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Restriction of public health policy: a challenge for transsexuals in primary

Restrição de políticas públicas de saúde: um desafio dos transexuais na atenção básica

Carerestricción de las políticas de salud pública: um desafio para los transexuales em la atención primaria

Denildo de Freitas Gomes[1]
Enéas Rangel Teixeira[1]
Marta Sauthier[2]
Graciele Oroski Paes[2]

1. Universidade Federal Fluminense, Escola de Enfermagem Aurora Afonso Costa, Programa de Pós-Graduação em Ciências do Cuidado e da Saúde. Niterói, RJ, Brasil.

2. Universidade Federal do Rio de Janeiro, Escola de Enfermagem Anna Nery, Departamento de Enfermagem Fundamental. Rio de Janeiro, RJ, Brasil.

Corresponding author:
Denildo de Freitas Gomes.
E-mail: enffreitas@hotmail.com

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ABSTRACT

Objective: to identify and discuss the reasons that hinder or restrict transsexuals' accessibility to primary health services. **Method:** original research with a qualitative approach. Twelve semi-structured interviews were conducted with transsexuals between December 2018 and March 2019. Bardin's thematic content analysis was used. **Results:** the following thematic categories emerged from data analysis: *Low resolution and multiple barriers to access of transsexuals to primary health care*; *Non-inclusion and self-exclusion: the explicit non-belonging to the Unified Health System*. **Conclusion and implication for practice:** the non-recognition of transsexuals as citizens with the right to access health care, abjections by the transsexual body, prejudice and lack of value are factors that restrict this population to health system. This difficulty reverberates in an important challenge to be overcome by transsexuals in the search for qualified care. For practice, it is understood the importance of bringing to the center of discussions, in all spheres of health care, issues about values, principles and social morals that are intertwined in health professionals' conduct and performance.

Keywords: Primary Health Care; Nursing; Ethics; Public Policy; Transsexualism.

RESUMO

Objetivo: identificar e discutir os motivos que dificultam ou restringem a acessibilidade dos transexuais aos serviços básicos de saúde. **Método:** pesquisa original com abordagem qualitativa. Realizadas doze entrevistas semiestruturadas com transexuais entre dezembro de 2018 e março de 2019. Utilizou-se a análise de conteúdo do tipo temática de Bardin. **Resultados:** emergiram, da análise dos dados, as seguintes categorias temáticas: *Baixa resolutividade e múltiplos entraves do acesso do transexual ao atendimento básico de saúde*; *Não inclusão e autoexclusão: o explícito não pertencimento ao Sistema Único de Saúde*. **Conclusão e implicação para a prática:** o não reconhecimento do transexual como cidadão de direitos ao acesso à saúde, a abjeção pelo corpo transexual, o preconceito e a menos valia se apresentam como fatores restritivos dessa população ao sistema de saúde. Essa dificuldade reverbera em um importante desafio a ser suplantado pelo transexual na busca por uma assistência qualificada. Para a prática, entende-se a importância de se trazer para o centro das discussões, em todas as esferas de atendimento à saúde, questões acerca de valores, princípios e da moral social que se encontram entremeadas na conduta e atuação do profissional de saúde.

Palavras-chave: Atenção Primária à Saúde; Enfermagem; Ética; Política Pública; Transexualidade.

RESUMEN

Objetivo: identificar y discutir las razones que dificultan o restringen el acceso de las personas transexuales a los servicios básicos de salud. **Método:** investigación original con enfoque cualitativo. Se realizaron doce entrevistas semiestructuradas con transexuales entre diciembre de 2018 y marzo de 2019. Se utilizo el análisis de contenido temático de Bardin. **Resultados:** Del análisis de datos, surgieron las siguientes categorías temáticas: *Baja resolución y múltiples barreras de acceso de transexuales a la atención básica de salud*; *No inclusión y autoexclusión: la no pertenencia explícita al Sistema Único de Salud*. **Conclusión e implicación para la práctica:** el no reconocimiento de las transexuales como ciudadanas con derecho a acceder a la salud, las abyecciones por parte del cuerpo transexual, el prejuicio y la desvalorización son factores que restringen a esta población al sistema de salud. Esta dificultad repercute em un importante desafío a superar por el transexual en la búsqueda de una asistencia calificada. Para la práctica, se entiende la importancia de traer al centro de las discusiones, em todos los ámbitos de la salud, cuestiones sobre valores, principios y moral social que se entrelazan em la conducta y desempeño de los profesionales de la salud.

