

Care for the Transsexual Population in Primary Health Care: Nursing Perceptions

Atendimento à População Transexual na Atenção Básica: Percepções da Enfermagem

Atención a la Población Transexual en la Atención Primaria: Percepciones de Enfermería

RESUMO

Objetivo: compreender como a equipe de enfermagem da Atenção Básica realiza o atendimento à população transexual, identificando dificuldades, conhecimentos e lacunas formativas. **Método:** estudo qualitativo, exploratório, desenvolvido em uma Unidade Básica de Saúde de Santo André, com 12 profissionais de enfermagem. Os dados foram produzidos por entrevistas semiestruturadas, gravadas, transcritas na íntegra e submetidas à análise de conteúdo temática de Bardin. Na redação do manuscrito, foram considerados os critérios para relatos qualitativos.

Resultados: emergiram quatro categorias: se confundindo entre identidade de gênero e orientação sexual; realizando citologia oncológica no homem trans; atendendo com equidade e uso do nome social e percebendo o conhecimento incipiente sobre o atendimento e os direitos da pessoa trans. **Conclusão:** persistem fragilidades conceituais e institucionais que comprometem o cuidado equitativo, o que reforça a necessidade de educação permanente.

DESCRIPTORES: Atenção Primária à Saúde; Enfermagem; Pessoas Transgênero; Acesso aos Serviços de Saúde; Equidade em Saúde.

ABSTRACT

Objective: to understand how primary health care nursing teams provide care to the transsexual population, identifying difficulties, knowledge gaps, and training needs. **Method:** qualitative, exploratory study conducted in a primary health unit in Santo André with 12 nursing professionals. Data were produced through semi-structured interviews, audio-recorded, fully transcribed and analyzed using Bardin's thematic content analysis. Criteria for reporting qualitative studies were considered in manuscript preparation. **Results:** Four categories emerged: confusion between gender identity and sexual orientation; performance of Pap smears in transgender men; providing equitable care and using social names; and recognizing the incipient knowledge about the care and rights of transgender people.

Conclusion: conceptual and institutional weaknesses still compromise equitable care, reinforcing the need for continuing education.

DESCRIPTORS: Primary Health Care; Nursing; Transgender Persons; Health Services Accessibility; Health Equity.

RESUMEN

Objetivo: comprender cómo el equipo de enfermería de la Atención Primaria realiza la atención a la población transexual, identificando dificultades, conocimientos y vacíos formativos. **Método:** estudio cualitativo, exploratorio, desarrollado en una Unidad Básica de Salud de Santo André con 12 profesionales de enfermería. Los datos fueron producidos mediante entrevistas semiestructuradas, grabadas, transcritas íntegramente y sometidas al análisis de contenido temático de Bardin. En la redacción del manuscrito se consideraron los criterios para informes cualitativos. **Resultados:** Surgieron cuatro categorías: la confusión entre identidad de género y orientación sexual; la realización de pruebas de Papanicolaou en hombres transgénero; la prestación de atención equitativa y el uso de nombres sociales; y el reconocimiento del conocimiento incipiente sobre la atención y los derechos de las personas transgénero. **Conclusión:** persisten fragilidades conceptuales e institucionales que comprometen la atención equitativa y refuerzan la necesidad de educación permanente.

DESCRIPTORES: Atención Primaria de Salud; Enfermería; Personas Transgénero; Acceso a los Servicios de Salud; Equidad en Salud.

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INTRODUCTION

The 1988 Federal Constitution recognized health as a right of all and a duty of the State, a milestone that was consolidated with the creation of the Unified Health System (SUS), guided by the principles of universality, comprehensiveness, and equity^{1,2}. Despite this progress, transgender people still face barriers in accessing services, particularly in Primary Care, the gateway to the System^{3,4}.

Transgender identity can be understood as a multifaceted phenomenon that spans bodily, identity-related, and social dimensions. Academic studies are not limited to medical definitions but also challenge the concepts themselves, highlighting the diversity of trans experiences. In this sense, it is a topic that involves not only health but also culture, rights, and social, political, and ethical debates⁵⁻⁸.

