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Technologies of Trans* Citizen Configuration: the case of South Africa[1]

Thamar Klein[2]

Abstract

This paper explores the relation between biomedicine and governance with regard to the (self)configuration of trans* citizens through technologies. Keeping the diversity of South African trans* citizens in mind, I will address the following questions: How are trans* citizens defined and configured as gendered/sexed citizens – and by whom or through which technologies? How do trans* citizens experiment with technologies? More specifically what are new uses for technologies that were originally invented/intended for a different cause? Rather than seeing trans* citizens solely as passive subjects of governmental legal and health care interventions I will as well have a look at them as active agents in the re-shaping of their identities. The present study explores their local and global agency within the realms of supranational citizenship, citizen science and medical tourism.

[1] The paper is based on my research project *Que(e)rying Body Perceptions in South Africa*, which I carried out as a member of the Max Planck Fellow Group 'Law, Organisation, Science and Technology' at the Max Planck Institute for Social Anthropology (2006–2009). I would like to thank Kirsten Endres, Babette Müller-Rockstroh, Bettina Mann, and Ralph Orlowski for valuable comments on an earlier version of this paper.

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Introduction

This paper examines the relation between biomedicine and governance with regard to the (self)configuration of trans* citizens through technologies. The term trans* refers in this text to citizens whose gender identity differs from their assigned sex at birth and/or challenges male-female dichotomies. Time and again, I have found myself struggling with a language dilemma when searching for non-discriminatory terminology. Usually this problem is circumvented in social anthropology by using local terminology. However, South Africa has eleven official languages and recognises quite a number of other non-official local languages. Thus there is no single local terminology. What is more, local terms contain different meanings and often have no equivalent in English (e.g. intersexed persons, trans* people and individuals who engage in same-sex practises may be called *istabane* in Zulu). Additionally all of the local terminology I encountered during the eleven months of fieldwork between 2007 and 2008 (as e.g. *moffie, italasi, istabane*, and *skesana*) was considered hurtful, derogatory, and discriminatory by the interviewees. It could only be used by individuals to describe themselves. This is also true for pathologising medical terminology. In an effort to resolve this dilemma, I use the term trans* as employed by Gender DynamiX (GDX)[3] for people described as transsexual or transgendered. I would like to point out, however, that many people subsumed under this terminology do not identify with it.

Feminist scholars and those contributing to sexual, queer, or intimate citizenship studies as for example Ruth Lister or Ken Plummer, have pointed out repeatedly that citizenship rights are intimately connected with the sex and gender of a citizen. Accordingly and unsurprisingly, the situation faced by trans* citizens differs from those who are cis-gendered.[4] Naturally, trans* citizens are not a homogenous group and the term trans* is a complex, and contested umbrella term encompassing miscellaneous subjectivities. Due to limited space I cannot even scratch on the surface of discourses on difference and sameness, universal claims to equal rights and differentiated rights claims, the balancing of the needs of special sub-groups against the good of the whole, and so on. The term trans* citizen is, however, useful in the distinction from traditional notions of citizenship imagining the citizen as being white, male, cis-gendered, heterosexual, and able-bodied. These models have been challenged by feminist and sexual citizenship theorists (e.g. Lister 1997 and 2008, Richardson 1998) as well as theorists on queer and intimate citizenship (e.g. Plummer 2001). Already in the early 1990s for example, Young and Yeatman analysed the exclusion from citizenship of the ‘other’ and the ‘different’ (Young 1990, Yeatman 1990).

Keeping the diversity of South African trans* citizens in mind, I will concentrate on the questions of how trans* citizens as users of gendering/sexing technologies are defined and configured and – more importantly – by whom. For the purpose of this paper technology is understood in the broad sense of the word as not only material objects and techniques (e.g. medical technologies) but also as methods of organisation (e.g. the (re-)categorisation of gender). Therefore, I take a look at the practises of classifying and standardising sex and gender and query how power structures are mediated in and through biomedical knowledge. Even though medical classifications are instruments of normalisation and medico-legal technologies configure very specific citizens, South African trans* citizen are not passive subjects of governmental legal or medical intervention. On

[3] Gender DynamiX is the first and only South African organisation that offers services exclusively to trans* people.
[4] The Latin prefix *cis* stands for “on the same side”, whereas the prefix *trans* stands for “on the opposite side”. “Cis-gendered” or “cis-sexual” describes people whose gender identity matches their perinatally assigned sex.

the one hand, medical ideas of normality and the practises through which they are generated shape individuals' experiences of the body. On the other hand, however, some citizens resist or modify the processes of configuration and claim their gender and their right to adapt their bodies in opposition to state policies. Therefore I will query which specific technologies are envisaged by policy makers to be used by what kind of trans* citizens and which citizens use the available technologies in an unforeseen and unintended way or do not use them at all. Are these technologies in fact (sufficiently or at all) available to the citizens they were intended for? This subject will be addressed along with the question: what are new uses for technologies that were originally invented/intended for a different cause? This question becomes also relevant with regard to citizens whose identities are located beyond the binary of male and female and who actively experiment with biomedicine in order to modify their bodies and in order to alter discourses (neither male nor female). Thus sexing/gendering technologies as objects of identity projects may stabilise or de-stabilise hegemonic representations of gender. The process of normalisation does not necessarily result in docile, disciplined citizens. Indeed, unexpected, unruly subjectivities arise that disrupt biomedical and legal taxonomies: New identities and social relations emerge around biomedical classifications and normalizations that have consequences beyond the field of health.

The present study explores trans* citizens' local and global agency within the realms of supranational citizenship, citizen science, and medical tourism – drawing on Aihwa Ong's observation that:

> In theory, citizenship as protected entitlements depends on membership in a nation-state. But increasingly in practice, entitlements and benefits are realized through specific mobilizations and claims in milieus of globalized contingency. (Ong 2005: 697)

I start with an outline of the methodology of my research project. This section will be followed by a discussion of the role of technology (as method of organisation) in the configuration of trans* citizens and the practises of classifying and standardising sex and gender through legislative, executive and judicial organs. I then move on to the usage of medical technologies as well as the local and global agency of trans* citizens pointing to supranational citizenship, citizen science, and medical tourism.

Methodology

The research for this paper was carried out as a member of the project 'Biomedicine in Africa', conducted by the Max Planck Fellow Group 'Law, Organisation, Science and Technology' at the Max Planck Institute for Social Anthropology. My research project *Que(e)rying Body Perceptions in South Africa* examines medico-legal practises and discourses around queer sexes and genders in South Africa. As part of my current work on medical, legal, and political discourses on gender and globalisation, I query the relationships between law, medicine and queer bodies in South Africa.

