

Experiences of transgender women/ transvestites with access to health services: progress, limits, and tensions

Experiências de acesso de mulheres trans/
travestis aos serviços de saúde: avanços, limites
e tensões

Experiencias de acceso de mujeres trans/travestis
a servicios de salud: avances, límites y tensiones

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Abstract

Given both the changes in sexual customs, norms and policies and the persistent patterns in Brazil, the article analyzes the experiences of transgender women/transvestites with access to health services and discusses sexual/gender discrimination and their demands for gender transition and AIDS prevention services. The study involved interviews with nine transgender women/transvestites 23-45 years of age from low-income strata in the Baixada Fluminense region of Greater Metropolitan Rio de Janeiro, Brazil, in 2016 and observation of contexts of prostitution and sociability. Compared to the violence experienced years previously, the narratives of transgender women/transvestites highlight important social strides. They report that health professionals do not discriminate against them based on their condition, although they resist calling them by their social names. This embarrassment and the structural problems of the Brazilian Unified National Health System (SUS) are minimized by the agency of trans women/transvestites in obtaining care, such as recourse to contact networks and awareness of their civil rights. The narratives on their search for body changes for transitioning often reveal a tense combination of the technologies offered by health services and those managed by transvestites themselves. Although AIDS policies focus on measures for trans women/transvestites, HIV prevention is not among their main demands on health services. There are subjective barriers for accessing services, resulting from internalized stigma and the association of HIV infection with their living conditions. Improvement in healthcare for the trans/travestite population requires a debate on structural problems in the SUS, the defense of its expanded view of care, and investments in professional training.

*Transgender Persons; Transvestism; Health Services Accessibility;
Social Discrimination*

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Introduction

The life stories of transvestites and the trans population as a whole in Brazil have been marked by exclusion, discrimination, and violence, as attested in the literature^{1,2,3,4}. National studies on the implications of social marginalization in this population's access to comprehensive healthcare feature situations of discrimination and hostility in services. Other reports include lack of physical examination, difficulty in understanding the physician's instructions, and especially disregard for their social name. Although specialized services now appear to be better qualified, there are still frequent reports of discrimination. Studies have highlighted the need to train the health teams to provide more humane care and respect for different sexual and gender identities^{5,6,7,8,9}. International studies on barriers to healthcare for the trans population have shown similar results^{10,11,12,13,14}. Inequalities in meeting this population's needs for care become more evident when comparing different social groups¹⁵.

In this article, we assume that social exclusion and sexual discrimination relate to the hierarchies and differentiations fomented between social groups. Their expressions vary historically according to the prevailing structural and cultural dynamics^{16,17}. From this perspective, to understand access to health services by trans/transvestites, it is necessary to understand their experiences in these contexts taking into consideration changes in the legal sphere and social practices in relation to sexual and gender tolerance and diversity in recent decades, as well as resistance to them.

The trans/transvestite population has gained recognition and social visibility in Brazil as the result of its political affirmation and growth as a collective social subject. The 1988 *Brazilian Federal Constitution* and the action by the LGBT movement (lesbians, gays, bisexuals, and transvestites, transsexuals, and transgenders) have strengthened social debates on their living conditions and public policies for their civil rights.

There are several examples. At the government level, the program Brazil without Homophobia, in 2004, was a political milestone that involved linkage between organized civil society and different ministries and departments in the definition of action to promote rights in such areas as security, education, work, and health for LGBT persons. In 2009, responding to demands by the social movement, a new national plan was launched, centered on the promotion of LGBT rights¹⁸, including proposals in health. Meanwhile, Brazilian society began to debate the inclusion of sexual and gender diversity in the work market, teaching institutions, and cultural production. The LGBT Pride Parades became mass events, and the circulation of these groups in the public space, communications media, and social media gained unprecedented dimensions.

