Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

“Politics Is Interfering Where It Should Not”: Healthcare Professionals’ Responses to Brazil’s New Regulation of Gender-Affirming Care

Bruna Caruso Mazzolani
Universidade de São Paulo https://orcid.org/0000-0002-4687-3128
Breno Artuso Lage
Universidade de São Paulo https://orcid.org/0000-0002-1787-0622
Samuel Bittar
Universidade Federal de São Paulo https://orcid.org/0009-0002-5139-9181
Luana Cordeiro de Oliveira
Universidade de São Paulo https://orcid.org/0000-0003-0272-9412
Igor Longobardi
Universidade de São Paulo https://orcid.org/0000-0001-6669-9553
Mariana de Mattos Baratojo
Universidade de São Paulo https://orcid.org/0009-0008-1588-1601
Lucas Arantes da Silva
Universidade de São Paulo https://orcid.org/0009-0004-7054-3913
Fernanda Sabatini
Universidade de São Paulo https://orcid.org/0000-0002-3037-4447
Fernanda Evangelista Bandeira de Melo
Universidade de São Paulo https://orcid.org/0000-0001-7592-0301
Thifany Helena Torres
Universidade de São Paulo https://orcid.org/0000-0002-3741-3461
Fernanda Baeza Scagliusi
Universidade de São Paulo https://orcid.org/0000-0001-7590-4563
Alexandre Saadeh
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo https://orcid.org/0000-0002-6591-8838
Hamilton Roschel
Universidade de São Paulo https://orcid.org/0000-0002-9513-6132
Bruno Gualano
gualano@usp.br

Universidade de São Paulo https://orcid.org/0000-0001-7100-8681

Research Article

Keywords: transgender youth, longitudinal care, multidisciplinary care, qualitative research, health policy, gender-affirming care

Posted Date: October 30th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11542263/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: The authors declare no competing interests.

Abstract

Introduction

Gender-affirming care for transgender children and adolescents has become increasingly contested following recent regulatory changes. Although public and regulatory debates have largely focused on medical interventions, less is known about how healthcare professionals understand and enact care within changing regulatory contexts. This study explored professionals' perspectives on gender-affirming care, transition, and the implications of Brazil's Federal Council of Medicine Resolution No. 2,427/2025.

Methods

A qualitative study was conducted using four online focus groups, held between January and March 2026, with 15 multidisciplinary healthcare professionals involved in the care of transgender children and adolescents in Brazil. Discussions were audio-recorded, transcribed verbatim, and analyzed using qualitative content analysis combining deductive and inductive approaches.

Results

Professionals described gender-affirming care as a longitudinal, relational, multidisciplinary, and intersectoral process extending beyond medical interventions to include family support, school collaboration, psychosocial care, and advocacy. Participants perceived the resolution as misaligned with this model of care and described divergent interpretations of its transitional provision, resulting in heterogeneous practices regarding treatment eligibility and continuity. They also reported increased legal involvement, psychosocial demands, regulatory uncertainty, and concerns about self-medication and unsupervised hormone use.

Conclusions

Professionals experienced the resolution not only as a restriction on medical interventions but as a disruption of a longitudinal model of care, with heterogeneous implementation across services and a shift of clinical work toward legal, psychosocial, and harm-reduction demands.

Policy Implications

Regulatory frameworks should recognize the multidimensional nature of gender-affirming care, provide clear implementation guidance, protect continuity of care, and incorporate the perspectives of healthcare professionals, transgender young people, and their families.

INTRODUCTION

Transgender and gender-diverse children and adolescents experience substantial disparities in mental health, quality of life, and access to healthcare, largely driven by stigma, discrimination, and barriers to gender affirmation rather than by gender diversity itself (Gutiérrez et al., 2024; Hendricks & Testa, 2012;

Kearns et al., 2021; Malpas et al., 2022; Meyer, 2003). Over the past decade, an expanding body of evidence has suggested that gender-affirming care, including social, psychological, and, when appropriate, medical interventions, is associated with improvements in psychological well-being, reductions in depression and suicidality, and better overall functioning among transgender youth (Chen et al., 2023; Gutiérrez et al., 2024; Tordoff et al., 2022). Accordingly, major professional organizations recommend that care for transgender children and adolescents be individualized, developmentally appropriate, and delivered by multidisciplinary teams capable of supporting young people and their families across different stages of development (Coleman et al., 2022; Rafferty, 2018).

Unlike many areas of pediatric healthcare, however, gender-affirming care is characterized by considerable uncertainty. Clinical decisions frequently unfold over years of follow-up and require balancing developmental changes, evolving identities, family expectations, ethical considerations, and the best available scientific evidence (Coleman et al., 2022; Olson-Kennedy et al., 2019). Rather than focusing exclusively on medical interventions, care involves continuous dialogue with children, adolescents, and caregivers, allowing decisions to emerge from an ongoing process of multidisciplinary assessment and shared decision-making (Belmont et al., 2024; Coleman et al., 2022; Malpas et al., 2022; Puckett et al., 2019; Rafferty, 2018; Stamm et al., 2025). In this context, longitudinal follow-up is a central component of pediatric gender-affirming care, encompassing ongoing assessment, dialogue, and coordination across developmental stages.

Despite this, access to gender-affirming care has become increasingly contested worldwide (Gualano et al., 2026; Gutiérrez et al., 2024; Kraschel et al., 2022; Longobardi et al., 2025; Noone et al., 2025). In England, the 2024 Cass Review recommended a more cautious approach to medical interventions for transgender children and adolescents, emphasizing comprehensive psychosocial assessment and support, recommending clinical trials to evaluate puberty suppression, and advising extreme caution regarding gender-affirming hormones for adolescents under 18 (Cass, 2024). National Health Service England subsequently implemented changes to clinical pathways and prescribing policies, including restrictions on the routine provision of puberty-suppressing hormones to minors (NHSE, 2024). In the United States, these changes have increasingly affected the organization and continuity of clinical services. In January 2025, Children's National Hospital paused prescriptions of puberty blockers and hormone therapy for transgender youth following a federal executive order, while maintaining mental health counseling, social support, and other supportive services (CNH, 2025). In August 2025, Michigan Medicine announced that it would discontinue puberty blockers and gender-affirming hormonal therapy for minors, citing a federal criminal and civil investigation and escalating external threats and risks (Masson, 2025). Such developments illustrate that regulatory changes may extend beyond decisions regarding specific medical interventions, reshaping how gender-affirming care is organized and delivered. These changes have generated uncertainty not only for transgender children and adolescents and their families, but also for the professionals responsible for providing their care, who must reconcile evolving regulations with clinical judgment, ethical responsibilities, and patients' needs (Stamm et al., 2025).

