

CHILEAN TRANS MEN: HEALTHCARE NEEDS AND EXPERIENCES AT THE PUBLIC HEALTH SYSTEM

Samantha Gonzalez¹, Margarita Bernales²

¹School of Psychology, Pontificia Universidad Católica de Chile, Santiago, Chile

²School of Nursing, Faculty of Medicine, Pontificia Universidad Católica de Chile, Santiago, Chile

Author for correspondence: Margarita Bernales: mmbernal@uc.cl

Submitted: 24 June 2022; Accepted: 24 November 2022; Published: 13 December 2022.

Abstract

Introduction: Research shows high rates of discrimination against the transgender population in healthcare centers, which has negative consequences for their quality of life. There are few studies in this area that focus upon the experiences of trans men, although, they tend to experience higher levels of violence and stigmatization in healthcare settings.

Method: We explored the perceptions of 14 Chilean trans men regarding discrimination in healthcare centers from an ethnographic approach, with the aim of analyzing their experiences in these facilities, and identifying their needs in relation to healthcare.

Results: The majority of trans men perceived health centers as a source of discrimination. The most important expressions of discrimination involve questioning their gender identity, and disregarding their social names and pronouns. In view of this, interviewees placed fear of discrimination as the main factor preventing them from being attended at healthcare centers. On the other hand, having access to health workers who are trained in providing care to the transgender population, being provided with information, and the possibility of receiving psychosocial support are the main factors promoting their attendance at these facilities.

Discussion: The study has implications both for health professionals and public policies focused on the trans-masculine community. Recommendations are made for professionals and administrative staff to provide respectful and sympathetic care in order to generate spaces free of discrimination that encourage attendance at healthcare centers, improving the welfare of trans men.

Keywords: trans men, discrimination, healthcare centers, healthcare professionals, healthcare public policies

INTRODUCTION

Trans persons are those whose sex assigned at birth does not represent their gender identity, according to their subjective perception and the sociocultural context that surrounds them.¹

Although this community is becoming increasingly visible, it is still victim of stigmatization and transphobic violence.²⁻⁴ Chilean studies show that 76.1% of the trans population has suffered discrimination due to their gender identity, the most recurrent being

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernales M

verbal (63.9%), psychological (47%), and disallowing public or private services (17.7%).⁵

Among the most frequent discrimination events are those occurring in healthcare centers,⁵ where denying healthcare services, and verbal or physical harassments have been reported. In addition, professionals do not always regard gender identity, social names or pronouns,^{6,7} all of which may prevent trans people from receiving medical and psychological care. In fact, research shows that 43.9% of the focus population often needed healthcare services, but did not attend healthcare centers for fear of harassment.^{8,9}

Although this affects the entire transgender community, trans men (TM) have been particularly invisible in terms of their experiences and needs in this area. In the Chilean context this is no different, as the country has produced scarce psychosocial research on the transmasculine population in comparison with other Latin American countries.¹⁰ This is concerning, because research reveals that more than 40% of TM have suffered verbal harassment, physical aggression, or denial of care in clinics or hospitals; in addition, they are twice as likely to postpone medical care when compared to trans women, due to the discrimination suffered in these facilities.¹¹

Thus, studies reveal that TM's perception of healthcare centers sees them as a source of violence, mockery, fear, and uncertainty regarding the ability of health professionals to meet their needs, and is one of the main obstacles in seeking help in these contexts.¹² This may cause transmasculine patients to prefer not to respond to calls from healthcare professionals, or to respond to their legal name and/or sex assigned at birth, in order to avoid feelings of shame or possible acts of discrimination, thus generating high emotional discomfort.¹³

In turn, this may result in TM refusing to undergo examinations necessary for their health, such as the Papanicolaou test (PAP). In fact, the literature shows that they are less likely to undergo the examination when compared to cisgender women, due to possible discomfort.^{14,15} This is mainly due to

the fact that health professionals are not sensitive to the needs of TM during this procedure, and do not take measures to ease the pain or trauma of individuals. The procedure is an instance in which their masculinity is questioned, given that, from a gender-binary perspective, the PAP test is understood as an exclusively feminine examination.^{16,17}

One of the main reasons TM attend healthcare centers is because of the transition process (TP), defined as a modification of physical, social, and/or legal characteristics, consistent with the affirmed gender identity.¹⁸ However, services related to TP are mainly centered on the following therapies: hormone suppression, cross-hormone therapy, and genitoplasty.¹⁹ Thus, the importance of psychosocial support has been overlooked, perpetuating the biomedical approach to TP from a perspective that does not consider the emotional impact of the process for TM, whether due to the effect of hormones, their relationship with the environment, or their own emotions.^{20,21}

Both the discrimination suffered in healthcare centers and the prevailing biomedical perspectives have serious consequences for the TM's health. On the one hand, failure to attend healthcare facilities may lead to cases of hormonal self-medication and self-mutilation, which are the results of the absence of resources and education related to the TP.⁷ On the other hand, scarce psychosocial support may lead to an increase in anxiogenic as well as depressive symptoms and risk behaviors, among others.¹⁸ This comes in addition to a lack of training in gender issues, sexual diversity and care for the transgender population from healthcare professionals, which has had a negative impact on seeking care.^{22,23}

The lack of research focused on TM has hindered the understanding of their experiences and demands in healthcare centers, and the development of public policies to ensure that healthcare facilities could be spaces free of discrimination. Furthermore, although the literature provides general guidelines for the care of the transgender population, not only does it not consider specifics about TM, but the information is also not usually based on

their voices and life stories. This is a situation that is even more significant in the Chilean context, and is cause for alarm when considering the high rates of violence and transphobic discrimination in Chile.²⁴

In this context, the aim of the article is (a) to analyze the experiences of Chilean TM in healthcare centers, and (b) to identify their needs in relation to care in healthcare centers. The main research questions for the study are: (a) What are the experiences of TM in healthcare centers? (b) What factors promote and inhibit attendance at healthcare centers? and (c) What is the perception of TM on Chilean public policies aimed at reducing discrimination in healthcare centers? This article describes relevant points of interest to understand the types of discrimination suffered by transmasculine people, and the consequences in their lives. It is hoped that this study will allow Chilean TM to show their views and make their voices heard, in order to improve their quality of life, as well as physical and psychological well-being.

