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ORIGINAL ARTICLE

HEALTH CARE ASSISTANCE IN PRIMARY CARE: ACCESS TO CARE ASSISTÊNCIA EM SAÚDE ÀS TRAVESTIS NA ATENÇÃO PRIMÁRIA: DO ACESSO AO ATENDIMENTO ASISTENCIA EN SALUD A LAS TRAVESTIS EN LA ATENCIÓN PRIMARIA: DEL ACCESO AL ATENDIMIENTO

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ABSTRACT

Objective: to know the health care of transvestites, from the point of view of nurses, in primary care. **Method:** descriptive, field study, with qualitative approach. Participated ten nurses linked to Family Health Strategies. Data were collected through a semi-structured interview. The analytical procedure adopted was the Thematic Analysis technique. **Results:** primary health care was not the gateway for transvestites to health care, since they are unstructured to serve this population. The welcoming was presented as a tool for the implementation of transvestite care. **Conclusion:** the study showed that health care actions aimed at the care of transvestites are not developed. The few initiatives that were presented occurred in an isolated and fragmented way, from the individual initiatives of some nurses. **Descriptors:** Comprehensive Health Care; Gender Identity; Nursing; Primary Health Care.

RESUMO

Objetivo: conhecer a assistência em saúde às travestis, sob a ótica dos enfermeiros, na atenção primária. **Método:** estudo descritivo, de campo, com abordagem qualitativa. Participaram dez enfermeiros vinculados às Estratégias Saúde da Família. Os dados foram coletados por meio de entrevista semiestruturada. O procedimento analítico adotado foi a técnica de análise temática. **Resultados:** a atenção primária em saúde não se constituiu na porta de entrada das travestis para a assistência à saúde, visto que o serviço se encontra desestruturado para atender esta população. O acolhimento se apresentou como ferramenta para a implementação do cuidado às travestis. **Conclusão:** o estudo evidenciou que não são desenvolvidas ações de assistência à saúde direcionadas ao atendimento das travestis. As poucas iniciativas que se apresentaram ocorreram de maneira isolada e fragmentada, a partir de iniciativas individuais de alguns enfermeiros. **Descritores:** Assistência Integral à Saúde; Identidade de Gênero; Enfermagem; Atenção Primária à Saúde.

RESUMEN

Objetivo: conocer la asistencia en salud a las travestis, en la perspectiva de los enfermeros en la atención primaria. **Método:** estudio descriptivo, de campo, con abordaje cualitativo. Participaron diez enfermeros vinculados a las estrategias de salud familiar. Los datos fueron recogidos a través de entrevista semiestruturada. El procedimiento analítico adoptado fue la técnica de análisis temático. **Resultados:** la atención primaria en salud no se constituyó como una puerta de entrada de las travestis para la asistencia de salud, el servicio no es desestructurado para atender población. El acogimiento se ha presentado como una herramienta para la implementación del atendimento a travestis. **Conclusión:** el estudio ha demostrado que las acciones de asistencia a salud no son desarrolladas, ni direccionadas para el atendimento a las travestis. Las pocas iniciativas que se han producido de manera aislada y fragmentada, a través de iniciativas individuales de algunos enfermeros. **Descriptores:** Atención Integral de Salud; Identidad de Género; Enfermería; Atención Primaria de Salud.

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INTRODUCTION

The construction of the concept of health as a social right was structured in the Brazilian reality in a recent past through Article 196 of the 1988 Federal Constitution, amplifying its meaning with the advent of the Unified Health System (UHS). A system that, in order to obtain comprehensive health care for citizens, presupposes social participation, as well as articulation between the principles of universality, integrality and equity. The UHS seeks to consolidate the role to be exercised by the State in formulating and implementing social and economic policies aimed at improving the life and health of different social groups, taking into account their equally differentiated health needs.¹

Precisely, considering such particularities, it became necessary to formulate new policies to assist specific demands. Thus, in 2011, the Ministry of Health presented the National Policy on Integral Health for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals.² This policy reflects the struggle for rights, initiated by movements of the population of Lesbian, Gay, Bisexual, Transvestites and Transsexuals (LGBT), structured from the "Brazil without Homophobia: Program to Combat Violence and Discrimination against LGTB and Promotion of Homosexual Citizenship". This program aims at the promotion of LGBT citizenship based on the equality of rights and the fight against homophobic violence and discrimination.³

