


The logo for TransBuddy, featuring the word "TransBuddy" in a stylized, rounded font with a blue and pink gradient and a drop shadow effect, enclosed in a blue rectangular border.

TransBuddy

A large, stylized transgender symbol in white with a blue outline, centered on a light pink background. The symbol consists of a circle at the top, a vertical bar at the bottom, and two diagonal bars extending from the circle to the left and right. The top-left and top-right diagonal bars are mirrored, while the bottom bar is a simple vertical bar.

**TRANSGENDER PEOPLE DURING THE
COVID-19 EPIDEMIC:
ACCESS TO HEALTHCARE SERVICES**

Final report on the results of the study

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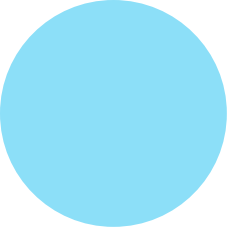


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At the end of December 2019, COVID-19 was first identified in the Wuhan area of China, on 13 January, 2020 it was recorded for the first time outside China and at the end of that month it was already in Europe (World Health Organization, 2020a, 2020b). On 11 March, 2020 with at least 118,000 confirmed cases of COVID-19 disease in 114 different countries, the World Health Organization (WHO) declares a pandemic (World Health Organization, 2020c) and recommends numerous protective measures in order to curb the pandemic. As a matter of fact, some of them have been more or less integrated into everyday life (e.g. regular hand washing, cough and sneezing hygiene, avoiding contact with ill people), other are later measures (e.g. avoiding touching eyes, nose and mouth). However, some more or less radically interfere with self-evidence of everyday life (e.g. regular disinfection of surfaces and objects), including its social perspective (e.g. avoiding socializing in larger groups, what is more, limiting contact to an individual household, maintaining physical distance or safe distance of 1.5 or 2 meters) (World Health Organization, n.d.; see also National Institute of Public Health - NIJZ, 2021).

1.1.

COVID-19 and epidemic-related protective measures in Slovenia

Slovenia, where the first infection with COVID-19 was confirmed on 4 March, 2020 (Government of the Republic of Slovenia, n.d.), followed the declaration of a pandemic by WHO and the next day, 12 March, 2020, declared the epidemic in Slovenia. In addition to that, it took some protection measures to curb the epidemic and prevent overloading the health system, e.g. closure of educational institutions, border crossing restriction with Italy, slowing down or stopping public life and work at home - in short, measures that are recognized by the general public as “lockdown” or “quarantine” (Government of the Republic of Slovenia, 2020a) (Government of the Republic of Slovenia, 2020). The set of protective measures in Slovenia included (anticipated 14-day) cancellation of all specialist examinations as well as surgical procedures except those with a level of urgency “urgent” or “very fast” (with the exception of treatments for pregnant women and oncology services), including screening prevention programs (ZORA, DORA and SVIT, with the exception of emergency interventions), which entered into force on 16 March, 2020 (ibid.).¹ A day after the declaration of epidemic, on 13

¹ In addition to the cancellation of all specialist examinations and surgical procedures, the set of protective measures also included: temporary ban and restrictions on passenger transport in Slovenia, temporary ban on the sale of goods and services (accommodation, catering, wellness, sports, cultural and other services) directly to consumers in Republic of Slovenia. There were certain exceptions (pharmacies, post offices, banks, groceries, other services and emergency services to ensure public safety and health), where the number of consumers who were allowed be in the business premises at once was also limited (Government of the Republic of Slovenia, 2020c). On 15 March, Ordinance on temporary prohibiting gatherings of people in educational institutions and universities and independent higher education institutions” that prohibits gathering of people in school institutions, hall of residences for high school and university students (15/3/2020). On 20 March 2020, the Ordinance on the temporary prohibition of the gathering of people at public meetings, at public events and other events in public places in the Republic of Slovenia enters into force, with some exceptions (e.g. arrival and departure from work) (Government of the Republic of Slovenia, 2020cc). On 30 March, the Ordinance on prohibition of movement outside the municipality of permanent or temporary residence (Government of the Republic of Slovenia, 2020d) enters into force as well, being valid to the same extent until 30 April 2020, when the prohibition of movement outside the municipality of permanent or temporary residence was lifted. However, the prohibition of the gathering of people at public meetings, at public events and other events in public places remained in force (Government of the Republic of Slovenia, 2020f). Protective measures of the first wave of the epidemic began to be lifted to a greater extent in the second half of April 2020.

March, 2020, the 14th Slovenian Government was appointed (Government of the Republic of Slovenia, 2020b). On 20 March 2020, at its 7th correspondence session, the Government passed Ordinance on temporary measures in health care to contain and control the COVID-19 epidemic, extending the suspension of preventive health services (except for those that could have had negative consequences for a person's health if suspended) (Government of the Republic of Slovenia, 2020d).

Approximately one month after the first set of protective measures, on 10 April the government approved an ordinance reintroducing the provision of elective medical services at the level of specialist clinics, diagnostics and rehabilitation in other forms of medical treatment, provided that a patient has a negative epidemiological history as well as for those patients for whom the cancellation or postponement of a medical service would lead to a worsening of the medical condition. According to the ministry in charge, the measure was adopted with the aim of relieving the primary health care level, ensuring the flow from the primary to the secondary level and in order to reduce the effect of the adopted measures on extending waiting times (Ministry of Health, 2020a). On 9 May, the Order on Interim Measures in health care to contain and control the COVID-19 Epidemic came into force, allowing medical treatment at all three levels for people with a negative epidemiological history and without clinical signs of respiratory infection (Government of the Republic of Slovenia, 2020g). Healthcare activities were thus carried out to a limited extent between 12 March and 9 May, 2020. A few days later, on 14 May, 2020, the Government revoked the epidemic declared on 12 March, 2020 by passing Ordinance on the revocation of the COVID-19 epidemic resulting in ending the first wave of the epidemic also as far as the protective measures are concerned (Government of the Republic of Slovenia, 2020h).

In the first half of October, the government started readopting protective measures due to the worsening epidemiological situation, including the implementation of distance education and gradual reduction of health programs (given the spare capacity to treat COVID-19 and other patients). This time, from 14 October onwards, in contrast to the first wave by the space of March - May 2020, the total ban on providing elective services did not come into force, but an attempt to implement the programs as smoothly as possible did, in order to prevent further weakening of the system and extension of the waiting period above the tolerable limit (Ministry of Health, 2020b).

On 19 October, 2020, the COVID-19 epidemic was re-declared in the territory of the Republic of Slovenia (Government of the Republic of Slovenia, 2020i), and during October and November other protective measures began to tighten (first restricting movement between regions

and at night, next also between municipalities; restriction of gathering in public places, with the exception of close family members or members of a shared household; prohibition of people gathering in educational institutions and interruption of public passenger transport, etc.) (, 2020j).

In the second half of October, the delivery of elective health services was curtailed again: the number of specialist examinations was adjusted, providing preventive health services was suspended, except for emergency surgical procedures with a level of emergency “urgent” and “very fast”, oncology services, prenatal and postnatal care for women and newborns as well as some other preventive medical services (Ministry of Health, 2020c). In January, 2021, in parallel to the start of vaccination against COVID-19, protective measures began to be gradually lifted (but to a limited extent, e.g. by maintaining the prohibition of people gathering outside the same household and close family), first regionally and then in the entire territory of Slovenia (Government of the Republic of Slovenia, 2021).

1.2.

Protective measures and vulnerable social groups

With the declaration of the pandemic on a global scale, warnings soon arose about the sensitivity and vulnerability of the situation related to COVID-19 and using protective measures to curb the pandemic on a national scale as well as to potentially abuse human and exacerbate existing social and other forms of social inequalities. Amon and Wurth (2020), in a broader (virtual) context, draw attention to the potential restrictions on rights and the strengthening authoritarian rule resulting from the introduction of quarantine or isolation and practices that restrict freedom of movement. Amon in Wurth (2020) thus draw attention, in a broader (virtual) cast, to the potential restrictions on rights and the reinforcement of authoritarian rule originating from the introduction of quarantine, isolation and practices that restrict freedom of movement; Browne, Banerjea, and Bakshi (2020) warn of the growing precarisation both in terms of the amplification of pre-existing precariousness as well as the general extent of precariousness.

Milan and Treré (2020) focus on the issue in a similar way, but mainly in connection to the Global South by specifically pointing out the phenomenon of so called “the data poverty”, against a background of deepening of social inequalities during the COVID-19 pandemic that remains invisible.

In April 2020, the Fundamental Rights Agency (FRA) published a more detailed review of the effects of COVID-19-related protective measures on specific, particular groups in society from February to March 2020. It included people in institutional settings (non-family placement

educational settings, correctional centres, asylum centres), people with disabilities, people without housing, the elderly, the Roma and Travellers as well as women and children at risk of domestic violence (FRA, 2020). In addition to particular vulnerable groups, the intensification of discrimination (especially racism and xenophobia) is also highlighted (ibid.).

Protective measures, in particular the measure of physical distancing and limiting social contacts per household unit, have had various effects on different social groups. Researchers studying pandemic situations warn that on the one hand, one should sensibly distinguish between primary or direct effects of the pandemic and its related protection measures and the secondary or indirect effects of the pandemic on the other hand. The former are considered to be effects that result directly from the reality of the pandemic (e.g. infection), while the latter are considered to be effects that are actually the result of attempts at dealing with the pandemic (e.g. job loss due to the public life brought to a standstill; restricted access to healthcare system with the aim of preventing the healthcare system overload prevention) (see, e.g., Ye et al., 2020; Garfin, 2020).

One of the more important effects of the pandemic as such and pandemic-related protective measures is also the increase in issues with mental health as well as substance abuse. A report by the The United States Centers for Disease Control and Prevention (CDC) (Czeisler et al., 2020) is a proof of that as it indicates an increase in symptoms of depression (by approximately 400%), anxiety (by approximately 300%), and suicide (by approximately 200%) in comparison to the same period in 2019. Furthermore, a significant increase in the above-mentioned problems is particularly visible among young people, in the age group 18-24 years (as well as among ethnic and racial minorities) (ibid.). After all, that is quantity-wise roughly confirmed by a qualitative research titled *Exploring personal strategies for managing everyday life in emergency situations*, which reveals that the “pandemic time” does not work for everyone in the same way. In this respect, younger age groups tend to be more exposed to negative affective burdens arising during the COVID-19 pandemic most likely due to their potentially greater intensity of social life as well as involvement in various social areas and institutions, although the research focus of social isolation and loneliness is predominantly put on older groups assuming their greater exposure to social isolation (see, e.g., Cornwell, 2009; Courtin & Knapp, 2017).

In this respect, a differentiated approach to studying the effects of pandemic and its related protective measures proves to be crucial for addressing and alleviating the so-called “data poverty” (Milan & Treré, 2020). The aim is to thoroughly identify vulnerable groups and factors that intensify or amplify existing inequalities and vulnerabilities, as well as to plan

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protective measures in a more appropriate way, communicate them with different kinds of public and provide effective support systems (Choi & Powers, 2020; Kamin & Perger, 2020; Ihm & Lee, 2021; Kamin et al., 2021;).

Based on all of the above mentioned, we are, in this research, focusing on the situation of the transgender community in Slovenia during the epidemic, namely during the first wave of tougher protective measures (March - October 2020), during the interim period when protective measures were lifted and during the second wave of tougher protective measures (October - November 2020)², especially by taking into consideration the effect of amplification of pre-existing social inequalities in the pandemic period. Existing and mostly quantitative studies on the impact of the pandemic on daily lives of the LGBTIQ+ community indicate that the effects of pandemic-related factors are reflected in various areas.

Abroad-based studies from the “pre-pandemic” period in connection to the experiences of transgender people highlight many inequalities when it comes to access to health services (lack of experts and expertise for trans-specific health services) and negative experiences of transgender people with the health system (experiences of unjust, discriminatory treatment, disrespect of their gender identity, stigmatization and pathologizing, etc.) (Edenfield, 2020; Poteat et al., 2020; Signorelli et al., 2020; OutRight Action International, 2020; Wang et al., 2020). Both also arise the actual inequalities in health, as transgender people tend to avoid and delay screenings against a background of negative experiences in the health system (American Psychological Association, 2020; Edenfield, 2020; Herman and O’Neill, 2020; see also Valentine, 2016). At the same time, some studies related to the pandemic situation suggest that transgender people tend to be more exposed to health complications in case of COVID-19 infection (Egale, 2020; Herman and O’Neill, 2020; Human Rights Campaign Foundation, n.d. ; TGEU, n.d.) due to the nature of their daily lives (e.g. increased exposure to poverty because of socially produced employment issues and employment instability; unstable housing conditions and increased exposure to homelessness) and also due to a higher incidence of certain chronic diseases (e.g. asthma) and other features (e.g. smoking) ; other studies indicate that compared to the general population, transgender people (or the LGBTIQ+ community as such) are also more concerned about possible infection (Egale, 2020), so fear of infection may also be regarded as a factor in avoiding access to the health system (Flentje, 2020). ; Gibb et al., 2020); van der Miesen, Raaijmakers and van de Grift, 2020).

In comparison to the general population, an increase in unemployment or worsening of the economic situation to a greater extent is indicated in the LGBTIQ+ community, including endangered access to food (Drabble and Eliason, 2021; Movement advancement project - MAP, 2020; Kidd et al., 2021), more problems by balancing work and private life (MAP, 2020),

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² LGBTIQ+ refers to lesbians, gays, bisexual and transgender people, intersex people, queer people as well as other non-normative gender and sexual identities (+).

more mental health problems (Kidd et al., 2021; Gato et al., 2021; Moore et al., 2021; Drabble and Eliason, 2021), the reason also being a limited access to resources, which otherwise act as important turn-offs (Gato et al., 2021), last but not least due to increased exposure to stressors (e.g., living in environments that are unsupportive or less supportive in relation to gender identity) (Moore et al., 2021). Research conducted by Kidd et al. (2021) also indicates that the higher incidence of stress is reported by those who were left without community support or LGBTIQ+ during the pandemic period, even more specifically for the case of transgender people without the support of the transgender community; the same applies to transgender people who experienced a delay or cancellation of hormone therapy during the pandemic (however, there are no statistically significant differences in experiencing of stress before and during the pandemic in the case of their trans-specific surgery being cancelled or delayed during the pandemic). Gato et al. (2021) report on a similar importance of the community support and the impact of lacking this kind of support or the feeling of isolation from LGBTIQ+ friendships on the psychosocial state of LGBTIQ+ youth. For the present study, a particularly meaningful piece of information is also that transgender people (43.8%) report on a more difficult access to trans-specific health services during the pandemic and its related protective measures, with the majority (33%) reporting that they have experienced a delay in receiving or a delay in starting hormone therapy and only a minority (11%) reporting on pre-planned surgeries having been cancelled or postponed (Kidd et al., 2021). When it comes to the effect of COVID-19 pandemic and its protective measures regarding a specific gender identity, there is not any statistically significant difference between transgender binary and non-binary individuals (ibid.).

The existing studies on the state of the health system (outside COVID-19 pandemic period) in relation to transgender people predominantly focus on the transgender people's perspective, the aspect of healthcare workers, certainly important, though remains neglected. The existing research on their perspectives generally indicates that they face a number of obstacles in delivering healthcare services to transgender people, most commonly pointing out 1) the lack of familiarity with interventions and services available, 2) lacking in knowledge of transgender people's treatment, 3) the lack of knowledge about transgenderism in formal education, 4) the lack of self-confidence when treating transgender people, 5) the ignorance of others and transgender-friendly specialists and other professionals (Snelgrove et al., 2012; Vance et al., 2015). According to research, most health workers claim that they are in favour of treating transgender people - the identified obstacles being more of an institutional rather than of a subjective nature (see, e.g. Rowan et al., 2019), which in some places contradicts the findings from the perspective of transgender people who frequently report on experiences of discrimination, negative attitude and prejudice on the part of the experts who they come in contact with during the treatment (Seelman and Poteat, 2020).

Research questions

Against this backdrop, we are, in this study, interested in the experiences of transgender people in the period of the COVID-19 epidemic, which was declared in Slovenia from March to May 2020 and from October 2020 onwards. In doing so, we are focusing on their experiences with protective measures as such, on their experiences with the health system before the COVID-19 epidemic in order to gain insight into the usual healthcare treatment of transgender people, and during the COVID-19 epidemic (focusing on medical transition) with the intention of analysing a possible amplification of pre-existing issues in accessing healthcare as well as focusing on sources of coping strategies with the healthcare system, significantly marked by cisnormativity. At the same time, we are interested in the perspective of healthcare workers in the wider field of healthcare, which often remains neglected. Namely, their perception of the current situation in the medical aspect of the gender confirmation process and medical transition as well as specifically their perception of the healthcare system in relation to transgender people during the COVID 19 pandemic. The research questions are the following:

- I. How do transgender people experience COVID-19-related protective measures with respect to the period March-May 2020, when lockdown was in force, with particular focus on the following everyday life situations: a) possible comebacks to family or primary settings, b) a more difficult access to the LGBTIQ+ community and its support, and c) difficult access to healthcare services?
- II. What were transgender people's experiences with the healthcare system before the pandemic was declared, especially when it comes to healthcare services related to the gender confirmation process?
- III. What are the experiences of transgender people with the healthcare system during the period of protective measures related to COVID-19, especially regarding the measure of cancellation of non-urgent medical procedures?
- IV. How are transgender people coping with access to the healthcare system, considering COVID-19 epidemic and in particular, focusing on healthcare services related to the medical transition?
- V. How do healthcare professionals perceive the health aspect of the gender confirmation process in relation to the current situation and guidelines in this area?
- VI. How do healthcare professionals perceive the state of healthcare during the period of COVID-19 epidemic regarding health services in relation to the gender confirmation process?

Sample, methodology and analysis

In the research, we used 1) the snowball method for sampling transgender people, relying also on non-governmental organization (hereinafter referred to as NGO) LGBTIQ+ and 2) purposeful sampling for participants working in healthcare as well as participants working in the field of relevant NGOs (i.e. health professionals and experts for the area of transgenderism within NGOs), which enables targeting of participants according to pre-established criteria and research parameters (Moser and Korstjens, 2018). The snowball method is an established method for sampling or getting participants from usually marginalized social groups that are difficult to reach (Brečko, 2005). We sent out an invitation to the participants to participate in the research, naming specification of the research's purpose, the form of participating (focus groups, in-depth interviews) as well as conditions of participating and duties of the researcher. After the initial confirmation of interest in participating, the participants received a form of informed consent with a more detailed description of the participation process, terms of participation, expectations in terms of participation and the duties of the researcher. By doing so, we ensured that the research participants had sufficient time to think about participating. For transgender people the inclusion criteria for participating in the study were the following: 1) the age of 18 or older, 2) residence in Slovenia, 3) transgender identity and 4) involvement in the medical aspect of gender confirmation process (regardless of stage). For experts from the relevant NGO the inclusion criteria were the following: 1) activity within the NGO LGBTIQ+ and 2) work in the area of transgenderism. For experts from relevant healthcare-related areas of expertise the inclusion criteria for participation in the survey were the following: 1) activity within the healthcare and transgender-related healthcare areas, either directly (i.e. direct activity within trans-specific medical treatment) or indirectly (i.e. activity in the wider area of healthcare, namely at the level of public health policy-making in general, which is also reflected in the guidelines for the area of transgenderism.³ Even though we tried to follow the principle of heterogeneity when sampling transgender people, we have not managed to comprise a balanced number of transgender women who were consequently underrepresented in this study. The sample of transgender people thus to a large degree consists of transgender men and people with non-binary gender identity. In order to ensure at least minimal representation of transgender women in the course of the study, in addition to focus groups, we also offered the possibility of carrying out individual in-depth interviews due to the discomfort expressed by the transgender women contacted, when it comes to sharing their experiences in a group setting. The response rate of transgender people was high, though. In total, the final sample comprises 12 transgender

³ A complete sample of participants is available in Annex A.

people with ten people participating in three focus groups, while two participating in in-depth interviews. Eight of them identify themselves as male, three as gender non-binary and one as female; seven of them are university of high school students, three are employed and two are unemployed. The average age of eleven people whom we have the exact age data on is 24.7 years (median is 25 years), one person asked to record the broader age range (28+ years) for further protecting their anonymity. In addition to the unbalanced representation along the axis of gender identities, the sample is also lacking overrepresentation of transgender people coming from the urban environment: among the transgender interviewees, only one person states that they currently live in a rural environment. We have had slightly more issues with sampling healthcare professionals, where the response rate was somewhat lower: in the course of purposeful sampling a list of identified health professionals was compiled, including those with experiences in treatment of the transgender (regardless of the level of treatment) (9), they all received an invitation to participate in the study by email. Four out of nine experts expressed an interest in participating in the study, one of them participating provided that the interview is conducted to special requirements (written questions sent in advance, with expert' giving written response.⁴ We did not face any particular difficulties in sampling experts working in NGOs, and the response rate was high.

