5
Do you know the difference between gender identity and sexual orientation?		
Yes	25	80,7
No	6	19,3
Are you familiar with PNSILGBT?		
Yes	6	19,3
No	25	80,7
Did you participate in training or technical guidance related to the policy addressed?		
Yes	4	12,9
No	27	87,1

Although most participants (58%) stated that they were familiar with the acronym LGBT, 29 CHWs (93.1%) were unable to explain which groups each letter of the acronym referred to. Despite the fact that most (64.5%) had never had any previous contact with this topic, a large proportion (80.7%) stated that they knew how to differentiate between gender identity and sexual orientation. Regarding the PNSILGBT, 80.7% of participants were not familiar with it, and 87.1% had never participated in any training or received guidance on this policy.

The discussion of sexual diversity has gained prominence over the last few decades, both due to the achievements of social movements, which have resulted in intersectoral public policies and social advances, and due to the dissemination of information about the multiplicity of these expressions, especially in recent years with the expansion of the internet and social media[13].

However, even with the popularization of these discussions, it is essential to offer periodic training so that not only CHWs, but all professionals can qualify to meet the specific needs of these users within their scope of practice[14].

The lack of training on this topic also appears in other studies that have identified that most professionals feel unprepared to serve the LGBT population[13,14] which may explain the complaints of these users and, consequently, their low access and connection to teams for reasons that could be solved through simple technologies such as an appropriate approach, welcoming attitude, and training[15,16].

In addition, it is necessary to reflect on the absence of a line of care for the LGBT population in health departments, which could bring organizational elements and support the structuring of improvements, stimulating these activities in the units, giving visibility and generating a culture

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of importance for professionals, who end up valuing other more conventional lines of care to the detriment of discussions that address the needs of LGBT users[16].

This scenario seems contradictory, given that the PNSILGBT has been in place for over a decade since its creation and little has been seen in terms of concrete and widespread developments in services, especially with regard to its objectives of developing intersectoral actions for continuing education on this topic in the SUS[2] . In other words, the creation of a policy without a decentralized management logic does not mean progress in guaranteeing this right in everyday life.

Table 3 shows data on the applicability of the theme of sexual diversity in the daily work of CHWs.

Table 3. Applicability of the theme of sexual diversity in daily work (N=31)

Variables	n	%
Do you address sexual orientation when filling out the identification form?		
Yes, always	12	38,8
They do not address it out of embarrassment	1	3,2
They don't bring it up because they find it uncomfortable	6	19,3
Do not address it because they find the question invasive	10	32,3
Never thought about the importance	1	3,2
Never received guidance to ask this question	1	3,2
Do you know any LGBT users in the area?		
Yes, and this information is included in the registry	13	41,9
Yes, but this information is not included in the registry	11	35,5
No	7	22,6
Are you aware of any measures or initiatives that support this population?		
Yes	2	6,4
No	28	90,4
Did not know how to answer	1	3,2
Do you consider it necessary to carry out actions to promote the health of the LGBT population at the unit?		
Yes	24	77,4
No	7	22,6

When asked about the approach to sexual orientation during user registration, the majority (54.8%) stated that they did not ask this question for reasons such as embarrassment or because they found it uncomfortable and invasive. This behavior was also observed in the discrepancy between users who declared themselves to be LGBT, but whose gender identity or sexual orientation was not included in their registration (35.5%), while less than half (41.9%) reported that their LGBT users' registrations contained their actual information. Another way of looking at this information is that 24 participants (77.4%) were aware of these users, and 7 participants (22.6%) reported not being aware of any LGBT users in their territory.

This feeling of discomfort when addressing issues inherent to sexual diversity is part of a structure that is based on a heteronormative standard, that is, where the norm is the adoption of heterosexual relationships, which creates a barrier in the process of bonding professionals who believe that such expressions of affection are wrong or inappropriate[14].

Unfortunately, in Brazil, it is culturally taboo to discuss issues related to sexuality in general, even within heterosexuality, which is greatly reinforced by structural machismo and sexism in society[16].

