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Healthcare: action research with trans people living on the streets

Cuidado em saúde: pesquisa-ação com pessoas trans em situação de rua

Cuidado de la salud: investigación-acción con personas trans de la calle

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ABSTRACT

Objectives: to analyze the representations of healthcare provided to trans people living on the streets. **Methods:** ten women (three trans) and three cisgender men participated in this action research. Popular health education groups, focus groups, seminars and interviews were held, the data of which were organized in the software Nvivo®, submitted to content analysis and interpreted in the light of intersectionality theory. **Results:** healthcare was represented by the technical, relational, structural and citizenship dimensions. The relationship between gender and poverty determines the specific health needs of trans people living on the streets. **Final Considerations:** the need to expand conceptions and practices on healthcare to meet the specific health needs of trans people living on the streets was evidenced. Nursing, with competence and cultural sensitivity, can contribute to positive health outcomes and, consequently, break with the logic of exclusion, illness and poverty.

Descriptors: Nursing Care; Transgender Persons; Homeless Persons; Intersectionality; Qualitative Research.

RESUMO

Objetivos: analisar as representações sobre o cuidado em saúde prestado às pessoas trans em situação de rua. **Métodos:** pesquisa-ação, com participação de dez mulheres (três trans) e três homens cisgêneros. Realizaram-se grupos de educação popular em saúde, grupos focais, seminários e entrevistas, cujos dados foram organizados no *software* Nvivo®, submetidos à análise do conteúdo e interpretados à luz da teoria da interseccionalidade. **Resultados:** o cuidado em saúde foi representado pelas dimensões técnica, relacional, estrutural e cidadania. A relação gênero e pobreza determina necessidades específicas de saúde das pessoas trans em situação de rua. **Considerações Finais:** evidenciou-se a necessidade de ampliar concepções e práticas sobre o cuidado em saúde para satisfazer as necessidades em saúde específicas das pessoas trans em situação de rua. A enfermagem, com competência e sensibilidade cultural, pode contribuir com desfechos positivos em saúde e, consequentemente, romper com lógicas de exclusão, adoecimento e pobreza.

Descritores: Cuidados de Enfermagem; Pessoas Transgênero; Pessoas em Situação de Rua; Interseccionalidade; Pesquisa Qualitativa.

RESUMEN

Objetivos: analizar las representaciones de la atención de salud brindada a las personas trans que viven en la calle. **Métodos:** investigación acción, con la participación de diez mujeres (tres trans) y tres hombres cisgénero. Se realizaron grupos de educación popular en salud, grupos focales, seminarios y entrevistas, cuyos datos fueron organizados en el software Nvivo®, sometidos a análisis de contenido e interpretados a la luz de la teoría de la interseccionalidad. **Resultados:** el cuidado de la salud estuvo representado por las dimensiones técnica, relacional, estructural y ciudadana. La relación entre género y pobreza determina las necesidades de salud específicas de las personas trans que viven en la calle. **Consideraciones Finales:** se destacó la necesidad de expandir las concepciones y prácticas sobre el cuidado de la salud para satisfacer las necesidades específicas de salud de las personas trans que viven en la calle. La enfermería, con competencia y sensibilidad cultural, puede contribuir a resultados positivos en salud y, en consecuencia, romper con la lógica de la exclusión, la enfermedad y la pobreza.

Descriptores: Atención de Enfermería; Personas Transgéro; Personas sin Hogar; Interseccionalidad; Investigación Cualitativa.

INTRODUCTION

The absence of official data on the number of homeless people, including trans people in this situation, reinforces their invisibility and negatively impacts the proposition of specific public health policies for this group[1-3].

Lack of knowledge about the sociocultural, demographic and epidemiological profile of the trans population results in precarious health conditions for these people, which may be more harmful to those who accumulate derogatory experiences, such as those living on the streets.