In the area of health, government action for transvestites emerged with HIV/AIDS prevention policies drafted in the 1990s, which included them at that time in such categories as "homosexuals" and "men who have sex with men" (MSM). The year 2007 witnessed the launch of the *Integrated Plan for Confronting the Feminization of the AIDS/STD Epidemic, including transgender women*, and the *National Plan for Confronting the AIDS/STD Epidemic among Gays/MSM and Transvestites*¹⁹. The responses to AIDS and the matter of police violence fueled the production of an agenda of demands and organization of the transvestites' social movement in the country^{2,3}.

More recently, another important victory was the regulation of technical and ethical guidelines for the transsexualizing process in the Brazilian Unified National Health System (SUS), which included gender reassignment surgery and care for transsexuals. In 2013, the regulation was redefined, and surgery is no longer an exclusive treatment target, thus favoring the demands of transvestites who are interested in hormones and implants alone²⁰.

The National Policy for Comprehensive LGBT Health, issued in 2011, meant progress in care for trans/transvestite populations, such as in relation to over-medication and guaranteed use of the person's social name. These concerns were addressed again in 2016 with new government measures for comprehensive health, humane care, and respect for transvestites and trans women and men, reinforcing the state's roles in relation to their needs. Considering that these regulations make public services legitimate settings for the body changes wanted by trans/transvestites, it is important to discuss how this medicalized dimension of gender transitioning is consolidated in their actual experience.

These legal and public policy proposals indicate progress in the recognition of the LGBT population as social subjects and subjects of rights. However, the actual achievement of legal, political, and social strides in Brazil still faces obstacles due to the stigma of transvestism, resistance by some social

segments, and macrostructural problems. The implementation of minority groups' proposals involves time, negotiation, and disputes between various forces, institutions, and social actors²¹. There are also tensions and specificities in the demands within the LGBT world and between different "T" segments, making the enforcement of formal rights complex².

Given the historical and social processes of changes and persistent values at the cultural, legal, and political levels in Brazil, this article analyzes experiences of transgender women/transvestites with access to health services. The article discusses sexual/gender discrimination and this population's demands for gender transitioning and HIV/AIDS prevention services. This qualitative study involved social groups belonging to low-income strata in Rio de Janeiro.

Methodology

This was a qualitative study informed by the contributions of social sciences to understanding the relations between practices, social structures, and cultural systems²². The work is part of a larger research project on HIV prevention and testing policies in three cities in the Baixada Fluminense region in Greater Metropolitan Rio de Janeiro, which studied sexually marginalized groups' health demands and experiences with discrimination in services²³.

Semi-structured individual interviews were conducted with nine transgender women/transvestites on their family relations, scholastic and professional background, affective-sexual interactions, networks of sociability, transits, and access to health services. The study included interviews with AIDS program administrators and health professionals, other health services and social assistance staff, and focus groups with health professionals and LGBT leaders on local programs and activities for prevention and care for sexual minorities. The fieldwork was conducted from January to October 2016, plus observation of prostitution scenes (a gasoline station on the Presidente Dutra highway connecting Rio de Janeiro and São Paulo), spaces of sociability (bars, city squares), and activities on LGBT Pride Day. The data were categorized and interpreted with thematic content analysis²⁴. The study was approved by the Committee on Ethics in Research of the Oswaldo Cruz Institute, Oswaldo Cruz Foundation (n. 45267315.9.0000.5248) and complied with its standard ethical procedures.

The current article focuses on the testimony of nine transvestites and field observations. Access to the interviewees, hereinafter identified by fictitious names followed by their ages, resulted from indications by staff at the Baixada Fluminense LGBT Resource Center, community leaders, and the snowball strategy. The interviewees' ages ranged from the twenties (23-25 years) to the thirties (31-38 years) and forties (41-45 years). We found variations in the experiences with gender transition and discrimination between the different generations and life phases, given the changes in the sexual norms and customs and in health policies for LGBT persons in Brazil, as addressed in the Introduction.

