INVISIBLE CITIZENS

Transgender Bodies and the Right to Health in India, Brazil and South Africa

Debjyoti Ghosh
SJD, Comparative Constitutional Law, Central European University, March, 2018

Supervisor: Professor Judit Sandor, Central European University

Declaration of originality

This dissertation contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

_____

(Debjyoti Ghosh, Kolkata)

Table of Contents

Abstract

India, Brazil and South Africa are generally acknowledged as three rising forces of the Global South. Connected with a common history of colonialism and exploitation, the constitutions of the three countries set out to right historic wrongs. Yet, despite best intentions, some minorities, primarily those who are especially marginalised for their non-conformity in a heteronormative society, have often fallen through the sieve.

In all three countries, such individuals have articulated movements and given rise to an indigenous vocabulary to represent their identities. Despite such movements, the medico-legal systems still lag and are not as inclusive as they need to be in order to make exercising their citizenship and accessing rights straightforward.

One particular right that I focus on is the right to health. While on the face of it, it seems to be a socio-economic right, it is heavily connected to various civil and political rights, primarily the right to life. Thus, it gives the scope of checking the exercising of citizenship against its various components, and to see the (dys)functionality of the systems.

Being intrinsic to human rights, the right to health has to be facilitated by the State for citizens to be able to exercise such a right. However, what does citizenship mean for such a person from a marginalised minority? How does such a person exercise their citizenship, being an unequal citizen, when it comes to accessing rights?

This work aims at tying together the exercising of the right to health in India, Brazil and South Africa by transgender people, thus showcasing their navigating their citizenship in systems fraught with legal ambiguities, lacunae and stigma.

In order to aid my work, I delve into international and domestic legislation and jurisprudence. For further information, I carried out qualitative interviews with primary and secondary stakeholders in all three countries.

Acknowledgements

I dedicate this dissertation to my mother, late Keya Ghosh, and my father, late Chandan Kumar Ghosh.

At the outset, I would like to thank Central European University for giving me this wonderful opportunity and platform, and for standing with me as an institution. This dissertation has been a culmination of almost six years of immense pleasure, pain, adventures and misadventures. Within a year of my starting, my mother passed away, and as I was coming towards its completion, my father passed away. I would not have been able to carry this project forward without significant contributions by several people around me, especially my extended family and friends.

I was propelled towards doing a PhD by my partner, Dr. Caio Simoes de Araujo, who is also my editor-in-chief. Without his unwavering support, I would not have reached this stage. My supervisor, Professor Judit Sandor, has been a tremendous support in every way. She helped me find confidence in myself, and held me up when I was faltering. The Legal Studies Department has stood by me through thick and thin, especially during the bereavements of my parents. My sister, Devidyuti Ghosh, carried huge familial responsibilities on her shoulders in order to make sure I pull through.

I would like to thank OUT and GenderDynamix in South Africa for their immense support in helping me collect data and for connecting me to wonderful individuals. The Gay and Lesbian Archives (GALA) at the WITS University need a special mention here because of the tireless support they gave me.

I would also like to thank Associação Brasileiro Interdisciplinar de AIDS (ABIA) in Brazil for taking me on as an intern and introducing me to several key people in my field, without which I would not have been able to collate data, given the barriers I have as a non-portuguese speaking foreigner.

My former employers, Solidarity and Action Against The HIV Infection in India (SAATHII), who had initially introduced me to the world of gender minorities, have been

pivotal in my data gathering. Through them I was connected to the India HIV/AIDS Alliance, who also helped me further my research in a meaningful manner.

Lastly, but not the least, my eternal gratitude lies towards the SJD family, my colleagues-in-arms – you know who you are. We have laughed together, cried together, stood by each other, been the home away from home for so many years. Without them, it would have been impossible to reach the finishing line.

Glossary of terms and acronyms

This dissertation is spread over three different countries from the Global South with vividly different terminologies around transgender identities. Yet, most of the literature we have around sexual orientation and gender identity have a tendency of depending on Anglo-centric terminology from the Global North. For the benefit of the reader, here are some terms and acronyms around sexual orientation, gender identity and institutions that may have been explained later as well, but would be useful for understanding the research from the get go[1]:

Terms

- ***Aravani/Ali***: The term for *Hijras* in Tamil Nadu. They identify themselves as women trapped in male bodies, although many *aravanis* would prefer to be called 'Thirunangi'.
- **Bisexual**: One whose sexual or romantic attractions and behaviors are directed at members of both sexes to a significant degree.
- **Cisgender/Cis-gender/Cis:** A person who is born biologically male or female, and feels his or her gender is congruent with his or her body.
- **Cross-dresser (or transvestite)**: Refers to an individual who wears clothes and adopts behaviours associated with the other sex for emotional or sexual grati cation, and who may live part time in the cross-gender role.
- **Drag queen or king**: An individual who cross-dresses in women's or men's clothing, adopts a hyperfeminine or hypermasculine presentation, and appears part time in the cross-gender role.

[1] The terminology has been collated (mostly verbatim) from several sources, but primarily from my travels, interviews and the usage by Jack Byrne, 'Transgender Health and Human Rights' (United Nations Development Programme, December 2013); A De Villiers, 'Statement of Motiviation to Medical Aids and Medical Scheme Administrators: Medical Cover and Reimbursement for Transgender Adults' (GenderDynamix, October 2013); Robert Graham et al., 'The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding', *Washington, DC: Institute of Medicine*, 2011; Aarefa Johari, 'Hijra, Kothi, Aravani: A Quick Guide to Transgender Terminology', Text, Scroll.in, accessed 16 October 2017, https://scroll.in/article/662023/hijra-kothi-aravani-a-quick-guide-to-transgender-terminology; Venkatesan Chakrapani and others, 'Hijras/Transgender Women in India: HIV, Human Rights and Social Exclusion', 2010, http://archive.nyu.edu/handle/2451/33612; Don Kulick, *Travesti: Sex, Gender, and Culture among Brazilian Transgendered Prostitutes* (University of Chicago Press, 1998); Amanda Lock Swarr, '" Stabane," Intersexuality, and Same-Sex Relationships in South Africa', *Feminist Studies* 35, no. 3 (2009): 524–548; Thabo Msibi and Stephanie Rudwick, 'Intersections of Two IsiZulu Genderlects and the Construction of Skesana Identities', *Stellenbosch Papers in Linguistics Plus* 46 (2015): 51–66.

- **Eunuch**: A person who is born male but is emasculated or castrated. If castration takes place at an early age, as is often the case, it can have major hormonal consequences. A eunuch can also refer to an intersex person whose genitals are ambiguously male-like at birth.
- **Female-to-Male (FtM):** Refers to transgender people who have a male gender identity but are biologically female.
- **Gay**: An attraction and/or behavior focused exclusively or mainly on mem- bers of the same sex or gender identity; a personal or social identity based on one's same-sex attractions and membership in a sexual-minority community.
- **Gender binary:** The two most commonly referred to genders, male and female. The opposite of this is Gender non-binary.
- **Gender dysphoria**: A term for distress resulting from conflicting gender identity and sex of assignment.
- **Gender expression/ Gender self-expression**: Characteristics in appearance, personality, and behaviour culturally de ned as masculine or feminine. Transgender people are particularly vulnerable to discrimination when their gender expression combines elements of both masculine and feminine gender expression.
- **Gender Identity Disorder [GID] or Gender Incongruence:** the diagnostic term used in the case of transgender people who experience a level of incongruence between gender identity and birth-sex. This may be associated with variable degrees of emotional distress. In Brazil, this is referred to as *Transtorno de identidade de gênero* or TIG.
- **Gender identity:** The inner sense of being male, female, or something other or in-between. I use the term 'transgender' to include all people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. There are many other transgender identities, including those that describe a third gender, being both male and female, or identifying as gender non-conforming or gender variant. The opposite term to transgender is 'Cisgender'. It refers to someone whose biological sex matches their gender identity.
- **Gender non-conforming or gender variant:** Gender non-conforming encompasses people whose gender expression is different from societal expectations and/or stereotypes related to gender. Not all transgender people are gender non-conforming. Some transgender women, just like other women, are very comfortable conforming to

societal expectations of what it means to be a woman. Similarly some transgender men simply wish to blend in among other men.

- **Gender reassignment/Gender affirming/Gender realignment therapy:** refers to surgical-/medical and/or other modalities of treatment used in the process of transition.
- **Gender-variant children**: Children who are gender role nonconforming.
- **Gender:** Refers to the roles, patterns of behaviour, activities and attributes that are labeled as masculine or feminine or by any given society. It is culturally and socially constructed.
- ***Gharana:*** Literally meaning "household" in Hindi, it refers to the organisation of *Hijras* in the sub-continental area who are split into different *Gharanas*.
- **Hermaphrodite:** Refers to individuals who have both male and female sexual/reproductive organs. For this dissertation, I have subsumed them under the umbrella of transgender.
- **Heterosexual**: Refers to individuals who identify as "heterosexual" or "straight" or whose sexual or romantic attractions and behaviours focus almost exclusively on members of the other sex or gender identity.
- ***Hijra***: The Persian word is loosely translated as "eunuch" in English, but unlike eunuchs, not all *Hijras* are necessarily castrated. According to the Supreme Court of India's judgment referred to later on, *Hijras* are biological males who reject their masculine identity and identify either as women, or "not-men", or "in-between man and woman" or "neither man nor woman".In India, *Hijras* tend to identify as a community with its own initiation rituals and professions (like begging, dancing at weddings or blessing babies). The identity of the *Hijras* has traditionally been conflated with eunuchs and hermaphrodites in India. I use a capital "H" for the word as many *Hijras* often refer to the term in their names.
- **Homophobia**: A term used broadly to refer to various manifestations of sexual stigma, sexual prejudice, and self-stigma based on one's homosexual or bisexual orientation.
- **Homosexual**: As an adjective, used to refer to same-sex attraction, sexual behaviour, or sexual orientation identity; as a noun, used as an identity label by some persons whose sexual attractions and behaviours are exclusively or mainly directed to people of their same sex.
- **Hyperandrogenism**: A medical condition characterised by excessive levels of

androgens (male sex hormones such as testosterone) in the female body and the associated effects of the elevated androgen levels. It is an endocrinological disorder similar to **hyperestrogenism**, which is the opposite.

- **Hysterectomy:** Surgical procedure to remove part or all of the uterus generally in women.
- **Intersex**: Characterised by ambiguous genitalia [neither clearly male nor female]. While a trans person is usually born with a male or female body, an intersex person is born with sexual anatomy, reproductive organs and/or chromosome patterns that do not fit the typical definition of male or female. These may be apparent at birth or emerge later in life, often at puberty. There are many different intersex medical conditions. Typically, intersex people do not want to be defined by a medical condition or term. Surgeries altering an intersex child's body may limit the surgical options available if that child wishes to transition later in life. It does not describe gender identity and must not be confused with transgender. However, in several regions, transgender and intersex advocates work closely together on these issues. Intersex people who also identify as transgender face additional barriers if they wish to medically transition. For the purposes of this dissertation, I consider intersex under the umbrella of transgender.
- ***Jogti hijras***: In Maharashtra and Karnataka, *jogtas* and *jogtis* refer to male and female servants who dedicate (or are made to dedicate) their lives to gods in different temples. *Jogti hijras* refer to male-to-female transgenders who devote themselves to the service of a particular god.
- ***Kinnar***: The term for *Hijras* in north India. In other parts of India, such as Maharashtra, the term *Kinnar* is being used more recently by the better-educated *Hijras* to refer to themselves.
- ***Kothi***: The judgment describes *kothis* as a heterogeneous group, because it refers to biological males who show varying degrees of being effeminate. They prefer to take the feminine role in same-sex relationships, though many *kothis* are bisexual. Some *Hijras* identify as *kothi* as well, while not all *kothis* identify as *Hijra* or even transgender. They do not live in separate communities.
- **Lesbian**: As an adjective, used to refer to female same-sex attraction and sexual behavior; as a noun, used as a sexual orientation identity label by women whose sexual attractions and behaviors are exclusively or mainly directed to other women.

- **Male-to-Female (MtF):** Refers to transgender people with a female gender identity but biologically male
- **Mastectomy:** Breast reduction surgery generally in women. such as mastectomy and hysterectomy.
- **Moffie:** A South African slang referring to an effeminate male who dresses like women (similar to a cross-dresser/drag queen).
- **Neophalloplasty**: penis construction through surgery, as opposed to phalloplasty which is about changing the shape or form of a penis.
- **Queer**: In contemporary usage, an inclusive, unifying sociopolitical, self- af rming umbrella term for people who are gay; lesbian; bisexual; pansexual; transgender; transsexual; intersexual; genderqueer; or of any other non-heterosexual sexuality, sexual anatomy, or gender identity.[1] Historically, a term of derision for gay, lesbian, and bisexual people.
- **Real life experience**: With respect to transgender persons, denotes living full time in the preferred gender role.
- **Seropositive**: a positive serostatus indicates that a person has antibodies to fight HIV and is HIV-positive.
- **Serostatus (or HIV serostatus)**: Blood test results indicating the presence or absence of antibodies the immune system creates to fight HIV. A
- **Sex**: In the context of the dissertation, it refers to the genetic, hormonal, anatomical and physiological characteristics on which basis one is labelled at birth [birth-sex] to be either male, female or intersex.
- **Sexual orientation**: An intrinsic part of a person's identity. It encompasses attraction, behavior, and identity. It refers to one's preference in sexual partnership. Terms describing sexual orientation include "heterosexual", "homosexual", "bisexual", "lesbian", "gay", etc. It is distinct from gender identity; trans people may be heterosexual, lesbian, gay or bisexual (or pansexual).
- ***Shiv-shakthis***: Typically referring to a community of transgenders in Andhra Pradesh, *Shiv-shakthis* are males who are considered "possessed by" or "married to" the gods, particularly Lord Shiva. They have a feminine gender expression and cross-dress as women during religious rituals and festivals. They work typically as astrologers or spiritual healers. The community is guarded by gurus who induct disciples and train them for the work.

- ***Skesana*:** A word of Zulu origin (but a combination of two dialects) which was used by men who took on the submissive role or the role of a wife in a relationship with another man.
- ***Stabane*:** A word of Zulu origin used to describe an intersex person. It is often connected with intersex people who identify as lesbians.
- **Third Gender**: A categorisation of gender for those gender nonconforming individuals who do not necessarily identify with the gender binary. The *Hijras* of India, Pakistan and Bangladesh, as well as the *Fa'afafines* of the Philippines are two such groups of non-western transgender communities who are often identified as third gender. It is categorised as "other".
- **Transgender/Trans/Trans***: An umbrella term for individuals whose birth-sex, gender identity and gender expression do not match. A person with male birth-sex may identify as female, adopt a female role and present as female. She may be referred to as a trans woman or male-to-female transgender (MtF). A person with female birth-sex may identify as male, adopt a male role and present as male. He is also referred to as a trans man or female-to-male transgender (FtM) . A transgender person can also be on the gender continuum between male and female and refer to themself as just trans. For this dissertation, I am using Transgender as the primary umbrella term for all gender nonconforming individuals. However, my interviewees and quotations may have the other terms.
- **Transition/Transitioning:** Refers to the process of physical change and psychological adaptation which is undertaken by persons with GID/Gender Dysphoria in order to achieve greater congruence between the birth-sex and experienced gender identity. Many of the steps aim to change how others perceive gender identity. These are sometimes called 'social gender recognition' and may involve changes to outward appearance, mannerisms or the name someone uses in everyday interactions. Other aspects of transitioning focus on legal recognition, and often centre on changing name and sex details on official identification documents. There are often overlaps, particularly in countries where it is difficult for people to informally change their name without going through a legal process. Transitioning may also involve medical steps such as hormone treatment and surgeries. However, transition is not defined by medical steps taken or not taken. As discussed later in the dissertation, many transgender people cannot access gender-affirming health services, and others may not

need to access such services. Controversially, most transgender people who do have access to gender-affirming health services are required to accept a mental health diagnosis in order to be eligible to transition.

- **Transphobia**: A term used broadly to refer to various manifestations of stigma and prejudice against one's gender role nonconformity.
- **Transsexual:** An individual who strongly identifies with the other sex and seeks hormones and/or sex reassignment surgery to feminise or masculinise the body; may live full time in the cross-gender role. For the purpose of this dissertation, I have subsumed them under the umbrella of the transgender label.
- ***Travesti:*** A gender identity unique to Latin America, and in the current research, particular to Brazil. *Travestis* are primarily male-to-female impersonators and like the *Hijras* of India, are unique insofar as they often go for sex-change operations, but they do not always identify as women. Many of them undergo hormone replacement therapy, and breast and buttocks augmentation, but not vaginoplasty.
- **Two spirit**: Adopted in 1990 at the third annual spiritual gathering of North American LGBT Natives, the term derives from the northern Algonquin word *niizh manitoag,* meaning "two spirits," and refers to the inclusion of both feminine and masculine components in one individual.

Acronyms

- **AIDS**- acquired immune deficiency syndrome
- **CBO**-community-based organization (here including non-registered networks and groups, as well as more formal and/or funded organizations)
- **CEDAW**- Convention on the Elimination of All Forms of Discrimination against Women
- **CESCR**- United Nations Committee on Economic, Social and Cultural Rights
- **DSM**- Diagnostic and Statistical Manual of Mental Disorders, currently in its 5th version
- **FSW**- Female sex worker(s)
- **GID**- Gender Identity Disorder
- **HIV**- Human immunodeficiency virus
- **IBSA-** The geo-political grouping of India, Brazil and South Africa which came to being in 2003 to form the basis of higher South-South Cooperation.

- **ICD** – International Classification of Diseases, currently in its 10th version, with the 11th version being tested out.
- **ICESCR**-International Convention on Economic, Social and Cultural Rights
- **LGB**- Lesbian, gay, and bisexual
- **LGBT**- Lesbian, gay, bisexual and transgender
- **LGBTTQIAA** – Acronym for Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Intersex, Asexual and Ally. There are many combinations of these identities. One of the most commonly used one is the acronym '**LGBT**' that stands for 'lesbian, gay, bisexual and transgender'. It includes three sexual orientation terms (lesbian, gay and bisexual) and one gender identity term (transgender, or trans). This distinction between sexual orientation and gender identity is not always clear-cut, particularly in communities and cultures where one term is used to describe both. In most of the Pacific and parts of Asia, the same term is used by transgender women and many gay men. For this dissertation, I am using LGBT as opposed to the longer acronym.
- **MSM**- Men who have sex with men
- **MSW**-Male sex worker(s)
- **NEPAD**- New Economic Partnership for Africa's Development
- **NGO**- Non-governmental organization
- **SOC**- Standards of Care introduced by WPATH, currently in its 7th edition
- **STD** – Sexually Transmitted Disease
- **TSW**- Transgender sex worker(s)
- **UN**- United Nations
- **UNAIDS**- Joint United Nations Programme on HIV/AIDS
- **UNDP**- United Nations Development Programme
- **WHO**- World Health Organization
- **WPATH**- World Professional Association for Transgender Health. The WPATH7 are the guidelines for transgender healthcare, also known as SOC7.
- **SAARC** – South Asian Association for Regional Cooperation, comprising of Afghanisthan, Bangladesh, Bhutan, India, Nepal, the Maldives, Pakistan and Sri Lanka.
- **SADC**- South African Development Community, consisting of Angola, Botswana,

Congo (DR), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Seychelles is still in the process of ratifying the SADC Treaty.

- **MERCOSUL/MERCOSUR -** *Mercado Comum do Sul/Sur,* consisting of Argentina, Brazil, Paraguay and Uruguay.
- **IBSA-** Association of India, Brazil, South Africa, formed as a platform for knowledge exchange and developmental practices.
- **BRICS-** Association of Brazil, Russia, India, China, South Africa for economic development, and better cooperation.

Introduction

> [I]f I go to the toilet and someone bars me from entering, there is a law that protects me, I have the number of the law, I can tell the person about the law, it is not ideal that I need to give a speech defending my rights at the door of a public toilet, but it is a start to change our culture, so yes, we need legal support in all manners, until people adapt, and society adapts, to sexual diversity.
>
> - Tais Azevedo[2]

Our world has over 7 billion human inhabitants, with several ancient cultures and languages, inhabiting almost every corner of the globe. Despite this rich fabric of diversity, which should have made our lived experiences richer, we have had instances in history of total annihilation of cultures and populations. Humankind refuses to accept everyone who exists within its folds, in all their forms. Whether defined on the basis of ethnicity, colour, religion, gender, sexuality, the "other" is constantly hunted by the spectrum of exclusion, discrimination, and denial of belonging.

The shock of the Second World War in the 20th Century was probably one of the few instances in human history when the world took stock of the devastation caused to humankind in general, and the planned annihilation of specific populations. Thus, came a commitment to a future where such incidents would not be repeated. While it may be amiss to say that the world has not seen several separate instances of barbarism of humans against humans, the scale of the devastation of the Second World War has not been repeated at one stretch. Despite these setbacks, the overall commitment towards democracy, civil and political rights, and economic, social and cultural rights has forged ahead, and a striking development is our

[2] Interview with Tais Azevedo, São Paulo, July 2016.

progressive commitment globally towards ensuring human rights and better and universal health.

The Sustainable Development Goals put forward by the United Nations, to be achieved by 2030, have a very important aspect relevant to this work, in its goal number three: good health for all. As of 2018, the mandate of leaving no one behind is still a fact in the making. How to better understand the difficult relations between the "other" and the universality of law? How to understand the process whereby some kinds of people get to exercise rights while others are excluded from them? When some get medical treatment while others are denied care? More importantly, how to address this situation by resorting to constitutional guarantees so that the "other" can, too, claim their rights, including the right to health and to dispose of their own bodies as they wish?

This is a critical question because bodies are created and regulated by medicine and law. Within this narrative of creation and regulation, some bodies fall through the sieve and receive less or no attention. When they do receive attention, it is generally the negative kind. Historically, the body, once it had manifested itself to be either of no use or having become diseased, along with the person, it was either pushed to the margins of society, or cast out entirely. For instance, at several moments in history, people with leprosy were shunted into lepers' colonies, and people with physical deformities became the cynosures of circuses or entertainment units.[3] Dwarves, midgets, giants, bearded ladies, even people with scarred faces who were considered ugly enough to be entertaining (for their shock value) were celebrated for their acts in the entertainment arena, but seldom looked upon as fully humans, worthy of claiming rights before the State.

[3] Robert Bogdan, *Freak Show: Presenting Human Oddities for Amusement and Profit* (University of Chicago Press, 2014); Rosemarie Garland Thomson, *Freakery: Cultural Spectacles of the Extraordinary Body* (NYU Press, 1996).

Likewise, a person with an undefined gender, a body with undefined biological and sexual characteristics becomes either venerated or relegated to the absolute side lines, excluded, outcast as a freak, a monster, or an abnormal being.[4] One such population were (and in many places of the world, still are) the incredibly varied persons who challenge established gender categories and are brought under the umbrella of "transgender".

This dissertation aims to analyse the interactions of transgender people with the State through the lens of the right to health. It focuses on the Global South[5], and more specifically on India, Brazil and South Africa – an unusual geopolitical grouping, given that most such bodies are formed within neighbouring nations. The study covers international and national jurisdictions while also paying attention to the ways in which laws are mobilised and translated (or not) into practice. This, in turn, allows me to analyse how transgender people exercise their citizenship and claim their constitutional rights from the State on their everyday life despite not fitting into the gender binaries that so powerfully shape many State-run institutions and services, including public health. At the end, this dissertation aims to come up with a best-practices scenario gleaned from the varied experiences of transgender citizenship in the three countries.

Viewing the Transgender Identity through the lens of HIV/AIDS

Both political advocacy and academic scholarship in the field of gender and sexuality studies has developed substantially in the last two decades. The 1980s were a crucial period, which led to the revitalising of the gay movement in the West and the emergence of various

[4] Foucault, Abnormal, refer to pages about hermaphrodites. Michel Foucault, Valerio Marchetti, and Graham Burchell, *Abnormal: Lectures at the Collège de France 1974 - 1975*, Lectures at the Collège de France (London: Verso, 2003), 55–61.

[5] For the definition of Global South, please refer to Dr. Harold Damerow, 'International Politics, GOV 207 Global South' (Union County College, 27 August 2010), http://faculty.ucc.edu/egh-damerow/global_south.htm., available online at http://faculty.ucc.edu/egh-damerow/global_south.htm(last accessed 20-12-2001.

local variants of gay mobilization across the world.[6] This was the era of the global HIV-epidemic as well, which has since been closely associated, in public debate and policy, to gay culture, and sexual and gender minorities. This situation served to redirect public concerns and state priorities on the gay population towards health issues and policy-making. In four decades, the relationship between HIV-policy and gay rights has changed dramatically with the pressure exercised by social movements pushing forward an ever more diverse agenda.