Described by many authors as a mismatch between biological or anatomical sex and the gender with which a person identifies and presents themselves socially, transsexuality is often associated with discomfort or

rejection regarding the bodily characteristics assigned at birth. A common definition understands transsexuality as a continuous misalignment between the sex assigned at birth (based on genetic, gonadal, and anatomical factors) and the gender with which the person identifies, often accompanied by discomfort regarding bodily characteristics and a desire to modify them through hormonal and surgical interventions in order to live socially as their affirmed gender⁵⁻⁸.

Other approaches broaden this understanding, defining transsexuality as part of a broader spectrum of trans identities, which includes the desire to live and be recognized in a gender different from that assigned at birth, encompassing experiences such as those of transgender and non-binary people⁵⁻⁸.

In day-to-day care, challenges persist regarding the use of a social name, the recognition of gender identity, the clinical management of specific needs, and the lack of adequate training for healthcare professionals^{3,4}. Recent studies indicate that a lack of technical preparation and cultural competence contributes to experiences of embarrassment, exclusion, and

fragmented care⁹⁻¹⁵.

In the field of nursing, these challenges are particularly relevant, as nurses play a direct role in welcoming patients, listening to them, providing health education, promoting prevention, and offering long-term follow-up care^{2,12,14}. Thus, understanding how these professionals perceive and provide care to the transgender population can contribute to improving the quality of care and strengthening equity within the Brazilian Unified Health System (SUS).

Given this context, the following research question was formulated: How do primary care nursing professionals perceive and provide care to the transgender population, and what difficulties and gaps in training are present in this process?

The objective of this study was to understand how the nursing team at the Primary Health Care Unit provides care to the transgender population.

METHOD

This is a qualitative, exploratory study conducted at a Primary Health Care Unit in the municipality of San-

to André, São Paulo, Brazil, involving 12 professionals from the nursing team. Professionals of both genders who agreed to participate in the study and signed the Informed Consent Form were included; those who were absent during the data collection period or who refused to participate were excluded. As theoretical frameworks, we adopted the principles of the Unified Health System (SUS)—universality, equity, and comprehensiveness—described in the Ministry of Health's manual *SUS from A to Z: Ensuring Health in Municipalities*² and Judith Butler's concept of gender identity and expression¹⁵, as they facilitate an understanding of care for the transgender population both in terms of the right to health and the recognition of gender singularities.

Data were collected through semi-structured, individual interviews, recorded with the participants' consent, lasting approximately 10 to 30 minutes, in a private room scheduled in advance. The interview guide included sociodemographic data and questions about gender identity, healthcare for the transgender population, use of a social name, Pap smear testing for trans men, and knowledge of regulatory frameworks.

The interviews were transcribed in full and subjected to content analysis, according to Bardin¹⁶. The analytical process involved a free-flowing reading, successive re-readings, identification of convergences and divergences, extraction of units of meaning, and construction of thematic categories.

This manuscript was prepared in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ)¹⁷.

This study complied with the recommendations of Resolution No. 466, dated December 12, 2012, of the National Health Council (CNS), and was approved by the Ethics and Research Committee under approval number 7,254,742.

RESULTS

Twelve nursing professionals participated, ranging in age from 24 to 64 years, with 7 months to 27 years of professional experience and varying levels of education. The analysis led to the identification of four categories.

CONFUSION BETWEEN GENDER IDENTITY AND SEXUAL ORIENTATION

Recurring confusion between gender identity and sexual orientation was observed, revealing basic and, at times, mistaken knowledge of fundamental concepts.

I believe that sexual orientation has to do with two things. It has to do with how a person identifies and who they are sexually attracted to (E 10).

