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Trans men and paternal pregnancy: experiences during the pregnancy-puerperal period

Rebeca Nascimento dos Santos Mascarenhas (http://orcid.org/0000-0001-6155-0290) [1]
Vitória Valéria Cristo Santos (http://orcid.org/0000-0002-6374-9532) [2]
Bruno Silva de Santana (http://orcid.org/0009-0003-6501-2432) [3]
Anne Alencar Monteiro (http://orcid.org/0000-0002-5769-845X) [4]
Telmara Menezes Couto (http://orcid.org/0000-0001-6836-8563) [1]
Anderson Reis de Sousa (http://orcid.org/0000-0001-8534-1960) [1]
Danilo Martins Roque Pereira (http://orcid.org/0000-0002-0962-2127) [5]
Lilian Conceição Guimarães de Almeida (http://orcid.org/0000-0001-6940-9187) [1]

Abstract *This study aims to analyze the experiences of a transgender man during the gestational-puerperal period and the perspective of obstetric nurses in training based on the dynamics and organization of obstetric healthcare in a hospital setting. This qualitative study is based on a case study approach, employing interviews and direct observations to collect data. The analysis was based on the theoretical and normative framework of the Nursing Process, the Theory of Caring, and the theoretical/critical perspective of transfeminism. The results are organized into six categories: Transgender man in the context of pregnancy, childbirth, and postpartum; partnership and parental dimensions; dilemmas faced by the pregnant couple; impressions recorded by the nursing professional; understanding of the case through a theoretical and epistemological lens; implications for healthcare professionals. We underscore the need to promote spaces for continuing education among healthcare professionals and to reformulate legislation in a way that enables the development of public policies based on respect for diversity and equitable care, recognizing the transgender population's specificities in the contexts of pregnancy, childbirth, and postpartum.*

Key words *Parenting, Paternity, Transgender Persons, Sexual and Gender Minorities, Outcome assessment in Healthcare*

[1] Escola de Enfermagem, Universidade Federal da Bahia (UFBA). R. Basílio da Gama 241, Canela. 40231-300 Salvador BA Brasil. rebeca.nascimento@ufba.br
[2] Departamento de Ciências da Vida, Universidade do Estado da Bahia. Salvador BA Brasil.
[3] Universidade Estadual de Feira de Santana. Feira de Santana BA Brasil.
[4] UFBA. Salvador BA Brasil.
[5] Programa de Pós-Graduação em Enfermagem, Universidade Federal de Pernambuco. Recife PE Brasil.

Introduction

This study was developed from the organization of care and health practices dedicated to trans men and their partners in the context of parenting during the pregnancy-puerperal period. The "parenting" concept transcends the borders of biological ties and broadens the idea of family to include families of people of different gender identities[1]. The "transparenting" term emerged in this context, which involves families made up of trans people and challenges cisheteronormative standards, promoting greater diversity in the parenting conception and experience[2].

The "trans" term refers to the transgender population, encompassing people with gender identities and expressions different from those assigned at birth[3]. Thus, gender transition involves several heterogeneous and non-linear factors in which self-identification plays a central role but does not necessarily involve behavioral, legal, or bodily changes.

In Brazil, health protocols for trans people are generally based on pathologizing perspectives, which do not reflect the complexity of individual experiences[4]. In this context, the "paternal pregnancy" concept underscores the possibility of trans men becoming fathers through pregnancy[5,6]. This term is based on the theoretical/critical and epistemological perspective of transmasculinity transfeminism, which emerged to encompass the demands and specificities of trans men and transmasculine people within transfeminism[7]. Therefore, trans men pregnancy challenges traditional masculinity and femininity notions, with profound implications for motherhood and fatherhood conceptions[8].

The theoretical and normative framework of the Nursing Process was used regarding the analysis for solving the problems highlighted in the case, defined by the Federal Nursing Council as "a method that guides the nurse's critical thinking and clinical judgment, directing the nursing team to care for the individual, family, community, and special groups"[9]. The Nursing Process framework was also used because it is considered a powerful strategy for clinical teaching and strengthening the use of a standardized language in health[10].