This paper draws mainly on data from 65 semi-structured interviews, of between 30 and 150 minutes in length, conducted in 11 months of fieldwork between 2007 and 2008 in Cape Town, Pretoria, and Johannesburg (Soweto) with trans* and intersexed persons, surgeons, endocrinologists, clinical social workers, sexologists, psychologists, legal specialists, and trans* and intersex activists. Besides innumerable hours of participant observation at social gatherings with trans* and intersexed people, the research involves many more informal interviews, private

e-mails and excerpts from chats in internet forums as early as from 2005, when I first got interested in the topic.

The Configuration of Trans* Citizens through the State

In the following section I will concentrate on the questions of how trans* people as citizens are defined and configured by legislative, executive, and judicial organs.

One of the main problems of trans* citizens worldwide is that states rely profoundly on a bi-sexed/gendered system and laws are developed along a binary sex/gender model without defining exactly which attributes define a person as male or female. Legislation addressing sex (e.g. for purposes of marriage, inheritance, military service, etc.) more often than not falls short of defining the terms. It is needless to mention that non-binary sexes and genders are hardly recognised as legal sexes and genders at all.

With regard to this South Africa has an exceptional legislature. The rights of intersexed[5] people were secured in January 2006 through an amendment of section 1 of Act 4 of 2000 (the PEPUDA also known as *Equality Act: Promotion of Equality and Prevention of Unfair Discrimination Act*). After the successful intervention of activist Sally Gross (founder of ISSA: Intersex South Africa) a definition of intersex was inserted through this amendment. Most importantly, however, it was stated that the term ‘sex’ in the Equality Clause includes intersex. This is important as there had been a court case in the US (Wood v. C.G. Studio) where the intersexed plaintiff brought action claiming discrimination when her employer terminated the employment after having learned that she is intersexed.

> The court determined that “sex” under the provisions of the PHRA [Pennsylvania Human Relations Act] included men discriminated against because of their sex and women discriminated against because of their sex, but excluded intersexed individuals. Relying upon Webster's Dictionary for its definition rather than medical evidence, the court ruled that there were only two sexes and Wood wasn't one of them. (Bilharz 2005: 271)

Even though the South African Constitution has afforded guaranteed protection in law to intersexed people, it has to be noted that no certificates or legal documents are issued stating that intersex is the legal sex of a person. It signifies how state legislatures struggle to acknowledge more than two sexes.

Sex, in the scope of a heteronormative binary model, refers to a male and female duality of biology and reproduction. From a medical point of view, the sex of an individual is defined by its chromosomal, gonadal, hormonal, psychological, social, internal and external genital differentiation (Pschyrembel 1994). Nonetheless these ascribed sex-dichotomous differences[6] are not absolute in the human population, and there are individuals who are biologically or behaviourally “in-between” (e.g. intersexed, transsexual, and transgendered persons). Thus a first difficulty is already posed by the birth of intersexed children and the fact that some children can not (or not easily) be placed within the binary model. Other legal complications may occur later in

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[5] Intersex is a general biomedical term for a huge variety of physical conditions in which a person is born with chromosomal, gonadal, hormonal, internal and/or external genital features, which do not fit with conventional definitions of male or female (e.g. ambiguous external sex organs; simultaneous presence of both testicular and ovarian tissue in one individual; chromosome combinations other than XX or XY etc.). Approximately 1.7 percent of all humans are born intersexed (Fausto-Sterling 2000, Samelius and Wagberg 2005: 13).

[6] Sex-dichotomous differences refer to aspects, which are wholly characteristic of one sex only.

life whenever the sex assigned at birth does not match a person's gender identity or when it becomes apparent that the outer genitalia of the infant may have looked male or female but that other sex characteristics do not match the assigned sex. In still other cases (so called 5-alpha-reductase deficiency) infants appear phenotypically female at birth and until puberty when secondary male sex characteristics develop with the descent of the testes, deepening of the voice, and growth of what had been identified as a clitoris into a functional penis. There exists a huge variety of biological and psychosocial conditions due to the complex interaction of 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 definition.

As this paper is about trans* people, I am not going to elaborate further on intersexuality. Instead I will concentrate on sexual ambiguity issues that concern trans* citizens. In cases of ambiguity and unclarity, the definition of legal sex relies on biomedical definitions. However, as stated above, the medical definition is not unambiguous in itself. The psychological make-up of a person/the gender identity is already part of the medical definition (chromosomal, gonadal, hormonal, *psychological*, *social*, internal and external genital differentiation). Thus the conventional divide of sex (biological) and gender (psychological, social) is already intermeshed. Hines (2009) nevertheless sees an advantage in the divide and argues for an understanding of gender as separate from sex.

> An understanding of gender as separate from sex thus holds the potential for a greater diversity of masculinities and femininities. From this perspective, rights can be articulated and protected on the basis of subjectivity. Such a move would represent a radical departure from medical understanding of (trans) gender, which continue to influence rights discourse and law. Accounting for subjective gender difference in this way would signpost a genuine utopian model of human rights, which foregrounds the very concept of diversity. (Hines 2009: 96)

I strongly agree with Hines that it would be a significant step to base rights on an individual's gender identity, I am however doubtful that a legal division of sex (as something inherently free of psychological factors) and gender would lead to the desired results. I am instead convinced that this division might lead to a considerable backwards move that bears the great danger of having legal sex based on a biological sex (that has become now inherently free of psychological factors). In fact, rulings of the highest courts – even though very inconsistent in their definitions of legal sex – are already often relying on an individual's chromosomal sex (for an extensive review of legal decisions see Hucker 1985, Green 1992, Eskridge and Hunter 1997, Greenberg 1999 and 2000, Dunson 2001, Frye and Meiselman 2001, Walker 2001, Hong 2002, Bilharz 2005, Sabatello 2009). I fear that the already achieved rapprochement of biomedical to formerly non-medical gender concepts and the paradigm shift by scientific and trans-communities (as described by Bornstein 1994, Hubbard 1998, and Boswell 1998) from traditional understandings of sex and gender identity towards fluidity and free expression will be undermined.

My argument is informed by the South African status quo where, despite a legal definition of sex entailing both biological and social aspects, the latter are ignored by executive organs in favour of the former. In South Africa, sexual characteristics are defined as "primary or secondary characteristics or gender characteristics", the latter referring to "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" (Government Gazette 2004:30). Thus South Africa's legal definition of sex entails both biological and social aspects. These social aspects – inscribed by

legislative organs into the law – are, however, still ignored by executive organs such as the Department of Home Affairs where the appeals for Sex Description Application have to be handed in. But let me go into a bit more detail: In 1996, South Africa became the first – and is still the only – country worldwide to enshrine the rights of its trans* citizens in its constitution. Even though sex, gender, and sexual orientation were included in the constitution's Equality Clause, this mere inclusion was not sufficient to enshrine the rights of trans* persons as the *Births and Deaths Registration Act* stated that only persons who had commenced sex reassignment prior to 1992 could apply to have their sex status adjusted in their documents. Accordingly, only ongoing transitions could be finalised but none could be initiated. As a consequence, nobody could legally start transitioning after 1992.

