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VEILED TRANSPHOBIA: NURSES-CREATED MEANINGS VIS-À-VIS THE USER EMBRACEMENT OF TRANSVESTITES AND TRANSGENDERS

Transfobia velada: sentidos produzidos por enfermeiros (as) sobre o acolhimento de travestis e transexuais

Transfobia velada: sentidos producidos por enfermeros en la recepción de travestis y transgender

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ABSTRACT

Objective: The study's main purpose has been to understand the nurses-created meanings regarding the user embracement of transvestite and transsexual people in primary care. **Methods:** A qualitative study has been undertaken with four registered nurses who work in basic health units from the Southeastern region of *Manaus* city, *Amazonas* State, Brazil. Data collection took place from May to June 2016. Socio-anthropological studies were used to analyze and discuss the data and had the field research as a methodological reference. The data were analyzed using the constructive-interpretative analysis technique. **Results:** The meanings produced by nurses addressing the user embracement of transvestites and transsexuals in primary care are based on issues such as embarrassment, neutrality and lack of knowledge about gender issues beyond gender binarism. **Conclusion:** There is a dominant education of biomedical basis, and nursing care still cannot handle the sociocultural and political aspects of people, their bodies and their health.

Descriptors: Transsexuality, transgender, primary care, gender, nursing.

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RESUMO

Objetivo: Compreender os sentidos produzidos por enfermeiros (as) sobre o acolhimento de pessoas travestis e transexuais na atenção básica. **Método:** Estudo qualitativo, realizado com quatro enfermeiros (as) que atuam em uma Unidade Básica de Saúde na Zona Sul Oeste de Manaus. Os dados foram coletados de maio a junho de 2016. Utilizou-se estudos socioantropológicos para a análise e discussão dos dados e teve como referencial metodológico a pesquisa de campo. Os dados foram analisados por meio da técnica de análise Construtivo-interpretativa. **Resultados:** Os sentidos produzidos por enfermeiros (as) sobre o acolhimento às pessoas travestis e transexuais na atenção básica se alicerçam em questões como constrangimento, neutralidade e desconhecimento frente às questões de gênero para além do binarismo de gênero. **Conclusão:** Existe uma formação dominante de base biomédica, e o cuidado de enfermagem não dá conta de aspectos socioculturais e políticos das pessoas, dos seus corpos e da sua saúde.

Descritores: Transexualidade; Travesti; Atenção básica; Gênero; Enfermagem.

RESUMEN

Objetivo: Comprender los sentidos producidos por enfermeros (as) sobre la acogida de personas travestis y transexuales en la atención básica. **Método:** Estudio cualitativo, realizado con cuatro enfermeros (as) que actúan en una Unidad Básica de Salud en la Zona Sur Oeste de Manaus. Los datos fueron recolectados de mayo a junio de 2016. Se utilizaron estudios socioantropológicos para el análisis y discusión de los datos y tuvo como referencial metodológico la investigación de campo. Los datos fueron analizados por medio de la técnica de análisis constructivo-interpretativa. **Resultados:** Los sentidos producidos por enfermeros (as) sobre la acogida a las personas travestis y transexuales en la atención básica se basan en cuestiones como constreñimiento, neutralidad y desconocimiento frente a las cuestiones de género más allá del binarismo de género. **Conclusión:** Existe una formación dominante de base biomédica, y el cuidado de enfermería no da cuenta de aspectos socioculturales y políticos de las personas, de sus cuerpos y de su salud.

Descriptores: Transexualidad; Travesti; Atención básica; Género; Enfermería.