In this context, we applied the assumptions of the Theory of Caring proposed by Kristen Swanson, developed in 1988 on the American scene using the inductive method, which has been widely used in obstetric practice, mainly by Nursing professionals, focusing on caring processes as interventions to be implemented in Nursing[11-13].

This theoretical framework can support the construction of a relationship between professional and patient, organizing care, and advocates stages for reflection on care and its dimensions: "know", "be with", "do for", "enable", and "keep the belief"[13]. This practice is consistent with and essential for promoting inclusive care that respects the complexities of pregnancy, childbirth, and the puerperium for trans men[14].

This study aims to analyze the experiences of a trans man during the pregnancy and puerperal period and the perspective of obstetric nurses in training based on the dynamics and organization of obstetric healthcare in a hospital environment, providing insight into the healthcare needs and barriers faced by pregnant trans men and underscores the importance of respecting individual experiences in the healthcare environment.

Methods

This qualitative, narrative, and reflective case study of everyday professional experiences involves an in-depth investigation of real life and contexts that deserve attention[15,16].

It was conducted in a capital city in the Brazilian Northeast, where the trajectory of an adult trans man during the pregnancy and puerperal period was followed in public health services (outpatient, hospital, and specialized care).

The participant was intentionally recruited based on the inclusion criteria of being an adult trans man who experienced pregnancy and prenatal care with their partner. No exclusion criteria were applied as this was a single case study.

The research team comprised transgender and cisgender people with Nursing Obstetric Residency, Master's and Ph.D. in Social Sciences, Anthropology, Nursing, Physical Education, and Law. Part of the team directly accessed the participant, returning the collected material to them for appraisal.

Data production involved different methodological strategies for triangulating data sources, gaining a more comprehensive understanding of the event, and locating data consistency and validity: 1. Field notes recorded from the residency training experiences (conducted in a coordinated fashion and guided by a roadmap); 2. Completing an analytical matrix (study planning, project development by determining the model, the stages, and the required instruments); and 3. Val-

idation, sharing the data collection/analysis, and construction of the study[16].

Data collection was followed by an instructional roadmap for preparing the clinical case study (Case identification, formulating the guiding questions, a summary of problems identified, theoretical basis, alternatives or proposals, actions implemented or recommended, and case discussion)[17].

Subsequently, we adopted a structured form (sociodemographic, identity, work, and health questions - gynecological, obstetric, and puerperal aspects) and open-ended questions targeting the experiences of the pregnancy-puerperal period, parenthood/parenting, and the affective-marital relationship. Moreover, an in-depth interview (couple dynamics and parenting) was conducted in two stages, using the audiovisual resource on the WhatsApp application. The thematic categories were then derived through data saturation, considering the occurrence, convergence, and complementarity regarding reflexivity.

The participant was approached during a collaborative activity on transparenting (a group of trans men, health services, activists, universities, and civil society representatives). The participant was informed and invited to participate in the study. The Informed Consent Form was applied, and consent was granted. Subsequently, the collection procedures were scheduled, guaranteeing autonomy, convenience, and confidentiality.

The audios lasted 110 minutes, were transcribed verbatim, and processed using NVIVO12 software, which allowed the generation of theoretical codes (nodes), streamlining the data coding process. No images were employed to analyze the data. This procedure was organized by two researchers to systematize the data, grouping it by units of meaning concerning standardization by thematic content based on the establishment of a *corpus* of analysis.

Data were submitted to Thematic Content Analysis, as proposed by Bardin[18] to identify emerging themes and patterns: Trans men in the context of pregnancy, childbirth, and the puerperium; partnership and parental dimensions; the pregnant couple's dilemmas; impressions recorded by the nursing professional; understanding the case from a theoretical and epistemological lens; implications for health professionals.

The results were analyzed from the theoretical and normative framework of the Nursing Process, the Theory of Caring proposed by Kristen Swanson, and the theoretical/critical perspective of transfeminism[11-13]. Strategies such as peer review (researchers who developed the study), review by transgenderism and health experts, study participants' analysis, and the research team's reflexivity were adopted to guarantee the generated data's (study results) credibility. In this sense, the transferability of the results was addressed through a detailed description of the case study's context and the participants. The detailed information recording, methodological procedures, and research decisions ensured the study's reliability.

