

INSTITUTIONAL HEALTH SPACES AS “NO PLACE” OF TRANSVESTITES IN THE SOCIAL REPRESENTATIONS OF NURSES

ESPAÇOS INSTITUCIONAIS DE SAÚDE COMO “NÃO LUGAR” DE TRAVESTIS NAS REPRESENTAÇÕES SOCIAIS DE ENFERMEIRAS

ESPACIOS INSTITUCIONALES DE SALUD COMO “NO LUGAR” DE TRAVESTIS EN LAS REPRESENTACIONES SOCIALES DE LAS ENFERMERAS

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Objective: to discuss the invisibility of the transvestite person in health institutions based on the social representations of nurses. **Method:** qualitative research with a theoretical-methodological approach of social representations that conducted a semi-structured interview with 20 nurses registered in postgraduate courses at a public university. The collected information was processed through the Iramuteq software, which generated the Hierarchical Descending Classification with five classes. **Results:** in the representational content, the invisibility of transvestites is implicated in the way health professionals perceive the need/possibility of occupation of these spaces, especially those who offer primary care. **Conclusion:** the social representations of the surveyed nurses revealed meanings for invisibility, exclusion, difficulties in care and care dispensation for transvestites in health institutions. The invisibility identified in the nurses' representations occurs by the way health professionals perceive the need/possibility to occupy these spaces.

Descriptors: Transvestism. Nurses. Health Facilities. Sexual and Gender Minorities. Free Association.

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Objetivo: discutir a invisibilidade da pessoa travesti em instituições de saúde com base nas representações sociais de enfermeiras. Método: pesquisa qualitativa com abordagem teórica-metodológica das representações sociais que realizou entrevista semiestruturada com 20 enfermeiras matriculadas em cursos de pós-graduação de uma universidade pública. As informações coletadas foram processadas por meio do software Iramuteq, que gerou a Classificação Descendente Hierárquica com cinco classes. Resultados: identificou-se, no conteúdo representacional, que a invisibilidade das travestis está implicada no modo como profissionais de saúde percebem a necessidade/possibilidade de ocupação desses espaços, principalmente aqueles que ofertam atenção básica. Conclusão: as representações sociais das enfermeiras investigadas revelaram sentidos para a invisibilidade, exclusão, dificuldades no atendimento e dispensa de cuidados às travestis em instituições de saúde. A invisibilidade identificada nas representações das enfermeiras ocorre pelo modo como profissionais de saúde percebem a necessidade/possibilidade de ocupar esses espaços.

Descritores: Travestismo. Enfermeiras. Instituições de Saúde. Minorias Sexuais e de Gênero. Associação Livre.

Objetivo: discutir la invisibilidad de la persona travesti en las instituciones de salud sobre la base de las representaciones sociales de las enfermeras. Método: investigación cualitativa con un enfoque teórico-metodológico de las representaciones sociales que realizó una entrevista semiestructurada con 20 enfermeras matriculados en cursos de postgrado en una universidad pública. La información recopilada se procesó a través del software Iramuteq, que generó la Clasificación Jerárquica Descendente con cinco clases. Resultados: se identificó, en el contenido representativo, que la invisibilidad de los travestis está implicada en la forma en que las profesionales de la salud perciben la necesidad/posibilidad de ocupación de estos espacios, especialmente aquellos que ofrecen atención primaria. Conclusión: las representaciones sociales de las enfermeras investigadas revelaron significados para la invisibilidad, exclusión, dificultades en la atención y dispensación de cuidados para travestis en instituciones de salud. La invisibilidad identificada en las representaciones de las enfermeras se produce por la forma en que las profesionales de la salud perciben la necesidad/posibilidad de ocupar estos espacios.

Descriptores: Transvestismo. Enfermeras. Instituciones de Salud. Minorías Sexuales y de Género. Asociación Libre.

Introduction

Health is determined by the Brazilian Constitution of 1988 as “the right of all and the duty of the State”. The National Comprehensive Lesbian, Gay, Bisexual, Transvestite and Transsexual (LGBT) Health Policy, instituted in 2011, represents a milestone in the history of resistance and struggle of this population to guarantee their rights. Its formulation stemmed from the active participation of the organized social movement. Despite the advances and achievements of transgender people regarding the government agenda, which resulted, among other aspects, in the implementation of outpatient clinics for transsexual and transvestite people in some Brazilian capitals, it must be considered that the challenge of producing and incorporating technologies that contemplate the singularities of this segment weighs on the health service network.