Characteristic traits of the transvestite world that have been described repeatedly in academic studies^{3,4,25} were also found in the life stories of the interviewees here, including: belonging to lower-income strata, estrangement from the nuclear family in adolescence, and work in prostitution. Entry into the work market in low-paid occupations or in prostitution was explained by the need to support themselves or to complement the family income and was concurrent with the process of body/gender transformation. Some had finished secondary school, such as Andressa (35 years), Barbara (25 years), Gracy (45 years), and Hillary (31 years); others had resumed their studies to finish secondary school, like Crislene (38 years) and Ellen (41 years); and one, Ivan (43 years), was enrolled in university (nursing). The younger interviewees, Dayanne (23 years) and Jeniffer (25 years), had not finished secondary school. Three interviewees are HIV-seropositive (Barbara, Gracy, and Ellen), which allowed a more diversified analysis of the relationship between this social world and health services, health professionals, and available social and biomedical technologies.

All maintained affective-sexual relations with men; four were single, one was in a long-term non-cohabiting relationship, three were in stable unions, and one was legally married. The majority lived in their own homes with a partner or their original family, while two lived alone. Their current occupational situation varied, including one who was an administrative assistant in a private hospital and others working in social programs and projects in citizenship and sexual diversity. The younger

interviewees worked both in prostitution and at other activities (hairdresser, secretary, school lunch worker) to complement their income. Some had quit prostitution, earning money from renting houses or apartments purchased with money made in Europe in the 1990s and 2000s. Experience in France, Italy, and social programs linked to LGBT rights in Brazil gave them greater familiarity with the language of social rights, as noted in their quotes.

As for self-identification, only Gracy (45 years) introduced herself as a “transvestite”, while the others called themselves “trans woman”, “transsexual woman”, or “trans”. One had undergone gender reassignment surgery and three were awaiting the procedure in the public health system, including Gracy. Ivan (43 years) identified as a transvestite called Iris but had recently stopped taking hormones and had assumed a “neutral” appearance (short hair, unisex clothing), introducing himself as a homosexual and resuming his male name. The use of these categories does not assume a simplified or homogeneous view of their gender-building experience, nor does it ignore the self-classifying fluidity. Such modes of identification are linked to a broader process of changes in identity policies in Brazil²², besides reiterating the consolidation of the term “trans” as a category that encompasses other identity forms related to gender transitions².

Results and discussion

Discrimination and access

According to various studies, discrimination prevents or hinders access to health services by trans persons/transvestites^{5,6,7,8,9}. Still, in the narratives here, discrimination based on their condition as trans woman/transvestite appears not to have prevented their access to services. All of them are users of the SUS and use the system in emergencies and for follow-up at the primary care units, usually in the Baixada Fluminense, and in specialized services in the state capital city of Rio de Janeiro. None of them has a private health plan, but they do turn to the private system exceptionally for aesthetic procedures. Although saying that their presence in hospitals and health centers cause “looks” and “reactions” by health professionals and other users, most feel that the prejudice is not explicit and that they are treated with respect.

“The medical attendance was good. I thought it was normal. There was none of the discrimination thing. Maybe because we’re very friendly with the people. Among the people working in health, I don’t see this prejudice treatment. Either that, or it’s very well hidden” (Ellen, 41 years).

Many of the interviewees, especially the older ones, were to acknowledge greater tolerance with trans persons/transvestites in social spaces, including institutions. When citing the legal and juridical strides with LGBT rights, they argued that even without profound changes in the social representations, the effects could be seen in practice.

“It wasn’t this easy before. People today talk about discrimination. I honestly haven’t seen. And I circulate all over Rio de Janeiro, and I still haven’t seen anything like that. The police used to beat me up in the 1980s, and now they call me ‘ma’am’, you know? I don’t see the discrimination. I’m from a time when transvestites were seen as delinquents, when people were afraid of us. They’re still afraid. But the fear has changed, right? Now they’re afraid of paying a fine. Like, if somebody offends me and I file a complaint against them, understand? I used to be afraid of getting stabbed. The situation hasn’t changed much. But the words have changed” (Gracy, 45 years).

In relation to the SUS, several interviewees cited difficulties in access to healthcare that were not related to sexual/gender discrimination, but to problems frequently experienced by other users of the system. Long lines, difficulty scheduling appointments, red tape, information gaps, lack of welcoming, and lack of physicians on duty were situations cited to describe the system’s weaknesses and reasons for sometimes giving up on looking for care.