Therefore, we conducted three focus groups with ten transgender participants: four people participated in the first focus group and three participants in both the second and the third group. Smaller focus groups are especially useful in case of studying complex and sensitive research themes, at the same time however, it also enables the acquisition of more detailed information due to the smaller number of participants (Moser and Korstjens, 2018). A smaller structure of focus groups is also recommended in case of virtual conduct, although at the expense of decreased variety of ideas that emerge during conducting a group (Lobe and Morgan, 2020). A protocol for the implementation of focus groups with guidelines for questions as well as content sections was prepared beforehand with the purpose of conducting focus groups. In-depth interviews were conducted with two transgender people, healthcare professionals and experts working in NGOs. With the purpose of conducting interviews, a semi-structured questionnaire was prepared beforehand with possibility of open-ended topics and content sections, according to the specifics of the position of a healthcare professional or an expert working in a field of NGOs. Questionnaires or protocols were previously pilot tested, especially from the content relevance for transgender people point of view.

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⁴ For the purpose of ensuring a consistent research process, we rejected the possibility of written questions in advance and receiving written answers.

Due to the epidemiological situation, the focus groups and interviews were conducted entirely using the Zoom platform. We did not encounter any issues with subsamples of transgender people and experts in NGOs when conducting interviews and focus groups via Zoom, whereas we sometimes encountered minor technical problems interviewing healthcare professionals (e.g. unsuccessful internet connection), which we successfully eliminated. Interviews and focus groups were carried out in November and December 2020 by being audio recorded and then literally written down or transcribed. While transcribing erased possible identifiers (anonymization) and each interviewee received or chose a pseudonym that will be used in case of quoting a part of an interview or focus group (with the exception of healthcare professionals).

Having completed transcribing, we read the transcription several times in order to identify key content highlights from the data itself (inductive coding), which we added to the expected content highlights, defined based on the overview of pre-existing studies (deductive coding). Within broader categories we inductively added codes and subcodes based on the analysed material, using simultaneous coding due to the complexity of the data and the topics being interrelated (Braun and Clarke, 2013). The data was analysed by using qualitative data analysis software. Due to three different subsamples (transgender people, experts from NGOs, healthcare professionals) that can be joined into two basic perspectives (transgender people's perspective - at the individual level and at the general level with the insight of experts from NGOs) we established a coding scheme on two axes; namely, one for the transgender people's perspective, which combines data obtained through focus groups and interviews with transgender people and the data obtained from interviews with experts from NGOs; and another for the health professionals' perspective for the data got from interviews with health professionals. In the course of the research process, we followed The Code of Ethics for researchers at the University of Ljubljana (2014).

The following is a presentation of research's key findings, namely in four major content sections: 1) perceiving protective measures by transgender people, 2) experiences of transgender people with the healthcare system before the COVID-19 epidemic, 3) experiences of transgender people with the health system during the COVID-19 epidemic and 4) transgender people's coping strategies and resources with the healthcare system by putting greater emphasis on the second, third and fourth content section. Where relevant, we will complement the perspective of transgender people, including the perspective of experts from NGOs, with the perspective of healthcare professionals (perception of the current situation in the medical aspect of the gender confirmation process; perception of the healthcare system during the COVID-19 epidemic).

3.

TRANSGENDER PEOPLE EXPERIENCING PANDEMIC-RELATED SITUATIONS AND PROTECTIVE MEASURES

In this part, we are interested in how transgender people experienced the pandemic situation and its related protective measures, given the disproportionate negative effect of the pandemic situation, which according to studies, tend to amplify pre-existing inequalities.

We examine the data in four major subparts, referring exclusively to the experiential dimension of transgender people, therefore they include data from transgender people focus groups and interviews with transgender people as well as with experts from NGOs LGBTIQ+ for a broader insight into the situations of transgender people.⁵

3.1. Economic and housing situation

When it comes to the economic and housing situation during the COVID-19 epidemic transgender people often recount worsening in the economic situation or 1) on an increase in economic instability, to a large degree being as a consequence of a loss of income (a loss of full-time job, a loss of student work due to a general lockdown). Slavko, for instance reports on the (TG, personal interview, 2020),⁶ by pointing out the partner's family (financial) support.

“For me that meant losing the only source of income. I have lost my job. Well, I used to work in a restaurant, which closed down right before the lockdown and then, when it relocated, but then...also due to poor relations with my employer, I basically lost that job, I had to...had to be...I even had to go and nag her to receive February's salary to even have something. My partner has also lost her income, so her family financially basically helped us...”

Matevž (focus group, 2020) also similarly reports his source of financial support is not being his original or biological family, but rather his so-called “family of choice”, which bore the part of the costs that Matevž could not cover due to his loss of student work.

“/.../ at that point when the previous lockdown began, I lost my student work, which happened again with this one taking place. So there was some kind of an economic distress, although I was lucky enough to live with two friends/ family of choice who could eventually bear a part of the costs so that

⁵ Transgender people who participated in focus group and interviews also “authorized” the quotations used. We used member check or respondent validation with the purpose of ensuring accurate and adequate representation of the data obtained (Hewitt, 2007; Brown, 2010).

⁶ For indicating the data obtained from focus groups with transgender people it will hereafter be cited within the text as FG; for indicating the data obtained from in-depth interviews with two transgender people (2) it will hereafter be cited within the text as “TG, personal interview”; for indicating the data obtained from in-depth interviews with experts from NGOs, it will hereafter be cited within the text as “NGO EXP, personal interview”; and for indicating the data obtained from interviews with healthcare professionals, it will hereafter be cited within the text as “HLTH PRO, personal interview”, by not distinguishing among individual interviewees in the last two groups, but rather interpreting the data in groups from the perspective of position (healthcare, non-governmental organization) in order to protect anonymity.

I didn't go back to the family environment of my biological family, but I could remain living on my own, in that apartment.

A greater instability of the economic situation due to the loss of student work is also specifically highlighted in connection to the covering of expenses related to the gender confirmation process. Despite the fact that Alen (FG, 2020) talks about the financial support of his family and the fact that he is not afraid of being left without food or a roof over his head, the loss of income is reflected in increased inability of covering the transition-related costs, all the more so because it is impossible for him to do student work. With transition-related costs family help is not an option and that creates specific stress for Alen:

Well, in principle my parents are still helping me, so I don't feel any fear of being left with no food or roof over my head. But, this is definitely some sort of stress for me, as I pay for my own transition-related stuff. /.../ various prostheses are the thing that costs, I'm going to change identity documents again as I left my old name on them and now I realised that this won't go through because of the way society treats me so just the reapplication costs 130€. So there – there are those kinds of expenses that aren't really some sort of standard ones and I would need an income to cover them. In fact, because of this, I couldn't even talk to my parents about that. And then I knew that – even talking about trans was a problem, let alone I would ask them for some sort of help, especially at the beginning that wasn't even an option. Now, everything has become better, but I still somehow don't feel for me to go and say...hey, I would need money for that now, though.

In addition to the economic situation, some people also report on growing 2) housing insecurity, especially applying to those who before the pandemic lived either in non-family educational institutions or in student halls of residence that closed in accordance with Ordinance temporarily prohibiting gatherings of people in educational institutions, universities and independent higher education institutions. In this respect, some of the participants talk about unwanted comebacks to less supportive family environments, e.g. Tony (FG, 2020), who lived in a supported living residence before the pandemic, however, in accordance with the Ordinance, this form of living arrangement closed, therefore Tony first returned to the family environment to live with his mother, then with his father and in the meantime, between the first and the second wave of the epidemic, he went back to the supported living residence. What is crucial, is the fact that all of these environments are marked by transphobia (with the exception of stay at his father's), so Tony has mostly just relocated from more to less supportive environments (a supported living residence,⁷ stay at

⁷ Tony (FG, 2020) also recounts the experiences of transphobia in this respect when living in the supported living residence.: "They pretend that they are very, that they fully support you, but in fact they really don't /.../it happened quite a lot that they sort of "punished" me for doing things so they could call me by my old name, as the fact that they called me by my name was a kind of "gift" for my behaving.

his mother's), until he started living on his own with his partner before the second wave of epidemic:

“Basically this is a supported living residence, if you are familiar with it, that is a sort of home for teenagers with issues, I used to live there [anonymized] and now I live on my own. /.../and then it basically all became closed so I went straight back home. Actually, I went to my pop's who basically supports me, so it wasn't all that bad for me, I also stayed at my mum's, which was worse. But it wasn't all that bad after all. Then I basically went to the hall of residence where actually...I was basically... there I wasn't that into transition or actually I wasn't that out, so I was used to not being that accepted /.../Now, me and my mum, we have conflicts due to various reasons/.../so it's quite stressful at home also because of other stuff. I actually tried to distance myself, well I tried to be in contact with her as little as possible. It is very stressful indeed, besides the fact that I am trans.”

Cimet (FG, 2020) who returned to his home environment during the first wave of the epidemic (March - May 2020) when the student halls of residence closed, also relates a similar comeback to a less supportive family environment. Before the epidemic, he had just started receiving hormone therapy, which proved to be a major source of conflict in the family environment:

“Well, during the first wave, I found it all quite scary, as I didn't even know what was going to happen/.../I was scared, I didn't know what was about to happen. I also had to move out from the hall and last year, so in 2019, I had only moved in. At first, I was at home almost every weekend, until I started with my hormone therapy in January, so then I didn't go home as much, well, because we argued a lot over that. But in March I was actually two months on testosterone and I didn't yet have that many... visible changes. So I went home /.../ and getting used to the fact of being at home 24/7 /.../ it was a bit difficult to navigate the situation at home; especially in the first few days, weeks I had - there was a lot of conflict between me and my father.”

In the period of the second wave some people expected considerably better “practically” prepared: the lessons of the first wave were learned and in this respect transgender people successfully took advantage of the exceptions made in Ordinance prohibiting gatherings of people in educational institutions and invoked the exception due to avoiding exposure of vulnerable people to danger in their home environment or due to less supportive family environment; the exceptions allowing them to remain accommodated in halls of residence during the second wave, despite their temporary closure:

“Well, I live in a hall, I am currently based in a hall, so I...was fighting against the government over me staying home during that time - well my home is the hall /.../ So I - during the last lockdown and also

this one, for me the biggest stress was when they wanted to kick us out. Um, eventually it all got sorted out somehow; I mean nobody was checking for real anymore and the management had said that we could stay. Later, they added some sort of exceptions. (Alen, FG, 2020).

However, major economic and housing insecurity does not involve all research participants: a minority of participants recount 3) maintaining or even improving their then economic security (e.g. by regularly receiving alimony, by maintaining existing jobs or getting new employment during the epidemic itself), while others report on 4) a stable housing situation that has not been affected by the epidemic. What is being pointed out from this perspective is an independent living within an intimate relationship or cohabitation, which is not only stable from the point of view of housing situations as such, but a supportive LGBTIQ+ environment as well:

The fact that, well, I luckily live in a city and I don't bear any expenses with the flat. That is a huge relief. So I am not forced into going to some domestic violence environment (Nejc, FG, 2020).

I am lucky enough to live with a flatmate who is also a part of LGBT community. Honestly, that helped a lot, things would have been much worse in some other way and at least I wasn't home alone.⁸ (Maja, personal interview, 2020).

In short, for a larger part of transgender people, experiencing COVID-19-related protective measures is burdensome in terms of growing housing and economic insecurity, however a minority of them report on maintaining economic and/or housing security or stability, especially in case of having employment prior epidemic as well as in case of various forms of co-living with other LGBTIQ+ people.

3.2. Access to LGBTIQ+ community

Living in a supportive LGBTIQ+ environment – with other LGBTIQ+ people – at least partially compensated for the loss of LGBTIQ+ community events and support due to temporary prohibition of people's gatherings or restricting social life to members of same household only. Some transgender people in this respect 5) do not talk about feeling the lack of LGBTIQ+ community presence, mainly due to the fact that they were not heavily involved with it prior epidemic:⁹

⁸ The translation from the foreign language, in which the interview was carried out, into Slovene is the author's.

⁹ In those cases, it is mostly about slightly older people, people living in a clearly supportive LGBTIQ+ environment, e.g. with a partner and persons who have already completed the gender confirmation process.

¹⁰ Some events have been moved to virtual space, which, according to the interviews, has also been quite decentralizing – events and support services, which have been otherwise predominantly accessible only in the capital, have now become more widely available due to shrinking distances: "It's actually really cool, due to better accessibility for people not coming from [the city] so they could attend the events which is fantastic" (Slavko, TG, personal interview, 2020).

“To be honest, I would say not that much. As I haven’t been highly active in the community in recent years. The fact that I have been in a relationship for a long time might have something to do with it, when I was younger I was definitely more present, it was also a change of lifestyle /.../ I go there once in a while [to community events] to meet people, I feel comfortable, but I wouldn’t say that because of it I felt very – that I lost something significant in that moment (Timotej, FG, 2020).

“Well, I mean, I haven’t really experienced a lack of anything. In principle, I haven’t really mixed a lot with LGBTIQ+ community for quite some time so it didn’t have any effect on me at the moment. (Jakob, FG, 2020)

Especially for younger people and people who are still in the gender confirmation process, 6) the suspension of LGBTIQ+ community events in their various forms (social events, transgender support group, psychosocial services, etc.)¹⁰ was more burdensome with particular emphasis on the suspension of events or meetings organized within the support group for transgender people:

“Yes, that trans group from [NGO], meant a lot to me ever since I moved to the city /.../ every time it took place I was there. I think I was only absent for three times in the last three and a half, four years. Um, it really kind of was a support system of mine, to meet every two weeks, to talk about what has been happening, to hear others, well yes, /.../ I really missed those group meetings, because...well if you get used to something and it’s the same for three years and then if it suddenly ends, it has had quite an effect as a matter of fact. (Dylan, FG, 2020).

In addition to support group for transgender people, some also pointed out the lack of psychosocial services or counselling, which they attended within non-governmental organizations: some of them were indeed transferred to a virtual space, but some people did not have adequate conditions for virtual counselling:

“Well, yes, I attend counselling sessions at [NGO] and I really wasn’t, didn’t have space where I could attend online counselling session because in the hall everybody was there and I didn’t feel comfortable with anyone hearing me or whatever, so I basically hadn’t had counselling for several months and then at one point I thought I started feeling internalised transphobia /.../ I know, that one day I realized that I really did miss going to an event where I would feel ok. (Alen, FG, 2020).

A more restricted access to such services within either the LGBTIQ+ community (at the level of NGOs) or within the healthcare system (more on this in the following) is all the more problematic regarding the intensification of mental health issues, especially the increased

incidence of anxiety in this respect. The individual transgender people's accounts as well as those of experts from NGOs being a proof of that.:

“ I mean, the current distress – it was showing in the first wave, it was....it slightly went downhill, but what is currently happening, during the second wave, that's just – Never in my life have I worked in the sense that I practically don't have any people attending, for whom I could say they would be ok until next week, if I give them counselling today. So that they won't face any major crisis and so on. Currently, my work situation is a state of emergency as far as my attendees are concerned and as far as the number of people turning to me goes or the past attendees, who have already completed the treatment, but they need it again /.../ I am currently having a huge amount of work, so to speak (NGO EXP, personal interview, 2020). ”

3.3.

Political situation

The aforementioned potential factors of experiencing the pandemic situation in a negative way and its related protective measures are associated with 7) a specific political situation. Namely, a day after the declaration of the epidemic, a new, 14th government was appointed in Slovenia, which is in some places known for its conservative political orientation when it comes to topics and areas related to the LGBTIQ+ community (see e.g. Mencin Čeplak, 2005a, 2005b; Mencin Čeplak and Kuhar, 2010; Kuhar, 2015; Vezovnik, 2015; Maljevac and Gobec, 2017). Based on the data, we can identify various areas, in which the coincidence of the aforementioned political situation with the pandemic one operated as a negative factor in experiencing this period, namely: an ineffective government communication, the perception of protective measures as being insufficient or inadequate (also from the perspective of extra vulnerable groups and including conceived unpreparedness for the second wave of the epidemic), doubting the justification of protective measures and concerns about potentially taking advantage of the epidemic,¹¹ moreover, these perceptions are accompanied by a feeling that the situation will indeed worsen as well as by a sense of helplessness for any type of (political) engagement severely limited precisely because of COVID-19-related protective measures.

I also agree with everything said, to me actually, it seems that when the lockdown took place I experienced a feeling of anxiety in a way that I can't really do anything, that everything is going downhill and... that it will...I don't know, I mean I had ideas about them reintroducing this conscription

¹¹ It is similarly shown within the qualitative research of the experiential dimension of the pandemic situation (see Kamin et al., 2021) and the quantitative research, in which the authors find that Slovenia is already characterized by a low level of trust, and throughout the pandemic period the interviewees mostly trusted doctors and civil protection, whereas they least trusted mass media and the government (Hafner-Fink and Uhan, 2021).

and me ending up in the army. Then I was given some comfort from the fact that I am probably too old for this, but still [laugh]. It was rather at the emotional lever (Nejc, FG, 2020).

Jakob (FG, 2020) and Slavko (TG, personal interview, 2020) for instance, also recount the government's unpreparedness for the second wave of the epidemic with the latter clearly highlighting the element of negative emotional strain due to the coincidence of pandemic situation with the political situation of changing the government as well as pointing out the feeling of powerlessness:

“ /.../ mostly during the summer, that in fact we didn't plan anything ahead, as if the second wave wouldn't come. Let's say mostly because of the fact that remote education was already provided and we are currently, in fact, in the same situation and nothing has changed since then and it still isn't exactly good. That alone being some serious indicator of it.”

Besides that, I don't trust the government in itself anyway, so I even doubted those protective measures that might have seem reasonable for a moment only because of this, because this fucking government introduced them. And all those affairs and all that, I mean, don't know, that was...well, nothing but crap. It seems to me that it also – as much as COVID did, I mean, not only has COVID mentally affected me, but also the fact that this government came, this also mentally wrecked me, besides the fact that they locked us into our houses so we couldn't do anything and it really was an uphill struggle.

3.4.

Summary

In the context of experiencing COVID-19 pandemic and its related protective measures it is indicated that when it comes to highlighted factors of burdensome experiencing of the pandemic situation economic and housing insecurity seem to be standing out (including: moving, living in residential type of accommodation e.g. hall of residence, non-family supported living residences, living in an LGBTIQ+ unsupportive environment).

The participants also pointed out a restricted access to the LGBTIQ+ community, both in terms of access to social events and to a more specific support available within the LGBTIQ+ community (counselling, peer support, transgender support group). The specificity of the political situation is also highlighted as a particular factor in burdensome experiencing of the pandemic situation: the declaration of the epidemic coincided with the formation of a new, 14th right-wing government, known for its conservative views related to the LGBTIQ+ community as such and its relevant topics while unease rises from the perception of

3.

ineffective government communication, insufficient protective measures, doubts over the justification of measures as well as a sense of powerlessness and concern about potentially taking advantage of the epidemic situation.

The interrelationship of these factors, including the insecure economic situation - and certainly others that we were unable to identify in the study - according to participants' accounts raises an increasing incidence of mental health issues, predominantly in terms of growing anxiety along with feelings of powerlessness (especially in relation to the political situation).

Transgender people point out a stable housing situation (e.g. cohabitation with another LGBTIQ+ person), economic security and not experiencing a lack of LGBTIQ+ community.

4.

EXPERIENCES WITH THE HEALTHCARE SYSTEM
OUTSIDE THE COVID-19 EPIDEMIC PERIOD

In this part, we are focusing on the experiences of transgender people in the healthcare system in general: a review those experiences in general will inevitably include, at least partially, experiences with the healthcare system within medical aspect of the gender confirmation process. Namely, those experiences present one of the principal dimensions of interactions with the healthcare system, which we (also) discuss in further detail in the following part. In general, there is a lack of studies in Slovenia focusing directly on transgender people; one of the minor surveys conducted by one of the NGOs (Koletnik, 2019) on a small sample of 113 people aged between 14 and 50 between February and May 2019 indicates that transgender people recount experiencing others addressing them with inaccurate pronouns (50%), experiencing ignorance of basic information by healthcare professionals when it comes to transgenderism (48%), experiences with invasive and inappropriate personal questions by healthcare professionals (37%), having a healthcare professional clearly lacking knowledge on transgenderism in a particular area of expertise (36%), experiences with others addressing them using a wrong name (35%) as well as experiences with inappropriate comments about their body or body parts (27%).

