Self-reported health conditions, quality of Primary Health Care and associated factors according to sexual and gender minorities

Condições de saúde autorreferidas, qualidade da Atenção Primária à Saúde e fatores associados segundo minorias sexuais e de gênero

Elisa Riboli Senne[1] (iD), Lucas Felippe do Carmo Miranda[1] (iD), Géssica Luísa Silva de Souza[1] (iD), Simone Albino da Silva[2] (iD), Murilo César do Nascimento[2] (iD)

ABSTRACT

Introduction: Lesbians, gays, bisexuals, transvestites, transsexuals, transgenders, queers, intersexes, asexuals, pansexuals, and other sexual and gender minorities constitute a population that has been little studied regarding the use and care of health services. **Objective:** From this perspective, the general objective of this study was to evaluate the quality of Primary Health Care according to members of sexual and gender minorities. **Methods:** This is evaluative research, with a cross-sectional and descriptive-analytical design and a quantitative approach, performed by a web survey in Brazil. The script for data collection addressed sociodemographic characteristics, sexual orientation, gender identity, self-reported health conditions, and the 23 items of the Primary Care Assessment Tool, a reduced version for adult users. **Results:** The results represent 314 LGBTQIAP+ people, predominantly young, white, cisgender, homosexual, and bisexual, from the five Brazilian regions, highlighting the states of Minas Gerais and São Paulo. The use of alcoholic beverages and other substances, weight change, and the presence of mental diseases were the most frequent self-reported health conditions. Primary health care was mainly evaluated with low overall scores, thus indicating low quality. The attributes "community guidance" and "coordination" (care integration) were marked by unfavorable evaluations, indicating small extensions. People belonging to sexual and gender minorities who worked had kidney problems, had been hospitalized recently, and that had their gender identity and sexual orientation known by health professionals were more likely to evaluate the Primary Health Care as good. **Conclusion:** This work points out weaknesses in the care of the LGBTQIAP+ population the following attributes: family guidance, accessibility, longitudinality, and available services, which can be prioritized to improve the quality of Primary Health Care in the Brazilian Unified Health System.

Keywords: Health evaluation, Gender and health, Gender equity, Sexism, Transgender persons, Cross-sectional studies.

RESUMO

Introdução: Lésbicas, gays, bissexuais, travestis, transexuais, transgêneros, queer, intersexos, assexuais, pansexuais e outras minorias sexuais e de gênero constituem uma população pouco estudada no que se refere ao uso e atendimento em serviços de saúde. **Objetivo:** Nessa perspectiva, o objetivo geral deste estudo foi avaliar a qualidade da Atenção Primária à Saúde segundo integrantes de minorias sexuais e de gênero. **Método:** Trata-se de uma pesquisa avaliativa, com delineamento transversal, descritivo-analítico, de abordagem quantitativa, por meio de *web survey* no Brasil. O roteiro de coleta abordou características sociodemográficas, de orientação sexual, identidade de gênero, condições de saúde autorreferidas e os 23 itens do instrumento *Primary Care Assessment Tool, versão reduzida para usuários adultos.* **Resultados:** Os resultados representam 314 pessoas LGBTQIAP+, predominantemente jovens, brancos, cisgêneros, homossexuais e bissexuais, provenientes das cinco regiões brasileiras, com destaque para os estados de Minas Gerais e São Paulo. O uso de bebidas alcoólicas e outras substâncias, a alteração ponderal e a presença de doenças mentais foram as condições de saúde autorreferidas que mais se destacaram. A atenção primária à saúde foi majoritariamente avaliada com baixa pontuação geral, indicando baixa qualidade. Assinalam-se os atributos *orientação comunitária* e *coordenação (integração de cuidados)* pelas avaliações negativas, indicando pequena extensão. As pessoas de minorias sexuais e de gênero que trabalhavam, possuíam problema renal, haviam sido internadas recentemente e sua identidade de gênero e orientação sexual eram conhecidas pelos profissionais de saúde apresentaram mais chance de avaliar bem a Atenção Primária à Saúde. **Conclusão:** Este trabalho aponta como fragilidades no cuidado da população LGBTQIAP+ os atributos de *orientação familiar*, *acessibilidade*, *longitudinalidade* e *serviços disponíveis* que podem ser priorizadas para a melhoria da qualidade da Atenção Primária à Saúde do Sistema Único de Saúde brasileiro.

Descritores: Avaliação em saúde, Gênero e saúde, Equidade de gênero, Sexismo, Pessoas transgênero, Estudos transversais.

1   Federal University of Alfenas. Faculty of Medicine, Alfenas, (MG), Brazil
2   Federal University of Alfenas. Nursing School, Alfenas, (MG), Brazil

INTRODUCTION

Lesbians, Gays, Bisexuals, Transvestites, Transgenders, Queers, Intersexes, Asexuals, Pansexuals, and other sexual and gender minorities (LGBTQIAP+) have experienced inadequate, low-quality care, disrespect, and discrimination in health services. We can list the various barriers to accessing appropriate health care by such people: denial of service, harassment, and lack of clinical knowledge. Thus, non-binary individuals experience many significant health disparities compared to the cisgender population[1–3].

