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ORIGINAL ARTICLE

EXPERIENCES OF TRANS PEOPLE ABOUT THE EMBRACEMENT IN PRIMARY HEALTH CARE[1]

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ABSTRACT

Objective: to identify the experiences of trans people about the embracement in primary health care. **Method:** this is a descriptive research with a qualitative approach, conducted with eight trans people in 2020 in a city of the upper *sertão* of Paraíba, a state in the northeast of Brazil. The data were organized and analyzed through the Collective Subject Discourse. **Results:** it was noticed that the process of embracement experienced by trans people in this scenario of attention was sometimes marked by negative feelings, reinforced by disrespect for the social name. It was also observed transphobia as a structure in health services and the unpreparedness of professionals to deal with the demands of this diversity of gender identity (trans people). **Conclusion:** the embracement experienced by trans people in primary health care was permeated by several barriers and factors that can drive their evasion from health services. Although there have been several rights conquered in the decades of demands by social movements, the path towards sensitive embracement needs to go through reformulations.

Keywords: Primary health care. Transgender persons. Sexual and gender minorities. User embracement..

INTRODUCTION

The primary potential to promote health and prevent diseases, Primary Health Care (PHC) is configured as the main and priority access to the different scenarios of complexity of the Health Care Network (HCN) that structure the Unified Health System (UHS). In addition to just one access, PHC is also an environment that, when strictly operationalized by its guidelines, is able to achieve a high level of resolution for most health demands of the population[1].

To effectively operationalize the UHS principles of integrality, universality and equity in health care, PHC needs to use a variety of technologies, especially interactional, to better understand the health needs presented by the population of the assigned territory. The embracement is one of the technologies with emphasis on interpersonal relations indispensable for the achievement of the UHS objectives and should occur during each moment in which users and health teams or services meet[2].

Equitable, ethical, sensitive and universal access to health has been the standard of demand of social movements for decades. Despite this, more than 30 years after the implementation of the UHS, a milestone in the universalization of access to health, several groups composed by social minorities, especially LGBTQIAPN+ people (lesbians, gays, bisexuals, transvestites, transgenders, queer, intersex, asexual/agender/arromantic, poly/pansexual, non-binary and other identity

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people that make up the universe of sexual diversity and gender identity), still find barriers that hinder their health care[3].

The national policy for comprehensive health of lesbians, gays, bisexuals, transvestites and transsexuals (the National LGBT Health Policy) reaffirms the position of vulnerability that LGBTQIAPN+ people go through when seeking access to health services, as well as a complex group in demands and specificities[4]. Among its objectives, this Policy reveals the guarantee of respect during assistance, in addition to combating prejudice and discrimination, among other types of violence[5].

Although there is no exact or widely available number on how many transgender people use the Brazilian Unified Health System (UHS), it is estimated that approximately 3 million people are transgender or non-binary in Brazil[6].

Although advances have been achieved in the world by sexual minorities and gender identities in the health field, study results demonstrate the unpreparedness of professionals during the embracement of trans people in primary health care spaces. The attribution to gender identities contrary to the personal ones by professionals and their lack of knowledge about trans identities are recurrent in the routines of public and private health services[7].

Converging with the data presented, international experiences show that 25.7% of respondents, composed of trans and non-binary people, avoided seeking Primary Health Care during the first year of the COVID-19 pandemic, and among the reasons that caused this evasion were, in addition to the difficulty of transportation, discomfort or mistrust with service providers, transphobia and anxiety prior to appointment[8].

Being the embracement constituted of qualified listening, respect to the demand brought and problem-solving[9], to embrace, the professionals involved in health care need to be qualified before the demands of health, also regarding the rights guaranteed to sexual minorities and gender identities, such as the right to a social name, avoiding constraints. The forms of continuing and permanent education are not only essential, but necessary in this context[10].

Therefore, the following guiding question was elaborated: what are the experiences lived by trans people in the embracement of Primary Health Care in the Upper *Sertão* of Paraíba? The objective is to identify the experiences of trans people in the Upper *Sertão* of Paraíba about embracement in Primary Health Care.

METHOD

This is a descriptive research with a qualitative approach conducted by the action-research[11] carried out at the LGBTQIA+ Municipal Council of a municipality located in the upper *sertão* of Paraíba, a state in the northeast of Brazil.

The present study was developed in four stages, from April to November 2020, namely: situational diagnosis; planning of actions; implementation of planned actions and evaluation of actions by participants of the research.

The focus of this study was the stage of situational diagnosis that proposes to raise problems or situations that need resolution from the knowledge of the territory and social group that participated actively as a protagonist of the research. The stages of planning, implementation and evaluation of actions will be the focus of other studies.