With regard to this population, even in societies with advanced measures to protect human rights, discrimination and stigma related to the non-heteronormative exercise of sexuality and gender issues are still present and constitute symbolic barriers to access to health care services for this minority.⁴ These barriers are especially aggravated when related to the gender identity group of transvestites, based on determinants such as the need to attend specialized demands, homophobia⁵, the stigmatized correlation of this group with prostitution⁶ and HIV / AIDS infection⁷ and discriminatory processes related to other social markers, such as levels of income and schooling, race / color and physical appearance, among others.⁵

The transvestite figure breaks with the traditionally constructed gender and sexuality binary, through the experience of femininity in a (biological) body of man, with feminine as well as masculine characteristics, coexisting man and woman. The transvestite is, therefore, As a "different being," "out of the

ordinary," and below the restrictive model agreed upon by society.⁸

This identity constitution configures itself as a vulnerability in the confrontation of health-disease processes in the health care setting, considering the existence, at times, of prejudice in the discourses and behaviors of the professionals working in these services, as well as the values that permeate health institutions with regard to gender conformations and the treatment of users according to heteronormativity patterns.^{5,8} Thus, the distance and exclusion of transvestites from health services results from the establishment of hostile and unhappy environments for The assistance, in clear disagreement with the whole care and exercise of citizenship of this group.¹⁰

The scenario of Primary Health Care (PHC) is highlighted for the implementation of these precepts, due to its position as the gateway and communication of users with the entire network of the health system, acting in a decentralized and capillary fashion close to daily life of the subjects within the scope of the principles of the HSP.¹¹ PHV needs to be organized based on the users' health needs, with a view to welcoming, co-responsible, providing resolution and empowering.

The nurse is an important professional for this articulation, as it acts directly in the management, planning and execution of activities in the primary health care spaces. In these spaces, they have as general competencies to seek an action backed by ethics, values and principles; promote commitment to health as an individual and collective right; be responsible for health care and contribute to its organization; know the community and establish links; promote prevention and health protection actions; Identify health problems; working with groups, respecting and interacting with cultural differences; Knowledge of the health problems of the population, as well as social determinants.¹²

Regarding the follow-up of transvestites by nurses, it is perceived that the accomplishment of the humanized welcoming, the formation of links between the user and the health service, the clarification of doubts and, above all, the resolution of their demands are fundamental to ensure the realization of comprehensive, universal and equitable care. Therefore, considering the health needs of transvestites and the importance of making them visible in services for comprehensive care, this study sought to answer the following guiding question: How does it happen Health care for transvestites in

primary care? To answer this question, the study aims:

- To know the health care of transvestites, from the point of view of nurses, in primary care.

METHOD

Descriptive field study, and with a qualitative approach, carried out in Family Health Strategies (FHS) of the urban area of a municipality in the South of Brazil. The scenario of this study is justified by the fact that FHS are the gateway to and communication of users with the entire UHS network.

Ten nurses working in these FHS were selected to participate in this study. The sizing of the number of subjects surveyed followed the data saturation criterion. The saturation of the data is characterized when no new information is added to the research process, denoting that the researcher was able to understand the internal logic of the group or of the collectivity under study.¹³

Regarding the criteria for inclusion of the participants, the following were considered: being a nurse, being linked to the FHS of the primary care network of the aforementioned municipality and being active during the information collection period. In view of this, therefore, nurses who were away for vacation or leave were excluded.

The nurses were invited to participate in the study from a personal invitation. On this occasion, the objective and the methodology of the study were presented, clarifying the doubts, and a date for the interview was combined, according to the availability of each nurse.

The production of data was performed in the first half of 2015, through semi-structured interviews that followed a previously defined roadmap, which served as the guiding thread for the study focus. The interviews had varying lengths of time and were conducted individually in the FHS spaces. All the information obtained in this study was recorded in a digital recorder, by means of authorization, and transcribed integrally.

The data were processed using the Thematic Analysis technique composed of the following phases: pre-analysis, material exploration, treatment of results obtained and interpretation.¹³

This research followed the ethical precepts of Resolution 466/12 of the National Health Council,¹⁴ of the Ministry of Health, which governs research involving human beings. Prior to the interview, the nurses signed the

Informed Consent Term (TCLE). The study obtained approval of the research project in the Ethics and Research Committee of the Federal University of Pampa, under the number of CAAE 37095714.7.0000.5323.

As a way to ensure the anonymity of the subjects interviewed, the participants were identified using the alphanumeric system using the E-code, related to nurses, followed by a randomly chosen Arabic numeration.

