HAUTE AUTORITÉ DE SANTÉ

RECOMMEND
BEST PRACTICES

GUIDELINE

Care for transgender adults

Adopted by the HAS Board on 17 July 2025

Clinical practice guidelines (CPGs) are defined in the health field as systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

CPGs are rigorous summaries of the state-of-the-art and scientific data at a given time, described in the evidence report. They do not exempt healthcare professionals from exercising discretion in the patient's treatment; this must be the treatment considered to be most appropriate on the basis of their own findings and the patient's preferences.

These clinical practice guidelines were developed according to the method summarised in the evidence report and in the HAS methodological guide available online: Development of best practice guidelines – Clinical practice guidelines method.

The objectives of this guideline, the population and the professionals concerned by its implementation are summarised in the description of the publication and described in detail in the evidence report.

The latter and the guideline summary can be downloaded from www.has-sante.fr.

Grades of recommendations

A	**Established scientific evidence** Based on studies with a high level of evidence (level of evidence 1): randomised controlled trials with high power and without major bias or meta-analysis of randomised controlled trials, decision analysis based on well conducted studies.
B	**Scientific presumption** Based on scientific presumption provided by studies with an intermediate level of evidence (level of evidence 2) such as low power randomised controlled trials, well conducted non-randomised controlled studies, cohort studies.
C	**Low level of evidence** Based on studies with a lower level of evidence such as case-control studies (level of evidence 3), retrospective studies, case-series studies, comparative studies with major biases (level of evidence 4).
EC	**Expert consensus** In the absence of studies, the recommendations are based on agreement between experts in the working group after consultation of the review group. The absence of grading does not mean that the recommendations are not relevant and useful. However, it should prompt additional studies.

Description of the publication

Title	Care for transgender adults
Method of production	Clinical practice guidelines
Objective(s)	Develop guidelines with a view to improving support and care for trans people
Targets	These guidelines are applicable to people over 18 years of age who have engaged in a medical and surgical transition pathway. They are aimed at professionals likely to provide care to trans people, in particular: general practitioners, endocrinologists, psychiatrists, psychologists, fertility and reproductive medicine physicians, obstetrician-gynaecologists, urologists, plastic surgeons, occupational physicians, social workers.
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Literature search	Performed by Ms Gaëlle Fanelli, archivist (Head of the Documentation-Literature Monitoring Department: Ms Frédérique Pagès)
Declaration of interests	The members of the working group have submitted their public declarations of interest to the HAS. They are available to view on the https://dpi.sante.gouv.fr website. They were reviewed according to the analysis grid of the HAS guidelines for the declaration of interests and management of conflicts of interest. In its analysis, the HAS also included the "Transparence-Santé" database, which requires manufacturers in the healthcare sector to publish the agreements, remuneration and benefits that bind them to players in the healthcare sector. The interests declared by the members of the working group and the information included in the "Transparence-Santé" database were deemed to be compatible with the participation of the experts in the working group.
Adoption	Version dated: 17 July 2025
Updating	
Other formats	Evidence report and guides for the clinical practice guideline, available for download at www.has-sante.fr

This document and its bibliographic reference are available to download at www.has-sante.fr

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Contents

Abbreviations and acronyms

Cegidd	Free information, screening and diagnosis centre
ICD	International Classification of Diseases
CMP	Medico-psychological centre
CMPP	Medico-psycho-educational centre
CSAPA	Addiction care, support and prevention centre
DSM	Diagnostic and Statistical Manual of Mental Disorders
GnRH	Gonadotropin-releasing hormone
HAS	Haute Autorité de santé (French National Authority for Health)
STI	Sexually transmitted infection
WHO	World Health Organization
MRM	Multidisciplinary review meetings
SOC	*Standard of care*
ASD	Autism spectrum disorder
WPATH	*World Professional Association for Transgender Health*

Introduction

Referral

The clinical practice guideline (CPG) entitled Care for transgender adults has been developed in response to a referral by the French Ministry for Solidarity and Health in 2021 (see Appendix 1), with a view to:

- assessing the impacts in terms of care pathways of the WHO decision of 2018;
- reviewing the role of psychiatric assessment in the hormone and surgical sex reassignment process;
- developing a new protocol in conjunction with healthcare professionals and community associations with the aim of improving the organisation of care in order to ensure the quality and safety of the care provided to this cohort;
- structuring medical management of the transition pathway, by fostering a link between the primary care physician and medical specialists (endocrinology, surgery, psychiatry);
- establishing the role of community medicine in the care pathway and its methods (particularly the role of hormone treatment);
- structuring care for transgender minors (primary care, child psychiatry, and psychological support);
- meeting the expectations of users, who must play a central role in defining care pathways and provision.

This request is justified by the need to introduce pathway diversity, and to implement de-psychiatrisation in these pathways following international updates.

Implications and objectives of the clinical practice guideline

The objective of this work is to develop guidelines with a view to improving support and care for trans people.

The associated implications are as follows: decrease in delays in individual medical care, stigmatisation, self-medication, fertility preservation and better overall health.

These implications involve raising awareness among professionals and providing the relevant training, harmonising practices, and a better organisation of care, while allowing transition pathway diversity.

Population concerned

The target population consists of trans people over 18 years of age who have engaged in a medical and surgical transition pathway.

The population under 18 years of age will be discussed in different guidelines.

Professionals concerned

These guidelines are aimed at professionals likely to provide care or support to trans people, in particular:

general practitioners, endocrinologists, psychiatrists, psychologists, fertility and reproductive medicine physicians, obstetrician-gynaecologists, urologists, plastic surgeons, occupational physicians, social workers.

Foreword

General – Definitions

The term “trans” (from Latin, meaning “beyond” one’s initial state) is used to describe people whose gender expressions or gender identities are different from those associated with the sex to which they were assigned at birth. As an umbrella term historically established in France, which continues to evolve, the term trans is based on the person’s self-determination.

The extension of the definition of a trans person to the whole spectrum of gender identities (binary, nonbinary, gender fluid, etc.) is used more variably, the scope of this term being more or less restricted depending on the sources.

In the 11th version of the International Classification of Diseases (ICD-11) adopted in 2018, the concept of “transsexualism” was abandoned, and “gender incongruence” was de-psychiatrised. Gender incongruence has been transferred from the category of mental disorders to conditions related to sexual health. The latest version of the Diagnostic and Statistical Manual of Mental Disorder (DSM5) adopted in 2013 also makes a distinction between “gender dysphoria associated with clinical significant distress or impairment in social functioning” and “gender incongruence [which] is not explicitly a mental disorder”. The standards of care of the *World Professional Association for Transgender Health* (WPATH) describe the “trans” reality as a choice of gender identity, noting the “de-psychopathologisation” recognised by ICD-11, emphasise patients’ active participation in decision-making about their own healthcare, and highlight the importance of training healthcare professionals to conduct the necessary assessment and provide appropriate care.

The terms used to define trans people are continually evolving, depending on their source and societal changes. These guidelines account for this scope for change, and try to align with the currently most relevant usage and definitions, while acknowledging that this terminology used is rooted in a specific geographical setting and time.

