Special article

Full care for the transgender population: what is the role of primary health care (PHC)?

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INTRODUCTION

For a long time, anatomical sex–the one assigned in birth and established by primary sexual characteristics–was believed to be responsible for developing binary behaviors known as male and female. Even today, it is a widespread mistake to confuse the terms sex and gender; however, we must point out that belonging to male or female sex does not define male and female identities, respectively. Below there are some definitions to be used in this article.

Box 1: Terminology and definitions

Anatomical sex: a term used to classify a person according to the phenotypic expression of their genitalia, with the influence of chromosomal and hormonal interaction in intrauterine life.

Gender identity: a term used to classify typified roles in a society according to what they understand as male and female, or non-binarism.

Cisgender: a term used to refer to a person whose gender identity conforms to the sex they were assigned to at birth.

Transgender: a term used to refer to a person whose gender identity does not conform to the sex they were assigned to at birth, regardless of their having or desiring hormonal or surgical gender affirmation. The International Classification of Diseases, in its 11th edition (ICD-11), considers transgenderism to be gender incongruence.[1]

Male trans (MT): a term used to refer to people of the male spectrum identity who were designated as a woman at birth.

Female trans (FT): a term used to refer to people of the female spectrum identity who were designated as a man at birth.

Transvestite: a term used to refer to people of the female spectrum identity who were designated as a man at birth, redefining the marginalization assigned to their identity in the past.

In 2011, the Brazilian Department of Health established, through Decree No. 2,836, of December 1st, the National Policy for Integral Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals.[2] Few bills and protocols, however, were implemented so that the population would be provided with appropriate public healthcare to their particularities. The issue of sexual diversity, aside from being relatively new to evidence-based medicine (EBM), is not a fully discussed topic in graduation and medical residency, making generalist physicians oftentimes insecure regarding their specific care.

Out of the Brazilian people of child-bearing age, 0.69% (95%CI = 0.48-0.90) identify as transgender, and 1.19% (95%CI = 0.92-1.47) as non-binary.[3] Despite of those numbers, they face many barriers to accessing healthcare networks due to their invisibility. Health

workers have no training on how to receive those people and ignore what kind of care should be offered to them, making quality and equitable access impossible.[4,5] Considering the gender identity perception happens during childhood, service to that population must be available in all public health scopes.[6] Acknowledging the diversity of bodies is essential for discussing on how to prevent sexually transmitted infections (STI); on contraception, pregnancy planning, and pregnancy and postpartum cycle monitoring; on health promotion, cardiovascular and oncological diseases prevention; and on how to assess risk behaviors and mental health.

PUBLIC POLICIES FOR TRANSGENDER POPULATION

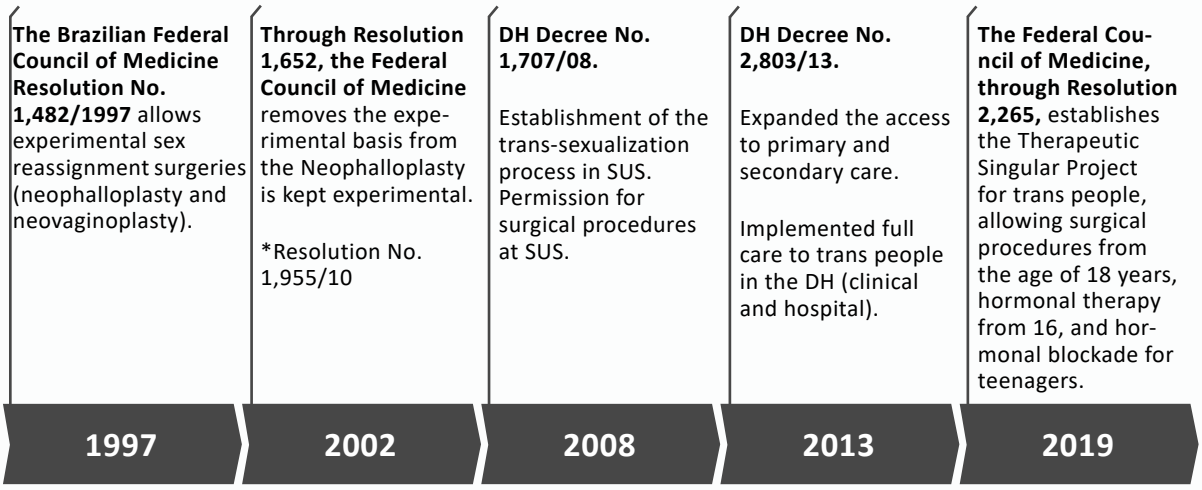
Resolution No. 1,482/1997 of the Brazilian Federal Council of Medicine (CFM), allowed experimental sex reassignment surgeries for research purposes. Until then, surgical procedures involving the removal or confirmation of any genital organ in transgender population would be interpreted as mutilation, thus being subject to legal sanctions. The first procedure of that kind in Brazil was performed on patient Waldyrene, in 1971, and the attending physician was tried for battery.[6]

