Report on

TRANS PEOPLE AND THEIR EXPERIENCE WITH HEALTH CARE AND LEGISLATION

in the Czech Republic

Platforma pro rovnoprávnost uznání a diverzitu z.s.

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SUMMARY

DOPORUČENÍ VYPLÝVAJÍCÍ ZE ZPRÁVY (EXECUTIVE SUMMARY)

Předkládaná zpráva vychází z polostrukturovaných rozhovorů s jednotlivými trans lidmi s různými osobními zkušenostmi v oblasti zdravotní péče a rozmanitými názory na témata, která se společenské situace trans lidí v ČR bezprostředně týkají. Tři základní okruhy zkoumané v rámci projektu zahrnují osobní identitu, zkušenosti s českým zdravotnictvím a zkušenosti s českým právním systémem. Úvod zprávy nastiňuje současnou pozici trans lidí v české společnosti a zejména v normativním sexuologicko-medicínském diskurzu, od něhož jsou odvozovány i právní požadavky na změnu jména a úředního pohlaví. Pozornost je rovněž věnována mezinárodně uznávaným standardům zdravotní péče pro trans osoby publikované organizací World Professional Association for Transgender Health (WPATH, dříve Harry Benjamin Association/ HBIGDA), jejichž zatím poslední verze se značně distancuje od dříve prosazovaného modelu založeném na konceptu trans identity jako poruchy charakterizované genderovou (pohlavní) dysforií. Současné standardy WPATH jsou o poznání otevřenější a jasně stanovují, že trans identity jako takové poruchami nejsou a ne všichni trans a genderově nekonformní lidé musejí nutně zažívat genderovou dysforii. Tyto změny v konceptualizaci trans identit jsou důležité nejen proto, že představují názor respektované a vlivné mezinárodní organizace, ale také pro svou odlišnost od všeobecných tendencí v české sexuologii a medicíně obecně – ty jsou dle našich rozhovorů i samotných sexuologických textů stále bližší starším (a v mnoha ohledech problematickým) standardům HBIGDA. Napětí, které mezi těmito směry panuje, se odráží i v různorodosti názorů jednotlivých trans lidí v našich rozhovorech.

První část zprávy se zabývá zkušenostmi trans lidí se zdravotní péčí v České republice. Věnuje se otázce (ne)dostupnosti zdravotní péče pro trans lidi, spolupráci trans lidí se sexuology a sexuoložkami a standartizaci komise, která schvaluje operativní přeměnu jednotlivým trans osobám. Dále poukazuje na negativní jevy v rámci zdravotní péče jako je objektifikace trans lidí a nerespektování preferovaného oslovení. Dotýká se rovněž tématu přetíženosti a vzdělávání lékařek, lékařů a zdravotnického personálu.

V posledních dvaceti letech došlo v rámci zdravotní péče o trans osoby k několika významným posunům. Zkrátila se doba procesu přeměny z 5,5 na 3 roky. Lékaři a lékařky postupně ustoupili od ponižujících diagnostických praktik jako je měření vzrušivosti trans lidí či „přeměřování“ jejich těl a posuzování jejich „vhodnosti“ pro přeměnu. Trans lidé, kteří se rozhodnou podstoupit operativní přeměnu a mají děti, již nejsou nuceni, aby se vzdali svých rodičovských práv. Mohou se o své děti dále starat i po operativní přeměně.

Z rozhovorů s participujícími vyplynulo, že český zdravotnický systém je relativně vstřícný vůči těm trans osobám, které akceptují medicínskou konceptualizaci transsexuality a chtějí podstoupit proces přeměny standartním způsobem. Tito lidé se příliš nesetkávají se strukturálními překážkami v rámci zdravotní péče. Konzultace s lékaři, základní operativní zákroky a skupinové terapie mají hrazené z veřejného zdravotního pojištění.

Vůči transgender, genderqueer, non-binary osobám již nastavení českého zdravotního systému tak vstřícné není. Pokud se neztotožní s medicínskou diagnózou transsexuality, nemohou projít komisí, což v praxi znamená, že pokud usilují o operativní modifikaci těla, tak jim ji zdravotní pojišťovna neuhradí. Zároveň jak se ukázalo v rozhovorech s participujícími, někteří sexuologové a sexuoložky nenabízí transgender a genderqueer lidem dlouhodobou spolupráci.

Za stávajícího nastavení zdravotní péče jsou lékaři, lékařky a zdravotní personál často přetěžováni a není nijak systematicky podporováno jejich vzdělávání v oblasti transsexuality a transgenderu. Absence systematické podpory vzdělávání v této oblasti a dlouhodobá přetíženost může ztěžovat komunikaci a spolupráci s trans lidmi.

Zkušenosti participujících ukazují, že v nemocnicích a zdravotních zařízeních jsou trans lidé nezřídka oslovováni na základě občanského jména, ne v rodě, který preferují. Dalším jevem, k němuž v rámci zdravotní péče dochází, je objektifikace trans lidí. Týká se například označení dané osoby za „to“, může být též spojena s exotizací trans těla, kdy netypické části těla jsou považovány za kuriozitu.

Kritickými připomínkami k právní a medicínské normě v ČR se zabývá hlavně druhá část textu. Součástí výše zmíněných zkušeností jsou neoddělitelně také názory, které se během interakce se státními institucemi u participujících rozvinuly. Z rozhovorů jasně vyplývá, že nelze ani v českém kontextu hovořit o jakémkoli všeobecně sdíleném „trans náhledu na svět“, jelikož názory jednotlivých participujících na zdravotnický a právní systém v ČR se mnohdy zásadně různily. Zatímco část participujících vnímala své zkušenosti v rámci lékařsky asistované přeměny jako pozitivní v tom, že jim bylo umožněno prezentovat se podle svých představ, jiní participující se vyjadřovali kriticky k tomu, že český stát určité operace (povinnou sterilizaci) předpokládá automaticky a nenabízí možnost volné změny jména či úředního pohlaví bez operativních zákroků. Někteří z participujících také negativně hodnotili normativní roli sexuologického diskurzu, v němž nenacházeli respekt k vlastní identifikaci mimo dichotomní kategorie (jako např. muž/žena, hetero-/homosexualita atd.) nebo tento aspekt své identity během konzultací v sexuologických ordinacích pod vlivem obav z nepochopení či zamítnutí další spolupráce lékařem/kou vůbec nezmiňovali.

V této souvislosti si text všímá patologizačních tendencí v české medicíně a kontrastuje je s modelem trans identity jakožto oblasti lidských práv, což je politický model, který se v posledních letech prosazuje v evropských i mimoevropských demokraciích. Na rozdíl od současného občanského zákoníku ČR tyto státy (např. Dánsko, Švédsko, Velká Británie, Argentina, Indie, Austrálie a další) upouštějí od požadavku na jakýkoli operativní zásah do těla (respekt ke svobodě volby a tělesné integritě jako základním lidským právům) pro uznání pohlaví trans lidí příslušnými úřady. V některých z těchto zemí (např. Argentina, Dánsko) není pro právní uznání nutná ani oficiální diagnóza, tj. dochází zde k úspěšnému přetváření patologizačního přístupu k trans identitám na přístup zakotvený v principech občanské společnosti. Z rozhovorů vyplynulo, že ačkoli v současnosti používaný model přeměny v ČR nezanedbatelné části dotazovaných vyhovuje, zvláště pokud jde o starší generaci, z výpovědí některých dalších trans osob je zřejmé, že omezení současného systému vnímají negativně a ztotožňují se více se zmiňovaným lidskoprávním diskurzem. Tato perspektiva zatím není dominantní, ale neměla by jen pro svou marginalitu být opomíjena, protože nabízí zcela odlišné paradigma nahlížení na trans identity, které s nimi nezachází jako

s příznaky poruchy a umožňuje trans lidem pozitivní způsoby sebeidentifikace a v neposlední řadě také větší možnost individuální volby, pokud jde o ne/podstupování tělesných modifikací v rámci procesu přeměny a za jakých podmínek.

Z první a druhé části zprávy vyplývají následující obecná doporučení:

- Trans lidé by měli dostávat prostor na sebevyjádření a neomezenou definici vlastní identity bez obav, že jim nebudou umožněny potenciálně chtěné tělesné modifikace na základě genderově „nekonformní“ sebeidentifikace.