Population estimates

In a 2022 report by the General Inspectorate for Social Affairs (IGAS), the authors noted that chronic condition-related data are still incomplete in order to ascertain demand for and access to transition treatments, and do not provide a basis to specify the number of trans people in the population. The number of chronic condition beneficiaries under a transgender or gender dysphoria diagnosis has increased significantly in the last 10 years, while remaining relatively low: 9,000 people concerned in 2020, including 3,300 included within the previous year (i.e. 10 times more inclusions than in 2013 according to the French National Health Insurance Fund (CNAM)). Seventy percent of beneficiaries are between 18 and 35 years of age. In 2023, the number of chronic condition beneficiaries under this category was 22,550.

The WPATH 2022 Standards of Care (version 8), which include studies published after 2009, arrive at an estimate of 0.02 to 0.1% trans people from health systems-based studies, and a proportion of 0.3 à 0.5% trans people from survey-based studies. If broader manifestations of gender diversity (i.e. people with gender incongruence, gender ambivalence, etc., but not identifying as “transgender”) are taken into account, proportions of 0.3 to 4.5% are cited.

It is difficult to establish a summary of these different estimates, given the differences in the methodologies used (definition of transgender identity used, cultural setting, manner in which the question was asked, etc.).

Prevalence has been growing significantly for several years. For example, prevalence increased from 4.3/100,000 in 2007 to 22.1/100,000 in 2015 in one study in Madrid; it increased from 3.5/100,000 in 2006 to 33/100,000 in 2013 in a study based on veterans' data in the United States. Incidence has increased more moderately, and it was estimated at 2/100,000 in one study including patients in Madrid, with incidence remaining stable between 2008 and 2015. Studies based on veterans' data in the United States show a rising trend in incidence from 3.5 to 6.7/100,000 between 2006 and 2013.

Regarding the ratio of trans women to trans men, while it can vary depending on the methods used, it would appear to be fairly balanced in the adult population. The most recent studies tend towards a ratio of 2 trans women to 1 trans man. This figure has been fairly stable over the last 10 years. Recent literature suggests a reversal of the ratio, which appears to be observed more in adolescents and young adults.

The estimate of transgender people based on self-reported measures is variable, but appears to be around 0.5% in the general population in the most methodologically robust studies. The most recent data show higher figures in line with updates to legal, social and medical recognition options for trans people.

Overexposure to associated risks and disorders

The trans population is exposed to an excess risk of abuse and vulnerability, as demonstrated in numerous studies. Among the many issues encountered by trans people, it is worth noting the effects of transphobia (real, anticipated or perceived by those concerned): family rejection, abuse in public areas, work issues, housing issues, etc. The prevalence of mental disorders among trans people is particularly high, with excess risk compared to the general population, particularly in terms of depression, anxiety and suicidal ideation or behaviour.

Major discriminations in access to care (denial of access to care, very long intervals to access care, financial cover of treatments, etc.) are also identified in studies. In its latest framework ruling of June 2025, the Defender of Rights noted that problems and obstacles encountered in access to care impair transgender people's mental and physical health, resulting in isolation from care, and may lead to an increase in suicidal risk.[1]

Medical treatment of trans people also involves other important aspects. Particularly, prevention and control of various disorders or diseases to which trans people are more exposed than the general population: sexually transmitted diseases, including HIV infection; mental health disorders, often associated with discrimination (suicide attempts, eating disorders: anorexia, bulimia, etc); and psychoactive substance use. Neurodevelopmental disorders are observed in several studies and an 11% prevalence of autism spectrum disorder (ASD) was observed in a 2022 meta-analysis encompassing 25 studies (of which 12 studies on adults, including 8 self-reported autistic trait identification population surveys).

Access to care

The IGAS report mentioned above noted that the medical-surgical transition pathway, which allows the person to match their physical appearance to their gender identity, remains a major challenge for trans people. These guidelines have been established in a French context in which access to gender-affirming surgery is expanding nationwide but continues to be difficult to access on account of geographically restricted and poorly distributed care provision. This strain on care provision is a potential obstacle to the quality of surgical support, which is facing demand beyond its resources.

[1] Droits des personnes transgenres : la Défenseure des droits publie une nouvelle décision-cadre | Défenseur des Droits [Transgender rights: Defender of Rights publishes new framework ruling | Defender of Rights]

Access to transition care is not a “convenience”, but essential in terms of well-being, self-image, personal life, overall health, and also social life. Given the substantial psychosocial risks highlighted in studies, transition pathways must factor in social and economic health determinants, and include screening for abuse scenarios, to enable appropriate medical, psychological, and social support. The previous HAS publication on the medical care for adults (2009) included, in the standard case (to be adapted to specific circumstances), diagnosis and assessment of gender identity disorder, followed by real-life experience, hormone treatment, and surgery.

Current practices have moved away from this recommendation in terms of commencing the transition process (for psychiatric transgender validation and real-life experience). This new guideline incorporates these changes, and focuses on the trans person's pathway, in order to provide appropriate support. The initial interview is an opportunity to understand where the person is at in terms of their transition, how it came about, any impacts (positive and/or negative on the person’s family, physical and mental health, or resources), and their level of information. It should be used to record person’s perceived needs, any plans for medical gender-affirming treatments, support needs, etc.

Trans people have the basic right to non-discrimination on account of their gender identity (Law No. 2017-86 of 27 January 2017 on Equality and Citizenship). Non-discrimination is particularly applicable to access to care (Defender of Rights framework ruling 17/06/2025[2]).

The ethical framework of compassionate care is a precondition of good professional practice when dealing with trans people.[3]

The working group tasked with this guideline observes that there is no “typical” transition pathway: for each trans person, these pathways are marked by their individual priorities, and follow a specific timeframe for each individual. Each person’s own constraints, associated with their family, social and work circumstances, often set the pace of transition.

In this context, the guideline mainly focuses on these “medical transition” phases, which concern all medical treatments associated with gender transition: access to feminising or masculinising hormone treatment, access to gender-affirming surgery (facial feminisation surgery, chest masculinising surgery, genital surgeries, etc.), taking into consideration that this care pathway only partially overlaps with the transition pathway. The latter is broader than the former in that it may be confined to social, legal, and administrative processes.

Alongside recommendations for the professionals concerned, the working group tasked with this guideline wanted to draw the attention of public authorities and National Health Insurance Fund to a number of key points to ensure effectiveness, quality, and safety of transgender care:

- adaptation of regulations in respect of medicinal product prescription, dispensing and cover;
- structuring of specific care provision and local organisation with suitably trained professionals to address needs for support and medical and surgical treatment;
- harmonised nationwide cover of procedures;
- increase in initial and ongoing training of professionals supporting trans people by including those concerned in the development of training content;
- development of research on medical treatment for trans people, their care pathway, access to care and their overall health, with input from those concerned (participatory research).

[2] Droits des personnes transgenres : la Défenseure des droits publie une nouvelle décision-cadre | Défenseur des Droits [Transgender rights: Defender of Rights publishes new framework ruling | Defender of Rights]

[3] Haute Autorité de Santé - La bientraitance : définition et repères pour la mise en œuvre [French National Authority for Health - Compassionate care: definition and benchmarks for implementation]

1. Definition

R1. Unless the person wishes otherwise, it is recommended to use the term “trans(gender)” to describe people whose gender identities and/or gender expressions are different from those associated with the sex to which they were assigned at birth (EC). The adjective “trans” is used as an umbrella term covering all gender variance. The characterisation of a trans person is based on their self-determination.