METHOD

This research is part of a grant FONDECYT: Young masculinities and health in the current context of increase of HIV in Chile (N° 11190286). The aim of the project was to explore perceptions and experiences of young men and healthcare workers about how the gender role of men is constructed. From an ethnographic methodological perspective, the FONDECYT project mentioned above involved one of the health clinics that currently accompanies young transgenders actively in Santiago, Chile.

Research design

The FONDECYT project incorporates a qualitative approach from an ethnographic perspective, including participant observations at the health clinic and interviews conducted with cisgender and transgender men and health workers. However, for the purposes of this article, we only consider trans-men interviews. These interviews allow us to understand the sense and meaning that TM assign

to events in their daily contexts, creating knowledge from their perspectives, experiences, and voices.^{25,26}

Study population

To participate, individuals had to be residents of the southeastern sector of Santiago de Chile and be over 18 years old. It should be noted that all interviewees reported having initiated TP medically, socially, and/or legally. No exclusion criteria were used. The description of the characteristics of the participants is presented in Table 1.

Recruitment and data collection

Two methods were used for data recruitment: firstly, a TM who is part of the research team

TABLE 1. Sociodemographic characteristics of participants

Sociodemographic characteristics	n (%)
Age, years (14)	
18–21	5 (36%)
22–25	5 (36%)
26–29	3 (21%)
56	1 (7%)
Educational level	
Primary education	7 (1%)
Secondary education	8 (57%)
Bachelor's or equivalent level	5 (36%)
Student status	
Yes	5 (36%)
No	9 (64%)
Employment status	
Paid job	7 (50%)
Nonpaid job	7 (50%)
Sexual orientation	
Heterosexual	10 (71%)
Homosexual	1 (7%)
Bisexual	2 (15%)
Prefers not to answer	1 (7%)
Public health insurance	
Public	11 (79%)
Private	3 (21%)

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernales M

recommended potential participants; secondly, a public hospital with programs focused on the trans population was contacted. A survey was conducted in the hospital—with the authorization of the psychosocial team of the hospital—which sought to survey various sociodemographic data of the people on the waiting list to enter the center and start a medical TP. At the end of the survey, the purpose of the research was presented, and participants were asked if they were interested in participating. Those who wished to be part of the project provided both their telephone number and email address, and were contacted by these means to coordinate the interview. In addition, each person interviewed was asked to recommend potential participants, thus constituting a snowball sampling strategy.

Once all interested participants were contacted, interviews were scheduled at a time agreed upon by both parties. Each participant was given an informed consent form, which was sent in advance and reviewed before the interview began. At the same time, acronyms were used to refer to names and institutions, in order to protect the confidentiality of the TM and their environment. The final sample consisted of 14 TM. The research was approved by the Scientific Ethical Committee in Health Sciences of Pontificia Universidad Católica de Chile (*Pontifical Catholic University of Chile*).

Data was produced through semi-structured interviews. Because of its flexible nature, this allows adaptation to the subjects interviewed and to the various topics that could arise during the interview.²⁷

Each interview lasted approximately 1 h and, due to the health restrictions imposed by the COVID-19 pandemic, they were conducted online, through the Zoom videoconferencing service. The areas addressed were—based on the FONDECYT project—men's health, men's beliefs about HIV and sex education, social and cultural expectations about masculinity, TM health, and men's experiences and perceptions related to care in healthcare centers. This article analyzed the information related to TM health and their experiences in healthcare services.

While interviews were being conducted, note was taken of ideas that were repeated among participants or that were of particular interest to the research team. Those topics that had not been covered in previous interviews due to the framework, but were nonetheless relevant to the study, were addressed in subsequent interviews, with the aim of exploring them in greater depth. Similarly, during the interviews the participants were asked to explain unclear ideas and to define the concepts they used to refer to different phenomena.

Data analysis

Each interview was recorded and later transcribed. Once this stage was completed, a thematic content analysis was carried out.²⁸ Considering a reflexive approach, including:

- familiarization;
- coding;
- generating initial themes;
- reviewing and developing themes;
- refining, defining, and naming themes; and
- writing up.²⁹

To carry out the analysis, the NVivo software was used.

RESULTS

Three themes emerged during the research:

- (a) Perception of healthcare centers as a source of discrimination,
- (b) Precluding factors and promoters of attendance at healthcare centers, and
- (c) Healthcare needs and public policies.

