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People of all colors: Palliative care for the LGBTQIAPN+ population

Gente de toda cor: Cuidados paliativos para a população LGBTQIAPN+

Gente de todos los colores: Cuidados Paliativos para la población LGBTQIAPN+

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ABSTRACT

This essay critically reflects on access to and the quality of palliative care for the LGBTQIAPN+ population. Although essential for quality of life, these services are accessed by only 12% of the global population in need of them, a figure that becomes even more concerning among vulnerable groups, such as the LGBTQIAPN+ community. Historically, health care systems, shaped by colonialist and cisheteronormative paradigms, have perpetuated structural inequalities by neglecting cultural and identity-specific needs. In Brazil, despite inclusive public policies such as the National Policy for Comprehensive LGBT Health Care, a gap remains between legislation and practice. Health professionals still demonstrate insufficient preparedness to adequately address the specific needs of this population, exhibiting both implicit and explicit prejudice. The “discourses of no” (no difference, no knowledge, no willingness) systematically operate as mechanisms of exclusion, rendering identities invisible and disregarding family structures and grieving processes within this community. To overcome these barriers, adopting a decolonial and affirmative approach to palliative care is imperative. This perspective requires continuing education for health professionals, recognition of diversity, the use of inclusive language, and respect for support networks and “chosen families.” Decolonizing health care practices is an essential step toward building an equitable, ethical, and humanized health care system that actively values diversity and respects the dignity and individuality of all people, especially those historically marginalized and stigmatized.

Descriptors: Palliative Care; Sexual and Gender Minorities; LGBTQIAPN+ people; Health Equity.

RESUMO

Este ensaio reflete criticamente sobre o acesso e a qualidade dos cuidados paliativos para a população LGBTQIAPN+. Apesar de essenciais para a qualidade de vida, esses serviços são acessados apenas por 12% da população mundial que deles necessita, um número que se agrava para grupos vulnerabilizados, como a comunidade LGBTQIAPN+. Historicamente, a assistência à saúde, moldada por paradigmas colonialistas e cisheteronormativos, perpetua desigualdades estruturais, negligenciando as especificidades culturais e identitárias. No Brasil, mesmo com políticas públicas inclusivas, como a Política Nacional de Saúde Integral LGBT, persiste uma lacuna entre a legislação e a prática. Profissionais de saúde ainda demonstram despreparo para atender adequadamente às necessidades específicas dessa população, manifestando preconceitos implícitos e explícitos. Os “discursos do não” (não diferença, não saber, não querer) operam sistematicamente como mecanismos de exclusão, invisibilizando identidades e desconsiderando configurações familiares e processos de luto dessa comunidade. Para superar essas barreiras, torna-se imperativo adotar uma abordagem decolonial e afirmativa nos cuidados paliativos. Essa perspectiva exige educação permanente dos profissionais, reconhecimento da diversidade, uso de linguagem inclusiva e respeito às redes de apoio e “famílias de escolha”. Descolonizar as práticas de saúde é um passo essencial para construir um sistema equânime, ético e humanizado, que valorize ativamente a diversidade e respeite a dignidade e individualidade de todas as pessoas, especialmente aquelas historicamente marginalizadas e estigmatizadas.

Descritores: *Cuidados Paliativos; Minorias Sexuais e de Gênero; Pessoas LGBTQIAPN+; Equidade em Saúde.*

RESUMEN

Este ensayo reflexiona críticamente sobre el acceso y la calidad de los cuidados paliativos para la población LGBTQIAPN+. A pesar de ser esenciales para la calidad de vida, estos servicios son accesibles solo para el 12% de la población mundial que