In 2008, the Brazilian Unified Health System (SUS) approved surgical treatment. Accredited hospitals were authorized to perform neovaginoplasty and neophalloplasty, even experimentally.[8] Only in 2010, through CFM Resolution No. 1,955, neovaginoplasty was no longer considered an experimental surgical practice.[9]

The Department of Health Decree No. 2,803, of November 19th, 2013, redefined and expanded the trans-sexualization process in SUS, increasing care integrality–from primary to tertiary care, responsible for hormonal and surgical interventions. Thus, it has ensured the possibility of hormonal therapy starting at the age of 18 years, and surgery performance from the age of 21.[2]

In 2019, the CFM, through Resolution No. 2,265, instituted the Therapeutic Singular Project (PST) for the transgender person, a set of proposals for coordinated therapeutic conducts, resulting from discussions of a multiprofessional, interdisciplinary team with the individual. Comprising all the assistance network including that person, the Resolution meets their needs and demands, regardless of their age. Furthermore, it authorizes hormonal therapy starting from the age of 16 years, and surgery from 18, as well as the possibility of blocking the hormone axis from Tanner II stadium.[2] Figure 1 shows that historical timeline.

Figure 1. Chronology of policies regarding health services to trans population in Brazil.



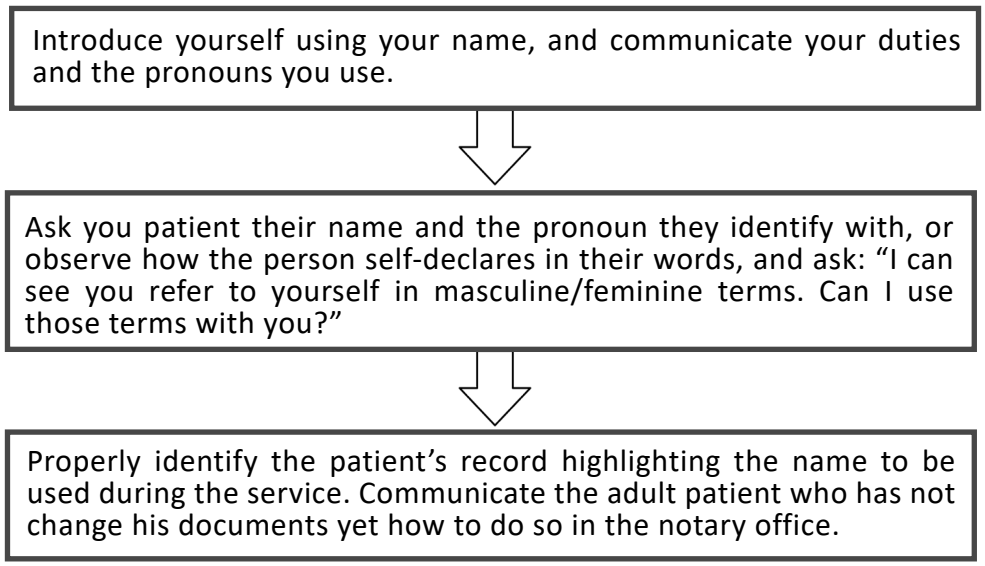
RECEPTION

Presidential Decree No. 8,727/2016 appointed that direct federal public administration bodies and entities will use the preferred name[a] of transgender people. Such a measure made essential to offer that option in the patient's records, and established that all the health service team (reception, cleaning, security, triage, pre-consultation, consultation, and post-consultation) should use it. Besides the preferred name, in order to begin a good relationship with the patient, they should use the preferred pronouns relating to their gender. Therefore, whoever receptions female trans and transvestites will use feminine articles and pronouns; while whoever receptions male trans will use masculine articles and pronouns. Figure 2 shows a suggested template for that approach.

