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Nursing in specialized care for the trans population: from the normative framework to the challenges of the PAES Pop Trans

La enfermería en la atención especializada a la población trans: desde el marco normativo hasta los desafíos del PAES Pop Trans

A enfermagem na atenção especializada à população trans: do arcabouço normativo aos desafios do PAES Pop Trans

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Abstract

This essay aims to critically reflect on the strategic role of nursing in specialized care for the trans population within the Unified Health System (SUS), specifically addressing the stagnation in the number of nursing professionals proposed in the Program for Specialized Health Care for the Trans Population (PAES-Pop-Trans). The methodological approach consists of a critical, theoretical-reflective essay that bridges the regulatory framework of the "Transsexualization Process" (the official Brazilian policy for gender-affirming care) with concepts from health technologies and nursing theories. The discussion highlights that nursing serves as the frontline in outpatient clinics, playing an indispensable role in dialogical care (utilizing "light" technologies), mitigating institutional transphobia, conducting systematic clinical consultations, and managing the complex pharmacovigilance required for hormone therapy. However, despite the clinical expansion proposed by the PAES-Pop-Trans, the document presents a serious contradiction: while it expands the overall size of the healthcare teams, it keeps the number of nurses capped at just one professional and entirely excludes nursing technicians. It is concluded that this undervaluation threatens both the viability and the clinical safety of the policy. There is an urgent need for professional nursing organizations to advocate for an increase in the number of nursing staff within the program's guidelines, thereby ensuring comprehensive and emancipatory care.

Descriptors: Nursing; Transgender Persons; Unified Health System; Equity Policies; Humanization of Care.

Resumén

El objetivo de este ensayo es reflexionar críticamente sobre el papel estratégico de la enfermería en la atención especializada a la población trans dentro del Sistema Único de Salud, cuestionando el estancamiento cuantitativo de esta categoría profesional en la propuesta del Programa de Atención Especializada a la Salud de la Población Trans (PAES-Pop-Trans). El enfoque metodológico consiste en un ensayo teórico-reflexivo crítico que vincula el marco normativo del «Proceso Transexualizador» con referentes sobre tecnologías en salud y teorías de enfermería. La discusión pone de relieve que la enfermería constituye la primera línea de atención en los centros ambulatorios, siendo insustituible en la acogida dialógica (tecnologías blandas), la mitigación de la transfobia institucional, la consulta sistematizada y la compleja farmacovigilancia de la hormonización. Sin embargo, a pesar de la ampliación clínica propuesta por el PAES-Pop-Trans, el documento presenta una grave contradicción: al expandir los equipos, mantiene estancado el número de enfermeros en un solo profesional y, además, excluye al personal de nivel técnico. Se concluye que esta subvaloración amenaza la viabilidad y la seguridad clínica de la política. Resulta urgente que las entidades profesionales aboguen por un redimensionamiento cuantitativo de la profesión en el programa, garantizando así una atención emancipadora e integral.

Descriptores: Enfermería; Personas Transgénero; Sistema Único de Salud; Políticas de Equidad; Humanización de la Atención.

Resumo

O objetivo deste ensaio é refletir criticamente sobre o papel estratégico da enfermagem na atenção especializada à população trans no Sistema Único de Saúde, problematizando a estagnação quantitativa da categoria na proposta do Programa de Atenção Especializada à Saúde da População Trans (PAES-Pop-Trans). O percurso metodológico caracteriza-se como um ensaio teórico-reflexivo crítico que articula o resgate normativo do Processo Transexualizador a referenciais de tecnologias em saúde e teorias de enfermagem. A discussão evidencia que a enfermagem atua como a linha de frente dos ambulatórios, sendo insubstituível no acolhimento dialógico (tecnologias leves), na mitigação da transfobia institucional, na consulta sistematizada e na complexa farmacovigilância da hormonização. Contudo, apesar da ampliação clínica proposta pelo PAES-Pop-Trans, o documento apresenta uma grave contradição ao expandir equipes, mantendo estagnado o quantitativo de enfermeiros em apenas um profissional e, ainda, excluir o nível técnico. Conclui-se que essa subvalorização ameaça a viabilidade e a segurança clínica da política. Urge a articulação de entidades de classe pelo redimensionamento quantitativo da profissão na publicação do programa, garantindo um cuidado emancipador e integral.

Descritores: Enfermagem; Pessoas Transgênero; Sistema Único de Saúde; Políticas de Equidade; Humanização da Assistência.