“They don’t explain things properly. Like this girl where I went [at a clinic] in Nova Iguaçu. She said, ‘Oh, no. It’s not here. You have to go there [to another clinic] where you live.’ She really treated me badly. So, I went to Caxias that same day, to a clinic they have there. I got there and there was no doctor. I said to myself, ‘You know something? I’m going home’” (Dayanne, 23 years).

Depending on the degree of importance and urgency in the problems and the fact that they cannot afford access to private health services, many confront the obstacles and insist on being seen: *“I wake*

up early, I face the waiting line” (Gracy, 45 years). To deal with the difficulties in care, they also report mobilizing their contact networks in the health sector and other government agencies, especially those who work in social programs/projects or belong to LGBT organizations/collectives. These ties, plus the friendship with LGBT community leaders in the Baixada Fluminense and the local political patronage for solving formal problems, help understand the way they overcome limitations in access to services. For example, given the difficulty in access to medicines, Barbara (25 years), who is HIV-positive, turned to LGBT activist friends for the administrators at the Municipal Health Department to solve the problem.

Strategies for solving difficulties in access to public services also include the “playing refined” performance, which mixes intensification of feminine docility with an attitude of refinement displaying typically middle-class manners. There are also reactions resulting from their awareness of their civil rights and knowledge of how the rules work in public institutions.

When asked about discrimination experienced in health services, they report no discriminatory treatment by health professionals due to their condition as trans persons/transvestites. Compared to the situations of offenses, humiliations, and aggressions years before in public spaces, their narratives now tend to focus on the strides by the Brazilian LGBT movement and its effects on the health system. Thus, treatment in health services was not considered an important locus of discrimination for them.

Nevertheless, in relation to the difficulties experienced in the context of the medical appointments, they were unanimous in reporting experiences of embarrassment due to lack of the use of their social name by the health professionals. As already shown in the literature^{6,7,8}, conjugation in the feminine was an extremely sensitive topic in their reports. The majority know the legislation that guarantees recognition of their social name and gender identity in the public administration. Lack of enforcement of this right emerged in the interviews as a measure of discrimination in the services: “I went there, I fought. I fought, let’s say, in a friendly way? I said, ‘No way! We have rights.’ I cited the law that we have rights in the public health system. They included it in the system. But at the bottom of the page there’s always your name as it is on your birth certificate. That’s the heavy part. But thank God, they always treated me by my social name. Which is the name I identify with” (Andressa, 35 years).

“I was actually treated properly. But not addressed by my name. They call out the name that’s on the document. So, I felt a little embarrassed, understand? When I go, I prefer to go with a [male] friend of mine. When I know they’re about to call my name, I pretend it’s him. I play crazy. I say to him, ‘Go on, it’s your turn.’ It’s because I’m embarrassed” (Dayanne, 23 years).

The legal backing that requires using the social name and the right to a name change and sex change in the civil registration (a system they view as overly bureaucratic and slow) are extremely significant elements in their gender transition. Although for many it is extremely difficult to completely erase the stigma of transvestism in social contact, these resources related to their recognition in the feminine allows them maneuvering room or control over the travestite stigma, including in the health system.

The office hours at health services were not mentioned as an inconvenience preventing their access. This situation was only cited by some transvestites that engage in prostitution at the gas station, but not by the nine interviewees (few of whom are involved in prostitution regularly, and not necessarily at night). As they report, the expansion of access to services could be achieved by other strategies, along the lines of what they call an incentive. This can be expressed as encouragement from another transvestite or health professional to care for their health and find a service, company, transportation voucher, stipend, or other benefit (refreshments, socialization with other transvestites). Through their network of sociability, they form their views on the health services and professionals, review their fears, and support each other. The hope is that this encouragement will be practiced by transvestites seen as leaders due to their professional success and respectability in society.