Ethical aspects were complied with at all stages of the study. The Research Ethics Committee approved the project under CAAE 11851619.2.0000.5531 and Opinion No. 3.960.330. The Brazilian legislation in force for the development of human research and the recommendations issued by the National Research Ethics Committee for conducting case studies were respected. Generic descriptions of the participants have been used to preserve their image, integrity, and anonymity. No additional information was included in the case in order to ensure its veracity, reliability, and internal validity, preserving the sociocultural sensitivity of the investigated experience.

Results and discussions

The results of this research were structured from the description of the guiding questions formulated, outlined by the summary of the survey of problems, changes identified, the theoretical framework, presenting alternatives, and proposing actions to be implemented or recommended in order to streamline the case's conduct, structured in six thematic categories.

Thematic Category 1: The case - A trans man in the context of pregnancy, childbirth, and puerperium

This category presents data from the case study of a transgender man in the context of pregnancy, childbirth, and the puerperium, which expressed events experienced in hospital care. It points to previous clinical contexts resulting from the therapeutic trajectory in Primary and Specialized Care health services, specifically an outpatient clinic for transgender people. Data include sociodemographic, general health, gynecological, and obstetric characteristics, diagnostic tests performed, clinical manifestations expe-

rienced during the pregnancy-puerperal period, including mental health (Chart 1).

This context highlights the urgent need to integrate mental health care into the gestational care of transgender people, given the substantial influence of the pregnancy-puerperal period on physical and emotional health. Moreover, the decision to terminate the pregnancy due to mental health issues emphasizes respect for the life of the pregnant woman and the medical intervention when necessary to ensure the well-being of both parties. In short, this case illustrates the complexity of pregnancy care for transgender people and underscores the need for sensitive and inclusive approaches to healthcare during this period[5].

The pregnancy experienced by a transgender man undermines and challenges the preconceived idea that this process is intrinsically associated with femininity. Beyond the biological conventions traditionally associated with the designations "father" and "mother", parenting encompasses diverse approaches to caring and identifying within the binary parental structure. Each trans man plays the parental role that best aligns with his journey[8].

Thematic Category 2: The case - the partnership and parental dimensions

This category explains the relationship with the partner, a cisgender woman, according to the participant. The results pointed to a parental perception limited to the condition of companion and not co-participant, active throughout pregnancy, childbirth, and the puerperium in the hospital context. The report allowed for the identification of the participant's dissatisfaction with the daily care routine and interactions with health professionals regarding recognizing the pregnant couple's parenting. Information on the patient – a pregnant trans man and the father of the newborn – was recorded in the parturient field of the Live Birth Declaration, which was at odds with the parturient father's wishes, and the mother/partner did not have her data entered on the declaration (Chart 2).

In Category 2, we can see that the legal weaknesses associated with transparenting create obstacles to the civil registration of the gestated child and, consequently, to receiving social ben-

Chart 1. Case categorization - transgender person/patient in the context of pregnancy and childbirth. Salvador, Bahia, Brazil, 2023.

