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Masculinities under construction, bodies under (re)construction: trans men's desires, contradictions, and ambiguities in the transexualizing process

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Abstract *This paper presents the research results on the strategies, expectations, and desires of 28 transsexual men in building their masculinities and reconstructing their bodies through cross-hormonization. The qualitative research was carried out in an outpatient clinic of the transsexualization process in a city in the metropolitan region of Rio de Janeiro. We employed semi-structured interviews and participant observation from November 2019 to January 2020 to collect data. Content analysis guided the analysis of the statements from which the discussed categories emerged. The categories were discussed in the light of the concepts of gender, transsexuality, and masculinity, besides references from studies on ethnicity/skin color in their articulations with health. The data revealed desires, contradictions, and ambiguities regarding the construction of masculinity and the (re)construction of bodies more suited to it. They also evidenced the desire for the male bodily standard achieved through hormonization and surgeries, and black skin color emerged as a critical inequality mark. We concluded that, while refuting many male model features, these men want to enter this world and blend in with the crowd as men, thus experiencing fuller masculinity.*

Key words *Gender, Trans health, Trans men, Transsexualizing process*

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Introduction

Studies reveal the impact of gender and sexual orientation on health care quality, almost always reinforcing inequalities and asymmetries between the promotion of female and male health[1,2]. Concerning trans identities, the health system imprints a movement to dehumanize this population, reducing it to beings with pathology and an International Classification of Disease (ICD), not seen as subjects of rights in health[3-7].

Formulating the idea of natural sex and a gender that is constructed, which supported the powerful feminist critiques of the 1960s, ended up limiting the historicization of nature and the body as also shaped by historically situated power relationships and narrowing the limits of understanding of uncoherent gender narratives. Rethinking sex as a cultural construction, Guacira Louro[8] argues that this "order only seems safe because it is based on the dubious assumption that sex exists outside of culture and, consequently, inscribed in an apparently stable and universal domain, the domain of nature"[8] (p. 81), while "the discontinuities, transgressions, and subversions that these three categories (sex-gender-sexuality) can experience are pushed into the misunderstood or pathological terrain"[8] (p. 82).

This paper will adopt Judith Butler's definition, which understands gender as an identity tenuously established in time "through a stylized repetition of acts"[9], becoming a belief. Gender "must be understood as the everyday way in which bodily gestures, movements, and enactments of all kinds are the illusion of a permanent gendered "Self"[9] (p. 3), which "complies with a truth-falsity model that contradicts its performative fluidity and serves a social gender regulation and control policy"[9] (p. 14). While its fluidity allows us to think about "the several possible forms of repetition and the disruption or subversive repetition of this style"[9] (p. 3).

Taking the sexed body also as construction and gender as performance allows moving beyond the sex-nature versus gender-culture binarism and understanding transsexual identities, those not deriving directly from sex, not as incongruous, but as possibilities[10,11]. This theoretical perspective also leads us to understand that the transsexual experience derives from "the historical and social articulations that produce the sexed-bodies, and where heterosexuality is the matrix that gives genders intelligibility"[10] (p. 16), and the inconsistency between these experiences and the sex-gender binary system gives them the status of pathology[5,7,12,13].

We understand transsexuals as "people who, in different social and cultural contexts, conflict with their gender (assigned at birth and which was reiterated in most of their socialization) and, to some extent (which does not need to be surgical/chemical), decide to modify it"[14] (p. 515). Concerning trans men, Almeida[9] states that it is a "complex 'watercolor of masculinities'" that, although it cannot be allocated to the same group, the transitivity between them must be considered.

Transitivity is often revealed in these men's desire and search for masculinity that corresponds to the hegemonic model, especially regarding the body, which must be muscular, have a smooth but protruding chest, and a face with a beard. In other words, a model that submits and exerts a controlling effect on cisgender or transsexual men but is incapable of erasing the multiple experiences that allow us to speak of masculinities, in the plural, as a concept and plurality within a persistent gender system[15-19].

The transsexualizing process[20,21] is a health program and a line of care with a set of health care strategies for the trans population, including body changes. Initially, it only included trans women's care and was expanded and redefined in 2013[21], including trans men (and transvestites), offering cross-hormonization and surgeries such as masculinizing mammoplasty hysterectomy and oophorectomy. The program was fundamental in the therapeutic itinerary of this population, but also reveals that their health needs have been restricted to the desire for body adequacy, disregarding the principle of comprehensiveness that should guide health care[22-26]. Moreover, joining the program and the possibility of transition assisted by a health team is facilitated by the diagnosis and pathologization of these experiences.

