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Perceptions, expectations, and recommendations of trans adults on gender-affirming care in France: a qualitative study

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Abstract
Trans people have diverse life experiences which may include gender-affirming care (GAC). GAC positively impacts the quality of life of trans adults. However, they are often met with barriers to care and are particularly vulnerable within the healthcare system. The needs and expectations surrounding GAC may vary between individual patients. This article aims to analyze trans adults' perceptions, expectations, and recommendations on GAC. Twenty-seven semi-structured interviews were conducted by a team of academic and peer researchers; transcribed interviews were then analyzed using a codebook and thematic analysis. Three main themes were identified; *the liberating experience of GAC; the uneven distribution of knowledge and power between patients and providers*; and *the recommended practices in GAC*. Additional training and research are necessary to facilitate high-quality care for trans adults accessing GAC.

Keywords Trans health, Gender-affirming care, Healthcare in france, Health experience, Patient expectations

Introduction

"Transgender" and "trans" are umbrella terms to describe people whose gender doesn't align with the gender they were assigned at birth [1]. Trans people often choose to socially or medically transition to better express their gender [3]. According to the WHO, gender-affirming care (GAC) refers to "any single or combination of social, psychological, behavioral, or medical interventions designed to support and affirm an individual's gender identity [2].

This article will focus on medical care which may include, but is not limited to, gender-affirming hormonal therapy (GAHT), and gender-affirming surgery (GAS) [1]. While gender-affirming care is usually voluntary it is important to acknowledge that, before 2017, certain procedures (vaginoplasties, hysterectomies) were mandatory

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in France to access legal recognition of gender [2]. The past few decades have seen increased awareness and protection of the existence of trans people leading to an increase in openly trans patients [1]. In 2020, 9000 people in France had completed the GAC reimbursement process compared to roughly 900 in 2013 [3]. France is faced with an increased demand for GAC and the necessity to correctly identify and respond to the healthcare needs of trans patients [2]. Further research on trans health is necessary to promote high-quality care [4].

In France, GAHT requires the involvement of a general practitioner or an endocrinologist [5]. GAS requires the expertise of plastic surgeons, urologists, gynecologists and their teams [6]. Patients can also seek various health professionals for other forms of GAC [7]. The majority of the roughly 1000 GAS performed in France in 2020 were in large urban centers but they were also available in some smaller cities [3].

In France, services specific to trans patients are relatively new and have undergone significant changes [2]. Before 2017, trans patients were required to be medically sterilized in order to legally change their gender [8]. The typical requirement was for trans women to undergo vaginoplasties and for trans men to undergo hysterectomies [8]. Before 2013, most professionals specifically seeking to care for trans patients were trained abroad, usually in the Netherlands and Canada [2]. The current literature still suggests that the majority of French health professionals do not consider themselves adequately trained to care for trans patients [7].

Trans patients are more likely to access care atypically. They are more likely to find providers through online forums and discussion groups with other trans people [9]. Trans patients are typically more willing to travel to access care [5], making them more likely to need time off work [5]. If they are unable to access kind and professional treatment by healthcare providers, trans patients are also more likely to avoid or delay care [5].

Trans patients experience stigma within, and outside of, the healthcare system [10]. The French Higher Health Authority (HAS) estimated in 2020 that a third of trans patients forewent some form of medical care because of prejudice by healthcare workers [11]. Research done in 2021, found that in a sample population of trans patients, half had experienced stigma from medical professionals and two-thirds had experienced it from secretarial or administrative professionals [11]. Three quarters of the respondents said they feared experiencing stigma when accessing healthcare [11]. Additionally, trans patients are at higher risk of medical complications and negative health outcomes [7].

Research in trans health supports the idea that facilitators can improve trans patients health outcomes [10]. In general, trans patients are highly motivated to seek out health information and to create support networks [12]. Having supportive healthcare professionals predicts better quality of care [5] and supporting trans patients as they navigate these systems has the potential to have a strong and lasting effect on their overall physical and mental health [1].