Demands on health services

Concerning their demands on the public and private health system, we highlight two issues that have defined public health measures for these groups in Brazil: gender transition and STI/AIDS prevention. Until recently, health policies for trans persons/transvestites in Brazil focused on prevention and care in HIV/AIDS, due to the high HIV prevalence rates²⁶ attributed to practices in sex work.

However, critical analyses showed that such measures overlooked their demands for body changes, such as hormones implants and gender reassignment surgery^{3,27}. Due to the founding principles of the SUS, namely equity, universal coverage, and comprehensive care, plus the pressure from the social movement, these demands began to be addressed in the SUS.

Although implementation of the transsexualizing process in the SUS poses various challenges, for example pathologizing transsexuality as a criterion for access, predominance of the binary gender logic, and waiting time^{27,28}, the supply of such services represents a major victory in the interviewees' eyes, given the social value they assign to building a beautiful female body²⁹. Thus, for gender transition, they can rely on both available health services and informal practices shared in the peer network, such as application of industrial liquid silicone performed by "bombadeiras" ("pumpers")³⁰ and self-administration of hormones. We detected tensions in the interviewees between official knowledge and practical knowledge in terms of the means, risks, and performance of body change procedures, issues that also been identified in the literature^{3,30}.

Informed by the feminist literature, we consider that becoming a transvestite or trans woman entails intervention with different gender technologies, the effects of which are produced in bodies, behaviors, and relations. Gender transition thus involves a set of social technologies, discourses, practical knowledge, scientific knowledge, laws, institutionalized and everyday practices, and artifacts, including from the biomedical world³¹.

Gender transition

All the interviewees had already turned to health services for support in their life-course gender transition. Despite common elements in their stories, the generational and financial differences and diverse networks shape this process differently. The type of procedure sought by the individual and the way they combine the physical interventions also vary.

All the interviewees described the beginning of gender transition as a diffuse phase related to an awakening of their identification with the feminine world or their awareness of affective/erotic interest in men. Experimenting with and rehearsing feminine expressions begin in childhood or adolescence, imitating gestures and wearing women's clothing and accessories. Although this moment is a source of conflicts, due either to family members' negative reactions or subjective dilemmas, none of them had been taken by their families to doctors or psychologists.

Most of the interviewees had made the decision to transform before they turned¹⁶, which coincided with leaving home and entering prostitution; they had learned the new trade and the techniques for transitioning from other transvestites (none had identified as trans women until then). Although they reported unique subjective experiences, gender transition occurred initially in the context of peer-to-peer social relations, not in medical institutions. The fabrication of the female body or fabrication of the feminine in the body⁴ and erasing the masculine³ happened with growing long nails and hair, modulating the voice, and incorporating new language and gestures. Simultaneously, they began using hormones, and some started applying silicone. The possibility of a medicalized transition was not a given, especially for the older individuals, who began their transition in the 1980s, when medical follow-up for hormone therapy or plastic surgeries was the exception: *"I applied silicone early. It was all we could do back then. Plastic surgery was out of the question in the 1980s. Today you can pay six or seven hundred and have implants put in"* (Gracy, 45 years).

In fact, the search for health services for gender transition started later, mostly for plastic surgeries, of which the most common procedure was placement of breast implants in private services. This gender technology competes with liquid silicone. Crislene (38 years) and Gracy (45 years) were living in Italy when they started looking for this procedure to replace breasts built with liquid silicone. Dayanne (23 years) and Jennifer (25 years) had the surgery done in Brazil, and this was the first intervention to "grow boobs". In all the cases, prostitution enabled them to afford the procedures provided by private physicians.

Crislene was the only one to have gender reassignment surgery, in 2005, in a private service in Brazil. But she required subsequent reconstructive surgeries, one in Spain and the other in Brazil, in the SUS. Three other interviewees had gone directly to the SUS in hopes of obtaining this procedure. According to them, due to the precarious situation with the specialized services and the long waiting

lines, especially given the economic crisis in the state of Rio de Janeiro, hormone therapy and gender reassignment surgery are unfeasible in practice in the public healthcare system.