Besides this social, legal, and health problem, there are also academic challenges since the literature on sexuality and diversity has significant scientific gaps[4]. Accordingly, many clinical and care guidelines for specific populations, such as the LGBTQIAP+ population, are based on a low degree of scientific evidence[5]

In Brazil, given the vulnerabilities to which these sexual and gender minorities are subject, the National Policy on Integral Health of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals, instituted by Ordinance No. 2.836/2011, represents a landmark in recognition of the specific needs of this community. By signaling efforts to combat prejudice, discrimination, and problems in access to health, the expectation is to ensure universality, equity, and integrality in health to LGBTQIAP+ people as well[6,7].

Nonetheless, the advances regarding the legal landmark, and the ethical/doctrinal principles of the Brazilian Unified Health System (SUS, as per its Portuguese acronym) are not yet fully practiced with the sexual gender minorities[8,9]. Despite numerous recommendations for providing health care to such people, many report negative outcomes and problems accessing competent, affirmative, and quality primary care[1]. Even when LGBTQIAP+ people do not experience mistreatment or disrespect, they describe an interaction with inadequately trained health teams unprepared to provide culturally appropriate care or address many health problems and challenges such audiences face[3].

In this context, the general objective of the study was to evaluate the quality of Primary Health Care according to members of sexual and gender minorities. As for the specific objectives, it was intended: to identify sociodemographic aspects and self-reported health conditions/situations by Lesbians, Gays, Bisexuals, Transvestites, Transsexuals, Transgenders, Queers, Intersexes, Asexuals, Pansexuals, and other sexual/gender minorities in Brazil; to investigate how members of the LGBTQIAP+ population evaluate the quality of the Primary Health Care (PHC) provided to them; to check if there is an association between sociodemographic variables and health conditions/situations of users with the PHC quality scores generated by them.

METHOD

It was evaluative research, with a cross-sectional and descriptive-analytical design and a quantitative approach[10,11], performed by a web survey. The actors/social agents invited to participate were Lesbians, Gays, Bisexuals, Transvestites, Transsexuals, Transgenders, Queers, Intersexes, Asexuals, Pansexuals, and other identities/orientations (LGBTQIAP+), possible PHC users, distributed throughout Brazil.

The Google Forms resource[12] was used to create a Digital Form. Thus, the script for data collection was set up in electronic sections containing the Free and Informed Consent Form – FICF, inclusion criteria, questions about the participants' characteristics and sociodemographic information, self-reported health conditions/situations extracted from the e-SUS Individual Registration Form[13] and the 23 items of the Primary Care Assessment Tool (PCATool-Brazil), adult users version[14]. Finally, LGBTQIAP+ participants were asked if primary care professionals knew their sexual orientation and gender identity.

Three professionals were invited to participate as judges of the digital form developed, to whom the link to access the virtual collection instrument was made available, as well as a semi-structured questionnaire for recording the analysis of the appropriateness of each question and suggestions. As a result of the evaluation, several essential suggestions to improve the collection instrument were accepted by the study's executing team.

Next, a pilot study was started to enhance and systematize the work. Mainly to test the

application of the electronic instrument by the researchers in the population approached and assess whether the participants' answers indicated the expected understanding of the proposed questions, the invitation with the link/form was shared with several people whose profile of interest was identified in social media.

It was stipulated that the first ten returns via Google Forms would be followed up by checking the reported content and automatically loaded into the corresponding spreadsheet. It took ten days of active search to obtain the data of ten LGBTQIAP+ people. The preliminary analysis of the answers during the pilot study allowed the executive team to consider the research instrument suitable to reach the proposed objectives.

Since the participants showed an appropriate understanding of the investigated variables and answered consistently with the presented assertions, no adjustments to the collection script were needed. Accordingly, the ten participants of the pilot study were kept in the study population and were also considered the first participants of the research.

The study included members of sexual and gender minorities in Brazil, through a web survey. Accordingly, the form containing the invitation and the research questions was made available on homepages, virtual groups, and various social networks such as Instagram, Whatsapp, Twitter, and Facebook, which had as members people with the profile or connected in some way to the interested audience. So, the sample was of the convenience or accessibility type, the reason why there was no sample size determination, and it was supported by the *snowball sampling* technique[10].

As inclusion criteria, we defined the participation of people over 18 years old; people who self-identified as non-binary concerning sex/gender (lesbians, gays, bisexuals, transvestites, transgenders, and other identities/expressions/orientations); from different locations in the national territory, given the broad geographic reach of social media.

