Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.4
DOI: 10.1590/1413-81232024294.19222023EN

THEMATIC ARTICLE

Who are the sexual and gender minorities who frequently interact with children and their association with healthcare

Claudia Rafaella Santos Oliveira (https://orcid.org/0000-0002-1988-2256) [1]
Carolina Campos Vieira de Sousa (https://orcid.org/0009-0003-1119-7443) [1]
Juliana Lustosa Torres (https://orcid.org/0000-0002-3687-897X) [1]

Abstract *This study aimed to examine the sociodemographic profile of sexual and gender minorities who regularly interact with children and investigate whether such frequent interactions are associated with healthcare factors. This cross-sectional study utilized data from the LGBT+ Health Survey in Brazil, conducted online and anonymously from August to November 2020 with 958 participants. Regular interaction with children was defined as living with children or engaging in bi-weekly face-to-face meetings with children residing in different households. Healthcare factors encompass having a professional or reference service, feeling comfortable in discussing personal issues, and receiving worse quality medical or hospital care. The statistical analysis used the Poisson regression with robust variance. The prevalence of interaction with children was 5.3%. We observed a statistically higher prevalence among cisgender women (13.4%) and Black/brown and other non-white people (7.9%) after adjusting for age. The results showed a positive association only between regular interaction with children and worse-quality medical or hospital care received (PR=6.00; 95%CI 1.22-29.67). These findings highlight a persistent stigma and prejudice within healthcare services.*

Key words *Sexual and Gender minorities, Quality of Health Care*

[1] Departamento de Medicina Preventiva e Social, Universidade Federal de Minas Gerais. Belo Horizonte, Brasil. Av. Professor Alfredo Balena 190, Santa Efigênia. 30130-100 Belo Horizonte MG Brasil. rafaellacrso@gmail.com

Introduction

Homoparenting can be understood as a family setup in which at least one of the parents is in a same-sex relationship, and this parent acts as the child's caregiver[1]. Homoparenting has existed for a long time but only gained greater visibility and more legislation regarding social rights in recent decades[2]. One of the significant issues related to the context of this family configuration is how living with and caring for children is mediated by the caregivers' sexuality. Although there is no difference between gay and heterosexual parents[2] concerning their ability to educate and raise a child, homoparenting is clearly much more affected by the socio-cultural environment (prejudice and stigma), which can lead to a smaller support network by family members[3], also due to the parents' characteristics[4].

Several health benefits attach to interacting with children. The study conducted by Goldman[5] revealed that when parents address the responsibility of caring for a child, a direct pathway explains the improved conception of health, from better health behaviors to greater monitoring by health professionals to engage in the provision of care. Another means of explanation stems from keeping strong social ties, which is associated with better mental health in older people of sexual and gender minorities[6]. Moreover, individuals benefit from being raised by sexual minority parents, as evidence points to better results in psychological adjustment and parent-child relationships, and these individuals become more tolerant of diversity[7].

However, in the context of homoparenting, even with the benefits mentioned above, we may observe more significant adverse effects, mainly related to discrimination against minorities, so that healthcare is not equitable and, consequently, sexuality is not exposed. Although the National Policy on Comprehensive Health of Lesbians, Gays, Bisexuals, and Transsexuals was implemented in 2011, setting out objectives that include eliminating discrimination and institutional prejudice[8], minority-related discrimination can still be suffered in the health services, whether or not culminating in worse-quality healthcare. Primary Health Care should be a receptive space but sometimes becomes a place of violence and neglect in healthcare[9]. Data from the 2015-2017 Notifiable Diseases Information System[10] showed that 28.7% of notifications of violence against people from sexual and gender minorities were psychological, and almost 40% were repeated violence cases. Moreover, suffering gender identity-related discrimination reduces the use of health services by almost 70%[11].