For convenience, the participants of this survey were people registered in the LGBTQIA+ Municipal Council, since it was a reference and embracement space for sexual minorities for the entire municipality, which had a total quantity of 1,000 registrations at the time of collection. The study included those who had active frequency in the activities of the Council and 18 years or more. As an exclusion criterion, transgenders who were not registered on the council during data collection.

It is added that this research took into account the theoretical saturation, when realized that there was no addition of new information, the data collection was terminated, totaling the participation of eight people in the survey. The respondents were users of different PH Units in the city of the survey.

Theoretical saturation is reached when the

occurrence of new information during interviews is no longer identified[12]. Thus, the theoretical density was reached in the third interview, since, from then on, there was no emergence of new statements. Five other interviews were conducted to ensure that the theoretical saturation was actually reached.

For the data collection, during the situational diagnosis, a semi-structured interview script was applied with the following questions: "Describe your understanding about the embracement you receive when looking for care in Primary Care"; "What problems or difficulties do you notice or have experienced during your search for care in Primary Health Care?" and "How do you interact with the professionals of Primary Care?". It should be noted that the elaboration of the questions was made from the researcher and guiding-researcher with participation of activist of the trans cause residing in the city of Upper *Sertão* of Paraíba.

The interviews were conducted remotely, with each participant at different times, in order to ensure the privacy of respondents, through the video conference system of Google Meet, mediated by the LGBTQIA+ Municipal Council of Cajazeiras. They lasted an average of 40 minutes, were heard and recorded with the consent of the participants and subsequently transcribed and analyzed. They were also conducted by the mediator, a nursing graduate student, under the supervision of the guiding-researcher after the participants read and signed the Informed Consent Form (CIF), which was sent by e-mail through Google Forms. All participants invited to the survey accepted and did not show resistance to the semi-structured interview, so there was no refusal.

Prior to the application of the questionnaires, there was space for the creation of a bond between the researcher and the research participants, in which the achievement of trust and the provision of welcoming space were prioritized. At this initial moment, the objectives of the research and the motivations of the researcher in carrying it out were presented. However, in order to precede this moment described in the remote environment, the researcher had no relationship with the participants. The Consolidated Criteria for Reporting Qualitative Research – COREQ was used to enhance the credibility of the study.

For the analysis of the material found and collected during these interviews, the technique of the Collective Subject Discourse (CSD) was used. In order to analyze the data, Central Ideas (CI) and their referent Key Expressions (KE) were generated[13].

The first step during the analysis of the speech, which was performed manually without the aid of software, was the reading of the material obtained after the interviews, seeking the interpretation of the positions. Subsequently, it was necessary to perform in-depth readings, aiming to detect the essence of the discourse, which should be associated with the guiding questions present in semi-structured interviews. Finally, the KE were defined, corresponding to the findings of each question, and the CI were organized.

The speeches collected during the interview allowed building the CSDs, transcribed and associated with the pseudonyms of the participants that gave rise to it in the results of this study, from which it was possible to extract four categories of CI. The theme that encompasses the CSD discussed below was obtained through the inquiry on how people experience embracement in PHC and what are the main problems they face or perceive during this embracement.

The participation and development of the study occurred only after prior approval of the project by the UFCG's Research Ethics Committee (REC) under opinion n. 4.216.477, guaranteeing the confidentiality and anonymity of the information collected, as well as all actions implemented. To keep the participants anonymous, the terminologies of the eight planets in the solar system were used to replace their names.