RESULTS AND DISCUSSION

This study was carried out by ten nurses working in the FHS of the urban area of a municipality in the west frontier of Rio Grande do Sul. Nurses were predominantly female, with nine women and one man, ranging in age from 26 to 52 years. Regarding marital status, five nurses reported being married, three having a stable union and two being single. Of the total number of nurses, only one reported had a profession other than Nursing. The year of graduation in Nursing ranged from 1984 to 2010, and the professional experience lasted from three to 30 years. Already the time of performance in health services was from two to 14 years. The work shift predominated the daytime period, contemplating morning and afternoon, only one reported working only in the afternoon shift. With regard to the *latu sensu* postgraduate course, the majority reported having and / or being in progress, being the family health specialization (six nurses) the most mentioned, due to the implementation of FHS in the municipality. In addition, they reported having postgraduate courses in emergency and emergency (four), nephrology (one), intensive care unit (one), public health (one), collective health (one) and Nursing worker (one).

Based on the thematic analysis of the data, two themes emerged: the weaknesses in attending to the demands of transvestites in primary health care and the reception as an integrative practice in primary health care.

♦ The weaknesses in meeting the demands of transvestites in primary health care

With regard to the presence of transvestites' demands in the health units, it is possible to perceive that they are distanced from the assistance offered at the primary level. This can be exemplified in the following nurses' statements:

So far, in my public health experience, I've never been looking for any, I've never had to guide. (E1)

Here I did not answer, because I have been since June 2014, recently. (E2)

Here at the unit I have not had the opportunity to attend to transvestites, I would like to, I find it very interesting. (E3)

In that short time, in the two years that I have been here, I have never performed any service to this public. (E4)

I never attended to transvestites, never saw them here in the unit. Homosexuals, I have. (E5)

Since I'm here in the unit I did not attend to any transvestites. (E8)

Such statements reiterate that health units, in some way, do not constitute the gateway for transvestites in health care. In this way, they often resort to self-medication or to the action of bombers, transvestites with greater experience in performing body modification techniques.¹⁵ When they need specialized care, the search for private practices is particularly noteworthy, especially for the understanding of payment as a barrier to discrimination. However, in situations of financial impossibility and the advance of illness, the demand for emergency and emergency services becomes the main alternative, not experiencing the experience of integrality in care.¹⁵

The concept of integrality is articulated around the quality of care, in the microprocesses of health work, in the practice of each professional who must adopt a welcoming, committed and integrated position with the team in a multidisciplinary effort for the promotion, prevention, Treatment and rehabilitation.¹⁶

Its definition as a process of governmental responses to the health problems of the population, ensures the universality and equity of health actions. This principle works by articulating levels of care, the capacity of health services to perceive the needs of groups, and the capacity of health professionals to meet the demands of users through their singularities.¹⁵ In addition, it seeks to break the history of ineffective and inefficient public services, resulting from curativist health policies, centered on the hospital model, privatizing and, especially, exclusionary.

Despite the commitment of the government spheres to implement the UHS and its principles, it is perceived that in many respects it is not efficient in its practice, demonstrating prejudice and discrimination to health care for transvestites when they seek care in services Public health services. Factors such as mismatch, long waiting times, lack of resolving and fragmentation of care have

contributed to the distancing of transvestites from public health services.¹⁷

In the Brazilian scenario, the large municipalities are indicated as reference for corporal modifications of transvestites. The circulation patterns presented by this group have emerged as a possible justification for the non-occurrence of transvestite demands in inland municipalities, due to high migration rates, especially, in medium-sized cities, towards the capitals.¹⁸

The identification of the causes related to the absence and distance of this population from access to health services is fundamental for the organization of effective actions of promotion and prevention. This organization is directly conditioned to the recognition by professionals of the existence of such demands.¹⁹

When nurses were questioned about the organization or development of care actions to care for this specific public, they reported that they did not develop them or when they did, it was isolated and fragmented. This is explained in the following lines:

I believe that the moment I have the demand for this audience, I will create a way to meet the needs as they come to look for it. (E1)

I even made a banner and put it in the waiting room, saying: "No prejudice", I put various types of prejudice, racist, homophobia, bullying. I put it this way: "Prejudice is a disease of the soul." (E3)

[...] we have no program, no specific activity for this part of the population. (E5)

It's not, to be honest I never thought why. When I develop something, some lecture, I do it in general, not for them, because I have the feeling that if I go to do something to them, it seems that it will be exclusion, "Ah, just you!". So it's for the general public. (E6)