Ironically, it was HIV/AIDS that acted as a uniting and inclusive force, even if through a medicalised gaze. This also brought about ties between the lesbian and gay communities, who started working in a united political front. The very expansion of the "gay" movement to include a much broader spectrum of identities – encapsulated in the acronym "LGBT" – is representative of this shifting landscape. More recently, for instance, the inclusion of bisexual men under the guise of the label of men who have sex with men (MSM) opened the door for even greater inclusivity. Moreover, the relatively little known population of male-to-female transgender people also came with the purview of HIV-related health approaches.[7]

HIV/AIDS also helped to globalise the queer rights movement since the 1980s. It was an international issue, alongside which lesbian, gay, bisexual and transgender organising and advocacy has grown. Certainly, while it is important to acknowledge the cultural and social specificities of every domestic situation, there is no doubt that transnational organisations and a globalised human rights architecture have created the impetus for change in polices and law. However, on a different level, there is a growing concern that this universalisation of LGBT identities, by prioritizing the global stage as a place of struggle, is making it more difficult for indigenous identities to access citizenship and justice. Recognizing multiple or intersectional

[6] However, scant attention has been paid to the differences in the Global South versus the Global North till quite recently.
[7] Diane Richardson and Surya Monro, *Sexuality, Equality and Diversity* (New York, NY : Palgrave Macmillan, 2012, n.d.), 14.

gender and sexual identities has, thus, become an important concern in political and academic circles alike, particularly in relation to feminist and queer theorizing.

One resorts to the LGBT acronym not only as an attestation of diversity, as mentioned above, but also because the usage of individual categories becomes problematic in contexts in which sexual and gender minorities face similar challenges and fight connected battles. Yet, we must not lose track of the specificities of the transgender phenomena. In terms of its chronology, transgender politics have surfaced in mainstream identity politics far more recently than cisgender gay and lesbian politics have. While cis bodied sexual minorities still struggle with asserting their rights before (and sometimes against) the State, transgender people often face aggravated and magnified forms of exclusion and denial of their rights, for the simple reality that they are not recognised in the gender of their choosing. As we shall see, this dissertation looks at the right to health – which is still much tied to the ambit of HIV/AIDS when it comes to sexual minorities – as a window into the differentiated citizenship being exercised by transgender people in India, Brazil and South Africa.

Choice of jurisdictions

Over the last few decades, several countries of the Global South have been on the rise both economically and politically, which has led to an increase in South-South cooperation in several key areas. This includes the formation of alternative platforms of diplomatic exchange beyond traditional spaces such as the United Nations and the World Trade Organisation, both of which are criticised as being essentially dominated by the demands and agendas emanating from the Global North, while major Western powers still hold a disproportionate amount of

influence and weight in the debate.[8] Yet, through growing mechanisms of cooperation, both bilateral and multilateral, emerging countries of the South started challenging the hegemony of Western countries. In this regard, the failure of the Cancun Talks was possibly a turning point, in which some of these countries laid the foundation stones for a future partnership and a new non-aligned movement, such as the trilateralist diplomatic partnership of India-Brazil-South Africa. Often called the new 'Middle Powers'[9], they act as catalysts or facilitators for building new coalitions or managing specific regions.[10] Moreover, they are considered to be challengers of a global architecture that is not representative of the current state of world politics.

These new Middle Powers are using some familiar tools of multilateral diplomacy, such as insisting on the sovereign equality of States along with allocation of positions as per each State's resources and capacity, thus furthering their interests. They are utilising their newfound developing status to their advantage and creating regional or platforms within which they are generally the central, speaking, powers. Examples of these are SAARC[11], SADC[12] and MERCOSUL[13]. Often, other regional actors are invited to come into the foray, but in a subordinate role to the Middle Powers on these platforms. In this dissertation, I draw on the platform formed by India, Brazil and South Africa through which to understand the transformations of constitutionalism and legal frameworks in the Global South. The platform in question here was moulded by these countries for similar goals but different rationales, due

[8] Richardson and Monro, *Sexuality, Equality and Diversity*, 14.
[9] Richardson and Monro, *Sexuality, Equality and Diversity*, 14.
[10] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South: South Africa, Brazil, India and Trilateralism', *Third World Quarterly*, Vol. 26, no. No. 7 (2005) (2005): 1077–95.,1078,Chris Alden and Marco Antonio Vieira, 1078. The Classic Middle Powers have, through successful negotiations between the two original blocs, have managed to gather great decision-making power with the Great Powers. However, they are not of the break-away questioning mindset, for they accept the hegemonic Western multilateralism, and are situated within the formal and informal frameworks such as the International Monetary Fund, the World Trade Organisation and various other bodies.
[11] South Asian Association for Regional Cooperation
[12] South African Development Community
[13] *Mercado Comum do Sul* (Sur in Spanish)

to their history, economy, internal political situations as well as their regional ambitions. I will now briefly look at each case.

India is a country with a much-entangled socio-political heterogeneity. Coupled with its bulls and bears of economic development, it has been difficult to create a 'national identity appropriate for a major power'[14]. In its postcolonial period, it became a part of two parallel movements – the Non-Aligned Movement (NAM)[15] and the SAARC. Its emergence as a power has not been questioned. Yet, at the same time, New Delhi's policies, when it comes to the duality of fostering actively friendly foreign relations while having engaged in making Pakistan (a member of SAARC) cede the territories of modern-day Bangladesh (also a member of SAARC), to making other smaller States formally or informally dependent, are often looked upon askance. Also, with the constant strains among relations with Pakistan and a formerly aggressive but currently relatively neutral stance with China has acted as a barrier to India's regional ambitions. With an economy that was liberalised as late as 1991, it is still struggling to catch up on the development pathway with China. SAARC has remained intact, despite the strained relations amongst some of the members, whereas the Non-Aligned Movement has fallen apart in various respects, one being that one of the major members, Yugoslavia, no longer exists. With so many ambiguities, it becomes difficult to be interpreted as the main leader in a region.[16]

From the early 1960s, Brazil has tried to delineate its foreign policies from the North American international agenda. In 1985, it led the way in the formation of the MERCOSUR (or MERCOSUL) with Argentina as a trade organisation for Latin American countries, which

[14] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South: South Africa, Brazil, India and Trilateralism', 1086.
[15] The Non-Aligned Movement was formed in 1961 in Belgrade under the auspices of the then-leaders, Jawaharlal Nehru of India, Sukarno of Indonesia, Josip Broz Tito of then-socialist Yugoslavia, Gamal Abdel Nasser of Egypt and Kwame Krumah of Ghana. Known as "the Initiative of Five", it was formed as a reaction to the Eastern Bloc and Western Bloc that had formed and were against each other in the Cold War. These leaders felt that developing countries should not be aligned with either, as it would put them in their power, given their nascent stages of development. Today it has over 125 members.
[16] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1087.

has been successfully running and expanding till date. In 2003, the decision of Lula da Silva's administration to align Brazil with other Southern states recalibrated this earlier rhetoric, this time investing in formalised trilateralism instead of informal or short-lived diplomatic talks, as in the past. However, domestic support has been lacking towards such trilateralism, and critics of this approach raise concerns about its economic consequences, fearing that Brazil may be ousted from accessing Northern markets. For instance, the most recent failure of MERCOSUR trade talks with the European Union made the São Paulo's Federation of Industry voice its fears about the lack of a long-term strategy. With Brazil being very dependent on developed markets for its international trade, there is bound to be resistance and scrutiny against changing trade policies and diplomatic priorities, which also questions the country's power as a leader in regional geopolitics.[17]

South Africa's domestic politics in the post-apartheid period has been tarnished by the fear that principally white-owned multinational companies may take over the business scene, in a quasi-neo-colonial situation. With white South Africans still holding high positions, and around five million black South Africans still under the poverty line[18], it is no surprise that, to many critics, neoliberal economic policies can do little to improve the status quo. South Africa is also the leader in a regional body, the South African Development Community (SADC), by contributing 70% to the overall GDP in the membership[19]. Yet, there has been a brewing disagreement within the community over the military interventions in the Democratic Republic of Congo, and South Africa's inability to assert itself through diplomatic tactics. Other initiatives in foreign policy, such as NEPAD[20], have not been completely successful in bringing the region together. Therefore, despite its economic strength and soft power as it

[17] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1084.
[18] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1083.
[19] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1086.
[20] New Economic Partnership for Africa's Development, created to bring together industrialised countries to aid economic development for South African countries.

leads industrialisation and technological advancements in the region, South Africa is on shifting sands as a classic Middle Power[21].

Despite all these challenges, the Foreign Ministers of India, Brazil and South Africa signed the Brasilia Declaration in June 2003, formally instituting the IBSA Dialogue Forum. Two months later, the three heads of State at the time presented IBSA to the United Nations' General Assembly. While this forum is intended to promote cooperation in a wide array of specific areas – such as defence, trade, technology, social and environmental development – it has an important role to play in fostering further South-South cooperation in general terms as well. With the setting up of a Trilateral Commission and a Trilateral Business Council comes the formation of a stepping stone for further cooperation among developing countries, based on the shared aspiration to improve and reform established institutions of global governance through regional articulation, even within the United Nations itself.[22]

The Brasilia Declaration brought about the IBSA Dialogue Forum, which aims towards better South-South cooperation. While the primary focus is on exchange of information, technologies, and knowhow, this platform also focuses on social development and poverty alleviation, taking cognizance of their social situation. While on the face of it, the countries seem to be an unlikely grouping, they have more in common than meets the eye. As discussed later in the context of each country individually, all three countries have been subject to different regimes of oppression – colonial exploitation, racism, apartheid, marginalisation of majority populations, etc. This in turn had a major impact on all rights including the right to health, given that local populations often received the dregs of the welfare services. To build from a legacy of separate and unequal treatment and to make amends for past wrongs towards society at large is a major challenge that these countries are still grappling with. Moreover, with populations such as transgender people being either

[21] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1084.
[22] Chris Alden and Marco Antonio Vieira, 'The New Diplomacy of the South', 1088-90.

unacknowledged or criminalised during the colonial era, this has led to a different basket of complications altogether, as we shall see later in the dissertation.

It has been widely debated in literature about the affect and legacies of colonial systems of governance and law, especially in the contexts of India, Brazil and South Africa. The legal systems existent in the countries are primarily colonial legacies. The first constitution of Independent Brazil was referred to as a "Slave Constitution". India still has the legacy of population categories as well as its penal code that criminalises non-procreative sexual behaviour. South Africa is still reforming its legal systems after the fall of the Apartheid Era. Also, despite coming into a post-colonial era, internal racism is rife within all three countries – with South Africa and Brazil having cases of direct discrimination on the basis of colour, and India having a more nuanced form of it through skin colour categorisation, the Hindu caste system and the regional and religious divides. These struggles perhaps reach a crescendo when it comes to marginalised populations who have to deal with public platforms that are formed within the constructions of colonial legacies, but trying to go beyond, like exercising the right to health through public services.

IBSA and health

The formation of IBSA is no minor achievement. For one, the three countries together represent a GDP of $1.1 trillion, which means that economic decisions taken by the group are bound to be of much international consequence. Yet, despite the powerful economy of its members, till date IBSA as a platform has not fully achieved the potential it represents. While knowledge exchange carries on, it has not yet assumed an abundant scale or the contours of a concerted policy. Politically, even if the three countries have robust democratic institutions, they have experienced recent turmoil, including successive corruption scandals, regime shifts

and the escalation of political conservatism and divisiveness. In other areas, too, India, Brazil and South Africa face serious challenges, in all factors concerning exercising one's right to health, especially in the field of public health.

The health dynamic in South Africa, for instance, is rather complex. The country has a well-documented medical history as far as diseases, malnutrition and high mortality rate due to sero-positivity complications is concerned. HIV prevalence shot up by 20% from 2001 to 2011[23], and the public health system, albeit partially funded by the government is stretched to its limit. There is much legislation on the issue, but real-time implementation is still lacking.[24] Even then, the government has recorded a lowering of mother-to-child transmission rate from 2011.

In India, despite decades of planning, the health system is still lagging far behind. Like South Africa's, it has a complex layering of diseases and afflictions due to the tropical nature of the environment. The government mandates a universal health system, but the burgeoning population promises the implementation of such a system to be a difficult task, particularly as it is estimated that about 36% of South Africans are HIV positive. On the more positive side, the country implemented a strong HIV control and prevention programme despite cultural odds and domestic inequalities.

Brazil, on the other hand, has been referred to as one of the best among health systems and outreach systems through its universal health care. At least on paper, it has proved that it is possible to carry out the constitutionally mandated fundamental right to health.[25] Even sexual reassignment surgery is offered under universal health care, along with a strong HIV

[23] Kathleen Kahn, 'Population Health in South Africa: Dynamics over the Past Two Decades', *Journal of Public Health Policy* 32, no. 1 (2011): S30–S36.
[24] "Health Care in South Africa", available online at http://www.southafrica.info/about/health/health.htm#.UNIYwqwxFzs. For instance, J. Uwimana et al., 'Health System Barriers to Implementation of Collaborative TB and HIV Activities Including Prevention of Mother to Child Transmission in South Africa', *Tropical Medicine and International Health* 17, no. 5 (2012): 658–665.
[25] 'Free Healthcare: Betting on Brazil', Pulitzer Center, 30 July 2012, https://pulitzercenter.org/reporting/free-healthcare-betting-brazil.

prevention campaign. However, as I will explore below, some feel that the programme is getting dated and renovations are severely needed.[26]

While on paper all three countries, especially Brazil, seem to be headed in the right direction as far as policy directives go, there may be much to learn from each other, given the similarity of the problems they face in dealing with developmental issues. Also, ground level realities are often very different, and much is left unaddressed along the way. This is especially true in the case of transgender people, an argument I will come back to at various points of this dissertation. I will now elaborate on this specific case.

Evaluating transgender citizenship through the lens of health in IBSA

India, Brazil and South Africa have a unique relationship with transgender people and their bodies. As we shall see later in detail, Brazil and India have had socially and historically acknowledged populations of gender non-binary people, people who have dressed in the clothes of the opposite gender, masculinised and feminised themselves to suit their gender identity. Yet, legal acknowledgement has been lacking. South Africa, on the other hand, as we shall see, has relatively little social or historical acknowledgement of transgender people as such, but at the same time, carried out sex-change operations in the military hospital during the Apartheid Era[27].

It has taken several years of activism across the globe for transgender visibility to reach its current position. Yet, problematically, transgender people, despite being a highly diverse population, are reductively put into one large category for the purposes of public policy and political debate, without necessarily taking regional and personal (identity-related)

[26] 'An Injection of Reality', *The Economist*, 30 July 2011, http://www.economist.com/node/21524879.
[27] Throughout my work, I have used capital letters for "Apartheid Era" but where the word "apartheid" comes alone, I have used lower caps to make it grammatically congruent.

specificities into account. This is where the unique transgender identities in India and Brazil play a pivotal role, and their rights' movements in their regions need highlighting. As we shall see, these identities often have friction with global, more western notions of transgender.

From a purely healthcare perspective, beyond general healthcare, transgender people may want some or all of the following procedures: gender alignment surgery, hormonal therapy, or other medical and psychological interventions. Patients are often denied access to these services because of their gender identity and/or expression, and more so if they are unacknowledged by law, even when the same or similar services are readily available to other groups. In this regard, as I shall showcase later, India, Brazil and South Africa have similar barriers to such access.

While many public service sectors behaving in this discriminatory manner might not affect the quality of life of a transgender person directly, when it comes to the healthcare sector the situation is rather different. Indeed, if it is true that health and healthcare is crucial for the basic minimum that human beings need for their existence, transgender people need it even more. First, medical treatment is a fundamental requirement of the process of gender transitioning that so many non-gender conformant people aspire to. Second, for a variety of reasons I will elaborate in more detail later, transgender people are particularly susceptible to various diseases. Thus, when they are denied access to health services, it affects them disproportionately, and affects various aspects of their lives. Because of their already marginalised situation, they often live in fear of discrimination by health-service providers, which has pushed many towards self-medication and other remedies. This combination of direct and indirect discrimination in various fields affecting health leads to them being deprived of their right to health.

The denial of services in medical settings often comes with experiences of abuse and harassment, both mental and physical. Sometimes, many transgender people are pushed

towards private, transgender-friendly medical services that are generally very costly. Even if they have private health insurance, it does not cover body realignment costs. This situation is not just prevalent in the jurisdictions covered in this dissertation, but in several other places across the world. The gap between law (and policy) and reality is vast.

Law and medical policy often go hand in hand in constructing the transgender body. In many instances law leads to medical policy, and in others, vice versa. Legal documents that guarantee citizenship often reflect the name assigned at birth, as well as sex assigned at birth. With a visual appearance differing in the normative gender lines set in the documents required in everyday activities such as opening bank accounts, buying transport passes, etc., people are dragged through uncomfortable and humiliating circumstances. The same identity documents, when used in public healthcare settings, can propagate discrimination even further.

Thus, the right to health – which includes access to public healthcare as well as state policies to address various social determinants of health – is a highly useful lens to analyse how transgender people exercise their citizenship and claim their rights before the State, despite gender-recognition obstacles.

Choice of Terminology

At the outset, it is important to point out that throughout my work, I use the term "transgender" as defined in my glossary – as an umbrella term to encompass the multitude of terms that are associated with gender non-conformity. The reason for this is to give it some level of uniformity. Each of the countries in question have highly developed vocabularies of their own to term gender non-conformity. Many of the people who associate themselves with local identities have significant concerns regarding using westernised terms. For the purposes

of this dissertation, I have referred to these identities within the contexts of those countries, but in general, have referred to all of them as transgender.

In certain cases, where relevant, I have referred to hermaphrodites, eunuchs and intersexed people specifically and not under the umbrella term. This is because of the way narratives were built around them in those geo-legal contexts.

Methodology

This dissertation is primarily concerned with assessing the constitutional framework on the right to health existing in India, Brazil and South Africa, specifically in what relates to transgender people's rights to access public services such as general and specific healthcare. As such, a large part of my analysis is grounded on legal research and examination of public policy. I have examined the constitutional provisions existing in each of the three countries on the right to health as a fundamental and universal right (and a human right), without ignoring the relevant international laws, conventions and directives that help to substantiate and shape domestic legislation on this matter. Yet, I was not only interested in the substance of the law as such, but also the ways in which legislation translates into public policy and affects people's lives. Hence, a second research approach was focused on evaluating past and present public policy on healthcare in these countries, with particular attention on the existence or absence of provisions to allow or facilitate transgender people's access to health.

Both research approaches were based on a variety of sources, from legal texts themselves – including the three constitutions in question and relevant international treaties – to a much more diverse set of documents, such as policy papers and special regulations issued by medical professional bodies or health-related organizations. When it turned to evaluating implementation, however, it was not enough to survey published materials, academic or not.

Especially because public policy on transgender peoples has suffered rather dramatic changes over recent years, it was important to engage in fieldwork research to assess the situation on the ground. Hence, I have conducted qualitative interviews with activists, scholars and NGO-workers in each of the countries. More significantly, some of these interviewees identify as transgender themselves. Through the interviews, I gained first-hand access to the battles being waged by civil society organizations on both the legal and the non-legal terrain, while also being able to collect unique transgender perspectives on the advancements and failures of past and present policy and legal frameworks.

Tour d'Horizon

This dissertation has two primary aspects – the right to health, and transgender citizenship. While exploring both, I aim to tie the two together and connect them with the countries of India, Brazil and South Africa and the implementation of the right to health in the three jurisdictions. The aim of the dissertation is to showcase how transgender people exercise their citizenship rights through the right to health. Throughout my dissertation, I shall aim to corroborate my findings with the interviews I conducted with primary and secondary stakeholders in all three countries.

Chapter 1 shall showcase the evolution of the right to health in international law from a socio-economic right to being connected directly to civil and political rights. I shall look at the right to health as a larger right with various components that are interconnected to other rights. I shall explore the wordings of international covenants and comments, and how the right has been expanded. From there, I shall enter into the domestic legal realms of the countries in question and examine their constitutional provisions and how they have been implemented through litigation.

Chapter 2 shall explore citizenship from two angles – firstly, the theoretical aspects of citizenship and how the theory has evolved to include various aspects of citizenship, and secondly the historical aspects of citizenship – from its origins to the ways it is exercised today. Finally, I shall aim to expound on how the theory and evolution of citizenship may help us to understand the challenges facing transgender people when they try to exercise their citizenship today.

Chapter 3 aims to encapsulate South Africa's history and interaction with transgender identities. I shall explore the Apartheid Era with respect to sexual and gender minorities, and how the situation has evolved ever since the current constitution was promulgated. I shall also shed light on the laws and policies prevalent in South Africa, the latter both generally and in specific relation to transgender people. Finally, I shall look at legal engagements of the transgender population of South Africa.

Chapter 4 explores Brazil and its tumultuous history both politically as well as with transgender people. I shall explore the differentiated vocabulary that exists in Brazil around transgender identities and the varied movements that have taken place over the years, and gained legitimacy primarily through a medicalised lens. I shall also explore how it has affected law and policy around transgender identities.

Chapter 5 journeys through India's varied history of occupation and historic associations with transgender identities. I shall explore the indigenous transgender identities in India, primarily the *Hijra*, and shed light on the current socio-legal contexts around them. Currently, there are many changes happening in India around sexual and gender minorities, and I hope to be able to draw a congruent picture around the population and the Transgender Bill.

Chapter 6 brings various aspects of the above chapters together while engaging with how legal regulations and policies are put in practice in the exercising of the transgender

citizen with the right to health through healthcare. I shall aim to give a brief picture of the healthcare systems of the three countries and set it in the context of a minority as marginalised as transgender people.

Chapter 7 brings the dissertation to a close, and I shall present my various conclusions drawn from my research. I shall also draw a list of recommendations that ought to help in mitigating the negative circumstances that transgender people face when exercising their rights.

1. The Right to Health from a social right to a human right

1.1. Introduction

> [I]n most situations, health achievement tends to be a good guide to the underlying capabilities [to achieve good health], since we tend to give priority to good health when we have the real opportunity to choose.
>
> - Amartya Sen[28]

Many scholars differ on how health became a right in international law. Not exactly a new concept, health-related laws, in the negative sense, emerged in diplomatic history in the form of war-time requirements, quarantines when it came to epidemics, and other health issues of grave importance. For instance, the Geneva Convention of 1864 laid down articles respecting the neutrality of ambulances and military hospitals, and the treatment to be meted out to the wounded and to those under care. This might be taken as the first inclusion of a humanitarian biomedical direction in international law.

However, it was with the spread of diseases beyond borders of specific countries that brought about the consideration of public health at the international level. Primarily, health crises were considered as a threat to international trade[29]. As early as 1903, the *Office International d'Hygiene Publique* (OIHP), which later became the health organization of the League of Nations, set up a conference on international sanitation, where the issue of primary health care for all was raised. This was later taken up by the United Nations. With the formation of the International Labour Organisation (ILO) in 1919, the issue of work-related

[28] Amartya Sen, 'Why Health Equity?', in *Public Health, Ethics and Equity*, ed. Amartya Sen, Fabienne Peter, and Sudhir Anand (Oxford: Oxford University Press, 2004), 25.
[29] Eibe Riedel, 'The Human Right to Health: Conceptual Foundations', in *Realising the Right to Health*, ed. Andrew Clapham et al., vol. 3, Swiss Human Rights Book (Rueffer & Rub, 2009), 22.

health surfaced. Also, with the Second World War came about the ideas of social rights and, specifically, the right to health. After the war, with the formation of the United Nations in 1945, the founding charter itself reflected the right in Article 55[30]. This was later elaborated in the WHO charter[31].

Health is intrinsically related to human rights. Indeed, it has been iterated as "a fundamental human right, indispensable for the exercise of many other rights, and necessary for living a life in dignity"[32]. The link between being able to exercise one's civil and political rights and the right to health seems quite explicit, as I shall showcase later. Thus, the reverse should also hold true, that is: abrogation of human rights leads to the degrading of the right to health. A non-discriminatory, inclusive approach is decidedly necessary when it comes to understanding a population's need and going beyond a utilitarian approach to health.

Engaging a population in voicing their needs and wants in primary, secondary and tertiary categories can positively affect policies, making them more inclusive. At the end of the day, it is the individual who must be at the centre of any service delivery system, especially when exercising the right to health through healthcare. This becomes key when considering the social situation of transgender people and their general lack of access to a variety of rights. Consequently, human rights help to ensure accessibility to that health system, reduce health vulnerability as well as give a specific standard to adhere to. Health equity[33] is what needs to be realised, and in order to achieve this, a human rights framework provides the ideal context. In other words, to realise health equity, people need to be

[30] Quoted later.
[31] 'Constitution of the World Health Organization' (WHO Basic Documents, Forty-fifth edition, Supplement, October 2006, 1948). The Constitution of the WHO starts with the following: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the **highest attainable standard of health** is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." (emphasis added). Needless to say, the constitution elaborates on other aspects of health and achieving them.
[32] 'WHO Constitution', 21. The highest level of health attainable for everyone.
[33] In Sen, 'Why Health Equity?', 25. He says that "the violation of health equity cannot be judged merely by looking at inequality in health."

empowered and be able to exercise their rights and voice their needs – especially those in marginalised communities.

Thus, keeping health as the primary focus, this chapter examines the transformation of the right from a socio-economic right to a primary right. To do that, this chapter shall examine the core treaties and charters which influence socio-economic rights the most. It shall analyse the wordings of the documents to see how inclusive or specific they are, and, in turn, how it affects gender and sexual minorities. This chapter then moves away from international treaties to focus on the domestic formulations of rights in the constitutions of India, Brazil and South Africa. The domestic litigation on health is also brought into the foray in order to understand how the right to health plays out at the ground level when exercised through the courts of law.