los necesita, cifra que se agrava en grupos vulnerabilizados, como la comunidad LGBTQIAPN+. Históricamente, la atención en salud, moldeada por paradigmas colonialistas y cisheteronormativos, perpetúa desigualdades estructurales, desatendiendo las especificidades culturales e identitarias. En Brasil, incluso con políticas públicas inclusivas, como la Política Nacional de Salud Integral LGBT, persiste una brecha entre la legislación y la práctica. Los profesionales de la salud aún demuestran falta de preparación para atender adecuadamente las necesidades específicas de esta población, manifestando prejuicios implícitos y explícitos. Los "discursos del no" (no diferencia, no saber, no querer) operan sistemáticamente como mecanismos de exclusión, invisibilizando identidades y desconsiderando configuraciones familiares y procesos de duelo de esta comunidad. Para superar estas barreras, se vuelve imperativo adoptar un enfoque decolonial y afirmativo en los cuidados paliativos. Esta perspectiva exige educación continua de los profesionales, reconocimiento de la diversidad, uso de lenguaje inclusivo y respeto a las redes de apoyo y "familias elegidas". Descolonizar las prácticas de salud es un paso esencial para construir un sistema equitativo, ético y humanizado, que valore activamente la diversidad y respete la dignidad e individualidad de todas las personas, especialmente aquellas históricamente marginadas y estigmatizadas.

Descriptores: *Cuidados Paliativos; Minorías Sexuales y de Género; Personas LGBTQIAPN+; Equidad en Salud.*

INTRODUCTION

Health care encompasses a broad range of services aimed at promoting, maintaining, and restoring individuals' well-being. Within this context, palliative care stands out as a specialized form of care directed toward individuals facing life-threatening illnesses and their family members/caregivers. This approach is characterized by interprofessional teamwork, with the primary goal of alleviating suffering and promoting quality of life. To achieve this, palliative care involves the comprehensive management of physical, emotional, social, and spiritual symptoms while considering the unique needs of each patient and their family members/caregivers[1,2].

The relevance of this practice is widely recognized in national and international documents. Access to palliative care is legally supported by United Nations conventions and has been advocated as a human right by multiple international organizations, grounded in the right to the highest attainable standard of physical and mental health[3]. Despite this recognition, the reality of access to palliative care remains concerning. It is estimated that among the 56.8 million people who require palliative care services, only 12% have access to them[4]. In Brazil, despite important advances, such as the approval of the National Palliative Care Policy[5], palliative care continues to face substantial barriers, particularly for socially vulnerable groups.

Among these groups, the LGBTQIAPN+ community (including lesbian, gay, bisexual, transgender, queer, intersex, asexual, pansexual, nonbinary, and other gender and sexual identities) deserves special attention[6]. Although the National Policy for Comprehensive Health Care for Lesbian, Gay, Bisexual, Transvestite, and Transgender Individuals has been implemented[7,8], this population continues to experience institutional and social prejudice within health care settings[6].

The persistence of cisheteronormativity contributes substantially to these challenges by imposing a care model grounded in conventional assumptions regarding sex, gender, and sexuality. This framework normalizes only relationships between individuals of different genders and identities aligned with sex assigned at birth[9,10]. Consequently, across multiple contexts, including health care, experiences that do not align with this hegemonic standard are often excluded and invalidated[11].

Therefore, we raise the following questions: Which bodies are considered legitimate and recognized as deserving care? Does the limited proportion of access to these services effectively include individuals from the LGBTQIAPN+ community? What kind of care is offered to these individuals? Based on these questions, we propose an essay grounded in critical and in-depth reflection on the provision of palliative care for the LGBTQIAPN+ population, aiming to promote a more inclusive and equitable practice.

DECOLONIAL, AFFIRMATIVE PALLIATIVE CARE

Historically, health care has been dominated by a colonial paradigm that perpetuated inequalities and exclusions by imposing care models that disregarded the practices and traditional knowledge of subordinated populations. Coloniality, characterized by a racial, imperialist, colonial, Euro-American, heteronormative, patriarchal, and Christian hierarchy, established a hegemony of rationality and power that resulted in symbolic and structural violence, perpetuating disparities in access to and quality of health care services into contemporary society[12].