This situation changed in 2004. Owing to written and oral submission of some groups and activists[7], improvements and corrections could be inserted into *The Preliminary Alteration of Sex Description and Sex Status Bill* compiled by the South African Law Commission, so that the act succeeding the bill now conforms with the constitution. One of the improvements was that people could legally start transitioning again due to *The Alteration of Sex Description and Sex Status Act*, No. 49 of 2003 (in the following referred to as Act 49). With it came another important legal change: genital surgery was no longer required for the alteration of one's sex description. The preceding bill stated that only persons "whose *sex organs* have been altered" could apply. Thus a report from a medical practitioner stating that *sexual characteristics* have been altered has become mandatory for the alteration of one's sex description. Opportunely, the term "medical practitioner" was defined in such a broad way that it can include both biomedical therapists as well as so-called "traditional health practitioners".[8] However, the Department of Home Affairs – where the appeals for Sex Description Application have to be handed in – still only issues documents after completed genital surgery and demands letters from the surgeon who carried it out, even though Act 49, 2.(1) states that:

> Any persons whose sexual characteristics have been altered by surgical *or medical treatment or by evolvement 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. (Government Gazette 2004: 30; emphasis is mine)

As already stated above, 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" (Government Gazette 2004: 30). According to Act 49, the Department of Home Affairs may not reject applications from persons who choose surgery that does not involve primary sex characteristics or who choose hormone therapy without surgery. Theoretically, any treatment by "traditional health practitioners" that has led to changes in the ways in which a person expresses his or her social identity as a member of a particular sex must be recognised as sufficient for the alteration of the sex description on his or her birth register.

[7] These were the Cape Town Transsexual/Transgender Support Group around activists like Estian Smit and Simone Heradien, and activist Sally Gross on behalf of intersexed people. Further input was given by the Human Rights Commission and the Lesbian and Gay Equality Project.

[8] The term 'traditional' is highly and rightly contested within medical anthropology as it indicates a static or ahistoric practise. I am nevertheless using the term in this context as it is the official term used in the Traditional Health Practitioners Act of 2004.

However, this is not legal practise. The Department of Home Affairs is caught in a rather awkward position: by upholding mandatory sterilisation[9] it violates both the Equality Clause in the Bill of Rights and Act 49.

Even those trans* citizens who desire (or are at least happy to comply with) genital surgery face a difficult situation. Only two South African hospitals – of the 16 provincial tertiary hospitals and national central hospitals that provide Level III care – provide reassignment surgery. These are Groote Schuur Hospital in Cape Town and Pretoria Academic Hospital. In addition, there are budgetary restrictions which limit the number of patients that can be seen there. At Groote Schuur Hospital it was stated that they can only provide surgery for one FtM (Female to Male) and one MtF (Male to Female) per year. At Pretoria Academic Hospital one interviewee stated that they "can only do one full profile per quarter" (Anonymous, 28 November 2007). Thus waiting lists grow extremely long.

Theoretically, surgery can be obtained in the private medical sector. Persons who are willing and *able* to pay for the much more expensive private care can visit any private clinic in and outside the country. The few services offered in the public sector are, however, of crucial importance to the vast majority of people. Since income is still intimately connected with gender and skin colour, the situation is especially difficult for persons who did not grow up categorised as white males – but private care is much too expensive even for many who have been categorised in this way. Two of my interviewees who were fortunate enough to be house owners sold their houses in order to finance their surgeries.

Besides the extremely limited numbers of patients who can be seen, the budgetary constraints in the public sector produce further restrictions for both patients and medical specialists. The latter have to work with limited theatre time and there is only a small team of medical experts available. There is only *one* psychiatrist available for the gender clinic at Pretoria Academic Hospital, and this psychiatrist only does private sector work, which is at the very least an astonishing fact for a public hospital. Especially as the – significantly higher – fees for the services of the psychiatrist have to be paid by the clients. Every patient at the gender clinic needs to be declared fit for surgery by this psychiatrist. As most clients come from various parts of the country and do not live in the direct vicinity of the psychiatrist, the necessary travel time and money complicate regular visits and make them unfeasible for many.

De jure South African trans* citizens have a right to the legal recognition of their gender identity without genital surgery – *de facto* this right is denied to them through the Department of Home Affairs. For those citizens who desire genital surgery, it is complicated by the very restricted access to medical technologies.

South Africa is, however, not the only country dealing with ambivalent agendas. Sharpe (2007) has dealt with a similar situation in Great Britain where the *Gender Recognition Act* of 2004 does not require surgery either, but where

> it is clearly the expectation of the government that surgery will occur. (…) in the case of an applicant who has not undertaken surgery, the possibility remains (…) that this fact may hinder a diagnosis of gender dysphoria [which is essential for the legal adjustment of one's sex]. (Sharpe 2007: 71–72).

[9] The term sterilisation is an umbrella term encompassing all surgical techniques leaving a person unable to reproduce. In the South African case, however, it refers to the complete removal of all reproductive organs.

Currently, the UK (since 2004) and Spain (since 2007) are still the only European countries where genital surgery is not a prerequisite for a new birth certificate in the lived gender. First steps have also been made by Austria. Although legislative organs have not yet reacted, the Austrian Administrative High Court declared in a judgment of 27 February 2009 that mandatory genital surgery for trans* people is unlawful. Permanent sterility remains a requirement for a new birth certificate in the lived gender – or at least the entry of the lived gender into the old birth certificate (a highly contested procedure since it fails to protect a person's privacy) – by Belgium, Denmark, Finland, France, Germany, and the Netherlands. Genital surgery is required in Lithuania and secondary sex characteristics surgery is compulsory in the Czech Republic and Greece. The birth certificate cannot be changed at all in Ireland, Italy, Portugal, and Sweden (compare Whittle et al. 2008: 22–23). This excursion into the legal practises of other countries will become of interest again in the section on supranational citizenship.