“I’ve been going there [to the specialized hormone therapy service] for eight years. What do you think? What have they scheduled? For 2050? You have to laugh. The state’s in a crisis, darling. They’re not even distributing cyproterone acetate, which is the male hormone inhibitor. You really think they’re going to operate on anybody? Give me a break! There’s no insulin for diabetics. Do you think there’s going to be cyproterone acetate for transsexuals? The state’s crisis is horrid” (Hillary, 31 years).

Although acknowledging that transitioning procedures are safer when administered by physicians, some reported serious problems resulting from interventions in health services.

“I redid my surgery in August, because my canal is closed, I couldn’t have intercourse. That’s why I have a problem in my leg. I went for eight and a half hours with my legs up, and I guess it affected a nerve. And that led to a bunch of things, even depression that I haven’t gotten over. My abdominoplasty turned out horrible. The doctor wants me to come back to fix it, but I don’t want to back until my leg gets better” (Crislene, 38 years).

To understand these comments, it is necessary to focus on the combinations of gender changes performed in the health services and outside of them, as well as the transits and borders between the two worlds. For example, hormones, which are a technology available in the biomedical context, have often been self-administered by the interviewees. After the transsexualizing process was regularized in the SUS, which allowed hormone therapy, Hillary (31 years), Gracy (45 years), and Andressa (35 years) began medical follow-up at the State Institute of Diabetes and Endocrinology (IEDE), but the others continue self-administering. We found that hormone use varies according to type and dose, and that there are periods of interruption.

Hormones have a special place among the gender technologies appropriated early on by trans persons/transvestites. They easily cited the names, dosages, and side effects (circulatory and liver problems and impotence/sexual disinterest resulting from continuous use). The interviewees showed that they were aware of the risks and effects of off-prescription use and weighed these factors in their decisions. In practical experience with hormones, they even weigh how they compete with other gender technologies (plastic surgeries) and biomedical substances (antiretrovirals). Their reports suggest that the management of gender technologies by healthcare professionals eliminates their own autonomy in the process. Self-prescribed doses or types of hormones are associated with greater control to accelerate the transition or to interrupt when they have achieved the results with other procedures.

“If you have implants and you’re taking a lot of hormones, you create skin because your breasts are going to grow, they’re going to swell a little, but they might also droop. So, I’m afraid. I haven’t taken hormones for a long time. Trans people always figure out ways to become a little more feminine, understand? So, I discovered a thing called Decadron [dexamethasone]. It’s an anti-inflammatory. It’s an antiallergic and makes the person swell up. It’s like a hormone, it swells you up. But it also makes you feminine, makes your body curvy. On the other hand, Perlutan [algestone acetophenide + estradiol] is a hormone. It makes you rot inside and beautiful outside. Because the hormone destroys you inside” (Dayanne, 23 years).

Importantly, regulation of the transsexualizing process in the SUS not only met the interests of trans persons, but opened the possibility of persons with a history of transvestism to access medicalized gender technologies. This has led to a clash between the classification system managed personally and the classification assumed by health professionals in the routine work of specialized services. The health professionals employ the concept of “gender dysphoria” and the category “transsexual” for all those who come for the services. On the one hand, this perspective is incorporated by some interviewees into their ways of understanding their condition and their identity. However, others question and resist these classifications and state that their desire for surgery and hormones does not change their condition as transvestites, reaffirmed throughout life. The analysis of the relationship of medicalization of gender transition in the classificatory processes helps understand the dynamism of how identity categories are used.

Access to HIV/AIDS services

When investigating how transgender women/transvestites relate to HIV/AIDS services, we found that the interviewees did not seek these services spontaneously. One exception was Ellen (41 years), who went to a testing center when she learned that her partner was HIV-positive. Meanwhile, Barbara

was diagnosed with HIV in a routine checkup at a primary care clinic in the SUS. Importantly, this does not mean low perception of risk, but an intense fear of the test result. HIV infection is reported as a latent possibility. Their explanations point to an intertwining of AIDS with a moral assessment of their practices (anal sex, prostitution, and relations with men). The metaphor of HIV infection as “*a shadow that follows us*”, used by Andressa (35 years), expresses this association quite accurately. In other words, there were subjective obstacles to accessing services, resulting from the effects of the internalized stigma and the association of HIV with their living conditions.