RESULTS

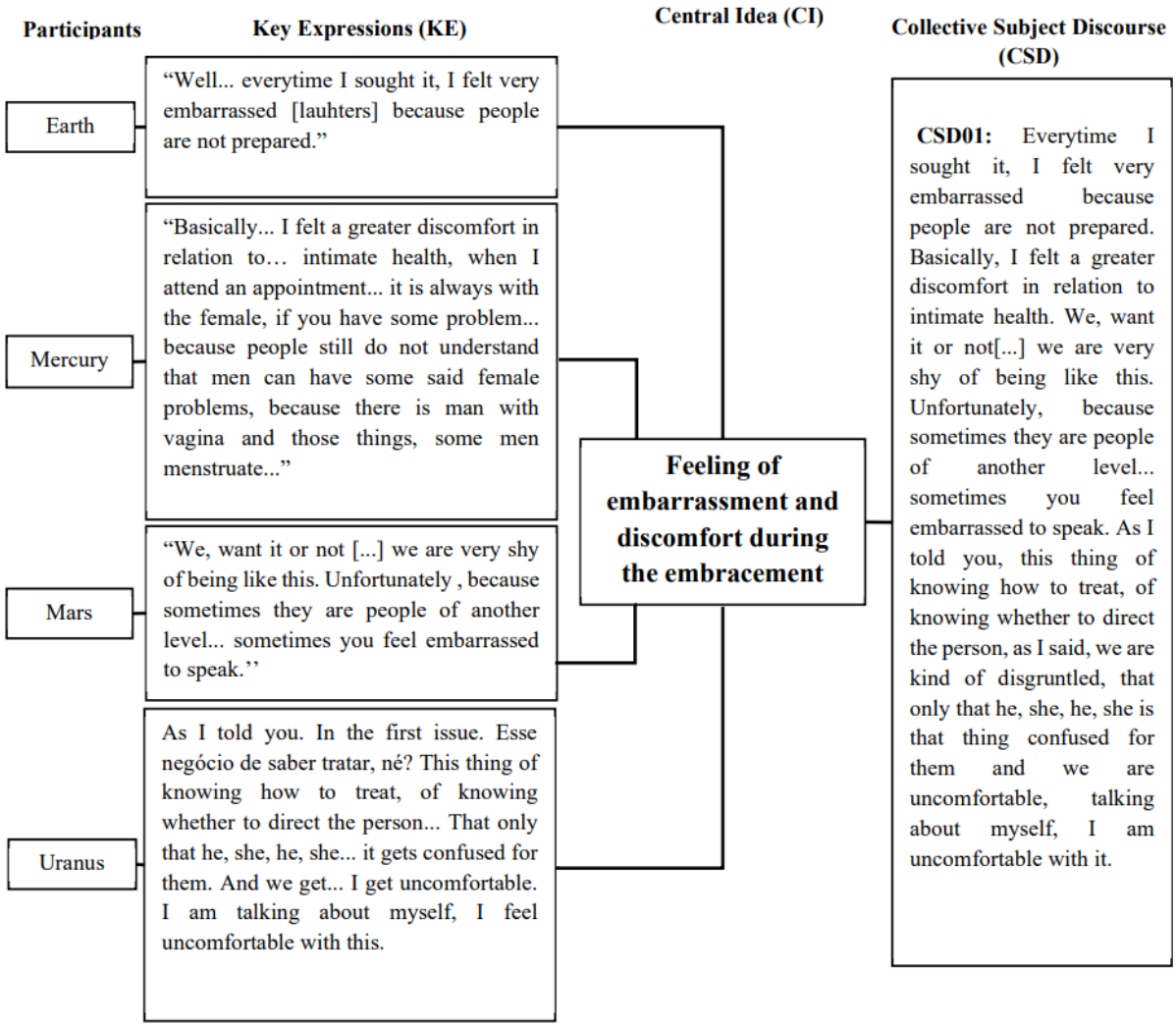
The first CI reveals the discomfort and embarrassment faced by trans people when seeking embracement in health services. This CSD was built from the speeches of four participants: Earth; Mercury; Mars and Uranus.

CI 01 – Feeling of embarrassment and

discomfort during the embracement

CSD01: Every time I sought it, I felt very embarrassed because people are not prepared. Basically, I felt a greater discomfort in relation to intimate health. We, want it or not[...] we are very shy of being like this. Unfortunately, because sometimes they are people of another level... sometimes you feel embarrassed to speak. As I told you, this thing of knowing how to treat, of knowing whether to direct the person, as I said, we are kind of disgruntled, that only that he, she, he, she is that thing confused for them and we are uncomfortable, talking about myself, I am uncomfortable with it. (Earth; Mercury; Mars and Uranus)