I have outlined above how the South African state helps to configure trans* citizens as users of sexing/gendering technologies in a certain kind of way. Interestingly, a concurrent definition of sex/gender does not exist. Trans* citizens are defined and configured differently by legislative and executive organs. Unfortunately, there has not yet been a judicial intervention to overcome the contradicting definitions. This is partly due to the fact that the Department of Home Affairs has in some cases given in (only after extended periods of time and when seriously threatened with a trial) and to some extent to the willingness of surgeons to write rather vague reports about the surgeries[10] that were carried out (personal communication, anonymous activist, 9 May 2009). Additionally, many trans* citizens are not willing to go public with a trial due to the many forms of vulnerability to violence and discrimination that they face despite Act 49 and the Equality Clause.

Two answers have to be given when posing the question of where the South African State draws the line between the greater good/the benefit to the community (usually described as the prevention of fraud through unambiguous sexes) and the risk imposed on the individual (usually described as health risks deriving from surgery and the loss of reproductive abilities).

First: the Equality Clause in the Bill of Rights and Act 49 both secure trans* citizens' rights to marriage and parenthood and protect them from discrimination. Thus legally South Africa subscribes at least partially to the Yogyakarta Principles[11] (with the exception of mandatory hormonal therapy).

> No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation, or hormonal therapy, as a requirement for legal recognition of their gender identity. (…) No status, such as marriage or parenthood, may be invoked as such to prevent the legal recognition of a person's gender identity. (Jurisprudential Annotations to the Yogyakarta Principles 2007: 11)

According to this, the line has been decisively drawn in favour of trans* citizens' rights and against the – by the religious right – often called for greater good (the clear demarcation between female and male).

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[10] Reassignment surgeries may entail any of a variety of non-genital surgical procedures such as mastectomy, chest reconstruction, breast augmentation, facial feminising surgery, buttock and hips augmentation, liposuction, Adam's apple contouring, etc.

[11] The Yogyakarta Principles are a set of international principles that clarify the nature, scope and implementation of States' human rights obligations under existing human rights treaties and law in relation to sexual orientation and gender identity.

Second: The lived reality does not reflect this legal decision. The Department of Home Affairs places the greater good of a binary sex/gendered system that is able to clearly distinguish between male and female trans* citizens by means of genital surgery above the risk imposed on the individual. Why and how the removal of reproductive organs – which are usually hidden to the eye of the public anyway – prevents fraud has, however, never been convincingly argued. Nevertheless, all trans* citizens (whether happy to comply or not) are coerced by the Department to undergo sex reassignment surgery that entails sterilisation and thus to use specific (however only very difficult to access) medical technologies, if they want to be legally recognised in their lived gender.

Users and "Script-Changers" of Sexing/Gendering Technologies

So far I have only talked about the role of state, legislature, and biomedicine in defining and configuring the trans* citizen as a user of sexing/gendering technologies.[12] But not only the trans* citizen is configured as a user – technologies also carry "scripts". "Madeleine Akrich (1992) observed that assumptions about users are "inscribed" into technologies – in the form of a "script" – by the innovators that develop them" (Rose and Blume 2003: 108). In the same way that trans* citizens are not passive subjects and can resist their configuration, they can as users of technologies also resist, modify or differently interpret the "scripts" of certain technologies. In fact "To resist the configuring, and disciplining, effects of (…) technologies may be to protest the social policies implicated by the technologies themselves" (Rose and Blume 2003: 106). Due to the fact that trans* users are not a homogenous group, but heterogeneous along e.g. gender, ability status, 'race'/ethnicity, religion, class, sexual orientation, and their socio-economic possibilities there are innumerable possibilities in the ways they accept, resist, modify, and interpret the "scripts" of technologies. This is also true for the choices of technologies themselves. There is, however, some risk associated with choice: some choices are considered less acceptable than others, and those citizens who choose to resist, modify, or differently use technologies face social and legal sanctions.

Keeping the diversity of South African trans* citizens in mind, I will address the following questions: How do trans* citizens experiment with technologies? More specifically, what are new uses for technologies that were originally invented/intended for a different purpose?

In the following I will present two examples. First, the example of the birth control pill and hormone replacement therapy as technologies originally invented for cis-gendered women and appropriated by trans* women as a substitute for female hormones, and second, the experimentation with technologies other than the pill or hormone replacement therapy by citizens who define their identity outside of a binary-sex/gender-system (e.g. breast implants in physically male citizens or the re-categorisation of gender with regard to the corporeality of pregnant transmen).

Birth Control Pill and Hormone Replacement Therapy

The birth control pill is an excellent example for a technology put to new uses, experimentation with technologies as well as citizen science. Knowledge about the usage is gained through acquaintances, the internet, and self-experiment.

[12] Naturally, the range of actors involved in the configuration is much broader and includes for example journalists, public-sector agencies, policy makers, and social movements. Due to limited space, this has to be discussed in a different paper.

> (…) because everybody think that you're a little moffie[13], they start telling you stories and whatsoever, and then this one girl said something like (…) she's got a moffie friend and she takes birth control and it actually makes her tits big. You could never tell that to me! So there I was like looking for birth control everywhere – even telling my friend to get me some. So I like had a whole packet, like swallow it, yeah, like I went to school and I actually like fainted [laughs]. (…) I've learned then (…) it doesn't work like that. So that is when I first heard about the pill. (Anonymous, 24 September 2007)[14]

The contraceptive pill is especially popular with trans* women as it is said to cause a greater increase in breast size than the hormones available at GPs and endocrinologists. Another reason for its popularity is that access to biomedical care and body-altering products depends to a great extent on financial resources. Many of the MtF interviewees with low or no income stated that they had tried to gain access to birth control pills instead of (or after unsuccessfully) seeking admittance to biomedical supervised hormone treatment. Contraceptive pills are available free of charge at public sector family planning clinics. However, they are only given to cis-women and not to MtFs. Thus the interviewees were dependent on cis-gendered women (and sometimes FtMs who could still pass as women) for help as long as they were not able to pass as cis-women themselves.

> I'm actually starting to run out of the pill now, so I have to like look for nice friends again, to say 'go fetch me the pill at the clinic'. But then most of my friends are on the injection. (…)
>
> Th.K.: Can't you go yourself?
>
> (…) I don't know, I haven't tried it, but I'm scared [pause] because if you go to a clinic, you have to open a folder. (…) they are obviously going to see I'm male. Who gives birth control to males if it's not condoms? So (…) yeah, I can't go hey? They'll probably tell me that the mental institute is that side. (Anonymous, 24 September 2007)

Trans* citizens are not only resourceful in finding access to hormones but also in increasing the dosage. An 82-year-old transwoman told to me how she accesses the dosage she finds agreeable.