The collection script was shared with the target audience for self-completion from March 6, 2020, to June 6, 2020. The returned data were saved in an electronic spreadsheet, where we calculated the scores referring to the attributes: accessibility, longitudinality, coordination and care integration, coordination of information systems, integrality – available services, integrality – services provided, family guidance and community guidance[15] Subsequently, the essential, derived, and overall scores concerning the PHC quality were calculated[14,16].

When recognizing the possibility of selection bias due to convenience sampling and snowball sampling, as well as possible information bias because of the web survey strategy, the possible control measure for researchers was to ensure due attention concerning the external validity of the results. The returned data were automatically stored in a spreadsheet associated with the collection script, and the double-entry process was replaced by database normalization.

Next, the variables were analyzed descriptively, and the results were presented and discussed based on frequency distribution and measures of central tendency observed. In preparation for the inferential approach, we proceeded by dichotomizing the nominal and ordinal polytomous qualitative independent/dependent variables according to the groupings of interest.

Accordingly, the polytomous independent variable "labor market situation" was recoded to the dichotomous variable "works" (yes or no). The independent variables "kidney disease", "history of hospitalization in the last year", "health professional knowing the user's sexual orientation", and "health professional knowing the participant's gender identity" were kept in their original binary format (yes or no). In turn, the dependent variable "standardized PHC scores" was recoded to "PHC quality – QAPS" (good or bad), as per its Portuguese acronym, translated into *Qualidade da Atenção Primária à Saúde*, adopting the value 6.6 as the cutoff point[14,17].

The checking of normality for numerical variables was performed using the Shapiro-Wilk test. Associations were analyzed using Pearson's chi-square or Fisher's exact test, with crude Odds Ratio (OR) estimation. All tests were performed adopting 5% significance and had the support of the Statistical Package for the Social Sciences (SPSS) software. The study was approved by the Research Ethics Committee of the proposing institution, according to CAAE No. 97909018.0.0000.5142 and Opinion No. 3.695.990, on November 11, 2019.

RESULTS

Sexual orientation, gender identity, and sociodemographic characteristics

The group of 314 participants comprised mostly homosexuals (56.37%) and bisexuals (31.53%); cisgenders (85.04%); white (65.92%) and young people (an average of 24.09 years old). As for the spatial distribution, there were participants from 17 of the 27 Brazilian states belonging to the five large Brazilian regions, with a predominance of those who lived in Minas Gerais (41.46%) and São Paulo (40.86%). Regarding the situation in the labor market, the individuals who did not work (43.31%)

and the wage earners with a work permit (20.38%) were the most frequent conditions. The income range most frequently registered was from 1.5 to 3 minimum wages, with 21.34% of the answers.

Self-reported health conditions

The use of alcoholic beverages, the perception of change in body weight and the presence of mental disorders were the health conditions that stood out most in terms of frequency. Figure 1 displays the graphic representation of the distribution of self-reported health conditions by the surveyed LGBTQIAP+ participants.
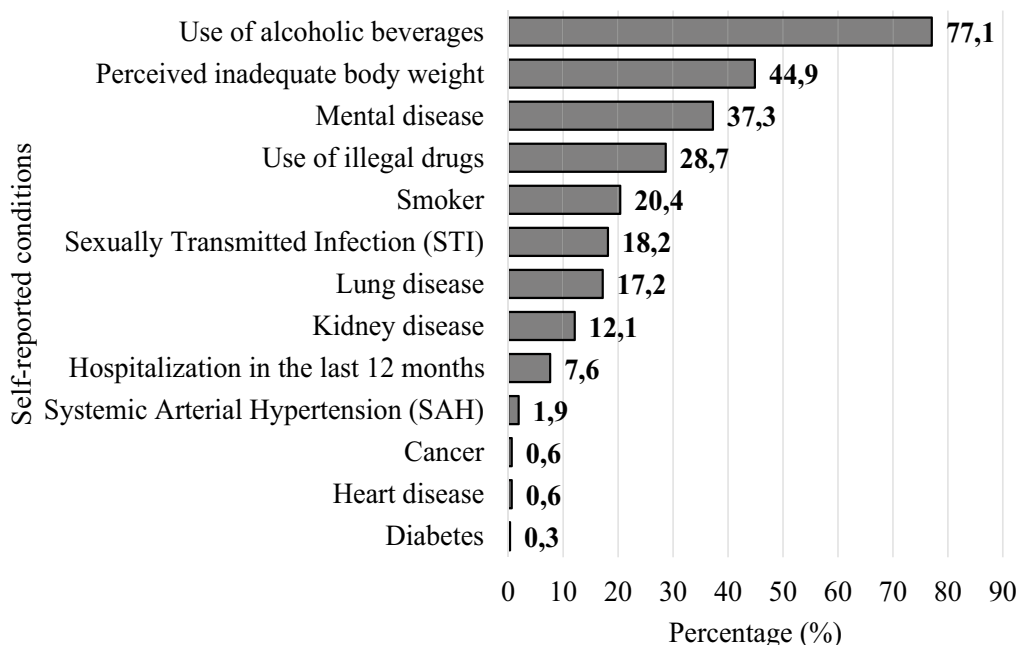
Image 1: Distribution of self-reported health conditions by the surveyed LGBTQIAP+ participants, Brazil, 2020.