Taking vital signs during pre-consultations depends on neither the sex nor the gender of the person who seeks medical services. In order to follow up hormonal therapy, checking blood pressure and weighing the patient are necessary measures; for male trans, it is also required to ask them about their last menstrual period in case they have not undergone hysterectomy (surgical removal of the uterus).

[a]In order to change the name and/or gender on the birth certificate, the person needs to take to a vital records office all their documents and certificates (birth, marriage, ID, CPF [the Brazilian SSN], voter ID, and proof of address) issued in their home location for the last five years (electoral, civil and criminal justice, criminal execution, labor and military justice, and protest notary offices). The home page https://www.poupatrans.org.br/

Figure 2. How to approach the trans patient?



ASSISTANCE AT PRIMARY HEALTH CARE (PHC)

Centralized assistance and the lack of professional training in primary health care for that population directly affect the Brazilian Unified Health System (SUS) principles of universality, integrality, and decentralization. While that kind of care does not demand specific skills beyond what cis populations are offered, it has often been neglected or even unavailable in some PHC units.

INTERVENTIONS FOR PROMOTING HEALTH AND PREVENTING CHRONICAL HEALTH CONDITIONS

Some evidences point out that behaviors and lifestyles are significant social determinants of chronical conditions. Unhealthy habits like smoking, excessive alcohol use, and physical inactivity are risk factors for increasing chronic metabolic, cardiovascular, and oncological diseases. Increased blood pressure, overweight, alcohol and tobacco use, and increased cholesterol levels are associated with the main risk factors attributed to mortality in Latin America.[12]

Smoking seems to be more frequent among transgender people than cis people, and it associates with an increased risk of developing thrombosis.[13,14] For that reason, investigating such a habit is mandatory before prescribing hormones, especially in female trans, due to the secondary cardiovascular risk of oral administered estrogen.[15]

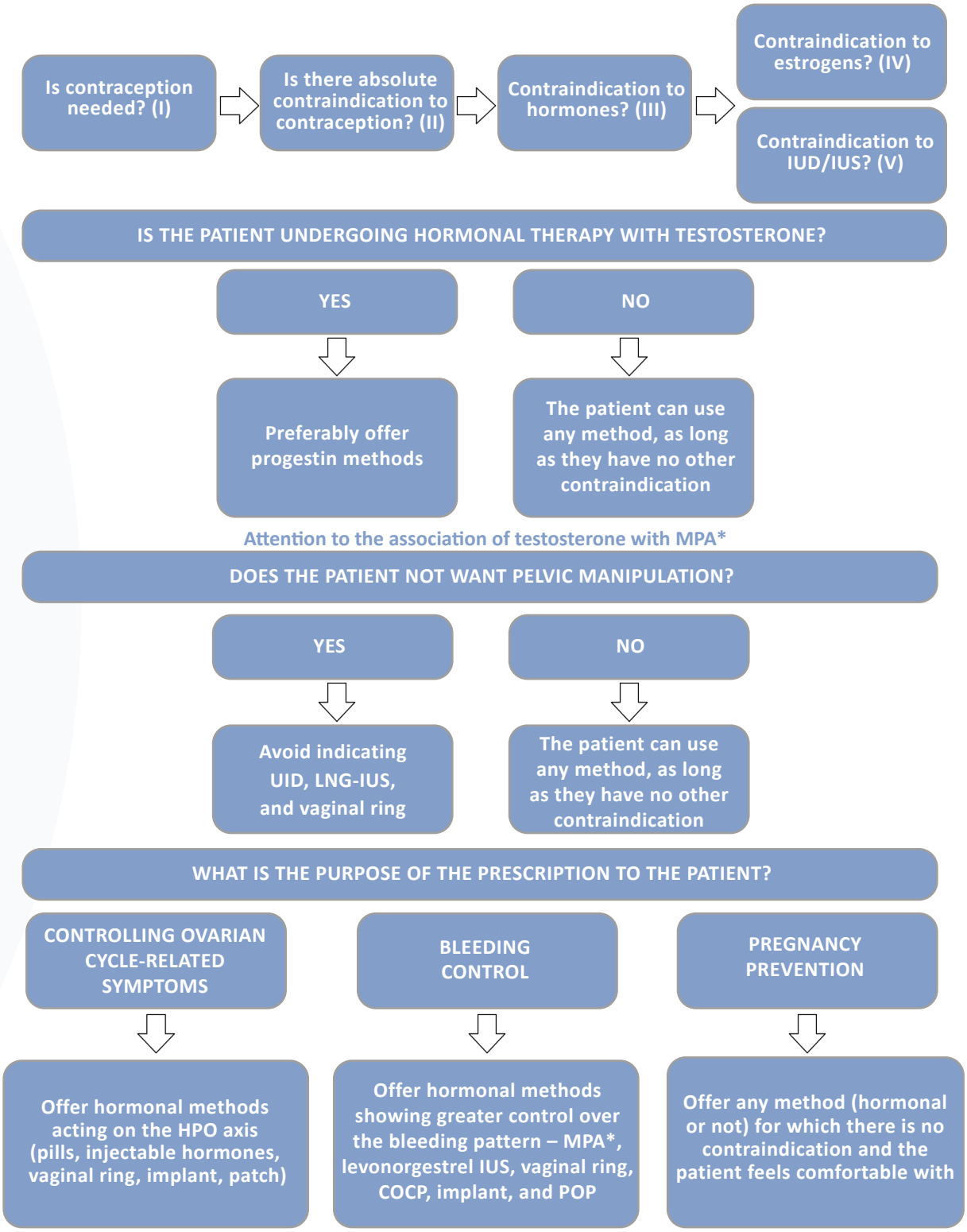
Tobacco use is also related to osteoporosis development in menopausal or gonadectomized people who have not used hormones for more than five years.[15,16] Corticoid users, underweight people (BMI < 18.5 Kg/m²), and those with family history of osteoporosis or personal history of low-impact fracture also have risk factors for its development. Medical advice regarding the possible continuity of hormonal therapy, the practice of high-impact physical activities, a calcium-rich diet, sun exposure, and quitting addictions are essential for reducing that risk in patients with such preconditions.[17]