Case description
Case: *[...]gestational follow-up in a specialized hospital, a reference in the care of transgender people in the pregnancy-puerperal cycle. The patient was a middle-aged, self-declared Black transgender man, who identified himself as a Candomblé adept, lived in an urban area, in a suburban region, had studied until high school, was unemployed, and worked in informal occupations to generate income. He had no previous references to associated comorbidities, nor any history of surgery, alcohol and tobacco use, use of other drugs, or known allergies. The laboratory tests he underwent showed no hematological or serological alterations (non-reagent serologies). He was experiencing mental health issues, had received a medical diagnosis of bipolar disorder, accompanied by gender dysphoria (anxiety, dysphoria, and suicidal thoughts), and was being monitored by a team from a Psychosocial Support Center. [...] as for the pregnancy and puerperal period, he had an obstetric history of two pregnancies, one normal birth and zero miscarriages. The second pregnancy was a single, topical pregnancy, identified on ultrasound, resulting from home insemination, planned by the couple and previously accepted by the parturient. The decision to get pregnant was motivated by the fact that the cisgender partner had known gestational risks. The pregnancy was monitored in a hospital because of the manifested psychological distress associated with the pregnancy changes experienced. Three prenatal care visits were performed. The assessment of fetal vitality was normal, with adequate fetal growth, according to the ultrasound (obstetric doppler). The gestational age was 33 weeks and one day, and was experienced with complaints of frequent pelvic pain, low back pain, dental pain, nausea episodes, feelings of anguish, anxiety, negative thoughts and self-mutilation. [...] motivated by mental health issues, expressed by the patient's free will, a protocol termination of pregnancy was recommended. The birth occurred in an obstetric surgical center, at 34 weeks and 2 days, without complications, resulting in a newborn, identified as male, with an APGAR* index/score of 9/9, on a scale of 0 to 10, and a weight of 2,510 kg.*

*APGAR - Activity, Pulse, Grimace, Appearance, and Respiration.

Source: Authors.

efits, which weaken the child's rights since the lack of documentation prevents the infant from accessing health services, such as vaccinations, visits to monitor growth and development, and education, such as nurseries. However, the Manual of Instructions for Completing the Live Birth Declaration states that only the full name of the parturient who gestated the child should be included, regardless of their gender identity[19].

Decree No. 8,727, of 2016, "provides for the use of the social name and the recognition of the gender identity of transvestites and transsexuals within the direct, autarchic and foundational federal public administration". Article 1 explains the social name as the "designation by which the transvestite or transsexual person identifies and is socially recognized;" and gender identity as the "dimension of an individual's identity that concerns how they relate to representations of masculinity and femininity and how this translates into their social practice, without being necessarily related to the gender assigned at birth", and these rights are essential for the individual's dignity. Once the patient has changed their name and gender on their documents, they can change their registration[20].

Thematic Category 3: Discussing the case - the pregnant couple's dilemmas

The discussion of the case is described in this category, which points to the pregnant couple's dilemmas regarding the care context vis-à-vis parenting and healthcare (Chart 3).

In Category 3, the story shows the couple's lack of financial resources and their choice of home insemination to realize their parental project. Brazil has unequal access to reproductive technologies, which is because access to assisted reproduction in clinics for the population, especially LGBTQIANP+ people, faces several barriers, such as the high cost of private procedures, the public health system's limited supply, the concentration of clinics in urban areas, and the presence of a cis-heterocentric clinical environment.

In this complex context, home insemination emerges as a self-insemination practice performed outside of assisted reproduction clinics[21]. It is a tool and strategy for reproductive autonomy that allows trans men and transmasculine people to realize their parental projects[22].

Faced with this conflict over the expectations created during the pregnancy and puerperal pe-

Chart 2. Case categorization - partnership and parental dimensions. Salvador, Bahia, Brazil, 2023.

Case description
Case report: *[...]it was about a middle-aged, obese, cisgender woman, who was accompanying the pregnant transgender man throughout the pregnancy-puerperal period, the mother of the child [...] the desire to breastfeed came from the partnership, but due to the high cost of hormones, the lactation induction was interrupted [...] people made fun of her; they didn't want her to say or answer anything; they referred to her as a companion and not as a mother. We heard a lot of things from the health professionals: "Oh, you're just a companion, you can't see the child, you're not considered to be the mother". She didn't have the right to take part in all the birth monitoring and initial care; it was all very protocol-like, and she wasn't allowed to see any of my tests, although she was the mother. She was the mother, but couldn't take part in everything, including the ultrasounds. When the declaration of live birth was being made, my wife would say "put my name on it, I'm the child's mother, not him, he's the father". My wife also found it strange that they hadn't put her name on the baby's ID bracelet after the birth. They put the bracelet on my arm, but they didn't put it on the mother's arm [...] nobody worried about her health conditions, although they knew that professionals had important bodily needs to take care of [...] to feed the child. She couldn't breastfeed directly. We're having to buy milk, which is very expensive, causing us financial hardships [...] as my wife didn't have the right to register the child, we're experiencing difficulties caring for the child, such as having access to the milk provided by the government. My wife has struggles accessing her child's milk. It's as if she hadn't given birth. This is very sad, because it's the child who suffers. The services don't recognize that a man gave birth to the child and not the woman. Seeing my wife look at the birth certificate and not seeing her name makes me feel anguished. So, all these things have made the process more difficult.*

