

Transgender women's experiences in the healthcare system: visibility towards equity

Experiências de mulheres transexuais no sistema de saúde: visibilidade em direção à equidade (resumo: p. 16)

Experiencias de mujeres transexuales en el sistema de salud: visibilidad en dirección a la equidad (resumen: p. 16)


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Abstract

Aiming to understand how transgender women have been served in institutions of the Unified Health System, the study adopted the qualitative design. The thematic content analysis of interviews and focus group resulted in three categories: Use of health services by trans women; Violence in health care; Lack of specialized care. The participants reported having no links with primary care, seeking care in the outpatient clinic linked to the teaching hospital and in emergency care. Cases of institutional violence, negligence, and prejudice permeate their experiences. Humanized care; accreditation of the hospital for the transsexualization process; investment in the worker's well-being; creation of care protocols and complaint channels were suggested. Equity and integral attention require the expansion and qualification of services. Investments in permanent education are essential.

Keywords: Health equity. Sexual and gender minorities. Delivery of health care.



Introduction

Associated historically with the naturalization of criteria for body reality, bodies have been classified, ordered, and defined. Studies developed by Butler¹ point out that gender is both constructed and determined by culture, and that such construction is responsible for the expression of what is understood as the “essence” of the individual.

Gender identity may be defined the internal and individual experience that may correspond to the sex assigned at birth (cisgender) or not (transgender). Gender expression indicates the social manifestation through “body image. Biological sex is defined by genetic, phenotypic, and hormonal characteristics. Thus, biological sex by itself does not determine gender identity or expression, these are distinct dimensions².

Gender studies expand the understanding of different identities, but the discursively naturalized patterns of feminine or masculine binarity, perpetuated by cisnormativity, still echo multidimensionally in the lives of nonconformists³. The countless faces of violence have permeated the experiences of people who identify themselves as lesbian, gay, bisexual, transgender, transvestite, queer, intersex, asexual, pansexual, and others (LGBTQIAP+). However, studies have shown that transgender people are the ones who face more and more serious cases of prejudice and hostility within the LGBTQIAP+ population^{4,5}.

In the cisnormative reality, transvestite, transsexual, and transgender (trans) bodies become objects, pejoratively “abnormal”, and therefore disposable⁶. Among possible situations of vulnerability are the lack of family and community support.⁷ Regarding health, we can highlight psychological suffering, licit and illicit substance abuse⁸, lack of knowledge and non-use of preventive methods against Sexually Transmitted Infections (STI), inappropriate use of hormones, clandestine aesthetic and surgical procedures, among others^{9,10}.

Public institutions sometimes reiterate institutional violence and disrespect by offering reduced number of specialized services and professional unpreparedness to attend to sexual and gender diversity¹¹.

In this scenario, the National Policy of comprehensive LGBT Health (PNSILGBT in the Portuguese acronym) represents a landmark for the promotion of health, the fight against discrimination and institutional prejudice, and the reduction of inequalities¹². Consequently, the PNSILGBT must be understood as an institutional support that needs initiatives and engagement from managers, institutions, and professionals to become effective.

Studies show that, despite the advances in the implementation of the PNSILGBT, the users of the SUS network are faced with situations that violate the principles of the Brazilian National Health System (SUS) and signal ignorance, insecurity, and lack of ability to carry it out, which contribute to the distance between the population and the service^{13,14}.

Aiming to contribute to the settling studies on the effectiveness of the PNSILGBT and the advances in the organization of health care for these minorities, the guiding question of the study was outlined as follows: how have transgender women experienced care in services of the SUS Network?



Thus, the present study aimed to understand how transgender women have been cared for in institutions of the SUS Network, in a city in the interior of Minas Gerais.

Methods

This is a descriptive exploratory study, applying a qualitative approach¹⁵. The qualitative design was based on establishing processes for listening to transsexual women that allowed us to capture nuances about their experience in the SUS network, fundamental to understanding the effectiveness of the PNSILGBT and how, in different places, the barriers to equity in health have been overcome.

The study was conducted based on the understanding that qualitative research in the field of Collective Health may contribute to the “elucidation and overcoming of social and health problems”, a task that requires “ample access to the results and the direction of the investigation, bringing together academia, services, management and community”¹⁶ (p. 584).

