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Challenges in Collecting LGBT+ Health Data in Primary Health Care in Minas Gerais, Brazil

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Abstract

Background: This study aimed to understand the obstacles involved in recording data on sexual orientation and gender identity in the individual registration form of the eSUS system in two municipalities in the central region of Minas Gerais, Brazil. Understanding these barriers is essential, as this registration process enables the identification, reception, and qualified follow-up of the LGBT+ population within Primary Health Care (PHC).

Results: A qualitative, cross-sectional study was conducted, involving 42 semi-structured interviews with health professionals and administrative assistants working in PHC, analyzed using content analysis. The results revealed barriers related to three thematic axes: Professional Limitations, Lack of Institutional Integration, and Tensions Between the Family-Community Model and LGBT+ Identification. These axes unfold into issues such as lack of training and non-recognition of the importance of collecting this data.

Conclusions: These findings show that the difficulty in collecting such information is not merely a technical problem, but a reflection of how LGBT+ people continue to be marginalized within health institutions, despite advances in public policies aimed at equity.

Background

The inclusion of the population of Lesbians, Gays, Bisexuals, Travestis (a gender identity category specific to the Brazilian/Latin American context), Transsexuals and other dissident sexual and gender identities (LGBT+) in public health policies represents a global challenge, especially in contexts marked by stigma and discrimination, which hinder access to essential services[1–3]. In Brazil, the creation of the National LGBT Comprehensive Health Policy (PNSI-LGBT)[4] in 2011 was an important milestone for the recognition of the specific demands of this population in the Unified Health System (SUS). However, the implementation of this policy faces structural and cultural obstacles, especially in Primary Health Care (PHC), the preferred gateway to the SUS, which should play a fundamental role in the coordination of care, in the identification of the LGBT+ population in the territories[5–6] and in the promotion of equity[7–8]. Since the creation of the National Primary Care Policy (PNAB) in 2006 and its updates, PHC has sought to expand universal and comprehensive access to services, covering historically marginalized populations, such as the LGBT+ community[9–10]. The PNAB reinforces the importance of continuous monitoring, essential to ensure full access to health services throughout life. However, this model requires a qualified collection of sociodemographic data, including gender identity and sexual orientation, the absence of which hinders planning and makes the LGBT+ population invisible in public policies[10–11].

The organization of PHC, centered on territorialization and the family approach, adds an important obstacle: the centrality of the territory and the family unit, often spaces for the reproduction of LGBTphobia[12]. In addition, the collection of information on gender identity and sexual orientation, carried out mainly by Community Health Agents (CHA) in home visits, can increase the vulnerability of LGBT+

individuals, who often feel insecure about sharing this information in a potentially hostile environment with a professional who is part of their community[13–14]. This situation reinforces a cycle of institutional invisibility, which is not exclusive to Brazil[1–3], in which the absence of data on the LGBT+ population in administrative records contributes to the lack of targeted policies and adequate funding.

In Brazil, one of the recent advances in this regard was the inclusion of the question about sexual orientation in the 2019 National Health Survey (PNS), conducted by the Brazilian Institute of Geography and Statistics (IBGE). Although this was an important step towards quantifying the LGBT+ population, the methodology used drew criticism, since in some cases it failed to guarantee the confidentiality of the answers, which may have led to underreporting of valid answers[15]. Thus, data collection on gender identity and sexual orientation in PHC needs to be improved to ensure that it is carried out safely, ethically, and respectfully. Therefore, the alignment between PNAB and PNSI-LGBT is crucial to ensure that PHC functions as a safe and qualified space for care and registration for this population.

Accordingly, this research seeks to understand the obstacles in filling out data on sexual orientation and gender identity in the individual registration form of the eSUS (administrative system for SUS) in two municipalities in the central region of Minas Gerais, based on the analysis of the perceptions of 42 health professionals and administrative assistants interviewed. The study aims to answer the following question: What are the main obstacles in collecting data on gender identity and sexual orientation in PHC?