Source: Authors.

riod, which may not align with the reality experienced, emotional changes and challenges that lead to gender dysphoria emerge. We should underscore the importance of the support network, especially the partner's involvement during the pregnancy and puerperal period, along with family and close friends who can offer positive support[23].

Moreover, the findings of this study pointed to transphobia among health professionals. This event is characterized by historical and cultural denial through fear, discomfort, hatred, and stigmatization of how a trans person constructs their gender identity. Veiled or materialized violence causes suffering in this population, imposing barriers that prevent approaching them and providing them with healthcare. The presence of a trans man in the health service breaks with the ideological binary discourse, such as the idea that only cisgender women can get pregnant because the uterus is only female[24].

Law No. 7,716, of 1989, which "defines crimes resulting from the prejudice of race or skin color", in its Article 1, states that "Crimes resulting from discrimination or prejudice of race, skin color, ethnicity, religion or national origin shall be punished under this Law". It extends its protection to several types of intolerance, even if it does not directly mention discrimination on the grounds of sexual orientation and gender identity, but this law[25] can cover them.

The reflections raised from the experience of the case highlight the high relevance of understanding the complexities of gender identity and the mental health of trans people. This case emphasizes the urgency of improving the quality of care provided to trans patients, especially within the Unified Health System (SUS), which involves the continuous training of staff regarding gender issues and requires developing protocols, ensuring that the rights and health of all patients are respected.

Thematic Category 4: Contextualizing the case - impressions recorded by the nursing professional

The data in this category show the impressions recorded by nursing professionals in the context of Obstetric Nursing residency training regarding the contextualization of the assisted case. We identified the difficulties and challenges and the perceptions of the care team regarding the conduct adopted, dilemmas experienced, and the need to review professional health practices in the obstetric hospital context for the care of trans men in the pregnancy-puerperal period, with notes to reflect on and build new care set-

Chart 3. Case contextualization - impressions recorded by the nursing professional. Salvador, Bahia, Brazil, 2023.

Case description
Case contextualization: *[...]Our nursing team faced significant challenges that deserve attention during trans patient care. One of the main obstacles was the appropriate use of pronouns and the fear of making mistakes that could be interpreted as obstetric violence. Moreover, having experienced the case raised personal questions. Why did the patient plan the pregnancy and then develop a phobia about the pregnant body? This question raises the importance of psychological support for trans patients in situations of vulnerability, from before conception, so that they can prepare for the bodily changes [...] the decision to terminate the pregnancy was not taken in consultation with obstetricians, as is common, but with a psychiatrist, due to the psychiatric risks involved. Moreover, it was necessary to carefully assess the pros and cons of this interruption, considering the advanced stage of the pregnancy, which was at 34 weeks, which would result in the birth of a premature newborn [...] Therefore, taking care of mental well-being is equally important for overall care, as is with the physical body [...] drawing up a birth plan was fundamental. This allowed the obstetric nurses to follow the labor and birth good practice protocol. However, through this lad's birth plan, I realized that these practices may not be desired by everyone in the immediate postpartum period, such as immediate skin-to-skin contact between the baby and the parturient and breastfeeding in the first hour, which we learn is important, but not everyone wants at the time. [...] Another issue with this same case was that I, as an obstetric nursing resident, didn't feel comfortable carrying out the physical examination on this vulnerable patient, because he didn't like the breasts and the pregnant body, and there I was, having to inspect, palpate and auscultate extremely sensitive areas for that person, in a ward shared with several women there and we didn't have anywhere else to put this lad, separately, because of the structure.*

Source: Authors.

tings for the production of health care in the public service (Chart 4).

