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Exploring health care for transgender people in the Brazilian health system: Qualitative descriptive-interpretative study

Research Paper

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ABSTRACT

The guarantee of rights in Brazil is legitimized through its Constitution of the Republic and its national health system needs to follow a list of prerogatives that include, also, transgender people. Currently there are situations in which the expectation of rights is broken and the free exercise of life of this population is prevented. This article analyzes access to health services by trans people in the health system in Brazil. The investigation was carried out in cities in the metropolitan region of a municipality in southeastern Brazil, through qualitative, exploratory and descriptive-interpretive research. The trans population faces many difficulties in accessing the services that make up the Brazilian Health System, such as the lack of qualification of health professionals, barriers to the use of the social name and structural prejudices in society.

KEYWORDS

Health Services Accessibility; Social Vulnerability; Transgender Persons; Unified Health System

BACKGROUND

With the promulgation of the Constitution of the Federative Republic of Brazil in 1988, health becomes a right of every citizen and the duty of the Brazilian State to guarantee it through public health and social policies. In this context, the Unified Health System (SUS – Sistema Único de Saúde) was created with the aim of offering the Brazilian population services of different levels of health care (hospital, specialized and community based). Health care in the SUS must be based on principles such as universality and equal access and must occur without prejudice or privilege of any kind, aiming, in this way, to guarantee a service free from any type of discrimination to the person who seeks public health services (Brasil, 1988; 1990).

Based on the principles and considering the Charter of Rights of SUS Users, health services should ensure attention that is humanized, welcoming, free from prejudice and judgment to all individuals, guaranteeing the right to promotion, prevention, and health rehabilitation at all levels of care (Brasil, 2009). However, in the daily lives of these institutions, it is observed that transgender person – an individual whose gender identity or expression differs from that of their assigned sex at birth - find it difficult to achieve care that meets their health specificities (Ziegler et al., 2019). It is commonplace that gender identity is confused with concepts such as sexual orientation, however, the term refers to the way a person identifies and recognizes himself based on the gender standards that are attributed by society (Silva et al., 2016).

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The barriers that emerge in access to the health system are the convergence of different factors, as shown in extensive reviews that point to difficulties in health care access, avoidance of care and perceived discrimination in health care. In addition, this context of violation of rights may reflect a society that still produces stigmatization and different forms of violence that are based on heteronormative patterns and customs (Rocon et al., 2019). In a study developed during the first year of the COVID-19 pandemic, it was sought to identify the main difficulties for trans people in accessing the Brazilian health system. The main results showed that the main barriers are discrimination, pathologization of transsexuality, lack of qualification of health professionals and absence of specific public health policies for this group (Rocon et al., 2020). Such difficulties make some Brazilian health services become hostile spaces for trans people, directly impacting their health condition.

Health Policies for Trans People

In Brazil, one of the advances towards guaranteeing the rights of trans people occurred in late 2010. On that occasion, the Brazilian Ministry of Health instituted the Transexualizador Process in SUS that enabled university hospitals to carry out the specialized procedures necessary for gender-affirming process, demanded for decades (Brasil, 2008). Sometime later, from pressure from social movements, a review of the care logic for this population group was carried out, resulting in Ordinance no. 859 of the Health Care Secretariat of the Ministry of Health, which guides the structuring of a comprehensive care network that goes from primary to specialized care, with the strengthening of outpatient care services (Brasil, 2013). Still in 2010, two other ordinances strengthened the clinical guidelines and protocols necessary for the expansion and institutionalization of the gender-affirming process in SUS (Brasil, 2013).