- Lékařská péče a operativní zákroky by měly být přístupné nejen transsexuálním lidem, ale i transgender, genderqueer, non-binary osobám, pokud o modifikaci těla či jinou lékařskou péči projeví zájem.

- Vzdělávání lékařů, lékařek, zdravotnického personálu, studentů a studentek medicíny v oblasti transsexuality a transgenderu a sledování vývoje v této oblasti na mezinárodní úrovni by mělo být systematicky podporováno.

- Lékaři a zdravotnický personál by se měli trans osob zeptat, jaký rod při oslovení preferují. Měli by trans osobám dát prostor, aby se identifikovali a ne je identifikovat automaticky na základě jejich dokladů.

- Vzájemná spolupráce psychiatrů, psychologů a sexuologů v rámci péče o trans osoby by měla být systematicky posilována.

- Lékařsky asistovaná přeměna (hormonální terapie, operace apod.) by neměla být vnímána jako nutnost pro to, aby (trans) identita daného jednotlivce byla platná.

- Úřední uznání pohlaví by nemělo být závislé na podstoupení jakéhokoli lékařského zákroku, ale mělo by se řídit lidskoprávním modelem, jenž je v současné době aplikován ve stále větším počtu zemí.

- Chtěné lékařské zákroky v rámci přeměny mohou být nadále hrazeny stávajícím způsobem, i když by se nejednalo o právní podmínku uznání pohlaví úřady. Podobně jako finanční podpora rodičovství státem nespočívá v tom, že by těhotenství a porod byly klasifikovány jako nemoci (ačkoli do jejich průběhu zdravotnický systém většinou významně zasahuje), nemusí ani finanční podpora přeměny u trans lidí záviset na jejich patologizaci. Nárok na tělesnou sebedeterminaci (možnost volby podstoupit či nepodstoupit určitý zákrok) je sám o sobě argumentem pro to, aby tyto zákroky byly hrazeny, pokud bude společensky uznán jako legitimní na základě principů lidských práv. Zároveň by otázka přístupu k operativním a jiným zákrokům měla být posuzována odděleně od otázky, zda budou takovéto zákroky vyžadovány pro úřední změnu pohlaví.

- Česká republika by se měla zajímat o mezinárodní vývoj, jehož tendence směřuje k depatologizaci trans identit v oblasti medicíny (za podpory lékařské trans organizace WPATH) a k liberalizaci podmínek pro úřední uznání pohlaví v oblasti práva.

EXECUTIVE SUMMARY

This report is based on a series of semi-structured interviews with individual trans people whose personal experiences with health care are diverse, as are their opinions of the social situation of trans individuals in the Czech Republic. The project is focussed on three general areas of inquiry: gender identity, experiences with the Czech medical establishment, and experiences within the Czech legal system. In the introduction, we outline the present position of trans people in Czech society, particularly as it relates to the normative discourse of medicine (and sexology more specifically), since this in turn strongly influences the legal requirements for gender recognition. International benchmarks such as the *Standards of Care (Version 7)* formulated by the World Professional Association for Transgender Health (WPATH, formerly HBIGDA) play an important part in contextualizing the situation in the Czech Republic, as the most recent version of the WPATH standards has distanced itself significantly from its predecessors, which proceeded from the idea that trans identity should be classified as a disorder characterized by gender dysphoria. According to the present WPATH standards, trans status in itself does not qualify as a disorder, and not all trans and/or gender-nonconforming people experience dysphoria as part of their identity. These developments in how trans identities are conceptualized are important not only because they are now championed by an established international organization, but also for the difference from the prevailing beliefs of Czech sexology, which are still couched in the earlier problematic HBIGDA standards. The tensions between these two schools of thought are understandably reflected in the variety of opinion found among our study participants as they navigate this conflicted landscape.

The first part of the report deals with trans people's experiences with health care providers in the Czech Republic. Questions of in/accessibility, cooperation with sexologists, and the standards formed by committees approving surgical procedures are all addressed as major and often ambivalent issues. In addition, it points out negative occurrences in health care such as the objectification of trans people and misgendering by care providers. On the other hand, the problem of overworked and oversubscribed doctors and other medical personnel is investigated, along with the possibilities of their continued professional education that would address many of the present deficiencies.

Over the past two decades, there have been some notable developments in trans health care, including a shortening of the minimum medical transition period from 5.5 years to 3 years total. Arbitrary and degrading diagnostic practices, such as taking body measurements to assess a person's "suitability" for medical transition or estimating sexual arousal upon seeing different images as a marker of gender identity, have steadily fallen out of favour. Trans people who have become parents by the time they undergo medical and legal transition no longer have to give up their parental rights, being able to continue caring for their children after transitioning.

Our interviews indicate that the Czech medical system is relatively open to those trans people who accept its definition of transsexuality and whose transition goals align with the "standard" trajectory. People in this category rarely face structural barriers in health care.

Their appointments with doctors, group therapy sessions as well as basic surgical procedures are covered by public health insurance.

Trans people who identify outside the dominant medical model – as transgender, genderqueer, nonbinary, etc. – are much more likely to encounter adversity in the Czech health care system. For instance, by not conforming to a medical diagnosis of transsexuality, they will not have approved funding by the regulatory boards if they wish to pursue any surgical procedure, leaving them to pay the bills in full if they succeed in finding a surgeon at all. Some individuals have also reported unwillingness to provide long-term support on the part of sexologists.

Doctors and other medical personnel are often oversubscribed, and thus their further education on trans issues has little to no systematic grounding. These combined factors can easily have a negative impact on their communication with trans people and their ability to provide individualized support. Participants' experiences with hospitals and other health facilities often included misgendering and being addressed by their legal name instead of one that would reflect their identified gender. Tying in with this is the objectification of trans people in the medical field, sometimes literal by referring to a trans patient as "it", other times by exoticizing trans bodies by treating body parts that diverge from the normative male or female image as curiosities.

The second section of the report concerns mainly critical commentary on the medical and legal norms in the Czech Republic. The variety of opinion among the interviews conducted during this project clearly shows that despite the relatively uniform dominant view of transsexuality as a medical disorder, there is no universally shared "trans worldview" among trans individuals. Participants' beliefs were sometimes radically different from one another. While some rated their overall experience with medical transition as positive in that it enabled them to present themselves authentically to the world, others were critical of the fact that Czech state institutions automatically prescribe certain procedures (e.g. compulsory sterilization) and refuse to allow gender recognition or fully self-determined name change without surgical intervention. Some participants also commented negatively on the normative role of the sexological discourse, which they felt disrespected their identification outside dichotomous categories (male/female, hetero-/homosexual, etc). Having to withhold these aspects of their identity during consultations with doctors for fear of being invalidated or prevented from accessing further resources was a common complaint.

The current pathologizing tendencies in Czech medicine are analyzed and contrasted with a competing model of trans identity as a human rights issue with political significance. This outlook has been increasingly adopted by countries both within the EU and globally. Unlike the Czech Republic with its current legislature, these countries (e.g. Denmark, Sweden, the UK, Argentina, India, Australia and others) have abandoned the prerequisite of surgery in order to achieve gender recognition, representing a legal change founded on respecting freedom of choice and bodily integrity as basic human rights. In some of these jurisdictions (Argentina and Denmark), legal recognition does not even require an official diagnosis, demonstrating a successful shift from a model that pathologizes trans identities to one that respects gender identity in accordance with the tenets of civic society.

Based on our interviews, it can be argued that although the current model of medical transition in the Czech Republic does suit a number of trans people, particularly those of older generations, there is also a considerable amount of criticism on the part of those who are adversely affected by its limitations and/or subscribe to the human rights model of trans identity. While this latter perspective may not yet be the dominant one, it should not be disregarded simply for being somewhat marginal, as it offers a completely different paradigm of viewing trans identities not as symptoms of a disorder but as a positive mode of self-identification that is valid in its own right. It also allows for a greater sphere of individual choice when it comes to undergoing specific medical treatments or not, or under what conditions.

The following recommendations are offered on the basis of this report:

- Trans people should be given the space to articulate their identity on their own terms, without being made to fit categories that they would not personally use for self-description. Priority should be placed on respecting and understanding each trans person as an individual, and special attention should be devoted to the inclusion of nonbinary gender and sexual identities with a clear message that trans people will not be discriminated or denied resources on the basis of identifying outside a strictly binary gender system.

- Medical transition should not be treated as a prerequisite of having a valid trans identity, and even within the realm of medical transition, it should be acknowledged that multiple options exist rather than a single normative trajectory.