As such, the following terms shall be used:

- trans woman for a trans person engaged in or seeking a feminising pathway;
- trans man for a trans person engaged in or seeking a masculinising pathway;
- nonbinary for people whose gender may consist of several gender identities at the same time or at different times, gender neutral, or gender fluid.

2. Background

R2. Given the substantial psychosocial risks affecting trans people, care pathways must factor in social and economic health determinants, and include screening for abuse scenarios, to enable appropriate medical, psychological, and social support (EC).

R3. It is recommended to include trans people systematically in sexual health prevention messages and initiatives (information, screening, inclusion of gender in patient history, choice of combined prevention tools, method of administration of treatments, dosage, etc.) (EC).

3. Procedure to be followed for a person seeking transition

3.1. Receipt of request

R4. It is recommended to tailor support to the individual, according to their needs throughout their pathway, in order to create a positive consultation environment (EC).

R5. It is recommended to receive the person without judgment or preconceptions in respect of their gender identity and support needs (EC).

R6. It is recommended to provide a compassionate setting, appropriate for receiving trans people, particularly using their requested name and pronouns (in all communication) to avoid any stigmatisation. This involves training all professionals on best practice for receiving trans people (EC).

This implies promoting active listening and understanding when receiving trans people and those close to them with their consent, particularly by setting up a safe meeting space, and adopting appropriate communication methods and materials.

3.2. Initial assessment

3.2.1. Interview

R7. As for all medical care, the aim of the initial interview with a trans person is to provide appropriate support for the person's needs, and will be tailored according to their transition objectives (EC).

R8. It is recommended that the initial interview describe (EC):

- the person's history in relation to gender incongruence, its persistence, and the person's gender-affirming needs (medical treatments, support, etc.);
- screening for specific risks is performed according to the requests (hormone prescription, surgeries, etc.), and it includes an assessment of health vulnerability factors and of any abuse experienced;
- the person's autonomy and capacity to give their informed consent;
- the individual's resources (social, associations, family), and transition security (retention of these resources during transition).

R9. The person's decision-making ability must be assessed on a case-by-case basis. There is no specific assessment tool to use (EC).

3.2.2. Clinical assessment (organ anomaly, concomitant disorders)

R10. At the initial request, the clinical assessment will be guided by questioning and the clinical context with the patient's consent (EC).

R11. This assessment can be an opportunity to offer screening and provide prevention information on sexually transmitted infections (STIs) and addictive behaviours (EC).

3.3. Relational framework

3.3.1. Importance of working with family members

R12. It is recommended to assess the person's social and family support, and to undertake initiatives to promote and increase this support (Grade C). These initiatives may include referral to associations to increase community support.

R13. It is recommended to offer a specific space for family members (parents, partner, children, etc.), in order to offer them appropriate information and emotional support (Grade C).

3.3.2. Shared medical decision and consent

R14. Each person's free and informed consent must be requested.

As a reminder, Opinion 136 of the National Ethics Advisory Committee[4] reports updates in consent-related ethical issues in care.

3.4. Treatment-related information provided to person

R15. The person must be informed with regard to the different options in terms of gender-affirming treatments and support before any decision is made. This information must address the expected effects and include a review of the benefits and risks of the different options, and details on the degree of scientific certainty of the different information (EC). It will allow the person seeking transition to provide their free and informed consent for the suggested treatments after a reasonable and proportionate reflection time frame.

R16. It is recommended to inform people that there is no typical pathway, so that they are encouraged to express their individual needs in order to tailor their own pathway (Article L. 1111-2 of the French Public Health Code).

R17. It is recommended to inform the person about the potential outcomes and limitations of the different treatments, so as to avoid any unrealistic expectations (EC).

R18. It is recommended that the information be adapted to the person's capacity for comprehension and that of anyone accompanying them (EC).

3.5. Definition of treatment goals

R19. It is recommended to support the person (and their family, if applicable) in developing their personalised transition pathway, taking into account the person's various goals and expectations, and also the resources envisaged and the various constraints for meeting goals. This pathway will be adapted according to needs and any changes in these needs (EC).

3.6. Referral of person according to their needs

R20. Each person must be able to access healthcare professionals capable of meeting their needs. Each healthcare professional must be able to inform the trans person about appropriate specialists and other healthcare professionals for the different treatment options (EC).

[4] Avis 136 L'évolution des enjeux éthiques relatifs au consentement dans le soin | Comité Consultatif National d'Ethique [Option 136 Updates in consent-related ethical issues in care | National Ethics Advisory Committee]

In addition, it is important to inform the person about user associations, so that they can supplement the information available to them, join self-support and support networks, and benefit from peer support. This information is also relevant for anyone accompanying the person (family members) with the person's consent (EC).

4. Hormone prescription

4.1. Effects on mental health and on quality of life

R21. Hormone prescription by trained physicians for trans people seeking transition, after obtaining informed consent, and conducting a personalised assessment of the benefits and risks, is recommended, because, under these conditions, it may help improve their mental health and their quality of life (Grade C).

This information will allow the person seeking transition to provide their free and informed consent for the suggested treatments after a reasonable and proportionate reflection time frame (see R15).

4.2. Feminising hormone prescription

4.2.1. Expected effects of hormones

The expected effects of oestrogens and testosterone-lowering drugs are shown in Tables 1 and 2.

Table 1. Expected physical effects of oestrogens

Average time	Effect of oestrogens
1-3 months after start of treatment	Change in body odour Decrease in muscle mass Increase in fat mass Fat redistribution (buttocks and hips) Softening of skin Change in sexual desire Decreased nighttime, morning, or spontaneous erections (in some cases, less firm erections or lack of triggered erections) Decreased sperm production
Gradual changes (at most 1 to 2 years after start of treatment)	Nipple and breast growth Decreased hair growth Slower or discontinued baldness progression Decreased testicular volume

Table 2. Expected physical effects of testosterone-lowering drugs

Average time	Effect of testosterone blockers
1 to 3 months after start of treatment	Decreased sexual desire Decreased nighttime, morning, or spontaneous erections. In some cases, difficulty having erections even when stimulated Decreased sperm production

Gradual changes (usually at least 2 years)	Decreased hair growth Decreased or discontinued baldness progression Moderate breast growth (only reversible in some cases)

Note: oestrogens and testosterone-lowering drugs do not cause voice changes.

4.2.2. Patient history and assessment

The physician's work is unchanged from their routine practice. They will compile the person's personal and medical history, along with any treatments; they will take care to screen for risk factors associated with feminising hormone treatment.

They will also conduct a clinical examination, with the person's consent, and will request a laboratory workup guided by questioning and the envisaged prescription.

R22. In the absence of specific scientific studies, the clinical assessment prior to feminising hormone prescription for a trans person will consist of recording their medical history (personal and family), and a clinical examination guided by the interview after the person's consent. More specifically, it will include screening for vascular (arterial and venous) and cancer risk factors, a metabolic profile, a blood pressure reading, and a record of height and weight (EC).

Laboratory workups will focus on the effects of any treatments (EC):

- in the case of spironolactone use: blood creatinine and blood electrolytogram;
- in the case of use of any hepatotoxic medicinal products, such as cyproterone acetate, bicalutamide: transaminase level;
- screening for lipid disorders, diabetes or STIs will be performed according to the guidelines for the general population.