Palabras clave: Atención Primaria de Salud; Enfermería; Ética; Política Pública; Transexualidad.

INTRODUCTION

Current health policies are constructed from gender binarity. Health notebooks, used by professionals, direct a method of care based on biological concepts, seeking to meet the health needs of individuals who fit the definitions of what is established as belonging to the male and female gender.

Although there are some prescriptive directions to people who have their biological sex diverging from their gender status, these are still little applied in practice due to a deficiency in the dissemination of knowledge that meet transsexuals in their specificities, transforming this gap into an important challenge in the effectiveness of transsexual people' health, which require, above all, practices aimed at meeting the expanded conception of health.[1]

The creation of a public policy ensures access to health services for all citizens, regardless of gender or sexual orientation, being a right guaranteed by the Federal Constitution and implemented by the Unified Health System (SUS - *Sistema Único de Saúde*), which, in its guidelines, does not guide this right to specific genders, but also does not support the creation of an egalitarian health model that includes or considers those whose biological bodies are different from the gender to which they identify.[2]

In order to clarify the terminology, transgender people on the female spectrum are individuals who identify, to varying degrees, as female or as an alternative gender that differs from the male they were assigned at birth. They include individuals who describe their gender identity as a woman (transgender or transsexual), nonconforming or non-binary women.[3]

Associated with the aspects already raised, it is reiterated that, currently, the government model with an extremist ideological policy, depending on the stifling of questions about the gender theme, can directly interfere in the creation or expansion of public health policies aimed at this population

Government discourse sometimes stimulates prejudice and discrimination against this human group. Thus, despite a growing understanding of transgender identity, this community continues to experience higher levels of discrimination, impacting its quality of life.[4]

As an outcome, this narrative reinforces the non-recognition, abjection of the transsexual body and, consequently, its invisibility. Thus, these factors come from a society that does not include or support transgender individuals in multiple contexts, including housing, education and health services.[5]

It is understood that the State must guarantee health, consisting in the formulation and execution of economic and social policies aimed at reducing the risk of diseases and other aggravations. Moreover, it must lay down conditions ensuring universal and equal access to actions and services for their promotion, protection and recovery.[6]

The uniqueness of the human being makes them complex, even in their specificities in health demands. Although we understand the unfeasibility of individual health policies, it is understood that there are possible policies that include specific groups, such as existing health policies for the care of older adults, women, children, among others, carried out in Primary Health Care (PHC).

Considering the plurality of the human being, it is necessary to think about the way in which health needs are presented and guide work, because different forms of organization of life result in different needs, different ways of satisfying them and, consequently, different articulations with work processes.[7]

When relating the deficiency in the implementation of health policies related to gender, several other issues are listed that may justify this gap in PHC, which are being discussed by these authors in other studies. In this, specifically, the focus is on the fragility of access to public health services by transsexuals, reverberated by the need to implement a more inclusive and less restrictive health policy.

One issue that can justify the transsexuals' invisibility within work processes in primary care would be the abjection of the transsexual body. As it is understood as a prejudiced factor, this could determine the non-inclusion of a person or group in the health services offered, more specifically in the basic network, where the group of transsexuals was studied. Thus, an abject body is the unrecognized, the unperceived, it is the rejected body, invisible to a society that denies it rights for not recognizing its existence.[8]

The transsexual experience is initially presented through medicalization and judicialization processes, together with a logic of recognition linked to victimization and individual suffering. Then, gradually, it became a socialized and politicized experience, based on spaces of collective participation and recognition that enable an active role of people in their negotiations with the State and health professionals.[9]

Social control policies, as well as the adoption of biomedical and aesthetic technologies in the production of bodies, are not restricted to a reductionist explanation, but refer to the understanding of the subjectivation process. This dimension has its historical character and is subject to recognition and social validation in addition to purely technical scientific criteria.[10]

The dissonance between gender and the biological body goes against all construction of secular social concepts about gender. A society that considers only binary gender as a form of to experience human sexuality has difficulty recognizing subjects that do not fit heteronormative standards, which reverberates in an abject health policy.

The understanding of gender is related to normative issues, which determine and differentiate the normal from the pathological, and excludes other forms of being in the world that do not correspond to the official standard. Binarism exists, this is a fact, as it remains in the reproduction of common sense that relates man/penis and woman/vagina as exclusive normality, which was defined as a form of heterorrorism accompanied by stigmatization, thus creating motivational systems that are aversive to sexual dissidence.[11]

The premise of the difficulty in including transsexuals in a public policy, implemented in PHC, weakens and restricts access to services due to the lack of an offer of specialized care for this group, a fact that leads them to unsafe and clandestine treatments, increasing vulnerability of that group.