The study setting was the endocrinology outpatient clinic of a teaching hospital in the interior of Minas Gerais. The hospital is not accredited for the transsexualization process, but offers endocrinology care. The invitation to the participants was made in person at the waiting room of the clinic. The participants met the following inclusion criteria: being 18 years old or older and identifying themselves as transsexual. The exclusion criteria were: being undergoing health treatment that prevented them from attending the meeting; being a coordinator or health professional; living in a municipality other than the one hosting the clinic where the recruitment took place.

Ten people showed interest in participating in the study. Of them, only four attended the focus group meeting and gave interviews.

The following instruments were applied for building the data: (a) form for socio-demographic characterization prepared by the researchers; (b) focus group technique (FG); (c) semi-structured interview (SSI). The FG technique contributes to the collective construction of information on specific themes. As a differential, the method is based on the human being's ability to communicate and to build positions together¹⁷. The interviews were used to expand on points that had been little explored in the FG.

The FG meeting took place in November 2019, in a space of the educational institution, with conditions of secrecy and privacy. The FG meeting was conducted by a researcher with a degree in Social Sciences and experience in qualitative research, and was observed by undergraduate students in Nursing and Psychology.

The FG was guided with a script that aimed to encourage dialogue about the participants' experiences in the SUS. The following questions were applied: “When I seek the health service, I feel...”; “When I seek the health service, I am treated with...”; “I don't seek the health service because...”; “I have my problems solved when...”; “Do you know of any municipal program/action that addresses the social equality rights of the LGBT population?”; “What suggestions would you make to improve the care for the LGBT population in the SUS?”. In turn, the interviews aimed to elucidate singularities about the participants' experiences in the SUS.



The participants consented to the audio recording of the FG and interviews and were clarified about the responsibilities regarding the confidentiality of the information shared in the group.

The data from the SSIs and FGs were considered jointly, according to a triangulation method¹⁸. Data analysis followed the thematic content analysis guidelines established by Braun *et al.*¹⁹, involving six phases. The first and second phases were carried out individually, consisting of the “familiarization” of the data obtained and active reading, and the “codification” carried out later allowed the organization of the data set into groups, with the purpose of finding patterns. From this coding, the search for “themes” was performed, in which the codes were grouped into potential theme candidates, looking for ways to associate them in an overarching theme. The fourth, fifth and sixth phases were developed in teams. We proceeded to the “themes review”, refining the data set, defining and naming the themes, then it was possible to capture the meaning of what was coded and the selection of elucidative excerpts from each category. In the end, it consisted of the narrative and interpretation of the data for the final writing based on the literature.

It must also be contextualized the epistemological position of the research, referring to the issue of partiality inherent in the process. Given that the researchers use as starting step a culturally normative identity place, the influences of this place on the interpretation of trans experiences is problematized in the research field. In this sense, we adopt Favero's position²⁰ that the identification of a place of speech is not enough to fulfill a requirement of clarifying partiality, but, above all, we must discuss the exchanges established and their potential to create cracks in the barriers that prevent the opening of the pain of the other. A position of estrangement is assumed, in which the formation of one's own identity is problematized, allowing the opening of a cis-trans “in-between” that makes explicit the experiences of the participants in the health contexts²⁰.

The research complied with the precepts and guidelines of Resolution No. 466/2012 of the National Health Council, and was approved by the Research Ethics Committee, opinion 4,081,363. Each participant expressed consent in a specific term and received a copy of it. To ensure confidentiality, the excerpts extracted from the interviews are indicated by SSI and those of the focus group by GF, followed by the fictitious name chosen by the participant.

Results

Frame 1 presents the characterization of the participants. The participants were by four trans women between the ages of twenty-five and thirty-two. Three self-declared white and one brown. The professions referred to were: veterinary assistant, hairdresser, decorator, and security guard. One of them was retired and the others were in the informal labor market.

As for sexual orientation, three participants declared themselves heterosexual and one lesbian; three were single and one was in a stable union. Two participants lived with family members and the others lived alone. The declared family income was up



to one minimum wage. All of them finished high school, but two interrupted higher education. None had private medical insurance.