Definitions grounded in biological or documentary explanations also emerged, reinforcing the conceptual fragility present among some of the participants. It's that person who doesn't identify with their birth gender but identifies with another gender. For example, if it's a man who was born with all the characteristics of a man—male genitalia—but identifies with a female gender identity (E12). Oh, the concept? Is it whatever each person is? Gender identity is what's on the document. I don't know (E3).

The results reveal confusion and overlap between gender identity and sexual orientation, with a mistaken understanding that links identity to affective-sexual desire. Difficulty in defining the concepts was also observed, indicating knowledge gaps possibly associated with a lack of adequate training on gender diversity and sexuality, both in formal education and in professional training programs.

PERFORMING ONCOCYTOLOGY IN TRANS MEN

With regard to the cytopathological exam, there was a mix of welcoming perspectives and approaches focused exclusively on anatomy. Some professionals emphasized the importance of using the patient's social name, providing a prior explanation of the procedure, and minimizing discomfort.

We explain the procedure to the patient and address them by their social name, treating them exactly as they would like to be treated (E 3).

I provide guidance and ask how they want to be addressed; the important thing is to try not to expose the patient, not to use the name on their records, but rather their social name (E 2).

However, some statements revealed a tendency to conduct the exam as a neutral procedure, without fully considering the subjective experience of the trans man, which may limit the comprehensiveness of care.

"The issue is biological in nature and independent of gender identity; we just need to visualize the cervix... I frame the issue within the context of normality, and generally speaking, I would treat them the same way I treat any woman coming in for a Pap smear" (E 9).

There won't be a cervix, just the genitalia, so the exam wouldn't be performed. In that case, we would provide guidance on health promotion and prevention (E12).

Despite advances in the humanization of care, limitations persist in understanding the specific needs of the transgender population, indicating the need for ongoing training to promote more comprehensive, sensitive, and stigma-free care.

PROVIDING CARE WITH EQUITY AND USE OF THE SOCIAL NAME

Equity emerged as a practical principle of care, particularly through the adaptation of language and respect for how each patient wishes to be addressed. The main obstacle reported was the discrepancy between the social name and the name on official records.

The difficulty was really about the name, because since they had two names, we weren't sure which one to use. So I asked which one they preferred (E 2). I've treated patients before and didn't feel any difficulty at all, because I like to keep things very open. I ask how they'd like to be addressed and what makes them feel comfortable—just a casual chat. Keeping things less formal creates fewer barriers (E11).

These excerpts suggest that direct dialogue with the client serves as a welcoming strategy, but it does not replace the need to adapt institutional systems.

RECOGNIZING THE LIMITED KNOWLEDGE ABOUT CARE AND THE RIGHTS OF TRANSGENDER PEOPLE

In this category, there are reports of insufficient content on gender and sexuality during training and a lack of systematic training in healthcare settings.

Colleges did not address gender-related issues at all. I still feel this is sorely lacking in academia and in the health sector (E 9).

Professionals also reported a lack of knowledge about Ordinance No. 1,820/2009, although some of them empirically recognized the right to a social name and respectful treatment.

I've never read that ordinance, but I know it exists. I think we

have to respect everyone's wishes (E 5).

Honestly, I haven't seen it, but I know that a person has the right to identify with their social name. We'll call the person by their social name, setting aside the name on their birth certificate—it's the social name that takes precedence (E 6).

This finding reveals a disconnect between specific ethical practices and a formal understanding of the legal frameworks that guide humane care.

Excerpts from the interviews revealed varying levels of understanding regarding transgender men and women. Some participants offered definitions consistent with the literature; others reversed concepts or linked them to behavioral stereotypes.

A transgender man was born with female biological sex but identifies as a man. A transgender woman may be born biologically male and identify as a woman, a transgender woman (E. 9).

Although some appropriate responses emerged, misconceptions persisted, indicating a need for greater literacy regarding gender diversity.

A transgender man is a man who acts as if he were a woman (E. 4).

A transgender man was born a woman and later transitioned to become a man. A transgender woman was born a man and is now a woman (E3).

