Walls, gaps and shortcuts: transmasculine people's agencies for hormonization in the Transsexualizing Process in the city of São Paulo

Muros, frestas e atalhos: agenciamentos de pessoas transmasculinas para hormonização no Processo Transexualizador na cidade de São Paulo

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Abstract

This article proposes to know some factors in the hormonization process of transmasculine people from the idea of agency and care. Initially, the article recovers productions that deal with how body and gender differences raised to natural and biological categories, legitimize and recognize cisgenderism as a norm, were recovered. Then, the ordinances of the Transsexualizing Process for the hormonization process aimed at transmasculine people in the Brazilian National Health System (SUS) were analyzed. Finally, we present the experience of ethnographic work accompanying two transmasculine people in the city of São Paulo between the months of March 2019 and November 2020, as well as discourses on the use of hormones/testosterone by cisgender men on the internet. It is observed that these people seek access to hormones through the Transsexualization Process of the SUS and the agencies put into action in the production of their bodies, with their access facilitated or hindered by gender norms and cisnormativity.

Keywords: Hormonization; Agencies; Transsexualizing Process; Transmasculinity; Public health.

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Resumo

Este artigo propõe conhecer alguns fatores no processo de hormonização de pessoas transmasculinas a partir da ideia de agenciamentos e de cuidado. Inicialmente, foram resgatadas produções que tratam sobre como as diferenciações do corpo e de gênero, elevadas a categorias de natural e biológico, legitimam e reconhecem a cisgeneridade como norma. Em seguida, foram analisadas as portarias do Processo Transexualizador referentes ao processo de hormonização voltado a pessoas transmasculinas no Sistema Único de Saúde (SUS). Finalmente, apresentamos a experiência do trabalho etnográfico acompanhando duas pessoas transmasculinas na cidade de São Paulo entre os meses de março de 2019 e novembro de 2020, além de discursos do uso de hormônios/testosterona por homens cisgênero na internet. Observa-se a busca destas pessoas pelo acesso à hormonização por meio do Processo Transexualizador do SUS e os agenciamentos colocados em ato na produção de seus corpos, tendo seu acesso facilitado ou dificultado pelas normatividades de gênero e a cisnormatividade.

Palavras-chave: Hormonização; Agenciamentos; Processo Transexualizador; Transmasculinidade; Saúde Pública.

Introduction

According to the guidelines based on the Federal Constitution and on the Law no. 8.080/1990, universality, equality, equity, comprehensiveness, intersectoriality, right to information, people's autonomy, problem-solving capacity, and epidemiological basis are foreseen for the Unified Health System (SUS) (Carvalho, G., 2013). However, recent works (Paulino; Rasera; Teixeira, 2019; Pelúcio, 2009; Santos, 2020; Souza, M. et al., 2015) have already demonstrated that some of these guidelines, in practice, do not extend to transgender and *travesti*[1] people, making it difficult for them to access the public health system, which directly impacts the care processes and the very process of building these people's lives and humanity.

This article derives from a master's thesis (Santos, 2022), which aimed to analyze the **care agencies** produced by transgender people, *travesti* and non-binary people[2] to make their existence possible and create ways to survive, live and exist in the face of contexts of abjection imposed by society. The research was carried out in the city of São Paulo, through an ethnographic work following up six transgender, *travesti* and non-binary people aged between 21 and 51, between March 2019 and November 2020. In this trajectory, the possibilities of body production became one of the central themes of the research, some of which emerged due to the search for interventions offered by the SUS, based on the so-called Transsexualizing Process, and which reached Michel Santos, author of the dissertation, due to the place where he was as a psychology professional in welcoming spaces for LGBTQIAP+ people.[3]

1 *Travesti* does not correspond to the English travesty [transvestite], which is related somewhat to a performance in drag. Unlike the English 'transgender,' *travesti* articulates aspects of race, class, ability, and other forms of difference. The *travesti* identity politics evoke the historical marginalization of the collective, one with clear racial, able-bodiedness, and elitist undertones.

2 *Não-binárie* (non-binary) is one of the possibilities of gender performativity where the person does not feel fully or partially included in the male/female binary. Non-binarity is under the umbrella of transgenderism, since they also do not recognize themselves in the gender assigned to them since birth. In some works, it can also appear as *não-binário* (Carvalho, M., 2018), but I choose the word ending with the letter "e", which is the way many of these people present themselves, considering the non-genderization of words.