The last census of the homeless population in the city of São Paulo estimated the existence of 386 trans people living in this situation, which corresponds to 1.6% of the total (24,344 people). This estimate included trans women (55.5%), transvestites (10.5%) and trans men (9.5%), with a predominance of black people (67%) and aged between 31 and 49 years[4].

Extreme poverty and other consequences of unemployment, which are more prevalent in the trans population compared to the general population[5], such as homelessness, restricted or absent employability and low income, are effects and causes of the several exclusions that determine precarious health conditions. The homeless situation, in this case, sheds light on the importance of understanding the possibilities of combinations between gender, race, social class and other categories of analysis in determining their health-disease-care process.

In the health field, this process that articulates different mechanisms of oppression reflects worse health outcomes for trans people living on the streets, especially those related to the high prevalence of harmful use of psychoactive substances, situations of violence, sexually transmitted infections (STI), complications related to the clandestine use of hormones, mental health problems and vulnerabilities related to precarious sex work[5-12].

These health disparities indicators explicitly articulate socioeconomic aspects and issues related to gender identity, which show structural aspects of healthcare based on the cisheteronormative matrix that does not recognize the bodies that subvert this gender norm, delegitimizing their health needs.

This practice of institutional violence, which has a strong influence on the actions and services offered in public and private health institutions, is called institutional transphobia and is responsible for most part of the health inequities that trans people on the streets experience involuntarily.

In specific cases, the inseparability of gender, class, race, age, sexual orientation, disabilities and work activity[2] announces a peculiar perspective of health needs, while tending to guide a flow in which poverty, vulnerability and social exclusion determine specific disease processes that feedback this cycle.

In this scenario, the standardized perspective of healthcare is problematized, whose policies[13] and healthcare protocols for the trans population[14] tend to homogenize and universalize different identities and experiences. As a result, the health needs of specific groups among the trans population, such as those on the streets, become as invisible as the reality of the group.

The previous experience of one of the authors as a nurse at a Basic Health Unit, in the city of São Paulo, which assists the homeless population, including trans people who are part of this group, guided the construction of this study, since that context, healthcare for them represented challenges and social complaints.

Acknowledging the impacts of gender inequalities on the health of the population in general and its influences on the interaction of professionals with trans people living on the streets allowed reflections on the context of healthcare production, whose pillars of race, class and gender structure and sustain and reproduce universalistic forms of knowledge and practices that exclude them.

Lack of scientific evidence and the empirical acknowledgment of poverty impacts on the health of trans people living on the streets justify the need for in-depth knowledge that can contribute to filling gaps in healthcare for these people.

This includes broadening conceptions and practices about healthcare considering the intersections of gender, race and social class[15] that participate in the production of subjectivities of people in this group and the limits imposed by a reductionist approach to the multiple experiences of trans people, basing care predominantly on the biomedical paradigm[16], which generally focuses on the production of intelligible bodies to the current standard (hormonization and surgeries) and interventions for the active search, diagnosis and treatment of STIs.

This scenario of "identity avenues" that intersect[15] and in which different subjectivities of trans people living on the streets pass through, contributes to the development of their conceptions, interpretations and practices about healthcare that, when accessible, can contribute to the proposition of more far-reaching strategies to meet the health needs of this group.

In this article, the term trans people living on the streets refers to those people who, during the research, presented themselves verbally as a transsexual or transvestite woman and who, due to precarious, unviable or non-existent housing and income conditions, spent the night on the streets, tenements or in public, private spaces shelter for the homeless population.

OBJECTIVES

To analyze the representations of healthcare provided to trans people living on the streets.

METHODS

Ethical aspects

This article presents data from a thesis entitled "*Cuidado em Saúde: pesquisa-ação com pessoas trans em situação de rua*", developed with the Department of Administration and Collective Health of *Escola Paulista de Enfermagem* (DASC/EPE) of *Universidade Federal de São Paulo* (UNIFESP).

