

Oral health care in the LGBTQIA+ population

Assistência à saúde bucal na população LGBTQIA+

Michele de Oliveira Soares¹, Vania Reis Girianelli¹

DOI: 10.1590/2358-28982023E18970I

ABSTRACT This study analyzes oral health care for the LGBTQIA+ population in view of the lack of information on oral health in this population and the recent changes in the National Oral Health Policy (PNSB), that have weakened progress and enabled setbacks in this area. A descriptive cross-sectional study was carried out, using a semi-structured questionnaire that was self-applied online. A total of 359 people answered, 329 (91.9%) were eligible. Of these, 38% gays, 23.4% lesbians, and 13.4% transgenders. Most were between 18 and 39 years old (73.3%) and Black (51.4%). The percentage of people receiving care was high in the five years prior to the survey (92.9%), as well as in the last six months (44.7%); it was lower in the transgender population (88.7% and 18.2% respectively). Only 18.8% of this population had been treated in the public health system, and this was higher among transgender people (45.5%) and Black people (25.4%). The self-perception of oral health for the majority was good or very good (53.2%); but bad or very bad (45.5%) for transgender. Most reported preferring to be assisted by an LGBT professional (69.0%). The transgender and Black population were the most vulnerable to assistance, indicating that race, gender, and sexuality directly influence access to health care, so an intersectional approach is essential for the organization of the service.

KEYWORDS Human rights. Sexual and gender minorities. Oral health. Intersectional framework.

RESUMO *Objetivou-se analisar a assistência à saúde bucal da população LGBTQIA+ sob a perspectiva do usuário, considerando a ausência de informação sobre a saúde bucal nessa população e as recentes mudanças na Política Nacional de Saúde Bucal (PNSB), que fragilizaram avanços nessa área e possibilitaram retrocessos. Realizou-se estudo transversal descritivo, utilizando questionário semiestruturado autoaplicado on-line. Responderam ao questionário 359 pessoas, sendo elegíveis 329 (91,9%). Dessas, 38% eram gays, 23,4%, lésbicas, e 13,4%, transgêneros(as). A maioria tinha entre 18 e 39 anos (73,3%) e era negro(a) (51,4%). A prevalência de assistência foi alta nos cinco anos anteriores à pesquisa (92,9%), bem como nos últimos seis meses (44,7%); sendo mais baixa na população transgênera (88,7% e 18,2% respectivamente). Apenas 18,8% dessa população foi atendida na rede pública, sendo maior entre transgêneros(as) (45,5%) e negros(as) (25,4%). A autopercepção da saúde bucal para a maioria foi boa ou muito boa (53,2%); mas ruim ou muito ruim (45,5%) para os(as) transgêneros(as). A maioria informou preferir ser atendida por profissional LGBTQIA+ (69%). A população transgênera e negra foi a mais vulnerável à assistência, sinalizando que raça, gênero e sexualidade influenciam diretamente no acesso ao cuidado em saúde, portanto, o enfoque interseccional é imprescindível para organização do serviço.*

PALAVRAS-CHAVE *Direitos humanos. Minorias sexuais e de gênero. Saúde bucal. Enquadramento interseccional.*

¹Fundação Oswaldo Cruz (Fiocruz), Escola Nacional de Saúde Pública Sergio Arouca (Ensp) - Rio de Janeiro (RJ), Brasil.
michelesoares2@yahoo.com.br



Introduction

Historically, healthcare and access to medicine practiced during the colonial period in Brazil were exclusive to the bourgeoisie and the clergy. Marginalized and enslaved people, faced with the need to survive and resist the inhuman and precarious conditions to which they were subjected, relied on health care through the hands of healers, midwives, bleeders and barbers¹.

While barbers shaved, many also bled, applied suction cups and performed minor surgeries, including tooth extractions. This was an activity of low social prestige, usually practiced by marginalized people, for example, enslaved or freed Black people².

In the twentieth century, dentistry underwent various advancements, initially adopting a hygienist healthcare model, with iatrogenic and mutilating dental practices centered on disease. This sparked discussions about the need to align a new dental practice model with the proposals of the Health Reform movement³.

The process of consolidating the Unified Health System (SUS) and its doctrinal and organizational principles – such as universality, equity, integrality, decentralization, regionalization, hierarchization, and social participation⁴ – demanded a reorganization and restructuring of oral health actions and services⁵. This process made it possible to break away from obsolete practices and unresolvable techniques that did not meet society's needs.

In 2004, the Ministry of Health published the guidelines for the National Oral Health Policy (PNSB), *Brasil Sorridente* (Smiling Brazil), aiming to organize oral health care in the SUS⁴. This process enabled the breakaway from obsolete practices and techniques that were inadequately solving society's needs.