With regard to the presence of LGBT people in the country, despite the intrinsic issues surrounding the assumption of their gender identities and sexual orientations, epidemiology shows that, according to data from the National Health Survey (PNS) conducted by the Brazilian Institute of Geography and Statistics (IBGE), in 2019 there were approximately 159.2 million Brazilians over the age of 18, and of this sample, 94.8% declared themselves to be heterosexual, 1.2% homosexual (with a higher prevalence among men), 0.7% as

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bisexual (with a higher prevalence among women), 0.1% declared another sexual orientation (such as asexual, pansexual, among others), and 3.4% of participants did not know or did not want to answer. When added together, the groups that self-identified as "non-heterosexual" represent 1.9% of the population, equivalent to more than 3 million Brazilians[17].

In other words, these users exist and are present throughout the national territory; however, it is necessary for CHWs to proceed with the accuracy of the questions on the registration form, filling it out in its entirety so that real data aligns with national findings.

Corroborating their perception of the low availability of devices and initiatives to promote the health of this population in the network (6.4%), 24 participants (77.4%) believe that actions to promote the health of this population are necessary.

In the organizational logic of the Health Care Network, Primary Health Care, seen as the first level of care and the organizer of care, is responsible for being one of the gateways to health for individuals, families, and communities in the SUS[4,5] .

However, the literature has pointed out that this gateway may be "selectively stuck and rusty" for some population groups, such as the LGBT population, which encounters barriers and difficulties in access, such as disrespect, delegitimization of their demands, and perpetuation of social stigmas and stereotypes that end up alienating these people from this level of care[18].

Historically, this population has remained (and remains?) poorly and inadequately served, which weakens their experience of illness and increases their social vulnerability to health issues. it is no wonder that these people have higher rates of suffering and mental illness, suicidal behavior, as well as greater complications from chronic diseases, since they have little connection to healthcare teams for fear of institutional violence[16,19].

Looking more specifically, it is unfortunate and necessary to point out that Brazil has been the country that has killed the most transgender people worldwide for over 10 years in a systematic manner, which alludes to the many forms of violence that transgender and LGBT people suffer in their daily lives, bothliterally and symbolically.

Therefore, it is urgent to rethink a qualified service network that can strengthen intersectoral initiatives to promote and guarantee the rights of this population, seeking to expand these citizens' access to SUS health services and restoring PHC's leading role in this context[18,21].

In order to substantiate a discussion based on the responses captured by the open-ended questions in the questionnaire that dealt with the main demands of the LGBT population in the service and what reception strategies the participants used for this population, two thematic islands of debate were formed: 1) What does the LGBT population demand from the perspective of the CHW? and 2) What strategies does the CHW use in welcoming the LGBT population?

1) What does the LGBT population demand from the perspective of the ACS?

The most common requests were about STIs and mental health issues. This response profile corroborates findings in other studies[14-16], but it is possible to consider an already established narrative in the collective, which permeates a socially constructed stereotype that associates LGBT people with promiscuity, especially gay men[13,18], which leads professionals and CHWs, who usually occupy the spaces where users are welcomed and received, to relate complaints to possible outcomes involving contexts of sexual exposure and associating them with the image of potential HIV carriers[13,18].

In general, the mere assumption that someone seeking care is more likely to have a sexually transmitted infection (STI) because they are LGBT is in itself a manifestation of prejudice on the part of health professionals and hinders a comprehensive view of other care needs[15] .

Prejudiced and discriminatory attitudes not only distance users from PHC, but also limit their relationships and possibilities with the network, impacting their resources for resolving their demands in general[20] . To make matters worse, it overshadows the agenda of people living with HIV (PLHIV) or those who discover some other STI, accentuating the stigma and intolerance of professionals, impacting their follow-up and quality of life[17].

Another reason for seeking care was mental health issues, which makes sense if we consider the context of denial of rights and social exclusion experienced by a large part of the LGBT population[12] .

The literature points out that the adversities experienced by these people begin in childhood and adolescence with family rejection, attempts at healing through religious methods, and school dropout, and such difficulties become predisposing factors for self-abusive and suicidal behaviors due to the potential damage to these people's mental health[19, 22] .

Taking into account the potential for prevention and early detection of diseases in PHC, this data is also important to reinforce the need for professionals to be attentive, especially CHWs, who are present in the territory on a daily basis and are able to gain early knowledge of cases.