3 LGBTQIAP+: acronym for lesbians, gays, bisexuals, *travesti* and trans people, queer, intersex, asexual, pansexual people and other sexual orientations and gender identities that are not represented in the other letters.

Faced with difficulties in accessing institutionalized health services and the interventions offered, these people produce **agencies** to move forward in the research, in the intensely performative and multiple construction of the body (Butler, 2003; Preciado, 2018; Vergueiro, 2015). In this text, we will be limited to the shared agencies of two transmasculine people – Ju and Alex –, followed up during the search for one of these technologies, hormonization, so as to understand transmasculine people's agency process for body production in the city of São Paulo (SP), in relation to corporal and gender technologies in the SUS.

Theoretical transitions

As a first turn, it is important to place some theoretical choices that are presented as guidelines for this article and the work carried out. The use of the notion of agency here is an analytical proposal, also maintained in the master's thesis, inspired mainly by Fátima Tavares's (2017) ethnographic work, which puts into debate the most common theoretical proposals in the anthropology of health and in the public health regarding **experience** and **therapeutic itinerary**. This displacement made by the author, allowed, among many other things, to problematize the temporal dimension and the punctual moment considered in the itinerary thinking model (directly influenced by the hegemonic biomedical thinking), apprehended in a scientific model that seeks an explanatory logic in order to raise meanings (Tavares, 2017).

In the conception of this present research, the concept of therapeutic itinerary was one of the first choices to get to know part of the research of *travesti* and transgender people for the Transsexualization Process, hormonization and other technologies available in institutionalized health services. However, in weekly conversations held in different spaces and contexts, the idea of itineraries did not seem to be enough to encompass movements and transitions that these people experienced, so that a change was necessary that would allow reflections in other directions.

Tavares's proposal is close to the ideas of assemblage developed by Deleuze and Guattari (2004), according to whom assemblage would consist of an association defined by the "co-functioning" of its heterogeneous parts. In other words, it is about a multiplicity that establishes relationships between different natures. In this perspective, an abstract reality would be actualized in the material scope, while the concrete dimension is produced in the connection with the abstract. These two dimensions of agency coexist and make it possible to produce connections, records and reality. The ethnographic moments during the fieldwork converged, so that this approach gained meaning in the way of interpreting what transmasculine people I met, presented about their search for physical and bodily interventions, but who were never detached from the desire to produce another body, with everything that it would make possible: other affective-sexual relationships, other ways of moving around the city, other ways of presenting themselves in virtual spaces.

However, while Tavares (2017) uses the predicate "therapeutic", I will use the term "care" to think about these processes, since the former has become almost synonymous with therapy, that is, associated with healing and treatment processes, provided by medical care, gaining other aspects when we refer to people in gender and/or sexuality dissidence, since until recently they were considered pathological characteristics and subject to some type of "reversal" (Eddine, 2018; Silva, 2007). Therefore, the concept of care would also facilitate this epistemological and analytical expansion, inspired by the works of Annemarie Mol (2008), Maria Puig de La Bellacasa (2012), Nathália Reis (2020) and José Miguel Olivar (2019), when thinking about care processes that are not limited to institutionalized health spaces, professionalized practices and hegemonic academic-scientific forms of knowledge.

From her ethnography in a hospital setting, the Dutch philosopher Annemarie Mol (2008) proposes that care should inspire thinking in action in everyday life. Care takes place in doing and would not exist as an a priori form, accompanying

the modes of existence of those who are involved. In this perspective, the relational is ontological, located in an interdependent sociotechnical network in which objects, places, human and non-human beings, environment and hormones meet in **crossings**, producing themselves, allowing forms of life to become possible. In these relationships and interactions, those who demand care actively participate, producing an open and infinite process, which will be negotiated and renegotiated, depending on the effects produced.

Maria Puig de la Bellacasa (2012) proposes a look at care based on an ethics-methodology that minds and cares, recognizing the other as a world, with its differences, powers, contradictions and possibilities. Since care is relational, it would also be ontologically collective, not being possible to think about it in a solo, unique and individual way, allowing to consider the coexistence of different worlds in which things are related without necessarily adding up or following a univocal and linear order. The multiple lenses presented here would make it possible to think about medical and institutional protocols and guidelines, as well as the content of transmasculine people on social networks and YouTube, as narratives in dispute, which produce ways of thinking about the body, but which do not overlap or cancel each other out.

From these theoretical convergences, thinking about agency and care related to the body and its possibilities, these bodies in relationships are crossed by the gender norms that we will see below.