> I get them from the chemist down the road. (…) Some of them I get from the day hospital (…) in XXX. (…) I got a prescription from the doctor at the corner. (…) And he gave me the prescription without any query at all. (…) At the hospital of course I don't pay but I have to pay for them here [at the chemist with the prescription from the doctor]. I get both things. So I get a higher dosis [Premarin]. You see, I get 2.5, [laughs] just what I want. 1.25 is not enough! (Prier, 17 March 2008)

In the cited case she does not refer to birth control pills but to Premarin, which is a form of hormone replacement therapy. Premarin pills were developed for post menopausal women but are used for trans* and intersexed persons as well.

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[13] *Moffie* is a derogatory South African term for (feminine) gay men. It also connotes intersexuality.

[14] Some interviewees requested on their informed consent forms to have their names or a pseudonym of their choice used in quotations, others preferred not to be identified. However not all of the interviews are transcribed fully yet, therefore only few interviewees had the possibility to check their transcripts and get their forms back to me. Interviewees who had not the chance to check their transcripts, will not be identified in this article. This is also true for citations from internet fora.

Citizens with Un-accommodated Gender Identities

I have outlined above how the executive organs of the South African state configure the trans* citizen user of sexing/gendering technologies as a person whose gender identity does not match the assigned sex at birth, but who is willing to adjust his or her body in a way that reflects the binary of the sex/gender system. Nevertheless, technologies are also used by trans* citizens that identify differently.

> (…) choosing an identity is a difficult one because I change and shift and move around. [pause] I am...South African. Hmm, I am, I identify myself as male *mostly*, uh, but that is not a strict definition. (…) I have a BA, an LLB, and a Masters in Social Science from UCT and, uh, I'm a non practising attorney and I am currently doing my PhD in sexuality studies. (…) I'm not particularly attached to whether I'm identified as male or female because I don't really think that there's that much of a difference between them anyway. (…) So I identify myself as male because I was brought up as one and that's fine – but there's certain elements within my sexuality and within my self-identity which don't really fit that male mould, hmm, and are more on the feminine side for want of a better term. (…) as a result I've shifted my own (…) physicality to reflect that in certain ways. I've had breast implants hmm, and sometimes play with hormones (…) but that's a reflection of an internal sense of self in terms of accessing my more feminine side. Now identifying, identifying what 'feminine' *is*, for me is very difficult because to me it's a *human* experience, and (…) identifying masculine and feminine *traits* is not necessarily a very helpful way of looking at things because if you could use all of those old stereotypes of hmm, kind of dominant versus submissive as male versus female and active versus passive, none of that really worked because everybody's got all of that, every human being has got all of that inherent or implicit in them. (Lincoln Theo, 07 February 2007)

Lincoln neither identifies in a way the South African state envisaged for its trans* citizens:

> I've never wanted to kind of go from one box to another box. Hmm, so it was a questionable(...) uh, how do I then reconcile wanting to be both and altogether or *neither* male nor female. (Lincoln Theo, 07 February 2007)

nor does ze[15] agree with the current practise of the Department of Home Affairs that ensures that the physiognomy of South African trans* citizens matches their gender identity while it ensures at the same time that there are only two sexes and genders.

> I get a sense that if there was a different world, if we had a different social structure, that those people would not necessarily be attached to their identity, they would be more fluid and just identify (…) the kinds of *self* that they feel they need to be without having to, without feeling the need to *transition*, to become what they want. (…) some people feel as though there is something very, very different from the role they're sort of encouraged to perform and therefore make a transition. Other people do this in a (…) different way and don't feel a need to transform themselves physically to match their emotional state. (Lincoln Theo, 07 Febuary 2007)

However, due to the powerful sex-binary structures mediated through biomedicine and implemented through the state, it becomes quite difficult to express ones identity when it is in opposition to state policies. Some trans* citizens' bodies thus become quintessentially outlawed

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[15] Ze, hir, hirself, etc. are gender neutral pronouns. They are used as a step in the direction of gender-neutral language and an attempt to work against a linguistic consolidation of the gender-binary in order to make trans* and intersexed people visible.

bodies. This means, Lincoln could not access surgery through a state hospital. Ze accessed surgery via a private surgeon who was only willing to perform the surgery after several years of hesitation.

> It only happened when I was about twenty eight, (…) I mean I've been wanting breasts for a *long time*, but I never allowed myself to imagine that that would be a possibility (…) and then I realized that it actually *is* a possibility. (…) I'd stretched my ear lobes and they'd gotten thin on the inside so I needed to go see a plastic surgeon to go, to get them fixed. So I went in and I just suddenly, as I was sitting there, thought I want breasts and I want to see if I can ask this person if he would do them... so and as I was sitting there it suddenly kind of bubbled up from the inside – I *know* I've always wanted this, hmm, but I can actually possibly *have* it... and so I'd asked and it was a whole long kind of process from then in terms of actually getting them [he got them four years later]. (Lincoln Theo, 07 February 2007)

Breast enhancement also belongs to the technologies that were originally intended for a different cause. Even though this technology has a long tradition of being used in reassignment surgery it has only been performed in state hospitals on trans* citizens who identify firmly as female. As has become quite apparent in hir statements, Lincoln does not identify as a woman nor can ze place hirself in a bi-gendered system.

Another example of unforeseen and un-accommodated citizens (though explicitly not gender outlaws) are pregnant trans* men. As there is no homogenous trans* community pregnancy in trans* men was discussed very controversially. This was especially the case as Thomas Beatie – the US American transman falsely celebrated by the press as the first[16] pregnant (trans-)man – made the headlines in the South African Press. Comments within the trans* community ranged from dismissive

> What do you guys think of Thomas Beatie being pregnant again? The outrage from the "normal" crowd saying he went too far, calling him a mutilated lesbian on the Barbara Walters show. I think he just screwed up the TS cause for us very badly and put us back a few years. (Comment on a South African internet trans* forum by a transwoman, 20 November 2008)

> Maybe FTM should be sterilised. After all MTF are. It would make the playing field even and then Thomas Beatie things won't happen. (Comment on a South African internet trans* forum by a transwoman, 1 December 2008)

to supportive

> I think it's very brave. Personally I wouldn't do it, because I didn't want any female body parts. (…) I think he is very brave to come out doing it in public and maybe it's high time! (transman 40 years old, 27 April 2008)

> I thought about this issue again in terms of what I can argue and what not. I can not argue that men don't have babies. Men don't have babies. (…) Being transgender though.... FtM's can have babies. (…) So anti-Beatie people would like to argue that FtM's should NOT be PERMITTED to have babies? (…) You get to be of the opinion that FtM's should not have

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[16] Trans* parents or pregnant trans* men are not such an unusual case as depicted by the press. In 2005 – three years before Thomas Beatie's pregnancy – filmmaker Jules Rosskam featured the experiences of 19 female-to-male transgender parents in his documentary film "Transparents", broaching the issue of the invisibility of transgender parenting in the contemporary discourse. And already in 2000 the Village Voice provided an article about the parenthood of two trans* men in 1999 (Califia-Rice 2000).