According to data from the survey “Sexual Diversity and Homophobia in Brazil”, conducted in 150 cities, 25% of the Brazilian population is homophobic. Among the research participants,

63% pointed to the qualification of health professionals to provide quality care to the LGBT population as an important measure to be adopted to combat discrimination against this segment⁽¹⁾.

Thus, equal access to health services and actions is a constant demand of the organized social movement of Lesbian, Gay, Bisexual, Transvestite, Transsexual and Intersex (LGBTI) people. This aspect highlights the need for investments in processes of political, epistemological, technical-assistance and sociocultural changes in the way the health sector relates to the transgender population. The construction of health actions among this population, admitting their lead role in the production of their health, is a way to materialize the constitutional principles of equity, integrality, universality and social justice of the Unified Health System (UHS)⁽²⁾. In this sense, concerning transsexuals and transvestites, the recognition and respect for their identity positions should be privileged, considering gender self-determination, in view of singularities⁽³⁻⁴⁾.

Within the collective of LGBT people, transvestites are endowed with authenticity and experience a singular femininity. Their condition as a dissenting population of hegemonic gender normativity weighs on their lives, placing them in a situation of denial of rights and, in general, in several contexts of vulnerabilities⁽⁵⁾. In this sense, transvestites are considered transgressors of a “social norm” that still naturalizes and privileges a congruent line between genitalia-gender-desires and sexual practices as a model of humanity and morality, which is called (cis) heteronormativity, being the target of prejudices, stigmas, discrimination and exclusion. These aspects greatly intensify vulnerabilities for social and health problems that can have repercussions on quality of life⁽⁶⁻⁷⁾. Given that, even in specialized services, considered as the most qualified meet this population segment, situations of discrimination experienced by transvestites when accessing these services are not uncommon⁽⁸⁻⁹⁾. From this angle, it is essential to know the social representations of health professionals and students about transvestites, since these representations may not correspond to the way people self-determine.

In this segment, the professional field of nurses, as it allows knowing their imaginary about transvestites, will evidence nuances concerning social values and practices. Added to this is the fact that the number of studies that have been dedicated to knowing the nuances of the relationship between nurses and transvestites is still restricted, especially about the representational component of this professional category.

In this study, the Theory of Social Representations (TSR) is presented as a guiding axis for the production of knowledge about transvestites. Thus, the choice of the research object in question allowed accessing nurses' opinion about the transvestite's place in the institutional health space. Social Representations (SR) are constructed based on the symbolic of social relations, experience and social knowledge, as they allow the individual or group to attribute meanings, as well as the understanding of reality based on their system of references⁽¹⁰⁾.

Thus, this study aims to discuss the invisibility of the transvestite person in health institutions based on the social representations of nurses.

Method

This is a qualitative research, focusing on the TSR, conducted with 20 nurses, selected according to the following inclusion criteria: being, in the semester 2015.1, registered in one of the *lato sensu* or *stricto sensu* courses offered by the Postgraduate Program of the Nursing School of the Federal University of Bahia (UFBA); participation in the previous stage of the research, in which the Free Word Association Test (FWAT) was performed, and experience of at least one year in care, teaching and/or management activities. For the production of information, the semi-structured interview technique guided by a previously elaborated script focused on the objectives of the study was used.

The number of interviewees was defined by the repetition of information about the object studied. In this sense, a consensual number of about 20 to 30 interviews in qualitative research studies can be considered⁽¹¹⁾. This article was developed based on the information collected in the interviews conducted from March to April 2016, in a previously scheduled place, with an average duration of 35 minutes.

All participants interviewed were women aged between 25 and 55 years, with predominance for the age group of 25 to 35 years. Among the participants, 18 declared to be *pardos*, 16 professed the Catholic religion and had an employment relationship at the time of data production and 12 worked in care and teaching.

