

## **The training of health worker for an integral, equitable, and universal health access for Trans people<sup>1 2 3 4</sup>**

*A formação dos(as) trabalhadores(as) da saúde na construção de um acesso à saúde integral, equânime e universal à população trans*

*La formación de los trabajadores de la salud en la construcción de un acceso integral, equitativo y universal a la salud para las personas trans*

Rocon, Pablo Cardozo <sup>(i)</sup>

De Barros, Maria Elizabeth Barros <sup>(ii)</sup>

Rodrigues, Alexsandro <sup>(iii)</sup>

<sup>(i)</sup> Universidade Federal de Mato Grosso – UFMT, Instituto de Saúde Coletiva – ISC, Cuiabá, MT, Brasil. <https://orcid.org/0000-0003-2696-5786>, [pablocardoz@gmail.com](mailto:pablocardoz@gmail.com)

<sup>(ii)</sup> Universidade Federal do Espírito Santo – UFES, Centro de Ciências Humanas e Naturais – CCHN, Departamento de Psicologia, Vitória, ES, Brasil. <https://orcid.org/0000-0003-1123-4374>, [betebarras@uol.com.br](mailto:betebarras@uol.com.br)

<sup>(iii)</sup> Universidade Federal do Espírito Santo – UFES, Centro de Educação – CE, Departamento de Teorias do Ensino e Práticas Educacionais, Vitória, ES, Brasil. <https://orcid.org/0000-0002-5998-4978>, [xela\\_alex@bol.com.br](mailto:xela_alex@bol.com.br)

<sup>1</sup> Responsible editor: Silvio Donizetti de Oliveira Gallo. <https://orcid.org/0000-0003-2221-5160>

<sup>2</sup> References correction, bibliographic normalization services and portuguese review: Vera Lúcia F. Gouvêa Bonilha - [verah.bonilha@gmail.com](mailto:verah.bonilha@gmail.com)

<sup>3</sup> Funding: Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES) – Doctorate scholarship.

<sup>4</sup> English version: Viviane Ramos - [vivianeramos@gmail.com](mailto:vivianeramos@gmail.com)

## Abstract

We identified a lack of scientific production on the training of health personnel to work with transgender people, a population that faces barriers such as discrimination, disrespect for the chosen name, and dependence on the diagnosis of transsexualism to access the Unified Health System (SUS). In this article, from 25 interviews recorded in audio during two qualitative studies, we analyze, from the category of enaction of Francisco Varela, that only a training processes not limited to the transmission of information will enable the creation of a health work process that affirms the access of the Trans population to integral, equitable, and universal health services.

**Keywords:** Training, Enaction, Health Workers, Transgender People, Health Care Access.

## Resumo

*Identifica-se uma carência na produção científica sobre a formação dos(as) trabalhadores(as) da saúde para atuar com pessoas transgênero, transexuais e travestis, população que enfrenta barreiras como discriminação, desrespeito ao nome social e dependência ao diagnóstico de transexualismo para acessar o Sistema Único de Saúde (SUS). Este artigo, a partir da categoria enação de Francisco Varela, analisa 25 entrevistas gravadas em áudio, produzidas por duas pesquisas qualitativas, e conclui que somente processos de formação não limitados à transmissão de informações possibilitarão a criação de um processo de trabalho em saúde que afirme o acesso da população trans aos serviços de saúde de forma integral, equânime e universal.*

**Palavras-chave:** Formação, Enação, Trabalhadores da saúde, Pessoas Trans, Acesso à saúde

## Resumen

*Se identificó una falta de producción científica sobre la capacitación de trabajadores de la salud para trabajar con transexuales y travestis, una población que enfrenta barreras como la discriminación, la falta de respeto por el nombre social y la dependencia del diagnóstico de transexualidad para acceder al Sistema Único de Salud (SUS). En este artículo, a partir de 25 entrevistas grabadas en audio producido por dos investigaciones cualitativas, analizamos, desde la categoría de enacción de Francisco Varela, que solo los procesos de capacitación no limitados a la transmisión de información permitirán la creación de un proceso de trabajo de salud que afirme el acceso de la población trans a los servicios de salud de manera integral, equitativa y universal.*

**Palabras clave:** Formación, Enacción, Trabajadores de la salud, Personas trans, Acceso a la salud.

## Introduction

Literature presents the body transformation undertaken by Trans population as health issue (Almeida & Murta, 2013; Arán & Murta, 2009; Bento, 2006; Rocon et al., 2016; Romano, 2008). In this direction, the *Processo Transsexualizador* (Gender Reassignment Process) of *Sistema Único de Saúde* (SUS- Unified Health System), created in 2008 and amplified in 2013, is an important health service to meet the demands of Brazilian Trans people. It is one of the main State actions to promote and care for Trans health in Brazil.

However, studies have pointed out that, despite State efforts in creating the Gender Reassignment Process, and other important policies, such as the National Policy for the Integral Health of Gays, Lesbians, Bisexuals, and Transgenders (Brasil, 2011) and the Letter of Rights of SUS users (Brasil, 2006) which guarantees a non-discriminatory service and the use of their chosen names, trans people still have problems to access health services, from basic care to highly complex ones, due to a series of embarrassments. Regardless the use of the chosen name, such chagrins can be seen in episodes of discrimination from personnel of different health services and equipment, as well as in the transgender diagnosis (Rocon et al., 2018; Romano, 2008). The diagnosis of transsexualism, according to the International Classification of Diseases (ICD), paired with the diagnosis of gender dysphoria, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM), reinforcing the pathologization of transsexuality, hinders the access to health services to the transformation of the bodies through gender reassignment (Almeida & Murta, 2013; Bento, 2006) and contributes to the social marginalization of this population (Butler, 2009).