In Brazil, these debates culminated in the publication of Resolution No. 2,427/2025 by the Federal Council of Medicine (CFM), which replaced Resolution No. 2,265/2019 and introduced more restrictive criteria for gender-affirming medical interventions in children and adolescents. Under the previous resolution, puberty suppression for gender incongruence was considered experimental and restricted to approved research protocols, while gender-affirming hormone therapy could be initiated from the age of 16 under specified clinical and follow-up requirements. The 2025 resolution prohibited puberty suppression for gender incongruence or gender dysphoria in children and adolescents, raised the minimum age for gender-affirming hormone therapy to 18, and established a minimum age of 21 for gender-affirming surgeries with potential sterilizing effects. It also introduced a requirement for at least one year of medical evaluation, emphasizing psychiatric and endocrinological follow-up, before the initiation of gender-affirming hormone therapy (Medicina, 2019, 2025). Although recent research has begun to document how transgender adolescents and caregivers experience Brazil's changing regulatory landscape, less is known about how healthcare professionals directly involved in their care interpret and navigate these changes in everyday clinical practice. In a recent qualitative study, transgender adolescents and caregivers described the new CFM resolution as harmful and disconnected from scientific evidence, while emphasizing that gender-affirming interventions are preceded by long-term, multidisciplinary clinical follow-up (Mazzolani, Cordeiro de Oliveira, et al., 2025; Mazzolani, Longobardi, et al., 2025). These findings provide important perspectives from those receiving and supporting care, but the perspectives of the professionals responsible for delivering that care have not yet been examined in the Brazilian context. Understanding their experiences is particularly important because healthcare professionals must translate changing regulations into clinical practice while balancing clinical judgment, ethical responsibilities, multidisciplinary collaboration, and the needs of young people and their families.

Examining this perspective may also clarify whether and how regulatory frameworks correspond to the broader processes through which gender-affirming care is understood and delivered in clinical settings. We therefore aimed to explore (i) how healthcare professionals understand and provide care for transgender children and adolescents, and (ii) how they perceived and navigated the implementation of CFM Resolution No. 2,427/2025, including its implications for clinical decision-making, the organization and continuity of care, and interactions with young people and their families.

METHODS

This study draws on data generated within a larger project aimed at investigating experiences and health outcomes in transgender lives. Here, we used descriptive qualitative focus group discussions and open-ended survey responses to explore how healthcare professionals understand, negotiate, and provide care for transgender children and adolescents in a changing clinical and sociopolitical context.

The study received approval from the local Ethics Committee (Commission for Analysis of Research Projects – CAPPesq; approval number: 83553224.2.0000.0068), and all participants provided electronic informed consent before taking part.

Participants

Eligible participants were healthcare professionals involved in the care of transgender children and/or adolescents in Brazil. Potential participants were identified through a mapping of Brazilian healthcare services providing care to transgender children and/or adolescents. The mapping identified seven healthcare centers providing care to both transgender children and adolescents and two additional centers providing care to transgender adolescents but not children. Representatives from nine specialized centers were contacted and invited to disseminate the study invitation among colleagues. Eight healthcare professionals from four of these centers participated in the study: five from the Transdisciplinary Gender Identity and Sexual Orientation Service at the Clinical Hospital of the University of São Paulo Medical School (AMTIGOS), and one each from the Reference Center for Comprehensive Trans-Specific Healthcare (CRAIST), the Aquarela Program (NESA-UERJ), and the Gender and Sexuality Outpatient Clinic at the University of Campinas (UNICAMP). To broaden recruitment beyond these specialized centers, the study invitation was also disseminated through the SAMPA Trans Network, through which an additional seven healthcare professionals were recruited, bringing the total sample to 15 participants. Professionals from different disciplines and levels of care were invited, including physicians, psychologists, social workers, nurses, and other professionals working in specialized gender identity services or related healthcare settings.

Twenty-two healthcare professionals completed the online informed consent form and expressed interest in participating; 15 participated in the focus groups, and the remaining seven were unable to attend owing to scheduling constraints. All participants received information about the aims and procedures of the study before agreeing to participate. Sociodemographic and professional characteristics were collected through a structured online questionnaire completed prior to data collection.

Study design

Four online focus group discussions were conducted between January and March 2026 using a secure videoconferencing platform (Google Meet). The online format was chosen to facilitate participation from professionals working in different services and geographic locations across Brazil. Focus groups were selected to explore how experiences and meanings were collectively constructed and negotiated through interaction among professionals working within similar clinical and regulatory contexts, allowing both shared and divergent perspectives to emerge.

Four focus group discussions were conducted with the 15 participating professionals. Group size ranged from two to six participants, as attendance varied across sessions. Participants from different healthcare services were brought together in the same focus groups. The groups were initially planned to include more participants; however, coordinating the schedules of professionals with highly specialized clinical roles resulted in smaller groups in some sessions. Each discussion lasted between 75 and 130

minutes. One group required a second meeting to complete the planned discussion, whereas the remaining groups were completed in a single session.

A semi-structured discussion guide with open-ended questions was used (SM1 in Supplementary Material). The guide addressed topics related to childhood and adolescence, body and development, gender transition, family dynamics, school experiences, healthcare encounters, public and community interactions, and future perspectives.

All focus groups were moderated by experienced qualitative researchers (BCM, PhD, cisgender woman; LCO, BSc, cisgender woman; FE, MSc, cisgender woman; or FS, PhD, cisgender woman), with support from trained co-moderators (BAL, BSc, cisgender man; SB, BSc, transgender man; LA, BSc, cisgender man; MMB, BSc, cisgender woman), who assisted with logistics and recorded field notes. At the beginning of each session, participants were informed about the objectives and procedures of the study. Oral consent for audio recording was obtained, and confidentiality and anonymity were assured throughout transcription and analysis. Only moderators and participants were present.

Research team and positionality

Focus groups were conducted by researchers with previous experience in qualitative research and focus group facilitation. At the time of data collection, the research team included professionals from different disciplines, including psychiatry, psychology, nutrition, physical education, anthropology, and public health, reflecting the multidisciplinary perspective of the broader research project.

Some participants were members of the Transdisciplinary Gender Identity and Sexual Orientation Service (AMTIGOS) at the Institute of Psychiatry, University of São Paulo, and therefore were already familiar with some members of the research team. BCM occasionally attended pediatric consultations and caregiver support groups as part of the broader research project and contributed to discussions related to nutrition and lifestyle when relevant. BAL and MMB were psychologists involved in the clinical care of transgender pre-adolescents at AMTIGOS while also serving as researchers within the broader project. The remaining researchers were not involved in the participants' routine clinical activities. These pre-existing professional and institutional relationships were considered relevant to the research process, as they could have influenced participants' interactions with the research team and their willingness to express particular views.

The research team also included members who had previously contributed to research and public discussions concerning Resolution No. 2,427/2025. Although this prior involvement provided contextual knowledge of the regulatory changes and their implications for clinical practice, it also meant that researchers brought pre-existing perspectives to the topic under investigation. The potential influence of these perspectives on data collection and interpretation was therefore considered as part of the team's reflexive approach.