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Introduction

The institutionalization of transgender healthcare within the Brazilian Unified Health System (SUS), currently regulated by Ordinance No. 2,803/2013[1], represented a historical milestone by establishing a more comprehensive care pathway that extends beyond surgical procedures to include welcoming services, clinical follow-up, and hormone therapy. The care pathway was structured so that Primary Health Care (PHC) would serve as the point of entry and coordinator of care, while Specialized Care, through specialty outpatient clinics, would address the specific aspects of the gender-affirmation process and body modifications.

However, there is a profound gap between the legal framework and empirical reality, as PHC frequently fails due to a cisnormative institutional culture and inadequate professional training, resulting in an exclusionary environment in primary care facilities. This structural failure, combined with the fear of institutional violence and disrespect for individuals' chosen names, drives transgender people away from preventive healthcare services, overburdening the few existing specialized outpatient clinics with waiting lists that extend for years and resulting in a bureaucratic and stigmatizing process of navigating the healthcare system[2,3].

Nursing constitutes the largest workforce[4] and the backbone of the SUS, assuming a strategic position at the forefront of care delivery, care pathway management, and patient reception. In this context of continuous patient interaction, the profession faces the challenge of reshaping its practices in response to the transition from a historical model centered on pathologization to a contemporary paradigm grounded in human rights, self-determination, and the depathologization of transgender identities.

This paradigm shift requires abandoning gatekeeping, the control of access based on subjective assessments and reports, in favor of informed consent, which ensures individual autonomy[5]. For nursing professionals, this evolution requires deconstructing binary biological assumptions and reorienting the Systematization of Nursing Care (SAE), transforming care into an active instrument for mitigating vulnerabilities and addressing institutional violence that has historically driven this population away from healthcare services.

The contemporary clinical and methodological milestone of this paradigmatic transition was the publication, in September 2022, of the eighth version of the Standards of Care (SOC8) by the World Professional Association for Transgender Health (WPATH)[5]. The document replaced the psychiatric term “gender dysphoria” with “gender incongruence,” aligning with the World Health Organization's ICD-11 and seeking to remove the historical stigma of mental illness from the gender-affirming care process and facilitate access to healthcare.

In the Northern Hemisphere, advanced practice nursing has led to the implementation of SOC8[5] based on informed consent, expanding nurses' autonomy to conduct everything from initial assessments to hormone therapy management. Accordingly, nursing history-taking shifts its focus away from psychopathology toward documenting patients' life experiences, assessing their capacity to provide informed consent, eliminating obsolete requirements, and prioritizing harm reduction and respect for each individual's unique pace. Although SOC8 represents the global gold standard, critical literature in public health has identified methodological limitations in its development, indicating that the automatic transfer of Global North models to Brazil requires caution[6]. It is essential to adapt these guidelines to the local socioeconomic and epidemiological context by developing protocols tailored to Brazilian nursing practice that integrate international evidence with the realities of the SUS.

Translating the ethical principles of gender-affirming care into the operational context of the SUS therefore requires a careful analysis of the evolution of Brazilian regulations. Historically, Ordinance No. 1,707/2008[7] restricted the formal role of nursing in the Transsexualization Process (PrTr) essentially to the surgical and hospital teams, undervaluing its clinical role in patient follow-up. It was only with the restructuring introduced by Ordinance No. 2,803/2013[1] that the State recognized the essential role of this professional category in continuous care, formally including nurses in the minimum staffing requirements for specialized outpatient clinics. This recognition represented an undeniable institutional advancement, aligning the human resources structure with the complexity of hormone therapy and outpatient follow-up.

More than a decade after this guideline, Brazil faces an attempt to update this care pathway through the Specialized Healthcare Program for the Transgender Population (PAES-Pop-Trans)[8]. The proposed program carries the promise of a genuine epistemological and structural shift, seeking to decentralize the still-prevailing paternalistic model and establish user self-determination as the fundamental basis of interprofessional relationships. Given the strengthening of depathologization guidelines and the natural expansion of the healthcare network, it was expected that the development of PAES-Pop-Trans would be accompanied by an appropriate and equitable reallocation of the healthcare workforce.

However, the structural design of the new program presents a serious contradiction by increasing the minimum staffing requirements for other specialties while maintaining the nursing requirement at only one professional per team (PAES-Pop-Trans)[8]. This asymmetry disregards the importance of nursing in patient reception, health education, mitigation of institutional transphobia, pharmacovigilance in hormone therapy, and the Systematization of Nursing Care (SAE), thereby overburdening frontline professionals.

In this context, the present essay critically reflects on the strategic role of nursing in transgender healthcare within the SUS. It examines how the numerical undervaluation of the nursing workforce threatens the feasibility, clinical safety, and effectiveness of the comprehensive care envisioned by the State.