Research suggests that most French healthcare professionals hold neutral or positive views of trans patients and want to provide high-quality care for them [7]. Simultaneously, many do not feel comfortable seeing trans patients due to a lack of understanding of their specific needs [7]. It is thus necessary to inform healthcare professionals about best practices, and about the realities of trans patients [7]. Collaboration between research teams and patients is crucial to understand this rapidly evolving context. Research-centring trans experiences, and involving trans people, allows for better comprehension of their needs, desires, and concerns relating to GAC. In this context, our research question is: what are trans people's experiences of health services for GAC ?

The aim of this study is to analyze the perceptions, expectations and recommendations of trans adults on GAC in France.

Methods

We conducted this qualitative study according to the "Consolidated criteria for reporting qualitative research" checklist (COREQ) [13] (see Multimedia Appendix I).

Context

This project used data from the *Quality of Life of Transgender People - Implementation and Monitoring of an Online Cohort (e-QoL-Trans)* study [14], a mixed-methods project involving both research institutes and hospitals [14]. This article is based on qualitative data and focuses on trans adults' perceptions of GAC in France, their experiences navigating and receiving care, and implications for the future.

Theoretical framework

This study uses qualitative analysis to investigate trans people's interactions with health professionals and health services. A social theoretical framework was thus applied, as social theory is concerned with the social context of human actions, asserting that actions and beliefs are generated in part by social structure, but also by communication between individuals and within social groups [15]. This framework of analysis allows a better understanding, through in-depth interviews, of the nuances of trans people's experiences navigating GAC.

Interview guide

An interview guide was created and validated by the e-QoL-Trans team to investigate quality of life and focus

on the following four topics: (1) Quality of Life and its dimensions, (2) Social Support, (3) Emotional, Sexual and Reproductive Health, and (4) Stigma, Health Pathways, and Best Practices in Research [14] (see Multimedia Appendix II). Specific questions were asked regarding positive and negative experiences with healthcare providers, stigma, and factors contributing to quality of life. The questions were written collaboratively by health experts and peer researchers. Participants remained free to respond in as much detail as they wished to any question.

Recruitment and interview procedure

Participants were above 18 years of age, francophone, living in France, had access to a reliable internet connection, and identified as trans. Participants were primarily recruited through three participating teams offering GAS during an information or follow-up meeting. Consent forms were given to each participant and were then sent to a member of the recruitment team who was tasked with creating an anonymized database of participants (see Multimedia Appendix III for consent forms).

Semi-structured interviews were conducted over Zoom or in person between September 2022 and May 2023 and an audio recording was kept. One or two researchers were present for each interview (PM and MV). PM has a doctorate in public health and is trained in the methodology of qualitative interviewing. MV is a sexologist and public health master's student. Also present were one or two peer-researchers (MB and ML) who had previous experience supporting trans people undergoing GAC. Participants were informed of their right to access and rectify the data transmitted (transcribed and anonymized). No such requests were received.

Table 1 Summary of participant characteristics

	N	%
Gender		
Masculine	16	59.3
Feminine	10	37.0
Non-binary	1	3.7
Age		
20–29	11	40.7
30–39	4	14.8
40–49	8	29.6
50–59	4	14.8
GAC		
GAHT	26	93.3
Top surgery*	18	66.6
Bottom surgery**	15	55.5
In progress***	3	11.1
Other medical GAC	14	51.9
Geographical location		
South East	9	33.3
South West	7	25.9
North East	5	18.5
North West	2	7.4
Paris Metropolitan Region	2	7.4
Unassigned	2	7.4
Employment status		
Employed	15	55.5
Student	3	33.3
Other	9	11.1
Highest level of education		
Completed high school	10	37.0
Some higher education	13	48.1
Other	4	14.8

* Top surgery: Includes mastectomy and breast augmentation

** Bottom surgery: Includes phalloplasty, metoidioplasty, and vaginoplasty (does not include hysterectomy)

*** Phalloplasty is a complex surgery requiring several steps. "In progress" refers to participants who have completed at least one surgical step of phalloplasty