> babies. I am also free. I get to think that FtM's SHOULD have the OPTION of having babies. (Comment on a South African internet trans* forum by a transman, 23 November 2008)

> I would say that is the ultimate trans experience. (...) I think it is a very, very bold, very enlightened step. Because he is offering his whole self. You know? And *yeah*, it is not compartment, compartmentalizing, he is not saying that "This is what I was and I don't want anything to do with it!" You know? Now I'm this! He is saying, "This is who I am". (transwoman 65 years old, 02 April 2008)

Those who were dismissive mostly feared that their rights as fully acknowledged citizens would suffer from gender identities or bodies outside the socially accepted bi-gendered/sexed-system.

> We have to remember that the DSM V [Diagnostic and Statistical Manual of Mental Disorders] is about to be discussed and will [be] put in place. The doctors who write these guidelines will have a look at what is happening and the criteria can be come stricter because of one individual's action. (…) People see this as a joke and view TS issues as weird and unnatural. We want to be accepted as part of society and therefore need to play by society rules. (Comment on a South African internet trans* forum by a transwoman, 27 November 2008)

Even though it was acknowledged that the case of Thomas Beatie might be used to harm the rights of trans* people it was also pointed out that it might in fact benefit the trans* cause.

> Society wasn't ready for slavery to be abolished, or for women to gain the vote, or for racial equality, or for any other big revolution. Let's face it folks, society has to be dragged into the future kicking and screaming. And it is brave individuals like Mr. Beatie and his wife who do so. The only reason any of us find this abhorrent is because of social conditioning – the very same conditioning we rail against when we try to get people to accept us. (Comment on a South African internet trans* forum by a transwoman, 24 November 2008)

Even though the trans* citizen as a user of medical technologies is configured in a bi-gendered model, these citizens are not always passive recipients but, as seen in the examples above, quite active participants. The agency of users in the re-shaping of their bodies and identities as consumers in markets is often overlooked when analysing them solely in their role as citizens of states. In the following section I will move on to explore their local and global agency within the realms of supranational citizenship, citizen science, and medical tourism – depending on their economic possibilities.

Supranational Citizenship, Citizen Science, and Medical Tourism

Citizenship is increasingly perceived as more than the legal rights and duties one gains through the membership in a political community. Instead it has become defined in terms of a social process through which rights are expanded and claimed. One of these claims entails the right to be healthy, achieve health or transition in ways that might be in opposition to state policies. In order to claim rights in opposition to state policies international courts gain importance. "Where citizenship rights fail to provide protection of individuals from the state, the individuals will appeal to international courts for protection of human rights" (Isin and Turner 2008: 7). Similarly, the significance of

supranational citizenship increases. Linklater states in his extensive discussion of cosmopolitan citizenship, that:

> The universal human rights culture is deemed to be evidence of the emerging law of world citizens; cosmopolitan citizenship is thought to be exemplified by the increasing global role of INGOS[17] and by efforts to promote the democratisation of world politics. (Linklater 2008: 330)

Without wanting to go too deep into the discussions around cosmopolitan citizenship, the importance of international non-governmental organisations such as the Trans Secretariat[18] of the International Lesbian and Gay Association (ILGA) and the International Gay and Lesbian Human Rights Commission (IGLHRC), international conferences (e.g. the Yogyakarta Conference of November 2006 and the Global Arc of Justice Conference 2009), and the possibility of individuals to invoke international law against their own state have clearly become important factors for the work of trans* activists and have led – if not to a cosmopolitan trans* citizenship – at least to international trans* activist networks and movements. I have demonstrated elsewhere (Klein 2009) that South African trans* activists are involved in a broader international social movement addressing gender and sexuality.

> As a simple matter of law, nationality is the primary axis by which peoples are classified and distributed in polities across the globe. However the continuing rise of new forms of cultural politics has challenged modern understandings of belonging and has contributed to rethinking the meaning of citizenship. (Isin and Turner 2008: 4)

This internationalisation has led to an extension of the idea of citizenship to an international level and is already reflected as for example in the European Union and within the Commonwealth of Nations. Both the European Union as well as the Commonwealth of Nations offer citizenship to South Africans of European descent. This is interesting for trans* citizens who would like to transition, for example, in the Netherlands or in the UK. Thus the idea of citizenship as connected to a specific political community such as a country has increasingly expanded through international human rights to larger entities. "In the last two decades of the twentieth century, postmodernisation and globalization challenged the nation-state as the sole source of authority of citizenship and democracy" (Isin and Turner 2008: 4). Trans* citizens not only visit other countries in their capacity as supranational citizens, they also have the possibility to get the surgeries they desire as medical tourists. Many South African transwomen travel to Thailand. Thailand has very experienced surgeons who carry out many more surgeries than the experienced surgeons in South Africa. As of January 2006, Dr. Suporn (a Thai surgeon frequented by some of my interviewees) performed almost 1100 primary cases of reassignment surgery. In the same time period (2006–2008) the team of surgeons at Pretoria Academic Hospital carried out surgeries on about 8–12 people.

> Look, at the end of the day it is your personal choice. I am sure the local doctors are competent enough and are capable of doing a good job. My personal choice was to go to Thailand though as I felt that they are by far more experienced than anything local. One

[17] International Nongovernmental Organisations.

[18] The purpose of Trans Secretariat is to connect all the activist groups around the world who are working on transgender, transsexual, or transvestite issues.

> thing I am sure about (...) when it comes to medical care, nothing we have locally comes even close to what I have experienced in Thailand. Their pain management was absolutely brilliant. They treat you with respect and are gentle and kind. For me, this was something very important to me, so I went what I thought was the best person for the job. I wasn't about to take any chances. I had no complications and everything went very smoothly. (Comment on a South African internet trans* forum by a transwoman, 28 June 2005)

Gender Reassignment is regarded as a common procedure in Thailand. There are over 170 active surgeons. Two local associations provide education or certification for surgeons doing Sex Reassignment Surgery (SRS). *The Society of Plastic and Reconstructive Surgeons of Thailand* and *The Thai Academy of Cosmetic Surgery and Medicine*. This is in stark contrast to South Africa where there is no such society and only very little training available. South African trans* citizens who were able to be classified as transsexual by a psychologist, in line with the World Professional Association for Transgender Health's (WPATH) Standards of Care for Gender Identity Disorders[19] will only be seen at two hospitals: Groote Schuur Hospital in Cape Town and Pretoria Academic Hospital.