The interviews were conducted in a previously scheduled place, lasting an average of 35 minutes and their content was fully transcribed. For data analysis, the software Iramuteq alpha 2 was used, which performs, among others, the content analysis of the Lexical type, through the context of a Set of Text Segments that conformed the Descending Hierarchical Classification (DHC). Iramuteq is a tool that enables the analysis of textual data and allows analyzing the content present in the text through textual statistics⁽¹²⁾.

The data from the interviews were inserted in this software to obtain a series of statistical procedures applied to textual databases.

Thus, the analysis achieved by the program classifies the utterances by comparing lexical profiles, which delimits lexical separation. After dividing into statements, the researcher will be responsible for recovering the elements of interest based on the delimited object of study⁽¹³⁾. The interviews were demarcated by the insertion of a command line, with only the participants as variable. This command line also delimits the beginning of each unit to be analyzed and is called “initial context unit (ICU)”, through which the software originates the different classes and generates the graphical form of the dendrogram.

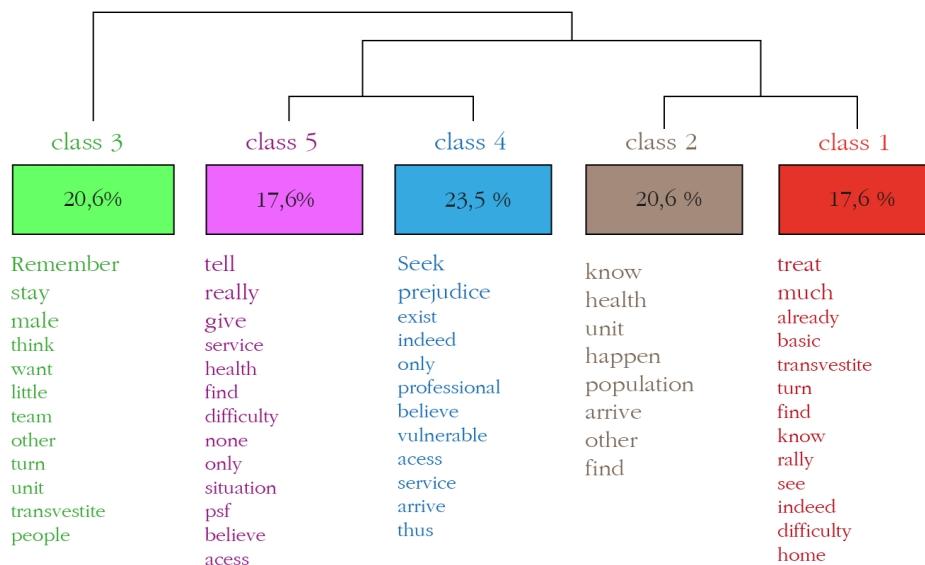
The research project that originated this article was approved by the Ethics Committee at the Nursing School of the Federal University of Bahia, through Opinion n. 1.203.257. During the development of the research, we sought to meet all ethical principles established by Resolution n. 466/2012 of the National Health Council. All participants signed the Informed Consent Form and were warned about the validity of an optional participation activity and the lack

of material or financial benefits. In compliance with ethical principles, especially regarding the anonymity of the participants and the confidentiality of the information provided, each person was identified by the letter “N” followed by the number corresponding to the order of the interview.

Results

The corpus was composed of 58 text segments, 612 distinct forms and an average frequency greater than or equal to 3.98 for each form. The DHC analysis focused on 78.3% of the collected material, allowing the description of discursive contents from the interviews. These evidenced dimensions of the social representations of nurses, with the generation of five classes or categories of analysis. The distribution of these classes reveal that class 4 added the largest number of terms, corresponding to 23.5% of the content. However, the ICU quantity between classes was relatively equitable. The DHC allowed analyzing the parameters of division of classes and defining the thematic axes that generated the classes based on the dependency relations established among themselves (Figure 1).

Figure 1 – Dendrogram of nurses’ social representations about the invisibility of transvestites in health institutions



Source: Created by the authors.

The description of the data, according to the partitions present in the DHC dendrogram (Figure 1), demarcated the construction of three thematic axes: the first formed by class 3; the second by classes 4 and 5 and, more distantly, the third axis formed by classes 1 and 2. Thus, the following terms were chosen to name each axis: 1 – “remember after thinking about”; 2 – “prejudice as a barrier to access to health services”; and 3 – “the ‘being unable’ to meet”.