Overall, the findings reveal that, although there is a basic understanding of the topic, conceptual gaps and misconceptions persist. This points to the need for educational and training initiatives that expand knowledge and promote greater clarity regarding gender identity.

Overall, the results indicate efforts

toward inclusion, though these are still marked by conceptual gaps, institutional weaknesses, and a need for ongoing education.

DISCUSSION

The findings show that care for the transgender population in primary care is marked by tensions between acceptance, conceptual ignorance, and institutional limitations. This picture aligns with a Brazilian study that identified, in primary care, a lack of knowledge regarding policies, inappropriate associations, and the persistence of cisnormative approaches⁴. It also resonates with national research that described persistent barriers to access, the need for adequate records, and the strategic role of primary care in coordinating care³.

The recurring confusion among participants regarding the concepts of gender identity and sexual orientation reveals a rudimentary and, at times, distorted understanding of fundamental concepts in the field of sexual and gender diversity. This conceptual overlap reflects a limited understanding that still prevails in various social and educational contexts, often reinforced by the lack of adequate training on the subject¹⁸.

It is possible to analyze this conceptual confusion in light of the contributions of Judith Butler, who proposes a deconstruction of the idea of gender as something fixed, stable, or biologically determined. For the author, gender is not an essential identity, but rather the effect of a repetition of performative acts that are socially disciplined¹⁵.

The conception of gender identity based on biological sex or as something documented is a view rooted in and grounded on an essentialist and binary logic, which ignores the constructed, multiple, and fluid nature of gender, as problematized by Butler¹⁵.

By starting with the question of

what it means to be a transgender man, we arrived at a heterogeneous understanding, pointing to varying levels of familiarity with the concept in question, where this variation once again signals both disparities in access to information and gaps in training for working with the LGBTQIAPN+ population. It can be said that the construction of trans masculinity involves not only bodily actions and physical modifications but also social performativities that go beyond appearance and physical features, thus highlighting significant differences from hegemonic standards of masculinity¹⁹.

Gender identity was understood as something distinct from the sex assigned at birth and associated with a process of subjective recognition, thus indicating a partial assimilation of inclusive discourses, though one that still contains limitations. The results align with recent research demonstrating how understanding of gender identity varies according to the sociocultural context, being influenced by media visibility, public policies, and the presence of educational spaces that address the topic responsibly^{13,20}.

On the other hand, there were misconceptions in which the definition of a transgender man was confused with that of a transgender woman, or even associated with behaviors that deviate from the “expected norm” for a male individual. Conceptual misunderstandings are recurrent in studies analyzing the training of health and education professionals, in which the normalization of cisnormative understandings and a lack of preparation to address the complexity of the identities and needs of the transgender population are still evident^{13,21}.

The variety found in the statements can be interpreted once again using Judith Butler’s (2003) performative theory, in which the subject does not possess a pre-given gen-

der but is produced and recognized through discursive and social practices¹². Based on this, it can be said that the statements that reveal a fundamentalist understanding of gender and confuse gender identity with behavioral roles demonstrate the extent to which identity is still regulated by heterocisnormative norms^{15,22}.

The overlap between the concepts of “trans man” and “trans woman” in some statements indicates not only a certain degree of misinformation but also the social difficulty in recognizing gender identities outside the cisgender logic. The low visibility of transsexual experiences in national research and statistics contributes to their symbolic marginalization and hinders the formulation of effective affirmative actions^{3,13,23}.

The fact that we are bringing to light the health needs of the transgender population aligns with the core principle of the Unified Health System—equity—thereby enhancing the visibility of this minority group. Trans men who have a cervix need to undergo a Pap smear (a screening test that analyzes cells from the cervix to identify possible tissue changes) because the risk of developing cervical cancer persists even after gender transition; although testosterone may cause atrophy of cervical tissue, it does not completely eliminate the risk of HPV (Human Papillomavirus) infection and the subsequent cellular changes that can lead to this neoplasm^{2,22,24}.