Before each focus group, participants were informed about the aims of the broader research project, the researchers' professional roles, and that the study sought to explore healthcare professionals' perspectives on the care of transgender children and adolescents. Throughout data collection and analysis, the research team held regular reflexive discussions to examine how their disciplinary backgrounds, professional experiences, and prior involvement with transgender healthcare could shape data collection and interpretation.

Data analysis

Descriptive quantitative data on participants' characteristics are reported as mean ± standard deviation and range [min–max] for continuous variables, and as absolute and relative frequencies for categorical variables. All focus group recordings were transcribed verbatim by BCM, who also checked the transcripts against the original recordings to ensure accuracy. All analyses were conducted in Brazilian Portuguese to preserve semantic and contextual nuances, and excerpts were translated only at the stage of manuscript preparation. Transcripts were not returned to participants for comments or correction, and participants did not review preliminary findings.

The qualitative material was examined using content analysis, following the procedures described by Burnard et al. (2008), combining deductive and inductive approaches. A preliminary coding framework was first developed based on the study aims and the discussion guide. This was followed by an inductive analytic phase using the cutting-and-sorting technique proposed by Bernard et al. (2016), supported by the MAXQDA software.

In the first step of analysis, two researchers (BCM and BAL) independently read the transcripts and produced analytic memos. Subsequently, one researcher (BCM) conducted open coding, identifying core meanings within each excerpt and constructing a codebook based on the approach proposed by MacQueen et al. (1998) in combination with Burnard's method. The codebook was then reviewed and discussed by BCM and BAL and submitted to validation by the full research team. For the purposes of the present analyses, codes related to healthcare encounters, gender transition, childhood and adolescence, relationship with the body, and professionals' perceptions of the Brazilian Federal Council of Medicine (CFM) resolution were examined (SM2 in Supplementary Material). Reporting followed the COREQ checklist (Tong et al., 2007) (SM3 in Supplementary Material).

After this stage, two researchers (BCM and BAL) independently coded the entire dataset. Interrater agreement was evaluated using Cohen's kappa coefficient (Cohen, 1960). The two coding versions were compared, disagreements were discussed, and a final classification was established by consensus. To document the level of agreement in the finalized coding framework, Cohen's kappa coefficient (Cohen, 1960) was then calculated in MAXQDA based on the final coding of 371 coded segments, using a minimum code overlap rate of 90% at the segment level. The resulting kappa coefficient demonstrated excellent agreement ($\kappa = 0.983$).

Participants' statements were anonymized using the letter P followed by a number (1–15).

RESULTS

Participants' characteristics and context

A total of 15 healthcare professionals participated in the study (Table 1). Participants had a mean age of 47.8 years (SD = 10.2; range 34–64). All identified as cisgender and reported a mean of 7.8 years of experience working with transgender children and adolescents (SD = 4.9; range 0.7–16). Most participants identified as women (73.3%) and as White (60.0%). The sample included psychologists (40.0%), psychiatrists (20.0%), social workers (13.3%), endocrinologists (13.3%), one anthropologist (6.7%), and one nurse (6.7%), reflecting the multidisciplinary nature of gender-affirming care.

Table 1
Characteristics of Participants (n = 15).

	Healthcare professionals (mean or n)	SD [min-max] or %
Age	47.8	10.2 [34–64]
Gender		
Cisgender women	11	73.3
Cisgender men	4	26.7
Race*		
White	9	60.0
"Pardo"/Brown	4	26.7
Black	2	13.3
Occupation		
Anthropologist	1	6.7
Social worker	2	13.3
Psychologist	6	40.0
Psychiatrist	3	20.0
Endocrinologist	2	13.3
Nurse	1	6.7
Years working with transgender children/adolescents (years)	7.8	4.9 [0.7–16]
Outpatient clinic location		
Minas Gerais	2	13.3
Rio de Janeiro	1	6.7
São Paulo	12	80.0
Type of outpatient clinic		
Municipal/State SUS Network	7	46.7
University Hospital SUS	8	53.3

Legend: SD = standard deviation. *Race was self-reported using fixed categories: White, Black, Asian, and “Pardo”/Brown (a term used in Brazil to describe individuals of mixed racial backgrounds). **Some professionals worked across more than one level of care; therefore, frequencies do not total 100%.

	Healthcare professionals (mean or n)	SD [min-max] or %
Level of care**		
Primary	3	20.0
Secondary	12	80.0
Tertiary	6	40.0
Population served		
Children and adolescents	5	33.3
Only adolescents	10	66.7

Legend: SD = standard deviation. *Race was self-reported using fixed categories: White, Black, Asian, and “Pardo”/Brown (a term used in Brazil to describe individuals of mixed racial backgrounds). **Some professionals worked across more than one level of care; therefore, frequencies do not total 100%.

Participants were recruited from services located in three Brazilian states, predominantly São Paulo (80.0%), followed by Minas Gerais (13.3%) and Rio de Janeiro (6.7%). They worked in university hospital services (53.3%) or in municipal or state services (46.7%), all within Brazil’s Unified Health System (SUS), representing different levels of care, including primary, secondary, and tertiary settings. Most professionals worked with adolescents exclusively (66.7%), while the remainder provided care to both children and adolescents (33.3%).

Professionals described working in highly heterogeneous settings, including specialized gender clinics, university-based programs, hospital outpatient services, community mental health services, and primary-care-linked initiatives. Services differed considerably in their history, team composition, referral pathways, and approaches to care. While some were structured around endocrinological follow-up and medical transition, others emphasized psychosocial support, family work, group activities, and coordination with schools and community networks.

Participants also highlighted important differences in the populations served. Some services primarily followed white, middle-class adolescents with substantial family support, whereas others reported caring for socially vulnerable youth from peripheral areas and racialized backgrounds. Several professionals noted that referral mechanisms and local availability of services influenced which children and adolescents were able to access specialized care.

Encounters in healthcare settings

Healthcare encounters were described as extending well beyond direct clinical interactions, encompassing ongoing work with families, schools, legal institutions, and broader protection networks.

Participants portrayed gender-affirming care as a process that unfolds across clinical, social, and institutional contexts, requiring professionals to negotiate multiple demands while maintaining continuity of care.

A recurrent feature of these encounters was the need to articulate care across sectors. Participants described working with schools, the judiciary, professional councils, other healthcare services, and broader protection networks, sometimes assuming responsibilities that extended beyond traditional clinical roles. These activities were portrayed as important for protecting children's and adolescents' rights and maintaining continuity of care, but also as emotionally demanding and time-consuming.

When we think about caring for children, we need to create spaces that are prepared to welcome both children and their families. Once care extends beyond the family, to schools and other social settings, it requires different and often more complex strategies. (...) It is not enough to care for the child in isolation within the clinic. (P13, 40 years old, cisgender woman, psychologist)

Schools were particularly prominent in these accounts, both as settings that could contribute to distress and as potential sites for health promotion and broader social change.