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Methodology

The methodological approach is characterized as a critical theoretical-reflective essay that, based on an analysis of the role of nursing within the SUS and the evolution of regulations governing the Transsexualization Process (PrTr), seeks to critically examine the lack of workforce reallocation in response to the new policy reformulation, which has yet to be officially published. To this end, the study develops its argument through a historical and documentary review of regulations concerning transgender healthcare (particularly Ordinances No. 1,707, No. 457/2008, and No. 2,803/2013), contrasting them with the new scope proposed by the Specialized Healthcare Program for the Transgender Population (PAES-Pop-Trans). The argument is supported by fundamental theoretical frameworks in the nursing profession, such as the propositions of Wanda de Aguiar Horta and Madeleine Leininger, articulated with the concepts of light, light-hard, and hard technologies in healthcare. Through this analytical lens, the text highlights the structural contradiction between the high clinical, relational, and pharmacovigilance complexity required of nursing professionals in specialized outpatient clinics and the maintenance of a stagnant workforce size, exposing the material undervaluation of the profession in the new government guidelines. The authors prepared, wrote, and reviewed this article in August and September 2026.

Results and Discussion

The Regulatory Paradox and the Undervaluation of Nursing

The origins of the institutionalization of care for the transgender population within the SUS, established by Ordinance No. 457/2008[9], were characterized by a strictly biomedical and surgery-centered approach. At that historical moment, outpatient procedures functioned exclusively as a preparatory stage, an evaluative funnel for access to surgical body-modification procedures. Reflecting this hypermedicalized approach, the minimum team composition for follow-up excluded the nursing profession, formally restricting its role to surgical centers and excluding it even from the multidisciplinary team. This assertion is evidenced by the fact that, in the ordinance, nursing is explicitly mentioned only in Annex I, Section 3, which establishes the minimum and multidisciplinary healthcare team:

> *"3.4.2 – Minimum Healthcare Team: a. Surgeon: [...]; b. Anesthesiology: [...]; c.* ***Nursing: coordinating nurse and nurses, nursing technicians, and nursing assistants in sufficient numbers*** *(emphasis added by the authors); d. Multidisciplinary team: – Medical team: [...], – Psychologist; – Social worker"[9].*

This institutional invisibility of nursing during the period in which the 2008 ordinance was in force was not merely an administrative oversight; rather, it directly reflected a pathologizing paradigm focused on modifying the bodies of transgender individuals[10]. The absence of nurses from the multidisciplinary team, beyond the surgical team, effectively meant the exclusion of a professional category whose practice is structured around patient reception, qualified listening, continuity of care, and health education. The 2008 model centered on diagnostic scrutiny, neglecting the need for longitudinal follow-up that considered individuals' biopsychosocial vulnerabilities beyond surgical oversight.

The regulatory and care landscape underwent a decisive and necessary shift with the publication of Ordinance No. 2,803/201[1]. This new legal framework reconfigured the Transsexualization Process by decoupling care from the requirement of a surgical outcome. By establishing and regulating outpatient procedures not conditional on surgery, particularly hormone therapy, clinical follow-up, and ongoing social support, the framework recognized the plurality of transgender identities and users' autonomy. Outpatient care thus ceased, in part, to function merely as a psychiatric-evaluative gateway and became a therapeutic setting for the promotion of health.

It was precisely this structural change that required the formal inclusion of nursing professionals in the minimum staffing requirements for transgender outpatient clinics. The text of the new ordinance formalized this advancement by redefining the human resources required for service accreditation:

> *"Reference Team: The Specialized Care facility within the outpatient modality of the Transsexualization Process must have at least: 1 psychiatrist or 1 psychologist, 1 social worker, 1 endocrinologist or 1 general practitioner, and 1 nurse"[1].*

The inclusion of nursing represented the State's recognition that the clinical complexity of hormone therapy, pharmacovigilance, and the need for comprehensive follow-up could not be adequately addressed without the professional category responsible for care management and the Systematization of Nursing Care (SAE) within SUS.

The evolution of regulations between 2008 and 2013 illustrates a profound paradigm shift that goes beyond expanding the clinical scope of care: it represents the increased recognition of relationship-building practices[11]. The inclusion of nursing in outpatient clinics strengthens the use of light healthcare technologies, which are essential for building trust between the public healthcare system and a population historically marginalized by institutional violence. Nurses act as a continuous link, transforming the outpatient setting into an environment characterized by listening, harm reduction, and health education. It is the strengthening of this bond, fostered daily by nursing professionals, that enables therapeutic adherence and shifts transgender healthcare from a corrective approach toward an emancipatory one.