Participants

28 participants were recruited and filled the initial consent form. One participant cancelled their interview due to personal reasons; 27 participants completed the interview process. The mean age was 36.6 (Min=23, Max=53), 16 participants were men, 10 were women, and one person's gender was non-binary. The average age for men was 33.3 (Min=24, Max=53), the average age for women was 41.4 (Min=23, Max=51), and the non-binary participant was 28. Twenty-six participants were on GAHT and 25 had had some form of GAS. All participants were seriously considering at least one form of GAS. Participants were from all major regions of France, from urban and rural areas, and had varied levels of academic education, and employment. Recruitment of a diverse sample was made possible due to peer-researchers' considerable efforts and contacts. A summary of participant characteristics can be found in Table 1. For each participant, a pseudonym has been chosen to guarantee anonymity during analysis and presentation of the results.

Analysis

Data analysis was done by three members of the research team (MV, PM and MB). Researchers followed Braun and Clark's methodological guidelines for thematic analysis and used an inductive approach [16]. To help ensure trustworthiness note-taking was carried out after each interview and compared among researchers. Several working meetings (with MV, MB and MP) were held to pool each person's analysis of the different topics, with discussions leading to consensus. The three coders then gathered to establish a preliminary codebook in order to start coding the data through NVivo (version 1.7.1).

For this article, only the parts of the grid referring to GAC were focused on and key information relevant to the perceptions, expectations and recommendations

started to emerge. Defining the final themes was an iterative process and researchers used both a descriptive and interpretative approach. The participant number was deemed sufficient once saturation was reached for the research question. Inductive thematical saturation is reached when no new themes or codes emerge [17]. Given the large array of topics covered it is likely that saturation was not reached for individual subjects.

Results

The thematic analysis highlights three main themes: 1) The liberating experience of GAC, 2)The uneven distribution of knowledge and power between patients and providers, and 3) The recommended practices in GAC. Each of these themes has two sub-themes that can be consulted in Table 2.

Theme 1: the liberating experience of gender transition

> *"I feel free, really free…I feel like myself!" (Jeanne, 40–49 F).*

Every participant noted that GAC had positively impacted their quality of life. These positive outcomes were contrasted by the difficult moments that were also acknowledged. Due to the positive impact reported, challenges, such as surgical complications, stigma, and barriers to care, were often minimized in patient discourse. While this may speak to the resilience of participants it is important for professionals to remain aware of the significant obstacles faced by patients and strive to improve care.

GAC care has strong positive impacts on quality of life

> *"What I feel today is nothing like I've felt before, it's a boom boom in my heart, it's stars in my eyes." (Juliette, 40–49 F).*

Positive emotions generally increase as patients notice changes in their appearance. "*You see a hair start to grow, and it's so joyful, even if you can barely see it in the mirror, but that's transition, you go from small victory to small victory.*" (Florian, 30-39 M). Improvements were noted in self-confidence, body image, relationships, and sex life.

Strong positive feelings were tied to most experiences of GAC. Generally, GAC that produced highly visible physical change led to increased comfort around going out in public. These included mastectomies "*It was like a rebirth, it's hard to explain, but when you wake up from surgery you just can't wait to take the bandages off and see.*" (Kyan, 40-49 M), facial feminization surgeries "*it was the start of my happiness*" (Olympe, 50–59 F), and breast augmentation "*It changed my life, it completely opened me up to the world*" (Aliza, 20–29 F). Gender-affirming hormone therapy (GAHT), and genital surgeries, were generally experienced in a more intimate way. They were more likely to be described as impacting patient's sense of well-being as well as their sexual relationships.

Coping with challenges despite the overall positive impact of GAC

> *"If I hadn't transitioned, I feel certain I wouldn't be on this earth today […] my transition saved my life" (Zelly, 40–49 F).*

GAC is viewed by participants as vital, essential, and non-negotiable part of well-being that is achieved despite structural barriers such as difficult administrative procedures, long wait times, lack of providers, issues with insurance coverage, and lack of available information (examples in Table 3). Interpersonal stigma in the form of verbal abuse, misgendering, outing, physical abuse (Naveen, 30-39 M), and breaches of privacy were also experienced (examples in Table 3). Refusals could range from refusals to perform specific procedure, such as a hysterectomy (Henri, 20-29 M), to prescribing appropriate dosage of GAHT (Emma, 40–49 F), to outright refusal to take on a patient because they were trans.

