Medical performance in primary care about assistance with LGBTQIAPN+ people

Atuação médica na atenção básica acerca da assistência com pessoas LGBTQIAPN+
Actuación médica en atención primaria sobre la atención a personas LGBTQIAPN+

RESUMO
Objetivo: Analisar as evidências científicas disponíveis na literatura acerca da atuação médica na atenção básica acerca da assistência com pessoas LGBTQIAPN+. Método: Trata-se de uma revisão integrativa. Realizou-se a busca por artigos; 2002-2022; nos idiomas português, inglês e espanhol; disponíveis na íntegra. Nas seguintes plataformas de dados: DOAJ, LILACS, MEDLINE, SciELO, SCOPUS e Web of Science. Resultados: Os dados foram organizados e apresentados em figuras e tabelas. Dos 286 estudos encontrados, 0 estava disponível na DOAJ, 8 na LILACS, 227 na MEDLINE, 0 na SciELO, 45 na SCOPUS e 6 na Web of Science. Contudo, após a leitura permaneceram apenas os que atendiam aos critérios para inclusão e exclusão descritos na metodologia, 5 estudos. Conclusão: Este estudo possibilitou mostrar que grande parte dos profissionais médicos, não estão capacitados para lidar com a população LGBTQIAPN+. Apontando a necessidade de educação continuada para se alcançar uma assistência qualificada.
DESCRITORES: Assistência Médica; Atenção Primária à Saúde; Minorias Sexuais e de Gênero.

ABSTRACT
Objective: To analyze the scientific evidence available in the literature about medical performance in primary care about care with LGBTQIAPN+ people. Method: This is an integrative review. The search for articles was performed; 2002-2022; in the Portuguese, English and Spanish; available in full. On the following data platforms: DOAJ, LILACS, MEDLINE, SciELO, SCOPUS and Web of Science. Results: The data were organized and presented in figures and tables. Of the 286 studies found, 0 was available in DOAJ, 8 in LILACS, 227 in MEDLINE, 0 in SciELO, 45 in SCOPUS and 6 in The Web of Science. However, after reading, only those that met the inclusion and exclusion criteria described in the methodology, 5 studies remained. Conclusion: This study made it possible to evidence that most medical professionals are not able to deal with the LGBTQIAPN+ population. Pointing out the need for continuing education to achieve qualified care.
DESCRIPTORS: Medical Assistance; Primary Health Care; Sexual and Gender Minorities.

RESUMEN
Objetivo: Analizar la evidencia científica disponible en la literatura sobre el desempeño médico en atención primaria sobre la atención con personas LGBTQIAPN+. Método: Esta es una revisión integradora. Se realizó la búsqueda de artículos; 2002-2022; en portugués, inglés y español; disponible en su totalidad. En las siguientes plataformas de datos: DOAJ, LILACS, MEDLINE, SciELO, SCOPUS y Web of Science. Resultados: Los datos fueron organizados y presentados en figuras y tablas. De los 286 estudios encontrados, 0 estaba disponible en DOAJ, 8 en LILACS, 227 en MEDLINE, 0 en SciELO, 45 en SCOPUS y 6 en the Web of Science. Sin embargo, después de la lectura, solo aquellos que cumplieron con los criterios de inclusión y exclusión descritos en la metodología, permanecieron 5 estudios. Conclusión: Este estudio permitió evidenciar que la mayoría de los profesionales médicos no son capaces de tratar con la población LGBTQIAPN+. Señalando la necesidad de una educación continua para lograr una atención calificada.
DESCRIPTORES: : Asistencia Médica; Atención Primaria de Salud; Minorías Sexuales y de Género.

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INTRODUCTION

Gender identity is the way in which a person identifies with genders, which can be male or female or other non-binary identities, and sexual orientation refers to sexual, affective, and emotional attraction to a similar, different, or both genders. To understand the lesbian, gay, bisexual, trans, queer, intersex and asexual, pansexual, non-binary and all other (LGBTQIAPN+) population, it is necessary to recognize the diversity of gender expression, as in the case of transvestites and queer populations, and of biological sex, as in the case of the intersexual population. [1]

In Brazil, primary health care (PHC) or primary care (AB) is implemented as a state policy and is the main gateway for health services in coordinating care and being a reference in the health care network. The National Primary Care Policy (PNAB) was created in 2006 and revised in 2011 to improve access, coverage and resolution for the consolidation of PHC. However, in 2017 a new version of the PNAB was implemented with important changes, among which some criticisms include concerns about the provision of minimal care with a selective design of PHC; However, some professionals hope that interests will converge with the strengthening of the Unified Health System (SUS) for accessible and fundamental primary health care[2].