Flowchart 1. Schematic representation of the construction of CSD01



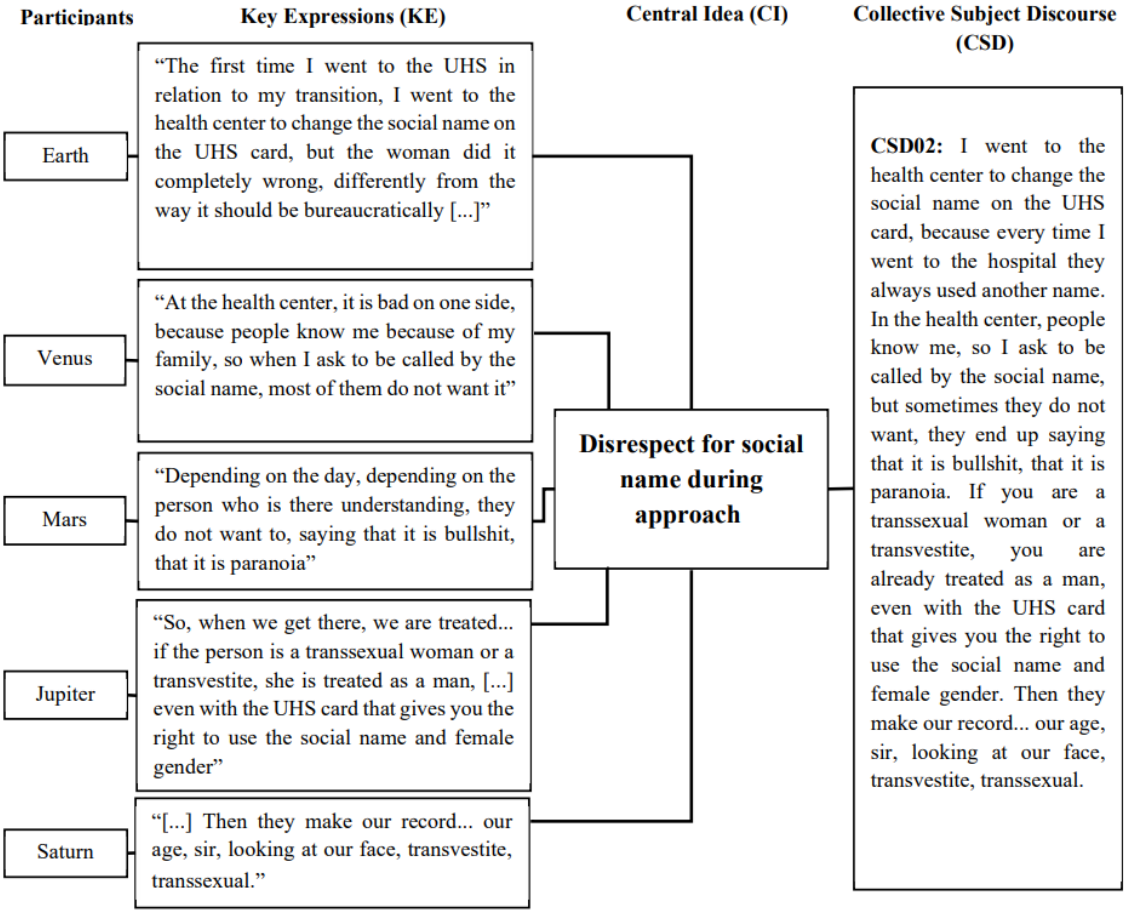
Source: the authors.

In the second CI, the problem of the continuous disrespect to the social name by the health care team emerges, starting with the embracement. For this CSD, the speeches of five participants were used: Earth; Venus; Mars; Jupiter and Saturn.

CI 02 – Disrespect for social name during approach

CSD02: I went to the health center to change the social name on the UHS card, because every time I went to the hospital they always used another name. In the health center, people know me, so I ask to be called by the social name, but sometimes they do not want, they end up saying that it is bullshit, that it is paranoia. If you are a transsexual woman or a transvestite, you are already treated as a man, even with the UHS card that gives you the right to use the social name and female gender. Then they make our record... our age, sir, looking at our face, transvestite, transsexual. (Earth; Venus; Mars; Jupiter and Saturn)

Flowchart 2. Schematic representation of the construction of CSD02



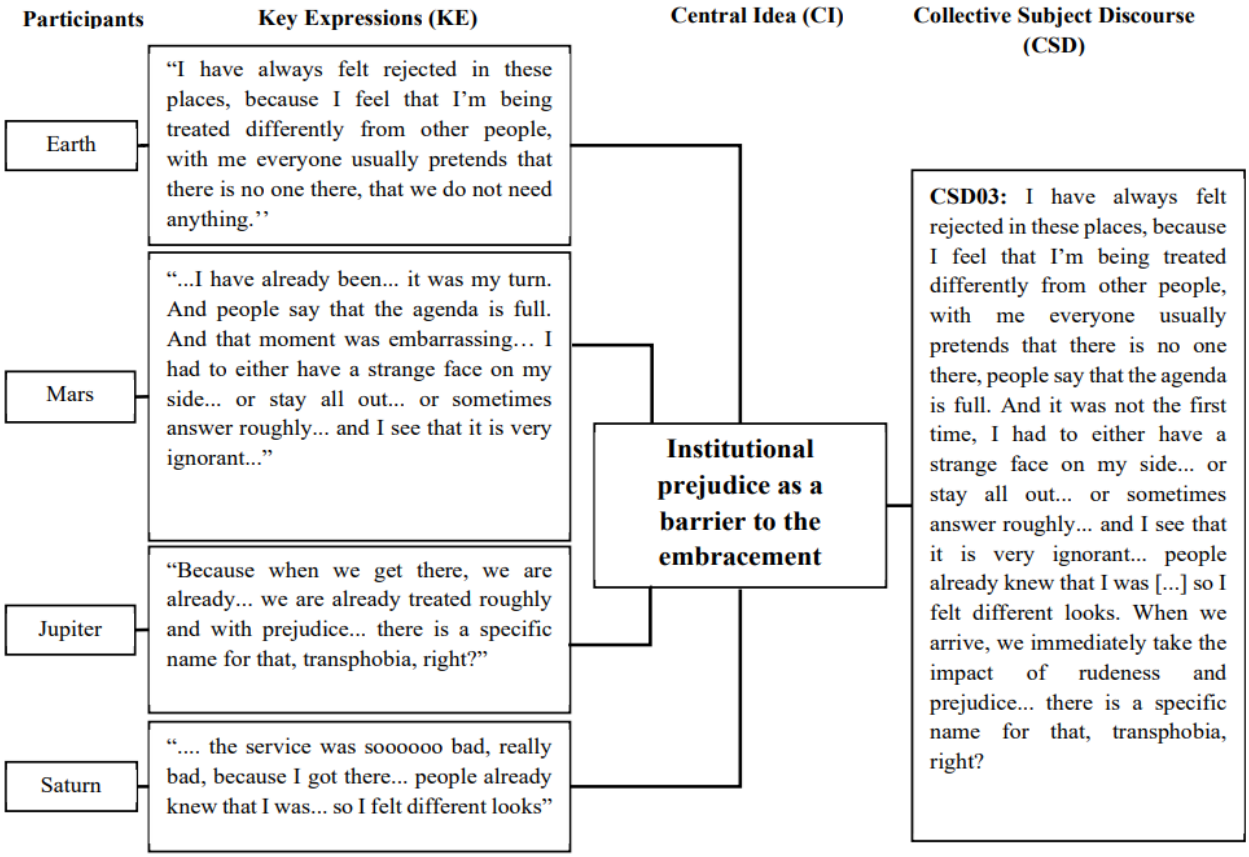
Source: the authors.