Brazil still lacks data on the characteristics of people from sexual and gender minorities with children and how health professionals approach them. The literature already describes the challenges of sexual and gender minorities in accessing healthcare, from discrimination and lack of training for health professionals to understanding the needs of this population beyond sexually transmitted infections[12]. Consequently, healthcare for sexual and gender minorities is not equitable, and sexuality is often not exposed to health professionals. So, the first search for services ends up being in pharmacies or self-medication[13] instead of consulting a health professional. However, it is unknown whether there is a difference in the healthcare provided to this population when homoparenting is present. Thus, this study aimed to analyze the sociodemographic features of sexual and gender minority individuals with children and their frequent interaction with them and see whether there is an association between interacting with children frequently and healthcare.

Methods

Design and sampling

This cross-sectional study was based on data from the LGBT+ (Lesbians, Gays, Bisexuals, Transsexuals, and other related identities) Health survey conducted through a self-completing and anonymous online link disseminated nationwide on social networks such as Facebook, Instagram, and WhatsApp, available from August to November 2020. Sampling was non-probabilistic, through snowball dissemination, until the minimum sample of 664 respondents was reached, as per sample calculation[14]. All individuals aged 18 and over who lived in Brazil during the data collection period and self-declared as belonging to the sexual and gender minority population were included, totaling 976 respondents. The LGBT+ Health survey was previously approved by the Research Ethics Committee of the Universidade Federal de Minas Gerais (CAAE 34123920.9.0000.5149) under Opinion No. 4.198.297.

Frequent interaction with children

For the classification of frequent interaction with children, we considered participants who either lived with their children or whose children lived in another household but had face-to-face meetings with their children at least every two weeks. The other participants were considered not to have frequent interaction with their children.

Sociodemographic variables

The sociodemographic variables included affective orientation (gay, bisexual person, or other), gender identity (cisgender women, cisgender men, or transgender, non-binary or other gender minorities), age group (18-29 years, 30-49 years, or ≥50 years), schooling (Secondary school or less, incomplete or complete Higher Education, incomplete or complete postgraduation), ethnicity/skin color (white or Black/brown/other), having a partner (no or yes), considering "no" as single, divorced, or widowed, and having health insurance (no or yes).

Healthcare

Healthcare was assessed through self-reporting and included having a health professional or service of reference when getting sick or requiring healthcare (yes or no); feeling comfortable telling health professionals about personal issues (yes or no); and receiving worse-quality medical or hospital treatment (no or yes), assessed by the frequency perceived by the participant of receiving worse quality medical or hospital treatment than other people, with four response options. It was classified as "no" when the participant answered "sometimes" or "never" and "yes" when participants answered that they received worse treatment at least once a week or almost every day.

Statistical analysis

Initially, a descriptive data analysis was conducted using the variables' frequencies and 95% confidence intervals (95%CI). Next, the prevalence of frequent interaction with children and crude and age-adjusted Prevalence Ratios (PR) were estimated using Poisson regression with robust variance. The PRs were used to verify the sociodemographic characteristics, among which frequent interaction with children varied significantly between the categories of variables, adopting a 5% significance level. After this stage, the prevalence of frequent contact with children was stratified among the statistically significant sociodemographic characteristics after adjusting for age. Finally, taking each healthcare variable in isolation as a dependent variable, Poisson regression with robust variance was used to identify an association between those who interacted with their children frequently and healthcare. All statistical analyses were conducted through Stata 17.0 SE software (Stata-Corp., College Station, Texas, USA), considering post-stratification with weights by geographical region to increase sample representativeness by geographical region[15].

Results

Nine hundred fifty-eight of the 976 respondents included had complete information on the variables in this study and made up the final sample, with a mean age of 31.7 years (±11.5 years). Fifty-eight (5.3%; 95%CI 3.1-8.8) interacted frequently with their children. Most were gay (75.0%; 95%CI 69.7-79.6), cisgender men (57.2%; 95%CI 51.4-62.7). Other characteristics can be found in Table 1.