The National Policy on Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transgenders puts into question the importance of understanding the social determinants of people's health, which directly impact their quality of life. The vulnerability of the LGBTQIAPN+ population, the constitutionally guaranteed right to universal and free access to health and the role of primary health care are aspects to be considered in the care of this population. [3,4]

From this perspective, the Brazilian PHC structure contemplates the performance of a multidisciplinary team within a Basic Health Unit (BHU). Among the different compositions that a PHC team can have, the Family Health Team (FHS) stands out, composed of a doctor and a nurse (preferably family health specialists), paramedics and/or nursing technicians, community health representatives who may be part of this composition, representatives of endemic disease control and oral health professionals. The role of the primary care physician as a member of a family health team implies the exercise of functions based on the principles of the SUS, fundamentally non-exclusive and committed to the promotion of equity. [5]

Based on surveys conducted with some physicians, the performance of the sexual health doctor's office in general health is limited. Hospitals, clinics and authorities are not interested in providing training or courses for their specialists. Therefore, the process of changing the perception of the LGBTQIAPN+ population involves improving the care, mentality and behavior of health professionals involved in this process. [1-5]

Therefore, this study aims to analyze the scientific evidence available in the literature about medical practice in primary care regarding assistance with LGBTQIAPN+ people.

METHOD

This is a bibliographic, descriptive, integrative review study with a qualitative approach that offers opportunities to analyze the scientific literature and broadly understand research topics, thus contributing to patient care practices based on scientific knowledge. (6)

The fulfillment of the following steps was determined: (1) elaboration of the guiding question and objective of the study; (2) definition of inclusion and exclusion criteria for scientific productions; (3) search for scientific studies in databases and virtual libraries; (4) analysis and categorization of the productions found; (5) results and discussion of findings.(7)

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To raise the guiding question, the PICo strategy was used, a methodology that helps in the construction of a research question and search for evidence for a non-clinical research, where P = Population/Patient; I = Interest; and Co = Context (P: LGBTQIAPN+; I: medical practice in primary care; Co: Quality of life). In this way, the following guiding question of the research was defined: "How is the medical performance in primary care regarding assistance with LGBTQIAPN+ people?".

For the selection of articles, the following inclusion criteria were used: original article, available in full, with delimitation in the last 20 years (2002-2022) in Portuguese, English or Spanish, which responded to the objective of the study. Gray literature was excluded, as well as repeated publications of studies in more than one database and articles that did not answer the guiding question of the study and that allowed access through the Virtual Private Network (VPN) of the University of Pernambuco (UPE).

Data collection took place during the month of August 2022 in the following Databases: Directory of Open Access Journals (DOAJ); Latin American and Caribbean Literature in Health Sciences (LILACS); Medical Literature Analysis and Retrievel System Online (MEDLINE); SCOPUS and on the Web of Science. And in the Scientific Electronic Library Online (SciELO) virtual library.

Articles indexed from the Health Sciences Descriptors (DeCS) were searched: "Assistência Médica", "Atenção Primária à Saúde", "Minorias Sexuais e de Gênero". The respective terms from the Medical Subject Headings (MeSH) were used: "Medical Assistance", "Primary Health Care", "Sexual and Gender Minorities". The operationalization and search strategy were based on the combination of the Boolean operator AND and OR, performing the search together and individually so that possible differences could be corrected (Chart 1).

Chart 1: Database search strategy. Recife, Pernambuco (PE), Brazil, 2022.