The third CI to be discussed highlights one of the most subtle, but no less harmful, ways that prejudice can take place during the embracement in PC. The construction of this CSD included the statements of four participants: Earth; Mars; Jupiter; Saturn.

CI 03. Institutional prejudice as a barrier to the embracement

CSD03: I have always felt rejected in these places, because I feel that I'm being treated differently from other people, with me everyone usually pretends that there is no one there, people say that the agenda is full. And it was not the first time, I had to either have a strange face on my side... or stay all out... or sometimes answer roughly... and I see that it is very ignorant... people already knew that I was [...] so I felt different looks. When we arrive, we immediately take the impact of rudeness and prejudice... there is a specific name for that, transphobia, right? **(Earth; Mars; Jupiter; Saturn)**

Flowchart 3. Schematic representation of the construction of CSD03



Source: the authors.

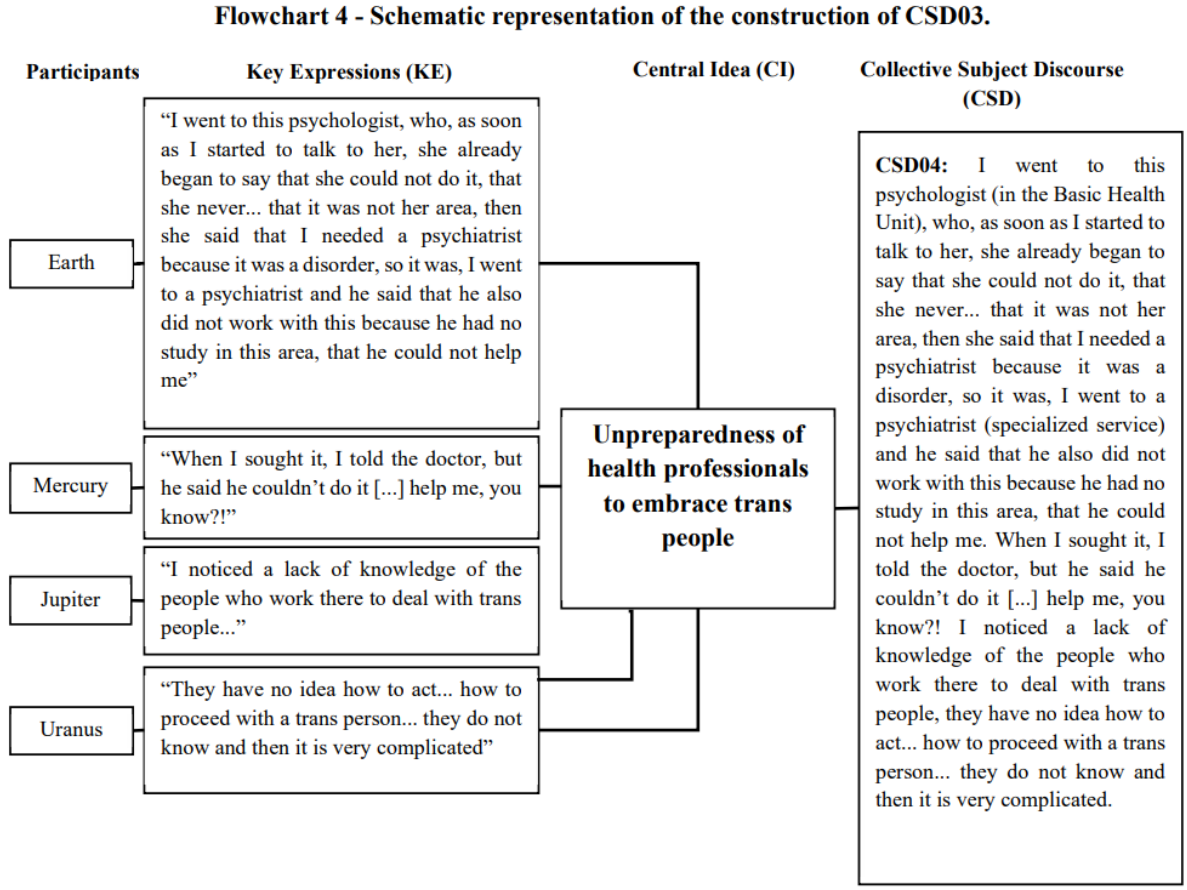
Finally, the fourth CI to be addressed reveals the lack of preparation of health professionals to deal with the demands made by sexual and gender minorities when they try to access health care through PC. The speeches of four participants were used to construct CSD04: Earth; Mercury; Jupiter and Uranus.

