

Who Decides Whose Gender? Medico-legal classifications of sex and gender and their impact on transgendered South Africans' family rights

Thamar Klein

Despite the generally decreasing importance of a person's sex/gender for most legal matters in countries that seek to promote the equality of their citizens, sex/gender is still of crucial importance for a number of laws and institutions. This paper deals with the medico-legal aspects of family law, which relies on a binary sex/gender model. When it comes to family-building, for example, states regulate who may marry whom, who may have access to reproduction technologies, who may adopt children, and who gets child custody when families split up. Even those countries that afford (some) rights to same-sex couples generally distinguish legally between same-sex and opposite-sex marriages. The ability to make such distinctions presupposes the validity of at least two suppositions: first, that sex is unambiguous; and second, that there is a sex-binary. Both premises have, however, been severely questioned from both medical and social perspectives.

Medical anthropology strives to understand the social and cultural context of health and illness by examining conceptions of body, affliction, intervention and treatment. This paper deals exclusively with biomedicine (sometimes referred to as Western medicine) which is only one of the many forms of medical traditions practiced in South Africa. From a legal perspective, however, it is the most respected medical tradition¹. Biomedicine - like any other medical tradition - is a product of specific cultural assumptions, and the implementation of its technologies is influenced by not only medical but also by social and political interests. This paper's main focus therefore lies on the relation between biomedicine and law with regard to perceptions of trans* citizens' sex and gender, and the resulting implications for their family rights.

I use the term trans* for people, who have in common the fact that their gender identity differs from their assigned sex/gender at birth and/or challenges male-female dichotomies. The asterisk (*) marks a blank space for people with many dif-

ferent gender identities and sexual orientations. It is thought as an encompassing term and explicitly not used in order to impose any specific Western concept of transgenderism or transexuality on people who do not wish to be identified with it. Even though the term is also employed by Gender DynamiX (a South African non-governmental organization that offers services exclusively to trans* people), I must point out, that many trans* people might not apply this word to themselves. Therefore it should be read as a placeholder that constantly reminds us of the diversity of gender flexibility.

When analyzing the relation between biomedicine and law with regard to perceptions of trans* citizens' sex and gender, and the resulting implications for their family rights, I will pursue this topic by posing two questions:

What are the practices of classification and standardization of sex/gender with regard to trans* citizens? What impact do these practices have on trans* family rights?

Gender and Sex

Before discussing medico-legal interventions into transgendered citizens' family rights, it is first necessary to take a closer look at the line conventionally drawn between sex and gender in the English speaking parts of the world. This distinction was first developed in the 1950s by psychiatrists (e.g. Stoller 1968) working with intersexed² and trans* patients in order to distinguish between a person's sex and gender identity, and was then taken up by feminists. From the 1960s, sex began to be increasingly understood as being defined by biology/medicine, whereas gender was regarded rather as a cultural construct. From this perspective, sex came to be regarded as an objective scientific fact, and thus fixed. In contrast, gender was considered a fluid and variable category: the cultural or social interpretation of sex made visible, e.g. in the roles, behaviours, activities, and attributes that a particular society assigns to discriminate between the sexes. The significance of this distinction, as pointed out by feminist thinkers, was that gender expectations are cultural products, an insight that challenged the view that unequal social positions between men and women are somehow directly representative of, or 'caused by', their biology. This sex-gender distinction allowed feminist discourse to counter biological determinism and criticize gender inequality on the basis that biology is not destiny

(e.g. Rubin 1975, Unger 1979).

Since the 1980s this distinction has been massively questioned by poststructuralist feminist and queer theorists (e.g. Jaggar 1984, c1983, Haraway 1987, Butler 1990). Sex began to be understood, like gender, as a historical and social phenomenon, and as such a fluid, variable and constructed category. “Gender is not what culture created out of my body’s sex; rather, sex is what culture makes when it genders my body” (Wilchins in Monroe 2005: 29-30). The objectivity of scientific knowledge is questioned in that it is regarded as continually and inseparably linked to political and social forces.

“Science can never be and never was ‘objective’. [...] ‘Objective knowledge’ is an oxymoron”. (...) Science is the practice of systematic observation and experiment as a means to test predictions from hypotheses while reducing or eliminating (i.e., controlling) the effects of perceived and possible biases on results and conclusions. So, what it means to be self-consciously political is that one is thereby in a scientifically better position relative to those who are unaware of the political and social forces potentially affecting their science.” (Gowaty 1997: 14)

Scientific knowledge is co-produced by socio-political power relations. The situated knowledge of science has in the last 30 years occupied the focus not only of feminist and queer theorists’ work but also, and especially, that of Science and Technology Studies: “Knowledge and its material embodiments are at once products of social work and constitutive of forms of social life” (Jasanoff 2006: 2). The mathematical biophysicist and philosopher/historian of science Evelyn Fox-Keller has emphasized the influence of gender in science as well as the social construction of biological and medical science in her influential body of work (Keller 1995, c1985, Keller and Longino 1996, Keller 2010). She emphasizes that the scientific quest to understand nature is always embedded in a socially-constructed environment. Similar observations have been made in Brain Organization Studies (Jordan-Young 2011, c2010) and Neurosciences (Fine 2011).