The National Policy for the Integral Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals was instituted in 2011 with the aim of promoting comprehensive health for this population^{6,7}. It also seeks to eliminate

discrimination and institutional prejudice, as well as contributing to the reduction of inequalities and consolidating SUS as a universal, comprehensive and equitable system, although access to public health services for the LGBTQIA+ population is guaranteed in the Federal Constitution⁸ and reiterated with the principle of universality of SUS⁹. The acronym LGBTQIA+ is the most widely used today, and is an abbreviation for Lesbian, Gay, Bisexual, Transsexual, Transvestite, Transgender, Queer, Intersexual or Intersex, Asexual and other possible existences. Like people, LGBT terminology is evolving with a view of inclusion, though different acronyms can be used depending on the context or the position of those using them.

We live in a society with a cis-heteronormative and binary standard – feminine and masculine – where men and women are defined according to their sexual organs. However, this construction is not biological; it is social¹⁰. Therefore, it is essential to use inclusive concepts and terms: “Writing or speaking according to a vocabulary recognized by the people represented is essential for valuing citizenship”¹⁰⁽¹³⁾.

The importance of accessing and guaranteeing oral health in Brazil has been thought about and built up for over 30 years, since the first National Oral Health Conference (CNSB) in 1986¹¹, after the Nacional Health Conference.

In this context, the PNSB focuses on universal care, but in a generalized way, with organization into lines of care: life cycles, and age groups⁴. In addition, the publications that build the Oral Health Care Network (RASB) do not make it explicit that there is a cross-cutting approach – a principle of the National Humanization Policy¹² – with policies and programs for specific populations.

The National Oral Health Survey (2021/2022) aims to assess the oral health epidemiological profile of the Brazilian population, but makes it impossible to identify LGBTQIA+ people, as it does not include gender identity and sexual orientation¹³.

In this context, the PNSB focuses on universal care, but in a generalized way, with the organization along lines of care: life cycles and age group⁴. Furthermore, the transversality – principle of the National Humanization Policy¹² – with policies and programs for specific populations is not explicit in the publications that build the Oral Health Care Network (RASB).

The National Oral Health Survey (2021/2022) aims to evaluate the epidemiological profile in oral health of the Brazilian population, but makes it impossible to identify LGBTQIA+ people, as it does not include gender identity and sexual orientation¹³

However, changes in the national political scene have jeopardized the achievements of years of struggle. Progressive losses with the dismantling of SUS, neoliberalism and fascism strengthened through fake news, and other tricks have put democracy and the achieved rights at risk. The dismantling of the SUS through de-funding makes it unfeasible to implement public policies, particularly for the most vulnerable populations, such as the LGBTQIA+ population¹⁴.

The study sought to identify the difficulties highlighted by LGBTQIA+ people regarding access to the public oral health service, as well as to give visibility to the singularities of these users in order to qualify the RASB. Therefore, the objective of the study was to analyze oral health care for the LGBTQIA+ population from the user's perspective. It was also inspired by the lack of information about the oral health of the LGBTQIA+ population and the dismantling of the PNSB.

Methodology

This was a descriptive cross-sectional observational epidemiological study to find out about the use of oral health care and the difficulties faced by the LGBTQIA+ population. In a cross-sectional study, the unit of analysis was the individual from a well-defined population and period with the aim of cutting across

the historical flow of the event of interest in order to describe its characteristics. Data was collected at a single point in time for all the previously established variables of interest¹⁵.

The eligible participants for the study were LGBTQIA+ people who answered the semi-structured, self-administered questionnaire online using Google Forms. Participants were reached via a WhatsApp group by means of an invitation letter using the snowball technique, with the initial contacts being students on the first author's master's degree course. In addition, the link to access the research was shared within social movements.

The questionnaire covered socioeconomic and demographic characteristics: sexual orientation (lesbian, gay, bisexual, asexual, heterosexual and others), gender identity (cisgender and transgender), race/color (white, black, yellow or indigenous), schooling (up to complete elementary school, incomplete or complete high school, incomplete higher education or higher), occupation (unemployed, public servant or in a high school, technical or higher education occupation), age (18 to 39 years, 40 years and over), municipality, state and region of residence of the study participants; as well as discrimination, self-assessment (good or very good, fair, poor or very poor) and use of oral health care in the last five years, and the difficulties experienced.

The prevalence of use of oral health care in the studied population and the respective 95% confidence interval (IC95%) were calculated, as well as the percentage of each category of the other variables. Pearson's chi-square test was calculated to assess the existence of a statistically significant difference ($p \leq 0.05$) between the strata, with Yates' correction when necessary. The data were exported to the Excel[®] program and analyzed using the R statistical program R version 3.4.3.