The importance of this study lies in the fact that it contributes both to academia and to the formulation of public policies. By documenting the challenges of collecting data on gender identity and sexual orientation in PHC, it provides concrete subsidies for SUS managers and for the training of health professionals. In addition, the findings can assist in the development of more effective guidelines to ensure that the LGBT+ population is properly included in official statistics and public health actions.

Methods

Type of study

This cross-sectional study adopted a qualitative approach, based on content analysis[16] and complemented by the thematic networks method[17]. The methodological choice is justified by the need to understand the perceptions, challenges, and strategies adopted by Primary Health Care (PHC) professionals in identifying and welcoming the LGBT+ population in two municipalities in the central region of Minas Gerais, Brazil.

The qualitative approach was chosen because it allows for exploring the institutional, cultural, and technical barriers faced in collecting information on gender identity and sexual orientation, as well as identifying strategies to improve these processes. In addition, PHC in Brazil operates with a territorialized model, which means that interactions between health professionals and users are mediated by

community and family dynamics, making it essential to have an in-depth understanding of the experiences of professionals who work directly in these contexts[5, 18].

Data Source

Data collection was carried out between March and July 2024, through semi-structured interviews with 42 Primary Health Care (PHC) professionals, covering different professional categories: doctors, nurses, nursing technicians, community health agents (CHA) and administrative assistants. These professionals work on the front line of care and play a central role in the coordination between health services and the territories, especially in the registration, monitoring and reception of local populations.

The study was conducted in two municipalities in the central region of Minas Gerais, intentionally selected because they present contrasting characteristics regarding the structure of the primary care network and the degree of institutionalization of the guidelines of the National LGBT Comprehensive Health Policy. In one of them, there is a more consolidated network of Family Health Strategy (FHS), with coverage close to the entire population, in addition to the recent implementation of a municipal LGBT+ health committee, which has acted as an instance of institutional support for equitable care. In the other municipality, in contrast, FHS coverage remains below 50% and there are no formal management instances focused on the health of the LGBT+ population, although both share important similarities, such as population size and geographic insertion in the same state macro-region.

The selection of municipalities was based on the criterion of differentiation in the stage of implementation of health policies aimed at equity, in order to allow a comparative analysis between different organizational conditions, institutional capacities and care contexts. In addition, the research was built in dialogue with local managers and coordinators of PHC units, which facilitated access to professionals and strengthened the engagement of participants in the analytical process.

The definition of the interviewees followed inclusion criteria focused on the diversity of experiences and functions within PHC. Professionals with at least one year of experience in the territory and who, directly or indirectly, were involved in activities of reception, registration or monitoring of information related to gender identity and sexual orientation, whether in clinical care, administrative records or territorial actions, were considered eligible. The mobilization of the participants was carried out with the support of the coordinators of the health units and the municipal health departments, ensuring legitimacy to the process and qualified adherence to the study.

Data collection was carried out through semi-structured interviews, carried out in person, according to the availability of the participants. The interviews were conducted based on a script with three main axes. The first axis addressed the experiences and perceptions about the collection of data on gender identity and sexual orientation in PHC, exploring how this information is recorded in the units, whether there is standardization in filling out the e-SUS AB system and what difficulties professionals face in this process. The second axis dealt with the training and preparation of professionals, investigating whether

they have received specific training to deal with the LGBT+ population, whether they feel insecure or uncomfortable when addressing the topic with patients, and how they evaluate their own knowledge about LGBT+ health. Finally, the third axis sought suggestions to improve the identification and reception of the LGBT+ population, asking about strategies to improve this process, ways to increase the preparation of professionals, and how municipal management could contribute to qualifying the collection and use of data.

The interviews lasted an average of 40 to 60 minutes and were recorded with the participants' permission, later transcribed in full for analysis. The sample consisted of 42 participants, 17 professionals from one municipality and 25 from the other. This difference in the number of participants stems from the availability of professionals and the interest of municipalities in implementing improvements in the identification and reception of the LGBT+ population.

