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Transmasculinity and Pregnancy: Care, Support, and the Pregnancy-Puerperal Process in the SUS

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ARTIGO ORIGINAL

Abstract

The following text presents a reflection on the pregnancy of trans men and transmasculine people, focusing on support and care within the Brazilian Unified Health System (SUS). It addresses concepts of transmasculinity, sociocultural and legal aspects, as well as public policies aimed at the comprehensive health of the LGBTQIAPN+ population. Based on theoretical references, official documents, and experience reports, the text highlights initiatives such as the *TransGesta Booklet* and the *Guide to the Pregnancy of Trans Men and Transmasculine People*, which provide guidance for inclusive care practices. It also shares diverse experiences during prenatal care, childbirth, and the puerperium, pointing out both challenges and positive experiences in healthcare services. The text contributes to expanding knowledge on the subject and promoting strategies for humane, respectful, and appropriate care tailored to the specificities of this population.

Key Words: Gender, health, pregnancy

Ethics declaration: not applicable.

Introduction

Transmasculine is the general term used for people who were assigned female at birth but who throughout life built a body or not and a gender identity associated with different masculinities. This does not necessarily mean that all transmasculine people may identify as men, being able to move between their sexual and gender identities and among the different patterns established in society.

In the matter of gender, it is important to consider the existence of decentered identities expressed by performances, conduct, ways of thinking, and words. All these elements and others that may exist have fluid and transitory meanings in modernity, being thought of from sociocultural constructions and destined to change endlessly.

For Stuart Hall (2014), the act of naming the identities of subjects as immutable and essential belongs to the past. In the current world, the different decentering's of thought caused by the advancement of science and social movements, especially feminism, have profoundly altered both social relations and our patterns of subjectivities. Just like language, which is always fluid and transitory because society and culture constantly change the meanings of words, individual decentered identities of the current era never assume a final form and can be modified throughout the lives of subjects.

In this context, this article seeks to contribute to the debate on the implementation of support and care practices for men and transmasculine people in the pregnancy-puerperal process within the Brazilian Unified Health System (SUS), taking into account public health policies aimed at the population of lesbians, gays, transsexuals, intersex, asexual, pansexual, non-binary, and other identities (LGBTQIAPN+).

Throughout the text, to identify the segment of trans men and transmasculine people, the term transmasculine will be used in the singular or plural depending on the context, as it is considered more inclusive by the transmasculine social movement of Campo Grande/MS. The term "*transmasculine appears as the broadest designation and encompasses people with a fully or partially male identity, with or without identification as trans men.*" (IBRAT, 2025, p. 2).

From a methodological point of view, this text was built from exploratory research on the subject, mapping readings of articles that reflected on care, support in LGBTQIAPN+ public

policies, and the pregnancy-postpartum process of transmasculine men in the SUS. For this purpose, a survey of the bibliography published in the last 5 years on the subject was carried out in Google Scholar, focusing more on breadth than depth. Around 40 articles were found, most of them dealing with scoping reviews and other topics of transmasculinity. Only 7 academic works address the proposed subject and are discussed in this text.

An analysis was also carried out of the public health policies for the comprehensive care of the LGBTQIAPN+ population, as well as reports from trans men and transmasculine people who became pregnant and underwent the entire follow-up process in the SUS, from conception to the postpartum period. The reports presented here were only partially reproduced; they are published on social media, in the bibliography, and in the Ibrat-MS booklet, identified with the proper references. Other reports were obtained from three trans men in Campo Grande through interviews with informed consent, whom we will call collaborators 1, 2, and 3. The interviews with the collaborators were conducted through the WhatsApp application, according to their preferences.

The collaborators were referred by the coordinator of Ibrat-MS, having been informed about the objectives of the research, and they showed willingness to help, as they understand that it is a subject of interest to the local trans community, since the idea arose from lectures by trans men connected to Ibrat-MS, given to students and professors of the UFMS Health Equity PET Program (PET Saúde Equidade UFMS).

Through these lectures, it was identified that at least four trans men and transmasculine went through the pregnancy-postpartum process in the SUS, but only two wanted to share their experiences for this research. Another report is from a trans man who still intends to become pregnant. There are also accounts of transmasculine pregnancies that were posted on social media and analyzed with the aim of enriching the debate on support and care in SUS Health Units. These reports are in the public domain.