For theoretical support of this research, the authors used Axel Honneth's Recognition Theory. Based on Hegel's Critical Theory, which considers economic inclusion as one of the pillars of recognition within social groups, Honneth expands the concept of recognition based on the social psychology of Georg Herbert Mead, which describes the formation of individuals' identity in a conflictive way, in which self-recognition expands in the same proportion as the social circles of this individual, starting with family, work and acquisition of rights.

In his theory, Honneth believes that individuals form their identities and feel recognized when they perceive themselves socially accepted by the other (sphere of love), when included in institutional practices (sphere of law) and when they are accepted and establish a good coexistence within society (sphere of solidarity).[12]

In the face of the above, this study aimed to identify and discuss the reasons that restrict or hinder the accessibility of transsexuals to primary health services.

METHODS

This was an exploratory, descriptive study with a qualitative approach. Accordingly, the study worked with the universe of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a deeper space of relationships, processes and phenomena that cannot be reduced to the operationalization of variables.[13]

The research setting was the Family Clinics, located in a neighborhood in the West Zone of the city of Rio de Janeiro, where participants who make up the study population reside.

It is an area with a high rate of urban violence and a wide coverage area in PHC. It has a low-income population, where most users survive through government social programs.

Another important characteristic of the investigated area is to have a fluctuating numerical population, mainly related to transsexuals, possibly because they are not within any health program related to their gender or even due to lack of opportunities in the local labor market.

The study population was the transsexuals living in the investigated area who identified themselves as transsexuals. The gathering of the subjects elected to participate in the research was mainly due to personal contact when transsexual users sought care at the health unit. The electronic medical record was also used to identify users who defined themselves as transsexuals. Moreover, the convenience sample was naturally used by the authors, due to the ease of visits to the deponents for the first contact and easy access to the location of the interviews, which were carried out in a reserved room, provided by health unit managers.

Those aged 21 years and older, who defined themselves as transsexual and who have already sought some care in the Primary health Unit attached to the researched area, were included. Those who did not have a fixed residence in the locality and who did not have a record in the Family Clinics located in the programmatic area were excluded.

Data collection was performed through a semi-structured interview, applied to transsexual users, who, at first, identified the research participant and their socioeconomic profile. Then, five open-ended questions focused mainly on the perception of this user about access, professionals and health services offered, namely: could you talk about your transgenitalization process (if any), saying if the first search was in the private or public network? Which professionals attended it in the Primary health Unit? What is your impression of this care? In your understanding, during your consultations, what could you say about the care received by health professionals, especially about nurses in relation to their social rights? Do you think that your rights are being met? Do you think you have received enough information for that?

All interviews were recorded on digital media. After finishing the recording of each interview, some participants continued to describe situations they considered relevant, which were recorded by the interviewer in a field diary, with the research participants' knowledge and authorization.

In this journal, we tried to record, in addition to the statements that the respondents preferred not to be recorded, because they felt safer, emotions impossible to be perceived in the recordings.

Data were collected from December 2018 to March 2019, through previously scheduled meetings. The mean time of each interview was 60 minutes, totaling 12 hours. All interviews were recorded and transcribed, and these transcripts were the first contact with the results. The number of participants was limited to 12 people by the occurrence of data saturation.

It is worth noting that all meetings with research participants, from the initial approach to the end of data collection, took place with the same researcher, in order to establish a greater bond of trust between the actors involved in this study.

The study obtained approval from the Research Ethics Committee (REC) of the proposing institution, CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 85804518.8.3001.5279, with Approval Opinion 2,710,416 of the proposing institution. It also received approval from the co-participant institution's REC, which issued approval through Opinion 2,820,474 on August 14, 2018.

It is emphasized that this research complied with all ethical and legal precepts related to investigations with human beings, according to Resolution 466 of December 12, 2012, of the Brazilian National Health Council.[14]

In order to guarantee the research participants' anonymity, in agreement between interviewer and interviewee, their names were changed to Research Participant (RP), followed by numbering, according to the order in which the interviews took place.