INTRODUCTION

The first level of complexity of care within the scope of the *Sistema Único de Saúde (SUS)*[1] [Brazilian Unified Health System] is the Primary Care (PC), responsible for health promotion, prevention, and treatment interventions.[2] For this reason, PC is also referred to as the *SUS*'s first gateway, and it is through it that users are welcomed by the system.[3]

PC encompasses both the Basic Health Units (BHUs) and the Basic Family Health Units. It is in this type of unit that health actions of a singular and collective character are developed, in a comprehensive way, maintaining the long-reaching care, with the objective of generating impact in the community where the unit is inserted, with the purpose of spreading information and enhancing changes through health education practices.[4]

In these units, the health team, and nurses, in particular, use the light technology called "user embracement", defined by the National Humanization Policy (PNH) as a guideline of action, in order to create a bond with the user, with the aim of knowing the reality and the context in which he/she is inserted in the community. User embracement is understood as an act or effect of user embracement and expresses in its various definitions, an approximation action, a "being with" and a "being close to", in other words, an attitude of inclusion of users of the health service in PC.[5:6] User embracement is considered as one of the most effective ways of inserting the health team in the life of each user, since it is part of a dialogue in which the professional needs to empathize, listen carefully to be able to understand the cause of the current complaint, in other words, which led the user to seek primary care.[6]

Nevertheless, when reflecting on the user embracement of transvestite and transsexual people in PC, a author[7] emphasizes that many health team professionals, when they encounter a transvestite or transsexual person, most of them, do not know how to act, and consequently, this limits the practice of promoting comprehensive health for these people.

Before the implementation of the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (NCHPLGBT), authors[8] already pointed out the need to raise awareness among health team professionals for non-discriminatory care for the population of Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (LGBT). The study showed that transvestite and transgender people are the ones who face the most difficulties when seeking care in public health services.

User embracement of transvestite and transsexual people in public health services ends up, for the most part, not being effective in the user's life. And the environment, which would be for health promotion and prevention, often ends up being characterized in an environment of social exclusion.

After the implementation of the specific health policy for LGBT, it became evident, for instance, that the disrespect to the social name, the transphobia in health services and the pathological diagnosis in the transsexual process were presented as the main impediments to universal, complete and equitable by transvestites and transsexuals in public health services.[9]

Transphobia is understood here as a form of fear, disgust, aversion or any negativity in relation to forms of expression that are distinguished from the matrix of compulsory heterosexuality. Transphobia can mean specific forms of exclusion and violence against people who construct their expressions, sexual and gender, different from compulsory heterosexuality, in other words, "male, then masculine, then man"; and "female, then feminine, then woman", along with the assumption and its consequent discrimination for assuming, or being suspected of assuming, a sexual orientation different from heterosexual.[10:271]

Bearing in mind the aforesaid, this study meant to understand the nurses-created meanings regarding the user embracement of transvestite and transsexual people in primary care, with a view to enhancing the light technology "user embracement" in basic health units in the *Manaus* city, *Amazonas* State.

METHODS

It is a qualitative study, which was guided by the socio-anthropological perspective to provide the analysis and discussion of the data produced and had field research as a methodological reference. Four nurses participated in the study, and all were working at basic health units from the Southeastern region of *Manaus* city, *Amazonas* State, Brazil. The sample consisted of two nurses from the Family Health Strategy team (Nurse 1; Nurse 2), one nurse from the BHU Emergency Service (Nurse 3), and one nurse manager from the BHU (Nurse 4). Participants were between 30 and 49 years old, with working period at the BHU that ranged from 2 to 9 years.

It is understood that each participant appropriates in a subjective and particular way the social, bringing with them not only their voice. Their speeches express multiple voices and meanings constructed in the social framework.[11] It is not intended to generalize the data discussed here, but it is understood that the reflections built with the participants can contribute to reflections in other areas of primary care and for the training of health team professionals.

The selection of participants was carried out by intentional sampling and contact was possible after a key informant. Firstly, contact was made with a transsexual person, which was mediated by one of the authors of the article; in an informal conversation, he was asked to indicate in which BHU, in Manaus, he performed his health care.

Subsequently, during a visit to the indicated BHU, the researchers' first meeting with the health team professionals took place; by that moment, with the presence of the key informant, the presentation of the researchers was made and the first personal contact with the possible participants; the meeting was used to explain the objectives of the study and its reasons, as well as to invite them to participate. Four nurses accepted the invitation.