According to the World Health Organization (WHO), alcohol abuse is a risk factor for non-communicable chronic diseases, as well as for accidents and exposure to vulnerabilities involving violence.[18] A Brazilian study has shown alcohol abuse is high among transvestites, and it is associated with a higher risk of unprotected sex, psychoactive substances use, and therefore, higher prevalence of HIV infection.[19] According to Day (2017), the prevalence of psychoactive drugs use is up to 2.5 to 4 times higher among the transgender population than in cisgender population, and the younger ones are the most susceptible to precociously using those substances.[20]

Male trans who have sex with people with penis may get pregnant, therefore they need contraceptive counselling. Advice and contraindication may be the same as proposed by the WHO medical eligibility criteria for contraceptive use – or the Center for Disease Control and Prevention (CDC) criteria – and for cis women.[21,22] For those who have no risk of spontaneous pregnancy, contraceptive use may associate with decreased vaginal bleeding volume, menstrual cramps, and premenstrual syndrome (PMS) symptoms. Thus, teenage male trans or to adults whose PMS and uterine bleeding characteristics may worsen dysphoric moods should also be offered contraception. Okano et al. (2022) suggest a board template for discussing contraception for that group.[13] (Figure 3).

Advice for preventing sexually transmitted infections (STI) should be in accordance to the patient's sexual experiences. While advice for preventing STI is usually limited to using external preservative (formerly known as male condom), the use of internal preservative (formerly known as vaginal or female condom) and latex panties or dental dams (plates made by cutting the male preservative) can help in the vulva external protection.[23] Though they are less widespread and applicable, latex gloves and finger cots associated with proper hands and nails hygiene can also be allies in that cautious conduct.[23] If penetration occurs by penis or sexual devices (a vibrator, for example), it is important to use the external preservative and change it when sharing the device with the partner, or when switching orifices. Male trans should be advised against potential risks of transmitting infections during the menstrual period, due to external bleeding.[24-26]

Figure 3. Contraceptive counselling template.[13]



*Attention to the association of testosterone with MPA
MPA: medroxyprogesterone acetate; LNG-IUS: levonorgestrel intrauterine system; COCP: combined oral contraceptive pill; POP: progestin-only pill.