The research (CAAE:54050321.8.0000.5240) was approved by the Research Ethics Committee (CEP) of the National School of Public Health Sergio Arouca, number 5.196.679, issued on January 10, 2022.

Results

The questionnaire was accessed by 359 people, but 1 did not agree to take part and 29 were ineligible. Of the 329 (91.9%) eligible for the study, 125 (38%) were gay; 77 (23.4%)

lesbian; and 44 (13.4%) transgender (*table 1*). Among transgender people, the majority were heterosexual (36.4%) or bisexual (34.1%). Transsexual men accounted for 52.3% of transgender participants.

Table 1. Characteristics of the population participating in the study according to gender identity and sexual orientation. Brazil, 2022

Sexual Orientation	Gender identity					
	Total		Cisgender		Transgender	
	N	%	N	%	N	%
Lesbian	77	23.4	76	26.7	1	2.3
Gay	125	38.0	121	42.5	4	9.1
Bisexual	89	27.1	74	26.0	15	34.1
Asexual	3	0.9	2	0.7	1	2.3
Other	19	5.8	12	4.2	7	15.9
Heterosexual	16	4.9	-	-	16	36.4
Total	329	100.0	285	100.0	44	100.0

Source: Own elaboration.

The participants were predominantly between the ages of 18 and 39 (73.3%); black (51.4%); with incomplete higher education or more (69.6%); living in the Southeast region (79.6%), mainly in the state of Rio de Janeiro (62.9%); and civil servants or in middle, technical and higher education occupations (43.8%) (*table 2*). The transgender population was proportionally higher than the cisgender population in terms of black race/color

(65.9%; $p = 0.028$); having completed high school or less (68.2%; $p < 0.001$); living in the North (25%; $p < 0.001$), mainly in the state of Amazonas (20.5%); and unemployment (15.9%; $p < 0.001$). Among lesbians, there were proportionally more residents in the Northeast region (19.5%; $p < 0.001$), especially in the state of Bahia (18.2%), and the other populations were younger (77.4%; $p = 0.004$).

Table 2. Sociodemographic characteristics of the population participating in the study according to gender identity and sexual orientation. Brazil, 2022

Characteristics	Total		Cisgender		Transgender		p	Lesbians		Other		p
	N	%	N	%	N	%		N	%	N	%	
Age range												
18 to 39 years old	241	73.3	207	72.6	34	77.3	0.064	46	59.7	195	77.4	0.004
40 years or older	88	26.7	78	27.4	10	22.7		31	40.3	57	22.6	

Table 2. Sociodemographic characteristics of the population participating in the study according to gender identity and sexual orientation. Brazil, 2022

Characteristics	Total		Cisgender		Transgender		p	Lesbians		Other		p
	N	%	N	%	N	%		N	%	N	%	
Race/skin color												
White	156	47.4	143	50.2	13	29.5	0.028	32	41.6	124	49.2	0.297
Black	169	51.4	140	49.1	29	65.9		44	57.1	125	49.6	
Yellow or indigenous	4	1.2	2	0.7	2	4.5	-	1	1.3	3	1.2	-
Schooling												
Up to complete elementary school	12	3.6	3	1.1	9	20.5	< 0.001*	3	3.9	9	3.6	0.401
High school incomplete or complete	88	26.7	67	23.5	21	47.7		16	20.8	72	28.6	
	229	69.6	215	75.4	14	31.8		58	75.3	171	67.9	
Region of Residence												
North	22	6.7	11	3.9	11	25.0	< 0.001*	1	1.3	21	8.3	< 0.001*
North East	28	8.5	25	8.8	3	6.8		15	19.5	13	5.2	
Southeast	262	79.6	233	81.8	29	65.9		58	75.3	204	81.0	
South	7	2.1	7	2.5	0	0.0		0	0.0	7	2.8	
Midwest	10	3.0	9	3.2	1	2.3		3	3.9	7	2.8	
Profession												
Public servant, occupation of secondary, technical or higher level	144	43.8	139	48.8	5	11.4	< 0.001*	42	54.5	102	40.5	0.001*
Student and/or intern	42	12.8	37	13.0	5	11.4		3	3.9	39	15.5	
Other occupations	104	31.6	81	28.4	23	52.3		23	29.9	81	32.1	
Retired	8	2.4	6	2.1	2	4.5		2	2.6	6	2.4	
Self-Employed	10	3.0	8	2.8	2	4.5		2	2.6	8	3.2	
Unemployed	21	6.4	14	4.9	7	15.9		5	6.5	16	6.3	
Total	329	100.0	285	100.0	44	100.0	-	77	100.0	252	100.0	-

Source: Own elaboration.

