Objective: To analyze the stigma evidenced in doctors’ and nurses’ perception regarding prenatal care for transgender men.

Methods: A qualitative study developed with nine health professionals (six nurses and three doctors) working in Family Health Units in a municipality in Bahia. In-depth interviews were carried out, subjected to reflective thematic analysis and interpretation based on the theory of social stigma and the concept of cisgender normativity.

Results: Two topics were derived that explained the establishment of labels and stereotypes on the body, mind and gender identity of pregnant trans men: professional (un)preparedness and distancing from cisgender normative demands and perspectives for prenatal care for trans men. Elements of stigma observed were distance, labels, stereotype, discredit and discrimination. Such elements (stigmatizing perceptions) manifested themselves within the logic of normality and cisgender equality of trans men’s health needs in the prenatal context.

Conclusion: There is stigma in doctors’ and nurses’ perception regarding prenatal care for trans men. Stigmatization can negatively impact the quality of prenatal care and trans men’s health and safety in the pregnancy and puerperal cycle, anticipating thoughts, attitudes and practices that contribute to the deterioration of transmasculine identity during pregnancy.

Keywords
Transgender persons; Masculinity; Sexual and gender minorities; Gender norms; Social stigma; Prenatal care; Social support; Primary health care

Descritores
Pessoas transgênero; Masculinidade; Minorias sexuais e de gênero; Normas de gênero; Estigma social; Cuidado pré-natal; Atenção primária à saúde

Resumo
Objetivo: Analisar o estigma evidenciado nas percepções de médicas e enfermeiras sobre o pré-natal de homens transexuais.

Métodos: Estudo qualitativo desenvolvido com nove profissionais de saúde (seis enfermeiras e três médicas) atuantes em Unidades de Saúde da Família em um município na Bahia. Foram realizadas entrevistas em profundidade, submetidas à Análise Temática Reflexiva e interpretação baseada na teoria do estigma e do conceito de cishe normatividade.

Resultados: Foram derivados dois temas que explicitaram o estabelecimento de rótulos e estereótipos sobre o corpo, mente e identidade de gênero do homem trans grávido: (des)preparo profissional e distanciamento das demandas e perspectivas cishe normativas para o cuidado pré-natal de homens trans. Elementos do estigma evidenciados: afastamento, rótulos, estereótipo, descrédito e discriminação. Tais elementos (percepções estigmatizantes) se manifestaram dentro da lógica da normalidade e equiparação cigmenero das necessidades de saúde dos homens trans no contexto pré-natal.
Stigma in doctors’ and nurses’ perception regarding prenatal care for transgender men

Introduction

Transgenderness is a broad concept that encompasses different gender identities. Among them are trans people, who seek social and legal recognition of their gender identity.(1) Stigma related to construction of transgender identity has been revealed as a public harm to the dignity and maintenance of essential human rights of trans people (or transgender and/or transsexuals) around the world.(2) According to a study carried out by a Brazilian Higher Education Institution, there were an estimated four million trans and non-binary people in Brazil, although the gender identity category has not yet been incorporated into the Brazilian demographic census.(3)

For instance, in relation to the promulgation of the Brazilian National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (implemented in 2023), there are Brazilian initiatives that stand out in Latin America; they must allocate efforts to promote health, including disease prevention and treatment, protection and reduction of vulnerabilities and risks as well as the necessary rehabilitation of this population.(4)

Following the example of the prenatal strategy for fathers and/or partners and other actions implemented by the Brazilian National Policy for Comprehensive Care for Men’s Health (which also includes cisgender), government health actions still lack progress.(5) In this regard, global actions must be developed and propagated to ensure social justice and equity and promote this group’s health in all life cycles, including sexual and reproductive health.(2)

Stigma is a form of depreciation of people who present one or more characteristics considered a deviation from the social norm. Given a category of attributes considered common or natural to a given society, people who fit the norm are classified as “normal”; those who do not fit the norm are classified as “others” or “strangers”, being the target of labeling, stereotyping, discredit, loss of status and/or discrimination and distance.(6,7) In the case of trans people, stigma occurs because they contradict heteronormative expectations in all contexts, persisting post-transition, when experiences of inferiorization become more frequent and noticeable as physical changes become evident.(6)

The experience of stigmatization of trans people has been investigated especially among trans women, although the literature highlights that trans men experience stigmatizing situations created mainly by cisgender men as a negative response to transgender expression.(2) However, the stigmatization that occurs to these people in health services has received little attention from researchers. Thus, this study aimed to advance scientific knowledge and professional practice in nursing and health regarding perceptions, attitudes and practices related to transgenderism and health during pregnancy.

Transgender men and transmasculine people can become pregnant, with the right to qualified...
health care to meet their demands and needs. To this end, it is necessary to review the cisgender and heterosexual paradigm (cisheteronormativity) that still regulates actions, behaviors and practices in health work.\(^{(8,9)}\) Fragilities are still noted in decision-making and clinical-health care conduct in Brazil regarding the pregnancy-puerperal process of trans men (prenatal care), especially in non-specialized health units such as Basic Health Units and Family Health Units. According to the dossier of the Brazilian National Association of Transvestites and Transsexuals (ANTRA - Associação Nacional de Travestis e Transexuais),\(^{(10)}\) 131 trans people were murdered in Brazil in 2022. Brazil has a significant rate of transphobia, including in health services, in addition to a high number of homicides of trans people.\(^{(11,12)}\)

Cisheteronormativity\(^{(13,14)}\) must be reviewed in health institutions and in professionals’ practice to recognize and value trans people’s demands and health needs in the context of therapy. Cisheteronormativity is a social phenomenon in which the system of power relations is based on the heterosexuality of bodies, presupposing cisgenderity (cisgender bodies as the norm).\(^{(15)}\) Thus, standardizing professional conduct from a single perspective can generate exclusions and erasure of other possible gender identities, such as trans men and transmasculine people.\(^{(13)}\)

This study was guided by the following question: What is doctors’ and nurses’ perception about prenatal care for trans men? Therefore, the objective was to analyze the stigma evidenced in doctors’ and nurses’ perception regarding prenatal care for trans men.

**Methods**

This was a qualitative study, anchored in the interpretative paradigm and conducted from a socio-anthropological perspective.\(^{(7,16)}\) It was developed in Family Health Units (FHU) in a municipality in Bahia, Brazil. This is a large municipality with the organization of Primary Care represented by head of the Primary Care Division, management advisory services for the Primary Care Division, head of the Nursing Division, institutional monitoring of the FHU and Technical References for Primary Care. Moreover, the municipality has 96 FHU, seven Basic Health Units (traditional BHU), 133 Family Health teams (FHt), made up of Community Health Workers, administrative assistants, nurses, doctors, general servants and nursing technicians. Additionally, the municipality has five Saúde na Hora Units, 25 doctors (Programa Mais Médicos), 44 Oral Health teams (OHt) and 22 Expanded Family Health Center teams (NASFt).

To understand the phenomenon in depth, obtain data transfer from the results\(^{(17)}\) and meet the inclusion criteria (accepting to participate in the research, carrying out prenatal activities and having at least six months of experience in the role held), three doctors and six nurses were selected by purposive sampling to participate in the study. Professionals who were on health, paternity and/or maternity leave and/or vacation did not participate in the study. We emphasized that other health professionals were invited, but 21 refused for different reasons. We observed that the high number of refusals was justified by transphobia, lack of affinity with the topic and insecurity in answering the questions. Therefore, they were not included in data collection.

As this was a qualitative study, no generalization or representativeness was sought for analytical purposes. In this regard, the theoretical saturation criterion was considered as a model to be adopted.\(^{(17)}\) Thus, its theoretical-empirical density was considered, including the co-occurrence, convergence and complementarities of the data obtained.\(^{(18)}\)

The initial approach to participants was possible after prior contact with the Municipal Health Department, which provided the necessary information. Anonymity was preserved, considering participants’ autonomy and right to refuse, respecting the General Data Protection Law (Law 13.709/2018).

Data production took place by prior appointment, from November to December 2021, in a private virtual room via Google Meet, due to the ongoing COVID-19 pandemic. Interviews were scheduled at times opposite to work shifts, as de-
fined with each participant. Only the audio content was considered for analysis, and participant images were preserved. During the interview, professionals were in a private environment. The research team involved undergraduate, master’s and doctoral students in nursing and health with experience in the area investigated and the method used. We emphasized that, during the research, the team of interviewers had no direct connection with participants.

A semi-structured form, prepared by the authors, was used to obtain sociodemographic and employment data as well as to guide the in-depth individual interview. The interview was guided by a script previously assessed and adjusted in the executing team’s research group, after a pilot test with five participants. In this script, there were four questions to analyze participants’ perception of the topic covered in the research. The interviews lasted about 30 minutes. To maintain confidentiality, all participants were identified by the letter “P”, and the numerical order was defined as the interviews were carried out.

The empirical material resulting from the interviews was recorded with participants’ authorization, transcribed in full and submitted to reflective thematic content analysis proposed by Braun and Clarke, structured based on the following steps: a) reading line by line; b) location of occurrences, convergences, divergences and complementarities of data; c) location of codes and/or thematic labels; d) adjustment of data homogeneity (agglutination); e) abstraction, naming and/or formulation of topics, subcategories and categories from a spiral perspective seeking reflexivity; f) synthesis, presentation of categories and representation of image through an explanatory model.

Data were interpreted based on Erving Goffman’s theory of social stigma and the theoretical concept of cisheteronormativity according to Rosa’s and Vergueiro’s perspective. Stigma was understood as a special type of relationship between attribute and stereotype in which an individual is distanced from everyday social relations because they have characteristics that differ from the expectations of those considered normal. When organizing the data, the COnsolidated criteria for REporting Qualitative research (COREQ) recommendations were met. Data were organized and then assessed by research group members to obtain quality and analytical rigor, but were not returned to participants.

The research project was approved by the Research Ethics Committee (31/10/2021; CAAE 50575421.4.0000.0053; Opinion 5.073.655/2021) of the Brazilian National Health Council (Resolutions 466/2012 and 512/2016), which provides for research involving human beings.

Results

The results present participant characteristics, and the topics were created based on their narratives about the stigma evidenced in doctors’ and nurses’ perception regarding prenatal care for trans men.

Participant characterization

Figure 1 summarizes participant characteristics.

Subsequently, the findings were structured into analytical topics that explain stigma directed
at trans men in prenatal care considering the content of professionals in the fields of nursing and medicine involved in daily care in Primary Health Care. Thus, two reflective topics emerged that were framed in the stigma theory based on its component elements: label, stereotype, discredit, distance and loss of status and/or discrimination (Topic 1).

Topic 1. Labels and stereotypes attributed to the body, mind and gender identity of pregnant trans men

This topic explains how trans men are perceived by professionals. By asking participants to think about pregnant trans men, they sought to fit trans identity into the social norm, adopting a biological discourse about the body and the sex assigned at birth. In doing so, they attempted to anchor the image of a trans man in the image of a woman, attributing to trans identity a subjective and sometimes metaphysical condition like the soul. Thus, a heterogeneity of perceptions about trans men was observed: one of the participants was confused and said she did not understand the acronym LGBTQIAPN+ (Lesbian, Gay, Bisexual, Transvestite, Transsexual, Queer, Intersex, Asexual, Pansexual, Non-Binary people and more); another sought to explain the difference between biology, sexual and gender identity:

[...] a trans person is one who has a “biological sexual identity”. He is a man, but he does not see himself as a man, presenting feminine characteristics, dressing and characterizing himself in a feminine way (P2);

[...] a trans man is in reality a “woman with the body”; he has the physiology of a woman, but the “soul and appearance of a man” (P5);

[...] a trans man was born in a “woman’s body” but identifies as a man (P6).

[...] my God..., transgender, transsexual, trans and now? There are many denominations. Transsexual would be a person who “changes sex”, who, for instance, is born a man and identifies as a woman. I mean, I don’t think you necessarily have to change your sexual organ, but if you identify as a woman [...], the person “thinks” they identify (P7);

[...] “her” psychology is that of a man, so “she” will dress and “characterize herself as a man”. She will have masculine feelings and tastes, but she will have “a woman’s sexual organ” (P8).

The narrative contents above also highlight the stereotypes surrounding trans men (“woman with body” and “woman’s body”) expressed by the professionals interviewed. When using the expression “equal to a normal woman”, the “other” is positioned as abnormal, denoting a basic classification of stigma, as a deteriorated and deviant condition of the subject was attributed, marked by having characteristics distinct from what is conceived as acceptable or normal. Furthermore, the content showed ignorance that trans women cannot be pregnant, and trans people were placed in the same reproductive condition.

Topic 2. Professional (un)preparedness, distance from demands and cis-heteronormative perspectives for prenatal care for trans men

This topic indicates the unpreparedness perceived by professionals when realizing that they do not have the experience and knowledge to provide prenatal care and meet trans men’s health needs. This causes insecurity about their role as caregivers of a vulnerable population that seeks to break with discrimination and claim their sexual and reproductive rights. The contents reflect on the lack of interest and motivation to seek knowledge, take professional updating courses and be linked to continuing education actions and technical-scientific training for clinical management of trans men’s health. This leads to a feeling of inability to care for and establish initiatives to assist pregnant trans men in prenatal care related to the absence of health education initiatives aimed at the LGBTQIAPN+ population:

[...] I never stopped to look for information about prenatal care for trans men. I never studied the reproductive rights of this audience [...], I never came across any trans man to follow up in prenatal
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care; therefore, I never looked for information in the literature about this (P3);

[...] I have no knowledge about prenatal care for transgender men. It’s a very specific topic that I’ve never been interested in researching (P4);

[...] I’ve never read anything in the literature about trans men’s pregnancy. I have already participated in training instructing how to assist these people without prejudice. I was unaware of the reproductive rights of this population (P6);

[...] the knowledge I have about trans men’s pregnancy is vague. Is it a sexual and reproductive right? I have no knowledge (P7);

[...] I don’t get very close to this audience. I don’t feel prepared to assist prenatal care; I don’t feel qualified, although I have already participated in training on LGBT health, how to manage and treat patients (P9).

Participants recognize the insufficiency or lack of knowledge to provide prenatal care to trans men, even those who have already been trained. They consider a trans person’s pregnancy to be a very specific health situation, highlight the lack of interest and distance in seeking technical training and use the same care protocol intended for pregnant women, thus equating the needs of cis women with those of trans men.

In this context, professionals revealed that they would offer prenatal care to cis women, as this care stems from their learning already institutionalized in basic university education and consists of their practice in services. This topic shows that participants do not recognize the subjectivities and specificities that are involved in trans men’s health, especially during the pregnancy and postpartum period. Bodily changes, emotional and social aspects that involve this group will be neglected if particularities are disregarded.

[...] a pregnant trans man is the same as a normal cis woman. There is no difference; it’s all the same.

[...] if I cared for a pregnant man, it would be the same care as pregnant women, with the same prenatal routine as women. It would all be the same. I would provide the same guidance, clinical assessments and physical examination (P1);

[...] I will answer normally, without knowing the issue of whether you are trans or not (P3);

[...] caring for trans men will be the same as for trans women and women who are not trans (P5);

[...] prenatal consultation would be normal, the same as for any pregnant woman. Specific exams will also be assessed and will have the same treatment approaches. The prenatal protocol would be the same. Being a trans man does not change the prenatal exam (P6).

[...] I treat you without prejudice, as if I were a normal patient, with the same reproductive rights (P8);

[...] if a trans man arrives to perform prenatal care, I will perform it as if he were a normal pregnant woman, a normal hetero pregnant woman (P9).

From the categorized findings, it was possible to understand the phenomenon and explain it visually. It was observed that stigma manifested itself from the memory of deep-rooted social structures such as cismorheteronormativity. The expression of learned cismorheteronormativity, which is projected into the daily lives of medical and nursing professionals in prenatal care based on perceptions about the possibility of transgender men becoming pregnant. This cyclical relationship between the elements of labeling, stereotyping, discredit, distance and discrimination may directly affect trans men in prenatal care if they are treated and exposed to stigmatization (Figure 2).

Discussion

This study analyzed perceptions and stigma that arises in the form of manifestations of cismorheteronorm-
mativity in doctors’ and nurses’ professional practice who work in Primary Health Care in the context of prenatal care for transgender men.

The findings of this study made it possible to elucidate the structural elements that configure stigma as an expression of cisgender normativity, such as labeling of trans men in the gestational process, formulation of stereotypes about this person and their prenatal care, institution of discrediting transgender identity in gestation, not implicated in the care given to this population due to the distance from the context and erasure of the status of “being a trans man and being able to conceive”. Such elements constitute discrimination, which is anchored in cisgenderness and compulsory and naturalized heterosexuality in daily health work.

There is a socio-historical mark of stigmatization of the transgender population in several countries around the world, with significant situations of violence and daily impact on their lives and health (including their families). This may indicate the reasons for the beginning of the formulation of stereotypes about the conception of body, mind and transmasculine identity during pregnancy, as observed in daily medical and nursing practice. Some countries, such as Canada and the United Kingdom, have established measures to address this public health problem with debates on the reproductive health dimension of transgender men. However, this scenario is still little known in Brazil, mainly in numerical terms, as there is a lack of official data to characterize the transgender population sociodemographic profile in the country and data from scientific literature related to prenatal care, gestational health, childbirth and the postpartum period experienced by trans men.

We believe that the reasons for the stereotypical perception of medical and nursing professionals (e.g., not understanding the biological and behavioral differences related to the social construction of gender) is a reflection of the delay in debates and qualified national investments on transgenderism and health, resulting in low literacy and literacy of health professionals on this topic. In this regard, the Ministry of Health published a technical document on transsexuality and transvestism in 2015, to bring together the content produced by organized social movements and present concepts and strategies to be formulated within the scope of training health services and management.

Advances in the literature have shown that stigma directed at the trans population becomes a serious “minority stress” with significant psychosocial impact, as it operates at the micro level regarding individual subjectivity (such as the subject’s psycho-emotional dimension), restricting the psychological and social well-being of people subjected to stigmatization, especially when this occurs frequently. However, stigma also covers the macro level in the social dimension (involving communities that promote and perpetuate stigmatization as a practice of deterioration of human identity), as it is involved in structural causes arising from collective responses related to phenomena of social interaction (e.g., the way of looking at transgenderity using the references of cisgenderity). This explains why doctors’ and nurses’ perception is based on genitalia, making it difficult to understand gender as a social construction, also differentiating it from sexual orientation.

Furthermore, stigmas directly interfere with quality, meaning and purpose of life (including the...
gestational processes of these people). Our results illustrate the lack of understanding of trans men’s health needs who experience pregnancy, which materializes in the lack of interest and search for knowledge and professional qualifications on the topic. Given transgender men’s health needs during the pregnancy and puerperal cycle, stigma was evidenced in an integrative literature review that summarized the lack of professional competence, adequate professional guidance and scientific production supporting care production.\(^{(28)}\)

The constant labeling of trans men (also present in health services) can imply depersonalization and deconfiguration of their identity, which has specificities and singularities, including in the context of pregnancy. Specifics of care that need to be implemented are disregarded. Equating trans pregnancy with cisgender pregnancy is a problem that must be reversed and given new meaning within the scope of health work.\(^{(27,29)}\) The same occurs with the equating of trans men with “normal patients” (i.e., cisgender women), which apparently agrees with the idea that care protocols to be applied do not differ in relation to transgenderism. This is a reality that still exists in Brazil, where there is still no official public document regulating professional health practices.

When considering that prenatal care is the same for all pregnant people, the uniqueness of trans men and their needs disappear, including body changes, self-image, hormone suppression and characteristics modified during pregnancy. When health professionals construct this thinking, they can impose care and therapy aimed at cis women on trans men, which devalues the identity and self-concept of trans men, resulting in psychological distress. Therefore, it is important to point out that the use of the expression “normal”, which refers to the normal-pathological dichotomy,\(^{(27,30)}\) should awaken the reflection that a reanalysis of the health-disease process is necessary for many health workers. Our findings point to the possibility of classifying trans patients in the prenatal context as “pathological”. This is in line with the idea of transexuality, which until 2019 was included in the International Statistical Classification of Diseases and Related Health Problems (ICD-10) as a mental disorder (or even the notion of “dissident” bodies adopted by psychiatry) and labeled people who escaped the cisgendernormative standard as “sick” and subject to treatment.\(^{(31)}\)

Trans men who wish to become pregnant will present demands and health needs, behaviors, attitudes and practices that are different from those observed in cisgender women, and should not be understood from the perspective of cisgenderness and the set of socially established norms based on a fixed idea about masculinity and femininity. Such conduct essentially highlights an attitude of invisibility that leads to the loss of the social status of trans male identity.\(^{(32)}\) Furthermore, the non-recognition of this identity certainly causes implications for care and highlights the regulation of actions, behaviors and practices in health work based on the perspective of cisgendernormativity.

We also emphasized that the results of this study showed that stereotypes reflect the influence of the cisgendernormative perspective regarding gender diversity, conditioning them to their sex at birth, biologically determined in an organic perception focused exclusively on the body, ignoring the individual and subjective perception of an individual. This understanding produces and reproduces transphobic discourses, configuring a barrier to access the health system.

Socially, transgender identity is still invisible. This invisibility is linked to the cisgendernormative standard, leading to actions and reactions that have repercussions on the different levels of care, through bureaucratization of systems, which do not incorporate the social name, do not read trans men as people who need gynecological and obstetric care and do not appear in health systems databases.\(^{(2,11,30-32)}\) Therefore, it is necessary to expand knowledge about transgenderity, uncover cisgenderity, compulsory heteronormativity and its articulation with power relations. From the perspective of queer theory, transgenderism can be better understood by its position contrary to gender normalization, making it possible to shift positions that can be useful to guide the work of Community Health Workers, nurses, healthcare technicians, nurses, doctors and other professionals involved in prenatal care.\(^{(28,30)}\)
In our findings, the use of labels mischaracterizes trans men’s pregnancy and moves towards the logic of normal and pathological (pathologization of trans male bodies and experiences in prenatal care). In practice, pathologization can occur when the clinical-care narrative is made only by cisgender people, without listening, presence and trans people’s leading role, causing moral degeneration, deviation from true human nature, reduction of a person to their genital organ, which is seen as incongruous or “abject” body. (7) This model permeates professional training in the health area, which is still restricted to cisheteronormative care, and may not find space to include discussions about the specificities of health care for trans men. (2,6-8,10)

In this context, depathologization is urgent and necessary, due to the possibility of understanding, respect and legitimization of trans people, aiming for comprehensive care during the transsexualization process and review of the concept of transsexuality in terms of ICD. (28) This was revised in 2023 following a broad debate between the organized social movement and the Brazilian Ministry of Human Rights. Its expansion is expected based on qualification within the scope of the outpatient specialized care component (33) as well as health issues such as hormoneization and guarantee of the right to fertilization. (30-32) Therefore, it is important to commit to overcoming the erasure of the trans population in health services and achieving better scenarios where trans men’s demands are prioritized in prenatal care, childbirth and the postpartum period. This must start from a process of emancipation in health, affirmation of gender identities in relation to pregnancy and recognition of the figure of a “pregnant trans man” as well as “paternal milk” in care spaces. (34,35)

The lack of updating by health professionals, as well as the weakness in acquiring knowledge about trans men’s pregnancy (found in our study in the form of these professionals’ distance from the issue of transgenderism in health) can help explain a problem evidenced in the literature, which reveals limited health care regarding transgender reproduction. The pregnancy and birth experiences of trans men are still unknown to most professionals who work in this context. This can imply an impoverishment of care practices, lack of production of singularized care, negligence and iatrogenesis. It can also imply compromising patient safety and patient advocacy in terms of denial of rights, often motivated by institutionalized cisheteronormativity incorporated into health care standards. (32)

We highlighted that, in the clinical context, there is knowledge to be learned about peripartum risks and complications for trans men, hormoneization (use of testosterone) and pregnancy, which are often unknown and conditioned by the context of high-risk prenatal care. (36)

Scientific evidence has shown that trans men’s pregnancy is marked by fear of parturition and the care to be provided by health professionals during labor and birth. Fear is related to cesarean birth for those using testosterone and postpartum breastfeeding, especially for those who underwent masculinizing mammoplasty surgery before pregnancy. (4,9)

Therefore, we drew attention to the need for preconception counseling, including questions about testosterone hormone therapy and pregnancy, encouraging trans men to adopt daily sexual and reproductive health (fertility) care. Furthermore, we mentioned that psychosocial support is essential in the production of care in the context of pregnancy for transgender men. (32)

With the stigma installed, the stereotype emerges as an attribute of apparent devaluation, which can contribute to deteriorating trans men’s self-image, self-perception and self-concept, as evidenced by a qualitative study carried out in Brazil during the COVID-19 pandemic. This study showed biographical ruptures resulting from structural transphobia among adolescents and young trans males, reinforcing the emergence of narratives about the stigmatization suffered in health services, such as the problematic relationship experienced with health professionals. (37) Such a scenario could result in even greater damage to trans men’s well-being and quality of life, as they are impacted by discredit and exposed to loss of social status of being who they want to be (and have the right to be and exist), as stigma reproduces social inequality based on the hierarchization of social groups. (7)
In the present study, discredit and discrimination emerged as a mark of structural transphobia, already introjected, naturalized, and often imperceptible in health professionals’ imagination. This may imply a reduction in reproductive autonomy in terms of human rights for trans men, resulting from cisheteronormativity and the biopolitical structure.

In this context, exposed to situations of vulnerability and influenced by the social, cultural, and economic context that trans identities are constantly questioned by cisgender people. This is a movement in which a position of protection of cisheteronormativity is observed to maintain this “status quo”, as transgenderism breaks with this logic in different contexts. Thus, not even the “other’s” statement about themselves can become valid and valued information during the health care process, having negative consequences on professional practice. By going against what is socially expected, transgender people are often “discredited”, dehumanized and placed at the disposal of “social acceptance”. Furthermore, we drew attention to the need to fully value trans male parenting as well as the various dimensions of reproduction and kinship among trans men who become pregnant.

The difficulty in gathering participants willing to address the topic and trans men in the context of pregnancy as well as the use of a unique data collection technique may have made obtaining data difficult, thus resulting in methodological limitations of this study. However, the data points to some potential, such as the recognition of the structural elements of stigma based on expression of cisheteronormativity by medical and nursing professionals in prenatal care for trans men, the opening of a space to locate the possible impacts of professional training and practice and reflection on possible harm to trans men’s health during pregnancy calls on health professionals, workers and public managers to think about the need to cope with transphobia and provide the necessary support for efforts to destigmatize.

Therefore, this study presented contributions reinforcing the need to include disciplines in health training curricula to overcome the heteronorm and the essentialist form centered on biology. It also filled in gaps regarding pregnancy from a transgender perspective, pointing out paths for Nursing and Health practice in clinical and social terms and indicated problematic points in meeting the principles of universality, equity, territorialization in Family Health Strategy. Furthermore, it calls on managers to review and advance the implementation of public health policies aimed at the transgender population, especially given the advancement of a conservative agenda in the Brazilian scenario that has hampered the care of pregnant trans men in Primary Health Care, diverting them to specialized services.

**Conclusion**

The establishment of labels related to pregnancy and the pregnant trans body; the creation of stereotypes about transgender identity and prenatal care; the institution of disbelief that it is possible for a trans man to get pregnant, the distance of the search for and involvement in the demands of trans men in prenatal care and the reproduction of the loss of status and discrimination portray stigmatizing perceptions, manifested through the logic of normality and cisgender equalization of trans men’s health needs in the prenatal context. The stigma directed at trans men in the context of prenatal care is manifested through the expression of cisheteronormativity in medical and nursing care. The elements that constitute stigma can impact the quality of prenatal care and trans men’s health and safety in the pregnancy-puerperal cycle, anticipating thoughts, attitudes and practices that contribute to deteriorating transmasculine identity during pregnancy.

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Collaborations

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References