Schools are fundamental in this process, both as spaces that can contribute to distress and as settings that can promote health. We work directly with schools to foster these discussions. Even if our actions are limited, they allow us to engage with the community, and we see that these initiatives have a very positive impact on the lives of the adolescents we follow, as well as many others we would not otherwise reach. (*P6, 37 years old, cisgender man, psychologist*)

Families also emerged as central actors throughout healthcare encounters. Rather than focusing exclusively on children and adolescents, participants described family support, education and guidance as integral to clinical practice. At the same time, professionals acknowledged that families often seek certainty regarding the future, whereas healthcare teams frequently need to work within conditions of uncertainty.

The greatest challenge is managing the anxiety of children and their families. Many arrive seeking specific interventions, but we need to listen to each child and adolescent and develop an individualized care plan. We also need to listen when the adolescent wants to wait. (P12, 41 years old, cisgender man, psychiatrist)

These accounts positioned family work not as an adjunct to clinical care, but as part of the ongoing therapeutic process.

Uncertainty was also repeatedly described as part of everyday care. Participants characterized childhood and adolescence as developmental periods in which definitive answers are rarely possible, requiring professionals to balance protection with openness to future possibilities. Rather than providing certainty, they described their role as creating conditions in which children and adolescents could develop while preserving their well-being (P1, 57 years old, cisgender woman, anthropologist: "Childhood is a space of possibilities.").

Across these accounts, participants described care as extending beyond medical interventions to include emotional support, family guidance, advocacy, protection of rights, educational actions, and coordination with other sectors.

There is a common assumption that if a young person is transgender, they will necessarily need hormone therapy or surgery. But every transition is unique. Gender-affirming clinics are not defined by providing medical procedures alone; they are defined by welcoming children, adolescents, and their families while addressing the many issues that shape their lives. (P13, 40 years old, cisgender woman, psychologist)

These accounts illustrate how the work of gender-affirming care extends across multiple relational and institutional contexts, encompassing forms of support and coordination that are not captured by the provision of specific medical interventions.

Transition process

The transition process was described as a continuous, singular and non-linear experience, marked by different temporalities and developmental needs. Rather than being understood as a specific event or a process restricted to hormone therapy, transition was portrayed as a dynamic trajectory involving social, bodily and relational transformations.

Across the focus groups, participants emphasized that children and adolescents may move through different stages of exploration and affirmation over time. Changes in trajectory were not necessarily interpreted as expressions of uncertainty, failure, or inadequate clinical care, nor were they necessarily understood as changes in gender identity. Rather, participants described them as part of the developmental process itself (P3, 62 years old, cisgender woman, psychologist: "Everyone transitions, and each person does so in their own time.").

Among children, transition was predominantly described through social experiences rather than medical interventions. Changes in names, clothing, participation in gendered activities, family recognition and everyday interactions emerged as central elements of this process. In these accounts, care was directed less toward medical interventions and more toward creating conditions that allowed children to express their identities and participate in social life in more comfortable and affirming ways.

It's really about making those first years more possible and happier. I think the issue of the body comes together with the possibility of broader care. That's what they want to talk about. They want to figure out how they're going to move through the world with our support, and the team needs to be prepared for that different role. (P1, 57 years old, cisgender woman, anthropologist)

In contrast, participants described adolescence as a period in which bodily concerns become increasingly central to the transition process. Hormone therapy frequently emerged as an important expectation among adolescents and their families, making the management of anxiety surrounding bodily changes a recurring challenge reported by professionals (P14, 36 years old, cisgender woman,

nurse: "If they could, they would ask in the very first appointment when they could start hormone therapy."). Narratives also revealed that adolescents commonly sought guidance about bodily changes and their implications for everyday life and sexuality (P1, 57 years old, cisgender woman, anthropologist: "They want to talk about binders, prostheses, and how they will have sex using their penis.").

Across these accounts, professionals described their role as continuously negotiating expectations regarding the possibilities and limits of transition. Unrealistic expectations surrounding hormone therapy were mentioned as recurring in conversations with adolescents.

Overall, transition was portrayed as a process requiring continuous follow-up, negotiation of expectations and recognition of each individual's unique trajectory. Professionals described their work as balancing the wishes of adolescents and their families with the clinical, ethical and regulatory limits that shape gender-affirming care.

Healthcare Professionals' Responses to the New Resolution

Opinions and Feelings

Healthcare professionals overwhelmingly perceived CFM Resolution No. 2,427/2025 as misaligned with the clinical practice and model of care they had developed with transgender children and adolescents. Rather than viewing the resolution simply as a restriction on specific medical interventions, participants described it as removing a resource that professionals understood as central to patients' well-being.

It is a form of violence; yet another institutional and political act of violence against this population because it deprives us of a resource that is invaluable as emotional life support. (P13, cisgender woman, 40 years, psychologist)

Participants also questioned the scientific basis underpinning the resolution. They argued that the evidence used to support its recommendations was selective, misinterpreted, and methodologically weak. In particular, professionals questioned estimates of regret and detransition, arguing that discontinuing follow-up at a public healthcare service should not necessarily be interpreted as regret about gender transition or a desire to detransition.

The cases classified as regret were not cases in which people requested detransition or a new transition, but cases in which people stopped attending the service. That is a very significant distinction, including in the discourse. (P1, 57 years old, cisgender woman, anthropologist)

More broadly, participants argued that the evidence underpinning the resolution did not adequately reflect the Brazilian model of care for transgender children and adolescents. They emphasized that specialized Brazilian services provide continuous longitudinal follow-up, regular multidisciplinary assessments, and individualized clinical decision-making tailored to each patient's needs.

For example, when puberty suppression is prescribed, there are concerns about bone health. The medication used is the same one prescribed for children with precocious puberty. Because it is used for a longer period, it may indeed have effects on bone health. However, these patients are monitored extremely closely, with continuous examinations. The care is so rigorous, specialized, and carefully delivered that it is difficult to understand why a regulation would prohibit something that has been achieved through such careful practice and that has enormous value for these individuals. (P15, cisgender woman, 55 years, psychologist)

Ideological influences on the decision-making process, particularly in relation to the rise of political conservatism in Brazil, were perceived by most participants (P3, cisgender woman, 62 years old, psychologist: “What we are witnessing is a situation in which politics is interfering where it should not. What should prevail is healthcare, above any ideology - the well-being of patients.”). Participants viewed this as undue interference by the CFM in public policy development and as part of a progressive weakening of the Ministry of Health as a technical body, with increasing political influence over healthcare decisions. In this context, some participants expressed concern about the potential broader social consequences of conservative ideologies' growing influence on clinical practice (P15, cisgender woman, 55 years old, psychologist: “Everyone is afraid. People are afraid of what might happen next. If a right that I once had can be taken away, what else could happen?”).