Considering that trans experiences are unique and do not fit into universalist formulas, we discussed the expectations, desires, certainties, ambiguities, and contradictions in the statements of transsexual men users of an outpatient transsexualization process clinic about the construction of their trans masculinities. Discussions rely more heavily on the concepts of gender, transsexuality, and masculinities, but we also sought references in studies on race/ethnicity in their articulations with health.

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Methods

The paper was produced within the research "Gender, sexualities, diversities and sexual and reproductive rights: access, inclusion, promotion, and education in health", approved by the Research Ethics Committee (CEP) of the Federal Fluminense University (UFF) and registered under the CAAE n. 10003219.6.0000.5243 in 2019.

We opted for a qualitative approach using participant observation and interviews with a semi-structured roadmap as data construction techniques[27,28]. The research field was the Outpatient Clinic of the Transsexualization Process of one municipality of Rio de Janeiro Metropolitan Region II, launched in November 2018. The clinic works a single shift weekly and serves users from several surrounding municipalities without this service.

Twenty-eight semi-structured interviews were held from March 2019 to February 2020, with trans men invited to participate while waiting for care at the outpatient clinic. The interviews lasted approximately forty minutes and were carried out in one of the outpatient clinics, mainly by a pair of researchers, audio-recorded, and transcribed by the research team.

In compliance with the research norms of Resolutions n. 466/12 and n. 510/16 of the National Research Ethics Committee, all of them read and signed the Informed Consent Form. As a guarantee of anonymity, the participants were identified by the letter H followed by numbers per the order of interviews.

The inclusion criterion of the participants was their self-declaration as transsexual men. Age was not relevant data, as at that time, there were no children under 18 in the clinic, since reducing the minimum age to 16 years for entering the transsexualization process only came into force in January 2020 with resolution n. 2.265/2019. However, the field research was terminated shortly after due to the COVID-19 pandemic.

The observations were made after the interviews. The service works in a single shift once a week, which facilitates the availability of at least one researcher every service day. Observations occurred in the waiting room and during medical or social assistance visits, always after authorization from users and professionals and never with more than one researcher in the offices. Field diaries were adopted to record relevant events brought up in the discussion.

The theoretical saturation sampling technique was employed to define the number of participants and conclude the interviews, which consists of interrupting data uptake by repeated ideas, at which point additional interviews no longer contribute to achieving the proposed objectives[29]. We already had enough data for analysis when the service was interrupted due to the pandemic.

Data were processed by content analysis, a technique where the constructed statements are assessed by instruments that allow an organized and impartial description of the content to be analyzed and the definition of analysis categories[30,31]. The analysis of the statements that addressed the construction of trans masculinities gave rise to five categories of analysis, and we chose two and discussed them in this paper: (1) desires, contradictions, and ambiguities in building trans masculinities; and (2) ethnicity/skin color as inequality markers in this construction.

Results and discussion

Men were the majority in the clinic during the research period and relatively young, which caught our attention. In this regard, the participants stated that, unlike trans women and transvestites, they did not have an information and support network regarding body changes. They would also only be able to buy testosterone legally upon presenting a medical prescription. Twenty-eight transgender men aged 18-53 were interviewed, most under 25. Fourteen self-declared heterosexuals; four said they were "undefined"; seven were pansexual, and three were bisexuals. Seven said they were in a common-law marriage; three said they were married, and the others were single at the time of the interview.

Regarding race-ethnicity, 13 self-declared black, eight white, three brown, and four preferred not to identify themselves. Four were unemployed, three had formal employment, three were only studying, two said they were freelancers, and the others were self-employed/service providers. Noteworthy was that 12 of these men were attending university or had momentarily interrupted the course, which deviates from the pattern of this population whose school dropout is a milestone in their trajectories[32-34].

Some reported that they self-identified as *butches* lesbians for a while until trans identity was imposed or, as they said, discovered. This discovery occurred through videos on the internet, YouTubers, and, in particular, a soap opera character – Ivana/Ivan – who walked along his path of estrangement vis-à-vis cis identity, understanding, and self-acceptance as a trans man, serving as a mirror for some participants. Four respondents reported having already used hormone purchased on the "parallel" market, administered per the guidance of YouTubers or other trans men users, while the others said they feared this practice. Although three said they participated in social movements, most were oblivious to this type of action, preferring the discretion they already experienced or would gain with the use of hormones.