Modern nursing is intrinsically grounded in the systematization of care and the development of its own epistemological framework. Since Florence Nightingale's pioneering propositions in the nineteenth century, nursing practice has moved away from empiricism toward a structure based on rigorous technical and scientific foundations, contributing to the consolidation of the profession as an autonomous discipline. Historically, nursing has claimed and assumed a leading role not only in the direct provision of care through a comprehensive approach but

also in service management, health education, and the strategic coordination of healthcare networks[12].

From this perspective, nursing practice is operationalized through a multifaceted technological arsenal applied to the production of health. The clinical encounter between healthcare professionals and users is mediated by a complex intersection of tangible instruments, structured knowledge, and interpersonal dynamics, categorized, respectively, as hard, light-hard, and light technologies[11]. While hard technologies encompass the material resources and equipment essential to the work process, light-hard technologies are embodied in the technical and scientific knowledge acquired by professionals. Light technologies, in turn, emerge within the relational space and take shape through listening, welcoming, and the therapeutic bond that is essential to effective care[13].

Beyond the mere classification of these technologies, the complexity of healthcare work lies in how these resources are mobilized and integrated into the actual delivery of care. The consolidation of nursing as a profession has transcended its subordination to the traditional biomedical model, requiring the development of specific instruments, methodological frameworks, and theories to organize care. Throughout this historical process, the Systematization of Nursing Care (SAE), inseparable from the development of robust theoretical frameworks, has been essential to defining the practical scope of the profession and promoting a practice that integrates scientific rigor with the realities of healthcare delivery[12].

In the Brazilian context, this epistemological movement has taken shape through the development of genuinely Brazilian theories and the progressive institutionalization of the Nursing Process (NP). Of particular note is the pioneering work of Wanda de Aguiar Horta, whose Theory of Basic Human Needs provided the foundation for structuring care around psychobiological, psychosocial, and psychospiritual dimensions. From this theoretical perspective, individuals are understood beyond anatomical fragmentation, in their biopsychosocial entirety; their specific vulnerabilities and needs determine clinical reasoning, assessment, and the prescription of nursing interventions[14].

The enduring relevance of this structural foundation is currently reflected and legitimized in the legal framework governing the profession, particularly through Cofen Resolution No. 736/2024. This regulatory provision reaffirms that the NP must be grounded in theoretical support and implemented through interrelated and interdependent stages. The regulation establishes nursing assessment, based on the continuous and systematic collection of objective and subjective data, as the fundamental stage for identifying care needs. This process encompasses not only individuals but also families, communities, and groups experiencing vulnerability. Nursing practice is therefore not a mechanical execution of tasks but a dynamic cycle requiring critical assessment, sound clinical judgment, strategic planning, and evidence-based decision-making[15].

Historically, the regulation and scientific consolidation of nursing have maintained a symbiotic relationship with its strategic integration into healthcare delivery settings. The profession is present at all levels of system complexity, from primary to specialized and hospital care, operating across direct and indirect care, educational activities, operational management, and intersectoral care coordination. The magnitude of nursing's contribution to sustaining the healthcare system is reflected and legitimized by its substantial workforce. Recent data from the Federal Nursing Council (COFEN) indicate that Brazil's registered nursing workforce exceeded three million professionals in 2026, comprising the coordinated and hierarchical work of nursing assistants, nursing technicians, and registered nurses, and representing 70% of the country's healthcare workforce[4].

Given this undeniable reach, it is essential to examine how nursing knowledge and practices are mobilized in healthcare settings characterized by high clinical specificity and social vulnerability, such as care for the transgender population. In this context, healthcare work requires the coordination of patient reception, careful assessment of health demands and needs, longitudinal follow-up, continuing education, and systematic documentation, as well as ongoing coordination with other services within the healthcare network and the multidisciplinary team. These activities require the simultaneous integration of technical and scientific knowledge, rigorous protocols, and light technologies. In the care of transgender individuals, this relational dimension assumes an indispensable central role, since their healthcare needs extend far beyond interventions limited to body modifications[16].

This premise is supported by Matta, Costa and Dias[11], who emphasize the urgent need to value light technologies during clinical encounters. According to the authors, a practice predominantly guided by hard technologies carries the serious risk of reducing transgender individuals to their strictly anatomical and physiological dimensions. This is a particularly limiting phenomenon when the healthcare system narrows care to hormone therapy and surgical interventions alone. Conversely, the intentional use of light technologies enables recognition of each individual's unique characteristics, fostering a specialized and empathetic approach to social and family dynamics, as well as to the complex needs expressed by users.

It is therefore the adoption of this perspective that ensures the realization of comprehensive care for the transgender population. By moving beyond the biological aspects of body modification, nursing promotes the development of therapeutic bonds, qualified patient reception, and active listening as highly effective technological tools for identifying needs and ensuring individuals' autonomy throughout safe care pathways. From this perspective, healthcare work is not exhausted by technical and scientific expertise or the mere repetition of procedures; rather, it takes shape and acquires meaning through the relational dimension, consolidating care as a

direct and emancipatory outcome of the encounter between individuals[17].