Data analysis

The data collected were analyzed based on content analysis[16], allowing the identification of emerging thematic categories in the participants' discourses. The analytical process followed four main steps. The pre-analysis involved an exhaustive reading of the transcripts of the interviews, focusing on the identification of patterns and recurrences in the reports. Next, thematic coding was performed, segmenting the answers into units of meaning and classifying them into pre-defined and emerging categories. Subsequently, the data were organized into thematic networks[17], using concept maps to visualize the connections between the main challenges reported by the professionals. Finally, the findings were interpreted in the light of the existing literature on the implementation of LGBT+ health policy in PHC.

Results

The highest concentration of respondents is found in the age groups of 30 to 49 years (Additional file 1 – Table 1), reflecting the predominant age distribution among PHC workers in these territories. In addition, most participants identify as cisgender, that is, people who identify with the sex assigned at birth (e.g., women who were assigned female at birth), and heterosexual (who relate to people of the opposite gender to theirs), which shows a relatively homogeneous profile in terms of gender identity and sexual orientation. The inclusion of professionals of different age groups allowed us to capture intergenerational perceptions about the collection of data on gender identity and sexual orientation, highlighting specific challenges that may vary according to the professional experience and sociocultural context of each age group.

The analysis of the interviews revealed in a broad and detailed way the main challenges faced in collecting data on gender identity and sexual orientation. No significant differences were observed between the municipalities that could be attributed to the different forms of PHC organization. The findings were organized into three major thematic axes: Limitations of Professionals, Lack of

Institutional Integration, and Tensions between the Family-Community Model and LGBT+ Identification. Each axis is explored below based on the reports obtained, offering a rich panorama of perceptions and experiences.

Figure 1 - Thematic network, focusing on the challenges of identifying the LGBT+ population in PHC, Minas Gerais, 2024

Source: Prepared by the authors, 2025

Knowledge Limitations of Professionals

The knowledge limitations of professionals in relation to the theme proved to be one of the main barriers to the collection of data on gender identity and sexual orientation in Primary Health Care (PHC). The reports show three major dimensions of this problem: lack of training, insecurity in addressing the topic and lack of technical knowledge about concepts and practices related to the LGBT+ population.

The lack of specific training on LGBT+ health was a recurring point. Many professionals highlighted that they never received training to address gender identity and sexual orientation in an adequate way. One interviewee (APS29) reported: "When I came here I had no training at all [...] I always read a lot, I always saw a lot of videos, I always talked to patients. It was my way of training". This training gap was also highlighted by other professionals: "Our training [at the college], I believe that the girls also trained more or less together with me, this is not part of our training. So we realized that it was our need too" (APS06).

In addition to the deficient academic training, the absence of continuous institutional training was also pointed out. One professional (APS20) observed: "One of the things that I think would be very interesting is training focused on this, for the CHAs, for the employees, because many times even the employees do not know, there is no such discussion. Here at the unit we have many people from the LGBT+ community, but there is still a lack". This lack of training generates a feeling of collective unpreparedness: "[...] Because from time to time primary care sends me the girls, who are going to start in the administrative department, for me [sic] to train. I'll explain, the registry has this, you have to ask this, you have to ask the option and everything. [They answer] "I'm not going to ask", "Neither do I, I'm embarrassed", "What if the person curses me?" So we realize that this way, the person does not have this experience, they are unable to ask" (APS39).

Insecurity when addressing issues of gender identity and sexual orientation was a predominant factor in the reports. Many professionals described fear of being interpreted as invasive or prejudiced. One interviewee (APS04) said: "I think that in certain parts I even feel uncomfortable asking the person this, but depending on whether I see that the person is calmer, I ask. I think that [other professionals] are, in general, a little afraid to ask, the person thinks it's bad, thinks they're accusing, because a word already generates confusion." This fear generates omissions in the data collection process, resulting in incomplete records.

In addition to the fear of the patient's reaction, the professionals fear negative reactions from the community itself. One interviewee (APS03) reported: "[...] When the person also lives in the area covered by the CHA, they know everyone, we have to work with the issue of ethics. Because they also become aware of people who are close to him. So, the issue sometimes has a lot of stigma. He has to have a very high level of ethics, because he does not have the right to pass on information to his family, or to neighbors, or to friends." This ethical dilemma can be more intense in small areas, where the community bond is strong.