Regarding individual income, most earn between two and four minimum wages, followed by those with variable income and the smaller group, which included those who did not have an income. This last group included the students who depended on family support. All said they could buy the hormone but recognized that testosterone is expensive for continued use treatment, regretting that it was not dispensed by the Unified Health System (SUS). All with health plans spoke of the difficulty of finding willing or competent professionals to meet their demands, and four reported having had bad experiences in medical offices.

Most sought breast reduction, voice thickening, chest and face hair growth, menstrual cycle suspension, and the loss of "body curves" in the use of testosterone. They reported having already started the transition by changing clothes, cutting their hair, and adopting a social name more fitting to their gender. Many of these changes received the help of relatives, especially grandmothers and mothers. As a way of honoring their mother, some assumed the name that she would have called him had she registered him as a boy. On the other hand, some reported that the refusal of family members, especially parents, to call them by their social name was a source of suffering and a reason for resentment.

Although admission to the outpatient clinic is an essential step in the itinerary of those seeking masculinizing mammoplasty, this was not an immediate demand of these men. The arguments were the lack of financial resources and the certainty of the delay in performing in the public service. Those who had voluminous breasts used a binder – a band or bandage used to compress the breasts and keep the chest straighter, a strategy that, if adopted for a long time, usually causes discomfort and harm to health, such as bruises, shortness of breath, spine fractures, and breast dysplasia[35]. Two participants self-declared mastectomized and resorted to private services.

A respondent's statement especially surprised us regarding the relationship between income, bodily change, and married name correction: H24 (31 years old, pansexual, black, incomplete university degree, accounting technician, variable income) said changing the married name would make him lose the pension left by the father, which only single daughters are entitled to receive, which would hinder masculinizing mammoplasty in the private service. Thus, he saw himself linked to a name that did not represent him but would ensure the transition to the body that represents him.

The outpatient clinic was described as a space of reception and care. Some revealed having made their first contact with other trans men there, exchanging experiences and information. Others revealed that it was the first public space where they felt good and relaxed about their gender expression. H22 (26 years old, heterosexual, black, married, high school, clerk, an income of three minimum wages) affirmed, *I don't need the protection I have on the street here; I can be more comfortable*. These characteristics of the outpatient clinic are essential for adherence to any health service or program, but they gain importance because it is a poorly understood population and excluded from the SUS.

Unlike the transvestites and trans women who used the clinic, who were almost always alone, men, accompanied mainly by girlfriends, wives, partners, mothers, sisters, aunts, and one of them, his older brother. This aspect is already described in the literature when it points out that male health care is historically also a female role, who must care for the health of the men in the family since self-care is not a valued aspect in the construction of masculinity[36,37].

Therefore, we should highlight that the clinic did not issue a "true transsexual" diagnosis, valuing the users' self-declaration of gender. Thus, the team conferred autonomy and freedom of expression that were uncommon in other outpatient clinics that had built their protocols from the classifications and manuals to define transsexual experiences as pathological and disregard the current discussions about depathologizing these identities[7,12,38].

Thus, in this service, one could find trans women with some beards, trans men with painted nails, and self-declared non-binary people. From the medical protocols and manuals perspective, these people should not have access to the transsexualization process, but they were received at the clinic. The presence of these bodies

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not entirely tied to gender norms reminds us of Preciado's[39] statement that binarism is no longer sufficient to characterize the contemporary production of queer bodies.

Regarding the interview, some participants revealed that it was the first opportunity to talk about themselves in depth and aspects that everyday conversations do not permit. However, when they were invited to talk about their trans masculinities, they could perceive already consolidated aspects and others still fragile, under construction. When put into words, such discoveries reverberated as contradictions inherent to their complex trans experiences.

"I came to seek this freedom to be whom I wanted to be": desires, contradictions, and ambiguities in constructing trans masculinities

Cross-hormonization consists of administering drugs based on testosterone (for trans men) and estrogen (for transsexual women and transvestites) to inhibit some secondary characteristics while developing others, enabling the construction of a more coherent and gendered body with which they identify. It is called *cross* because these hormones are available in both bodies, but one less than in the other[23]. Taking the Foucauldian assumptions[40], we can consider the transsexualization process as an essential mechanism for disciplining and controlling transsexual and transvestite bodies performed by Medicine while pathologizing these identities and offering their "cure"[7,12,25,26].

When this dichotomous and deterministic relationship between body and gender is debated, "other constitutive levels of identity are also released to compose multiple arrangements outside the body's binary referent"[13] (p. 17). In Louro's words, "this is not intended to deny bodily materiality, but to emphasize the discursive processes and practices that make physical aspects convert into defining gender and sexuality agents and, consequently, end up becoming subject definers"[8] (p. 80).