Source: Developed by the authors, 2021.

Evaluation of primary healthcare attributes

The details of the PHC evaluation according to the presence and extension of its attributes can be seen in the frequency distribution of Table 1.

Regarding the description of the standardized scores between the groups for QAPS-1, we obtained: average - 7.50 (95% CI: 7.29 - 7.70); median -

7.24; variance - 0.56 (SD: 0.75); minimum and maximum scores from 6.66 to 8.98 points. In turn, the descriptive measures for the scores of the QAPS-2 group were: average - 3.72 (95% CI: 3.52 - 3.91); median - 3.76; variance - 2.56 (SD: 1.60); minimum and maximum scores from 0.57 to 6.52 points. The representation of the descriptive measures on the standardized scores according to the PHC evaluation is presented in the Box Plot of Figure 2.

Table 1
Distribution of answers to the PCA-Tool (reduced), Brazil, 2020 (314 = 100%)

Attributes	Question codes	Surely yes		Probably yes		Probably no		Surely, no/I don't know/ don't remember	
		N	%	N	%	N	%	N	%
First contact access – use	B2	47	14.97	114	36.31	65	20.7	88	28.03
First contact access – accessibility	C4	42	13.38	67	21.34	68	21.66	137	43.63
	C11	30	9.55	53	16.88	102	32.48	129	41.08
Longitudinality	D1	50	15.92	57	18.15	85	27.07	122	38.85
	D6	80	25.48	58	18.47	95	30.25	81	25.8
	D9	46	14.65	69	21.97	68	21.66	131	41.72
	D15	68	21.66	81	25.8	68	21.66	97	30.89
Coordination – care integration	E6	44	14.01	88	28.03	39	12.42	143	45.54
	E10	34	10.83	72	22.93	45	14.33	163	51.91
	E11	56	17.83	61	19.43	58	18.47	139	44.27
	E13	47	14.97	58	18.47	54	17.2	155	49.36
Coordination – information system	F3	97	30.89	92	29.3	53	16.88	102	32.48
Integrality – available services	G9	67	21.34	92	29.3	53	16.88	102	32.48
	G17	51	16.24	94	29.94	26	8.28	143	45.54
	G20	36	11.46	98	31.21	48	15.29	132	42.04
Integrality – services provided	H1	106	33.76	112	35.67	37	11.78	59	18.79
	H5	100	31.85	101	32.17	45	14.33	68	21.66
	H7	128	40.76	107	34.08	24	7.64	55	17.52
	H11	32	10.19	62	19.75	52	16.56	168	53.5
Family guidance	I1	52	16.56	75	23.89	62	19.75	125	39.81
	I3	55	17.52	77	24.52	60	19.11	122	38.85
Community guidance	J4	28	8.92	56	17.83	82	26.11	148	47.13

Source: Developed by the authors, 2021.

No correlation was identified between age and standardized scores on PHC evaluation (p=0.080). Regarding the existence and strength of associations, there was a weak association between being working and good PHC quality (p = 0.004; OR: 2.360; 95% CI: 1.297- 4.294), and more expressive associations between having kidney diseases and good PHC quality (p = 0.000; OR: 4.698; 95% CI: 2.261 - 9.760); having a history of hospitalization in the last year and good PHC quality (p=0.002; OR: 4.103; 95% CI: 1.713 - 9.830); health professional knowing the user's sexual orientation and good PHC quality (p=0.000; OR: 4.706; 95% CI: 2.497 - 8.868); and health professional knowing the user's gender identity and good PHC quality (p=0.000; OR: 4.163; 95% CI: 1.887 - 9.181).

In this sense, it is conceived that those who evaluated PHC as good quality presented: 2.36 chances of being working; 4.69 chances of having referred kidney disease; 4.10 chances of having been hospitalized in the last year; 4.70 chances of having had their sexual orientation known by the professional who assists them; and 4.16 chances that the health professional knew their gender identity.
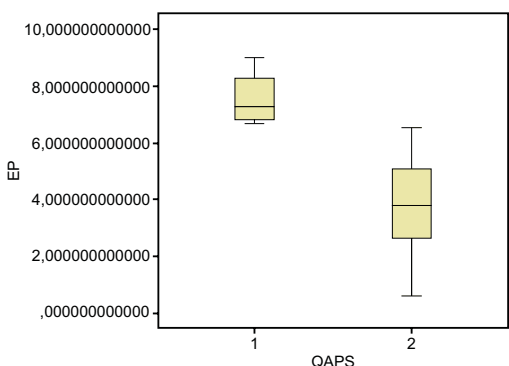
Image 2: Box Plot on the standardized scores generated by users who evaluated PHC as good quality (QAPS-1 group) and by people who pointed to a less qualified level of care (QAPS-2 group), Brazil, 2020.