* Chi-squared approximation may be incorrect.

The prevalence of oral health care in the five years prior to the survey was high (92.9%; 95%CI: 89.7% – 95.3%), being proportionally lower for the transgender population (88.7%; 95%CI: 76% – 95.1%) than for the cisgender population (93.7%; 95%CI: 90.2% - 96%). The majority of participants had had oral health treatment in the last six months (44.7%;

95%CI: 39.4% - 50.1%) (table 3). There was no statistically significant difference in the prevalence of use between lesbians and other sexual orientations ($p = 0.184$) or in relation to race/skin color ($p = 0.993$). However, with regard to the transgender population, most of them had last been to the dentist 2 years ago or more (40.9%; $p < 0.001$).

Table 3. Prevalence of use of oral health care by study participants according to gender identity, sexual orientation, and race/skin color. Brazil, 2022

Last time went to the dentist	Total*			Cisgender		Transgender		p [‡]	Lesbian		Other		p [‡]	White		Black		p [‡]
	N	%	IC95%	N	%	N	%		N	%	N	%		N	%	N	%	
Up to 6 months	147	44.7	39.4 - 50.1	139	48.8	8	18.2	< 0.001	35	45.5	112	44.4	0.184	71	45.5	75	44.4	0.993
6 months to 1 year	52	15.8	12.3 - 20.1	39	13.7	13	29.5		10	13.0	42	16.7		26	16.7	25	14.8	
1 year to 2 years	52	15.8	12.3 - 20.1	47	16.5	5	11.4		19	24.7	33	13.1		24	15.4	27	16.0	
2 years to 3 years	35	10.6	7.8 - 14.4	28	9.8	7	15.9		6	7.8	29	11.5		15	9.6	19	11.2	
3 years to 4 years	11	3.3	1.9 - 5.9	6	2.1	5	11.4		2	2.6	9	3.6		5	3.2	6	3.6	
4 years to 5 years	9	2.7	1.5 - 5.1	8	2.8	1	2.3		1	1.3	8	3.2		5	3.2	4	2.4	
5 years or more	23	7.0	4.7 - 10.3	18	6.3	5	11.4		4	5.2	19	7.5		10	6.4	13	7.7	
Total	329	100.0	-	285	100.0	44	100.0		77	100.0	252	100.0		156	100.0	169	100.0	-

Source: Own elaboration.

* Includes yellow and indigenous population.

‡ The categories of 4 to 5 years and 5 years or more were grouped to allow analysis.

Oral health care was mainly provided in the private sector (50.5%), whereas among transgender people, attendance was proportionally higher in the public sector than among cisgender people (45.5%; $p < 0.001$) (table 4). The majority did not inform the reason for the consultation (27.1%). However, the main reason was preventive care, such as a check-up, routine, prevention or cleaning (26.6%). A

minority reported having experienced difficulties with care (24.9%), but this was proportionally higher among the transgender population (54.5%; $p < 0.001$), who also experienced more discrimination (13.6%; $p < 0.001$), especially due to LGBTphobia. Difficulty in accessing care was particularly due to delays or the impossibility of making an appointment (40.2%), and financial difficulties (22%).

Table 4. Characteristics of oral health care of study participants according to gender identity, sexual orientation and race/skin color. Brazil, 2022

Characteristics	Total*		Cisgender		Transgender		p	Lesbians		Others		p	White		Black		p	
	N	%	N	%	N	%		N	%	N	%		N	%	N	%		
Type of consultation																		
Public	62	18.8	42	14.7	20	45.5	< 0.001	11	14.3	51	20.2	0.587	18	11.5	43	25.4	0.007	
Health Insurance	95	28.9	90	31.6	5	11.4		22	28.6	73	29.0		48	30.8	47	27.8		
Private	166	50.5	147	51.6	19	43.2		40	51.9	126	50.0		86	55.1	77	45.6		
Other	6	1.8	6	2.1	0	0.0	-	4	5.2	2	0.8	-	4	2.6	2	1.2	-	
Difficulty of assistance																		
Yes	82	24.9	58	20.4	24	54.5	< 0.001	18	23.4	64	25.4	0.835	30	19.2	49	29.0	0.055	
No	247	75.1	227	79.6	20	45.5		59	76.6	188	74.6		126	80.8	120	71.0		

Table 4. Characteristics of oral health care of study participants according to gender identity, sexual orientation and race/skin color. Brazil, 2022