Information on spontaneous fertility or fertility preservation when undergoing feminising hormone treatment should be given multiple times if required. As such, it will be necessary to ensure that the information provided is clearly understood, and account for changes in the person's expectations over time. Information on contraception options and methods will be provided to trans people if required or if requested by the person.

The initial interview is an opportunity to review the person's overall circumstances (see 3.2.1), and information about spontaneous fertility when undergoing feminising hormone treatment and on the option of fertility preservation (specialist consultation and information option) will be provided (EC).

R23. Unless suggested by any anomalies, it is not recommended to perform karyotyping prior to feminising hormone prescription for a trans person (Grade C).

4.2.3. Hormones

4.2.3.1. Oestradiol

R24. On account of high between-subject variability, it is recommended that the 17-beta-oestradiol dose be adapted to the trans person's blood workups and clinical symptoms (EC).

R25. It is recommended to take into account the wishes and lifestyle of the trans person in question, along with the benefit/risk ratio of each administration route of 17-beta-oestradiol (see Table 3) (EC). In the absence of personal preference or in the case of risk factors, percutaneous administration will be preferred over oral administration (EC) (see R61).

R26. It is not recommended to combine multiple administration routes of 17-beta-oestradiol (EC).

R27. It is recommended to inform trans people about the effects of feminising hormones (EC).

Table 3. Use of 17-beta-oestradiol for feminising hormonal transition

17-beta-oestradiol	Initial dose	Maximum dose that can be used	Note
Transdermal "gel"	1.5-3 mg/day	6 mg/day	Very highly variable according to application site or deposition surface
Weekly or twice-weekly transdermal "patches"	100 µg/day	400 µg/day	Highest dosage 100 µg, therefore several patches simultaneously in some cases
Oral	2-4 mg/day	8 mg/day	If > 2 mg taken twice daily
Intramuscular injection	4 mg/wk	-	Not currently available in France
Subcutaneous injection	3.5-4 mg/wk	-	Not currently available in France

4.2.3.2. Testosterone blocking (excluding orchiectomy)

R28. Taking 17-beta-oestradiol alone may be sufficient to inhibit testosterone, but only in some cases and at high dosages, the risks of which must be discussed with the trans person (EC). Otherwise, combination with a drug aimed at lowering testosterone production or action is to be discussed on a case-by-case basis, and must not be systematic (EC).

R29. Isolated use of testosterone blockers without associated 17-beta-oestradiol is not indicated for feminising hormonal transition for a trans person. If the person requests it, this use may be discussed, and must be reviewed regularly in view of the potential risks in the long term (particularly in relation to bone and mental health) (EC).

R30. If bitherapy (concomitant use of 17-beta-oestradiol and a testosterone blocker) is used for feminising hormonal transition for a trans person, tapering off the blocker may be envisaged with the person once the sought clinical effects have stabilised (EC).

R31. Testosterone blocking is not indicated post-orchiectomy in a trans person (EC).

Spironolactone

R32. Use of spironolactone, alongside oestrogens, may be envisaged in the case of feminising hormone prescription for a trans person (EC) subject to blood pressure, blood electrolytogram and blood creatinine monitoring in accordance with standard prescription conditions. Use may be envisaged after discussing the benefit/risk ratio, either at the start of treatment, or at a later stage according to the clinical effects of the feminising hormones prescribed.

5-Alpha-reductase inhibitors

R33. Use of 5-Alpha-reductase inhibitor for feminising hormonal transition for a trans person has not demonstrated a particular benefit over other treatments. Its use is not recommended as a first-line anti-

androgen, on account of a potentially negative impact on mental health (depression, suicidal ideation) (EC).

Androgen receptor antagonists

R34. Use of bicalutamide in feminising hormonal transition has not been sufficiently assessed, and involves a liver toxicity risk. It is not recommended to use bicalutamide as a first-line treatment when starting feminising hormones (EC).

GnRH agonists

R35. Use of gonadotropin-releasing hormone (GNRH) alongside oestrogens may be envisaged when prescribing feminising hormones for a trans person (EC). Use may be envisaged after discussing the benefit/risk ratio, either at the start of treatment, or at a later stage according to the clinical effects of the feminising hormones prescribed. Use of another anti-androgen may be discussed during the first weeks to prevent a flare-up effect and an associated increase in testosterone (EC).

R36. GnRH-antagonists show promise, but have not been assessed in trans people, and cannot be recommended outside study protocols (EC).

Progestins

R37. Use of cyproterone acetate for feminising hormonal transition for a trans person is not recommended as a first-line treatment at doses of 50 to 100 mg/day on account of the excess risk of meningioma and the availability of alternative drugs (EC).

R38. As a last resort, it is possible to suggest use of cyproterone acetate over a short period at dosages of 25 mg/day or 25 mg every two days for feminising hormonal transition for a trans person in accordance with the prescription rules for this drug (EC).

R39. There is no evidence of the effect of progesterone on mammary gland growth. Micronised progesterone may increase mammary gland volume, and improve the person's well-being, but there are uncertainties around cardiovascular, breast cancer, meningioma risk, and mood. Its use for trans people will be discussed on a case-by-case basis, particularly after 45 years of age (see Table 4) (EC).

Table 4. Overview of anti-androgens that can be used for feminising hormonal transition with concomitant oestrogen use

Drug	Initial dosage	Maximum dosage	Specific monitoring	Note
Spironolactone	100 mg/day	200 mg/day	Renal function, potassium	Diuretic effect
Triptorelin/leuprorelin	3.75 mg/month or 11.25 mg/3 months	-	No monitoring	Flare-up effect in first few days. Possible use of another anti-androgen to counter effect (e.g. spironolactone)
Cyproterone acetate	12.5 mg/day	25 mg/day	Blood prolactin, brain MRI before start of treatment and at 5 years, then every 2 years	2nd line
Bicalutamide	50 mg/day	-	Liver function (transaminases)	2nd line. Little assessment available

Micronised progesterone	100 mg/day	200 mg/day	No monitoring	Little assessment available. Uncertain benefits

4.2.4. Clinical and biological follow-up of trans people undergoing feminising hormone treatment

Feminising hormone treatment monitoring will include clinical follow-up, compiling the person's experience, expected effects, and any adverse effects. Once again, risk factors will be screened, because they may change with age and hormone treatment duration.

R40. In the absence of specific clinical studies, clinical assessment for monitoring trans people undergoing feminising hormone treatment will be conducted at 3 months, then at a frequency adapted on a case-by-case basis, until the level is within reference values, and once per year thereafter. It will consist of a clinical interview to check safety (signs of hormonal over- and under-dosages, adverse effects), treatment efficacy, risk factors, and the person's satisfaction (EC).

R41. Laboratory workups for monitoring trans people undergoing feminising hormone treatment will focus on the effects of any treatments, and will be performed at 3 months, then at a frequency adapted to age and on a case-by-case basis, until the level is within reference values, and if needed thereafter. They will include (EC):

- oestradiol and testosterone levels. As a first-line approach, oestrogen and total blood testosterone levels are sufficient for trans people who have retained their gonads;
- in case of spironolactone use: blood creatinine level and blood electrolytogram;
- in case of use of any hepatotoxic treatments, such as bicalutamide: transaminase level.

R42. Screening for lipid disorders, diabetes or STIs in a trans person undergoing feminising hormone treatment will be performed according to the guidelines for the general population (EC).

R43. For trans people at a risk of osteoporosis, a higher serum oestradiol level may lower subsequent fracture risk and treatment compliance should be confirmed (EC).