This ideology continues to shape health care approaches by globalizing and standardizing practices without considering cultural and social specificities or markers of difference such as ethnicity, gender identity, sexuality,

and social class. This phenomenon is particularly evident in developing countries, where health care systems often mirror external paradigms and imported models that fail to account for local contexts and population needs. Likewise, palliative care is not exempt from this influence and may be structured according to cisheteronormative practices disconnected from patients' lived experiences. As highlighted by Bezerra and colleagues[12]:

> *Under the premise that outside the individual there exists a set of care operators capable of knowing what another person needs, professionals unilaterally define and prescribe what the other should or should not do. Consequently, subjectivities are suppressed and bodily heterogeneities are disregarded (p. 3; free translation).*

Therefore, the legacy of colonialism, with its structures of power and domination, continues to permeate contemporary health care practices, influencing health professionals' attitudes toward LGBTQIAPN+ populations. This influence manifests through norms and values that privilege certain bodies and identities over others, creating environments where diversity is frequently ignored or minimized. Colonial thinking may lead professionals to adopt universalist approaches that fail to recognize the specific needs and lived experiences of LGBTQIAPN+ individuals, resulting in care that is not only inadequate but potentially harmful.

Health care practices may therefore be permeated by prejudice, expressed directly through verbal and physical violence, insults, humiliation, and segregation perpetrated by patients, professionals, and authorities[13] as well as through subtle and implicit forms of discrimination known as "discourses of no." These operate in distinct ways: the "discourse of no difference" ignores the specific needs of vulnerable populations, standardizing care and rendering identities invisible; the "discourse of not knowing" reflects inadequate professional preparation, as providers claim insufficient knowledge regarding population-specific needs, exposing educational gaps; and the "discourse of unwillingness" attributes low health care utilization to individual choice, disregarding the impact of hostile environments and service organization on care-seeking behavior. By shifting responsibility onto educational systems or individuals themselves, these discourses perpetuate cycles of neglect and invisibility, limiting equitable and inclusive care access[14].

Within palliative care for LGBTQIAPN+ populations, these prejudices take specific forms and directly compromise care quality. Beyond explicit manifestations of homophobia and transphobia that create hostile environments[15], "discourses of no" also emerge insidiously. The "discourse of no difference" appears when professionals assume heterosexuality and cisgender identity as normative, failing to ask about gender identity or sexual orientation and consequently not recognizing same-sex partners as family members or essential components of support networks. The "discourse of not knowing" is reflected in omissions regarding specific needs, such as continuity of gender-affirming hormone therapy for transgender individuals, and in inadequate training for discussing identity and sexuality with cultural sensitivity. The "discourse of unwillingness" assigns responsibility for low palliative care utilization to patients themselves, disregarding how prior discrimination experiences and fear of judgment discourage health care engagement.

Palliative care professionals must develop awareness of implicit biases, critically examine assumptions, and actively seek knowledge to provide truly inclusive care that respects dignity and addresses the unique needs of LGBTQIAPN+ individuals throughout care processes.

Persistent LGBTQIAPN+ phobia within health care settings[16] represents a major barrier to equitable health care access, producing immeasurable consequences for population health. This structural phenomenon manifests through microaggressions, discriminatory attitudes, and institutional neglect that collectively function as adverse social determinants of health. Anticipation of discrimination, often based on prior experiences of institutional violence, results in health care avoidance behaviors and delayed health care seeking. Studies demonstrate that these delays correlate with diagnoses at more advanced disease stages and more complex clinical outcomes associated with poorer prognoses[15,17].

In many cases, LGBTQIAPN+ patients access health care systems only when symptoms become intolerable, resulting in highly complex clinical conditions with reduced potential for disease-modifying interventions. Delayed access compromises timely implementation of comprehensive care, substantially limiting therapeutic possibilities[9,15,17]. The impact of disparities in access extends beyond morbidity indicators and directly affects end-of-life quality parameters. Scientific evidence indicates that limited palliative care access among LGBTQIAPN+ individuals contributes to inadequate symptom control and reduced dignity, perpetuating health inequities through the end of life[15].