In relation to this discussion, it is important to note that the demands of LGBT users may indeed be related to sexual issues, as is the case with oth-

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er users. The key point is the burden attributed by professionals to the restricted exclusivity of these demands to the LGBT population, which ends up being directly related to mental illness, which arises as a symptom of discriminatory and exclusionary experiences [21,22] .

It is therefore worth mentioning that CHWs who adopt attitudes that contribute to this scenario of omission and denial of rights contribute in some way to the perpetuation of this segregating structure, which runs counter to the guiding principles of comprehensiveness, universality, and, above all, equity advocated by public health policies[4,5]. It is necessary for them to be attentive to this care, devising welcoming and humanized strategies, which brings us to our next discussion.

2) What strategies do CHWs use in welcoming the LGBT population?

There was no consensus on the answers to this question; however, 23 CHWs (90.3%) responded that they treated everyone "equally." This response also appears in other studies[16-18] .

The issue with this "equal" treatment is precisely the loss of uniqueness that permeates the view of demands in light of the equity that should guide the care needed for each population group, depending on which criteria are being used for this analysis. With regard to issues of sexual diversity, what is demanded is almost always not just procedures and medications but respectful interpersonal treatment that encompasses the specificities of dissident existences.

Thinking about welcoming strategies means recognizing that these people have less access to health services and that when they do access them, they suffer institutional violence due to the disrespect of basic rights such as social name and invalidation of their demands, contributing to a higher prevalence of self-medication or treatments based on the internet or friends, delaying the search for care, aggravating health problems, and favoring the worsening and emergence of cases[13,14,22].

Among the (few) strategies that appeared are "*appointment scheduling*" (ACS27) and "*service provision*" (ACS7).

Understanding that most believe that treating everyone equally is sufficient to provide access, it makes sense for participants to think of actions that are usual in the work process, such as offering services and scheduling appointments, which are the rights of all users, but which are not generally considered to be differentiated ways of attracting these populations.

For example, when considering strategies for attracting groups such as pregnant women and children, among other lines of care, actions such as collective groups and activities in units and facilities in the territory seem to be effective for this purpose[15]. It seems unusual to think of strategies that go beyond everyday life to increase supply and provide access for the LGBT population.

FINAL CONSIDERATIONS

This study aimed to evaluate strategies for welcoming the LGBT population by a group of CHWs from an FHS unit in the municipality of Rio de Janeiro and to verify the level of knowledge about health issues relevant to the LGBT population by a group of CHWs from an FHS unit in the municipality of Rio de Janeiro.

The main limitations are the lack of data on LGBT youth and the universalization of the concept of homosexuals, which, in this study, referred to gays and lesbians.

Participants recognize that aspects such as lack of training and capacity building impact their knowledge about issues related to sexual diversity and the quality of care they provide to the LGBT population.

It was evident that stigma and prejudice still permeate the lives of these users and that this also seems to extend to the approach of the ACS, due to issues such as lack of preparation and insecurity in dealing with these people.

It is urgent that this issue be included in the planning agendas of government departments, with a view to establishing flows that meet the specific needs of this group, strengthening the appreciation of these demands by professionals, since there are no specific and standardized lines of care in health services to support them, emphasizing the need for continuing education as a tool for professional development.

We suggest further research addressing this nuance of care by CHWs, given its importance and relevance in territorial care in PHC, seeking to identify gaps that can guide future improvements in the actions provided for in their scope of work.

The ESF needs to occupy its prominent place in the on-site care of these people, providing humane and sensitive assistance, where the CHW is a reference professional for all its users, materializing a comprehensive and equitable SUS for everyone.

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REFERENCES

1. Silva ATC, Rosa CAP, Gagliotti DAM. LGBTQIA+fobia institucional na área da saúde. In: CIASCA, Saulo Vito et al. Saúde LGBTQIA+ Práticas de cuidado transdisciplinar. São Paulo: Manole. 2021; 328-347.

2. Brasil. Ministério da Saúde. Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais. Brasília, 2013.

3. Organização Pan-Americana da Saúde. A atenção à saúde coordenada pela APS: construindo as redes de atenção no SUS: contribuições para o debate. 2011.