We thank the Brazilian Institute of Transmasculinity—Mato Grosso do Sul (Ibrat-MS), in the person of Luan Henrique, leader of the trans men and transmasculine movement of Mato Grosso do Sul, for being a tireless partner in the conception of this article, and PET Saúde UFMS (UFMS Health PET Program) for indicating the collaborators of this research. In addition, he provided support and relevant information on the subject addressed, bringing light to a topic that is still little known in the academic field.

It is important to emphasize that this article is closely linked to the Tutorial Education Program at UFMS (PET Saúde Equidade-UFMS), the Ministry of Health, and the Health Department of Campo Grande, through the subproject "Men and women who gestate: the lives of health workers matter" (*Homens e mulheres que gestam: a vida de trabalhadores em saúde importa*), in which I participate as a tutor. Participation in PET Saúde made possible the dialogue with social movements, integrating teaching, research, and outreach, and involving professors and students in understanding the reality of the local LGBTQIAPN+ community and other social groups such as Indigenous peoples, Black people, women, and other minorities.

Transmasculine Pregnancy

Pregnancy is deeply associated with femininity. Frequently, an overly feminine experience is created during this period. However, if for many women it is challenging to recognize themselves in this environment, imagine a pregnant trans or transmasculine person who needs to access these same spaces, since they were not designed to serve them?

When conceiving, social gender norms establish the "gestating body" as a function of the "cisgender and heterosexual woman." Thus, health care during pregnancy ignores the subjective particularities of individuals and the presence of bodies that do not fit this standard.

According to Zambrano (2006), the naturalization of pregnancy and the heterosexual and cisgender family organization is based on a biological order, sanctified by Christian religion in the West, associating it with elements that form the family bond. Kinship, filiation, and care for offspring are seen as just as natural as conception, making any family configuration or pregnancy outside the cisgender and heterosexual context be considered unthinkable, ignoring its social character.

From the perspective of comprehensive health, the pregnancy process in transgender men and transmasculine individuals is entirely possible, since most preserve the organs of the reproductive system, such as the vagina, uterus, fallopian tubes, and ovaries, with the capacity to conceive and give birth. This makes gynecological and obstetric care essential as a guarantee of sexual and reproductive rights, as well as the safety and protection of pregnancy and the postpartum period (SILVA et al., 2024).

According to studies by Todxs-Unaids (2021), the disrespect for social names has been one of the obstacles that hinder or even prevent transgender people from accessing healthcare systems. Regarding trans men and transmasculine individuals, the research presents reports that, at times, they avoid visiting gynecological clinics for fear of going through embarrassing experiences. Some of them report having suffered prejudice and even violence during their consultations. In addition to this, the lack of preparedness among healthcare professionals in attending to trans men and transmasculine individuals creates a healthcare environment that is unwelcoming and even hostile, violating the right to comprehensive health as well as the right not to be discriminated against.

Health care and transmasculine pregnancy involve multiple dimensions that must be addressed in a comprehensive, individualized, and respectful manner. In this sense, Ibrat-MS, through the booklet *Caring with Respect: Pregnancy of Trans Men and Transmasculines* (*Cuidando com respeito: Gestação de homens trans e transmasculines*) (2025), emphasizes the need for "*professionals who are trained and welcoming and who understand the specificities of transmasculine health*" (p. 4). Since the monitoring of the pregnancy and postpartum process "*must involve regular consultations, routine examinations, and, when necessary, specific tests such as ultrasounds and hormonal evaluations—always respecting the person's gender identity*" (p. 4).

In Brazil, trans and transmasculine people who become pregnant are still not identified in the data of the Unified Health System (SUS). The impossibility of filling in the field "gender identity" occurs for two reasons: first, due to the gap between legislation and practice, especially regarding the *Live Birth Certificate (Declaração de Nascido Vivo – DNV)*, regulated by Law No. 12,662 of June 5, 2012, and other system documents, in which the term "mother" still predominates. Although there have been advances such as the right to a social name and access to the transsexualization process, the reality of pregnant trans and transmasculine men is still not fully reflected in health systems, which can generate embarrassment and difficulties in care at reference sites for obstetric assistance, such as Primary Health Units (UBS), birthing centers, and maternity hospitals. In addition, this lack of information prevents the understanding of different experiences during pregnancy, childbirth, and the postpartum period, as well as making the inequalities in access visible and the impact on the comprehensive health of these individuals. Studies on the subject still do not provide

prevalence data on pregnancy in trans men, *"since health information systems are still limited in the inclusion of users' gender identity, thus hindering the production of indicators"* (SILVA, 2024, p. 02).