From the biological to the gendered

Since the beginning of the 1930s, the anthropology field has identified the body as an instrument and social construction, the way in which each person lives their bodily reality and conceives of the body they inhabit, contributing to the notion of person, proper to the collectivity of which they are a part (Sarti, 2010). In this article, the body is understood, in this conception in which it is constituted as a human reality by the meaning attributed to it by the collectivity, distancing itself from the idea of a previous bodily existence, natural or biological, that precedes the cultural intervention (Sarti, 2010).

In this space, it would be impossible to trace the enormous and heterogeneous social and human sciences production that make it possible to understand the body, not just the human body, as an effect and agency[4] of social and biosocial relations (Sarti, 2010). Therefore, in this universe of production, the work of authors such as Teresa de Lauretis (1987), Viviane Vergueiro (2015) and Paul Preciado (2018) is taken as a reference.

Viviane Vergueiro (2015) points out how the categorization of bodies in the biomedical perspective would be allocated in binary categories – penis/male/man and vulva/female/woman – and would be much more a norm to recognize and legitimize bodies that only follow the pattern of a heterosexual cisgenderism.

Judith Butler (2003, p. 43) points out how "gender not only designates persons", but also "constitutes a conceptual episteme by which binary gender is universalized." Cisgenderism, therefore, ceases to be just one of the possibilities of existence and becomes a **CISnorm** (Vergueiro, 2015), that is, a compulsory norm. The normalization of bodies based on a binary, cisnormative view of body and gender would not recognize other possibilities of existence, such as bodies in transgenerity and travestility.

Teresa de Lauretis (1987), inspired by Foucault's theories of sexuality conceived as "sex technologies", called by analogy "gender technologies" the set of sociosemiotic technologies destined to the production and reproduction of gender in its construction quality. Going a little further than Foucault (1988), to the extent that he did not include the category gender, in *Technologies of gender*, Lauretis (1987) provides a notion of gender understood as relational, that is, one that does

4 The idea of agency that I use here as an investigative possibility to understand the concrete forms of production of the world, both material and immaterial, adds to the classic works on itineraries, practices, trajectories and therapeutic experiences the idea that practices and knowledge are produced in the gaps of power relations (Maluf, 2013; Tavares, 2017; Santos, 2022).

not exist by itself. It presents it as a relationship that runs through everything, as a semiotic product/process and, consequently, not as a natural and spontaneous manifestation linked to sex: "as representation and as self-representation, is the product of various social technologies, such as cinema, and of institutionalized discourses, epistemologies, and critical practices, as well as practices of daily life." (Lauretis, 1987, p. 208).

From these concepts, it is possible to understand how the normalization of behaviors and identities that appear in social relations and institutional regulations produces engendered differences, that is, specificities that are naturalized as gender differences, while some technologies will produce social representations in relation to gender, such as clothes, bathroom, soap operas, professions, literature, religion, toys, etc. Viviane Vergueiro (2015) warns that, in order to think about bodily formations and gender identities, it is also important to analyze cisgender normativity or cisnormativity, which is entangled in these devices.

Vergueiro (2015, p. 45) points out that the normativity of cisgenderism is "produced through the naturalization of pre-discursivity, binarity and permanence for bodies and gender identities", placing it as defining the legitimate possibilities of gender and crossed by the idea that these bodies, if "normal", will be found in these genders defined from two – and only two – alternatives: male/man and female/woman.

This means that all bodily diversity and gender variability beyond cisgenderism are constrained, by colonialities of knowledge, to supposedly objective medical-scientific interpretations of bodies, placing travestility and transgenerity, for example, in an absence of recognition.

Paul Preciado (2018) collaborates with the discussion by bringing an analysis of the interventions that bodies receive/choose to have their gender or sexualities recognized. According to the author, the invention of the gender category is the result of a biotechnological discourse that emerged in the 1940s, in the United States, with the adoption of the "pill", so that sex was no longer linked to heterosexual sex with the aim of procreation; however, such discourse also allowed hormonal interventions, which allowed changes in the body and intentional production of subjectivity. In a system that the author called **pharmacopornographic**, we receive visual, hormonal, drug and prosthetic interventions that (dis)shape our bodies and guarantee (or withdraw) recognition.