This service is currently included in the National Health Policy for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (LGBT), a political artifact dedicated to government actions and strategies aimed at guaranteeing the right to health and life for this population (Brasil, 2011). Even with all the legal framework and institutional regulations in the health sector, there are still "walls" in the social imaginary and within health services that prevent humanized and welcoming care for this group. It is understood that barriers to access and continuity of care for trans people are multidimensional - organizational, political, socioeconomic, symbolic, and technical barriers are rooted in the structure of SUS and other partner institutions in trans health care (Carvalho & Chazan, 2019). In addition, mobilizations have delegitimized the demand and existence of these bodies on the political scene, in the name of preserving the values of the traditional family or to protect children. Conservative mobilizations have become even more robust in Brazil, starting in 2018 with the rise to power of an ultra-conservative government linked to the extreme right. With this, a scenario of stagnation and setbacks in programs emerges that have as principles the guarantee of integral assistance, mainly for groups historically stigmatized (Browne & Nash, 2020). This scenario conflicts with the right to health guaranteed by the 1988 Constitution, with the assumptions of the SUS and with all other democratic provisions and respect for gender diversity (Carvalho & Carvalho, 2019).

Thus, it becomes necessary to discuss the health issues of the trans population, in order to reaffirm the importance and the existence of these dissent from the cis-heteronormative matrix, understood as a set of exclusive practices and discourses based on compulsory heterosexuality coupled with the presupposition of that bodies must follow a sex-gender-sexuality linearity, that is, not a full and immobile structure, but an ordering discourse that ends up hierarchizing subjects, practices and cultures as more or less legitimate within a social spectrum - which also ends up composing the subjectivity possibilities of the subjects, where they end up having to negotiate their identities within these hierarchical notions (Galindo et al., 2017).

OBJECTIVE

It is during this political, historical, and social scenario that the speeches that will be analyzed in this investigative work emerged. Therefore, the objective of this article is to present and discuss a narrative inquiry on trans experiences about their health.

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METHODS

The research proposed in this article uses the experiences narrated by a participant of the research conducted within the scope of the Instituto René Rachou of Fundação Oswaldo Cruz about violences against the LGBTQIA+ population in a Brazilian metropolis, which was approved by the Research Ethics Committee of the Instituto René Rachou of Fundação Oswaldo Cruz under the number CAAE 63857317.6.0000.5091 and has an Approval Opinion no. 1,925,485. The report of one of the participants caused a lot of reflections because it is crossed by specific aspects of trans health in Brazil.

He, indicated here as a pseudonym Paul, is a person who was assigned female at birth, in a city in the interior of the state of Minas Gerais, Brazil. When narrating his story, Paul mentions that it was in adolescence that he began to understand that he was different from other people, understanding himself as a lesbian in high school and, with the move to the state capital, Belo Horizonte, he had contact with other performativities and came to understand himself as a trans person. Performativity is a Judith Butler's (R) concept that indicates the subject, its gender, and even the sexed body itself come into being through reiterating or parodying preexisting norms and discourses of power. The beginning of the transgender journey coincided with the entry into Higher Education. The interview was carried out in a place chosen by Paul, being recorded, and transcribed for later analysis.

To aid the analysis, the Transitivity System proposed by Halliday & Hassan (1985) was used. Through the scheme of Figure 1, we can apprehend meanings of the experiences of people participating in the research about the world, about their actions and especially about their constructions of truth networks about violence and coping strategies.

According to this theoretical-methodological approach, processes are terms, in general verbs, that express action, state or idea practiced by the oral subject. Other terms are associated with these processes to characterize, modify, or re-signify them, which are called modalizers, and may be adjectives, adverbs, or other words that play such a role. It is also possible to separate some processes because of their similarity, such as relational, behavioral, mental, verbal, existential or material, as shown in Figure 1.

The interviews were recorded, transcribed, and analyzed under the perspective of Critical Discourse Analysis (ADC), of British origin, developed and proposed by Norman Fairclough (Ramalho & Rezende, 2011). This perspective is inserted in the Social Theory of Discourse (TSD), whose assumption is the existence of dialectical relations between discourses and social life, in which discourses build and constitute social relations and not only reflect them (Ramalho & Rezende, 2011). Based on the critical-realistic posture, TSD assists research on the functioning of discourses in the establishment, maintenance and/or overcoming of problems built in the social sphere (Halliday & Hassan, 1985).