The second problem is related to the idea of pregnancy as a strictly biological occurrence, and therefore exclusive to women, reproducing the logic of body, sex, and gender, historically enshrined in medical manuals and in the training of health professionals. According to Gabriel Martinn, a trans man and obstetric midwife, when discussing the pregnancy–postpartum process in an interview with *Jornal da USP* in 2024, he notes that there is:

> "a gap across all courses, including the midwifery program at USP. At no point during my undergraduate studies did I study the sexual and reproductive health of transmasculinities. In the field of health, I believe we are not making progress. We are still not studying gender. In my undergraduate program, which is quite different within the health field, we did not study non-normative genders, only the man–woman binary."

He also points out that the notion of sexual and reproductive health and the pregnancy of trans people is still not on the formal health agenda. *"At the hospital where I work, when I say what I am researching and studying, they say, 'Wow! But how can a man get pregnant?'"* According to him, people do not know the difference between gender identity and sexual orientation, emphasizing that this is an important issue in his professional practice, since there are no discussions about gender in health services, despite advances in legislation on the subject.

Gabriel's statement reveals the logic of body–sex–gender coherence discussed by Butler (2015), based on the question of whether "sex" has a history or whether it is a given structure, considering the medical consensus on its indisputable materiality. Butler disagrees with the idea that we could only construct social theory about gender, while sex would belong to the body and to nature. By producing a history of the body and sex, Butler dissolves the sex/gender dichotomy as limited possibilities for problematizing the biological nature of men and women. The "compulsory order" that demands total coherence among one sex, one gender, one body, and desire is obligatorily heterosexual. Thus, the prevailing concept of

gender legitimizes this order, insofar as it would be an instrument expressed mainly through culture and discourse that situates sex and sexual differences outside the social sphere; that is, gender imprisons sex within a nature deemed unreachable by critique and deconstruction.

There are still few published studies on the subject in Brazil. In particular, there is a significant gap in the scientific field regarding healthcare for trans men and transmasculine individuals during the pregnancy–puerperal cycle, since these aspects are addressed in professional training only from a cis-heteronormative perspective. This contributes to a limited view of care and excludes the specific experiences and needs of this social group.

In a bibliographic survey conducted on Google Scholar, forty articles and master's theses on the topic of transmasculine pregnancy were found, produced between 2021 and 2025, of which only four focus on the relationship between public health policies and the pregnancy–puerperal process, reception, and care within the SUS.

In this context, Madeleine Leininger's Theory of Cultural Care Diversity and Universality (ORIÁ, XIMENES, ALVES, 2005), in her conceptual model "Sunrise," proposed to consider human care in a way that is congruent with the knowledge of one's culture and worldview, discovering the meaning of transcultural care based on practices specifically directed toward each culture and its influencing factors in the provision of healthcare.

Studies on Leininger (SOUZA et al., 2024; GUALDA, HOGA, 1992) state that the theorist must interpret the existence of cultural diversity and universality with a focus on the structuring of care so that the person can be cared for in a satisfactory and humanistic way, with the concepts of "Culture," "Worldview," "Environmental Context," "Care," and "Health" being fundamental for the understanding of this study.

Advancing on health care and the transmasculine pregnancy-puerperal process, the study by Oliveira and Ferreira (2022) addresses the experiences of trans men and non-binary people assigned female at birth who went through gestational, abortive, and parental processes. It is qualitative research, built on experience reports, focusing on the perspective of the transmasculine subjects themselves. It also shows that although pregnancy is generally associated with femininity, it is also part of the experience of transmasculine people, even if burdened with particular challenges. For these subjects, gestating can generate conflicts with gender identity, in addition to triggering psychological distress, especially when pregnancy occurs without planning or in contexts of institutional and social abandonment. The text

highlights the lack of preparation of health teams and the cisnormative structure of services, which reinforce exclusions and the delegitimization of transmasculine reproductive experiences.

