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Perspectives of healthcare professionals on caring for transgender adolescents: A qualitative study

A perspectiva dos profissionais de saúde no atendimento a adolescentes trans: uma análise qualitativa

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ABSTRACT The article examines conflicts, enabling factors, and barriers in the provision of care for transgender adolescents in specialized outpatient clinics, based on the experiences of 14 healthcare professionals. Using a qualitative design with semi-structured interviews, the analysis identified five thematic classes: 1) care dynamics and family involvement; 2) social impacts and violence against transgender people; 3) challenges in gender-affirming hormone-related processes; 4) gender and identity issues; and 5) specialized professional training. The findings highlight: 1) the complexity of caring for transgender adolescents, particularly concerning rights, confidentiality, and family support; 2) the impact of cisnormativity on care experiences, which may generate either distress or support depending on professional attitudes; 3) concerns about the safe use of hormones and the importance of specialized follow-up; 4) professionals' recognition of gender diversity terminology and lived experiences, reflecting respect and sensitivity; and 5) significant gaps in undergraduate health education and limited academic debate on transgender health. The study concludes that there is an urgent need to strengthen public policies and professional practices that ensure comprehensive, empathetic, and inclusive care for transgender adolescents. Valuing their identities and investing in continuous professional education are essential steps toward building a more equitable and genuinely welcoming health system.

KEYWORDS Transgender persons. Adolescent. Public health. Professional training. Health personnel.

RESUMO *O artigo explora conflitos, facilidades e dificuldades no atendimento a adolescentes trans em ambulatórios especializados, mapeando experiências de 14 profissionais de saúde. Com abordagem qualitativa e entrevistas semiestruturadas, a análise identificou cinco classes: 1) dinâmica do atendimento e envolvimento familiar; 2) impactos sociais e violências contra pessoas trans; 3) desafios nos processos de hormonização; 4) questões de gênero e identidade; e 5) formação profissional específica. Os resultados evidenciaram: 1) nuances do cuidado a adolescentes trans, especialmente quanto a direitos, privacidade e apoio familiar; 2) impacto da cisnormatividade nas experiências de cuidado, podendo gerar sofrimento ou acolhimento conforme a postura profissional; 3) preocupações com o uso seguro de hormônios e a importância do acompanhamento especializado; 4) reconhecimento, pelos profissionais, de termos e vivências da diversidade de gênero, com respeito e sensibilidade; e 5) carência de formação acadêmica e de debate sobre saúde trans nas graduações em saúde. Conclui-se que é urgente fortalecer políticas públicas e práticas profissionais que promovam cuidado integral, empático e inclusivo a adolescentes trans, valorizando suas identidades e a formação contínua dos profissionais como caminho para um sistema de saúde equitativo e acolhedor.*

PALAVRAS-CHAVE *Pessoas transgênero. Adolescentes. Saúde pública. Capacitação profissional. Profissionais da saúde.*

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Introduction

In Brazil, formal regulation of the transsexualizing process was only established in 1997, with the enactment of Resolution No. 1,482 of 10 September 1997 by the Federal Council of Medicine (Conselho Federal de Medicina – CFM)[1]. Despite this regulatory milestone, until 2016, transgender children and adolescents had no guaranteed access to regulated clinical follow-up. The first service to offer care to this population was the Transdisciplinary Outpatient Clinic for Gender Identity and Sexual Orientation (AMTIGOS) at the University of São Paulo (USP)[2]. Only later, in 2019, did the CFM, through Resolution No. 2,265 of 20 September 2019[3], authorize medical care for transgender children and adolescents[4]. Subsequently, in 2025, the CFM revoked the 2019 Resolution, once again leaving transgender children and adolescents without adequate care. As a result, at the time this article was written, there was neither a structured nor an implemented public health policy specifically addressing the needs of transgender children and adolescents.

While important advances have been made, significant challenges persist. Health professionals continue to encounter difficulties stemming from bioethical tensions, institutional constraints, and inadequate training, highlighting how limited specialized knowledge can adversely affect adolescents' health. From this perspective, there is an urgent need to review and reform professional training curricula to ensure the meaningful incorporation of issues related to gender identity. In addition, prejudice and stigma remain pervasive within health services, directly compromising the quality of care[5-7].

In light of this context, this article—drawn from the doctoral dissertation entitled 'It is My Workplace: Health Professionals' Knowledge and the Care of Transgender Adolescents'—aims to examine the conflicts, enabling factors, and challenges observed in the provision of outpatient care to transgender adolescents.