For data analysis, thematic content analysis was used, in which the technical strategy for working categorization was as follows: organization of analysis; coding of results; categorizations and inferences. The different phases of content analysis were organized around three poles: pre-analysis, which aimed to organize the analysis material so that the researcher could conduct subsequent operations; material exploration, which referred to the application of analysis techniques in the corpus, such as coding and categorization; treatment of results, inference and interpretation.[15]

The results of the coding and analysis of transcriptions, after a thorough and attentive reading, allowed to identify the expressions most used by the research participants in their answers. From this phase, a total of 02 (two) thematic categories related to the theoretician that underlies this study were established: *Low resolution and multiple barriers to transgender access to Primary Health Care*; *Non-inclusion and self-exclusion: the explicit non-belonging to the Unified Health System*.

RESULTS

Aiming at a better contextualization of participants of this study residing in the programmatic area investigated, the authors considered relevant a synthesis of the following sociodemographic results: the research participants' age ranged between 21 and 50 years, with the highest percentage being equivalent between 21 and 40 years.

Regarding profession, participants have the following professions: teacher (public network); hairdresser; tourism management; self-employed; kitchen assistant; cleaning aid; event promoter. The highest percentage related to this data was 18% for hairdresser and 18% for kitchen assistant.

Regarding family income, the highest percentage was 46%, equivalent to less than 01 minimum wage, followed by 27% up to 02 minimum wages and 27% higher than 02 wages. It is worth mentioning that the respondents' family income is directly related to level of education and declared marital status, whose percentage was 30% married and 70% single.

According to the answers, all interviewees had already sought health services in search of medical or nursing care for other health problems; however, the search for health services, with the purpose of aesthetic adaptation to the gender of identification, occurred from the age of 18 in 35% of interviewees and in 65% after 21 years old.

Low resolution and multiple barriers to transgender access to Primary Health Care

In addition to restrictive issues to health services, here emerges a fundamental ethical issue, which is the low resolution in meeting the specific needs of this population. The interviewees' reports described here unanimously suggest a feeling of dissatisfaction of this population regarding the offer or even the lack of services in the Primary health Units, characterized as a restriction on access by transsexuals to public health policies that meet their demands.

We notice failures that begin in welcoming, in which this human group goes through situations of discrimination, ignorance of professionals about their specific needs and non-obedience to the use of social name.

> *In my surgery, my first option was the private network, because in the public, it was very bureaucratic, everything was very difficult as well as access. (RP12)*
>
> *When I thought about hormonization and transgenitalization, I thought about starting on the public network, but I never had access. Every time she went to talk to the doctor about it, she said, "No, today you can't talk about it." (RP06)*
>
> *The doctors at the family clinic didn't know what to do with me. They didn't know which ICD to put to be referred, nobody knew, I had to research and take it so they could make my referral. (RP11)*

From another perspective, the difficulty or restrictions of access can present a bias of non-recognition of a transsexual person as a citizen with rights, which possibly generates conflicting relationships between users and professionals and/or users and health institution, as every struggle for recognition begins through the experience of disrespect.

Non-inclusion and self-exclusion: the explicit non-belonging to the Unified Health System

The non-inclusion and self-exclusion of services offered by PHC are established by a relational model that precedes disrespect that, in addition to being able to exclude social groups from the care of their health needs, can also promote self-exclusion by developing a feeling of social worthlessness or even by the lack of service offering, generating in the transsexual person a feeling of not belonging to SUS.

> *The first time, in the public network, I could not do it. I've been told that we don't do it because we're not a woman, because we can't have breasts, I don't know what, as there's still prejudice, right? (RP02)*
>
> *I was humiliated in the Basic Unit, they laugh at your face, you know. When I went to remove the silicone she rejected, she told everyone to hear, "ah, these are men who want to be a woman, but they never can, they put it in their body and then come here to give others a headache". (RP04)*
>
> *I do not believe that neither doctor nor nurse would be able to inform me of anything about my situation. The nurse did not know, nor that she was referring, so much so that she passed me to the doctor, and no one knew anything, no one knew what to do in the family clinic. (RP05)*

Through the testimonies described, from the perspective of the Honethian Theory, there is a lack of respect regarding the guarantee of comprehensive and risk-free care, also denoting a relationship between professional and user devoid of empathy and reciprocity.

The statements express a perception of invisibility in care. However, respect for rights and access to health services is intrinsic in an efficient reception that is only possible through the recognition and visibility of this population, becoming fundamental for humanization in relationships.

Disrespect and lack of specific guidance reverberate in the search for alternative and unsafe treatment, in order to satisfy their peculiar needs of adequacy of the physical body with the gender to which users identify themselves. This evidences a non-effective inclusion in public health policies directed to them.