The project was approved by an Institutional Review Board and assent by the Municipal Health Department of the Municipality of São Paulo (SMS-SP). To ensure participants' anonymity, an alphanumeric identification system was adopted, containing the letters IP as an acronym for "Interviewed Person", followed by an Arabic numeral indicating the order of the interviews.

Study design

This is an exploratory, descriptive, and qualitative study based on the action research theoretical methodological framework[17]. The CONsolidated criteria for REporting Qualitative research (COREQ) guided the structuring of this manuscript[18].

Study setting

This action research began with the exploratory phase, which consisted of approaching trans people living on the streets during the period of work as a nurse in the special Family Health Strategy (FHS), now called Street Outreach (CnR – *Consultório na Rua*).

The perception of access difficulties culminated in fortnightly meetings of this FHS team with trans people living on the streets, occasions in which collective activities were carried out, such as the preparation and distribution of breakfast, sponsored by a local bakery.

"*Café com Saúde*", as each meeting became known, it represented an important stage for gathering information, approaching, discussing topics of interest to the group and engaging with the health issues of this audience.

As a continuation of this process, the researcher developed a voluntary work in the same institution where "*Café com Saúde*" took place, which consisted of holding popular health education groups and two focus groups, in which in-depth discussions were held on the specific health needs of trans people living on the streets.

The experiences of this process were systematized and presented at a seminar at the EPE of UNIFESP, with the aim of communicating them with different sectors - government, health services, social assistance, social movement and the academic community.

Other actions that emerged from the identification of health needs of the people involved in the research and ensured their participation throughout the research process were: a parade to claim rights related to trans identity (performance art); visit to photographic exhibitions on the theme of gender and social class; collective production of a book chapter with/about the participation of trans people living on the streets in the university's extension project; basic training in first aid; integration of students from the technical nursing and podiatry course with the project for trans people living on the streets.

These experiences showed the importance of deepening and producing knowledge about healthcare for trans people living on the streets; however, the researcher's lack of knowledge about the existence of a network of professionals and services that provided this specific assistance, as well as the dynamics of people who supposedly could contribute to the research, motivated the choice of the snowball technique[19] for data collection.

The data presented in this article were collected through open-ended questions asked during interviews carried out in places chosen by the person invited to participate in the research (rooms in the health and social care services, university, researcher's house and bar). Some external interferences, during the execution of the technique, did not result in its compromise.

Data source

People who met the following inclusion criteria were interviewed: being an adult; being directly involved in healthcare for trans people living on the streets; and agreeing to participate voluntarily in the research.

The sample delimitation in 13 people, being ten women (six cisgender, three trans and one homosexual) and three cisgender men, of which only one identified as gay, occurred by repetition of indications, not being possible to access new participants.

The average age of the people who participated in the survey was 40 years old, ranging between 28 and 67 years old, extremes occupied by two trans women. They had completed higher education (8), high school (4), of which three were trans women, one of whom was completing a degree in social work. A cisgender man, affectionate partner of one of the trans women participating in the research, reported not having completed elementary school.

As for occupation, four had a service coordination position; four performed technical functions; and the four people with high school mentioned were service workers, two in social assistance and two in health. The man with the lowest educational qualification was included in a work preparation program.

Data collection

The data presented in this article were collected by the researcher between July and October 2016, through interviews guided by a script with open-ended questions about healthcare for trans people living on the streets.

All people received an invitation by email, cell phone or in person, occasions in which the proposal, methodology, conditions for participation and definition of an agenda were presented. None of the people invited and nominated refused the invitation to participate in the survey.

To start data collection, three people who met the criteria for participation in the research were eligible. These were intentionally selected due to the work and approach to healthcare for trans people living on the streets.

The interviews were recorded and took place after reading the Informed Consent Form (ICF). The average duration of each interview was one hour and fifteen minutes, totaling 16 hours.