A 2018 survey focusing on the daily lives of the LGBTIQ+ community as such shows that 58% of LGBTIQ+ youth have experiences of concealing their own sexual and/or sexual identity in the context of healthcare services; in this respect, it is not surprising that 54% of LGBTIQ+ persons believe healthcare providers being better informed about the rights and needs of LGBTIQ+ persons is one of the elements that would enable them to live a more comfortable life as a LGBTIQ+ person in Slovenia (Perger, Muršec and Štefanec, 2018).

A narrow insight offered by the limited range of studies in Slovenia confirms the findings of similar studies from abroad. A systematic review of studies on the present topic indicates that in the context of transgender people's experiences with the healthcare system, the following topics are most commonly highlighted: the importance of knowledge, communication and relationship dynamics, with the importance of knowledge and training of healthcare professionals most likely prevailing. These two topics are most commonly focused on both in terms of lacking the knowledge of healthcare professionals as well as in terms of the need for taking on educational roles by transgender people (Heng et al. 2018). An equally important topic is the communication dimension of the healthcare system, which is highlighted in terms of acceptance, respect as well as affirmation of gender identity (ibid.)

To put it more specifically, in a positive sense, the communication dimension is highlighted in terms of the absence of condemnation, in the use of appropriate pronouns and names, in professionalism and sensitivity, e.g. in the use of gender-neutral vocabulary for describing

sociogender-marked parts of body; whereas, in a negative sense, it is emphasised in the use of inappropriate terms, the use of a wrong name and pronouns, due to uncertainty by a healthcare professional etc. (ibid.).

In the context of relational dynamics, the feeling of vulnerability, dependence on healthcare “gatekeepers” and the feeling of lacking psychosocial support are highlighted, the general systemic and institutional characteristics of the healthcare system (e.g. long patient queues) are also of significant importance, also with respect to specific healthcare services (e.g. the absence of consistent policies and practices) (ibid.).

Other studies also suggest a sense of invisibility (unrecognition, non-affirmation of gender identity), burden of responsibility that arises in parallel to taking on an educational role, considering costs and benefits when it comes to practices of gender identity self-disclosure in the healthcare system i.e. consideration of consequences of self-disclosure in terms of potential “benefits” and “harm” (Persson Tholin and Brostrom, 2018). In this respect, Vermeir et al. (2018) also recount specific obstacles experienced by transgender people when accessing the healthcare system, which are also reflected in the poor medical status of transgender people in comparison to the general population, with the accumulation of so-called “micro-experiences of marginalization and discrimination” being of significant importance, which emerges an accumulative negative effect when it comes to accessing healthcare services: “Many feel that the healthcare system acts against them, as they are constantly coming up against extended waiting times, issues with access, a lack of trans-friendly clinics and resources as well as incessant experiences of all-pervasive discrimination ”(ibid., pp. 240).

In the following, we discuss the experiences of transgender people in the healthcare system outside the COVID-19 epidemic period, also with the help of the NGOs experts’ perspective working in the area of transgenderism. We analyse the experiences in the following major content subsections, namely: courteous experiences with the healthcare system, ambivalent experiences with the healthcare system and negative experiences with the healthcare system.

4.1.

Courteous experiences in the healthcare system

To a lesser degree, transgender people recount courteous experiences in the healthcare system. Most commonly, these are related to 1) primary level healthcare treatment (i.e., interaction with general practitioner). The latter is not surprising, as people are still allowed the most room for manoeuvre when choosing general practitioners (hereinafter referred to as GPs in plural, GP in singular), which also implies that in this context they can, mostly

rely on the practical knowledge on trans-friendly healthcare professionals already known to the transgender community. When it comes to perception of general climate in general in the healthcare system related to transgenderism, even more telling is the fact that those courteous experiences are treated mainly in terms of “lottery” or “luck”, coincidence, which indicates that courteous treatment seems to be the exception rather than the rule.

“/.../indeed, but as far as doctors are concerned in general, it’s a bit of a lottery. You can be quite lucky or quite unlucky. I was lucky in a sense that apart from having [anonymized] other things were quite fine, I mean my doctor–patient relationship. So, I had that...I was fortunate. (Cimet, FG, 2020).”

I am very lucky to have a great GP, though. She commits herself to this and provides me with everything I need, well, or even more (Slavko, TG, personal interview, 2020).¹²

The experience of courteous treatment is perceived as a surprising, unexpected “victory” that is a cause for celebration - as opposed to expectations that are significantly marked and filled with expectations of transphobia, as being evident in the excerpt below (NGO EXP, personal interview, 2020):

“/.../ what I was trying to say, it’s so interesting, how we all pleasantly surprised when actually being treated courteously and we are like - “Wow, that was great!” The other day someone told me he had gone to get his first shot and when three nurses and a doctor came they were all very kind to him, very courteous by asking him whether it hurt him, whether he needed anything, really like wrapped him up in cotton wool being all kind-hearted and wonderful and we were all like - “Damn mate, we hit the jackpot”, and we were all celebrating with him.”

Even if people recount frequent courteous experiences, it is worth bearing in mind bear that the “correctness” or “positiveness” of experiences is also assessed on the basis of the absence of “terrible experiences”, that is on the basis of 2) low parameters of expectations or anticipations: as transgender people often expect (and frequently it is justified) to experience transphobia within healthcare, the absence of “terrible transphobic” experiences itself, which does not necessarily imply a completely positive treatment as such, is enough to evaluate the experience as a positive one:

¹² In order to protect the anonymity of individual healthcare professionals mentioned and exposed in selected quotes of transgender people, the grammatical gender of the healthcare professional does not necessarily reflect the actual gender of the latter. In short, when a quote from a transgender person relates to a specific healthcare professional, we use grammatical gender, regardless of that particular professional’s gender meaning that we intervened in the otherwise literally transcribed focus groups and interviews or quotations to such an extent that we changed the grammatical gender in some parts. The same applies to all following transgender people’s quotes as well as to healthcare professionals’ quotes (HLTH PRO) and experts from NGO (NGO EXP) where grammatical gender used in the quote does not necessarily reflect the actual gender of the healthcare professional and expert from NGO.

“Me too in fact, if I draw a line, I don't have any terrible experiences with the healthcare, as it was said before (Nejc, FG, 2020).”

Nevertheless, the key topic remains the fact that positive experiences are most commonly reported in relation to the primary level, also against the background of knowledge and information exchange about which GPs are the ones being trans-friendly, as agreed by the general insight of a NGO expert (NGO EXP, personal interview, 2020):

“In general, the experiences are bad when it comes to GPs and it seems to me that they are quite ok, but only because it became known once again, which GPs are fine so everyone wants to go there.”

The key to a positive evaluation of experiences with the healthcare system is also what similar studies call “relational dynamics”, that is 3) the involvement of a healthcare professional, also in terms of overcoming their own shortcomings (e.g. lack of knowledge of transgenderism by involving in additional self-learning) - in this respect, it is worth highlighting that meeting with GPs at primary level who would have pre-existing sufficient knowledge of transgenderism from the point of view of the specifics of medical treatment is rarely reported.

“/.../ I have a fantastic experience with a GP, who used to know nothing about it so she wanted to learn and she helped me a lot. (Matevž, FG, 2020).”

In the context of surgery, which can be particularly sensitive due to exposure of body aspect, Nejc also points out a very courteous experience related to a specialist treatment, which is a proof of careful and 4) sensible treatment, as a surgeon explicitly paid attention to protecting privacy and integrity of gender identity related to genitals marked by gender:

“I was actually surprised as I have had a surgery at the department of traumatology last year /.../and the surgeon called me to speak to me in private by telling nurses to step out. She told me that if I don't agree with this, on anyone being present in the room except her because of my genitals I should tell her so that she can stay there alone or as many people can as necessary. So in fact that was such a nice thing coming from her, that she actually thought of me not being comfortable. (Nejc, FG, 2020)”

Also Slavko recounts courteous experiences that do not only refer to doctors, but also to nurses or medical staff of that type (TG, personal interview, 2020):

“/.../ then I had a minor surgery and it was ok /.../overall, it was quite ok. The attitude was cool also

when it comes to nurses I was pleasantly surprised. They came to hang out with me, everyone was super courteous, it really was nice.

Alen (FG, 2020) also talks about a similar experience in the context of a (gynaecological) treatment, distinctly gender-marked, during which the gynaecologist recognized the intensity of gender dysphoria and tried to alleviate it sensitively or offer support:

“ /.../ in a way, she really guided me through it, she was like – listen, it will only take a second, one more thing, listen, just a second, she was soothing me all the time and in a way tried to, I don’t know, she ensured me that it would be over soon, that she would do only minimal, what she has to because she saw that it was really bad for me, so I actually had a positively negative experience /.../ it seemed to me that she wasn’t like –“oh come on, have a little patience, why are you being so...”, but she really had this right attitude, I do remember her saying to me once, that she saw me being in distress, but we would try to sort it out as quickly as possible.”

In addition to a wholehearted approach to the subject of trans-specific medical treatment, 5) the use of appropriate pronouns and names is also highlighted in the context of courteous experiences with the healthcare system:

“ /.../ I have recently been going to my GP who has come back from sick leave and is also very respectful, she always addresses me in a right way, she knows sufficiently about this subject and she was nice and so when I came for bandage changing as well (Dylan, FG, 2020).”

Dental care services and distinctly gender-marked healthcare services (though to a lesser extent) are also pointed out in the context of courteous experiences - this is reported by e.g. Matevž (FG, 2020), who started interacting with a distinctly gender-marked healthcare area expecting dilemmas and problems due to his gender identity, which were “surprisingly” not met during the treatment:

“ I used to be in the system a lot as I had problems with reproductive organs, so I was in a gender-marked situation /.../ And I had surprisingly little...regarding the gender-marked situation, I would say I was pleasantly surprised, there, there was a lot of them, having told them that I came out, it was all fine. I was full of prejudice at the beginning, whether it would go through or not, so I was really happy about it.”

In the context of courteous experiences, the following is worth highlighting: 1) the importance of the primary healthcare level, which is more commonly stressed in terms of courteousness

of experiences, even if these experiences are contrary to expectations and even though they are discussed in terms of “luck” and surprise, as well as 2) relational dimension in terms of sensitive and trans-sensitive treatment (e.g. regarding the respect for privacy, respect for gender identity with appropriate use of names and pronouns as well as 3) engagement of a healthcare professional in terms of self-learning on transgenderism and trans-related healthcare services.

4.2.

Ambivalent experiences

By “ambivalent experiences” we are mainly referring to those borderline experiences in the healthcare system that cannot be fully denoted as positive, but at the same time they are not experienced as (rather) negative experiences. In this section we can place so-called 1) “poor well-intended practices”, i.e. practices that are caused by “good intentions” - practices that “want” to be good, supportive, respectful – however, they fail to do so in some places also against the background of spontaneity and ubiquity of merely subtler transphobia in the context of cisnormative social order. However, due to good intention that drives this practice, the experience is not perceived as totally transphobic. Discerning or attributing a good intention by a healthcare professional is the one that can raise greater “tolerance” for transgender people for such failed well-intended practices. E.g. Timotej (FG, 2020) and Maja (TG, personal interview, 2020) tell about such experiences:

“It did later happen to me that one nurse - she felt the need to tell me: “You know, when I look at you, I would never be able to guess”. Actually, it’s a bit – I mean, thanks I guess, I mean...it is a compliment, and at the same time it’s not, really. It wasn’t intended to provoke, no one asked her anything. And it was totally unnecessary and an inappropriate comment. I may consider it as less invasive as it was meant in a positive way, but now – if the comment had been like “You know, when I look at you, I would never think that you are a man”, that would have come out quite differently. So that’s that.”

“The urologist is.... more personal. And very sexist. In a quite typical cis-het sexist way /.../ she wants to socialize and telly funny jokes, but those always miss the point and tend to be somewhat sexist or even transphobic and she doesn’t even get it. She really just wants to socialize; you can really tell. She only wants to be a nice, fun person telling funny jokes to lighten the atmosphere.”

Besides poor well-intended practices, we can also place so-called 2) uncomfortable situations, which are not necessarily transphobic as such, but raise to gender-related discomfort on the part of transgender people, in the context of ambivalent experiences with the healthcare system. Such situations are recounted mainly in the context of radiology or, to be even more specific, in the context of abdominal ultrasounds e.g. by Jakob (FG, 2020):

“It’s more that I now frequently have some...some a bit more awkward encounters, as I have to tell what is it about when going for an abdominal ultrasound. Since – that happened to me during my last abdominal ultrasound, as the doctor looked at me in a strange way and I said “Yeah, yeah, I have a uterus and ovaries.”, and she was like, “Oh, so you know! Then there’s no problem at all”, I mean these things tend to happen.”

These situations, which in the case of ambivalent experiences, which otherwise remain borderline ones, include discomfort, as well as potential for transphobia, i.e. for deriving borderline experiences into negative ones, the data analysed in the next subsection being a proof of that. It is precisely that potential for deriving a borderline experience into a negative one experience that causes discomfort of those situations as well as their ambivalence.

4.3.

Negative experiences with the healthcare system

Transgender people point out numerous and various experiences with transphobia and other negative experiences that they had when interacting with the healthcare system. Transgender people in the context of 1) experiences with transphobia also recount experiences with exoticization, a phenomenon of transgender people being treated as an exotic phenomenon, as an “everyday” phenomenon, but rather an “anomaly”, which as such is established against the background of cisnormative assumptions. Timothy (FG, 2020) and Allen (FG, 2020), for instance, talk about that:

“/.../ let’s leave those silly jokes aside – to me it actually happened that one doctor who filled in for my GP, she actually said “Oh, you are her second [transgender] such patient, I don’t have any such”, I mean...Lego figures. She has two, and I have none, I mean, do you want me to send one of my friends to you, so that you can have one?”

“/.../ I have registered with a GP in [city], as I realized that from that point on I would need a GP several times and when I came there she was thrilled, as she had only known of Salome. And he found it like wow /.../ and now both of them [my GP and the nurse] are very courteous, it still feels a bit like – wow, the trans is back! /.../ well, I don’t know, like a creature or something, in a zoo in some display – wow, look at what they brought us today!”

Similar experiences with exoticization are also told from a broader, non-governmental perspective:

“/.../ as they tell you with excitement that you are the first transgender person they have met and they

even brag about it – and I’m like, seriously? After all these years. Having been in practice, you think it’s a compliment for me being the first trans human that you have known of and you say it like it’s one thing, making me feel like an exotic creature here, as you don’t even know what you are supposed to do with me ((NGO EXP, personal interview, 2020).

Apart from the exoticization of transgender people, they also point out a direct pathologization, which, as we will also discuss in the following, is in fact an integral part of the medical aspect of the gender confirmation process. Tony (FG, 2020) recounts the pathologization, he experienced in the medical (psychiatric) area. Him being transgender was treated as a mental illness during the psychiatric treatment (unrelated to the medical aspect of the gender confirmation process):

I mean, I was at the doc’s a lot, mostly because of my mental issues. I was also hospitalized and so on and a lot of times they treated it as some mental illness. Well, when I outed, my mum also found a whole lot of excuses why am I in fact trans and among those was also borderline personality disorder. As being fluid is supposed to be typical.

One of the more common practices that reflect a lack of respect for gender identity is *the use of wrong name and / or pronouns*. Those practices are by Matevž (FG,2020) highlighted as the “biggest catch” of interactions in the healthcare system, as that obstacle that is actually the most difficult to surmount:

In general, in the healthcare it’s bit of a mix, the biggest catch that is usually, the worst thing to get through to them are pronouns, you just can’t get through, even if I explained the situation you just drop it at some point and “ok let’s go on”.

Healthcare professionals - at all levels and of different profiles, from doctors to nurses – in some places insist on using incorrect names and pronouns, despite multiple explanations and warnings from transgender people, what is more, despite prior notice of an individual’s transgender identity before registering with GP. When it comes to discomfort, caused by those practices, other gender-marked terms of these misidentifications of a person’s gender identity also have a significant role (e.g. “miss”) and “the public”:

/.../ as I mentioned before, I kept my old name and she saw the old name and the new one, I told her of me being trans, what I came for and also when I was looking to register with a GP I let them know I was trans and that I would need this kind of care and a GP who – that things would run smoothly. When I came into the waiting room the nurse wouldn’t call me by my new name, she only would by

my old name and say miss, even though I had told her that I am a trans guy. And she did it in front of the whole waiting room, multiple times, she came out and “Miss, please come in”. /.../ to me that was the most like it, that she in fact used “miss”, even though I had told her (Alen, FG, 2020)

Some transgender people also talk about experiences when they were faced with more or less direct, as well as more subtly formulated *demands for the legitimization of their transgender identity*. Dylan (FG, 2020) recounts this in the context of psychiatric treatment or hospitalization, which is supposed to be even more supportive than a usual medical treatment. He received those demands mainly from his fellow patients, although the medical staff was not able to protect him from those pressures and demands or react accordingly and ensure a safer situation for him; what is more the medical staff also actively demanded the same legitimization of transgenderism and Dylan was, in the context of group therapies, also forced to reveal and was thus exposed to a situation of extreme vulnerability:

“I went [in some period] into the psychiatric setting for a month, and there was a lot of transphobia. Mainly coming from other people who were also staying at the department. But they weren’t even, I don’t know, even coming from nurses – they were like...” “Why would you want to change your nature?” and some other questions of that sort and they kept discussing it with me that it wasn’t cool. And they didn’t know how to protect me from those mentally attacking me /.../ and they even did this...we had group therapies where there was approximately 30 or 25 of us and in a way they forced me to declare in front of everyone that I am trans and I defend myself being trans as others stared to kind of ...” I don’t get it, I don’t believe in it” and I had to somehow defend myself /.../ that was really stressful, I was there for a month.

Psychiatric setting, which is supposed to be more distinctly based on a sense of security and trust, is in this case in fact a space, in which other people question the legitimacy of transgender identity – thus a space in which transgenderism (rather than cisnormativity) is brought into question by broaching it as a subject of discussion and debate. Alen (FG, 2020) also recounts the same, but still a subtler and seemingly benevolent demand for the legitimization of transgenderism in the context of the relationship with nurses. His experience indicates 1) that people who are not actually qualified to assess gender identity of an individual still feel qualified to make such assessments, and that 2) this vocation is accompanied by a sense of “benevolence”, although it only reveals ignorance of transgenderism and the medical aspect of transgenderism at its core, which is not a matter of cosmetic interventions (“but you are so handsome, why are you doing this to yourself”), but rather a matter of necessary medical treatment:

“ /.../ a nurse came, who I got along quite well with at the hospital, the visitations still weren't allowed back then so I was basically more or less hanging out with the staff. And she came in saying, “Can I ask you something?” and I said, “Yes, you can ask me.” She asked, “You are so handsome, why are you doing this to yourself?” She did ask me that five hours before the [top] surgery. I only said to her that that was exactly why I was doing it, because I was so handsome /.../ so that people would grasp that it's not – I haven't come there for a surgical procedure because I'm ugly or whatever, but because it's something I need, it's a sort of medical care I need, it's not something I came up with yesterday by saying let's just have a quick operation.”

Besides the demands to legitimize transgenderism, transgender people also talk about actual and more or less aggressive *invasions of privacy*. These invasions of privacy include experiences of mockery and direct “guessing” about the supposedly “correct” gender assigned at birth, direct questions in a sense of “are you a man or a woman?”, checking a “real” gender in medical record as well as direct and invasive exposure of a body to the gaze of others. Slavko's account below is a proof of all those dimensions (TG, personal interview, 2020):

“ /.../ I was there lying on a bed and they were getting ready for my operation in the operating room as I heard their conversations and they were conversation in a sense – “What do we have here, which sex is this, he just might be a hermaphrodite, ha-ha, ha-ha,” and they had been cracking jokes, making fun of me and then came to me wearing poker faces. The most horrible thing was that /.../ I heard some heated discussion in the nurses' station /.../ and just like that [a nurse] directly asked me, – “Are you a man or a woman?” and I was like, “Good morning!” /.../ And then one nurse there sitting at the computer desk says – “I did look into the computer file and it says you are an “F”, what is that supposed to mean? /.../ Well, next they also, when they gave me that stuff for heart rate and she completely uncovered me so that it was clearly visible to everyone that I still had breasts then I covered myself again and said that she should fucking do it in a more discreet way /.../ And really, I mean, I later got the anaesthesia and they could later have a look at my genitals, I don't know. Anyhow. So that was by far the worst experience I have had.”

Such intrusions or invasions of privacy also include asking inappropriate or unsuitable questions that are not related to medical (in this case gynaecological) treatment as such, e.g. questions about an intimate relationship and the “satisfaction” of a partner with genitals of a transgender person. Slavko (TG, personal interview, 2020) recounts such experience (again):

“ /.../ during the gynaecological examination she asked me whether my partner's ok with me having such genitals. And I was like – excuse you? Why do you care about my romantic, I mean, it's none of your damn business?”