Caption: *EP = Standardized Score (Escore Padronizado); *QAPS-1 = Good Quality Primary Health Care (Atenção Primária à Saúde de Boa Qualidade); *QAPS-2 = Poor Quality Primary Health Care (Atenção Primária à Saúde de Má Qualidade).
*As per their Portuguese acronyms
Source: Developed by the authors, 2021.

DISCUSSION

Sexual, gender, and sociodemographic characteristics and self-reported health conditions

In this paper, the acronym LGBTQIAP+ has been used to refer to the population of sexual and gender minorities. However, it should be noted that the authors recognize and value the freedom of individuals to use a diversity of terms to describe their sexual orientation and gender identity or even prefer not to use descriptors that resemble categories or labels.

The study sample represented a digitally included LGBTQIAP+ population, predominantly young, student (58.28%), cisgender (85.04%), homosexual (56.39%) or bisexual (31.53%), white (65.92%), and who have completed or incomplete higher education (85.99%). The identification of this profile enables us to better understand and interpret the findings in a contextualized way based on the universe/social field of the respondents, as discussed below.

Among the participants, 37.26% reported having their sexual orientation known by the professional, while 62.1% reported having their gender identity known by them. When LGBTQIAP+ community members experience culturally incompetent or disrespectful care, they are less likely to disclose their identities to members of the health team, which can result in inadequate communication, lack of preventive services, inaccurate diagnosis, inadequate treatment, and poor health outcomes[3]. In addition, the lack of accurate and inclusive gender, sex, and sexual orientation data in electronic health records perpetuates the inequalities of sexual and gender minorities[18,19].

Health professionals need to make clinical environments more affirming by making the physical space friendly, documenting gender identity appropriately, approaching patients according to how they identify themselves, ensuring confidentiality, using affirmative language and clinical approaches based on training on how to work with such patients[1]. The fact of not knowing the sexual orientation and gender identity of those assisted, nor registering them, makes such positive behaviors unfeasible.

As for the self-reported health issues, the most frequent was alcohol consumption (77.07%). In addition, drug use (28.66%) is the fourth most self-reported health condition in this research. In this sense, although the study did not investigate the abuse of legal and illegal drugs, these data converge to the increased risk of alcohol and other drug abuse[20].

The second most recorded condition was perceived inadequate weight (44.91%), with 37.90% of the participants considering themselves overweight. In the third place, 37.26% of the study participants claimed to have some "mental disease". In an online study conducted with students at a university in the United States comparing heterosexual students with students belonging to sexual minorities, it was observed that LGBQ students had higher rates of depression, anxiety, stress and were more prone to being overweight. The percentage of students with a history of major depression disorder was almost twice as high among sexual minorities (32.1%)[21].

Thus, multiprofessional attention is needed to identify cases of substance use and abuse, changes in body weight and/or distortions in the perception of it, as well as an approach, focused on mental health, disease prevention,

and health promotion. Therefore, we corroborate the need for more studies directed to the analysis of the implementation of LGBTQIAP+ public health policies that bring evidence about the health needs of this population[4].

PHC quality and associated factors

Considering the set of attributes represented by the reduced PCATool questions (Table 1), the answers "Surely, I don't/I don't know - I don't remember" stood out due to the increased frequency, which, in 91% of the instrument's items, indicate unfavorable aspects of the PHC. In this sense, it was noted that quality left something to be desired, mainly regarding the attributes Community Guidance and Coordination (care integration). On the other hand, Integrality (services provided) and Coordination (information system) were the best evaluated attributes.

Taking into account the standardized scores generated by users who evaluated PHC as good quality (group QAPS-1) and by people who pointed to a less qualified level of care (group QAPS-2), it was observed that the most satisfied group showed an average standardized score equal to 7.5. In contrast, the least satisfied group showed an average standardized score equal to 3.7. Accordingly, the preponderant distribution of answers that point to a negative evaluation, "Surely no/I don't know – don't remember" are corroborated by low standardized score averages. It is inferred, therefore, that the studied group of LGBTQIAP+ people mainly evaluated PHC as of low quality.

LGBTQIAP+ people have unique health needs, but experience great diversity in the quality of care they receive[22]. In a study with speeches of Community Health Workers from a Brazilian capital about health care for the LGBT population, for example, a mix of denial of sexism and symbolic barriers, lack of understanding of the sense of equity and prejudice embodied in the subjectivities of these professionals was identified, with the existence of professionals sensitized to the issue of respect for diversity and receptive to formative processes for a better offer of integral care to this population[23]

There is growing evidence that gender--affirming interventions, also called gender-affirming health care (affirmative care), improve health outcomes for transgender and gender-diverse young people, despite remaining barriers to accessing such care[24,25]. There are also successful experiences signaling the possibility of improving work processes and assistance to sexual and gender minorities, such as the revision and evolution of clinical guidelines for primary care and family planning directed to LGBTQIAP+ people[22].