As Áran[5] pointed out, the bodily readjustments performed by trans people convert aspects of discontinuity and incoherence in these bodies into "intelligible genders" facilitated by several technologies. Taking the Butlerian assumptions, these bodies "suffer" the action of history and culture and transform themselves to adapt and begin to walk within the culture while blurring their borders with nature as they exist.

When we asked the participants what their expectations were regarding the use of hormones, most responded that they seek to build canonical male corporeality, harmonization between the man they are and what society has chosen and they have learned to value. This body should preserve an adequate relationship with the gender and should not be an escape from its norms but an encounter with them and their ratification. However, in the statements below, it is interesting to notice that H4 is willing to be part of the group of men, "the guys", but relativizes the importance of the beard, an indelible mark of masculinity, when saying later that *hair is not a masculine thing, everyone has hair*. Let us see:

I look for the male body, which is a body I've always found beautiful. I wanted to have that chest, that beard, to cut my hair like that, you know? I came to seek personal satisfaction and a new vision of happiness. I came to seek this freedom to be whom I wanted to be (H8, 28 years old, heterosexual, black, high school, common-law marriage, nursing technician, two minimum wages).

The distribution of fat, which I don't like... I have dysphoria with my curves. I do not particularly appreciate having hips or breasts. All this bothers me (H10, 23 years old, heterosexual, black, incomplete higher education, freelance, single, variable income).

I'm already trying to comfort myself with the fact that I'm not going to grow or be more prominent in size and height. But having bigger shoulders, a deeper voice, and more masculine features, which guys usually have (H4, 22 years old, undefined sexual orientation, white, single, high school, freelance, variable income).

The transitivity amidst the watercolor of possibilities[14] was strong in the search for a body coherent with the gender norm and the hegemonic standard of masculinity[15,17]. Building oneself as a man is a permanent project. It requires much care and encounters with institutions and cultural forces, such as Medicine[15,18]. In Connell's words, gender is built on bodies and, from this logic, we can say that masculinities are "embodied without ceasing to be social", as they are experienced "(in part) as certain muscular tensions, postures, physical abilities, ways of moving, and so on"[15] (p. 189).

We identified that breasts are highly inconvenient as they are the most evident marks of a gender they did not identify, and they embraced cross-hormonization for their reduction. However, the solution was surgery for others:

Having a mastectomy is what I want most… what I try to hide the most, you know? It's enor-

mous dysphoria. I feel very uncomfortable, so much so that I can't go around the corner when I come back because I feel uncomfortable. If I do it, it will be something that... well, will raise my self-esteem, which is a little hurt (H3, 18 years old, heterosexual, dating, did not want to define his color, incomplete high school, unemployed).

A recent survey involving 391 trans people and transvestites in Rio de Janeiro and its metropolitan region showed that hormones had been the first and most crucial bodily change technology used by transsexual men seeking body change, which tends to be more critical than genital reassignment surgery[41]. As Almeida[14] pointed out, unlike trans women, testosterone enables bodily changes very close to what is considered a male body, which allows "impersonating a cis man", accelerating the erasure of some female body marks. This quality of going unnoticed is called passability[42,43], which means having a body that allows for some social invisibility and brings personal satisfaction, more security, and opportunities in the love and professional market that a less "norm-abiding" body might not allow.

While the militancy criticized the desire for norm-abiding bodies, which considers that "passing as cisgender" camouflages the marginalization experienced by the population, the participants did not report this type of concern. The lack of criticism may be related precisely to the greater ease of reaching this body and the historical distance of trans men from social movements where discussions like this occur.

One aspect caught our attention: for some participants, changing their voices should have taken place before changing their civil status; otherwise, they would appear to be "*fake men*". One of them spoke of it as follows:

"H*ow am I going to introduce myself with the name* [he said his social name] *with that voice? The voice gives in and gets even worse. I will change my civil name after I change my voice a little*" (H13, 19 years old, white, heterosexual, university student, no income). Statements lead us to the Butlerian premise that gender is made and responds to a model of truth and falsity that serves its regulation. Thus, "performing gender inappropriately triggers obvious and indirect punishments, and performing it well provides a sense of reassurance that there is, after all, an essentialism in gender identity"[9] (p. 13-14).