- No medical treatment or procedure, including but not limited to HRT, top surgery, surgical or non-surgical sterilization, or genital surgery should be a prerequisite of legal gender recognition.

- There should be systematic support for continued professional development and education of qualified doctors, medical personnel, and medical students on trans issues, including an awareness of international developments in this field.

- Health care providers should make an effort to ask about trans people's preferred name and pronouns, rather than assuming them from legal documents alone.

- Trans people should enjoy open options in choosing a name to identify with, without a gender-neutral form being mandatory even for those who would prefer a clearly masculine or feminine form.

- The option to undergo any treatments including HRT and/or transition surgeries should remain recognized as medically necessary for those trans people who wish to undergo them, preserving the current funding situation. Choosing to undergo one treatment (e.g. HRT) should however not be taken as automatic

consent to other treatment (e.g. any surgery unless desired by the individual). HRT and surgeries should be accessible on the basis that every person has the right to make choices about their health and to be supported in these choices, rather than making funding contingent upon the definition of trans status as a disorder. It should be noted that a condition does not have to be classified as an illness to receive financial assistance from the state. (For example, pregnancy, childbirth, parental leave and child benefits are all related to the medical sector and not classified as pathological in order to be eligible for assistance; the fact that they receive financial support is based on the value placed on them by society/the state. The same principle can apply to bodily self-determination in general.) The question of accessing specific treatments should be also judged separately from the question of gender recognition.

▶ The Czech Republic should closely observe international developments that tend towards the depathologization of trans identities in the medical field (actively endorsed by the medical organization WPATH), and towards making legal gender recognition contingent on self-identification rather than on approval by a regulatory body or on any particular medical procedure in the legal field.

INTRODUCTION

ALEX LORENZU

The focus of this survey is on trans people as a broad category that is subject to various kinds of marginalization, which has historically been overlooked as a human rights concern in the Czech Republic. Some previous reports, such as the *Analysis of the Situation of the Lesbian, Gay, Bisexual and Transgender Community in the Czech Republic* published in 2007 by the Office of the Government of the Czech Republic, have only provided an overview of the major issues facing Czech LGBT people at the time and have not engaged in a significant discussion of how these marginalized groups are constituted in the discourse. As our interview research comprises a relatively small sample of 17 semi-structured interviews, it cannot be taken as an exhaustive portrait of Czech trans people; however, its qualitative nature enables it to portray the Czech trans community[1] as a conglomerate of varied individuals and beliefs, which is not usually the focus of summary reports. The primary purpose of the research is to examine structural inequalities on the basis of individual examples that cannot be generalized, yet still offer salient insights into the kinds of struggles faced by trans people in the Czech Republic.

Identifying and contacting participants had been a principal challenge in conducting the research, partly because of the lack of a strong trans community, which was repeatedly mentioned by our study participants. Not all interviewees rated this aspect as negative; to some trans people, identifying with a specifically trans or LGBT community was not desirable because they preferred to be seen as "just" men or women without any additional descriptor. Others described the lacking community as a problem, both an obstacle to political organizing and a further contributing factor to the isolation and the largely invisible status of trans people in society outside of medical definitions. The widespread relegation of trans issues (those being reduced to diagnostics, HRT, and surgical procedures) into the hands of supposedly impartial experts such as sexologists and advisory boards on the expense of articulating trans issues as identity politics or a human rights cause seems to be typical of the Czech sociopolitical context, not only in relation to trans issues but other gendered issues as well (see e.g. Sokolová 2005). The resulting pathologization and depoliticization of trans identities, then, may have at least in part determined the low turnout of our survey, although it is by no means the only factor that may make it difficult for members of a marginalized group to be involved in research.

Our methodology for contacting prospective participants has been largely based on the snowball method, as this had the greatest chance of reaching trans people with a potential interest in either activism or in some manner of self-representation. (Not all of the survey participants identified as activist, which is influenced by multiple factors ranging from personal beliefs to the risks associated with visibly identifying as trans in a society where systemic discrimination and anti-trans sentiment is still present.) There were some delays to the project due to the aforementioned difficulty in gaining widespread support for the research and finding enough interested participants. Logistical difficulties, such as being able to follow up with individual trans people and to secure an interview appointment with them

1 We will return to the question of whether there is a singular, cohesive Czech "trans community" shortly.

(in a few cases, the only way to obtain an interview was via Skype), also presented a major challenge. In addition, even among the trans people who did participate in the research, there was an instance of a participant requesting to have parts of their interview withdrawn after having second thoughts about the "activist" nature of the survey as opposed to the normative medical discourse. Both the low number of interviews and the high level of detail have resulted in our analysis of the findings being qualitative, applying particular focus to recurring themes and notable general tendencies in the collected material. All participants entered the study with informed consent. They have been made anonymous and, when quoted in the report, appear under invented names that reaffirm their identified genders.

In the Czech Republic, the dominant sexological discourse is still grounded in the previous version of the WPATH (then HBIGDA) *Standards of Care*, not accounting for WPATH's change in paradigm "urging the de-psychopathologization of gender nonconformity worldwide" (Coleman et al. 2011: 168). Combined with a persistent stigma attached to both feminist and gay and lesbian (and later more broadly queer) activism (Sokolová 2005), trans people may often feel that the relevance of their own lived experience ranks below established medico-legal norms when it comes to determining the legitimacy of their gender identity and expression. The epistemological grounding of our survey in social constructivism and human rights necessarily challenges that notion, but these challenges are at present far from the accepted norm in the Czech discourse on trans issues. Even among trans people, not all representatives of the group currently identify with the social constructivist model or conceptualize their position in terms of human rights.

Compared to the medicalized outlook, this position is relatively new in the Czech cultural context and does not yet appear to have the majority of supporters even among trans people themselves. Regardless, the importance of this approach in offering an alternative to the established model that treats trans status as a disorder and in being more in tune with recent developments in trans advocacy abroad should still be taken into account, as its comparatively marginal position in the discourse does not necessarily imply lesser validity. As there are fewer trans people overall who articulate this type of criticism, the same interviewees may be quoted more than once to cover all the relevant points in this report. This is due to the less widespread status of human rights criticism in the Czech cultural context when it comes to trans issues specifically.

Trans people in the Czech Republic thus cannot be said to share a single outlook, and as such the presence of a unified "trans community" in the country is debatable at best. The views articulated by the participants in our study are testament to the fact that trans people's opinions on the same core issues can diverge vastly. Based on this diversity of survey responses, it would be an oversimplification to state that there is a cohesive "trans community" in the Czech Republic with universally shared outlooks or goals – in other words, we have not been able to ascertain any universal "trans experience" even in our relatively small sample, although one is often assumed to exist by normative texts. Some trans people are characterized by a tendency towards gender essentialism, appear less keen to be involved in discourses perceived as "activist" and, on the whole, showed a lower degree of criticism of the current medical practices and codes of conduct, or expressed concerns that criticisms of it would jeopardize the funding of transition as part of public health care. Members of this group were generally more likely to identify with the label *transsexual* and not be in favour of sweeping changes to the medical discourse. Most emphasized the unchangeable quality of their own gender identity;[2] some were suspicious of gender theory as a potential "threat" to the essentialist medical discourse that, in their view, rightly legitimizes fixed binary genders, including those of trans people who follow the expected transition path and identify in binary terms. Trans women prevailed in this group, which may possibly be related to the higher demands of femininity exerted upon them by society and even by medical professionals, particularly for the older generation. Age may indeed play its part in some of the responses, considering that the trans people whose views leaned on a more conservative side tended to be older on average than those who were more inclined to articulate the need for reforms. However, these explanations remain generalized and largely speculative, and should not be taken as universal determinants of opinion or assumed to be a shared trait among all trans people with a particular essentialist or non-essentialist outlook.

Participants who conceptualized their gender identity as being more of a human rights issue and who articulated constructivist criticisms of the medical establishment did not tend to share a single identity label like *transsexual*, but used a wider variety of descriptors in their interviews including *transgender*, *queer* and *genderqueer*, or otherwise displayed some degree of conscious gender nonconformity or nonbinary self-identification. Most, but not all, of these primarily critically-leaning individuals had been designated female at birth; ages varied from early 20s to 40s. The discourse highlighting the necessity for change was generally shared among this group and included proposed changes both to the medical establishment and its tendency to prescribe individuals' transition options in rigid binary terms *and* to the legal system that incorporates mandatory sterilization, limited naming conventions, gatekeeping by doctors and regulatory bodies, and the obligation to dissolve a marriage or a civil union upon gender recognition. In addition to obstacles based on trans status enshrined in law and/or medical practice, some intersecting oppressions appeared in this sample, including one participant who had experienced domestic abuse, harassment, and stalking without the police being willing to intervene. Economic concerns were also a frequent topic, both with respect to discrimination in the workplace and education and regarding the cost of medical transition, which was most often a point of contention between groups of trans people with differing moral and epistemological standpoints.