Data analysis

The content of the interviews was transcribed in full and systematized through the program Qualitative Analyzes Software Certified Partner® (NVivo®, version 11).

Exhaustive readings and coding of the transcribed material allowed the organization of units of meaning and subsequent coding and definition of analysis categories.

The empirical categories, presented below, were analyzed according to the framework of content analysis and in the light of intersectionality, defined as a theory that integrates, in its analysis, the multiple paths of oppression, especially those that articulate race, gender and social class[15].

> Intersectionality aims to give theoretical-methodological instrumentality to the structural inseparability of racism, capitalism and cysheteropatriarchy – producers of identity avenues where black women are repeatedly affected by the crossing and overlapping of gender, race and class, modern colonial apparatus[15].

The results that follow were presented in public sessions at the university and scientific meetings, occasions in which feedback and validation were made with the people who contributed to this study. There was also validation of the contents of the interviews by most of the participating people; they received and returned the material by email.

RESULTS

In the definitions of healthcare, its scope was observed, covering aspects that go beyond its technical boundaries. The definition of care "in a broad sense" signaled greater vulnerability of trans people living on the streets in relation to lesbians, bisexuals and gays.

> *Care, I say, is care in a broad sense* […] *the population of lesbians, bisexuals and gays they, most of the time, have a greater empowerment to be able to come, discuss, denounce much more than transvestites and transsexuals. Transvestites and transgender people require this notion of care more.* (IP1)

The biomedical approach was represented as attention to the need for the biological body and consists, on the one hand, in carrying out procedures (surgical or not) to transform it, in order to meet social expectations regarding the symbolism of the body and the female universe.

> […] *caring, you are thinking about people, human beings who, in short, have a biological body that needs care.* (IP1)

> *It's just that, like, a trans with a beard mark, she tries to do a laser, if she's fat, she tries to do a liposuction, got it? This is the care for them: the more you look like a woman for them, the better.* (IP2)

Healthcare also emerged as a synonym for guidelines or interventions for the treatment and prevention of STIs, a term that replaced sexually transmitted diseases (STDs), used at the time of the research.

> […] *it is to guide her so that she follows the treatment, yes, for her to come back, for her to recover or if not, suddenly, in a health issue related to STDs, the use of condoms.* (IP3)

The relational dimension emphasized coexistence, welcoming and mutual support among people. The report of a trans woman stood out, who warned about the need for horizontalization and humanization of the relationship, as well as language approximation for healthcare promotion.

> *So, care is walking together, it is living together with the other within what each one can give* […] *care depends on this relationship - it is a relationship.* (IP5)

> *It would be through the reception itself, talking, listening* […]. (IP4)

> […] *the possibility of people looking at each other, of people being together, of people effectively taking care of people, supporting themselves when she is raped on the street, when she is psychologically raped, when she is physically raped, when she is raped institutionally.* (IP1)

> *Sometimes sitting and talking to sick people about nice things makes her forget she's in the hospital, it makes her forget that I'm a nurse, because I'm just a person* […]. (IP6)

In the duties and rights dimension, a trans woman living on the streets drew attention to the importance of "being accepted in society". From this perspective, aspects related to respect and commitment were also identified.

> *Treating the other as a being with rights and duties, looking at him as a citizen* […] *showing the paths he can take in this trajectory he is currently living in this matter of social vulnerability.* (IP3)

> *Be accepted in society. That this is also a care, got it?* (IP2)

> *Respect is a form of care, if you don't respect, you can't take care of the other.* (IP7)

The last aspect of the multidimensional character identified in this study has to do with structural issues, not restricted to the satisfaction of material needs. The interaction with subjective aspects, especially those related to the effects of poverty in the lives of trans people living on the streets, was presented as a resource for healthcare.