A description of each theme follows:

(a) Perception of healthcare centers as a source of discrimination

When TM were asked about their experiences in healthcare services, the main theme that emerged

was discriminatory situations in these facilities. In this context, although some participants reported positive experiences, most of the interviewees reported at least one event of discrimination by healthcare professionals and workers (including interviewees who had previous positive experiences). On deeper inquiry, participants mentioned that discriminatory events may range from disapproving gestures or disapproving looks from personnel, to questioning their gender identity with no respect for their social name and/or pronouns. For example, D commented: [Healthcare professionals] *look at me like a freak when I tell them that my name is D., they tell me: "But you are a woman" and there I have to say: "I am a trans man."*

The concept of *freak* was mentioned by another participant and is described by both as feeling out of place in healthcare centers. This comes in addition to feelings of shame, rejection and discomfort in these facilities due to verbal mistreatment and even through nonverbal communication, for example, through staring, as S commented:

At the clinic in my area, they made me feel like I was a freak, like they always looked at me, looked at my ID card, then they looked back at me and called the doctor [to ask] if I was right in what I was saying or not

Both interviewees reported that personnel usually resorted to another professional to confirm the truthfulness of what they express in the medical consultation, in this case, regarding their social name and gender identity. For S and D this is complex, as their identity seems to be validated only when another official corroborates it, rendering their "word" to be insufficient. However, the fact that healthcare workers "accept" their gender identity does not ensure that they will respect the social name or pronouns of the participants in the registry or in their clinical history. For example, S reported that he decided to see the gynecologist who also sees his mother, with the aim of ensuring a space free of discrimination and mistreatment. However, while

the professional respected his gender identity and social name, this did not happen with his pronouns.

One of the interviewees (G) stated that receiving respectful healthcare is often a matter of luck. The participant explained that although he completed the legal TP and his identity card shows the gender with which he identifies, there were still professionals who refer to him as "she." In addition, he comments that even though he "looks" masculine, personnel treat him in a feminine way and use his old name, even when he clarifies his social name and asks them to use it. This makes him self-conscious, and he prefers to present himself at the doctor's office as a woman, because of how exhausting it is to clarify his identity to the professionals. However, this also entails critical looks from them, since he does not wear clothes perceived as feminine.

Therefore, and according to some participants, physical image permeates into the type of care they could receive. Thus, S explains that interactions are associated with image: if doctors do not "see" them as men, they will not respect their social name or their masculine pronouns. Along these lines, the participant commented that on several occasions while attending the hospital, professionals made him feel bad about his appearance, telling him that he should act and look feminine, invalidating his gender identity, a situation that negatively affected his self-esteem.

This has been a recurrent issue for another of the interviewees (D) since childhood. When he had to go to the hospital to receive medical care, doctors used to make comments and stare at him because of his image. He presented himself as a woman because he had not yet started TP, but he did not look feminine, which led to rejection by professionals. For the interviewees, one of the main consequences of undergoing these situations is the perception of healthcare centers as a space that could be unsafe and that, therefore, generates fear, according to F:

Most of trans people I know are terrified of going to the healthcare system, either clinical or psychological—maybe not so much at

psychological consultations, but there you never know if there are pathologizing ideas about being trans. You may find anyone [...] I personally am afraid of healthcare, as well as to get medical attention now, to get a checkup as a trans person, because you may meet with anything, and one knows stories of doctors who have refused to treat people for being trans and it is scary, because in the end your life is in their hands and they can do anything they like...

All participants agreed that the main discriminatory events in healthcare centers corresponded to the questioning of their gender identity, as well as the lack of respect for both their social name and their pronouns. It should be noted that discrimination can be exercised by any healthcare official, such as professionals, administrative staff, or others.

(b) Precluding factors and promoters of attendance at healthcare centers

When participants were asked, it became clear that fear of discrimination was the main factor precluding attendance at healthcare centers. K commented that there are TM who are greatly affected by this, so they prefer to avoid healthcare consultation and thus avoiding possible mistreatment. A similar experience was shared by another participant GA, who pointed out: *It has happened to me that I need to go to a doctor and in the end I do not go because I wonder, how are they going to treat me? What are they going to tell me? So I prefer not to go.*

On the other hand, when asked about the health of TM, another interviewee, A, referred that they do not go to medical checkups because these can be particularly complex for transmasculine patients, because they generate significant discomfort, due to the possible complex relationship with their body. In addition, he pointed out that they must explain their needs to professionals, as the former do not have the tools or knowledge necessary to provide sensitive and respectful care.

Additionally, according to some participants, clinical records are not always updated in the system, which generates uncomfortable situations for TM when attending healthcare centers, because they must repeatedly explain the situation to the administrative personnel, as GA declares:

When I started transitioning, being in the room and being called with the legal name was uncomfortable; to stand up and have all the people start talking, so sometimes you are not so sure... I was not sure about going to the doctor and start the treatment because I was afraid; it was embarrassing, it is embarrassing to go and be like: "Hey, I am trans, this is my social name, can we change my file?"