Table 2 shows the crude and age-adjusted prevalence of frequent interaction with children and PR for each sociodemographic characteristic. Analyzing the crude prevalence rates, we observed that the prevalence of frequent interaction with children was higher in the 30-49 years age group (10.1%) than in the 18-29 years age group (Prevalence 1.9%; PR=5.48; 95%CI 1.32-22.66). Similarly, it was also higher among Black/brown and other non-white ethnicities/skin colors (Prevalence 8.6%: PR=3.90; 95%CI 1.21-12.53) and individuals having a partner (Prevalence 10.8%: PR=4.48; 95%CI 1.52-13.14). When adjusting for age, we observed a statistically higher prevalence among cisgender women (13.4%) than cisgender men (3.2%) and transgender, non-binary, or other gender minorities (2.7%) (PR=0.22; 95%CI 0.06-0.77 for cisgender men and PR=0.18; 95%CI 0.04-0.82 for transgender, non-binary, or other gender minorities). Frequent interaction with children remained statistically higher among Black/brown and non-white people after adjusting for age (Prevalence 7.9%: PR=3.46; 95%CI 1.07-11.20).

Figure 1 shows the prevalence of frequent interaction with children adjusted by age for gender identity, stratified by ethnicity/skin color, which

Table 1. Characteristics of participants - LGBT+ Health Survey, Brazil, August-November, 2020.

	Total (%)	95%CI
Affective orientation		
Gay	75.0	69.7-79.6
Bisexual person	20.1	15.9-25.1
Other	4.9	2.8-8.5
Gender identity		
Cisgender women	31.3	26.4-36.8
Cisgender men	57.2	51.4-62.7
Transgender, transvestite, non-binary or other gender minorities	11.5	8.1-16.2
Age group		
18-29 years	54.5	48.7-60.1
30-49 years	36.8	31.5-42.5
≥50 years	8.7	5.9-12.6
Schooling		
Secondary school or less	14.6	10.8-19.4
Incomplete or complete Higher Education	46.5	40.8-52.4
Incomplete or complete Postgraduation	38.9	33.3-44.8
Ethnicity/skin color		
White	54.8	49.1-60.5
Black/brown/other	45.2	39.5-50.9
With companion		
No	68.8	63.1-74.1
Yes	31.2	26.0-37.0
Health plan		
No	45.2	39.7-50.8
Yes	54.8	49.2-60.3
Frequent interaction with children		
No	94.7	91.2-96.9
Yes	5.3	3.1-8.8
Having a reference health professional or health service		
Yes	53.3	47.5-59.1
No	46.7	40.9-52.5
Feeling comfortable telling health professionals about personal issues		
Yes	59.4	53.5-65.0
No	40.6	35.0-46.5
Receiving poorer quality medical or hospital treatment		
No	96.4	93.5-98.0
Yes	3.6	2.0-6.5
N total	958	

Source: Authors.

were the variables that remained statistically different after adjusting for age. Although all gender identities (cisgender women, cisgender men, transgender people, non-binary people, or other gender minorities) and Black/brown people or people of other ethnicities/skin colors other than white appeared to interact more often with their children, the prevalence rates found for these people were similar to the prevalence rates for whites. For example, for cisgender women, the prevalence of frequent interaction with children was 6.7% (95%CI 2.9-10.5) among whites and 17.8% (95%CI 8.7-26.8) among Black/brown people or people of other ethnicities/skin colors other than white.

Table 3 shows the adjusted associations between frequent interaction with children and each type of healthcare. Frequent interaction with children was only positively associated with receiving worse-quality medical or hospital treatment (PR=6.00; 95%CI 1.22-29.67).

Discussion

This study showed that the total prevalence of interacting with children in Brazil (5.3%) is relatively low compared to the estimate of sexual minority couples with children in the United States (33%)[16]. Among the sociodemographic characteristics, cisgender women and Black/brown people or people of other ethnicities/skin colors had a higher frequency of interacting with children after adjusting for age. When assessing whether interacting with children frequently was associated with healthcare, we identified that people who frequently interacted with children were likelier to receive worse-quality medical or hospital treatment.