One of the main and more highlighted elements of incorrect medical treatment or negative experiences in health care is also 2) the lack of knowledge of healthcare professionals. That is something, according to participants' accounts, that is actually encountered at all levels of medical treatment, even when it comes to trans-specific healthcare services. Timotej (FG, 2020) below e.g. tells of lack of knowledge about the basic distinction between "transgender woman" and "transgender man" in the context of radiology:

“They were doing an abdominal ultrasound /.../and as they were doing the ultrasound that woman kept looking and looking and suddenly she started frowning and stuff. I had told her everything – that I was in transition and my name had been changed. I had told her everything, while doing that ultrasound she kept nodding, kept frowning and said, “I’m getting another colleague, it’s probably nothing, but we are still going to take a look at it.” And her colleague came along. They were both looking, frowning and I was like, “Fuck, I’m going to die,” I had no idea what had they found, a tumour or something. And one said to another – is that the uterus?? For god’s sake people, I almost died of fear there lying on the examination table /.../ Are you not the one who’s a doctor? /.../ Regardless of profession – can you call a person a trans man, a trans woman, they don’t know, which is the course of direction...from a to b, which direction is that? Does this mean he was born as a woman or that he has become a woman? I mean, it is a problem in the healthcare, people don’t even get what you’re telling them about, when you say that you are a trans man, they have no clue what you have said to them /.../ I mean, if she had understood what does it means to be a trans man, she should have expected that there is a chance to see the uterus at ultrasound, instead she almost fainted. Two doctors!”

Dylan’s experience below (FG, 2020) refers to the lack of knowledge of the healthcare professional about the basic distinction between intersex and transgender, people also tell about the ignorance of more trans-specific healthcare services, e.g. not knowing how to take hormone therapy, etc.:

“Otherwise, as far as transphobia is concerned, a couple of doctors, one at the ultrasound, for instance, she didn’t even know, what it meant for me to be trans and thought that I was intersex and she really was confused about why was I sent to her for an examination and she didn’t know what to write and she was very like...I don’t know, she must have thought I was intersex. But then, it was an abdominal ultrasound, she was looking and she was like – everything is normal, your uterus is normal, it’s all normal, I don’t see why they sent you here.”

In parallel with the lack of knowledge of healthcare professionals, transgender people are forced to 3) take on so-called “educating tasks”, where transgender people are actually those who educate healthcare professionals about transgender specific healthcare needs. Those

tasks do not come without an additional (affective) strain, as they tend to be onerous for a transgender person due to taking on responsibilities other than their own (concern for an appropriate medical treatment) by exposing them to potentially vulnerable situations at the same time. Cimmet (FG, 2020) talks about “getting used” to taking on an educational role by pointing out that informing or educating healthcare professionals is less exhausting and burdensome, as long as it is framed within the parameters of respect for gender identity, i.e. in the appropriate relational dimensions, but also because he does it on behalf of transgender people who will enter medical treatment after him:

“ I got so used to it, explaining, education people around me /.../ But, I mean, they were still respectful. And if you show me respect, I can explain things to you. I can't explain it all, because it still a lot of information, and ...I explained if they were interested because I find it important that those coming after me or after us will in fact...so that they won't have to repeat it all over again. ”

Dylan (FG, 2020) talks about the burdensome side of that role - those educational excursions are accompanied by vulnerability and fear of the reaction of a healthcare professional:

“ /.../ I don't feel like explaining why I was sent there and there and there and I put myself into a certain vulnerable situation and then you never know how a person may react or how much does this person know about this topic and I think all healthcare workers should know what is it about because...well, you still become scared how to explain, how to tell a doctor, will they understand, will they react favourably and so on. ”

As the key element of the absence of experience with transphobia, the participating transgender people mainly highlight 4) the importance of passing¹³ both at the levels of a gender marker and gender expression. In other words, according to the interviewees, transphobia should be avoided by leaving as little doubt as possible about the “authenticity” of gender, i.e. by meet the matrix of gender-marked expectations of healthcare professionals as much as possible:

“ Otherwise, have I had any other more distinctly negative experiences? Am, I did not. Maybe it's also related to the fact that in most social situations people read me well and there's no doubt and then people don't even bother (Timotej, FG, 2020). ”

“ /.../ I mean now, when I pass, of course everything is a lot easier and folks are, if nothing else, a bit

¹³ The term passing refers to those situations in which a transgender person is identified according to gender identity (e.g. a woman) in absence of any gender interviews and / or transgender status. So far, we do not have an effective translation in Slovene at the moment, the alternatives are more descriptive, so we use the English term in the text.

4.

confused, but that's it /.../ I don't even think that in that period when I changed or changed my documents and I haven't yet passed, at that time, it was really horrible (Slavko, TG, personal interview, 2020).

Another way of reducing experiences of transphobia is, paradoxically, the absence of interactions themselves with the healthcare system - those transgender people who mostly say that they no longer have experiences with transphobia, are to a large degree the people whose interactions with the healthcare system have been considerably reduced to maintaining their state having completed the gender confirmation medical process. In that case, interactions are largely limited to interactions with - often supporting - GPs (e.g. to adjust hormone therapies). Timothy (FG, 2020) tells about that:

Well, I mean, I really don't that much /.../ once you're there where you want to be, in principle that only means doing some regular maintaining, so every now and then I pop over at the endocrinologist's, then also at someone else's, but I don't have a whole lot of interactions, mostly with my GP every 14 weeks for an injection.

Experiences of transphobia and their effects do not remain limited only to specific situations, in which transphobia is experienced, but also significantly and considerably mark the entire attitude of a transgender person towards medical staff and the system as such. Slavko (TG, personal interview, 2020), whose accounts of invasions of privacy we have pointed out above, recounts that against the background of such and similar experiences, he lost confidence in the healthcare system:

I did see after that, what kind of reactions the medical staff had, I really did lose confidence, I am lucky though, to have a GP, just as she is, to slightly instil hope into me.

Extensive social experiences with transphobia, as well as specific experiences with transphobia within the healthcare system, also establish *anticipations of transphobia* and thus form the perception of future experiences or the future (i.e. in Bourdieu's sense: what has been experienced in the past is confirmed in the present and foreseen in the future). Against a background of numerous experiences with transphobia in everyday life, including the healthcare system, transgender people therefore enter the latter in a "crunch" and ready to tackle transphobia, which is recounted within the non-governmental sector (NGO EXP, personal interview, 2020):

As it is so unusual, you know, to have a courteous medical treatment and it's more an exception to the

rule, we are constantly faced with a crunch and prepared for the worst so we prepare the responses to have when treated incorrectly in advance. That just seems sad to me.

Many of transgender people also talk about *avoiding medical treatment* or avoiding healthcare services due to previous experiences with transphobia they went through or because of the anticipation of transphobia. Dylan (FG, 2020), for instance, tells about it and from a broader perspective, but also within the scope of non-governmental organizations (EXP NGO, personal interview, 2020):

I have always been putting it off. I was really waiting, if it was necessary to go there, at the doctor's or it would just clear on its own or something, I really was putting it off until the last minute and then went there all scared (Dylan, FG, 2020).

One thing, not only related to the fear though, but as it is also very uncomfortable for them, namely, a gynaecological examination for trans men /.../ That is one thing, but also in general when it comes to other things, until it becomes really really urgent, going to the doctor's is not an option as they don't know what will happen there (EXP NGO, personal interview, 2020).

The medical treatment of transgender people is, as can be seen from the account, significantly filled with fear and discomfort, which makes it more difficult to seek medical help when that is needed: medical treatment is in some places delayed for as long as possible. However, other participants say that despite negative experience in the healthcare system, they tend to seek medical help in time when necessary; and LGBTIQ+ friendships or a social network or to be more specific other transgender people occupy a significant role in *taking care of their own health*, regardless of other negative experiences.

/.../ I can't even tell you, how many times have I done it, that I had to slag them [other transgender people] off or they slagged me off – come on man, it's time to take care of yourself, it's your health, I know it's tough, you'll survive, but you have to take care of your health. It really is a problem among us. If we only can, we avoid it. We pretend that we do not have those problems, health-related ones or whatever and this really is a big problem (NGO EXP, personal interview, 2020).

In the context of accessing healthcare services, those transgender people who otherwise come from more rural areas and smaller towns, where also registered with a GP, face specific dilemmas. Namely, the GP also provides other family members with medical treatment. In this respect, it highlights a dilemma of seeking medical care for fear of self-disclosure - either to the family or to the local environment. Tony (FG, 2020), for instance, tells about that, the

dilemma is also pointed out from a broader perspective of non-governmental experts (NGO EXP, personal interview, 2020):

“I mostly avoid the health centre [in a smaller town], because, well.... I've been there – when you have a GP there, you're there from day one and well, my GP, I have two older sisters and my mum is super chatty and the whole place [small town] knows her and the GP knows exactly who we are, oh yes, you are this and that.”

“Again, even more so, if that's in places where – something that a lot of families have, the same GP as their family – then potentially people talk a bit louder in the waiting rooms, “well, you know he was the one who...” – so even this confidentiality is a very big problem and a huge factor, for which I know - people consider outing themselves there [at GP] or not.”

4.4.

Summary

In the context of experience with the healthcare system, transgender people and NGO experts highlight negative experiences to a large degree, including experiences of transphobia, the lack of knowledge, the need to take on frequently onerous educational role; the importance of passing to avoid the experience of transphobia is pointed out as well. In the context of courteous experiences, the primary healthcare level or GPs are being most often focused on, not surprising though, since transgender people, especially in that relation, have the most room to manoeuvre and the possibility to choose those professionals who are (more) trans-inclusive.

In this respect, transgender people point out the engagement and sensible approach to the medical treatment of transgender people, respectful attitude for gender identity being shown through the use of appropriate names and pronouns and basically sufficient knowledge of trans-specific medical treatment or at least the presence of engagement directed to self-learning. Between the two poles of experiences of courteous treatment on the one hand and negative experiences on the other - there is also a spectrum of ambivalent experiences, which roughly includes failed, but well-intended practices, which often fail due to lack of basic comprehension of transgenderism as well as uncomfortable situations, which a person does not necessarily perceives as transphobic, but cause a gender identity-related discomfort, mainly due to the potential for transphobia. The experiences of transphobia are not negligible: according to participants' accounts, they significantly frame the attitude of a transgender person towards the healthcare system, also in terms of avoiding healthcare due to anticipation of transphobia, thus reproducing existing health inequalities.

5.

EXPERIENCES WITH THE MEDICAL ASPECT OF GENDER CONFIRMATION PROCESS

In this section, we discuss data in relation to a perspective of transgender people when it comes to medical process of gender confirmation.

In the following, the empirical material is analysed in sections as follows: I) positive aspects of the gender confirmation medical part, II) negative aspects of the gender confirmation medical part, and III) identified changes necessary for greater inclusivity of the medical part of gender certification process.

In this part, similarly to what has been described above, we give prominence to the perspective of transgender people (both those who participated in the focus groups and those who participated in the in-depth interview) and the perspective of NGO experts, relevant to the subject of transgenderism, we are also adding the data obtained during interviews with healthcare professionals.

5.1.

Positive aspects of the gender confirmation medical part

Transgender people set out relatively few elements within the positive aspects of the medical part of gender confirmation process, especially compared to the negative aspects discussed in the following. In doing so, they most commonly point out the circumstances of being able to carry out the process of gender confirmation, including its medical aspect, and 1) the circumstances of this possibility within public healthcare services, namely the fact that the medical part of gender confirmation process is (mostly) available free of charge or within supplementary health insurance. This aspect stands out especially when compared to some other foreign countries. Matevž (FG, 2020) and Dylan (FG, 2020), for instance, discuss that:

“ In the first place, I would say that we have a process, which can be started, um, I think that for us is a plus, it’s a way to get things within public healthcare. ”

“ /.../ Everywhere, they have to pay for hormones – not everywhere, but mostly – or at least some minimum, a sort of surcharge, as the insurance company doesn’t cover 100%. So... I like it a lot. Especially having talked with other trans activists from other countries, I realized that our system is quite fine. But also elsewhere.... even if you have to pay, the waiting times as extended as here, I think. ”

In addition to the possibility of entering the medical gender confirmation process, the participants, to some extent, also highlight the 2) courteous attitude of healthcare professionals responsible for this process, both in terms of *absence of transphobia* and in terms of *expressing an interest and comprehension for the subject of transgenderism*. Cimet and

Nejc, for instance, discuss this:

“/.../ having been at my endocrinologist’s, at my gynaecologist’s, I never felt any transphobia. In anyway, these people work with trans people a lot and so they – she respected it and anytime I see her, it’s almost a positive environment, which you don’t always feel at doctor’s, of course. Well, it is true though that nurses are really really nice (Cimet, FG, 2020).”

“Well, I mostly, as far as my interaction with healthcare goes, it’s obviously transgender-related or related to hormones, so...it’s a bit specific, as you always meet some people who know of you being trans and there’s no problem with them (Nejc, FG, 2020).”

As a positive aspect of the gender confirmation process, transgender people also stressed 3) a laxer legislation, which allows *obtaining a certificate to change the marker quickly* via administrative units without any more invasive medical procedures (e.g. gender reassignment surgery). This positive element is also stressed against the background of comparison with some foreign countries with more complex (e.g. court proceedings are being conducted) and lengthy procedures. As, for instance, Cimet (FG, 2020) recounts it:

“Yes, that is true. I have seen noticed it mostly – I think it was in Great Britain, someone had a bottom surgery a year or two ago and couldn’t have changed the marker until now, I think that also in the US it’s a lot more difficult. You have to go to court and so on, there’s a whole process for it. Here, it actually takes a couple of months, so there you go, you go and change it.”

It is of significant importance that the process is not perceived as a matter of deliberate regulation, but rather as a disarray of this area or a loophole (see also Kuhar, Monro and Takács, 2017 for a discussion of trans citizenship, which arises in a fragmented form). The procedure of changing the gender marker on official documents (e.g. identity card) is not regulated by trans specific legislation with clear guidelines regarding the procedure (as opposed to Malta with the *Gender Recognition Act*), but with the Rules on the implementation of the Civil Register Act, which Jeričević Šušteršič (2020) draws attention to. The latter actually requires “a certificate from a competent medical institution or doctor showing that a person has changed gender”, at the same time, it does not however specify who the competent doctor or medical institution is.¹⁴ A similar “flexibility” and even greater “*unintentional*” producing of legislative effects, both being realized in practice, is also highlighted in case of

¹⁴Jeričević Šušteršič (2020) points out, that in practice means that a competent doctor is in most cases a psychiatrist from an interdisciplinary council for confirming gender identity, where a person must obtain a diagnosis of transsexualism, i.e. a diagnosis of mental disorder for the purpose of legal recognition. According to TGEU data for 2020, Slovenia is classified to the group 31 (out of a total of 41) countries that require getting a diagnosis of transsexualism to change the gender marker (TGEU, 2020).

biomedically-assisted procreation (also IVF), which is, according to existing legislation only available to heterosexual couples without (justifiably) drawing any distinctions between the gender assigned at birth and gender identity of a person or gender marker. Timotej (FG, 2020) points out that the “unintentionality” of the effect of existing legislation, which is available against the background of the heterosexual composition of an intimate relationship, even if one person in a relationship is transgender.

“Yes, the same as for IVF process – we were entitled this process as we have different gender markers on our documents, which is basically loophole. I am sure that they [activists opposing access to IVF for single women] hadn’t had in mind when he was lobbying against single the fact that women and lesbians wouldn’t be allowed to have children and I would. But it’s again just- something you don’t want to point out, as we don’t want to attract the wrong kind of attention because then someone is going to go close that loophole in law.”

As the most frequently highlighted positive aspect of the medical part of gender confirmation process it is worth mentioning the recent 4) formalization of the interdisciplinary council. The intention of establishing an interdisciplinary council is also evident in the minutes of Expanded professional board for psychiatry’s meeting on 29 May 2019, during which the board responded to a call by two non-governmental organizations LGBTIQ+, namely, TransAkcija InSTITUTE and Legebitra, for establishing a formal regulation of gender identity confirmation processes for transgender people (in a clear, transparent and in a way of describing medical processes of confirming gender identity that is comprehensible for transgender people.) (Ministry of Health - EPB, 2019). The importance of the formal establishment of the interdisciplinary council for transgender people was stressed by transgender people in several respects, namely in terms of *standardisation of procedures and commitment to comply with international guidelines in this area (WPATH)*, as well as in terms of the *possibility of formal appeal and the commitment to cooperation* (all in all, the above-mentioned is evident in the minutes of the meeting, where it is stated that the council will also consist of “other experts” in law, human rights and administrative authorities). Matevž (FG, 2020), for instance, discusses that, however it is also highlighted within the non-governmental perspective:

“Related to purely structural I have no more up-to-date information, but also that all these doctors - that this is formalised, because, let’s say, when I was still in the process, this council was not formalized, which means that there were volunteers, meaning you can’t prosecute them, they don’t have a formal way to appeal because in this way they are all volunteers.

Because if there is no legal form, it is very difficult a) to require some standard regulation in the implementation of this service, and because in general there is a major discrepancy in the quality of

implementation of those services when it comes to the process of medical transition or all procedures involved (NGO EXP, personal interview, 2020).

Although the formalization of the council is roughly perceived as a welcome step to take, it nevertheless, also highlights certain shortcomings that remain despite the formalization, especially by experts from LGBTIQ+ NGOs. In this respect, the attention is drawn to the lack of contact with the actual needs of transgender people, the *lack of cooperation with relevant non-governmental organizations and the “wide” interpretations of the guidelines by WPATH*:

By doing so, appointing the council in such a way, that the medical professionals are clearly identified and at the same time the agreement states that they must work with [the non-governmental sector] as far as everything is concerned. Now, they are supposed to meet twice a year, [no meeting has taken place so far] and it's the end of the year. The protocol according to which WPATH is supposed to be implemented as well, these are international guidelines and... also this is a lot like, hmm... a broad interpretation of whether this is really being implemented or not; the council asserts that it is, I somehow don't know, if we read the same guidelines, but the process definitely doesn't go that way. So this is now some short story, we were all jolly when it was being formalized, but the reality of it is that from the time it happened it has been at a standstill. We don't meet, we don't discuss, emails are left unresponded when meetings are summoned and so on (EXP NGO, 2020).

As opposed to the perception of non-governmental experts, a slightly different perspective on council's formalization can be seen by healthcare professionals. Namely, in the context of the positive aspects of the council's formalization, healthcare professionals point out *compliance with international guidelines and working with NGOs*, so the point where there is an apparent discrepancy between the transgender people's and NGO experts' perception on the one hand and the healthcare professionals' perception on the other; in addition to the highlighted fact, as positive aspects of council's formalization, healthcare professionals also point out *the possibility of getting expert opinions and participation of individual medical professions*:

When it comes to those rules, the rules [anonymised] state that the councils work in accordance with the Declaration [anonymised] by following WPATH Standards of Care recommendations, version 7 (HLTH PRO, personal interview, 2020.¹⁵)

That is actually new, that the council, which is professional and the highest authority, shall

¹⁵ In order to ensure the greatest possible anonymity of healthcare professionals, we do not use pseudonyms, but we present data obtained during interviews with them in groups, and only with a reference HLTH PRO.

work with a NGO, we would have already had those meetings by now, well, it will be the end of the year, but I find it important that - this meeting will be held in December - for each area, the colleagues will tell how they envision this work, what we will do, won't they, and what shall be reached will also be the starting point for talks with the representatives [LGBT NGO] (HLTH PRO, personal interview, 2020).

We can, based on the data, roughly conclude that in addition to the above-mentioned discrepancies - regarding compliance with international guidelines and working with NGOs - there are no major divides between one and the other group to be seen, when it comes to perception of positive aspects of the medical part of gender confirmation process: namely, healthcare professionals also stress *the absence of prejudices among specialized medical staff, general availability of trans-specific healthcare services within public health and working together with different healthcare professionals*:

“ So I think the situation is exemplary, as far as, I'll put it this way, if we were to report, if we were to report at TGEU, well, if we were to report on Slovenia, I think we should be honest and say that we practically have treatment free of charge, there are some services that you have to pay for, aren't there, but not when it comes to facial hair removal, for instance - why? Because even women who have a hormonal condition that results in excessive hairiness don't get that, do they? That therapy is still self-funding (HLTH PRO, 2020). ”

“ That sort of body is always important for solving some problems or taking on challenges, if you like, in areas that involve different sectors and also require different profiles of professionals working on that. As everyone sees this from their own narrow field, but for that sort of body... by adopting team approach they can focus more comprehensively on the issues (HLTH PRO, 2020). ”

5.2.