For participants, the globally positive effects of GAC outweighed the considerable difficulties faced in the process. It was noticed that challenges, stigma, and medical complications, were minimized in participant discourse when compared to the benefits of GAC. One participant synthesizes this feeling of being willing to go through phalloplasty and ensuing complications in the following way: *"I won't lie to you, it tires the body, surgery tires the body, the last few years I've seen my body take a hit…it will take time to get over it, all of the back to back*

Table 2 Description of the themes and subthemes that will be explored further in this analysis

Themes	Subthemes	
1) The liberating experience of GAC.	GAC has strong positive impacts on quality of life.	Coping with challenges despite the overall positive impact of GAC
2) The uneven distribution of knowledge and power between patients and providers	Trans patients take on the roles of experts and advocates in the field of GAC.	Trans people use adaptation strategies to cope with their vulnerable position in the health system.
3) The recommended practices in GAC.	Recommended practices are diverse but center professional's attitudes towards trans patients.	Patients and providers are currently engaging in healthcare bricolage to address gaps.

Table 3 Examples of the forms of systemic or interpersonal stigma experienced by trans patients when accessing gender-affirming care in France

Forms of systemic stigma experienced	Example
Difficult administrative procedures	*"I had the case several times of a person preparing for surgery and we discuss all the things they have to do to get the CPAM* [French Health insurance system] *coverage…and then the person's CPAM request gets rejected because they've never had psychiatric follow-up…for the CPAM, without a signed psychiatric attestation, very few surgeries are approved." (Jessie, 40–49 F)*
Long wait times	[The Professional Concertation Reunion or PCR] *"It's a commission that assembles a psychiatrist, an endocrinologist, and other people that decide if, yes or no, the person is eligible for hormones, you need minimally a year of psychiatric follow-up at the hospital…at the public hospital, same for the mastectomy, you have to wait a year of being on hormones to get that PCR…that's how it works in the public hospital." (Pierre, 20-29 M)*
Lack of providers	[Lack of endocrinologists accepting trans patients in her region] *"It's a real problem…I've seen people use parallel medications…I spoke to a young woman recently, it's rock and roll, she gets hormones from Ukraine and does her own injections… there's no traceability, we don't know what's in those products. I think if we had better local care it would be much easier… some people go straight to those products because they feel like it's complicated to get a prescription locally." (Zelly, 50–59 F)*
Issues with insurance coverage	[He was refused a health insurance contract] *"I told them the truth, I said I had had a mastectomy, I told them everything…I was 21 and asking for a health insurance plan, not a loan eh, just health insurance…and I was refused as a healthy 21-year-old." (Dale,30-39 M)*
Refusals of care	[Speaking of his general practitioner] *"When I had my mastectomy, I developed an infection and required treatment. The nurses [from the clinic] called her to tell her that the wound was oozing, that there was pus leaking out, and that it needed to be treated immediately…and yet she refused." (Adam, 50-59 M)*
Forms of interpersonal stigma experienced	**Example**
Physical abuse	"[the nurse] *she ripped off my bandages after surgery very roughly, she knew she was hurting me and yet she said… 'well you wanted to be a man, now deal with it'." (Naveen, 30-39 M)*
Verbal abuse	*"I went to see a psychiatrist who told me that it wasn't because I like football and beer that I was a man, and I don't like football and I don't drink beer…I left the meeting in tears, he had completely rejected everything I had told him, it was the first person I had talked to about it, so I took it pretty hard. (Robin, 20-29 M)*
Misgendering*	*"Sometimes they call me ma'am…even though I have been going to the same clinic for several years, there are still times I get called ma'am." (Olaf, 20-29 M)*
Outing**	"[speaking about a paramedic] *I was hospitalized for my hysterectomy, so I still had my old name on my card, and he would use my old name and say to his colleague 'oh that's strange it's a female name' but I was there for my hysterectomy, he was familiar with the service, and he knew why I was there. Yet he would still ask 'oh, why are you getting a hysterectomy, you don't look like a girl', it was hurtful." (Naveen, 30-39 M)*
Breaches of privacy	*"My friend doesn't have phalloplasty yet but every time he sees his endocrinologist he asks him if he can get pictures done when he gets surgery and show him….and it is probably curiosity, to show to other doctors etc, but would he ask that of a biological man…can I see your penis?" (Robin, 20-29 M)*