This chapter forms the platform for understanding how transgender people exercise their citizenship while engaging with something as diverse as the right to health. At the outset, it is important to differentiate between the right to health and access to healthcare. Healthcare and access to healthcare is a part of the right to health, whereas the overall right to health is influenced by all other civil and political rights as well as socio-economic and cultural rights that determine the overall well-being of a person, as we shall see later in this chapter.

1.2. The origins of the right to health in modern international law

Several international conventions, covenants and policies elaborate on the right to health and its essential linkage to the human rights. The right to health is a part of socio-economic rights in international as well as national policies in many countries across the world today. However, few people recall where this need for including and elaborating health

as a right stemmed from. "The forgotten crucible", as Mary Ann Glendon[34] calls it, is the tremendous influence of Latin America in the formulation of the Universal Declaration of Human Rights (UDHR) and the United Nations Charter for including what is commonly referred to as second-generation rights.

It is generally assumed that the UDHR reflects western ideological thought. However, many provisions have their root in Latin American submissions that had been formulated with a world-view. This is of particular interest here, as, just like India, Brazil and South Africa, the Latin American countries carried the legacy of being post-colonial. While they kept the European Civil Codes in place, they modelled their constitutions to reflect rights and duties of both the individual and the State in both first generation as well as second generation rights. While many European countries had also turned towards a similar constitutional regime after the World War I, after World War II, it was at the insistence of the Latin American contingent that human rights, including socio-economic rights, were made a part of international legislation.[35]

In the post-World War II period, Stalin, Roosevelt and Churchill's main aim was to secure world peace, without necessarily looking at empowering human rights. Once the Big Three had put the draft UN Charter together, it was introduced to the rest of the powers – "smaller powers" – among which was a twenty-nation contingent from Latin America. The delegates of this contingent had a vision that went beyond the ambit of what the Big Three had as their priorities. In fact, they had already been engaged in focusing on human rights within their region. The Inter-American Conference (later the Organisation of American States) adopted the "Declaration in Defense of Human Rights" in their eighth meeting in

[34] Mary Ann Glendon, 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea', *Harvard Human Rights Journal* 16 (2003): 27–39. In this context, it is important to mention here that Mexico included medical entitlements to workers and their families in the constitution of 1917. As we will see later in the dissertation, Brazil has a similar constitution today. Latin American courts have been leading the way when it comes to spearheading health rights decisions.

[35] Discussed later in the chapter. Most of the Latin American countries barring Brazil were Spanish colonies.

1938, which laid down the necessity for respecting human rights and "humanitarian sentiments and to the spiritual and material inheritance of civilization". This historic moment also saw the adoption of three other resolutions – one condemning religious and racial persecution, one in favour of women's rights, and one on the freedom of association. In 1945, they met again, before the meeting in San Francisco, and resolved to push for the inclusion of human rights in the UN Charter.[36]

This surge in interest in human rights in Latin America relates to a regional tendency of that time towards constitutional democracies in which citizens' rights would be protected. In fact, several countries of Latin America were going through periods of stable democratic regimes at the time. At the San Francisco conference, Panama submitted a draft declaration of human rights including the right to education, work, health, and social security. Chile, Cuba and Mexico joined hands with Panama, but were not successful in having it included in the charter. The US was nonchalant, and others, like the Soviet Union, the United Kingdom, and France, were hostile towards such suggestions.[37]

A turning point occurred when the proof of the various acts conducted in the Nazi concentration camps that started pouring out. The evidence was horrifying enough for the United States to drop its opposition to including human rights, and thus, the UN Charter was incorporated with human rights in seven places, including the creation of a Human Rights' Commission. [38] Article 55 of the UN Charter states:

> With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

[36] Glendon, 'The Forgotten Crucible', 28.
[37] Glendon, 'The Forgotten Crucible', 29.
[38] Glendon, 'The Forgotten Crucible', 30.

a. higher standards of living, full employment, and conditions of economic and social progress and development;

b. solutions of international economic, social, health, and related problems; ….[39]

The Human Rights Commission, headed by Eleanor Roosevelt, was tasked with creating an "international bill of rights", which would set down common standards for all countries to look at and measure their own situations and progress as well as others'. The first draft was based on a review of existing rights' documents gathered from all around the world as well as submissions from various countries. Panama, Chile and Cuba followed up on their stance at the San Francisco conference, and submitted free proposals. The Panamanian and Chilean submissions became the backbone of the new bill (including the wordings of the economic, social and cultural rights).[40]

Given the amount of cross-national research that formed the basis of drafting the Panamanian and Chilean submissions, they resonated well with both western and non-western frameworks. Also, the submissions were an amalgam of first generation rights – political and civil liberties – with second generation rights – relating to social justice. Thus, although several countries and cultures from across the world contributed to the *jus cogens* of today, these two submissions had in making what was named the Universal Declaration of Human Rights (UDHR). Passed in 1948, the document was proclaimed by the UN General Assembly

[39] 'Charter of the United Nations', 10 August 2015, http://www.un.org/en/charter-united-nations/. The reference to health is repeated in Articles 57 and 62 of the Charter, with respect to making it part of the mandate of the Economic and Social Council (ECOSOC).

[40] Glendon, 'The Forgotten Crucible', 31–32. The Panamanian submission was a draft document that had been constructed from the research across several cultures by the American Law Institute with an international committee drawing members from all corners of the world, including pre-Nazi Germany and pre-independent colonies like India. The Chilean submission was a preliminary version of the American Declaration of the Rights and Duties of Man. The wordings of much of the UDHR resonate with these two documents.

"as a common standard for all humanity"[41]. With this, the UN mandated health as a right in its fullest form. Although it was not binding at the time, today the UDHR is *jus cogens*[42].

1.3. Conventions, Covenants and their different approaches to health

The right to health set out in Article 25(1) of the UDHR clusters health with other economic and social rights, which are also the social determinants of health[43]. Overall, it is a pioneering document. "Every individual and every organ of society"[44] is responsible for the realisation of rights – including both domestic and international bodies. It has become the foundation for the mandate of "the highest attainable standard of physical and mental health"[45] for which there is a Special Rapporteur, who submits reports to the UN Human Rights Council and the former Commission for Human Rights. The Council as well as the former Commission have passed multiple resolutions on the right to health, especially pertaining to HIV/AIDS, access to medication of HIV/AIDS, etc.[46]

As a substantive right, the right to health came up in global legislative rhetoric as early as the Constitution of the World Health Organisation (WHO) in 1946, which declared itself in its constitution to be the health advocate of the world.[47] It took cognizance of the impact that

[41] Alicia Ely Yamin, 'The Right to Health Under International Law and Its Relevance to the United States', *American Journal of Public Health* 95, no. 7 (2005): 1156–61.
[42] 'Statute of the International Court of Justice' (1945), Article 38(1)(c). It acknowledges the UDHR as a source of international law (26 June 1945).
[43] "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."
[44] UN General Assembly, 'Universal Declaration of Human Rights', *UN General Assembly*, 1948, Preamble.
[45] 'Resolution 2002/31, The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (The UN Commission on Human Rights, 2002).
[46] 'Resolution 1999/49 on The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)' (The UN Commission on Human Rights, 1999).. See also the former Commission's 'International Guidelines on HIV/AIDS and Human Rights, U.N. C.H.R. Res. 1997/33, U.N. Doc. E/CN.4/1997/150 (1997)', accessed 4 March 2018, http://hrlibrary.umn.edu/instree/t4igha.html.
[47] Thérèse Murphy, *Health and Human Rights* (A&C Black, 2014), 27.

social and political conditions have on health, and the need for intersectoral collaboration in agriculture, education, housing and social welfare. Although the WHO took on a technology-driven approach in the 1950s and 1960s, the social condition model (where health is not just dependent on the prevention of disease or infirmity, but also on social and economic conditions) was reiterated in the Alma Ata Declaration of 1978 and the World Health Declaration of 1998.

The WHO and the ILO, while looking at the same goals, approach them through different means. The WHO, on one hand, is involved in strategizing and intervening in health issues. It has a more policy-oriented approach than a treaty-oriented one, and has seen a considerable amount of success[48]. It has implemented multiple programmes and passed many recommendations, which have been adhered to by various countries. More recently, in 2003, it used its constitutional provision allowing it to elaborate and adopt other international conventions[49]. On the other hand, the ILO, which *prima facie* deals with workers' rights, has followed a treaty-oriented approach. It has focused on occupational health and safety[50], and has even considered the need for contextualised healthcare for indigenous people with respect to their labour rights[51].

The importance of health care and the mitigation of diseases have been reiterated through various policies at the UN General Assembly[52]. In fact, when defining health, the UN

[48] For instance, in 2016, the WHO raised the red flag over vaccine shortages in Africa, gender-related health issues for young people, rising alcoholism in Europe, and the consequences of pollution on health. It also worked with mitigating Ebola and Zika, along with controlling sudden outbreaks of yellow fever across Africa. For more information, refer to 'WHO | 2016 Year in Review: Key Health Issues', accessed 28 February 2018, http://www.who.int/features/2016/year-review/en/. (last accessed September 15, 2017)
[49] Murphy, *Health and Human Rights*, 27.
[50] 'International Labour Organisation Convention No. 155 on Occupational Safety and Health' (1981); 'International Labour Organisation Convention No. 161 on Occupational Health Services' (1985).
[51] 'International Labour Organisation Convention No. 169 on the Indigenous and Tribal Peoples' (1989).
[52] 'The UN Millennium Declaration' (The United Nations, 8 December 2000 focuses on the need for health care and prevention of disease through the improvement of maternal and child health, and combating HIV/AIDS, malaria, and other major diseases.). The UN Development Goals (MDGs) have three direct healthcare goals (goals 4, 5 and 6), while goal no. 8 looks at affordable essential drugs through cooperating with pharmaceutical companies in developing countries. They have currently been replaced with the Sustainable Development

has included the "optimum level of physical, mental and emotional well-being"[53]. Through its various guidelines, the organization has taken cognizance of the different needs of different segments of society, for example children, mothers, older people, prisoners, people living with HIV, people with mental illness, and so on[54]. For instance, there is a distinct need to promote human rights to reduce vulnerability to HIV/AIDS, HIV related discrimination and HIV-related stigmatization, which often keeps many infected people at bay from health services, and makes their families highly vulnerable.[55]

However, it is to be noted that, while none of these guidelines have any legal binding on states, their success is measured by the fact that many states have adhered to them and implemented policies accordingly. In fact, given their voluntary aspect, it makes it easier to pass through than treaties where States feel that their sovereignty might be impinged upon[56].

The idea behind treaties is that whichever country is party to them shall adhere to and reform its system to suit the treaties. Many states have already ratified a variety of treaties dealing with human rights issues, some of the more important being the International Covenant on Civil and Political Rights of 1966 (hereafter: "ICCPR") and the International Covenant on Economic, Social and Cultural Rights of 1966 (hereafter: "ICESCR"). While these cover rights in general, specific covenants such as the Convention of the Rights of the Child of 1989 (hereafter: "CRC") and the Convention on the Elimination of All Forms of

Goals. 'United Nations Millennium Development Goals', accessed 4 March 2018, http://www.un.org/millenniumgoals/.

[53] 'The UN Principles for Older Persons' (The United Nations, 1991).

[54] 'The Standard Minimum Rules for the Treatment of Prisoners' (Economics and Social Council, 1977); 'Basic Principles for the Treatment of Prisoners' (United Nations, 1977); 'Principles for Older Persons'; 'The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care' (The United Nations, 1991); 'The UN Declaration of Commitment on HIV/AIDS' (The United Nations, 2001). These are some of the rules and principles propounded by the UN focusing on health and access to health.

[55] Lisa Oldring and Scott Jerbi, 'Advancing a Human Rights Approach on the Global Health Agenda', *Realizing the Right to Health. Edited by Zurich Uo*, 2009, 103.

[56] For instance, the United States of America, while being home to the headquarters of the United Nations, has not ratified several treaties, and sometimes not even signed them. They include the 'Convention on the Elimination of All Forms of Discrimination against Women', accessed 4 March 2018, http://www.un.org/womenwatch/daw/cedaw/; 'Kyoto Protocol', accessed 4 March 2018, http://unfccc.int/kyoto_protocol/items/2830.php; 'Mine Ban Treaty Text', accessed 4 March 2018, http://www.un.org/Depts/mine/UNDocs/ban_trty.htm.

Discrimination Against Women of 1979 (hereafter: "CEDAW") have also been signed and ratified by various countries.

With regard to health in particular, the ICESCR, in its Article 12[57], states:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the **highest attainable standard of physical and mental health**. (emphasis added)
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) **The creation of conditions which would assure to all medical service and medical attention in the event of sickness**. [emphasis added]

As can be seen above, the ICESCR talks of the highest attainable standard of health for all, and the healthy development of the child. It also takes into consideration the social determinants of health (with specific mentioning of environmental and industrial hygiene). What is notable is that there is no specific mention of gender when it comes to providing

[57] The WHO was instrumental in creating Article 12 of the ECOSOC – "the highest attainable standard of health" – but for many years, its engagement with human rights was negligible. Despite adopting various declarations such as the Alma-Ata declaration and the revised International Health Regulations, which specifically mention human rights, when the World Bank was demanding that many states upgrade their health systems, the WHO did not act as a strong voice in advocating the importance of primary health systems. In Murphy, *Health and Human Rights*, 28.

medical services, which allows for the tacit inclusion of transgender people or people identifying as belonging to a third gender.[58]

While the ICESCR specifies health as a right, the ICCPR's reference to the inherent right to life has, consequentially, been utilised by many state parties to elevate the right to health from a second-generation right to a primary right, for the primary right cannot be fully attained without this specific second-generation right. Many other globally recognised international covenants and conventions have mentioned the right to health either directly or indirectly. While the ICESCR gives the most comprehensive definition, Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (hereafter: "ICERD") also mentions the right to health. Specific human rights instruments such as the European Social Charter of 1961 as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10) also speak of the right to health.

The European Social Charter, however, spells out health in a very health-care oriented manner, and elaborates the social determinants' aspects of it, covering social welfare and social protection separately.[59] As there is no gendering in the rights laid out, it may be interpreted as being valid for all persons, irrespective of gender. The Banjul Charter, as the African Charter is commonly called, on the other hand, speaks specifically of physical and mental health[60]. This can be extended to include emotional health, which is intrinsically linked to the question of social determinants of health[61]. However, the Additional Protocol of San Salvador for the Organisation of American States is the most comprehensive:

[58] However, this non-gendering is not a universal phenomenon in the language of treaties, as discussed later in the chapter.
[59] 'European Social Charter' (1961), Articles 11-15.
[60] 'African People's Charter' (1981), Article 16.
[61] Discussed later in this chapter.

Article 10. Right to Health

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:

a. Primary health care, that is, essential health care made available to all individuals and families in the community;

b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;

c. Universal immunization against the principal infectious diseases;

d. Prevention and treatment of endemic, occupational and other diseases;

e. Education of the population on the prevention and treatment of health problems, and

f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

Thus, in a single stroke, it covers physical, mental and social health, primary healthcare for all, and specifies the need to look out for people who are socio-economically vulnerable.[62]

1.4. Different approaches to health beyond access to healthcare

Health, as a phenomenon, has many facets to it. Accordingly, it can be interpreted in a variety of ways. Sometimes health has been approached from a totally medical vantage point, without looking at the surrounding factors which influence it, while at other times it has been

[62] 'Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights' (1988), https://www.oas.org/juridico/english/treaties/a-52.html.

understood as a "social phenomenon, requiring more complex forms of intersectoral policy action, and sometimes linked to a broader social justice agenda"[63]. Therefore, the right to health is not a one-dimensional right, that is, it is not just about access to healthcare, or having autonomy over one's own health data. Rather, it is about the complex intersection of multiple factors. On the one hand, there are the duties of the State towards the individual's wellbeing. On the other hand, there are the fundamental rights of the individual against the State.

The General Comment No. 14[64], adopted by the Committee on Economic, Social and Cultural Rights (CESCR), looks at the various dimensions of Health as follows:

> 1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the Right to Health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the Right to Health includes certain components which are legally enforceable.
>
> […]
>
> 3. The Right to Health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the Right to Health.

[63] 'Social Determinants of Health Discussion Paper 2 - A Conceptual Framework For Action on the Social Determinants of Health' (World Health Organisation, 2010), 10.
[64] 'General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12) by the CESCR', *Adopted at the Twenty-Second Session of the Committee on Economic, Social and Cultural Rights*, 2000.

The General Comment goes on to elaborate on Article 12 of the ICESCR, which, while not adopting the WHO definition of health, does speak about "the highest attainable standard of physical and mental health" in Article 12.1. The Comment states that this does not mean that this standard is limited to health care, but should be read with Article 12.2 which speaks about the intersection of different factors which determine whether a person can lead a sound life, including, among others, access to food, housing, potable water and sanitation.

However, the Comment cautions that such full enjoyment is an ongoing process, and that for many countries, due to underdevelopment and poverty, such goals might be difficult to achieve. The ICESCR, therefore, recognizes that each country should try and achieve it as much as possible[65]. This approach offers governments a certain flexibility to circumvent their obligations towards their citizens. While there is no specific method to accurately measure the progressive fulfilment of these rights, some states may go to the extent of stating that there is no minimum core to the right to health[66].

Most importantly, in paragraph 8, the Committee states that the right to health is not just the right to be healthy, but also the right to certain freedoms and entitlements, i.e., to "control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[67] The last part may be interpreted to include the various determinants which influence the health of a person.

[65] 'General Comment 14', Paragraphs 8, 12.
[66] Explained later in the same chapter.
[67] 'General Comment 14', Paragraph 8.

The Committee also takes cognizance of the expansion of the notion of health since the time of the adoption of ICCPR and ICESCR. Different factors that have influenced the definition of health and are being taken into consideration now include social concerns, socio-economic positioning and physical violence. In addition, recent decades have witnessed remarkable changes, with the epidemic of HIV/AIDS, a higher rate of cancer and a larger global population around the world. In this context, the right to health is not just about health care, but the right to overall wellbeing.[68]

General Comment 14 makes a succinct statement on non-discrimination, by recommending that States undertake policy changes to create a viable atmosphere for vulnerable populations such as women, children, older people, indigenous people, people living with HIV/AIDS and people with disabilities to be able to access, especially physically, health care and treatment wherever necessary. It also considers that the health systems set up by governments should try and reach more people than less, give out more basic treatment if necessary as opposed to highly expensive specific treatment to few.

General Comment 14 suggests that a utilitarian approach is desirable in situations where budgets are tight, so that more people have access to services and basic treatments. However, the idea is not for the State to impose limitations on what can be accessed, but to empower the freedom of individuals to be able to access a public system. States should also safeguard the needs of minorities, detainees, prisoners, undocumented immigrants, people suffering from mental disability, so that they may procure any basic healthcare that may be required. It is necessary for public policies not to be exclusive and discriminatory[69]. It is to be noted here that while the Comment approaches almost every section of society, it does not specifically single out sexual or gender minorities.

[68] 'General Comment 14', Paragraphs 10,11.
[69] 'General Comment 14', Paragraphs 18-28, 34.

The Committee also acknowledges the necessity for contextualizing healthcare to the local contexts of specific countries. For instance, a country with a high sero-positivity rate needs a larger number of anti-retroviral treatment centres than it needs, for example, x-ray units. However, this is not to say that specific health interventions, or a vertical approach to healthcare, can sustain itself in the face of long-term goals. Rather, in my view, what is required is an integrated approach with the capacity of vertical interventions if the need arises.

Overall, the right to health and its underlying factors have definitely been given impetus over recent decades in international law. With increasing globalization and several initiatives of international cooperation it has become ever more important to orchestrate similar social policies across the world. The persuasive power of international treaties can often bring about different types of changes. Yet, when it comes to dealing with epidemics, global health policies have often encouraged countries to cooperate, as we saw during the Cold War and its aftermath[70].

1.5. Determinants of health

Health, as seen above, is an inclusive right. It is not just about access to healthcare and healthcare provisions. Although the latter are crucial components of it, several other factors make up for the actualisation of the right. These components or determinants of health can be split into three categories: the socio-economic environment, the physical environment and the individual's behaviour traits and characteristics. These categories are also connected with various other civil and political and socio-economic rights. While each one of them might be

[70] Ilona Kickbusch, 'Global Health Diplomacy: How Foreign Policy Can Influence Health', *BMJ: British Medical Journal* 342 (2011), http://search.proquest.com/openview/af19b9668b89d557b80fb28f6343f452/1?pq-origsite=gscholar&cbl=2040978.

separately justiciable, when it comes to exercising the right to health, they are interconnected and inter-related, as we shall see later in the chapter.

According to a WHO factsheet, the basic "underlying determinants of health" that are required for a healthy life as laid out in General Comment 14 include: safe food and potable water, adequate nutrition, adequate housing and sanitation, healthy working and environmental conditions, health-related information and education, and, of course, gender equality.[71] The WHO also points out that the right to health contains freedoms and entitlements, such as freedom from non-consensual medical treatment and experiments, freedom from torture and other cruel, inhuman and degrading punishment, entitlement to protection of one's health through a system of health protection, access to essential medicines, and participation in health-related policy-making, among other things.

What this suggests is that there are several factors that affect health. Thus, public policies in every sphere, every department, affect the way health is achieved. The way income and resources are distributed at every level of the social structure, for instance, shapes a society's ability to achieve better equity in health. Income and social status, education and physical environment, thus, play pivotal roles in overall health and determine one's ability to exercise the right to health. In addition, supportive emotional environments such as friends, families and communities influence emotional and physical well-being. Finally, genetics and personal behaviour cannot be ruled out when it comes to health issues. For instance, genetic heart conditions or propensity to cancer can be aggravated with addictions such as smoking, drug usage, etc.

Surely, gender plays a very important role in health as men and women suffer from many similar issues, but some of them affect men and women at different times of their lives. Also, there are several health issues that are specific to one's biological sex. In the case of

[71] 'WHO | The Right to Health', WHO, accessed 15 March 2018, http://www.who.int/gender-equity-rights/knowledge/right-to-health-factsheet/en/.

transgender people, these differences often overlap, as discussed later, and there are several situations and needs that arise that are unique to transgender people who are undergoing gender realignment surgery and/or hormonal therapy.

Social determinants of health, such as inclusion or exclusion of particular groups of people from society at large, be it on the economic, political or socio-cultural front, affect health negatively. For instance, if a country's population census or legal system is structured only along the gender binary, and do not recognise non-heteronormative genders and relationships, this filters into other public departments such as healthcare, and leave little room for people who do not fit into mainstream categories to access services. This type of social exclusion leads to marginalisation, high levels of vulnerability through deprivation and misinformation, and in turn, poor quality of life due to poverty and unemployment. Perhaps one sector where the social determinants of health can be seen at work immediately is the public health system in any given country.

1.6. The role of public health in the right to health

Initially, those advocating for the right to health within the human rights framework tended to focus on public health as a particularly relevant area. At that point in time, it was less about demanding the "highest attainable standard of health" and more about advancing a "rights-based approach to health"[72]. In the last decades, this approach has been useful when tackling the HIV/AIDS pandemic, for it offers public health "a more coherent, comprehensive and practical framework of analysis and action on the societal root causes of vulnerability to HIV/AIDS than any framework inherited from traditional health or biomedical science"[73].

[72] Murphy, *Health and Human Rights*, 30.
[73] Jonathan M. Mann, 'Human Rights and AIDS: The Future of the Pandemic', in *Health and Human Rights: A Reader*, ed. Jonathan M. Mann, et al. (Great Britain: Routledge, 1999), 223.

Jonathan Mann started theorising about a three-fold framework wherein he surmised that human rights abuses affect health adversely, and health worsens when human rights are ignored. Thus, working in synergy, health and human rights create a path for global betterment. Consequently, human rights and health both need to be promoted and protected, and are interlinked inseparably.[74] Creating a link between health and human rights has led to a new discourse, a new language that has helped in claiming rights around health,

> one rooted in dignity, freedom or basic needs (and increasingly in consensus), which had a degree of urgency and priority over other claims and came with a set of local, regional and international fora wherein states as duty-bearers could be held to account, and new or underdeveloped duty-bearers, such as pharmaceutical companies, could be considered.[75]

This can be seen in the way HIV/AIDS-related health movements have come along. Accessing anti-retroviral treatment (hereafter: ART) has become not just a part of public good but a part of human rights. This has also led to intellectual property regimes being scrutinised, i.e. the WTO, as well as the pharmaceutical companies and several states involved in manufacturing and distributing ART. This led to the regime of compulsory licensing in India.

Domestic courts have also played a significant role, generally pushed forward by NGOs in strategic litigation in order to open the access gates to medication or medical facilities for various people. For instance, the Treatment Action Campaign managed to push several human rights claims through constitutional provisions in order to secure the right to ART against the state of South Africa.

Public health is a useful path towards achieving the right to health. But is it possible that creating easy access to medicine might lead to less focus on prevention? What about the

[74] Murphy, *Health and Human Rights*, 30.
[75] Murphy, *Health and Human Rights*, 30-31.

gearing up of the commercial pharmaceutical market who have more to gain by creating further access to medication than addressing the social determinants that affect human health adversely? Given that health is not a central concern in many rights narratives, how to ensure that human rights' discourse and practice address inequity in health, rather than ignore them? For instance, has the high attention being paid to HIV/AIDS detracted from looking at other illnesses and conditions?