Another obstacle highlighted was the lack of technical knowledge about terms and categories related to gender identity and sexual orientation. Many professionals reported difficulties in formulating the questions in a clear and respectful manner. One interviewee (APS21) commented: "When we make this individual registration, we ask for affiliation, full name, personal data, when it comes to this part of informing sexual orientation, in this part the population has a little difficulty and usually so do we. There is a little difficulty in distinguishing nomenclatures, we are kind of lost. That's the truth." This lack of knowledge not only generates embarrassment, but also compromises the quality of the data collected.

The professionals highlighted that this gap in colleagues is also generational: "they are afraid of being prejudiced or saying something inappropriate and not knowing how to deal with it, but for some it is still difficult for professionals who are older, have an older education, to understand this a little better, it is more difficult. They are afraid to say something that may sound like prejudice or inferiority" (APS36).

The lack of understanding of technical terms also generates situations of misunderstanding, as reported (APS25): "I have already asked a woman who I know is married, has a child of her own and such, apparently she is a straight woman. When I asked, she was so confused that she replied, "I am a little bit of each one" for lack of understanding. And the person ends up not understanding those terms."

The sum of insecurity, unpreparedness, and lack of technical knowledge directly impacts the completion of registration systems, especially e-SUS AB. Professionals have reported that they often leave fields blank or fill in based on assumptions. One interviewee (APS31) admitted: "Sometimes I don't ask the question for fear of embarrassing the person. Because maybe I know the person, maybe the person I've known for a long time, so I already know the person's preference [sic], the sexual one, so I fill it in."

Professional knowledge limitations, manifested by the lack of training, insecurity and lack of technical knowledge, reveal a cycle of institutional unpreparedness. The reports show that, without continuous training and adequate institutional support, professionals become involuntary agents of the invisibility of the LGBT+ population in health records. These findings reinforce the urgent need for practical training, with simulations of care, clarification of terminologies, and continuous training that enable safer, more respectful, and more accurate approaches during data collection.

Lack of Institutional Integration

The lack of institutional integration between Primary Health Care (PHC) units and management bodies is a significant barrier to the collection and completion of data on gender identity and sexual orientation. This obstacle manifests itself in three main dimensions: absence of clear flows and protocols, lack of awareness campaigns and continuous training, and lack of coordination between PHC teams and municipal administrations.

Professionals highlighted that the lack of specific protocols for approaching the LGBT+ population compromises the quality of care. One interviewee (APS03) reported: "[...] he enters as a citizen, like anyone else". For another group of professionals, even when instructions arrive on how to deal with this population "[...] The resolutions come very ready. Out of context. Ah, but you are going to do such a thing to the LGBT population. We don't even know the population" (APS07).

The absence of guidelines generates insecurity in the approaches: "We don't know if we should ask, how to ask, or if it is mandatory" (APS31). In addition, many professionals are unaware of the importance of these data for the formulation of public policies: "I don't see any difference. In my view, I don't see that there is a difference in relation to the approach and access of LGBT to non-LGBT. The access is the same, the approach is also the same. [...] On these issues. So I believe that sometimes this is a little lacking, knowing how to better address this issue of LGBT, but I believe that access is the same for everyone." (APS12).

Attempts to reach this population are marked by uncertainties, attempts and, often, little adherence by users. One interviewee reports that: "[...] we have a certain difficulty in understanding, even what is the impediment of the patient to reach us" (APS01). In another case, the professional says that she "tried to make campaigns to bring this audience to the unit. We didn't have any people join. The medical students came to make groups with them, the health agents distributed the leaflets. None came" (APS35).

The interviewees highlighted that the lack of dialogue between the PHC units and the municipal health departments generates a vacuum of support. This lack of coordination hinders the implementation of the few projects that arise with this theme: "We proposed a training action, but it was barred by bidding problems" (APS01). The lack of institutional focal points was pointed out as another obstacle: "We don't have structure here. There is no preparation. I don't think there is a professional here who is a reference for that." (APS08). In addition, professionals reported feeling obliged to support each other even without much training and depending on professionals who are LGBT + to discuss these issues: "we work together with this, to see if I have an opinion, what I think, what the patient's questioning was, so we can see what we do. But maybe another health agency that doesn't have anyone from the LGBT+ community, they should keep their hands tied" (APS18).