Pharmacopornographic regime, according to Paul Preciado (2018), feeds on two self-supporting pillars, which work more in congruence than in opposition: pharmacology (both legal and illegal) and pornography. In this context, the pharmacopornographic body would not be docile or pre-discursive, with limits on the envelope of its skin, but a technobody, an entity, intersected by pixels, hormones, optical fibers and nanometers. From these reflections, the processes of "pharmacopornographic production of somatic fictions of femininity and masculinity" (Preciado, 2018, p. 129) through estrogen, progesterone and testosterone are also considered. Gender would not be (only) something produced on the exterior (social behavior, appearance, style, clothing), but also a biological process (Camargo, W.; Rial, 2010).

Preciado (2018) also proposes, based on the concept of pharmacopornographic regime, the appropriation and use of biotechnologies, such as synthetic hormones, to pirate (*hack*), circumvent and shuffle instituted gender boundaries. Important ethnographic works (Benedetti, 2005; Pelúcio, 2009) record *travesti* and transgender women in the appropriation and use on their own of these hormone-based medications, "in order to build a 'feminine' image and identity" (Benedetti, 2005, p. 51).

Preciado's proposals also inspire thinking from a sociotechnical perspective, which underlines the various relationships between humans and non-humans configured in therapeutic networks (Akrich, 1996). According to Akrich (1996), we seek to avoid the conception of medication – and here I bring testosterone close to medication by the way it is made available in society – as a simple

"cultural construction" that attributes meanings to a given object. This theory can cause a problem: the assumption of an ontological stability of this element, balanced only by the impression of different representations external to them. The synthetic hormone could not be defined a priori, constituting rather a heterogeneous and complex set of relationships, from which different notions of health, body and care intersect.

It is possible to understand, approaching the work of Eduardo Vargas (2008) regarding the genealogy of "drugs" – safeguarding the proportions and limitations, since substances considered "illicit" will circulate in other spaces and contexts –, that the testosterone presented here remains indeterminate until it refers to the agencies that constitute it as such. Agency would thus allow one to understand testosterone – and, consequently, its use and its effects – as a sociotechnical object that constitutes an effect that is more contingent on its heterogeneous articulations than on its intrinsic properties or external social representations, if taken in isolation or in a genealogical search.

Hormonization in institutional health

Hormonization is not a process adopted by all *travesti* and transgender people; some works even indicate that its use is linked to contexts of large urban centers, either because of the ease of access to these technologies or also because people who do not live in these regions do not have this process as central to their (self)recognition (Paiva, 2020). The use of this medication, to have their bodies read as more feminine or masculine, but also to soften traits and characteristics, does not always aim to approximate a cisgender binary image. However, this process appears in several narratives presented in research with *travesti* and transgender people (Benedetti, 2005; Pelúcio, 2009), just as it was one of the central processes raised by Alex and Ju during the research.

Márcia Brasil Santos (2020) shows that hormone therapy is one of the technologies made official by Ordinance No. 1,707/2008, allowing procedures for body changes related to "gender adequacy" and incorporating them into the SUS procedure table. The care provided by this ordinance and by Ordinance No. 457, also from 2008, were the basis for the Transsexualizing Process in the SUS, a national policy that authorizes care for "transsexual" people (the term used at the time) in health spaces, even if from a pathologizing perspective.[5] Such a policy is limited to some genital surgical procedures, aimed exclusively at those who were **diagnosed** as transgender women. Although these instruments recognized the need for follow-up for hormone therapy and breast surgery, the Ministry of Health regulations did not provide for the supply of hormones and breast prostheses in the referenced health units or any other. In addition, such ordinances did not provide for meeting the demands of transgender men and *travestis*.

Only five years later, after the publication of Ordinance No. 2.803/2013, which redefines and expands the Transsexualization Process in the Brazilian National Health System, *travesti* and transgender men could have access to accredited services to start follow-up in the Transsexualization Process, always through a psychiatric report (to exclude serious psychiatric disorders, which would be impediments to the process), psychological evaluation (performed by a psychiatrist and psychologist) and evaluations by professionals in the areas of gynecology or urology, endocrinology and plastic surgery, in addition to the deadlines required for starting any surgical and hormonal intervention.

In addition, access to hormones by transgender men, *travesti* and transgender women only happened through the concomitant acceptance of surgical interventions. A person who

5 In this period, the national policy was based on the DSM-IV and ICD-10 diagnostic manuals, considering that these people would be diagnosed with "transsexualism" and the medical interventions available would serve to reduce these people's distress (Bento; Pelúcio, 2012).

did not express interest in undergoing reassignment surgery (in the case of transgender women and *travestis*) or masculinizing mammoplasty[6] (in the case of transgender men) would not have access to hormones.