Therefore, HIV/AIDS treatment access can be viewed either as making way through draconian HIV/AIDS programmes and bringing it to the mainstream and destigmatising it, as well as creating a focus on other health issues, or it could be viewed as a one-off, inequity-producing movement which fed off the factors of HIV being viewed as a pandemic, the sudden cheap cost of generic manufacturing of ART, and that several sections of the human population were being stigmatised and discriminated against, clear rights and duties, and "right holders facing certain death".[76]

1.7. Justiciability of the right to health

For many years, the right to health had very little movement on international fora, especially when compared to other economic social and cultural rights. With the onset of the HIV pandemic, however, it started being acknowledged as a right whose realisation is crucial for global development With the rise of global movements for HIV infected people, access to medical treatment became a policy concern of great priority.[77] While these movements were not always in collaboration with each other, health rights litigation, activist judiciaries, civil society movements, radical constitution-making, and failure of governments to react in time to control the pandemic all played an important role in creating a more robust right to health

[76] Murphy, *Health and Human Rights*, 35.
[77] Murphy, *Health and Human Rights*, 39.

framework. Global advocacy around HIV, therefore, paved the way for further health rights litigation. Indeed, perhaps no other question received as much attention as the availability of ART medicine, which was object of much litigation domestically and internationally. These cases served to demonstrate that the right to health is, undeniably, a justiciable right.

The matter of justiciability was further discussed in General Comments 3 and 9 by the CESCR[78]. The former removed the aspect of progressive realisation as a blanket cover for all ESC rights by establishing that various rights require immediate action, such as prevention of discrimination[79]. The latter decided that not allowing domestic courts to decide on matters of allocation of resources for the implementation of rights hindered the indivisibility of rights, while grouping rights under justiciable and non-justiciable adversely affects the courts' ability to protect the most vulnerable and disadvantaged groups. Moreover, the comment stated that there is a minimum core to these rights that must be uphold, otherwise the entire system of rights established by the ICESCR becomes futile.[80] In this view, a state that fails to provide food, essential primary health care, basic housing and education to a large number of people would be considered to have failed in its obligations under the covenant. The comment further states that "[i]n order for a state party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations."[81] Thus, this makes it highly difficult for states to renege their responsibilities when it comes to meeting the basic minimum obligations towards their citizens.

[78] 'General Comment 3: On the Nature of States Parties' Obligations by CESCR', *UN Doc E/1991/23*, 1991, Paragraph 5; 'General Comment 9: The Domestic Application of the Covenant by CESCR', 1998, Paragraph 10.
[79] 'General Comment 3', Paragraph 3.
[80] 'General Comment 9', Paragraph 10.
[81] Murphy, *Health and Human Rights*, 40–42.

A decade later, General Comment No. 14 followed, explaining Article 12 of the ICESCR further: it was not to be understood "as a right to be *healthy*"[82] as good health "cannot be ensured by a State, nor can States provide protection against every possible cause of ill health". Nevertheless, at the same time, it stated that Article 12 is not merely about timely and appropriate healthcare, but also about the various determinants of health, such as potable drinking water, unpolluted environment, sanitation, among others. The right to health, thus, carries with it with both "entitlements and freedoms, including the 'right to control one's health and body, including sexual and reproductive freedom' and the 'right to be free from interference', such as the right to be free from torture, experimentation and non-consensual medical treatment."[83]

General Comment No. 14 gave several standards with which one may measure different aspects of the right to health, particularly the following four standards for health facilities: availability, accessibility, acceptability and quality. Following similar directives already adopted regarding food and education, the Comment also recommended a three-fold requirement for state obligations, i.e. to respect, protect and fulfil human rights by facilitating, providing and promoting them. Finally, according to this framework states not only has the positive duty to facilitate, provide and promote access to health but also the negative duty to prevent third parties from violating the right to health.[84]

Article 2 (1) of the General Comment 14 also obligates states internationally, particularly to promote international assistance and cooperation, in all resources especially technical and economic. This, in turn, means that states can reach out to other states for help with resources should they be unable to provide them. The same article is also used when examining the limits of Article 12. For instance, while it is acknowledged that there should be

[82] Original emphasis. Article 8, 'General Comment 14'.
[83] Murphy, *Health and Human Rights*, 42.
[84] Murphy, *Health and Human Rights*, 43.

progressive realisation of ESC rights, various steps are to be taken with immediate effect. Moreover, some core obligations are absolutely non-derogable, even in times of emergencies. In fact, the CESCR goes so far as to say that the core obligations are not merely national responsibilities but also "international responsibilities for developed States, as well as others that are "in a position to assist"'[85] .

1.8. IBSA and their constitutions

Currently, there are 115 countries across the world that include the right to health in their constitutions. Chile led the way as early as 1925, as did other Latin American countries as discussed earlier. Constitutions formed in the aftermath of World War II and the Universal Declaration of Human Rights have generally been more inclusive of rights in an explicit manner. This is not to say that constitutions that do not include them explicitly do not guard them. However, the Constitutions of India, Brazil and South Africa, being a product of their times, were keen on reflecting these rights in as many words.

The Constitutions of India, Brazil and South Africa are relatively new. The oldest amongst them, the Indian Constitution, was brought into force only in 1950. It was essentially a true child of the times. A former colony of the British Empire, India's independence was witness to large-scale violence, public unrest, and possibly the greatest mass displacement of human populations in history.[86] Thus, when drafting the foundational legal document of the new nation, the Constituent Assembly very clearly laid down civil and political rights and

[85] Murphy, *Health and Human Rights*, 45.
[86] In 1947, at the onset of the independence of India, the Indian sub-continent was partitioned into India and Pakistan. Pakistan was a combination of two land areas flanking both sides of what became India. Then known as East Pakistan and West Pakistan, East Pakistan seceded and became Bangladesh in 19…1971. During the partitioning, there was mass population displacement as Pakistan was formed with a Muslim majority and India with a Hindu majority. This led to mass murders on both sides of the border during the displacement of the populations. For more information on the numbers involved, etc. refer to Yasmin Khan, *The Great Partition: The Making of India and Pakistan* (Yale University Press, 2017).

social, economic and cultural rights within the ambit of the legal system. Part III of the Constitution talks of fundamental rights, which include, among others, a negative right to life – wherein "[n]o person shall be deprived of his life or personal liberty except according to procedure established by law."[87] Later, a new clause was added regarding the right to education as a part of the right to life[88]. However, nowhere does it immediately connect itself to the right to health, which comes up only in the Directive Principles of State Policy, in Article 39:

> (e) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;[89]
> (f) that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

Much later in the Constitution, it goes further in the list of Directive Principles to state under Article 47:

> The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

[87] 'The Constitution of India', Article 21, accessed 28 February 2018, http://lawmin.nic.in/olwing/coi/coi-english/coi-indexenglish.htm.
[88] 'The Constitution of India', Article 21A.
[89] Despite having a sizeable *Hijra* population and having a history of indigenous transgender people, the Constituent Assembly, while trying to accommodate every minority group possible, entirely left out any mention of any person who may refer to her/himself as *Hijra*. Possibly, it may have been left for interpretation as a cultural group, as opposed to a constructed gender identity.

The Supreme Court of India played a lead role in expanding the right to life under the Constitution and linking the Directive Principles of State Policy with it, as we shall see later in this Chapter.

The Brazilian Constitution[90], on the other hand, is not the first Constitution of the country, but the seventh. It was two years in the making, being promulgated only in 1988 – three years after a civilian government came to power after almost two decades of military rule. The dictatorship (1964-1985) was a period of great industrialization but also of restrictions of civil liberties and great oppression. Censorship, disappearances and torture were common practices to control the population and eliminate political dissent. The new Constitution – often called *Constituição Cidadã* (Citizen Constitution) – set out to rectify the oppressive tendencies of the previous political regime by creating a wave of legal and social changes, particularly where social rights are concerned.

The current Constitution sets out the right to life in Article 5:

> [A]ll persons are equal before the law, without any distinction whatsoever, Brazilians and foreigners residing in the country being ensured of inviolability of the right to life, to liberty, to equality, to security and to property[.]

Article 5 is highly elaborate and, unlike the Indian Constitution, looks at multiple civil rights together, containing also multiple sub-clauses for each part. In addition, the right to health is set out in the Social Rights portion under Articles 6, and is read with multiple other Social Rights, as follows:

[90] 'The Constitution of the Federative Republic of Brazil' (1988).

Education, health, food, work, housing, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute are social rights, as set forth by this Constitution.

In Chapter II on Social Welfare, the Constitution of Brazil elaborates social welfare in great detail under Article 194, the starting of which is:

[S]ocial welfare comprises an integrated whole of actions initiated by the Government and by society, with the purpose of ensuring the rights to health, social security and assistance.

However, it is from Article 196 to 200 that Health is spoken about in intricate detail:

Article 196. Health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.
Article 197. Health actions and services are of public importance, and it is incumbent upon the Government to provide, in accordance with the law, for their regulation, supervision and control, and they shall be carried out directly or by third parties and also by individuals or private legal entities.
(…)
Article 198. Health actions and public services integrate a regionalized and hierarchical network and constitute a single system, organized according to the following directives: (CA No. 29, 2000; CA No. 51, 2006; CA No. 63, 2010)
Article 199. Health assistance is open to private enterprise.

Paragraph1. Private institutions may participate in a supplementary manner in the unified health system, in accordance with the directives established by the latter, by means of public law contracts or agreements, preference being given to philanthropic and non-profit entities.

Paragraph 2. The allocation of public funds to aid or subsidise profit-oriented private institutions is forbidden.

Paragraph 3. direct or indirect participation of foreign companies or capital in health assistance in the country is forbidden, except in cases provided by law.

Paragraph 4. the law shall provide for the conditions and requirements which facilitate the removal of organs, tissues and human substances for the purpose of transplants, research and treatment, as well as the collection, processing and transfusion of blood and its by-products, all kinds of sale being forbidden.

Thus, while the Constitution starts off on an abstract note, it goes into heightened detail on how the health system of the country should function and keeps its horizons open for expansion. It does not take a constricted view of the right to health, only speaking about healthcare, but also contains many actions and policies that act upon the social factors influencing health care. Articles 196, 198 and 200 are exemplary in this manner, with article 200 even directing the health programmes to consider environmental concerns. However, *prima facie,* it does not seem to immediately connect it to any primary right. Health is considered from a social welfare perspective, albeit in an expansive manner, and includes suitable conditions at the workplace, which can be interpreted as creating safe spaces for everyone irrespective of gender.

The South African Constitution[91] is the youngest of the three Constitutions compared herein, being promulgated as late as 1996. It was the child of the decades-long anti-apartheid struggle in South Africa, brought into force by the first democratic government to be elected by universal suffrage in the country.[92] The Constitution reflects the different values and

[91] 'The Constitution of the Republic of South Africa', 108 § (1996).
[92] The transition was a long and painful process, leading to the promulgation of the "never again" constitution, as discussed in detail in a later chapter.

aspirations of which the South African people were deprived under discriminatory laws and, as such, it tries to redress and remedy the ills of the Apartheid Era.

The Constitution is unique in the manner it is laid out. In the preamble itself, it makes an indirect reference to healthy living by setting as one of its primary aims to "[i]mprove the quality of life of all citizens and free the potential of each person". Moreover, in its body, the Constitution does not differentiate between civil and political rights and socio-cultural rights. Instead, it mentions all the rights in the Bill of Rights, including a list of non-derogable rights. The right to health is defined as follows:

> Health care, food, water and social security
>
> 27. (1) Everyone has the right to have access to -
>
> (a) health care services, including reproductive health care;
>
> (b) sufficient food and water; and
>
> (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
>
> (3) No one may be refused emergency medical treatment.

The Constitution also determines the layout for a Human Rights Commission, which has its duties written down, and includes the following under Article 184:

> (3) Each year, the Human Rights Commission must require relevant organs of state to provide the Commission with information on the measures that they have taken towards the realisation of the rights in the Bill of Rights concerning housing, health care, food, water, social security, education and the environment.

Thus, the fact that the right to health, as a progressive right, is given cognizance in the Constitution itself does not prevent that provisions be made for an overseeing body to ensure that access to this right actually progresses. Moreover, there is a constitutional duty through which the government is bound to react to the needs of the people:

> 195. (1) Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:
>
> (…)
>
> (d) Services must be provided impartially, fairly, equitably and without bias.
>
> (e) People's needs must be responded to, and the public must be encouraged to participate in policy-making. …

A positive aspect of the wording of the South African Constitution is that it does not gender the need for right to health. *Prima facie*, the right to health seems to be elaborate and considers the social determinants of health. However, as we shall see later from the litigations that followed after the constitution came to force, universal healthcare is still far from fruition.

The three constitutions, as shown above, have tried to be quite inclusive in their phrasings, and, given the different historical moments they were promulgated, different sorts of inclusions were thought more necessary than others. This has led to some very interesting litigation in supporting the rights laid out in the constitutions. The right to health, as we shall see, is no exception.

1.9. Constitutionally protecting the right to a healthy life

As reiterated in the international conventions and covenants seen above, the notion of the "highest attainable standard of health" can be interpreted as pertaining to having a right to a healthy life, or to quality of life. General Comment 14 stated that the right to health cannot be held to be a progressive right in all its aspects, to be achieved in stages. There is a minimum obligation that a state has towards its citizens in aiding them towards the various determinants, such as housing, food, essential medicine, among others[93], which in turn aid in achieving a healthy life. The constitutions of India, Brazil and South Africa, have, interestingly, not spoken about the right to a healthy life under the right to health or the right to life.

South Africa, as seen above, has made a reference to the quality of life being affected, which may be interpreted as referring to the right to a healthy life. This has been pivotal in particular cases and has led to unprecedented decisions from their apex court, as we shall see in the next section.

In Brazil, the right to a healthy life is not placed under the right to health, but rather under Chapter VI on the Environment, Article 225. Here the Constitution refers to a "healthy quality of life" – or "*sadia qualidade de vida"* – to be achieved through "an ecologically balanced environment"[94]. Workers' health has also been expanded on through the Articles 7-11 of the Constitution, which speak primarily about workers' rights, with suitable legislations on healthy working environment and general well-being of workers being promulgated to support connected jurisprudence.

In India, given the lack of expansive explanations in the Constitution and the fact that the right to health is a directive principle as opposed to a justiciable right, the right to a healthy life has been interpreted by the Supreme Court of India through several cases,

[93] 'WHO | The Right to Health', WHO, accessed 15 March 2018, http://www.who.int/gender-equity-rights/knowledge/right-to-health-factsheet/en/.
[94] 'The Constitution of Brazil', 150.

especially on issues of hygienic environment issues and ameliorating the plight of the poor and the downtrodden. From interpreting life as going beyond mere animal existence[95] to including the right to live with dignity[96], drawn from the Preamble of the Indian Constitution, the Indian Supreme Court has created a body of jurisprudence around the right to a healthy life, as we shall see in the next section.

1.10. The "Judicialization" of the right to health[97]

The guaranteeing of rights for all citizens by constitutional entrenchment has often been inadequate where ground level realities are of severe inequality, racial segregation, poverty and gender gaps. In light of this, many a time, individuals and groups have had to resort to the courts of law to claim their rights. While civil and political rights are somewhat easier to claim, as my research shows, socio-economic rights have had an uphill journey in being claimed in India, Brazil and South Africa. Such rights, such as rights on adequate shelter, water, environment, etc. have often been the site of concern by many on how to strengthen them and enforce them. With international conventions in general looking at them as progressive rights to be achieved to the best of the resources available in a country, their exercise and implementation can be partial and incomplete. Despite several constitutions around the world entrenching socio-economic rights within their ambit, at the ground level, there is often a lack of policy and oversight to see them carried through.

The role of courts in enforcing socio-economic rights has also come to prominence, as already pointed out above. While there is still disagreement on whether "social goods" ought

[95] Kharak Singh v. State of Uttar Pradesh, AIR 1963 SC 1295
[96] *Mullin*, 2 SCR; Maneka Gandhi v. Union of India, 1978 AIR 597 (Supreme Court of India 1978).
[97] Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil', *Tex. L. Rev.* 89 (2010), http://heinonline.org/hol-cgi-bin/get_pdf.cgi?handle=hein.journals/tlr89&section=61. Ferraz refers to the heightened litigation to invoke social rights as "judicialization".

to be legal rights, entrenched in the constitution and/or in domestic legislations of a country, in those jurisdictions where they have indeed been legally or constitutionally sanctioned, their justiciability through litigation is admitted as a principle. For instance, in the *Treatment Action Campaign* case, the South African Constitutional Court decided that "[i]nsofar as that [social rights adjudication] constitutes an intrusion into the domain of the executive, that is an intrusion mandated by the Constitution itself."[98]

Although the last decades saw a spurt in health rights litigation all over the world, there are still two schools of thought as to whether mobilizing the judiciary will have a positive effect or a negative effect on the right to health. Will it bring more justice, or will it merely create a path for the people who have access to the Courts (also known as financial ability) be the ones fighting for their own individual needs? Moreover, specific sections of society may lack access to justice not just because they are poor, but also because of their social affiliation to a sexual or gender minority. Despite this, it is undeniable that litigation has paved the way for many HIV-related health interventions, including the development of various social security measures.

The right to health, as seen above, is defined and elaborated in different conventions, covenants, international treaties and national constitutions – albeit in different manners. On the ground, access to the Courts is also different in each context. India, for instance, allows petitioners to present cases involving fundamental rights directly to the state-level High Courts and even to the Supreme Court of India. Any person can represent any group and send in something as simple as a postcard to a sitting judge and if the judge deems it fit, the Court can decide to entertain the case[99]. On the other hand, in Brazil, while private persons may approach the Court for securing their individual rights, or even rights for groups, litigation is

[98] Treatment Action Campaign vs Ministry of Health, 2002 (10) BCLR 1033 (South African Constitutional Court 2002).
[99] Look at fn.28 of Lloyd Rudolph and Susanne Hoeber Rudolph, 'Redoing the Constitutional Design: From an Interventionist to a Regulatory State', *The Success of India's Democracy*, 2001, 137.

an expensive affair, thus making it easier for the rich to access the justice system.[100] It might now be illuminating to look at each of the three cases separately.

1.10.1. Brazil

Right to health litigation has taken rather unique directions in Brazil. As seen earlier, Brazil has a highly elaborate social rights framework within the Constitution itself. However, the current criticism around the justice system implementing the social rights schemes is that there is an over-judicialisation of the system. [101]

Statistics reveal that while class action suits are capable of being brought to the Brazilian Courts, most cases being litigated are by individuals, to strengthen their claims on some specific benefit that they feel they ought to get from the State. Given the very expansive nature of the right to health in Brazil, often, the cases are won in favour of the individual. The Court may decide to extend such benefits to the rest of the population if it feels that it would be for the greater good, or keep it limited to the petitioner, which is how most judicial decisions are passed in Brazil.[102] Also, despite having an apparently robust healthcare system in place for ART and HIV prevention, many people currently receiving the treatment have had access to it not because of governmental measures, but because of judicial interventions.[103]

How do these lawsuits actually influence the social rights system? In itself, the high volume of litigation could indicate a strengthening of the State's accountability towards its

[100] Studies reveal that the more developed and richer areas of Brazil, such as the southern states have a greater penchant to enter into litigation pertaining to the right to health, as opposed to many northern states, which are economically poorer, in Octavio Luiz Motta Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?', *Health and Human Rights*, 2009, 33–45.
[101] Octavio Luiz Motta Ferraz, 'Right to Health Litigation in Brazil: Why Are Collective Suits so Hard to Enforce?' (University of Warwick, School of Law, n.d.).
[102] Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil', *Texas Law Review* 89 (2011): 1653.
[103] Ferraz, 'Harming the Poor through Social Rights Litigation', 1651.

citizens. This would probably be correct if the majority of litigants were actually people who were suffering from some type of social disadvantage, such as poverty or disability. Yet, in reality, because of socio-economic barriers, the litigants who do manage to battle their way through the Courts are economically or socially privileged. Thus, the impoverished masses, who probably need to benefit the most from public welfare and State-run services, are not the primary beneficiaries. Moreover, according to the available data, collective class-action suits are few and far between – had they been there, they would have likely benefitted the poorest of the poor far more than all the individual claims put together[104].

The types of individual claims which come up at the Brazilian Courts range from access to medication, surgical or diagnostic procedures either abroad or in private hospitals which the public hospitals cannot carry out, specialised medical equipment or products and special dietary products and supplements[105]. As most of the claimants are individuals, the claims satisfied are done so individually, and seldom is any action taken to make it apply on the entire public health system altogether. Furthermore, as there is a generally limited budget for entire health policies to be implemented as a public service, judicial activism such as mentioned above cuts into that budget to provide individual claimants with higher-end services.

Brazilian jurisprudence on health has had a significant journey. First, from looking at health as a programmatic norm, which is thus not deemed to be justiciable in a court of law, the jurisprudence now recognizes it as a justiciable individual right (as opposed to a collective right). For instance, in a case at the Rio de Janeiro's Court of Appeals in the mid 1990s, the court stated that "programmatic norms established in the Federal Constitution do not give rise to individual rights of citizens to claim from the state high cost medicines, at the expense of

[104] Octavio LM Ferraz et al., '7. Judging the Price of Life: Cost Considerations in Right-to-Health Litigation', *Juridification and Social Citizenship in the Welfare State*, 2014, 121.
[105] Ferraz, 'Harming the Poor through Social Rights Litigation', 1651.

other patients, equally needy…. Given scarcity of resources, the State cannot privilege one patient over hundreds of others" and went on to say that the judiciary should refrain from interfering in government policy[106]. Critics of the decision believe it disempowers socio-economic rights, and creates precedents of ineffective rights.

However, the Brazilian judiciary took a turn from this stance of deferring to the government when it came to social policies from the late 1990s. Since then, the judiciary has passed mandatory injunctions on the government, sometimes even going against governmental policies and creating massive dents in fiscal budgets.

The turning point came in 1997, with the case of João Batista Goncalvez Cordeiro, a man suffering from Duchenne's muscular dystrophy, a degenerative disease which leads to the gradual death of the patient. Cordeiro was looking for medical treatment non-existent in Brazil, but available in a private clinic in the United States of America, called Cell Therapy-Research Foundation. The full treatment would cost, inclusive of travel, transport, boarding and lodging, a sum of USD 63,806, which at the time was twenty times Brazil's nominal GDP per capita.[107] Cordeiro used his constitutional right to health to move the courts and was granted relief by the lower court with a mandatory injunction for action by the government within 48 hours. Despite multiple appeals by the state lawyers, the lower court's decision was upheld by the *Supremo Tribunal Federal* (STF), the highest court of adjudication in Brazil on constitutional matters.[108]

[106] TJRJ – 8, Ap. Civ. No. 1994.001.01749, Relator: Des. Carpena Amorim, 20.10.1994, DJRJ, 07.02.95, 1, No. Ap. Civ. No. 1994.001.01749 (Court of Appeals, Rio de Janeiro 2 July 1995). This decision is similar to the *Soobramoney* decision from South Africa, which I shall discuss later.
[107] STF Petition No. 1246-1, Relator Sepulveda Pertence, 10.04.1997, 64,65 (Supremo Tribunal Federal 17 April 1998).
[108] STF Recurso Extraordinario (Extraordinary Remedy), Relator: Min. Celso de Mello, 12.09.2000, No. 271.286-8 (Supremo Tribunal Federal 24 November 2000).

The state had tried its best to give utilitarian arguments, but the STF let go of *stare decisis* and created a landmark decision, a passage from which is the benchmark for all decisions on the right to health since:

> Between the protection of the inviolable rights to life and health, which are subjective inalienable rights guaranteed to everyone by the constitution itself (art. 5, caput and art. 196), and the upholding, against this fundamental prerogative, of a financial and secondary interest of the State, I believe - once this dilemma occurs – that ethical-juridical reasons compel the judge to only one possible solution: that which furthers the respect of life and human health…[109]

Thus, the conflict is clear – it is between the individual's right to life and the financial interests of the State. The Brazilian judiciary has given the individual's right to life absolute prerogative, which allows them to satisfy any health needs required through the courts, in what Ferraz calls "maximum health attention"[110]. Health care becomes individualised to an extent where the utilitarianism of a public service is diminished. While the expansion of the health budgets remains an unlikely possibility – and one must consider that budgets are allocated earlier than judicial decisions – it is up to public officers complying with the judicial decisions to figure out where to draw their financing from.

In the case of Brazil, for the judiciary to have a positive impact on the right to health and access to health, its approach should perhaps be more restricted. Allowing a vast interpretational scope for individual claimants has served to detract from the larger picture of the right to health for all. The statistics reveal that the majority of the litigants are coming from privileged socio-economic backgrounds, rather than from those groups that require access the most, because members of more vulnerable populations seldom have the financial

[109] STF Recurso Extraordinario (Extraordinary Remedy), Relator: Min. Celso de Mello, 12.09.2000 at 1418.
[110] Ferraz, 'Harming the Poor through Social Rights Litigation', 2011, 1658.

resources to reach the courts. This way, the judiciary will only be serving a relatively small and exclusive class and, thus, in turn denying justice to those who need it the most.