Healthcare professionals reported feelings of helplessness, powerlessness, and indignation as the predominant emotional responses to the new resolution. They described being particularly affected by their inability to adequately address the distress and suffering experienced by their patients, despite their confidence in the quality of the care they provide and their disagreement with the rationale underlying the resolution (P12, cisgender man, 41 years old, psychiatrist: “We feel, in a way, controlled by something we fundamentally disagree with.”).

Actions and positioning

In response to the new resolution, healthcare professionals described adopting several strategies to ensure the continuity of care for transgender children and adolescents while remaining compliant with the current legal framework. They described relying on mutual professional support by sharing experiences, exchanging clinical perspectives, and engaging in collective advocacy against the resolution.

Following the enactment of the CFM resolution, most services discontinued puberty suppression and gender-affirming hormone therapy for patients under 18. One service, however, interpreted the transitional provision differently, understanding “follow-up care” as comprehensive multidisciplinary care rather than as ongoing medical treatment. Under this interpretation, adolescents already enrolled in the service were considered to be under ongoing care and could continue along their clinical pathways.

We read the resolution and adopted what we believed was a reasonable interpretation. The resolution stated that nothing would change for adolescents who were already receiving follow-up care. For us, follow-

up begins the moment a patient enters our service - they are already under our care. We did not interpret follow-up as meaning hormone treatment alone; we understood it as comprehensive care. Therefore, from the moment they entered our service, they were already receiving follow-up care. If they would only become eligible for puberty blockers two or three years later because of their age, they were still already under follow-up. [...] We believed we were acting within the resolution because, when it states that someone must already be receiving follow-up, it is referring to care. And care is provided by the entire multidisciplinary team, not restricted to hormone therapy. (P1, cisgender woman, 57 years old, anthropologist)

Most services, however, understood that both puberty suppression and hormone therapy were prohibited for patients under 18 unless treatment had begun before the resolution took effect. In these circumstances, professionals informed families about the possibility of seeking access to these medical interventions through individual legal action, and multidisciplinary teams prepared medical reports and expert opinions, contributed with technical documentation, and participated in court hearings as specialized expert services. Professionals also emphasized providing emotional support and a welcoming environment for families through active listening.

In the context of these restrictions, harm reduction emerged as another important strategy adopted by healthcare teams. Professionals described providing guidance on the risks associated with unsupervised use of gender-affirming hormones and helping patients make informed decisions by discussing the potential risks and benefits of different healthcare choices.

What I used to do before, until they reached 16, and what I do now until they reach 18, is essentially harm reduction - talking about the risks. When they start relying heavily on information from the internet, I tell them: that person is not responsible for your health. I've seen transgender girls applying estrogen gel three times a day. I tell them, 'You're going to end up with a thrombosis because you're using so much estrogen just to try to develop more breast tissue.' (P7, cisgender woman, 53 years old, endocrinologist),

Finally, participants emphasized the growing need to invest in the training of healthcare professionals with expertise in transgender health, particularly in the care of children and adolescents. They also highlighted the importance of disseminating scientifically grounded information across healthcare and other professional fields as a strategy to counter misinformation and politically driven narratives surrounding transgender healthcare.

Impact on clinical practice

Healthcare professionals reported that the new resolution had affected clinical practice, including both the organization of healthcare services and the mental health of transgender children, adolescents, and their families. The most frequently described consequences were related to mental health, including increased psychological distress, anxiety, fear, and uncertainty among patients, with some participants reporting cases of suicidal ideation. Participants also reported an increased demand for psychiatric care.

It deprives us of a resource - a resource that is invaluable as emotional life support. Access to this type of treatment is not only a mental health resource but also a resource for overall well-being. (P13, cisgender woman, 40 years old, psychologist)

According to participants, many patients experienced frustration due to restrictions on access to care, which, in their view, increased the risk of self-medication and the unsupervised use of gender-affirming hormones, particularly among adolescents approaching the age of 16 years, the age at which hormone therapy had been permitted under the previous regulation.

The adolescent will no longer receive healthcare; instead, they will turn to the unregulated market. They do not care about the law. They are far more concerned with coping with the desperation they are experiencing. As a result, they will lose access to proper healthcare, placing themselves at considerable risk. (P15, cisgender woman, 55 years old, psychologist)

The resolution also required healthcare services to reorganize their clinical practice in order to respond to demands arising from the regulation itself. Many services became involved in legal proceedings initiated by patients and their families, while also having to closely monitor successive regulatory changes, which participants described as inconsistent and evolving over time.

We continue providing care and doing our work, but instead of helping these families move forward, we now have to deal with this new demand - the fear and anxiety about what might happen next, knowing that they no longer have access to certain rights and that the age requirements for treatment have changed. These new demands, in my view, end up delaying the entire mental healthcare process and the developmental trajectory of these families. (P12, cisgender man, 41 years old, psychiatrist)

Taken together, participants described the regulatory change as affecting not only access to specific medical interventions, but also the organization, continuity, and broader therapeutic work of gender-affirming care.

DISCUSSION

This study explored how healthcare professionals understand and provide care for transgender children and adolescents as well as how they perceived and responded to CFM Resolution No. 2,427/2025 and how the regulation affected their provision of gender-affirming care in Brazil. Overall, participants perceived a marked mismatch between the regulatory framework and the clinical model of care they had developed with transgender children and adolescents. Rather than viewing the resolution as a discrete restriction on specific medical interventions, professionals described it as a regulatory change that disrupted a broader, longitudinal, multidisciplinary, and relational model of care. This mismatch was particularly evident in the divergent interpretations of the resolution's transitional clause and in the reorganization of clinical practice that followed its implementation.

Consistent with international guidelines (Coleman et al., 2022; Rafferty, 2018), participants described multidisciplinary follow-up as a therapeutic process that includes psychological support, family work, developmental assessment, shared decision-making, and ongoing negotiation of expectations. Within this perspective, the value of longitudinal care does not depend on whether it ultimately culminates in puberty suppression or hormone therapy. Instead, accompanying children, adolescents, and families through developmental uncertainty was itself understood as one of the primary goals of gender-affirming practice (Belmont et al., 2024; Malpas et al., 2022; Puckett et al., 2019; Riggs et al., 2020; Stamm, 2026).

This understanding of care also helps explain one of the most interesting findings of the present study: the markedly different interpretations professionals gave to the resolution's transitional clause regarding adolescents already "under follow-up". Rather than reflecting merely different legal strategies or political positions, these interpretations emerged from different conceptions of what constitutes care itself. For the service that understood follow-up as beginning with entry into multidisciplinary care, regardless of whether hormonal treatment had started, this interpretation reflected an established clinical model in which accompaniment, rather than medication, defines the therapeutic process. Thus, ambiguous regulatory language interacted with pre-existing clinical viewpoints, producing different yet internally coherent forms of implementation across services.