The Transsexualizing Process was a breakthrough in offering spaces that welcomed transgender and *travestis* and their demands in health, as well as the practical recognition of the existence and importance of technologies that produce the body, gender and sexuality (despite being in the grammar of "pathology" and of "correction"). In the first moments, however, no logic was thought of other than that of a mechanical transition from one place of gender to **another**. Thus, non-binary bodies and bodies of *travesti* and transgender people that do not fit the mold of binary cisnormativity were completely on the fringes.

The focus of assistance on the surgical aspect, established by the Ministry of Health in the first ordinances of the Transsexualizing Process, did not present a perspective of health and, much less, of care. On the contrary, it was strictly a pathologizing look, of illness, where surgical intervention – performed only by medical professionals – not only resolved the diagnosed illness, but also surgically restored a place to nature (in this case, to the surgical nature of the corrected gender). This perspective, of course, contradicts health proposals in a broader and more integrative view, such as those promoted by public health.

These **technopolitical decisions** had the effect of blocking any and all other care issues presented by *travesti* and transgender people. In practice, as shown by Pelúcio (2009), Martha de Souza et al. (2015) and Santos (2022), among others, they are denied the right to meet their needs for comprehensive health care, whether at the primary care level or for more complex issues, such as accompanied hormone therapy, implantation of silicone breast prostheses, masculinizing mammoplasty, etc.

In Resolution No. 2,265, published in September 2019, the Federal Council of Medicine (CFM) authorized *travesti* and transgender people to begin "psychotherapeutic" outpatient follow-up and hormone therapy through the SUS, following the Singular Therapeutic Project (PTS).[7] This measure no longer required a psychiatric report for the start of hormone therapy, in addition to indicating 28 Basic Health Units in the city of São Paulo capable of providing outpatient care for *travesti* and transgender people. However, until February 2021, only eight of these services offered the service, on the grounds that there were no trained professionals (Reis, V., 2021).

So far, only eight hospitals in the country – Hospital das Clínicas (HC) of Universidade Federal de Pernambuco, in Recife (PE); HC of Universidade Federal de Goiás, in Goiânia (GO); HC of Universidade Federal do Rio Grande do Sul, in Porto Alegre (RS); HC of Universidade Estadual do Rio de Janeiro, in Rio de Janeiro (RJ); HC of Faculdade de Medicina da Universidade de São Paulo (FMUSP), in São Paulo; Hospital Universitário (HU) Cassiano Antonio Moraes, in Vitória (ES); Hospital Jean Bitar, in Belém (PA); HU of Universidade Federal de Juiz de Fora, in Juiz de Fora (MG) – are authorized to perform surgical procedures through the Transsexualizing Process.

The extensions of ordinances by the Ministry of Health are not accompanied by counterparts at the state and municipal levels, and this distancing becomes one of the difficulties of the effective capillarity of the Transsexualizing Process proposals in the practices of professionals of institutionalized health services (Santos, 2020). The isolation of the process in relation to

6 I add here the quality "masculinizing" because the procedure called mammoplasty was first developed in the oncological context for cisgender women, with total or partial removal of the cancer-affected breast. The procedure in transmasculine people consists of removing the mammary gland and, usually, reducing the nipple, where the surgical team seeks to approximate the image of what is considered a male pectoral.

7 The PTS is formed by a set of proposals for articulated therapeutic conducts, directed to a person, family or community. It aims to design an intervention strategy for the user, relying on the resources of the team, the territory, the family and the subjects themselves, and involves an agreement between these same actors (Hori; Nascimento, 2014).

institutionalized health services contributes to the little involvement of regional managements in relation to the training/qualification of health professionals to provide assistance to *travesti* and transgender people. As a consequence, it is common for physicians, even in endocrinology, to point out that they have doubts or are unaware of the hormonization protocols for *travesti* and transgender people; that they do not know the effects of hormones; or who feel insecure and do not have the support of hospitals, among other manifestations, which are commonly located between transphobia and lack of qualification for care management, leading to insecurities (Santos, 2020).

These multiple and complex factors allow us to think about the walls and barriers resulting from disputes in the various public health spheres, so that the specific needs of *travesti* and transgender people end up not entering the debate of political decisions due to epistemologies and structures designed by cisgender people and for cisgender bodies. From what has been presented here, it is possible to think that the walls that surround access to institutionalized health services, care and technologies in favor of life and the well-being of certain bodies may have their bases in the legislation and determinations that structure the public health system.