In this context, what we can see the abandonment of on-going treatment, absenteeism, resistance to search for health services when sick, as well as processes of suffering, as the effects of the use of industrial silicone and self-medication with hormones (Rocon et al., 2016; Romano, 2008). Thus, trans people face the hardest difficulties to access health services in Brazil among the lesbian, gay, bisexual, and transgender- LGBT- population (Mello et al., 2011).

Confronted by reflections on how to intervene in this reality, studies such as Sampaio and Coelho (2012), Sehnem et al. (2017), Souza et al. (2015), and Spizzirri, Anker, and Abdo (2017) suggest the training of health personnel as a fruitful option to act on the problem of Trans people access to health services. In this article, we aim to problematize the understanding of training that, hegemonically, has been pointed out as a pathway to dismantle the barriers that

prevent the access of Trans people to health service. Training is not a *sui generis* concept and, in this sense, though permeated by “good intentions”, formative proposals restricted to the transmission of information and to present gender, sexuality, and transsexuality will not be enough to create a work with this population that enables an integral, universal, and equitable access to health in the basic care of gender reassignment.

## Methodology

The issues raised here analyze researchers’ experience in two empirical studies. Part of the data, produced in two qualitative studies with semi-structured interviews, will compose the text based on the objective proposed: analyze the training of health personnel as a strategy to build an integral, fair, and universal health for Trans people. The studies were approved by the Ethics Committee of *Universidade Federal do Espírito Santo*.

The first, held in 2013, interviewed 15 Trans people, aiming to raise their challenges to access basic care health services for the gender reassignment process. The second took place in 2017 and interviewed 10 Transwomen, 9 who went through the reassignment process and 1 that was being followed-up by a gender reassignment service, aiming to analyze the challenges to access this process, as well as the health care services after the surgeries. Both studies took place in the state of Espírito Santo (ES), Brazil. Participants were selected through the indication of friends and Trans-solidarity networks or through snowball. The number of participants was delimited by theoretical saturation. All participants were interviewed after signing a Term of Consent.

The anonymity of participants was guaranteed: in the first study by the use of fictional names randomly chosen by researchers; in the second, we opted for the non-identification, as the number of Trans people who have undergone gender reassignment surgery in ES is little, and thus there was a risk to identify former users of the service, even if not a participant.

In this article, we propose a new problematization of the data, based on Francisco Varela’s proposals of cognition by enaction, reflecting that, to transform the everyday life of health services experienced by the Trans population, there is the need for a cognitive policy paired with the creative dimension of the work process, focusing on the learning that emerges from the concrete experience of working with health and with the Trans population.

## Results and questions

### **Amidst a crossroads on the training of health personnel, between technique and political awareness**

Literature has been pointing out training as a way to intervene in the discriminatory reality faced by Trans people in health services. According to Spizzirri et al. (2017), “several studies aim to identify how health professionals approach the particularities of this group. These studies report attitudes that can be seen or considered discriminatory and transphobic” (p. 176). In this sense, the authors point out that the health needs of Trans population demand capable professionals, relying on the specialization discourse of workers in Trans health. Sampaio and Coelho (2012) indicate training, stating that,

Regarding the concepts and expectations of Psychology professionals, interviewees asked for them to be trained, so as not to cause any embarrassment, feelings of exclusion, and discrimination due to a lack of knowledge or curiosity, what, sometimes, can lead to attempts to promote a cure or convincing the forfeit of surgeries and other interventions, arguing on their seriousness and irreversibility. (p. 646)

Arán and Murta (2009), when dealing with the implementation of gender reassignment process in Brazil, also indicate the need for training. According to the authors, “We can see that one of the main challenges to implement this type of assistance is the professional training of the interdisciplinary team and humanization measures, to guarantee a quality and non-discriminatory service” (p. 17). Sehnem et al. (2017) discuss that one of the chagrins to improve the access of people, especially in basic health care, is “the lack of training of health professionals to attend this population” (p. 1682). Souza et al. (2015) suggest that “maybe the first step is to rethink professional training to attend transgender people, mainly, the education of health personnel. Perhaps we could increase the debates on themes as sexuality, gender, and difference” (p. 774).

During the interviews held in 2013 (Rocon et al., 2018), participants were emphatic when questioned what they would do to change the discrimination experienced in health services:

- Lectures and seminars on sexual diversity to all those working in the Basic Health Unities and hospitals. (Afrodite)
- Trained personnel able to attend all types of people. (Pandora)
- There should be more guidance on sexual diversity and difference, so as to have more respect on gender identity and sexual orientation (Efigênia)

Literature and participants point out health personnel training as a possibility to intervene in the challenges faced by Trans people to access health services. Based on this, we might ask: are there no training courses on Trans health in Brazil? Why are the determinations of the National Policy for the Integral Health of LGBT (Brasil, 2011) and the Letter of Rights of SUS users on the right to use the chosen name and the non-discriminatory service, respectively published in 2009 and 2011, not been routinely followed by health services? Is the problem we face the lack of training and information of health workers or is it the way we train them?

We should note that, in the last years, there has been political efforts to intervene in this reality, including the training of health personnel to work with LGBT people. An interesting movement was the creation of a course on LGBT Health Policy promoted online by *Universidade Aberta do SUS* (UNA-SUS). The website of the course indicates that the target audience is

health professionals, but [such profile] it is open to any professional that wishes to carry out actions of care, promotion, and prevention, with quality and equality, guaranteeing to the LGBT population the access to integral health, therefore improving the health of this group. (Brasil, 2019)

As an objective, it states that,

by the end of the course, we expect that the participant, with competence and scientific, humanistic, and ethical-social knowledge, will understand the importance of equitable access, providing a better life quality to LGBT people and guaranteeing the enactment of their human rights. (Brasil, 2019)

We can perceive that there is a reliance on training, on specialization, and preparation. Thus, in the accumulation and transmission of information and representations on gender, sexuality, and transsexuality to health workers, to acquire abilities and competences. Such training proposals have been oscillating between the transmission of technical information or the search to raise political awareness to produce an affective disposition with Trans population.