Frame 1. Characteristics of the study participants

Participant	Race	Age	Schooling	Occupation	Income
Ágatha	White	32	High School complete	Decorator	1 – 2 minimum monthly wage
Estepélia	White	25	Higher education incomplete	Vet auxilliary	Less than 1 monthly wage
Parveti	White	31	High School complete	Hairdresser	2 - 4 minimum monthly wage
Rosa	Brown	31	Higher education incomplete	Security/Retired	Less than 1 monthly wage

Source: Authors.

The process of analysis of the data as built in the focus group resulted in outlining three categories: a) Use of health services by trans women; b) Violence in health care; c) Lack of specialized care. The results are presented according to the categories.

Utilization of health services by trans women

Regarding the health services of the SUS, the participants reported having no links with primary health care (PHC), seeking care in the outpatient clinic linked to the teaching hospital and, sometimes, access to emergency care units (UPA in the Portuguese acronym).

I used to have the habit of seeking the [health unit], making appointments, these things and I stopped going, I didn't go anymore [...]. Sometimes I go about four times and I miss the appointment [I hear] “- Now it's only a month away” and sometimes depending on the level of the situation you are in, you don't wait, it discourages you. (SSI Ágatha)

Sometimes I use the UBS but, generally, I almost don't go, because as I search for the specific specialty, I go straight to the hospital [reference to the outpatient clinic]. (FG Rosa)

We identified in the reports of the participants experiences marked by barriers in access to services: the need for judicialization for surgical care, delay in care, absence of an outpatient clinic for specialized care to the trans public.

The last [health institution] that I really used was the UPA. I was 25 days hospitalized with kidney problems [...] and to get the surgery, I had to file a writ of mandamus, that is, I had to go to court to get it. (FG Ágatha)

It has been five months since I got care and [did] the exams. Now, I can't get to see the results of the exams. (FG Ágatha)



They don't have a specific schedule open for transgender people, understand? They [at the endocrinology clinic] are fitting us in "- Oh, do you have a schedule? It fits. Don't you have a schedule? Patience". (FG Rosa)

The participants also explored the importance of advances in de-pathologization, seen as necessary to overcome transphobia and advance in the recognition of rights, they identified that the "diagnosis" has been the guarantee for access to the SUS.

Transsexuality is not a disease, but society sickens us for being trans. So, the de-pathologization was wrong because it will bar the redesigning surgery, from the moment that it is not linked to an ICD [International Disease Code], it will become aesthetic, and the SUS will no longer be forced to pay for it. (FG Rosa)

I am totally against de-pathologizing transsexuality and homosexuality because if you de-pathologize, you are simply stating that this person does not need the SUS. (SSI Rosa)

One of the participants also referred to the reception in a psychiatric hospital on the occasion of attempted self-extinction:

The sanatorium was crucial in my life [...] it was where I had all the support I needed for the period of my transition [...], it was in my first frame of depression that I had the attempt of self-extinction. [In the sanatorium] I had access to everything that every trans person needs in the health field, which was a multi-professional team, which is social service, psychology, psychiatry, general practitioner, all that nursing staff. Everything that we need I had there. They started to have the sensibility to refer me to everything that I might need and that would be favorable for my transition. When I left the sanatorium, they referred me to the CAPS [Center for Psychosocial Attention]. (SSI Rosa)

Violence in health care

According to the participants, violence in health care can be veiled or not and manifests itself in prejudiced, negligent or sloppy situations:

Even though it was a kidney problem, I experienced prejudice [...]. They asked or I heard "- Too thin, ah she uses drugs", but I always had this body [...] And I heard a nurse saying "Oh, she is a drug user, ah she drinks [...]. (FG Ágatha)

The Dr. [from the clinic] told me that inside the hospital there are many doctors that say: "How? You are crazy to attend to these people". (FG, Ágatha)

On a daily basis the use of the social name is violated and the use of the registered name is used, especially with a loud tone and even after due requests and clarifications from the participants, it was reported as violence:



I included the social name in all the documents I had, I always tried to have the support of documenting. [...] In the SUS card it was on the baptismal name and the social name, but when you play in the system and the form comes out, it comes out with the baptismal name, it doesn't have the social name on it. When it came, it came with small letters, in the corner, you know, an upside-down footer, almost like this. So, many times, the person called [by his or her registered name]. (Rosa FG)

When I was hospitalized, I experienced prejudice, the nurse made fun of me, shouting the name that was not social in the middle of everyone and they put me in the male ward to sleep with the men, they told me not to use the women's bathroom, to use the men's. (SSI Ágatha)

The negligence in health care can be observed in the following statement:

When I had my [kidney] surgery I was in shock because I couldn't get off the stretcher, so I went to the [recovery] room. [...] I had my surgery three hours in the afternoon and they [nurses] went to open the probe one o'clock in the morning. I screamed of pain. When I looked, I was all bloody, they hadn't opened the tube, I was left with the catheter, and then the doctor treated me as if I were a street dog. I had hospital trauma [...]. (FG Ágatha)

Attempts of suicide were reported by three of the participants. In these delicate moments, instead of feeling welcomed, they reported care permeated by prejudice, neglect and punishment.

I took 40 pills of a black-target drug and then [...] I threw myself into a hole. I stayed there for eight hours. So, the pills that I had already taken had already been absorbed [...] The doctor himself looked at me and said: "There's absolutely nothing in your stomach, but you can still wash it. Stop? If there was nothing in my stomach, will you wash it so that I feel pain? [...] When it was time to pass the probe, the nurse stuck it in so hard that the probe bent in my nose [...]. I said "- It's bent." and she said "- Oh, is it bent?" She jerked and pulled and the tube came down and blood came down with it. (FG Estapélia)

There was another time that the admission [to SUS] was emergency. In a situation in which I had a depressive crisis and attempted suicide. This time, I was not treated by my social name at any moment, and to tell the truth, they didn't even treat me with much respect. (FG Estapelia)

I was intubated, when I started to wake up, I pulled out my own tube, I pulled out my vein accesses and my mother called the nurse [...]. I was coming back to consciousness, it was something that marked me, [she] said [with an arrogant air]: "You are like this because you are getting better [...]. (FG Rosa)



Unlike the others, one of the participants reported having positive experiences at the SUS:

I was super well treated [in public services], thanks to God, no case of treating me happened. I also made it very clear how I wanted to be called, [...] I had a certain patience, because I know that not everyone understands, but the way you arrive also [interferes], [...] I don't know if it was by luck or by catching people with a little more open consciousness [...]. (FG Parveti)

Lack of specialized care

The participants emphasized the lack of specialized care for the trans public in the local SUS Network. They demonstrated to know the guidelines of the Ministry of Health (MoH) on the transsexualizing process and the expectation that the federal teaching hospital will organize itself to be accredited.

The outpatient clinic [of the university] needs trained people to carry out the care [for transgender people] [...] The transsexualization process makes clear the list of professionals and what needs to be done and here [teaching institution] has everything, the only thing missing is the will to do it and establish it, because it includes surgery for gender reassignment, breast implant, follow-up and surgery, speech therapist, facial feminization. It encompasses all of this, and it is not mandatory for trans people to do everything [...] (FG Rosa)

Some of the limitations that we have, is because there is no professional trained to attend to our reality. Is there a psychologist? There is a psychologist. Is there an endocrinologist? There is an endocrinologist. Is there a urologist? Yes, there is a urologist. But they are not specialized in the area of andrology, do you understand? (FG Rosa)

The complaint of lack of specialized care for the transsexual public was also mentioned in relation to private institutions and professionals by one of the participants:

I have a false care in the private service [...] I arrived [in the private service] and [the doctor] passed 12 hormonal tests. Progesterone and estrogen, which I was taking and that could kill me, he didn't pass to evaluate [...]. So, he doesn't know what he is doing. [...] In practice, he has no idea what is happening with my body or with the gender transition that I am doing [...]. (FG Estapélia)

It was also reported an understanding that professionals need to be specialized in relation to psychology, since two participants had previous experiences of being assisted by a psychologist specialized in sexuality and gender. According to them, the psychological support can be a great ally to face the conflicts of recognition and understanding of their gender identity.