Seeking gaps in and beyond walls

During the field work period from 2019, two transmasculine persons became important research partners from two organizations that welcome those who identify themselves as part of the LGBTQIAP+ community.[8] They are Ju, who identifies himself as white, aged 27, resident of the east zone of the capital, and Alex, black, aged 21, resident of the north zone of São Paulo. Both were interested in accessing the technologies offered by the Transsexualizing Process, especially hormone therapy. At that time, the CFM ordinance in effect required psychiatric and psychological reports for the initiation of the procedure in institutionalized health services, which led Alex and Ju to the reception spaces in search of other ways to access the process.

Although Ju and Alex had not started the process of hormone therapy and other interventions – surgical, for example –, it does not mean that they were not yet in their "transition processes". Other gender technologies were already being operated to bring the reading and recognition of their bodies closer to images of masculinity, or, at least, to distance themselves from femininity stereotypes. The use of short hair, sneakers larger than foot size, large and baggy clothes, use of binder[9] and band on the chest, conscious voice modulation to make it more low-pitched, negotiations in their relationships in the use of male pronouns, and adoption of names other the ones assigned to them at birth are some of the technologies that Alex and Ju were already using long before starting the follow-up with any healthcare professional. Therefore, it is important to emphasize that this process of producing a body that fits – as Alex brought up during the research –, often called gender transition, does not begin with the adoption of technologies offered by institutionalized health services.

Alex, for example, told in one of our meetings that he always wanted to start hormone therapy and undergo mammoplasty, however, he would not like to acquire "completely masculine characteristics" that would make him look like a cis man. He says that he feels good with a certain "androgyny" and that, therefore, he would not like to have characteristics such as defined muscles, but he has a great desire to remove the "intruders".[10]

8 Instituto Pró-Diversidade, located in the east zone of the capital, and Centro de Referência e Defesa da Diversidade (CRD), in the central region of the municipality of São Paulo.

9 A binder is a band or a vest made of elastic fabric designed to compress the breasts, reducing the chest volume and leaving it with a more rectilinear shape. This device is seen as an important resource for building a male self-identity (Ribeiro, 2018).

10 Word used by some transmasculine people and non-binary people to refer to breasts (Santos, 2022).

The walls raised by some health services and professionals were brought up by Alex and Ju during the research trajectory at different times. The first endocrinologist who assisted Ju, upon learning that the follow-up would be for the hormonization process, refused to go ahead with the consultations, stating that she did not have the specialization that would allow her to accompany him and that the best indication would be a specialized professional in the care of *travesti* and transgender people.

With Alex, the rupture of the doctor-patient relationship occurred after the experience in consultation when using the term "non-binary":

> I told her [the doctor] that I wanted to start "hormone therapy", but that I didn't want to do it like my friends did, without medical supervision. I wanted to do everything right. She told me that I would have to undergo therapy and several tests to see if my hormone levels were normal. But when I said I was a non-binary transgender man, she said that there was no such thing. She said that because I was so young, I still didn't really know about "these things". I didn't go back there anymore. (Santos, 2022, p. 167)

Érica de Souza (2020), when interviewing health professionals at the trans outpatient clinic at the Federal University of Uberlândia, identified that they lacked information and training on hormones for *travesti* and transgender people. At the time, Ordinance No. 2.803/2013, of the Transsexualizing Process, contained a mention of "hormone therapy" or "hormonal drug therapy", but without any specific prescription and without defining what type of hormone should be used, its doses and intervals. The author also reinforces that the absence of indication of hormones to be used becomes a complicating element for claiming the offer of such drugs in the public health network.

Krüger et al. (2019) also point out that the scarcity of services and medical professionals who master the specifics of transgender and *travesti* issues and who are able to safely prescribe medications for these people are factors that make many carry out the hormonization process on their own. The use of hormones without medical supervision is considered a risky practice, but what to do when medical professionals do not have enough data and training to prescribe and monitor the hormonization process? Or when, on the contrary, their technical, moral and social formation tells them not to recognize the person in front of them and, therefore, they act towards exclusion and vulnerability?

The use of medication without professional supervision, or self-medication, is a topic that has yet to be addressed in relation to hormone therapy for transgender and *travestis.* However, self-medication related to other drugs is seen by the anthropology of medications as an important care resource. Ethnographic works on the relationship with medications, mainly in contexts of native peoples, have shown that there is no essential medicine independent of the history of interaction between different social groups. Health professionals, intensely contaminated by notions of rationality and biomedical efficacy, constantly ignore that the daily behavior of the other in the search for health care is guided by local knowledge and cultural norms, individual experience, along with power conflicts that cross access to institutionalized service and drug distribution, in addition to broader political and economic influences (Diehl, 2016). Close to these experiences are those of transgender people and *travesti* brought here, since the knowledge related to the use of hormones is not considered in the relationships within the institutionalized spaces of health.