The impacts of this institutional fragmentation are evident: inconsistent data collection processes, fragmented care, and the absence of adequate records. One interviewee (APS12) observed: "What is the point of registration if when the patient arrives here, that LGBT+ issue will not influence our treatment, our medical conduct. Many times we don't even look. I myself, when the patient comes here to me, I won't look at how his registration is. That's what the patient tells me right away. I don't even have time,

most of the time, to look at the file, see how it's registered, see how it was titled. There is no such thing" (APS12). This administrative invisibility harms both the formulation of public policies and the monitoring of the health of this population.

The lack of integration also contributes to the precariousness of preventive and educational actions: "there has never been a specific work with this public, there is no programming at the secretariat level, not even here at the unit, which follows the secretariat's programming, there is no specific programming for care, nor for educational action, group work, we don't have it" (APS03).

The absence of clear flows, the lack of awareness campaigns and the lack of coordination with municipal administrations are interconnected facets of the lack of institutional integration. These factors, evidenced by the professionals themselves, not only compromise the collection of data on gender identity and sexual orientation, but also reinforce the invisibility of the LGBT+ population in the health system.

Tensions between the Family-Community Model and LGBT+ Identification

The territorialization of Primary Health Care (PHC), structured in the family-community model, was identified by professionals as an important challenge to the collection and completion of data on gender identity and sexual orientation. This subsection explores the difficulties faced, evidenced in three main dimensions: embarrassment in home visits, impact of community dynamics, and influence of family structure on the secrecy and identification of the LGBT+ population.

Home visits carried out by Community Health Agents (CHA), a pillar of the Family Health Strategy (FHS), emerged as a space of strong constraint for the collection of sensitive information. The interviewees reported that the dynamics of registering family members does not always allow each one to identify themselves directly and/or anonymously. A group of interviewees (APS06-08) commented: "[...] when the ACS looks for family, he will look for the family responsible to register. The questions you will ask the family responsible, things that each one should answer for themselves". Another professional reported that even working in the network, he would not report being bisexual to a CHA: "Taking into account that I am not out to the family, this answer I was going to say that I am straight. And that's it, in the registration I would look like this. But because of the family, because it is also in my home, there is a little resistance to saying this" (APS14). This self-censorship reflects the fear of family and social reprisals.

In addition, the professionals highlighted the impact of the community bond on the approaches: "I think that the biggest difficulty is the issue of approximation and identification with the health agent herself" (APS35). This proximity, although essential for longitudinal follow-up, becomes a barrier to dialogue. The feeling of community surveillance leads some patients to seek care in other areas: "That's right, [fear] of people suspecting something and commenting. I speak for myself [a patient telling his situation to the

professional]. I do my tests [for HIV and other STIs] every year. And whenever I do it, I don't do it at the health center in my neighborhood, I always go to another one" (APS13).

The dilemmas of relationships in the family environment cast doubt on whether information on gender identity and sexual orientation should be collected in the registry: "Perhaps the registry is really not the best time for this approach. [...] Even for you to have real data, it has to be at the time of service. [...] a conversation that flows better [...] has to be individualized because of the family issue" (APS07). Other professionals also agreed with this perception: "Because with the professionals in care, just as I see that with me, with the doctor, there is more freedom to talk about these issues than with the health agent. Because they live in the same area, because they have not yet come out to their families, because they are afraid to talk and think that the health agent will pass this information on to other people, and this question of response is more reserved" (APS35).

The family structure, often seen as the central unit of care, was pointed out as a significant barrier. Professionals reported cases of patients who face family pressure to hide/change their identity. One professional (APS17) reported: "I receive a lot of patients for counseling. A patient brought by mother, mostly teenagers, like, absurd, I think this is absurd. Mothers who bring their teenage son or daughter, who in their point of view has some behavior that diverges from what they want, and they want me to advise [to 'change' their sexual orientation]" (APS17).