> […] *matters of need, of needs that are from the material field, objective things: they want food, sleep* […] *but there is an issue that complements this, which are the issues that result from the suffering that poverty brings to a person's life. So, care means looking at these issues, the suffering and trying to see what the needs this person has as a result of this set of sufferings that they carry throughout life.* (IP8)

In this trajectory of poverty, healthcare is understood as a look at this path and the possible "barriers it faces" in this therapeutic itinerary.

> […] *when we talk about care, there are subjective issues that permeate this care and they are not properly looked at because, in addition to looking at the person I'm referring, I have to look at the institution to which they will be referred. And understand what traffic is from here to there, right?* […] *it's related to the barriers she faces to get to this place of health.* (IP8)

DISCUSSION

The broad character attributed to healthcare for trans women living on the streets revealed their multidimensional perspective regarding the greater vulnerability of these people compared to other groups. This multidimensionality, also referring to the exclusions that these people experience[2], indicated specificities and health needs that require qualification of care practices.

In a "broad sense", healthcare contemplates technical, ethical and aesthetic dimensions, which do not exempt health professionals from reflections and actions on the structure in which it is (re)produced.

Caring, however, implies considering the social, historical and cultural agencies involved in this practice, whose vulnerability emerges from mechanisms of combinations between gender,

race and social class or "identity avenues", which intersect[15], shaping discourses and strategies (formal or clandestine) more or less accessible.

In practice, it means broadening the perspective of care based exclusively on the classical epidemiology and biomedical paradigm, from which interventionist, preventive and curative approaches predominate, which tend to pathologize trans identities[16].

In this regard, the reports related to body transformation (surgical or not) and strategies aimed at prevention and treatment of STIs for trans people living on the streets as synonymous with healthcare revealed their possible meanings with direct reference to gender and sexual orientation, in a way that denounces specific contexts of vulnerability and stigma.

Reductionist conceptions of care, such as those on STIs based on the conception of risk[16] and disconnected from the intersections that interfere in the health-disease process of trans people living on the streets, tend to guide the development of police practices (or surveillance) as the only form of care whose approaches do not fully meet their health needs.

It is noteworthy that the scarcity of studies on this group, as well as the lack of specific public policies on their health[2-3,5], reflect a context of vulnerabilities that feedback, defining a cycle of poverty-stigmatization-exclusion - illness.

In other words, the intersection between transgender people's gender identity and social class, such as homelessness, results in worse health outcomes, especially those related to mental illnesses, inhumane conditions of sex work, harmful use of psychoactive substances, among other grievances[5-12].

Understanding these mechanisms does not ignore the knowledge and practices deriving from classical epidemiology and the biomedical paradigm, such as the reality of high prevalence of STIs among trans people[7-9,12]. It is argued that, coupled with this knowledge, it is necessary to develop the skills and cultural sensitivity necessary for the proposition of comprehensive healthcare that recognizes and meets the specific health needs of these people.

The development of specific health policies and a change in the paradigm of care for achieving comprehensive health and promotion of LGBT equity[2,6] are also points of attention that should consider "identity crossings"[15] that participate in the "patchwork quilt" process[20], an analogy to refer to the constituent elements of low-income trans people's identity.

The paradigm shift in attention to the search for specific care, such as body transformation claimed by some trans people[21], implies the recognition that these women also demand an inter and multidisciplinary, trans and multidisciplinary, intersectoral and, above all, intersectional.

In this regard, the transsexualizing process (TP)[22] guaranteed by law, within the scope of Unified Health System (SUS – *Sistema Único de Saúde*), although it is a resource that results in a new material and symbiotic body[23], in practice, is inaccessible for trans people living on the streets, especially because aspects of gender and social class intertwined in this path impose barriers to this type of care.

The dynamics of these people, most of the time determined by economic factors, make it impossible to enter and continue on the itinerary recommended by this document. Even the acquisition of lower cost and supposedly more accessible resources, such as equipment for shaving the beard and mustache, clothing and accessories that would allow the expression of women, according to socially imposed expectations, they are not always possible.