Database	Search terms	Results	Selected
DOAJ	(("Medical Assistance") AND ("Primary Health Care" OR "Basic Care" OR "Primary Care" OR "Primary Health Care" OR "First Level of Assistance" OR "First Level of Service" OR "First Level of Attention" OR "First Level of Health Care" OR "First Level of Care") AND ("Sexual and Gender Minorities" OR "Bisexual" OR "Sexual Dissidents" OR "Gay" OR "Gueis" OR "HSH" OR "Men Who Have Sex with Men" OR "Gay Men" OR "Homosexual Sis Homosexuals" OR "Homosexual" OR "Lesbian" OR "Lesbians, Gays, Bisexual, Transsexual, Queer, Intersex, Asexual and Other Identities" OR "Sexual Minorities" OR "Gender Lesbian" OR "Lesbian Women Having Sex with Women" OR "Women Who Have Sex with Women" OR "Lesbian Person" OR "People GLBT" OR "People GLBTQ" OR "People LGB" OR "People LGBT" OR "People LGBTQ" OR "People LGBTQIA+" OR "Lesbigays" OR "Lesbian People" OR "Non-Heterosexual Queer" OR "Queers" OR "Non-Heterosexual People"))	0	0
LILACS	(Medical Assistance) AND ((Primary Health Care) OR (Basic Care) OR (Primary Care) OR (Primary Health Care) OR (First Level of Assistance) OR (First Level of Service) OR (First Level of Attention) OR (First Level of Health Care) OR (First Level of Care)) AND ((Sexual and Gender Minorities) OR (Bisexual) OR (Sexual Dissidents) OR (Gay) OR (Gueis) OR (HSH) OR (Men Who Have Sex with Men) OR (Gay Men) OR (Homosexual Sis HomosexualS) OR (Homosexual) OR (Lesbian) OR (Lesbians, Gays, Bisexual, Transsexual, Queer, Intersex, Asexual and Other Identities) OR (Sexual Minorities) OR (Gender Lesbian) OR (Lesbian Women Having Sex with Women) OR (Women Who Have Sex with Women) OR (Lesbian Person) OR (People GLBT) OR (People GLBTQ) OR (People LGB) OR (People LGBT) OR (People LGBTQ) OR (People LGBTQIA+) OR (Lesbigays) OR (Lesbian People) OR (Non-Heterosexual Queer) OR (Queers) OR (Non-Heterosexual People))	8	0
MEDLINE	(Medical Assistance) AND ((Primary Health Care) OR (Basic Care) OR (Primary Care) OR (Primary Health Care) OR (First Level of Assistance) OR (First Level of Service) OR (First Level of Attention) OR (First Level of Health Care) OR (First Level of Care)) AND ((Sexual and Gender Minorities) OR (Bisexual) OR (Sexual Dissidents) OR (Gay) OR (Gueis) OR (HSH) OR (Men Who Have Sex with Men) OR (Gay Men) OR (Homosexual Sis HomosexualS) OR (Homosexual) OR (Lesbian) OR (Lesbians, Gays, Bisexual, Transsexual, Queer, Intersex, Asexual and Other Identities) OR (Sexual Minorities) OR (Gender Lesbian) OR (Lesbian Women Having Sex with Women) OR (Women Who Have Sex with Women) OR (Lesbian Person) OR (People GLBT) OR (People GLBTQ) OR (People LGB) OR (People LGBT) OR (People LGBTQ) OR (People LGBTQIA+) OR (Lesbigays) OR (Lesbian People) OR (Non-Heterosexual Queer) OR (Queers) OR (Non-Heterosexual People))	227	2
SciELO	(Medical Assistance) AND ((Primary Health Care) OR (Basic Care) OR (Primary Care) OR (Primary Health Care) OR (First Level of Assistance) OR (First Level of Service) OR (First Level of Attention) OR (First Level of Health Care) OR (First Level of Care)) AND ((Sexual and Gender Minorities) OR (Bisexual) OR (Sexual Dissidents) OR (Gay) OR (Gueis) OR (HSH) OR (Men Who Have Sex with Men) OR (Gay Men) OR (Homosexual Sis HomosexualS) OR (Homosexual) OR (Lesbian) OR (Lesbians, Gays, Bisexual, Transsexual, Queer, Intersex, Asexual and Other Identities) OR (Sexual Minorities) OR (Gender Lesbian) OR (Lesbian Women Having Sex with Women) OR (Women Who Have Sex with Women) OR (Lesbian Person) OR (People GLBT) OR (People GLBTQ) OR (People LGB) OR (People LGBT) OR (People LGBTQ) OR (People LGBTQIA+) OR (Lesbigays) OR (Lesbian People) OR (Non-Heterosexual Queer) OR (Queers) OR (Non-Heterosexual People))	0	0