As a consequence, these family conflicts impact the emotional health of patients. The same professional (APS17) described an emblematic case: "There was a case that made me very uncomfortable at the time. He was a teenager of about 14 years old, clearly also in the transition phase [of gender]. And the mother brought him to psychological care. And this boy, he started somatizing, he started having symptoms. [...] Because of his mother's pressure. It was very difficult, because in fact we were going to take care of the mother, it wasn't the boy. And the father had an excellent acceptance. [...] We had to do a lot of work with the father, this mother took this boy to another [professional]."

These tensions directly impact the quality of records. Many professionals reported that, in the face of discomfort, they end up omitting the collection of this data: "So, generally, I don't ask [the questions]. Because most of the people in my area are married, it's kind of weird for you to ask the person what they are. There are also a lot of people who don't like to talk, I end up not asking. If the person is single, lives alone, I ask. But so far no one has claimed to be [LGBT+]" (APS04). Others pointed out that community pressure generates false records: "[...] I know the area where I live my whole life, I know the person, he knows me, I live there in the neighborhood and everything. We know, we live on a day-to-day basis, but we don't assume [being LGBT+], in the documentation he doesn't admit it." (APS25)

The tensions generated by the family-community model of PHC, far from promoting inclusion, contribute to the invisibility of the LGBT+ population. The cycle of embarrassment in visits, community repression and family conflicts culminates in incomplete records and inadequate care. These findings highlight the urgent need for strategies that ensure privacy and security in approaches, such as individualized

interviews and spaces reserved for the collection of sensitive information, ensuring that the community model can coexist with the protection of the identity and dignity of the LGBT+ population.

Discussion

The findings of this study reveal that the lack of collection and completion of data on gender identity and sexual orientation in Primary Health Care (PHC) is not a merely technical problem, but a reflection of the way in which health institutions reproduce structures of exclusion and invisibility of the LGBT+ population regardless of their form of organization in the territory. The resistance of professionals to ask about gender identity and sexual orientation, pointed out by several participants in the research, is not only due to lack of knowledge, but also because the theme is still perceived as secondary within clinical practice, something already evidenced by Reis & Carvalho[5] when they highlighted the persistence of cisheteronormativity as an organizing principle of health services. This structural logic perpetuates a cycle in which the absence of data contributes to the lack of specific public policies, while the lack of policies reinforces the perception of LGBT+ identity as irrelevant in the context of health.

The insecurity of the professionals, evidenced in the reports of the participants in this study, is not only due to the lack of training, but also to a care model that rarely places them in situations in which they need to deal with sexual and gender diversity in a reflexive way. Ferreira and colleagues[2] point out that, in the absence of specific training, professionals end up adopting defensive or avoidant postures, often failing to record essential information for the adequate monitoring of the health of LGBT+ people and transferring to this population the task of educating them about the specific needs of the group. This reinforces the finding of this study that many PHC professionals are not only unaware of how to collect this data, but also do not understand its importance. The difficulty in addressing the topic, therefore, is not restricted to a specific training gap, but rather to the absence of an institutionalized training process that normalizes the approach to gender and sexuality diversity in care.

Although the Primary Health Care (PHC) model, centered on territorialization and the family approach, is widely recognized as one of the most successful experiences in Brazilian public health, especially in facing general health demands, the findings of this study indicate that it still lacks effective strategies to ensure the visibility and recognition of the LGBT+ population. It is important to highlight that the criticism here is not of the model itself, but of the way it impacts the identification of users with dissident gender identities and sexual orientations.

The results of this study indicate that the data collection carried out by Community Health Agents (CHA) during home visits generates embarrassment and often prevents LGBT+ people from identifying themselves freely. This data reinforces the conclusions of the Manas Survey[14], which points out that, in contexts of community surveillance, the confidentiality of gender identity and sexual orientation is compromised, which leads many users to omit this information for fear of exposure and discrimination. This situation is particularly serious for LGBT+ young people who live in hostile family environments, making PHC, paradoxically, a space of exclusion instead of welcoming. To mitigate this issue, it would

be necessary to reformulate the processes for collecting those informations in PHC, ensuring that these questions are asked in safe spaces and preserving the autonomy of users.