The end of the search for that desired masculinity would come with access to testosterone prescribed by the endocrinologist, which made the appointments where they received the prescription for the first time exceptional. On these occasions, always permeated by strong emotions, they almost always cried and hugged their companions, usually present at the visits. Those who could not get the prescription on the expected day due to some test problems also cried; however, out of sadness for having to delay this happiness for a while longer. Participant H17 (20 years old, pansexual, white, dating, incomplete high school, no occupation, an income of less than one minimum wage):

Oh, I have no words! I don't think I ever thought pieces of paper would make me so happy. Happiness I wasn't feeling lately. As much as I've had the surgery [masculinizing mammoplasty], *I'm still a little unhappy with my body. However, that will change when I apply it. It will uplift my life*.

In his statement, H17, one of the two men who had already undergone masculinizing mammoplasty surgery before joining the outpatient clinic, poignantly reveals "the weight" breasts have on a body that does not want to be feminine:

It changed a lot in bodily health and in my mind too. It was something that I felt very trapped [referring to the track], *which made me very short of breath and very sad. I was thrilled after the mastectomy! I get all silly when I rub the site with my hand... I don't even have anything to say* [he laughs and expresses great joy as he runs a hand over his smooth chest]. *It's a very surreal feeling! I would never have imagined taking off my shirt and feeling complete like this, you know? I had no idea that this feeling would be so great!* (H17).

Then, he reveals a shift in his complaints and desires regarding the body. When he solved the biggest problem, the breasts, he could look more closely at other parts of his body that have now started to bother him.

I have been to the beach, but I still feel ashamed because of the curves when I take off my shirt. At first, I took it off because it was all that joy [right after the surgery], *but now I started to see my curves more and don't like taking my shirt off so much* (H17).

Since July 2020, through Ordinance n. 1.370, SUS has performed vaginectomy and metoidioplasty surgeries, which are still experimental, and building the neophallus, which can only be performed in university hospitals. The desire for genitalia reassignment was mentioned only by this participant, H17, who showed that he knew the risks and limitations of the surgery, but stated, *one day I will try to change that; I will have the surgery*.

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We met H8 another three times at the clinic, and in each of these meetings, we talked a little about body changes and new experiences based on them. He affirmed, and we noticed acne on his face and back. He had gained a little weight and already had fuzz on his chin. These changes boosted his confidence; he was happy and increasingly willing to proceed with the process. He also reported that he felt very irritable, and his sexual desire increased, making him reflect on what he had learned about men and their sexuality.

Despite the great desire for a normative body that includes them in the masculine universe and makes them "invisible" socially, the participants revealed valuing attributes that deviate from the masculinity standard regarding certain behaviors and performances, showing the investment in their unique masculinity. In their plans, they were determined not to assume certain marks of patriarchal masculinity:

There is nothing that is too much man or too little man. I just want to be passable like any other man. I want to be seen as a man. That's all (H4).

I'm just me. Suppose people define masculinity with machismo and the like. I wasn't raised that way. The cis men in my family are all loving, and I learned that from them. So, I don't get caught up in a masculinity pattern. I don't think that's right (H10).

I started to deconstruct those masculinity symbols and that pattern. I saw that it was not to my liking. So, I deconstructed everything. I don't precisely have masculinity (H11, 21 years old, undefined sexual orientation, single, white, high school, unemployed, variable income).

All of them formulated some criticism of patriarchy and cisheteronormative masculinity, which they defined as *standard man*, *toxic masculinity*, *sexist, and the man who is authoritarian, who wants to be the king of the house, who does not want to listen, who doesn't want to show his feelings, who wants to boss the woman in any way*, as H12 said. As a positive aspect, they linked masculinity to ethics and righteousness.

In particular, two participants relativized the importance of breasts. The first, H6, a 19-year-old middle-class college student, told us that he had wanted so much to have a mammoplasty that he made a "virtual crowdfunding" to get the funds. Then he revealed that he had dreamed of hysterectomy but no longer wanted it because he regretted having the mammoplasty. He says, *I don't need to take another part of my body to be the man I am*. Whereas H18, the oldest of our respondents, aged 53, stated, *sometimes I use the belt, sometimes not. Today, I'm without it. I would have liked to have breast surgery, but now I'm too old for that*.

"I am black before being trans": skin color as a marker of difference in the construction of trans masculinities

It can be said that ethnicity, class, and gender intersectionality, as socially structuring and determinant in the health-disease process[44], takes on other contours when building masculinities and their health demands. Intersectionality is understood as the possibility of bringing to the fore of discussions the "multiple gender-articulated differentiations that permeate the social sphere"[45] (p. 264).