The data collection technique was the semi-structured interview, guided by a script prepared following the objective of the study. Individualized interviews were performed from May to June 2016, lasting between 20 and 30 min; a room was used in the BHU, which allowed privacy and comfort for the participants. There were used audio recording and subsequent transcription in full of the responses. The interview total period was adjusted to the routine and availability of the participating nurses, as well as the date and time of the interview.

The interviews were analyzed using the constructive-interpretative analysis technique. This proposal is operationalized in a process that begins with the elaborations and interpretations, they represent the forms of concretization and organization of the constructive-interpretative process and allow its development through the categories that emerge from the interpretation.[12]

In the procedural aspect, the analysis took place as follows: audio transcription of the interviews - the transcription process allowed an initial reading of the dialogue developed with each participant, and a previous assessment of the speech, when it was possible to have a previous interpretation about the information; fast reading and organization of the transcription material - a kind of pre-analysis, which consisted of signaling and highlighting the significant elements, given the theoretical support that supported the study; systematic reading - this step provided the identification of the indicators, "[...] elements that acquire meaning thanks to the researcher's interpretation, in other words, their meaning is not directly accessible to the experience, nor does it appear in a correlation system".[12:112] The indicator is only built based on implicit and indirect information, as it does not determine any conclusions from the researcher concerning the studied; it represents only a hypothetical moment in the information production process; construction of thematic categories – as follows:

> *[...] they are instruments of thought that express not only a moment of the object studied, but the historical-cultural context in which that moment appears as meaning and, with it, the history of the researcher, who is a relevant element in explaining his creative sensitivity.*[12:112]

Unlike the understanding that the categories are a fragmentation of the data collected, in qualitative epistemology, they reveal the theoretical construction that the researcher elaborates based on the information produced with the participants at the empirical moment.

Due to the characterization of the analysis process, it can be understood that the results found must be seen as dynamic and open to new interpretations, breaking with the concept of final and universal results that are exhausted in a single research.[12] Three thematic categories have arisen from this process: Abjection - embarrassment, neutrality, and universalization; health policy for LGBT people - from invisibility in training to challenges during professional practice; universal and neutral - veiled transphobia.

All participants signed two copies of the Informed Consent Form (ICF). This research was approved by the Research Ethics Committee involving Human Beings from the *Universidade do Estado do Amazonas (UEA)*, under the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 55669416.0.0000.5016.

RESULTS AND DISCUSSION

Abjection: embarrassment, neutrality, and universalization

The first meaning produced by nurses, concerning the user embracement of transvestites and transsexuals, was named embarrassment, neutrality, and universal health care services.

According to the speech of Nurse 1, nursing education is still ensured by the binary gender logic, in which two

fixed and coherent sexes are assumed,[13] which are opposed, like all binary oppositions of Western thought: male versus female, masculine versus feminine, man versus woman, penis versus vagina, etc. Nonetheless, this logic that presupposes linearity between sex, gender, and desire makes it impossible to embrace the specificities of health care that transvestite and transsexual people need, as advocated by the National Health Policy for LGBT people (2013), as transvestites, trans women and men subvert this linear assumption. This premise is organized through the following speech:

> *[...] well, to tell you the truth, I am a little embarrassed... not in terms of... not prejudice... on the contrary, I am in doubt about the college because we had no guidance [...] no guidance at all... related to this... so I have difficulty asking questions [...].* (Nurse 1)

> *[...] there is nothing aimed at this individuals, we have difficulties... I at least have... for me... it's a little embarrassing because I don't know what to ask [...].* (Nurse 2)

Therefore, understanding the experience of transvestite or transsexual people can enable differentiated care to identify health needs. The speeches reveal a technical gap in the training of nurses about gender and sexuality. How to perform user embracement and/or a nursing consultation of bodies that subvert the compulsory order - naturalized characterization, which aims at total coherence between sex, gender, and desire/practice that is necessarily heterosexual - that guided personal and professional training who work in nursing care? These ambiguous or confused bodies are, for the most part, relegated and seen as illegitimate for providing care, becoming abject.