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SCOPUS	(Medical Assistance) AND ((Primary Health Care) OR (Basic Care) OR (Primary Care) OR (Primary Health Care) OR (First Level of Assistance) OR (First Level of Service) OR (First Level of Attention) OR (First Level of Health Care) OR (First Level of Care)) AND ((Sexual and Gender Minorities) OR (Bisexual) OR (Sexual Dissidents) OR (Gay) OR (Gueis) OR (HSH) OR (Men Who Have Sex with Men) OR (Gay Men) OR (Homosexual Sis HomosexualS) OR (Homosexual) OR (Lesbian) OR (Lesbians, Gays, Bisexual, Transsexual, Queer, Intersex, Asexual and Other Identities) OR (Sexual Minorities) OR (Gender Lesbian) OR (Lesbian Women Having Sex with Women) OR (Women Who Have Sex with Women) OR (Lesbian Person) OR (People GLBT) OR (People GLBTQ) OR (People LGB) OR (People LGBT) OR (People LGBTQ) OR (People LGBTQIA+) OR (Lesbigays) OR (Lesbian People) OR (Non-Heterosexual Queer) OR (Queers) OR (Non-Heterosexual People))	45	2
Web of Science	(Medical Assistance) AND (Primary Health Care) AND (Sexual and Gender Minorities)	6	1
Total		286	5

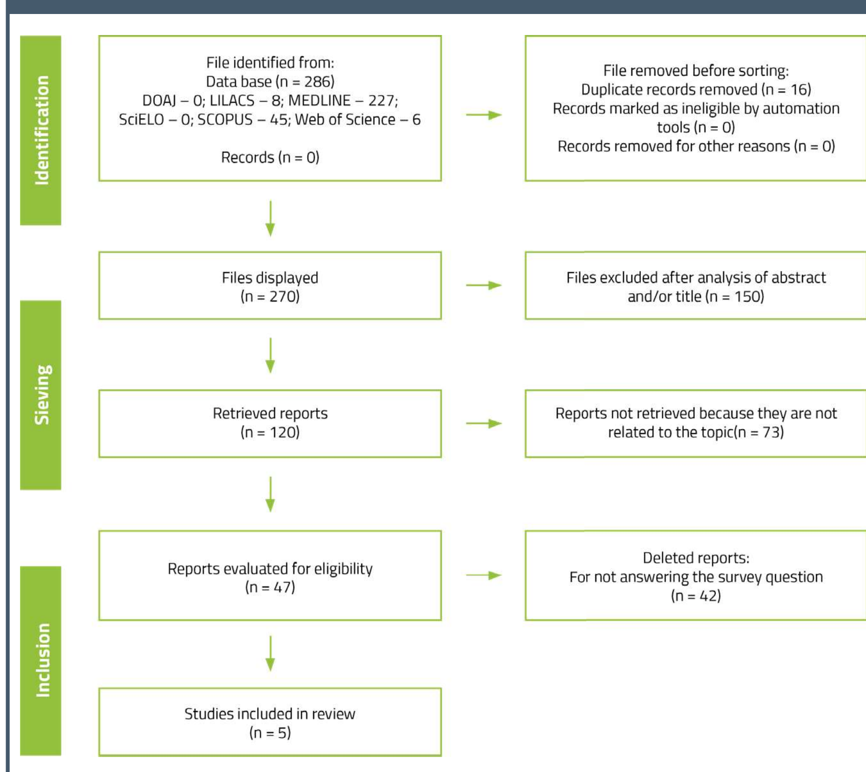
Source: Survey data, 2022.

The selection of studies was based on the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) with the aim of assisting in the development of articles [8] At first, duplicate studies were eliminated by reading titles and abstracts. Of these pre-selected, a full reading was carried out in order to verify those that meet the guiding question and the inclusion/exclusion criteria. The final sample was then constructed with studies relevant to the pre-established criteria (Figure 1).

After reading the selected articles, the studies were categorized, classifying the knowledge produced in levels of evidence according to Melnyk and Fineout-Overholt [9]: level I, evidence is related to the systematic review or meta-analysis of randomized controlled clinical trials or from clinical guidelines based on systematic reviews of randomized controlled clinical trials; at level II, evidence derived from at least one well-designed randomized controlled clinical trial; at level III, evidence from well-designed clinical trials without randomization; at level IV, evidence from well-designed cohort and case-control studies; at level V, evidence from a systematic review of descriptive and qualitative studies; at level VI, evidence derived from a single descriptive or qualitative study; and at level VII, evidence derived from the opinion of authorities and/or the report of expert committees.

Also, quality of evidence according to the GRADE system: High – There is strong confidence that the true effect is close to that estimated; Moderate – There is moderate confidence in the estimated effect; Low – Confidence in the effect is limited; and Very Low – Confidence in the effect estimate is very limited. There is a significant degree of uncertainty in the findings. [10]

Figure 1: Flowchart of the selection process for primary studies adapted from PRISMA. Recife, Pernambuco (PE), Brazil, 2022.