Access to the gender technologies supplied by health services was described as an opportunity to have an HIV test. Testing appeared as part of the pre-operative or routine tests in the follow-up of the transsexualizing process in the SUS, as in the case of Gracy, diagnosed in 2008 in Ibiza, where she was scheduled for surgery. Crislene reports that she had never been tested for HIV until her first plastic surgery. Andressa (35 years) and Hilary (31 years) mentioned periodic testing, but because they were in regular follow-up in the State Institute for Diabetes and Endocrinology (IEDE) in Rio de Janeiro.

Knowledge of recent HIV prevention policies was reported by those working in social programs or in the health area, like Crislene (38 years), Andressa (35 years), Iván (43 years), Bárbara (25 years), and Ellen (41 years), the latter two who are HIV-positive. Even among them, there was no report of a demand for PEP (HIV post-exposure prophylaxis) and PrEP (pre-exposure prophylaxis). Only Crislene had used PEP, but she interrupted it due to the side effects, although she had been properly oriented by the medical team.

An important finding is that although Brazil’s national policies in response to HIV/AIDS include measures for transgender women/transvestites, prevention is not among their main demands on health services, except those in follow-up because they are HIV-positive. The others describe HIV prevention and testing as procedures that are subordinated to their health appointments for other purposes, pertaining to gender transition or general health problems. We found that mobile HIV testing activities became an opportunity to deal with their general health demands, such as having their blood pressure measured, changing bandages, and scheduling appointments. These findings, plus the fear of testing due to the internalized stigma of AIDS, reiterate the importance of comprehensive healthcare as the proper perspective for this population.

Final remarks

Sexual/gender discrimination has been evoked in the literature to reflect on the access by transgender women/transvestites to health services and care. Although this study found evidence of embarrassment caused by health professionals, such as disregard for the use of their social name, such situations did not actually prevent them from attending the services. Understanding this issue also requires considering the agency of trans women/transvestites and the resources mobilized to obtain care, including their personal contact networks (social movements, health system, and social assistance). Beyond discrimination, trans women/transvestites indicate that access to healthcare is linked to the availability of services that meet their health needs comprehensively, not limited to HIV/AIDS prevention, as well as certain incentives that facilitate their visit to the services.

The regularization of the transsexualizing process in the SUS raised expectations among trans women/transvestites that they would not depend on private health services to access gender technologies in medicine. However, the public services’ capacity has been insufficient to meet the demand. Some individuals in the study have not even succeeded in enrolling in the specialized services as users with indication for gender reassignment surgery, and they have no real prospects for obtaining the surgery. In addition, the promise that gender transition procedures in health services would be less painful and with less risk of complications has not always been met.

Historically, the affirmation and recognition of trans/transvestite populations as subjects of rights in Brazil have taken place in parallel and linked to expansion of the SUS and the understanding of health as a civil right and an obligation of the state. The principles of universal coverage, equity, and comprehensive care in the SUS have backed policies for sexually marginalized populations. Thus the improvement of attention to their health needs thus requires stepping up the debate on structural problems in the SUS and defense of the system’s platform of health for all and its expanded view of

care. Analyses of access to gynecological care for women who have sex with women are in keeping with this conclusion³².

In short, relations between trans women/transvestites and health services should consider the legal and programmatic panorama that regulates care for this population in health and their rights as a whole. A process of medicalization of gender transition experiences has appeared in this context in Brazilian society in recent years, supporting health services as legitimate settings for this purpose. In programmatic terms, these novelties are seen as progress for the trans/transvestite population, as recognition by government and society in general. However, in practical experience, some limits and tensions arise from this medicalization.

The study's findings suggest that health services have consolidated themselves as a legitimate setting for access by trans persons/transvestites to gender transition procedures. However, their implementation depends on improvements in the SUS's functioning, professional training, and recognition of each gender technology's specificities and how they compete with each other, without making a moral judgment on the technologies managed by the transvestites/transsexuals themselves.