RESULTS

Paul's life story and narrative highlighted the challenges for a trans person to guarantee the right to health and a dignified life in the Brazilian social and health system. Their statements, incorporated into the analyzes in the next topic of this article, show: I - the importance of meeting and talking to other trans people who have already gone through the process, II - the pathologization of the trans condition as a requirement to access the health system, III - the lack of trained health professionals to meet trans demands.

Although it is customary to separate discussion and results, we chose to present them together, as the theoretical-methodological framework of the TSD advocates the semiotic inseparability between discourse and analysis, as has also been done in other articles (Narley, 2022; Loureiro & Resende, 2021; Asante, 2020).

DISCUSSION

In Brazil, access to services and health care, even though it is a constitutional right, is characterized, in large part, by long waiting lines for care, lack of information, lack of professionals and dehumanized care (Rocon et al., 2019). For the trans population these difficulties take on an even greater magnitude in view of the inadequate care that this group receives and the embarrassing situations they are subjected to, for example, the rejection of the preferred name

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by health professionals (Carvalho & Chazan, 2019; Brasil, 2019).

Paul, when reporting the search for health services that would help the start of hormone therapy - the main objective of this process is to suppress endogenous hormones and replace them with others that are consistent with the preferred gender – he uses terms that express attitudes towards its own statement, indicating processes of subjectification in relation to what is said: of duty (*having to*), indicating an obligation in the process of *seeking* professionals qualified for their demand; of time, combined with material processes (*already went and had already seen*), demonstrating that the action taken by Paul was preceded by other similar acts; intensity, associated with an attribute (*very complicated*), in order to characterize the search for a professional gynecologist who adequately treats trans men:

(...) ***I had to look for professionals*** *to start my hormones****. I was lucky because I talked to other trans men before*** *and they gave me the names of doctors who serve trans people, I arrived at a doctor I knew, I didn't look at a list and chose a name,* ***I already went to a professional who had already seen trans people before****, because if I need a gynecologist,* ***it's very complicated****. (Paul)*

The use of terms, mostly material, indicates certain conditions necessary for health care to be provided for this population group, with a value of *luck*, justified by the material process *talk*, whose interlocutors are other trans men and the goal, the *names of doctors*. The discourse laden with barriers, perceived in Paul, is the reflection of a complex process experienced by trans people who seek care in health services in Brazil and in other countries. In a survey that aimed to identify studies that addressed the access of trans people to health services, it was identified that there are symbolic and organizational barriers in the field (Carvalho & Chazan, 2019). However, technical barriers are the most perceived, like what emerged in Paul's discourse, in which there is a complicating factor in the search for professionals who understand and meet their specificities during the harmonization process.

(...) I went to a psychiatrist and there is this issue, that ***you need a psychiatric report to start anything*** *you are going to do, like a hormone or surgery, which already enters* ***another type of violence: you get a certificate saying that you are mentally ill and I went into the psychiatrist's office pretty afraid because you have to talk, you have to convince the professional that you are a trans man*** *and if I don't fit in all masculine patterns, because there are trans men who don't like these masculine patterns or trans women who don't like feminine patterns very much and then for the psychiatrist to recognize you for the gender you are, you have to fit in those patterns, if you get out of those standards,* ***he may not understand that you are trans*** *(Paul)*

The material process *starting* and its generalized phenomenon *anything* is only made possible by the psychiatric report that categorically affirms the existential process *you are a mental patient*, that is, that the existing trans not healthy. Paul classifies this situation as violence and modifies it with the term *another*, indicating that it is not the only violence that trans people experience in this journey through the desired body changes. Until 2019, people who did not identify with the sex assigned to them at birth were considered mentally ill by the main medical diagnostic manuals. However, in May of the same year, the World Health Organization (WHO) made official, during the World Health Assembly, the removal of transsexuality from the International Classification of Diseases and Health Problems (ICD). In January 2020, the Federal Council of Medicine (CFM) made Resolution No. 2,265 available, which provides for the expansion of access to care in the public health system and establishes greater security in the performance of procedures with hormone therapy and gender-affirming surgeries (Coacci, 2019). It is important to reaffirm that depatologization should not be understood to generate disassistance to this population, and that they should be assured of the care and rights in health (Rocon et al., 2016).