The trans experiences shared with the researchers revealed the crossing of social markers that limited and subordinated these experiences, some of which have already been mentioned here. However, for this discussion, we chose the ethnicity/skin color marker, as most of the participants self-declared black, and some formulated essential reflections on the impact of this marker on the construction of their trans masculinities.

As Fraga[46] states, research on the black population and the black trans population is still insufficient, but one could say that skin color determines relationships and curbs or elevates the risk of dying, regardless of social class. When it comes to the health field, it produces "inequalities and adversely affects the quality of care and assistance provided to the black population from childhood to adulthood" (p. 23).

Black masculinity is historically seen as virile and tireless, with its body reduced to an animalistic corporeity, balancing itself between marginalization and exaltation, hypersexualization and dehumanization, not having the right to prestige nor to the place of "human-man".[47] A racialized body permeated by negative attributes and opposite to those of white bodies, which feed and naturalize racial inequality[48-50].

For our respondents who self-declared black, the feeling of insecurity and fear of social exclusion was expanded when they started the transition. The certainty that skin color matters in building their masculinity led H24 to emphatically say that *being a black woman is very different from being a black man*, as she has come to fear urban violence, especially police violence since the transition began.

Before being trans, I'm black. They saw me as vulgar but not as a danger. This fact shook me *more than my own family's denial. I insist within the movement because my mental health is linked to it. Today, children don't talk to me. If I'm wearing shorts, I'm a pickpocket. I can't go to a bank* (H24).

In another passage, he recalls his father's teachings, a black man, about masculinity. He discusses what he has learned from his experience:

My father, God rest his soul, believed that a man has to be strong and have a big dick. So, this started to mess with my head because I'm fat. I'm not that short, I'm of average height, but I don't have a dick! So, what am I going to do now? People will read me as a black man. I have to be rude. I can't cry. I have to be strong... "Why is a nigga like that crying? You fall, you get up!" I'm learning to be a black man because until then, just being a man was enough, but no! (H24).

Regarding skin color, another participant drew attention to a relevant aspect regarding healing surgical cuts among black-skinned people: the greater propensity to develop keloids. Despite his desire to reduce his breasts, H10 said he feared surgery and preferred other strategies. In his words, *the surgeon said that the probability of having keloids in this area is greater, and I have this tendency. Then I joined the gym, and it decreased a lot. I'm going to try to decrease it even more with testosterone.*

Final considerations

This study allowed understanding that the use of hormones implies more than body changes per gender identity. Cross-hormonization results in new social and political positions these men begin to experience after acquiring identified male body. This achieved body brings advantages, and the most outstanding was being able to move around the city without facing discriminatory looks and comments and looking in the mirror with more pleasure, liking what you see, and recognizing yourself as a man.

The desire for these achievements makes them tolerate the physical and social side effects that hormone therapy usually brings, such as acne, abdominal fat, baldness, and irritability, besides intangible consequences, such as an increased likelihood of suffering racism and physical violence.

Being trans is looking at yourself in the mirror and looking a little bad. This sentence said sadly by one of the participants touched us like a cutting knife. We consider that this cannot be an acceptable definition for transsexuality and, above all, must be denied and reviewed mainly by health workers who have a professional obligation to promote health and act to not make this statement a sentence.

We prefer to take the phrase said by another participant when asked about what he was looking for in that service, to which he replied confidently and full of hope, *I came to seek this freedom to be whom I wanted to be*. We believe that this statement reveals what the health system can and should be for these people, an institution that collaborates to meet these men's dreams through care that dignifies them and is worthy of them.

Collaborations

CR Ribeiro: construction and data analysis, conception, writing and final review of the article. AF Ahmad, BS Dantas and A Lemos: construction and analysis of data and final review of the article.