The three axes gather aspects related to “invisibility” and demarcate dimensions of SR that encompass the personal, the social and the relational. The first evidence shows that the professionals participating in the study did not even remember when they met a transvestite, or even if they had already met; the second groups together questions relating to the barriers faced by transvestites in the access and/or in the search for health services and goes through coping with situations of prejudice and discrimination; while the third evidences the difficulties faced by nurses in the health services, concerning embracement, care and care provided to transvestites.

Axis 1, class 3 – “remember after thinking about” is consolidated in the reports of the interviewed nurses:

I remember the doctor who treated her in the ER, treated her very badly. She had a breast abscess due to the silicone extravasation that had happened [...] (N12).

I worked two years in the FHP and in the hospital, but I have never treated any nor in the FHP. During visits and other activities I did not know any [transvestite] in the community I worked in. (N13).

[...] I remember this transvestite worked at night as a prostitute and were seeking a condom to use at work. It was a very peaceful relationship, then she returned and even brought me some fruits. (N2).

In axis 2, classes 4 and 5, “prejudice as barriers to access to health services” was evidenced through the nurses’ discourses. The professionals recognized that transvestites experienced situations of prejudice that resulted in discrimination. They also revealed that they seek to offer a care practice different from that offered by other professionals:

There is still much prejudice. So when these people get here, because they often do not even seek the service, I notice that they do not seek service precisely because of

the violence they suffer and prejudice. Because people [nurses] do not want to meet them. (N1).

Sometimes they are distanced from the service, because of the prejudiced eyes, but I already understand that they also have a struggle on their part to seek to improve, in a timid way, because I think that this group, these transvestite people could be even a little more daring in seeking health services. (N10).

I think that the difficulty of accessing these health services [leads] to self-treatment, taking medication on their own, doing things in clandestine services, or on their own, empirically and only seeking a health service in the last minute. (N4).

In situations of two visits [transvestites], in which I and another colleague were concerned with providing care within the rights of the [transvestite] person. (N8).

I think this happens because, when I worked in the care unit, I worked in the family health unit and, unfortunately, we know that some vulnerable populations, such as transvestites, prostitutes, homeless people, they do not reach the health units because normally the health units shut the doors to these people [...] (N5).

Axis 3, composed of classes 1 and 2, called “the ‘being unable’ to meet”, is related to health care actions that should contemplate the demands of this population segment, considering their specificities. However, most mentioned the “sexual deviation”, evidencing the lack of knowledge about the transvestites, and/or pointed out specific care actions, which does not always produce favorable long-term outcomes, as can be seen in the following excerpts:

I do not see transvestites in the services. I do not know if there are specialized services for them [...] There has not been much time since I graduated. (N9).

In primary care, thinking about prevention, there is no room for this other user, who is either man or woman. She is in prenatal care or he is in the hypertensive or men’s group, as a man, so there is no room. (N6).

I have never treated a transvestite. That is because they do not get to the health services. (N10).

Discussion

The three axes contain elements that overlap in the elaboration of a social representation, especially regarding an object guided by social, cultural and moral issues that are intertwined with ethical and religious issues that concern sexuality. Thus, the elements that make up the axes of analysis reverberate into one of the principles of the Theory of Social Representations,

as it reproduces social thought, based on myths, beliefs, ideologies, opinions and attitudes, which can be transformed over a period of time based on personal and social experiences.

According to the reports, the presence of the transvestite person in the institutional health spaces in which the interviewees worked is a rare situation, since they had to resort to memory to access records of sporadic contacts. This absence and/or rarity of the presence of the transvestite person in health services denounces the disrespect of a basic human right approved in the Federal Constitution: right to health.

The Charter of the Rights of Health Users, approved by Ordinance MS/GM n. 675 of March 30, 2006, reaffirms respect for the social name, in addition to ensuring humanized care free of prejudice and discrimination by sexual orientation and gender identity⁽¹⁴⁾. Although more than 14 years have passed since the publication of this Charter, the difficulty in actualizing these rights persists, as indicated by the statements of the participants who, mostly, are under 30 years of age.