No possible explanations for the associations between being working, having kidney diseases, having been recently hospitalized, and a good PHC evaluation were identified in the literature. Nevertheless, the good evaluation of participants regarding the attributes of "integrality – services provided" and "coordination – information system", to the detriment of the worst evaluated attributes such as "community guidance" and "coordination – care integration", leads to believe that LGBTQIAP+ people who use or have used primary care services better evaluate the assistance provided by the teams. This also stands out for the answers related to positive aspects regarding the services provided, information and use, compared to the predominantly negative answers regarding family guidance, accessibility, longitudinality, and available services, as seen in Table 1.

In the present study, it was found that those who evaluated PHC as of good quality were more likely to have had their sexual orientation known by the professional assisting them and more likely that such professional knew their gender identity. These data are in line with findings from works that also indicated a positive association between the professional's knowledge of gender identity, sexual orientation, and the involvement of the LGBTQIAP+ person assisted during health care[26,27].

Taken together, the data on the relationships between sociodemographic variables and health conditions/situations of the participants with the PHC quality scores generated by them signal the importance of rescuing and applying references such as the social determination of health-disease as possible explanatory models for LGBTQIAP+ health and its interfaces. A study conducted in a South American country with trans men about their social and health needs described health as multidimensional and influenced by social, economic, and legal contexts, including family, school,

employment and work, legal identity recognition, discrimination in public spaces and peer support[28].

Regarding the needs unmet by health professionals and services, it is worth reinforcing that access to care is paramount to achieving equality/equity in health, especially among the most vulnerable social groups[29]. Still in this context, significant gaps also persist in the training of health professionals regarding the care of people who identify themselves as lesbians, gays, bisexuals, transvestites, transsexuals, transgenders, queers, intersexes, asexuals, pansexual, and other sexual and gender minorities[30]. Given this scenario, it is possible to rethink more comprehensive curricula to enable professionals to understand better and feel more confident about the primary healthcare needs of the LGBTQIAP+ population[30].

There is much to be done to understand the social determinant/conditioner of the health of sexual and gender minorities, as well as the holistic interpretation of the multiple intervening factors present in the process of caring for LGBTQIAP+ people, especially during multidisciplinary training in health and during the performance of the various actors in the field of primary care. We hope the results of this study will shed light on the theme and contribute to reflections that reduce the gaps in knowledge that currently exist.

The adopted non-probability sample and the fact that the accompanying family members were invited to participate in an exclusively virtual way were limitations of the study. Despite their operational, temporal, and logistical advantages for data collection, we recognize that the snowball sampling technique and the web survey strategy may provide a partial selection of the target audience. Accordingly, the heterogeneous return rate from a geographic perspective, coupled with the lack of knowledge about the access of the interested population to the investigated social media, as well as the low participation of queers, asexuals, pansexuals, transsexuals, transvestites, and transgenders, are highlighted as non-controlled factors that may interfere with the representativeness of sexual/gender minorities and the external validity of the survey. Nevertheless, the results presented here, although not generalizable to the whole of Brazil, are an important portrait of the self-reported health conditions of LGBTQIAP+ people in the country,

as well as of their evaluation of the quality of primary care teams and associated factors.

Although the type of study presented does not enable us to determine or discuss causality since, in cross-sectional studies, the criterion of temporality cannot be contemplated, we believe that, given one of the methodological advantages of sectional approaches, this work contributed to the proposition of hypotheses that need investigation and clarification. The hypotheses are the following: LGBTQIAP+ people who work, who have kidney problems, who have been recently hospitalized and who are assisted by professionals who know their sexual orientation and gender identity evaluate the PHC they receive as of better quality. Therefore, we suggest that further research might be conducted to elucidate the hypotheses listed here.

CONCLUSION

The socio-demographic aspects and the health conditions/situations self-reported by lesbians, gays, bisexuals, transvestites, transsexuals, transgenders, queers, intersexes, asexuals, pansexuals, and other sexual and gender minorities addressed here corroborate a situation of vulnerability that can boost the existing health problems and also contribute to the emergence of new unfavorable health-disease conditions. When dealing with silent, invisible, and/or neglected health problems, such as the use of legal or illegal substances, bodyweight problems, and mental health issues, we face a perverse and undesirable cycle of inequalities/inequities in the field of health that need to be urgently addressed.

LGBTQIAP+ people participating in the study mainly evaluated PHC as of low quality. The attributes Community Guidance and Coordination (care integration) stood out for negative evaluations, which may indicate little extension of these attributes in the communities where they live. The distribution of answers to the PCATool suggests that participants who use PHC services evaluate the quality of health care better when compared to individuals who report difficulties in access to this level of care of SUS. People belonging to sexual and gender minorities who were working, had kidney problems, had recently been

hospitalized, and that had their gender identity/ sexual orientation known by health professionals were more likely to evaluate the PHC (un) available to them as good.