DISCUSSION

In the light of the study of ethics, with social morals as its object, issues arise, such as racism, discrimination in general, as well as restrictions related to care policies directed at the transsexual population. In this bias, this study showed that the restrictions of health policies offered in primary care are presented, not only by the lack of implementation of actions aimed at this human group, but also by disrespectful behaviors that lead to human suffering, promoting a feeling of not belonging to SUS.

The thematic categories defined in this study emerged from the speech fragments most emphasized by transsexuals, such as disrespect for their human condition and social name, suffering, sadness and lack of health care, configuring themselves in restrictive attitudes.

The dehumanization of relationships, although not verbalized, is perceived between the lines, injuring the first sphere of Axel Honneth's Recognition Theory, namely the sphere of love. It is at this moment that transsexual users perceive themselves in a relationship of less social value in which, for instance, the disrespect for the social name and other transphobic expressions given by health service professionals emerge as the main barriers of access.[16]

The reports are in line with the initial reflections on the abjection of the transsexual body, which ends up sending them to ghettos, where they are recognized and accepted as equals. In this way, the depreciation of the gender condition of this population, which permeates all health professionals' negative actions, who serves this population, operates by preventing an autonomous action of this user in relation to their physical and mental health.

Disrespect for love, in the logic of Honneth's recognition, includes ill-treatment and rape, which threaten physical and psychological integrity. Disrespect for the right includes deprivation of rights and exclusion, as this affects the social integrity of individuals as a member of a political-legal community.[17]

The feeling of inclusion, according to Honneth, is through recognition. In this analysis, when individuals experience disrespect in one of the three spheres that affect the formation of their identity, harmful consequences are generated that compromise success in socialization.[18] The rupture in the empathic and reciprocal relationship in the first contact between professional and user, arising from disrespect, leads to self-exclusion.

Important forms of devaluation of the human person were portrayed in the interviewees' statements. The social invisibility of transsexual people, understood in this context as a non-existent or undervalued being within a political conjunction, is determined in the first offense suffered in the search, by these users, to meet their health demands, which already determines a failure to comply with what is recommended both by the Federal Constitution and by the SUS guidelines.

In this sense, the sole paragraph of the Charter on Health Users' Rights (CDUS - *Carta dos Direitos dos Usuários de Saúde*) reaffirms that it is the right of a person, in the health services network, to have humanized, welcoming care, free from any discrimination, restriction or denial due to age, race, color, ethnicity, religion, sexual orientation, as well as gender identity.[19]

Meeting the specific health needs of transsexual people, when denied or restricted, increases the vulnerability of this user to the extent that, in the search for harmonization between their gender identity and body aesthetics, they end up looking for unsafe means for their health.

Public policies are presented in activities planned and implemented by the State. They aim to guarantee the security of society, fight hunger, promote improvement in education, reduce inequalities and guide actions that universalize health care, which must be supported by the concept of equity. From this perspective, it is possible to affirm that it becomes increasingly urgent to implement inclusive public and health policies that assist the transsexual population in its entirety and based on the SUS basic principles.[20]

Thus, the formulation of own and inclusive health policies is essential, and it is worth noting that, as they have rights as citizens, these policies must be considered, built and implemented, independent of governmental political ideologies.

The low inclusion in LGBTQIA+ public policies (Lesbians, Gays, Bisexuals, Transsexuals/Transvestites, Queer, Intersex and Asexual), especially for people who identify as transsexuals, is a problem that goes beyond Brazilian borders. A recent study conducted in the United States shows that the Affordable Care Act provisions, once considered status quo protections for the LGBTQIA+ community, they are now threatened as lawmakers are reversing health care mandates, exposing members of that community to potential exacerbations of prejudice, discrimination and stigmatization previously seen as historic human rights violations.[21]

Faced with this important public health problem, derived from ineffective or absent public health policies, the productions of that country tend to reflect on health demands presented by this population, even in older age. Projected estimates for the LGBTQIA+ population in the United States reach 4 to 8 million seniors by 2030. Due to the lack of transgender providers and barriers to access to health care, transgender seniors rely on cisgender service providers more than ever before.[21,22]

In Brazil, the implementation of the Transsexualization Process in the SUS, which regulates procedures for genital surgical readjustment, is part of the context of LGBT policy, and the subsequent challenge is to guarantee access to all people who need this form of care.[23]