Health professionals who provide care must identify all possible family configurations and understand which sociodemographic aspects are most prevalent and their associated determinants, especially regarding sexual minority issues and homoparenting. This analysis of family composition aims to provide more qualified healthcare ethically and respectfully. We can see a similar picture when comparing the results of this survey with data from the general population. Firstly, we found that cisgender women interact with their children more often than cisgender men. According to data from the United States, the most prevalent homoparental family setup is by lesbian mothers, followed by gay fathers[16], which corroborates this finding. Possibly, this

Table 2. Crude and age-adjusted prevalence of interaction with children in sexual and gender minorities and prevalence ratios between sociodemographic characteristics - LGBT+ Health Survey, Brazil, August-November, 2020.

	Crude prevalence	Crude models	Age-adjusted prevalence		Age-adjusted model	
	%	PR	95%CI	%	PR	95%CI
Affective orientation						
Gay	5.7	1.00		5.1	1.00	
Bisexual person	3.7	0.64	0.24-1.71	5.8	1.14	0.33-3.90
Other	2.6	0.45	0.14-1.43	3.3	0.63	0.16-2.45
Gender identity						
Cisgender women	8.1	1.00		13.4	1.00	
Cisgender men	3.7	0.47	0.15-1.44	**3.2**	**0.22**	**0.06-0.77**
Transgender, transvestite, non-binary or other gender minorities	3.6	0.43	0.10-1.95	**2.7**	**0.18**	**0.04-0.82**
Age group						
18-29 years	1.9	1.00				
30-49 years	**10.1**	**5.48**	**1.32-22.66**			
≥50 years	3.8	1.99	0.48-8.25			
Schooling						
Secondary school or less	4.0	1.00				
Incomplete or complete Higher Education	4.9	1.23	0.24-6.20			
Incomplete or complete Postgraduation	5.9	1.48	0.29-7.52			
Ethnicity/skin color						
White	2.3	1.00		2.4	1.00	
Black/brown/other	**8.6**	**3.90**	**1.21-12.53**	**7.9**	**3.46**	**1.07-11.20**
With companion						
No	2.5	1.00		2.8	1.00	
Yes	**10.8**	**4.48**	**1.52-13.14**	8.7	3.26	0.94-11.35
Health plan						
No	6.0	1.00				
Yes	4.5	0.75	0.26-2.16			

Note: PR: Prevalence Ratio; 95%CI: 95% Confidence Interval. Bold: p<0.05, based on the Poisson regression model with robust variance. Prevalence and age-adjusted PR only for variables with p<0.20 in the crude analysis.

Source: Authors.

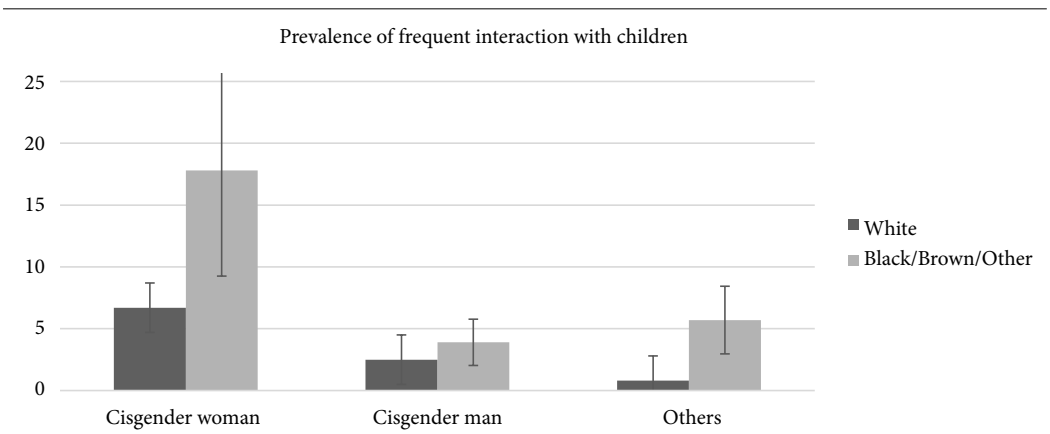

Figure 1. Prevalence of frequent interaction with children adjusted by age for gender identity, stratified by ethnicity/skin color - LGBT+ Health Survey, Brazil, August-November, 2020.