Such an achievement is considered an advance in the path of depatologizing gender identity, however, in the social imaginary and, above all, in the conduct of some health professionals, the existence of gender diversity is still seen as a psychopathological disorder. Entering the office is also marked by behavioral processes - the journey is made with fear, modeled by the intensity of the term *pretty afraid* and, during the consultation, the fit, together with the sense of obligation (*having to*), conforms this enunciative scene in which patient and professional perform their

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knowledge. According to Paul, it is up to the trans person to convince, to sell their gender expression, so that the holder of the psychiatric knowledge-power performs a mental process, that is, his inner world, so that he experiences the phenomenon in a similar way to the patient. A *match* between phenomena is required. If not, there may be an existential process of denial (*you are not trans*) conditioned by the professional's mental process (*he may not understand*):

(...) ***I had to go into the office like: 'please give me a report attesting that I am mentally ill'****, it was practically that, and then as this psychiatrist already understood about it and he even talked to me that he does not agree with the pathologization of transsexuality and he knows that the report is a bureaucratic thing, but that it is still necessary. So, he gave me the report and, at the first consultation,* ***I didn't even have to go there because there are some professionals who want to do a follow-up of I don't know how many months*** *... before my hormones, I had this thing of living these humiliations all days, so* ***I was dying to start hormones****. And I was lucky to get this quick report (...), I scheduled the endocrinologist [and]* ***I went to a professional who had already seen other friends of mine****. (Paul)*

The report regulates the existence of the trans person, since it delimits which, existential processes will or will not be legitimized. *I am mentally ill* becoming, in this context, synonymous with *I am trans* and luck appears iteratively in this enunciative scene, by attributing an aspect in the relationship between professional and user. The modalization (*already, until*) returns to highlight how the psychiatrist's mental processes are important for the conditions and possibilities of the participant's existence. When the professional *doesn't understand this*, there is yet another complicating factor: *monitoring of I don't know how many months*. This affirmation attributes to the material process of accompanying a modalization of time that tends to the infinite, impacting the mental process *to die to start the hormone*. The barriers identified during the hormonalization process were also perceived in a survey conducted with trans people in a metropolitan region of Brazil. In this study, some interviewees reported that, when perceiving the barriers imposed by health services and professionals, they decided, even at risk of life, to resort to the use of hormones without monitoring by health professionals (Sousa, Rocha & Barros, 2018).

The participant says he experiences these humiliations every day, referring to the discriminatory acts that affect the trans population. This type of discrimination occurs in different contexts such as in the family, school, and professional environment, culminating in physical and, above all, emotional violence. In addition, disrespect to the preferred name, school dropout - reflecting the trans person's non-acceptance at school - and unemployment, increase the vulnerabilities and violence that affect this group (Brasil, 2013). Experiencing a gender identity outside heteronormativity makes the individual vulnerable and susceptible to discrimination, hostilities and inferiority, also called transphobia, that is, "prejudice and / or discrimination based on the gender identity of transsexual or transvestite people" (Soares, 2018). Prejudices that violate the rights of the trans person reiterate the heteronormative logic, which dictates the patterns of behavior to be followed by men and women, compulsorily reproducing the pattern of heterosexual alignment between body-gender-sexuality (Costa & Dell'Aglio, 2009).