Flávia Freitas (2016) carried out a study that sought to evaluate the competences in medical professional training to care for the LGBT population in a capital in the Brazilian Northeast region. Among the narratives of the physicians interviewed, it was recurrent that they had not addressed any LGBT health-related issue during their training – except when talking about sexually transmitted infections (STIs) or psychiatric health conditions. Likewise, the author did not identify any specific approach

to LGBT people's health in the curriculum of the medical specializations analyzed, which points to a gap in the training of medical professionals in relation to the specificities of this population. The study by Rufino, Madeiro and Girão (2013), carried out with medical students in the state of Piauí, brings similar results: gender and sexuality are approached from an organicist and reductionist perspective, bringing little approach to social aspects, which makes teaching in medicine limited in terms of compliance with guidelines that direct assistance to people with gender variability or sexual dissidence (Rufino; Madeiro; Girão, 2013).

Given the difficulties in accessing institutionalized health services and the few places where the transition process is addressed in public health, it was on virtual platforms such as Instagram, Twitter and YouTube that Ju and Alex reported seeking information. Several texts, images and videos by *travesti* and transgender people about their own experiences in the transition processes are available on these platforms. Ju described how he found a huge universe about transgender people on YouTube and explains that, if in the "real" world there were few places where he could talk and learn more about the topic, on the internet the debate was wide and diverse, and many already beyond only definitions about transgender experiences.

> Nowadays, everything is on YouTube. I follow some transgender boys on YouTube who explain in detail how their transition process was. It was good for me, because I realized that it would not be something quick or simple. There is no place where we can find out about these things, only on the internet, and that already helps a lot. It was there that I found out that I was transgender and non-binary. (Santos, 2022, p. 86)

Research carried out with *travesti* and transgender women indicate that the onset of hormones occurs through relationships with older or more experienced acquaintances. The advice and guidance of these people are crucial guides in the process with hormones, and usually happen in the context of the street and prostitution (Benedetti, 2005; Galindo; Rodrigues; Moura, 2012; Pelúcio, 2009). With the experience of the older ones, they learn, initially, which hormone has the best effect according to what they hope to obtain from the modification, which are the best doses, which are the risks and how to avoid them. With Alex and Ju, the exchange of information with more experienced people also happens, but in other spaces. Alex says that, in conversations with other transgender men through social networks and YouTube, he was able to learn a little about their experiences, such as breast reduction in some of them after the start of hormone therapy, which contributed to Alex's choice of not to perform any surgery at first, and if his "already small" breasts became smaller, he would not need to have a mastectomy.

It was on these platforms that information and knowledge were shared about how a certain type of hormone/testosterone was used, the number of doses and intervals of application, side effects and the periodic record of the appearance of body changes, such as hair on the face and the rest of the body.

The motivations for using hormones were not the same for Ju and Alex.

> One thing I want is to make my voice deeper and have hair on my face. If I get the testosterone, I think I already get those changes. I also don't want to look like a man at all. That's not what I want. (Santos, 2022, p. 101)

While Alex sought to make his voice deeper, it was the chest that Ju wanted to change. The use of a bandage to make the breasts less noticeable under the clothes was an agency that could be abandoned, according to him, if he managed to start hormone therapy. Breast reduction was an important change, since, when visiting the beach or in spaces with a swimming pool, wearing breast-covering garments caused him distress and embarrassment.

Ju and I agreed to look together for videos on YouTube about transmasculine people's experiences with mammoplasty, especially those who lived in

São Paulo. Some of these content producers referred in the videos to the Reference and Training Center (CRT) on STI/AIDS, located in the Santa Cruz neighborhood, and to the outpatient clinic at the HC in São Paulo. YouTube emerges as a space where users discover ways of **knowing how to do** in relation to health, care and the body, based on videos and interaction with people who have already started the process. Furthermore, and very importantly, the materiality of the youtuber's body is also presented as a visual experimentation of the future of the process that Ju and Alex had not yet started. The exchange between transgender and Ju youtubers works as a circulation of knowledge and constitutes a relationship of care, since the sharing of stories and experiences enables new ways of existing and building bodies; a capacity to produce worlds that are composed and transformed.