Another relevant point revealed by this study is the belief that the presence of LGBT+ professionals in health teams, by itself, would be enough to ensure more inclusive care. The results showed that, although this representativeness can contribute to a more welcoming environment, its existence does not replace the need for structured training. Some authors[3,19] point out that structural changes in health care for the LGBT+ population cannot depend on the individual identity of the professionals, but rather on institutional protocols that ensure that the entire team is prepared to deal with this population in an intersectional, respectful and qualified way. This is in line with the finding of this study that the vast majority of PHC professionals interviewed identify themselves as cisgender and heterosexual, showing that the mere presence of some LGBT+ people in the teams is not enough to transform the institutional culture of care.

The absence of structured records of gender identity and sexual orientation in PHC information systems also emerged as a central challenge. The participants' report that these data are often not filled in or are recorded inappropriately reinforces the diagnosis of Streed and colleagues[10], who demonstrate that, even in countries where the collection of this information has already been incorporated into electronic medical records, its adherence by professionals is still low. The impact of this failure extends beyond individual care, affecting the planning of public policies and the allocation of resources to this population. The absence of concrete data makes it impossible to formulate health strategies aimed at the specific needs of LGBT+ people, perpetuating a cycle of institutional neglect.

Given this scenario, the findings of this study point to the urgent need for structural changes that go beyond the simple recommendation for professionals to ask about gender identity and sexual orientation. As suggested by Santos, Silva & Ferreira[20], the training of health teams should be continuous and part of the general training of professionals, so that the approach to sexual and gender diversity is not treated as a marginal issue, but as an essential dimension of comprehensive health care. In addition, information systems need to be reformulated to ensure that the collection of this data is carried out in a standardized and confidential manner, avoiding omissions and ensuring that the identity of users is respected[10].

The results of this study indicate that the implementation of the National LGBT Comprehensive Health Policy continues to face significant challenges in PHC, especially with regard to the implementation of guidelines that ensure data collection and qualified reception of this population. The alignment of the findings of this research with the literature demonstrates that PHC has the potential to be a space for inclusion and promotion of equity in health, but, for this, it is essential that structural changes are implemented. The invisibility of the LGBT+ population in PHC is not an inevitable consequence, but a reflection of the way health services are organized. Changing this reality requires the commitment of managers, professionals, and public policy makers, ensuring that the SUS, in its premise of universality, is also a system that recognizes and values diversity.

In view of these challenges, we suggest some strategies to improve the identification and reception of the LGBT+ population in PHC. Municipal management plays a key role in promoting awareness campaigns and building partnerships with LGBT+ organizations, fostering a more welcoming institutional culture. In addition, the creation of focal points within the health network, responsible for advising PHC teams in approaching the LGBT+ population, can reduce the insecurity of professionals and ensure more qualified care at the PHC without sending them to specific or specialized services. Another relevant strategy is the inclusion of continuous training on sexual and gender diversity in the scope of permanent education of health professionals, promoting spaces for the exchange of experiences and updating of knowledge.

With regard to data collection, it is essential that the managers of PHC units systematically monitor the rate of completion of the variables of gender identity and sexual orientation, identifying failures and proposing strategies to ensure their correct updating. The adoption of individualized approaches to collecting this information, especially in sensitive cases, can also contribute to minimizing the negative effects of the family-community model of PHC. In addition, health professionals should be encouraged to check and update these records whenever necessary, ensuring that the LGBT+ population is adequately represented in health information systems.

Although this study contributes to the understanding of the barriers faced by PHC professionals in identifying the LGBT+ population, some limitations must be recognized. The geographic scope, restricted to two municipalities in Minas Gerais, may not fully reflect the diversity of realities found in other regions of Brazil, especially in contexts with greater or lesser structuring of LGBT+ health services. In addition, the research is based on the perception of health professionals, without directly including the perspective of the population served, which could offer complementary elements on the impacts of underreporting on the experience of SUS users. As strengths, the theme of this study reinforces the need to deepen discussions on the challenges of LGBT+ data collection in PHC and broadens the debate on the impacts of the organizational structure of health services on the implementation of the National LGBT Comprehensive Health Policy.