Having a network of relationships, it seems, is more important than having access to health services, because, as Paul indicates, this "sub-system" of care for trans people is formed by the exchange of information about which professionals are receptive to the demands of hormonization and documentation necessary for the transformation of the body:

(...) what happens is that we have a network of trans people and we change these names, we have a list of doctors that we say are trans friendly and ***there are very few professionals****, endocrinologists who I know there are three, who attend most trans people here, and* ***this is when the person is able to pay or a private individual or has a health plan****. (Paul)*

After all, it is the relational processes that allow the construction of a strategic network to face the difficulties in the transgender journey: having a network, having a list of doctors, being able to pay. The modality of the quantity - very few - denotes another difficulty, in addition to the necessary

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financial capacity to afford the treatment. In a similar survey, the support network and the availability of quality public services are considered protective factors for the group of transvestites and trans who, in addition to these, have friendships as one of the main components of the network (Brasil, 2017).

And the Brazilian public health system - which, among other characteristics, is recognized for its universality and gratuity - how does it care for and care for trans people? According to Paul:

When a person needs to go to SUS, it is very complicated because ***he will be attended by a professional who he does not even know who will be and who may not understand, and he will wait months for an appointment that the guy will get there and say 'No , I will not give you a hormone'*** *because you may not understand about it and we are talking about the most basic thing that is hormonization,* ***because when it comes to the issue of surgery [laughs], it is much more complicated because*** *it is a process that will change your life. So, the professionals who do mastectomy for trans men, which is different from a gynecomastia, which is in cis men, or a mastectomy for cis women, it is very different for you to do the process. So, if a professional does not have a knowledge of this, the result will not be good. (Paul)*

Currently in Brazil, the set of clinical and surgical procedures performed for the purpose of sexual reassignment, or the transgender process does not have mandatory coverage by the Private Health Care Plan Operators (Romano, 2008). Therefore, it is even more important that the State guarantees this right. Seeking free and universal care in SUS is both modalized and attributed by an adjective in an absolute superlative synthetic degree *extremely complicated*. Its use summarizes all possible difficulties: the lack of understanding by professionals (*he may not understand*), the delay in the process (*will wait months*), the denial of treatment thanks to the idealization of gender of those who attend and the gender desire of those who are served (*I will not give you a hormone*), the gap in training for the surgeries mentioned (*will not be a good result*). In SUS, the experience starts *very complicated* by something that is considered basic - hormonization - and ends *much more complicated,* with body modification surgery. The rupture in the narrative of difficulties appears with laughter, which resembles incredulity more than comicality in the face of the painful process of trans people in the health system. The difficulties imposed in the context of health care for the trans person may be the effect of unpreparedness or even disrespect from workers. Fact that may imply abandonment of health treatment and the resistance of the trans person to seek the service when they need care (Benevides & Nogueira, 2020).

The following report, although long, reiterates some of the difficulties and constraints experienced by those seeking attention and care in health services:

(...) several friends of mine who have gone through very embarrassing situations, that the person is really transphobic and humiliating you there inside the office. And then, ***we don't feel safe even in a doctor's office*** *(...) if I have a sore throat and need to go to the hospital,* ***I know I will undergo some humiliation****, if I need to have an exam anyone and anyone calling my name out loud in a room full of people, I will go through a humiliation. I went to book an exam and said 'Look, I want you to put my preferred name in the observation to be treated by my preferred name' and the woman says 'it's okay'. Two hours later, another person calls confirming my exam and calling me by my registration name, and I say 'I asked to put my preferred name on the note, can you please put it there?'. And then I get there, on the day of the exam, and say 'Look, I want you to call me by my preferred name' and have no way, in the system, for this to be done. On that day, the sector coordinator explained to the doctor that she was going to see me and I was going to have a mammogram, for my surgery, and then you enter an area that is only female, that has a lot of women sitting next to you to have a mammogram and you sit there, and the person calls you and it's an embarrassment because everyone says 'What is this guy doing here?' Then you will be exposed [on mammography], because I still had breasts and I had a huge dysphoria with breasts, (...) if the person is not prepared, they may be scared (...) so there are "n" constraints that happen. (Paul)*