R44. Testing the oestrone level is not recommended in routine practice in the follow-up of trans people undergoing feminising hormone treatment (Grade C).

R45. Clinical safety assessment is to be considered alongside blood levels. Prescription is to be adapted to each trans person undergoing feminising hormone treatment, on a case-by-case basis. In the event of levels unexplained by the prescribed dosage, dialogue must be initiated with the person in order to adopt a risk-reducing approach with respect to potential self-medication (EC).

4.2.5. Monitoring of trans people undergoing feminising hormone treatment

4.2.5.1. Cardiovascular risk

R46. For trans people over 37 years of age, or in the case of risk factors of thromboembolism (body mass index (BMI), smoking, familial factors), first-line transcutaneous 17-beta-oestradiol use is recommended on account of a potential reduction of excess risk of thromboembolism (Grade C).

4.2.5.2. Hepatic risk

R47. Besides the use of a potentially hepatotoxic treatment, such as bicalutamide, or a history of liver disorders, it is not recommended to monitor liver function in asymptomatic trans people undergoing oral or transdermal oestrogen treatment (EC).

4.2.5.3. Oncological risk

R48. It is not recommended to conduct specific oncological monitoring for trans people (EC). Trans people should undergo screening for cancers of their organs (breast, prostate, and testicular).

4.2.5.4. Endocrinological risk

R49. It is recommended to test the prolactin level in trans people undergoing feminising hormone treatment in the event of onset of headaches, galactorrhoea, or vision disorders (EC).

4.2.5.5. Other effects

R50. Kidney function monitoring will be conducted on a case-by-case basis in line with clinical practice guidelines for any prescribed treatments (EC).

R51. As 17-beta-oestradiol use at effective doses has a neutral effect on bone densitometry, it is not recommended to conduct specific bone monitoring for trans people (EC). Particular attention must be paid to people with suboptimal oestradiol levels.

4.2.6. Hormone treatment duration

R52. The maximum duration of feminising hormone treatment for trans people is not known to date. Introduction, maintenance or reduction of feminising hormone treatment will be discussed on a case-by-case basis, taking into account the person's needs, the benefit/risk ratio, and particularly age-related issues (EC).

4.3. Masculinising hormone prescription

4.3.1. Expected effects of hormones

The expected effects of testosterone are shown in Table 5.

Table 5. Typical changes with testosterone treatment (varying from one individual to another)

Average time	Effects of testosterone
1 to 3 months after start of treatment	Increased sexual desire Vaginal dryness and decreased vaginal elasticity Clitoral enlargement (clitoral hypertrophy 1 to 3 cm) Increased leg, arm, chest, back, and abdominal hair growth, thickness, length Body odour Skin oiliness and acne Increased muscle mass and strength Fat redistribution with increase on abdomen and decrease on hips
1-6 months after start of treatment	Cessation of menses

3-6 months after start of treatment	Onset of deepening of voice (may take up to one year)
1 year or more after start of treatment	Gradual beard growth (usually 1 to 4 years) Possible male pattern baldness

4.3.2. Patient history and assessment prior to hormone prescription

R53. In the absence of specific clinical studies, the clinical assessment prior to masculinising hormone prescription for a trans person will consist of recording their medical history (personal and family), and a clinical examination guided by the interview after the person's consent. More specifically, it will include screening for vascular and cancer risk factors, a metabolic profile, a blood pressure reading, and a record of height and weight.

R54. Laboratory workups prior to masculinising hormone prescription for trans people will focus on any treatments and data from the initial clinical interview (EC):

- red and white cell count for the initial haemoglobin and haematocrit assessment (see R67);
- screening for hepatic cytolysis and cholestasis;
- screening for lipid disorders, diabetes or STIs will be performed according to the guidelines for the general population.

R55. Unless suggested by any anomalies, it is not recommended to perform karyotyping prior to masculinising hormone prescription for trans people (EC).

R56. The initial interview is an opportunity to review the trans person's overall circumstances (see 3.2.1), and information about fertility preservation (specialist consultation and information option) will be provided (EC).

R57. It is not necessary to make gamete removal a precondition for commencing testosterone treatment for trans people (EC).

R58. Testosterone must not be considered as contraception (EC). Non-hormonal or progestin contraception may be proposed in accordance with standard prescription rules (EC).

4.3.3. Hormones

4.3.3.1. Androgens

R59. On account of high between-subject variability, it is recommended to adapt the testosterone dose for trans people to their blood workups and clinical symptoms (EC).

R60. The testosterone administration route (percutaneous or injection) must be personalised and adapted to the trans person (EC).

R61. It is advised to take into account the wishes and lifestyle of the trans person in question, along with the benefit/risk ratio of each administration route of testosterone (see Table 6) (EC).

R62. It is recommended to inform trans people of the benefits and risks of testosterone treatment (personal and family vascular history, advice to quit smoking) (EC).

R63. It is necessary to consider potential self-medication by trans people (EC).

Table 6. Testosterone use for masculinising hormonal transition

Testosterone	Minimum dose	Initial dose	Maximum dose	Note

Subcutaneous or intramuscular enanthate	20 mg/wk	50 mg/wk	100 mg/wk	Double doses if every 2 weeks
Subcutaneous or intramuscular undecanoate		750 mg repeated at 4 weeks, then every 10 weeks		-
Testosterone gel	12.5-25 mg/morning	50 mg/morning	100 mg/morning	Variable according to application site

4.3.3.2. 5-Alpha-reductase inhibitors

R64. Use of 5-alpha-reductase inhibitor in trans people is not recommended systematically in cases of androgenetic alopecia. Lowering the testosterone dose to counter alopecia may be discussed on a case-by-case basis, accounting for the potential negative impact on virilisation and mental health (EC).

4.3.3.3. Androstanolone gel (dihydrotestosterone or DHT)

R65. Use of androstanolone gel for trans people is not recommended (EC).

4.3.4. Clinical and biological follow-up of trans people undergoing masculinising hormone treatment

R66. In the absence of specific clinical studies, clinical assessment for monitoring trans people undergoing masculinising hormone treatment will be conducted at 3 months, then at a frequency adapted on a case-by-case basis, until the level is within reference values, and once per year thereafter. It will consist of a clinical interview to check safety (signs of hormonal over- and under-dosages, adverse effects), treatment efficacy, risk factors, and the person's satisfaction (EC).

R67. Laboratory workups for monitoring trans people undergoing masculinising hormonal treatment will focus on the treatments used and will be performed at 3 months the first year, then until the level is within reference values, then once per year with dose changes, and if needed thereafter. They will include (EC):

- testosterone level. Total blood testosterone levels are sufficient for people who have retained their gonads;
- in the case of gonadectomy, luteinising hormone (LH) level;
- red and white cell count for the haemoglobin and haematocrit assessment.

R68. Screening for lipid disorders, diabetes or STIs will be performed according to the guidelines for the general population (EC).

R69. There is no threshold value with evidence of a preferable benefit/risk ratio for masculinising treatment (EC).

R70. In this context, clinical safety is prioritised over blood levels. If testing the testosterone level, the testosterone concentrations must be equivalent to those of men based on age (EC).

4.3.5. Monitoring of trans people undergoing masculinising hormone treatment

4.3.5.1. Cardiovascular monitoring

R71. Cardiological monitoring of trans people undergoing testosterone treatment is the same as for men (EC).