It is noteworthy that these situations may take place not only in the administrative area—such as clinical records—but, as K explains, also directly with healthcare professionals. K pointed out that he knows TM who have consulted in the gynecology area, and despite the fact that their social name appeared in the record, professionals insisted on finding out their legal name, even when this was not relevant for the consultation and the individuals did not wish to say it. For the interviewee, it was precisely the professionals' insensitivity and their lack of knowledge in this regard that caused transmasculine patients to desist from seeking care in the healthcare services. In relation to this and based on his own experience, K reported that the first time he received psychological attention was to solve doubts about his sexual orientation, and although the professional provided help in this regard, when K began to doubt his gender, the specialist did not know how to deal with the situation:

I left much more anxious than I went in, the psychologist tried to force this on me: "Yeah, but are you trans or not? Do you want to be a mom?" And I don't know if I want to be a mom or a dad, but I do want to have a child, for

example. So these were things that generated trauma, and I was like: “No, I don’t want to go, I don’t want any psychological care, because they won’t know how to deal with the issue.” In the end, I was going to feel much more anxious than I already was

The above-mentioned experiences not only have consequences on their physical and mental health, in general terms, but also influence how TP is performed, in which context, F said: *There is a fear towards healthcare because of prejudices; so, many of us prefer to get hormones or surgeries—that may not be as legal.*

With the aim of avoiding discrimination in healthcare centers, interviewees refer to two strategies: (a) Attend facilities that family, friends or acquaintances know and that are conceived as safe spaces, or (b) create information networks whose purpose is to share contacts of healthcare professionals trained in LGTBQ+ issues, who can provide empathetic and respectful care.

In this context, one of the interviewees (S) comments that he keeps a WhatsApp group with trans people from all over Chile, in which they share information of healthcare professionals (e.g., psychiatrists, psychologists, gynecologists), whose care is trans-friendly. This can also be done by establishing contact with institutions or organizations that specialize in LGTBQ+ issues, a situation that is exemplified in G’s account.

I was careful when looking for psychologists, so I contacted an organization and asked them to refer me to psychologists who dealt with LGBT issues. They put me in touch with and I was seen by two psychologists who were trained on the subject, who managed patients sensibly, had studied LGBT issues, and who also were in touch with, for example, endocrinologists, [or] places known for managing patients well, where it is known that they give talks—that there is training. So, that is why my experience has been good: it’s because I have

been visiting different places where I know they are informed.

G’s statement is relevant, because it shows the factors that promote attendance at healthcare centers. When asked about this, the interviewees allude to different aspects that make care a safe instance. In this context, the use of both the social name and the correct pronouns stand out, to which one of the interviewees (MC) expresses: *Having respect for the name and pronouns is very important for us. Using them can save the life of a transgender person.*

This comes in addition to situations in which TM do not have to provide further details about their gender identity if they do not wish to and/or if it is not required, because these details are *de facto* validated. For example, S reported that he went to a healthcare center for a physical examination, and at the exam, he explained to the nurse what his gender identity and social name were, a detail that both the medical and psychosocial teams effectively validated. Similarly, he commented that a psychiatrist had his data modified in the clinical record, especially his name, so that every time he goes to the office or to the laboratory—for tests—he is called by his social name and his pronouns are used. This has persuaded him to go, because he felt comfortable and at ease.

Other interviewees shared this perception. For example, F pointed out that he was part of a prevention program focused on PAP smears, which he qualifies as positive not only because of the general fair treatment, but also because they used his name, and provided him with information about the exam. As mentioned by B, this is in addition to participants not perceiving a change in treatment by the professionals when they present themselves as TM: *When I arrived at the healthcare center, the lady [receptionist] treated me well. I showed her my ID card, [even though] I had not yet changed my name—but there was no change, no change in her attitude.*

In addition to the above-mentioned, one interviewee (G) expressed that he felt comfortable in healthcare centers when the hospital doctors are

empathetic, provide information related to transsexuality, and offer psychological support both for them and their families. He provided the example of his mother, who asked for an appointment with the psychologist, and in this appointment, they explained to her the hormonal treatment related to TP.

Thus, participants attend healthcare centers when they perceive them to be respectful and safe spaces in which they will not be discriminated. Along these lines, one of the interviewees (A.L.) commented that he “likes” to go when he feels safe, when he can “be himself” and will not be mistreated in any way (e.g., verbally or attitudinally):

The fact that you feel like a person—that type of human relationship is super effective, and in the long run, it favors [attendance at centers], because one feels that one actually matters, and the safer the environment is, the more likely it is that you go again, as long as you are treated with the respect and gentleness deserving of every situation

(c) Healthcare and public policy needs

In order to generate a safe environment in healthcare centers, the interviewees mentioned the importance of training health professionals, and administrative staff. The employees should receive tools and information related to the transgender population, considering their characteristics and needs, which would promote respectful and comprehensive care observing their specificity. Participants emphasize that training should be carried out in all areas of health, since TM may require assistance in multiple specialties. For example, one interviewee (K) said:

Regardless of the unit you are in at the hospital, you can come across a TM and you have to know how to address them and understand how [hormone use] is going to affect a certain disease in TM. For example, testo [testosterone] increases blood pressure, can cause thrombi, increases triglycerides, which also affects

diabetes, and there is a lot of misinformation among professionals about this.

This is also shared by F, who, in addition, highlighted the importance of also providing TM with information in healthcare contexts, so they become empowered and active agents during care.

In the healthcare area, I would recommend training and lectures for professionals. Another important thing about the health of transmasculinities as well is that there should be sex education, so that [transmasculine people] know how to discern whether something is good or bad for them and their health.

Interviewees alluded to the fact that training should be aimed at the ability of professionals to respond to the particular needs of each TM, so they are capable of providing a specialized service focused on their characteristics, as exemplified by G:

Care is not generalizable, because sometimes one TM may be bothered by something that another one is not, he may be bothered by everything or may not be bothered by anything. It is necessary to check what bothers or what does not bother the person in order to treat him the way he should be treated. For example, I have no problem in my genital area, but the breast area is an issue for me: I will never leave my house without a binder. However, it maybe is the other way around or it is not relevant for someone else...