1.10.2. India

While India has cherished the reputation of being one of the strongest growing economies of the world, the country's social situation has not deserved the same praise. Indeed, when it comes to the state of the population at large and their access to social rights, such as the right to health, there is much room for improvement. Statistics show that India still has one of the highest maternal death rates in the world, among other incidents, and has one of the lowest expenditures towards the health budget by a government[111].

In these circumstances, litigation may be used as an important tool in ensuring the right to health in the country. However, with its burgeoning population and other social problems, in India, litigation and adjudication of people's rights by the Courts has to go hand in hand with implementation of laws and policies and the enhancement of the various social determinants related to health. A step forward in this direction had been the increase in the budgeting behind health policies[112].

The health policies brought about by the Indian Parliament are often very intricate and aim at changing the prevailing system and reforming it. However, it has repeatedly failed to

[111] Sharanjeet Parmar and Namita Wahi, 'Citizens, Courts and the Right to Health: Between Promise and Progress?', *Litigating Health Rights…, Op. Cit*, 2011, 159. In 2015, the health budget was increased by 2% from the previous year which has brought it to about 1% of the gross domestic product of the country. For more data, refer to 'India Keeps Tight Rein on Public Health Spending in 2015-16 Budget', accessed 20 February 2018, https://www.reuters.com/article/india-health-budget/india-keeps-tight-rein-on-public-health-spending-in-2015-16-budget-idUSL4N0W20CA20150228. As of 2017, India is still the lowest spender on healthcare with China spending as much as five times per capita. For more details on the general growth of the private healthcare industry in India, refer to a bureau article (June 2017), 'India's Healthcare Sector: A Look at the Challenges and Opportunities Faced by $81.3 Billion Industry - Firstpost', accessed 20 February 2018, http://www.firstpost.com/india/indias-healthcare-sector-a-look-at-the-challenges-and-opportunities-faced-by-81-3-billion-industry-3544745.html.

[112] From 0.9% of the total GDP, there has been a jump to 1.3% with a promise to go to 2.5%. This is still the least amongst all three countries spoken of here. Pavitra Mohan, 'Health Budget Figures Tell a Sick Story', *The Wire* (blog), 16 March 2016, https://thewire.in/24924/health-budget-figures-tell-a-sick-story/.

serve its large population. There is no universal healthcare system, and most of the population depends on the private sector for all its needs. In this situation, the most economically vulnerable strata of society suffers the most. Health policies in India have, more often than not, focused on disease eradication and family planning than on providing primary care to all. As a matter of fact, many observers and commentators even question the financial viability of trying to provide universal healthcare to a population of 1.2 billion people (and growing).[113]

In this context, the judiciary has taken up the active role of interpreting the Indian Constitution and calling the State to live up to its promises, wherever required. It has often felt that while the government may fail to act for a variety of reasons in implementing the necessary services and aids in order to serve the population, legislations need to be updated. In the 1980s, it was the judiciary's active role in entertaining a wave of public interest litigation that brought about an unprecedented change in public access to the justice system in India[114]. This new wave of activism saw the Supreme Court of India interpreting the right to life in a prisoners' rights case as the "right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter."[115] However, it was only in 1996, where the government was directed to pay compensation to a petitioner, who had a medical emergency and had been denied treatment at 7 hospitals, that health was considered a justiciable right of its own accord[116]. Since then, the Court has gone on to declare the right to health as an integral part of the right to life[117].

[113] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 160.
[114] The primary trigger for public interest litigation was the case of Hussainara Khatoon & Ors. v. Home Secretary, State of Bihar, AIR 1369 (Supreme Court of India 1979). A lawyer, Pushpa Kapila, broke the rules of *locus standii* and filed a *habeas corpus* petition to get several prisoners out of jail, languishing there at times for periods beyond what their sentencing would have been. This led to 40,000 such releases across India, and thus, the first public interest litigation was born. Justice PN Bhagwati judged over this at the Supreme Court of India, and thus the doors opened for judicial activism.
[115] Francis Coralie Mullin v. Union Territory of Delhi, 2 SCR 516 (Supreme Court of India 1981). The case referred to conditions of detention of prisoners.
[116] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 4 SCC 37 (1996).
[117] State of Punjab v. Mohinder Singh Chawla, (1996) 4 SCC 37, 4 SCC 37 (Supreme Court of India 1996). The Right to Life in Article 21 was read with various directive principles of state policy, and it was considered by the

The Indian High Courts and the Indian Supreme Court have been seeing litigants coming to them with the requirement of empowering various aspects of the right to health. Yet, till now, no core definition of the right to health, or what it entails, has been articulated.[118]

Research reveals that the right to health litigants in India can be broadly put under two categories - people who are impoverished and have been denied treatment or find it difficult to access the social determinants of health and health services (public health services are included in this), and people who are employed by the government, looking for reimbursement under medical benefits for services derived from private enterprises as the public sector was unable to provide them the same.[119]

The Supreme Court of India has repeatedly referred to the UDHR for the country's obligations towards its citizens when it comes to the right to health. As stated earlier, the Constitution of India provides a very limited text for the right to health, being a part of the Directive Principles of State Policy as opposed to the Fundamental Rights. Thus, the entire constellation of social rights is taken indivisibly and derived from the right to life in the Constitution.

Statistics show that most of the cases that may be framed under the right to health are either cases of public health issues, medical negligence and malpractice or medical practices related to HIV/AIDS. There are some varied others, which include assisted suicide.[120] While most petitioners have raised issues under the aforementioned areas, some have instituted

Court that there is a constitutional obligation to provide government workers with health facilities, thus firmly installing the right to health in the right to life.

[118] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 166.

[119] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 167.

[120] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 169.

public interest litigation on grounds of environmental health[121], disability rights and drug regulations, with many of these cases being decided within the ambit of the right to health[122].

While most of the litigation raised at the Courts was in the broader interest of the public, many of the petitioners were members of the affected groups themselves. NGOs and workers' unions raised some of the cases, even though they are statistically insignificant. It is to be noted though that not all cases that have a far-reaching effect on larger groups are filed as Public Interest Litigations, but often as normal cases for individual rights claims.[123]

One of the reasons why legal battles become so significant and far-reaching in India is that the Indian Supreme Court, acknowledging a possible lag in implementation, has often retained supervisory jurisdiction over its orders, thereby ensuring they are carried out.[124] This is of great consequence, particularly on issues relating to ameliorate and remedy the social factors determining the right to health. Among the varied orders given out by the Court in this field is the determining of the minimum requirements for emergency healthcare, which the government has been henceforth instructed to implement. Other orders include issues related to sanitation, environmental pollution, and compensatory orders for people affected by industrial pollution, etc.[125] To be sure, all socio-economic claims might not be directly linked to access to health services. Yet, they definitely have a bearing towards the social determinants of the right to health.

[121] Rural Litigation and Entitlement Kendra, Dehradun and Ors. V. State of UP and Ors., 2 SCC 431 (Supreme Court of India 1985); Subhash Kumar v. State of Bihar, AIR SC 42 (Supreme Court of India 1991). In the former case, the Supreme Court recognized the right to a clean environment when looking into the ecology, and the latter case was about the pollution of a river by the release of sludge from a factory. The Supreme Court held that there was a right to pollution-free water here, and in a way reflected the earlier decision

[122] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 169. The drug regulations included using compulsory licensing as one of the aspects, and is used extensively to generically manufacture drugs for anti-retroviral treatment and cancer treatment, among others. The first time that compulsory licensing was used in India was against the German company, Bayer, for its cancer drug Nexavar, and the license to produce generically and at a fraction of the price was granted to a local firm, Natco ltd., in the case, Bayer Corporation v. Natco Pharma Ltd., No. 45 (Intellectual Property Appellate Board, Chennai 2013).

[123] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 170, 175.

[124] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 174.

[125] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 178 Table 7.3.

Given that the Supreme Court holds the authority to supervise the implementation of its own orders, its decisions have produced remarkable results in the making of public policy. As a matter of fact, investigative bodies and inquiry commissions have been set up to monitor and evaluate various public sector services following a decision by the Court. As a result, from emergency health care to mental disability issues to tobacco control, the Supreme Court's orders have often been met with a policy movement from the Government's side.

Thus, starting with the *suo moto* actions brought about by the Supreme Court, to allowing public interest litigation by parties with or without *locus standii*, it is evident that there is a progressive tendency in the Indian justice system. The judiciary not only seems to encourage social rights activism, but is activist itself. However, the main criticism levelled against the Indian judiciary is its rather *ad hoc* approach to resolving issues around socio-economic rights, leading to a piecemeal approach in policy change and implementation[126]. It has managed, however, to shed light on various failures and larger, systemic issues of the government's enforcement of socio-economic rights, which is a stepping-stone in the right direction.

1.10.3. South Africa

Given the nature of its recent transition from a white-minority regime to a democratic majority-run democracy, the "new" South Africa has faced a very specific set of problems from the very outset of the post-Apartheid era. These include high levels of poverty and social inequality, along with decreasing levels of economic development, and the high sero-positivity rate of its population, one of the highest in the world. In this context, litigants have

[126] Parmar and Wahi, 'Citizens, Courts and the Right to Health', 182,183.

often used fundamental rights, such as the right to life, dignity, equality, access to information and bodily integrity, to support their claim to health rights.

However, accessing the South African legal system is expensive. Litigation comes under civil law, where there are no provisions for providing public prosecutors for claimants. Moreover, filing a case with the Courts requires a fair amount of technical knowledge and procedural knowhow that most people do not possess. Also, while direct access to the Constitutional Court exists in theory, in practice it requires the applicant to exhaust all other remedies before approaching the Constitutional Court, as the latter is disinclined to be the Court of first or last resort. All in all, statistics show that most cases involving fundamental rights and social rights have been forwarded by NGOs, while private individuals have brought only a few. Indeed, the legal intricacies and expenses involved in trying to file a case has often worked to keep individual litigations away.[127]

The cases falling under health-rights claims reaching the South African judiciary can be thematically divided into three groups – policy gaps, regulatory gaps and implementation gaps. For the sake of this chapter, I shall elaborate the first two[128].

Under the first aspect, different cases involved claims that there was a gap in the existing healthcare policy disallowing medical intervention by the public healthcare system for certain people. In one case, due to the specialised nature of the treatment required, while sympathizing with the petitioner, the Constitutional Court felt that the healthcare policy's utilitarian aspect had to be upheld due to the limited resources available in the country[129] and gave the following reasoning:

[127] Carole Cooper, 'Health Rights Litigation: Cautious Constitutionalism', *Litigating Health Rights…, Op. Cit*, 2011, 191–93.
[128] The third aspect shall be explained in a following chapter.
[129] Thiagraj Soobramoney v. Minister of Health, KwaZulu-Natal, 17 ZACC (South African Constitutional Court 1997). Hereafter referred to as *Soobramoney*, the case was about a person requiring dialysis due to kidney failure.

> The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.[130]

This reasoning resonates with the non-interference standards[131] found in Brazil in the 1990s, as mentioned earlier. At the same time, though, the Court mentioned the following:

> [M]illions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them and transform our society into one in which there will be human dignity, freedom and equality, lie at the heart of our new constitutional order.[132]

However, in the case of HIV/AIDS, the Mbeki government's denialist position[133] had to be fought by individuals and groups in order to make sure treatment was made available. With the government refusing to provide anti-retroviral drugs, a social movement emerged, known as the Treatment Action Campaign (TAC). The TAC operated through a multi-

[130] *Soobramoney*, para. 29.
[131] That is, the Courts wanted to allow the government time to fix things before they stepped in, sometimes showing deference to government decisions.
[132] *Soobramoney*, 17 ZACC, para. 8.
[133] HIV denialism is a belief that HIV does not cause acquired immune deficiency syndrome (AIDS). Even if the proponents of this denialism believe in the existence of AIDS, they claim it is caused by a combination of a variety of other issues including the drugs used to treat HIV infections. HIV denialism had a powerful and devastating proponent in the form of the South African President Thabo Mbeki, during whose denialist presidency, it is estimated that between 330000-340000 people died of AIDS-related issues, along with another approximately 200,000 new infections, including infants. For further details on this, please refer to Pride Chigwedere et al., 'Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa', *JAIDS Journal of Acquired Immune Deficiency Syndromes* 49, no. 4 (2008): 410–415.

layered, multi-pronged approach which included litigation, community mobilization by making stakeholders aware of their rights, and treatment literacy and advocacy. While it had initially avoided litigation, the TAC was forced into it when the government's response to HIV/AIDS, once it finally acknowledged it, was felt to be highly inadequate[134].

Relying on the constitutional principle binding the government to respond to the needs of the people, the TAC argued that the denial of access to health benefits caused by the government's actions infringed on the right to life and the right to dignity. The case was taken to the Constitutional Court, resulting in a favourable decision for the TAC, thus establishing a strong pathway for future social rights litigation[135]. Other cases have involved the rights of prisoners to receive medical treatment[136] and the right to water for the residents of Phiri in Johannesburg[137]. It was interesting to note that the reluctance to adopt a minimum core in socio-economic rights, as seen in the right to housing case[138] and the right to water case (while acknowledging the social inequities), was once again reiterated in the TAC:

> [T]he socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1).[139]

[134] While the change in the government meant that the denialists were rooted out, it did not necessarily translate into immediate action. Treatment Action Campaign estimated that around 600 people were dying on a daily basis due to HIV/AIDS related causes.
[135] Minister of Health and Others v Treatment Action Campaign and Others, 5 SA 721 (CC) (SACC 2002) hereafter referred to as the *TAC* case.
[136] EN and Others v Government of RSA and Others, 6 SA 575 (D) (2006).
[137] Mazibuko v City of Johannesburg, 4 SA (CC) (2010). The case was around the installation of pre-paid water meters in a particularly poor neighbourhood of Johannesburg. It was also decided under Section 27 of the Constitution, but with deference towards the government and the disallowing of a minimum core.
[138] Government of the Republic of South Africa and Others v Grootboom and Others, 1 SA 46 (CC) (SACC 2001). The case was on the constitutional right to housing, and was decided against the petitioners with deference towards the government, once again disallowing a minimum core.
[139] *TAC* case, para. 34

Perhaps one of the most interesting aspects of litigation on the gaps in policy in South Africa has been the changes in policy that social movements and legal cases have produced, many of which were instituted while popular campaigns and litigation were going on. In this case as in elsewhere, when a government publicly acknowledges the gaps in its policies, individuals and groups tend to find better grounds to claim their rights.

Regulatory gaps, on the other hand, have an indirect but an equally important role to play in depriving people of their rights. Due to such policy and regulatory gaps during the Apartheid era, necessary drug prices were extremely high. When the post-apartheid democratic regime was instituted, it enacted legislation to control such prices, and also to allow the large-scale import of generic substitutes, which cost a fraction of the branded drugs. Naturally, the pharmaceutical giants who had vested interests in selling drugs at exorbitant rates tried to get an indictment against the legislation, stating that their fundamental rights were being infringed upon. Had this claim been successful, anti-retroviral medication availability and accessibility would have dropped radically.

Once again, the TAC started litigation, and this gave rise to a worldwide social movement, which led to the withdrawal of the case on the condition that South Africa would respect International Trade Laws. On a similar note, when private manufacturers of HIV-related medication brought new drugs into the market at very high prices, the TAC, through litigation and advocacy, managed to push them to lower their prices even before the Court had decided, making the much-needed medication available to the people living with HIV[140]. The second case acted as a catalyst for the TAC to advocate for the price reduction of other drugs as well.

Thus, even without judicial decisions, these cases show the possibility of a favourable outcome through advocacy, public litigation and mass movement.

[140] Pharmaceutical Manufacturers Association of SA (PMA)v. President of the RSA (TAC as the amicus curiae) Case No. 4183/98 (n.d.).

Overall, the South African judiciary has often actively worked to realise the rights enshrined in the Constitution. When confronted with mortal danger such as the need for anti-retroviral medication for all, the judiciary took a strong stance against state policies and pushed forward. However, when it came to the right to water, it took on a relatively reverent stance by not deciding against the state, though questioning the state about its approach to empowering and enhancing social rights. Also, while the judiciary questioned the state's budgetary allocations in decisions passed in civil and political rights cases, the same cannot be said of social rights cases[141].

1.11. The Inter-American Court of Human Rights and the right to health in Brazil[142]

The Inter-American Court of Human Rights has been a judicial game-changer in recent times. Through current decisions, it amalgamated civil and political rights with socio-economic rights. Generally, civil and political rights are considered to be "negative rights" and socio-economic and cultural rights as "positive rights". However, this differentiation has often been debated. In recent times, civil and political rights have often gained precedence in enforcement over and above socio-economic rights.

Despite having been a part of the rights regime for a while now, the right to health, as discussed above, is yet to be set a workable standard. The ambiguity around its definition and

[141] Cooper, 'Health Rights Litigation', 222. While the South African Judiciary has taken cognizance of pandemics such as HIV/AIDS, it has a relatively deferential stance towards the government. However, many a time, even the threat of litigation (thus naming and shaming) has been enough to bring about a massive change.
[142] The Inter-American Court of Human Rights drafts primarily in Spanish, in which it states "*vida digna*" and "*existencia digna*" for dignified life and dignified existence respectively. For the sake of clarity and to avoid confusion, I have used translation changes as used in Steven R. Keener and Javier Vasquez, 'A Life Worth Living: Enforcement of the Right to Health through the Right to Life in the Inter-American Court of Human Rights', *ColuM. HuM. RTS. l. Rev*. 40 (2008): 595.

limited resources (as is the case with India, Brazil and South Africa) of states have often led to difficulties in implementation.

Most countries in the world are party to at least one convention that explicitly protects the right to health, but given its separation in many instances from civil and political rights, it becomes difficult to claim against the state. This particular factor has been bridged by the Inter-American Court in the cases of *Yakye Axa Indigenous Community v. Paraguay*[143], *Sawhoyamaxa Indigenous Community v. Paraguay*[144] and *Ximenes-Lopes v. Brazil*[145].

In the *Yakye Axa* and the *Sawhoyamaxa* cases against Paraguay, the Inter-American Court went beyond the mere wordings of the American Convention's Article 4 on the right to life[146], which says:

> **Article 4 Right to Life**
>
> 1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.
>
> 2. In countries that have not abolished the death penalty, it may be imposed only for the most serious crimes and pursuant to a final judgment rendered by a competent court and in accordance with a law establishing such punishment, enacted prior to the commission of the crime. The application of such punishment shall not be extended to crimes to which it does not presently apply.
>
> 3. The death penalty shall not be reestablished in states that have abolished it.

[143] Yakye Axa Indigenous Community v. Paraguay, Ser. C No.125 2005 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2005) hereafter referred to as the *Yakye Axa* case.
[144] Sawhoyamaxa Indigenous Community v. Paraguay, Ser. C No. 146 2006 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2006) hereafter referred to as the *Sawhoyamaxa* case.
[145] Ximenes-Lopes v. Brazil, Ser. C No. 149 2006 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2006) hereafter referred to as the *Ximenes-Lopes* case.
[146] 'American Convention on Human Rights (Also Known as the Pact of San José)' (1969), www.hrcr.org/docs/American_Convention/oashr.html.

> 4. In no case shall capital punishment be inflicted for political offenses or related common crimes. 5. Capital punishment shall not be imposed upon persons who, at the time the crime was committed, were under 18 years of age or over 70 years of age; nor shall it be applied to pregnant women.
>
> 5. Every person condemned to death shall have the right to apply for amnesty, pardon, or commutation of sentence, which may be granted in all cases. Capital punishment shall not be imposed while such a petition is pending decision by the competent authority.

It, in fact, became quasi the right to health. The State is not only held accountable in actions directly related to the government, but also circumstances created by the State. The Court found a precedent in the *Street Children* case[147], where the Court had stated that

> The right to life is a fundamental human right and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning…. In essence, the fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required in order that violations of this basic right do not occur…[148].

This created the foundation for a positive interpretation of the right to life, rather than a typical negative interpretation. This was further confirmed in *Case of Juan Humberto Sánchez v. Honduras,* when the Court insisted that it was not enough to just not deprive a person of

[147] 'Street Children' Villagrán Morales et al. vs. Guatemala, Ser. C No. 63 1999 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 1999) hereafter referred to as the *Street Children* case.
[148] *Street Children* case, 144.

his/her life, but rather that the "States [need to] take all appropriate measures to protect and preserve the right to life (positive obligation)…"[149] This method of expanding the right to life was referred to as the "evolutionary interpretation of the right to life".

This "evolutionary interpretation" became the backbone of the 2005 and 2006 cases against Paraguay. Both these cases were about highly deprived indigenous groups, the Yakye Axa and the Sawhoyamaxa communities. Traditionally hunter-gatherer communities, both groups were displaced when non-indigenous groups took over their lands. In order to reclaim their lands, they took legal steps, and in the interim, settled on a strip of land between a public road and a wire fence next to their indigenous lands. The peoples were living in highly degraded conditions with the lack of clean water, sanitation and even access to basic medical care. Given the fact that they had been removed from their natural habitat, the peoples could no longer hunt or gather food, nor farm or fish. This led to several health-related problems including high infant mortality.

In both cases, the Court expansively interpreted Article 4 that was laid out in the Street Children cases. In the *Yakye Axa* case, the Court said:

> One of the obligations that the State must inescapably undertake as guarantor, to protect and ensure the right to life, is that of generating minimum living conditions that are compatible with the dignity of the human person and of not creating conditions that hinder or impede it. In this regard, the State has the duty to take positive, concrete measures geared toward fulfilment of the right to a [dignified life], especially in the case of persons who are vulnerable and at risk, whose care becomes a high priority.[150]

The Court took a very similar stance in the *Sawhoyamaxa* case, in which it stated that

[149] Case of Juan Humberto Sánchez v. Honduras, Ser. C No. 99 2003 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2003), 110.
[150] *Yakye Axa* case, 161-62.

> States must adopt any measures that may be necessary to create an adequate statutory framework to discourage any threat to the right to life; to establish an effective system of administration of justice able to investigate, punish and repair any deprivation of lives by state agents, or by individuals; and to protect the right of not being prevented from access to conditions that may guarantee a [dignified life], which entails the adoption of positive measures to prevent the breach of such right.[151]

Thus, the interpretation of Article 4 by the Court entails more than just survival. It becomes similar to the South African stance of life with dignity.

Although the above two cases have very similar facts and the Court started from a similar expansive standpoint, the decisions are quite dissimilar. In the *Yakye Axa* case, the Court said it needed to ascertain the fact that the State was indeed responsible for the difficulties of access to a dignified life that the community faced, and in case this was ascertained, then the State had not taken adequate measures to alleviate those conditions. To reach this conclusion, the Court stated that two factors needed to be taken into consideration. Firstly, the vulnerability of the individuals of the group, and secondly that the right to life ought to be interpreted with the economic and social rights as recognised under Article 26 of the American Convention[152], the ILO Convention 169 on Indigenous and Tribal Peoples[153], and the Protocol of San Salvador[154]. The latter specifically mentions the right to health, the right to a healthy environment, and the right to food.

[151] *Sawhoyamaxa* case, 153.
[152] "The State Parties undertake to adopt measures, both internally and through international cooperation, especially those of an economic and technical nature, with a view to achieving progressively, by legislation or other appropriate means, the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States as amended by the Protocol of Buenos Aires, "American Convention on Human Rights (also known as the Pact of San José).
[153] 'Convention C169 - Indigenous and Tribal Peoples Convention, 1989 (No. 169)', C169 §, accessed 5 March 2018, http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C169.
[154] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

The Court held Paraguay responsible for the poor conditions that the Yakye Axa community was living in and that the State had also failed in creating "living conditions that are compatible with their dignity." The court did not fail to point out the high vulnerability quotient of the indigenous community, especially with regard to their infants and their elderly. However, despite such strong statements against the State, the Court did not connect its findings to the death of 16 members of the Yakye Axa community.

Thus, while the *Yakye Axa* case did not hold the State culpable for the deaths of several vulnerable people, it did expand the right to life to include various elements of the right to health. It had moved away from the *Street Children* case, and gone beyond the duty of the State to prevent arbitrary killings to including a dignified existence that requires medicine, food, clean water, sanitation.[155]

A few months later, the *Sawhoyamaxa* case gave the Court the opportunity to correct its final stance on the previous case. Thus, it not only found the State culpable in causing the destitution of the group, but it also found the State connected directly to the deaths of individuals of the group. However, at the same time, the Court was cognizant of the possible issues arising out of such an expansive or "evolutionary" reading of the right to life, such as limited resources or public policy planning. Hence, it crafted a decision that set the golden standard. A violation of Article 4 would firstly require that "the authorities knew or should have known about the existence of a situation posing an immediate and certain risk to the life of an individual or a group of individuals" and secondly, "that the necessary measures were not adopted within the scope of their authority which could be reasonably expected to prevent or avoid such risk"[156].

[155] The other aspect of this case was that the right to life was not interpreted formalistically, which would have meant that the right to life would have been directly linked to the deaths of the vulnerable individuals. Instead it found a violation of the right just by the destitution of the group concerned.
[156] *Sawhoyamaxa* case, 155.