Both proposals are based on perspectives of a certain cognitivism grounded on representation, in a strong sense, which “establishes that cognitive activity is explained by the hypothesis according which a system acts from internal representations” (Varela, n.d, p. 79).

Varela (1993, n.d) offers a problematization pathway on the changes in cognitive sciences to think the movements of knowing-learning. Believing in the thesis that “information must arise not as an intrinsic order, bur as an order that emerges from the cognitive actives themselves” (Varela, n.d p. 11), the author analyzes cognition sciences and technologies.

In the approaches of a cognitivism with a strong sense of representation, the “only solution to explain intelligence and intentionality relies on the justification that cognition consists in acting in the base of representations that have a physical reality under the symbolic code in a brain or machine” (Varela, n.d, p. 31). Thus,

the evaluation criterion of cognition is always the adequate representation of a predetermined exterior world. We refer to information elements that correspond to properties of the world (as shapes and colors), or resolutions of well-defined problems that imply a well-designed world. (Varela, n.d, p. 72)

In this perspective, the world is understood as pre-established, its existence is previous to the subject and the cognitive activities, Varela (n.d., 1993) disagrees, as, in this way, the concepts of learning are grounded on transmitting solutions to problems and learning by representation/imitation. Learning and training mean producing an adaptation of the cognizant subject to the world. To Varela (1993), it is a model that “thus, ignores, the fluidity of the living and lived experience” (p. 74).

The ideas of education as technical training aiming to acquire abilities, competences, and adaptability to contexts, which have been hegemonic in the academic education of health workers seem to be based on these perspective of cognition. According to Kastrup (2013),

The emphasis has been on information-based training. A great part of academy still works with the dichotomy theory-practice, as well as the idea that practice should be the application of a previously-known theory. On the other hand, the current training is hegemonically grounded in specializations and the emphasis on diagnosis, based on the information released by DSM and ICD. This guidance has removed students from clinical practice, mainly learning through observation, through listening, and the experience with the patient that requires time, patience, and the constant exercise of a sensible and delicate care. (pp.152-153)

Training in health sciences has been hegemonically grounded on the transmission of body representations, rules of its biological workings (biology, anatomy, physiology, histology, etc.), and its pathological deviations (pathology, parasitology, infectology, etc.). Based on several subjects, presented in fragments under the aegis of specificities, this training perspective aims to transmit universal clinical protocols (representations) to interventions on pathological processes to rescue bodies to their biological working rules.

These formative focuses might be contributing to the chagrins promoted by the diagnosis as a requirement to the gender reassignment process. About the follow-up on this process, the participants of the 2017 study said:

- they demand you to have a feminine experience. They say they don't operate man...I was tired to say the same things. You have to prove you were a woman, that you were a woman in your head...In the way you dress, in everything. (Participant 7)

- About the person, he [professional] focuses a lot if you can pass as a woman. I think. I believe so. But he also studies the person, he also analyzes the person. How...how the person talks. I think he observes the person as a whole. Appearance does count. (Participant 5)

- It was difficult. Four years...But he [professional] actually says: "-No. You have to be improving"...The appearance, I think this is it...I think they pay attention to this social issue really. If you will be accepted. I think there's also this...I don't agree. (Participant 4)

- Here in the hospital someone with a beard will not get a surgery...The Professional says: "You are so feminine. You can get a surgery". It's not what makes the person get a surgery, it is not the physical, it is the head. You know? So, many girls that were in the plan that were not feminine, that couldn't take care of themselves, the Psychologist thought they were not ready because they weren't feminine. You know? (Participant 6)

- Sometimes we would get there with the girls and he would even correct them. Because if you are a woman you have to be a woman. You know? He would say this a lot". (Participant 8)

Participants allow us to resume the discussion held by Bento (2008, 2006) on the dramatic search for a real transsexuality. According to the author, there is not an atom of neutrality in the diagnosis process and that, in fact, the target – real transsexuality- is produced by the diagnosis itself, which, as the author points out, is based on stereotypes of what is to be a man or woman, grounded on a binary gender, and compulsory heterosexuality. Dialoguing with the author, Rocon et al. (2016) help us reflect that, in a society where gender is understood as binary, from the genitals, and a sexuality that has heterosexuality as a natural destiny, Trans bodies who by-pass these standards are considered sick. Thus, the search for a real transsexuality

is based on representations spread by the diagnosis manuals CID-10 and DSM-V, which pathologize Trans identities, presenting assumptions that can be applied in health routines.

The diagnostic devices are actual checklists, as pointed out by Caponi (2014), so health workers are guided by representations, ignoring users' experiences with transsexualities, as shown by participants, when they disagree with the representations produced about them, thus producing a selectivity in the access to health services to all those that do not fit the required representations: *"someone with a beard will not get a surgery"*; *"You are so feminine. You can get a surgery"*; *"They say they don't operate man"*.

This issue can be an effect of a training fundamentally grounded on a biomedical perspective. Camargo Jr. (2005) outlines three propositions on biomedicine:

It is guided towards the creation of discourses with universal validity, proposing models and laws of general application, it does not focus on individual cases: it has a generalizing character; these models tend to naturalize the machines produced by human technology, the Universe is seen as a gigantic machine, subordinated to principles of linear causality translated in mechanisms: a mechanical character; the theoretical and experimental approach used to decode the general laws of this universal machine presupposes the isolation of the parts, assuming that the working of the whole is necessarily given by the addition of the parts: analytical character. (pp. 178-179)

Biomedicine presents to in-training health workers a predetermined body and work, whose invariability is safeguarded by a normalcy dictated by universal biological working rules. In this perspective of education, one needs to know and transmit information on universal norms and rules that regulate the so-called normal body and world working, so as to apply them, when needed, to combat what is understood as social and pathological deviations.