In this sense, it was possible to verify that the study participants recognized the existence of barriers faced by transvestites in public health institutions, due to the unawareness of health professionals of the problems that affected them, including the lack of resolution, non-respect for their expression and gender identity and the social name (for those who have not yet rectified civilly) during the call, among others. Transvestites feel bothered by the treatment received, by moral judgment and by the distance denounced by the gestures, looks and speeches of the professionals who meet them in health services^(9,15).

The memories of some nurses about care, embracement and care provided reaffirm that prejudice generates the scenario of tensions and violence, as it distances transvestites from health services and from various institutional spaces. Prejudice is an active way to dehumanize and reinforce exclusionary practices, as it is more related to moral values

and social practices that violate basic human rights^(3,6,8-9).

In the LGBTI segment, a possible movement to face prejudice, discrimination and violation of basic rights is the creation of care strategies for transvestites, focusing on the identification of their health demands, in line with what the organized social movement advocates. It is, therefore, not to think only of their bodies or their social location (where they live, where they work, how they sleep, etc.), but include the praxis that provide the organization of the nurses' work. In this sense, the nurses' reflection on the singularities that involve the various forms of existence can contribute to a singularized care aimed at this segment⁽⁶⁾.

Axis 2 presents the statements that reveal how prejudice based on discrimination constitutes the main barrier to access to health services. In classes 4 and 5 of this axis, cultural factors related to the way these professionals act and those of the organizational structure of health services, which contribute to distancing this population from health units, were identified in the representational content of the study participants. The professionals, in their statements, reported that transvestites were people who suffered prejudice by the various professionals of the team and, therefore, could not always cross the barriers to access health institutions in an attempt to solve their demands.

The need to raise awareness among health professionals about non-discriminatory care of the LGBTI population is still one of the most recurrent themes in the debates on public health policies formulated for these segments. The opinion is the same among managers and activists regarding the scope of actions to sensitize health workers, in relation to individual and social damage resulting from transphobia, and there is still much to do, since the initiatives and the public reached are little significant⁽¹⁶⁾.

The difficulty of health team professionals ranges from the definition of the ward for admission of a transgender patient, in the hospitalization situation, to the way of treating

the patient, with respect to his/her social name. These situations illustrate scenes from the daily life of health professionals and transvestites in public services in general. However, attention should be paid to the fact that such experiences can interfere in the care provided and have repercussions on the quality of life of transvestites⁽¹⁷⁾. Thus, it is also essential to raise reflections around the limits and challenges in the execution of these actions, so that they are pointed out and/or elaborated with transvestites, with a view to knowing the specificities, health demands and care supported by the discourses that circulate among them⁽¹⁸⁾.

The conditions of vulnerabilities that are part of the life context of transvestites, especially violence and prejudice, produce situations of worse health condition. Care laws have been broken, neglected and violated for more than a decade. Thus, the existence of barriers that hinder transvestites achieving the actions of education, prevention and health promotion, influence the option for self-medication related to the use of hormones and the use of industrial liquid silicone, with a view to conforming the body, which greatly contributes to the processes of self-affirmation and increased esteem. This fact also results from the economic difficulty of accessing the supplementary network, to carry out the process of medical follow-up. This aspect may influence self-medication and the adoption of body modification/alteration practices that can potentiate risks and compromise health and quality of life^(3,9,15).

The cisheteronormative conception gave life to a model of functioning under which relationships, people, objects and environments are structured. Thus, living outside the binary standard is something unbearable to the cisheteronormative society, which, in this case, builds and uses gears to subjugate, punish and frame people who are still seen and classified as "different"⁽¹⁹⁾. Thus, as those people are excluded from the social environment because their experiences do not correspond to the standard that society imposes, they receive a type of condemnation, which not only abandons

them to their own fate, but also seeks to inflict violence and violation of rights on them on behalf of ethics⁽²⁰⁾.

Socioculturally and historically, "[...] the notion that there is 'true' sexual identity and that it is associated with 'true' sex was constructed, which is the biological"^(21:85). Therefore, individuals with sexuality "divergent" from the cisheterosexual norm, in which binary gender positions (man/woman, male/female) exist, are still seen as "abnormal". Regarding transvestites, the fact that their genders are still seen and/or conceived as "not intelligible" there is no possibility of establishing coherence relationships between sex, gender, sexual practice and desire⁽²²⁾.