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References

1. Gomes R, Murta D, Facchini R, Meneghel SN. Gênero, direitos dexuais e suas implicações na Saúde. *Cien Saude Colet* 2018; 23(6):1997-2005.
2. Cobo B, Cruz C, Dick PC. Desigualdades de gênero e raciais no acesso e uso dos serviços de atenção primária à saúde no Brasil. *Cien Saude Colet* 2021; 26(9):4021-4032.
3. Braz C. Vidas que esperam? Itinerários do acesso a serviços de saúde para homens trans no Brasil e na Argentina *Cad Saude Publica* 2019; 35(4):e00110618.
4. Lima AM, Nascimento RT, Caselli CM, Carvalho TGF. Atributos da Atenção Primária à Saúde e ferramentas de medicina de família no atendimento às diversidades sexual e de gênero: relato de caso. *Rev Bras Med Fam Comunidade* 2019; 14(41):1785.
5. Áran M. A transexualidade e a gramática normativa do sistema sexo-gênero. *Ágora* 2006; 9(1):49-63.
6. Simpson K. Transexualidade e travestilidade na saúde. In: Ministério da Saúde. *Transexualidade e travestilidade na saúde*. Brasília: Ministério da Saúde; 2015. p. 9-15.
7. Bento B, Pelúcio L. Despatologização do gênero: a politização das identidades abjetas. *Rev Estud Fem* 2012; 20(2):569-581.
8. Louro GL. *Um corpo estranho – ensaios sobre sexualidade e teoria queer*. Belo Horizonte: Autêntica; 2002.
9. Butler J. Actos perfomativos e constituição de género. Um ensaio sobre fenomenologia e teoria feminista. In: Macedo AG, Rayner F, organizadores. *Gênero, cultura visual e perfomance. Antologia crítica*. Minho: Universidade do Minho/Húmus; 2011. p. 1-16.
10. Butler J. Sujeitos do sexo/gênero/desejo. In: Butler J. *Problemas de gênero. Feminismo e subversão da identidade*. Rio de Janeiro: Civilização Brasiliense; 2015. p. 17-70.
11. Haraway D. "Gênero" para um dicionário marxista: a política sexual de uma palavra. *Cad Pagu* 2004; 22:201-246.
12. Bento B. A campanha internacional de ação pela despatologização das identidades trans: entrevista com o ativista Amets Suess. *Rev Estud Fem* 2012; 20(2):481-484.
13. Bento B. *A reinvenção do corpo – sexualidade e gênero na experiência transexual*. Salvador: Editora Devires; 2017.
14. Almeida GS. 'Homens trans': novos matizes na aquarela das masculinidades? *Rev Estud Fem* 2012; 20(2):513-523.
15. Connell R. Políticas da masculinidade. *Rev Edu Real* 1995; 20(2):185-206.
16. Connell R, Messerschmidt JW. Masculinidade hegemônica: repensando o conceito. *Rev Estud Fem* 2013; 21(1):241-282.
17. Kimmel M. A produção simultânea de masculinidades hegemônicas e subalternas. *Horiz Antropol* 1998; 4(9):103-117.
18. Almeida MV. *Senhores de si*: *uma interpretação antropológica da masculinidade*. Lisboa: Fim de Século; 2000.
19. Ribeiro CR. *Sexualidade, corpo e saúde masculinos: transformações e permanências nos discursos de homens e da revista Men´s Health* [tese]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2011.
20. Brasil. Ministério da Saúde (MS). Portaria nº 1.707, de 18 de agosto de 2008. Institui, no âmbito do Sistema Único de Saúde (SUS), o Processo Transexualizador, a ser implantado nas unidades federadas, respeitadas as competências das três esferas de gestão. *Diário Oficial da União* 2008; 18 ago.
21. Brasil. Ministério da Saúde (MS). Portaria nº 2.803, de 19 novembro de 2013. Redefine e amplia o Processo Transexualizador no Sistema Único de Saúde (SUS). *Diário Oficial da União* 2013; 20 nov.
22. Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyler E, Garofalo R, Karasic DH, Lev AI, Mayer G, Meyer-Bahlburg H, Hall BP, Pfäfflin F, Rachlin K, Robinson B, Schechter LS, Tangpricha V, van Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. *Normas de atenção à saúde das pessoas trans e com variabilidade de gênero*. 7ª versão. World Professional Association for Transgender Health (WPATH); 2012.
23. Ahmad AF. *"Ah sei lá, só quero ser eu!": significados, saberes e práticas da hormonização cruzada na saúde de mulheres e homens trans* [dissertação]. Rio de Janeiro: Universidade Federal do Estado do Rio de Janeiro; 2020.
24. Dantas BRSS. *Buscas pelo cuidado: o itinerário terapêutico de transexuais no município de Niterói* [dissertação]. Niterói: Universidade Federal Fluminense; 2021.
25. Borba R. *O (des)aprendizado de si: transexualidades, interação e cuidado em saúde*. Rio de Janeiro: Editora Fiocruz; 2016.
26. Pinto DL, Costa DFP, Carvalho LCF, Ribeiro CR. Ambulatório de Atenção à Saúde da População Travesti e Transexual João W. Nery: cuidado e respeito à diversidade. In: Fernandes VR, Magalhães MG, D'Oliveira CBLC, Campos Filho E, Sergio JV, Silva JPV, Amorim AC, Jardineiro JC, Machado KS, organizadores. *IdeaSUS: saberes e práticas nos territórios do Sistema Único de Saúde*. Rio de Janeiro: Cebes; 2020, p. 121-142.
27. Nogueira-Martins MCF, Bógus CM. Considerações sobre a metodologia qualitativa como recurso para o estudo das ações de humanização em saúde. *Saude Soc* 2004; 13(3):44-57.
28. Minayo MCS. *O desafio do conhecimento: pesquisa qualitativa em saúde*. São Paulo: Editora Hucitec; 2014.
29. Fontanella BJB, Ricas J, Turato ER. Abordagem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. *Cad Saude Publica* 2008; 24(1):17-27.
30. Bardin L. *Análise de conteúdo*. São Paulo: Edições 70; 2016.