Source: Authors.

Table 3. Models adjusted by sociodemographic characteristics of the association between frequent interaction with children and health care in sexual and gender minorities - LGBT+ health survey, Brazil, August-November, 2020.

	Not having a reference health professional or health service		Not feeling comfortable telling health professionals about personal issues		Receiving poorer quality medical or hospital treatment	
	PR	**CI95%**	**PR**	**CI95%**	**PR**	**CI95%**
Gender identity						
Cisgender women	1.00		1.00		1.00	
Cisgender men	0.98	0.90-1.06	0.90	0.65-1.24	**5.63**	**1.82-17.41**
Transgender, transvestite, non-binary or other gender minorities	1.04	0.92-1.19	1.18	0.75-1.86	**5.25**	**1.44-19.20**
Age group						
18-29 years	1.00		1.00		1.00	
30-49 years	**0.85**	**0.78-0.93**	0.87	0.63-1.21	1.49	0.39-5.70
≥50 years	**0.79**	**0.69-0.91**	0.55	0.28-1.06	**0.07**	**0.01-0.17**
Ethnicity/skin color						
White	1.00		1.00		1.00	
Black/brown/other	0.99	0.92-1.08	1.07	0.80-1.43	0.58	0.18-1.82
Frequent interaction with children						
No	1.00		1.00		1.00	
Yes	0.91	0.75-1.12	1.05	0.50-2.18	**6.00**	**1.22-29.57**

Note: PR: Prevalence Ratio; 95%CI: 95% Confidence Interval. Bold: p<0.05, based on the Poisson regression model with robust variance. PR adjusted by the variables listed in the table.

Source: Authors.

difference between men and women is linked to the social role of women as natural carers of children and men as material providers for the family, even after a separation[17]. Secondly, we identified that Black/brown women interact with their children more than white women. Black/brown women have the most children in the general population: Black/brown women have the highest fertility rate, with 1.88 children, compared to white women, who have 1.69 children[18].

Although the literature points to the benefits of interacting with children[5-7], including greater monitoring by health professionals, this study showed that people who frequently interacted with their children were likelier to receive worse quality medical or hospital treatment. Some hypotheses emerged for interpreting this finding. Firstly, children can provide support during the use of health services. While the literature indicates that having a companion during doctor visits is not directly associated with greater use of health services[11] in sexual and gender minorities, the presence of children as companions during the doctor visit may suggest heteronormative behavior in healthcare since homoparenting is not yet so frequently exposed, generating a lack of specificity in the healthcare provided by professionals. A systematic review showed that one of the main difficulties of homosexuals in accessing health services is due to the health professionals' heteronormative attitudes[13].

On the other hand, homoparenthood itself can lead to deteriorated healthcare due to discrimination against sexual and gender minorities, especially when combined with the masculinized appearance of these women and being attended to by a male professional[19]. This study also found that Black/brown women interact with their children the most and, concomitantly, due to institutional racism, they receive the worst quality of care from health professionals[20]. These hypotheses point to a need for specific training for health professionals, mainly because many professionals report a lack of knowledge about the needs of sexual and gender minorities and difficulty in dealing with this population[9]. Interventions that combine a cognitive-based approach, such as education on sexual and gender minority issues, with an affective-based approach, such as intergroup contact with minority individuals, must, therefore, be implemented to change the prejudiced attitudes of health profes-

sionals. Besides service interventions, it is necessary to include topics on diversity in the training of health professionals[21].