Within the scope of the Transsexualization Process (PrTr), this epistemological reflection assumes a central role, given that the historical organization of specialized services has been predominantly structured under the biomedical paradigm, prioritizing the provision of surgical interventions for body modification. The establishment of authentic and comprehensive care, however, requires moving beyond these strictly anatomical demands and recognizing the unique characteristics, diverse demands, and needs of users[18]. As discussed by Matta, Costa and Dias[11], placing hard technologies at the center of care perpetuates a reductionist, intervention-focused approach, whereas the continued appreciation of light technologies has the transformative potential to broaden the clinical perspective, shifting the focus from pathology to the individual and the relationships established throughout the therapeutic journey.

The actual delivery of care in specialized outpatient clinics reveals that, beyond ministerial regulations, nursing consistently operates at the forefront and serves as the operational driving force behind these services. Empirical evidence from studies demonstrates that nursing professionals play a leading role in every stage, from initial patient reception and clinical triage to appointment scheduling and the detailed management of users' pathways through the healthcare system. Nurses are responsible for translating the bureaucratic complexity of the healthcare network into a navigable pathway for transgender individuals, establishing the first therapeutic contact, a critical moment that may determine treatment adherence or discontinuation[19,20].

Within the strictly clinical and preventive scope, the responsibilities of the nursing team prove extensive and indispensable to the safety of the gender-affirmation process. Longitudinal care encompasses parenteral administration and hormone therapy monitoring, the collection of cytopathological samples, which is often hindered by embarrassment and gender dysphoria and therefore requires a highly qualified approach, and ongoing health education. These activities require refined clinical reasoning, establishing the outpatient clinic not merely as a setting for endocrinological prescriptions but also as a space for promoting self-care and comprehensive health surveillance[19,20].

Nevertheless, the impact of the formal exclusion of nursing from the mandatory minimum team at the inception of the Transsexualization Process has left lasting structural scars across the healthcare network. For years, this legal invisibility severely hindered specific funding and budgetary allocation for nursing positions in specialized centers. The absence of an official staffing requirement and designated budget allocation for this professional category delayed the development and nationwide standardization of nursing care protocols for transgender health, leaving many institutional practices dependent on improvisation or inadequate adaptations of general primary healthcare guidelines.

Efforts to reverse this erasure and formally institutionalize the role of nurses have more recently begun to take shape through regulations issued by the professional regulatory bodies themselves. In the absence of comprehensive operational guidelines from the Ministry of Health defining the practical scope of nursing in this setting, regional nursing councils have stepped in to address the need for legal certainty. Noteworthy in this process of recognition and validation is the issuance of documents such as Coren-BA Technical Opinion No. 04/2025, which established, detailed, and formally endorsed nurses' responsibilities in supporting gender transition, reaffirming nursing as an indispensable and autonomous pillar of specialized care[21].

In specialized outpatient clinics and the few Primary Health Care units that provide gender-affirming and inclusive care, the core of nursing clinical practice can be organized around three key dimensions. This operational triad comprises mitigating transphobia through dialogic patient reception, conducting structured nursing consultations grounded in care theories, and implementing pharmacovigilance in hormone therapy follow-up. Far from being isolated stages, these activities form a continuous network of care that ensures both technical safety and respect for users' identity and dignity throughout the Transsexualization Process.

The first dimension, nursing patient reception, goes beyond mere administrative intake to become a light healthcare technology and a genuine act of reparation for historical institutional violence. Recognizing that many patients actively avoid healthcare services, even when experiencing advanced stages of illness, because of a history of pathologization of their bodies and public humiliation, nursing professionals work to deconstruct assumptions based on visual anatomy and rigid bureaucratic systems. Unconditional respect for individuals' chosen names and preferred pronouns is treated not merely as a legal right but as an essential therapeutic prerequisite that influences treatment adherence. This dialogic approach helps eliminate operational barriers, such as calling patients by their birth names because of inflexible medical records and validates users' self-identification without imposing moral judgments regarding their ability to pass as cisgender[19,20,22,23].