Apart from barrier methods, the vaccination schedule must be checked. Vaccines against hepatitis A, hepatitis B, and HPV infection are effective in preventing those infections. HPV vaccination is available at SUS for all girls aged 9 to 14, and for immunosuppressed cisgender women up to 45 years old, as well as for boys aged 11 to 14 and immunosuppressed cisgender men up to 26 years old.[27] People who engage in oral and anal sex should be advised of their need of hepatitis A vaccination, due to transmission risk from that practice.[28,29]

People who show sexual risk behavior, or who have sex with HIV risk behavior people, can also make use of HIV pre-exposure prophylaxis (PrEP). Both PrEP and post-exposure prophylaxis (PEP) are effective drugs to prevent HIV transmission. PrEP is available as daily pills and bimonthly injections (the latter is not currently available in Brazil), and both options can prevent over 95% of infections.[31] For information about services offering PrEP in Brazil, access: http://www.aids.gov.br/pt-br/acesso_a_informacao/servicos-de-saude/prep

People who have receptive anal sex should be advised of lubricant use and anal hygiene. Using enemas to prevent stool discharge during the sexual act associates with a higher susceptibility to HPV and HIV infection.[32] Using disposable, personal-use flasks minimizes the risk of infection transmission.

Box 2: Health promotion

- Advise on practicing regular physical activities and a balanced diet, especially of patients with a higher risk of osteoporosis.
- Advise on quitting unhealthy habits (smoking, drinking and psychoactive substances use).
- Advise on preventing unplanned pregnancy, and talk about contraception, even with patients with no risk of pregnancy due to non-contraceptive benefits.
- Advise on STI prevention (barrier methods, PrEP, PEP, and vaccines).

ONCOLOGY SCREENING

Nulliparity, smoking, obesity, physical inactivity, and alcohol abuse are risk factors for the development of neoplassia.[33] In 2001, Marrazzo noted that sexually active lesbian women could have cervical cancer precursor lesions even without prior penis-vagina penetration.[34] According to a 2017 meta-analysis, bisexual women have higher odds of being diagnosed with cervical cancer compared to heterosexual women (OR 1.94 [95% CI 1.46-2.59]).[35] While those data have cisgender women as study population, we might infer equal importance of gynecological testing and cytology collecting in transgender man aged 25 to 65 years who have had receptive penetrative vaginal relations, due to the potential risk of contact with HPV and hence cervical cancer development.

In trans men, testosterone use promotes vaginal atrophy, sometimes requiring estrogenization prior to gynecological testing for colpocytology collection.[36] For those who feel embarrassed and uncomfortable with gynecological examination, self-testing for HPV detection is a possibility to be considered.[37]

Anal rectal cancer incidence is quite low, although both its incidence and mortality are increasing.[38] We lack data sustaining its universal screening; however, due to a seemly increased incidence in some groups, we might still need to discuss it. In individuals living with HIV who had HPV-related diseases, as well as in men who have sex with men (MSM), there seems to be higher anal rectal cancer incidence.[38, 39] The low quality of evidences, and the lack of data showing that precursors identification can indeed change the prognostics and the mortality of that condition, raise questions about such screening. Therefore, it is worth discussing risks and benefits with the patient, as well as considering the availability of resources for that investigation.

On average, breast cancer diagnosis seems to occur earlier in the trans populations than in the population at large (51.5 years old in female trans; 44.5 years old in male trans).[40,41] The higher exposure to estrogen in female trans, especially for the use of exogenous sources, may be associated with that increased risk.[42,43] Nevertheless, there is no data confirming a higher incidence of that neoplasia in the female trans population compared to the population at large.[44,45]

Based on expert opinion, female trans who are, or were, under estrogen therapy for at least five years, as well as non-mastectomized male trans, are recommended to be investigated for breast neoplasia according to the guidelines for cis women;[37] mastectomy is a risk-reducing procedure.[46] Therefore, there are no current evidences of asymptomatic mastectomized male trans who need breast screening.[41]

There are some reports on prostate cancer in female trans, however most of the diagnosis were confirmed in patients who had started hormonal therapy after 50 years old, possibly already having an undiagnosed neoplasia.[47] The Brazilian Cancer National Institute (Inca) does not recommend universal screening to cisgender men, since there are no studies showing that kind of investigation can reduce prostate cancer mortality.[48] Patients with low testosterone levels–due to drug suppression or gonadectomy–are recommended to consider prostate specific antigen (PSA) normality levels when lower than <1.0ng/ml.[47]

While there is no universal recommendation, when risk factors such as long-standing smoking and obesity are taken into account, they require closer attention to developing oncological conditions, as well as cardiovascular diseases. Therefore, advice regarding lifestyle changes should be reinforced, and the screening of those other oncological conditions should be individualized for each patient's risk factors.