Characteristics	Total*		Cisgender		Transgender		p	Lesbians		Others		p	White		Black		p	
	N	%	N	%	N	%		N	%	N	%		N	%	N	%		
Experienced discrimination																		
Yes	11	3.3	5	1.8	6	13.6	< 0.001	1	1.3	10	4.0	0.436	3	1.9	7	4.1	0.190	
No	318	96.7	280	98.2	38	86.4		76	98.7	242	96.0		153	98.1	162	95.9		
Tooth loss																		
Yes	151	45.9	124	43.5	27	61.4	0.040	40	51.9	111	44.0	0.277	54	34.6	94	55.6	< 0.001	
No	178	54.1	161	56.5	17	38.6		37	48.1	141	56.0		102	65.4	75	44.4		
Preference for care by LGBT Professional																		
Yes	227	69.0	192	67.4	35	79.5	0.124	54	70.1	173	68.7	0.704	99	63.5	125	74.0	0.115	
No preference	93	28.3	86	30.2	7	15.9		20	26.0	73	29.0		53	34.0	40	23.7		
No	9	2.7	7	2.5	2	4.5		3	3.9	6	2.4		4	2.6	4	2.4		
Total	329	100.0	285	100.0	44	100.0	-	77	100.0	252	100.0	-	156	100.0	169	100.0	-	

Source: Own elaboration.

* Including yellow and indigenous populations.

Tooth loss was also proportionally greater among transgender people (61.4%; $p = 0.040$). The main cause reported by participants was caries, periodontal disease or abscess (29.8%), followed by poor oral hygiene, lack of care or interruption of treatment (19.9%). Among those who had tooth loss (151), 72.8% had less than five teeth (72.8%).

Regarding self-assessment of oral health (table 5), the cisgender population reported being good or very good (57.5%), while the transgender population said it was bad or very bad (45.5%; $p < 0.001$). The majority of participants reported preferring to be seen by an LGBTQIA+ professional (69%).

Table 5. Self-assessment of oral health of study participants according to gender identity, sexual orientation, and race/skin color. Brazil, 2022

Self-evaluation of oral health	Total*		Cisgender		Transgender		p	Lesbians		Other		P	White		Black		p
	N	%	N	%	N	%		N	%	N	%		N	%	N	%	
Good or very good	175	53.2	164	57.5	11	25.0	< 0.001	47	61.0	128	50.8	0.137	93	59.6	80	47.3	0.071
Regular	97	29.5	84	29.5	13	29.5		22	28.6	75	29.8		42	26.9	55	32.5	
Bad or very bad	57	17.3	37	13.0	20	45.5		8	10.4	49	19.4		21	13.5	34	20.1	
Total	329	100.0	285	100.0	44	100.0	-	77	100.0	252	100.0	-	156	100.0	169	100.0	-

Source: Own elaboration.

* Including yellow and indigenous populations.

Discussion

The prevalence of oral health care utilization among the LGBTQIA+ population participating in the study was high in the last five years (92.9%), particularly in the six months prior to the survey (44.7%). The prevalence among whites and blacks was similar, but the transgender population, which represented only 13.4% of participants, had a lower prevalence (88.7%), especially in the last six months (18.2%). Transgender participants also had proportionally less schooling, lived in the North, and were unemployed compared to the others ($p < 0.001$). In the national survey carried out in 2013, more than 40% of those interviewed reported having seen a dentist in the last year¹⁶⁻¹⁸. Regular visits to the dentist were reported by 63.7%, with greater variation in relation to schooling, 36.6% among those with no schooling and 85.5% with more than 11 years of schooling; however, being black, living in the North or Northeast and belonging to a lower social class were also more likely to have never been to the dentist or to have irregular follow-ups¹⁹.

Only 18.8% of the participants in the study had been treated in the public health system, but this was proportionally higher among transgender people (45.5%). However, a survey carried out in 2013 found out that 11% of those interviewed had been treated in the SUS¹⁸.

Difficulty in finding care has also been higher among transgender people (54.5%) than others (20.4%); as well as having suffered discrimination – 13.6% and 1.8% respectively. Transgender people find it more difficult to access services, so they avoid seeking health care for fear of discrimination²⁰. The majority of participants reported preferring to be seen by an LGBTQIA+ professional (69%), especially among transgender people (79.5%) and Black people (74%); but the differences between the proportions were not statistically significant ($p \geq 0.115$), probably due to the small sample size in the category that has no preference.

It is important to emphasize that transgender people experience various difficulties in the society they live in, since their transvestility and transsexuality are exposed in their bodies. Louro²¹ points to the social construction of a binary and heterosexual matrix that shapes sexual and gender patterns. In this context, the insecurity inherent in gender norms shows that these people are despised and are on the margins of society, where there is no guarantee of rights and their very humanity is denied. This is echoed in various spheres, including health²².