Among the main findings, the article points to the erasure of these pregnant bodies in clinical protocols, in spaces of reception, and in official statistical data. There is a critique of the inadequacy of SUS sexual and reproductive health services, which remain anchored in a binary and exclusionary logic. Parenthood, in turn, is also marked by linguistic and social challenges, requiring from these subjects continuous negotiations between identity, body, and affection. Many create new forms of naming and organize family and affective structures, even while facing institutionalized prejudice.

The article's strong point is its ethical-political commitment to active listening and transmasculine protagonism, breaking with the historical silencing around trans pregnancy. Its empirical basis, although limited, gives depth to the analyses and allows articulating lived experience with the normative frameworks of the National Policy for Comprehensive LGBT Health (Ordinance No. 2,836/2011).

Research with trans men and transmasculine people correctly points out the limits of the SUS in approaching this population. From a methodological standpoint, it does not provide detailed information about the number of participants, their sociodemographic characteristics (race, class, region), or the context of the interviews, which reduces the possibility of intersectional analysis—a fundamental point for understanding how social markers (such as race and territory) intersect with trans pregnancy. Despite this, the study is relevant as it contributes to strengthening an ethical and political critique of cisgender normativity in health services. It serves as a starting point for the formulation of new research and more welcoming and safe practices, especially in the context of prenatal care, birth, and transmasculine parenthood within the SUS.

The article by Avelino et al. (2025) reflects on the implications of pregnancy among trans men and transmasculine people for health services and policies, based on intervention research conducted in a sexual and reproductive health outpatient clinic at a maternity hospital in the Brazilian Northeast. It presents the "Pregnant Person's Handbook" (Caderneta do Gestante) as a healthcare approach that promotes the inclusion of gender diversity, the exercise of reproductive rights of transmasculine people, and comprehensive healthcare.

The authors emphasize that policies aimed at sexual and reproductive rights are still developed based on the traditional model of the nuclear family and on the biological aspects of human reproduction. These aspects are often reinforced by discourses that impose heterosexuality, considering pregnancy as a female norm, which generates exclusion and violence against trans and transmasculine people in health policies. However, pregnancy and parenthood are experiences that may or may not be desired by transmasculine people; therefore, it is essential that these individuals have their sexual and reproductive rights guaranteed, as well as access to quality prenatal care.

They also reflect on the contributions of the feminist movement as fundamental for the development of health policies, promoting the inclusion of transmasculinity in approaches to pregnancy, childbirth, the postpartum period, and breastfeeding. The experience of pregnancy among trans men and transmasculine people brings to light issues about reproduction, childbirth, and birth as integral parts of comprehensive human health care. Transfeminism, together with its intersections with transmasculinities, prioritizes the discussion of the reproductive rights of these men, helping to create spaces that meet their needs.

Even considering all these obstacles and advances, it is possible to affirm that the social meanings surrounding trans experiences have been undergoing an important process of transformation in Brazil, thanks to the demands of trans activism, whose emergence dates to the end of the past decade. The emergence of different concepts and theories about gender and sexuality, which criticize traditional meanings anchored in biological perspectives, as well as the public demands of trans activism on both national and international scales, have fostered a productive synergy in this regard. Changes in the categories referring to trans experiences in diagnostic manuals, such as the DSM in its 5th edition and the ICD in its 11th revision, are consistent with these processes. This effort toward the pursuit of recognition and visibility has made possible advances in public health policies aimed at this population since the first decade of this century.

The SUS and Comprehensive Health Policies for the Trans Population in Brazil

In 2006, through the Charter of the Rights of Health Users, SUS introduced the right to use the social name by which travestis and transsexuals identify themselves and choose to be called socially—and not only in the specialized services that already welcome them, but in any other within the public health network. The Transsexualizing Process was instituted in 2008, allowing access to procedures such as hormonization, body and genital modification surgeries, as well as multiprofessional follow-up.

The guarantee of the right to health for transmasculine people within the Unified Health System (SUS) is grounded in a set of regulations that, although recent and still in the process of being implemented, represent important advances in recognizing the specificities of this population. Ordinance No. 2.836/2011, which establishes the National Policy for Comprehensive LGBT Health, marks a watershed by institutionally recognizing the need to eliminate discrimination and prejudice in health services, in addition to proposing actions aimed at equity and comprehensiveness. This policy serves as the basis for all other initiatives directed at the comprehensive care of the LGBTQIAPN+ population, including trans men and transmasculine people in the gestational process.