Box 3: Oncology screenings

1. **HPV screening**
    a. **Cervic cancer**
    - Target: people with vulva, vagina e uterus who have already had sexual relations.

    - **Colpocytology:**
        - Start at age 25, end at age 65;
        - Estrogenize patient taking testosterone with estriol or topic promestriene prior to colpocytology collection;
        - After two negative testing, space out to triennial collection, if low risk.

    - **HPV-DNA**:
        - Start at age 30;
        - Offer PCR-HPV self-collection for people who do not want a physical examination;
        - If negative, offer a new collection every 3 to 5 years, according to the patient's risk factors.

    b. **Anal rectal cancer**
        - Target: people living with HIV who have receptive anal sexual relations; immunosuppressed people; and people who have had cervical, vulvar and vaginal cancer secondary to HPV.
        - Collecting anal or HPV-DNA cytology (not available at SUS).

2. **Breast cancer screening**
    a. **Male trans**
        - With no mastectomy: physical examination after age 40; mammography after age 50;
        - With mastectomy: there is no evidence of a need for screening. Individualize the case.
    b. **Female trans**
        - With no hormone use: there is no evidence of a need for screening. Individualize the case.
        - With at least five years of estrogen use: physical examination after age 40; mammography after age 50;
        - Other cases: individualize according to risks and age.

3. **Prostate cancer screening**
    - Target: all trans women, even if redesigned.
    - There is no evidence of benefits from screening. Offer it to people with risk factors or symptomatology.
    - Mind PSA values above 1 ng/ml in estrogen users or gonadectomized women with low testosterone levels.

MENTAL HEALTH AND SUPPORT NETWORKS

Although there is no causal link between understanding oneself as a LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual…) person and developing anxiety and/or depression, the odds of their showing those disorders is higher than in the population at large (OR = 2.94; 95% CI 2.27-3.80, p<0.001).[49] Social anxiety disorder, specific phobia, and depression are the most usual mental health diagnoses in those groups.[50]

According to minorities stress standards, stigmatization and internalized prejudice impact that population's building of self-perception, self-care, and interpersonal relationships in that population. Despite LGBTQIA+ experiences being legalized in Brazil, transgenders still face several barriers to accessing healthcare networks, and mental health challenges.[50] Trans people also have a high risk of depression and anxiety, as well as higher rates of suicidal ideation and suicide. A European research has shown a 38% prevalence of depression among trans,[51] while suicide ideation/attempt rate in that population is up to 20 times higher than in the population at large.[52]

Box 4: Mental health

- Assess symptoms of anxiety and depression.
- Assess support networks.
- Investigate cases of social vulnerability and violence.

CASES SUGGESTED TO BE REFERRED TO SECONDARY AND TERTIARY CARE

All patients presenting demands regarding the trans-sexualization process must be referred to referral services,[10] through a reference guides requesting the proper procedure: surgery or hormonal therapy. Annex I shows the available referral services in the Brazilian Unified Health System (SUS).

CFM currently considers surgeries possible after the age of 18 years. The trans-sexualization process in SUS, however, allows surgery only after 21 years old, and after a two-year monitoring of a multi-professional team.[10] Patients undergoing partial follow-up in a SUS unity (hormonal and mental health therapies) need a report confirming such follow-up to get surgery authorization.

Despite trans-sexualization not being commonly performed in PHC, being aware of surgery possibility, and the correct referring may prevent patients from resorting to parallel procedures such as unsupervised use of industrial silicone, binders, and hormones.[2,37]

Widely spread among trans women and transvestites, silicone associates with infections and thromboembolic events.[53]

Assisted reproductive technology is not yet universally available in the Brazilian public system. Transgender people demanding pregnancy or fertility preservation, in need of highly complex procedures, should be advised to seek services in the private system, or be referred by SUS to places where training collaborations in assisted reproduction are available, especially the ones linked to universities.[54]

Trans people's pregnancy and prenatal care rarely have specific demands nor are they considered as high-risk. During the pregnancy and postpartum cycle, however, reference and reception in better prepared places can mitigate discomforts, prejudice, and misconduct.[37]

Box 5: When to refer?

1. **Trans-sexualization process demand**
- Refer to regional or state services for assessment and follow-up
- If the patient is undergoing hormonal therapy and psychological follow-up, send a report with the referral.
- Requirements: being at least 18 years old to begin hormonal therapy, and 21 for surgery. Note: some places have already reclassified their services to the new CFM Resolution (no. 2.265/2019) allowing hormonal therapy to begin at age 16 and surgery after 18.