R72. Haematocrit monitoring of trans people undergoing testosterone treatment should be conducted at 3 months with dose changes. If the value is less than 54%, and in the absence of a dose change or risk factor, it is recommended to conduct annual monitoring subsequently (EC).

4.3.5.2. Hepatic risk

R73. For trans people undergoing testosterone treatment who are asymptomatic, it is not recommended to conduct liver enzyme monitoring solely on the basis of hormone treatment (EC).

4.3.5.3. Oncological risk

R74. Breast cancer monitoring of trans people, whether they have had a mastectomy or not, will follow the guidelines (HAS 2014) for women (EC).

R75. Pelvic cancer monitoring of trans people will follow the guidelines for women (EC).

4.3.5.4. Fertility

R76. Testosterone must not be considered as contraception (EC). Non-hormonal or progestin contraception may be proposed in accordance with standard prescription rules (EC).

R77. In the first years of testosterone treatment, gamete removal may be offered (EC).

4.3.5.5. Other effects

R78. It is recommended to monitor kidney function in trans people as for the general population (EC).

R79. Apart from microdosing or discontinuation of masculinising hormone treatment after gonadectomy, it is not recommended to conduct specific bone monitoring for trans people (EC).

4.3.6. Hormone treatment duration

R80. The maximum duration of masculinising hormone treatment for a trans person is not known to date. Maintenance or reduction of masculinising hormones will be discussed on a case-by-case basis, taking into account the person's needs, the benefit/risk ratio, and particularly age-related issues (EC).

5. Surgical treatment

5.1. Surgical treatment methods

R81. In the case of transition, it is recommended to respond to requests for surgery from trans people, according to the same methods and time frame as for other requesters (EC). This surgery will be performed by physicians with the necessary expertise.

R82. Systematic psychiatric assessment is not recommended (EC).

R83. It is recommended to provide clear, honest and appropriate pre-operative information, in order to allow the trans person to give their informed consent. This information must cover all surgical regimens and their short-term and long-term risks, and irreversibility in the case of some procedures (EC).

R84. Appropriate post-operative follow-up and care for the type of surgery must be set up systematically in the course of surgical treatment (EC).

R85. Subject to expertise and availability, a surgeon will accept to reoperate on a person on whom they have not previously operated.

5.2. Feminisation surgery

5.2.1. Facial surgeries

Surgery type

R86. It is recommended to respond to requests from trans people seeking facial feminisation surgery, including in the absence of hormone treatment (Grade C).

Recommended surgery-specific conditions

R87. It must be possible to discuss facial feminisation procedures (rhinoplasty, facial contouring (chin, jaw, thyroid cartilage, forehead and hairline, soft area remodelling, hair transplant)), as well as alternatives to surgery (e.g. wig, expected effect of hormone treatment on face), in order to meet the trans person's request insofar as possible, while specifying the conditions under which cover is provided by the National Health Insurance Fund or not (EC).

5.2.2. Chest surgeries

Surgery type

R88. It is recommended to respond to requests from trans people seeking chest feminisation surgery (Grade C).

Recommended surgery-specific conditions

R89. It must be possible to discuss all chest feminisation procedures (breast implants, implant replacement (Grade C), fat transfer, flap (EC)), as well as alternatives to surgery (e.g. expected effect of hormone treatment, external prosthetics), in order to meet the trans person's request insofar as possible. Undergoing hormone treatment must not be a precondition for access to these surgeries.

Specificity of pre-operative information

R90. It is recommended to inform the trans person in question specifically about the risks of surgical revision, and about all of the risks associated with breast implant use, in particular that of large cell lymphoma associated with textured implants (Grade C).

Follow-up

R91. Standard medical follow-up for these procedures according to breast implant type is recommended (EC).

5.2.3. Genital surgeries

Surgery type

R92. It is recommended to respond to requests from trans people seeking genital feminisation surgery (EC).

R93. For people not yet undergoing hormone treatment, it is advisable to recommend trialling feminising hormone treatment prior to surgery (EC).

Recommended surgery-specific conditions

R94. It is not necessary to discontinue feminising hormone treatment prior to surgery.

R95. It must be possible to discuss the different options (orchiectomy, vulvoplasty, vaginoplasty), and all of the different procedures (e.g. use of penile skin, peritoneum, colon, etc), in order to meet the trans person's request insofar as possible (EC).

Specificity of pre-operative information

R96. It is essential to inform the trans person in question specifically about (EC):

- the irreversibility of orchiectomy and vulvoplasty and their impact on fertility;
- stopping endogenous hormone production and its impacts on physical and mental health;
- the need for long-term post-operative care in cases of vaginoplasty (vaginal dilations).

This information will allow the person seeking transition to provide their free and informed consent for the suggested treatments after a reasonable and proportionate reflection time frame (see R15).

Follow-up

R97. No specific long-term urological and/or gynaecological follow-up is recommended, except in the case of symptoms (EC).

R98. Sexual health support must be provided (EC).

R99. Hormonal follow-up must be encouraged after genital surgery (EC).

5.2.4. Voice surgeries

Surgery type and recommended surgery-specific conditions

R100. The recommended treatment for voice feminisation is speech therapy (EC).

R101. In the event of an unsatisfactory outcome from speech therapy, other techniques are available (breathwork, singing), or even voice feminisation surgery, taking into consideration the risks of these procedures (dysphonia, etc.) (EC).

R102. It must be possible to discuss all of the different procedures available (cricothyroid approximation, endoscopic glottoplasty), in order to meet the trans person's request insofar as possible (EC).

R103. Speech therapy follow-up is recommended after a surgical procedure (EC).

5.3. Masculinising surgery

5.3.1. Chest surgeries

Surgery type

R104. It is recommended to respond to requests from trans people seeking chest masculinising surgery adapted to the trans person's anatomy (Grade C).

Recommended surgery-specific conditions

R105. Obesity or overweight are not contraindications to chest masculinising surgery for trans people.

R106. It must be possible to discuss all of the different options (e.g. double incision, periareolar incision), and alternative techniques (binding), in order to meet the trans person's request insofar as possible (EC). Undergoing hormone treatment must not be a precondition for access to these surgeries.

R107. Breast cancer screening may be carried out pre-operatively according to the guidelines in force (EC).

Specificity of pre-operative information

R108. It is recommended to inform the trans person in question specifically about (EC):

- the impact of weight fluctuations;
- nipple sensitivity disorders;
- the high rate of surgical revision;
- persistence of residual breast tissue (theoretical breast cancer risk).

5.3.2. Internal genital organ surgeries

Surgery type

R109. It is recommended to respond to requests from trans people seeking female internal genital organ ablation surgery (Grade C).

Recommended surgery-specific conditions

R110. It must be possible to discuss all of the different procedures available (ovariectomy, total hysterectomy [hystero-salpingo-colpectomy], vaginectomy), in order to meet the trans person's request insofar as possible (Grade C).

Specificity of pre-operative information

R111. It is recommended to inform the trans man in question specifically about (EC):

- the irreversibility of ovariectomy and hysterectomy and the effects on fertility;
- the option of uni- or bilateral ovary preservation, and the lack of knowledge about its long-term effects;
- stopping endogenous hormone production in the case of ovariectomy and its impacts on physical and mental health.