Thus, the results of this and other studies warn that, although important and directly related to trans people's health, body change is not always a universal priority or need among people who make up this group[24-25].

The search for resources for survival relocates priorities and the expression of gender, often in this context of poverty, subverts expectations about being trans in contexts where access is differentiated. In this regard, we emphasize the importance of raising awareness for specific healthcare for this group, which has peculiarities and differences whose grouping is due to the condition of poverty.

The emergence of these new esthetics on the street, whose variations in gender expressions do not always match socially constructed expectations, provide data that can support processes of professional training and organization of services, reducing their distance from trans people living on the streets.

The legitimization of trans identity as a subject of rights, the acquisition of power, access and social inclusion through body transformation[25-26], for trans people living on the streets, when possible, is generally linked to the risks arising from clandestine procedures[27] accessible in networks created from the experience on/from the streets.

Searching for low-cost clandestine procedures, such as hormonization without medical supervision or application of industrial silicone in "*bombadeiras*" (the person who clandestinely injects the silicone)[23], as older transvestites or transsexuals who dominate the application technique (*bombação*, the act of clandestinely injecting the silicone) are known of industrial silicone to transform the body, generate complications to the health of people who use them and can increase the risk of death[23,27-28]. The ambiguity between risk and care emerges, in this study, as another important element to be deepened about healthcare practices.

Reflecting on gender identity as performative acts from which own narratives and fluid identities are created can contribute to the proposition of healthcare through the prism of depathologization[21,23,29-30], which is intersectional and capable of questioning the cisgenderness that delegitimizes trans bodies and experiences.

Subversion to the gender norm, in relation to the poverty that trans people live on the streets, confers on them pejorative attributes, since it also subverts the expectation on the expression of gender of the trans population[20]. Queer, decolonial and intersectional studies are epistemic bets that can overcome partial and dichotomous views about the body and corporeality that, based on structural and structural inequalities, compromise the fight for sanitary rights and perpetuate colonizing models that generate oppression and inequities in health[30].

The triple subversion of the norm - being trans, a woman and living on the streets[2] - marks differences that justify the need to produce decolonial and intersectional knowledge[15,30] that extrapolate the current logic that favors actions and interventions based exclusively on the biomedical model whose only reference is the biological binarism of bodies.

However, it is crucial to recognize that this perspective based on pathology, both with regard to the demand for the TP and

the active search for cases of STIs, is still one of the ways in which the right to health is accessed by trans people[31]. However, it becomes fragile for the group of those living on the streets, which is overlaid with derogatory attributes related to extreme poverty that pose barriers to accessing health resources.

Valorization of the technical and pathologizing dimension, attributed to care opposed to the relational perspective, exposes situations of weakening of bonds between professionals and trans people due to heteronormative, racist and classist frameworks that disqualify the identities of trans people living on the streets. Aspects, such as coexistence, welcoming and mutual support among people, that emerged in the research, seem antagonistic to this perspective.

In this regard, the bond and care free from discrimination of any kind, based on the horizontalization and humanization of care recommended in policy recommendations[13] and those of a trans woman who participated in the interview, reinforce the importance of using language for promoting comprehensive care for trans people living on the streets.

The distance between professional and user through the use of technical language[32] is one of the multiple forms of violence that trans people living on the streets suffer in health services, reflecting institutional transphobia and, consequently, negative health outcomes[12].

The fear of embarrassing and embarrassing situations[32] and the way in which trans women living on the streets are represented motivate withdrawal from health services, absenteeism and treatment abandonment and determine how they will be (or not) received in these spaces[2,32-33]

Bond weakening and disbelief in services introduce challenges with regard to the creation of spaces for qualified speech and listening from a horizontal and humanized perspective of care for trans people living on the streets that undo the crystallized logic of care that reproduce strategies for the practice of institutional transphobia.