Ju and Alex also pointed to the exchange of messages with transmasculine people from various parts of the country to share their own history and the progress of the transition processes, but also messages of support regarding the difficulties faced in different areas, not just related to body and health issues (Santos, 2022).

Other authors (Almeida, 2012; Amorim, 2016) also highlighted the importance of the Internet for recording transmasculine people's experiences and daily lives, as well as for public-political organization and coordination. Acquiring information about hormones through social networks has also become essential to move more effectively through bureaucracies within the scope of health services. Ju and Alex learned from some YouTube videos which lines and terms to use or avoid in medical appointments, which would be crucial to getting a prescription to start hormone therapy. The performativity of the body/gender, a technology amplified through digital social networks, has been tested and put into action from time to time in the medical field, in order to achieve recognition and access to the desired devices.

The transmasculine youtubers that Ju and Alex watched and indicated were all thin, and a considerable part sought in bodybuilding ways to "burn fat", "reduce curves" and "gain muscle". Alex followed similar strategies and started bodybuilding to slim his chest and hips. Such a choice, according to Alex, would make a difference when he had a masculinizing mammoplasty, that is, changes were put into action in a linkage with a technology based on the circulation of discourses beyond institutionalized health services. The consumption of materials on YouTube, produced by transmasculine people; exchanges on social networks; and the use of bodybuilding, clothes and other body-altering devices, such as hormone/testosterone, can be understood as part of the care agencies, led by transmasculine people in a more satisfactory way.

A study carried out in the city of Belo Horizonte, state of Minas Gerais, with *travesti* and transgender women who perform sex work showed that approximately 98.2% of them reported learning about hormones from colleagues, while only 1.8% reported learning from a public health service. (Alecrim, 2014). A survey carried out by the Mosaico portal, in 2021, with 189 transgender and *travesti* internet content creators, showed that 47.6% were between 18 and 24 years old, 33.9% lived in the city of São Paulo, 41.27% were transmasculine people, and 48.7% declared themselves whites (Pesquisa..., 2022).

At the same time that difficulties are imposed in accessing institutionalized health services and hormone therapy, some health professionals are engaged in meeting these demands of transgender and *travestis*, even without specific prescriptions, clear guidelines or extensive studies by their regulatory boards. Márcia Santos (2020) shows how doctor Dorina Quaglia, for example, provided care to *travesti* and transgender people at the FMUSP HC outpatient clinic in the late 1970s and 1980s, prescribing and monitoring these people's hormone levels over a period in which the practice was even considered illegal and unethical (Santos, 2020). Another case was with João W. Nery (2010), who performed surgical interventions and started hormone therapy in the 1970s, based on networks of relationships with Roberto Farina and other

physicians, at a time when transmasculinity was not in the public health debates.

Final considerations

The relationships built in the ethnographic work made it possible to learn about Ju's and Alex's care arrangements, who present a universe of exchange of knowledge, information and stories of themselves that cross and reorganize the desire launched for the production of another being. The relationships in these digital intersections create their own dynamics, through which adverse effects and visible and invisible changes due to hormones are shared, in the sense of shared support and the production of a care network.

The agency perspectives, based on the research experience presented here, emerge as one more analytical possibility on the production of the body, especially of people who were historically placed in pathologized categories by health areas. This perspective can also contribute to thinking about this production of the self that does not necessarily involve only individual choices, considering multiple networks involved in the paths chosen by each of these people, and how the search for some technologies is not only focused on physical modifications, but on a body/world that is in relationship, online and offline, and that makes it possible to think of such changes not as rigid, nor as predictable or finite.

The multiple forms of existence of transmasculine people are still a subject little known by public health, and the hybrid efforts between anthropology and public health can indicate directions to learning the knowledge produced, accumulated and that circulates with these people in non-institutionalized health spaces, such as the internet, so that a broader and more equal form of access to health and care can be built. Transmasculine people's experiences also help to think about how self-medication can be reviewed from an agency and care point of view, with local autonomies that can contribute to the expansion of public health knowledge, and not as an absence of knowledge or information.

The training of health professionals, especially in medicine, also becomes a point of reflection, considering that the gap on gender variability and sexual dissidence becomes yet another factor in access obstacles for those who wish to undergo the hormonization process under professional follow-up in institutionalized health services.

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Contribution of the authors

Santos was responsible for the design and writing of the article. Olivar was responsible for guiding the research, reviewing the analysis and the final article.

Received: 11/03/2022
Resubmitted: 11/03/2022
Approved: 12/13/2022