2. **Assisted reproduction**
- Indication: fertility preservation; assisted reproductive technology for pregnancy.
- Not universally available at SUS. Individualize with regional or state reference.

3. **Prenatal care and childbirth**
- Although it is not a high-risk pregnancy, awareness of places with the best reception conditions mitigates prejudice and misinformation

CONCLUSIONS

Health services for transgender people, while having their particularities, are perfectly possible in primary health care.

Approaches regarding reproductive health, chronic disease prevention and screening, and mental health assessment are part of any doctor's basis, by and large following the same guidelines proposed for cisgender people. Preparing the environment, training teams, and knowing the ways of referring are important measures to improve health access for that population, who are extremely neglected of full care.

The approach regarding reproductive health, chronic disease prevention and screening, and mental health evaluation is part of the basic matrices of any doctor, and most of the time, it follows the same guidelines proposed for cis-people. Adjusting the environment, training teams, and knowing referral routes are important measures to improve the access of this population, extremely neglected from comprehensive care.

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ANNEX I

Hospital	City
UFG – Hospital das Clínicas da Universidade Federal de Goiás	Goiânia/GO
UFRGS – Hospital de Clínicas de Porto Alegre	Porto Alegre/RS
UFP – Hospital das Clínicas	Recife/PE
UERJ – Hospital Universitário Pedro Ernesto	Rio de Janeiro/RJ
FMUSP – Hospital de Clínicas da Faculdade de Medicina	São Paulo/SP

SUS walk-in clinics:

Clinic	City
CPATT – Centro de Pesquisa e Apoio a Travestis e Transexuais	Curitiba/PR
Instituto Estadual de Diabetes e Endocrinologia	Rio de Janeiro/RJ
Hospital Universitário Professor Edgard Santos	Salvador/BA
Centro de Referência e Treinamento DST/AIDS	São Paulo/SP
Ambulatório do Hospital das Clínicas de Uberlândia	Uberlândia/MG
Hospital Universitário Cassiano Antônio de Moraes	Vitória/ES

Ambulatório Transexualizador da Unidade Especializada em Doenças Infectoparasitárias e Especiais	Belém/PA
Ambulatório de atenção especializada no Processo Transexualizador do Hospital Eduardo de Menezes	Belo Horizonte/MG
Ambulatório Trans do Hospital Dia	Brasília/DF
Ambulatório LGBT Darlen Gasparelli	Camaragibe/PE
Ambulatório de Saúde de Travestis e Transexuais do Hospital Universitário Maria Pedrossian	Campo Grande/MS
Centro de Saúde Campeche	Florianópolis/SC
Centro de Saúde Estreito	Florianópolis/SC
Centro de Saúde Saco Grande	Florianópolis/SC
Ambulatório de Saúde Trans do Hospital de Saúde Mental Frota Pinto	Fortaleza/CE
Ambulatório de Transexualidade do Hospital Geral de Goiânia Alberto Rassi	Goiânia/GO
Ambulatório para travestis e transexuais do Hospital Clementino Fraga	João Pessoa/PB
Ambulatório de Saúde Integral Trans do Hospital Universitário da Federal de Sergipe	Lagarto/SE
Ambulatório LGBT Patrícia Gomes, Policlínica Lessa de Andrade	Recife/PE
UPE, Centro Integrado de Saúde Amaury de Medeiros	Recife/PE
Ambulatório LBT do Hospital da Mulher	Recife/PE
Ambulatório de Estudos em Sexualidade Humana do HCRP	Ribeirão Preto/SP
Ambulatório do Centro Estadual de Diagnóstico, Assistência e Pesquisa	Salvador/BA
Ambulatório trans do Hospital Guilherme Álvaro	Santos/SP

Ambulatório Municipal de Saúde Integral de Travestis e Transexuais	São José do Rio Preto/SP
Ambulatório AMTIGOS do Instituto de Psiquiatria do Hospital das Clínicas	São Paulo/SP
Ambulatório Roberto Farina, UNIFESP	São Paulo/SP
UBS Santa Cecília	São Paulo/SP
Ambulatorio de Saúde Integral de Travestis e Transexuais João W. Nery	Niterói/RJ

HISTORIC

Received	Approved	Publication
05/10/2022	05/17/2022	06/21/2022

Acesso aberto/Open Access

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