Another relevant demand of interviewees was related to the medical TP. Both, the use of testosterone and body readjustment surgery, were mentioned due to the importance that both procedures have for TM. Along this line, a participant (MC) considered that a greater allocation of economic, physical and human resources for the realization of the body readjustment surgery is an urgent demand. In this

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernalles M

sense, MC emphasized that surgery is not an aesthetic need, but a way to improve their quality of life and well-being.

Regarding hormone treatment, one of the participants (B) demanded that hospitals have the necessary resources to avoid delays in hormone injections. However, he emphasized that due to the COVID crisis, this was not a priority for healthcare centers, so he and other TM could not go to these facilities to receive hormones. Moreover, the participant reported that, due to the complex situations caused by the pandemic, importation of hormones was being hindered in the country, having physical and emotional consequences on his health due to hormonal deregulation.

Although, hormone treatment and the performance of tests linked to medical TP are the main reasons stated by interviewees for attending healthcare centers, the search for psychological support (n = 8) becomes a crucial element before and during this process and, therefore, is a reported need in the healthcare area. For example, one participant (GA) told of his crises related to mental health before starting TP that led him to commit self-injury, and professional psychological support saved his life. Similar situation was shared by another interviewee (A):

Last year, I started psychological therapy, because the treatment put me through lots of emotions—there were too abrupt mood swings, I wanted to escape all the time, I wanted to end my life. They were very stressful situations. If there had not been someone who understood the issue there with you, sitting and talking to you and saying: “I understand you and we can do this, you can make this better”...

For the participants, psychosocial support is crucial for their health and could be necessary at any stage of the TP. Moreover, the support provided by professionals may constitute the first step to initiate this process. In this sense, both the information and the support provided by the staff enable a better understanding of TP, not only from a medical

perspective but also from an emotional one. For S, this is conceptualized from the standpoint of “feeling.” The interviewee points out that TM need a space to express how they feel, in which their ideas and questions are validated, and which will allow them to start the TP in a calmer and more informed way.

Another relevant idea for the interviewees was that psychosocial accompaniment should not only be limited to TP. Participants mentioned that the context in which they are immersed can have a negative impact on emotional well-being. For example, GA commented that some TM lack a safe space at their homes, which can cause distress, leading individuals to self-harm and even suicide. In addition, situations like this go beyond the family nucleus as they may suffer discrimination in different contexts based on their gender identity, so having safe spaces becomes a first-line need. G mentions:

[Due to discrimination] Some end up taking away their own lives, they self-harm, they end up falling into a hole from which they cannot get out, so accompaniment is super important. Having someone listen to you—because when you have someone to listen to you, you get relief from a lot of grief, while when you are alone you end up saying: “I can’t stand living like this anymore, because what I want to be does not seem right to society and it will always pull me down,” and some leave the treatment or take drop their own lives.

The third area where needs were stated was related to Chilean public health policies focusing on the transpopulation and transmasculinities. In this sense, one of the interviewees (K) commented that, at the present time, there are public plans and programs focused on women (cisgender and trans), but there is a lack of policies to ensure the training of professionals in TM care, which take into consideration the characteristics of this group. Likewise, participants highlighted the importance of increasing the number of specialized centers or hospitals

with areas dedicated to the transpopulation (referred to as politrans), as these promote care focused on their specific characteristics, while providing a safe space. This was pointed out by S, who acknowledged the importance of the Gender Identity Law, but emphasized the lack of public projects focused on the transpopulation and, along this line, the small number of specialized centers for this community throughout the national territory:

The law does nothing more than allow you to change your name, and although it is something good for us—it helps us with our mental health— it's nothing more than that; because not all the centers are trained or MINSAL [Ministry of Health] does not have projects for TM.

DISCUSSION

The results obtained in the study are consistent with wider evidence which relates the experience of the transcommunity in healthcare centers and the effects of discrimination on their perception of these spaces. However, the data presented here are new in the Chilean context, as TM needs are presented with a focus on general care in healthcare facilities, as well as on factors that affect their seeking health care services behaviors.

This is relevant, because research on trans-masculinities and health has focused on the prevention and analysis of the prevalence of HIV-AIDS, sexually transmitted infections, their association with risky sexual practices,^{30–32} substance use³³ and obstacles to body treatments for the reaffirmation of the male body. As a result, there is almost no official data on other needs and problems in relation to the healthcare system.

In the study, participants discussed their experiences in healthcare centers and the obstacle to accessing them. Consistent with the literature⁷, although the importance of receiving healthcare is highlighted, participants may be deterred from it by previous discriminatory experiences, and fear

of mistreatment by healthcare personnel. In fact, at least two of the interviewees commented that they prefer to attend the centers only when they are seriously ill, when they have suffered accidents and/or emergencies.³⁴ This not only refers to medical care but also to psychological care services.

Participants considered this area as fundamental for their health, both for the changes associated with TP, and for the individual difficulties that may precede the experience of their identity as TM.³⁵ However, they do not always have access to these services, due to the lack of training of professionals in gender issues and the discriminatory events that occur in these spaces. This is of concern considering that, on many occasions, healthcare professionals are the ones most likely to detect the presence of depressive or anxious symptoms that require timely support, as well as being able to detect suicide-risk indicators,¹⁰ elements that have been present in the lives of participants.