We could maybe add a fourth proposition regarding biomedicine. It is a cognitivist reading that, when presenting the body and the world under biological, naturalizing, invariable, and universal perspectives produce educational processes that transmit information. Thus, educating is training, normalizing, presenting ways to intervene in health-disease processes, to intervene will always mean imitate an intervention, a representation through the application of protocols and controlled therapeutic conducts. Such training perspective is similar to modelling, to shaping a way to work with health that intends to be standardized and reproducible.

It is from this informational training that unfolds the ideas of technical and political training, also understood as awareness or the acquisition of humanistic and ethical-social competences, as described in the UNA-SUS course. Barros (1997) questions these discourses that affirm a technical training (a strong hegemony of the technique) or a political awareness. To this author “the first sense is impregnated by the idea of an ability to be reached. The second by the idea that critical awareness allows...the interference on social processes can unravel the established order” (p. 64).

Sometimes, we believe that the chagrins arisen in the meeting between health workers and Trans people result from a lack of technical training, considering that the health demands of Trans people are very recent among the procedures offered by the health system. Therefore, the need to train – to disseminate information – so that they can intervene on Trans bodies (surgical procedures, hormone therapy protocols, clinical psychiatric, psychological reports, etc.). Furthermore, when analyzing the discrimination problems in the routine of health services, we, once again, appeal to the transmission of information, under discourses that believe to be critical to the process of exclusion and creation of inequality, and that are supposedly present, through a given understanding of political awareness, behaviors to be imitated (respect to the chosen name, gender identity, and sexual orientation) to break away from the current ideas of gender and sexuality. Perhaps, we have reached such conclusions because they are easily understandable and recognizable.

However, among these training perspectives, we can highlight the emergence of two great issues: first, laying the blame on workers- either under the supposition of technical incapability, or accusing them of been inhuman, cruel, perverse, malicious in their work; the second, when trained by the transmission of applicable representations, they are not open to formative processes based on the concrete experiences of health work processes. Therefore, this situation does not allow the creation of new techniques, protocols, and routines regarding Trans people health.

***Training by action, breaking away from dichotomies, creating possibilities between technical training and political awareness***

Despite the issues raised here around the hegemonic understanding on technical training or political awareness, we do not want them to be in a limbo, but to understand them as insufficient to create ways of manage and work with Trans health users, who face difficulties to access health. Larrosa (2017) points out the need for “experts, because they can help us improve the practices. Also, the critics because there still needs to be an education that fights against extreme poverty, inequality, competitiveness, and authoritarianism” (p. 36).

We need the technique, we need to create and improve clinical protocols and surgical techniques for the specific health needs of the transforming body of Trans people. We also seek political ideals to keep on problematizing violence, inequality, and the suffering/diseases produced by gender inequality, gender binarism, and compulsory heterosexuality. However, when we believe that only technique or political awareness in health training are enough to solve the problems of health access to Trans people, we risk affirming a technical mentality, as if the transmission and accumulation of information were enough to face this challenge. Based on studies, we believe this not true.

We wish to affirm the impossibility of doing the previous actions disregarding the concrete experience of health workers in reassignment processes, so that it is not enough to receive a set of information to be applied when working with Trans health, but to create then, produce them in the everyday life of health, learning through action, through a collective work between health workers and users, through a common goal that does not separate management and care with the increase of communication among actors.

The same participants who, in 2017, talked about how the teams involved in the diagnostic process of reassignment represented them and how such representations were determinant to access reassignment health services after the surgery, also stated that:

- I didn't feel sick, I felt incomplete. Though I was the same way I'm now, no matter how feminine, when I looked in the mirror, it seemed I was back to the time I was a boy. It was like this, like, I can't explain, there was something missing, it was not a disease. (Participant 6)

- I think sick is a very heavy work. I think the surgery has helped fix something nature has denied. That Mother Nature...it hasn't denied...it let us learn. I think disease is quite heavy...But I think they say disease because when one says it is a disease, the prejudice decreases (Participant 7)

- I feel like a woman today. With a vagina. Because there is penetration. And I can feel pleasure. Being a woman is a combination of little things. (Participant 7)

- I feel more of woman after the surgery. I feel more confident, freer, and more comfortable. Before I couldn't be naked in front of anyone, but now I can. (Participant 6)

- In my mind I was already a woman. I became a woman so I could relate with other people. Then I think that people, men, started to see me in a different way. My mind was this. Woman. I've always been. The penis between my legs bothered me. Oh! How I've suffered with that penis, during sexual intercourse, and also to tuck it. It hurt! It was not pleasant. I was always a woman in my mind. That's because of these cultural issues, and also the fetish of men, there is, right? Men don't understand that a transsexual is transsexual and a transvestite is a transvestite<sup>5</sup>, they saw a girl before surgery, that hasn't gone into surgery yet, they think it is a transvestite. (Participant 5)

Rocon et al. (2020) point out that the senses given to health workers regarding transsexuality and the reassignment procedures, for instance, the surgery, have been important barriers for trans people access to services, “ as such senses are produced by a binary and heterosexual gender matrix, thus pathologizing transsexualities” (n.p).

What we perceived amongst participants is the nonexistence of a true transsexuality as the senses they produce for reassignment procedures cross the search for the freedom of their bodies, through nudity, sexual relations, use of certain clothes, i.e., a strategy to build the conditions to appear in the gendered world. Such nonexistence is also measured, considering that, when demanded a certain appearance, users adapt their narratives and body performances

---

<sup>5</sup> Translation note: Throughout the translation, we have opted to use the umbrella term transgender to refer to transsexual, transvestite, and transgender people. However, in this excerpt, Participant 5 reinforces the differences, in Brazilian context, between transsexual women and transvestites, pointing out the gender reassignment surgery as a marker of difference and that this marker is not always used by men, with whom they have relations, to distinguish such identities.

to the demands of the multiprofessional staff to have the reports that will guarantee access to services, as we can see by the statement of participant 8:

At first, the professional didn't want to give me the report, then she talked with me. I was very positive in my words, very firm, she was still reticent, but after she gave me the report. I think it's because I speak a lot, so I ended up convincing her.

