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# Oral health care in the LGBTQIA+ population

## *Assistência à saúde bucal na população LGBTQIA+*

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**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.*

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## 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 barbers[1].

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 people[2].

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 movement[3].

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 participation[4] – demanded a reorganization and restructuring of oral health actions and services[5]. 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 SUS[4]. 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 Constitution[8] and reiterated with the principle of universality of SUS[9]. 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 social[10]. 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 1986[11], 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 groups[4]. 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 Policy[12] – 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 orientation[13].

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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 orientation[13]

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+ population[14].

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 interest[15].

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

| | | | Gender identity | | | |
|---|---|---|---|---|---|---|
| | Total | | Cisgender | | Transgender | |
| **Sexual Orientation** | **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

| | Total | | Cisgender | | Transgender | | | Lesbians | | Other | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Characteristics** | **N** | **%** | **N** | **%** | **N** | **%** | **p** | **N** | **%** | **N** | **%** | **p** |
| **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 | |

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| | Total | | Cisgender | | Transgender | | | Lesbians | | Other | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Characteristics** | **N** | **%** | **N** | **%** | **N** | **%** | **p** | **N** | **%** | **N** | **%** | **p** |
| **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 | 88 | 26.7 | 67 | 23.5 | 21 | 47.7 | | 16 | 20.8 | 72 | 28.6 | |
| complete | 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 | Total* | | | Cisgender | | Transgender | | | Lesbian | | Other | | | White | | Black | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| went to the dentist | N | % | IC95% | N | % | N | % | p‡ | N | % | N | % | p‡ | N | % | N | % | p‡ |
| 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

| | Total* | | Cisgender | | Transgender | | | Lesbians | | Others | | | White | | Black | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Characteristics | N | % | N | % | N | % | p | N | % | N | % | p | N | % | N | % | p |
| **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

| | Total* | | Cisgender | | Transgender | | | Lesbians | | Others | | | White | | Black | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Characteristics** | **N** | **%** | **N** | **%** | **N** | **%** | **p** | **N** | **%** | **N** | **%** | **p** | **N** | **%** | **N** | **%** | **p** |
| **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** | Total* | | Cisgender | | Transgender | | | Lesbians | | Other | | | White | | Black | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **of oral health** | **N** | **%** | **N** | **%** | **N** | **%** | **p** | **N** | **%** | **N** | **%** | **P** | **N** | **%** | **N** | **%** | **p** |
| 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 year[16-18]. 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-ups[19].

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 SUS[18].

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 discrimination[20]. 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. Louro[21] 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 health[22].

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 experiences[24]. In an integrative review study[25], 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 services[26]. 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 experienced[27].

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 health[25].

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 jobs[16]. Bordin e colaborators[18] 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 men[28].

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 policies[29].

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 significantly[32].

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 health[33].

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+ population[35].

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 enforced[6].

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. ■

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