This is relevant insofar as the needs of TM in healthcare centers generally have been conceived from a biomedical approach, so that healthcare services have been based almost exclusively on medical interventions related to hormone treatment and surgeries. However, from an integrated health perspective, TM well-being involves much more than this aspect and healthcare center attendance is not based exclusively on TP.³¹

The fact that the healthcare supply for TM is centered on medical TP can be explained by the gender-binary approach present in the healthcare systems, a perspective that just validates the TM when their body conforms to hegemonic gender norms.^{36,37} One of the main consequences of this is the invisibilization and exclusion in the healthcare systems of TM who do not wish to access medical interventions during the TP.^{38,39} This also promotes a binary conception of the body when performing physical examinations, feeding a lack of knowledge on the part of professionals regarding specific information, and treatments required by TM, and results in a lack of skills to meet the needs of this group during the procedures.^{16,17}

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernalles M

Regarding general recommendations for the care of transmasculine patients in healthcare centers, it is essential to respect the social names and pronouns of the individuals, both in the records, and in their clinical history and in verbal reference. At the same time, it is essential to avoid questioning the gender identity of TM. In this sense, it is important to inquire about aspects that are relevant during care (e.g., history of hormone treatments, surgical and/or surgical history, and mental health interventions), always using respectful and sensitive language, but not attempting inquiries on the type of clothing, legal name, or other aspects that may cause discomfort to individuals.

In addition, it is important to consider that each TM has different needs and characteristics, similar to what was reported by Peruvian TM in a recent study in which the diverse needs of TM and the social complexity they face are reported.⁴⁰ Therefore, it should not be assumed that everyone has initiated or wishes to initiate medical TP. Likewise, it is necessary to consider that the needs of individuals go beyond interventions of this type, so that care should be comprehensive and consider multiple aspects of their lives. Providing respectful care to transmasculine persons, which considers their specific characteristics, experiences and needs, has an undeniably positive impact on their quality of life, not only in terms of medical and psychological care, but also in terms of their dignity as people.⁴¹

This has implications for public health policies in Chile, because participants highlighted the absence of programs and policies focused on generating spaces that meet their needs. In this sense, references were made to the Gender Identity Law, and Memos N°21 and N°34, whose purpose is to establish the use of the social name in verbal addressing, and in medical records. In addition, such legal stipulations state that when an individual does not voluntarily ask to be identified according to his/her name and social gender, the professional should ask how he/she prefers to be addressed.^{2,42} However, not only a lack of awareness was highlighted about these legal stipulations on the part of healthcare professionals and administrative staff but also the lack

of state regulation regarding their implementation. The Chilean healthcare system and its professionals have a central role in providing different instances of support to the transcommunity in general, and specifically to TM.

Additionally, there are four areas in which public policies could place greater focus: (a) ensuring the training of healthcare professionals and administrative personnel in the care of transgender people, which promotes respectful and informed treatment during care; (b) the creation of healthcare centers for the transgender population, with a greater amount of resources oriented to them; (c) promoting compliance with antidiscrimination laws and memos; and, (d) the reduction of costs associated with medical TP, when this is pursued privately, along with a greater allocation of funds for those individuals who cannot afford such interventions in private facilities. All these actions are necessary and pertinent considering that transgender adults in general have poor physical and mental health, and higher rates of chronic conditions and disability.⁴³

LIMITATIONS

One major limitation of the study was the use of a virtual format (zoom) to collect data that may have affected the relationship between the research team and participants. However, the limitations imposed by the confinements associated with Covid-19 did not allow the interviews to be conducted face-to-face, as it was the originally designed.

FUNDING

The study was funded by ANID (Chilean National Agency for Research and Development), Initiation FONDECYT (National Fund for Scientific and Technological Development), N°11190286.

CONCLUSION

Despite the scarce literature focusing on understanding the types of discrimination suffered by

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernales M

transmasculine individuals in the healthcare system, recent research has documented that this population experiences higher levels of exclusion, harassment, and violence in these contexts when compared with the rest of the LGBTQ+ population.^{44,45} The main consequence of this situation is a reluctance to attend healthcare centers, due to fear of possible mistreatment.⁴⁶ It is clear that healthcare workers play a central role in the creation of safe spaces that provide empathetic and competent care for the needs of transmasculine patients. To this end, respect for gender identity, and providing information and psychosocial support are essential to reduce barriers related to the search for support and care. In this context, public health policies focused on reducing discrimination are fundamental, as they enable the promotion of competences in all workers at healthcare centers, improving their ability to understand the sensibilities and needs of the transmasculine population, under the premise that the entire health and disease process is mediated both by the experiences of the patients, as well as the beliefs and values of professionals.⁴⁷