The difficulties in accessing this health service explain the saga of constraints experienced by trans people. The marking of the mental process *I know* demonstrates how the experimenter prepares for the phenomenon - discrimination and misunderstanding

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seem to be inherent in the social relationships in which the body is being object of intervention. *Not feeling safe* is another mental process, negatively modeled by *even*, denoting that there is no guarantee of dignity to trans life, since the office can be understood as a space of intimacy, of health care, but not for trans people. The path in the laboratory for scheduling and conducting an exam, the insistence on legitimizing the preferred name, the inadequacy of information systems that respond to this social demand and the expectation of a professional training that does not contemplate trans health are summarized in the index *n constraints*, pointing out that there is more. *not feeling safe* may also be the result of processes that violate the rights of the trans person that occur daily. In 2019, 124 trans were murdered in Brazil, this group being the most victimized by situations involving violence against dissident bodies (Grade, Gross & Ubessi, 2019)

Experiencing constant constraints causes different feelings, especially fear in the face of unpredictable situations, as reported below:

(...) after I started my transition, I haven't been to the gynecologist yet for fear, it's a necessary thing, I need [laughs] to go at least to do standard procedures to see how my body is doing and most trans men don't go because of this fear that you have to go to the gynecologist who only has a woman waiting and the person who will attend you, will look at you and say 'Wow, but you have a vagina, how come, you are a man!'. (Paul)

The material process of going to the gynecologist is restricted by the mental process of being afraid. Another interesting point is that, before the transition, female performance was more prevalent mainly because of the body, and this prevented her movement in public spaces out of fear. After the transition, with a predominance of male performances, there are still off-limit spaces for the same fear of causing embarrassment in relation to be idealized images of man / woman.

In a linear language between sex-gender-body, it is not permissible for men to have a vagina, so they do not need gynecological services, which excludes the multiplicity of bodies: changing *is*, static *and* ideal, for and, multiple and inclusive, it better represents the crossings of social markers today. Paul is understood as male and bisexual and with a vagina and has the right to do so. It is necessary that society embraces the modes of existence and subjectivities of trans people. One way that points to overcoming this problem is the expansion of dialogue and discussions about the theme at home, in the school space, in the work environment and in all other spaces of social coexistence (Sousa, 2019).

One of the barriers to health care is the lack of technical knowledge of health professionals and teams, limited access to health plans, poor quality of care and insufficient research on the health of the population itself. Lack of knowledge can lead to prejudice, however, the increase in technical education alone does not have the power to reduce prejudice alone. A predisposition for cultural and attitudinal changes is required (Sousa & Iriat, 2018).

On the other hand, both the medical research agenda and the classification of surgeries, specific attributes of medical professionals, make trans life difficult:

(...) all the procedures that we have to go through, mastectomy, for example, it is not recognized as a necessary surgery for our body, it is still recognized as cosmetic surgery, so the plan [health] does not cover. Reassignment surgery too. In the world, it is not a surgery that is very advanced, that has good results and that are functional. ***Here in Brazil, even less (...) the results I see are terrible.*** *I wouldn't do (...) surgery for trans women even has some references and that already has great results but for trans men it is really long overdue, because people really have no interest in doing research in these specific areas. (Paul)*

In addition, Paul uses a comparative relational process (*to suffer more* prejudice) to locate two identifiers, *trans men* and *trans women*, with respect to violence.

Currently, epidemiological information and research in relation to the health of trans men are scarce, because of this the technological development of surgical practices that guarantee the efficacy of gender-affirming surgeries becomes more complex (Rodovalho, 2017). It is known that surgeries for trans men (phalloplasty) are still very

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"experimental", every day surgeons develop new techniques, due to the great complexity. Gender-affirming surgeries for trans women is better known and better results are obtained because it is easier to define the anatomical structure of a penis in a vagina.