Negative aspects of the gender confirmation medical part

In the context of negative aspects of the gender confirmation process medical part, the participating transgender people point out several different elements, which are discussed in smaller sections, namely: 1) general features of the healthcare system, 2) ambiguity of procedures, 3) a lack of possibilities during the process, 4) the length of process, and 5) psychiatrization as well as psychologization.

In connection to 1) the general features of the healthcare system, transgender people point out two key features in particular; one of them are mainly *general waiting times*, also related to *staff shortages or their work overload*:

“I mean, the lack of staff - the first reflection of that are the waiting times, which I see as a problem of the entire Slovenian healthcare, because trans people - just like other people - wait in the same queues for endocrinology or plastic surgery. It's a systemic problem, universal for absolutely everyone (EXP NGO, personal interview, 2020).”

Apart from general waiting times, transgender people also stress *the growing privatisation* of the entire healthcare system, which, also considering general waiting times, is becoming increasingly difficult to access, especially for those who cannot afford to avoid the queues in the public health system by seeking self-funding options. Slavko TG, personal interview, 2020), for instance, recounts that:

“It seems to me that it would be difficult for me to talk about some specifics of the procedure if you don't take a look at the entire healthcare system, which is becoming increasingly privatised, increasingly difficult to access, I'd say, I mean, even with the complementary insurance, which they wanted to cancel, it didn't work.”

The negative features of the existing healthcare system as such, are particularly outlined in case of specific forms of social marginalization and exclusion. The latter is evident in Maja's account (TG, personal interview, 2020), a migrant in Slovenia. Although at the theoretical level health insurance is actually universal, at least at the level of emergency medical care - and thus compulsory and regulated by the principles of social justice and solidarity - in practice it gets complicated over a minimum and emergency care in case of *migratory status and supplementary health insurance*:

“Slovenia doesn't have a universal healthcare. For most local cis het employees, privileged [people] - yes, they have it all. But as a migrant, and as I see it, even for some local people who are in a bad financial situation or unemployed and in a worse financial situation, it can happen that you are not actually insured. And if that can happen, then love, it's not a universal healthcare insurance. For a migrant the situation is even worse, as I don't even have the right to buy health insurance. I have been systematically excluded from healthcare, at least insurance-wise, and next, from care as well. I had to postpone numerous medical treatments as I had no insurance and cannot pay € 25,000 for care. I'm sorry, it's just not working. And that had a very bad effect on both, my mental and physical health.”

In the following subsections discussed, the participants refer directly to the medical part of the gender validation process. In this respect, they highlight 2) the ambiguities of the processes. When it comes to ambiguity related to the medical transition, transgender people stress *different timelines and consecutive steps* of treatment that do not follow standardised

guidelines but rather - on the background of unclear criteria - differ from person to person. Jakob (FG, 2020), who had an experience of a relatively rapid gender confirmation process (within 5–6 months), whereas Domen (FG, 2020), who has not even had his name changed after two years of transition and does not receive hormone therapy etc. They both share their experiences:

“ I don’t actually remember that well anymore, but I know that at the time I was, when everyone was waiting for a year or more to get certificates at all, I think I had in about 5-6 months already received all the certificates. Which really was quick back then. I think I’m the second one to have got it so quick, there was one before me. Then there was again another period when there was - in fact, there were a few of them after me who went through pretty quickly, and then they started to prolong again. So back then, there were some changes regarding those certificates that they started to make them a bit quicker. ”

“ It’s fascinating to me because they both had it quick - it seems quick to me because I’ve been in transition for two years and I still don’t have my name changed, hormones or surgery. ”

As evident in Jakob’s quotation, the course is in some places conditioned by the specifics of the period (quicker issuance of certificates in one period, slower issuance of certificates in another one), and in some places by what is evident in the account below, which we will discuss in further detail in the section of coping strategies with practical knowledge of manoeuvring through a *deficiently standardized procedure*. Although that sort of practical knowledge is crucial to speed up medical transition process, the issue, also pointed out by Alen, remains i.e. an uneven availability and distribution of practical knowledge of this type or sources of practical information. Namely, those are roughly speaking, accessible mostly to (a part of) the transgender community in the city. Alen (FG, 2020), for instance, recounts that:

“ Well, I actually made it through the process really quickly, mostly because of that, because I knew so many people and those people knew loopholes in this system. Only the fact that you’re - for example - a trick that can make it shorter for more than half a year are the referrals, you tell your GP, which ones you need before you even come to endocrinologist as you’ll wait for it seven months and meanwhile you can already do other check-ups before. Already the fact that I know that we in the community know that, we, based in [the city], we as a small circle, we share that with others, but it somehow to reach people. ”

In connection to the lack of standardization of the process, transgender people also point out a lack of (available) information or a lack of being informed, which is actually a consequence

of lower standardization: provided there are no clear and direct guidelines about the process, the information about the process is more limited as well. *Non-compliance with international guidelines* also leads to ambiguities and reduced availability of information, as highlighted in the non-governmental perspective:

“ If we follow WPATH, as we say we do – it’s stated very clearly there. A psychiatrist is the one who has to present to a person absolutely all the possibilities, not only the initial part, but also hormone therapies, surgeries and so on, so that a person has a chance to think, know what the options are and decide what’s next (NGO EXP, personal interview, 2020). ”

Besides lacking the availability of information, which is intertwined with a less standardized process, it is also worth mentioning the *social attitude towards the phenomena of transgenderism* and the gender confirmation process, which is significantly filled with taboos and invisibility. In this respect, transgender people point out not only that they did not have or found it more difficult to obtain relevant information on the gender confirmation process, but also that basically they did not even know whether in Slovenia this process was possible at all. It’s also an extended effect of the usual social invisibility of the transgender community and transgenderism as such:¹⁶

“ I remember thinking, I didn’t even know if there’s an option of getting testosterone in Slovenia. It’s a total blackout. Also the fact that those are compete taboo subjects in Slovenia doesn’t help (Cimet, FG, 2020). ”

“ I didn’t even know that this process exists and it did surprise me and then I gathered all the information (Jakob, FG, 2020). ”

In addition to lower or insufficient standardization and reduced availability of information on options and gender confirmation process (including a lack of being informed on potential side effects of individual trans-specific healthcare services), lack for information and incoherence among healthcare professionals themselves are pointed out in the context of ambiguity of procedures. In this respect, the participants stress a specific incoherence of healthcare professionals regarding the course of the procedure, as well as a lack of knowledge about services available within the gender confirmation process (e.g. the possibility of freezing genetic material free of charge). All in all, that *mutual incoherence and being inadequately informed* are also the ones that prolong duration of gender confirmation process in some

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¹⁶ NGOs LGBTIQ+ certainly contribute to transgender people being more informed on their options by providing specific material, as discussed in the section about coping strategies and resources. (see e.g. Koletnik, Grm and Gračanin, 2016).

places. Timotej (FG, 2020) and Cimet (FG, 2020), for instance, discuss this:

“The problem is also being the fact that within the council, doctors among themselves do not know exactly what and how does the following of one thing after another go. And then it's also difficult to get information if the people running this process can't agree with each other on the possible sequence of events. All the information I got back then, three years ago, I got from other people in the community. None came from doctors.”

“/.../ then the endocrinologist told me what if I would have had my cells frozen, blah blah, because I might have been infertile /... / And then I had said it back then that I didn't want to wait any longer, and she said – well, on the long run, I might as well wait for another month, it wouldn't change a thing and I was like - ok, that's fair enough. And - but, that one month didn't turn out to be just one month. At first, when I got to a gynaecologist, I had to wait, I was waiting for two months for a check-up, which wasn't even so bad - for her at that point telling me that I as a healthy trans person, wasn't entitled to freezing genetic material free of charge /... / I mean, could you please get more in touch with one another, all of you doctors who work with trans people. It's not ok that one thinks something is possible and another - no, actually not. Well because... I could've started with hormones four months earlier.”

In the third section of negative features of the medical transition, the participants point out 3) a lack of options in the process itself. By doing so, they have in mind four types of options that are lacking in the process of medical transition itself, one of them referring to the period before the formalisation of the council, i.e. *impossibility of appeal procedures* - a lack of this option was supposed to have been eliminated by formalizing the interdisciplinary council:

“/.../ well let's say when I was still in the process, this council was not formalized, which means there were volunteers there, meaning you can't prosecute them, they don't have a formal way to appeal because they're all volunteers, in this respect (Matevž, FG, 2020).”

Besides the impossibility of using appeal procedures themselves, they highlight the unaddressed (or at least not yet effectively addressed) *lacking the possibility of getting a second opinion*, which is in fact, a universal right defined in the Patients' Rights Act. The possibility of getting a second opinion is, as pointed out from NGO experts' perspective (NGO EXP, personal interview, 2020), technically available, but practically unavailable, also due to lack of staff, adequately and sufficiently trained in the field of trans-specific medical treatment:

“/.../ you can, if you let's say need an opinion from [a specialist], you can go to anyone in Slovenia, it doesn't have to be her. The problem that arises is that others just don't want to give you that as they

want to protect themselves, because they just aren't trained and educated enough to feel independent. So in theory, you can – me and that user, we wrote, I'd say, to all of them [specialists in this field] being there in Slovenia, but simply no one wanted. So we can't technically say that someone's right to a second opinion has been violated. Because technically it hasn't been. It is practically unavailable, though.

A lack of sufficiently trained staff who are independently providing trans-specific healthcare services is after all, also reflected in the impossibility of *choosing among different healthcare providers*: from this perspective, transgender people recount the feeling of “being at the mercy” of those available providers, regardless of courteousness and/or quality of the provision of healthcare services:

“It's also hard because you have nothing to compare to, because there's no competition - you have one doctor in the whole council who can provide this service and that's your only option, so take it or leave it. Even if that were the worst doctor in the world, as that doctor is the only one in our country who can actually do something for us in this field (Timotej, FG, 2020).”

When it comes to lack of options, *the impossibility of access to specific genital surgeries* within the Slovenian public healthcare system is also pointed out. Those are available abroad (Serbia) with Health Insurance Institute of Slovenia (ZZZS) covering the healthcare costs.

Above, we have already pointed out, at least indirectly, 4) the length of procedures (both with respect to the general features of the healthcare system and respect to the mutual incoherence among healthcare professionals). The length of procedures is by transgender people perceived as a negative feature of the existing medical transition process, also considering experiences of *cancelling pre-scheduled healthcare services or surgeries*. The area of plastic surgery being exposed, we can, based on the accounts, conclude that those cancellations occurred due to objective and unforeseen circumstances (more a one-off rather than continuously), nevertheless they had a burdensome effect on transgender people, especially as regards the ambiguity of the procedure and different timelines as discussed above:

“/.../ of course it got complicated with plastic surgery because I was called a day before the surgery and told that my surgery had been cancelled because [the surgeon] who was supposed to operate on me had resigned. Well that totally mentally fucked me up at the time, because of course I was planning everything, I wasn't even looking for a job or anything, it was like whatever (Slavko, TG, personal interview, 2020).”

Last but not least, the length of procedures is also reflected in *irregular endocrinological check-ups*. Those are supposed to be carried-out on a regular basis,¹⁷ however in practice they are often postponed with endocrinologists often being less responsive or difficult to access. Concerns of transgender people about this kind of insufficient monitoring are deep, they also talk about the feeling of forced (and excessive) self-reliance when it comes to assessing their own health status in connection with hormone therapy. Due to distress and reduced accessibility they are, to some extent, forced to rely on self-funding check-ups:

“ I don't know, we have been waiting for answers for three months, we have been waiting for a check-up more than a year, which should otherwise take place once every three months, maybe not a check-up, but at least a blood test. So more and more of us are opting for private become self-funding patients, because our health is more important to us than those queues (EXP NGO, personal interview, 2020).

“ /.../ after the surgery I started with those injections and it seems to me that I may have a little too much time, I've been waiting for my next shot for too long because in the last week everything has become a bit...I mean it's a bit too hectic and I really don't feel ok. And I did want to talk to her about it and I'm also a bit worried because I also don't know what it means for my health in case I have honestly been waiting too long for the next shot /... / Well yes, because I am supposed to have a check-up [in the summer], meaning almost half a year has gone by since I was supposed to have a check-up. For me it's like - because they're constantly emphasizing that we should be careful and that it's not some sort of a joke and that we need those blood tests, etc., but at the end of the day I don't even get a reply to why I don't get an appointment (Alen, FG, 2020).

Due to the length of procedures, as a result of a combination of various factors (from general waiting times, ambiguity about the procedure, miscommunication among different healthcare professionals to lack of their responsiveness), transgender people also stressed *the need for constant pressure* to be the one of negative aspects of medical transition, through which the process of medical transition would despite different timelines be completed in due course.

It is exactly that element of pressure, which also poses as one of the factors in different timelines of medical transition: the more proactive a transgender person is, the more that person commits herself/himself to it and does not leave the course of medical transition in the hands of healthcare professionals only, the less lengthy the procedure. However, the need for such continuous pressure and engagement can be quite burdensome or even

¹⁷ The World Professional Association for Transgender Health (WPATH) also draws attention to the importance of regular medical monitoring in case of hormone therapy, including regular check-ups and blood tests (WPATH, 2012).

unbearable for some transgender people. Nejc (FG, 2020) and Matevž (FG, 2020), for instance, discuss that:

“Yeah, I mean, I basically... I feel like I've been plunged into a situation where you have to deal with it and then, I mean, if you want to get something out of the system, you just have to insist. It's not going to get any easier, there will never get a brainwave that maybe they're the ones to reach out [laugh] so I just... I don't know, I know I had a lot of issues with calling people. Mostly the medical stuff, but now I'm like, until they pick up I keep ringing and there are usually 50 calls, until they pick up. But you really have to insist. Just because - it's a lot easier to call 50 times more than to change them at the end of the day, you'll also get things faster. It seems to me that... I don't know if you really want something like testosterone or hormone therapy, which after all is a very - has a very strong effect on your body and you have to maintain it somehow, you must not give up. Of course it's hard, there's often some crying about why does it have to be so hard, for every crap in this world, but yeah - you throw a tantrum and then you move on, from your own experience [laugh].”

“Well, character-wise I'm more of an awkward bean and there was something I definitely had to learn - that you need to stand up, claim because otherwise you don't get through, and that they'll get rid of you if you don't give them hard time over the phone. You need to stand up for yourself so that it was a good growth experience, it's something that always comes in handy, so that I know how to set the boundaries.”

One of the most commonly indicated negative aspects of medical transition are also 5) psychiatrization and psychologization of gender confirmation process. It is worth drawing attention to from the outset that transgender people do not a priori object to any psychological and / or psychiatric treatment, however they are quite critical of the way in which the latter is implemented in the current process of medical transition. In other words, they partially recognize the pertinence of psychological and/or psychiatric check-up, whereas they express dissatisfaction with the way they are performed:

“I mean, first and foremost the fact that, they were really digging deep into me. Which is exhausting anyway. Digging into me didn't seem problematic to me as such because I think it's better to discover some things before the procedure that can later come out of all proportion /... / I agree with the fact that there's ___ for you to stop and think that you really....that it's something like a process at some points and I agree with that /... / Well, some things seem suitable, as personality tests and stuff, it's a part of clinical check-up, but how it's interpreted that is a different matter (Jakob, FG, 2020).”

In spite of at least partially recognized importance of psychological and/or psychiatric

treatment, many transgender people recount that this part of the medical transition is the most difficult and burdensome for them - *the experiential dimension of this phase of the medical transition is distinctly negative*: the participants used expressions such as “very traumatic” (Jakob, FG, 2020; Nejc, FG, 2020; Matevž, FG, 2020), “the most, the most difficult and the most stressful part” (Jakob FG, 2020), “terribly exhausting” (Cimet, FG, 2020); “the most difficult part of the process” (Alen, FG, 2020) and “catastrophe, an absolute catastrophe” (Slavko, TG, personal interview, 2020):

“It seems to me that this part is very... very - to me that was the most, the most difficult and the most stressful part of the whole process. Like, the operation itself wasn't half as stressful. The first month of taking hormones was not as stressful (Cimet, FG, 2020).”

This burdensome experiential dimension also stems from the feeling of *sincerity by transgender people actually being “punished”* by delaying the procedure, in parallel with, as we will discuss in the following, “gatekeeping” practices of healthcare professionals in this field, a lack of psychological support and undefined agenda for psychological and/or psychiatric treatment:

“/.../ I didn't feel like they were supporting me, I felt more like it was a door to be closed as I just gave the wrong answers, in that sense (Jakob, FG, 2020).”

“/... / and you just can't trust them and be honest. And even when you are, it hits you right back. Because then they blame you or interpret it in a completely different way. And there is no room for confusion, which is a disaster. A disaster, because no one in life can know anything 100%, but this is exactly what is expected from us and it's a huge pressure we are facing (EXP NGO, personal interview, 2020).”

In addition to the burdensome experiential dimension, which is accompanied by the feeling of honesty in the process of psychiatric and/or psychological treatment related to medical transition is being punished, transgender people are also draw attention to 2) practices that we shall refer to as “gatekeeping”. According to the perception of transgender people, the main part of these gatekeeping practices are *practices of assessing the legitimacy of transgenderism*, by healthcare professionals acting according to the criteria, which transgender people perceive as biased, groundless or inadequate. From this point of view, they draw attention to the criteria bias in the following elements of expert judgment, namely according to:

5.

- 1) gender normativity or compliance with gender-marked expectations regarding “doing gender”, including passing, where, according to the participants’ accounts, preference is given to transgender men compared to transgender women by thus enabling a faster process of medical transition, meanwhile non-binary people are to a large extent stopped or attempted to be stopped,
- 2) accompanied diseases or conditions (e.g. autism spectrum disorders, mental health issues, e.g. depression; alcoholism, etc.),
- 3) age (with priority and faster treatment of older people in comparison to younger ones with implicit assumptions about stability and maturity, which are a priori attributed to older people, but not to younger people),
- 4) disclosure status (lack of disclosure - especially in the family environment - slows down the process of medical transition),
- 5) personality traits (e.g. eloquence and assertiveness or those traits due to which a stability and maturity can be attributed to a person, as opposed to more shy, less independent people),
- 6) possible family support (existence of family support as an element that speeds up the process of medical transition)
- 7) performing sex work, and
- 8) other criteria irrelevant to the individual’s gender identity (e.g. a stable financial situation, independent living).

Some biased criteria (sexual normativity, age) for assessing the legitimacy of transgenderism in the context of psychiatric and/or psychological treatment is apparent from Timotej’s account below (FG, 2020):

“As [anonymized] has had a very, let’s say a courteous attitude towards me since the first conversation we had, courteous in a sense that she accepted me as a grown up human being or as an adult whose personality has been shaped and she told me that to my face when we finished that first conversation. She told me, “You’re a shaped personality, you seem to know what you want” and at no point did she try to stop or slow down my process, even though when I got there, I was probably essentially more insecure than someone who’s younger, and who has more information, is more informed, has been more secure for a longer period of time and feels this identity /... / Because that’s why, and it’s in fact the point - it’s unfair, you can’t just make conclusions based on age, I don’t know what the criteria she perceived back then, but one was definitely age and the other perhaps the introduction itself. Then we’re back to this passing - if people read you visually as what gender is supposed to be according

to them and if it's the gender you feel as your own, it kind of makes it more legitimate for them. It's unfair, someone from the outside can't assess the legitimacy of it based on their visual perception of your gender only.

Aljaž (FG, 2020), for instance, tells about his personal experience of trying to stop the process of medical transition in case of non-binary gender:

“ /.../ I also entered as a non-binary person and despite the fact that there were full of some...how to put it, they directed me into admitting the fact that I'm a man or...such things. I mean, in the end I just didn't answer things like that anymore, I just said 'yeah, yeah' or something like that. But yeah, in my case it was extended exactly because of that. I basically started two years ago and I have recently had my first surgery, so it did take a while.”

Accompanying diagnoses or health conditions and their effect of stopping or slowing down the medical transition process are also described in the broader perspective of non-governmental experts (NGO EXP, personal interview, 2020), by drawing attention to paradoxicality of expectation of mental health issues not being resent when it comes to a social group that is highly exposed to marginalization, social exclusion, discrimination and stigmatization. Plenty of studies from abroad also report a (socially co-formed) higher incidence of mental health problems:¹⁸

Because what's going on is that people don't tell, I don't know, they have problems with depression, anxiety, and so on, because they're afraid that's going to be the reason for stopping the process. This cannot be the reason because the population of trans people is among the most vulnerable in terms of mental health - depression, anxiety, suicide rates are very high. And it's impossible for this not to be present in the Slovenian population.