REFERENCES

1. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychol.* 2015;1(9):832–64. <http://dx.doi.org/10.1037/a0039906>
2. Zapata A, Díaz K, Barra L, Maureira L, Linares J, Zapata F. Atención de salud de personas transgéneros para médicos no especialistas en Chile. *Rev Méd Chil.* 2019;147(1):65–72. <http://dx.doi.org/10.4067/S0034-98872019000100065>
3. Day M. La discriminación que enfrentan personas trans y no binarix en servicios de salud en Santiago, Chile. Chile: Salud Pública, Medicina Tradicional y Empoderamiento de La comunidad; 2017. pp. 1–35.
4. Melin A, Ruíz P. Experiencias trans en el sistema público de salud de la región de los ríos. Universidad Austral de Chile, Tesis de Grado; 2019. pp. 1–66.
5. Movimiento de Integración y Liberación Homosexual. Encuesta Identidad; 2018.
6. Jaffee KD, Shires DA, Stroumsa D. Discrimination and delayed health care among transgender women and men. *Med Care.* 2016;54(11):1010–6. <http://dx.doi.org/10.1097/MLR.0000000000000583>
7. Organización Panamericana de la Salud. Por la salud de las personas trans: Elementos para el desarrollo de la atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe. Buenos Aires, Argentina; 2016.
8. Giblon R, Bauer GR. Health care availability, quality, and unmet need: A comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Serv Res.* 2017;17(1):1–10. <http://dx.doi.org/10.1186/s12913-017-2226-z>
9. Macapagal K, Bhatia R, Greene G. Diferencias en el acceso a la atención médica, el uso y las experiencias dentro de una muestra comunitaria de lesbianas, gays, bisexuales, transgénero y adultos emergentes racialmente diversos. *Salud LGBT.* 2016;3(6):434–42.
10. Barrientos J, Saiz L, Gómez F, Guzmán M, Espinoza R, Cárdenas M, et al. La Investigación Psicosocial Actual Referida a la Salud Mental de las Personas Transgénero: Una Mirada Desde Chile. *Psykhe.* 2019;28(2):1–13. <http://dx.doi.org/10.7764/psykhe.28.2.1482>
11. Shires DA, Jaffee K. Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health Soc Work.* 2015;40(2):134–41. <http://dx.doi.org/10.1093/hsw/hlv025>
12. Davies J, McCrae BP, Frank J, Dochnahl A, Pickering T, Harrison B, et al. Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *J Am Coll Health.* 2000;48(6):259–67. <http://dx.doi.org/10.1080/07448480009596267>
13. Pinto Novais de Azevedo, D. Acolhimento de Homens Trans em Consultas de Ginecologia. Universidade Beira Interior, Tesis Doctoral; 2021. pp. 1–68.
14. Peitzmeier S, Khullar K, Reisner S, Potter J. Pap test use is lower among female-to-male patients than non-transgender women. *Am J Prev Med.* 2014;47:808–12. <http://dx.doi.org/10.1016/j.amepre.2014.07.031>
15. Peitzmeier S, Reisner L, Harigopal P, Potter J. Female-to-male patients have high prevalence of

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernalles M

- unsatisfactory Paps compared to non-transgender females: Implications for cervical cancer screening. *J Gen Intern Med.* 2014;29:778–84. <http://dx.doi.org/10.1007/s11606-013-2753-1>
16. Braz C. “Acá yo soy un pibe normal”: Narrativas sobre la espera y el acceso a derechos entre varones trans en Argentina. *Sexualidad, Salud y Sociedad. Rev Latinoamericana.* 2019;119–38. <http://dx.doi.org/10.1590/1984-6487.sess.2019.31.07.a>
 17. Peitzmeier SM, Agénor M, Bernstein IM, McDowell M, Alizaga NM, Reisner SL, et al. “It can promote an existential crisis”: Factors influencing Pap test acceptability and utilization among transmasculine individuals. *Qual Health Res.* 2017;27(14):2138–49. <http://dx.doi.org/10.1177/1049732317725513>
 18. Aduay A, Sandoval J, Ríos R, Cartes A, Salinas H. Terapia hormonal en la transición femenino a masculino (ftm) androgénica, para trans masculino o para hombre transgénero. *Rev Chil Obstet Ginecol.* 2018;83(3):318–28. <http://dx.doi.org/10.4067/s0717-75262018000300319>
 19. González V, Catalán M, Pantoja de Prada V. Evaluación con enfoque de salud de la situación de personas trans en Chile: Una realidad invisibilizada. *Cuadernos Méd Soc.* 2018;58(2):49–55.
 20. Aylagas M, García Ó, Rodríguez B. Barreras en la asistencia sociosanitaria en personas transexuales: Revisión sistemática de estudios cualitativos. *Enferm Clín.* 2018;28(4):247–59. <http://dx.doi.org/10.1016/j.enfcli.2017.09.004>
 21. Valenzuela A, Cartes R. Salud comunitaria, la experiencia de salud trans en el Servicio de Salud Talcahuano, Chile. *Psicoperspectivas.* 2020;19(2):142–53. <http://dx.doi.org/10.5027/psicoperspectivas-vol19-issue2-fulltext-1789>
 22. Tomicic A, Gálvez C, Quiroz C, Martínez C, Fontbona J, Rodríguez J, et al. Suicide in lesbian, gay, bisexual and trans populations: Systematic review of a decade of research (2004–2014). *Rev Méd Chil.* 2016;144(6):723–33. <http://dx.doi.org/10.4067/S0034-98872016000600006>
 23. Romanelli L, Lu W, Lindsey M. Examining mechanisms and moderators of the relationship between discriminatory health care encounters and attempted suicide among US transgender help-seekers. *Adm Policy Ment Health.* 2018;45(6):831–49. <http://dx.doi.org/10.1007/s10488-018-0868-8>
 24. Movimiento de Integración y Liberación Homosexual. Informe Anual de Derechos Humanos (HECHOS, 2020) 2020.
 25. Creswell J. Five qualitative approaches to inquiry qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage; 2017. pp. 53–84.
 26. Lewis S. Qualitative inquiry and research design: Choosing among five approaches. *Health Promot Pract.* 2015;16(4):473–75. <http://dx.doi.org/10.1177/1524839915580941>
 27. Troncoso-Pantoja C, Amaya-Placencia A. Entrevista: Guía práctica para la recolección de datos cualitativos en investigación de salud. *Rev Fac Med.* 2017;65(2):329–32. <http://dx.doi.org/10.15446/revfacmed.v65n2.60235>
 28. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77–101. <http://dx.doi.org/10.1191/1478088706qp063oa>
 29. Braun V, Clarke V. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res.* 2021;21(1):3747. <http://dx.doi.org/10.1002/capr.12360>
 30. Quattrucci C. Los límites del dispositivo médico en la atención de la salud sexual de hombres trans. [Presentación de congreso]. XXXI Congreso ALAS Uruguay 2017. Montevideo, Uruguay; 2017. pp. 1–12.
 31. Dowshen N, Lee S, Franklin J, Castillo M, Barg F. Access to medical and mental health services across the HIV care continuum among young transgender women: A qualitative study. *Transgend Health.* 2017;2,81–90. <http://dx.doi.org/10.1089/trgh.2016.0046>
 32. Denson DJ, Padgett P, Pitts N, Paz-Bailey G, Bingham T, Carlos JA, et al. Health care use and HIV-related behaviors of black and latina transgender women in 3 US metropolitan areas: Results from the transgender HIV behavioral survey. *J Acquir Immune Defic Syndr.* 2017;7(5):268–75. <http://dx.doi.org/10.1097/QAI.0000000000001402>
 33. Oberheim ST, DePue MK, Hagedorn WB. Substance use disorders (SUDs) in transgender