Furthermore, the practice of genuine coexistence, based on respect for differences, equality of rights and solidarity, can contribute to healthy interactions and mutual commitments that, as part of the care process for trans people living on the streets, should consider the implications arising from this process of cultivation of affective bonds[34].

This ethical dimension of care, as an act of care based on commitment, respect and encouragement to exercise citizenship, underlies healthcare actions, contributing to trans people living on the streets, as reported, find the means to "be accepted in society"; the denial of citizenship and the accumulation of violations suffered (physical, psychological, sexual and institutional) resulting from heteronormativity, increase the vulnerability and subordination of trans women living on the streets[2], especially when combined with class and race issues.

The street, as a path to support gender identity, not accepted by the family[2], is also a space for promotion of comprehensive healthcare for trans people living on the streets, from which knowledge coexists, care practices and therapeutic itineraries[34-35] which, when improved, can enable the compression of barriers that impede the path of these people to the service and access to public goods and resources necessary for health.

The professional training of nurses, with inclusion of gender, race and class themes, as well as other markers of difference (region, religion, corporeality, generation, etc.) in the curriculum and in continuing education programs, is an essential condition for overcoming the barriers to access to health imposed by this excluding system.

The low scientific production in this area and, consequently, the difficulties of clinical management of nursing professionals[36-37] require the development of studies that identify what are these barriers preventing access to health rights for trans people, such as they operate intersectionally in practice and privilege identity binarism, contrasting human and non-human persons[15], as trans in street situations are represented, from the aspects that mark their differences.

This work offers information that can contribute to the formulation of theories and technologies for assistance, management, education and research that can support services and universities in the proposition and implementation of healthcare for trans people living on the streets.

The action research methodology with trans people living on the streets added value to the research, researchers and participants, promoting changes in conceptions and practices during the process reported.

As in other studies, this methodology offers subsidies for research that seek to defend the health rights of people in vulnerable situations and contributes to strategies to overcome the barriers of access that they experience[38].

Acknowledging the combination of oppressions that constitute the subjectivities of trans people living on the streets, determining worse health outcomes in this group, can be added to the efforts already made to build new knowledge and practices related to nursing care and in health in general.

Study limitations

The specific context in which the research was developed and the number of participants do not allow generalization of the data, and further studies on the health of this population in different contexts are recommended.

The scarce scientific production on the health of these people in indexed databases was a limiting factor for this study, which was based on professional experience and studies classified as gray literature, which is a justification for citing them.

Contributions to nursing, health, and public policies

This study brings to light, at the same time as it deepens, a theme of relevance to public health. This study broadens horizons as it makes use of accumulations and reflects on the specificities indicated by the people who participated in the research, who experience a reality that warns them to overcome fragmented analyzes or isolation of categories that, in practice, intersect, producing illnesses.

In this sense, in addition to indicating paths for further studies, this research contributes to health and nursing, supporting the design of research, care protocols, organization of services and work processes, professional training, as well as the proposition,

implementation and monitoring of public health policies that can result in the guarantee the right to health and comprehensive care for trans people living on the streets.

FINAL CONSIDERATIONS

The reductionist perspective of current care practice in health services, based on pathologization, conception of risk and anatomical and physiological changes of the body, although it has its importance, it can make it impossible to carry out comprehensive healthcare for trans people living on the streets, considering the intersectionality between race, gender and social class.

Acknowledging their health needs, as well as care specificities, implies contemplating the understanding of the multidimensionality of healthcare and the complexity of this reality, including biological aspects, mainly those related to the social determinations of this process.

The inclusion of gender, race and class themes in nursing training in academic and health services scope is one of the strategies for overcoming the existing barriers to accessing healthcare.

Action research promotes the encounter with reality and, therefore, contributes to the redefinition of processes, conceptions and visions about healthcare. Through integration of scientific and popular knowledge, with the participation of trans people living on the streets, it is possible to increase their health sensitivity and contribute to the development of sensitive and culturally competent professionals.

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