CI 04 – Unpreparedness of health professionals to embrace trans people

> **CSD04:** I went to this psychologist (in the Basic Health Unit), who, as soon as I started to talk to her, she already began to say that she could not do it, that she never... that it was not her area, then she said that I needed a psychiatrist because it was a disorder, so it was, I went to a psychiatrist (specialized service) and he said that he also did not work with this because he had no study in this area, that he could not help me. When I sought it, I told the doctor, but he said he couldn't do it [...] help me, you know?! I noticed a lack of knowledge of the people who work there to deal with trans people, they have no idea how to act... how to proceed with a trans person... they do not know and then it is very complicated. (Earth; Mercury; Jupiter and Uranus)

During the construction of each CSD, participants brought insights and experiences regarding the embracement and/or care in PHC by the teams that make up these services and even situations involving other patients who access the same scenario of offering care.

Flowchart 4. Schematic representation of the construction of CSD03



Source: the authors.

DISCUSSION

As noted in CSD01, there is discomfort that permeates the search for health care by trans people during the embracement in PHC that is strengthened when the practice of embracement is not well established [14,15], which may prevent the creation of a link between the trans person and health services or professionals, essential for achieving comprehensive care.

It is noticed, throughout the construction of the discourse, that feelings of shyness and inferiority are experienced by trans participants before PHC professionals. This situation may be linked to negative experiences that are sometimes responsible for feeding the discomfort of trans people when accessing the health service scenario.

Converging with this data, a national survey shows that half of the participants felt discomfort during care in the PHC scenario. In the study, 15% of participants reported a sense of fear when accessing these services, since they feel vulnerable to embarrassment and disrespect[16]. This reality is able to reveal fragility found in PHC, because it expresses the existence of negative feelings for trans people, implying that care that must be governed by ethics, respect and resolution, in certain situations, may be the main causes of discomfort and suffering for this social segment.

Among the embarrassing visits, CSD01 participants emphasize those that are focused on intimate health. In this sense, research in France shows that trans and non-binary men also report low level of comfort when attending gynecological consultations and that the search for these consultations was focused, mostly, to investigate specific problems, especially in the pelvis, and fewer motivated by routine consultations[17].

Assuming that PHC should be responsible for promoting and effectively preventing diseases and conditions, there is possibly a distance from this objective when certain services offered do not have gender-sensitive care. Having as a consequence the weakened link between trans patients and health professionals, making it difficult to adhere to services and increasing the distance of this social segment from health care.

In a fragment of the speech, confusion in the use of appropriate pronouns appears as a factor that also leads to discomfort. Corroborating this finding, in the literature, it was possible to identify that the difficulty established in communication between health professionals and trans people, especially in the use of pronouns or referring to the "dead name", constitutes barriers that prevent and distance this group from accessing health care services[18,19].

One must still reflect on the flexibility of information systems to receive the appropriate identifications of gender identity signaled by trans people. Tools that are restricted to gender-based binary options hinder the process of embracing minorities of gender identities, and negatively interfere in the formation of statistics on the incidence and prevalence of some diseases related to sexual organs. In a research conducted in the UK, it was possible to identify that systems inflexible to gender diversity can amplify the errors related to the use of pronouns, but also influence the non-recommendation of some preventive examinations such as the cytopathological examination of the cervix for trans men[19].