Thus, when studying topics within medical anthropology such as the classification of sex and gender, it is inappropriate to detach a specific medical tradition from its cultural background. This implies that one should keep in mind the socio-political power relations inherent in (medical) infrastructures. Medical knowledge

is the outcome of specific historic cultural reasoning, as well as being constituent of and essential to it. Knowledge and social life forms prove to be interdependent. As classifications of sex and gender presuppose each other, in this text I reunite both in the single term sex/gender.

Classifications of Identity

Classification systems that are used to identify people are, first and foremost, political and social entities. They are not natural or objective objects, but become naturalized.

“As layers of classification system become enfolded into a working infrastructure, the original political intervention becomes more and more firmly entrenched. In many cases, this leads to a naturalization of the political category, through a process of convergence. It becomes taken for granted. (We are using the word naturalization advisedly here, since it is only through infrastructures that we can describe and manipulate nature.)” (Bowker and Star 2000, c1999: 196)

One such infamous system of classification in South Africa has been that of race under apartheid law. Even though racialized discrimination supposedly rested on biological facts, descent was ruled out as the determining factor. The official reason for this decision was technical problems, as birth and death registrations were insufficient and therefore the tracing of ancestry impracticable. A more likely reason, however, was the fact “that nearly all white South Africans had some traceable black African ancestry” (Bowker and Star 2000, c1999: 208) and that no unambiguous scientific system of race classification could be devised. Classification systems, as naturalized social constructs – especially those that are used to identify people – often lack impartiality in their implementation. Different classes within a classification system rarely denote differences between *pari passu* entities. More often they constitute a value-laden hierarchy.

“(...) since the middle of the nineteenth century, medical science has played an increasingly central role in defining everyday life. It has often been used for very conservative social purposes – ‘proving’ that black people are inferior to white people, or that females are inferior to

males. Medical practitioners and institutions have the social power to determine what is considered sick or healthy, normal or pathological, sane or insane – and thus, often, to transform potentially neutral forms of human difference into unjust and oppressive social hierarchies.”
(Stryker 2008: 36)

Indeed, inequality and power divides are habitually incorporated into such classification systems because they serve specific cultural and political purposes. “(...) power and knowledge directly imply one another; (...) there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (Foucault 1995: 27). Classification systems therefore repeatedly become the target of protest and social movements. One such system – apartheid – was successfully challenged by the South African people. In its aftermath sex, gender, and sexual orientation were also included in the 1996 Constitutions Equality Clause in an effort to highlight and promote the prevention of any form of discrimination. However, while race is today acknowledged to be a social construct, only used e.g. in forensic anthropology or biomedical research to make distinctions between fuzzy sets of traits (traits that have only degrees of membership), the same perspective with regard to sex is only inching towards general acceptance.

Medical and legal classifications of sex/gender presuppose each other. When studying classification systems we must not only ask how things/people are classified, but also why. Why do we care how a person’s body looks when granting civil rights to that person? Is it appropriate to force citizens into normed and standardized categories (in a process Foucault has called normalization) for legal expediency instead of customizing laws that cater to the intricacies of life? “It must be questioned whether it is correct that people should be required to fit the convenience of legal categories rather than the law reflecting the complexities and realities for individuals” (Chau and Herring 2002: 354). Such an attempt to bring the law more closely into line with the complexities of reality would not necessarily entail refining legal gendered categories; it could be achieved simply by abstaining from using them altogether: “For purposes of marriage, why do we care how a person’s body is configured?” (Kogan 2003: 371). The promotion of equality does not mean ignoring differences, but rather ensuring that everybody has access to the same rights de-

spite their individual differences.

Sex and gender classifications are highly contingent, and change according to spatiotemporal and political dimensions. In the following passages I will first give a brief historical outline of international sex classification systems and then of medico-legal configurations of trans* citizens in South Africa.

Globalized Medico-Legal Configurations of Trans* Citizens

Sex is discursively constructed as natural through interactive performative practices by different human actors and institutions on local, national and international levels. Concepts of gender, and so of transgenderism, are therefore time-bound, localized, attached to certain cultures, and very fluid. Sex classifications and (re)categorizations are negotiated in specific publications such as the World Health Organization's International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM), and implemented on a local level such as that of the South African Department of Home Affairs. The ICD is the most important internationally recognized and utilized diagnostic classification system of biomedicine. International morbidity and mortality statistics, medical research, insurances/reimbursement systems and healthcare facilities all (co-)operate with it. Both the ICD and the DSM are revised periodically, and at the time of writing the use of the term "gender identity disorder" (a label assigned to trans* people) is being discussed by both publishing bodies as the ICD and DSM are again under review. Homosexuality, for example, was only removed from classification as a mental disorder in the ICD in 1990 – three years after its removal from the DSM.

"(...) the definition and diagnosis of homosexuality as spelled out in the Diagnostic and Statistical Manual of Mental Disorders [DSM] published by the American Psychiatric Association, had a new definition of homosexuality for each new edition. DSM-I (1952) listed it with 'other sexual deviations' and included it among the sociopathic personality disturbances. In the revised edition of 1968 [DSMII] it was still listed with 'other sexual deviations', but called a 'non-psychotic mental disorder'. By the time DSM-III was due in the 1970s, struggles to have homosexuality removed as a mental disorder had taken place. After much

lobbying on both sides of the fence, a show of hands led to homosexuality being removed as a mental disorder from DSM-III (1980), but it was replaced with Ego-Dystonic Homosexuality. In the revised edition, DSM-III R (1987) it too had slipped quietly into obscurity.” (van Zyl et al. 1999: 35)

The definition of “gender identity disorder” is part of an ongoing and controversial public debate involving not only trans* activists and medical experts but also other stakeholders, e.g. the Parliamentary Assembly of the Council of Europe, the United Nations Human Rights Council, and the European Parliament, among others. The influence of biopolitical standardizing bodies on the definition of sex/gender should not be underestimated. The European Parliament, for example, calls for the protection of trans* citizens’ rights to both bodily integrity and reproductive rights.