I think that the follow-up is very necessary in the case of trans people to be able to help in what is happening, because it is a moment that needs a lot of attention [...] So, the psychologist specialized in transgender may be helping in this process, if it is another type of psychologist, I believe that it may increase the confusion, because she will not understand, we will have difficulty and will leave everything confused. (FG Rosa)

With private care, I felt much more comfortable, I showed that I was trans [...] and the private care, especially with X, who is a specialist in sexuality and gender, was fantastic. (FG Estapélia)

In these support networks [...] having psychological support, to be able to come to a conclusion of what [you] are [...]. The acceptance of yourself and what the world out there is like [...], even family, outside of your body, outside of yourself [...] I think changing people won't, so you have to treat those who live the way they want to live. I believe that it would be this kind of support through support networks or institutions. (SSI Ágatha)

Facing this situation of lack of specialized care, the participants expect the hospital to be accredited to provide care for the transsexualizing process. Besides that, they suggested actions to encourage and qualify workers, as well as to curb situations of violence and negligence such as those experienced.

At the hospital level, I think that one of the ways to improve is the accreditation, to join forces in favor of a common benefit, because wanting it or not, the transgender clinic is for the transsexualizing process, because it is not only the redesigning surgery, because the transsexualizing process encompasses all the surgical and ambulatory specialties [...] Because it is a procedure that we have to have here, because the public already has it, people qualified to command the surgery already have it [...] So, the accreditation is the main aspect. (FG Rosa)

And I think that improving their salary, because it seems that they are not happy doing their job. So, I want them to be happy and the base of this is having a better salary. (FG Parveti)

I don't know if there is, for example, [...] ethics and accountability committee [...]. There could be this about working in SUS, because there are certain unethical attitudes, just like what I went through with the nurse [in the UPA], it was unethical [...]. (FG Estapélia)

Discussion

The Brazilian Institute of Geography and Statistics (IBGE in the Portuguese acronym) has not included insofar in its surveys, means to measure the education, salary range, family situation, and life expectancy of the trans population²¹. The



absence of this data creates obstacles for the implementation of public policies that meet trans demands. It is necessary to invest in the production of knowledge in the field of Collective Health, and also in other areas that allow the development of programs and actions that promote equity²².

Regarding the use of health services by the study participants, it was found the predominance of emergency and specialized services, with no link to PHC institutions. The women's experience points to a SUS challenge, which is to ensure the network articulation, thanks to the strengthening of PHC and its attributes²³.

In the SUS, the search for care is guided by the manifestation and identification of a symptom or clinical complaint. The prioritization of acute conditions generates barriers to comprehensive care²³. It is worth analyzing the experience of trans women in the municipality studied as a possibility to recognize that the integrality of care, at all points of the network is a challenge for the implementation of the PNSILGBT.

The judicialization in order to ensure care, delays, overcrowding and shortage of specialist professionals are not problems exclusive to LGBTQIAP+ users, but rather, to the entire population that uses the services of the SUS Network, which does not delegitimize the complaints reported by the study participants. There is an unequal impact of institutional issues, considering that cisnormativity inferiorizes this population and places them in worse health conditions, compared to heteronormative individuals, experiences that violate the principle of equity in health, by positioning the LGBTQIAP+ population in yet another place of rights restriction²⁴⁻²⁶.

The participants explored the issue regarding the International Classification of Diseases (ICD) acting as an element that contributes to the stigmatization of access to health services, tangent to the pathologization of sexual orientation and gender identity, imposed as "sexual perversions" restricting the understanding and performance of health professionals and managers, hindering the reception and care of several demands from LGBTQIAP+ people^{3,26,27}.