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernalles M

- communities: The need for trans-competent SUD counselors and facilities. *J Addict Offender Couns.* 2017;38,33–47. <http://dx.doi.org/10.1002/jaoc.12027>
34. Puckett JA, Cleary P, Rossman K, Newcomb ME, Mustanski B. Barriers to gender-affirming care for transgender and gender nonconforming individuals. *Sex Res Soc Policy.* 2018;15:48–59. <http://dx.doi.org/10.1007/s13178-017-0295-8>
 35. Madera SLR, Díaz NV, Padilla M, Pibernus XR, Neilands TB, Segarra ER, et al. Just like any other patient: Transgender stigma among physicians in Puerto Rico. *J Health Care Poor Underserved.* 2019;30:1518–42. <http://dx.doi.org/10.1353/hpu.2019.0089>
 36. Abelson M. ‘You aren’t from around here’: Race, masculinity, and rural transgender men. *Gender Place Culture.* 2016;23(11):1535–46. <http://dx.doi.org/10.1080/0966369X.2016.1219324>
 37. Anderson A, Irwin J, Brown A, Grala C. “Your picture looks the same as my picture”: An examination of passing in transgender communities. *Gender Issues.* 2020;37(1):44–60. <http://dx.doi.org/10.1007/s12147-019-09239-x>
 38. Borck C, Moore L. This is my voice on T: Synthetic testosterone, DIY surveillance, and transnormative masculinity. *Surveill Soc.* 2019;17(5):631–40. <http://dx.doi.org/10.24908/ss.v17i5.12931>
 39. Catalano D. “Trans Enough?” The pressures trans men negotiate in higher education. *Transgender Stud Quart.* 2015;2(3):411–30. <http://dx.doi.org/10.1215/23289252-2926399>
 40. Reisner SL, Silva-Santisteban A, Salazar X, Vilela J, D’Amico L, Perez-Brumer A. “Existimos”: Health and social needs of transgender men in Lima, Peru. *PLoS One.* 2021;16(8):e0254494. <http://dx.doi.org/10.1371/JOURNAL.PONE.0254494>
 41. Donoso C, Nuñez S, Parra-Villaruel J. Significado que otorgan las personas trans a sus experiencias en la atención en el sistema de salud chileno. *Rev Chil Salud Púb.* 2018;22(2):126–34. <http://dx.doi.org/10.5354/0719-5281.2018.53235>
 42. Chile. Ministerio de Salud. Orientaciones técnicas para actualizar o elaborar protocolo de trato y registro para personas trans, en el marco de la circular N° 21. 2019. pp. 1–11.
 43. Fredriksen Goldsen KI, Romanelli M, Hoy-Ellis CP, Jung H. Health, economic and social disparities among transgender women, transgender men and transgender nonbinary adults: Results from a population-based study. *Prev Med.* 2021;156:106988. <http://dx.doi.org/10.1016/j.ypmed.2022.106988>
 44. White J, Reisner S, Pachankis E. Transgender stigma and health: A critical review of stigma determinants, mechanism, and interventions. *Soc Sci Med.* 2015;147:222–231. <http://dx.doi.org/10.1016/j.socscimed.2015.11.010>
 45. Bockting W, Coleman E, Deutsch MB, Guillamon A, Meyer I, Meyer W 3rd, et al. Adult development and quality of life of transgender and gender nonconforming people. *Curr Opin Endocrinol Diabetes Obes.* 2016;23:188–97. <http://dx.doi.org/10.1097/MED.0000000000000232>
 46. Roberts T, Fantz C. Barriers to quality health care for the Transgender population. *Biochem Clin.* 2014;47(10):983–87. <http://dx.doi.org/10.1016/j.clinbiochem.2014.02.009>
 47. Dolores M, Solano M. La aplicación del modelo de competencia cultural en la experiencia del cuidado en profesionales de Enfermería de Atención Primaria. *Atención Primaria.* 2017;49(9):549–56. <http://dx.doi.org/10.1016/j.aprim.2016.10.013>

DOI: <http://dx.doi.org/10.22374/ijmsch.v5i3.93>

Int J Mens Com Soc Health Vol 5(3):e1–e14; 13 December 2022.

This article is distributed under the terms of the Creative Commons Attribution-Non Commercial 4.0 International License. © Gonzalez S and Bernalles M