Conclusions

The results indicate that the lack of data collection and completion of data on gender identity and sexual orientation stems from a combination of factors, including limitations of professionals, lack of institutional integration, and tensions between the family-community model and LGBT+ identification. These elements demonstrate that the difficulty in collecting this information is not just a technical problem, but a reflection of the way in which the LGBT+ population is still marginalized within health institutions, even with the advancement of public policies aimed at equity.

Abbreviations

PHC

Primary Health Care
SUS
Unified Health System (Sistema Único de Saúde)
PNAB
National Primary Care Policy (Política Nacional de Atenção Básica)
PNSI-LGBT
National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Travestis and Transsexuals (Política Nacional de Saúde Integral LGBT)
eSUS
electronic information system of the Unified Health System (eSUS Atenção Básica)
CHA
Community Health Agent
FHS
Family Health Strategy
IBGE
Brazilian Institute of Geography and Statistics
PNS
National Health Survey (Pesquisa Nacional de Saúde)
ICF
Informed Consent Form
CAAE
Certificate of Presentation for Ethical Appreciation (Certificado de Apresentação para Apreciação Ética)
UFMG
Federal University of Minas Gerais.

Declarations

Ethics approval and consent to participate

Regarding ethical considerations, the study was approved by the Research Ethics Committee of the Federal University of Minas Gerais (UFMG), CAAE 85561717.0.0000.5149, in accordance with Resolution No. 466/12 of the Brazilian National Health Council. All participants were informed about the objectives of the research, their voluntary participation, and the guarantee of absolute confidentiality of identifiable information. All of them signed the Informed Consent Form (ICF).

Consent for publication

Not applicable. No individually identifiable data, images, or videos of participants are included in this manuscript; interview excerpts are reported using de-identified codes.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

S.A.G.S., J.L.T. and A.T.G.M.M. contributed to the conception and design of this study. S.A.G.S. and B.M.O. performed the data analysis and interpretation. All authors contributed to drafting and critically revising the manuscript for important intellectual content and approved the final version for submission.

Acknowledgement

Not applicable

Data Availability

The interview transcripts analyzed in this study contain sensitive information and are not publicly available due to confidentiality commitments made to participants and the terms of approval by the Research Ethics Committee of UFMG (CAAE 85561717.0.0000.5149). De-identified excerpts supporting the findings are presented within the manuscript; further data may be made available by the corresponding author upon reasonable request and subject to ethics committee approval.

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Tables

Table 1 is available in the Supplementary Files section.

Figures

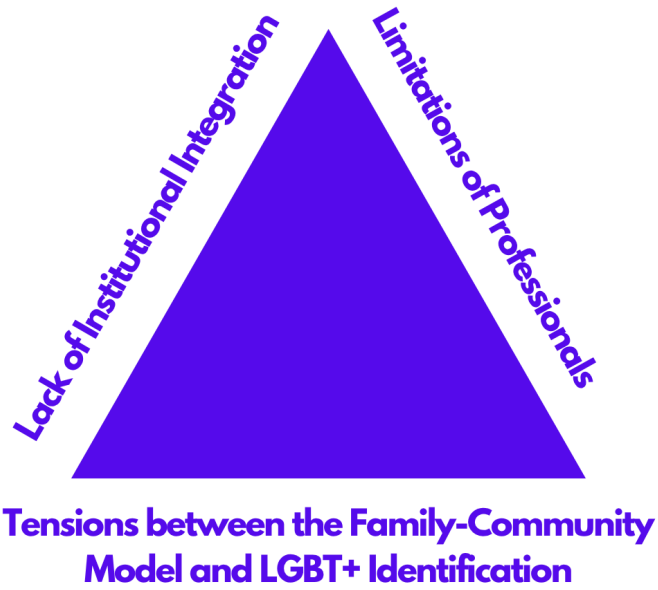


Figure 1

Thematic network, focusing on the challenges of identifying the LGBT+ population in PHC, Minas Gerais, 2024

Source: Prepared by the authors, 2025

Supplementary Files

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