The difficulties encountered in care in Primary health Units and non-inclusive professional attitudes are in line with what is recommended by the Brazilian National Humanization Policy (NHP), in which transversality is fundamental for health care and work processes, in addition to recognizing that the different specialties and health practices can speak to the experience of those who are assisted. Together, this knowledge can produce health in a more co-responsible way.[24]

User service must be primarily due to the problem-solving capacity and an effective and quality reception.[25] Primary care must consider people in their uniqueness, promoting sociocultural insertion, also seeking to produce comprehensive care and incorporate health surveillance actions, which constitute a continuous and systematic process of collection, data consolidation, analysis and dissemination on health-related events; also, it aims to plan and implement public actions to protect the population's health, prevent and control risks, injuries and diseases, as well as promote health.[26]

Primary health actions should ensure both access to services and resolve user restrictions that, due to the inefficiency of services, sometimes end up looking for the private health network to meet their demands.

This question is whether refers to the ability of teams to recognize local health needs and offer actions to meet them. Issues related to the way care networks are organized and how the quality of care offered to users is constituted are associated with comprehensive care and also with the service problem-solving capacity.[27]

Although the public service is the first option, In the aforementioned fragments, important obstacles to care are perceived, such as lack of supplies to maintain treatment, difficulty in accessing services due to stigmatization of transsexual people, prejudiced attitudes, lack of knowledge about the process of gender transition of health professionals and unpreparedness in reception.

In this context, the lack of training of professionals becomes an interfering factor in the lack of reception and care offered, in which the search for specialized treatment occurs, but with little success, due to the scarcity of services for demand and the little multidisciplinary qualification.[28]

Nevertheless, it is important to highlight and highlight the existence of a health policy directed to the population surveyed. However, reality manifests a destitution of rights that can be solidified by various issues, such as prejudice, abjection, stigma, among others, which leads us to think that the health policy, directed to the existing LGBTQIA+ layer, still needs to be implemented efficiently within the work processes developed in primary care

In this regard, professional performance, especially of nursing in primary care, as nursing is recognized as a protagonist in the implementation of SUS health policies, implies the performance of functions guided by the SUS principles that does not admit exclusions of any nature and has the duty to promote equity.[29]

CONCLUSION AND IMPLICATION FOR PRACTICE

The results of this study show that this social group has been jettisoned from the political processes of public health, which is a reflection of the very construction of policies that, in the current model, are designed for the target population, not with this population, offering opportunity of more effective and efficient exchanges of knowledge between professionals of the multidisciplinary team and users.

Professionals' invisibility and disrespect, in addition to constraints and suffering that lead to self-exclusion of the health system, serve as a warning for these professionals, especially nurses, to seek to promote care that brings users to the center of discussions as a participant in care or instituting care.

In this context, this reality is conceived as the main contribution of this study, providing opportunities for the visibility of these participants and the identification of their real needs, in addition to bringing to light the need to implement a more inclusive health policy, in which this awakening by professional nurses is encouraged since their graduation.

This article presented the following limitations: fluctuation in the number of surveyed participants residing in the area assigned to the Programmatic Area Coordination (PAC) and urban violence that, at times, made it difficult to access the scheduled location, generating repetitive absences and even withdrawal of some participants. It is also noteworthy that another limiting factor is specific to the methodology implemented, qualitative, which does not allow generalizations. The authors understand that these limitations require studies in other geographical areas, with different socioeconomic and urban security profiles, so that the results can be compared.

AUTHOR'S CONTRIBUTIONS

Study design. Denildo de Freitas Gomes e Enéas Rangel Teixeira

Data collection: Denildo de Freitas Gomes

Data analysis. Denildo de Freitas Gomes. Enéas Rangel Teixeira. Marta Sauthier e Graciele Oroski Paes

Interpretation of results. Denildo de Freitas Gomes. Enéas Rangel Teixeira. Marta Sauthier e Graciele Oroski Paes

Article writing and critical review. Denildo de Freitas Gomes. Enéas Rangel Teixeira. Marta Sauthier. Graciele Oroski Paes

Approval of the final version of the article. Denildo de Freitas Gomes. Eneas Rangel Teixeira. Martha Sauthier. Graciele Oroski Paes

Responsibility for all aspects of content and integrity of published article. Denildo de Freitas Gomes. Enéas Rangel Teixeira. Marta Sauthier. Graciele Oroski Paes

ASSOCIATED EDITOR

Cristina Rosa Baixinho

SCIENTIFIC EDITOR

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