The invisibility in nursing education on gender issues can also be evidenced in the discourse as a challenge to deal with these bodies that escape the norm "*... that I am in doubt is because in college itself we did not have any guidance*". However, it is considered that Nurse 1 constituted society and training in nursing that is still structured through the "compulsory order" of gender and makes those bodies that subvert this logic of the heterosexual matrix illegitimate. In other words, this logic maintains a false notion of stability, of two fixed and coherent sexes.[13]

In this regard, authors[14] consider that a state of abjection and disgust is present in the sexual order to the experiences that dismantle the sex/desire/gender linearity, which constitutes the maintenance of heteronormativity. And, in this sense, public health or educational policies make an investment in gender control in relation to bodies and subjectivities. And they foster illegitimate bodies for those who subvert the norms built on gender and sexuality and, therefore, tend to experience exclusion in different aspects of life: health, education, social assistance, etc.

Health policy for LGBT people: from invisibility in training to challenges during professional practice

The second meaning produced by nurses, concerning the user embracement of transvestites and transsexuals, was named "from invisibility in training to challenges during professional practice".

To destabilize rigid and apparently fixed notions and rules, which take certain versions of masculine and feminine and sexualities as truths, seems to break the cycle of discourse reproduction that naturalizes inequalities. Such versions, once naturalized, give shape to the knowledge taught and learned at the University, composing the explanatory arsenal, in other words, the possibilities considered legitimate or not for the subjects to live their desires, bodies, sexualities, etc., and which have profound effects in professional practices.[15]

Understanding the possibilities of experiencing desires, bodies, sexualities are necessary for a welcoming and comprehensive care. In the case of transvestites and transsexuals, it is necessary to know the specific demands in health care, such as: use of the social name; protocols and guidelines vis-à-vis hormone therapy, implantation of silicone prostheses and removal of industrial silicone for transvestites and transsexuals; attention to mental health; guarantee attention to comprehensive health and sexual and reproductive rights at all stages of life, for lesbian, bisexual and transsexual women, within the *SUS* scope.[16]

It is also evident in the speech of Nurse 1, that although he found himself providing nursing care within the scope of the public health service, the participant states that there is nothing directed towards this public. However, since 2010, the Ministry of Health has worked together with social movements to implement specific Health Policies for the LGBT population in 2011.[16]

Nevertheless, once again the knowledge gap about a formation that contemplates cultural studies of gender and sexuality in health in the speeches of the research participants is reaffirmed, as can be unveiled below:

> *[...] I understand that 'the transvestite is that one' who only dresses as a woman... who dresses either as a man or woman... he has his option [...] 'the transsexual' is not that person... she is... let's say... she is a man she wants to be a woman... she feels like a woman [...].* (Nurse 1)

> *[...] for me it is those people, like, they have a gender, but they love to perform in other types of clothes with another garment, different mind [...] for me it would be 'the transsexual'. 'The transvestite' he dresses, yes, but the vast majority... I don't know very well [...].* (Nurse 2)

Authors[17] point out that the discussion about the health-disease process of the LGBT population also requires the specification of the concepts of sexual identity and gender identity. Although they are together in the same acronym and

the same health policy, in care it is necessary to understand that the categories of lesbians, gays and bisexuals must be understood as sexual identities. And transsexuals and transvestites must be understood as forms of gender identity. Despite everyone going through an illness process, the path is different in each case.