* Misgendering is as the act of referring to a person using the incorrect gender

** Outing is the act of revealing personal information about a person without their consent (for example revealing someone's sex assigned at birth)

anesthesia, it's not easy…but if it had to be done again, I'd do it again eh! There's no question I'd sign all over again!" (Florian, 30-39 M). The high satisfaction of patients with their GAC requires professionals to be vigilant to ensure patients are reporting any difficulties faced in the course of their care.

Theme 2: the uneven distribution of knowledge and power between patients and providers

> *"I needed my psychiatrist to help me, clearly, but he just wasn't trained, and I think that's the problem today, the lack of practitioner training on gender and trans identities." (Henri, 20-29 M).*

The relationship between patients and providers was characterized by uneven distribution of knowledge and power. Patients found themselves having to explain trans identity to their providers to get the care they required, especially when seeing providers who were not specialized in trans health but could still prescribe forms of GAC. Providers could significantly facilitate or complicate participants' experience of GAC, tipping the balance of power in their favor.

Trans patients take on the roles of experts and advocates in the field of gender-affirming care

> *"The nurses there weren't trained […] so I spent hours with them, I explained some practices, words to avoid […] I'm fighting so that they know how to gender people like us, how to care for us […] the nurses spent time with me, and they told me, thanks to you, next time we have a trans person, we'll know what to do." (Fiero, 50-59 M).*

Participants often described being one of their providers' first trans patient (Henri 20-29 M; Fiero 50-59 M). This was particularly the case for patients who accessed GAC through their general practitioners, and non-specialized psychiatrists and endocrinologists. Patients described many ways in which they adapted to navigate the French healthcare system. These adaptation strategies included: calling multiple professionals to secure an appointment (Florian 30-39 M; Juliette 50–59 F; Zelly 40–49 F), coming to appointments with a trusted individual (Adam 50-59 M; Henri 20-29 M; Eugène 40-49 M; Juliette 50–59 F), contacting trans associations for guidance, finding information and social support in online peer groups, reading studies to follow research developments, identifying trans friendly providers, and travelling to access care. Despite efforts to educate providers and advocate for themselves, participants were not always able to access the GAC they required. Jo explain how they were still rejected for a mastectomy because they are not on testosterone ("on T"): "*I called some surgeons on my own, I asked for information and many refused me because I'm non-binary, but mostly because I'm not on T, I explained to them that when you're non-binary, or in the case of any trans person actually, you get to choose. We get to choose not to be on T…but yeah a lot refused because I wasn't on T, because I don't want to, I don't want to be more masculine than I currently am…" (Jo, 20-29NB).*

Trans people use adaptation strategies to cope with their vulnerable position in the health system

> *"At the time it really felt like the doctor was God… and that he held my life in his hands." (Florian, 30-39 M).*

To deal with the unbalanced relationship participants had with providers, they used a variety of strategies including avoidant behaviors. Some participants lied to professionals (Dale, 30-39 M), or only told them what they thought they wanted to hear (Naveen, 30-39 M). They were worried that they would reveal something that would lead to more delays in their care or to a denial of care. Naveen (30-39 M) describes interactions with his psychiatrist in the following way: "*I was scared to say something wrong, even though I was showing up as 100% myself, I was scared that if I said something wrong they would slow me down, so when I was out of work I didn't tell them, because sometimes they can hold back hormonal therapy if they don't think the family situation is stable enough, so I never said I had lost my job, and that was complicated.*" Others tried to avoid healthcare services as much as possible (Dale, 30-39 M) or put off finding new providers when they retired or moved (Lionel, 20-29 M). Participants who had the means sometimes avoided issues by either bypassing the public system or leaving France altogether. A few participants also chose to spend a significant amount of money to access services abroad and avoid either long wait times or restrictive legislation. Services received abroad include a vaginoplasty in Thailand (Jeanne, 40–49 F), two chest surgeries in Belgium (Naveen, 30-39 M; Florian, 30-39 M), and fertility treatments in Spain (Fiero, 50-59 M) and the Netherlands (Dale, 30-39 M).