Once the barrier to access has been overcome, the second dimension is consolidated through nursing consultations structured around care theories, such as those developed by Callista Roy, Wanda Horta, Dorothea Orem, and others. An example of this is the transition from empirical care to the rigorous application of Madeleine Leininger's Theory of Culture Care Diversity and Universality (TCCDU). Adopting this model provides nurses with a robust theoretical and methodological framework for understanding transgender individuals from a truly holistic perspective. Leininger argues that care can only achieve effectiveness when it considers an individual's cultural, social, and structural dimensions. In transgender outpatient care, this means that the Systematization of Nursing Care (SAE) must extend beyond the biological aspects of transition and integrate clinical data with technological,

religious, economic, and political factors when formulating accurate nursing diagnoses. The use of validated instruments based on this theory organizes the health history into operational domains, ensuring that no biopsychosocial need goes unnoticed and substantially reduces the risk of professional negligence[16,24].

The third dimension directly addresses the most frequent and pressing demand in these services: safe access to hormone therapy for the alignment of secondary sex characteristics. Considering that a substantial proportion of users initiate body modifications independently, often relying on informal advice exchanged through social media that may lead to unsupervised substance use, nursing assumes responsibility for coordinating treatment from a harm reduction perspective. Clinical pharmacovigilance performed by nurses involves continuous monitoring of vital signs, careful assessment of the risk of deep vein thrombosis and thromboembolic events, and surveillance for changes in lipid profiles, early signs of erythrocytosis (polycythemia), and liver dysfunction[25].

Alongside metabolic monitoring, pharmacovigilance also encompasses integrated health education and training in self-care. Nurses are responsible for the proper administration of injectable therapies and, when feasible, for training patients in safe self-administration, providing guidance on rotating injection sites, disposing of sharps, and recognizing local adverse reactions. Professionals also act as critical health educators, making use of the ongoing therapeutic relationship. Since the immediate desire for body modifications often outweighs concerns about chronic adverse effects, nursing professionals have a responsibility to encourage healthy habits, maintaining the scientific and empathetic foundations of long-term care.

This entire theoretical framework is directly related to the recent restructuring proposals for specialized healthcare for the transgender population within the SUS. During 2024, the Ministry of Health presented the Specialized Healthcare Program for the Transgender Population (PAES Pop Trans), a regulatory framework designed to revise the Transsexualization Process, with the aim of expanding, improving, and reorganizing access to the healthcare network. The new regulatory framework stratifies care into modalities of varying levels of complexity, establishing Specialized Outpatient Clinic 1, intended for patient reception, individual and family care, group interventions, health education, and coordination with primary care, and Specialized Outpatient Clinic 2, focused on preoperative follow-up and direct referral for surgical interventions[8].

An analysis of the minimum staffing requirements established for these new care settings, however, reveals underlying contradictions in the material recognition of nursing work. The regulations require only one nurse for Specialized Outpatient Clinic 1, in contrast to the requirement for one specialist physician (family and community medicine, endocrinology, or gynecology), two psychologists, two social workers, one dentist, and one oral health technician/assistant. This disparity becomes even more pronounced in Specialized Outpatient Clinic 2, where the team is substantially expanded to include three physicians (an endocrinologist, a dermatologist, and a gynecologist), two psychologists, two social workers, one physical therapist, one speech-language pathologist, one dentist, and one oral health technician/assistant, while paradoxically retaining the limitation of a single nurse[8].

When compared with the previous model governed by Ordinance No. 2,803/2013, it becomes clear that PAES Pop Trans proposes quantitatively larger teams yet promotes a disproportionate expansion that overburdens nursing. Maintaining a single nursing professional, regardless of the increase in complexity and volume of care demands between Outpatient Clinics 1 and 2, disregards the workload inherent in the quantitative and qualitative breadth of nursing activities in these settings. Furthermore, the structure of the new program raises serious concerns by completely omitting nursing technicians from the minimum staffing requirements, a professional group that represents more than 60% of Brazil's nursing workforce[4]. This lack of growth in the number of nurses and the exclusion of nursing technicians reveal a structural mismatch between the Ministry of Health's stated commitment to expanding care and the material recognition of the professionals who deliver it on the front lines. Beyond devaluing the nursing team, this configuration is likely to compromise the quality of many services that already organize their activities around systematic care and health education, ultimately undermining harm reduction and the prevention of health complications among the transgender population.

Final Considerations

The reflections presented in this essay reinforce the understanding that nursing plays an irreplaceable role in reshaping healthcare for the transgender population within the Brazilian Unified Health System (SUS). Representing the backbone of care and accounting for approximately 70% of Brazil's healthcare workforce, with more than three million professionals, nursing is the operational driving force enabling the transition from a model once centered on pathologizing oversight to a paradigm grounded in depathologization, autonomy, and the protection of human rights.