The policy for these people was implemented in 2010, guided by the guidelines of the federal government, in response to the 2004 program, Brazil free of homophobia.[18] In health care, the specificities of these people in the health-disease process are considered, especially concerning hormone therapy, the desire to perform transgenitalization surgery, observation to request tests, considering that there are cases of diseases such as the Human Papillomavirus (HPV), herpes genital and trichomoniasis in women who have never had heterosexual intercourse. The policy aims to build more equity in the *SUS*.[16,17]

In the context of access to health services, internationally, some problems surround health care for transvestite and transsexual people. In Virginia, in the United States of America, a survey carried out from 2005 to 2006 revealed indicators of social determinants of health in the experience of transgender people (transvestites and transsexuals). The study found that 41% of the subjects surveyed reported unsuccessful experiences in obtaining health care, especially with regard to hormone therapy and mental health services. The investigation also revealed that these same subjects experience discrimination in the employment and housing sector, indicating the need for legal protections. Such aspects interfere as social determinants in the worsening of the health process.[19]

Universal and "Neutral": a veiled transphobia

The third meaning produced by nurses, concerning the user embracement of transvestites and transsexuals, was named "universal and neutral: a veiled transphobia".

Such meanings can verify the absence of ignorance of a specific care line concerning the health demands of transvestite and transsexual people, which can result in a practice far from the promotion and prevention in health care based on the specificities of each person, as well as the possibility of equality in health considering the differences, according to the equity principle from the *SUS*. Such conjectures can be observed in the following speeches:

> *The user embracement of patients here in general is the same. I don't have any kind of... fear or I feel some difficulty and... so they introduce themselves and say what they want here at the unit, right... [...] there is no... differentiated service... the service is the same [...] any type of patient is not so specific [...].* (Nurse 3)

> *The user embracement I can't see differently, right? I respect. It is like that in the first moment... it actually exists in our daily lives and the naturalness they assume, right? This choice of their identity... but I follow it naturally, it makes no difference to me [...].* (Nurse 4)

It was evident in the speeches of both Nurse 2 and Nurse 4 the insistence on the idea of "neutral" service. Nonetheless, there is a difficulty: communication with transvestite and transsexual people. It is noteworthy that in the statement of Nurse 2 their care is given by the patient: they introduce themselves and say what they want from the unit. The transvestite and transsexual person often has difficulty accessing and staying in health services.

Herein, the discourses crossed by the idea of neutrality of both Nurse 2 and Nurse 4 can be a veiled form of transphobia with transvestite and transsexual people, denying and making that foreign body illegitimate at the time of care worthy of health/nursing care.

It is argued that, in the field proper to the health of transvestite and transsexual people, as well as sexual identities, it is necessary that the principles of universality, integrality and equity constituting the *SUS* be materialized in public policies that promote coping with the exclusionary consequences of homophobia, transphobia and heteronormativity, which lead health professionals to serve all users of public and private services as if they were heterosexuals conforming to gender norms, which generates serious situations of discrimination and prejudice against lesbians, gays, bisexuals, transvestites, and transsexuals.[8]

The neutral position of not making a difference in the user embracement of nursing practices with transvestite and transsexual people, might be due to the invisibility of such issue in nursing education, since, as it is not widely addressed, it can produce these meanings in professionals. The consequences of this for primary care might be the absence of transvestite and transsexual people in services, as well as the impossibility of access and permanence in public health services, as they will not perceive them being understood in the unit and will prefer to informally discuss care with their peers, and often in a clandestine manner.

CONCLUSIONS

Herein, the meanings produced by nurses addressing the user embracement of transvestites and transsexuals in primary care are based on issues such as embarrassment, neutrality and lack of knowledge about gender issues beyond gender binarism.

Some participants point to a personal difficulty in dealing and project the guilt in nursing training. Hence, it is considered that the various curricular matrix from the pedagogical course projects, based on the current National Curriculum Guidelines for nursing graduation courses, still do not provide care for sexual and gender diversity.

Bearing in mind the aforesaid, it was also observed the possibility of the existence of a discourse that watches over

transphobia, disguised through the logic of universalization and neutrality. In general, there has been verified that there is a dominant biomedical training, and nursing care does not cover the socio-cultural and political aspects of people, their bodies and their health.

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