This information will allow the person seeking transition to provide their free and informed consent for the suggested treatments after a reasonable and proportionate reflection time frame (see R15).

Follow-up

R112. In the absence of colpohysterectomy, cervical cancer screening follow-up must be conducted according to the screening methods in force (EC).

5.3.3. External genital organ surgeries: metoidioplasty

Surgery type

R113. It is recommended to respond to requests from trans people seeking metoidioplasty surgery (Grade C).

Recommended surgery-specific conditions

R114. It must be possible to discuss all of the different procedures available (urethral lengthening, scrotoplasty, vaginectomy), in order to meet the trans person's request insofar as possible (Grade C).

Specificity of pre-operative information

R115. It is recommended to inform the trans person in question specifically about (Grade C):

- reconstructed phallus size generally varying between 4 and 10 cm;
- frequent complications, particularly with urethral lengthening.

Follow-up

R116. Long-term urological follow-up is recommended for urethral lengthening (EC).

R117. Sexual health support must be provided (EC).

5.3.4. External genital organ surgeries: phalloplasty surgeries

Surgery type

R118. It is recommended to respond to requests from trans people seeking phalloplasty surgery (Grade C).

Recommended surgery-specific conditions

R119. It must be possible to discuss all of the different procedures available (phalloplasty, glanuloplasty, urethral lengthening, scrotoplasty, vaginectomy), in order to meet the trans person's request insofar as possible (Grade C).

Specificity of pre-operative information

The incidence of short- to medium-term complications requires comprehensive information and an understanding of the treatment plan.

R120. It is recommended to inform the trans person in question specifically about (Grade C):

- all of the phallus construction procedures available;
- the risk of total flap loss with phalloplasty;
- the complications frequently associated with urethral lengthening and erectile prosthetic device implantation;
- the limited lifetime of erectile prosthetic devices;
- donor site morbidity (scarring);
- possible genital sensitivity disorders;
- the duration of surgical treatments.

Follow-up

R121. Long-term urological follow-up is recommended for urethral lengthening and erectile prosthetic device implantation (EC).

R122. Sexual health support must be provided (EC).

6. Psychological support

6.1. Screening for associated psychiatric disorders

There have been no empirical studies to date assessing the benefit of systematic or standardised screening for psychiatric disorders in trans people.

R123. Potential psychiatric, mental health, neurodevelopmental disorders, or other psychosocial problems in trans adults may be identified prior to hormone treatment, by a primary care healthcare professional, and included in the overall assessment. Trans people may thus be referred to appropriate health services for their needs in the context of shared decision-making.

R124. In any case, gender identity must not be the subject of a specific psychiatric assessment (EC).

R125. If needed, referral to a mental health professional must not result in an additional delay in treatment, and must be organised alongside the overall treatment process.

R126. It is recommended that healthcare professionals assessing trans adults in anticipation of their physical treatments be capable of identifying mental health or neurodevelopmental problems, or coexisting psychosocial problems.

6.2. Support throughout the pathway

R127. Full recognition of the person's gender expression is a key condition for ensuring quality support (EC).

R128. For trans people:

- psychotherapy is not systematically made mandatory in the context of a transition pathway (EC);
- as transition pathways may evolve over time, decision-making capacity may be reassessed throughout the pathway (EC)
- conversion therapies have been shown to be harmful and are prohibited by law;[5]
- professional mental health support may be required, and may include the use of self-affirmation tools, stress management learning techniques, and psychoeducation focusing on combatting stereotypes (Grade B).

[5] Law of 31 January 2022 prohibiting practices aimed at modifying a person's sexual orientation or gender identity.

7. Other care

7.1. Modifying body shape with compressive garments

R129. Body shape-modifying practices using compressive garments are important aids in transition phases, and it is recommended to use a risk reduction approach around these practices. As such, possible adverse effects must be screened and managed (EC).

7.2. Dermatological treatments

R130. It is recommended to respond to requests from trans people seeking hair removal from the face and/or body (EC).

R131. Pre-operative hair removal may improve surgical outcomes of some gender-affirming surgeries (clinical principle) (EC).

R132. Acne is a very frequent adverse effect, particularly in trans men, which has a very strong psychological and social impact; therefore, it should be screened and treated (EC).

R133. Tetracycline and isotretinoin acne treatments may be offered, but require liver function monitoring in view of increased risk of liver toxicity when associated with testosterone. Contraception must be offered (mandatory). If prescribing isotretinoin, a monthly pregnancy test and monitoring of potential psychological effects (depression, anxiety) must be conducted according to the regulatory principles described in the summary of product characteristics (EC).

R134. It is recommended to respond to requests from trans people seeking wigs and hair transplants (EC).

R135. It is recommended to screen for non-professional practices or body-contouring self-medication with injections, and inform the trans person of their side-effects and dangers (EC).

R136. It is recommended to provide care for people who have had injections of silicone and other unauthorised substances for monitoring, support and surgical treatment in the event of complications (EC).

7.3. Voice modification with speech therapy

R137. It is recommended to respond to requests from trans women and trans men seeking speech therapy (EC).

7.4. Physiotherapy care

R138. It is recommended to set up physiotherapy care pre- and post-vulvo-vaginoplasty surgery, in order to reduce the rate of pelvic dysfunction (urinary incontinence, defecation disorders, anal incontinence, vaginal atrophy, etc.) (Grade C).

R139. It is recommended to offer specific physiotherapy care throughout medical transition support (EC).

7.5. Gamete preservation

R140. It is recommended to systematically offer trans people counselling about gamete preservation before commencing hormone treatment (success rate, side-effects) (EC).

R141. It is recommended to inform the trans person about the impact of different treatments on fertility, the different options available for gamete preservation, and about alternative parenthood options (EC). In addition, they should be informed about the legal provisions in force relating to gamete removal, preservation, and use (EC).

R142. It is recommended to systematically offer cryopreservation to trans people prior to gonadectomy (Grade C) and other genital surgeries (EC). The impact of transition pathways on future fertility, and the role of cryopreservation have only been partially elucidated to date.

7.6. Routine care

R143. For routine care for trans people, comparable follow-up and care to those for the general population are recommended (EC).

R144. Trans people have the same overall health needs as the general population, considering health vulnerability factors (see Section 2), obstacles to access to care, and the person's physiology (EC).

R145. Cancer screening will be adapted to the trans person's profile according to their organs, and their personal and family history (medical and surgical) (EC).

R146. It is recommended that healthcare professionals adapt the application of healthcare guidelines, regimens and literature so that they are inclusive of people's diversity (EC).

7.7. Role of associations

Transgender associations play an important role in access to healthcare and improving the healthcare system for trans people. They provide a useful link between trans people and competent professionals, while fostering peer support, reliable information broadcasting, and overall mental and sexual health, and social support. Their involvement in health bodies makes it possible to update practices in qualitative terms, and respond better to trans people's specific needs, thereby improving inclusiveness.

R147. It is recommended that healthcare professionals refer trans people and their families to local associations, and use community resources (literature, posters, diaries, etc.) to provide appropriate information and additional support (EC).

R148. It is recommended that associations be included in regional health organisations to improve the quality, continuity and accessibility of care for trans people (EC).

8. Fluidity of transition pathways (detransition, retransition, etc.)

8.1. Definitions, epidemiology and examination of concept

Due to a lack of consensus around the definition of detransition and the lack of robust studies in this field, it is difficult for researchers and clinicians to arrive at a clear consensus around this concept.