The structuring of integral attention to the health of transvestites is urgent in the agenda of the demands of primary health care. This lack of care directed at this public contrasts with the mortality rates presented in the Report on Homophobic Violence in Brazil, of the Presidential Secretariat of Human Rights. This report shows that 40% of deaths in Brazil are transvestites for all causes of death and in practically all age groups. In Rio Grande do Sul, 202 denunciations were registered concerning 396 violations related to the LGBT population.²⁰ In the year 2013/14, the Gay Group of Bahia (GGB) released an Annual Report on Homosexual Assassinations in Brazil, demonstrating that they were killed 108 transvestites (35%), being behind only the gays, who counted 186 (59%) of the

homicides. It is considered that this number can be even greater, considering the disinformation of the categories of gender in the denunciations, which denotes the invisibility of this population more vulnerable to the violence and homicides.²¹

The performance of health professionals who (re) produce gender conceptions due to the ambiguity of the transvestite body and sometimes are unaware of the care related to this body, in addition to the current structuring of health services, tend to keep transvestites invisible. Interventions. In this way, these users have difficulty accessing the services and being met with their demands as potential care individuals.

In this context, programmatic vulnerability is evident in this study through the difficulty in the access of transvestites to the services and health resources offered in PHC; And the way the service is organized today, with the lack of resolving and fragmentation of care. In addition, it is also confirmed by the poor quality of care, denounced by the lack of knowledge of the professionals about the demands of transvestites; by insufficient reception; disrespect for the rights of transvestites; Lack of necessary link between health professional and user; and the lack of programs and actions that advocate the promotion, prevention and monitoring of transvestites' health, thus disrupting the integrality of care and the equity of health actions.

With regard to the programmatic component of vulnerability, this research seeks to evaluate how institutions, especially health, education, social welfare and culture, act as elements that reproduce or deepen socially given conditions of vulnerability. In this way, elements such as the degree and quality of commitment of these services and programs, the resources they have, the values and competencies of their management and technical staff, the monitoring of actions, the sustainability of the proposals and the encouragement of participation and autonomy of the social subjects are fundamental aspects in the focus of situations of vulnerability.²²

In addition, nurses emphasized that the non-search of transvestites of public health services may occur due to the stigma and fear of suffering situations of prejudice and embarrassment. The following are evidence of this:

I think the transvestites have a certain fear of coming, a bit of a shame, maybe even because they do not know how they are going to be welcomed, because, wanting or not, we know that there is still a great

prejudice, people treat in a different way. (E1)

I think it has a lot of prejudice, so they are a little withdrawn. They do not identify with the health service. A patient who attended reported that during a surgery the professionals thought he was not listening and he was hearing everything, he felt very humiliated, very sad. (E3)

Here in the unit we know that it has neighborhoods with a little more of this population, but maybe it is even for the stigma that they do not appear in the service. [...] for the sake of shame and / or because they are not accepted or because of a negative experience at some other time, because they have been treated inappropriately or even because they have not been cared for. (E5)

The embarrassment imputed to transvestites begins upon arrival at the service, right at the reception, when the name is requested. When they ask the professional to use the social name and not the civil name, and the same is not met, a humiliating situation is generated, this being the first impediment of transvestites in having access to one of their rights as a citizen, health.

After this step, the next is the waiting in the waiting room with other users, where the same should wait for the professional to call his name. Often, his/her civil name is used, as it is in his/her service record, going through another situation of stigma and discrimination related to not using his/her social name. It is believed that these events contribute to the fact that transvestites do not seek health services.

When they decide to confront all these stages, which cause embarrassment, and wait for the assistance of the requested professional, sometimes they use a different approach to transvestites, as if they did not know how to act in that situation.

In this sense, one of the challenges that the implementation of health actions directed at transvestites has to face is their own insertion in PHC services. The scarce literature⁶ on the subject has pointed out that this insertion faces several difficulties, shaped by the cultural characteristics of the construction of gender, body and sexuality, which shape the travestis' ways of dealing with health.

♦ The host as an integrative practice in primary health care

The nurses participating in this study identified the host as a common denominator for the implementation of transvestite health care, as can be seen below:

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I will not have any difficulty with regard to the service and I believe that I will know how to make this person feel free to ask, ask questions and certainly return. I will try to make her feel good and know that in return, in the next need of care, will be so welcome, without any difficulty or without indifference. (E1)

A good welcome, without prejudice, I have even advised the team here about the use of the social name. If he says that his name is Roberto, but his name is Fernanda, let's call her Fernanda, that's what we've already advised. (E3)

[...] the reception is everything today, if you provide a good reception you do not need to direct you to certain areas. Anyway, I think the whole point is to have a welcoming and a good care environment. (E5)

[...] is the reception, receiving and seeing why he is coming to seek unity, to receive with education, to listen, to see what is the problem that he is bringing here, why he is seeking the service and trying to help, That we can. It has to be available for those needs that it is presenting. (E7)

[...] you have a good reception, listen to that person, without any prejudice, because nowadays people know that it exists. I think that welcoming, getting the doubts, be able to call this individual to unity. We have to be cozy, listen, without any prejudice and do the Nursing guidelines. In short, what is needed. (E9)

Reception is an important instrument and strategy for primary care, aimed at improving the quality of health care aimed at the needs of the population and not exclusively for the provision, through the construction of a dialogue between the service, the professionals of health and the community.²³

Strategy, which arises to reorganize the work process by expanding access to comprehensive care, proposing qualified listening and responding to spontaneous demand, in order to guide, prioritize and decide on the necessary referrals for solving the user problem.