2 To clarify, there is no issue when an individual trans person asserts that their identity is unchangeable and strictly binary. What is problematic is the assumption that this is the *only* way to exist as trans in society, which has so far been the prevailing assumption in the medical and legal discourses in the Czech Republic, contributing to the pathologization of trans identities and the coercive nature of gender recognition procedures.

TRANS PEOPLE AND HEALTH CARE IN THE CZECH REPUBLIC

DITA JAHODOVÁ

HEALTH CARE CURRENTLY AVAILABLE TO TRANS PEOPLE

Health care for transsexual people[3] has had a long tradition in the Czech Republic, starting with the sexologist Josef Hynie in the 1960s. According to Hynie, a sexologist's task was to differentiate "true transsexualism" from "transvestitism" and "psychic hermaphroditism" (Hynie 1974). If "true transsexualism" was ascertained, sexologists should strive to integrate the individual into society by means of hormone replacement therapy (HRT) and by recommending a name change to a gender-neutral form. Hynie did not recommend genital surgery, not only because plastic surgery of the day would not have been capable of functional results, but also because he feared the possibility of a trans person being able to get married after an amendment of their birth certificate granted via surgery (Hynie 1974). By the 1980s, genital surgery was on the contrary viewed as part and parcel of "curing" transsexuality (Raboch 1984).

The number of people seeking medical transition increased sharply after 1989. Multiple factors contributed to the rising numbers of transition-related surgeries performed, one being the gradual lifting of taboos around sexuality-related topics along with a growing adherence to the ideals of authenticity and autonomy in society (Pullman 2011). Information on transsexuality, the health care options in the Czech medical system, and the experiences of some trans people began to be featured in newspapers and popular magazines (e.g. Bumbová 1994, Klausová 2001, Vodrážka 2001). Changes to the diagnostic practices of doctors and the shortening of the expected minimal length of the transition process from five and a half years to three years (Fifková et al. 2008) also affected the viability of medical transition. The original schema had trans people undergo various physical and psychological examinations in the first year, begin HRT in the second year, acquire the doctor's recommendation for a name change to neutral in the third year, and only then be able to set an appointment with the regulatory body approving transition-related surgeries. A name change to an explicitly gendered one in accordance with the person's identified gender was only possible in the fifth year, after undergoing sterilization surgery (Fifková et al. 2008).

Attempts to measure trans people's bodily dimensions to determine their "suitability" for transition were gradually abandoned. Additionally, the concept of transsexuality as a brain disorder shifted to instead signify a long-term unchanging identification with the "opposite" gender from the one assigned at birth (Dvořáčková 2008). Other abusive techniques of "measuring" transsexuality, such as the plethysmograph, which attempted to gauge the supposed arousal of trans people while being shown erotic footage featuring different sexualities as a "proof" of their trans identity, have also gradually fallen out of favour as a mainstream practice.[4] Based on available information, the ethically dubious practice of archiving naked photographs of trans people has likewise lost widespread support.

As recently as the 1990s, those trans people who began their transition after having children were forced to give up their parental rights. Transition, particularly when including surgery for the purposes of gender recognition, was associated with "traumatizing" the children. Leaving the family altogether was recommended by some doctors as a desirable outcome, arguing from the assumption that the presence of a transitioning parent would be detrimental to a child's gender identity. One of the sexologists who rejected this notion was Hana Fifková, asserting that a person's transition has no direct influence on their child, but that the child should be encouraged to develop an understanding of what is happening. With adequate communication from the parent(s), there is no reason to think that a trans person's child would be more likely to experience trauma than children whose parents break up and fall out of touch (Fifková et al. 2008).

It was because of her contribution to a large extent that trans people are nowadays in principle allowed to continue to care for their children after gender recognition.

A number of trans people who gave up the prescribed transition trajectory before 1989, be it for family reasons or due to their negative experiences with the behaviour of certain doctors (Spencerová 2003), have opted to start transitioning more recently.

3 The term "transsexual" has historically been written into the standards of health care in the Czech Republic; it is not the umbrella term for the purposes of this report, but is used where contextual.

4 Tereza Spencerová describes her experience with this examination in her book Jsem tranďák! *(I'm Trans!)*.

HEALTH CARE CURRENTLY AVAILABLE TO TRANS PEOPLE

Trans people are able to choose which sexologist's practice to attend when seeking assistance with medical transition. The given sexologist is then expected to guide them through the transition process. It is possible to switch providers during the transition process if their mutual cooperation doesn't suit them. But it is not a frequent practice as interviews with participants indicate.

The standard transition path according to Czech sexology is divided into the following sections: diagnosis, the decision process, Real Life Test (RLT), HRT, surgical intervention(s), and the post-operative phase (Fifková et al. 2008). There is no predetermined length of the each phase according to individual needs of individual trans person. The only set term is that the duration of HRT must be at least one year before an appointment with the surgery-approving committee (Fifková et al. 2008). Some trans people undertake every phase as soon as possible, totalling up to around three years; for others, these steps are spread across many years.

In the following chapters based on 17 semi-structured interviews with trans people living in the Czech Republic. I will focus on questions: Have trans people encountered obstacles with health care? What has characterized these obstacles? Do they perceive any negatives in the current system of trans health care? I will engage in the theme of accessibility and inaccessibility of health care for trans people and difficulties they contended with. These chapters do not have ambition to evaluate trans health care in the Czech Republic as whole. It only attempts to point out particular aspects and propose some suggestions for improving the quality of already existing quality health care.

THE IN/ACCESSIBILITY OF TRANS HEALTH CARE

MtF and FtM transsexual people [as labelled in the literature] who opt for the "standard" transition process (and whose health allows them to undergo it) typically face few structural obstacles in the Czech legal system when pursuing their transition, as Czech medicine is relatively welcoming of their situation. They have the option of choosing their primary sexologist, as well as any surgeon(s) for their transition procedure(s). Individual consultation by a sexologist, group therapy sessions supervised by doctors, and endocrinological as well as other initial health check-ups are all covered by public health insurance. Basic transition-related surgeries are also covered in both the cases of FtM and MtF transsexual people, which in itself is a major positive of the Czech medical system.

The FtM and MtF transsexual people opting for this transition path we interviewed had a largely positive experience of the medical system. They tended towards overall satisfaction with their cooperation with sexologists. Not all of these participants had undergone surgery at the time of the interviews, so only some addressed this issue from experience directly.

To those trans people who identify as transgender, genderqueer, nonbinary, queer or otherwise express gender fluidity, the health care system is not so open. If they do not wish to align with the medical definition of transsexuality yet wish to obtain any of the transition-related body modifications, their situation becomes quite precarious. In order to benefit from public health insurance for surgery as approved by the committee they must first nominally accept the F64.0 transsexuality diagnosis. Even when willing to pay out of pocket, one nonbinary genderqueer participant reported being denied top surgery by Czech doctors. Even those doctors who accept transgender, genderqueer and nonbinary identities find themselves unable to refer their client for surgery, as it would not be covered from health insurance without the committee's stamp of approval. One genderqueer person reported being taken as far as the operating table several times on recommendation from their doctor, then always having the surgery cancelled on these grounds. Eventually the person opted for surgery abroad, but the conditions were extremely unsatisfactory; for instance, there was no standardized post-operative care. The person simply moved to a hotel immediately after surgery, where the surgeon involved performed occasional health check-ups; only severe complications would have resulted in their admission back into hospital. When, after returning to the Czech Republic, the person sought medical assistance for amending the results of their surgery, they were immediately offered a revision without a single demand for the committee's consent as had been the case before.

Our interviews have also reported that not all sexologists offer sustained long-term support to transgender, genderqueer and nonbinary people. This leaves especially those who are not interested in surgery yet would welcome general consultations and/or HRT in limbo.

CENTRALIZATION OF THE SURGERY COMMITTEE

Historically, the regulatory bodies/committees approving transition-related surgeries were based locally in regional hospitals. The Act No. 373/2011 Coll., on specific health services, paragraph 22, has instead established a central committee run by the Ministry of Health. Participants' experience indicated that the introduction of the central committee has limited or completely closed down alternative options through which trans people could bypass health care system without having to undergo „standard" transition.

On the other hand, some other participants' experience with this new committee was positive in that they were not asked invasive questions (such as to describe their sexual practices in detail). They rated the committee members' behaviour as respectful and welcoming.

> Well, the committee, the people were quite decent, quite welcoming, they only asked me a few questions. They asked what I'd been through, if there were complications or not. If I'm aware of all the things that can potentially happen. *(Karolína)*

> Their behaviour was appropriate, the communication beforehand was very good, for example the Ministry people were respectful and polite and the committee itself, it felt a bit formal to me really. But all the people there acted appropriately, I just answered a few questions and that was it. *(Karel)*

Trans people wishing to access HRT do not have to make an appointment with the central committee. In the past, one medical practice required them to be seen by the local committee before prescribing HRT, but this was not an explicit legal requirement that would have been universally adhered to.

Nevertheless, the existence of the committee by itself was considered to be problematic by some participants. It was humiliating for them to have to appear in front of the committee and defend their identity in front of group of doctors and lawyers, some of whom they were meeting for the first time. They asserted that the committee was redundant when they cooperated with a sexologist in the long term.

A number of participants were also critical of the whole premise of the Czech health care system and its treatment of trans people. They highlighted their impression that the current system forces people into undergoing transition only in the prescribed way.

> The whole system is an obstacle, or not obstacle, but it is set up so that you have to conform and correspond to those things they set out for you, otherwise you have no chance of getting what you want. *(Robert)*

> I have a huge problem with the idea that it has to be a process, as if I'm becoming something or someone across from who or what I used to be, that it has these two extremes and I just can't be anywhere in between. And I get it clearly told what I must do, in order to be on the so called other side. That seemed seriously limiting to me. *(Matouš)*

In the "standard" transition model, it is expected for the person to "cross" from point A to point B (from male to female or vice versa). There is little room for other options. Only some particulars can be negotiated with doctors or sexologists on an individual basis.

COOPERATION WITH SEXOLOGISTS

A significant number of participants did have positive comments about their cooperation with the sexologists who have facilitated their transition process. In these cases, the sexologists' role was described as professional, welcoming and supportive. Some felt a debt of gratitude to their provider for assisting them in difficult situations.

> I can't say anything bad about [the sexologist]. For one "they"[5] saved my life, and for another thing, I saw "them" get into some precarious situations and always resolve them psychologically with professionalism. *(Karolína)*

> I'm seeing [the sexologist] and I think it was a very good choice, very good choice. […] They [the sexologist and psychiatrist] reacted very quickly. Very quickly. Professionally and quickly. But especially professionally.
>
> Interviewer: What was the professionalism about?
>
> I think in their attitude and in their understanding and analysis, relatively quick understanding of what was going on and to what degree. *(Lucie)*

Participants who had encountered an individualized attitude from their sexologist or other doctor were appreciative of how their situation and changing needs were addressed – both in terms of the actual transition process and its length, and in terms of psychological support.

> If you tell [the sexologist] that you just don't know, "they" suggest some options and that helped me. […] Actually, I was there with my mother that time, and "they" really stuck up for me. My mum was constantly giving arguments like, "All right, but what about the parents, what will people think about them with a child like this?" And to that, "they" said," But what about the child?" And mum retorted, "What about the parents?" And there "they" went again, "What about the child", like, it's their life. *(Jindra)*

> As far as [the sexologist the participant switched to after two others] is concerned, "they" never forced me into anything, "they" said, "You do what you want, I'll give you the hormones." […] There wasn't any coercion there, especially not on his part, his attitude was basically you do whatever suits you. All [the sexologist] did was make it possible. *(David)*

It was not always the case that trans people would find their ideal health care provider on the first try. Some participants, including those identifying as transsexual, had a negative experience with sexologists from before 1989 or from the early 1990s, and they did not seek medical assistance again until many years later. Separately from this, some transgender, genderqueer and nonbinary participants were still looking for a sexologist with whom they could adequately cooperate.

As has been outlined above, people identifying as transgender, genderqueer, nonbinary or

5 Expression „they" is used in quotations to increase anonymity of doctors.

otherwise gender-nonconforming more often face sexologists' unwillingness to provide long-term support. One possible reason is the oversubscribed character of trans health care in the Czech Republic, causing some sexologists to prefer working with trans people wishing to follow the "standard" transition path. However, some other sexologists, despite high client numbers, do cooperate with gender nonconforming trans people, so it would be oversimplifying to claim that being oversubscribed is the only reason some sexologists reject such clients.

THE CAPACITY AND CONTINUED PROFESSIONAL DEVELOPMENT OF HEALTH CARE PROVIDERS

Doctors and other health professionals are routinely oversubscribed and overworked in the present health care system. Their continued professional development in the field of trans issues has no systematic support or core curriculum. They often lack the time or financial means to be involved with trans-related developments in the international context, meaning there are no incentives aside from each individual practitioner's interest and capacity to develop their expertise in this area.

Participants often highlighted long waiting times complemented by short, formal consultations:

> When I first came to Prague, I got lost and struggled to find the place. I arrived ten minutes late, which is just about testing [the sexologist's] tolerance, since the consultations take some fifteen, twenty minutes max. So I got there late, there wasn't much time, and most of all [the sexologist] had no idea who I was and what was up. "They" sat me down and asked me some things and what "they" can do for me. So I said, I sent "them" such a long email and "they" wrote back for me to call. I had waited quite long for this appointment, I'd called "them" in September or so and only got through sometime after the New Year, in January. *(Matouš)*

On the other hand, when there was an urgent matter to attend to, health professionals usually carried out the procedure quickly. Some participants remarked that they would have welcomed more time dedicated to them by surgeons, along with an explanation of what was to be done in greater detail:

> [The surgeon] did a very good job – if I were to complain about anything, it would be that "they" could have explained it better in advance. The doctors don't talk to you that way, like I don't know, showing you a picture and saying, "We'll do that." They expect you to read up on that somewhere, or something. And actually the appointment beforehand was so short, I don't know, ten minutes. "They" told me to take off my T-shirt and said well, that's obvious then. So I approximately knew what was involved, but I didn't have a closer idea. They didn't explain to me as a layman, "We'll use such and such method, and then it's going to look like this." If I hadn't read up on it before, I would've had no idea. *(Karel)*

Additionally, the ongoing strain on health care professionals can, together with the lack of systematic education on trans issues, complicate their communication with trans people. The fact that trans people are often addressed by legal names and pronouns without confirming their identification with them may not always express health professionals' unwillingness to be inclusive, but also simply their lacking information on recommended practices.

MISGENDERING AND DISRESPECT OF NAMES

Most trans people view it as important that others refer to them in their identified gender, expressing respect of their identity. In the health care system, participants have often encountered doctors and other staff using their original legal names and the associated gender markers. This problem may be exacerbated in hospitals and other health care institutions by the staff not communicating all the information amongst themselves and/or not ascertaining each person's pronouns in the first place.

> And there's also the problem that all the staff there constantly rotates, so if you want to make sure that everyone knows, you're going be coming out over and over. [The doctor] didn't write it down anywhere, didn't record it, or the information just didn't spread in any official way, so it was the same thing over and over. The day shift was four different nurses, the night shift was four different nurses, then you have all the psychologists, therapists, add to that the doctors, then you might want to go to yoga or to the gym or to art therapy and you just keep telling them, and 90% of them will just totally ignore it. *(Vil)*

Repeated coming out during inpatient treatment can be not only stressful, but also degrading. Participants indicate that trans people would have preferred being asked about their pronouns and the name that they went by; that is, doctors and staff should give trans people space to identify themselves and avoid labelling trans people based on their (usually misgendering) identity documents alone.

THE OBJECTIFICATION OF TRANS PEOPLE

Doctors' and health professionals' attitudes to trans people are varied. It cannot even be generalized that those who deal with trans people more frequently would automatically be more accepting.

> The endocrinologist is a great person, very conscientious. Both the endocrinologist and the nurse, perfectly professional behaviour. So that worked out great. With other doctors, I've just been to an appointment, I went to book my surgery already. At [the hospital] I feel like it's a worse attitude than at the bank. Because they don't tell you anything, it's just here sign this, sign that. They tell you nothing and treat you like a piece of meat. *(Karolína)*

It is a question to what extent the attitude encountered by this participant was due to her gender identity or an example of hospital routine and long term overwork of health care staff. Regardless, the participant has been objectified by this attitude. She would have preferred being approached as a subject by health professionals, with respect and openness.

Objectification can also take on more obviously dehumanizing characteristics, such as trans people being referred to as "it" or "what" instead of "who". Participants have reported statements such as "What is it that has just arrived?" in direct reference to themselves. In addition, objectification can also take the form of exoticizing trans bodies and treating body parts that do not conform to cisgender standards as a curiosity.

> For instance, there were medical students doing their practicals. They had a look at my legs [the participant was being hospitalized due to leg problems]. The doctor asked me in front of them whether they could have a look at my chest. I said no. I just felt an increased interest in the atypical parts of my body. *(Vil)*

A different form of objectification is the refusal to let trans people decide which pre- and post-operative ward they will be staying in. A common practice is to accommodate them in an ensuite room (*nadstandard*), which can be financially prohibitive.

> I don't want an ensuite room. And they're like: "Well, but you can't be at a gynaecological ward with the other patients." I asked them, "Is there no other room? Who says it has to be a gynaecological ward, I could stay at a general surgery one, I'm not fussed. Nobody will care who I am at the operating table, and afterwards, as long as it's not a storage room, you can sort me wherever you want, I don't insist on gynaecology." And they just go: "We can't do that, and whatnot." I said, "What you can't do is make me pay for a suite I don't want. A suite should be on request." "But you look like a man!" I say, "I don't know, we're talking over the phone, so how do you know what I look like." *(Matouš)*

Visiting a clinical psychologist, whose role in the prescribed transition path is to approve the F64.0 diagnosis first suggested by a sexologist, has also constituted an experience of objectification to a significant number of the participants. This applied both to the way these trans people were treated and to the contents of the psychologist's claims. The interviews have shown that patronizing behaviour was no exception on the part of

the psychologist. Another common trend was the attempt to fit trans person into a rigid framework of categories related both to gender and to sexuality (for example more than one person reported that the psychologist would not accept them identifying as bisexual, pressuring them into a gay/lesbian or heterosexual category). One of the participants summarizes the general attitude thus:

> To many of [the psychologist's] questions I just answered, after he asked is this black or white, I said grey. No. It's either black or white, so just choose. That really annoyed me, and after that I started answering with what he wanted to hear, just so he could tick off each box as "yes" or "no". *(Jindra)*

Our interviews suggest that the aim of the consultations has been less to understand each individual trans person's identity and more to fit their gender and sexuality into predetermined categories. For trans people seeking medical transition in the Czech Republic, the psychologist's consultation is currently more or less an inevitable step. In such a context, it is no surprise that some trans people tailor certain answers in order to "pass" the normative test and be allowed to proceed.

INTERDISCIPLINARY COOPERATION AMONG HEALTH PROFESSIONALS

Psychiatrists, psychologists and sexologists emerge as the most closely connected professions in the field of trans health care. It is common for trans people who are questioning their gender identity, are unsure of their feelings, or experiencing mental distress to seek a psychologist or psychiatrist in the first instance. For this reason, psychologists' and psychiatrists' familiarity with trans issues is paramount, along with the ability to react appropriately to the trans person's needs, including a referral to a sexologist if desirable. Those of our participants who had accessed transition this way rated psychiatrists' attitude positively in being guided to a sexologist.

> In the beginning I just went to a regular psychiatrist who didn't specialize in this in any way, and I was really lucky because this was back when I still had no idea myself. So I went there saying I was depressed and so on. And I mentioned this [gender identity] towards the very end of the session, when "they" was already shaking my hand goodbye. […] I had no idea what to expect, if [the psychiatrist] was going to send me to a mental hospital or what. But "they" acted amazing in that "they" instantly gave me the contact details for [the sexologist] and told me what to do. "They" were the first who started treating me like I wanted. So that was really great. *(Jindra)*

> I had a psychiatrist who already knew back then [before the participant decided to transition], I still see [the psychiatrist] now. […] "They" helped me quite a lot. It was actually "them" who told me to seek this kind of help and asked around "their" colleagues and they recommended me to see the sexologist. *(Lucie)*

In both cases, trans people were referred to the same high-profile sexologist. It should be a point for consideration whether to always recommend the same health care provider or whether to allow trans people to make the initial choice by presenting them with several options.

CLOSING RECOMMENDATIONS

Doctors' and other health professionals' awareness of trans issues should be developed, which would improve the quality of their communication with trans people as well as the quality of the health care provided. Respect of trans people should be practised, including the consistent use of each person's identified pronouns, name, and other gendered language. Health professionals should always confirm what gender a person identifies with and avoid automatic gendering on the basis of original legal gender documents such as an ID card.

Doctors, other health professionals and medical students should receive systematic support in continued professional development regarding trans issues. They should also observe international developments in this field and be aware of major documents detailing the ethics of trans health, such as the updated WPATH *Standards of Care*.

Transition-related health care and/or surgical procedures should also be accessible, if desired, to those trans people who do not identify as transsexual but e.g. as transgender, genderqueer, nonbinary, etc.

While in hospital, trans people should be able to decide what ward to be placed in, based on their comfort with that particular gendered space (such as a men's or a women's pre- or post-operative ward). Hospitals should not place trans people in a higher-cost separate room without prior consent.

TRANS HEALTH CARE AT INTERSECTIONS WITH THE LEGAL SYSTEM

ALEX LORENZU

The presence and codification of various gatekeeping practices in the Czech Republic makes it necessary to also examine the legal system in conjunction with health care. The major legal steps in the gender recognition process, particularly name change(s), the treatment of a trans person's marriage or civil union, and the legal gender marker itself are tied to medical interventions, specifically sterilization surgery. Sterilization surgery itself takes at least a year of HRT as its prerequisite, which in turn is premised on psychological testing and consultations with a sexologist. In order to obtain legal gender recognition, it is expected that a person will navigate the health care system first, putting both systems in close mutual cooperation. Simultaneously, the presumed link between particular medical interventions and gender recognition reinforces the idea that gender is determined by physical traits and that these traits should be policed according to an arbitrary standard set out in normative medical texts. This outlook is couched in pathologization as its primary source of legitimization, not giving space to potential arguments from a human rights perspective or from social constructivism, which would challenge the notion of a uniform and universal "gendered body" as a basis for legal recognition or indeed for one's treatment in society as a whole.

Where criticism appears in our interview sample, it is most commonly aimed at the three pillars of the current standard for medical and legal transition in the Czech Republic: naming conventions, compulsory sterilization, and the dissolution of marriage or a civil union as a prerequisite of gender recognition. Those participants who addressed these issues conceptualized them clearly as a human rights violation and a double standard that targets trans people specifically.

CRITICISMS OF NAMING CONVENTIONS

In the Czech Republic, naming conventions are currently based on birth-assigned gender to a large extent, which makes trans people particularly noticeable for e.g. having a different appearance from what is socially expected on the basis of their assigned name. Czech naming conventions are rigorously and explicitly policed in laws, such as the Name Register Act (*Matriční zákon 312/2013 Sb.*), not only in relation to trans people, but also in the legal definition of "feminine surnames" as derived from and secondary to their base forms (termed "masculine"), or in the demand to provide independent linguistic reviews for names that are considered not to exist in Czech. There is thus a clear imperative expressed by such laws to render society linguistically homogeneous and easily categorizable along perceived gender lines.

Since names are defined as "feminine" and "masculine" in the law and it is expressly prohibited for individuals categorized as male to have "feminine" names and vice versa, trans people are immediately "outed" by their legal names prior to name change and/or gender recognition. As a supposed compromise, Czech law now allows a person to change their name to an explicitly gender-neutral one even without undergoing sterilization; however, this does not address the fact that those trans people who identify as a binary gender will still wish to have a name that immediately corresponds with this and feel de-gendered by being made to choose neutral. There is also the assumption that trans people will automatically go through not one, but two name changes, creating unnecessary stress around paperwork and further eroding trans people's identities next to those of their cisgender counterparts, which are deemed inviolable by comparison.

Unlike most of the other areas of inquiry in our interviews, there was a virtually unanimous consensus that linguistically enforcing gender neutrality on *all* trans people by default in order to preserve an arbitrary naming system was detrimental. Among the group which did not have significant problems with medical transition requirements as such, the only common criticisms were that a woman (or a man) should be named clearly and that imposing a gender-neutral name was an infringement on their right to identify as they saw fit. Among the more "activist" group that proposed further changes to the present system, the focus was on the human rights aspect of prescribing particular naming practices to trans people and on the impossibility to choose a gender-neutral name without negotiating systemic coercion around naming.

> No, [I wouldn't take] a neutral name after gender recognition. I'm not even sure what my name is right now. I picked a name, argued with the lady registering them, then she let me have it. But I'm certainly not going to change my name fifty times, because that's counterproductive. *(David)*

CRITICISMS OF COMPULSORY STERILIZATION

Those trans people who are critical of sterilization as a requirement for gender recognition speak from two broad perspectives. There is a "general human rights" perspective, which focuses on the principle of the current legislation and highlights the double standard it subjects trans people to. In our interviews, it has been expressed by the majority of trans people who have not undergone sterilization surgery and by some of those who have. Contrary to the sexological discourse, there was not a universal rejection of the idea of giving birth among participants designated female at birth; one person had done so in the past before being sterilized and another would have considered it if sterilization had not been the only way to obtain gender recognition. Neither participant felt that this interfered with their identity and both expressed confidence in their life trajectory.

The eugenic character of denying specifically trans people reproduction was often brought up by participants who considered starting a family using their reproductive function, but the sterilization requirement and/or other legal obstacles prevented them from doing so. This again goes against the categorizing stereotype that no trans people would ever opt to have genetic children. In fact, the below participants felt that they or others around them were being deprived of a choice that they should have had a right to make.

> The other operation [hysterectomy] was really only because of my documents. Now I'm sorry I did it, in a way. For instance we're trying for a baby, my wife hasn't been able to get pregnant. I'm just thinking: you know, if only I had these organs, I might have been able to have the baby myself and now I can't, because I don't have them. And you know, it's kind of unfair that you shouldn't be allowed to reproduce. *(Roman)*

> I'd like to know what the legal situation would be, if say an MtF who had some sample of her sperm frozen before transition, if she wanted to be a donor for someone else and so the donor would be a woman. I have no idea how they'd deal with that in documents, if this is possible or not, if it's some sort of grey area. *(Vendula)*

The issue of human rights being at odds with compulsory sterilization and divorce was a frequent theme. There was a strong consciousness among some trans people of the arbitrariness of this requirement and of the fact that it personally limited their life choices, both in the context of health and more broadly. Activist-minded participants also spoke about the overall context of the Czech Republic as the "sterilization capital" of the EU and how the measures being implemented by the Czech state prioritize giving the impression of consent to radically challenging the present system.

> And this [new] nationwide committee […] is so that the Czech Republic can say why there are so many people undergoing sterilization and castration every year. Because we have the highest number in the EU, so all the people who see the committee and have the surgery, they're the ones who are voluntary. So the Czech Republic can say that all these numbers, these are voluntary sterilizations, castrations, which isn't entirely true. We're not doing them voluntarily, we're doing them

because there's no other choice. But on the surface, it looks voluntary. *(Roman)*

Sterilization should definitely not be necessary, or tied to some legislation – it should be voluntarily done on request. Castration applies here too, sterilization, castration. As for modifying the genitals, definitely not, don't touch. For the state to decide what I have between my legs, they have to be insane. […] No, definitely not, definite no to sterilization, no to forced sex modification. All that has to be on request. If someone wants these things, that's fine. If someone doesn't, don't make them. Don't make them. *(David)*

Alarmingly considering that surgical sterilization is a mandatory procedure for gender recognition, our comparatively small sample has contained mentions of malpractice and negligence during these surgeries. One participant reported sharing the hospital room with another trans woman who suffered from inadequate post-operative care in the presence of complications. Another participant reported directly experiencing a major complication after his sterilization surgery that was not acknowledged as a mistake by the hospital staff or awarded any sort of compensation. Victim-blaming together with a lack of accountability on the part of the health professionals were characteristic of this experience:

> But the next day they found out they forgot the gauze in me, this nice two-metre bit. Then I was the one who was considered a troublemaker, because they found out a few things had gone wrong and so it was me who was bad, not them, even though they had fleas in the ward and forgot something in me after surgery. So they took it as me being the one who annoys them, who complains. Only I wasn't complaining, I didn't ask anything of anyone, I just wanted to be out of there. Oh, and then they also forgot to book the ambulance for me, which I had been assigned. Because they refused to let me leave by train, I took six hours to travel home, if I had known that, someone would have picked me up by car. Instead I dragged a heavy bag home on a six-hour journey with a suspended train, and so on and so forth. For me, hysterectomy is something I'd like to forget altogether. *(David)*

Clearly, requiring certain medical procedures does not guarantee that they will be safe, respectfully done with minimized negligence, and that medical professionals will be held accountable for not adhering to proper practices. While there is not enough context in the interview alone to ascertain the reason for the malpractice, transphobia could certainly constitute a contributing or even the main factor to receiving subpar health care and cannot be ruled out.

In addition to cases of negligence leading to personal injury, some participants also reported being excluded from the ward for their gender and made to pay an additional fee for ensuite accommodation for their stay in hospital. Class and wealth disparity become a problem in their own right for trans people seeking various types of surgery, as the burden of paying for this enforced segregated accommodation is on trans people, who as a group already face substantial obstacles in employment and other areas. In addition, there is a complete de-gendering taking place in these instances, as the trans person is deemed unfit to share a room either with people of the same gender assigned at birth or with people of the same identified gender. The only "solution" offered by hospitals that place trans people in single accommodation against their will is exclusion, furthering the stigmatization of trans people in health care and in society.

As the above example suggests, criticisms of sterilization as such have been a mix of objections on principle and on the basis of individual hurt in the interviews. Many participants highlighted the link between sterilization as a means to gender recognition and the role it played in their (coerced) decision to undergo sterilization surgery. It should be noted that although according to the Czech state, transition-related sterilizations are classified as voluntary, the regulatory bodies overseeing them (such as the current centralized committee with the power to approve or veto transition-related surgeries, including sterilization procedures) do not have the insights to judge whether all of the surgeries truly are free of coercion, considering the power differential present in the situation and the systemic repercussions felt by trans people who do not undergo sterilization for the purposes of gender recognition. Two of the participants who have undergone sterilization remark that it was done primarily, if not only, for the sake of gender recognition, and that if their documentation along with the attendant discrimination had not been at stake, they would not have opted to be sterilized.

> The only thing I can say I delayed for two years, I delayed sterilization, and I felt a bit of pressure [from the doctor] as if I should want it, because what am I going to use these organs for, I'll have better facial hair afterwards, these are some of the things he said. And he probably took it as some expression of manhood, or an expression that I really wanted to be the opposite gender, or I felt it as this pressure to prove, by having this surgery, that I really want to transition and to finish it. Another surgery [aside from sterilization] wasn't necessary by him, but the pressure was there and it's a fact that after those two years I realized just how hard it was in many ways with the [ID] documents I had. So I had the [sterilization] surgery. But it was more for this reason, not because I would intrinsically feel I wanted these organs gone. […]
>
> No. I wouldn't have it [sterilization surgery] done. Maybe if I had health problems, as they say, but that is again only if. I still have a vagina anyway, something [health-related] could still happen to that, but I definitely wouldn't do it voluntarily. *(Roman)*
>
> It's total nonsense to legally prescribe that I have to have a hysterectomy, because that will make me a man. It's totally bogus, it's not going to change my chromosomal makeup, it is just nonsense of the highest order. Unfortunately it's dictated to us. […] I won't get the [correct] documents otherwise. It's not voluntary, I didn't feel I needed to have a hysterectomy, it went against my feelings, I don't agree with it. *(David)*

These examples demonstrate that the definition of "voluntary" as employed by prescriptive medical and legal discourses does not engage with these silently occurring scenarios of trans people consciously opting for sterilization only because

it is the only way to lessen their discrimination based on mismatched identity documents. Due to the power that gatekeepers wield in the Czech medico-legal establishment, it is not likely that a trans person asked at the time of application to the committee whether they would have opted for sterilization had it not been a prerequisite of gender recognition would feel safe enough to answer honestly, even if, as is the case with the two participants quoted above, this were the case. The patronizing nature of having to be assessed by a regulatory body before having medical procedures was often commented on by participants who disagreed with its general principle, regardless of the committee members' behaviour. There is thus a troubling opacity between voluntary and coerced decisions under the current system, which we believe will not be removed until sterilization (along with any other surgery) is made optional and not the only way to obtain legal gender recognition.