The uncertainty introduced by the new regulation therefore extended beyond questions of legal interpretation and became embedded in professionals' everyday clinical work. Participants described repeatedly having to negotiate between scientific evidence, professional ethics, institutional policies, regulatory ambiguity, and the expectations of adolescents and their families. Rather than involving isolated treatment decisions, clinical practice became characterized by continuous justification, documentation, and negotiation across multiple audiences with different understandings of what constitutes appropriate care. Within this context, professionals frequently reported feelings of helplessness, powerlessness, and indignation, experiences consistent with descriptions of moral distress among providers of gender-affirming care working under legislative restrictions elsewhere (Stamm et al., 2025).

This mismatch may partly reflect the narrow biomedical framing of pediatric gender-affirming care in public and regulatory debates. While these debates have largely focused on puberty suppression and hormone therapy (NHSE, 2024), participants described care as encompassing a broader set of relational, psychosocial, and institutional practices, including family support, school liaison, advocacy, harm reduction, and coordination across services. Similar dimensions have been described by transgender adolescents and their families (Belmont et al., 2024; Brecht et al., 2025; Hale et al., 2021; Malpas et al., 2022; Puckett et al., 2019).

Importantly, participants described the resolution as reshaping not only treatment eligibility but also the organization of everyday clinical work. Rather than simply restricting access to puberty suppression or hormone therapy, the new regulation redirected professionals' efforts toward responding to families'

uncertainty, producing technical reports, participating in legal proceedings, monitoring successive regulatory changes, and expanding psychiatric and psychosocial support. These findings suggest that restrictive policies affect healthcare services not only through the treatments they prohibit, but also by transforming how professional time, attention, and institutional resources are allocated. Similar patterns have been described among providers working under legislative restrictions in other countries, where legal uncertainty and documentation demands became major drivers of clinical disruption and professional distress (Stamm et al., 2025).

Another noteworthy finding concerns the emergence of harm reduction as an important clinical strategy following the resolution. Rather than abandoning adolescents who could no longer access medical interventions, professionals described providing guidance about the risks of unsupervised hormone use and supporting safer decision-making. These concerns resonate with those expressed by transgender adolescents and caregivers in our previous study, who similarly described restrictive access to gender-affirming care as potentially increasing psychological distress, uncertainty, and the risk of seeking hormones outside formal healthcare settings (Mazzolani, Cordeiro de Oliveira, et al., 2025). This convergence is important because it suggests that the consequences identified by healthcare professionals were not restricted to the clinical perspective, but were also experienced and anticipated by young people and their caregivers. Nevertheless, these perspectives appear to have been insufficiently considered in the regulatory process.

The findings are also consistent with international studies showing that barriers to gender-affirming care, including restrictive clinical pathways, long waiting times, and limited access to specialized services, may increase the likelihood that transgender individuals seek hormones outside formal healthcare systems (Burgwal et al., 2019; Burgwal & Motmans, 2021; Kearns et al., 2021). Data from the U.S. Transgender Survey similarly indicate that a substantial proportion of transgender people report previous use of non-prescribed hormones because of barriers to healthcare, including cost, limited access to knowledgeable providers, and anticipated discrimination within healthcare settings (James et al., 2016; James et al., 2024). Recent qualitative research further suggests that, in these contexts, transgender communities often develop informal networks to exchange information about hormone use, dosing, laboratory monitoring, and strategies to reduce the risks associated with self-managed treatment (August-Rae et al., 2024). In this context, the harm-reduction practices described by professionals can be understood as an attempt to preserve therapeutic relationships and reduce foreseeable risks when access to formal treatment is restricted.

Considered alongside our previous findings from transgender adolescents and caregivers (Mazzolani, Cordeiro de Oliveira, et al., 2025), the present results point to a consistent misalignment between the regulatory framework established by Resolution No. 2,427/2025 and the perspectives of those directly involved in gender-affirming care. While adolescents and caregivers described the implications of the resolution in relation to their needs, experiences, and access to care, healthcare professionals emphasized the challenges it posed to clinical practice, continuity of care, and the provision of appropriate support. Taken together, these findings suggest that the resolution has implications across

the care process, affecting both those seeking care and those responsible for providing it. The convergence of perspectives across these studies reinforces the importance of incorporating the experiences and needs of transgender young people, their families, and healthcare professionals into policy development and the regulation of gender-affirming care.

Implications for Policy and Practice

Taken together, these findings carry important implications for the regulation of pediatric gender-affirming care. First, regulatory frameworks should recognize that pharmacological interventions do not constitute the entirety of gender-affirming care, while also recognizing that the possibility of accessing puberty suppression or gender-affirming hormone therapy, when clinically indicated, may be an important component of comprehensive care. Participants described these interventions as embedded within a broader model of longitudinal, multidisciplinary, and relational care rather than as isolated treatments (Coleman et al., 2022; Rafferty, 2018). Thus, framing gender-affirming care primarily around the prescription of specific medical interventions risks overlooking the broader care process, whereas restricting access to these interventions may also compromise the comprehensiveness and continuity of care for adolescents who may benefit from them. Second, regulatory changes should provide clear and consistent guidance for clinical practice. In the present study, ambiguity in the interpretation of the resolution's transitional provision contributed to heterogeneous approaches across services, with professionals adopting different interpretations of who could continue treatment. This normative uncertainty had consequences beyond clinical decision-making, generating legal insecurity for professionals and increasing uncertainty and anxiety among adolescents and their caregivers. Clearer implementation guidance is therefore essential to reduce variability in clinical conduct and to protect continuity of care. Third, institutions and professional bodies should anticipate that abrupt regulatory changes can place healthcare professionals in positions of sustained moral, clinical, and legal uncertainty. Mechanisms such as clear implementation guidance, legal support, and structured spaces for professional debriefing may help mitigate these effects, particularly in contexts where providers must reconcile regulatory requirements with clinical judgment and patients' needs (Stamm et al., 2025). Finally, policymakers seeking to regulate pediatric gender-affirming care should engage directly with the perspectives of those who provide, receive, and support this care. Considered alongside our previous findings with transgender adolescents and caregivers, the present results suggest a broader misalignment between the regulatory framework and the perspectives of key actors involved in gender-affirming care. Regulatory decisions should therefore incorporate clinical expertise, the lived experiences of transgender young people and their families, and the practical realities of care delivery. In Brazil, the findings of this study reinforce calls to reassess Resolution No. 2,427/2025 in light of emerging evidence and its potential implications for gender-affirming care.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, although professionals from services across Brazil were invited, all participants were ultimately recruited