It is understood that the reception needs to be present in all relations of care, in the meetings between health workers and users, in the acts of receiving and listening, causing the demand presented to be received, listened, questioned and recognized as legitimate. This forms and reinforces the link between professional and user.²⁴

Although the nurses report that for a good care of the transvestites an efficient reception is necessary, they said they did not feel prepared to attend this public, as can be observed in the following reports:

I'm not prepared. I think it would be an apprenticeship, an exchange, and the health service to be available to address doubts and difficulties as they arise, but we are not ready. (E4)

[...] I will not say that we are 100% prepared, it is not a routine this service. (E5)

I think we're prepared to never be. For all things we have to always be learning more, but I think I would host it, listen to what it has and what it does not have and try to inform me so I can help better. (E7)

Very prepared I am not, because I never attended, but I think it always has the first time. (E8)

When transvestite care goes beyond condoms and HIV/AIDS testing, care offered by health professionals is permeated by doubts, difficulties, and inconsistencies.¹⁷ The Australian study recently pointed to, one of the most important barriers to access of the LGBT population with the health services, the incipient knowledge and the unpreparedness presented by the professionals.²⁵ Other national and international studies, also indicate such limitations in professional training, as well as the heteronormative character imposed by the determining institutions for such abstention.^{7, 26-8}

The limited approach of this topic in the academic training of health professionals has corroborated the consolidation of an assistance based on individual and collective discriminatory values by the direct association of transvestites with HIV/AIDS, disregarding the health of this group in an extended way.⁷

The stigma that links HIV to transvestites is silent, intrinsic to professional conduct. This is due to the association of transvestites with marginality and prostitution, and they are classified as risk behaviors, which were more evident at the beginning of the AIDS, epidemic in the 1980s.^{7,29-30}

For this to be a constant, it is necessary that the travestis approach the primary health care, not only referring to the STD/AIDS sectors of the municipalities, which ends up materializing and disseminating population segmentation and transvestites

CONCLUSION

The study showed that health care actions aimed at the care of transvestites are not developed. The few initiatives that were presented occurred in an isolated and fragmented way from the individual initiatives of some nurses. This fact, of course, makes it difficult for transvestites to access the health services and resources offered in PHC,

resulting in lack of resolution of their health / illness demands.

In order to modify this scenario, the nurses understood the host as the main tool to enhance the implementation of the assistance to this public in the PHC, considering that it allows the link between user and professional and the knowledge and attendance of their needs. However, the lack of qualification of health professionals to care for this part of the population may be impacting on the difficulty for the successful application of this tool.

It is important to emphasize that primary care must be the main entry point for transvestites in health services, and that it is necessary to reorganize them to accommodate them and to change the attitude of the professionals towards the visibility of this population, to live in these services.

When corroborating with this, the federal, state and municipal spheres are of great importance in the implantation and effective implementation of the LGBT politics in the municipalities. However, health professionals are often unaware of such policy. Continuing education can be the way to this process with health professionals, and the popular participation of the LGBT community becomes necessary.

This research revealed gaps in the care of transvestites, which directly influences the possibility of their becoming ill. Thus, it is suggested to rethink the applicability of the public policies directed at this part of the population; access to health services; the organization of the health sector to receive them; the quality of services to assist them; the integrality of attention; equity of shares; the integration between prevention, promotion and assistance; the techno-scientific preparation of health professionals to perform care; and, essentially, the respect, protection and promotion of human rights.

Regarding Nursing, the fundamental role in the effectiveness of public policies is highlighted, since the nurse is capable of being an agent of social transformation in the community and in the health service. It is suggested that Nursing absorb the discussion related to the diversity of gender, body and sexuality, starting from the recognition that this issue directly interferes with the care of the LGBT population.

The realization of this study contributed to the understanding of gender issues related to transvestites, considering their marginalization in health and other sectors of society, which deprives them of integral care. In addition, it provides the reflection on the

theme in the academic environment, aiming at the formation of new health professionals attentive to this look.

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