Furthermore, in Category 4, it is essential to reflect on breastfeeding, marked by periods of emotional distress. It is the height of discomfort with the body, as it is perceived as one of women's emblematic social roles[26]. It is essential to consider other feeding options for the children of trans men who choose not to breastfeed, such as the use of human milk banks, milk formulas, and the induction of lactation by their partners. Health professionals should provide information during prenatal care appointments about the alternatives available without putting pressure on individuals and respecting their autonomy[27].

Milk production is facilitated through a procedure that covers three distinct stages: hormonal preparation of the breast tissue, prolactin promotion, and hormonal weaning with breast expression[26,28]. The Lactation Induction technique expands the opportunity for non-biological mothers to breastfeed their children, thus benefiting a diversity of families, including those made up of adopters, transgender people, and lesbian couples. It helps to ensure that more children have access to human milk's nutritional, emotional, and affective benefits, promoting their proper growth and development[29]. Lactation induction requires time and effort, an assessment of health and psychosocial conditions to guarantee the health of the individual wishing to induce lactation and the baby who will be breastfed.

Reflecting the context of childbirth, the hospital-centric setting is centered on the medical figure, and the parturient is disqualified and unable to decide whether she would like a cesarean section or not, due to the attitude of health professionals[2]. This situation causes suffering for the patient, who requires guidance on delivery routes and the use of non-pharmacological methods for pain relief. In this sense, disrespect for autonomy is obstetric violence.

Obstetric violence includes disrespect, physical, verbal, and psychological abuse, negligence during childbirth, unconsented procedures, and preventing the presence of a companion[30,31]. In Vitória da Conquista, Bahia, Law No. 2,228, of 2018, which characterizes obstetric violence as the appropriation of women's bodies and reproductive processes, does not include trans men in childbirth, showing a gap in the legal protection of this population segment in the healthcare context[31].

In this case, the trans man who gave birth had conflicts with the bodily changes resulting from the pregnancy, the way he established his body and masculine identity, and the interactions with the health professionals who followed him up, which culminated in an intense psychological distress episode, a risk to the health and life of the trans man, his child, and the people around him. The bodily changes associated with pregnancy can be challenging and emotionally complicated to address for some trans men who are pregnant, especially for those who wish to masculinize their bodies through hormonal and surgical interventions. The way trans men and transmasculine people perceive and construct their bodies

Chart 4. Case discussion - dilemmas faced by the pregnant couple. Salvador, Bahia, Brazil, 2023.

Case description
Case discussion: *[...]the pregnancy was planned, but difficulties arose right from the start, as we carried out a home insemination with practically no support from health professionals. For health reasons, my wife was unable to carry the child. We couldn't afford the cost of an insemination carried out with the support of a professional [...] it was only after the home insemination had been carried out, with the support of a family member, that we spoke to a doctor, who ordered tests for both my wife and me, such as a preventive uterine exam [...] It was complicated to carry out prenatal care as well. I only had three appointments, because every time I scheduled appointment, I faced difficulties in scheduling and availability at the unit, which was also undergoing structural renovations [...] I experienced moments of acute pain, to the point where I had to go to the hospital called the maternity ward, and it was because of the stress and anxiety that increased after the pregnancy. As a result, my psychological problems deteriorated during pregnancy. Everything was fine as long as my belly didn't grow. Then it changed, my body didn't stay the same, and I started "doing stupid things", like trying to hurt myself, punching my belly and thinking about killing myself. I had to be hospitalized because of this [...] while I was in the hospital for prenatal care, I went through new difficulties, such as being called "she" or "mother" all the time by the health professionals [...] I also warned the staff that I didn't want to breastfeed and that I had some discomfort with my body, especially the parts that might refer to the feminine. This really affected me because I'm not her, I'm not the mother: I'm the father.*

Source: Authors.

is particular, whether or not it is affected during pregnancy. Choices carry emotional, social, and physical implications linked to how gender experiences are established and how discrimination is addressed[32].