The persistent association between LGBTQIAPN+ communities and HIV/AIDS epidemiology constitutes an important social determinant of health rooted in historical developments from the 1980s, when public health responses to the HIV pandemic disproportionately framed gay men as epidemiological vectors[18]. This sociopolitical and epistemological construction, extensively documented in scientific literature, produced a biomedical reductionism that persists in

contemporary health care practices through pathologizing stigma and the invisibility of multiple health conditions affecting this population[17]. Continued perpetuation of this stigma has neglected the complexity of LGBTQIAPN+ health experiences, creating concrete barriers to adequate care provision, including palliative care access. This restrictive narrative compromises care quality and equity by failing to recognize and address population-specific needs.

Many LGBTQIAPN+ patients prefer being surrounded by close friends and support groups, often referred to as "chosen family," rather than biological relatives, particularly within palliative care settings. This preference, frequently motivated by prior experiences of rejection or misunderstanding within family environments, reinforces the central role of alternative support networks in providing acceptance, respect, and understanding of identities and individual needs. Recognition of these relationships by health professionals may strengthen emotional and practical support, particularly when family-of-origin support is absent. Health professionals should therefore value and incorporate chosen family members into care decisions according to patients' wishes while also addressing potential limitations within these networks by providing additional support to prevent isolation and caregiver burden[17,19].

Fear of dying in pain, in isolation, or becoming dependent on others is frequently expressed by LGBTQIAPN+ individuals, increasing suffering and vulnerability at the end of life. To mitigate these concerns and ensure truly inclusive care, sexual and gender diversity issues must extend beyond macro-level public policy into institutional micropolitics, care environment planning, and palliative care training programs. Professionals should recognize and respect chosen family structures while ensuring legal documentation that safeguards patient autonomy and preferences regarding significant individuals within support networks during illness trajectories and particularly at the end of life[19].

Moreover, even when palliative care services are accessed, they frequently fail to adequately address emotional, social, and spiritual needs of LGBTQIAPN+ individuals and support networks compared with other patients. Financial, legal, and institutional barriers play substantial roles in limiting participation of partners and loved ones in care processes. Lack of formal marriage or civil union recognition between same-sex partners may prevent access to services or participation in decision-making processes, even when these individuals are closest to the patient and most familiar with their wishes. Such exclusion may intensify emotional suffering for both patients and partners, who often feel powerless during critical decisions[17].

Another essential aspect of palliative care concerns grief processes, which occur in two distinct phases: anticipatory grief and bereavement following loss. Anticipatory grief emerges when patients and family members begin confronting the reality of impending death associated with life-threatening illness[20,21]. This process allows emotional adaptation to anticipated separation and life without the loved one. Bereavement following death is experienced by family members and caregivers and represents a natural, individual, and dynamic process arising from loss of a meaningful bond[22]. For LGBTQIAPN+ populations receiving palliative care, grief experiences may be further complicated by lack of social recognition[23,24], particularly when relationships are not validated by society or institutions.

The lack of social legitimacy granted to LGBTQIAPN+ relationships frequently promotes emotional isolation among patients and compromises adequate grief expression among surviving partners, who may suppress public mourning due to fear of stigma or judgment. This dynamic may result in exclusion from funeral rituals and farewell ceremonies, which are critical components of loss processing and social support mobilization. Furthermore, partners may experience systematic marginalization from end-of-life decision-making and estate-related processes, intensifying perceptions of helplessness and psychological suffering[25].

Reflection on grief, particularly within LGBTQIAPN+ communities, must therefore acknowledge its social dimensions. Grief should not be viewed solely as an individual process but also as a collective and politicized experience. From this perspective, decolonial approaches expand their scope by creating safe spaces and emotional support structures specifically responsive to LGBTQIAPN+ patients' needs.

After understanding challenges experienced by patients receiving palliative care and their family members/caregivers, we reinforce the ethical imperative of building affirmative decolonial palliative care[25], aiming to transform care provision for LGBTQIAPN+ communities. This proposal seeks to dismantle traditional and hegemonic structures that perpetuate inequalities by promoting care models that are inclusive, equitable, and responsive to specific population needs.

As demonstrated, significant health inequities persist in palliative care for LGBTQIAPN+ populations despite progress in reducing disparities over the past decade. In Brazil, although policies such as the National Policy for Comprehensive Health Care for Lesbian, Gay, Bisexual, Transvestite, and Transgender Individuals exist[7,8], practical realities reveal that many health professionals remain inadequately prepared to provide inclusive and respectful care[26,27].

Education therefore plays a central role in developing planned interventions grounded in knowledge and cultural sensitivity. This includes continuing professional education addressing issues specifically affecting LGBTQIAPN+

communities, including gender diversity, sexual orientation, and discriminatory experiences that impact these individuals[9,19,25].

Such training initiatives should acknowledge the suffering and stress experienced by populations exposed to marginalization and stigma. According to Borret[28], it is essential to recognize how these experiences affect "subjectivity formation, self-perception and self-care development, as well as social relationships, including family relationships" (p. 234; free translation), factors that directly influence health and quality of life.

Incorporating affirmative practices[25,29] into palliative care is therefore essential because it extends beyond technical interventions and promotes approaches that value and respect diversity in gender identities and sexual orientations. Affirmative care recognizes and validates each patient's individuality, creating safe and welcoming environments where people feel respected and understood in their entirety. This approach involves not only acceptance but also active appreciation of patient experiences and identities, ensuring that voices are heard and choices respected.

Furthermore, affirmative decolonial palliative care requires health professionals to recognize and challenge personal biases while promoting cultures of respect and inclusion. This may include using inclusive language, adapting practices to meet individual needs, and involving families and support networks while respecting diverse family structures, including visitation policies and end-of-life decision-making participation.

Thus, health care decolonization, grounded in recognition of diversity, becomes essential to building more equitable systems that do not perpetuate exclusion and marginalization of vulnerable groups. Given that palliative care seeks ethical and critical practice, health care approaches must be reexamined to ensure inclusive care responsive to the particularities of every social group and individual receiving care.

FINAL CONSIDERATIONS

Reflecting on the challenges faced in palliative care highlights the urgent need to promote practices that are truly equitable, particularly for the LGBTQIAPN+ population. Although legislative advances and public policies exist in Brazil, substantial gaps remain in the practical implementation of these guidelines. These shortcomings are especially evident in addressing the specific needs of marginalized groups, who frequently encounter institutional and social barriers to accessing appropriate health care services.

The colonial legacy and power structures that continue to permeate contemporary health care practices must be challenged and transformed. Coloniality, through its hegemonic norms and values, continues to negatively influence how care is delivered, often overlooking or minimizing the diversity of experiences and needs among LGBTQIAPN+ individuals. Health professionals should adopt a decolonial approach that recognizes and values the cultural and social diversity of this population.

Furthermore, advancing research in this field is essential to validate the presence and needs of this population, amplifying LGBTQIAPN+ voices and ensuring that their experiences and perspectives are fully considered in the development of health care policies and practices. Academic research can play a fundamental role in identifying existing gaps and proposing solutions that promote equity and inclusion.

In this context, education and ongoing professional development are critical components in advancing affirmative and decolonial palliative care. Training health professionals to engage in self-reflection and recognize implicit biases and prejudices is essential. Such educational efforts should promote appreciation of diversity and consideration of nontraditional family dynamics to ensure care that embraces and understands each patient as a whole person.

Decolonizing palliative care represents an important step toward ensuring that these services are accessible, compassionate, and equitable for everyone, particularly the LGBTQIAPN+ community. By fostering a health care system that values diversity and inclusion, it becomes possible to move toward a model of care that not only respects differences but actively values them, ensuring that all individuals receive the dignified and respectful care to which they are entitled.

REFERENCES

1. The International Association for Hospice and Palliative Care. Global consensus based palliative care definition (Brazilian Portuguese) [Internet]. Houston: IAHPC;2018[cited 2025 May 20]. Disponível em: https://hospicecare.com/uploads/2019/2/Palliative%20care%20definition%20-%20Portuguese%20(Brazilian).pdf

2. World Health Organization. National cancer control programmes: Policies and managerial guidelines [Internet]. 2nd ed. Geneva: WHO; 2002[cited 2025 May 25]. Available from: https://iris.who.int/handle/10665/42494

3. Associação Europeia de Cuidados Paliativos. Carta de Praga [Internet]. Praga: EAPC; 2013[citado 20 maio 2025]. Disponível em: https://www.ghc.com.br/files/CARTA%20DE%20PRAGA%20SOBRE%20CUIDADOS%20PALIATIVOS.pdf

4. Connor SR, editor. Global atlas of palliative care [Internet]. 2nd ed. London: WHPCA; 2020 [acesso em 2025 May 19]. Available from: https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/csy/palliative-care/whpca_global_atlas_p5_digital_final.pdf?sfvrsn=1b54423a_3

5. Brasil. Portaria GM/MS nº 3.681, de 7 de maio de 2024. Política Nacional de Cuidados Paliativos [Internet]. Brasília, DF: Ministério da Saúde; 2024[citado 25 maio 2025]. Disponível em: https://ses.sp.bvs.br/wp-content/uploads/2024/05/U_PT-MS-GM-3681_070524.pdf

6. Lopes FG, Vieira PCD. (Re)construções necessárias: saúde LGBTQIA+ no ambiente hospitalar. In: Souza A, Castro D, Arrais R, editores. Psicologia hospitalar: debates contemporâneos. 2. ed. Curitiba: CRV; 2021. p. 95-109.

7. Brasil. Portaria nº 2.836, de 1º de dezembro de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (Política Nacional de Saúde Integral LGBT) [Internet]. Brasília, DF: Ministério da Saúde; 2011[citado 20 maio 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2836_01_12_2011.html

8. Ministério da Saúde (BR). Política nacional de saúde integral de lésbicas, gays, bissexuais, travestis e transexuais. Brasília, DF: Ministério da Saúde; 2013[citado 25 maio 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_lesbicas_gays.pdf

9. Campelo HC, Cordeiro FR, Bierhals L, Silva NK, Moscoso CR, Marques RS. Facilidades e dificuldades no acesso aos cuidados paliativos por tolerados em situação de rua e LGBTQIA+: revisão integrativa [Internet]. Saúde Redes. 2022[citado 25 maio 2025];8(1):161–78. Disponível em: http://revista.redeunida.org.br/ojs/index.php/rede-unida/article/view/3524

10. Ciasca SV, Hercowitz A, Lopes Junior A. Saúde LGBTQIA+: Práticas de cuidado transdisciplinar. São Paulo: Editora Manole; 2021.

11. Prado MAM, Junqueira RD. Homofobia, hierarquização e humilhação social. In: Ventiru G, Bokany V, editores. Diversidade sexual e homofobia no Brasil. São Paulo: Editora da Fundação Perseu Abramo; 2011. p. 51-71.

12. Bezerra PA, Cavalcanti P, Azevedo LB. Violência sexual contra crianças e adolescentes: a escuta especializada como campo de disputa de sentidos. Physis Rev Saúde Coletiva. 2023;33:e33025.

13. Daniel H, Butkus R. Lesbian, gay, bisexual, and transgender health disparities: executive summary of a policy position paper from the American College of Physicians. Ann Intern Med [Internet]. 2015[cited 2025 May 25];163(2):135-7. Available from: https://doi.org/10.7326/M14-2482

14. Paulino DB, Rasera EF, Teixeira FB. Discursos sobre o cuidado em saúde de lésbicas, gays, bissexuais, travestis, transexuais (LGBT) entre médicas(os) da Estratégia Saúde da Família [Internet]. Interface. 2019[citado 25 maio 2025];23:1-15. Disponível em: https://doi.org/10.1590/Interface.180279

15. Almeida FFX, Silva CP, Sant'Ana RSE, Melo RNR. Avaliação do conhecimento em oncologia acerca do atendimento às pessoas transgênero: revisão de escopo [Internet]. Rev Bras Enferm. 2024 [citado 25 maio 2025];77(3):1-12. Disponível em: https://www.scielo.br/j/reben/a/J8DPWNBB8hR3hYT3H9ZxxNS/?lang=pt&format=pdf

16. Silva ATC, Rosa CAP, Gagliotti DAM. LGBTQIA+fobia institucional na área da saúde. In: Ciasca S, Hercowitz A, Lopes A Júnior, editores. Saúde LGBTQIA+: Práticas de cuidado transdisciplinar. São Paulo: Editora Manole; 2021. p. 100-106.