Theme 3: the recommended practices envisioned in gender-affirming care

> *"We need to be supported by professionals who know the subject (…) who know all the details and can help guide the patient." (Naveen, 30-39 M).*

Participants identified recommendations to improve GAC (see Table 4). Participants also narrated how some patients and providers have taken the initiative to improve care through individual and organized actions.

Recommended practices are diverse but center on professional's attitudes toward trans patients

Participants highlighted the need to avoid stigmatizing behaviors such as intrusive questions, misgendering, and forcing patients to justify their identities: "*There are aggressions that are physically violent, but misgendering is morally violent, it's saying that whatever you do you'll never be a man, or you'll never be a woman, to me that's the most violent act, because it leaves psychological traces.*" (Zelly, 40–49 F). Along with misgendering, patients reinforced that professionals should be addressing them by their chosen names, even if those had not always been changed on identity documents. Participants noted the importance of context when approaching sensitive topics such as sexuality. Having the reasoning explained helped participants feel respected and safe when faced with sensitive questions.

Participants looked for kindness and openness in their GAC providers. This facilitated trust even with providers who had limited experience caring for trans people: "*Healing is more than a technical act, it's something you do with your soul because you genuinely want to help. A healthcare worker is someone who won't judge the patient in front of them, no matter why they're there.*" (Naveen, 30-39 M). Participants identified the need for additional training of professionals on trans identities: *"I think we need the transmission of information, and increased awareness (…) professionals that have experience with trans patients would show the rest that there is nothing to worry about!"* (Zelly, 40–49 F). Training should include information on social aspects of trans identities, including differentiating gender and sexual orientation: *"I think*

Table 4 Participants' recommendations regarding practices in GAC

Participant recommendations for practices	Example
	For professionals
Always use the correct name, pronoun(s), and gender	"*When I met my current psychologist it immediately went well, during the first meetings she asked me my pronouns before I even brought it up, it was amazing for it to be such a regular question…she knows my birth name but she never uses it, she always calls me Jo… there are no issues and she often asks me if my pronouns have changed.*" (Jo, 20-29NB)
Approach sensitive topics with care and provide context whenever possible.	[On a first consultation with an endocrinologist] "*She made me undress completely…and when I talk to friends, they tell me she didn't have to do it…and my new endocrinologist never asked me…it's hard for someone who isn't trans to undress in front of someone else, but for a trans person it's really not easy.*" (Pierre, 20-29 M)
(For professionals) Prioritize kindness and openness when interacting with trans patients.	"*The professionals that were extremely well-intentioned and kind towards me, that never questioned my identity, that believed me…. that's really what led to success for me…it's the reason I'm that person I am today, the reason I'm thriving.*" (Henri, 20-29 M)
	For institutions
(For institutions) Provide training to professionals about both technical and social aspects of caring for trans patients.	*"Finding psychiatrists was very hard, I wasted a lot of time because they didn't believe me and always ended up refusing to care for me, they questioned me a lot, finally the fifth psychiatrist I saw didn't know much about trans identities but she was willing to learn, she was willing to take me on…so I guess you could say I trained her…and now she follows several other trans people I know…but yeah I never found a psychiatrist that was specialized, the two that really ended up helping me on my journey are psychiatrists that I trained myself."* (Zelly, 460–49 F)
Promote inter professionals collaboration to facilitate knowledge transmission, referrals, and cohesion of services	"[The nurse from the clinic] *kept checking in on me, to see how I was doing, she offered to train my nurses on post-op care for phalloplasty because they had never done it before, it was all things they were discovering." (Kyan, 40-49 M)*
Create up-to-date, reliable, and easy-to-access sources of information including professionals that provide GAC services, and detailed information about the services	*"We always have to cross reference information we find [in online groups]…we quickly start drowning in a mass of information." (Juliette, 50–59 F)*
Provide opportunities for trans patients to interact among themselves in both formal and informal settings	*"I find it important not to feel alone, during a meeting about phalloplasty I met someone who thought they were pretty much the only trans person on earth…he felt alone for years…it's hard to imagine." (Florian, 30-39 M)*

it's time professionals learn to tell the difference between gender and sexuality...for some a person who is FTM and is dating a man, well that's just not something they can comprehend." (Kyan, 40-49 M).