Source: Survey data, 2022.

To assess the risk of bias, the Cochrane Collaboration tool was used, based on seven domains (1. Random sequence generation; 2. Allocation concealment; 3. Blinding of participants and professionals; 4. Blinding of outcome assessors; 5. Incomplete outcomes; 6. Selective outcome report; and 7. Other sources of bias), which assess different types of bias that may be present in randomized clinical trials, such as selection bias, performance bias, detection bias,

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attrition bias, reporting bias, and other biases. The judgment of each domain is performed in three categories (high risk of bias, low risk of bias and uncertain risk of bias). [11]

A summary of the information in the corpus was obtained through an instrument: identification of the original article; authorship of the article; year of publication; country; methodological characteristics of the study; and study sample. An analytical reading of the studies was carried out, identifying the key points for the hierarchy and synthesis of ideas.

RESULTS

The studies surveyed are arranged showing their titles, authors, years of publication, levels/qualities of evidence, objectives and results. After reading the selected articles, the studies were categorized, classifying the knowledge produced on the topic, into levels of evidence, mostly level VI - evidence derived from a single descriptive or qualitative study; in quality of evidence, Moderate – There is moderate confidence in the estimated effect. The main findings set out in the objectives and conclusions are directly associated with medical performance in primary care regarding care for LGBTQIAPN+ people (Table 1).

When performing the risk of bias analysis, it was observed that, regarding the generation of the random sequence, all studies had a low risk of bias; as for allocation concealment, all were uncertain; regarding the blinding of participants and professionals, only 20% (n = 1) had a high risk of bias; and finally, regarding incomplete outcomes, 80% (n = 4) of the studies had a low risk of bias (Table 2).

After reading the selected articles, the studies were categorized, classifying the knowledge produced on the subject, about the risks of bias, mostly low risk.

DISCUSSION

The LGBTQIAPN+ population's access to primary care

Costa-val et al. [17] observed that although many of the professionals have some knowledge about how to engage with the LGBTQIAPN+ population, there is no effective engagement in building care environments that genuinely welcome differences. Prejudice and resistance tend to be camouflaged

Table 1: Synthesis of the main findings on medical performance in primary care regarding assistance with LGBTQIAPN+ people. Recife, Pernambuco (PE), 2022.

N	Title/Database	Authors (Year)	Country	Level/ Quality of Evidence	Objective	Results	Sample
1	Project enhance: A randomized controlled trial of an individualized HIV prevention intervention for HIV-infected men who have sex with men conducted in a primary care setting. / MEDLINE	Safren, S. A., et al (2013)[12]	USA	IV / Low	Test a brief, culturally relevant prevention intervention for HIV--infected MSM that could be integrated into HIV treatment.	The intervention, provided by a medical social worker, included proactive case management for psychosocial problems, counseling about living with HIV, and reducing the risk of sexual transmission of HIV.	N = 201 Intervention and control group; USA 2012
2	Provider fatalism reduces the likelihood of HIV-prevention counseling in primary care settings. / MEDLINE	Steward, Wayne T et al (2006)[13]	USA	VI / Moderated	To examine the relationship between provider fatalism, the belief that behavior change among HIV-infected patients is unlikely, and HIV prevention counseling at 16 publicly funded clinics.	Clients at high fatalism clinics were more likely to be white, gay, educated, and older. Provider fatalism is a barrier that must be addressed when implementing HIV prevention counseling in primary care settings.	N = 618 Age group + 18; Semi structured interview; California 2005

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3	Medical and social assistance for the transgender community: Difficulties and particularities in psychiatric and psychotherapeutic assistance. / SCOPUS	Cantemir, Adrian et al (2021)[14]	Romania	VI / Moderated	Point out the difficulties faced by the transgender community when using psychiatric or psychotherapeutic services and their impact on the social, psychological and health level.	The important percentage of transgender people who do not live according to the desired identity and the existence of discriminatory situations in the interaction with the doctor or psychologist stand out.	N = 63 Age group 20-39 years; Questionnaire for the trans community and mental health; Romania; 2020
4	Qualitative inquiry into barriers and facilitators to transforming primary care for lesbian, gay, bisexual and transgender people in US federally qualified health centres. / SCOPUS	Gagnon, Kelly W et al (2022)[15]	USA	VI / Moderated	Explore barriers and enablers that emerged during an initiative to improve care for sexual and gender minority patients at qualified federal health care facilities from staff perspectives.	Common Clinic appointments were for behavioral health assistance, pre-exposure prophylaxis, and transgender hormone therapy. Predominant enablers included workflow change and staff training.	N = 40 Secondary data; USA; 2016-2017
5	Transgender Intimate Partner Violence and Help-Seeking Patterns. / Web Of Science	Kurdyla V, Messinger AM, Ramirez M (2021)[16]	USA	VI / Moderated	Explore attitudes and help-seeking behaviors of transgender adults and cisgender adults of sexual minorities in the United States	Renewed efforts are needed to tailor services, service advertising, and provider training to the needs of transgender communities.	N = 417 Age group +18 Online questionnaire; USA; 2018