The importance of disclosure - especially in the family environment - and the problematic nature of this expectation or (although non-explicitly formulated) requirement is highlighted in the following slightly longer but telling excerpt from an interview with a non-governmental expert (NGO EXP, personal interview, 2020):

“ Let me point out point out that they can also really pounce on the fact whether you came out or not. Because as I was talking to a lot of people who haven't come out to their families and that has complicated or made their process stuck. As the process of coming out is a very delicate thing, nobody

¹⁸ See e.g. Adams et al. (2013), Ellis et al. (2015) and MacKinnon et al. (2020).

should be forced to do it, no matter what point of transition they're at.

Social transition is in many cases significantly more tough than medical transition and no psychiatrist and no psychologist should meddle in it that way. If anything to offer you support, to suggest to you, I don't know, therapy with your parents to help them explain those matters, this concept and all that, but not in a way that they force people into coming out, it is totally unethical, if you ask me, and unprofessional and - who will tell who, when will he tell them? Nobody can take the right to do so, simple as that. At the very least, somebody who doesn't know you at all and hasn't got the slightest idea of about you, doesn't even delve into it, because in this case it's not about you going to one specific therapy, because you simply want or need it and it's going to be some in-depth process, but it's about them ticking off some virtual list to get what you need to make your life easier.

Slavko (TG, personal interview, 2020) emphasizes the importance of assertiveness, eloquence and independence when he talks about his experience with psychiatric treatment. In his case, assertiveness and eloquence have indeed facilitated the process of medical transition, but with him being aware that these are the traits not everyone possesses. It is evident in the following recount that healthcare professionals are aware of decelerated effect on gender identity of otherwise irrelevant personality traits, however they do not problematize their functioning - "such is life":

I even once said this to dr. [anonymized] that actually I am very talkative and assertive and all that and that I am aware this helps me in the process, that it just doesn't seem fair to me, in some way, for other people who aren't like me or they're less talkative and independent and they also have anxiety and all that stuff that we just don't have the same possibilities. Well, [anonymized] told me - yes, such is life. I'll never forget it.

Besides the highlighted goalkeeping practices, in the context of psychiatrization and/or psychologization of the medical transition transgender people also draw attention to a *lack of psychological support*, which is intertwined with the above-mentioned problematization of psychological and/or psychiatric treatment not being as such, but of its implementation. In this respect, transgender people discuss - also in the context of their experiences of "punishing" for being honest - that they cannot be relaxed during this treatment as the basic conditions of security and confidentiality are lacking. Matevž (FG, 2020) and Aljaž (FG, 2020), for instance, discuss this:

I may like to add, that at several points they said they were there to support us, but it seems to me that as far as I would be diagnosed with any kind of depression or any other thing; if you have a problem, the process stops. To me, that doesn't seem like any support. Let's say you have, they say, well, they consider it as support, but in a functional way it really isn't.

“Um, I think it would be, that it would be a lot healthier for all of us dealing with Centre for Mental Health if they would really be there for help and support rather than for them to basically judging who is and who isn't the one. I don't know, if there are there any statistics for these things, but how many folks actually get there and then they figure out that it's about something else? It seems to me that most of us who get there roughly know about it. Or actually, we don't roughly know about it, we'd been thinking it about it a while before we actually dared to go there and talk about it.”

Similar dilemmas are also highlighted in connection to the trans support group organized within public healthcare services, which, according to participants' perception, does not achieve its purpose also due to overlapping roles of healthcare professionals in implementing the support group as well as their gatekeeping practices, which enable them their positions. In short, due to the feeling of *inadequate implementation of the support group for transgender people*. Namely, the support group was organized by persons who at the same time decide on the further process of medical transition, which, in the experience of transgender people, is not a motivating factor for confidentiality and a sense of security; what is more, it has been said that the support group was perceived as a group with a pre-set and “external” agenda, which did not necessarily follow the actual needs of transgender people in this group - and thus did not provide sufficient or adequate support:

“And they kind of promote these groups, I had that feeling at least once that they did, but it's not... I don't know, it was difficult to go there because there wasn't a setting where you'd feel ok because even though there were just two, who are in the council and they in principle - they decide whether you are trans enough or not, how can you have a relaxed conversation about your feelings regarding your gender with them, if you are constantly afraid saying something that they won't like? So, to me that seems a bit wrong (Dylan, FG, 2020).”

“/.../ I don't know, we practically [in the above-mentioned trans support group] exchanged experiences regarding surgeries, bottom ones, and how it goes and all that stuff, and it was crucial for us at that moment to exchange information, that it was just something we needed in terms of support at the time, and a [healthcare professional] actually steered it towards a completely different subject and wanted to know in a sense if... are you not afraid of this surgery, don't you have any doubts, by all means towards this subject. Despite the fact that the answer was “no”, she didn't accept this answer, someone honestly answered that he was more worried about complications than anything else, but by all means she wanted a kind of regret, this... this is something that they really do hang on (NGO EXP, personal interview, 2020).”

Another negative side of psychiatrization and/or psychologization of medical transition

evident in Dylan's quote above is *the feeling of being trapped* in a relationship with a healthcare professional who is the one who decides the future process of the medical transition; this feeling of being trapped, as expected - especially with respect to the "punishment" of honesty pointed out above - is also accompanied by *the feeling of unease* due to the potential of blocking medical transition:

“Well, at the same time I was like, really like – I realize how important it is to pass those tests, where the [healthcare professional] really doesn't like if you call it a test, but it's more a [specialist examination] it actually decides on your life, but never mind, and at the same time I was like – ok, I need to get my shit together (Slavko, TG, personal interview, 2020).”

“And that's what's problematic, what we talked about earlier about [the healthcare professional] - once you only have one person and that person poses as a big obstacle to you on this journey, it causes some additional distress (Timotej, FG, 2020).”

Apart from a 1) burdensome and negative experiential dimension, 2) gatekeeping practices of healthcare professionals, together with assessing the legitimacy of transgenderism against a background of inadequate or at least groundless criteria, transgender people also draw attention to 3) confusion of check-ups agenda in the above-mentioned medical fields, which is partly evident in the above subsection, especially in relation to a lack of psychological support. In this context, they point out *non-transparency* and reluctance to providing insight into the test results (EXP NGO, personal interview, 2020), above all the experience with *misinterpretation of what was said* or test results during the treatment. This is recounted both within non-governmental experts (NGO EXP, personal interview, 2020) as well as from transgender people's point of view (Alen, FG, 2020):

“I don't know, for example, people talk about this - they say that they occasionally drink alcohol, the test result says that they regularly drink alcohol. They mention something from the past that is very difficult and uncomfortable, and that is put in a very different way it in the written opinion or medical history as such. I know that people have the possibility of later changing it, it's possible to go through medical history and opinion with people, still some things remain in there and if people feel things have been turned against them, they can't have a pleasant feeling.”

“And I was even called upon to retaking tests because I was too friendly at the first ones. That was her expert opinion. And I think after I was supposed to get the results and go with those results to get the papers, she brought them to a standstill for another two months and I was just helpless all the time. In my own kindness. Then when I came back, I got an even longer one, with more answers - she

assumed I was lying there. That there are no such kind people and that is why I lied. But when she did the second test with more questions and more answers, she just found out that I was just as kind as before [laugh] /... / Yeah, she basically just reminded me that she knew I wasn't being honest and that when I was going to have the top operation, I was going to experience a big emotional distress, just like my friends she knows and we'd all lied and we were all going to suffer distress then, because then we were just going to break down, because there would be no more of, of those I don't know, but no more having the option of calling her. And that was it - do you seriously think I'll call you? I went away and that was it, that's where it ended.

In addition to experience with misinterpretations of what has been said, transgender people also recount *strong tendencies for parental involvement*, especially among younger people, even if the person clearly expresses disagreement with such process, mainly due to a more distinct affective burden and potential exposure to violence. The element of exposure to violence is emphasized from a broader perspective (NGO EXP, personal interview, 2020, while Slavko (TG, personal interview, 2020) draws attention to the affective burden and potential worsening of the mental state resulting in such approach.

And when it comes to them, it's an even more significant factor, because another person must be very intensively involved in the process for that heteroanamnesis, it makes pledge of your character and stuff and with the younger ones this is very wrong if it's not one of the parents, because usually with the older ones it's a partner or, I don't know, some other people, but at the same time it puts the younger ones in a very... in a very high-risk position, because they have to come out in an environment where there may be - they are aware that it isn't the case and that experiences with it won't be okay and that they will consequently suffer verbal abuse, exclusion, financial abuse and so on.

Literally - despite the fact that I told her a hundred times that I would not involve my parents in this process because, first of all, I have no contact with them anyway, and second of all, I would stir up a hornet's nest and that would make my mental state a lot worse. Hey, I can call them, but you face a backlash that's coming, I won't. I mean, it's easy for you, damn.

Among the most commonly highlighted aspects of medical transition we find psychiatrization and psychologization, followed by ambiguity and lengthy procedures, whereas general characteristics of the healthcare system as such are pointed out to a lesser extent, it might partly be due to the fact that the state of existing healthcare system has to do with phenomena or barriers to healthcare access that are not trans-specific. Within psychiatrization and psychologisation section, transgender people, including experts from relevant LGBTIQ+ NGOs, most often drew attention to the topic of assessing the legitimacy of transgenderism

against a background of biased or ungrounded criteria (age, personality traits such as eloquence and assertiveness, gender normativity etc.) and other gatekeeping - therefore unsupportive or less supportive - practices by mainly highlighting a lack of psychological support and feelings of being trapped in a healthcare professional - patient relationship.

On the other hand, healthcare professionals - similarly to transgender people - in the context of negative aspects of medical transition highlight *general characteristics of the healthcare system*, namely in a similar way as transgender people do, for instance, in terms of staff overload, staff shortages and long queues:

“Long queues are a drawback, just me, the more I was searching it back then, in the Netherlands for instance, this isn't the case or in Sweden, queues are not as long, but there's the machinery of it. (HLTH PRO, personal interview, 2020).”

The only important difference in the perception of staff shortages is also the following attempt to explain *staff shortages* specifically in those fields of healthcare that are involved (also) in providing trans-specific (specialist) health services. Namely, the shortage of staff in this field is explained by the specific unwillingness of healthcare professionals to treat a group of transgender people, as evident in the quote below, which is in the following account being constructed as a particularly demanding group that allegedly requires an extra degree of patience:¹⁹

“/.../ I have to say that there is no interest because everyone who tries to work with those people - you really have to... well, you have to be patient. And you have to - feel their distress there. And to not be upset over all those demands they have. So there - a few people are willing to work with that, I haven't met anyone yet, but I have already tried to ask them to do it (HLTH PRO, personal interview, 2020).”

As an additional weak point of medical transition, healthcare professionals also point out *questionable long-term effects* - their questionability refers to two dimensions, namely to questionable effects in sexuality (especially in terms of (dis)satisfaction) and questionable effects related to potential detransition. The latter are pointed out in relation to gender non-binary people, where a specific narrative of services related to gender confirmation at the

¹⁹ The aspect of social group construction for transgender people deserves a longer discussion than addressed in this study. Let us point out at this point only that we can roughly distinguish two types of social group construction for transgender people by healthcare professionals, i.e. 1) as “vulnerable”, where it is mainly a sociologically delicate perception of the group against a background of broader social power relations, and as 2) “particular”, in this case the group is attributed excessive sensitivity and aggression - also in relation to NGOs. A specific construction is worth mentioning in connection to gender non-binary, which is perceived as an example of borderline personality disorder whereas surgical procedures as a matter of body mutilation and allowing medical interventions or medical transition as such as an example of positive discrimination against non-binary persons.

physical level also arises, for instance, “body mutilation”, which implies an understanding of surgical procedures in and on the body not as a way of confirming gender identity, but as violent and more intense physical (self-) abuse:

“Although they [gender non-binary persons] have different requirements and we also don’t know what will happen in a couple of years. That’s, the biggest concern here is that there will eventually be one big wish for detransition. And also some other procedures. So they are... in a way positively discriminated against, in their own way. By doing that, it can just happen that they will do themselves harm, though. From body mutilation point of view (HLTH PRO, personal interview, 2020).”

“And what I’m afraid of is that those people will go through the whole process of transition without anyone really specifically, thoroughly asking about sexuality. We shall see what will happen in ten years, what will the consequences of that be. Well, I’m afraid there will be quite a bit of dissatisfaction (HLTH PRO, personal interview, 2020).”

The next perceived weak point or negative aspect of medical transition within the healthcare professionals’ perspective is *non-selectivity of admission into the process of medical transition* or “permissiveness” of gatekeeping practices, including disregard for expert opinion from a relevant healthcare field:

“You know /... / I practically don’t know of a case with transition having been rejected. In fact, the bigger problem is that all patients enter transition and only then do the doctors, otorhinolaryngologists for example, determine that something wasn’t carried out correctly because the patient doesn’t only have gender dysphoria (HLTH PRO, personal interview, 2020).”

There is an apparent discrepancy between such perception, based on the idea of permissiveness, and transgender people’ perspective and their experience related to slowing down and attempts to stop the process of medical transition, which we discussed in the context of healthcare professionals’ gatekeeping practices (see above). On the other hand, healthcare professionals - those who are not directly involved or engaged in providing specific healthcare services for transgender people - also draw attention to *a lack of comprehensive approach*, including excessive psychiatrization of support or restricted access to psychological and psychotherapeutic treatment. The attention is drawn to the fact that transgenderism is primarily treated from the medical aspect, and less from the comprehensive bio-psycho-social aspect or the aspect of understanding “human as a whole being”:

“The fact that our healthcare system is primarily medically and less bio-psycho-social oriented. And here this is probably even more evident than elsewhere. It is clearly displayed. And that neither the

system nor the healthcare workers here – they’re underarmed, underprepared (HLTH PRO, personal interview, 2020).

“On the other hand, medicine has been for many years - the doctor was the one very biologically oriented or, how to put it, a lot like... I diagnose, cure and we were brought up in this way, to actually decide, make decisions very quickly, which is absolutely necessary in some emergencies, but... when it comes to precisely this subject, the one we’re talking about the second note is very important, that is, understanding, not only this physical or physiological state, but understanding man as the whole being. Here, however, I think that a lot will have to be done not only organization wise but also content wise (HLTH PRO, personal interview, 2020).

Besides 1) general characteristics of the healthcare system, 2) questionable long-term effects and 3) non-selectivity or permissiveness of admission into the medical transition process as well as lack of 4) comprehensive approach, the attention is also drawn to 5) disrespect for gender identity (e.g. the use of wrong name, pronouns and other gender-marked words) (mostly) among medical staff except for doctors:

“/.../ here, the nurses are just the way they are, they are used to addressing people by ma’am, sir, and they try to be - and they are kind, but they can, for example, hit exactly where they shouldn’t. And I tell them, I say, “you know, patients that you’re not quite used to are about to come”, and I prepare them in that way, but then it happens sometimes anyway. But we talk a bit about it, and well, they’re not resentful in principle (HLTH PRO, personal interview, 2020).

A concise presentation of the negative aspects of medical transition indicates major discrepancies between the perspectives of one group and another, as they agree in only one dimension, namely in general characteristics of the healthcare system, in other dimensions we can in some parts come across diametrically opposed perceptions (e.g. gatekeeping practices as opposed to non-selectivity or permissiveness of admission into medical transition).²⁰ Such discrepancies and contradictions may, after all, be proof of transgender people being overlooked as well as their needs, which are not necessarily the same as those attributed to them by healthcare professionals; from this point of view, the tabular presentation of thematic sections related to negative aspects of medical transition (see Appendix B) is also proof of the need to intensifying the dialogue among all relevant groups - from healthcare, NGOs to transgender people.

²⁰ It is worth keeping in mind that the sample of healthcare professionals covers a much smaller number of people as opposed to the group of transgender people, so the content complexity and diversification of the codes is correspondingly smaller.

Proposals for greater inclusivity within the healthcare system in the context of the medical transition

Transgender people point out many a deficient element of the existing medical transition process, which does not necessarily tally with the perception of the weaker points of medical transition by healthcare professionals. Apart from criticism of medical transition's individual elements, transgender people are already identifying the potential for changes to the existing procedure in the direction of its greater inclusivity and effectiveness. These proposals are briefly discussed in the following part, namely the proposals can be summarized in the following four sections, i.e.: 1) changes in the process of medical transition itself, 2) changes at the level of relevant healthcare institutions, 3) legislative changes, and 4) changes at the relational level. Within 1) changes in the process of medical transition itself – those are, in addition to changes at the level of relevant healthcare institutions, the most commonly highlighted necessary changes - participants draw attention to the need for *standardization of the procedure* or “official protocol” that would potentially delimit the impact of the above-mentioned gatekeeping practices, particularly biased criteria for assessing the legitimacy of transgender people:

“ I don't know how that has changed, but the fact that it's some official protocol of how things should be done, that seems to me like a right thing to do. Also let's say, when it was, that then... well, they are not treated, but ok, we'll treat everyone in their own way, but to reduce the impact of those... let's say you pass, and you'll go through it immediately, or you don't pass, and you'll have a two-year process, in that way. To regulate it, on paper with some considerations and so on. Those are my thoughts (Matevž, FG, 2020). ”

Here, it is also pointed out that greater standardization of medical transition process should not be carried out at the expense or at the cost of maintaining “flexibility” or individual approach in terms of *recognizing the diversity of needs and wishes* regarding specific steps in medical transition, surgeries and services that a transgender person wishes to make for the purpose of confirming gender.

“ Because it's really - one transition, medical one, it's not one kind of experience, it's not one process where you go through all the stages and then you come out of it. People just have different, different wishes, of what we want in this process (Timotej, FG, 2020). ”

In the context of changes in the medical transition process itself, *the need for cooperation of different relevant professionals* is also highlighted, where the subject of relevance should not

be delimited only to healthcare professionals, but also to other experts and transgender people who have gone through the medical transition process. To put it differently, “expertise” should not be delimited only to medical knowledge only, which is merely one of the possible perspectives in the treatment of transgenderism, but also should expertise be recognized by other relevant perspectives and professionals and in this respect strengthen cooperation with them:

“ /.../ I think, when it comes to this, an interdisciplinary approach should absolutely be taken, and I don’t have that interdisciplinary council in mind where all the docs are together, but there should be actual cooperation with us who have gone through it and see what’s not in shipshape, us who have the experience, us who are experts, but no one perceives or sees us in that way as we are just some people who have only been there in the process, but we are a lot more than that. And this is something that’s missing (NGO EXP, personal interview, 2020). ”

Within 2) changes at the level of relevant healthcare institutions, *the need to include the phenomenon of transgenderism in formal education* is most commonly highlighted, at least at the level of health sciences and medical faculties, as well as the need to strengthen and promote the tendency towards constantly self-informing and self-learning of healthcare professionals:

“ I totally agree with that - first, education, I mean, it seems to me that anyone who works in healthcare should go through some kind of training, through absolutely everything. You can’t be a doctor without knowing these things. From the very basic ones, that’s like, possible to have a uterus, to the fact that my GP should know that hormones are basically to be taken for life. That I do have a choice not to take them in principle, but it is basically a practice by us who need some external hormones (Alen, FG, 2020). ”

The need for staff recruitment is also pointed out to a lesser extent, which is not surprising given the negative aspects of medical transition (including general waiting times) as discussed above, as well as establishing of *an additional council or body*, which would provide a possibility of getting a second opinion:

“ /.../ what would be ideal and what also goes according to WPATH is the fact that it would be great to have two councils. Which means that – it’s exactly the purpose of having two councils, because in other countries this is done in such way that, don’t know, if I need a second opinion, I can go to another council. It’s just what’s missing in our country (NGO EXP, personal interview, 2020). ”

5.

At the level of 3) legislative changes, mostly *the separation of gender legal recognition and medical transition* or the introduction of the introduction of self-identification principle are mostly highlighted:

“It’s something we could work on - let’s regulate it so that it’ll be clear, down in black and white, that a person has actually the right to self-identification and that they have to enter their gender not on the basis of a psychiatric certificate or a certificate of surgeries, but rather based on how a person feels and requests for it. There’s still room for improvement here. (Timotej, FG, 2020).”

Transgender people also recognize the potential for changes in existing practices related to medical transition 4) at the level of relational dimensions, where in addition to *general sensitivity of the approach*, they also draw attention to *providing adequate psychological support in a safer relationship* beyond assessing the legitimacy of transgender identity. By doing so, adequate conditions of security and trust would be established, which psychological support relationship is actually based upon:

“Well, I’m an advocate of having someone to talk to in the process, which is something they should definitely offer, but just for a conversation. Not a person assessing whether you’re trans, not trans, you get it, you don’t get it. But basically just someone to talk to (Alen, FG, 2020).”