Keeping this standard in mind, the Court held Paraguay responsible for failing to provide communal property to the Sawhoyamaxa community because of slow and inefficient action on the State's part, thus failing to take "necessary measures" for the community to move to a place with adequate resources for a dignified life. The Court also found Paraguay's efforts in medical care for the community inadequate, despite domestic decrees being present for immediate action for medical care and food delivery. The actual services delivered were inadequate. Access to healthcare centres due to distance was already an impediment. However, coupled with denial of services because of the failure to pay for medicines resulted in the death of several children in the hospital, as well as in the community.

However, the Court, acknowledging finite resources and the "scope of authority" requirement, narrowed down the healthcare requirements from the State when it decided that the State was not responsible for the deaths of individuals from traffic accidents or work-related accidents (due to lack of evidence connecting the authorities to these accidents), as well as the deaths of elderly people from pneumonia and tuberculosis, reasoning that they had lived beyond the national life expectancy.

These decisions paved the way for the expansion of connecting the failure of a state's healthcare system to the right to life in the *Ximenes-Lopes* case. The case was about a 30-year-old individual, Mr. Damião Ximenes-Lopes, who suffered from a mental illness since childhood. In 1999, he was put in a mental health facility by his mother, *Casa de Reposo Guararapes* in Sobral, Brazil.

A few days prior to being admitted, Damião had been suffering from anxiety and sleeplessness. When admitted, he exhibited no signs of physical violence or outward wounds. Three days later, when his mother visited him, she found him wounded and bleeding and bruised. His clothes were torn, and he was smelling of excrement. His hands were tied behind his back. He was finding it difficult to breathe, and was struggling and shouting. Damião's

mother requested the facility's staff to clean her son and for him to be checked by a doctor. The doctor prescribed him medication without even a cursory examination. About two hours after that, Damião died, and there was no doctor in the unit.

The Brazilian State-run unified healthcare system or the SUS has several private institutions contracted under it to provide medical services to citizens. *Casa de Reposo Guararapes* is one such private institution. The Court did not mince words when describing the institution - "an atmosphere of violence, aggression, and abuse where many inpatients frequently suffered injuries" at the hands of the employees[157]. Apparently, it was a common practice to apply choke holds on the patients and physically restrain them without any such requirements from the physicians. Prior to Damião's death, at least two patients had died there, and on examination it was found that they had suffered blows on the head with a blunt instrument. They had been admitted in good physical condition. Several such incidents had gone uninvestigated by the hospital management as well as the State.

Applying the two-part Article 4 test from *Sawhoyamaxa*, the Court held that the State was aware of the appalling conditions of the hospital that threatened the right to life, and that the State had failed to take action within the "scope of its authority". More significantly, the Court said that the duty of states to provide and regulate healthcare stemmed directly from the American Convention Article 2, and thus did not need to stem out of domestic authority. Despite this, it did point out the domestic authority in this case as in Sawhoyamaxa.

What the three cases give is the inadequacy of environment and services that lead to a life which becomes unbearable or is cut short due to the inadequacy. Thus, the right to life is connected directly to the right to health, because the right to life is not just about bare life or to be protected from arbitrary deprivation of life, but also to a life with dignity.

[157] *Ximenes-Lopes* case, 112 para. 56

1.12. Conclusion

This chapter aimed to examine the core treaties and charters which influence socio-economic rights the most, especially the right to health. As we saw, while some of them are quite extensively worded, they seldom address specifically the issues of sexual and gender minorities. However, given the expansive interpretative nature of International law, a non-mention is often better than defining absolute specifics, which can be subsequently interpreted in a very narrow manner.

At the same time, in many instances the definition of the right to health encompassed determinants of health that are covered under other rights. This type of interconnectivity and interdependence between rights is not uncommon. However, perhaps, in the case of the right to health, given that it is generally considered a socio-economic right, for it to be given an intuitive basis in civil and political rights gives it more flesh and, in turn, impetus to be achieved.

International covenants, as mentioned earlier, are voluntary in aspect. However, when a country is a signatory to them, it becomes easier for oversight bodies and reporting bodies to point out the deficiencies of their systems, thus exposing them on an international platform. They help in persuading the countries that adopt them to do better than before, as well as gain knowledge about best practices of other countries in similar situations.

Traversing through the constitutions of three important countries of the Global South – all of which were formulated and promulgated in the aftermath of drastic political and social changes – it is evident that they attempted to right the wrongs of the previous regimes, and have consequentially built in themselves as many constitutional safeguards as possible, especially where social rights are concerned. However, whether their economic capacity,

burgeoning populations and overall apathy from governmental bodies will allow a timely and critical intervention to stop abrogation of rights is still a topic open to discussion.

In all three countries, litigation has played a role in elaborating socio-economic rights, especially the right to health. All three judiciaries have played an active role, with the Indian Supreme Court taking the lead – probably because of its early inception – and starting to remedy issues regarding sanitation and water in the 1980s. All three countries have taken steps in mitigating the lagging of social determinants of the right to health in different ways – and, crucially, the judiciaries have played a large role in these processes. Yet, the question of whether they have managed to create the necessary structures to make the right to health achievable for people on the ground, will depend on what we see in the future.

Brazil and South Africa proceeded from a similar perspective, by looking primarily at the reasonableness of giving into individual demands at the expense of public necessity. But then onwards, Brazil went into a highly individualised type of socio-economic rights protection regime[158]. South Africa avoided this trend, and used instead the standard of reasonableness to decide whether current policies towards progressively achieving the highest standard of health were sufficient or not. However, while the South African judiciary has been relatively assertive in later cases after *Soobramoney* with regard to socio-economic rights, it is yet to be as against state policies as its counterpart in Brazil. In India, a highly proactive judiciary has opened a prolific space for multiple rights-based litigations to be heard, and gives hope for socio-economic rights–strengthening adjudication.

The current inadequacy of Brazil's domestic policies and systems around health and its determinants was evidenced in the *Ximenes-Lopez* case at the Inter-American Court of Human Rights. Brazil was reminded of its failures and urged to remedy the situation by the

[158] That is, instead of empowering groups, it decided cases for individuals and gave them the fullest extent of the exercising of their rights possible, as seen above.

Court. Yet, as seen above, there is a distinct lack of access to justice in Brazil. Perhaps the judicial inaccessibility of the common man felt in the Brazilian situation will not emerge in India and South Africa, and will not prevent greater numbers of people being able to claim their rights.

While the right to health involves many social factors which in turn are linked to a variety of fundamental rights themselves, it is, by itself, a strong umbrella for establishing social rights. Having been linked to the right to life and the right to dignity by the jurisdictions in question, the right to health has been given a civil-political, rights-contextualised body. This enables litigants and activists to seek relief within that larger framework and allows courts to consign their decisions to it as well without it seeming like judicial overreach.

As seen above, the right to health has not always been articulated expansively across constitutions, while it has often occupied a central place in international covenants. Keeping it brief or, at least, expansively worded has allowed the constitutional courts, litigators, litigants and activists to interpret it to suit their specific agendas, thus allowing for social realities to be considered. Even though at times it has been used to establish rights for a select few who could afford accessing the courts, the right to health has also, more often than not, had a positive effect on overall governmental policy by forcing states to listen and respond to social demands. In addition, it has given litigants the hope of something more than the right to bare life.

Using the Human Rights framework to establish a basis for conceptualising the right to health at the ground level will not remove its inherent problems immediately, most of which derive from social conditions, such as inequalities and lack of resources. Yet, a strong human rights-based approach allows individuals and groups to claim redressal for the inequities met out to them in socio-economic rights. This framework, thus, moves away from the notion of charity and approaches the notion of dignity – for health is not a privilege, but a

right that can be claimed. However, as we shall see in a later chapter, minorities such as transgender people are often left behind, or when they do manage to claim their right, it is often at a price.

2. Transgender Citizenship

2.1. Introduction

Is Citizenship gendered or is it beyond such particularism?[159]

The question posited above by Sylvia Walby is at the basis of this chapter. Can citizenship be successfully universalist or does it act upon the divisions already existing within society? Does it bring together people who are different or does it differentiate them even further? In this situation of intersectionality, where does gender stand, and where do those people who do not identify with normative standards place themselves? And what happens to those people who, despite enjoying formal citizenship, are still deemed unequal? Or yet those people who are invisible in the eyes of the law, and therefore unable to exercise their citizenship.

Citizenship is a highly contested political phenomenon. It is a space of political rights that people aspire towards, without which it becomes nearly impossible to claim rights against the State. Within the macrocosm of citizenship and its surrounding controversies, transgender citizenship is a highly-debated notion, not just in the geographical contexts discussed in this dissertation, but across the world. Indeed, it is difficult to place the transgendered body in law and legislation, as these structures have inherently been created along binary lines. Because equal citizenship is denied to the transgender person, the non-conforming body becomes a site of primarily negative governmental regulation. Yet, transgender people are fighting oppression within the prevalent structures and garnering momentum in securing their rights.

[159] Sylvia Walby, 'Is Citizenship Gendered?', *Sociology* 28, no. 2 (1994): 379.

The sector of health is one of the prevailing structures where transgender people find it the most taxing to exercise their rights as citizens. The right to health, as discussed later in this dissertation, is affected by several factors, but access to healthcare is undeniably one of the primary zones of conflict when exercising citizenship rights for a transgender person. Thus, the aim of this chapter is to consider the underpinnings of citizenship and how it has guided us in the way we view fellow-human beings based on belongingness and otherness, and whether transgender people have a place within its framework.

This chapter has essentially three parallel aspects to it. For this reason, it is divided into three parts – the first part lays out the primary theory for understanding how transgender people are situated in it. It explores the construction of the human in society, and what constitutes its corollary. Then it looks at the universality of human rights and the theoretical underpinnings of it. From there it goes into briefly examining the usage of biopolitical control over the body and the creation of the abject or the monster and the controlling of it. There onwards, it considers redistribution and recognition of group rights and notions of being split between groups. Finally, it looks at how gender is constructed by society.

The second part looks at the historical trajectory of how citizenship developed into what we claim from the State today. By looking at several cases across history, the chapter investigates the gender bias in citizenship, the status of the woman, irrespective of colour, as well as slavery in the United States of America, the British and French empires. The chapter then moves towards the political enfranchisement of women in the 20th century, and finally to the historical processes leading to the idea of natural, inalienable and universal rights for all humankind being enshrined in the Universal Declaration of Human Rights.[160]

[160] The investigation into gender-based citizenship and slavery is important in the context of transgender people, as, for free women, it took away their immediate agency, irrespective of wealth, status and colour in many instances, and for slaves, the idealogy was that of chattel or property, or as shown later, politically only part-human, thus more akin to the concept of *homo sacer* spoken about later.

Departing from the historical explanation of gendered and coloured citizenship, the third part of the chapter engages with theorists who have tried to explain group rights either within the universalist approach or gone onto another theory of citizenship altogether and marked a departure from citizenship being described on ascertaining civil and political rights to being based on social rights. Finally, it looks at how sexual and gender citizenship evolved and how transgender people are placed within this framework and how they secure their rights against the state.

The questions that this chapter shall aim to answer are why citizenship is important in the context of transgender people and their right to health, why specific identities are required and whether they help in creating an inclusive system or further the fragmentation of an already divisive society.

2.2. Navigating the space between theory and practice

2.2.1. Being Human

Judith Butler argues that the category of the "human" is based on the distinction drawn between living creatures who are human, and other living creatures, rendered non-human or sub-human. She states that "[f]or the human to be human, it must relate to what is nonhuman, to what is outside itself but continuous with itself by virtue of an inter-implication in life"[161]. Butler engages with Frantz Fanon here, who propounds that the current articulation of human is highly racialised, to a point that a black is not a man. To Fanon, a black man is effeminised, by not fitting fit into the norms of dominant masculinity he cannot be considered to be human. This racialised definition of the human, making white and masculine the presumed universal

[161] Judith Butler, *Undoing Gender* (Psychology Press, 2004), 11.

standard, has been extended to women as well. There are many power aspects deeply rooted in the construction of the human – and race and gender as power differentials are two of them.

In this context, it is important to introduce the concept of the sub-human. Giorgio Agamben refers to the "werewolf" as such a figure – "neither man nor beast" – belonging to both groups and neither at the same time[162]. This brings about the state of exception (spoken about below), wherein this creature roams about homeless, as the given human framework does not allow a space for it to exist, and the chaotic bestial world sees it as an outsider as well. Despite their evident exclusion, those beings who are not recognised as fully humans – "deemed illegible, unrecognizable, or impossible" – by engaging the human-centric discourse end up pushing its boundaries and opening the vista for a more inclusive definition of the human itself. In that, they often work to challenge and potentially override existing power relations within the very definition[163]. The human rights agenda is one such movement that both draws on and opens up more restrictive understandings of the human, as we shall see.

2.2.2. Theorising Human Rights

Upendra Baxi argued that theory is a "constitutive characteristic of human rights"[164]. But Baxi differentiates between social theory "of" and "about" human rights, the former being more broadly related to ethics, while the latter is associated to the "juridico-political sphere"[165]. The theory "of" human rights engages with the basic questions underlying human rights, such as what constitutes a human, and being human, or what having rights actually mean. In raising these issues, it also engages with the hierarchy of the norms which form human rights. Theory "about" human rights, on the other hand, is more concerned with

[162] Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life* (Stanford University Press, 1998), 105.
[163] Frantz Fanon in Butler, *Undoing Gender*, 11.
[164] Sen in Upendra Baxi, *Human Rights in a Post Human World: Critical Essays* (Stranger Journalism, 2009), 30.
[165] Baxi, *Human Rights in a Post Human World*, 30.

human rights on two levels – doctrinal and historical. That is, firstly, it deals with the multiple ways in which "standards, principles, maxims, and precepts" which form the basis of human rights develop. Secondly, it delves into the past to see and examine the various contexts in which different human rights discourses and advocacy emerged. Thus, it provides grounds for comparison of human rights in different regimes of law (and in many cases, different regimes of truth)[166].

Another important participant in this debate, Amartya Sen, pointed out that a theory of human rights is needed to overcome what he sees as an "inadequacy of moral systems that do not give rights-based considerations any role in outcome judgments"[167]. Here, theory works to lay out the basis of understanding rights from different contexts, and in different contexts. As Sen envisages it, theory needs to address six main issues, namely: the 'kind of statement [that] a declaration of human rights makes'; justifying the 'importance' of human rights; the 'duties and obligations' emanating from the rights; the variety of actions and omissions required by which human rights may be progressively realised; the requirement to include 'economic and social rights' as a part of 'human rights'; and, finally, the need to justify human rights' claims of universality in a world divided by a myriad of cultural clashes and historic anomalies[168].

Likewise, Brooke Ackerley questioned the very premise of the so-called universality of human rights[169]. Drawing on the idea of the 'ideal theory'[170] from Rawls, Ackerley notes that the legitimation of theory depends on critical questions being asked. Thus, different

[166] Baxi, *Human Rights in a Post Human World*, 32,33.
[167] Sen in Baxi, *Human Rights in a Post Human World*, 34.
[168] Sen in Baxi, *Human Rights in a Post Human World*, 39.
[169] Brooke A. Ackerly, 'Universal Human Rights in a World of Difference', 2008, chap. 2.
[170] Ackerly, 43. Ackerly uses the distinction Rawls draws between ideal and non-ideal theories, where the former is a 'realistic utopia' – although there are disagreements on values, there is a "political agreement on norms of justice after a thorough discussion of our different views". Non-ideal theory, on the other hand is based on a notion of disagreement on the terms of justice – where there is not just value pluralism, but also political pluralism. While the former allows for a "well-ordered" society to share ideas of justice thus allowing for resolution of matters, the latter considers all states of non–compliance of shared notions of justice. Ackerly points out that the failure of such non-compliance may be because the background conditions of a "well-ordered" society may not exist in order to give room for such movement.

theorists develop different perspectives based on the politics of knowledge, difference, and dissent which our theoretical methods need to address in order that our theory of human rights reveals the silences and absences of justice"[171]. She notes, for instance, that the very definition of what constitutes a violation requires a shared or collective system of signification on human rights to begin with. In the Rawlsian approach, universal human rights require a societal consensus whereby people share a common notion of justice. The underlying assumption here is that all individuals are "free and equal" participants in a larger order of things. The problem with this framework, as Ackerley points out, is that the idea of a consensual notion of justice may very easily fail to account for diversity[172].

Conversely, Ackerly states that while sporadically consensus do emerge, polities are intrinsically dynamic and so are the consensuses they reach. As societies around the world get increasingly diversified, as multiple histories or memories begin to be recognised (as opposed to one unifying history of rule, law, governance), and as diverse political experiences proliferate even within the same state, the notion that an absolute social consensus is achievable becomes increasingly problematic[173]. Rather, as Ackerly pointed out, "a human rights theory ought to acknowledge the political struggles that call for human rights," however diverse they are[174]. In the same vein, she suggested that engaging theorists (and theories) dealing with Feminism, Queerness, and Colonialism, among other issues, may serve to foster critical perspectives in human rights by "draw(ing) our attention both to patterns of oppression and to the particulars of oppression"[175].

This is particularly pertinent when we look at the rights of a population that is hardly a part of the dominant social consensus, such as transgender people. Here as in other cases, the

[171] Ackerly, 'Universal Human Rights in a World of Difference', 44.
[172] Ackerly, 'Universal Human Rights in a World of Difference', 50–52.
[173] Ackerly, 'Universal Human Rights in a World of Difference', 52.
[174] Ackerly, 'Universal Human Rights in a World of Difference', 54.
[175] Ackerly, 'Universal Human Rights in a World of Difference', 57.

call for rights is not the product of abstract legal thinking alone, but is profoundly connected to grassroots mobilization and political experiences on the ground. But to help us understand how we got here, it will be useful to look at some relevant theorizing.

2.2.3. Of Monsters and Exceptions

Monsters are perhaps one of the most recurrent and universal constructs of the human imagination. As such, they populate folktales, myths, literary and artistic representation across the world. But monsters often serve as metaphors or allegories of living beings in our society: the prostitute, the mistress, the leper, the hermaphrodite, the eunuch, to name a few. These non-normative creatures were subject to either extremes of the good and evil axes, or dropped altogether from the social fabric. For every normative rule, there was a sexualised and racialised exception – hybrids living in-between acceptable and unacceptable, tolerated and not tolerated, white and black, and, in the case of transgender people, between heterosexual and homosexual.

In the wake of the industrial revolution came the formation of cities based on industry. This transformed the relations between the body and the different governing institutions which cropped up. The body was suddenly the primary focus for multiple reasons – in the industrialised age, it was required to heighten productivity, while at the same time controlling the conduct of people. On this highly political topography, a need was felt in which "the defining aspects of modernity could derive a sense of symbolic unity"[176]. The inclusion of the body within the workings of the state mechanism, the rules and regulations surrounding behaviour, and behavioural patterns emerged at a great scale. Gandy refers to this not just as a

[176] Matthew Gandy, 'Zones of Indistinction: Bio-Political Contestations in the Urban Arena', *Cultural Geographies* 13 (2006): 498.

requirement of modern societies getting urbanised at a fast pace, but also a justification of state intervention in every phase of human life. He draws on Foucault, amongst others, and notes that this specific rise of state power can be equated with Foucault's 'bio-political' dynamic where state intervention goes into those realms hitherto considered outside the areas of state focus.

Michel Foucault, in the first volume of *History of Sexuality*, suggested that modern biopolitics emerged in tandem with two distinct processes, themselves connected and contemporaneous. Because of the elegance of Foucault's prose, I will quote in length:

> One of these poles, the first to be formed, it seems centered on the body as a machine: its disciplining, the optimisation of capabilities, the extortion of its forces, the parallel increase in its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterised the disciplines: an anatomo-politics of the human body. The second, formed somewhat later, focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and regulatory controls: a bio-politics of the population. The disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed.[177]

Thus, the central object of biopolitical power is the individual as well as the collective body. As Foucault alerts us, this drive towards the regulation of the body arises in the context of the structuring the modern state, and was particularly associated to the double requirements of controlling productive and reproductive labour (which was achieved through the control of

[177] Michel Foucault, 'The History of Sexuality: An Introduction, Volume I', *Trans. Robert Hurley. New York: Vintage*, 1990, 139.

workers' and women's bodies, respectively). Gandy[178] points out that this control of the body became associated to multiple discourses and practices, including nationalism, militarism and colonialism[179]. Yet, in order to ascertain how the relationship between biopolitical power and state-formation came about and started manifesting itself into law and policy, we must look at other contributions as well.

2.2.4. Regulating the body through biopolitics

Agamben, in his *Homo Sacer: Sovereign Power and Bare Life*[180], moves away from Foucault's focus on European modernity and its quest for the regulation of the body, to search instead for the origins of biopolitics. Agamben traces the genealogy of the term back to the Greek "*zoe*" meaning life as a bare entity and "*bios*" as the way of socialising the life into the norms of human existence. Gandy states that, in this situation,

> [t]he Foucauldian thesis will then have to be corrected or, at least, completed, in the sense that what characterizes modern politics is not so much the inclusion of zoe in the polis which is, in itself, absolutely ancient nor simply the fact that life as such becomes a principal object of the projections and calculations of State power. Instead the decisive fact is that, together with the process by which the exception becomes everywhere the rule, the realm of bare life which is originally situated at the margins of the political order gradually begins to coincide with the political realm, and exclusion and inclusion, outside and inside, bios and zoe, right and fact, enter into a zone of irreducible indistinction.[181]

[178] Gandy, 'Zones of Indistinction', 497.
[179] Radhika Mohanram says that "[w]ithin the structure of surveillance the one who sees is invisible, but the one who is seen, the colonized in this case, is always subject to scrutiny", in Radhika Mohanram, *Black Body: Women, Colonialism, and Space*, vol. 6 (U of Minnesota Press, 1999), 67.
[180] Agamben, *Homo Sacer*.
[181] Gandy, 'Zones of Indistinction', 498.

Thus, biopower emerged as a key feature of modern systems of governance. Foucault, for instance, speaks of "the administration of bodies and the calculated management of life" which works to maintain a specific order or structure in society[182]. Agamben builds on this point to argue that "natural life" becomes an integral part and parcel of the mechanics of governance and state control. Therefore, "politics turns into biopolitics"[183] by "the growing inclusion of man's natural life in the mechanisms and calculations of power"[184]. Right from the beginning of life, every individual is born in a particular setting of laws and social mores. While these social rules may materialise in explicit legislation, they are not limited to specific prohibitions. Physical appearances – the ideal man, the ideal woman, social appearances, etc. – as much as ideals of fatherhood, motherhood, brotherhood, sisterhood are shaped by social norms (which are dynamic, but are frozen as moments of truth for every generation). These social norms can at times dominate over living individuals in a stronger manner than codified laws, because their application is more subtle and pervasive.

For Foucault, the conceptualization of biopolitics is important to "[bring] life and its mechanisms into the realm of explicit calculations and [make] knowledge-power an agent of transformation of human life"[185]. Yet, as Thomas Lemke points out, Foucault differentiated between two perspectives of this "power to life", one being the regulation and disciplining of the body individual and the other being the "social regulation" of the body collective. Lemke further states that, for Foucault, biopolitics marks the rise of "political modernity" in association with capitalism and the state, where political order is life-centric[186]. In this view, "society's control over individuals was accomplished not only through consciousness or

[182] Michel Foucault, '1990: The History of Sexuality, Vol 1: An Introduction', *Trans. Robert Hurley. London: Penguin*, 1976, 140.
[183] Agamben, *Homo Sacer*, 3.
[184] Agamben, *Homo Sacer*, 119.
[185] Foucault, 'The History of Sexuality', 143.
[186] Thomas Lemke, 'Biopolitics and beyond. On the Reception of a Vital Foucauldian Notion', *Frankfurt, Germany. Retrieved October* 14 (2005): 1.

ideology but also in the body and with the body. [It] was biopolitics, the biological, the corporal, that mattered more than anything else"[187].

In this world of social norms and mores, the colour of one's skin, or the formation of one's body, are normalised in specific universal categories[188]. Within this regulation of the social world, whenever an anomalous body takes entry, it is excluded as a monstrous figure, or made to conform to a hetero-normative bodily identity[189]. As Foucault states, "what defines the monster is the fact that its existence and form is not only a violation of the laws of society but also a violation of the laws of nature". For him, the monster is subjected to a "juridico-biological domain" where the fact of aberration itself represents the upheaval of the law. As a point of exception, the monster requires a response beyond law on law's behalf – either in the form of violence, in the form of medicalization or in the form of pity and sympathy.

However, the law, *per se*, does not respond to the attack on its normativity by the mere existence of this aberration[190]. While the monster symbolises the limits of law, it remains undefined in its entirety, for it exists as a constant exception to both law and nature[191]. Agamben says that "[t]he exception is that which cannot be subsumed; it defies general codification"[192]. Thus, a monster, a misfit, an exception has no space in a pre-existing social order. Agamben calls this the "original political relation"[193] wherein the misfit has no place inside the system, or outside the system – which in turn gives legitimacy to the social order, by creating this otherness. It is precisely by its exclusion, its otherness, that the monster as a category and a social position is defined.