On the other hand, cisgender people find it easier not to reveal their sexual orientation to health professionals and are, therefore, less vulnerable to discrimination because of the assumption that they are heterosexual, like lesbians^{20,23}.

In this sense, the LGBTQIA+ population avoids attending health services, postpones or abandons clinical and preventive treatments as a result of negative experiences²⁴. In an integrative review study²⁵, it was concluded that the LGBTQIA+ population has less access to oral health services and that there is a lack of formal preparation of undergraduate students for care. Furthermore, recurrent discrimination at the institutional level predisposes this population to the risk of diseases and disorders, such as depression, anxiety, poor diet, weight loss and, in particular, lack of hygiene – factors that, together, affect multiple facets and have an impact on oral health.

A study conducted in Ontario, Canada, identified that 43.9% of the transgender population did not succeed in accessing healthcare, presenting a percentage three times lower than cisgender and heterosexual individuals, as well as having a worse evaluation of health services²⁶. A study in the United States also identified that the transgender population tends to experience more fear and anxiety regarding dental treatment, which correlates with the high prevalence of discrimination and poor treatment experienced²⁷.

This situation is evident with the high percentage of participants who have experienced tooth loss (45.9%), especially among transgender individuals (61.4%) and Black individuals (55.6%). However, international studies indicate that periodontal diseases and increase in caries do not differ when compared with the heterosexual population, i.e. what differs is the inherent self-perception of oral health²⁵.

Self-perception of oral health was good or very good (53.2%) for the majority of participants in the study, as well as for cisgender (57.5%), lesbian (61.0%) and black (43.7%) people; however, for transgender people, it was bad or very bad (45.5%). A study based on the 2013 survey found that the prevalence of positive self-perception of oral health was 67.4% and that negative self-perception was higher in the population with an income of less than one minimum wage, illiterate people and precarious or elementary jobs¹⁶. Bordin e colaboradores¹⁸ found that negative self-perception of oral health is mainly related to difficulty in eating, negative evaluation of the last dental visit, negative self-perception of general health, and failure to adopt preventive dental measures such as flossing and routine check-ups.

A study on healthy lifestyle habits, such as self-care, not smoking, moderate drinking and physical activity, among others, found that lesbian and bisexual women were less likely to accept such habits when compared to heterosexual cisgender women. Transgender men, on the other hand, were more likely than transgender women and heterosexual cisgender people. There was no difference in the proportion of such habits among heterosexual cisgender men, gay men, and bisexual men²⁸.

A limitation of the study is that the research participants had high levels of education and were concentrated in large urban centers, especially in the city of Rio de Janeiro, a population that tends to have more access to information, services, and income, not representing the reality of the majority of the

LGBTQIA+ population. It is important to note, however, that even within this group, the transgender and/or Black population had the worst outcomes.

On the other hand, the study contributes to the topic by including, in an unprecedented way, oral health of the LGBTQIA+ population, encompassing gender identity and sexual orientation, while national research did not even include the binary perspective – female and male. Additionally, the study also included the lesbian population, providing greater visibility to this often neglected and invisible population in health studies and research, seeking to address the demand for lesbian identity in the reorganization of public health policies²⁹.

There is an insufficient amount of scientific literature on the topic of LGBTQIA+ oral health, with the majority coming from international sources. This lack of studies in other countries and the absence of national research further highlight and reinforce the invisibility in professional training and health research^{25,30,31}.

Discrimination and obstacles to accessing healthcare services are common occurrences. A patriarchal and heteronormative society stigmatizes, discriminates against, and excludes the LGBTQIA+ population due to a culture that predominantly focuses on heterosexuality; thus, health inequalities are growing significantly³².

The LGBTQIA+ population faces barriers in their daily lives when it comes to healthcare. There is a difficulty in finding health professionals who understand the real needs of this population, who treat them with discrimination delay or even refuse to provide care, failing to safeguard their right to health³³.

The search of this population for healthcare services is immersed in a perspective of denial, violence, neglect, and invisibility, being a structural issue associated with the lack of public policies. Non-recognition and lack of attention are prospectively rooted in patriarchy, sexism, and male-oriented society, along with prejudice that affects all social relationships,

occupying all spaces, including educational and healthcare institutions^{32,34}.

It is essential that professionals are trained on the subject, which enables a less stigmatized view that is closer to real needs. Permanent health education thus becomes the main resource to be used for recognizing, planning and implementing actions aimed at the LGBTQIA+ population³⁵.