Complementarily, Ordinance No. 2.803/2013, which redefines the transsexualization process in SUS, establishes clinical guidelines for outpatient and hospital care of trans people, including hormonization and gender-affirming surgeries. Although directed mostly toward the transition process, this ordinance also legitimizes the presence of trans people in SUS specialized services, which is crucial for trans men and transmasculines who are pregnant to have access to a network of care that understands their specific needs, such as prenatal care without cisnormativity.

Ordinance No. 1.820/2009, which addresses the rights of health users, reinforces the use of the social name and non-discrimination, which is especially relevant in the context of obstetric care for transmasculine people, who are frequently exposed to situations of embarrassment, institutional violence, and the erasure of their identities. Even more recently, Ordinance No. 841/2023 establishes guidelines for specialized care for the trans population, encouraging the creation of flows and protocols that cover everything from primary care to higher levels of complexity, which includes the monitoring of transmasculine pregnancy with respect, acceptance, and a comprehensive approach.

Putting public policies into practice, the TransGesta Program of SUS, created in 2021 by the Climério de Oliveira Maternity of the Federal University of Bahia (UFBA), made possible the creation of the TransGesta Booklet (Caderneta TransGesta) in 2024 as an official document for the monitoring of prenatal care of transmasculine people and pregnant trans men (TransGesta; 2024, p.).

Figure 1. Cover of the TransGesta booklet

The booklet is an instrument for recording, monitoring, and providing multiprofessional guidance on prenatal care, childbirth, postpartum, and baby care, designed for transmasculine people and their wives, girlfriends/boyfriends, and partners. It also serves as a guide for healthcare professionals involved in care (p. 37).

The TransGesta booklet prioritizes monitoring and collecting clinical, laboratory, and emotional information throughout the pregnancy-puerperal process, as well as ensuring care and support for the pregnant person and the multidisciplinary health team at the healthcare unit. It seeks to guarantee respect for gender identity, strengthen the bond with health services, and promote autonomy, active listening, and the protagonism of the trans pregnant person.

The booklet is individual, with fields to fill in social name, gender identity, sexual orientation, health data, education level, place of birth, and documents. There are also fields for the partner, acknowledging shared care.

It also provides clarifications about breastfeeding and lactation induction. Breastfeeding may be performed by the person who carried the pregnancy and/or by their partner, including through hormonal induction. The booklet explains that even after

mastectomy surgeries, milk production may still occur; breastfeeding is encouraged as a way to promote bonding, nutrition, and the baby's emotional health; and it emphasizes the role of multiprofessional teams and support networks (p. 34).

In addition to being a clinical instrument, the booklet is also a tool of citizenship and rights affirmation. By centering care around the experiences of trans pregnant people, it promotes inclusion, visibility, and comprehensive care.

In the analysis of the TransGesta Program, it is clear that this is a relevant initiative for humanized care, although there are still doubts regarding the understanding of concepts of gender identity and the use of appropriate language. These weaknesses may impact the quality of care provided, requiring further strategies for continuing health education.

However, it is important to highlight the multidisciplinary work of the team as one of the program's main strengths, allowing for a comprehensive approach to the physical, hormonal, and emotional demands of its users.

As an initiative of the trans men and transmasculine movement in Mato Grosso do Sul, gathered around Ibrat, the booklet Pregnancy of Trans Men and Transmasculine: Caring with Respect was created in 2025. It is an educational, informative, and guidance material aimed at trans men, transmasculine people, and professionals in healthcare, education, and other sectors working with this population.

Figure 2: Coverof the Ibrat-MS booklet

The booklet is a free publication focused on informing, empowering, and guaranteeing rights to trans men and transmasculine people in relation to the pregnancy-puerperal process. It also aims to raise awareness among health professionals for ethical and prejudice-free care, offering practical, clinical, and affective guidance on the pregnancy of transmasculine people. In addition, it promotes access to information and reproductive rights, contributes to inclusive, respectful, and humanized care, and seeks to support professionals and institutions in providing qualified care to the trans population.

Regarding care before and during pregnancy, the handbook provides guidance on respectful gynecological and obstetric follow-up; appropriate examinations and prenatal care; birth plan preparation; mental health and psychological support; nutrition, physical activity, and discussions about testosterone use; and strengthening the support network and respect for the social name.