In contrast, Thai surgeons are renowned for their skill and performance in very difficult cases. In 2005 I also got into contact with a transwoman who had taken to a rather unorthodox method to get rid of her male genitalia: She shot her genitalia in order to destroy them. This, however, led to a physique with very little material left to do reassignment surgery (often penile inversion). This is how she tells the story in a report to a South African trans* group in 2006 when she finally received surgery.

> My beginnings in Sex Change Surgery began many years ago in a very unusual way: In a twenty year old frustrated fit of pique I tried to do for myself what my ignorance prevented me from finding, and being skilled in the use of certain tools, chose as my scalpel a .357 Magnum revolver, loaded with 158 grain semi jacketed hollow point Norma round. Designed specifically to destroy flesh. Let's be honest and say the results to a mere penis and scrotum were not pretty. Even after reconstruction. So when I finally came to choosing my surgeon for SRS, my candid opinion is the 'lucky' surgeon was not starting on level ground, as he would be with most 'normal' cases. Yet my 'want list' now at age 49 was as ambitious as any girls': aesthetics, depth, being sensate. Well, perfection would be acceptable.
>
> Several of my South African sisters had been elsewhere, and I was not very impressed with the 'local' talent simply because although there is evidently one good doctor, there were seemingly few willing satisfied customers to testify. Cost was also no-where near realistic for me. The name Chettawut did begin to occur rather frequently, and in favourable light. More digging, more favourable results. What particularly hooked my attention was that he seemed to do more than his fair share of 'difficult' procedures, and yet still come out with exceptional results. (Report submitted by XXX to a South African TS-Yahoo-Group on 28 March 06)

A further advantage of Thailand is that under existing Thai law, it is not necessary to comply with the Standards of Care (SOC) as set by WPATH. I need to add though that this was never mentioned to me as an asset. A much more important factor is money.

> On FFS [Facial Feminisation Surgery]: I guess the USA has a few good plastic boffins around with Hollywood and the likes of Michael Jackson but obviously at a nice juicy price.

[19] Formerly known as the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, or simply as Standards of Care, SOC.

> Having looked around I found more affordable offerings in Thailand with the likes of Dr. Suporn (most expensive and two stage SRS) and Dr. Chettawut (more reasonable pricing). Their websites give you a good idea of before and after results as well. In SA [South Africa] we apparently have some of the world's best plastic surgeons but at a nice stiff price if you can find one who will do specifically FFS. I have not found one locally to be honest. For folks like us with little money to throw around I think Thailand will be the best option if you consider FFS. (Comment on a South African internet trans* forum by a transwoman, 17 August 2005)

Surgery in Thailand including recovery period, bringing a partner along and doing some sight seeing is still cheaper than going to a private surgeon in South Africa.

> It cost me R65 000 (@ R7 to the Dollar) things are better now. I also went to Dr. Chettawut and would recommend him. The R65 000 included my partner which I feel is a must. It is not something to even if you are surrounded by English people. Local would have cost me more, about R90 000 if I went from Cape Town to Dr Ladas. His fee alone = my whole trip to Thailand including some sight seeing and shopping! The best is that you can deduct all the expenses including travel from tax. (Comment on a South African internet trans* forum by a transwoman, 16 August 2005)

The kinds of surgery available, the procedures used by different surgeons, the outcomes and experienced problems of surgery are discussed in the internet and at private gatherings. The same is true for experimentation with hormones, how to circumvent official procedures and where to get the best medical treatment for little money. Medical science and technologies are discussed without the institutionalised presence of surgeons, endocrinologists and other medical experts. Transgender citizen science has become well established outside South Africa's public health care – with the internet playing an important role in the collection, dissemination and organisation of knowledge. It is peers – and not the established medical community – who have taken over the medical information and education of each other. Citizen science provides the answer to the question of how far the state or society may impose or limit medical intrusion on their bodies.

It is clearly the case that the state's executive organs use medical technologies as objects of identity projects to stabilise hegemonic representations of gender. Nevertheless, are trans* citizens as users of these technologies in a world market also able to de-stabilise these representations. Even if the latter is especially true for the more affluent and wealthy, that trans* citizens from poorer economic groups experiment in similar ways has been shown in the examples of the birth control pill and hormone replacement therapy.

Conclusion

The configuration of the trans* citizen by the South African state is inconsistent, to say the least. The already legally achieved change through the rapprochement of an outdated biological concept of sex defined as something physical that does not include gender identity to a contemporary biomedical understanding of sex as something fluent containing psychological and social factors has been undermined by executive organs. I have shown how the Department of Home Affairs configures trans* citizens as people who sacrifice their ability and right to procreation in order to have their gender identity legally recognised. In this case, reproductive organs – which are usually invisible to the public – become the identifier for a specific sex. As these organs cannot be surgically exchanged yet, they have to be removed. Despite a progressive legal background, the

silent background norm of a sex/gender binary carries on. Bodies and genders outside the binary of male and female are not accommodated for by the Department of Home Affairs even though they are protected by law. This deplorable state of affairs becomes even more problematic with regard to the limited amount of resources given to public reassignment surgery. At a rate of about six surgeries a year (including both FtM and MtF), access to surgery within public health care is practically unobtainable. By way of comparison, Conway (2002) gives the following estimates of MtF sex reassignment surgery operations among US residents: 1960s: 1,000; 1970s: 6,000–7,000; 1980s: 9,000–12,000; 1990s: 14,000–20,000. Theoretically, surgery can also be obtained in the much more expensive private medical sector. Thus it also becomes a question of racism, sexism, and classism as income is still intimately connected with gender and skin colour. In this sense, trans* citizens who cannot afford surgery, are denied surgery[20] or inhibited to define themselves outside the binary are denied their right to be legally recognised in their gender.

Nevertheless, trans* citizens are not solely passive subjects of governmental legislative, executive and judicial organs as well as public health care interventions but rather active agents in the re-shaping of their identities through their appropriation of sexing/gendering technologies. With regard to this some aspects of (unruly) trans* citizens' local and global agency within the realms of supranational citizenship, citizen science and medical tourism have been explored. I have shown how trans* citizens (try to) protect their right to procreation (threatening the Department of Home Affairs with trials and getting vague reports from sympathetic surgeons) and their human right to self identification (accessing technologies through supranational citizenship, medical tourism and citizen science).

[20] A history of no sex work or drug abuse, proof of employment and a stable relationship are the requirements to see the psychiatrist who evaluates trans* citizens eligibility for surgery at Pretoria Academic Hospital. People who cannot meet these criteria are not seen by this psychiatrist and therefore have no access to surgery.