31. Oliveira DC. Análise de conteúdo temático-categorial: uma proposta de sistematização. *Rev Enferm UERJ* 2008; 16(4):569-576.
32. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. *Lancet* 2016; 388(10042):390-400.
33. Nunes T, organizador. *Ensaio sobre vivências reais de crianças e adolescentes transgêneres dentro do sistema educacional brasileiro*. Curitiba: IBDSEX; 2021.
34. The European Sting. A major win for transgender rights: UN health agency drops 'gender identity disorder', as official diagnosis. 2019. [cited 2022 fev 11]. Available from: https://europeansting.com/2019/06/03/a-major-win-for-transgender-rights-un-health-agency-drops-gender-identity-disorder-as-official-diagnosis/
35. Sousa D, Iriart J. "Viver dignamente": necessidades e demandas de saúde de homens trans em Salvador, Bahia, Brasil. *Cad Saude Publica* 2018; 34(10): e00036318.
36. Gomes R, Moreira MCN, Rebello LEFS, Couto MT, Scharaiber LB. Os homens não vêm! Ausência e/ou invisibilidade masculina na atenção primária. *Cien Saude Colet* 2011; 16(Supl. 1):983-992.
37. Ribeiro CR, Gomes R, Moreira MCN. Encontros e desencontros entre saúde do homem, a promoção da paternidade participativa e a saúde sexual e reprodutiva na atenção básica. *Physis* 2017; 27(1):41-60.
38. Butler J. Desdiagnosticando o gênero. *Physis* 2009; 19(1):95-126.
39. Preciado B. Género y performance: 3 episodios de un cybermanga feminista queer trans. *Debate Feminista* 2009; 40:111-123.
40. Foucault M. Poder-corpo. In: *Microfísica do poder*. Rio de Janeiro: Graal; 1993.
41. Carrara S, Hernandez JG, Uziel AP, Conceição GMS, Panjo H, Baldanzi ACO, Queiroz JP, Dángelo LB, Balthazar MAS, Silva Junior AL, Giami A. Body construction and health itineraries: a survey among *travestis* and transpeople in Rio de Janeiro, Brazil. *Cad Saude Publica* 2019: 35(4):e00110618.
42. Pontes JC, Silva CG. Cisnormatividade e passabilidade: deslocamentos e diferenças nas narrativas de pessoas trans. *Periódicus* 2018; 1(8):396-417.
43. Lima F, Cruz KT. Los procesos de hormonización y la producción del cuidado sanitario en la transexualidad masculina. Sex Salud Soc 2016; 23:162-186.
44. Batista L, Barros S. Enfrentando o racismo nos serviços de saúde. *Cad Saude Publica* 2017; 33(Supl. 1):e00090516.
45. Piscitelli A. Interseccionalidades, categorias de articulação e experiências de migrantes brasileiras. *Rev Soc Cult* 2008; 11(2):263-274.
46. Fraga FA. *A percepção de homens negros transexuais acerca de saúde e adoecimento* [dissertação]. Rio de Janeiro: Universidade Federal do Estado do Rio de Janeiro; 2020.
47. Rodrigues WHS. Desmistificando a Sensualidade naturalizada do ébano: um estudo acerca da objetificação do corpo do homem negro. *Cad Gen Tec* 2020; 13(41):267-284.
48. Nogueira IB. *Significação do corpo negro* [tese]. São Paulo: Universidade de São Paulo; 1998
49. Carneiro S. *Racismo, sexismo e desigualdade no Brasil*. São Paulo: Selo Negro; 2011.
50. Bento MAS. Branqueamento e branquitude no Brasil. In: Carone I, Bento MAS, organizadores. *Psicologia social do racismo*. Petrópolis: Vozes; 2002. p. 25-59.

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