Rocon et al. (2017), when analyzing divergences in the interpretations on strategies to modify bodies – hormones and industrial silicone- among Trans people and health workers, could see that for Trans sex-workers,

The use of hormones, with or without medical follow-up, and the applications of industrial silicone are synonymous with health and vitality, as they help building a beautiful body, in synch with the body of a rentable woman in the market. (p. 528)

In this direction, Rocon et al. (2020) point out the need to understand and use the meanings that people “give to the biomedical procedures to transform the body, their identities, and the gender relations in the multiprofessional follow-up offered to reassignment services” (n.p.) aiming to minimize the access barriers imposed by a diagnosis grounded on transsexuality representations. To do so, we have to try training strategies that consider the concrete experience, through which “train is to create other ways of living-working, learn, unlearn, and not instrumentalize the other with new technologies or, still, to give a critical awareness to another” (Dias, 2012, p. 36).

With Kastrup (2012, 2013, 2015), we perceive that talking about training through experience cannot be interpreted as just a choice between different theoretical-methodological models, but, in fact, “a specific way to relate with knowledge, the world, and oneself” (2012, p. 56). Therefore, the problem of knowing is not restricted to debates or decisions about technical-scientific paradigms, but, as stated by Kastrup (2012), involves an attitude, an action before the world, pointing out Francisco Varela as an important name to think cognition as becoming.

Varela (n.d, 1993), analyzing cognitive sciences, proposes an approach based on knowing through action, relying on the co-determination between the world and the cognizant subject, which he names the enaction approach to cognition. According to this author,

The general concern of an enaction approach to perception is not to determine how a world independent to the perceiving subject will be built; it is to determine which common principles or admissible connections between the sensorial and motor systems that will explain how the action can be perceptively guided in a world dependent to the percipient subject. This central concern is basically a record of the existing environmental information, aiming to truly reconstruct a piece of the physical world. Reality is not projected as something given: it depends on the subject that is perceiving, not because he/she builds it as a whim, but because what is considered a relevant world is inseparable from the percipient structure....Thus, according to this approach, perception is not simply embedded and confined to the world around; it also contributes to the enaction of this world around. (pp. 79-80)

This analytical perspective on cognitive sciences is concerned with the “predominance of the action concept over that of representation” (Varela, n.d., p. 74), indicating an approach of knowing the world as we produce it, not a constructive approach, but a co-emergence one. We know the world because we co-emerge with it. Hence, we know and produce a world related to co-determination, therefore, the reconstitution of a world previous to the cognitive activity of perception. Here, the notion of representation will correspond to the interpretation of the state of the world (Varela, n.d.). There is an inversion of the representational attitude, “representation is seen as a particular case of enaction. [...] an enlargement of the concept of cognition, transforming it in a complex system in which representation, included to the price of its weakening and even its subversion, it coexists with the breakdowns” (Kastrup, 1999, p. 145).

To the enactive approach, it is only possible to know through action, a practice, an intervention, a ‘make-emerge’ with the world. To the enaction perspective of Varela (1993, n.d.), besides a perception that selects the stimuli by its sensitivity, that is, an implied perception, we know the world by a corporal action, “enacted through our history of structural coupling” (Varela, 1993, p. 86).

The evidences of Dias (2011, 2012), Kastrup (1999, 2012, 2013, 2015), and Varela (1993, n.d.) make us think about learning and inventive training, when dealing with an education based on the concrete experience, on the production of knowledge through action and not only the transmission of information.

When talking about her proposal of inventive learning, Kastrup (1999, 2015) gives us the example of a novice flutist who, when learning to handle the instrument, will need to attached their body to the instrument, connect to it and not to adapt themselves to the flute. The author offers us an understanding of learning as experience, invention, and creation of

oneself and the world, and not as an adaptation or imitation aiming to obtain some knowledge, ability, or competence. To the author,

learning is, above all, to be able to problematize, to be sensitive to the variations that take place in a present cognition... Therefore, we cannot talk about learning something previously existent. What I learn only emerges with my learning. (Kastrup, 2015, pp. 206-207)

Kastrup (2012) brings the discussion on inventive learning to the core of what she calls cognition policy, establishing inventive learning as a position in the world. Through those reflections, the author discusses that “learning starts as an experience of problematization, of creating problems, or positing problems. And it also involves the invention of the world. It is not a question of adapting to a preexisting world” (p. 53).

Rosimeri Dias (2011) affirms that, “to establish the problem of training in the scope of learning, one needs to advance the limits proposed by theories that situate it in its universal conditions” (p. 58). Following Varela’s clues in the discussions on enaction and Kastrup and her proposals on cognition and inventive learning, the author offers in her analysis the idea of inventive training. Dias (2012) states that inventive training has, as a raw-material, a cognition policy based on enaction, analyzing how we act together with the difference that establish us and the formative processes. When distinguishing it from the information-based training, by the acquisition of abilities and competences under the umbrella of technical perspectives or a certain understanding of political awareness, Dias (2012) presents inventive training as “make with the other, train is to create other ways of living-working, learning, unlearning, and not only instrumentalize other with new technologies or, even, to give others a critical awareness” (p. 36).

Dias (2011, 2012) situates inventive training as a ‘becoming’ training, demonstrating its apprentice character, towards a permanent unlearning, immersed in a creationist ‘becoming’. “The issue of a developing training is deeper, it is an experience of displacement that moves the problematization of so-called truths that transmit knowledge and embody a living knowledge, enactive, that problematizes the educator” (Dias, 2011, p. 162). She affirms developing training as a resistance strategy faced by the mercantilization of experience.