from the Southeast region, limiting the transferability of the findings to other regions with potentially different healthcare infrastructures, access to specialized services, and sociocultural contexts. Recruitment also depended on professionals' availability and willingness to participate, which may have introduced self-selection bias. In particular, professionals with stronger views about Resolution No. 2,427/2025 may have been more likely to participate, potentially influencing the perspectives represented in the study. Second, the sample was relatively small, and some focus groups included fewer participants than initially planned because of difficulties coordinating schedules among specialized professionals. One focus group included only two participants, which may have limited the diversity of perspectives and opportunities for interaction compared with larger groups. Although the multidisciplinary composition of the sample contributed to the diversity of perspectives, the findings may not capture the full range of professional experiences and interpretations. In addition, all participants identified as cisgender, meaning that the study did not capture the perspectives of transgender and non-binary healthcare professionals. Third, some participants were affiliated with AMTIGOS, where members of the research team also worked clinically or conducted research. These pre-existing professional and institutional relationships, together with the research team's prior involvement in discussions concerning the resolution, may have influenced recruitment, group interactions, or data interpretation. Although the team engaged in reflexive discussions throughout data collection and analysis, the potential influence of these relationships and prior perspectives cannot be entirely excluded. Finally, the reported consequences of the resolution for patients' mental health, including psychological distress and suicidal ideation, as well as concerns about self-medication and unsupervised hormone use, were based on healthcare professionals' accounts rather than direct assessments of patients or systematic measurements of these outcomes. These findings therefore reflect professionals' perceptions and clinical experiences and should not be interpreted as establishing the incidence, magnitude, or causal effects of the regulatory changes on these outcomes. As a qualitative study, the aim was not statistical generalization, but an in-depth exploration of professional perspectives on gender-affirming care within a specific regulatory and healthcare context.

CONCLUSION

In conclusion, our findings suggest that the effects of Resolution No. 2,427/2025 extend beyond restrictions on specific medical interventions. Healthcare professionals described the regulation as disrupting a broader model of longitudinal, multidisciplinary, and relational care, while generating uncertainty in clinical decision-making and reshaping the organization of everyday practice. The findings also highlight how restrictive regulatory frameworks may create unintended consequences, including increased reliance on harm-reduction practices and disruption of continuity of care. More broadly, the study underscores the importance of understanding gender-affirming care as a process that extends beyond pharmacological interventions and depends on stable therapeutic relationships, multidisciplinary support, and clear regulatory guidance.

DECLARATIONS

Funding: BCM was supported by São Paulo Research Foundation – FAPESP (grant # 2024/09028-0). The other authors are supported by the São Paulo Research Foundation (FAPESP), the National Council for Scientific and Technological Development (CNPq), and the Coordination for the Improvement of Higher Education Personnel (CAPES), however these funding had no role in the preparation of this manuscript.

Competing Interests: The authors have no relevant financial or non-financial interests to disclose.

Author Contributions: All authors had full access to all of the data in the study and took responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Gualano, Saadeh, Roschel, Scagliusi, Mazzolani.

Acquisition, analysis, or interpretation of data: Mazzolani, Longobardi, Sabatini, Evangelista, Oliveira, Torres, Bittar, Lage, Baratojo, Arantes.

Critical review of the manuscript for important intellectual content: All authors.

Administrative, technical, or material support: Saadeh, Scagliusi.

Supervision: Gualano, Saadeh, Roschel, Scagliusi.

Ethics approval: The study received approval from the local Ethics Committee (Commission for Analysis of Research Projects – CAPPesq; approval number: 83553224.2.0000.0068).

Consent to participate: Informed consent was obtained from all individual participants included in the study.

Data Sharing Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

REFERENCES

1. August-Rae BC, Baker JT, Buzzanell PM (2024) Not just rebellious, it's revolutionary: Do-it-yourself hormone replacement therapy as Liberatory Harm Reduction. Soc Sci Med 345:116681. https://doi.org/https://doi.org/10.1016/j.socscimed.2024.116681
2. Belmont N, Cronin TJ, Pepping CA (2024) Affirmation-support, parental conflict, and mental health outcomes of transgender and gender diverse youth. Int J Transgend Health 25(1):50–62. https://doi.org/10.1080/26895269.2023.2252418
3. Bernard HR, Wutich A, Ryan GW (2016) Analyzing qualitative data: Systematic approaches. Sage
4. Brecht A, Amacha M, Richter JA, Winter SM, Calvano C (2025) And I don't know how I can protect him from everything that's coming - A qualitative study on minority stress among parents of transgender adolescents. BMC Psychiatry 25(1):419. https://doi.org/10.1186/s12888-025-06822-3

5. Burgwal A, Gvianishvili N, Hård V, Kata J, García Nieto I, Orre C, Smiley A, Vidić J, Motmans J (2019) Health disparities between binary and non binary trans people: A community-driven survey. Int J Transgend 20(2–3):218–229. https://doi.org/10.1080/15532739.2019.1629370
6. Burgwal A, Motmans J (2021) Trans and gender diverse people's experiences and evaluations with general and trans-specific healthcare services: a cross-sectional survey. Int J Impot Res 33(7):679–686
7. Burnard P, Gill P, Stewart K, Treasure E, Chadwick B (2008) Analysing and presenting qualitative data. Br Dent J 204(8):429–432. https://doi.org/10.1038/sj.bdj.2008.292
8. Cass H (2024) Independent review of gender identity services for children and young people: Final report (Cass Report)
9. Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J (2023) Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. N Engl J Med 388(3):240–250. https://doi.org/10.1056/NEJMoa2206297
10. CNH (2025) *Children's National Hospital Statement on Executive Order*. Washington https://www.childrensnational.org/about-us/newsroom/2025/statement-on-executive-order?utm
11. Cohen J (1960) A coefficient of agreement for nominal scales. Educ Psychol Meas 20(1):37–46. https://doi.org/10.1177/001316446002000104
12. Coleman E, Radix AE, Bouman WP, Brown GR, De Vries ALC, Deutsch MB, Ettner R, Fraser L, Goodman M, Green J, Hancock AB, Johnson TW, Karasic DH, Knudson GA, Leibowitz SF, Meyer-Bahlburg HFL, Monstrey SJ, Motmans J, Nahata L, Nieder TO, Reisner SL, Richards C, Schechter LS, Tangpricha V, Tishelman AC, Van Trotsenburg MAA, Winter S, Ducheny K, Adams NJ, Adrián TM, Allen LR, Azul D, Bagga H, Başar K, Bathory DS, Belinky JJ, Berg DR, Berli JU, Bluebond-Langner RO, Bouman MB, Bowers ML, Brassard PJ, Byrne J, Capitán L, Cargill CJ, Carswell JM, Chang SC, Chelvakumar G, Corneil T, Dalke KB, De Cuypere G, De Vries E, Den Heijer M, Devor AH, Dhejne C, D'Marco A, Edmiston EK, Edwards-Leeper L, Ehrbar R, Ehrensaft D, Eisfeld J, Elaut E, Erickson-Schroth L, Feldman JL, Fisher AD, Garcia MM, Gijs L, Green SE, Hall BP, Hardy TLD, Irwig MS, Jacobs LA, Janssen AC, Johnson K, Klink DT, Kreukels BPC, Kuper LE, Kvach EJ, Malouf MA, Massey R, Mazur T, McLachlan C, Morrison SD, Mosser SW, Neira PM, Nygren U, Oates JM, Obedin-Maliver J, Pagkalos G, Patton J, Phanuphak N, Rachlin K, Reed T, Rider GN, Ristori J, Robbins-Cherry S, Roberts SA, Rodriguez-Wallberg KA, Rosenthal SM, Sabir K, Safer JD, Scheim AI, Seal LJ, Sehoole TJ, Spencer K, St. Amand, Steensma C, Strang TD, Taylor JF, Tilleman GB, T'Sjoen K, Van Mello GG, Veale NM, Vencill JF, Vincent JA, B., Wesp, L. M., West, M. A., Arcelus J (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1-S259. https://doi.org/10.1080/26895269.2022.2100644
13. Gualano B, Mazzolani C, Longobardi B, Roschel I, H., Saadeh A (2026) Centering transgender voices as a path to equitable healthcare. Lancet Reg Health Am 56:101391. https://doi.org/10.1016/j.lana.2026.101391