Partly, similar changes are proposed in the group of healthcare professionals, especially among those who *are not* directly involved and active in the medical treatment of transgender people, but work mainly at the broader public healthcare level. Their proposals, similarly to transgender people’s ones, include informing and awareness-raising, strengthening cooperation with NGOs, reducing or addressing work overload of medical staff and a broader social reduction of stigma associated with transgender people.

5.4.

Summary

In this part, we have discussed the experiences of transgender people with medical transition procedures. In this context, transgender people draw attention to the negative aspects of established medical transition procedures to a greater extent. With respect to the positive aspects of medical transition procedures, transgender people point out the possibility of accessing gender confirmation (both in legal and medical terms), together with the possibility of undergoing medical transition within public healthcare (i.e. mostly without self-funding of medical costs).

One of the most important positive aspects of medical transition is also the formalization of the interdisciplinary council (also with respect to the previously impossible initiation of appeal procedures due to the voluntary nature of the work performed by healthcare professionals). This aspect is also emphasized with some restraints, as the potential represented by such formalization has not yet been (fully) fulfilled in practice, especially with respect to cooperation among relevant professionals, including NGOs. They also point out the courteous attitude of the healthcare professionals that they meet during medical transition; as during medical transition they often come across professionals who are already skilled in providing trans-specific services (both at the “operational” as well as at relational level), the experiences of courteous attitude are also more common, according to accounts of transgender people. Laxer legislation, which in transgender people’s perception more by chance and “mistake” than on the background of serious legislative considerations raises the possibility of speeding up the process of legal gender recognition (changes of gender marker on official documents) and the possibility of IVF belong to the last set of positive aspects highlighted by transgender people.

In the context of the negative aspects of medical transition, transgender people drew attention to shortcomings that also include general characteristics of the healthcare system (e.g. staff shortages and their work overload and general waiting times). Besides this aspect, which is not specific for transgender people and trans-specific healthcare services only, but it applies to the entire healthcare system and as such concerns the entire population, they draw attention to elements that are directly related to medical transition. The most commonly exposed element is the process of psychologization and psychiatrization within medical transition, which includes practices of assessing the legitimacy of transgenderism against a background of dubious criteria, other gatekeeping practices and the ambiguous agenda of psychological or psychiatric check-ups; based on that, this element of psychological or psychiatric treatment is also perceived as extremely burdensome. Apart from that, they draw attention to the ambiguity of procedures related to medical transition, including not knowing what is available within the Slovenian public healthcare system, as well as a lack of possibilities in medical transition procedures, including the impossibility of using formal appeal procedures (before formalization of the interdisciplinary council) and a lack of choosing among different healthcare professionals.

From the health professionals’ perspective, the formalization of the council is highlighted as a positive aspect of medical transition, together with compliance with international guidelines and strengthening cooperation with NGOs, as well as the possibility of getting expert opinions from other relevant specialist fields for trans-specific medical treatment and

strengthening cooperation among individual medical professions. In the context of negative aspects, this group draw attention to general characteristics of the healthcare system (i.e. similar to transgender people), as well as questionable long-term effects of medical transitions (especially in case of non-binary gender and when it comes to sexuality) and non-selectivity of admission into the process of medical transition. In some places, the lack of comprehensive approach to the medical treatment of transgender people and a lack of respect for gender identity of transgender people (with plenty of practices, such as the use of appropriate names and pronouns) are also highlighted as a negative aspect.

While perceiving the negative aspects of transgender people, they also point out clear proposals for changes, which, in their opinion, would potentially contribute to greater inclusivity of the healthcare system with respect to medical transition procedures. The proposals for change refer to different levels of medical transition, from changes in the medical transition procedures themselves (e.g. greater standardization, but with maintaining sufficient flexibility of the procedure in order to identify and address individual specifics), refer to changes at the level of relevant healthcare institutions (e.g. including the topic of transgenderism into formal education, to legislative changes (e.g. a separation of gender legal recognition and medical transition) and last but not least, to changes at the relational level (e.g. providing adequate psychological support in a safer relationship).

6.

HEALTHCARE SERVICES RELATED TO MEDICAL TRANSITION DURING THE COVID-19 EPIDEMIC

When it comes to accessing the health system for the purpose of accessing healthcare services, mainly related to medical transition, during the COVID-19 epidemic, participants predominantly point out 1) worsening of pre-existing weaknesses of the healthcare system and specifically some medical transition procedures, however, to a far lesser extent they recount 2) there have been no changes in access to trans-specific health services.

Regarding 1) the worsening of pre-existing weaknesses in the healthcare system and trans-specific treatments, transgender people by far most commonly cite experiences with the *cancellation of “nonurgent” or elective services*, e.g. cancellation or postponement of plastic surgery services. Despite the experience of cancelling service of this type (plastic surgery) being a source of uncertainty and, to a lesser extent, frustration, especially regarding the pre-existing extended waiting times before the COVID-19 epidemic, it seems that experiences of cancellations or *irregular delivery of mental health services* (also as seen below, endocrinology services) are more burdensome. That is - given the data presented in the introductory part on the vulnerability of specific social groups to the negative effects of the COVID-19 pandemic - alarming:

“For a couple of months, I, I haven’t had a psychiatrist for a while and my mental health really really worsened because I know that back then I had just started with hormones and everything was so all over the place, it really did worsen. Well, also corona and everything (Cimet, FG, 2020).”

Transgender people draw attention to the fact that those services were partly provided relatively regularly also virtually, still it should be taken into account that such conditions of providing those services are not available to everyone (e.g. to those not having sufficient privacy):

“I can’t meet my therapist because I don’t have privacy for virtual therapy meetings at home and we meet in person because of new measures (Maja, TG, personal interview, 2020).”

For those transgender people who have actually completed medical transition and are accessing trans-specific services primarily for the purpose of maintaining their condition (e.g. hormone therapies)²¹ the situation of reduced access to healthcare due to COVID-19-related protective measures has been less burdensome²² as opposed to (more often younger)

²¹ The shift of responsibility for maintaining the prescribed hormone therapy in case of injections to a GP was particularly important, which made it easier for transgender people for maintaining as GPs successfully maintained appropriate availability and responsiveness.

²² Cancelled endocrinological check-ups were an exception, which are, according to the transgender people’s accounts above, already more difficult to access, however with protective measures the access was further limited and the waiting times were extended: “/... / then after about three months they did a blood test and found that I had too much testosterone in my blood and then reduced it to the lowest possible dose you can get. And I was supposed to keep that dose, let’s say one month, maximum two, then I was supposed to have another blood test and they were supposed to prescribe me injections, but instead of getting that lowest dose for a month, I had to be... like this... for about 10 months” (Dylan, FG, 2020).

people who have just entered or were about to enter the medical transition process when the epidemic was declared. For them, protective measures represent an additional delay in the long-awaited trans-specific healthcare services:

“Basically... not so fine because I was really looking forward to it. That maybe in two years I will really take a step forward. And now, when a couple of weeks ago he said they had announced there were no more of that non-urgent care, it was a bit like... can't you wait for a while anyway, just to pass this enough? (Domen, FG, 2020).”

Regarding the access to trans-specific services, *the impossibility of accompanying* another person to trans-specific medical treatment for the purpose of support is also highlighted in some places. Healthcare professionals were also more *unresponsive and less available*, the communication was poorer, creating uncertainty on the part of transgender people about the future process of medical transition:

“Then informing, communication has become worse, people were basically not informed about it at all, whether they would have a check-up or not, whether they are informed, let's say they get a text, I don't know, they were supposed to have endocrinology, but they get a text - your check-up had been cancelled, you will get a call by doctor next week, one month later, still no calls from anyone (NGO EXP, personal interview, 2020).”

Against a background of uncertainty and concern about their health state, some transgender people also recount serious considerations about finding the possibility of self-funding healthcare services. As public healthcare services have had limited access or waiting times have been significantly extended, Slavko (TG, personal interview, 2020), for instance, is considering a self-funding endocrinological check-up (see below), while in anticipation of unexpected extension of waiting times for plastic surgery services Alen (FG, 2020) was seriously experiencing distress due to stopping of public life and cancelled top surgery and also considered a fundraising campaign for a self-funding healthcare service:

“/.../ I mean, I have no choice but become self-funding patient and I will go and take those tests by self-funding them before the next shot, because what am I supposed to do, it's my health we're talking about. I'm not going to wait for them to get a move on and start dealing with me, I need to take care of myself, fuck it.

So yes - that also was... that was my great distress during the first lockdown because I it was when I was supposed to have the top surgery. And then just when I... I called University Medical Centre Ljubljana, they were just like – we shall let you know accordingly. I didn't know what that was supposed to mean at all and I had basically already started to think about raising money for private healthcare.”

Healthcare services abroad also posed a particular issue, especially due to changed border regimes, potential quarantine imposed upon arrival in a foreign country and/or upon return, as well as due to temporary restriction of public transport. Maja discusses the experience of complications related to covering the costs of transport abroad due to emergency healthcare services (TG, personal interview, 2020):

“Well, and then COVID comes along /... / Trains don't run and I wouldn't travel through a “red list” country, I don't have driving licence, so I had to ask someone else to go into quarantine and that would get a whole lot complicated, so I took a plane. Of course, then I tried to claim compensation back, but no, even though I tried to explain to them - look, there were health complications, here are the papers from a doctor in Slovenia who referred me abroad, and here you are, measures, trains didn't run, I don't own a car, I can't drive, so I took a plane. No. No. Even though the trains didn't run - no, “We said you can only go by train, you don't get anything back.” - they are extremely rigorous.”

Those transgender people who entered medical transition before the beginning of the COVID-19 epidemic at had by then to a large extent completed it, are the ones reporting that epidemic-related protective measures *have not significantly affected the access* to trans-specific health services as the primary level, according to the participants' accounts, in principle remained extremely accessible and responsive by respecting protective measures, including adapting towards telemedicine (e.g. consultation via e-mail and telephone):

But as far as access is concerned, the GP is super available and responsive and at disposal for everything, so as far as that is concerned, I had no problems (Slavko, TG, personal interview, 2020).

“Regarding transition, I didn't have as much - as far as transition is concerned COVID didn't have much impact on transition because I'd already entered. I don't know what would've been like if I'd had my first check-up at endocrinologist's in May, it would've probably been cancelled. But since I'd already entered, it didn't significantly extend. Except for surgery, yeah, but I'd been waiting for it for a while anyway. I didn't feel COVID had any further impact (Cimet, FG, 2020).”

Healthcare professionals also recognize the issue of cancelling non-urgent surgical procedures in general, including prevention programmes also regarding 1) the substantial extension of long queues as it is, however they point out resources of the healthcare system being limited and therefore require relocation in case of such unexpected load such as epidemic. Last but not least, transgender people who recognize the need for prevention of overloading the healthcare system in order to protect and provide the healthcare necessary for the most

vulnerable population:

“Well, look, the healthcare system is - I've said this metaphor many times before, it's like a blanket. As much - maybe we can stretch it a bit, if there are some bigger needs somewhere, it moves to that end and then on the other end you stay uncovered. Meaning, it cannot stretch indefinitely. There are no resources, no capacities and when you're considering how to organize it in a way that conditions will be provided for what is most urgently needed at a certain point, well you estimate what could be moved to a future for a short period of time (HLTH PRO, personal interview, 2020).”

At the same time, healthcare professionals also frequently recognize that the return to regularly providing healthcare services is necessary as soon as the epidemiological situation allows, also for the purpose of addressing extended waiting periods due to the epidemic, with 2) extra sensibility to maintaining healthcare for vulnerable groups. In the perception of some, transgender people are also exposed as a vulnerable group, but some other healthcare professionals see no need for that, as transgender person is perceived as a person “who is a man or a woman, you see, like any ordinary person. So I don't think there is - that we can't do it any other way”(HLTH PRO, personal interview, 2020). In this respect, another healthcare professional draws attention to 3) the possibility of individualised interpretation of ordinances, which potentially exceptionally allows or also allows the implementation of so-called elective services, as well as the need to strengthen 4) telemedicine, which can significantly complement (but not completely replace) medical treatment when accessing it becomes more difficult:

“/.../ no matter how we see it at the level of policy-makers, even if we'd say it's not a priority, of course, we must always look at each individual as well. It may be - if we'd say that it's not a priority, but maybe it's completely different for a certain individual and they would, it seems to me that this individual approach is needed.

/... / also when it comes to all ordinances and orders there has always been an emphasis on [individual approach] being needed and there has always been some door open, “unless it means... a direct impact on health”. And a direct impact on health – there is a lot of it (HLTH PRO, personal interview, 2020).”

7.

RESOURCES AND COPING STRATEGIES FOR NEGATIVE ASPECTS OF THE HEALTHCARE SYSTEM RELATED TO MEDICAL TRANSITION

Given the highlighted negative aspects of medical transition as such, and partly also the negative experiences with the healthcare system, in the following we are interested what resources and what strategies do transgender people use to help them cope with those experiences and highlighted aspects, taking into account the results of other foreign studies, which prove prevalence of prejudice against transgender people or transgenderism and cisnormative stranglehold of the healthcare system. Considering the data obtained mainly within focus groups and interviews with transgender people, we can distinguish between coping strategies with established and predominant medical transition processes, and two types of resources that help to make it easier for them to deal with the cisnormativity of the healthcare system. The latter is divided into two types, namely into so-called “intrasubjective resources”, where transgender people draw strength from within, from their own trajectory, considerations and experiences they have been through; and into “intersubjective resources,” where transgender people draw strength (and help, support) from different relational dimensions.

In the following, we discuss 1) coping strategies mostly for conditions and procedures of medical transition, especially the psychological and psychiatric part of treatment, which is most commonly highlighted, 2) intrasubjective coping resources for coping with the healthcare system as such, and 3) intersubjective coping resources for coping with the healthcare system as such.

7.1.

Coping strategies

When it comes to 1) coping strategies with the part of psychological and/or psychiatric treatment during medical transition, we can distinguish three different coping strategies based on the data, namely 1) what we called “tricks of the trade”, 2) exit strategies, and 3) confrontation. In the context of “tricks of the trade”, what we have in mind are the different principles and practices used by transgender people during medical transition with the intention of providing such healthcare services that confirm their gender identity, despite the obstacles and gatekeeping practices they come up against. In this respect, the principle of “fake it till you make it” is particularly emphasized.²³ By that, we mean various practices that enable a transgender person to carry out the process of medical transition with as little harm as possible and with as little experienced negative burdening as possible. With the help of those practices or strategies, transgender people relatively effectively surmount

²³ See also Latham (2017), Perger (2020) and Shepard & Hanckel (2020).

gatekeeping obstacles, especially those based on assessment of legitimacy criteria, perceived as biased or inappropriate, unrelated to gender identity, however with other groundless assumptions (e.g. age and assumption of stability, maturity). In this respect, this principle can be divided into the following practices: “mimicry” of gender binary, proving oneself and/or exposing one’s own independence and stability, creating “a narrative from time immemorial” and specific preparations for psychological or psychiatric examination, selective silence and passing.²⁴ Jakob (FG, 2020), for instance tells about the deliberate, conscious demonstration of his own independence and stability - because those are the sought-after and expected traits in the psychological and/or psychiatric process, at the cost of or the expense of confusion, uncertainty that are otherwise tolerated and expected with all others social groups and many social spheres of everyday life. Jakob (FG, 2020), who very explicitly highlights the paradox of expecting stability. Namely, at the very beginning of medical transition, transgender people are expected to show independence and stability in social conditions completely unfavourable for them, which are significantly marked by the cisnormative social order. However, for transgender people those two are in fact largely achievable only after completing medical transition:

“May I add something, because I’ve just come up with the idea that they should take into account the fact that this, meaning entering the process, is for most trans people one of the most difficult periods of life and back then, if I remember myself, I was truly a completely different person, really, incomparable to who I am today. And in fact, at the time, I pretended to be as good as I am now, on completion of the transition, to seems to me.”

In addition to attempts to meeting expectations under socially unfavourable conditions, the importance of *specific preparations for psychological and/or psychiatric examination* lasting several months is also pointed out, which is not surprising given the above burdensome experiential dimension of this part of medical transition.

Due to the anticipation of discomfort created on the basis of accounts and experiences of other transgender people who have already experienced that aspect of medical transition, this part of the process becomes something to be specially prepared for, also with respect to the biased criteria and preliminary processes of “attempts and mistakes”. Those are also being highlighted in the broader perspective of transgender people’s experiences (NGO EXP, personal interview, 2020) when referring to one of the cases pointed out in the interview, namely a transgender woman who attended the psychological or psychiatric examination in

²⁴ Due to space constraint, we will not illustrate each specific practice with a quote, we will focus on those that have been most commonly exposed by transgender people.

masculine clothing (worn in a workplace) and experienced bringing the process to a standstill or slowing it down due to a lack of passing:

“Those specific ones - how is it, what is it, what you have to do, how to prepare - and we are basically preparing for these things together, just so that it doesn't result in situation like the one with that previous case, when she came in masculine clothes, and that just wasn't ok, so that if only possible, we avoid such situations and do everything as they imagine should be, so that it basically meets their criteria.”

From this point of view, it does not come as surprise that the purposeful provision of the highest degree of *passing* possible, which comes in various forms, from gender expression and socially established gender-marked clothing to the use of a gender-marked name in accordance to gender identity. Such provision is the next most highlighted strategy.

“That I just have to... pass for as much as I can and similar things, really. That I have to look like I'm already there, that I'm just missing hormones, so to speak (Jakob, FG, 2020).”

Taking into account the above-mentioned gatekeeping practices, especially the biased criteria and misinterpretations of what has been said, as discussed above, transgender people also draw attention to the practices or strategies of *selective silence*. Being aware that what has been said can be interpreted in inappropriate or wrong ways, they pay extra attention to what they actually say or confide in someone: in this respect, selective silence is not a mere circumvention of the criteria, but rather an adaptation to a lack of confidentiality and security conditions in the process of psychological and/or psychiatric treatment:

“Consequently, with most trans people having contact with other trans people, this becomes some kind of test. How do I pass this test in the best possible way, with the least harm? In such a way that I simply leave out some pieces of information because they could jeopardize my future in terms of surgeries, hormones, diagnosis, and so on. Which is very, very counterproductive, because at the same time we don't detect people who have some serious mental issues and would need support, so... but these can be trans people - in the sense that people can be severely depressed and suicidal, but we don't detect that because they don't want to tell us. Also the fact that we let through those who just may not be there for the right reasons and would need some other treatment. So, in brief, roughly, well, it is the main issue (EXP NGO, personal interview, 2020).”

Besides 1) “tricks of the trade”, it is, among coping strategies for this part of medical transition, also worth mentioning 2) exit strategies where transgender people in one way or another

give up on conditions and the process of the medical transition itself and seek *self-funding options* that are particularly emphasized in the context of plastic surgery medical services and endocrinological check-ups, meaning in case of those services that are particularly overloaded by extended waiting times and which have been affected by the COVID-19 epidemic and its related protective measures that have only worsen the situation:

“So more and more of us opting for private [endocrinological check-ups] and self-funding, because our health is more important to us than those queues (NGO EXP, personal interview, 2020).”

“Exactly, basically I'd been waiting for this hypothetical [spring] operation for nine months at the time and I was already like... during that first lockdown I felt like it wasn't going to happen at all... I was like - anyway, I don't know until when it'll last, when it'll be, and that's why I started thinking about this self-funding option, which at first didn't seem like an option at all, because 3,000 euros in student life is a bit much and I don't know... my family helps me, but that is a hefty sum of money. Well yes, then I started thinking about it and I was like - ok, maybe in half a year I will raise it and actually get to this surgery (Domen, FG, 2020).”

The search for unregulated healthcare options, especially self-medicating hormone therapy in case of transgender women, is also highlighted, however less frequently. It happens due to a slower progression of medical transition (see also *criteria for assessing the legitimacy of transgenderism*) as opposed to, judging by accounts, faster medical transition procedures in case of transgender men:

“Those feminine people I'm in contact with, really are - one particular didn't even get hormones legally and basically regulates these things alone, regularly takes self-funding hormone tests and has found a cocktail that suits, I think they are ordered abroad (NGO EXP, personal interview, 2020).”

The last set of coping strategies for medical transition, which is also the most rarely mentioned, but still worth mentioning, are 3) confrontation in its various forms, from *direct confrontation* in the interaction with the healthcare professional itself to *legal and formal appeal procedures*, also via an institute of patients' rights advocates. Matevž (FG, 2020), for instance, whose medical transition was groundlessly extended “indefinitely” due to his non-binary gender identity recounts that:

“Yeah, if there's a way of you even doing anything. Otherwise, I went primarily with a second opinion, I also explained my situation, so at that time she said, “ok, now for you, the process has been extended indefinitely,” and I said, “ok, but is this the end of my journey, do I have to go abroad?”, but the

advocate said that they can't do that because my health condition can also change and they can't block me in this way. These are not things I would know on my own. There was a lot of searching and reading laws, that kind of experience.