As Paul explained earlier, female performance is more subjugated and uses the concept of passability to justify in part. Passability is a passing through, it is a reading of the world in relation to trans bodies. Unfortunately, trans men are non-existent for society, due to their invisibility and subordination, when compared to the significant *male lesbian* and *man*. This relationship is perpetuated with passability, as the existential process involved results in *comfort zone*, which, in fact, is a place without violence, without oppression, something that should be guaranteed to all bodies.

The pathologization of transgenderity, already mentioned, reappears in the speech of Angela, being temporalized when affirming its attributes (*is still a disease, it is still the scum of society*). In addition, the participant seeks to escape the identity delimitation that restricts the power of being: *she is still seen only as a travesti*. The modal iteration by the terms *still, only, never*, if represents the various conditions that hinder transfeminine life, especially survival itself - to continue to live for a few more decades is, for them, *all the time*. The transfeminine population suffers from invisibility, violence, vulnerability and stigma making it difficult for them to access education and, consequently, the labor market. Thus, the achievement of formal work becomes a barrier for the trans population and, although there is no official data, it is estimated that 90% of Brazilian trans and transvestite women have prostitution as their source of income (Benevides & Simpson, 2018). According to the National Association of Transvestites and Transsexuals (ANTRA), based in Brazil, the life expectancy of the transvestite and female trans population in the country is on average 35 years of age, while the life expectancy of the Brazilian population in general is 74 years old. This type of age gap reveals the vulnerability to which the trans population, especially the transvestite and female trans, are exposed (Parker, 2003).

The mental process of perceiving, of seeing dissident bodies from heteronormativity establishing asymmetric power relations with trans bodies is called: transphobia. Its attributes corroborate with the other arguments presented here: *daily, normal, relativized*. The oppressions identified *in the LGBT environment* are shaped by hegemonic male and female patterns. Such experiences of stigmatization, experienced by trans people, are socially constructed processes of devaluation of identities that give rise to relations of power and discrimination (Cunha, 2016).

In the acronym LGBT "LGB" (lesbian, gay and bisexual) it refers to sexual orientation, while the "T" (transvestites and trans) refers to gender identity; however, even within the LGBT group, trans and transvestites are stigmatized for fleeing heteronormative behavior and transgressing within the expected norms of gender and sexuality (Cunha, 2016). The reason for this is supported by a model of society that legitimizes behaviors based on their biological sex and what escapes from the gendered, culturally legitimized and naturalized conceptions is subjugated (Radix, 2019).

FINAL CONSIDERATIONS

This article aimed to understand some specific aspects related to the trans people health such as access to the gender-affirming process, relationship with health professionals and passability. We started from an inquiry with Paul who had, in their daily life, many demands related to trans health, so that we can outline and understand in depth the discursivities associated with trans life.

The conviction about gender identity appears strongly in the relations with health professionals, friends and other subjects inserted in everyday scenes. Making yourself recognized as a man or woman to access rights is still a constant in the lives of trans people. In Brazil, passability thus appears as a passport for less regulated and more fully-fledged citizenship.

It is possible to build some global implications for the results shown here, such as the need to institutionally establish in the SUS health care the figure of trans professionals or, at least, professionals trained in service to care the trans demand in health; the urgency of implementing other care protocols that prioritize the well-being of the trans person rather than their pathologization; and the

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consideration of passability as a social determinant of health, especially for trans and non-binary people.

Finally, this study enabled the punctuation of aspects necessary for further development by health institutions regarding respect for diversity in health care. In addition, this research produced evidence that demonstrates the susceptibility attributed to the health of trans people because of the Human Rights violations. With this, it is considered the importance of building answers to the problems that permeate the trans people lives. The changes, too, should reflect in the training of health professionals, in order to produce responses to the lack of reception and scientific technical knowledge about the specifics of the trans health care.

Although the limitations of the study fall on the number of analyzed histories and the geographical scope, its potentialities are based on the depth of the discourses associated with the daily lives of trans people.