The analysis of this case highlights gaps in the training of health teams in caring for transgender people during the pregnancy-puerperium period, highlighting the Obstetric Nursing Residency context. The failure to promote continuing education spaces for health professionals, especially in the field of gynecology and obstetrics, results in practices that compromise the quality of care, contributing to the reproduction of obstetric care performed under the cisheteronormativity rationale, where trans men's specificities are concealed in the several settings. It is, therefore, crucial to include topics such as "prenatal care, delivery, birth, and puerperium of trans men" during the training of health professionals in order to prepare these people for person-centered care approaches that consider the sociocultural particularities of transmasculinities[33].

Thematic Category 5: Understanding the case - adopting a theoretical and epistemological lens

The understanding of the case explained in this category was anchored in the Theory of Caring, based on the interrelationship with transfeminist epistemology, to think about the production of Nursing and Health professional care in the pregnancy-puerperal period of trans men and their parental relationship (Chart 5).

Thematic Category 6: Critical analysis of the case - implications for health professionals

In Categories 5 and 6, Swanson's Theory of Caring/Caregiving lens supported the care developed within the family in its diverse relational configurations. It helps to understand the care processes around what is expected of a pregnant person and the social roles to be assigned to men and women since it considers the element of "keeping the belief" – both in people and their abilities[11].

Nursing care is essential, centered on the relationship of affection, the development of the professional and the person being cared for, and accountability and involvement[11,12]. Recognizing homoparental health needs from the viewpoint of care, considering interpersonal relationships, is indispensable for recognizing sexual and gender diversity in family configurations and attention to the specificities of pregnant trans men and their partners, in which caring finds an essential place, especially when expressed and practiced effectively in an interpersonal way.

In this sense, it is recommended to create care devices in the services that guarantee the safety and protection of homoparental families in health services, empowering and strengthening the teams of health professionals and workers. In a perspective of making care transpersonal, to be permeated by different means of communication, feelings, harmonization of the mind, body, and spirit of the person being cared for in these spaces, overcoming medical-centric models, which give restrictive emphasis to protocols, control, rigor, objectivity, and high technological incorporation, disregarding the humanistic dimension and the sense of care as a valuable attribute for humanity[11,12].

The metaparadigm of the Theory of Caring understands "Nursing" as care based on the person's well-being in clinical and cultural terms. The "Person" is seen as a unique being who can constantly evolve and whose uniqueness can be expressed through thoughts, emotions, and behaviors; "Health" is considered a subjective, significant experience that can be associated with the human being integrity and totality. Finally, the "Environment" encompasses a situational level transcending the physical dimension[11]. Thus, we call on health professionals to "get to know" the human experience of transgenderism, to reframe the care logic and production, and to review the meanings and senses of affective-sexual relationships, family, and parenting.

The transfeminism perspective can build other types of masculinities that differ from hegemonic masculinity[34] and dialogue with feminism precisely because they have common agendas, such as the fight against machismo, misogyny, obstetric violence, and the fight for the right to the body. In this sense, transmasculine identities subvert normative discourses, giving visibility to other possibilities for constructing what it means to be a man[35]. These masculinities find space to tension and debate central issues such as pregnancy, childbirth, the puerperium, and the health of this population[7] within the field of transfeminisms of transmasculinities.

The mismatch between current Brazilian legislation and the experiences of trans men during pregnancy and childbirth creates a gap in the protection of rights and the guarantee of quality

Chart 5. Understanding the case - adoption of a theoretical and epistemological lens. Salvador, Bahia, Brazil, 2023.