The author (2011, 2012) also presents inventive training as a method of “do it with me”, differently from the “do it as I do” approach, whose practices are immersed in the pre-established. To Dias (2011), a “do it with me” approach is situated in a micro political plan that

affects a shared existence, open to unpredictability, the unlearning, that “acts to emerge what forces us to think, tensioning formation-truth by a method that cannot be applied and interpreted, but collectively and politically experiences, forging senses, and producing diverse effects” (p. 253).

Kastrup and Dias help us to resume the conversation with Trans participants that understood training as a strategy of trans-formation/trans-action of discriminatory experiences on health services. Learning and inventive training rely on knowing as a creation of oneself and of different worlds, in a perspective of co-emergency. Create new routines in Trans health requires giving up the “do it as I do” method, based on imitation and transmission of technical and political information, believing that only together with Trans people who use the health services, in a common pathway, through collective production- users, workers, and researchers- it is possible to trans-form the current reality of discrimination and pathologization of Trans health. Thus, Kastrup (2013) proposes that “in the scope of health workers’ training, diving into the experiences raises a challenge...the invention of new procedures, new practices, and new technologies of assistance and care” (p. 161). We need to disconnect from training perspectives that overwhelm health personnel with information and representations of transsexuality, that put on the sideline the actions, in a scope of knowledge production, hindering educational processes that take place in the meeting between health workers and Trans people. Such perspectives have often given us discourses on the disconnection between theory and practice.

These discourses are a result of a mistaken focus on political awareness, as if a given critical awareness on the discrimination suffered by Trans people in health services could be instilled in workers. Thus, it relies on the transmission of acceptable behaviors, considered *humane*, to be imitated- “do it as I do”, imposing the shaping of attitudes on the use of chosen names, pronouns, etc., that is not currently reflected on changes in the everyday life of health services, as seen by research participants and the literature on the theme.

Such scenarios is also the result of a biomedical education that, under the discourse of a training based on scientific evidences and specialization of the practice, has trained health workers in action models, in intervention prescriptions – protocols and diagnosis as applicable checklists.

Both training strategies have been insufficient to outdo the experience, frighten workers faced by the unpredictability of health routine and, thus, restrain the intervention possibilities of new ways of working with Trans population in health services.

We can follow some important evidences left by the *Humaniza SUS* movement to think about training strategies for the everyday health work, based on the dialogue established with previous mediators and the information from the meeting between health workers and Trans people. We call it a movement because we understand, as do Pasche and Passos (2010a, 2010b), the *Política de Humanização da Atenção e da Gestão* (PNH- Policy of Humanization in Care and Management) of SUS not as a governmental decree with information determining the steps to be followed, but as something established in the movements that created such policy, based on the “*SUS that works*”, with the challenges and paradoxes that emerge in health daily experiences.

Created in 2003, PNH aimed to “set off an ethical, political, and institutional movement to change health management and care” (Pasche & Passos, 2010a, p. 424), having as principles the “inseparability between management and care, the transversality (increase of communication; common production), and the foment of people’s protagonism” (Pasche & Passos, 2010b, p. 7). In this sense, we highlight three evidences that helped us think a training process through the experiences arisen in the meetings with health personnel and Trans people.

The first evidence: a new perspective to think humanization in health. Sometimes, the idea of humanization in training processes grounded on political awareness have been connected to benevolence, hospitality, goodness, or the awareness on the burdens faced by users of health services, to promote a harmonious interaction between the subjects in health systems. Thus, humanizing

can correlate to a purging action, asepsis, denying the difference that constitutes humans. Humanization is defined negatively, turning humanization of health practices into a hunt against what is contrary to human nature. (Pasche & Passos, 2010a, p. 425)

Thus, humanizing actions are understood as “confrontation to individual attitudes and behaviors considered inadequate” (Pasche & Passos, 2010b, p. 6), grounded on moralizing and prescriptive discourses based on the “do it as I do”.

It is common to find in formative perspectives based on transmitting representations on transsexuality, which rely on a certain concept of political awareness as a training strategy,

under the aegis of “do it as I do”, the naturalized understanding of trans people as “mercy” and a certain “vocation to be a victim”. Humanization when welcoming these people is then understood as benevolence and charity, placing Trans users in a relation of passivity and hierarchy with health workers, excluding them from decision processes in health work, care, and management.

From the movements of *HumanizaSUS*, health actors are invited to experience a humanization method that has inclusion among its pillars, proposing the creation a mutual solidarity and co-accountability, understanding humanization as an enlarged social practice (Pasche & Passos, 2010b). In this humanization perspective, humanization is “the creation of new health practices, new management ways, inseparable tasks when creating new subjects who are protagonists and co-responsible” (p. 428).

Therefore, the passive position is replaced by an active relation between trans users and health workers, as concrete experience produced in the meeting of this actors, in a lateral connection, establishes enactive training processes. Ideas of “vocation to be a victim” give way to the creation of co-accountability in the decision-making processes involved in the work, care, and management of Trans health, presenting humanization as a daily exercise of social criticism, creation of health practices, and understanding of trans people as protagonists of their care processes, health and disease.

The second evidence, announced in the first: the triple inclusion method. Pasche and Passos (2010a) do not indicate this as predetermined and sequential steps to be followed. The triple inclusion method proposes an experimentation to build targets to be reached collectively and through negotiation, whose pathway is not established by predetermined objectives, aiming the “inclusion of subjects with their stories, interests, and types of knowledge (lateralization); inclusion of conflicts, or tension points...that should be understood as institutional analyzers; inclusion, finally, of the collective, that consolidates itself in the inclusive action” (Pasche & Passos, 2010a, p. 430).