The discomfort of trans people in front of the actors of the embracement process when seeking assistance in health services is one of the reasons that lead this public to avoid PHC and postpone the search for health care[8,1]. This scenario may be able to result in the distancing of trans people from health care and, therefore, it increases the susceptibility to the development of diseases and conditions, besides also influencing the search for clandestine services to supply the health needs[20].

Developing care for the integral and participating in the embracement of the population assigned in a humanized way are measures attributed to all professionals working in PHC. Thus, producing respect and validation to the demands by the trans public during the embracement, from their embracement in the service to the continuity of care that must continue in a longitudinal way, is a measure of commitment to the operationalization of the National Primary Care Policy (PNAB)[1].

In CSD02, participants reported the occurrence of non-compliance with the right to use the social name. It is also noticed that this disrespect occurs consciously, as resistance to accept the social name legally present in the national health card, whereas the legitimation of trans identity occurs, accompanied by the use of pronouns and nouns that do not correspond to the self-identification of trans people.

In a survey conducted in New Zealand, it was shown that a portion of participants, trans people who accessed PHC services, reported that the respect and use of the social name by health professionals in this scenario were more frequent than the use of correct pronouns. However, even if the current (social) name is more respected when compared to pronouns, less than half of the participants reported the use of the social name by professionals[21]. It is understood, thus, the constant delegitimization of trans people and their rights.

As of April, 2016, the social name of trans and transvestite people is socially recognized, in addition, it must be adopted in public administration institutions according to the will of these people, including institutions that provide health care through the UHS. Despite being emphatically guaranteed as a right in decree 8.727 of 2016[22], the use of the social name by trans people and transvestites still finds resistance to be applied in practice.

Studies deepen the discussion by identifying that the lack of respect for the social name during the search for health care paves the way to the dissatisfaction of trans people with the service provided, as well as emerges depressive feelings in these patients, being all the staff involved in the PC embracement responsible for not limiting to the reduction of physical damage, but interfering with the development of emotional damage during the search for

assistance[18,19]. In view of the discussions regarding the divergence of the concepts of PHC and PC, it is indicated that these will be used as synonyms.

Feelings of insecurity and embarrassment are the products of, among other correlating factors, actions that disregard the social name of individuals seeking care in health services. In certain situations, professionals insist on considering only valid names in documents[20].

Resistance to using the social name can have several consequences, including the establishment of trust that is difficult or impossible with the trans person and withdrawal of access to health service by them[23]. The uncomfortable feelings produced within these environments cross the trans public, sometimes causing the evasion of services and stealing the longitudinal character that PHC assistance should assume.

As externalized in CSD03, the (dis)embracement and transphobia appear in an institutionalized way, starting from the professionals of PHC and generating the feeling of rejection. As mentioned above, PHC is the preferential access to the complex HCN offered by the UHS, and it is one of its attributions to order these services with a view to the comprehensiveness of care, thus, when the professionals directly involved in this scenario of attention interfere negatively in the access of the trans public to services, or even refuse its offer due to transphobia, they act against the principles of the UHS that govern the PNAB, and against the code of ethics of their profession.

In accordance with the statement made in CSD03, studies have identified that trans and other gender minorities have experienced situations of disrespect and invalidation[18,24]. Still following the analysis of the discourses presented in these studies, the practice of aggressive attitudes and refusal of treatment by professionals ended up being part of the experiences lived by these young people[24]. It is important to note that the delay in obtaining access to care interferes with the resolution and aggravation of the problems that led that patient to seek PHC.

According to CSD03, transphobia is not only present in the verbal form by health professionals of PC; participants recognized it from behaviors, expressions and looks capable of generating discomfort. This situation resembles the report of trans participants in a study developed in France in the PHC scenario, in which the difficulty to be received in the health service is self-reported, once they encounter unpreparedness of the health team at the embracement and during the waiting room, where, sometimes, there are gazes that generate discomfort, even from other patients[25]. These factors may gradually or abruptly distance trans people from health care.

The CSD04 highlights the unpreparedness of professionals to deal with sexual and gender diversity, a factor that may contribute to the low resolution of assistance and imply not reaching the service goals. This occurrence may present its origins in academic training, but its maintenance is operationalized by the lack of initiatives for training professionals.

Data found in a survey conducted in the United Kingdom indicate that health professionals perceive themselves as having little knowledge about the demands of sexual minorities and gender identities, since it is a subject that is rarely addressed in academic training[19]. Corroborating these findings, research data conducted in Australia also expose the inability of some professionals to respond to the needs of the trans public due to their low education and the few experience of caring for these people, which can generate anguish for them by the difficulty in finding answers to their demands[24]. In addition to knowing that they often encountered discrimination in health services during the search for their specific demands[25].