Participants who articulated criticisms of sterilization in general were also critical of the way it is currently carried out administratively in the Czech Republic, having to "pass" before a regulatory committee. To some participants this added yet another layer of being out of control of their own lives and served as an additional reminder of their body autonomy being disregarded.

> To me, the committee is useless, of course. I think it would be enough, if you're going [to a specialist] somewhere who assists you and knows what you're like and what you want, then why not make it possible that way. Why do you have to face some committee – it seems pointless to me and kind of degrading. To answer these people you barely know all these things they ask, sometimes pretty intimate. Why do you have to go through it all, it's completely pointless. *(Roman)*

> I'm not happy with the fact that the committee is sometimes useless. In a way, it's really degrading. […] I don't see why strangers should decide what I want or not. *(Patrik)*

TRANS IDENTITIES IN PERSPECTIVE

The research has shown that despite a widely standardized sexological narrative centered around a notion of "true transsexuality" or a "typical transition", there is a great variety in the identities articulated by Czech trans people and their associated goals. The less participants identified with the medical definition of transsexuality as a diagnosis and as a set of gender-normative characteristics, the more constrained they tended to feel by the "standard" transition model and the more likely they were to posit human rights and/or identity politics as a key concern in the discussion. On the other hand, trans people who felt more in line with the normative conceptualization of their trans status and whose transition goals, whether achieved or planned, corresponded with the trajectory delineated by medicine were less likely to explicitly criticize the current system and often cited concerns about transition expenses being struck from public health insurance if there were any reforms to the current system. Each group's concerns and ideal outcomes vary, as do each individual person's, but we have identified a need for change expressed in no uncertain terms by at least some trans people who would undoubtedly be helped by having any personally invasive requirements lifted off their shoulders (while still remaining an option for those who genuinely wished to undergo any of the currently compulsory treatments voluntarily). There was considerable support for abolishing the mandatory gender neutral name during transition, for allowing trans people to remain in their marriage or civil union if desired by both parties, and for making gender markers less prominent in documents as a middle-ground measure to alleviate systematic misgendering without drawing attention to only trans people in particular as is the case in the current application of gender-neutral designators in Czech names.

Often, trans people are penalized both for their birth-assigned gender and for their identified one, such as when being deemed unfit for both female and male wards in hospitals; neither their legal gender nor their gender identity are seen as being sufficient to accommodate them alongside others. Stereotypical associations with appearance are also often invoked as a way to delegitimize trans people, and normative expectations for taking particular steps in transition in a particular are commonplace. The dominant attitude towards trans identities is to perceive them as negative and in need of standardized treatments, often disregarding lived experience or individual preferences and goals.

A common problem is the medical establishment's drive to strictly categorize each trans person, both in terms of gender as male or female and in terms of sexuality as purely gay/lesbian or heterosexual. The attitude has been identified by many trans people dealing with sexologists and psychologists, leading to a further erasure of nonbinary gender and sexual identities, which is additionally fuelled by the unequal relationship between trans people and health care providers, leading many to strategically choose the expected answers so as to be able to access transition. This results in a distorted impression of overly simplistic and universalized gender/sexual identities that on the surface do not disrupt the long-held totalizing and often stereotypical frameworks employed by the medical discourse as well as by the popular imagination, although in reality many trans people do feel constrained by them.

CLOSING RECOMMENDATIONS

Trans people should be given the space to articulate their identity on their own terms, without being made to fit categories that they would not personally use for self-description. Priority should be placed on respecting and understanding each trans person as an individual, and special attention should be devoted to the inclusion of non-binary gender and sexual identities with a clear message that trans people will not be discriminated or denied resources on the basis of identifying outside a strictly binary gender system.

Medical transition should not be treated as a prerequisite of having a valid trans identity, and even within the realm of medical transition, it should be acknowledged that multiple options exist rather than a single normative trajectory.

No medical treatment or procedure, including but not limited to HRT, top surgery, surgical or non-surgical sterilization, or genital surgery should be a prerequisite of legal gender recognition.

Trans people should enjoy open options in choosing a name to identify with, without a gender-neutral form being mandatory even for those who would prefer a clearly masculine or feminine form.

The option to undergo any treatments including HRT and/or transition surgeries should remain recognized as medically necessary for those trans people who wish to undergo them, preserving the current funding situation. Choosing to undergo one treatment (e.g. HRT) should however not be taken as automatic consent to other treatment (e.g. any surgery unless desired by the individual). HRT and surgeries should be accessible on the basis that every person has the right to make choices about their health and to be supported in these choices, rather than making funding contingent upon the definition of trans status as a disorder. It should be noted that a condition does not have to be classified as an illness to receive financial assistance from the state. (For example, pregnancy, childbirth, parental leave and child benefits are all related to the medical sector and not classified as pathological in order to be eligible for assistance; the fact that they receive financial support is based on the value placed on them by society/the state. The same principle can apply to bodily self-determination in general.) The question of accessing specific treatments should be also judged separately from the question of gender recognition.

The Czech Republic should closely observe international developments that tend towards the depathologization of trans identities in the medical field (actively endorsed by the medical organization WPATH), and towards making legal gender recognition contingent on self-identification rather than on approval by a regulatory body or on any particular medical procedure in the legal field.

BIBLIOGRAPHY

Bumbová, Irena. 1994. „Transsexualita je porucha, kterou lze léčit poměrně úspěšně. *Zdravotnické noviny*. VIIL (44): 4.

Coleman, Eli; et al. *WPATH Standards of Care, Version 7. International Journal of Transgenderism, Vol. 13*. London: Routledge, 2011. 165-232.

Dvořáčková, Jana. 2008. „Diagnóza F 64.0: Transsexualita optikou sexuologie". *Sociální studia, Vol. 1/2008*, Brno: FSS MU, 55-75.

Fifková, H., P. Weiss, I. Procházka, L. Jarolín, J. Veselý, V. Weiss. 2002. *Transsexualita: diagnostika a léčba*. Praha: Grada.

Fifková, H., P. Weiss, I. Procházka, L. Jarolín, J. Veselý, P.T. Cohen–Kettenis,V. Weiss, F. Pfaffilin, P. Marešová, B. Sehnal, P. Paulin, O. Pechová, V. Reichlová. 2008. *Transsexualita a jiné poruchy pohlavní identity*. Praha: Grada.

Hynie, Josef. 1974. *Základy sexuologie*. Praha: Univerzita Karlova.

Klausová, Kamila. 2001. „Kouzelnice s pohlavími: sexuoložka Růžena Hajnová pomohla změnit identitu dvěma stovkám osob". *Týden. VIII (8)*: 44- 47.

Němec, Robert. 1993. Monika Němcová, Míla Němců, Robert Němec: biografie muže, který byl ženou. Praha: Cassandra.

Pullmann, Michal. 2011. *Konec experimentu: Přestavba a pád komunismu v Československu.* Praha: Scriptorium.

Raboch, Jan. 1984. Lékařská sexuologie. Praha: Univerzita Karlova.

Sokolová, Věra. "Identity Politics and the (B)Orders of Heterosexism: Lesbians, Gays and Feminists in the Czech Media after 1989". *Mediale Welten in Tschechien nach 1989: Genderprojektionen und Codes des Plebejismus.* Eds. Jiřina van Leuween and Nicole Richter. Munich: Kubon und Sagner, 2005. 29-44.

Spencerová, Tereza. 2003. *Jsem tranďák!* Praha.

Vodrážka, Mirek "Život mezi". *In Gender, rovné příležitosti a výzkum* 3:3/2001.

Working Group for the Issues of Sexual Minorities of the Minister for Human Rights and National Minorities. *Analysis of the Situation of Lesbian, Gay, Bisexual and Transgender Minority in the Czech Republic.* Prague: Office of the Government of the Czech Republic, 2007.

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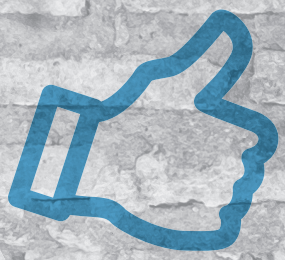

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