14. Gutiérrez JMG, Dusic E, Bambilla AJK, Restar AJ (2024) A Narrative Synthesis Review of Legislation Banning Gender-Affirming Care. Curr Pediatr Rep 12(3):44–51. https://doi.org/10.1007/s40124-024-00320-y
15. Hale AE, Chertow SY, Weng Y, Tabuenca A, Aye T (2021) Perceptions of Support Among Transgender and Gender-Expansive Adolescents and Their Parents. J Adolesc Health 68(6):1075–1081. https://doi.org/10.1016/j.jadohealth.2020.11.021
16. Hendricks ML, Testa RJ (2012) A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. Prof Psychology: Res Pract 43(5):460–467. https://doi.org/10.1037/a0029597
17. James S, Herman J, Rankin S, Keisling M, Mottet L, Anafi M (2016) *The Report of the 2015 US Transgender Survey* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf
18. James S, Herman JL, Durso LE, Heng-Lehtinen R (2024) Early insights: A report of the 2022 US transgender survey
19. Kearns S, Kroll T, 'Shea O, D., Neff K (2021) Experiences of transgender and non-binary youth accessing gender-affirming care: A systematic review and meta-ethnography. PLoS ONE, 16(9), e0257194
20. Kraschel KL, Chen A, Turban JL, Cohen IG (2022) Legislation restricting gender-affirming care for transgender youth: Politics eclipse healthcare. Cell Rep Med 3(8):100719. https://doi.org/10.1016/j.xcrm.2022.100719
21. Longobardi I, Mazzolani BC, Roschel H, Gualano B, Saadeh A (2025) The global rollback of transgender care, science and rights. Nat Med. https://doi.org/10.1038/s41591-025-03805-5
22. MacQueen KM, McLellan E, Kay K, Milstein B (1998) Codebook development for team-based qualitative analysis. Cam J 10(2):31–36. https://doi.org/10.1177/1525822X980100020301
23. Malpas J, Pellicane MJ, Glaeser E (2022) Family-Based Interventions with Transgender and Gender Expansive Youth: Systematic Review and Best Practice Recommendations. Transgend Health 7(1):7–29. https://doi.org/10.1089/trgh.2020.0165
24. Masson M (2025) Important update to our care services. Univ Mich Med School https://medschool.umich.edu/news-release/important-update-our-care-services?utm
25. Mazzolani BC, Cordeiro de Oliveira L, Longobardi I, Infante Smaira F, Sabatini F, Evangelista Bandeira de Melo F, Bittar S, Helena Torres T, Scagliusi B, Saadeh F, Roschel A, H., Gualano B (2025) I feel under attack: Transgender pre- and adolescents and caregivers opposition to restrictions on gender-affirming medical care in Brazil. Int J Transgender Health 1–16. https://doi.org/10.1080/26895269.2025.2573035
26. Mazzolani BC, Longobardi I, Saadeh A, Roschel H, Gualano B (2025) A Rapid Assessment of Stakeholder Agreement with Brazil's New Gender-Affirming Care Restrictions. *Clinics*(In press)
27. RESOLUÇÃO CFM nº 2.265/2019 (2019) https://sistemas.cfm.org.br/normas/arquivos/resolucoes/BR/2019/2265_2019.pdf

28. RESOLUÇÃO CFM N° 2.427/2025, DE 8 DE ABRIL DE (2025) (2025) https://sistemas.cfm.org.br/normas/arquivos/resolucoes/BR/2025/2427_2025.pdf
29. Meyer IH (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull 129(5):674. https://doi.org/10.1037/0033-2909.129.5.674
30. Clinical policy: puberty suppressing hormones (2024) https://www.england.nhs.uk/publication/clinical-policy-puberty-suppressing-hormones/
31. Noone C, Southgate A, Ashman A, Quinn É, Comer D, Shrewsbury D, Ashley F, Hartland J, Paschedag J, Gilmore J, Kennedy N, Woolley TE, Heath R, Goulding B, Simpson R, Kiely V, Coll E, White S, Grijseels M, Ouafik DM, M., McLamore Q (2025) Critically appraising the cass report: methodological flaws and unsupported claims. BMC Med Res Methodol 25(1):128. https://doi.org/10.1186/s12874-025-02581-7
32. Olson-Kennedy J, Chan YM, Garofalo R, Spack N, Chen D, Clark L, Ehrensaft D, Hidalgo M, Tishelman A, Rosenthal S (2019) Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study. JMIR Res Protoc 8(7):e14434. https://doi.org/10.2196/14434
33. Puckett JA, Matsuno E, Dyar C, Mustanski B, Newcomb ME (2019) Mental health and resilience in transgender individuals: What type of support makes a difference? J Fam Psychol 33(8):954–964. https://doi.org/10.1037/fam0000561
34. Rafferty J (2018) Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics 142(4). https://doi.org/10.1542/peds.2018-2162
35. Riggs DW, Bartholomaeus C, Sansfaçon AP (2020) If they didn't support me, I most likely wouldn't be here': Transgender young people and their parents negotiating medical treatment in Australia. Int J Transgender Health 21(1):3–15. https://doi.org/10.1080/15532739.2019.1692751
36. Stamm L (2026) Supporting Providers Who Care for Transgender and Gender-Diverse Youth: A Guide for Institutions. J Pediatr 289:114903. https://doi.org/10.1016/j.jpeds.2025.114903
37. Stamm L, Shirin A, Muneath I, Daly C, Daniello M (2025) Moral Distress Among Gender-Affirming Care Providers for Transgender and Gender-Diverse Youth. J Adolesc Health 77(6):1160–1167. https://doi.org/https://doi.org/10.1016/j.jadohealth.2025.08.014
38. Tong A, Sainsbury P, Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care 19(6):349–357. https://doi.org/10.1093/intqhc/mzm042
39. Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K (2022) Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open 5(2):e220978. https://doi.org/10.1001/jamanetworkopen.2022.0978

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SUPPLEMENTARYMATERIALSV2.docx