The scope of this contribution, however, extends beyond the mere performance of technical procedures and the rigorous monitoring of hormone therapy. The core of nursing practice is fundamentally grounded in the relational dimension of care, delivered through light technologies. Dialogic patient reception, active listening, and the development of continuous therapeutic relationships are highly valued principles within the profession and serve as the primary means of mitigating institutional transphobia. It is this relational dimension, implemented at the forefront of care, that helps overcome historical barriers, ensures therapeutic adherence, and validates individuals' identity and dignity, preventing transgender people from being reduced solely to anatomical and physiological interventions.

Nevertheless, the discrepancy between the practical importance of nursing and its bureaucratic recognition becomes alarming in the formulation of PAES-Pop-Trans. By designing a policy to expand specialized care that broadens the scope of several professional categories while maintaining the number of nurses at only one per outpatient clinic, and omitting nursing technicians, the State creates a serious contradiction. This numerical undervaluation disregards the importance of the Systematization of Nursing Care (SAE) and threatens clinical safety and the very implementation of the policy.

This structural contradiction is compounded by the seriousness of the current political and temporal context. Announced in 2024 with the promise of an epistemological shift in the care pathway, PAES-Pop-Trans remains unjustifiably stalled and has not been officially published as of 2026. Every day of delay in implementing this program translates into State inaction, the continuation of exclusionary waiting lists, and the perpetuation of the vulnerabilities and stigmatizing experiences of navigating public healthcare services faced by the transgender population.

In view of this situation, political coordination and active engagement are essential to challenge the current scenario. Urgent and assertive dialogue must be established with COFEN and other representative organizations so that they can engage in advocacy for the appropriate reallocation of nursing staff in the program's final text. The immediate publication of PAES-Pop-Trans, accompanied by due quantitative and qualitative recognition of the professional category that sustains it, is not merely a labor-related demand but an urgent and non-negotiable ethical commitment to ensuring the citizenship and lives of Brazil's transgender population.

References

1. Brasil. Portaria nº 2.803, de 19 de novembro de 2013. Redefine e amplia o Processo Transexualizador no Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2013 [citado em 23 nov 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt2803_19_11_2013.html
2. Popadiuk GS, Oliveira DC, Signorelli MC. A Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais e Transgêneros (LGBT) e o acesso ao Processo Transexualizador no Sistema Único de Saúde (SUS): avanços e desafios. Cienc Saude Colet. 2017;22(5):1509-20. https://doi.org/10.1590/1413-81232017225.32782016
3. Pereira LBC, Chazan ACS. O acesso das pessoas transexuais e travestis à Atenção Primária à Saúde: uma revisão integrativa. Rev Bras Med Fam Comunidade. 2019;14(41):1795. https://doi.org/10.5712/rbmfc14(41)1795
4. Conselho Federal de Enfermagem (COFEN). Semana da Enfermagem reafirma protagonismo da maior força de trabalho da saúde brasileira [Internet]. Brasília: COFEN; 2026 [citado em 4 nov 2026]. Disponível em: https://www.cofen.gov.br/semana-da-enfermagem-reafirma-protagonismo-da-maior-forca-de-trabalho-da-saude-brasileira/
5. 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(Suppl 1):S1-S259. https://doi.org/10.1080/26895269.2022.2100644
6. Zhang Y, Januś D, Kaltiala R, Karvonen M, Ptak JJ, Yepes-Nuñez JJ. Quality of the World Professional Association for Transgender Health guideline standards of care 8: an appraisal using the AGREE II instrument. Arch Sex Behav. 2026;55(4):1845-57. https://doi.org/10.1007/s10508-025-03399-6
7. Brasil. Portaria nº 1.707, de 18 de agosto de 2008. Institui, no âmbito do Sistema Único de Saúde (SUS), o Processo Transexualizador [Internet]. Brasília: Ministério da Saúde; 2008 [citado em 15 dez 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2008/prt1707_18_08_2008.html
8. Brasil. Ministério da Saúde. Programa de Atenção Especializada à Saúde da População Trans (PAES-PopTrans): apresentação à Comissão Intergestores Tripartite [Internet]. Brasília: Ministério da Saúde; 2024 [citado em 4 nov 2026]. 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
9. Brasil. Portaria nº 457, de 19 de agosto de 2008. Regulamenta o Processo Transexualizador no SUS [Internet]. Brasília: Ministério da Saúde; 2008 [citado em 31 jan 2026]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/sas/2008/prt0457_19_08_2008.html
10. Costa CMA. Análise bioética do Processo Transexualizador no Brasil à luz da perspectiva dos Funcionamentos [tese]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2015 [citado em 23 nov 2025]. Disponível em: https://www.bdtd.uerj.br:8443/handle/1/7737
11. Matta TF, Costa CMA, Dias MC. Transição tecnológica e o processo transexualizador: ensaio sobre aspectos tecnológicos e a produção subjetiva do cuidado nos ambulatórios de saúde trans. In: Conectando saberes: gênero, tecnologia e informação na era digital. 1ª ed. Belém: Universidade Federal do Pará; 2024. p. 99-127 [citado em 23 nov 2025]. Disponível em: https://livroaberto.ufpa.br/handle/prefix/1266
12. Cardoso RB, Caldas CP. A importância da ciência normal para a consolidação do processo de enfermagem. Rev Pesqui Cuid Fundam Online. 2022;14:e10796. https://doi.org/10.9789/2175-5361.rpcfo.v14.10796
13. Koerich MS, Erdmann AL, Meirelles BHS. Tecnologias de cuidado em saúde e enfermagem e suas perspectivas filosóficas. Texto Contexto Enferm. 2006;15(spe):178-85. https://doi.org/10.1590/S0104-07072006000500022
14. Cruz RAO, Silva VA, Costa MML, Oliveira JS, Fernandes MGM. Teoria das necessidades humanas básicas: análise crítica de contexto. REME Rev Min Enferm. 2025;29:e54421. https://doi.org/10.35699/2316-9389.2025.54421
15. Conselho Federal de Enfermagem (COFEN). Resolução COFEN nº 736, de 17 de janeiro de 2024 [Internet]. Brasília: COFEN; 2024 [citado em 18 fev 2026]. Disponível em: https://www.cofen.gov.br/resolucao-cofen-no-736-de-17-de-janeiro-de-2024/
16. Cabral IBV, Ferreira CB, Almeida TG, Bezerra AS. Elaboração de protocolo de enfermagem para apoio ao atendimento de pessoas trans no âmbito da APS à luz da Teoria de Leininger. Contrib Cienc Soc. 2024;17(1):8356-74. https://doi.org/10.55905/revconv.17n.1-504