Contributors

S. Monteiro, M. Brigeiro participated in the study's elaboration, analysis and discussion of the results, and writing of the article.

Additional informations

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Resumo

Frente às mudanças e permanências nos costumes, normas e políticas sexuais no Brasil, o artigo analisa as experiências de acesso de mulheres trans/travestis aos serviços de saúde e discute a discriminação sexual/de gênero e as suas demandas aos serviços de transição de gênero e prevenção da aids. O estudo envolveu entrevistas com nove mulheres trans/travestis, de 23-45 anos, das camadas populares da Baixada Fluminense, Rio de Janeiro, Brasil, realizadas em 2016, e observações de contextos de prostituição e sociabilidade. Comparando com as agressões vividas anos atrás, as narrativas das mulheres trans/travestis destacam avanços sociais. Relatam que os profissionais não as discriminam por sua condição, embora haja resistência ao uso do nome social. Esse constrangimento, somado aos problemas estruturais do Sistema Único de Saúde (SUS), são minimizados devido à agência das trans/travestis para obter atendimento, seja pelo recurso às redes de contatos, seja por sua consciência de direitos de cidadania. As narrativas sobre a busca por mudanças corporais para a transição de gênero revelam uma conjugação, por vezes tensa, entre as tecnologias oferecidas nos serviços de saúde e aquelas manejadas pelas travestis. Embora as políticas de aids focalizem ações para trans/travestis, a prevenção do HIV não está entre as suas principais demandas aos serviços. Há obstáculos de ordem subjetiva para acessar os serviços, decorrentes do estigma internalizado e da associação da infecção pelo HIV com suas condições de vida. A melhoria da atenção em saúde da população trans/travesti requer um debate sobre os problemas estruturais do SUS, a defesa da visão ampliada de cuidado do sistema e investimentos na capacitação profissional.

Pessoas Transgênero; Travestismo; Acesso aos Serviços de Saúde; Discriminação Social

Resumen

Frente a los cambios y permanencias culturales, normativas y políticas en Brasil, el artículo analiza las experiencias de acceso de mujeres trans/travesti a servicios de salud, y discute la discriminación sexual/de género y sus demandas respecto a los servicios de transición de género y prevención del SIDA. En el estudio se realizaron entrevistas con nueve mujeres trans/travestis, de 23-45 años, procedentes de estratos populares, de la Baixada Fluminense, Rio de Janeiro, Brasil, realizadas en 2016 y observaciones en contextos de prostitución y sociabilidad. Comparando las agresiones vividas en el pasado, los relatos de las mujeres trans/travesti destacan avances sociales. Describen que los profesionales no las discriminan por su condición, aunque haya resistencia al uso del nombre social. Este inconveniente, sumado a los problemas estructurales del Sistema Único de Saúde (SUS), son minimizados debido a la agencia de las trans/travestis para obtener atención, gracias a las redes de contactos y su conciencia sobre sus derechos como ciudadanas. Los relatos sobre la búsqueda de cambios corporales para la transición de género revelan una tensión, entre las tecnologías ofrecidas por los servicios de salud y aquellas que manejan las travestis. Aunque las políticas de SIDA enfatizan acciones orientadas a trans/travestis, la prevención del VIH no está entre sus principales demandas de servicios. Existen obstáculos de carácter subjetivo para acceder a estos servicios, derivados del estigma internalizado y de la asociación de la infección por VIH con sus condiciones de vida. La mejora de la atención en salud de la población trans/travesti requiere un debate sobre los problemas estructurales del SUS, la defensa de su visión amplia de cuidado e inversiones en la capacitación profesional.

Personas Transgênero; Travestismo; Accesibilidad a los Servicios de Salud; Discriminación Social

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It should read:

Keywords: Health Services Accessibility; Social Discrimination; Travestite; Transgender Women; Sex Reassignment Procedures

Palavras-chave: Acesso aos Serviços de Saúde; Discriminação Social; Travestis; Mulheres Trans;

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