Emphasizing the importance of using the social name, active listening, and careful explanations of the procedure demonstrates alignment with the guidelines contained in the SUS Manual from A to Z, which ensures health in municipalities by utilizing institutional support and humanized approaches in SUS health services as tools for respecting gender identity and promoting bonding as a pillar of care. Thus, when a healthcare profes-

sional mentions the effort to “not call the patient by the name on their birth certificate, but rather by their social name,” this approach reflects a direct application of the recommendations in the manual, ensuring a comfortable and non-judgmental care experience^{2,14}.

The body of findings highlights the need to expand ongoing training for health care teams on the specificities of care for the transgender population, and by using the SUS handbook as a foundation, it is also possible to emphasize that quality care involves overcoming stigma and valuing differences. Therefore, more than technical training, it is essential that professionals internalize the ethical and political guidelines of the SUS, ensuring that care is effectively patient-centered, with active listening, respect, and sensitivity to the particularities of each body and each identity^{2,22}.

Equity, one of the SUS guidelines that was highlighted in the statements of nursing professionals, was recognized as essential for tailoring care to the needs of each patient. This understanding is in line with what is recommended in the SUS Manual from A to Z, in which equity is identified as the starting point for promoting social justice in access to health services²².

Difficulties were mentioned regarding the use of the social name, especially when it differs from the registered name, thus highlighting tensions between the ethical practice of professionals and the structural and bureaucratic limitations of the system. As we continue to use the experiences of nursing professionals during patient encounters as a tool to understand the health context in which the transgender population finds itself, we encounter narratives that reveal not only the variety of lived experiences but also the need to address the social vulnerability faced by the transgender population. These

accounts highlight a care landscape that extends beyond the moment of consultations and technical procedures. Structural violence against the transgender population remains a critical obstacle to access to and continuity of care, perpetuating inequalities and weakening the connection with health services^{13,21}.

Judith Butler offers an interesting perspective when she argues that denying visibility, care, and recognition to transgender people amounts to operating within an authoritarian logic that dehumanizes and threatens democracy itself²². Thus, every act of care—such as respecting a person's chosen name and offering a judgment-free space—is also a political act of resistance against the forces that insist on denying trans existence^{1,13}.

Building relationships, especially in care related to sexual health, the prevention of sexually transmitted infections (STIs), and hormone therapy, emerges as a fundamental therapeutic tool. The trust established between professional and patient is crucial for care to be continuous and effective, reducing dropout rates and increasing treatment adherence. In the face of the violence that marks so many life journeys, sensitive care not only saves lives in the clinical sense but reaffirms that these lives are worthy of being lived to the fullest^{3,13,21}.

It can be said that trust and dignity in the care of transgender patients are not limited solely to direct clinical management, as the patient's experience must be considered in its entirety—from their arrival at the healthcare facility through the actual care provided—to ensure a welcoming environment at every stage. Ordinance No. 1,820/2009 is a regulatory instrument that guarantees the right to use a social name and establishes the foundations for humane care within the SUS by ensuring the recording of the social name in documents

and medical records and the provision of care free from discrimination based on gender identity. A lack of familiarity with the formal text of the ordinance highlights a certain disconnect between technical-legal knowledge and empathetic practice, for even though professionals recognize, through clinical experience, the importance of respecting and using the social name, an understanding of the essence of the regulation—and not just its general context—is indispensable, especially at the beginning of one's professional career, when one lacks extensive experience in caring for transgender patients. This gap in formal knowledge highlights a central issue in the implementation of the constitutional principles of the SUS: universality, comprehensiveness, and, above all, equity. The health system has a duty to ensure clear information, social participation, and the adaptation of services to the specific needs of each user. When professionals welcome patients by using their social names—even without a full understanding of the administrative ruling—they are reaffirming the principle of equity in a practical and tangible way, thereby treating those who face greater inequalities on an individual basis and acting in accordance with the mission of the SUS. However, the testimonies also point to operational weaknesses, especially regarding institutional systems. The failure to update systems and medical records—which still insist on displaying the civil registry name—results in embarrassment and prevents care that is consistent with the regulations set forth by the ordinance. Therefore, we can conclude that these non-compliances with legal provisions highlight the need for administrative improvements to effectively implement Ordinance 1,820/2009, as also provided for in the SUS Manual from A to Z^{2,14}.