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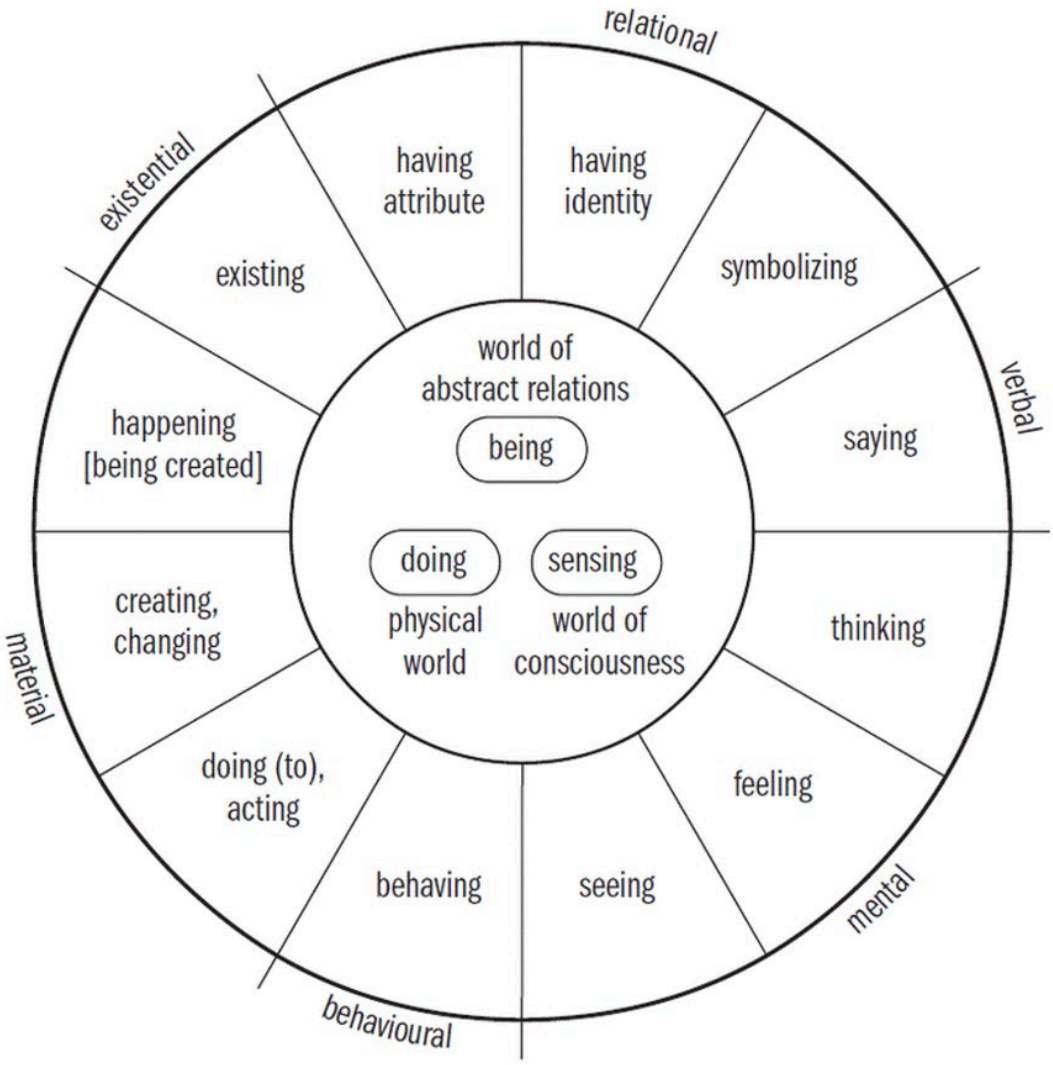
Figure 1. Types of transitivity system processes



Source: Halliday & Mathiessen, 2004, p. 58

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