“11. Regrets that the rights of (...) transgender people are not yet always fully upheld in the European Union, including the right to bodily integrity (...) 13. Roundly condemns the fact that homosexuality, bisexuality and transsexuality are still regarded as mental illnesses by some countries, including within the EU, and calls on states to combat this; calls in particular for the depsychiatrisation of the transsexual, transgender, journey, for free choice of care providers, for changing identity to be simplified, and for costs to be met by social security schemes; (...) 16. Calls on the Commission and the World Health Organisation to withdraw gender identity disorders from the list of mental and behavioural disorders, and to ensure a non pathologising reclassification in the negotiations on the 11th version of the International Classification of Diseases (ICD 11).” (European Parliament 2011)

At the same time, it appeals to the WHO to remove the entry ‘gender identity disorder’ from the ICD’s list of mental and behavioural disorders while simultaneously safeguarding a non pathologizing reclassification. The ensuing public discourses resemble the debates that occurred in the early 1990s when the ICD’s classification of homosexuality as a mental illness came to an end.

These changing conceptions of sexuality and sex/gender and the struggles accompanying their official recognition can also be observed within South Africa.

Medico-Legal Configurations of Trans* Citizens during Apartheid

From a historical perspective it is interesting to note that the numbers of gender re-assignment surgeries were higher during apartheid than they are today. This has nothing to do with a mysteriously decreasing number of trans* citizens, but reflects instead an authoritarian regime's view of the binary nature of sex. In a manner strikingly similar to that evident in Germany during National Socialism, the state believed that sexual control was central to the effective implementation and maintenance of apartheid policies. Sexual activity and marriages between members of same-sex/gender classifications, as well as different race categorizations, were criminalized. Homosexuality, gender nonconformity and non-whiteness were conflated in Apartheid South Africa with notions of threat, deception and treachery; the first two, additionally, with disease and sin.

“The twin cornerstones of apartheid ideology was [sic] white Afrikaner nationalism, and a rationale for it based on Christianity as interpreted by the major Afrikaner churches. Both shared a conservative biologicistic construction of gender which also permeated the armed forces.” (van Zyl et al. 1999: 47)

The South African Defence Force (SADF) amplified these ideologies as a repressive instrument of the state. All conscripts were screened for homosexuality and gender non-conformity. Those found “guilty” were mass-incarcerated in psychiatric wards and subjected to “aversion therapy”; those deemed “incurable” were forced into surgery.

“In what was a top-secret project during the apartheid years, psychiatrists assisted by chaplains scoured each intake of national servicemen, hunting for suspected homosexuals. Those identified as homosexuals were quietly separated from their comrades and sent to ward 22 of Voortrekkerhoogte military hospital for screening and a programme of "rehabilitation". Some of those who could not be "cured" with drugs or psychiatry were given sex-change operations or were chemically castrated.” (Kirk 2000)

During the period of universal conscription for white males into the SADF (1967 –

1991) about 900 conscripts were coerced into reassignment surgeries (Kaplan 2004). As the South African Medical Services (SAMS) – which provided the medical capacity – was under military control, its personnel were bound neither to the “Hippocratic Oath, nor to the Tokyo Declaration (of which South Africa was a signatory) banning doctors from participating in any form of torture” (van Zyl et al. 1999: 48). The SADF is certainly not the only military organization known for its violation of the Human Rights of its homosexual and/or gender variant staff. Medical experimentation, prosecution, torture and murder of homosexuals by the Nazis during National Socialism is well documented, and US American medical experimentation on homosexual and gender variant persons during the same time period is also known of, though to a lesser extent; these are only the two most obvious examples.

“During World War II, Bowman conducted research on homosexuality in the military, using as test subjects gay men whose sexuality had been discovered while they were serving in uniform, and who were being held in a military psychiatric prison at the Treasure Island Naval Base in San Francisco Bay. After the war, he was the principal investigator for a statewide project funded by the California Sex Deviates Research Act of 1950 to discover the ‘causes and cures’ of homosexuality; part of this research involved castrating male sex offenders in California prisons and experimenting on them by administering various sex hormones to see if it altered their sexual behavior.” (Stryker 2008: 41–42)

Human Rights abuses disguised as medical research were motivated by the underlying principle of purification of the state through the normalization or elimination of citizens regarded as inferior. This covered not only abuse of “the Other” on the basis of racism, sexism, homo- and transphobia, but also the confinement of conscripts who had resisted aspects of military service in psychiatric wards, as they were also “evidently disturbed” (van Zyl 1999: 49). The surgeries carried out on homosexual conscripts were an effort to uphold the heterosexual sex/gender-binary by eliminating homosexual behavior through its conversion into heterosexual behavior. In cases in which electroshock “therapy” proved to be ineffective, apartheid’s logic allowed only one other solution: if the behavior could not be changed to fit that deemed appropriate for the body, then the body must be

changed to fit the behaviour, in order to conform with the heterosexual binary matrix.

“(...) the rationale for giving homosexuals reassignment surgery, in complete ignorance of the scientific literature on transsexualism, can only be described as repulsive. It was based on the simplistic belief that male homosexuals were sissies, female homosexuals were tomboys, and surgery would end their preference for the same sex by allowing them to fulfill their projected role in the opposite sex.” (Kaplan 2004: 1415–1416)

Since apartheid times South Africa has come a long way concerning the biomedical and legal treatment of homosexual and gender-variant people. From a legal point of view, it is now among the most progressive nations worldwide, topped only by recent legal developments in Nepal and Argentina. Argentina’s new law N° 26.743 on gender identity coming into effect on June 4th 2012, states that all persons have the right to the legal recognition of their gender identity irrespective of a diagnosis, hormonal treatment and/or surgical procedures. Concurrently, hormonal treatment and surgeries are to be offered through the public health system to those who desire them. The law is firmly grounded in the recognition of informed consent as the best practice to ensure gender variant peoples’ access to health and the right to identity, independent of the gender/sex assigned to them at birth.

Contemporary Medico-Legal Configurations of Trans* Citizens

An essential consequence of the efforts to create a new, just and equitable South Africa after apartheid was the creation of a fundamentally non-discriminatory constitution claimed to be “the most progressive (...) in the world” (Walker 2005: 226).

The lateness of South Africa in the postcolonial moment is significant. In the drafting of the South African Constitution, an attempt was self-consciously made to learn from the failures of prior liberation movements across the globe. (Bonthuys 2008: 20)

While laws have improved and there exists an exceptional legislature with regard to the recognition of non-binary sexes, South Africa is still much attached to a binary system. Sadly, the legal gains do not in most cases reflect the actual life situations of

persons perceived as departing in any way from a heteronormative bi-gendered system, and outright sexism, homophobia, and transphobia prevail. Alone in June 2012 five South African citizens were murdered in homo- and transphobic motivated hate crime (not specified, Mambaonline 06.07.2012).

In the following, I will first provide a broader view of the exceptional legal issues involved before illustrating where the country falls back on outmoded, though still operational, configurations of sex and gender.

In an effort to acknowledge the ambiguity of sex and to safeguard the rights of intersexual citizens an amendment of Section 1, Act 4 of the Equality Act (Promotion of Equality and Prevention of Unfair Discrimination Act - PEPUA) in 2006 secured the fact that the term 'sex' in the Equality Clause includes intersex. This is by no means a trivial point, given that there was one 1987 US court case (*Wilma Wood v. C.G. Studio*) in which the court determined that only two sexes exist, and that protection against sex discrimination was only granted to men and women. The intersexed plaintiff thus had no recourse against employment discrimination and was left in legal limbo. The ruling *de facto* reduced intersexed citizens' lives from 'bios' (life of a community/life brought under law) to 'zoe' (biological life of individuals; also called "naked life" or "bare life", Agamben 1998). Their rights as citizens were thus no longer protected. In a 1979 Australian family law case, a similar judgment was handed down. After twelve years of marriage, the legal union of C and D (falsely called C) was nullified on the grounds that one party was intersexed. The judge emphasized that marriage was only possible between a man and a woman. This means that the intersexed husband was not able to enter into any legal marriage. The formal inclusion of intersex into the term 'sex' in the South African Equality Clause thus meant that intersexed citizens were protected from the effects of comparable judgments.

It is important to keep in mind, however, that even though the Constitution has afforded them guaranteed protection in law, no certificates or legal documents are issued stating that intersex is the legal sex of a person. Australia, India, Nepal, New Zealand, and Pakistan, for example, all offer an additional legal sex/gender identification option, besides those of female and male, to citizens who identify themselves as otherwise. Australia and New Zealand offer "X" besides "M" and "F" as sex/gender identification on passports, India has included "transgender" in the government citizen ID number system, and Pakistan uses the term "unisex" on the

national identity cards of transgendered individuals, whereas Nepal has incorporated the category “other” for official identity documents. In all cases, intersexed as well as gender-variant people may apply for these options. What is more, Nepal’s Supreme Court stipulated that no medical or other institution had the right to define a citizen’s sex/gender, but that “(...) the sole criterion for being legally recognized as third gender was based on individual ‘self-feeling’” (Bochenek and Knight 2012: 30). With this declaration, for the first time legal classification of sex/gender became independent of medical definitions. Argentina has since followed suit, but relies still on two categories.

South African law is also exceptionally progressive with regard to trans* citizens. Due to The Alteration of Sex Description and Sex Status Act, No. 49 of 2003 (hereafter referred to as Act 49) trans* citizens can now legally apply to have their sex status adjusted in their documents, a possibility which had been ruled out since 1992. As a further advancement, surgery is no longer required for the alteration of one’s sex description. Act 49 states that:

“2. (1) Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvment through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register.” (Republic of South Africa 2004: 2, emphasis mine)

Sexual characteristics are defined by the Act as “primary or secondary characteristics or gender characteristics” whereas gender characteristics “means the ways in which a person expresses his or her social identity as a member of a particular sex by using style of dressing, the wearing of prostheses or other means” (Republic of South Africa 2004: 2). From the above definitions it is evident that even in the minimally invasive case that, for example, treatment by traditional³ health practitioners has led to changes in the ways in which a person expresses gender identity (e.g. style of dressing), this must be recognized as sufficient for the alteration of sex description on the birth register.