O The material is also aimed at health professionals, who often lack the necessary preparation to handle these cases. It includes ways to act with active listening, respect, empathy, and without presuppositions (p. 11).

In this context, the role of civil society, especially Ibrat, has been fundamental in organizing this population by voicing their demands in the formulation of public policies, training professionals, and producing educational materials that deconstruct the cisheteronormative imaginary present in the health field. Its content, booklets, and public reports contribute to recognizing transmasculine pregnancy as a legitimate reality deserving of care, promoting support based on evidence, qualified listening, and a human rights perspective.

Transmasculine pregnancy and the challenges of care in the SUS: reports and contributions

Despite the normative and legal advances promoted by the SUS in the field of comprehensive health care for the trans population, the account below from a trans man points out that care in health services is still crossed by various institutional and symbolic barriers, showing how technical-scientific ignorance, prejudice, and cisnormativity directly interfere with the quality of care provided:

> *When I moved to Mato Grosso do Sul, I faced difficulties accessing quality care, especially in the public service, where I felt disrespected at times. I had many problems, the main one being the non-recognition of my gender identity. The nurse attending me insisted on calling me "mãezinha" (little mother), which made me very angry. I explained many times, but she pretended not to hear me. Both the older and the younger staff at the health unit showed no empathy toward us (p. 10).*

According to the collaborator, he reported having suffered psychological harm because of the embarrassments, since the staff, despite calling him "mãezinha" (little mother), did not apply the SUS regulations for the care of trans people, denying him access to a gynecologist.

> *I told the attendants that I needed gynecological exams and that I had the right to them; the law guarantees this right, but I was unable to schedule an appointment with a gynecologist. They always said they*

> *were following SUS protocols; I told them they weren't, because I couldn't access the service. The treatment I received during my pregnancy made me give up a dream, caused me trauma, and left a mark I wouldn't wish on anyone.*

The dream he says he gave up is to raise his child close to nature in Mato Grosso do Sul:

> *But that's it. Despite all the difficulties, I'm still trying to live here because I have contact with nature. But if this ends up making me psychologically ill again, I won't think twice about leaving and being welcomed and cared for by those who make a point of us.*

The second participant from Campo Grande said that he very much wants to become pregnant, but he is afraid of being embarrassed and suffering prejudice within the Health Unit:

> *We always need to keep giving lots of explanations to the receptionists, to the doctor, to everyone; it's exhausting. Some time ago I went to have an abdominal ultrasound at the public hospital, and the doctor simply left me in the room, walked out, and came back with another doctor. I hadn't told him that I was a trans man, so when he saw on the ultrasound that I had a uterus, he was shocked and called another doctor to look, as if I were a freak. That made me pissed off; he didn't keep the confidentiality of the patient/doctor relationship. So, that experience and others that we go through leave their mark on us. I keep thinking: me, who has a beard, pregnant in the waiting room of the clinic to have prenatal care among other women. It's going to be very embarrassing and exhausting. That's why I haven't yet decided when I'm going to have my child, but I dream of being a father.*

This other account is taken from an interview with Gabriel Martinn for Jornal da USP, exposing the violence in the relationships between healthcare professionals and trans masculine people:

> *"I was aware that giving birth in a hospital as a trans man was serious, but I had no idea how violent it already was during prenatal care. In fact, his childbirth was at home as an escape strategy so that it wouldn't take place in the hospital, an escape that had already begun during prenatal care. It is a violence that starts long before birth and extends after birth." (Gabriel Martinn in an interview with Jornal da USP)*[1].

Gabriel Martinn Franca (2024), in his master's degree at the School of Public Health at USP, conducted research on the healthcare provided to transmasculine people in the health system and discussed transphobia and obstetric violence based on the reports of his research subjects.

Identified as Carlos, one of his interlocutors reports the difficulties of prenatal care, since the doctor who attended him and his partner would not look them in the face, did not listen, and frequently interrupted their speech. He adds that this was a trigger for anxiety, and the couple found themselves trapped in that situation due to the need for medical care and concern for the baby (FRANCA, 2024, p. 84).

In addition to the unwelcoming care provided by the doctor, she tried to demonstrate that his pregnancy had been a mistake, an oversight, and that it had not been planned: "She just didn't listen to what we had to say and always treated our pregnancy as if it were a mistake, a misstep, as if we weren't prepared for it, you know?" (p. 84). Faced with the obstacles encountered in the health system, the couple decided to have a home birth to avoid the embarrassment and obstetric violence reported by many women (FRANCA, 2024, p. 80).