Material and methods

The study adopted a qualitative approach, using semi-structured interviews as the primary data collection method. Invitations to participate were sent via WhatsApp after the research project received approval from the Research Ethics Committee (CEP) of the National School of Public Health Sergio Arouca (Escola Nacional de Saúde Pública Sergio Arouca – Ensp/Fiocruz) (Certificate of Presentation for Ethical Review – CAAE No. 78710324.0.0000.5240; Ethics Opinion No. 6,772,085), followed by ethical approval from the CEPs of the participating institutions: Pedro Ernesto University Hospital (Hospital Universitário Pedro Ernesto) (CAAE No. 78710324.0.3002.5259; Ethics Opinion No. 6,996,995) and the Minas Gerais State Hospital Foundation (Fundação Hospitalar do Estado de Minas Gerais) (CAAE No. 78710324.0.3001.5119; Ethics Opinion No. 7.021.095). All procedures strictly complied with the ethical principles set out in Resolution No. 466 of December 12, 2012, issued by the National Health Council (Conselho Nacional de Saúde – CNS)[8].

The methodological approach relied on the practicality of WhatsApp as a communication tool. Contact information provided by the outpatient clinic coordinators was used to present the study objectives and invite professionals to participate. A total of 14 interviews were conducted with psychologists, social workers, physicians, speech-language pathologists, nutritionists, and educators from specialized public services—a number that alone underscores the scarcity of such outpatient clinics in the country. To protect confidentiality, the location of the study was kept undisclosed. No professional declined the invitation.

The interviews were conducted in October 2024, with an average duration of 40 minutes, at locations chosen by the participants to ensure privacy. All interviews were recorded, transcribed, and concluded once saturation was reached, as indicated by the recurrence

of themes and the stability of categories according to Bardin's content analysis[9].

The interview guide consisted of both open- and closed-ended questions and was organized into three sections: 1) general characteristics of the participants; 2) professional training and experience with the transgender population; and 3) a clinical case scenario.

The data were analyzed using content analysis, which Bardin defines as a "research technique aimed at the objective and systematic description of the manifest content of communication"[9(24)]. The textual analysis followed three stages: material exploration, data processing, and interpretation. The interviews were transcribed, and the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ) was then used to support the analysis[1] . This approach aligns with a growing trend in the social and human sciences, where the use of software for textual data analysis has become increasingly common, particularly in studies involving large corpora[11].

The study employed Descending Hierarchical Classification (DHC), applied to the processing of qualitative texts using the IRaMuTeQ software. This technique organizes texts or speech segments into progressively hierarchical classes based on word frequency and relationships between words, enabling the identification of groups of similar segments and their associations[12]. Despite its methodological contribution, the procedure depends on the quality of the initial coding, and poorly structured texts can compromise the results. Moreover, because it relies on statistical categories, the technique may oversimplify the nuances of discourse. Therefore, it should be regarded as a supportive tool that requires critical interpretation and does not replace in-depth qualitative analysis.

The DHC was carried out in four stages: 1) preparation and coding of interview excerpts; 2) statistical analysis of word frequency and relationships; 3) hierarchical classification of segments into classes and subclasses, producing the dendrogram; and 4) interpretation of the classes to identify emerging patterns and themes.

The analysis of the corpus using DHC produced five classes, all selected based on two main criteria: thematic relevance, as they contained the most representative vocabulary and segments of the professionals' discourse, highlighting the central dimensions of the phenomenon; and interpretive coherence, as they were semantically consistent and allowed the findings to be understood within the adopted theoretical framework.

Results and discussion

Given that healthcare for transgender adolescents is still a relatively recent development in Brazil, the results and discussion presented here aim to inform reflections on how care for this population can be improved. In this context, excerpts from the interviews are highlighted, emphasizing both the dynamics of care provided by health professionals and the role of the family. The findings also underscore the importance of the adolescent's right to be seen alone during consultations, while the denial of this right by some professionals reveals a lack of familiarity with the established guidelines for adolescent care.

Before proceeding, it is important to note that in Brazil, the Child and Adolescent Statute (Estatuto da Criança e do Adolescente – ECA), based on Article 4 as the Doctrine of Comprehensive Protection and Article 2, which provides the legal definitions, considers a child to be anyone under 12 years of age and an adolescent to be anyone between 12 and 18 years of age. In exceptional cases explicitly provided by law, the statute's provisions may also apply to individuals aged 18 to 21[13].

In addition, the ECA emphasizes that the designation of a 'person in a peculiar stage of development' (Article 6) does not diminish their right to comprehensive protection of their physical, psychological, and moral

integrity. This includes aspects such as identity, autonomy, values, and ideas, as well as the right to express opinions, to communicate, and to seek refuge, assistance, and guidance[13-15]. Accordingly, denying access to healthcare constitutes a violation of the rights guaranteed by law.

Family relationships play a crucial role in both the care and the lives of transgender adolescents, as understanding and respecting these dynamics is an essential part of providing respectful care. Family support is considered one of the key factors for their well-being, although such support does not always emerge immediately. For this reason, families should be encouraged to participate in healthcare appointments and in the decision-making processes of their children.

A review in another study highlighted how clinical approaches to families of transgender youth have evolved over time. It recommended providing (re)education to caregivers on gender diversity and the scope of multidisciplinary care, which can include social transition, hormonal and/or surgical interventions, legal rights, and school support. The study also underscored the value of offering separate spaces for caregivers to discuss potential conflicts of values—such as those related to religion or family relationships—thereby supporting more effective care for both the adolescent and their family[16].

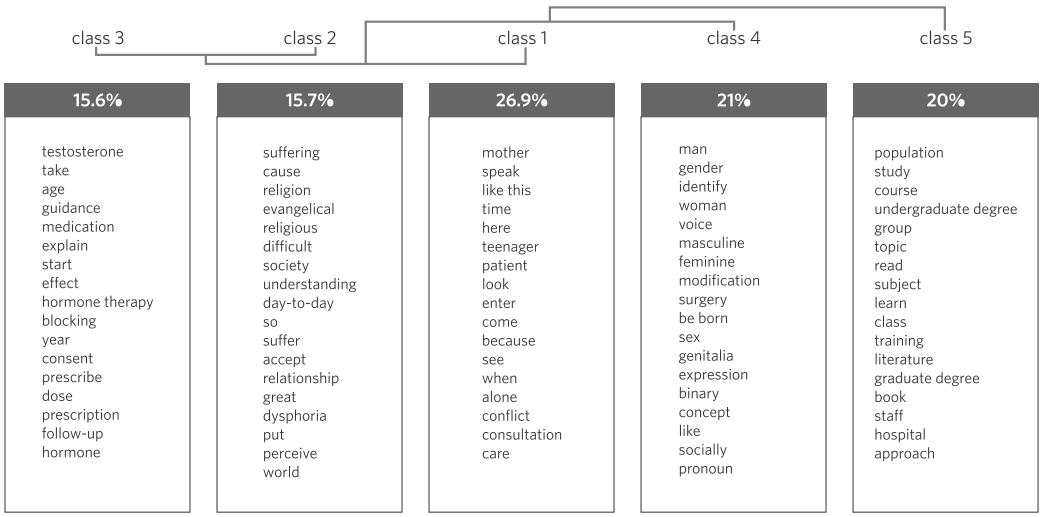
When a conflict arises in which a parent rejects their child's gender identity for religious reasons, the healthcare professional must listen to and respect both parties, while keeping the adolescent's well-being at the center of care. In this context, professionals must adhere to ethical principles and the guidelines established by their regulatory bodies.

Regarding care for transgender individuals, the Federal Councils of Medicine, Psychology[17], and Social Work[18] have issued specific resolutions addressing the needs of the transgender population. In contrast, the Councils of Nutrition[19], Speech-Language Pathology[20], and the National Education Council[21] do not have specific guidelines for this population, although professionals can still guide their practice according to their respective codes of ethics.

The findings of this study support this broader picture. Corpus analysis yielded a utilization rate of 89.82%, well above the expected 70%, indicating high-quality data. The material comprised 14 interview transcripts, totaling 1,611 segments, from which 4,717 distinct terms were identified, amounting to 56,179 occurrences overall. Of these, 2,292 were hapax legomena—terms appearing only once in the corpus—underscoring the lexical diversity and richness of the responses collected (*figure 1*).

A corpus utilization rate of 89.82% indicates that the material analyzed was both representative and of high quality. The remaining 10.18% consisted of segments affected by noise or inconsistencies and did not compromise the overall quality of the study. Given that 75% is considered the minimum quality threshold for Descending Hierarchical Classification analyses, as proposed by Camargo and Justo[11], the rate achieved further attests to the methodological robustness of the research.

Figure 1. Dendrogram of the Descending Hierarchical Classification based on the interviews



Source: Own elaboration.

The analysis and discussion of Class 1 – Care dynamics revealed important insights into how care is organized and into the roles played by both family members and health professionals within outpatient services for transgender adolescents. Prominent terms included 'mother', 'speak', 'adolescent', 'patient', 'conflict', 'consultation', and 'care'. Together, these keywords point not only to direct interactions between patients and health professionals but also to the central role of family relationships in the care process.

The analysis identified challenges and opportunities for improvement within health services, providing valuable guidance for managers and professionals to develop more effective, patient-centered care strategies that also acknowledge the integral role of families. Interview accounts further highlighted key care dynamics, including adolescents' right to be seen alone during consultations. The findings also underscored the importance of privacy and confidentiality, while noting that these rights are often denied by health professionals themselves.

> *[...] they often fail to read what is legally guaranteed—what has been regulated in adolescent healthcare in this country since 2006. And when I say 'people', I mean the professionals themselves. This is my workplace. They say, 'No, that's not allowed. Anyone under 18 can't come in alone'. And that represents a violation of rights. [...] In every consultation, regardless of the clinic, I explain the national guidelines for adolescent care: the right to privacy and confidentiality. I make this clear from the outset and say something like, 'Look, for you to be here'* (E14, 2024).

Taken together, these accounts—and the existence of regulatory frameworks and the ECA, which guarantee the right to individual care and confidentiality—highlight the need for health professionals to be familiar with these provisions, to respect them, and to actively inform adolescents about their rights.

Another dynamic that emerged was the role of family support, particularly maternal support, illustrating how family beliefs and moral frameworks can significantly shape young people's well-being.

> *I have a patient whose mother is very supportive and involved, while the father is very much against it. Even so, the mother—who is also evangelical—says, 'My daughter has always been this way', and continues to support her* (E13, 2024).

This example underscores the importance of considering the different family dynamics when caring for adolescents.

In Class 2 – Society, health professionals, and violence against transgender people, the most recurrent terms included 'suffering', 'religion', 'evangelical', 'society', 'suffer', 'accept', and 'dysphoria'. This class sheds light on the distress experienced by transgender adolescents, often intensified by barriers to social and religious acceptance. It outlines a landscape marked by complex emotional challenges that affect not only these young people but also the professionals involved in their care. One recurring difficulty refers to breaking ciscentrism, a concept presented as a "set of beliefs of superiority of the cisgender gender – or cisgenderism – and the cissexual sex – or cissexuality"[22].

> *[...] the 'greatest challenge is to break' with the machismo and cisheteronormativity of our 'society'. They 'cause' a lot of 'suffering for people', and sometimes people don't even realize it* (E7).

When seeking healthcare services, transgender people are exposed to a wide range of prejudice and discrimination. The literature documents these forms of violence extensively, showing that trans individuals frequently report being mocked for their gender identity, rejected by healthcare teams, denied care by physicians, subjected to breaches of confidentiality, and treated in discriminatory ways. In addition, they often encounter clinicians who advocate for the reversal of their gender identity, misuse pronouns, and fail to respect their affirmed name[23].

They further report having to educate physicians about aspects of their gender identity and describe feeling fearful of being harmed by professionals' lack of knowledge, particularly when clinicians are unsure how to refer cases or even how to initiate care. Feelings of insecurity are also expressed when patients realize that some physicians are unfamiliar with the potential consequences of treatments, such as hormone use. Even when specialized services are available, access is often hindered by the distance between patients' homes and care facilities, as well as long waiting lists. Another issue raised concerns the discomfort triggered by the use of anatomical terminology tied to biological sex—such as 'vagina', 'ovary' or 'prostate'—which frequently provokes anxiety[5,6].

> *[...] what really struck me was the fact that the parents took this boy to a pediatrician who spoke with him and stated that girls menstruate, that this is a normal and physiological process for all girls, and even said that God made it this way. For us, when we hear an account like this, it represents institutional violence, because saying that all girls menstruate ignores the specificities of his case. He is a boy, so how are we supposed to deal with that? Reaffirming these ideas to a trans person is a form of violence, because it triggers intense bodily dysphoria and leads to significant mental health suffering* (E1).

Conversely, evidence shows that access to health services that respect and affirm transgender adolescents has a positive impact and can be decisive for life preservation, contributing to improved mental health, reduced dysphoria, and enhanced well-being[24]. This context underscores the importance of ensuring access to such services, as well as the need for public health policies that respect gender identity and provide the conditions necessary for the gender affirmation sought by these adolescents.

In Class 3 – Hormone therapy processes, the most prominent terms included 'testosterone', 'take', 'age', 'guidance', 'medication', 'hormonization', and 'blocking'. These words reflect the centrality of discussions around medical transition in the gender affirmation process. The demand for bodily modifications and the desire for hormone treatment were particularly salient. In Brazil, until 2025, adolescents under 18 who wished to begin hormone therapy required the authorization of

a legal guardian. In 2025, the Federal Council of Medicine (CFM), through Resolution No. 2,427 of April 8, 2025[25], amended the previous regulation, establishing that hormone therapy could only be initiated from the age of 18. This change was seen by some medical specialists, researchers, and social movement advocates as a significant setback, particularly because there are reports of professionals indicating that many adolescents under 18 begin hormone therapy with testosterone clandestinely.

> *[...] He could attend alone. He wouldn't need a guardian. This would have been necessary for hormone therapy before the age of 18. He has already begun using testosterone secretly. This is a very common reality, and we see it frequently in our clinic* (E1).

> *[...] I would tell him not to use hormones on his own, obtained from unknown sources, without knowing the correct dosage, and I would explain all the side effects, just as we do when reviewing the informed consent form. I would also request lab tests to check whether he is already experiencing any negative effects from the testosterone* (E2).

This underscores the need for safe and appropriate follow-up throughout the gender transition process, involving both families or legal guardians and health professionals. In this context, clinical care should be firmly grounded in scientific evidence. Currently, health professionals working with trans populations primarily rely on two major references to inform practice. One of these is the clinical practice guideline on endocrine treatment for gender dysphoria/gender incongruence issued by the Endocrine Society, which supports the initiation of hormone therapy from the age of 16, provided that the adolescent is evaluated by a specialized multidisciplinary team able to confirm the persistence of transgender identity and the individual's capacity to provide informed consent. Notably, these guidelines do not offer explicit recommendations regarding the involvement of parents or legal guardians in this process. The second key reference is the Standards of Care for the Health of Transgender and Gender Diverse People, developed by the World Professional Association for Transgender Health (WPATH). This document emphasizes that decision-making regarding gender-affirming treatment should take adolescents' developmental characteristics into account, as these may influence their decision-making[26] capacity. It also directly addresses the role of parents and legal guardians, highlighting family support as a crucial factor and an important predictor of adolescent well-being, while acknowledging that such support is not available to all young people.

Moreover, engaging families through closer interaction with health professionals and ensuring access to clear, comprehensive information about the care process—as well as education on gender and diversity—can help bring parents into this pathway of care. When such engagement is not possible, adolescents may turn to the courts to secure access to hormone therapy[27].

The decision-making process in these cases is often neither straightforward nor linear, as shown by a study that examined how trans youth and their parents navigate decisions about initiating hormone therapy. Among adolescents, this process typically unfolds in three stages—discovery, interaction, and reflection. For parents, however, decision-making usually begins only after their child discloses their gender identity, creating a temporal mismatch: by the time they come out, many young people are already informed and actively engaged with the topic. While some parents initially respond with hesitation, many ultimately come to support the transition.

The absence of parental support, combined with systemic barriers in healthcare, adds further challenges to accessing hormone therapy. The cited study, which explored decision-making among trans adolescents and their parents, underscores the role of health professionals in facilitating informed

choices and guiding families, ensuring that adolescents' autonomy is respected even when communication is difficult or parental support is limited[28]. Restricted access can result in more severe mental health outcomes for those unable to receive care compared with peers whose access is guaranteed[29].

The main challenges to accessing specialized services include difficulty finding qualified healthcare providers, geographic distance, and long waiting lists. In Brazil, barriers to the gender-affirming care process through the Unified Health System (SUS) are similar. The geographic concentration of programs in the Southeast region, coupled with their absence in the North, alongside discrimination and failure to respect affirmed names, constitutes some of the primary obstacles. Additionally, the requirement of a diagnosis of transsexuality—based on socially constructed norms around gender—can restrict access to these services. Compounding these issues, a lack of trained professionals may lead to instances of disrespect and discrimination, further deterring patients from seeking care.

These barriers in accessing healthcare services often lead many transgender individuals to use hormones without a medical prescription or proper supervision. One study confirmed this, reporting that 87% of trans women had used hormones at least once in their lives without medical guidance. The study also found that the majority of trans women (57.2%) began hormone use between the ages of 12 and 18, while 10.1% reported starting even earlier, between 6 and 12 years of age[9].

A similar study conducted in the United States reported comparable findings. Trans women aged 40 to 49 were less likely to use hormones without a medical prescription than those aged 18 to 29[30]. Unsupervised hormone use often leads transgender individuals to take inappropriate medications, increasing the risk of thromboembolism, osteoporosis, and other adverse effects, including infertility. These findings highlight the importance of access to healthcare services and appropriate prescriptions, ensuring that hormone therapy is administered safely, with proper guidance and risk mitigation[30].

Classes 4 and 5 were discussed together, as both pertain to professional training. In Class 4 – Gender and identity issues, the most frequently occurring words included 'man', 'gender', 'identify', 'woman', 'masculine', 'feminine', and 'surgery'. These terms reflect a focus on gender identity and the processes of self-definition as male or female, as well as the links between gender and physical characteristics, including surgical interventions for gender affirmation.

In Class 5 – Professional training, the most prominent words included 'population', 'study', 'course', 'undergraduate', 'group', 'subject', and 'learn'. These terms provide insight into the academic training experiences of healthcare professionals and point to discussions regarding the inclusion—or absence—of content on gender diversity and the health of transgender populations in professional curricula.

> *There was no content on transgender health in undergraduate programs, and none in postgraduate studies. The only gender-related training I received occurred when I began working in the SUS* (E12).

It is clear that this statement highlights a gap in academic training on this topic, a point confirmed by another participant:

> *Absolutely nothing about transgender health was covered in my undergraduate studies 20 years ago, nor in postgraduate programs. In psychoanalysis, we cover a wide range of topics—Freud, Lacan, all sorts of issues—but this was never addressed* (E3).

Revisiting Class 4, participants demonstrated a clear understanding of gender expression and gender identity, a finding that contrasts with reports in the existing literature. Assessments of healthcare professionals' readiness in hospital settings to care for LGBTQIAPN+ populations have highlighted

significant challenges, with many providers struggling to appropriately address patients' sexual orientation and gender identity[31].

Discussions concerning the development and recognition of gender identities, as well as experiences of transition, reveal potential challenges in aligning gender identity with gender expression. The prevalence and context of these terms highlight the critical importance of addressing gender-related issues and bodily changes in the care of transgender individuals, emphasizing key aspects for both clinical management and emotional support.

One interviewee emphasized that gender expression differs across individuals:

> *[...] Some cisgender women are more or less feminine. Today, some gay men wear earrings and express themselves differently—that's part of gender expression* (E8).

Another interviewee understood a transgender individual as someone pursuing social and legal recognition of their gender as male or female.

> *[...] for me, a transgender person is someone who seeks social and legal recognition as a man or a woman. These are individuals who do not identify with the gender identity imposed on them—even during pregnancy—and who do not recognize themselves in it. Instead, they seek recognition, both socially and legally, in accordance with the identity with which they identify* (E7).

These remarks underscore the professionals' understanding of gender-diversity terminology and suggest that all interviewees were able to differentiate and respect both the terms and the lived experiences they represent.

Regarding Class 5, all fourteen healthcare professionals reported that during their undergraduate studies and most postgraduate or specialization programs, they received no specific training on the care of transgender populations; the topic was largely ignored in their formal education. Only one participant, who was completing a residency in gender-affirming care, reported having access to the subject. As a result of this gap, the majority indicated that they acquired the necessary knowledge later, independently, through professional practice. In other words, their learning occurred directly through interactions with transgender individuals.

> *None of the undergraduate courses formally covered transgender health, and the topic was also absent from both master's and doctoral programs. In adolescent health courses, the focus was on intersexuality rather than gender* (E14).

> *[...] Listening to the young people had a profound impact on me. Their words were powerful and insightful, and they demonstrated a deep understanding of gender—far beyond my own knowledge at the time. I thought, Wait, something is happening here - I need to better understand what was happening* (E4).

This pattern is also reflected in the literature through analyses of the pedagogical projects of medical schools at the Brazilian federal universities, which found that more than 50% include topics on gender and/or sexuality, particularly in the Northeast region, where there is a strong social movement on the subject . However, a gap was observed in clinical competency beyond the heterosexual body, with a predominant focus on sexuality and diseases associated with sexual practices rather than on gender. Thus, despite the inclusion of these topics in half of the schools, discussion beyond a biological perspective remains a challenge[7].

Similarly, an analysis of the curricula of nursing programs at Brazilian federal universities found that, among the 51 institutions evaluated, only 21 addressed transgender-related topics in their pedagogical projects[32]. The study also showed that most universities incorporating discussions on transgender issues are concentrated in the Northeast and Southeast

regions, revealing regional inequalities in the inclusion of this topic across Brazil[32].

Curricular guidelines for health-related degree programs recommend that gender identity and sexual orientation be addressed during undergraduate training. In the field of psychology, although the concept of diversity is reflected in professional resolutions, its implementation may remain superficial, often treating groups as homogeneous and failing to challenge the discipline's own assumptions that naturalize cisgender, heterosexual, white, and universal identities.

Without a critical examination of power structures and social norms—such as heteronormativity, cisnormativity, and whiteness—the concept of diversity risks becoming generic and ineffective in addressing the concrete health needs of different populations. In medicine, traditional training tends to emphasize pathological processes, reinforcing disease-centered reasoning and hindering a shift toward understanding individuals as social, historical, and plural beings. Machin, Paulino, Pontes et al.[33] frame diversity and difference as central challenges in health professional education, and emphasize the need to integrate knowledge from the social and human sciences into training. According to the authors, such integration can promote greater recognition of diversity and support more effective professional practice by accounting for its impacts on people's living conditions and health outcomes[33].

It is evident that professional training still requires significant improvement in diversity, particularly given the persistence of cisnormativity within health education, which often overlooks both the existence of diversity and the importance of critically engaging with it. There is a clear need to implement curricular guidelines rigorously and reflectively, free from prejudice or value judgments, and grounded in the social and human sciences. Ultimately, health training programs are oriented toward the care of human beings in all their complexity.

Final considerations

This study provides insight into the challenges and opportunities involved in the care of transgender adolescents in Brazilian outpatient settings, based on a qualitative analysis of healthcare professionals' perspectives. The findings highlight complex demands shaped by the vulnerabilities of this population and the need for recognition and affirmation of their gender identities, underscoring the importance of inclusive public health policies and ongoing professional training to support equitable and sensitive care practices.

In conclusion, fostering an inclusive health system requires an approach that moves beyond prescriptive norms and rigid protocols, incorporating practices grounded in respect, ethical consideration, and recognition of the specific lived experiences of transgender adolescents. Implementing meaningful change demands both institutional and societal commitment, through coordinated actions across education, health policy, and ongoing processes of professional training and awareness-raising. In this way, the findings presented here may inform the improvement of clinical practices, guide future research and public policies, and contribute to aligning the Brazilian Unified Health System (SUS) with the principles of comprehensiveness and universality of care, while ensuring dignity and protection for transgender children and adolescents.