This legal pre-setting is, however, ignored by the Department of Home Affairs. Even though local medical traditions distinct from that of biomedicine are thriving throughout South Africa, it is interesting to note the aforementioned low

impact of the opinions of traditional health practitioners on administrative processes of sex/gender classification. The Department of Home Affairs only accepts reports from biomedical surgeons. It denies those citizens who have not undergone gender-confirmation surgeries involving sterilization the right to amendment of their identity documentation, and in many cases unduly delays the applications of those who have undergone surgery. The administrative insurgency against legal authorities has repeatedly and over many years made media headlines, for example on the award winning South African TV show *Special Assignment* on 24 November 2007, or in the online newspaper *Mamba* in 2012.

“On Monday, SAPA reported that a trans woman had to obtain a court order against Home Affairs in order to have her gender officially changed in her identity document. Jacqui Louw (41) from Cape Town, who has undergone gender reassignment surgery, has been waiting for almost two years for the department to process her application with no success. She claims that the confusion resulting from the incorrect gender information in her ID has led to her losing her job and being unable to apply for a passport to travel.” (not specified, *Mambaonline* 08.05.2012)

“Tebogo Nkoana, a Cape Town based transman who has recently undergone full gender reassignment says it took two years, after his first application, to have gender changed in his identity document.

‘I have had to reapply for more than three times because my documents kept getting lost at the Home Affairs department. It was the most horrible process I ever had to go through. Imagine a post transition man like me with a female ID, I was ashamed to use it, so I had to wait for two years to finally own my life again’, Nkoana said.” (ILGA Trans Secretariat 2011)

Nevertheless, to my knowledge this media coverage has produced no significant change other than that, in cases where sterilization had taken place, the documents of those protesting were finally processed. A countermovement against the progressive constitution can not only be observed in administrative organizations; the National House of Traditional Leaders (the official body of traditional⁴ leaders under South Africa's government) even made a proposal in May 2012 to South Africa's

parliament to discuss the removal of the term "sexual orientation" from the Bill of Rights.

What must be addressed, though, is the fact that – despite allegations of the ‘un-Africanness’ of homosexuality and non-normative gender expressions as made, for example, by the National House of Traditional Leaders – there nevertheless exists a wealth of local identities outside the heterosexual binary matrix. It is accurate to say that Western homosexual and trans* identities only started to become popular within the general population of South Africa in the 1980s. This does not mean, however, that there did not previously exist any sexual behaviour and gendered expressions outside a strict heteronormative binary. *Moffies*, *skesana*, and *istabane*; female *Sangomas* with ancestral wives, and women in gynegamous relationships living the ‘male part’ are all South African categories locally regarded as neither entirely male nor female. The important difference between imported Western concepts and historically older local perceptions is that, in the case of the latter, it is impossible to either distinguish neatly between sex/gender and sexual orientation in a South African context outside of medicine and law, or to pigeonhole the gender of citizens who engage in “same-sex” sexualities into a neat binary of male or female. Local concepts cannot easily be conflated with biomedical and legal notions of homosexuality and transgenderism.

Letties, moffies, stabanes, skesanas, injongas ... (...) Our list of identifying terms is far from comprehensive and each item on that list indicates a different configuration of identity, desire, practice, possibility, held together by the phrase 'sexual orientation' in the South African Constitution (...). (Bonthuys 2008: 19)

In the global medicalization of variational sex and gender for all legal purposes, local alternative concepts become suppressed. This does not imply, though, that the availability of Euro-American discourses has led to a replacement of all South African sex/gender concepts. Local trans* identities outside or between the binary poles of the state-sanctioned sex/gender system are, however, susceptible to disappearance because they are not catered for by administrative processes. From a legal point of view they are nonexistent, as biomedical globalization processes have had an important impact with regard to terminology usage in classifications, legal proceedings and administrative processes. As persons’ rights (e.g to legalize their rela-

tionship with a partner) depend on their legal sex/gender, citizens are forced to orient themselves in the sex/gender-binary, necessitating decisions which may be fraught with conflict. Due to the coexistence of different sex/gender concepts and their simultaneously inflexible handling through state administrative organs, people might become obliged to change identities (i.e. from 'skesana' to 'transwoman'). This may in turn lead to an increased risk to their personal safety as they (in this case now legally heterosexual and female) may lose the protection of e.g. the gay community, while members of the surrounding society react to them with transphobic violence. The same is true for formerly as lesbian regarded people who become legally male and heterosexual.

So, we first have to deal with my long-time good friends being a little taken aback because they think that I am leaving the "club" - the relative [safety] of being part of the lesbian community. (...) I realised how much we rely on our friendships for safety and our community. The gay and lesbian community is a community. (Morgan 2009: 159)

In view of the incompatibility of classification systems of one locality with others, some medical anthropologists have therefore questioned the appropriateness of the presumed-universal diagnostic notions of ICD (International Classification of Diseases) or DSM (Diagnostic and Statistical Manual of Mental Disorders) in non-Western contexts.

Sexuality, Gender, and Marriage

What impact, then, have the above described classification practices on trans* family rights?

In the South African case, there are different forms of marriages available: civil marriage, civil union, and customary marriages (Bonthuys 2008). Both civil marriages and civil unions have full legal recognition. However, while opposite-sex couples may conclude either form, same-sex couples can only conclude the latter. A monogamous relationship is required for both forms. Customary marriages, on the other hand, may be polygynous, and, though fully recognized, have a lower legal status than the other two forms. Muslim and Hindu marriages do not count even as customary marriages, and are not legally recognized at all. Customary law has his-

torically allowed for same-sex marriages. Since the introduction of the civil union, however, marriages under customary law must be heterosexual.

From the perspective of local identities this raises questions: why must customary marriages be heterosexual? And what does it mean to define something like marriage as being for “members of opposite sexes” when many intersexed and trans* people fall outside the male/female binary? Legislation does not reflect the actual life situation of many South Africans when it stipulates that a person must be legally acknowledged as being one of two sexes, and that the form of marriage available to that person depends on their own and their partners’ legal sex. Their personal gender identity (if not legally formalized within the binary) and sexual orientation are ignored and are of no import. But, as I have stated above, sex and gender interrelate locally in complex and, from a biomedical point of view, diverging ways. Some gender-variant people with male genitalia were historically (and in rural areas sometimes still are) regarded as female, or as members of a third sex/gender, with the effect that two people with male genitalia might be regarded as being in a heterosexual relationship (Donham 2002). Irrespective of their personal identities and sexual orientations, they would, however, have to enter a civil union instead of a civil marriage.

The other possibility would be to change the legally assigned sex. Any person identifying with a sex different from that assigned at birth has the right to change their legal status in South Africa, which leads us to the question of how we are supposed to interpret marriage between two people of prescribed sexes when it is possible that the sex of one or both may legally change? This places an unnecessary hardship on the members of what may be a perfectly well-functioning marriage/civil union/customary marriage, in that under such circumstances they would first have to get divorced in order to then remarry the same partner in an “appropriate” new legally-recognized partnership form.

To cap it all, even though any person identifying differently from their birth-assigned sex/gender has the right to change their legal status, this is only done under the condition of psychiatric evaluation and alteration of sexual characteristics. The right to make use of medical technologies for these alterations is, however, controlled by psychiatric gatekeepers who, rather than basing their decisions solely on their clients’ needs, are frequently influenced by religious or traditional beliefs about sexuality and gender (Klein, accepted). Already married people or those with

children are often denied gender confirmation surgery.

It was even more difficult to get surgery if you were married or had children. It's one thing to do a sex-change on somebody who had never married and never had children, it's another thing if they were either still married or had children. And, of course, I was married and I had children so according to the law I wasn't a true transsexual. (Morgan 2009: 134)

The poor conditions of the South African public health system (inadequate infrastructure for gender confirmation surgeries; little or no specialized training available; medical specialists' lack of contact with or even awareness of one other; only one psychiatrist from the private sector working in only one of the two public hospitals) further limit the little access that is available for many trans* people. This limited access is another source of conflict, as it not only denies the acknowledgment of a citizen's gender but also impinges on his/her marriage rights.

To sum up: South African trans*people currently have to be legally recognized in one of two genders (male or female) regardless of the local wealth of gender identities. The legal contextualization of sex/gender in a binary system has historically relied heavily on biomedical definitions. These biomedical definitions have become much more detailed in recent decades, while at the same time increasingly coming to recognize and distinguish fuzzy sets rather than clear-cut categories. The administrative organs issuing identity documents, however, still cling to outdated biologicistic definitions and insist on reports by biomedical surgeons that entail sterilization. As access to these kinds of surgeries is very limited (Klein 2008, Vincent and Camminga 2009) even those trans* citizens who are wishing for surgery that compromises their fertility face correspondingly inadequate prospects of gaining legal identity documents that match their identities. The result is that, in the first place, those unwilling to undergo genital surgery and those outside the gender binary are unable to have their identities legally acknowledged; and in the second, that only very few of those trans* people who do firmly identify as male or female and who desire surgery obtain legal recognition, as the medical system is unable to cater to all of them. In some instances, already married trans* people or trans* people with children are denied gender confirmation surgery by psychiatric gatekeepers. All in all, only a very limited number of trans* people can access their rights in their own

gender identity. That minority will, however, be infertile, which then raises questions concerning access to parenting (e.g. through sperm donation, surrogate motherhood, assisted reproductive technologies, and last but not least legal or de facto adoption).

I realised I will never have my own kids, 'cause with me being a Zulu person, I mean, a child has to know his/ her surname; she has to belong to a certain family. To think that I only have a few options, that I thought maybe the only way I can have a child is if my brother is a donor, because I want my child to come from my family. (Morgan 2009: 171)

My current girlfriend and I are exploring various options. We are seriously considering artificial insemination by donor. For now, I make myself happy with my nephews and nieces. I always say to them they are my kids. I'm a godfather to them. (Morgan 2009: 32)

Those who enter civil unions instead of civil or customary marriages have to deal with further infringements on their family rights. In the case of sperm donation, for instance, “(...) laws dictate that donors be asked permission to use their sperm on (...) same sex-couples” (not specified, Triangle News 2007: 17) and the couple must be evaluated by a psychologist.

Conclusion

Medical classifications and societal explanatory models of sex/gender are mutually dependent. Sex/gender entries for legal and administrative purposes rely heavily on biomedical classifications. Thus, medical classifications enforce legal consequences upon citizens. At the same time, social changes evoked by social movements have led to entry changes in such internationally recognized classification systems as the DSM and ICD. Homosexuality has already been removed from being classified as a form of mental/behavioral disorder, and the depathologization of trans* people appears to be on its way. The process of negotiation of what constitutes sex/gender and what role sexual preference plays in it is never unidirectional; rather, it much resembles a tennis match in which spatiotemporally situated knowledge, rather than a ball, is passed from one side to the other. During this process

contradictory situations may arise while biomedicine and numerous other actors take an active part in defining sex/gender. While some laws regard sex/gender classification as an unambiguous binary (there exist only male and female citizens with regard to marriage rights, for instance) others have explicitly pointed out the fact that sex is indeed ambiguous and cannot be fitted into a binary through their acknowledgment of intersex as a legally-recognized category (Bill of Rights) and their recognition of the fact that sex/gender may change irrespective of surgery (Act 49).

In conducting research in medical anthropology, excursions into the socio-cultural contexts of the respective medical traditions become necessary so as to be able to understand the specific conceptions of the body held by medical and other institutions, as well as conceptions about its treatment and the interventions that are possible. Biomedicine as a form of science is as susceptible to its socio-cultural contexts as any other medical tradition, while specific cultural assumptions rely at the same time on biomedical knowledge.

Notes

¹ Though the Traditional Health Practitioners Act was legislated in the wake of an African Renaissance in 2008, registered South African healers do not play a major role when it comes to medico-legal classifications of trans* peoples' sex/gender and their family rights, as I will show below. The Traditional Health Practitioners Bill was created to "(...) establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith" Republic of South Africa (2008: 2).

² The biomedical term *intersex* is used for people with physical variations that cannot exclusively be labeled as either male or female. There exists a huge variety of physical conditions due to the complex interlocking of supposedly sex-dichotomous differences. A significant fraction of the human population simply does not correspond exclusively to either female or male with regard to every level of defi-

inition. I use the term intersexed instead of intersexual as the latter has a negative connotation for many activists. Intersexual/ity is a clinical term, indicating a pathological state which needs to be "cured". The term intersexed was coined as an alternative by activists as a self-chosen identity rather than a diagnosed and stigmatized one.

³ The term *traditional* is highly – and rightly – contested within medical anthropology, as it indicates a static or ahistoric practice. I am nevertheless using the term in this context as it is the official term used in the Traditional Health Practitioners Act of 2008.

⁴ The term “traditional” is a self-ascription. See also endnote III.

References

- Agamben, Giorgio (1998) *Homo Sacer: Sovereign Power and Bare Life*. Stanford, Calif: Stanford University Press.
- Bochenek, Michael and Knight, Kyle (2012) Establishing a third gender category in Nepal: Process and prognosis. *Emory International Law Review* 26 (1).
- Bonthuys, Elsje (2008) Possibilities Foreclosed: The Civil Union Act and lesbian and gay identity in Southern Africa. *Sexualities* 11 (6), pp. 726–739.
- Bowker, Geoffrey C. and Star, Susan L. (2000, c1999) *Sorting things out: Classification and its consequences*. Cambridge, Mass: MIT Press.
- Butler, Judith (1990) *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Chau, P.-L and Herring, Jonathan (2002) Defining, assigning and designing sex. *International Journal of Law, Policy and the Family* 16 (3), pp. 327–367.
- Donham, Donald L. (2002) Freeing South Africa: The "modernization" of male-male sexuality in Soweto. In: Ina, Jonathan X. and Rosaldo, Renato (eds.). *The anthropology of globalization: A reader*. Malden (Mass.), Oxford (UK), Carlton (Australia): Blackwell Pub., pp. 410–427.
- European Parliament (2011) European Parliament resolution of 28 September 2011 on human rights, sexual orientation and gender identity at the United Na-

tions. <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2011-0427+0+DOC+XML+Vo//EN&language=EN> (accessed 2/08/2011).

Fine, Cordelia (2011) *Delusions of gender: The real science behind sex differences*. London: Icon Books.

Foucault, Michel (1995) *Discipline and punish: The birth of the prison*. New York: Vintage Books.

Gowaty, Patricia A. (ed.) (1997) *Feminism and evolutionary biology*. New York [u.a.]: Chapman & Hall.

Haraway, Donna (1987) *Geschlecht, Gender, Genre: Sexualpolitik eines Wortes*. *Das Argument: Zeitschrift für Philosophie und Sozialwissenschaften* (166), pp. 795–804.

ILGA Trans Secretariat (2011) *South Africa Transgenders also bear the brunt of home affairs' red tape*. <http://ilga.org/ilga/en/article/mX4K5zt17Q> (accessed 26/05/2012).

Jaggar, Alison (1984, c1983) *Human Biology and Feminist Theory: sexual equality reconsidered*. In: Gould, Carol C. (ed.). *Beyond domination: New perspectives on women and philosophy*. Totowa, N.J: Rowman & Allanheld.

Jasanoff, Sheila (ed.) (2006) *States of knowledge: The co-production of science and social order*. London, New York: Routledge.

Jordan-Young, Rebecca M. (2011, c2010) *Brain storm: The flaws in the science of sex differences*. Cambridge, Mass: Harvard University Press.

Kaplan, R. M. (2004) *Treatment of homosexuality during apartheid*. *BMJ* 329 (7480), pp. 1415–1416.

Keller, Evelyn F. (1995, c1985) *Reflections on gender and science*. New Haven: Yale University Press.

Keller, Evelyn F. (2010) *The mirage of a space between nature and nurture*. Durham, NC: Duke University Press.

Keller, Evelyn F. and Longino, Helen E. (1996) *Feminism and science*. Oxford, New York: Oxford University Press.

Kirk, Paul (2000) *Mutilated by the military: Apartheid army forced gay soldiers in-*

- to sex change operations. q-online news. Mail and Guardian, 28/07/2000.
- Klein, Tamar (accepted) Necessity is the mother of invention: Access inequalities to medical technologies faced by transgendered South Africans. *Technology and Innovation – Proceedings of the National Academy of Inventors*. Volume 14.
- Klein, Tamar (2008) Querying medical and legal discourses of queer sexes and genders in South Africa. *Anthropology Matters Journal* 10 (2).
- Kogan, Terry S. (2003) Transsexuals, intersexuals, and same-sex marriage. <http://www.law2.byu.edu/jpl/Vol%2018.2/10Kogan.topublisher.pdf> (accessed 27/05/2012).
- Monro, Surya (2005) *Gender politics*. London: Pluto.
- Morgan, Ruth; Marais, Charl; Wellbeloved, Joy Rosemary (2009) *Trans. Transgender life stories from South Africa*. Auckland Park, South Africa: Jacana Media.
- not specified (2007) Falling pregnant. *Triangle News* (2), p. 17.
- not specified (2012) Home Affairs continues abuse of trans people. *Mambaonline*, 08/05/2012. <http://www.mambaonline.com/article.asp?artid=6921> (accessed 27/05/2012).
- not specified (2012) SA National AIDS Council: LGBTI Murders ‘Shameful’. *Mambaonline*, 06/07/2012. <http://www.mambaonline.com/article.asp?artid=7151> (accessed 10/07/2012)
- Republic of South Africa (2004) No. 49 of 2003: *Alteration of Sex Description and Sex Status Act, 2003*.
- Republic of South Africa (2008) No. 22 of 2007: *Traditional Health Practitioners Act*.
- Rubin, Gayle (1975) The traffic in women: Notes on the “political economy” of sex. In Rayna R. Reiter (ed.), *Toward an anthropology of women*. New York: Monthly Review Press, pp. 157–210.
- Stoller, Robert J. (1968) *Sex and gender: On the development of masculinity and femininity*. New York: Science House.
- Stryker, Susan (2008) *Transgender history*. Berkeley, CA: Seal Press; Distributed by Publishers Group West.

- Unger, Rhoda K. (1979) Toward a redefinition of sex and gender. *American Psychologist* 34, pp. 1085–1094.
- van Zyl, Mikki; Gruchy, Jeanelle de; Lapinsky, Sheila; Lewin, Simon and Reid, Graeme (1999) *The Aversion Project: Human rights abuses of gays and lesbians in the SADF by health workers during the apartheid era*. Cape Town: Simply Said and Done.
- Vincent, Louise and Camminga, Bianca (2009) Putting the “T” into South African human rights: Transsexuality in the post-apartheid order. *Sexualities* 12 (6), pp. 678–700.
- Walker, Liz (2005) Men behaving differently: South African Men since 1994. *Culture, Health & Sexuality* 7 (3), pp. 225–238.

Thamar Klein ist promovierte Ethnologin mit den Schwerpunkten *Medical Anthropology* und *Queer Theories*. Aktuell ist sie wissenschaftliche Mitarbeiterin am Somatechnics Research Centre der Macquarie University in Sydney, Australien.

Introduction to Gender, Sex, and Sexuality. When Harry was born, his parents, Steve and Barb, were delighted to add another boy to their family. But as their baby boy began to grow and develop, they noticed that Harry began to express himself in a manner that they viewed as more feminine than masculine. The Canadian Human Rights Act was amended in 1996 to explicitly prohibit discrimination based on sexual orientation, including the unequal treatment of gay men, lesbians, and bisexuals. Individuals who identify with the role that is the opposite of their biological sex are called transgendered. Transgendered males, for example, have such a strong emotional and psychological connection to the feminine aspects of society that they identify their gender as female. Women must battle expectations about their gender. We automatically take in that information to decide what are the [gender] characteristics," Prof Eagly says. How can we stop unconscious bias? The theory proposes that when women take on leadership roles that go against gender role norms, they are perceived less favourably than men as leaders, and their actions too are criticised. All of which could make it more difficult for women to achieve success in leadership positions - or even obtain them in the first place, according to Prof Eagly's research. The electability question. And among people who did hold gender stereotypes, Prof Dolan found those beliefs "made almost no impact on their choice when they were faced with a woman or a man candidate". The issues of gender assignment, gender verification testing, and legal definitions of gender are especially pertinent to a discussion on the ELSI of gender and genetics. These practices, however, are misnomers as they actually refer to biological sex and not gender. In addition to social implications, sex and gender categorization has important political and legal implications as well. The identification of an individual as either biologically male or female can have legal ramifications for marriage licenses, spousal support and eligibility for parenthood. The issue of sexual classification, however, is complicated by factors such as chromosomal complement, external genitalia, gender identification and surgical alteration.