Source: Survey data, 2022.

Table 2: Risk of bias analysis. Recife, Pernambuco (PE), 2022.

	Safren, S. A., et al (2013)	**Steward, Wayne T et al (2006)**	**Cantemir, Adrian et al (2021)**	**Gagnon, Kelly W et al (2022)**	**Kurdyla V, Messinger AM, Ramirez M (2021)**	**Obedin-Maliver; Haan (2017)**
Random sequence generation	-	-	-	-	-	-
Allocation concealment	?	?	?	?	?	-
Blinding of participants and professionals	+	-	-	-	-	-
Incomplete outcomes	+	-	-	-	-	-
Incomplete outcomes	-	-	-	-	-	-

(+) high risk of bias, (-) low risk of bias, and (?) uncertain risk of bias
Source: Research data, 2022.

behind certain discursive strategies, such as holding others accountable, naturalizing the phenomenon, mobilizing accusatory categories to refer to LGBTQIAPN+ bodies and denying their differences.

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Corroborating, Ferreira and Bonan [18] observed that although many of the professionals have some knowledge about how to engage with the LGBTQIAPN+ population, there is no effective engagement in building care environments that genuinely welcome differences. Prejudice and resistance tend to be camouflaged behind certain discursive strategies, such as holding others accountable, naturalizing the phenomenon, mobilizing accusatory categories to refer to LGBTQIAPN+ bodies and denying their differences.

It is clear that the barrier of discrimination makes it difficult or even impossible for people of sexual minorities to see a doctor. Thus, this community lacks better-prepared health professionals who have a better understanding of the specific issues faced by LGBTQIAPN+ people, which implies continuous learning that includes public policy guidance on sexual orientation, human sexuality and gender identity. [12-16]

Medical assistance to the LGBTQIAPN+ public

Gagnon et al.[15] point out in their study that medical care has often been used to support behavioral health, pre-exposure prophylaxis, and hormone therapy for transgender people. Key enablers included changes to workflow and staff training.

Still, Kurdyla, Messinger, and Ramirez [16] state that renewed efforts are needed to tailor services, service promotion and training of providers, especially medical professionals, to the needs of LGBTQIAPN+ communities.

Therefore, the non-recognition of LGBTQIAPN+ populations as users of primary care as a continuous flow leads to barriers to access and quality of care provided by health professionals, such as doctors, either through relationships (user-professional); either by the organization and dynamics of the services; or through the elements of this context, which is also related to the way these themes become visible in the channels of apparition. Only the triad recognition-redistribution-representation can correct social inequalities and injustices. [17-19]

The National Policy on Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transgenders puts into question the importance of understanding the social determinants of people's health, which directly impact their quality of life.

Using search strategies, we found a small sample size and little availability of academic articles to compare results. As few articles emerged based on the descriptors, few met the objective of the study. In addition, the included studies have limitations such as: single center, different comparison systems, small sample size and lack of randomization.

In this way, it was impossible to prove the existence of scientific evidence related to medical performance in primary care regarding assistance to LGBTQIAPN+ people. Making it necessary to carry out more studies containing a larger sample and enabling discussion about the medical care provided to LGBTQIAPN+ people.

This study can help to disseminate the importance of social inclusion of the LGBTQIAPN+ population in health services, especially in primary care and professionals trained to deal with these situations. Expanding the awareness of the profession and assisting in the training of the multiprofessional health team.

CONCLUSION

This study made it possible to show that most medical professionals are not trained to deal with the LGBTQIAPN+ population. Pointing out the need for continued and permanent education to achieve qualified assistance.

However, there is a lack of studies that give real importance to this topic, essential in training, profession, and continuing education, although this number has gradually increased in recent years. Therefore, this study provided the perception that, although timid, there is a growth in the number of studies that address medical practice in primary care regarding assistance to LGBTQIAPN+ people.

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