In this study, frequent interaction with children was neither associated with having a health professional or service of reference nor feeling comfortable talking about their personal issues. However, the descriptive results showed that only 50% of the individuals had a reference service and that around 60% felt comfortable talking to health professionals. We should underscore that the Brazilian PHC model is based on attributes such as longitudinality, comprehensiveness, and family and community orientation. Thus, longitudinal care should presuppose a solid interpersonal relationship between clients and health professionals, streamlining care biopsychosocial comprehensiveness. In this sense, the approach of health professionals needs to be family-oriented, considering the family context when assessing individual health[22], which reinforces the need to strengthen these attributes so that the care offered focuses on the real needs of sexual and gender minorities.

We should highlight some strengths and weaknesses of this study. Its strengths are the inclusion of individuals from sexual and gender minorities from all five Brazilian regions, the exploration of the issue of homoparenting in Brazil, and healthcare, a topic that has been scarcely identified in the national literature. Weaknesses include the lack of direct assessment of whether or not they had children, considering only living together with children and frequent meetings with children who lived in another household, which may have underestimated the number of people from sexual and gender minorities with children. However, the literature shows that the most important thing for social well-being is interacting with children and not their absolute number. Secondly, the study did not assess whether the children were from previous relationships or were adopted in some other way. Despite this, this difference did not affect the results. Thirdly, we should have evaluated whether healthcare addressed homoparenthood as part of comprehensive care. Finally, receiving worse quality medical or hospital treatment was assessed through the participant's self-perception, transcending the individual's subjectivity. It may only sometimes capture the actual quality of the services provided.

Conclusions

Public policies and healthcare aimed at homoparenting in Brazil should focus on cisgender women and Black/brown people or other non-white people, who are already the most vulnerable to discrimination. People from sexual and gender minorities who often interact with their children receive worse-quality medical or hospital treatment, showing that stigma against homosexuality and bisexuality is still present in Brazilian health services and requires more effective public policies for better quality healthcare.

Collaborations

JL Torres contributed to designing the study, analyzing and interpreting the results, drafting the paper, and approving the final version. CRS Oliveira and CCV Sousa contributed to designing the study, drafting the paper, and approving the final version.