Since 2008, the World Health Organization (WHO) has been working for a new non-pathologizing reclassification of transsexuality through the ICD, previously included in "mental disorders" and today, it is in "conditions related to sexual health" classified as "gender incongruence", in a revision carried out in 2018²⁶. De-pathologization is needed for the consolidation of the autonomy of transgender people, recognizing them as individuals capable of deciding about their bodies, giving them, again, the right to choose about themselves, transgender people, with gender incongruence, are recognized and classified within the ICD, without the burden of carrying with them the taxation of having a "mental disorder" or being "dysphoric". However, the de-pathologization is also seen as a threat and a barrier to their rights guaranteed by the transsexualizing process, since in this case it would not be up to the State to pay for the treatment. Therefore, the discussion about fighting (de)pathologization and (de)diagnosis remains undefined, given the paradox of the existence of a movement in the health field that no longer rates the trans population as sick, and the institutional need for a diagnosis to access their rights^{26,27}.

The trans body is different from the cisnormative gender standard, and it causes strangeness before normative looks. These individuals, when they seek health services,



may experience several complications (prejudice, neglect, and institutional violence), which contribute to the removal of this population from the SUS network, further aggravating situations of vulnerability⁴.

Building this socially passable female body (hormonization, use of injectable industrial silicone implants), usually done in clandestine clinics due to the lack of specialized services or difficult access, results in physiological complications to the user^{3,28}. Together with the construction of this body, comes the adoption of a name, which materializes a gender identity, being this the validation and recognition of his inner "I" displayed to the outside environment. Ordinance No. 1820/2009 of the MoH made it mandatory to fill in the social name in documents, records, and medical records of SUS service users, in a specific field, and the PNSILGBT, in its guidelines, regulated this right¹². Contrary to these norms, the rights of trans people are routinely disrespected, and trans people experience discrimination, prejudice, inferiority, and violence^{4,5,25}.

Using the social name promotes access of trans people to health services and favors humanized care. Disrespect for the social name presents itself as the main impediments to universal, full, and equal access. In this context, its use fosters ways to achieve comprehensive health care. However, the conquest of the social name as compulsory, despite an important advance for trans issues, by itself modifies the difficulty of access to the health system, especially with regard to care²⁹.

Institutional violence is an action practiced by public agencies and agents, whose function should be to ensure the care, protection, and defense of citizens. This violence reveals itself verbally, through negligence, dehumanized treatment, threats, punishment, reprimands, abuse of power, non-relief of pain, and sexual abuse¹¹. A study mapped that 37% of the trans population studied suffered homophobia, 36% experienced absence of care, 27% refusal and abuse of power, 24% excessive delay in care, and 40% suffered some type of physical or psychological violence within the health service³⁰, all this plethora of situations incurs in mental health demands for the trans public. Sometimes, alcohol consumption, tobacco abuse, and other drugs are presented as a way to deal with suffering. When the individual reaches the apex of suffering, such as attempts at self-extermination, when entering the health service, the reception is usually too painful^{4,5,30}.

Thus, the reports lead us to think about the access to health care as being interpellated by normative processes that, due to their pathologizing interpretations, promote the exclusion of trans people. The studies on cisnormativity, which find in Vergueiro³¹ a fundamental contribution, propose cisgenerity as one of the possibilities of gender, in an equal position to the others, a process that subjugates them. Thus, when looking at health issues from the viewpoint of cisnormativity, it is possible to tense the knowledge already built and investigate how cisgenerity is revealed in professional practices, even if not named^{3,30}.

It should be highlighted that the approach to gender issues in health care shows difficulties in separating what is gender politics and politics for women and men. The normative binarism that still remains in these discussions causes the exclusion of health care to the trans public, showing the exclusionary institutionalized prejudice¹¹.



There are specific policies that have been built for the LGBTQIAP+ public aiming to expand this debate, as well as specific policies for the trans population. One of the examples is Ordinance No. 2803/2013, which redefines and expands the transsexualization process in SUS¹² and establishes criteria for performing procedures (outpatient and hospital) to meet the demands of the trans population. The service is not limited or focused on transgenitalization surgeries, including among the numerous demands, hormone therapy. Interdisciplinary and multiprofessional care in several areas is emphasized, using the gateway of PHC, and users' welcoming based on the humanization policies, free of discrimination, through the sensitization of professionals and other workers in the unit in order to respect the differences and preserve the dignity of the human being in all levels of health care^{25,29,30}.