In light of the risk of biopsychosocial involvement of LGBTQIAP+ people described in the pertinent literature and the preponderant responsibility of PHC regarding their specific health characteristics and demands, there is much to be invested in the social, political, academic/scientific and teaching/services/health practices spheres to ensure the right to universal, integral and equitable health to gender and sexual minorities. In this context, this work points to family guidance, accessibility, longitudinality, and available services as weaknesses that can be prioritized in the search for the satisfactory presence and extension of all PHC attributes for the LGBTQIAP+ population in the scope of the Brazilian Unified Health System.

REFERENCES

1. Bizub B, Allen B. A Review of Clinical Guidelines for Creating a Gender-Affirming Primary Care Practice. WMJ [Internet] 2020;119(1):8–15. Available from: https://wmjonline.org/wp-content/uploads/2020/119/1/8.pdf

2. Morenz AM, Goldhammer H, Lambert CA, Hopwood R, Keuroghlian AS. A Blueprint for Planning and Implementing a Transgender Health Program. Ann Fam Med [Internet] 2020;18(1):73–9. Available from: http://www.annfammed.org/lookup/doi/10.1370/afm.2473

3. Cook S, Gunter K, Lopez F. Establishing Effective Health Care Partnerships with Sexual and Gender Minority Patients: Recommendations for Obstetrician Gynecologists. Semin Reprod Med [Internet] 2017;35(05):397–407. Available from: http://www.thieme-connect.de/DOI/DOI?10.1055/s-0037-1604464

4. Bezerra MV da R, Moreno CA, Prado NM de BL, Santos AM dos. Política de saúde LGBT e sua invisibilidade nas publicações em saúde coletiva. Saúde em Debate [Internet] 2019;43(spe8):305–23. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042019001300305&tlng=pt

5. Vieira RC, Teixeira DS, Borret R, Ornelas D, Sarno MM, Junior AL. Atenção Primária à Saúde quebrando tabus. Rev Bras Med Família e Comunidade [Internet] 2019;14(41):1821. Available from: https://rbmfc.org.br/rbmfc/article/view/1821

6. Brasil. Portaria No 2.836, de 1o de dezembro de 2011 [Internet]. Brasil: 2011. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2836_01_12_2011.html

7. Brasil. Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais [Internet]. 1. ed. Brasília: Ministério da Saúde; 2013. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_lesbicas_gays.pdf

8. Belém JM, Alves MJH, Pereira EV, Moreira FTL dos S, Quirino GDS, Albuquerque GA. Atenção à Saúde de Lésbicas, Gays, Bissexuais, Travestis e Transexuais na Estratégia Saúde da Família. Rev Baiana Enfermagem [Internet] 2018;32. Available from: https://portalseer.ufba.br/index.php/enfermagem/article/view/26475

9. Ferreira B de O, Pedrosa JI dos S, Nascimento EF do. Diversidade de gênero e acesso ao Sistema Único de Saúde. Rev Bras em Promoção da Saúde [Internet] 2018;31(1):1–10. Available from: http://periodicos.unifor.br/RBPS/article/view/6726

10. Polit DF, Beck CT. Fundamentos de Pesquisa em Enfermagem - 7ed: Avaliação de Evidências para a Prática da Enfermagem [Internet]. Artmed Editora; 2016. Available from: https://books.google.com.br/books?id=2AKpDAAAQBAJ

11. Malta M, Cardoso LO, Bastos FI, Magnanini MMF, Silva CMFP da. Iniciativa STROBE: subsídios para a comunicação de estudos observacionais. Rev Saude Publica [Internet] 2010;44(3):559–65. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102010000300021&lng=pt&tlng=pt

12. Google. Google Forms [Internet]. 2021 [cited 2021 Aug 22];Available from: https://www.google.com/intl/pt-BR/forms/about/

13. Brasil. e-SUS Atenção Básica. Fichas - CDS: Versão 2.1 do e-SUS AB. Cadastro Individual [Internet]. 2021;Available from: http://189.28.128.100/dab/docs/portaldab/documentos/Cadastro_Individual.pdf

14. Oliveira MMC de, Harzheim E, Riboldi J, Duncan BB. PCATool-ADULTO-BRASIL: uma versão reduzida. Rev Bras Med Família e Comunidade [Internet] 2013;8(9):256–63. Available from: https://rbmfc.org.br/rbmfc/article/view/823/585

15. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia [Internet]. Brasília: UNESCO/Ministério da Saúde; 2002. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/atencao_primaria_p1.pdf

16. Prates ML, Machado JC, Silva LS da, Avelar PS, Prates LL, Mendonça ET de, et al. Desempenho da Atenção Primária à Saúde segundo o instrumento PCATool: uma revisão sistemática TT - Performance of primary health care according to PCATool instrument: a systematic review. Ciênc Saúde Colet [Internet] 2017;22(6):1881–93. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1413-81232017000601881