17. Barroso P. Desafios da comunidade LGBTQIAP+ no acesso a cuidados paliativos [Internet]. Afya Participações S.A; 2024 Set 23 [acesso em 2025 Maio 25]. Disponível em: https://facamedicina.afya.com.br/blog/desafios-lgbtqiap-cuidados-paliativos

18. Sampaio JV, Germano IMP. Políticas públicas e crítica queer: algumas questões sobre identidade LGBT [Internet]. Psicol Soc. 2014[citado 25 maio 2025];26(2):290-300. Disponível em: https://doi.org/10.1590/S0102-71822014000200006

19. Crenitte MRF, Melo LR, Jacob WJ Filho, Silva TJA. Palliative care over the rainbow: Perspectives of middle-age and older LGBT+ adults regarding their end-of-life. Geriatr Gerontol Aging [Internet]. 2022 [cited 2025 may 25];16(1):1-4. Available from: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1399634

20. Franco MHP. Uma mudança no paradigma sobre o enfoque da morte e do luto na contemporaneidade. In: Franco MHP, editor. Estudos avançados sobre o luto. Campinas: Livro Pleno; 2002. p. 15-38.

21. Lindemann E. Symptomatology and management of acute grief. Am J Psychiatry [Internet]. 1994[cited 2025 May 25];151(6):155-160. Available from: https://doi.org/10.1176/ajp.151.6.155

22. Parkes CM. Luto: estudos sobre a perda na vida adulta. 3. ed. São Paulo: Summus; 1998.

23. Casellato G. Luto por perdas não legitimadas na atualidade. São Paulo: Summus Editorial; 2020.

24. Doka KJ. Disenfranchised grief: new directions challenges and strategies for practice. Illinois: Research Press; 2002.

25. Cavalcante LC, Lopes FG, Silveira KM, Bandeira RL, Fraga NE. Sensibilidade à diversidade: integrando cuidados paliativos e psicologia na assistência à população LGBTQIAPN+. In: Lopes FG, editor. Psicologia e cuidados paliativos: a tessitura de olhares e intervenções. Londrina: Lucto; 2024. p. 443-458.

26. Cerqueira-Santos E, Calvetti PU, Rocha KB, Moura A, Barbosa LH, Hermel J. Percepção de usuários gays, lésbicas, bissexuais e transgêneros, transexuais e travestis do Sistema Único de Saúde [Internet]. Ver Interam Psicologia. 2010[citado 25 maio 2025];44(2):235-245. Disponível em: https://www.redalyc.org/articulo.oa?id=28420641004

27. Filipiack IC, Gaspodini IB. Políticas públicas para a população LGBT no Brasil [Internet]. Perspect Psicol. 2019[citado 25 maio 2025];23(2):40-56. Disponível em: https://seer.ufu.br/index.php/perspectivasempsicologia/article/view/52211

28. Borret RH, Oliveira DOPS, Amorim ALT, Baniwa BA. Vulnerabilidades, interseccionalidades e estresse de minorias. In: Ciasca SV, Hercowitz A, Lopes A Junior, editores. Saúde LGBTQIA+: práticas de cuidado transdisciplinar. São Paulo: Editora Manole; 2021. p. 59-71.

29. Reis et al. Psicologia afirmativa e abordagens psicológicas. In: Ciasca S, Hercowitz A, Lopes A Júnior, editores. Saúde LGBTQIA+: práticas de cuidado transdisciplinar. São Paulo: Manole; 2021. p. 197-205.

APPENDIX – EDITORIAL GUIDELINES

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