In order to improve care, it is strategic to consider the importance of raising awareness about the peculiarities of LGBTQIAP+ users beginning in the professional training stage, in order to prepare professionals to deal with users, in a humane and integral way, in all spheres of public and private health services, bringing this public closer to health services²⁶.

The literature has indicated numerous challenges of gender fluidity accompanied by family conflicts. As pointed out by the study participants, it is necessary that the multiprofessional teams, and especially the psychology practitioners, have a broad knowledge about the peculiarities of this population in order to contribute to face the difficulties of living as a trans person². The process of training health professionals should, therefore, be aimed at understanding the specificities of care for the LGBTQIAP+ population, including the ongoing suffering produced by the cisnormative and heteronormative structure that permeates professional action. Thus, acting within the principles of universality, comprehensiveness, and equity implies the construction of, in Favero's¹⁹ words, "a methodology made of encounters".

There are common aspirations for the trans population: humanized care; accreditation of the hospital for the transsexualization process; investment in the well-being of the worker; creation of care protocols and channels for reporting cases of violence and negligence. Those aspirations are in line with results found in other studies^{4,5,13,14}. The breadth of the suggestions presented allows us to foresee the numerous challenges to be faced by the SUS to ensure health care for trans women.

Final considerations

By building a study with a broad process of listening to trans women, it allowed us to explore in detail their experiences in SUS, tracing in detail the entanglement of experiential issues with the exclusionary structure that permeates the processes in health. Although the research deals with experiences in a city in the interior of Minas Gerais, it allows us to reflect on how these experiences, crossed by countless situations of institutional violence, denial of rights, and negligence, reiterate the structure of exclusion. What allows us to problematize how much the advances that have occurred in the legal field and in public policies come up against transphobia and cisnormativity.



Creating specialized services and expanding the accreditation of institutions for the transsexualizing process will require financial investments and mobilization of the teams and will represent advances as long as they are anchored in the widest possible access to the SUS.

The comprehensive care for minorities is a task for the entire network and for society, as it must be addressed in the context of combating social inequities and cisnormativity, as a cause of illness. Therefore, a sensitive action based on respect for diversity is fundamental for the implementation of the PNISLGBT. In this sense, investments in the training and continuing education of professionals can contribute to increase the visibility of the demands of the transgender population, fostering improvements in care.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Resumo

Com o objetivo de compreender o modo como mulheres transexuais têm sido atendidas em instituições do Sistema Único de Saúde, o estudo adotou o delineamento qualitativo. A análise de conteúdo temática de entrevistas e de grupo focal resultou em três categorias: utilização de serviços de saúde por mulheres trans; violência na Atenção à Saúde; falta de atendimento especializado. As participantes referiram não possuir vínculos com a Atenção Primária e buscar atendimento no ambulatório vinculado ao hospital de ensino e em pronto atendimento. Casos de violência institucional, negligência e preconceito permeiam suas experiências. Atendimento humanizado; credenciamento do hospital para o processo transexualizador; investimento no bem-estar do trabalhador; criação de protocolos de atendimento e canais de denúncia foram sugeridos. A equidade e a atenção integral requerem ampliação e qualificação dos serviços. Investimentos em Educação Permanente são essenciais.

Palavras-chave: Equidade em saúde. Minorias sexuais. Atenção à saúde.

Resumen

Con el objetivo de comprender la forma en que las mujeres transexuales han sido atendidas en instituciones del Sistema Único de Salud, el estudio adoptó la delineación cualitativa. El análisis de contenido temático de entrevistas y de grupo focal resultó en tres categorías: Utilización de servicios de salud por mujeres trans; Violencia en la atención de la salud; Falta de atención especializada. Las participantes refirieron que no tenían vínculos con la atención primaria y que buscaban atención en el ambulatorio vinculado al hospital escuela y en urgencias. Casos de violencia institucional, negligencia y prejuicios atraviesan sus experiencias. Se sugirieron la atención humanizada, la acreditación del hospital para el proceso de transexualidad, la inversión en el bienestar del trabajador y la creación de protocolos de atención y canales de denuncia. La equidad y la atención integral requieren aplicación y calificación de los servicios. Son esenciales inversiones en educación permanente.

Palabras clave: Equidad en salud. Minorías sexuales. Atención de la salud.