References

Bilharz, Joy A. 2005. Paradigms Lost: cultural and legal implications of sexual ambiguity. *Forum on Public Policy* 1(3): 247–288.

Bornstein, Kate. 1994. *Gender Outlaw: on men, women, and the rest of us*. New York: Vintage Books.

Boswell, Holly. 1998. The Transgender Paradigm Shift toward Free Expression. In: Dallas Denny (ed.). *Current Concepts in Transgender Identity.* New York: Garland Press, pp. 55–62.

Califia-Rice, Patrick. 2000. Family Values: two dads with a difference – neither of us was born male. *Village Voice*. Tuesday, 20 June 2000.
http://www.villagevoice.com/2000-06-20/news/family-values/ (accessed 09 October 2009).

Conway, Lynn. 2002. How Frequently Does Transsexualism Occur?
http://ai.eecs.umich.edu/people/conway/TS/TSprevalence.html (accessed 09 October 2009).

Dunson, Marvin III. 2001. Sex, Gender, and Transgender: the present and future of employment discrimination law. *Berkeley Journal of Employment and Labor Law* 22(2): 465–506.

Eskridge, William N. Jr. and Nan D. Hunter. 1997. *Sexuality, Gender, and the Law*. Westbury, NY: The Foundation Press.

Fausto-Sterling, Anne. 2000. Sexing the Body. Gender politics and the construction of sexuality. New York: Basic Books.

Frye, Phyllis Randolph and Alyson Dodi Meiselman. 2001. Same-Sex Marriages Have Existed Legally in the United States for a Long Time Now. *Albany Law Review* 64(3): 1031–1072.

Government Gazette No. 26148. 2004. *Alteration of Sex Description and Sex Status Act, 2003*. Vol. 465, Cape Town, 15 March 2004.
http://www.info.gov.za/view/DownloadFileAction?id=68026 (accessed 09 October 2009).

Green, Richard. 1992. *Sexual Science and the Law*. Cambridge, MA: Harvard University Press.

Greenberg, Julie A. 1999. Defining Male and Female: intersexuality and the collision between law and biology. *Arizona Law Review* 41: 265–328.

Greenberg, Julie A. 2000. When is a Man a Man and When is a Woman a Woman? *Florida Law Review* 52: 745–768.

Hines, Sally. 2009. A Pathway to Diversity? Human rights, citizenship and the politics of transgender. *Contemporary Politics* 15(1): 87–102.

Hong, Kari. 2002. Categorical Exclusions: exploring legal responses to health care discrimination against transsexuals. *Columbia Journal of Gender and Law* 11: 88–126.

Hubbard, Ruth. 1998. Gender and Genitals: constructs of sex and gender. In: Dallas Denny (ed.). *Current Concepts in Transgender Identity.* New York: Garland Press, pp. 45–54.

Hucker, Stephen J. 1985. Medical – Legal Issues. In: Betty W. Steiner (ed.). *Gender Dysphoria: development, research, management.* New York: Plenum Press, pp. 393–410.

Isin, Engin F. and Bryan S. Turner. 2008. Citizenship Studies: an introduction. In: Engin F. Isin and Bryan S. Turner (eds.). *Handbook of Citizenship Studies.* London: Sage, pp. 1–9.

Jurisprudential Annotations to the Yogyakarta Principles. 2007. http://www.yogyakartaprinciples.org/yogyakarta-principles-jurisprudential-annotations.pdf (accessed 27 November 2009)

Klein, Thamar. 2009. Intersex and Transgender Activism in South Africa. *Liminalis* 3: 15–41. http://www.liminalis.de/2009_03/Artikel_Essay/Liminalis-2009-Klein.pdf (accessed 09 October 2009).

Linklater, Andrew. 2008. Cosmopolitan Citizenship. In: Engin F. Isin and Bryan S. Turner (eds.). *Handbook of Citizenship Studies.* London: Sage, pp. 317–332.

Lister, Ruth. 1997. *Citizenship: feminist perspectives.* Basingstoke: Macmillan.

Lister, Ruth. 2008. Sexual Citizenship. In: Engin F. Isin and Bryan S. Turner (eds.). *Handbook of Citizenship Studies.* London: Sage, pp. 191–207.

Ong, Aihwa. 2005. (Re)Articulations of Citizenship. *PS: Political Science & Politics* 38(4): 697–699.

Plummer, Ken. 2001. The Square of Intimate Citizenship: some preliminary proposals. *Citizenship Studies* 5(3): 237–253.

Pschyrembel. 1994. *Klinisches Wörterbuch*. 257. neu bearbeitete Auflage. Berlin, New York: de Gruyter.

Richardson, Diane. 1998. Sexuality and Citizenship. *Sociology* 32(1): 83–100.

Rose, Dale and Stuart Blume. 2003. Citizens as Users of Technology. An exploratory study of vaccines and vaccination. In: Nelly Oudshorn and Trevor Pinch (eds.). *How Users Matter. The co-construction of users and technologies.* Cambridge, MA: MIT Press, pp. 103–131.

Sabatello, Maya. 2009. Transgendered Parenthood: science and family life. Unpublished document. Draft – Work in Progress.
http://www.fondazionefeltrinelli.it/dm_0/FF/FeltrinelliCmsPortale/0388.pdf (accessed 09 October 2009).

Samelius, Lotta and Erik Wagberg. 2005. *Sexual Orientation and Gender Identity Issues in Development. A study of policy and administration*. Stockholm: Swedish International Development Cooperation Agency.
http://www.sida.se/shared/jsp/download.jsp?f=SIDA4948en_Sexual+Orientation+web.pdf&a=4855 (accessed 09 October 2009).

Sharpe, Andrew N. 2007. Endless Sex: the gender recognition act and the persistence of a legal category. *Feminist Legal Studies* 15(1): 57–84.

Walker, Kristen. 2001. Moving Gaily Forward? Lesbian, gay and transgender human rights in Europe. *Melbourne Journal of International Law* 2(1): 122–143.

Yeatman, Anna. 1990. Voice and Representation in the Politics of Difference. In: Anna Yeatman and Sneija Gunew (eds.). *Feminism and the Politics of Difference.* St. Leonards, Australia: Allen and Unwin, pp. 228–245.

Whittle, Stephen et al. 2008. Transgender Eurostudy: legal survey and focus on the transgender experience of health care. *ILGA-Europe.*
http://www.ilga-europe.org/europe/publications/non_periodical/transgender_eurostudy_legal_survey_and_focus_on_the_transgender_experience_of_health_care_april_2008 (accessed 27 November 2009)

Young, Iris M. 1990. *Justice and the Politics of Difference*. Princeton: Princeton University Press.