References

1. Pinto AV. *Pensar a homoparentalidade... A partir das atitudes de diferentes profissionais relativamente à parentalidade homossexual* [tese]. Porto: Faculdade Ciências Humanas e Sociais, Universidade de Fernando Pessoa; 2014.
2. Blankenheim T, Menegotto LMO, Silva DRQ. Homoparentalidade: um diálogo com a produção acadêmica no Brasil. Rev Psicol 2018; 30(2):243-249.
3. Lúcio FPS, Abreu PD, Vasconcelos EMR, Araújo EC. Social network: evaluation of the support or containment contexts of lesbian mothers. *Rev Bras Enferm* 2018; 71(Supl. 1):490-495.
4. Lawrenz P, Habigzang LF. Minority Stress, Parenting Styles, and Mental Health in Brazilian Homosexual Men. *J Homosexuality* 2020; 67(5):658-673.
5. Goldman MJ. *The Joy of Fatherhood, Expanded 2nd Edition: the first twelve months*. 2ª ed. Roseville: Harmony; 2000.
6. Kim HJ, Fredriksen-Goldsen KI, Bryan AE, Muraco A. Social Network Types and Mental Health Among LGBT Older Adults. *Gerontologist* 2017; 57(Supl. 1):84-94.
7. Zhang Y, Huang H, Wang M, Zhu J, Tan S, Tian W, Mo J, Jiang L, Mo J, Pan W, Ning C. Family outcome disparities between sexual minority and heterosexual families: a systematic review and meta-analysis. *BMJ Global Health* 2023; 8(3):e010556.
8. Brasil. Portaria nº 2.836, de 1º de dezembro de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (Política Nacional de Saúde Integral LGBT). *Diário Oficial da União*; 2011.
9. Ferreira BO, Bonan C. Cadê as populações LGBTT na Estratégia Saúde da Família? narrativas de profissionais de saúde em Teresina, Piauí, Brasil. *Cien Saude Colet* 2021; 26(5):1669-1678.
10. Pinto IV, Andrade SSA, Rodrigues LL, Santos MAS, Marinho MMA, Benício LA, Correia RSB, Polidoro M, Canavese D. Perfil das notificações de violências em lésbicas, gays, bissexuais, travestis e transexuais registradas no Sistema de Informação de Agravos de Notificação, Brasil, 2015 a 2017. Rev Bras Epidemiol 2020; 23(Supl. 1):e200006.
11. Leite BO, Medeiros DS, Magno L, Bastos FI, Coutinho C, Brito AM, Cavalcante MS, Dourado I. Association between gender-based discrimination and medical visits and HIV testing in a large sample of transgender women in northeast Brazil. *Int J Equity Health* 2021; 20(1):199.
12. Miskolci R, Signorelli MC, Canavese D, Teixeira FB, Polidoro M, Moretti-Pires RO, Souza MHT, Pereira PPG. Desafios da saúde da população LGBTI+ no Brasil: uma análise do cenário por triangulação de métodos. *Cien Saude Colet* 2022; 27(10):3815-3824.
13. Albuquerque GA, Garcia CL, Quirino GS, Alves MJH, Belém JM, Figueiredo FWS, Paiva LS, Nascimento VB, Maciel ÉS, Valenti VE, Abreu LC, Adami F. Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. *BMC Int Health Hum Rights* 2016; 16(1):2.
14. Torres JL, Goncalves GP, Pinho AA, Souza MHN. The Brazilian LGBT+ Health Survey: methodology and descriptive results. *Cad Saude Publica* 2021; 37(9):e00069521.
15. Macedo AON, Silva SAG, Gonçalves GP, Torres JL. COVID-19 vulnerability among Brazilian sexual and gender minorities: a cross-sectional study. *Cad Saude Publica* 2022; 38(8):e00234421.
16. Berrahou IK, Leonard SA, Zhang A, Main EK, Maliver JO. Sexual and/or gender minority parental structures among California births from 2016 to 2020. *Am J Obstet Gynecol MFM* 2022; 4(4):100653.
17. Botton A, Cunico SD, Barcinski M, Strey MN. Os papéis parentais nas famílias: analisando aspectos transgeracionais e de gênero. *Pensando Familias* 2015; 19(2):43-56.
18. População e Desenvolvimento do Fundo de População das Nações Unidas (UNFPA). *Fecundidade e dinâmica da população brasileira*. Brasília: UNFPA Brasil; 2018.
19. Rufino AC, Carvalho Filho CEWB, Madeiro A. Experiences of Violence Against Lesbian and Bisexual Women in Brazil. *Sex Med* 2022; 10(2):100479.
20. Oliveira BMC, Kubiak F. Racismo institucional e a saúde da mulher negra: uma análise da produção científica brasileira. *Saude Debate* 2019; 43(122):939-948.
21. Costa AB, Pase PF, Camargo ES, Guaranha C, Caetano AH, Kveller D, Rosa Filho HT, Catelan RF, Koller SH, Nardi HC. Effectiveness of a multidimensional web-based intervention program to change Brazilian health practitioners' attitudes toward the lesbian, gay, bisexual and transgender population. *J Health Psychol* 2016; 21(3):356-368.
22. Mesquita FM, Luz BSR, Araújo CS. A Atenção Primária à Saúde e seus atributos: a situação das crianças menores de dois anos segundo suas cuidadoras. *Cien Saude Colet* 2014; 19(7):2033-2046.

Article submitted 21/11/2023
Approved 14/12/2023
Final version submitted 15/12/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva