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ORIGINAL ARTICLE

# Fragments of care: The trajectory of health policy in gender transition processes

*Fragmentos do cuidado: trajetória da política de saúde nos processos de transição de gênero*
*Fragmentos del cuidado: trayectoria de la política de salud en los procesos de transición de género*

Jéssica da Silva Rodrigues[1], Sydia Rosana de Araújo Oliveira[2]

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**ABSTRACT** The article analyzes the trajectory of the public health policy for transgender people undergoing gender transition processes in Brazil, from 1997 to 2025. Based on an exploratory document analysis from a Trajectory Studies perspective, it identifies official federal records, regulations, events, and other institutional milestones to reconstruct the main phases of the policy, considering its relationship with the public policy cycle. Five distinct phases are identified: experimental and pathologizing; judicialization and initial institutionalization; expansion and normative disputes; regression and stagnation; and recent attempt at restructuring. The study highlights the persistent fragmentation of the policy, the dominance of the biomedical model, weak institutionalization of public policy cycle mechanisms, and limited social participation. It concludes that consolidating the policy depends on overcoming these weaknesses and strengthening participatory, evaluative, and federative structures to ensure effective and continuous comprehensive care for the transgender population within Brazil's Unified Health System.
**KEYWORDS** Health policy. Health services for transgender persons. Gender-affirming procedures.

**RESUMO** *O artigo analisa a trajetória da política pública de atenção à saúde de pessoas trans em processos de transição de gênero no Brasil, entre 1997 e 2025. A partir de uma análise documental exploratória, sob a perspectiva dos Estudos de Trajetória, foram identificados registros oficiais do governo federal, normativas, eventos e outros marcos institucionais, a fim de reconstruir as principais fases da política, considerando suas interfaces com o ciclo de políticas públicas. Identificam-se cinco fases distintas: experimental e patologizante; judicialização e institucionalização inicial; expansão e disputa normativa; retrocesso e congelamento; e retomada, com tentativa de reestruturação. O estudo destaca a persistente fragmentação da política, a centralidade do modelo biomédico, a baixa institucionalização de mecanismos do ciclo de políticas públicas e os limites da participação social. Conclui-se que a consolidação da política depende da superação dessas fragilidades e do fortalecimento de estruturas participativas, avaliativas e federativas que garantam a efetividade e continuidade do cuidado integral à população trans no Sistema Único de Saúde.*
**PALAVRAS-CHAVE** *Política de saúde. Serviços de saúde para pessoas transgênero. Procedimentos de afirmação de gênero.*

**RESUMEN** *El artículo analiza la trayectoria de la política pública de atención a la salud de las personas trans en procesos de transición de género en Brasil, entre 1997 y 2025. A partir de un análisis documental exploratorio, desde la perspectiva de los Estudios de Trayectoria, se identificaron registros oficiales del gobierno federal, normativas, eventos y otros hitos institucionales con el fin de reconstruir las principales fases de la política, considerando sus interfaces con el ciclo de las políticas públicas. Se identifican cinco fases diferenciadas: experimental y patologizante; judicialización e institucionalización inicial; expansión y disputa normativa; retroceso y congelamiento; y reanudación, con intento de reestructuración. El estudio destaca la persistente fragmentación de la política, la centralidad del modelo biomédico, la débil institucionalización de los mecanismos del ciclo de políticas públicas y las limitaciones de la participación social. Se concluye que la consolidación de la política depende de la superación de estas fragilidades y del fortalecimiento de estructuras participativas, evaluativas y federativas que garanticen la efectividad y la continuidad de la atención integral a la población trans en el Sistema Único de Salud.*
**PALABRAS CLAVE** *Política de salud. Servicios de salud para las personas transgénero. Procedimientos de afirmación de género.*

[1] Ministério da Saúde (MS) – Brasília (DF), Brasil.
*jrodrigues.bms@gmail.com*

[2] Fundação Oswaldo Cruz (Fiocruz), Instituto Aggeu Magalhães (IAM) – Recife (PE), Brasil.

## Introduction

The Brazilian Unified Health System (SUS) represents one of the greatest achievements of Brazilian society. Over the past decades, it has become firmly established as a fundamental public policy within the social security system. It coordinates guidelines, programs, and actions across the three government levels to organize and deliver health services, focusing on expanding access and reducing inequalities, especially among vulnerable populations[1].

Equity, which seeks to ensure fair and appropriate access to health services, is one of SUS foundational principles. Nevertheless, the system remains ineffective for marginalized and socially excluded populations[1]. Health care for people with gender-diverse identities, such as travestis and transsexual people, is characterized by an emphasis on specialized care, fragmented practices, rights violations, and inadequate service preparedness[2].

Within the SUS, trans people face barriers such as inadequate reception, discontinuous care, and limited responsiveness to their specific needs, besides the symbolic violence embedded in the daily routines of health facilities, manifested through discrimination, failure to recognize their social name, neglect, transphobic attitudes, and institutional violence[2-4]. Moreover, information systems are not prepared to accommodate trans identities, resulting in institutional invisibility[5].

Gender transition processes are experienced differently in trans people, and the desire to undergo – or not undergo – bodily modifications is individual. When mediated by health services, these processes require professional care and may involve mental health, endocrinological, speech-language pathology, surgical, and other forms of care, depending on the needs at hand. Historically, however, health care has sought to encapsulate trans identities within pathologizing definitions and apply biomedical technologies to gender-diverse bodies from a curative perspective[6-9].

Records of genital reassignment surgeries in trans women date back to the 1920s, although the more systematic and documented accounts date from the 1950s[10,11]. In Brazil, the first known record occurred in 1971 in the emblematic case of Waldirene, a trans woman who underwent surgery performed by physician Roberto Farina. The procedure led to criminal and disciplinary proceedings, although Farina was subsequently reinstated to medical practice[10,12].

The Federal Council of Medicine (CFM) issued its first resolution authorizing these procedures only in 1997. Since then, the work of social movements, judicial decisions, and institutional coordination led the Ministry of Health (MoH) to implement health care actions in the context of gender transition, culminating in the establishment of the Transsexualization Process within the SUS in 2008[13]. Since its creation, the policy has undergone important regulatory and institutional changes, reflecting political and technical disputes surrounding this population's right to health[14,15].

Accordingly, this article aims to describe and analyze the trajectory of Brazil's public health care policy for trans people undergoing gender transition processes between 1997 and 2025, identifying its different stages of development and the elements corresponding to the phases of the public policy cycle.

## Material and methods

This exploratory documentary analysis was based on the mapping of national institutional milestones from 1997 to 2025. Document selection followed a three-stage strategy: first, MoH ordinances were identified, including service accreditations, CFM resolutions, and other related federal regulations (n=63); next, MoH publications, such as books, booklets, and campaigns, that highlighted gender affirmation processes were gathered (n=7); finally, academic publications addressing the

construction and development of the policy were analyzed, and their content assisted in identifying other relevant milestones described in social productions, such as events, public letters, and records of debates (n=15).

As shown in *table 1*, the selection was performed by one of the article's authors, who has professional experience with the topic at the federal level.

Table 1. List of documents analyzed to map the trajectory of healthcare policy regarding gender transition processes in Brazil (1997–2025)

| Type | Documents |
|---|---|
| Federal regulations (63) | Res. CFM nº 1482/1997; Res. CFM nº 1.652/2002; Program 'Brasil sem Homofobia' (2004); Ordinance GM/MS nº 2.227/2004; Organizational Chart MS (2006); Ordinance GM/MS nº 1.707/2008; Ordinance SAS/MS nº 457/2008; Ordinance GM/MS nº 1.820/2009; Res. CFM nº 1.955/2010; Ordinance GM/MS nº 2.836/2011; Ordinance GM/MS nº 2.837/2011; Ordinance SAS/MS nº 859/2013; Ordinance GM/MS nº 1.579/2013; Ordinance GM/MS nº 2.803/2013; Opinion CFM nº 8/2013; Ordinance GM/MS nº 807/2017; Consolidation Ordinances GM/MS nº 2 and nº 6/2017; Res. CFM nº 2.265/2019; Ordinance GM/MS nº 1.370/2019; MoH Organizational Chart (2019); Ordinance GM/MS nº 4.700/2022; Ordinance Saes/MS nº 841/2023; Ordinance GM/MS nº 3.006/2024; Res. CFM nº 2.427/2025; and 38 Ordinances authorizing services within the Transgender Health Care Process (2014-2025). |
| Ministry of Health's Publications (7) | Poster 'Nome Social no SUS' (2013); Report on the First National Seminar on Comprehensive LGBT Health (2015); Book 'Transexualidade e Travestilidade na Saúde' (2015); 'Taking good care of everyone's health' campaign (2016); User Manual for the Health Policy Implementation Support System – 'SUS Gender Transition Process' Program (2023); Presentation on the Paes-PopTrans Agreement in the CIT (2024); National Paes-PopTrans presentation event (2024). |
| Academic and social outputs (15) | Carta da I Jornada Nacional Transexualidade e Saúde (Arán M, Delgado PG, Koff W, et al., 2005); Article 'Transexualidade e saúde pública no Brasil' (Arán M, Murta D, Lionço T, 2009); Relatório preliminar dos serviços que prestam assistência a transexuais na rede de saúde pública no Brasil (Arán M, Murta D, 2008); Article 'Atenção integral à saúde e diversidade sexual no Processo Transexualizador do SUS: avanços, impasses, desafios' (Lionço T, 2009); Open charter 'Avaliação do seminário sobre Processo Transexualizador no SUS: contra a patologização das identidades trans' (Santos AS, Barros AF, Guimarães A, et al., 2012); Review '(Re)encontrando Berenice Bento: uma década de afetações' (Teixeira FB, 2016); 'Carta-desaBAFO' em 'Transviad@s: gênero, sexualidade e direitos humanos' (Bento B, 2017); Article 'Avanços e desafios na implementação da Política Nacional de Saúde Integral LGBT' (Sena AGN, Souto KMB, 2017); Thesis 'Aos trancos e barrancos: uma análise do processo de implementação e capilarização do processo transexualizador no Brasil' (Santos MCB, 2020); Article 'Direito e padronização de corpos: uma análise crítica de julgados brasileiros sobre a transição do corpo trans' (Azevedo TAG, 2021); Article 'Protoformas do Processo Transexualizador no Brasil: apontamentos sobre a tortuosa institucionalização da assistência à saúde de pessoas Trans no SUS entre 1997 e 2008' (Santos MCB, 2022); Article 'A construção de políticas de saúde para as populações LGBT no Brasil: perspectivas históricas e desafios contemporâneo' (Ferreira BO, Nascimento MS, 2022); Article 'Entre o território e a gestão: construindo pontes na elaboração do Programa de Atenção Especializada à Saúde da População Trans' (Teixeira FB, Rodrigues JS, Cavadinha ET, et al., 2025); Joint Position Statement on Federal Council of Medicine Resolution Nº 2.427/2025 (Sociedade Brasileira de Endocrinologia e Metabologia e outras associações profissionais, 2025); Collective statement regarding the new CFM resolution concerning the care of transgender people (Associação Brasileira de Antropologia e outras associações signatárias, 2025); Note on CFM Resolution Nº 2.427/2025 (Sociedade Brasileira de Medicina de Família e Comunidade, 2025). |

Source: Prepared by the authors.

Based on the 85 selected documents, a comprehensive timeline of the intervention's trajectory was developed, grouping them into 43 relevant institutional milestones and considering the central role of the federal government in policy formulation and regulation. This mapping enabled us to distinguish different phases of the intervention, and the milestones were synthesized into 24 items, relating them to the stages of the public policy cycle and their institutional implications.

The analysis was guided by Trajectory Studies in conjunction with the public policy cycle, allowing us to understand the policy as a dynamic process marked by regulations, institutional disputes, and political and social contexts[16,17]. The historical reconstruction aimed to identify and analyze the policy's different phases by considering the following stages of the cycle: (1) agenda setting; (2) formulation of alternatives; (3) analysis of advantages and drawbacks; (4) decision-making; (5) implementation; and (6) evaluation[18].

To illustrate this categorization, the ordinances establishing and reformulating the intervention were considered decision-making stages, whereas events convened to discuss the program were associated with the formulation and analysis of alternatives. Although the public policy cycle simplifies the reality's complexity, it is a useful tool for understanding the decision-making processes involved in policy formulation, implementation, and evaluation[18].

## Results and discussion

The trajectory of the health care policy addressing gender transition processes was marked by important advances, as well as episodes of disruption, discontinuity, and institutional dispute. Drawing on the public policy cycle approach, the analysis sought to move beyond a description of the phases and critically examine how agenda setting, formulation, implementation, and evaluation developed – or were interrupted – in each period, revealing the underlying reasons for the fragmentation and intermittency that characterized its trajectory. *Table 2* summarizes the main findings of this analysis.

Table 2. Summary of the trajectory of healthcare policy for gender transition processes in Brazil (1997-2025)

| Phase | Public policy cycle stages | Key milestones | Political and institutional implications | Advances and limitations identified |
|---|---|---|---|---|
| I. Experimental and pathologizing (1997–2001) | Agenda-setting: partial;<br>Formulation of alternatives: minimal. | 1) Resolution CFM nº 1.482/1997. | Ethical and legal questions;<br>Lack of consolidated normative basis;<br>Start of experimental surgeries;<br>Creation of hospital services linked to research;<br>Strong pathologizing character (ICD-10);<br>Services with autonomy and little regulation. | The agenda was driven by medical-institutional pressures, not by social demands;<br>There was no participatory formulation;<br>Policy limited to the authorization of surgeries on psychiatric grounds. |

Table 2. Summary of the trajectory of healthcare policy for gender transition processes in Brazil (1997-2025)

| Phase | Public policy cycle stages | Key milestones | Political and institutional implications | Advances and limitations identified |
|---|---|---|---|---|
| II. Judicialization and initial institutionalization (2001–2008) | Agenda-setting: expanded;<br>Formulation of alternatives: intense debates, but lacking systematization;<br>Evaluation of alternatives: nonexistent or unsystematized;<br>Decision-making: publication of ordinances. | 2) Public civil action by the MPF/RS (2001);<br>3) CFM Resolution Nº 1.652/2002;<br>4) 'Brazil without Homophobia' Program (2004);<br>5) Creation of the GLTB Health Technical Committee (2004);<br>6) National technical workshops and events;<br>7) GM/MS Ordinance Nº 1.707 and SAS/MS Ordinance Nº 457 (2008);<br>8) Accreditation of 4 services. | Judicialization as a catalyst for institutionalization;<br>Emergence of the 'Transsexualization Process' concept;<br>Participation of social movements and researchers;<br>Initial standardization of the program within the SUS. | Inclusion of the trans population in institutional spaces;<br>Greater social participation via SGEP/MS;<br>Poorly structured formulation lacking clear mechanisms for analyzing alternatives. |
| III. Expansion and normative dispute (2008–2016) | Implementation: partial and uneven;<br>Formulation of alternatives: revised, yet contentious;<br>Evaluation of alternatives: non-existent or unsystematic;<br>Decision-making: contentious (two revision ordinances);<br>Policy evaluation: non-existent. | 9) Program revision: Ordinance SAS/MS Nº 859/2013;<br>10) Revocation and suspension of the Ordinance;<br>11) New revision: Ordinance GM/MS Nº 2.803/2013;<br>12) Expansion of target audience and services;<br>13) Campaigns, publication of materials, and events;<br>14) Authorization of new services: 1 hospital-based and 4 outpatient. | Internal conflicts among technical divisions of the Ministry of Health;<br>Strained social participation;<br>Beginning of the expansion of accredited services;<br>Partial redefinition of the care model;<br>Institutional de-pathologization limits. | Authorization of services within the SUS, albeit under significant institutional tension;<br>Regulatory revision without prior assessment;<br>Lack of monitoring and evaluation protocols. |
| IV. Setback and stagnation (2016–2022) | Implementation: localized and uneven;<br>Policy evaluation: non-existent. | 15) Impeachment in 2016;<br>16) Dissolution of SGEP/MS (2019);<br>17) Reduced ministerial initiatives;<br>18) CFM Resolution Nº 2.265/2019;<br>19) Inclusion of new procedures exclusively through litigation;<br>20) Up to 2018, accreditation of new services: 3 outpatient services. | Institutional discontinuity;<br>Partial progress achieved solely through court rulings;<br>Failure to authorize new services between 2019 and 2022;<br>Drift away from social participation;<br>Continuation of the policy with a weakened structure. | Federal stagnation;<br>Local expansion without central support;<br>Total lack of institutional policy evaluation. |
| V. Resumption and attempted restructuring (2023–2025) | Implementation: resumed;<br>Formulation and evaluation of alternatives: expanded debate with the Working Group and systematization via Regulatory Impact Analysis (RIA);<br>Decision-making: suspended.<br>Policy evaluation: in the early stages. | 21) Creation of the Working Group and the Paes-PopTrans proposal (2024);<br>22) Public presentation and agreement within the CIT;<br>23) CFM Resolution Nº 2.427/2025 (setback);<br>24) Accreditation of new services: 8 hospital-based and 24 outpatient. | Resumption of equity policies;<br>Attempt to overcome the limitations of the policy's original model;<br>New institutional design not implemented by the Ministry of Health;<br>Conservative backlash and regulatory conflict with the Federal Council of Medicine (CFM). | Reactivation of the policy, including service accreditation and the streamlining of that process;<br>Attempt at restructuring, involving a federal-level agreement;<br>Use of Regulatory Impact Analysis (RIA) to formulate and evaluate alternatives;<br>Incipient evaluation framework. |

Source: Prepared by the authors.

The findings are detailed below according to the five phases identified in the program's trajectory.

## Phase I: Experimental and pathologizing (1997-2001)

The trajectory of health care policy for trans people in Brazil is embedded in a broader context of historical struggles by social movements for recognition of identities and the protection of rights. While permeated by achievements and setbacks, this mobilization was essential in exerting pressure on institutions and producing changes in the field of Health[19,20].

For analytical purposes, the study focused on institutional action at the national level; accordingly, CFM Resolution Nº 1.482/1997 was considered the initial milestone in this trajectory. Although it did not constitute a public policy, the regulation reflected the predominance of a biomedical and pathologizing logic that would shape the contours of the intervention subsequently implemented within the SUS.

Although the biomedical technologies involved in gender transition processes, such as hormone therapy and genital reassignment surgeries, had been available internationally since the mid-20th century, Brazil remained without public regulation on the subject for decades. This regulatory vacuum produced emblematic and sometimes traumatic situations, marked by litigation against doctors and allegations of abusive practices[10,11,21].

The lack of legal consensus regarding the lawfulness of these surgeries led to the publication of CFM Resolution Nº 1.482/1997. Aligned with the International Classification of Diseases, 10th Revision (ICD-10), which classified transsexuality as a mental disorder, the regulation authorized the procedures on an experimental basis. It primarily sought to provide legal protection for medical practice rather than respond to the needs of the trans population[20,21].

Following this resolution, some hospitals established services linked to research protocols. The document entitled 'Preliminary Report on Services Providing Care to Transsexual People in Brazil's Public Health Network' identified at least six such services between 1997 and 2003, although reports indicate the existence of other unregulated care arrangements characterized by institutional opacity and ethical fragility. The role of service users, which should have been central to defining priorities, was systematically marginalized. As reported by Bento[22], trans people were subjected to symbolic and epistemic violence within services. They were often compelled to conform their experiences to the binary and heteronormative diagnostic models imposed by clinical protocols.

At the agenda-setting stage, recognition of the health needs of the trans population occurred belatedly and was initially mediated by a strictly biomedical and pathologizing logic. The emphasis on research protocols and 'medical experimentation' had direct and profound implications for service users' experiences. The lack of a formal public policy and national guidelines resulted in nonstandardized approaches, undermining the trust and safety of trans people seeking care[21].

## Phase II: Judicialization and initial institutionalization (2001–2008)

After the CFM published Resolution Nº 1.482/1997, the Federal Public Prosecutor's Office (MPF) filed a Public Civil Action in 2001 seeking the inclusion of genital reassignment surgeries in the SUS. This litigation continued until 2007, when a favorable ruling ordered the SUS to fund transgenitalization surgeries[23].

In 2002, the CFM issued Resolution Nº 1.652, which removed the experimental designation from surgeries performed on trans women but retained it for procedures involving trans men. The resolution continued to use pathologizing and universalizing definitions of trans identities[24].

In 2004, amid democratic advances and civil society mobilization for the rights of Gay, Lesbian, Transgender, and Bisexual people (GLTB – the acronym used at the time), the federal government created the 'Brazil without Homophobia' program. Despite its innovative nature and its encouragement of inclusion in employment, education, and health policies, the program faced limitations, including the lack of implementation mechanisms[25].

As part of this program, in 2004 the MoH established the Technical Committee for the formulation of the GLTB health policy, with the participation of social movements. Its role was to advise on the development of guidelines and strategies and to support professional training and the monitoring of actions within the SUS. The creation of this committee was crucial in opening institutional space for social participation in policy formulation. In parallel, social movements, researchers, health professionals, and legal practitioners organized into networks to include health care for trans people within the SUS[13,25].

The policy formulation stage was marked by several intersectoral events held between 2005 and 2008 that consolidated the debate on including trans people on the SUS agenda. Although discussions expanded substantially during this period, this study found no technical records indicating a formal systematization of alternative policy options.

The main advances observed at this stage involved destabilizing the hegemonic biomedical discourse and incorporating theoretical contributions from the social sciences and Collective Health. Particularly important were the contributions of researchers such as Bento[22], Teixeira[26], and Arán, Murta, and Lionço[20,27], who introduced critical foundations essential to policy formulation. These included advocating the right to gender self-identification, recognizing the plurality of trans experiences, and emphasizing the inclusion of trans people in deliberative forums[21].

In 2005, the National Conference 'Transsexuality and Health: Public Care in Brazil' was held and resulted in a letter of recommendations aimed at implementing health actions for the trans population within the SUS.

In 2006, the GLTB Health Technical Committee held the meeting 'Transsexualization Process within the SUS', a milestone in formalizing the use of this term. The initiative aimed to move beyond the centrality of surgery and promote recognition of the plurality of trans identities and autonomy over their bodies. These discussions influenced the seminar 'GLBT Population Health in Building the SUS', held in 2007[13]. In the same year, the MoH held the workshop 'Transsexualization Process within the SUS' to discuss implementation of the policy[28].

In the wake of social pressure and judicialization of the issue, the MoH was compelled to establish the Transsexualization Process within the SUS through GM/MS Ordinance Nº1.707 and SAS/MS Ordinance Nº 457, both issued in 2008. In terms of definitions and types of intervention in the gender transition process, the policy was very similar to the CFM resolutions. Thus, remnants of the pathologizing logic persisted, including the requirement for psychiatric reports and the regulation of bodies and subjectivities[21,24].

During policy formulation and implementation, persistent disagreements arose within the MoH, particularly between the Secretariat for Strategic and Participatory Management (SGEP/MS) and the Health Care Secretariat (SAS/MS). Whereas SAS/MS focused on the policy's technical and operational dimensions – establishing accreditation standards, standardizing procedures, and managing information systems – SGEP/MS worked from a social participation perspective and served as the gateway for demands from social movements. However, its activities were constrained by the lack of a budget for equity policies and by difficulties in translating the issues discussed into concrete action. In this context, SGEP/MS promoted participatory spaces while also transferring responsibility for shortcomings to other areas, particularly SAS/MS[21].

This distribution of responsibilities hindered coordination between policy guidelines and concrete actions. Consequently, advances such as expanding services, revising clinical protocols, and depathologizing care were incorporated in a fragmented manner, hampering the consolidation of a comprehensive policy responsive to the diversity of trans experiences and regional inequalities. Fragmented institutional responsibilities and implementation could be overcome through shared and participatory management mechanisms, formal definition of institutional roles, and a logical policy structure with objectives, targets, and indicators for monitoring and evaluation.

## Phase III: Expansion and regulatory dispute (2008–2016)

Decision-making was formalized in 2008 with the establishment of a policy that, in its initial format, provided care only to transsexual women aged 21 to 75 years. The ministerial ordinance established accreditation standards, clinical guidelines, management responsibilities, also creating procedures for registration and funding within the SUS. Four services were accredited in teaching hospitals, with funding tied exclusively to records entered into information systems.

The 2008 ordinances contained important contradictions. Although they recognized the singularity of trans experiences, they retained the pathologizing definitions of ICD-10. They linked clinical care and hormone therapy to genital reassignment surgeries, which were addressed as the mandatory outcome of the transition process[24,29].

The Charter of Rights and Duties of SUS Users, published in 2009, guaranteed trans people the right to be identified by their social name within the SUS and ensured discrimination-free care. In 2013, this recognition was expanded with the launch of the poster 'Social Name in the SUS', an SGEP/MS campaign designed to raise professional awareness and promote respect for trans people's identities.

CFM Resolution Nº 1.955 was published in 2010, with very few changes from the 2002 regulation. Pathologizing conceptions and alignment with ICD-10 prevailed. The resolution introduced changes by removing the experimental designation from certain surgeries performed on trans men and eliminating the requirement for affiliation with a teaching institution[24,29].

The National Comprehensive Health Policy for Lesbians, Gay Men, Bisexual People, Travestis, and Transsexual People (PNSI-LGBT), established by SGEP/MS in 2011, represented an advance by recognizing the health needs of the trans population beyond genital reassignment surgery. However, it did not define how the Transsexualization Process would be integrated into its actions, possibly because of institutional divisions with SAS/MS.

Despite these limitations, PNSI-LGBT promoted relevant actions, such as the 2012 seminar 'Transsexualization Process within the SUS', which highlighted disputes surrounding the care model. Disagreements among participants marked the event, the exclusion of trans people from decision-making processes, and criticism – expressed in an 'Open Letter' evaluating the seminar – of the continued pathologizing model and the limited participation of SAS/MS in the event[14].

Researcher Berenice Bento[30] described the episode as negotiated pathologization, criticizing the lack of commitment to depathologization even when the program's expansion to trans men was proposed. Bento also highlighted the role of Fernanda Benvenutty, the first trans person to hold a seat on the National Health Council, who challenged the framing of transsexuality and travesti identities as mental disorders and criticized the State's failure to address this population's historical demands.

From its inception, the policy was marked by tensions among sectors. Social movements, critical professionals, and researchers advocated a comprehensive approach based on self-determination, whereas biomedical sectors sought technical and institutional

recognition. In this context, the MoH alternated between mediation and centralization, often limiting social participation[21].

A policy review process began in 2012. According to Santos[21], after PNSI-LGBT was published, SGEP/MS began treating revision of the Transsexualization Process as a priority. However, the data analyzed in this study do not indicate the existence of systematically organized evaluation stages.

In July 2013, SAS/MS Ordinance Nº 859 proposed expanding the Transsexualization Process by incorporating Primary Care and broadening both the target population and the age groups served. However, it was suspended on the grounds that new protocols were needed, even though a Working Group (WG) had been reviewing the policy since 2012 and a draft had already been agreed upon by the Tripartite Interagency Committee (CIT)[24,28].

GM/MS Ordinance Nº 2.803 was published in November 2013 and resumed the process with few changes: it reinstated more restrictive age limits, included travestis and trans men in the services, and authorized new surgeries. Nevertheless, it did not incorporate clinical guidelines or define targets or incentives for expansion, thereby maintaining weaknesses in policy design[24,29].

The suspension of the July regulation suggested a political and institutional dispute rather than a technical issue. Despite its advances, the regulation retained pathologizing mechanisms and subjected trans identities to medical validation. Even so, it marked the beginning of a modest expansion in services and greater visibility for the program, although implementation remained uneven across regions[21,24,31,32].

Between 2013 and 2016, SGEP/MS promoted actions aimed at strengthening PNSI-LGBT and trans health care. In 2013, the 'First National Seminar on Comprehensive LGBT Health' identified expansion of the service network as the principal challenge in trans health care. In 2014, the seminar 'Transsexuality and Travesti Identities within the SUS' was held to monitor the policy and discuss implementation challenges across different territories[28]. In 2015, the book 'Transsexuality and Travesti Identities in Health Care' was published, gathering contributions from trans people, professionals, researchers, and managers. In 2016, SGEP/MS launched the campaign 'Taking Good Care of Everyone's Health Is Good for All' focusing on publicizing the Transsexualization Process and PNSI-LGBT.

The dynamics of regulatory conflict and lack of coordination directly affected care quality and equity. The lack of structured evaluation compromised feedback within the public policy cycle, resulting in decisions that expanded the target population and the number of accredited services while retaining pathologizing mechanisms and failing to incorporate inclusive clinical protocols or incentives for expansion, thereby perpetuating access barriers and weaknesses in policy design. Consequently, implementation was uneven across regions, care quality varied considerably, and the policy failed to move beyond the centrality of surgery and medical validation, generating frustration and mistrust among service users. Implementation weaknesses could be mitigated through intersectoral coordination linking health care to education, human rights, employment, social assistance, and public security policies. Such integration would strengthen comprehensiveness by addressing the social determinants affecting the trans population. However, the documents analyzed show that the federal sphere made little progress in this direction, limiting itself to isolated actions without institutionalizing cooperation across sectors.

## Phase IV: Setback and stagnation (2016-2022)

The institutional rupture caused by the 2016 impeachment led to changes in the MoH structure. In 2017, GM/MS Ordinance Nº 807 was published, removing responsibility for

regulating surgical procedures under the Transsexualization Process from the National Center for the Regulation of High-Complexity Care. Despite the low institutional priority, in 2018 the MoH accredited three new outpatient clinics under the Transsexualization Process, bringing the total number of services in the country to 12.

In 2019, the CFM published Resolution Nº 2.265, breaking with the previous regulatory model, which had historically been based on pathologizing texts and focused on the legal protection of medical practice[33]. The new resolution presented detailed clinical guidelines aligned with ICD-11, which was not yet in force at the time, and adopted the term 'gender incongruence' as an advance in the depathologization process.

Among its main provisions, the regulation authorized pubertal suppression from Tanner stage II, cross-sex hormone therapy from age 16, and gender-affirming surgeries from age 18. The text was developed with the participation of MoH representatives, professional councils, and social movements, constituting a technical and political advance.

Between 2019 and 2022, the federal government withdrew from social inclusion agendas. Within the MoH, SGEP was abolished, and the Transsexualization Process remained under the responsibility of the Secretariat of Specialized Health Care (SAES/MS). During this period, the policy stagnated. The minor changes and ordinances published were consequences of judicial decisions, such as the inclusion of genital reassignment procedures for trans men.

Although the federal administration did not promote advances, subnational initiatives gained prominence, with states and municipalities spearheading initiatives through local regulations and incentives. A technical survey conducted by the new MoH administration in 2023 identified more than 100 services operating in the country, organized and maintained through local initiatives but without federal accreditation or funding[15].

The period of federal setback and stagnation, including the dismantling of structures such as SGEP/MS, aggravated access barriers and eroded care quality. Service accreditation stagnation meant that expansion depended solely on local efforts without central support, widening regional inequalities. Without federal coordination and evaluation, the SUS failed to ensure equitable and comprehensive access, leaving many trans people without care or dependent on isolated initiatives. This phase exposed the fragility of a policy that remained dependent on administrations committed to the issue, as political and institutional changes resulted in its stagnation. Reducing this vulnerability would require more robust management tools, such as legal guarantees, mandatory budget allocations, and permanent intersectoral bodies for monitoring, evaluation, and social participation to ensure continuity even in unstable contexts.

## Phase V: Resumption and attempted restructuring (2023–2025)

Following the resumption of agendas promoting health equity in 2023, the MS proceeded with service accreditation requests that had been backlogged since 2019 and streamlined administrative processes[15]. By December 2025, 30 new accreditation ordinances had been published, bringing the country's total to 36 outpatient services and 12 hospital services.

In this context, SAES/MS Ordinance Nº 841 was published in 2023, establishing a WG to review the Transsexualization Process to improve care pathways and propose parameters for a new policy.

Also in 2023, at a WG meeting, the preliminary Regulatory Impact Analysis (RIA) report and the proposed Specialized Health Care Program for the Trans Population (Paes-PopTrans) were presented. The proposal provided for new types of services, expanded teams, accreditation of 153 outpatient clinics and 41 surgical services by 2027, and financial incentives, with an estimated investment of

BRL 443 million. The CIT agreed upon the program in February 2024[15,34].

In December 2024, the MoH held an event to present the new program, during which the next stages of its institutionalization were announced[15]. However, Paes-PopTrans had not been implemented by the time this article was submitted.

Implementation of the new program faces political resistance, particularly following the publication of CFM Resolution Nº 2.427 in 2025, which revised the criteria for medical care in gender transition processes. The resolution introduced setbacks, including a ban on puberty blockers, an increase in the minimum age for cross-sex hormone therapy, and a prohibition on procedures with 'sterilizing potential' before age 21. It also requires mandatory registration of service users with the Regional Medical Councils.

The Brazilian Society of Endocrinology and Metabolism (SBEM), together with other medical associations, issued a statement criticizing the resolution and emphasizing the scientific evidence supporting the use of puberty blockers and cross-sex hormone therapy. Social movements, associations, and professional councils also criticized the resolution's restrictive nature through statements and collective notes. The mobilizations were effective, and the resolution was suspended by the courts in response to a request from the MPF[35]. Nevertheless, the dispute remains unresolved, and the CFM may appeal.

Despite the resumption of inclusive agendas and efforts to restructure the Transsexualization Process, the contemporary political context creates severe obstacles to consolidating these advances. The failure to establish Paes-PopTrans, even after federative agreement, signals a weakness in the ability to translate technical and political consensus into concrete government action.

CFM Resolution Nº 2.427 exemplifies the prevailing conservatism by emphasizing detransition cases and minimizing evidence concerning the vulnerabilities of the trans population, reinforcing access barriers, encouraging judicialization, and generating legal uncertainty. In addition, it may undermine coordination of the care network by creating regulatory conflicts with the MS and hindering the consolidation of a comprehensive and cohesive model within the SUS.

Confronting the conservative backlash and ensuring policy continuity depend on mobilization by social movements and the scientific community, stronger federative coordination, and the federal government's commitment to equity policies grounded in evidence and SUS principles. The lack of institutional evaluation strategies further weakens the State's response, making the defense and continuous monitoring of trans health policy an urgent priority.

As an exploratory analysis based on secondary sources, this study has limitations inherent in gaps in the documentary record. Reliance on official documents may not capture the full range of unformalized internal decision-making processes, informal debates, or nuances in the experiences of service users and professionals. These limitations, however, do not invalidate the findings and reinforce the need for future research using complementary methods to achieve a more comprehensive understanding of the policy.

## Final considerations

The analysis of the trajectory of health care policy addressing gender transition processes within the SUS between 1997 and 2025 identified five distinct phases marked by regulatory advances, institutional disputes, and pronounced fluctuation between expansion and setback. Linking the analysis to the public policy cycle revealed fragmented formulation, uneven implementation, and a lack of systematic evaluation.

Phase I was dominated by a pathologizing approach restricted to the medical field. Phase II was driven by judicialization and social mobilization, placing trans demands on the MS

agenda. In Phase III, the policy was formally implemented, but amid internal disputes and without evaluation mechanisms. Phase IV was characterized by federal stagnation and dependence on local initiatives. Phase V, which is ongoing, signals a resumption and an attempt at restructuring, although it remains threatened by setbacks amid conservative pressure.

The findings of this study critically reinforce the need to overcome this fragmented policy, which has historically compromised the care comprehensiveness and equity. It is essential to establish robust, institutionalized evaluation processes that enable continuous monitoring, identification of barriers, and evidence-based decision-making, thereby ensuring feedback throughout the public policy cycle. The findings also underscore the importance of securing an institutional commitment to the rights of trans people and resisting pressures aimed at pathologizing them or restricting access to essential care.

This study contributes to the debate in Collective Health and to strategic health planning. Future research should deepen the analysis of the political, institutional, and social factors shaping this trajectory, including the experiences of service users and professionals, implementation across different contexts, and the strategies of social movements. Such studies are essential to consolidating an effective, participatory health policy aligned with the SUS principles of equity and comprehensiveness.

## Authorship contributions

Rodrigues JS (0009-0000-5177-2615)* contributed to the conception and design of the research, data acquisition, analysis and interpretation of data, and drafting of the manuscript. Oliveira SRA (0000-0002-6349-2917)* contributed to the conception and design of the research, analysis and interpretation of data, and critical revision of the manuscript for important intellectual content. ■

## References

1. Giovanella L, Escorel S, Lobato LVC, et al., organizadores. Políticas e sistemas de saúde no Brasil. 2ª ed. rev. ampl. Rio de Janeiro: Fiocruz; 2012. 1097 p. DOI: https://doi.org/10.7476/9788575413494

2. Lima RRT, Flor TBM, Noro LRA. Revisão sistemática sobre a atenção à saúde para travestis e transexuais no Brasil. Rev Saúde Pública. 2023;57:19. DOI: https://doi.org/10.11606/S1518-8787.2023057004693

3. Rocon PC, Wandekoken KD, Barros MEB, et al. Acesso à saúde pela população trans no Brasil: nas entrelinhas da revisão integrativa. Trab Educ Saúde. 2020;18(1):e0023469. DOI: https://doi.org/10.1590/1981-7746-sol00234

4. Jesus MKMR, Moré IAA, Querino RA, et al. Experiências de mulheres transexuais no sistema de saúde: visibilidade em direção à equidade. Interface (Botucatu). 2023;27:e220369. DOI: https://doi.org/10.1590/interface.220369

5. Miskolci R, Signorelli MC, Canavese D, et al. Desafios da saúde da população LGBTI+ no Brasil: uma análise do cenário por triangulação de métodos. Ciênc saúde coletiva. 2022;27(10):3815-24. DOI: https://doi.org/10.1590/1413-812320222710.06602022

6. Connell R, Pearse R. Gênero: uma perspectiva global. 3ª ed. São Paulo: nVersos; 2015. 325p.

*Orcid (Open Researcher and Contributor ID).

7. Bento B, Pelúcio L. Despatologização do gênero: a politização das identidades abjetas. Rev Estud Fem. 2012;20(2):569-81. DOI: https://doi.org/10.1590/S0104-026X2012000200017

8. Preciado PB. La invención del género, o el tecnocordero que devora a los lobos. In: Conversaciones Feministas: Biopolítica. Buenos Aires: Ají de Pollo; 2009. p. 15-38.

9. Butler J. Desdiagnosticando o gênero. Physis. 2009;19(1):95-126. DOI: https://doi.org/10.1590/S0103-73312009000100006

10. Galli RA, Vieira EM, Giami A, et al. Corpos mutantes, mulheres intrigantes: transexualidade e cirurgia de redesignação sexual. Psicol Teor Pesq. 2013;29(4):447-57. DOI: https://doi.org/10.1590/S0102-37722013000400011

11. Goddard JC, Vickery RM, Terry TR. Development of feminizing genitoplasty for gender dysphoria. J Sex Med. 2007;4(4 Pt 1):981-9. DOI: https://doi.org/10.1111/j.1743-6109.2007.00480.x

12. Rossi A. A história de Waldirene [Internet]. São Paulo: NucleoTrans/Universidade Federal de São Paulo; 2020 [acesso em 2025 jun 30]. Disponível em: https://nucleotrans.unifesp.br/producao-de-conhecimento/materias-jornalisticas/a-historia-waldirene

13. Lionço T. Atenção integral à saúde e diversidade sexual no Processo Transexualizador do SUS: avanços, impasses, desafios. Physis. 2009;19(1):43-63. DOI: https://doi.org/10.1590/S0103-73312009000100004

14. Teixeira F. (Re)encontrando Berenice Bento: uma década de afetações. Cad Pagu. 2016;(48). DOI: https://doi.org/10.1590/18094449201600480018

15. Teixeira FB, Rodrigues JS, Cavadinha ET, et al. Entre o território e a gestão: construindo pontes na elaboração do Programa de Atenção Especializada à Saúde da População Trans. Interface (Botucatu). 2025;29:e240520. DOI: https://doi.org/10.1590/interface.240520

16. Bourdieu P. A distinção: crítica social do julgamento. São Paulo: Edusp; Porto Alegre: Zouk; 2007. 560 p.

17. Howlett M, Ramesh M. Studying public policy: policy cycles and policy subsystems. 2nd ed. Oxford: Oxford University Press; 2003. 311 p.

18. Souza C. "Estado do campo" da pesquisa em políticas públicas no Brasil. Rev Bras Ci Soc. 2003;18(51):15-20. DOI: https://doi.org/10.1590/S0102-69092003000100003

19. Santos MCB. Protoformas do Processo Transexualizador no Brasil: apontamentos sobre a tortuosa institucionalização da assistência à saúde de pessoas trans no SUS entre 1997 e 2008. Sex Salud Soc (Rio J). 2022;(38):e22303. DOI: https://doi.org/10.1590/1984-6487.sess.2022.38.e22303.a

20. Arán M, Murta D, Lionço T. Transexualidade e saúde pública no Brasil. Ciênc saúde coletiva. 2009;14(4):1141-9. DOI: https://doi.org/10.1590/S1413-81232009000400020

21. Santos MCB. Aos trancos e barrancos: uma análise do processo de implementação e capilarização do processo transexualizador no Brasil [tese na Internet]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2020 [acesso em 2025 jun 8]. 483 p. Disponível em: https://www.bdtd.uerj.br:8443/handle/1/18382

22. Bento B. A reinvenção do corpo: sexualidade e gênero na experiência transexual. Rio de Janeiro: Garamond; 2006. 256 p.

23. Azevedo TAG. Direito e padronização de corpos: uma análise crítica de julgados brasileiros sobre a transição do corpo trans. Rev Fac Direito UFMG. 2021;(79):217-43. DOI: https://doi.org/10.12818/P.0304-2340.2021v79p217

24. Rodrigues JS. Processo Transexualizador no SUS: análise do acesso aos serviços entre 2008 e 2017 [dissertação na Internet]. Rio de Janeiro: Fundação Oswaldo Cruz; 2019 [acesso em 2025 jun 8]. 204 p. Disponível em: https://arca.fiocruz.br/handle/icict/71345

25. Ferreira BO, Nascimento M. A construção de políticas de saúde para as populações LGBT no Brasil: perspectivas históricas e desafios contemporâneos. Ciênc saúde coletiva. 2022;27(10):3825-34. DOI: https://doi.org/10.1590/1413-812320222710.06422022

26. Teixeira FB. Vidas que desafiam corpos e sonhos: uma etnografia do construir-se outro no gênero e na sexualidade [tese na Internet]. Campinas: Universidade Estadual de Campinas; 2009 [acesso em 2025 jul 3]. 243 p. Disponível em: https://repositorio.unicamp.br/Busca/Download?codigoArquivo=497877

27. Murta D. Os desafios da despatologização da transexualidade: reflexões sobre a assistência a transexuais no Brasil [tese na Internet]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2011 [acesso em 2025 jul 2]. 107 p. Disponível em: https://www.bdtd.uerj.br:8443/handle/1/4576

28. Sena AGN, Souto KMB. Avanços e desafios na implementação da Política Nacional de Saúde Integral LGBT. Tempus, Actas Saúde Colet. 2017;11(1):9-28. DOI: https://doi.org/10.18569/tempus.v11i1.1923

29. Miranda LFP. Desigualdade de acesso ao processo transexualizador no SUS [dissertação na Internet]. Belo Horizonte: Universidade Federal de Minas Gerais; 2023 [acesso em 2025 jul 21]. 219 p. Disponível em: https://repositorio.ufmg.br/handle/1843/58881

30. Bento B. Transviad@s: gênero, sexualidade e direitos humanos. Salvador: EDUFBA; 2017. 329 p.

31. Adorno LL, Jesus LS, Araújo MP, et al. The Historical Profile of the National Panorama of the Tran Sexualizing Process in Brazil. J Health Sci. 2022;24(4):283-9. DOI: https://doi.org/10.17921/2447--8938.2022v24n4p283-289

32. Grubba LS. Equidade em saúde para pessoas trans: análise do processo transexualizador brasileiro. Rev Direito Estado Soc. 2022;(60):164-89. DOI: https://doi.org/10.17808/des.0.1238

33. Sampaio JV. Permanências e rupturas das práticas de regulação da transexualidade no Brasil. Sanare. 2023;22(2):86-97. DOI: https://doi.org/10.36925/sanare.v22i2.1691

34. Ministério da Saúde (BR) [Internet]. Brasília, DF: Ministério da Saúde; [data desconhecida]. Apresentação do Programa de Atenção Especializada à Saúde da População Trans (PAES-PopTrans); 2024 fev 2 [atualizado em 2024 fev 2; acesso em 2025 jul 5]. Disponível em: https://www.gov.br/saude/pt-br/acesso-a-informacao/gestao-do-sus/articulacao-interfederativa/cit/pautas-de-reunioes-e-resumos/2024/janeiro/paespoptrans/view

35. Ministério Público Federal (BR) [Internet]. Rio Branco (AC): Procuradoria da República no Acre; [data desconhecida]. Justiça atende pedido do MPF e suspende norma do CFM que restringia atendimento médico a pessoas trans; 2025 jul 25 [acesso em 2025 jul 26]. Disponível em: https://www.mpf.mp.br/ompf/unidades/pr-ac/noticias/justica-atende-pedido-do-mpf-e-suspende-norma-do-cfm-que-restringia-atendimento-medico-a-pessoas-trans

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Lattes: http://lattes.cnpq.br/8933361259561564 – Orcid: https://orcid.org/0000-0003-4303-4211 – e-mail: elda.cab@gmail.com