[187] Foucault in Lemke, 'Biopolitics and beyond', 1.
[188] Janet Price and Margrit Shildrick, 'Openings on the Body: A critical introduction', in Janet Price and Margrit Shildrick, *Feminist Theory and the Body: A Reader* (Taylor & Francis, 1999), 3.
[189] Price and Shildrick, 'Openings on the Body: A critical introduction', 3.
[190] Foucault, Marchetti, and Burchell, *Abnormal*, 56.
[191] Foucault, Marchetti, and Burchell, 57.
[192] Agamben, *Homo Sacer*, 15–16.
[193] Agamben, *Homo Sacer*, 181.

As Foucault points out, "[t]he frame of reference of the human monster is, of course, law. The notion of the monster is essentially a legal notion, […] since what defines the monster is the fact that its existence and form is a violation [of the law]." [194] Likewise, Nadia Guidotto surmises that the monster is not problematic just by its existence as different, but because of "blatant non-conformity, its lack of adherence, to law" [195]. Her interpretation of Foucault suggests that the monster is that creature which not only cannot be included in a specific legal regime, but also stand to shake up the basis of existing legal regimes. She dialogues with Julia Kristeva, who calls the monster the abject, who has a specific position – that of opposing the "I"[196].

Othering and exclusion are, therefore, intrinsic mechanisms through which notions of bodily abnormality and monstrosity come into being. Throughout history, the non-normative body (in terms of race, gender, sexuality, or ability) has been conceptualised as the monster, the freak, or the aberration of nature. I shall now turn to how transgender people are affected by these processes of exclusion.

2.2.5. Monster Management

Sara Edenheim argues that the binary gender regime, organising bodies and society at large, informing our language and shaping our mindsets, is based on a heterosexual matrix[197]. However, this matrix can operate in different ways, one conservative and one liberal. She uses this differentiation to highlight the specific manifestations of biopower in the past and in our contemporary era. For Edenheim, a conservative paradigm is one in which a non-normative

[194] Foucault, Marchetti, and Burchell, *Abnormal*, 55.
[195] Nadia Guidotto, 'Monsters in the Closet: Biopolitics and Intersexuality', *Wagadu* 4 (2007): 4.
[196] Julia Kristeva, *Pouvoirs de l'horreur* (Columbia University Press, 1982), 1.
[197] Sara Edenheim, 'Bodies out of place - on Abjection, Exclusion, and Adaption of Intersexed and Homosexual Bodies within Legal and Scientific Discourses, 1919-1968', Paper Presented at the 5th European Feminist Research Conference, Lund University, 2003, 1.

body is exterminated[198]. Examples of this can be found in the historical record, for instance when intersex babies were killed at birth; or, more recently, where intersex people were forced to choose a gender to live under, and on changing their minds about the categorisation later on, were killed[199].

Edenheim contrasts the aforementioned binary heterosexual matrix to the more liberal approach prevalent today – where children, who at birth cannot be diagnosed as either gender, are assigned a gender through what she terms "medical management"[200]. This, in a way, is seen as a more progressive move, which can gradually shape a body towards more maleness or more femaleness through medical intervention. This would be the case, for instance, of a pre-operative transgender man and a pre-operative transgender woman, or a post-operative transgender man and a post-operative transgender woman. Therefore, as Nadia Guidotto puts it aptly,

> [t]echnologies that modify and augment bodies, for example, are of utmost importance in this particular strategy. When people are born with what is deemed to be 'ambiguous' genitalia – whether they are intersexual or not – they can be operated upon or given hormones in order to bring about the closest approximation to either pole of the socially constructed gender binary. In this category, the abjected body or exception is surgically altered and subsequently socialised into the dominant system, thereby erasing the conditions that rendered the body abject.[201]

A third method of controlling a monster is to destroy it pre-birth. Guidotto places this specific practice beyond assimilation and at the crossroads of modern technology (read as

[198] Edenheim,'Bodies out of place', 7.
[199] Leslie Feinberg, *Transgender Warriors: Making History from Joan of Arc to Dennis Rodman* (Beacon Press, 1996), 104.
[200] Edenheim,'Bodies out of place', 7.
[201] Guidotto, 'Monsters in the Closet', 2.

gender-discovery, chromosomal discovery and abortion) and eugenics. She argues that this is where Agamben's notion of a non-difference in totalitarian and democratic regimes becomes most obvious. Both regimes' biopolitical groundings give equal capacity to control and even remove what they consider to be unsuitable[202]. Guidotto roots this situation in the "colonial legacies" of modern state power, which essentially laid out the groundwork for reproduction planning in a way where "degenerate populations" could be controlled. In this context, ideas of racial purity and non-miscegenation laws proliferated, at times resulting in the compulsory sterilisation of undesirable people[203].

As these debates over constructions of monstrosity suggest, the specific truth regimes according to which the transgender body is imagined require us to examine the discourses and ideas grounding these practices of "othering." Here, Milliken speaks of discourses as systems of signification that aid in constructing social realities. Therefore, it is not the material reality which lends itself meaning - rather, meaning is socially constructed.[204] Linguistic structure, for instance, places signs in relationship to other signs, often in a binary opposition which is itself socially relevant. Binaries such as normal and abnormal, beautiful and monstrous, proper and deviant (pre-operative and post-operative, for that matter), are not merely abstract notions, but are activated and deployed in relation to specific people in manners that are socially determined. Therefore, as Milliken points out, discourses operate in propagating specific regimes of truth and, consequently, in perpetuating the social hierarchies and inequalities that these regimes naturalize.

While Milliken examines the role of discourses in the field of international relations, the same extrapolation can be drawn in the case of transgender issues and law. Milliken says that "discourses operate as background capacities for persons to differentiate and identify things,

[202] Guidotto, 'Monsters in the Closet', 2–3.
[203] Guidotto, 'Monsters in the Closet', 2–3.
[204] Jennifer Milliken, 'The Study of Discourse in International Relations: A Critique of Research and Methods', *European Journal of International Relations* 5, no. 2 (1999): 225–254.

giving them taken-for-granted qualities and attributes, and relating them to other objects"[205]. She further states that discourses are not abstract creations of rhetoric, but structures which gain social life due to the way they are deployed by people through everyday language practices and social interactions. She calls this "predicate analysis", and looks at the usage of language as a system of signification which forms a discourse.

In the same strain, Vivien Schmidt[206] looks at discourse as the "interactive process of conveying ideas", and says that a new institutionalism has been constituted through the interplay between ideas and discourses. According to the author, a distinct feature of this "discursive institutionalism" is that it focuses and explains change rather than continuity. Other forms of institutionalism, in Schmidt's view, tend to treat the institutions they are situating themselves in as static rather than dynamic, that is, as static creations which run into perpetuity. The idea behind discursive institutionalism, thus, is to look at where ideas and discourses are being used in institutional settings, and in what socially relevant ways.

When a political change happens, often there is a new crystallization of truth, and new discourses emerge, embedded in the interface of new practices of governance, political action and new legislation. Both Milliken's and Schmidt's approaches, and primarily, a combination of the two, are relevant to this dissertation. As it will become clearer in what follows, regimes of truth on gender binaries, sexuality and body normalcy – as well as the discourses associated with these issues – are crucial in shaping and mediating the ways in which various transgender groups interact with state structures, institutional settings and society at large. In addition, naming practices and discourses become important to transgender persons' experiences of belonging, identity and citizenship, as we shall see next.

[205] Milliken, Jennifer Milliken, 'The Study of Discourse in International Relations', 231.
[206] Vivien A. Schmidt, 'Discursive Institutionalism: The Explanatory Power of Ideas and Discourse', *Annual Review of Political Science* 11 (2008).

2.2.6. Personhood between Redistribution and Recognition

In her work, Judith Butler says that the normative construction of gender as we know it can disempower and curtail a person's freedom to experience gender identity in ways that disturb the normative pattern.[207] She notes that gender is performed socially, therefore always "with or for another, even if the other is only imaginary". Here, gender is created outside of oneself, while the very "viability of our individual personhood is fundamentally dependent on […] social norms." Butler points out that the social legitimacy of us as human beings depends on recognition. Yet, the criteria for being declared human are the same for declaring someone less than human[208]. This is particularly clear in those cases where one's personhood might be in conflict with a normative gender regime. In the cases where fitting into the prevailing norm (or legal regime of recognition) is an abhorrence to one's sensibilities, it might be better to go unrecognised. As Butler notices, one's "sense of survival depends upon escaping the clutch of those norms by which recognition is conferred". She observes that while norms conferring the right to live the way one wants might be needed, at the same time, those norms that insist on pushing an identity on oneself might be wholly undesirable[209].

Butler tackles these issues from the standpoint of the transgender person. If seen as a definite transition from male to female – or the other way around – the transgender experience might be disempowering, mostly because it overlooks the fact that many people might have been born with a different articulation of gender in the first place, or that certain people might in fact choose to ground their identity in gender indeterminacy (for instance *travestis* or *Hijras*, as I will explain later). There is, thus, an underlying assumption that masculine and feminine characteristics and traits – often rigidly defined – belong to men and women

[207] Butler, *Undoing Gender*.
[208] Butler, *Undoing Gender*, 2.
[209] Butler, *Undoing Gender*, 3.

respectively and exclusively. However, as Butler argues, the construction of masculine and feminine is socially and culturally informed, as well as varied across cultures. Thus, a one-size-fits-all discourse is a poor ground to start from[210].

Butler's work highlights the complexities of gender identities, as well as the danger of falling prey to a politics of recognition and rights based on a universal, static and rigid notion of personhood and citizenship. Others have raised the question of diversity as well. In order to explain the "politics of diversity", for instance, Ackerly,[211] quoting Iris Marion Young, and points out that, while Young's analysis of distributive justice is not cross-cultural, she lays out the basis for application in any cross-cultural situation. She points out that differences – irrespective of them being social, economic or political – can become a source of injustice when deployed to oppress. The same is true of individual behaviour which is validated by dominant social norms and can often result in exclusionary practices. In this context, social differences are made political and decision-making processes are seen not as a political vehicle, but as a social vehicle, that is, one may adhere to a role in society without actual empowerment. Here, decision-making becomes a vehicle of false political mobility, or in Ackerly's words, "a form of masking politics". This signals to the pitfalls of aspiring to the recognition of social roles and identities without securing the redistribution of resources, not only economic but also political.

Regarding this issue, Nancy Fraser refers to the claims of redistribution and of recognition as two important strategies to redress the various forms of injustices existing in society. For Fraser, redistribution involves the allocation of resources across social groups, often to reverse economic marginalisation, which frequently leads to social exclusion as well. Recognition, on the other hand, refers to a certain class or collective of people demanding to be recognised as a group or having some specific aspect of their identity to be recognised.

[210] Butler, *Undoing Gender*, 9–10.
[211] Ackerly, 'Universal Human Rights in a World of Difference', 61–63.

Thus, a conflict arises where certain groups want to be de-recognised, and others want to be recognised. Fraser goes on further to define a "collectivity" as "rooted wholly in culture, as opposed to political economy. It only exists as a collectivity by virtue of the reigning social patterns of interpretation and evaluation, not by division of virtue of labour"[212].

In this view, where certain groups are facing socio-economic injustice, redistribution of resources will change their belonging from their economically marginalised social group to other groups, and will thus take care of such inequalities and injustice. On the other hand, individuals spread across various socio-economic groups might bond culturally with each other on the basis of some specific need or attribute that they share. This makes them not necessarily regroup, but prompt them to create an alternate cultural/political collective over and above the socio-economic strata they belong to.

Sexuality, as interpreted by Fraser, stems entirely from culture, although she does agree that this is not the only interpretation of it. However, she differentiates between gender and sexuality and, in her view, all kinds of socio-economic injustices suffered by sexual groups stems out of culture. Thus, Fraser speaks of homosexuals as a collective not in the political sense, but in the socio-cultural sense. They are spread across socio-economic groups, and do not belong to any other specific exploited group. According to her, gays and lesbians suffer from the pervasive heteronormativity of dominant culture, and consequentially from the social devaluation of same-sex behaviour[213]. This situation has led to the degradation of the quality of life for people in this group, including the deprivation of life with dignity, of livelihood and family. For Fraser, the dominant heteronormative social order is rooted in an "unjust cultural-valuation structure". Hence, the remedy for social injustice of marginalised groups such as

[212] Nancy Fraser, "'Post-Socialist' Age', *Feminism and Politics*, 1998, 430.
[213] Fraser; Nancy Fraser and Axel Honneth, *Redistribution or Recognition?: A Political-Philosophical Exchange* (Verso, 2003), 18.

gays and lesbians is not redistribution but recognition. In other words, the recognition of the legitimacy of the sexual behaviour of these groups[214].

However, although there might be a neat black and white at either end of the line, in the middle, the grey area is where collectives appear to have both the features of a group needing to be de-grouped, as well as a group that needs recognition. To this situation, Fraser refers as "bivalence". She thus looks at gender from a bivalent perspective, and sees the need for both redistribution and recognition. For her, gender injustice includes the disparaging of not just women but also any kind of feminine behaviour. Here, she further explains that people of an "exploited class with features of the despised sexuality" as a group require both redistribution and recognition.[215] In other words, require the deinstitutionalisation of heterosexism. For her, gender is a compounded, two-dimensional, category of both status and class, and therefore it has to do with differences that are both economic as well as rooted in cultural value.

This idea of redistribution or recognition is articulated through the language of social movements, and this advocacy may translate into the language of law via official cognizance and codification of demands. The language of law, as a system of signification, creates and perpetuates a discourse about the personhood and identity of those being regulated or granted rights. As such, law and legal language help to freeze and encapsulate a moment in time. Yet, the law is born out of the interpretation of social constructions, which are dynamic. The legal system involves interpretations and re-interpretations of its laws and, therefore, allows for the creation of new discourses and dynamic practices. As I will demonstrate in what follows, much transgender and human rights advocacy in India, Brazil and South Africa are engaged in demanding different forms of redistribution and recognition from the state, and in the process demand a new legal language that is more accommodating of their identities as

[214] Fraser, "'Post-Socialist' Age'.
[215] Fraser and Honneth, *Redistribution or Recognition?*, 22.

citizens. The question of gender identities, categories and discourses are, therefore, a relevant part of the struggle for citizenship rights and legal recognition.

2.2.7. Gender categories as social constructions

According to Steven Pinker, "some categories really are social constructions: they exist only because people tacitly agree to act as if they exist"[216]. In a similar manner, gender roles are social constructions, and not inherent fruits of the biological sex of the individual. Society at large, often misinformed by a hetenormative and binary discourse on gender, assumes that gender roles pre-exist the individual, who simply and naturally carries them out. Similarly, the social determination of the biological sex of male and female is frequently taken as the only parameter to define gender identity[217]. While Butler points out that, on the one hand, cultural ascription sets out the gender of a body from its very birth, she also says that, on the other hand, Simone de Beauvoir's suggestion that "one is not born a woman, but rather, becomes one" might be problematic[218]. Beauvoir's famous statement implies, in a way, that there is an agent which takes on the role of a specific gender out of choice. However, Beauvoir clarifies this by stating that there is a "cultural compulsion" to do so, which is not determined by the sex of the body. She talks of the body as a state of being, which is gendered through culture and not through biology. While Beauvoir's followers would mark that the feminine gender is the point of divergence vis a vis the masculine gender which is conflated with the "universal

[216] Steven Pinker, 'The Blank Slate: The Modern Denial of Human Nature', *New York, NY, Viking. Popper, K.(1974). Unended Quest. Fontana, London*, 2004, 202.
[217] Although defined in the glossary, I shall look at medical definitions subsequently when dealing with the normalizing discourse surrounding sexual reassignment surgery and the terminology of pre-operative and post-operative transgender people.
[218] Beauvoir in Judith Butler, *Gender Trouble*, 8.

person", Butler takes gender as a system of signification of a body which is already "sexed" biologically, but not in its individual existence[219].

This allows Butler to continuously question the role of identity and identity politics in gender formation. While a specific identity may be guaranteed by the biological, social and cultural experiences of sex, gender and sexuality to a person, the very idea of personhood is questioned in those cases where a person does not conform to cultural or social norms. As she states, the heteronormative order "requires and introduces the production of discrete and asymmetrical oppositions between "feminine" and "masculine", where these are understood as expressive attributes of "male" and "female"'. The cultural matrix within which the gender binary operates can function only by occluding other gender identities, which do not follow the biological constructions of gender[220].

The heterosexual matrix Butler speaks of not only shapes identities, social perceptions and ideas of personhood, but also permeates individual's and group's relations to institutions, the state, and the law. Susan Edwards, for instance, argues that law has its own approach to the interplay between social, psychological and biological constructions of gender, even if for the larger part, the human body in law is mainly biologically determined. Law not only acts as the regulator of social conduct or social institutions, but it also operates by "regulating action in relation to the sex of the specific actor" [221]. Specific case law has gone further to determine that "[t]he fundamental purpose of law is the regulation of the relations between persons, and between persons and the State or community. For the limited purposes of this case, legal relations can be classified into those in which the sex of the individual concerned is either irrelevant, relevant or an essential determinant of the nature of the relationship"[222].

[219] Butler, *Undoing Gender*, 9.
[220] Butler, *Undoing Gender*, 16–17.
[221] Susan SM Edwards, *Sex and Gender in the Legal Process* (Oxford University Press on Demand, 1996), 9.
[222] Decision by Ormond, J. in Corbett v. Corbett (otherwise Ashley), 33 All England Reporter 48 (England and Wales 1970).

Surely, it is nothing new for the law to demarcate between biological and social events, whether it is determining the legal personhood of a foetus, the moment of consummation of marriage, or even who can rape and who can get raped. Yet, while law makes claims to being neutral and universal, it also claims to have an ontological base. A consequence of this is that it tends to regulate the lives of people on the basis of the biological discernments of male and female sexes, often with a leaning towards heterosexuality as the norm. In such a situation, people who do not conform to either gender, because either of the current state of their bodies or the state of their emotional selves, become what Edwards calls a "legal exile"[223].

Over the past few decades, social movements have been challenging these ontological claims of the law, and demands for legal recognition of non-heterosexual groups has gained momentum across the globe. However, non-heteronormative gender identities are yet to gain a strong foothold, even in cases where historically they have existed in mainstream society for hundreds of years, if not thousands, as in the South Asian context. Together, they come under a generic and global identity of transgender.

Butler defines transgender as "those persons who cross-identify or who live as another gender, but who may or may not have undergone hormonal treatments or sex reassignment operations"[224]. Among transsexuals and transgendered persons, there are those who identify as men (if female to male) or women (if male to female), and yet others who, with or without surgery, with or without hormones, identify as transgender (as transmen or transwomen). Each of these social practices carries distinct social burdens and promises. Butler notes that, in daily parlance, the term transgender has become an umbrella term and has come to purvey the full range of positions. Moreover, when defining transgender, she is keen to point out that

[223] Edwards, *Sex and Gender in the Legal Process*, 8-10; In this context, it is imperative to mention that Butler, too, surmises that regulations have an innate tendency to act as regulatory factors not just for behaviour, but for the gender performances underpinned within in. It goes beyond the people the regulations are for, and makes the people subject to the regulation conditional – for instance, a woman is a woman when subject to sexual harassment by a man. Butler, *Undoing Gender*, 56.
[224] Butler, *Undoing Gender*, 6.

Queer theory essentially positions itself against identity claims, while transgender activism centres on the question of sex assignment and upholds the desirability of identity categories. However, this is not to say that Queer theory is against the assignation of identities, especially in the case of intersex children, in order to afford them an easier life, especially given the fact that they shall have a chance to change the assignation later. Also, even transsexual desire to conform to a particular identity cannot be dismissed as a mere desire to conform to gender normativity – it can be a desire for transformation of the self. Also, adherence to identity might lend to various degrees of empowerment and stability in life (even though it does not necessarily do so)[225].

At any rate, while fluid and performative, gender identities are fundamental to the social and individual experience of a person as a human being and citizen in society. As this chapter intends to show, discourses on sex, gender and sexuality shape social and political relations in a variety of ways, from determining one's inclusion or exclusion from mainstream society, to one's access to economic and political resources or even one's freedom to live one's life with dignity. In contemporary society, a crucial part of doing gender relates to a person's ability to claim his or her rights before the state, or, in other words, to exercise their citizenship rights without discrimination. For transgender people, this aspect has often been a challenge, as the transgender body and identity has been historically excluded from citizenship regimes. In order to better understand their contemporary predicament, we must now revisit historical records and theoretical frames.

2.3. Historicising citizenship

[225] Butler, *Undoing Gender*, 7-8.

2.3.1 Ancient citizenship norms and the exclusion of the woman

Citizenship is a prerequisite of democratic society, for it allows the individual to move away from being a mere subject of power to being a claimant of rights. As a political ideal and a legal construct, its purpose is to guarantee that all individuals enjoy equality of rights and before the law. Understood in this way, citizenship defines the relationships between the polity and its citizens, as well as the relationship between citizens. Thus, being a citizen involves not only the granting of rights but also encompasses various duties. However, one must question what happens in those situations wherein the citizen is more a subject of State power, has duties towards the State but no, or few, rights. What if the individual, who is attempting to exercise his or her citizenship rights, does not satisfy the requirements of ideal universal citizenship after all? Does it mean that the person has no claims against the State?

Scholars have debated profusely the historical origins of citizenship, or belongingness to a unique polity. Most of the literature seems to converge in tracing such origins to Western societies, and particularly to ancient Greece. In this view, the roots of citizenship as we know today are to be found in the city-states, or the *polis*, and in the particular relationship between its political structures and its inhabitants. The *polis* was ordered by the notion of *nomos*, or laws, which essentially meant that there should be the rule of law for all, and all men were to be guided by the same rules. Anyone who believed himself to be immune to or above the rules was considered to be a *tyrannos* or a tyrant. The citizen shared responsibilities with other citizens and experienced different positions within a larger structure: the higher the status, the higher the powers and responsibilities.

Historian Geoffrey Hosking found that Greek citizenship was narrowly tailored and thus excluded women, children, slaves and immigrants (citizens of other city-states who had

relocated)[226]. In this form, it may be perceived as an exclusive club, restricted to men who owned property. Here, women and slaves – both male and female – were not considered to be citizens and were therefore devoid of full rights. For instance, without being a citizen, it was not possible to own property, or enjoy civil and political rights. This does not mean, however, that there were not certain exceptions to the rule. Some women could own land, which was the highest form of property in ancient Greece. In all other circumstances, women were bound to the *oikos*, headed by the *kyrios* – the house, home, family, headed by the lord and master, the patriarch. Once married, they were to abide by the husband. While the idea of divorce was relatively liberal, with either party or both choosing to divorce, women had to be represented by a male relative – either a father or a brother – since they were not citizens themselves.

While Greece was becoming the cradle of philosophy and the arts, it was distinctly a place where mostly men could access such knowledge, while imparting knowledge to women was limited to primarily domestic issues. Yet, two of the most prominent thinkers of the day, Plato and his student Aristotle, had differing views on the role of women. In his influential treaty *The Republic*, Plato stated that women, at least from the upper classes, ought to have equal roles to that of men, for he believed that "women and men have the same nature in respect to the guardianship of the state, save insofar as the one is weaker and the other is stronger"[227]. Aristotle, on the other hand, thought that "as regards the sexes, the male is by nature superior and the female inferior, the male ruler and the female subject'"[228]. To be sure, this view was not unanimous, and other philosophical schools of through disagreed with the Aristotelian perspective. The Cynics, followed later by the Stoics, for instance, believed that there was much to be gained with male and female equality. The former believed that men and women should dress the same way and receive the same education, while for the latter the

[226] Geoffrey Hosking and Recorded Books, *The Modern Scholar: Epochs of European Civilization: Antiquity to Renaissance* (Recorded Books, n.d.).
[227] Paul Shorey, 'Plato, The Republic. 2 Vols', *First Printed*, 1930, 456A.
[228] Harris Rackham, 'Aristotle in 23 Volumes', *Politics* 21 (1944), 1254b13-14.

sexes were equal according to the laws of nature[229]. In addition, the exclusion of women from citizenship did not take place homogenously across ancient Greece. In Sparta, women enjoyed a greater deal of freedom and the possibility of land-ownership. Even then, the primary barrier to universal citizenship in ancient Greek society was gender.

2.3.2. The Roman notion of the Patricians and the Plebeians

Roman citizenship drew from the Greek ideals, and was based on the notion of *ius gentium* (law of the people), then seen as a branch of *ius natural* (natural law)[230]. Yet, the Roman system was more inclusive on the question of who could be a citizen, and in what terms. For instance, while the Greeks enslaved captives from war – who only in some cases could later earn their freedom – the Roman idea was instead to offer them a "second category of citizenship"[231]. While these second-class citizens still did not have the power to vote, they enjoyed the protection of the law, the power to enter contracts, and to marry Roman citizens. Slaves could also buy their freedom from their masters, as well as be granted their freedom by them[232]. In many ways, this secondary category of citizenship was similar to the status of freeborn women as well. While children tended to be treated similarly across the sexes in terms of their education, adult women were not allowed to exercise their political agency in the same way as their male counterparts.

[229] Martha C. Nussbaum and Juha Sihvola, *The Sleep of Reason: Erotic Experience and Sexual Ethics in Ancient Greece and Rome* (University of Chicago Press, 2013) with particular reference to Chapter 11, "The Incomplete Feminism of Musonius Rufus, Platonist, Stoic and Roman".