Therefore, it is urgent to develop and evaluate a proposal for ongoing education for the oral health team, aiming to identify and support vulnerable populations, and to reflect on fight against various forms of discrimination. This is in order to promote the protection of the right to free sexual orientation and gender for the comprehensive health of these individuals, as well as to safeguard human rights and citizenship as provided for, but not fully enforced⁶.

Thus, it is a question of promoting the practice of health that is not limited to the treatment of sexually transmitted infections, in other words, integral health based on equity, which will help to tackle the social inequalities inherent in the health of the LGBTQIA+ population^{6,36,37}.

Final considerations

The research into oral health care for the LGBTQIA+ population aimed to analyze the oral health of these people, contributing in an unprecedented way to the inclusion of gender identity and sexual orientation in a national oral health study. Even among participants with higher education and in large urban centers, the transgender and Black population had the worst results. This demonstrates that

race, gender and sexuality directly influence access to health care; therefore, the intersectional approach is essential for organizing the service.

The difficulties faced by this population stem from multiple systems of structural oppressions, which fail to recognize them as individuals due to a patriarchal, heterosexual, cisgender, and white culture. The lack of studies in other countries and the absence of national research further reinforce and highlight the invisibility in professional training and health research.

The lack of studies in other countries and the absence of national research reinforce and highlight the invisibility of professional training and health research. In this sense, it is essential that professionals are trained on the subject, which enables a less stigmatized view that is closer to real needs. Continuous health education, in this context, becomes the main resource to be used for recognizing, planning and implementing actions aimed at this population. Moreover, there is an urgent need to promote and protect the right to free sexual orientation and gender identity, which will help to tackle the social inequalities inherent in the health of LGBTQIA + people.

Collaborators

Soares MO (0000-0001-9132-7065)* contributed to the conception, planning, analysis, and data interpretation, writing the first version and approval of the final version of the manuscript. Girianelli VR (0000-0002-8690-9893)* contributed to data analysis and interpretation, critical revision of the content and approval of the final version of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Pimenta TS. Entre sangradores e doutores: práticas e formação médica na primeira metade do século XIX. *Cad. Cedes.* 2003; 23-59.
2. Pereira W. Uma História da Odontologia no Brasil. *Perspec.* 2012; (47):147-173.
3. Foratori Junior GA. Brasil Sorridente – reconhecendo a história para reforçar a constante luta pela equidade em Odontologia. *Res., Soc. Dev.* 2021; 10(10):e75101018745.
4. Brasil. Ministério da Saúde. Diretrizes da política nacional de saúde bucal. Brasília, DF: Ministério da Saúde; 2004.
5. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Saúde Bucal. Brasília, DF: Ministério da Saúde; 2008. (Série A. Normas e Manuais Técnicos) (Cadernos de Atenção Básica; 17).
6. Brasil. Ministério da Saúde. 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). *Diário Oficial da União.* 2 Dez 2011.
7. 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 DF: Ministério da Saúde, 2013.
8. Brasil. Constituição, 1988. Constituição da República Federativa do Brasil. Brasília, DF: Senado Federal; 1988.
9. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União.* 20 Set 1990.
10. Jesus JG. Orientações sobre a população transgênero: conceitos e termos. Brasília, DF: Autor, 2012. 24 p.
11. Conselho Nacional de Saúde. I Conferência Nacional de Saúde Bucal: Relatório Final. Brasília, DF: 10 out 1986.
12. Conselho Nacional de Secretários de Saúde. A Atenção Primária e as Redes de Atenção à Saúde. Brasília, DF: Conass, 2015.
13. Brasil. Ministério da Saúde, Secretária de Atenção Primária à Saúde, Departamento de Saúde da Família, Coordenação Geral de Saúde Bucal. SB Brasil 2020 – Pesquisa Nacional de Saúde Bucal – Projeto Técnico. Brasília, DF: Ministério da Saúde; 2021.
14. Stevanim LF. Previne Brasil: mudança sem debate. *Radis.* 2019; (207):19-22.
15. Almeida Filho N, Barreto ML, organizadores. *Epidemiologia e Saúde: fundamentos, métodos, aplicações.* Rio de Janeiro: Guanabara Koogan; 2014.
16. Souza JL, Henriques A, Silva ZP, et al. Posição socioeconômica e autoavaliação da saúde bucal no Brasil: resultados da Pesquisa Nacional de Saúde. *Cad. Saúde Pública.* 2019; 35(6):e00099518.
17. Bastos TF, Medina LPB, Sousa NFDS, et al. Income inequalities in oral health and access to dental services in the Brazilian population: National Health Survey. 2013. *Rev. Bras. Epidemiol.* 2019; 22(supl2):E190015. SUPL.2.
18. Bordin D, Fadel CB, Santos CB, et al. Caracterização da condição percebida de saúde bucal na população adulta brasileira. *Ciênc. saúde coletiva.* 2020; 25(9):3647-3656.
19. Galvão MHR, Souza ACO, Morais HGF, et al. Desigualdades no perfil de utilização de serviços odontológicos no Brasil. *Ciênc. saúde coletiva.* 2022; 27(6):2437-2448.