Authorship contributions

Castro IF (0000-0003-2868-9842)* is responsible for preparing the manuscript. ■

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References

1. Conselho Federal de Medicina (BR). Resolução nº 1.482, de 10 de setembro de 1997. Autoriza a título experimental, a realização de cirurgia de transgenitalização do tipo neocolpovulvoplastia, neofaloplastia e ou procedimentos complementares sobre gônadas e caracteres sexuais secundários com o tratamento dos casos de transexualismo. Diário Oficial [da] República Federativa do Brasil [Internet], Brasília, DF. 1997 set 19 [acesso em 2025 out 26]; Edição 181; Seção I:20944. Disponível em: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=19/09/1997&jornal=1&pagina=208&totalArquivos=216

2. Saadeh A, Caetano LO, Gonzalez L, et al. AMTIGOS – Ambulatório Transdisciplinar de Identidade de Gênero e Orientação Sexual, do IPq-HCFM/USP: proposta de trabalho com crianças, adolescentes e adultos. Bol Inst Saúde. 2018;19(2):86-97. DOI: https://doi.org.10.52753/bis.2018.v19.34595

3. Conselho Federal de Medicina (BR). Resolução nº 2.265, de 20 de setembro de 2019. Dispõe sobre o cuidado específico à pessoa com incongruência de gênero ou transgênero [Internet]. Diário Oficial da União, Brasília, DF. 2020 jan 9 [acesso em 2025 out 26]; Edição 6; Seção I:96. Disponível em: https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2019/2265

4. Rocon PC, Sodré F, Rodrigues A. Regulamentação da vida no processo transexualizador brasileiro: uma análise sobre a política pública. Rev Katálysis. 2016;19(2):260-9. DOI: https://doi.org/10.1590/1414-49802016.00200011

5. Castro IF, Reis Filho A. Moreira RD. Os entraves à população transgênero no acesso à saúde. Rev Eletrôn Acervo Saúde. 2021;13(1):e5289. DOI: https://doi.org/10.25248/reas.e5289.2021

6. Chong LSH, Kosek J, Portillo M, et al. Experiências e perspectivas de jovens transgêneros no acesso à saúde: uma revisão sistemática. JAMA Pediatr. 2021;175(11):1159-73. DOI: https://doi.org/10.1001/jamapediatrics.2021.2061

7. Raimondi GA, Abreu YR, Borges IM, et al. Gender and Sexuality in the Federal Medical Schools in Brazil: an Analysis of the Curricular Pedagogical Projects. Rev Bras Educ Med. 2020;44(2):e045. DOI: https://doi.org/10.1590/1981-5271v44.2-20190050.ING

8. Conselho Nacional de Saúde (BR). Resolução nº 466, de 12 dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções CNS nºs. 196/96, 303/2000 e 404/2008 [Internet]. Diário Oficial da União, Brasília, DF. 2013 jun 13 [acesso em 2025 out 25]; Edição 112; Seção I:59-62. Disponível em: https://www.gov.br/conselhonacionaldesaude/ptbr/atosnormativos/resolucoes/2012/resolucao-no-466.pdf/view

9. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2019.

10. IRAMUTEQ [Internet]. Versão 0.8. Toulouse: Lerass; 2024 [acesso em 2025 out 25]. Disponível em: http://www.iramuteq.org/

11. Camargo B, Justo A. IRAMUTEQ: um *software* gratuito para análise de dados textuais. Temas Psicol. 2013;21(2):513-8. DOI: https://doi.org/10.9788/TP2013.2-16

12. Souza MAR. O uso do software IRAMUTEQ na análise de dados em pesquisas qualitativas. Rev Esc Enferm USP. 2018;52:e03353. DOI: https://doi.org/10.1590/S1980-220X2017015003353

13. Presidência da República (BR). Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências [Internet]. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1990 jul 16 [acesso em 2025 out 25]; Edição 135; Seção I:13563. Disponível em: https://www.planalto.gov.br/ccivil_03/leis/l8069.htm

14. Ministério da Saúde (BR). Diretrizes Nacionais para a Atenção Integral à Saúde de Adolescentes e Jovens [Internet]. Brasília, DF: Ministério da Saúde; 2023

[acesso em 2025 out 25]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_atencao_saude_adolescentes_jovens_promocao_saude.pdf

15. Fundo das Nações Unidas para a Infância. Convenção sobre os Direitos da Criança, 1989 [Internet]. Adotada pela Assembleia Geral das Nações Unidas em 20 de novembro de 1989. Nova York: ONU; 1989 [acesso em 2025 out 25]. Disponível em: https://www.unicef.org/brazil/convencao-sobre-os-direitos-da-crianca.