[1] Available at: https://jornal.usp.br. Transmasculinities face a wide gap in access to sexual and reproductive health. Jornal da USP, March 9, 2024. Accessed July 16, 2025

Franca also brings reports from other trans men and transmasculine people describing barriers such as the use of social name, gender identity, and untrained staff to deal with the sexual and reproductive health of this population. The author also points out that healthcare professionals are unable to provide adequate information on conception, contraception, prevention of sexually transmitted infections, and other guidance about the body and health of trans people (p. 96).

The reproduction of these accounts is relevant insofar as they reveal the urgency of promoting continuing education in healthcare with a focus on gender, sexuality, and human rights, training professionals to know how to handle diverse reproductive experiences without judgment or invisibilization. It must be understood that it is not enough to guarantee physical access to healthcare services; it is necessary to guarantee symbolic access, the recognition of identity, and qualified listening.

It is evident that the lack of specific care pathways for monitoring transmasculine pregnancies generates insecurity and suffering, which directly contradicts the constitutional principles of SUS: universality, equity, and comprehensiveness.

Thus, when addressing the issue of pregnancy among trans men and transmasculine people, despite advances in public policies and regulations, it becomes evident that SUS still faces the challenge of overcoming structural, epistemological, and symbolic barriers that affect the lives of these individuals. Even though ordinances provide legal support, their implementation depends on trained professionals, services committed to equity, and a cultural transformation that recognizes and values trans identities in healthcare, especially in the field of sexual and reproductive health. Valuing the experiences and testimonies of pregnant trans men is, therefore, essential for building practices that are truly inclusive and humanized within the public health system.

Even with all the limitations pointed out by trans people, this set of measures has changed the legal and social conditions that previously shaped healthcare practices for the trans population. Before its approval, trans people avoided going to healthcare institutions for fear of being mistreated and victimized by discrimination and institutional violence.

The approval of this regulation made it possible to unlock practices and produce specialized knowledge around the pregnancy-puerperal process and sexual and reproductive health, as well as body construction interventions requested by the trans population, since it

provided them with a framework of legality and visibility, still insufficient, that did not previously exist.

On the other hand, successful experiences are also reported, especially when they occur in contexts where there is interprofessional support, respect for the social name, the use of gender-neutral language, and active listening. Such good practices are usually associated with the work of professionals committed to gender equity, the presence of university outreach projects, and the critical training of healthcare workers.

One of the experiences is recounted by our third collaborator, stating that he went through the entire process in the SUS, from conception to birth and then the postpartum period, for which he could only be grateful to the professionals who attended to him.

> *I had no difficulty doing everything through the SUS; one learns, either by reading or hearing from friends, about the problem of disrespect for gender identity and about embarrassments, but for me everything was very normal. I have no complaints. During the birth as well, everything was very humanized.*

Good practices within SUS are also exemplified in the account of trans man and internet influencerRodrigo Brian[2] and his wife, Ellen Carine, a trans woman. They are well known online for documenting the entire pregnancy process on their YouTube channel, fofuxostrans[3], which currently has 30,000 subscribers.

In their social media posts, the couple narrates the entire pregnancy-puerperal process, from his decision to become pregnant to their interactions with their daughter, who was born in 2021 at a SUS birth unit in a city in the countryside of Minas Gerais. From the beginning of the pregnancy, he describes the medical environment in which all procedures were carried out as very welcoming, noting that his childbirth required constant medical interventions, including medication and anesthesia. He acknowledges that the delivery was highly humanized and highlights the work of the pediatrician responsible for their daughter. He speaks with emotion about the moment of birth, which included immediate skin-to-skin

[2] Available at: https://youtu.be/AUN8hHU71Jk?si=28X99QFi0JmvK3ic. Accessed on: 06/19/2025.
[3] Available at: https://www.instagram.com/fofuxa_transs/. Accessed on: 07/24/2025.

contact between father and daughter, as well as background music, contributing to a positive emotional atmosphere.

He also highlights the importance of the bond established with the medical team, especially with professionals from the Family Health Unit where they received prenatal care, as well as with one of the professionals who assisted during the hospital delivery. This ongoing care contributed to a sense of security, serving as an example of how SUS can provide comprehensive and humanized care.