In primary care, imbalances persist

in the training of healthcare workers, who face bureaucratic barriers and inadequate registration systems; these factors hinder the effective care of transgender individuals, including with regard to their social name. Another study reinforces that, although the social name is recognized as a right, its absence from official systems increases discomfort and diminishes the trust of the transgender population in the SUS³.

A gap became evident throughout the course of this study. A striking absence of the topics of gender and sexuality in the academic training of nursing professionals was noted, corroborating the perceptions of the research participants. This field of knowledge continues to be approached in an empirical and belated manner, with contact with this population occurring only in the course of professional practice. The gap regarding insufficient knowledge on issues involving gender identity and health care for the LGBTQIAPN+ population was also observed in another study involving primary care professionals. It is evident that there are gaps in knowledge regarding sex diversity, sexuality, and gender identity, which compromises the provision of truly humanized and inclusive care⁴.

In this regard, it is essential to emphasize the need for continuing education as a key driver for implementing the fundamental principles of the Unified Health System. When such content is absent, the educational system fails to train professionals capable of recognizing and responding to the specific and urgent needs of the transgender population, and the SUS, therefore, does not provide the equity it promotes in its principles^{2,14}.

From Judith Butler's perspective, we can gain a fundamental insight into the consequences of this omission. Regarding the issue of gender, Butler notes that it is not a latent essence but rather the result of socially

repeated actions—that is, a performance shaped and regulated by social norms. The absence of these debates throughout professional training perpetuates a cisgender normativity that renders trans people invisible, preventing new generations of professionals from learning to recognize and respect trans identities as legitimate, existing, and influential in our society^{15,22}.

Given this, it is essential to address this oversight by including formal modules on gender, sexuality, the ethics of care, and respect for identity diversity in both initial and continuing education programs. Such inclusion is not merely an academic update but an ethical and political imperative, consolidating not only technical competence but also deepening the SUS's moral commitment to justice, citizenship, and the right to dignity^{1,2,14}.

CONCLUSION

In response to the guiding question, the results show that care for the transgender population in primary care is characterized by the coexistence of welcoming, y practices and

significant conceptual, educational, and institutional gaps. Although there are initiatives based on respect for the social name, active listening, and the humanization of care, weaknesses still persist related to a lack of knowledge about gender identity and its confusion with sexual orientation, reflecting inequality in access to information and the need for ongoing professional training.

Care oscillates between sensitive approaches and practices centered on a biological logic, which can compromise the comprehensiveness of care and cause discomfort for patients. Added to this are institutional barriers, such as limitations in registration systems, which hinder the implementation of the principles of the Unified Health System (SUS), particularly equity. The social vulnerability of the transgender population, marked by experiences of exclusion and violence, also directly impacts access to and continuity of care, reinforcing the strategic role of primary care in building a more sensitive and inclusive care system.

We recognize that this topic requires ongoing reflection and is not

exhausted by this study. Thus, further research can be conducted to deepen the investigation, particularly by exploring the experiences and lived realities of transgender individuals in primary care. Consequently, we conclude that care for the transgender population in primary care is still a work in progress, requiring significant advances in the fields of academic training, continuing health education, and the organization of services. It is essential to incorporate content on gender, sexuality, and the ethics of care into both initial and continuing education programs, as well as to make structural adjustments to health care systems. In summary, this study reaffirms that the education and ongoing training of nursing professionals are fundamental for Primary Care to establish itself as a truly accessible and welcoming entry point for the transgender population. More than a situational assessment, this is a call for the nursing profession to recognize itself as a key player and driver of structural change in healthcare, transforming care into a space of recognition, dignity, and citizenship, in line with the principles of the SUS.

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