The second evidence highlighted: the training of health workers as a type of intervention. According to Pasche and Passos (2010b),

The guidelines of PHN training processes are grounded in the principle that training is inseparable from changing processes, that is, training is, necessarily, intervene, and intervene is to experience, in action, the changes in the management and care practices, aiming to affirm SUS as an inclusive, equitable, democratic, solidary policy, able to promote and improve the life of Brazilian people. (p. 8)

Heckert and Neves (2010) write on the integrality and inseparability between the ways of training, management, and work – train, manage, and care – in health, so that training is not understood as a repository and transfer of *a priori* knowledge in a hierarchical way. The effects of this perspective in training

In the ways of caring there is the establishment of perspectives that consider health not as a contraposition of disease, as the lack of illness, and the subject as an object of actions of fragmented and absolute types of knowledge that define the reality about a subject. Regarding management, this action is approached as the exclusive task of specialists (manager/administrator) who define the ways to organize the work process, the way to act in health institutions, reducing work to its prescriptive facet. (Heckert & Neves, 2010, p. 20)

This conception divides subjects involved in the training process into senders and recipients, using *a priori* information related to the learning process. Contrariwise, the authors question that “the specificities of health services/systems require bending the ways of training, so that it would be possible to welcome different realities, not as a given but as a destabilization movement of the training process itself” (Heckert & Neves, 2010, p. 25), so as to overcome patronizing practices that create networks of dependence and isolation. Thus, the authors believe in experience-based training, as an invention, as the creation of ways of caring and managing health, so that “training means, above all, the creation of reality, establishment of ways of existence – therefore, it is not disconnected from the creation of management in the work process” (p. 17).

Relying on an enactive training, health workers and Trans users educate themselves through the concrete experience produced in meetings on the processes of caring, working, and managing Trans health. A process of training that arises from conflicts and uneasiness created by the encounter of different concepts and senses of health and diseases produced by workers and Trans people. It destabilizes training processes based solely in representations and information transmission. On PNH perspective, train and intervene emerge together as one knows by enaction and, thus, creates possibilities to produce universal, integral, and equitable health services to Trans people presupposing their inclusion, their stories, and senses given to

the reassignment process, to the transformation of bodies, to gender, to sexuality, to health care, and to illness.

## Final remarks

Literature suggests that the training of health personnel is an important intervention field to confront the chagrin involved in the access of Trans people to health services. However, we question that the dependence on formative strategies, based on the transmission of representations on transsexuality, technical information, and political awareness, have been insufficient to intervene in the reality of difficulties experienced by trans people when accessing basic health services in the gender reassignment process.

The training strategies of health personnel, based on transmitting information and representations that consider only the technical dimension, tend to mold and universalize the ways of caring, working, managing, and train in the everyday life of health systems. When participants narrate their experiences on the requirements asked on the diagnosis process under the aegis of applying the representation of a true transsexuality, we can perceive the affirmation of hegemonic socially constructed stereotypes on gender and sexuality, which present gender in a binary fashion, *a priori* imprisoned by the genitals, by sexuality, understood on the opposition homo/hetero, valuing the later under the perspective of mandatory and complementarity of genders.

Therefore, a technical training for workers on the gender reassignment process tends to establish a health care based on corrective, disciplining, and readjustment actions, as the personnel is trained through the transmission of protocols and intervention techniques on bodies forged by the aegis of gender norms and, thus, understand their work as a process of imitating transmitted information, as well as requiring users to imitate gender norms routinely transmitted to them in the reassignment services, as we could see in the testimonies. Thus, those who do not pursue this imitation or to not enact them in the diagnosis process are denied their reassignment process, as shown in the literature.

It is impossible to install a given critical awareness in another, as previously stated by Dias (2012). Though important, formative processes that rely on political awareness, as dissemination of information on health services, that aim to transmit imitable behaviors faced

by issues such as the use of the chosen name and a non-discriminatory service, that questions the *status quo* of gender norms and sexuality which excludes trans people from health services, are not enough.

We need to move forward on the formative proposals for health work with Trans people, believing that, through concrete experience, through the actions during the everyday learning in health services it would be possible to produce techniques and ethical-political postures to favor the access to non-discriminatory health care, respecting the chosen names, and able to answer these population health demands for body transformation.

To move forward with a humanized gender reassignment process presupposes the creation of health routines that affirm the protagonism of users, intercrossing the relation of involved actors. There is the need to focus on the formation of personnel and users based on the affirmation of life in its multiplicity, not reduced to the training syllabuses established in some training institutions. To place side by side health workers and Trans users makes it possible to learn by creating ways of working, managing, and caring, connected to the senses that trans people give to transsexuality and reassignment procedures that favors an integral, fair, and universal health access to trans population.

## References

- Almeida, G.; & Murta, D. (2013). Reflexões sobre a possibilidade da despatologização da transexualidade e a necessidade da assistência integral à saúde de transexuais no Brasil. *Sexualidad, Salud y Sociedad*, (14), 380-407.
- Arán, M., & Murta, D. (2009). Do diagnóstico de transtorno de identidade de gênero às redescrições da experiência da transexualidade: uma reflexão sobre gênero, tecnologia e saúde. *Physis: Revista de Saúde Coletiva*, 19(1), 15-41.
- Barros, M. E. B. (1997). Formação em educação: serialização ou singularização? *Educação, Subjetividade e Poder*, 4(4), 63-70.
- Bento, B. (2006). *A (re)invenção do corpo: sexualidade e gênero na experiência transexual*. Garamond.
- Bento, B. (2008). *O que é transexualidade*. Brasiliense.

- Brasil. (2006). Ministério da Saúde. *Carta dos direitos dos usuários da saúde*. Brasília: Ministério da Saúde.
- Brasil. (2011). Ministério da Saúde. Portaria GM/MS n.º 2836, de 01 de dezembro de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (Política Nacional de Saúde Integral LGBT). *Diário Oficial da União*.
- Brasil. (2019). Universidade do Estado do Rio de Janeiro. Universidade Aberta do SUS. Política Nacional LGBT. <http://unasus.uerj.br/cursos-em-andamento/lgbt>.
- Butler, J., & Rios, A. (2009). Desdiagnosticando o gênero. *Physis: Revista de Saúde Coletiva*, 19(1), 95-126.
- Camargo Jr., K. R. (2005). A biomedicina. *Physis: Revista de Saúde Coletiva*, 15(Suppl.), 177-201.
- Caponi, S. (2014). O DSM-V como dispositivo de segurança. *Physis: Revista de Saúde Coletiva*, 24(3), 741-763.
- Dias, R. (2011). *Deslocamentos na formação de professores: aprendizagem de adultos, experiência e políticas cognitivas*. Lamparina.
- Dias, R. (2012). Formação inventiva como possibilidade de deslocamentos. In Dias, R. (org.), *Formação inventiva de professores* (pp. p.25-41). Rio de Janeiro: Lamparina.
- Heckert, A. L. C., & Neves, C. A. B. (2010). Modos de formas, modos de intervir: quando a formação se faz potência de produção de coletivo. In Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização. *Formação e intervenção*. (Vol. 1, pp. 13-28). Ministério da Saúde.
- Kastrup, V. (1999). *A invenção de si e do mundo: uma introdução do tempo e do coletivo no estudo da cognição*. Papyrus.
- Kastrup, V. (2012) Conversando sobre políticas cognitivas e formação inventiva. In Dias, R. (org.), *Formação inventiva de professores* (v. 1, pp. 52-60). Lamparina.
- Kastrup, V. (2013) Um mergulho na experiência: uma política para a formação dos profissionais de saúde. In Capazzolo, A., Casetto, S. J. & Henz, A. (orgs.), *Clínica comum: itinerários de uma formação em saúde* (pp. 151-162). Hucitec.
- Kastrup, V., Tedesco, S., & Passos, E. (2015). *Políticas da Cognição*. Sulina.

- Larrosa, J. (2015). *Tremores: escritos sobre experiências*. Autêntica.
- Mello, L., Perilo, M., Braz, C. A. de, & Pedrosa, C. (2011). Políticas de saúde para lésbicas, gays, bissexuais, travestis e transexuais no Brasil: em busca de universalidade, integralidade e equidade. *Sexualidad, Salud y Sociedad* (9), 7-28.
- Pasche, D. F., & Passos, E. (2010a). Inclusão como método de apoio para a produção de mudanças na saúde – aposta da Política de Humanização da Saúde. *Saúde em Debate*, 34(86), 423-432.
- Pasche, D. F., & Passos, E. (2010b) Apresentação: Cadernos temáticos PNH: formação em humanização. In Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização. *Formação e intervenção*. (Vol. 1., pp. 5-10). Ministério da Saúde.
- Rocon, P. C., Rodrigues, A., Zamboni, J., & Pedrini, M. D. (2016). Dificuldades vividas por pessoas trans no acesso ao Sistema Único de Saúde. *Ciência & Saúde Coletiva*, 21(8), 2517-2526.
- Rocon, P. C., Zamboni, J., Sodr e, F., Rodrigues, A., & Roseiro, M. C. F. B. (2017). (Trans)forma es corporais: reflex es sobre sa de e beleza. *Sa de e Sociedade*, 26(2), 521-532.
- Rocon, P. C.; Zamboni, J., Sodr e, F., Rodrigues, A., & Roseiro, M. C. F. B. (2018). O que esperam pessoas trans do Sistema  nico de Sa de?. *Interface - Comunica o, Sa de, Educa o*, 22(64), 43-53.
- Rocon, P. C., Sodr e, F., Rodrigues, A.; Barros, M. E. B. de, G.S., Pinto., & Roseiro M. C. F. B. (2020). Vidas ap s a cirurgia de redesigna o sexual: Sentidos produzidos para g nero e transexualidade. *Ci ncia & Sa de Coletiva*, 25(6), 2347-2356.
- Romano, V. F. (2008). As travestis no Programa Sa de da Fam lia da Lapa. *Sa de e Sociedade*, 17(2), 211-219.
- Sampaio, L. L. P., & Coelho, M. T. A. D. (2012). Transexualidade: aspectos psicol gicos e novas demandas ao setor sa de. *Interface – Comunica o, Sa de, Educa o*, 16(42), 637-49.
- Sehnm, G. D., Rodrigues, R. L., Lipinski, J. M., Vasquez, M. E. D., & Schmidt, A. (2017). Assist ncia em sa de  s travestis na aten o prim ria: do acesso ao atendimento. *Revista de Enfermagem UFPE*, 11(4), 1676-1684.

Souza, M. H. T. de, Malvasi, P., Signorelli, M. C., & Pereira, P. P. G. (2015). Violência e sofrimento social no itinerário de travestis de Santa Maria, Rio Grande do Sul, Brasil. *Cadernos de Saúde Pública*, 31(4), 767-776.

Spizzirri, G., Ankier, C., & Abdo, C. H. N. (2017). Considerações sobre o atendimento aos indivíduos transgêneros. *Diagnóstico e Tratamento*, 22(4), 176-179.

Varela, F. (n.d). *Conhecer: as ciências cognitivas, tendências e perspectivas*. Instituto Piaget.

Varela, F. (1993). O reencantamento do concreto. *Cadernos de subjetividade*, 1(1), 71-86.

---

### **Submission data:**

*Submitted for evaluation August 29, 2019; revised December 3, 2019; accepted for publication in January 14, 2020*

**Corresponding author:** Instituto de Saúde Coletiva (ISC) da Universidade Federal de Mato Grosso. (ISC/UFMT, Cuiabá, Brasil), Avenida Fernando Corrêa, nº2367, Bloco CCBSIII, 2º piso, Boa Esperança, Cuiabá (MT), 78060-900, [pablocardos@gmail.com](mailto:pablocardos@gmail.com)