His wife, Ellen Carine, reported that the support of the team and the respect for their gender identities contributed to a positive birth experience. In addition to emotional support and active listening, the team's preparedness was identified by the couple as a fundamental aspect in ensuring a dignified and respectful childbirth experience for trans people within SUS.

The delivery took place at the maternity ward of the University Hospital of Montes Claros State University, a reference in several specialties and providing care exclusively through SUS[4].

Another successful practice is presented by trans woman Erika Fernandes[5], married to YouTuber Roberto Bete. In a video posted on Mariana Kupfer's channel, she recounts her experience breastfeeding the child carried by her husband.

Breastfeeding by trans women can be achieved through induced lactation, which involves the temporary interruption of hormone therapy and continuous medical supervision.

The Albert Einstein Hospital Episode of Care Guide (2025) states that induced lactation can be used both by cisgender women and by transgender people and that three medications are involved in the process: the hormones estrogen and progesterone, in addition to domperidone, a drug indicated for stomach disorders. Together, they are capable of increasing prolactin levels, the hormone responsible for inducing milk production by the mammary glands, as well as breast enlargement.

> Induced lactation is a clinical strategy that enables individuals who have not recently experienced pregnancy to produce sufficient human milk for nutritional, immunological, and emotional purposes. The

[4] Available at: https://www.agenciaminas.mg.gov.br/. Accessed on: 07/04/2025.
[5] Available at: https://www.youtube.com/watch?v=tdJ4zcf7vME. Accessed on: 06/19/2025.

> practice has become particularly relevant in contexts such as adoption, same-sex couples, transgender people, and situations of relactation after early weaning or adverse events (p. 1).

Erika reports that, even with silicone implants, it was possible to produce milk and breastfeed successfully, as the milk ducts had not been compromised. Care provided by the SUS exceeded the couple's expectations, being highlighted as welcoming and respectful.

The video emphasizes that this type of care is made possible by the *National Policy for Comprehensive LGBT Health*, which provides for humanized and qualified care for trans and travesti people in the SUS. Erika points out that access to the outpatient clinic was made through registration and that there is a limited number of spots, which represents a barrier to access, even given the quality of care.

The documentary *Pregnant Father* (*Pai Grávido)*, produced in 2022 by Mov UOL, tells the story of several pregnant trans men, highlighting the importance of welcoming diverse family configurations and the obstacles faced by trans people in accessing public health care.

Although the accounts above highlight good practices in the SUS, the film reveals that this is not the standard for the entire trans population. There is still resistance from health professionals, a lack of training, and situations of refusal of care, despite the existence of the National Policy for Comprehensive LGBT Health, in effect since 2011. The report mentions that trans and travesti people, generally in situations of socioeconomic vulnerability, rely predominantly on the SUS, which underscores the urgency of increasing investment, staff training, and system efficiency, which, by 2025, still does not record the gender identity of the transmasculine parent, making this type of pregnancy unregistered in public databases.

The successful cases mentioned may represent exceptions that highlight the importance and potential of the SUS when public policies are implemented in a universal and equitable manner, addressing the specificities of each social segment.

In this sense, it is important to emphasize the need to transform these successful experiences into a universal standard of care, ensuring that the health system is accessible and safe for all people, regardless of their gender identity, sexuality, race, class, or other intersections.

Thus, when addressing transmasculine pregnancy, the SUS faces the challenge of confronting structural, epistemological, and symbolic barriers that permeate the lives of these

individuals. Although ministerial ordinances provide legal support, their implementation depends on trained professionals, services committed to equity, and a cultural transformation that recognizes and values trans identities in health care, especially in the field of sexual and reproductive health. The appreciation of the experiences and narratives of pregnant trans men is, therefore, essential for building practices that are truly inclusive and humanized within the public health system.

Final Considerations

To conclude, throughout this research, it is evident that care for transmasculine pregnancy within the SUS requires not only regulations but also political-institutional commitment to equity, collaboration with social movements such as Ibrat, and the construction of care spaces that respect the identities, bodies, affections, and life projects of all subjects. The recognition of pregnancy as a legitimate possibility for trans men is an act of reproductive justice and represents a fundamental step toward a truly inclusive SUS.

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