17. Perillo RD, Bernal RTI, Poças KC, Duarte EC, Malta DC. Avaliação da Atenção Primária à Saúde na ótica dos usuários: reflexões sobre o uso do Primary Care Assessment Tool-Brasil versão reduzida nos inquéritos telefônicos. Rev Bras Epidemiol [Internet] 2020;23(suppl 1). Avai-

lable from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1415-790X2020000200411&tlng=pt

18. Lau F, Antonio M, Davison K, Queen R, Devor A. A rapid review of gender, sex, and sexual orientation documentation in electronic health records. J Am Med Inform Assoc [Internet] 2020;27(11):1774–83. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7671624/

19. Davison K, Queen R, Lau F, Antonio M. Culturally Competent Gender, Sex, and Sexual Orientation Information Practices and Electronic Health Records: Rapid Review. JMIR Med informatics [Internet] 2021;9(2):e25467. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7906831/

20. Jun H-J, Webb-Morgan M, Felner JK, Wisdom JP, Haley SJ, Austin SB, et al. Sexual orientation and gender identity disparities in substance use disorders during young adulthood in a United States longitudinal cohort. Drug Alcohol Depend [Internet] 2019;205:107619. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0376871619303965

21. Grant JE, Odlaug BL, Derbyshire K, Schreiber LRN, Lust K, Christenson G. Mental Health and Clinical Correlates in Lesbian, Gay, Bisexual, and Queer Young Adults. J Am Coll Heal [Internet] 2014;62(1):75–8. Available from: http://www.tandfonline.com/doi/abs/10.1080/07448481.2013.844697

22. Klein DA, Malcolm NM, Berry-Bibee EN, Paradise SL, Coulter JS, Keglovitz Baker K, et al. Quality Primary Care and Family Planning Services for LGBT Clients: A Comprehensive Review of Clinical Guidelines. LGBT Heal [Internet] 2018;5(3):153–70. Available from: http://www.liebertpub.com/doi/10.1089/lgbt.2017.0213

23. Guimarães R de CP, Cavadinha ET, Mendonça AVM, Sousa MF. Assistência a população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários de Saúde? Tempus Actas de Saúde Coletiva [Internet] 2017;11(1):121. Available from: http://www.tempus.unb.br/index.php/tempus/article/view/2327

24. Call DC, Challa M, Telingator CJ. Providing Affirmative Care to Transgender and Gender Diverse Youth: Disparities, Interventions, and Outcomes. Curr Psychiatry Rep [Internet] 2021;23(6):33. Available from: https://link.springer.com/10.1007/s11920-021-01245-9

25. Gridley SJ, Crouch JM, Evans Y, Eng W, Antoon E, Lyapustina M, et al. Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth. J Adolesc Heal [Internet] 2016;59(3):254–61. Available from: https://linkinghub.elsevier.com/retrieve/pii/S1054139X16000963

26. Fisher CB, Fried AL, Macapagal K, Mustanski B. Patient–Provider Communication Barriers and Facilitators to HIV and STI Preventive Services for Adolescent MSM. AIDS Behav [Internet] 2018;22(10):3417–28. Available from: http://link.springer.com/10.1007/s10461-018-2081-x

27. Furness BW, Goldhammer H, Montalvo W, Gagnon K, Bifulco L, Lentine D, et al. Transforming Primary Care for Lesbian, Gay, Bisexual, and Transgender People: A Collaborative Quality Improvement Initiative. Ann Fam Med [Internet] 2020;18(4):292–302. Available from: http://www.annfammed.org/lookup/doi/10.1370/afm.2542

28. Reisner SL, Silva-Santisteban A, Salazar X, Vilela J, D'Amico L, Perez-Brumer A. "Existimos": Health and social needs of transgender men in Lima, Peru. PLoS One [Internet] 2021;16(8):e0254494. Available from: https://dx.plos.org/10.1371/journal.pone.0254494

29. Goldenberg T, Jadwin-Cakmak L, Popoff E, Reisner SL, Campbell BA, Harper GW. Stigma, Gender Affirmation, and Primary Healthcare Use Among Black Transgender Youth. J Adolesc Heal [Internet] 2019;65(4):483–90. Available from: https://linkinghub.elsevier.com/retrieve/pii/S1054139X19302502

30. Ufomata E, Eckstrand KL, Spagnoletti C, Veet C, Walk TJ, Webb C, et al. Comprehensive Curriculum for Internal Medicine Residents on Primary Care of Patients Identifying as Lesbian, Gay, Bisexual, or Transgender. MedEdPORTAL [Internet] 2020;16(1). Available from: http://www.mededportal.org/doi/10.15766/mep_2374-8265.10875

Corresponding Author:
Murilo César do Nascimento
murilo.nascimento@unifal-mg.edu.br