7.2.

Intra- in intersubjective coping resources

Among the resources that we divide into 2) intrasubjective and 3) intersubjective, the following should be pointed out. In the context of intrasubjective experience, having learned self-reliance is most often highlighted: practical knowledge and experience, which transgender people gain during the medical transition process, teach them that the healthcare system is rigid and unfavourable for them, therefore they cannot entirely rely on healthcare professionals and on the assumption about medical treatment being effective as such, as it is something they have to win themselves:

“Yes, similarly, just when you think you'll come there and they'll help you, when you say you need something, you quickly realize that you just have to take care of yourself, that there's no other way (Aljaž, FG, 2020).

In addition to having learned self-reliance that can be considered in parallel to the discussion above on the need for constant pressure (as one of the highlighted negative aspects of medical transition), past experiences as such should be pointed out, especially in case of those who have more or less completed the medical transition process. In those cases, a specific stability and tranquillity are emphasized, which in fact originate from the fact that the major part of medical transition is already behind them and that they can no longer take that away from them. To put it differently, it is implied that insecurity and lack of control, which transgender people experience during medical transition appears to be of such magnitude - despite the fact that it is about their gender identity, which significantly marks their everyday lives - that they actually find it constantly compromised. They feel the process of medical transition is something that can be taken away from them at any moment, hence the relief, when some steps have already been made:

“Yeah, also that, I don't know, that I'm actually taking injections right now, that surgery is behind me, that I realize that this fight is behind me. So feel so much more relaxed. So I'm not afraid that anything will stop for me. Because... it can't. Now they can't all of a sudden stop my hormones, the surgery has already been performed. Even if the corona situation worsens and health services become less accessible, I still know that it won't change anything for me (Dylan, FG, 2020).

When it comes to 3) intersubjective resources, the importance of support within more intimate relationships, especially friendships (mostly within the LGBTIQ+ community) and intimate partner relationships, is most commonly highlighted:

“And it seems to me that a big part of making me feel that way are my friends precisely, who seem to me to be a rock I can lean on. Because I always know that in case I should bow down to it, they’ll be there for me. And I know they’ll help me to get back on my feet and move on (Alen, FG, 2020).”

“Where do I get support - I honestly get it in my closest circle, but it’s not just my partner or my older sister, or let’s say... two, three of very close friends. But those are really people - those are people who’ve been in my life for a long time, even from the period prior transition, who made this transition to be very painless for me (Timothy, FG, 2020).”

The extended family (not parents, but siblings or other relatives) is also pointed out. It should be pointed out that those relational dimensions act as a source of various forms of broadly defined socio-emotional support, from informing or providing information that is otherwise difficult to access in connection to the medical transition process, encouraging to maintaining good health by regular check-ups (considering avoiding the healthcare system to some extent due to negative experiences with it), actually accompanying someone to their check-ups, providing and creating opportunities to vent frustration (so-called venting), however it is also important to bear in mind that those intersubjective resources – as far as transgender communities are concerned - are also highly centralized and thus unevenly accessible:

“So that, this is then definitely – the access to resources, who you know that can tell you that. Now, about what Alen’s said - if you’re in a [city], if you’re part of the community, you give a nudge to one or three people – can you give me some help, you know stuff, you’ve already had it - but if you’re from, heaven forbid, from the outskirts or you don’t know anyone who is in situations like these, but you don’t even know where to start. I don’t know, I’m so much older that I didn’t know anyone in my surroundings. I knew one person, one I met and before I got in touch, I looked that person up on the internet, and I wrote - mate, help me, what am I supposed to do, where should I start, where should I go? So yes - it all depends on how much you can get around something. This shouldn’t be the case; this process should be organized in a different way. To be accessible to everyone, even to those who come not knowing anything, how it goes at the operational level (Timotej, FG, 2020).”

One of the most frequently highlighted sources of support or resources are also (LGBTIQ+) non-governmental organisations (NGOs): those also, similar to more intimate relationships,

offer support in various forms, from advocacy, various activities in the LGBTIQ+ community, informing, professional psychosocial support, including trans support groups, to specific advocacy provided at the individual as well as collective level:

“Yes, I do too - the only thing maybe, I don't really know if it's a part of it, but all the organizations that are involved in it, and with advocacy and activism, at least for me, it was very helpful for me to always get information, and they were always at my disposal for all such things (Aljaž, FG, 2020).”

“/... / for me [LGBT NGO] was a place and also support from [their], from employees and volunteers, and I am also a volunteer now, but mostly at the beginning - it seems to me that it was the thing giving me some strength and... realistically speaking I don't know how would I've gone through the transition if I hadn't had all this support from [LGBT NGO] I had. As I knew that after every check-up, I could go there, sit down and I tell them all the horrible things that had happened to me at the check-up and they would listen to me and give me some support I truly needed (Alen, FG, 2020).”

7.3.

Summary

Based on the data, we distinguish between coping strategies, representing “practical knowledge” of manoeuvring through the medical transition process, which is - according to the fifth chapter of this study - significantly characterized by negative aspects and burdensome experiences as well as coping resources (resources that can be “mobilised” to make the experience of medical transition less stressful and make it to run more smoothly). With respect to coping strategies referring primarily, yet not only to the steps in psychological and/or psychiatric treatment in medical transition, it is worth highlighting so-called “tricks of the trade,” exit strategies, and confrontational practices. The first refer to those practices and principles that help a transgender person surmount obstacles and difficulties they come up against during medical transition, with the aim of obtaining those health services that are crucial for gender confirmation. Exit strategies are of a more “resigned” nature compared to “tricks of the trade”: it is about those practices that help transgender people seek alternatives outside the public healthcare options of medical transition, precisely due to a number of obstacles they come up against there. Confrontational strategies tend to be less frequent, however they represent those practices that transgender people use to more or less directly oppose those elements of medical transition that they perceive as problematic or inappropriate.

In the context of coping resources, we distinguish between intra- and inter-subjective resources. When it comes to the former, transgender people point out having learned self-

reliance and sense of security originating from the fact that certain steps of medical transition have already been made, which means that gender confirmation is partly out of the reach and control of healthcare professionals. When it comes to intersubjective resources, true to form, more intimate relationships and their sources of (socio-emotional) support are pointed out, including a variety of practices, from providing opportunities to vent frustrations through conversation (so-called venting) to specific support practices (e.g. accompanying someone to a medical transition-related check-up). NGOs are also emphasized as a key source of support, both in terms of providing opportunities for establishing and strengthening interactions within the LGBTIQ+ community, providing professional psychosocial and/or peer as well as legal support to inform about the possibilities of legal gender recognition and medical transition.

In connection to *(I) experiencing protective measures*, we establish that transgender people, including the broader perspective offered to us by NGO experts relevant to the subject of transgenderism, commonly report an intensification of economic and housing insecurity. Economic insecurity often occurs due to a reduced or complete loss of the regular income (due to loss of employment), which is the reason why transgender people also recount relying on various forms of personal assistance (e.g. family members, members of the so-called family of choice). Housing insecurity is most commonly recounted in terms of returning to primary environments or to a family of origin, especially when that one is less fond of LGBTIQ+ identities and communities. This type of insecurity is more exposed by those transgender people who, prior epidemic, lived in various forms of (temporary) institutional settings, from student halls of residence to non-family placement educational settings (e.g. supported living residence). In addition to housing and economic insecurity, reduced access to the LGBTIQ + community and the support it offers, both at the level of social type of events, peer support (e.g. trans support groups) as well as at the level of professional forms of support (e.g. providing psychosocial counselling support) is also pointed out. A specific source of insecurity also comes from the political situation, namely, based on the appointment of the new politically right-wing government the day after the COVID-19 epidemic was declared in Slovenia as well as on planning and implementation of protective measures for the purpose of curbing the epidemic (e.g. stopping public life) together with the government not being perceived as ready for the second wave of the epidemic and with the sense of epidemic being exploited for political purposes. The intertwining of those insecurities is reflected in major mental health issues, with the fact that other forms of support (from informal social support to non-governmental support programs and public healthcare services for mental health) have been more difficult to access or even cancelled. However, a small group of transgender people reports on maintaining pre-epidemic economic and housing security; this applies especially to those transgender people who had already stayed in private housing prior epidemic, often with other members of the LGBTIQ + community and/or while being in an intimate relationship.

In reference to *(II) the experiences of transgender people with the healthcare system outside the COVID-19 epidemic period*, before the epidemic was declared and especially with respect to those healthcare services related to medical transition, we establish that transgender people most commonly point out the primary healthcare level because of having positive or courteous experiences with it. In general, what is typical of courteous experiences is the fact that the healthcare professional is perceived as engaged - shows interest, if not knowledge, for the subject of transgenderism, while approaching the treatment of transgender people in a sensible way, by awareness and consideration of discomfort a medical treatment (e.g.

gynaecological) can cause. The respect for gender identity is also reflected in the use of an appropriate name and pronouns by a healthcare professional. It is true, however, that when discussing courteous experiences in healthcare, we should keep in mind that, according to accounts, transgender people often have low expectations regarding treatments in the context of healthcare: for courteousness or “positivity” of experiences it frequently suffices that “terrible” experiences are lacking. People also recount so-called ambivalent experiences, which we distinguish from courteous and negative, since they include too much unease and discomfort to be considered courteous. However, at the same time, it is not necessarily an experience of transphobia, but has a potential of being one, in short, it is about marginal experiences, such as “poor well-intended practices” and situations that are particularly uncomfortable (e.g. gynaecological examinations for transgender men or gender non-binary people).

In the context of negative experiences, frequent experiences with transphobia are pointed out, such as exoticization, as we have called the phenomena, in which transgender people are approached to as “rare trophies” and are as such a source of special “pride” without necessarily happening in courteous and respectful practices, next, pathologisation, the use of inappropriate names and pronouns (sometimes despite repeated reminders), demands for the legitimization of transgender person, last but not least situations of being forced into disclosing transgender identity and invasions of privacy. What we classify as negative experiences is also a lack of knowledge on the part of healthcare professionals (e.g. not knowing the difference between intergenderism and transgenderism), which often forces transgender people to take on so-called educational tasks, which are being perceived as burdensome due to the shifting responsibility of expertise from a healthcare professional, as the one who is supposed have knowledge, to a transgender person who is actually seeking medical care. From transgender people’s accounts, we can also recognize two ways of how to avoid experiencing transphobia namely, passing, and paradoxically, avoiding healthcare services. It is avoidance of healthcare services, together with the anticipation of transphobia, that is one of the more problematic effects on transgender people experiencing transphobia, that is, a social group whose position is already significantly burdened by health inequality and other forms of inequality. Still, some people report that they actively take care of their own health in this respect, regardless of - often realized - anticipations of transphobia where various support networks playing an important role (e.g. friendships and their support).

With respect to medical transition, transgender people point out the following positive aspects: existing possibility of carrying out medical transition within the public healthcare system and laxer legislation, which, rather by chance than by serious legislative consideration, allows a

fast completion of legal gender recognition without more intensive medical interventions (it suffices to be given a diagnosis of transsexualism) and the recent formalization of the interdisciplinary council. As far as negative aspects are concerned, they point out the existing characteristics or weaknesses of the Slovenian healthcare system. Regarding trans-specific health services, they point out the ambiguity of procedures related to medical transition, by highlighting different timelines and successive steps of medical transition or insufficiently standardized procedure, including difficult access to information about the medical transition process itself and healthcare professionals lacking information and coordination among themselves. In this context, they also draw attention to a lack of various options in the medical transition process, namely lacking possibility of using the appeal procedure (which refers to the period prior formalization of the council), lacking possibility of getting a second opinion and choosing among different but equally qualified healthcare professionals.

An important negative feature of medical transition is also the length of procedures, also due to the cancellation of pre-determined dates of medical treatments. Long duration is also reflected in irregular, though necessary, endocrinological check-ups. It is the long duration itself that raises the need for constant pressure on healthcare professionals by transgender people to get things done in good time, however those responsibilities can be quite burdensome for a transgender person, considering anticipations of transphobia. A so-called “psychiatrization and psychologization” of medical transition is presented as a major element of negative aspects of medical transition. This part is also the most burdening one, and refers to various practices of assessing the legitimacy of transgenderism. Those practices are based on criteria that are not perceived and seen as justified or appropriate (e.g. the age criterion, gender normativity, existence of accompanying conditions, etc.) as well as other gatekeeping practices, including a lack of adequately provided psychological support. Against a background of exposed gatekeeping practices of healthcare professionals, it is difficult for a transgender person to establish a sufficient degree of trust and a sense of security in order for psychological and / or psychiatric treatment to be truly supportive.

Regarding (III) *the access to the healthcare system during the COVID-19 epidemic*, transgender people recount reduced access to non-primary healthcare services in some places: while there were no cancellations of healthcare services at the primary level as healthcare professionals remained fairly responsive, transgender people experienced cancellations of so-called elective services (in accordance with epidemic-related protective measures), including cancellations or irregular provision of mental health services. The unresponsiveness of healthcare professionals and the unpredictability of postponed appointments were the ones that arising a specific form of uncertainty on the part of transgender people, especially

those at the initial stages of medical transition as the “end result” of transition moving further into an unforeseeable future. In some cases, transgender people - especially those who have completed the process of medical transition to a large degree and only need services to “maintain” the situation, report that there have been no major changes in the possibility of accessing the healthcare system.

In connection to (IV) coping with access to healthcare also in the context of the COVID-19 epidemic, we can distinguish between coping strategies used by transgender people during medical transition, which include a variety of practices that help them manoeuvre in the healthcare system significantly loaded with various gatekeeping practices and other negative experiences. Based on the data, we draw attention to mainly three major groups of such practices, namely, so-called “Tricks of the trade”, where those practices help transgender people provide healthcare services necessary for gender confirmation (e.g. passing), exit strategies, where these practices help at least partly avoid or minimize interactions with the public healthcare system and its structure of medical transition (e.g. seeking self-funding options), last but not least, confrontational practices where this structure and gatekeeping practices are directly dealt with (e.g. through formal appeal procedures). When it comes to coping resources, we distinguish between intrasubjective resources (e.g. learned self-reliance) and intersubjective resources with intimate relationships (friendships, LGBTIQ + community, intimate partnerships, and less commonly extended and/or nuclear family of origin) and NGOs playing an important role. The negative aspects of access to healthcare services, especially those in the context of medical transition, have been intensifying during the COVID-19 epidemic and its related protective measures. Namely, even outside the epidemic situation, the situation of medical treatment and medical transition is significantly burdened by uncertainties and ambiguities as well as long duration of procedures. All those features have been further intensified due to protective measures (cancellation of nonurgent or elective healthcare services), especially for those at the initial stages of medical transition.

Regarding the (V) *healthcare professionals' perception of medical transition*, we establish that there are have been major discrepancies between their perception of positive aspects of medical transition and that of transgender people: healthcare professionals, just as transgender people together with NGO experts draw attention to the importance of formalization of the council. In this respect, they emphasize compliance with the international guidelines and cooperation with NGOs, the possibility of getting expert opinions and strengthening cooperation between individual medical professions. In addition to that, healthcare professionals in terms of positive aspects point out the absence of prejudices among specialized medical staff. There are major differences in transgender people's perspective in the context of the negative

aspects: partly there is coherence (in connection to general drawbacks of the Slovenian healthcare system as such), otherwise healthcare professionals point out questionable long-term effects of medical transition (namely from two perspectives, both in reference to satisfaction with sexuality as well as in reference to the questionable effects of medical transition in case of gender non-binary – the latter is sometimes constructed as a matter of borderline personality disorder and not as a legitimate gender identity). Moreover, they also point out non-selectivity of admission to medical transition or so-called “permissiveness” of medical transition gatekeepers. Thus, where transgender people experience gatekeeping practices, healthcare professionals perceive “permissiveness”. A lack of comprehensive, bio-psycho-social approach or excessive psychiatrization of support is also, to a lesser extent, highlighted as a negative aspect distinctly by those healthcare professionals who are not directly involved in medical transition procedures.

In connection to (VI) *the state of healthcare during the COVID-19 epidemic period*, we establish that healthcare professionals perceive the issue of cancellations of elective healthcare services, however, given the epidemiological situation they consider it a necessary step to reallocate resources in order to prevent overloading the healthcare system. Despite being partly frustrated due to postponing services into the unforeseeable future, transgender people tend to actually agree in this respect. According to healthcare professionals, the key to the system going back to regulary providing all planned healthcare services as soon as conditions allow, also in the name of pre-existing health inequalities and socially vulnerable groups, is, in the meantime to make effective use of possibilities offered by telemedicine.



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A

APPENDIX A: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

Transgender people (participating within focus groups- FG and in-depth interviews – TG, personal interview)

Demographic characteristics	Category	Number of participants
Gender identity	Gender non-binary person	3
	Transgender man	8
	Transgender woman	1
Status	Employed	3
	Unemployed	2
	Student status	5
	High school student status	2
Age	18 – 22 years	4
	23 – 27 years	6
	28 + years	2
	The youngest	18 years
	The oldest	37 years
Place of residence	City	10
	Town	1
	Village	1
Total number of participants	Focus groups	10
	Interviews	2

Experts from non-governmental organisations, relevant to the subject of transgenderism and **public health institutions**, in/directly relevant to questions of medical transition and/or those involved in medical treatment of transgender people.

Type of organisation	Number of participants
LGBTIQ+ non-governmental organisation (EXP NGO)	3
Public health institution with direct relevance to questions of medical transition (HLTH PRO)	2
Public health institution with indirect relevance to questions of medical transition (HLTH PRO)	2
Total number of participants	7

TRANSGENDER PEOPLE'S PERSPECTIVE

Experiencing COVID-19-related protective measures

Burdening experience	Financial insecurity Housing insecurity Access to LGBTIQ+ community Political situation
Unburdening experience	Economic security Housing security Absence of strong need for LGBTIQ+ community

Experiences with the healthcare system outside the COVID-19 epidemic period

Courteous experiences in the healthcare system	Primary healthcare Low parameters of expectations Healthcare professional's engagement Sensibility of the approach Use of appropriate names and pronouns
Ambivalent experiences	"Poor well-intended" practices Uncomfortable situations
Negative experiences	Experiences with transphobia Lack of knowledge Taking on "educating tasks" The importance of passing The effect of negative experiences to accessing healthcare

Experiences with medical transition procedures

Positive aspects of medical transition procedures	The possibility of medical transition (within public healthcare) Courteous attitude of healthcare professionals Lax legislation Formalisation of multi-disciplinary council
Negative aspects	General characteristic of the healthcare system Ambiguity of procedures related to medical transition Lack of options in medical transition procedures Long duration of medical transition procedures Psychologization and psychiatrization of medical transition
Proposals for changes for greater inclusivity of healthcare system	Changes in the process of medical transition Changes at the level of relevant health institutions Legislative changes Changes at the relational level

Healthcare services related to medical transition procedures during COVID-19 epidemic

Worsening of pre-existing weaknesses of the healthcare system	<ul style="list-style-type: none"> Cancellation of »nonurgent« healthcare services Irregular provision of mental health services Unresponsiveness and reduced availability of healthcare professionals Seeking self-funding options of medical treatment Reduced access to healthcare services abroad
Without changes in the possibilities of accessing	<ul style="list-style-type: none"> Accessibility to primary healthcare Adapting with telemedicine options

Resources and coping strategies for the negative aspects of healthcare system in respect to medical transition procedures

Coping strategies	<ul style="list-style-type: none"> “Tricks of the trade” Exit strategies Confrontational practices
Coping resources	<ul style="list-style-type: none"> “Intrasubjective” coping resources “Intersubjective” coping resources

HEALTHCARE PROFESSIONALS' PERSPECTIVE

Perception of existing state of medical transition

Positive aspects	<ul style="list-style-type: none"> Formalisation of interdisciplinary council Absence of prejudice Major accessibility of trans-specific services within public healthcare Cooperation among different healthcare professionals
Negative aspects	<ul style="list-style-type: none"> General characteristics of public healthcare system Questionable long-term effects Non-selectivity of admission into the procedure of medical transition Lack of a comprehensive approach Disrespect for gender identity

Perception (of accessibility) of healthcare in the COVID-19 epidemic

Inevitability of cancelling elective services	<ul style="list-style-type: none"> Extending queue times Possibility of individualized interpretation of ordinances The need for sensibility for vulnerable groups Maintaining the accessibility of psychiatric treatment Telemedicine capacity building
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