Sexual orientation and gender identity are distinct dimensions of human life that can potentiate the vulnerabilities of the LGBTI population with regard to health problems and repercussions on quality of life resulting from coping with stigma, prejudice and discrimination. An example is the non-continuity, on the part of transvestites, of the treatment of chronic diseases and difficulty in accessing health services, for fear of being exposed to discriminatory and exclusionary processes that violate human rights, including the right to health⁽²³⁾. In this sense, the expropriation of institutional spaces produces invisibility for those who self-refer as transvestites.

Although more favorable conditions are perceived in the institutional sphere for respect for gender identities and the recognition of differences, the transformations of health networks require considerable investment, as they depend on transformations in the way health professionals think and act. The symbolic questions arising from the cisheteronormative pattern objectively influence the care provided by health professionals to transvestites⁽⁵⁾.

It is relevant to draw attention to nursing behavior in relation to transvestites. A study⁽²⁴⁾ points out that nurses' behavior, in the care of transvestites, deserves reflection, as little commitment and preparation for care is evident, especially concerning the specificities brought by them. It is worrying that the profile of attention

that has been conformed to the transvestite population is not in line with what the National LGBT Policy advocates, which strengthens the hegemonic representations that result in distancing the people in this segment from care spaces.

Thus, the sensitive and careful look towards the transgender population can greatly contribute to the transformation of social relations based on horizontality and to the effectiveness and equity of the UHS⁽²⁵⁾. It is noteworthy that scientific production based on social representations is still incipient, concerning transgender people⁽²⁴⁻²⁵⁾.

Thus, it can be inferred that the elements that make up the nurses' SR are based on this context, which, besides being harmful and excluding, implies the invisibility that is still imposed on the ways of being transvestite. This segment faces socialization barriers in the daily life of cities, in school institutions, on the streets and in the daily life of health services. This condition propels these people to what was called “no place”, because this underprivileged space deprives time, voice or opportunity, but only to follow the norm that is still hegemonic, unfair, inhuman and exclusionary towards differences.

The study on social representations deals with the analysis of the knowledge produced in daily life, that is, the process of construction of reality based on social relations. As a scientific study of common sense, the Theory of Social Representations considers that knowledge changes according to specific insertions in a context of social relations^(10,24). Thus, because of its normative/prescriptive character, when guiding nurses' social practices, it serves as a guide for social actions and relationships and care in the institutional environment.

The limitation of this study involves the participation of a single-type postgraduate student nurses. However, the results allowed visualizing elements for the (re)thinking and (re)making of nursing in a School that is the vanguard of the history of Brazilian nursing. The lack of studies on the theme has hindered the establishment of relationships between the research findings and the reality of professionals in different national contexts.

Conclusion

The social representations of the nurses investigated revealed meanings for the invisibility, exclusion, difficulties in care and care dispensation for transvestites in health services, aspects that negatively affect the adherence to the care proposals currently offered. The invisibility of transvestites, identified in the nurses' representations, occurs by the way health professionals and transvestites perceive the need/possibility to occupy these spaces.

Recognizing the invisibility of transvestites in the institutional health spaces, although limited to a group of nurses, provoked discussions in the academic and work space of the participants. Moreover, the dissemination of this data can constitute an element of reflection and discussion for other groups of professionals, enabling an approximation with the theme, in order to give visibility to transvestite people and all those who do not meet the cisheteronormative model.

The place and destination of transvestites need to be built, at first, in people's imaginations, which probably involves an ideological dispute for a non-normativity for human sexuality. In this field, due to the importance of nursing in the conception, management and operationalization of care, it is of utmost importance to reflect on its role and its commitment in the construction of conditions that allow transvestites to exercise their right to health and quality of life.

Thus, the training of health professionals centered on care needs to be involved in the respect for differences. Health work that does not value respect for the human being as a person who is different and unique may create barriers to access and quality in health care, besides neglecting rights, as in the case of transvestites.

Collaborations:

1 – conception, design, analysis and interpretation of data: Ester Mascarenhas Oliveira and Jeane Freitas Oliveira;

2 – writing of the article and relevant critical review of the intellectual content: Ester Mascarenhas Oliveira, Jeane Freitas Oliveira,

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3 – final approval of the version to be published: Ester Mascarenhas Oliveira, Jeane Freitas Oliveira and Cleuma Sueli Santos Suto.

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