Participants expressed frustration with the limited resources, and conflicting advice, regarding GAC. Others expressed that lists of services and providers were not kept up to date (Henri, 20-29 M; Olaf, 20-29 M): "*I think there should be something solid, state-sanctioned, that can go OK, you are trans, call this number and they will orient you*" (Juliette, 50–59 F). Participants expressed a desire for feedback and pictures from surgeries, suggesting that this could be facilitated through meetings or events (Florian, 30-39 M; Naveen, 30-39 M).

Patients and providers are currently engaging in healthcare bricolage to address gaps

> *"(On an online Facebook group) there was so much advice, from people, from doctors, it explained how hormone therapy worked, once I was in front of the doctors I was already completely informed." (Arthur, 20-29 M).*

Participants described behaviors that seem to correspond to the concept of healthcare bricolage: "*actions which involve individuals undertaking practices to augment existing provision, as an alternative to existing provision, or as a necessity go beyond existing provision*" [18]. Examples were provided of patients and providers taking these actions either to improve services or out of necessity.

Participants organized and shared health information such as names of providers, photos of surgeries, reviews of their experiences, and information on GAC, to circumvent the lack of resources. Once they had acquired a better understanding of the healthcare system, they shared it with people who may still be struggling: "*we try to find people who are a bit more advanced than us, that can give us perspective, we also try to find people who aren't as far along and that we will be able help.*" (Emma, 40–49 F). This movement meant that several participants experienced receiving help from peers and providing help to peers. Some got involved in initiatives to educate about trans identities and recommended practices. Training of professionals on trans identities seems to be on a voluntary basis but is still happening. Participants described a nurse who trained colleagues on post-op care (Henri, 20-29 M), a surgeon who counseled a colleague about the risks of a procedure (Juliette, 50–59 F), and a psychiatrist

who expanded GAC services in their community (Henri, 20-29 M).

Discussion

This study highlighted experiences, expectations, and recommendations of transgender people concerning GAC. Experiences varied widely, notably due to the range of GAC procedures and professionals [19]. At the personal level, every participant found that GAC improved their quality of life, even if it presented significant challenges. At the professional level, the relationships between patients and professionals were characterized by their uneven nature. At the systemic level, improvements to GAC were formulated by drawing on concrete experiences.

Meaning of the results

For participants, GAC was shown to improve the quality of life of patients in multiple ways, but France needs to ensure that trans patients do not face discrimination within the healthcare system. This study describes stigma similar to what has been found previously, including through misgendering and refusals of care [20]. The study found a double experience of high rates of satisfaction and stigma similar to what has been recorded elsewhere [21]. This calls for greater attention from public health experts to accurately reflect patients' experiences with GAC.

The need for evolving relationships between trans people and professionals

The power imbalance between providers and trans patients is strong [22] as providers control access to therapies on which trans patients rely for identity expression [22]. In France, trans patients are often faced with long wait times and few professionals with in-depth knowledge of GAC [7]. This contributes to higher unevenness in power dynamics as patients can't easily change providers.

As in previous studies [21, 22], participants educated providers on trans identities. However, not all trans patients will feel comfortable taking on the role of educator with their provider [23]. If they do not feel that they will be well received by their providers patients may take on avoidance strategies [5]. These include delaying care, increasing their financial burden through private healthcare, hiding information from providers, or acquiring treatments without prescriptions [24].

Recommendations for best practices concerning GAC in France

The recommendation to use appropriate names, pronouns, and genders was congruent with previous work done in France [25]. This study got a more detailed overview of what trans patients expected. It also got several concrete examples of participants and providers adapting to failings in the sector of GAC.