20. Calazans C, Kalichman A, Santos MR, et al. Necessidades de saúde: demografia, panorama epidemiológico e barreiras de acesso. In: Ciasca SV, Hercowitz A, Lopes Junior A, organizadores. *Saúde LGBTQIA+: Práticas de cuidado interdisciplinar*. Santana de Parnaíba [SP]: Manole; 2021. p. 82-91.
21. Louro GL. *Um corpo estranho: ensaios sobre sexualidade e teoria queer*. Belo Horizonte: Autêntica; 2018.
22. Butler J. O parentesco é sempre tido como heterossexual? *Cad. Pagu*. 2003; (21):219-260.
23. Gomes R, Murta D, Facchini R, et al. Gênero, direitos sexuais e suas implicações na saúde. *Ciênc. saúde coletiva*. 2018; 23(6):1997-2006.
24. Russell S, More F. Addressing health disparities via coordination of care and interprofessional education: lesbian, gay, bisexual, and transgender health and oral health care. *Dent. Clin. North Am*. 2016; 60(4):891-906.
25. Varotto BLR, Massuda M, Nápole RCD, et al. População LGBTQIA+: o acesso ao tratamento odontológico e o preparo do cirurgião dentista-uma revisão integrativa. *Rev. Abeno*. 2022; 22(2):1542-1542.
26. Giblon R, Bauer GR. Health care availability, quality, and unmet need: A comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Serv Res*. 2017; 17(1):283.
27. Heima M, Heaton LJ, Ng HH, et al. Dental fear among transgender individuals - a cross sectional survey. *Spec. Care Dent*. 2017; 37(5):212-22.
28. Padilha WAR, Crenitte MRF, Lopes Junior A. Prevenção e cuidados das doenças crônicas. In: Ciasca SV, Hercowitz A, Lopes Junior A, organizadores. *Saúde LGBTQIA+: Práticas de cuidado interdisciplinar*. Santana de Parnaíba: Manole; 2021. p. 346-356.
29. Jesus JG, organizador. *Transfeminismo: teorias & práticas*. Rio de Janeiro: Editora Metanoia; 2015. 206 p.
30. Bezerra MVR, Moreno CA, Prado NMBL, et al. Política de saúde LGBT e sua invisibilidade nas publicações em saúde coletiva. *Saúde debate*. 2019; 43(esp8):305-323.
31. Eliason MJ, Dibble SL, Robertson PA. Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *J. Homosex*. 2011; 58(10):1355-1371.
32. Guimarães RCP, Cavadinha ET, Mendonça AVM, et al. Assistência a população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários de Saúde? *Tempus*. 2017; 11(1):121-139.
33. Ferreira AP, Nichele CST, Jesus JG, et al. Evidências científicas sobre o acesso aos serviços de saúde pela população LGBTQI+: Revisão de escopo. *Res., Soc. Dev*. 2022; 11(10):e229111032519.
34. Ferreira BO, Pedrosa JIS, Nascimento EF. Diversidade de Gênero e Acesso ao Sistema Único de Saúde. *Rev. Bras. Promoç. Saúde*. 2017; 31(1):1-10.
35. Souza OSL. *Desafios no acolhimento à população LGBT nos serviços do Sistema Único de Saúde do município de Caicó, RN: um estudo sobre a atuação dos profissionais da atenção primária*. [monografia]. Caicó: Universidade Federal do Rio Grande do Norte; 2021. 36 p.
36. Mello L, Perilo M, Braz CA, et al. Políticas de saúde para lésbicas, gays, bissexuais, travestis e transexuais no Brasil: em busca da universalidade, integralidade e equidade. *Sex., Salud Soc*. 2011; (9):7-28.
37. Oliveira CP. *Aproximando a equipe de saúde bucal do cuidado às populações vulnerabilizadas*. [monografia]. Porto Alegre: Universidade Federal do Rio Grande do Sul; 2021. 30 p.

Received on 10/21/2023

Approved on 11/22/2023

Conflict of interests: non-existent

Financial support: none-existent

Responsible editor: Henrique Rabello de Carvalho