R149. Detransition is a term covering a number of realities (stopping transition, discontinuing transition, reassignment), associated with regrets or not.

It is recommended to examine the motivations for detransition and screen for any abuse, because reasons for detransition may involve vulnerability or social exclusion, pressure from family members, or a lack of medical information (EC).

8.2. Support

R150. It is recommended to support people seeking to detransition in the same way as for transition requests, to offer them a space for specific psychological support, and to refer them to peer groups (EC).

R151. It is recommended to examine detransition expectations (organ function, fertility), and to provide information on possible options (see 5.2.3 and 5.3.2) (EC).

R152. Genital detransition surgeries require specialist team support (EC).

No care model assessment data for people seeking to initiate medical detransition have been identified.

Annexe 1. Referral

MINISTÈRE
DES SOLIDARITÉS
ET DE LA SANTÉ
Liberté
Égalité
Fraternité

Le Ministre

Paris, le 23 avril 2021

CAB OV/DGOS/ PEGASE : D-21-011462

Madame la Présidente,

L'organisation du parcours de transition en France se fonde sur la proposition faite par la HAS dans son rapport de novembre 2009 « situation actuelle et perspectives d'évolution de la prise en charge du transsexualisme en France ».

La prise en charge des frais par les organismes de sécurité sociale est conditionnée au respect des étapes de ce parcours réalisé par une des équipes hospitalières officielles. Elles sont actuellement au nombre de huit et se sont fédérées au sein de la FPATH1 (anciennement « SoFECT2 »), association qui réunit des professionnels de santé impliqués dans la prise en charge des personnes transgenres, et fédère des réseaux régionaux en un seul réseau national.

Cette situation, qui conduit à un monopole de fait de la FPATH est critiquée par les associations de représentants des usagers qui dénoncent des délais trop importants causés selon eux, par l'expertise psychiatrique et réclament une liberté d'accès à la médecine de ville notamment dans le cadre de l'hormonothérapie.

Depuis ce rapport HAS, l'OMS a sorti en 2018 le sujet de la transidentité du champ de la psychiatrie en le déplaçant dans le domaine de la santé sexuelle. En effet, elle a dépsychiatrisé « l'incongruence de genre » (terme non validé en français) en sortant ce « diagnostic » du chapitre des troubles mentaux et du comportement de la classification internationale des maladies (CIM) et en l'intégrant dans la classification liée à la santé sexuelle (adoption de la CIM 11 en juin 2018).

Cette position est récente et les dispositifs existants de prise en charge du parcours de transition en France n'en n'ont pour l'instant pas tiré les conséquences.

La prise en charge de la transidentité a fait l'objet fin 2010 de travaux coordonnés par la Direction générale de l'offre de soins (DGOS) à la demande des usagers concernés et en s'appuyant sur les recommandations émises par la HAS en novembre 2009[3]. Ces travaux ont été suspendus début 2011 à la suite d'une absence d'adhésion des professionnels hospitaliers français, regroupés au sein de la FPATH. Les points de vue et les propositions des différentes parties prenantes ont alors fait l'objet, à la demande du Ministère en charge de la Santé, d'un rapport de l'IGAS[4] qui a préconisé, outre une réflexion partagée sur les protocoles et les parcours de prise en charge, la labellisation de deux centres chirurgicaux adossés à un réseau national de professionnels de santé de ville pour les prises en charge en endocrinologie et psychologique notamment. Le rapport IGAS a par ailleurs pointé différentes difficultés et notamment la place décisive de l'évaluation psychiatrique.

Pr Dominique Le Guludec
Présidente de la Haute Autorité de Santé (HAS)
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[1] French Professionnal Association for Transgender Health
[2] Société française d'études et de prise en charge de la transidentité
[3] Situation actuelle et perspectives d'évolution de la prise en charge médicale du transsexualisme en France
[4] Evaluation des conditions de prise en charge médicale et sociale des personnes transgenres et du transsexualisme, décembre 2011

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Faute de consensus, les travaux coordonnés par la DGOS n'ont pas repris.

Aussi, le besoin d'introduire la diversité des parcours et leur dépsychiatrisation effective suite aux évolutions internationales me conduisent à vous demander d'actualiser ses recommandations de 2009, en vue :

- D'évaluer les conséquences en termes de parcours de soins de la décision de l'OMS en 2018.
- De revoir la place de l'évaluation psychiatrique dans le processus de la réassignation sexuelle hormono-chirurgicale.
- D'élaborer un nouveau protocole en lien avec les professionnels de santé et les associations communautaires dans le but d'améliorer l'organisation des soins afin d'assurer la qualité et la sécurité de la prise en charge de ce public.
- De structurer la prise en charge médicale du parcours de transition, en promouvant une articulation entre médecine de premier recours et spécialités médicales (endocrinologie, chirurgie, psychiatrie).
- De statuer sur la place de la médecine de ville dans le parcours de soins et ses modalités (notamment place de l'hormonothérapie).
- De structurer la prise en charge de la Transidentité pour les mineurs (médecine de premier recours, pédopsychiatrie et accompagnement psychologique).
- De répondre aux attentes des usagers, dont la place doit être centrale dans la définition des parcours et de l'offre de soins.

Ces recommandations sont attendues pour le mois de décembre 2021.

Je vous remercie par avance de bien vouloir me faire connaitre vos propositions concernant ces demandes et vous prie d'agréer, Madame la Présidente, l'expression de ma sincère considération.

Olivier VÉRAN

Participants

The following professional bodies and patient and user associations were consulted to propose experts invited individually to take part in working/review groups:

Association ACCEPTESS-T

Association “C’est pas mon genre”

Association Chrysalide

Association CLAR-T

French Association of Child and Adolescent Psychiatrists (API)

Association Espace Santé Trans

French Urology Association

French Ambulatory Paediatric Association

French School and University Setting Health Promotion Association (AFPSSU)

Association Grandirtrans

Association Juristes pour l’enfance

Association OUTRANS

Association Réseau Santé Trans

Association RITA

Association Trans Inter Action

Association TRANS SANTÉ FRANCE

Association TRANSAT

Association TRANSPARENTS

Ypomoni community

French College of General Medicine (CMG)

French National College of Gynaecologists-Obstetricians (CNGOF)

French National Council of Endocrinology, Diabetology & Nutrition

French National Council for ENT and Cervicofacial Surgery Professionals

French National Council for Plastic, Reconstructive and Cosmetic Surgery Professionals

French National Council of Dermatology and Venereology Professionals

French National Council for Gynaecology-Obstetrics and Medical Gynaecology Professionals (CNPGO and GM)

French National Council for Infectious and Tropical Diseases Professionals (CNP MIT)

French National Council for Paediatrics Professionals

French National Council for Psychiatry Professionals

French National College for Quality of Care in Psychiatry (CNPP-CNQSP)

French Psychiatry Federation

French Federation of Psychologists and Psychology (FFPP)

French Rheumatology Society

French Society of Plastic, Reconstructive and Cosmetic Surgery (SOFCPRE)

French Exercise and Sports Medicine Society (SFMES)

French Paediatrics Society

French Pharmacology and Therapeutics Society (SFPT)

French Society of Child and Adolescent Psychiatry and Associated Disciplines (SFPEADA)

French Occupational Health Society (SFST)

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