Participants mirrored work done in France by reiterating the importance of training for professionals [7, 25]. They found that several professionals had inappropriate attitudes and felt uncomfortable caring for trans patients. This was echoed in research from the UK, where trans patients felt that their gender was being policed by professionals holding normative views [26]. As trans people gain visibility and openly utilize the healthcare system [27], the professionals must be able to receive them in a way that is competent and respectful of their rights [4].

Strengths

The data was part of a larger study looking at quality of life. This meant that GAC-related information could be situated more broadly in the context of participants' global well-being. The sample was of comparable size to other qualitative studies done with trans adults [25, 28, 29]. The sample mostly included participants with extensive experience of accessing GAC in France. Additionally, the two peer researchers involved in the recruitment and interviewing process were able to create a sense of trust and allowed for easier access to participants.

Limitations

This topic of GAC was explored based on the answers of participants to a broader interview guide. Had GAC been the focus of the interview guide some more precise questions might have been chosen, however interviewers always tried to get thorough and clear answers from participants through reformulations and questioning. In terms of interview processes, not all participants were in the same environment and not all of them were alone. The team chose to let participants make choices that ensured their comfort. The proximity between participants and peer researchers was also a limitation of the study as it might have increased desirability bias [30]. Additionally, all but one of the participants identified with one of the traditional binary genders thus results are not representative of non-binary patients.

Recruitment was primarily done through medical clinics [3]. Several of the participants were still being followed by professionals at these centers which could have created further desirability bias. The largest clinic was private, which may have led to an overrepresentation of patients able to access GAC privately [3]. Since participants were recruited through medical clinics, it is not surprising to see high rates of completed or planned surgical procedures in our sample. While this gives insight into the experience of undergoing GAS, it is important to note that results cannot be generalized, in particular to trans patients that do not desire GAS.

Additional research on the topic of GAC is necessary. Recruiting participants through various strategies could lead to more diverse experiences being represented. As private services are starting to develop more offerings in GAC [3], comparative studies between private and public services could put into focus any discrepancies between these sectors. As services will probably be seeing more non-binary patients in the next few years [1], research should be done to identify particular challenges, and needs, of both trans people with non-binary identities and trans patients who desire GAC in less traditional ways.

Conclusion

This article looked at the experiences of trans patients navigating GAC in France. Key findings include the strong positive impact of GAC on participants, the uneven distribution of knowledge and power between patients and providers, and the recommended practices for the future of GAC. The analysis clarified the value of GAC for trans patients who desire it, as well as their vulnerability to stigma within the healthcare system. Initiatives to improve GAC in France should be encouraged in order to promote the health of trans patients, while ensuring their rights are continuously respected [3, 4]. Finally, meaningful collaboration with peer-researcher helped structure research methods and objectives that were respectful of trans people's preoccupations and needs, and fostered trust between participants and heath researchers [30]. Their contribution to the research highlights the importance of the involvement of trans people in the development of quality GAC in France.

Abbreviations

GAC	Gender-Affirming Care
GAHT	Gender-Affirming Hormone Therapy
GAS	Gender-Affirming Surgery
e-QoL-Trans	Study on the quality of life of an e-cohort of transgender adults

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

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Author contributions

All the authors participated in the design of the study and the drafting of the study protocol. PM, MV, MB and ML conducted the qualitative interviews. MV transcribed the interviews. MV, PM and MB carried out the qualitative analysis. All the authors contributed to the drafting and final version of the article.

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Data availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The study was approved by Personal Protection Committee le de France IV. Informed consent was obtained from all the participants and/or their legal guardians.

Consent for publication

Not applicable.

Human rights

The study has been conducted in accordance with French law n°2004 – 806 of August 9th 2004, as well as in conformity with the agreement on good clinical practices (ICH version 4 of May 1st 1996 and decision of November 24th 2006). It has been approved by the *Comité de Protection des Personnes (CPP) Ile de France IV* and has been performed in accordance with the ethical standards as laid out in the 1964 Declaration of Helsinki and its later amendments.

Competing interests

The authors declare no competing interests.

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