4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: DF, 2012.

5. Brasil. Ministério da Saúde. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília, DF: Ministério da Saúde, 2017.

6. Brasil. Ministério da Saúde. Secretaria Executiva. Programa Agentes Comunitários de Saúde-PACS. Brasília: DF, 2001.

7. Costa SM, Araujo FF, Martins MV, Nobre LLR, Araújo FM, Rodrigues CAQ. Agente Comunitário de Saúde: elemento nuclear das ações em saúde. Ciência & Saúde Coletiva, 2013, 18(7):2147-2156.

8. Nunes MO, Trad LB, Almeida BA, Homem CR, Melo MCIC. O agente comunitário de saúde: construção da identidade desse personagem híbrido e polifônico. Cadernos de Saúde Pública, 2002, 18(6):1639-1646.

9. Silva RAC, Braga ST, Pinheiro WR. O atendimento dos agentes comunitários de saúde em relação as pessoas LGBTQIA+ na Atenção Básica: uma revisão integrativa de literatura. Revista de Casos e Consultoria, 2023, 14(1) e29183.

10. Durão AVRD. Relações de gênero e a formação das agentes comunitárias de saúde no município do Rio de Janeiro. TrabalhoNecessário, 2016, 14(23).

11. Cabral JFC, Gleriano JS, Nascimento JDM. Perfil sociodemográfico e formação profissional de agentes comunitários de saúde. Revista Interdisciplinar de Estudos em Saúde da UNIARP, 2019, V9(18).

12. Oliveira GS, Alves CG, Lima HC de, Oliveira AAS. Homossexualidade, família e religião: uma análise psicossocial de orações para Bobby. Psicol Estud, 2024;29:e54500.

13. Brandão BA. Cuidado à população LGBT: iniciativas das equipes da atenção primária em saúde no município do Rio de Janeiro [dissertação de mestrado] Escola Nacional de Saúde Pública, 2020. 128 f.

14. Lopes R, Cardoso GCP, Amorim TR, Santos JB. Avaliação do acesso ao acolhimento à população LGBTQIA+ por parte dos profissionais de saúde de um Centro Municipal de Saúde no Rio de Janeiro. saúde debate | Rio de Janeiro, 2023, 47e(1), e9045.

15. Costa-Val A, Manganelli MS, Moraes VMF, Cano-Prais HA, Ribeiro GMR. O cuidado da população LGBT na perspectiva de profissionais da Atenção Primária à Saúde. Physis: Revista de Saúde Coletiva, 2022, 32(2), e320207.

16. Guimarães RCP, Cavadinha ET, Mendonça AVMA, Sousa MF. Assistência à saúde da população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários de Saúde? Tempus, actas de saúde colet, Brasília, 2017, 11(1), 121-139.

17. IBGE. Pesquisa nacional de saúde: 2019: orientação sexual autoidentificada da população adulta. Coordenação de Pesquisas por Amostra de Domicílios. - Rio de Janeiro: IBGE, 2022. 24 p.

18. Reis AAR, Carvalho HR. A Atenção Primária à Saúde no Brasil e a população LGBTI+: uma revisão integrativa. saúde debate | Rio de Janeiro, 2023, 47e(1), e9135.

19. Depret DG. Efeitos das violências interpessoais sobre a violência autoprovocada entre travestis e mulheres transexuais. [Tese de Doutorado em Enfermagem] - Faculdade de Enfermagem, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, 2022.

20. Benevides BG. Dossiê: assassinatos e violências contra travestis e transexuais brasileiras em 2023. ANTRA (Associação Nacional de Travestis e Transexuais). Brasília, DF: ANTRA, 2024.

21. Depret DG. Acesso de travestis e mulheres transexuais aos serviços de saúde: subsídios para um cuidado equânime [dissertação de mestrado] Faculdade de Enfermagem, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, 2019.

22. Francisco LCFL, Barros AC, Pacheco MS, Nardi AE, Medeiros AE, Alves VM. Ansiedade em minorias sexuais e de gênero: uma revisão integrativa. J Bras Psiquiatr. 2020;69(1):48-56.

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