Another aspect of the professional unpreparedness identified in the literature is the lack of knowledge of referral services that correspond to the needs patients have[24,27], considering that only a health care scenario cannot solve all the demands of users. Therefore, intersectoral joints are needed to achieve comprehensive care[28].

Thus, to achieve the comprehensiveness of care, the various scenarios of HCN must be triggered according to the demand in question, however, such services will not be requested when the professional does not know them,

which results in a fragmented assistance, distant from problem solving and unable to produce satisfaction in the users of the service.

The limitations of this study concern the approach of only one population segment to other sexual minorities and gender identities of LGBTQIAPN+ people. However, it was also a factor that enabled the immersion and focus on trans people.

FINAL THOUGHTS

The embracement experienced by trans people in PHC was permeated by barriers and factors that possibly cooperate to boost their evasion from health services, since they have a tendency to negatively impact experiences of trans people in PHC. Although there have been several rights conquered in the decades of demands guided by social movements, the path towards sensitive embracement needs to go through reformulations when analyzing the perception of trans people in front of situations experienced in this scenario of health care.

The participants' speeches evidenced the feeling of discomfort and embarrassment, produced during the embracement conducted in a wrong way. Considering the embracement as a guiding tool of care towards the integrality of care questions the disrespect to the social name, since observing this right creates a bond of respect for trans identity.

To achieve the integrality of care based on a holistic view of the subjects to be cared for, it is necessary that the training of professionals surpass the heteronormativity still present in higher education institutions, but also that health managers seek the elaboration of strategies for permanent education for constant training of professionals under their supervision, as well as thinking about strategies that break the transphobic practices within health services.

This study can contribute to the promotion of training for PHC professionals to deal adequately with the trans population, making this point of the HCN more accessible, welcoming and less intimidating. Research should be developed on this subject taking into account the point of view of trans people. Moreover, studies should be developed on ways to combat LGBTIphobia in public health environments. Studies that reflect on the structure of information tools and systems in relation to sexual and gender diversity should also be conducted.

EXPERIÊNCIAS DAS PESSOAS TRANS ACERCA DO ACOLHIMENTO NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: identificar as experiências das pessoas trans acerca do acolhimento na Atenção Primária à Saúde. **Método:** trata-se de pesquisa descritiva de abordagem qualitativa realizada com oito pessoas trans, em 2020, em um município do alto sertão paraibano, estado do nordeste brasileiro. Os dados foram organizados e analisados por meio do Discurso do Sujeito Coletivo. **Resultados:** percebeu-se que durante o processo de acolhimento vivenciado pelas pessoas trans nesse cenário de atenção foi, por vezes, marcada por sentimentos negativos, reforçados pelo desrespeito ao nome social. Observou-se ainda a transfobia enquanto estrutura nos serviços de saúde e o despreparo dos profissionais para lidarem com as demandas dessa diversidade de identidade de gênero (pessoas trans). **Conclusão:** o acolhimento vivenciado pelas pessoas trans na Atenção Primária à Saúde foi permeado por diversas barreiras e fatores que podem impulsionar sua evasão dos serviços de saúde. Ainda que tenham sido diversos os direitos conquistados nas décadas de reivindicações pelos movimentos sociais, o caminho em direção ao acolhimento sensível precisa passar por reformulações.

Palavras-chave: Atenção Primária à Saúde. Pessoas Transgênero. Minorias sexuais e de gênero. Acolhimento.

EXPERIENCIAS DE PERSONAS TRANS SOBRE LA ACOGIDA EN LA ATENCIÓN PRIMARIA DE SALUD

RESUMEN

Objetivo: identificar las experiencias de las personas trans sobre la acogida en la Atención Primaria de Salud. **Método**: se trata de una investigación descriptiva de enfoque cualitativo realizada con ocho personas trans, en 2020, en un municipio de Alto Sertão Paraibano, estado del noreste brasileño. Los datos fueron organizados y analizados a través del Discurso del Sujeto Colectivo. **Resultados**: se ha observado que durante el proceso de acogida, vivido por las personas trans, en este escenario de atención fue, a veces, marcada por sentimientos

negativos, reforzados por la falta de respeto al nombre social. Se observó también la transfobia como estructura en los servicios de salud y la falta de preparación de los profesionales para hacer frente a las demandas de esta diversidad de identidad de género (personas trans). **Conclusión**: la acogida experimentada por las personas trans en la Atención Primaria de Salud fue permeada por diversas barreras y factores que pueden impulsar su evasión de los servicios de salud. Aunque los derechos conquistados en las décadas de reivindicaciones por los movimientos sociales han sido diversos, el camino hacia la acogida sensible necesita pasar por reformulaciones.

Palabras clave: Atención Primaria de Salud. Personas Transgénero. Minorías sexuales y de género. Acogida.

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