Care processes	Theoretical interpretations	Epistemological implications
Keep the belief	Believe that it is possible to be cared for with respect	Consider the diversity of bodies and possible identities for care in the production of scientific knowledge
Know	Seek information on the experience of trans men during pregnancy, childbirth, and the puerperium	Review cisheteronormativity, making multiple identities visible
Be with	Share planned care and responsibilities between users and professionals	Inclusive practice considering empirical knowledge from experience
Do for	Perform with respect, preserving individuality	Respect for fundamental rights, human rights and human dignity
Enable/ Empower	Guide and generate possibilities centered on the other	Pedagogical-therapeutic care process centered on the subject based on transgenderism
Care processes	**Problems**	**Implications for practice**
Keep the belief	Delegitimization of the culture of self-care and parenting and the transgender experience	Visibility of the unique and challenging experiences, encouragement of self-care, and recognition of the parental rights of transgender people
Know	Attitudinal and technical weaknesses in the clinical management of trans men's pregnancies	Commitment to continuing health education activities to raise awareness of gender identity issues and create inclusive and respectful care environments
Be with	Ethical dilemmas in the actions of health professionals in respecting autonomy and instruction, even in the face of judicialization and the preservation and protection of mental health	Supporting trans men in making decisions about childbirth and the puerperium and evaluating the termination of pregnancy protocol in situations of psychological distress and life-threatening risk
Do for	Care plans that follow the heteronormative pattern for cis women do not include the partner and do not think about the needs and specificities of the pregnant couple	Drawing up an extended and individualized care plan to avoid repetitive and unnecessary approaches
Enable/ Empower	A training plan that is not attentive to occurrences, has gaps, and does not match the profile of the population served	Create dynamic learning possibilities and strategies in the hospital environment, including emerging demands.

Source: Authors.

care. Therefore, implementing institutional protocols ensures that trans patients receive timely and adequate care.

Conclusion

Transgender people's pregnancy is a reality that needs to be recognized and incorporated into the organization of services. It requires investing in the promotion of continuing education spaces for health professionals aimed at understanding and respecting gender diversity and family configurations. Transgender individuals must be involved in organizing the care they wish to receive in order to prioritize the bioethical principle of autonomy in making decisions about their health.

There is a need to rethink professional training curricula to adequately prepare health professionals to provide care that is more inclusive and sensitive to diverse gender identities, with theoretical and practical experiences that enable their specificities in care and the development of skills

that meet the unique demands of transgender patients. Thus, the implementation of continuing education programs on care for transgender people in the context of pregnancy, childbirth, and the puerperium is essential as it could enable a more inclusive organizational culture.

Furthermore, there are still significant gaps in scientific output addressing trans men's transparency and obstetric trajectory. There is a need to produce new studies that address issues relating to sexual and reproductive rights, prenatal care, breastfeeding, and care during labor and birth based on the experiences of trans men, reflecting on the intersecting cisheteronormativity and the representations of transparency in the context of healthcare.

Collaborations

RNS Mascarenhas played a role in the conception and development of the research and writing of the manuscript. She worked on the conception and design of the study, literature review, data acquisition, data analysis and interpretation, and writing, besides working actively in approving the final version of the manuscript. VVC Santos played a crucial role in the conception, development, and writing of the manuscript, with contributions of substantial relevance in formulating the manuscript's design, besides the collection, analysis, and interpretation of the data. Furthermore, the author was involved in the literature review, data acquisition, data analysis and interpretation, and writing and participated in the approval process of the final version of the manuscript. BS Santana: regarding the activities related to the research, the author played a vital role in the comprehensive development of the manuscript, contributing to the analysis and interpretation of the data and writing with valuable contributions. He was also involved in the approval process for the final version of the manuscript. AA Monteiro contributed significantly to writing and reviewing the content. She also participated in the approval process for the final version of the manuscript. TM Couto contributed by developing the theoretical framework, analyzing the data, and critically reviewing the manuscript. She also participated in the approval of the final version of the work. AR Sousa contributed to developing the theoretical framework, data analysis, interpretation, and critical review of the manuscript. He also played a crucial role in approving the final version of the work and conducting a thorough analysis of the content to ensure its quality and academic rigor. DMR Pereira played a vital role in the conception, development of the research, and writing of the manuscript, outlining the study design, analyzing and interpreting the data, critical review and analysis, and approving the final version of the manuscript. LCG Almeida played a vital role in the conception, development of the research and writing of the manuscript, outlining the study design, analyzing and interpreting the data, critical review and analysis, and approving the final version of the manuscript.

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