16. Malpas J, Pellicane MJ, Glaeser E. Family-based interventions with transgender and gender expansive youth: systematic review and best practice recommendations. Transgend Health. 2022;7(1):7-29. DOI: https://doi.org/10.1089/trgh.2020.0165

17. Conselho Federal de Psicologia (BR). Resolução CFP nº 01/2018, de 29 de janeiro de 2018. Define as diretrizes para o exercício da profissão de psicólogo junto às pessoas travestis e transexuais [Internet]. Brasília, DF: CFP; 2018 [acesso em 2025 out 25]. Disponível em: https://site.cfp.org.br/wp-content/uploads/2018/01/Resolu%C3%A7%C3%A3o-CFP-01-2018.pdf

18. Conselho Federal de Serviço Social (BR). Resolução CFESS nº 845, de 26 de fevereiro de 2018. Estabelece diretrizes para a atuação dos profissionais de Serviço Social no atendimento às pessoas travestis e transexuais [Internet]. Brasília, DF: CFESS; 2018 [acesso em 2025 out 25]. Disponível em: https://www.cfess.org.br/arquivos/ResolucaoCfess845-2018.pdf

19. Conselho Federal de Nutricionistas (BR). Resolução CFN nº 599, de 25 de fevereiro de 2018. Aprova o Código de Ética e de Conduta do Nutricionista [Internet]. Brasília, DF: CFN; 2018 [acesso em 2025 out 25]. Disponível em: http://sisnormas.cfn.org.br:8081/viewPage.html?id=599

20. Conselho Federal de Fonoaudiologia (BR). Código de Ética do Fonoaudiólogo [Internet]. Brasília, DF: CFF; 2018 [acesso em 2025 out 25]. Disponível em: https://fonoaudiologia.org.br/Codigo_de_Etica/2021/12/codigo-de-etica-fonoaudiologia-2023.pdf

21. Conselho Nacional de Educação (BR). Código de Ética [Internet]. Brasília, DF: CFE; 2005 [acesso em 2025 out 25]. Disponível em: https://cfep.org.br/wp-content/uploads/2024/11/Codigo-de-Etica-CFEP.pdf

22. Gaspodini IB, Jesus JG. Heterocentrismo e ciscentrismo: crenças de superioridade sobre orientação sexual, sexo e gênero. Rev Univ Psi [Internet]. 2020 [acesso em 2025 jan 2];1(2):33-51. Disponível em: https://scholar.google.com/citations?view_op=view_citation&hl=ptBR&user=r7bNz_EAAAAJ&citation_for_view=r7bNz_EAAAAJ:IWHjjKOFINEC

23. Rocon PC, Sodré F, Rodrigues A, et al. Desafios enfrentados por pessoas trans para acessar o processo transexualizador do Sistema Único de Saúde. Interface (Botucatu). 2019;23:e180633. DOI: https://doi.org/10.1590/Interface.180633

24. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. J Clin Endocrinol Metab. 2017;102(11):3869-903. DOI: https://doi.org.10.1210/jc.2017-01658

25. Conselho Federal de Medicina (BR). Resolução CFM nº 2.427, de 8 de abril de 2025.Revisa os critérios éticos e técnicos para o atendimento a pessoas com incongruência e/ou disforia de gênero e dá outras providências. Diário Oficial da União [Internet], Brasília, DF. 2025 abr 16 [acesso em 2025 out 25]; Edição 73; Seção I:174. Disponível em: https://www.in.gov.br/en/web/dou/-/resolucao-cfm-n-2.427-de-8-de-abril-de-2025-624323599

26. Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, version 8. Int J Transgend Health. 2022;23(Supl 1):S1-259. DOI: https://doi.org/10.1080/26895269.2022.2100644

27. Clark BA, Marshall SK, Saewyc EM. Hormone therapy decision-making processes: transgender youth and parents. J Adolesc. 2020;79:136-47. DOI: https://doi.org/10.1016/j.adolescence.2019.12.016

28. De Vries ALC, Steensma TD, Doreleijers TAH, et al. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011;8(8):2276-83. DOI: https://doi.org.10.1111/j.1743-6109.2010.01943.x

29. Costa MCB, Farias N, Nabuco KCS, et al. Prevalência e correlatos do uso de hormônios sem prescrição entre mulheres trans em São Paulo, Brasil. Saude LGBT. 2021;8(2):162-6. DOI: https://doi.org/10.1089/lgbt.2020.0059

30. Olansky E. Nonprescription hormone use among transgender women—National HIV behavioral surveillance among transgender women, seven urban areas, United States, 2019–2020. MMWR Suppl. 2024;73(1):34-39. DOI: https://doi.org/10.15585/mmwr.su7301a4

31. Santos AN, Vasconcellos LCF, Pereira EA. Diversidade sexual e de gênero e estigmas sociais no SUS em relação às pessoas LGBTQIA+: observações no Rio de Janeiro. Saúde Debate. 2023;47(Esp 1):e9009. DOI: https://doi.org/10.1590/2358-28982023E19009P

32. Morais AVC, Jesus MEF, Santos IC. "Onde estão as pessoas trans?": temática da transgeneridade na graduação em enfermagem. Hygeia Rev Bras Geogr Méd Saúde. 2023;19:e1928. DOI: https://doi.org/10.14393/Hygeia1967954

33. Machin R, Paulino DB, Pontes JC, et al. Diversidade e diferença: desafios para a formação dos profissionais de saúde. Ciênc saúde coletiva. 2022;27(10):3797-30806. DOI: https://doi.org/10.1590/1413-812320222710.07332022

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