17. Pereira VP. Entre o acolhimento e a exclusão: experiências de cuidado, reconhecimento e barreiras institucionais em um ambulatório trans. Rev Tópicos. 2026;4(37):1-25. https://doi.org/10.70773/revistatopicos/788144963
18. Canavese D, Schreiber G, Signorelli M. Do processo transexualizador à atenção integral: uma revisão integrativa sobre a produção nacional nos principais portais científicos brasileiros. Tempus Actas Saude Colet. 2019;13(4):112-27. https://doi.org/10.18569/tempus.v13i4.2545
19. Santos JS, Silva RN, Ferreira MA. Saúde da população LGBTI+ na Atenção Primária à Saúde e a inserção da Enfermagem. Esc Anna Nery. 2019;23:e20190162. https://doi.org/10.1590/2177-9465-EAN-2019-0162
20. Oliveira EM, Porcino C, Suto CSS, et al. Acesso aos serviços de saúde pública por pessoas transgêneras: experiências na capital do Brasil. Rev Esc Enferm USP. 2026;60:e20250273. https://doi.org/10.1590/1980-220X-REEUSP-2025-0273pt
21. Conselho Regional de Enfermagem da Bahia (COREN-BA). Parecer Técnico nº 04/2025 [Internet]. Salvador: COREN-BA; 2025 [citado em 30 set 2026]. Disponível em: https://www.coren-ba.gov.br/parecer-tecnico-no-04-2025/
22. Vieira VF, Bermúdez XPCD, Goldberg A. O processo transexualizador a partir das narrativas de pessoas trans, gestores e profissionais da saúde. Saude Debate. 2025;49:e10026. https://doi.org/10.1590/2358-2898202514510026P
23. Santos Rocha KS, Silva Dos Santos MC, Souza JM, Souza Anacleto de Araújo DC, Louzado Sant'Anna TA. Assessment of transgender individuals' knowledge about their hormone therapy. Infarma Pharm Sci. 2026;36:437. https://doi.org/10.14450/2318-9312.v36.eSup3.a2024.pp1-934
24. Sousa JC, Araújo EC, Vasconcelos EMR, Galindo-Neto NM, Ramalho MNA, Abreu PD. Tecnologia para consulta de enfermagem às mulheres transexuais à luz da teoria transcultural de Leininger. Rev Bras Enferm. 2022;75(5):e20210525. https://doi.org/10.1590/0034-7167-2021-0525
25. São Paulo (Município). Secretaria Municipal de Saúde. Protocolo para o cuidado integral à saúde de pessoas trans, travestis ou com vivências de variabilidade de gênero no município de São Paulo [Internet]. 2ª ed. São Paulo: Secretaria Municipal de Saúde; 2024 [citado em 23 nov 2025]. Disponível em: https://drive.prefeitura.sp.gov.br/cidade/secretarias/upload/Protocolo-Trans_revis%203%C2%AA%20ed%202024.pdf