[230] The concept of natural law, law "innate in every human being," was initially found in Stoic philosophy and used by philosophers later on in order to showcase equality of man. For a detailed understanding of how stoicism has come through the ages, please refer to Laurens Winkel, 'The Peace Treaties of Westphalia as an Instance of the Reception of Roman Law', *Peace Treaties and International Law in European History: From the Late Middle Ages to World War One*, 2004, 222–37; Marcia L. Colish, *The Stoic Tradition from Antiquity to the Early Middle Ages: Stoicism in Classical Latin Literature. I*, vol. 1 (Brill, 1990), 360 onwards.

[231] Geoffrey Hosking and Recorded Books, *The Modern Scholar*, tracks 1-9.

[232] The Roman law aspect of *homo sacer* referred to earlier in this chapter is important here as they did not have any rights, unlike the specific situations of women and slaves. Drawn from Agamben, *Homo Sacer*.

Thus, fundamentally, the Greek and the Roman conceptions differed insofar as agency was concerned. The Roman model allowed for a greater participation of those existing in the fringes of mainstream society. Citizenship was not only about political rights, but also about one's interactions with society at large in a variety of areas, such as commerce and contracts, and several laws and regulations existed to protect as well as regulate the Roman citizen. Yet, here social and economic status played a pivotal role in drawing the line between full-fledged and second-class citizens. Indeed, the inequality between Plebeians, or the lower classes, and Patricians, or the higher classes, was a distinctive feature of ancient Roman society.

With the enlargement of the Roman empire, the notion of citizenship also underwent several changes. Religion and the State were separate, and several scholars have pointed out that this distinction became influential in shaping future models of citizenship[233].

2.3.3. The Magna Carta and the notion of all "free men"

The 13th Century was a rather eventful time in the history of England. In 1215, the barons, who were being heavily taxed by the Crown, drew up the *Magna Carta Libertatum*, popularly referred to as the Magna Carta, in order to protect themselves from the despotic rule of the Crown of England. It was drawn up under the auspices of the Archbishop of Canterbury and focused on the rights of free men, particularly of the barons themselves. It also included several articles about the rights of serfs and on taxation.[234] What is now called Article 61 included a baronial body to oversee King John's adherence to the charter.[235]

With every subsequent monarch, the charter was renewed with additional provisions. With the Parliament rising to become a permanent institution in the 14th Century, the Charter

[233] For instance, Jeffrey Ellsworth and Johan ven der Walt, *Constitutional Sovereignty and Social Solidarity in Europe* (Bloomsbury Publishing, 2015).
[234] Richard Barrington, *The Magna Carta* (Encyclopaedia Britannica, 2017).
[235] Ralph Turner, *King John: England's Evil King?* (The History Press, 2011), 189.

fell from prominence. However, whenever it came to opposing, or balancing, the powers of the Crown, the Magna Carta resurfaced, especially in the 1600s, due to the English Civil Wars[236]. That period saw a profound change in monarchical system, with the separation of Church and State, and paved the way for the constitutional monarchy in the UK as seen today. Till this date, the document's Clause 39 – "no free man shall be taken or imprisoned, or dispossessed or outlawed or exiled or in any way ruined, nor will we go or send against him except by the lawful judgment of his peers or by the law of the land" – remains one of its most used and influential provisions, and served as the basis for due process law in many jurisdictions.[237] Yet, despite being an inspiration behind various claims against the Crown, the Magna Carta affirmed the rights of free men - women, slaves, colonial subjects and minors fell through the sieve[238]. Centuries later, the document no longer exists in its original form, as several aspects of it have been rendered obsolete. Still, it remains a historical landmark in what relates to the affirmation of citizens' rights against the state.

2.3.4. American Independence and natural rights to equality

In 1776, thirteen British colonies in North America convened together to declare their independence from the Crown of England. Drafted by Thomas Jefferson, the founding text of the new independent nation, its Declaration of Independence, stated: "we hold these truths to

[236] It was the inspiration behind the American Constitution as well, which took its essence from the Virginia declaration that was inspired by the Magna Carta, as it was supposed to signify the people's reassertion of rights against an oppressive ruler, a legacy that captured American distrust of concentrated political power. In part because of this tradition, most of the state constitutions included declarations of rights intended to guarantee individual citizens a list of protections and immunities from the state government. The United States also adopted the Bill of Rights, in part, due to this political conviction. Also, in turn, they only included "all free men bearing arms" excluding women and slaves from being deigned as citizens. For more on the history of the constitution making of the US, refer to Jack N. Rakove, *Original Meanings: Politics and Ideas in the Making of the Constitution*, 1st Vintage Books Ed edition (New York, NY: Vintage, 1997).

[237] Claire Breay, *Magna Carta: Manuscripts and Myths* (British Library Board, 2002), 25.

[238] Ironically, the rights of women, although not entirely unquestioned, remained unresolved through the reigns of two queens of Great Britain – Elizabeth I and Victoria, the latter being not just the Queen of Great Britain but also the Empress of India.

be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." These words have resonated and become influential around the globe, especially the phrase "all men are created equal"[239]. The notion of inalienable or natural rights assumes a pivotal role here, and was later found elsewhere, more famously in the French revolutionary context as well. Interestingly, however, the American Declaration was only about men: specifically free, white, men[240]. Women and slaves were conspicuously excluded from such promises of equality and freedoms. Indeed, several members of the drafting committee, including Thomas Jefferson, were slave owners, and it was not until the end of the Civil War in 1865 and the abolition of slavery that the notion of citizenship above racial differences became a top political priority of the new nation. Moreover, the marginalization of women did not go unnoticed even to people living at the time. For instance, Abigail Adams, the wife of John Adams[241], asked her husband to "remember the ladies, [because] if particular care and attention is not paid to [us] we are determined to foment a Rebellion, and will not hold ourselves bound by any Laws in which we have no voice, or Representation."[242]

2.3.5. The birth of the French Republic and the equality of all men

[239] Abolitionist Thomas Day thought it abhorrent that such a document could be signed by people while still letting slavery exist – "If there be an object truly ridiculous in nature, it is an American patriot signing resolutions of independence with the one hand, and with the other brandishing a whip over his affrighted slaves." Thomas Day, *Fragment of an Original Letter on the Slavery of the Negroes, Written in the Year 1776, by Thomas Day* (J. Stockdale, 1784).

[240] Immanuel Kant derived natural rights from reasoning, whereas the US Declaration holds it to be "self-evident". Natural rights are derived from Stoic philosophy, mentioned in an earlier footnote, and more recently from the time of the Protestant reformation in the United Kingdom in the 1700s. Martin Luther referred to them and John Locke referred to them in his theory of social contract.

[241] John Adams was one of the Founding Fathers of the United States of America, as well as the second President and first Vice-President. His wife, Abigail Adams, is renowned for her accounts of the American Revolutionary War.

[242] Abigail Adams, 'Letter from Abigail Adams to John Adams, 31 March-5 April 1776', *Adams Family Papers: An Electronic Archive*, 1776.

As the American War of Independence unfolded, France, too, was experiencing great changes and political upheaval. French society at the time was divided in three groups, known as Estates. The first and second estates, composed by the nobility and the clergy respectively, held most of political influence and economic resources. The third estate comprised the rest of the population, mostly peasants and tenant farmers. In 1789, the latter group rose against the monarchy and the landed gentry, demanding fairer treatment and voting rights, which till then was only granted to landholding people. Failing to gain the rightful attention of their monarch, Louis XVI, they took over the polity in what is known as the French Revolution. Following the regime change, in August 1789, the "*Déclaration des droits de l'homme et du citoyen*" was adopted[243]. Influenced by the concept of "natural rights" emerging from the American Revolution[244], the "rights of man and of the citizen" were, too, considered as universal, non-derogable and innate to human nature[245]. Thus, post-revolutionary France was in principle a nation of free individuals held equal in the eyes of law.

However, while the declaration gave rights to all the men of the land, women were not immediately included in it, despite the fact that one of the first protests to take place in 1789 had been carried out by women to oppose the rising price of bread and to petition the State for their rights[246]. As early as 1790, Nicolas de Condorcet published the *De l'admission des femmes au droit de cite*, advocating for universal suffrage for women, but the suggestion was not well received. Indeed, while the new constitution passed in 1791 granted voting rights to previously marginalised groups, such as landless men, Jews and Protestants, women remained

[243] Currently, it is the preamble of the French Constitution.
[244] Thomas Jefferson influenced it. The Declaration, together with Magna Carta, the American Declaration of Independence, Constitution, and Bill of Rights, inspired in large part the 1948 United Nations Universal Declaration of Human Rights. Douglas K. Stevenson, *American Life and Institutions* (Ernst Klett Sprachen, 1996), 34.
[245] The notion of universal morality is also carried on today in a way through the Universal Declaration of Human Rights. However, it is widely agreed that it is applicable for similarly situated people as opposed to every person, and that while it is not possible to decide what is universally moral, issues of immorality are generally universal.
[246] Based on which is the unsubstantiated rumour about Marie Antoinette "let them eat cake".

excluded. Most revolutionaries followed Rousseau's prescriptions on women, which included the idea that their place is at home as spouses, and not outside as politicians[247]. This prompted Olympe de Gouge to write her *Déclaration des droits de la femme et de la citoyenne* also in 1791, where she states that men and women are equal and, accordingly, demands equal rights for women.[248] In its Article X, Gouge's Declaration argued that if women were punishable to the fullest extent of the law, they ought to have the right to protection of the fullest extent of the law. However, in the Reign of Terror that followed, such voices were quelled by the sharp edge of the guillotine, as was hers.

2.3.6. The Slavery Paradox

As seen above, over a span of two hundred years, rebellions in arms rose to guarantee citizenship rights for men – specifically free white men. While the wordings of the documents that so grandly spoke about inalienable rights of man are interpreted today as pertaining to all humankind, at the time, it left out everyone who did not fit into the able-bodied white man with arms or land, i.e. slaves, women, minors, and colonised peoples. Colonial empires depended on the exploitation of multiple forms of unfree labour, from slavery to servitude or indenture. It was not until the formation of international bodies such as the League of Nations and the *Bureau Internationale du Travail* that international covenants against slavery and for fair labour conditions in general were entertained[249]. Yet, as late as the mid-20th century, European overseas empires still held discriminatory legal regimes in place in which colonised

[247] Jean-Jacques Rousseau, 'Emile or on Education (A. Bloom, Trans.)', *New York: Basic (Originally Published 1762)*, 1979, 137.
[248] Camille Naish, *Death Comes to the Maiden: Sex and Execution 1431-1933* (Routledge, 2013).
[249] The Dutch, Portuguese, Spanish, French and English empires all had slavery in their colonies, if not on the mainland. In this context, I raised the question of slavery in the US, the British empire and the French empire in light of the fact that they had initiated several movements to empower men as citizens, but of course, equality is not for everyone.

populations were subjects rather than citizens.[250] In such contexts, this discrimination allowed the exploitation of large numbers of people who, because of their precarious legal status, enjoyed only few labour rights and protections, thus constituting a relatively cheap labour force.[251]

In addition, the historical records point to different dispositions when it turned to the question of slavery in Europe and the colonial world. The European countries did not want to witness the abhorrence of slavery being committed on their own soil, and were conspicuously quicker in fighting these practices at home. For instance, as early as 1315, Louis X of France abolished slavery on the French mainland, as well as allowed his serfs to buy their freedom[252]. Thus, any slave stepping foot on French soil would have been considered a free man. However, slavery continued in the colonies[253], and Nantes acted as an *entrepot* point for slave trade for different countries. Revolutionary France abolished it in its entirety in 1794, only to have it be reinstated in Napoleonic France[254]. It was again abolished across the French empire in 1848. Likewise, in Great Britain, while in 1772, the Somerset case determined that slavery did not exist in English Common Law[255], it was not until 1840 that slavery was abolished across the British Empire.

---

[250] Mahmood Mamdani, *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism* (Princeton University Press, 1996).

[251] Frederick Cooper, 'Reconstructing Empire in British and French Africa', *Past and Present* 210, no. suppl_6 (2011): 196–210.

[252] *Ordonnances des Roi de France*, V, p.1311, as quoted in Travers Twist, 'The Extraterritoriality of Public Ships of War in Foreign Waters', *The Law Magazine and Review: A Quarterly Review of Jurisprudence* 1, no. 219 (February 1876).

[253] The *Code Noir*, brought into force by Louis XIV gave several freedoms to slaves, including disallowing their masters to separate families. However, intermarrying with white people was absolutely forbidden, although it did take place in the colonies, creating a mixed caste of people. Also, severe corporal punishment was prescribed but only in certain cases. The fact that it forced slave owners to preach Catholicism was to indirectly imply that the slaves were not chattel, but human beings endowed with a soul. For more on this, read Rodney Stark, *For the Glory of God: How Monotheism Led to Reformations, Science, Witch-Hunts, and the End of Slavery* (Princeton University Press, 2003).

[254] It is to be noted here that in 1792, all free coloured people (read men) were given full citizenship, and in the 1795 constitution, the rights of man declared that slavery was abolished across all France and its colonies. Free coloured people were different from freed slaves.

[255] Somerset v. Stewart, 98 ER 499 (King's Bench 1772). This case was a significant landmark in the abolitionist movement.

Even during the high era of transnational anti-slavery activism in the 19th century, the emerging humanitarian ethos that abhorred slavery as an immoral system and an unjustifiable exploitation of fellow humans co-existed with opportunist calculations of an economic nature. Economically and socially, the transition from slave to post-slavery societies was facilitated by the availability of a large volume of cheap labour transferred to Africa and the Caribbean under the system of indenture labour. After abolition, thousands of indentured labourers from South Asia were taken to British and French territories for that purpose.

The United States is another interesting case insofar as the war of independence was waged by several slave-owning white men who demanded equality and equal representation in relation to the Crown across the Atlantic, but at the same time were not ready to offer the same equality to the slaves at home. The latter remained sub-humans, devoid of any rights of citizenship, trafficked from Africa and considered to be property[256]. In fact, it was not until the Emancipation Proclamation of 1863, passed during the American Civil War (and designed to cripple the Confederates who used slave labour to support the soldiers in the trenches) that the slaves were freed in the Southern States[257]. The former slaves were also invited to join the Unionist Army in late 1862. It was only in 1865 that slavery was officially abolished with the 13th Amendment of the US Constitution. While this freed every person held in slavery, voting rights were given to black men only in 1870, and that too was hindered in the Southern states through various loopholes in the local laws. Women, irrespective of their colour, were still not politically enfranchised.

Slavery presents such a paradox because its abolition carried with it the promise of universal equality based on the notion of mankind's natural right to freedom, and, to some, it

[256] The Electoral College suggested by James Madison, still prevalent in the US today, albeit without slavery, was formed on the 3/5th compromise – a slave was equivalent to 3/5th of a person for the electoral college. The notion of the sub-human comes in over here. Paul Finkelman, 'The Proslavery Origins of the Electoral College', *Cardozo L. Rev.* 23 (2001): 1145.
[257] The Northern states had already emancipated their slaves in 1802.

even involved an incipient idea of human rights. Yet, the historical records on the question of slave emancipation and transition to post-slavery societies show that there was much to be desired. Earlier considered as non-humans, the integration of slave populations into modern states often allowed several degrees of legal and quasi-legal discrimination to remain intact. Racial segregation, which remained a reality in the United States until the wake of the civil rights movement in the 1960s and in South Africa until the fall of apartheid in the 1990s, is a striking example of this. At any rate, the exclusion from or precarious integration of former slaves into citizenship regimes – as much as the case of other marginalised populations such as women, minors, lower classes, etc. – show that universal citizenship rather than a clear-cut process of inclusion, brings with it the dangers of new forms of exclusion to which we must be attentive.

2.4. Theoretical constructs on citizenship

2.4.1. Making of the universal notions of Citizenship

As seen above, in its most conventional form, citizenship was confined to male and heterosexual persons. The notion of including women within the boundaries of citizenry, of equal suffrage rights is something which came into the Western world only in the dawn of the 20th century – the United Kingdom in 1918, the United States in 1920, and France in 1945 for literate women (and subsequently in 1965 for all women). In fact, women did not have equal adult suffrage in Switzerland, the seat of several human rights bodies, till as late as 1971[258]. Even then, the ways in which citizenship has been designed to be exercised in political spaces

[258] For a full understanding of how this unfolded, refer to Robert Krulwich, 'Non! Nein! No! A Country That Wouldn't Let Women Vote Till 1971', National Geographic News, 26 August 2016, https://news.nationalgeographic.com/2016/08/country-that-didnt-let-women-vote-till-1971/.

places the able-bodied white male in a disproportionately privileged position[259]. The inclusion of women were an afterthought, and minorities even more so. It was only in the first half of the 20th century that international mechanisms for the protection of linguistic, racial and religious minorities were put in place following the First World War, being later supervised under the auspices of the League of Nations. In the case of racial segregation, as already explained, the timeline of inclusion is even more recent, with countries upholding discriminatory measures way into the second half of the century.

In the aftermath of the Second World War, the notion of inalienable rights or natural rights belonging to all mankind gained momentum and was celebrated in several institutional and political fora, most prominently the United Nations and its specialised agencies. In 1948, for instance, the Universal Declaration of Human Rights was approved by that organization's General Assembly[260]. In the opening lines of its preamble, the Declaration decidedly states that the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world". Likewise, its Article 1 stipulates that "[a]ll human beings are born free and equal in dignity and rights". On the one hand, this is reminiscent of the several historic documents spoken of above. One the other, the post-war legal architecture centred on the United Nations departs from earlier texts insofar as it openly and purposefully included all humans, irrespective of race, creed, sex or nationality. It envisioned a body of universal rights, both civil and political, and brought the concept of natural rights, hitherto deigned only fit for free men, to all human beings (albeit it was thought of only in gender-binary terms, but it is expansive enough to cover everything in between). While the Declaration of Human Rights was not considered to be legally binding, over time it assumed the status of *ius cogens*. Indeed, in the last decades, it

[259] Will Kymlicka, *Multicultural Citizenship: A Liberal Theory of Minority Rights*, Oxford Political Theory (Oxford : New York: Clarendon Press ; Oxford University Press, 1995), 32.
[260] 'Universal Declaration of Human Rights'.

has served as a basis for several international covenants as well as regional and domestic legislation. As the boundaries of inclusion are constantly expanded to recognise and address the question of human difference as well as universal equality, the very notion of universality in rights and citizenship has been called into question, as we shall see.

2.4.2. Challenging universal citizenship

According to the prominent political theorist and philosopher Iris Marion Young, the "ideal of universal citizenship" has been at the very core of how we understand modern rights and politics. At the same time, the aspiration for inclusion into citizenship has shaped choices and strategies of social mobilisation and inspired social pressures for change[261]. Ever since the rule of the sovereign was challenged by the ruled – who demanded to have a say in matters of governance and the state – minorities and marginalised populations have pushed for inclusive citizenship as a condition *sine qua non* of their rights of equality before the law and the State. Modern political thought, Young points out, has had a tendency of implying that the universal notion of citizenship necessarily transcends all differences, being a condition of full and blind equality. Thus, it groups people on the basis of commonality, not difference, and presupposes that, just the way everyone is equal in the eyes of law, the law is equal for everyone, and shall apply in the same manner to everyone[262].

With political struggles reaching great momentum thanks to the faltering and collapse of monarchic regimes and empires in the 19th and 20th century, those populations demanding full citizenship status generally assumed that on gaining civil and political rights, they would attain the aspired equality. Yet, decades later, the same oppressed groups are still wondering

[261] Iris Marion Young, 'Polity and Group Difference: A Critique of the Ideal of Universal Citizenship', *Ethics* 99, no. 2 (1989): 250.
[262] Young, *Polity and Group Difference*, 250.

why their inclusion in the world of civil and political rights, or their granting of citizenship, has not resulted in greater social justice and equality[263]. In many cases, they remain second-class citizens, or, even more relevant to this work, some are not considered to be citizens at all.

The main challenge here derives from the fact that modern citizenship is predicated on a universalist ideal, meaning that the citizen is foremost defined in relation to its constitution as an equal member of the polity. In this way, individuality and differences in social standing should not matter for the experience of citizenship. The problem with this view is that if fails to recognise that the practice of citizenship by everyone requires individual rights and group rights to be recognised and protected in order to prevent that some people be marginalised or excluded from the "benefits of citizenship because of their gender, 'race' or any other aspect of their identity".[264]

In this situation, Iris Young identifies three notions about the universality of liberal citizenship, which are: that all members of society are capable of political participation, that liberalism also demands that everyone adopt a universal point of view, and that liberalism upholds equality over difference[265]. Young agrees with the first aspect, which is not only desirable but highly required. However, she argues that the unequal distribution of resources across social groups effectively creates hindrances for equal political participation. Also, should all material barriers be removed, that is, should available resources be redistributed among people equally, the other two perceptions would ensure that the unequal participation carries on.

[263] Young, *Polity and Group Difference*, 250–51.
[264] Keith Faulks, *Citizenship (Key Ideas)* (London: Routledge, 2000), 84.
[265] Iris Marion Young, 'Justice and the Politics of Difference', *Princeton, NJ: Princeton*, 1990; *Young, Polity and Group Difference*.

For Young, another aspect that undermines the exercise of equal participation is the denial of social difference.[266] The ideal citizen is expected to leave behind the individualised identity s/he has and assimilate into a given set of ideals in order to fit the universal notion of citizenship. The problem with such an expectation, Young remarks, is that individuals are not a set of abstract beings following only logic and rationality. They are products of society, social relations and of the cultural worlds they are embedded in. To expect them to assimilate into an abstract understanding of citizenship is a fallacy that is bound to fail.

Young goes on to claim that political liberalism tends to ignore several unequal power dynamics, for it is supposedly based in objective abstraction and, consequentially, dismisses body and emotion[267]. Hence, non-males – for the longest time, defined as only women – cannot be full members of the citizenry because of the alleged irrationality governing them[268]. To be sure, such an exclusionary assumption only emerges in the first place because what is said to be "universal" about citizenship actually expresses the positionality of the dominant groups in society, whose views are normalised and generalised: generally, able-bodied white men. Deeply rooted in patriarchy and imperialism, citizenship in liberalist traditions is, in a nutshell, for the distinct group of the "civilised"[269].

Young argues that these deep roots carry on being reproduced in the collective psyche of the citizens. Citizenship, therefore, furthers the interests of those who are considered to be the "normal", the "mainstream", that is, those assimilated within the objective abstractions of liberal citizenship. Young identifies five types of oppression: exploitation, marginalisation, powerlessness, cultural imperialism and violence. According to her, any oppressed group would be experiencing at least one, if not more, of these oppressions. This group "includes

[266] Young, 'Polity and Group Difference', 274.
[267] Young, 'Justice and the Politics of Difference'.
[268] Notions that women suffered from hysteria was a method of controlling their bodies.
[269] Faulks, *Citizenship (Key Ideas)*, 85.

women and other groups as defined as different, because its rational and universal status derives only from its opposition to affectivity, particularity and the body"[270].

Having all this in mind, we are inclined to agree that citizenship for all can only be achieved by taking groups seriously. In this context, Young defines groups on the basis of a shared culture and not just mutual interest. She insists that where universal citizenship fails, "differentiated citizenship" can become a workable alternative, for it is based on the respect of groups' distinctiveness and on the assumption that equality does not mean the erasure of difference, but often the opposite. Here, the reality of group difference requires that certain instances of special treatment be recognised in order to guarantee equality. Young concludes that a just polity should adopt an extensive citizenship, which moves away from individual rights and goes towards group rights thus leading to a society not keen on assimilating under one identity but rather celebrating difference and diversity.

Another important theorist on this matter, Will Kymlicka, while accepting that group rights are necessary, understands universal citizenship differently. He argues that group rights are inherently rooted in universal citizenship, and proposes a 'multicultural citizenship' which acknowledges an individual's cultural identity. In addition, Kymlicka puts forward his notion of minority rights wherein "[a] comprehensive theory of justice in a multicultural state will include both universal rights, assigned to individuals regardless of their group membership, and certain group-differentiated rights or 'special status' for minority cultures"[271]. For him, such groups are based more on a common culture, even though he uses the term "culture" as interchangeable with "nation" and "a people" [272]. From here, Kymlicka advances three types of group rights: "self-government rights (the delegation of powers to national minorities, often through some form of federalism); polyethnic rights (financial support and legal

[270] Young, 'Justice and the Politics of Difference', 117.
[271] Kymlicka, *Multicultural Citizenship*, 6.
[272] Kymlicka, 22. He specifies that he does not define these national groups through race or descent. He specifies that he does not define these national groups through race or descent.

protection for certain practices associated with particular ethnic or religious groups); and special representation rights (guaranteed seats for ethnic or national groups within the central institutions of the larger state)."[273]

Dialoguing with Kymlicka's work, Faulk argues that, while the first is just one step away from absolute secession, the second and third work towards higher integration into the overall national fabric by acknowledging and working with difference as opposed to imposing cultural blindness on all of them[274]. Kymlicka calls this the 'group-differentiated notion'[275], and points out that "the orthodox liberal view about the right of states to determine who has citizenship rests on the same principles which justify group-differentiated citizenship within states, and that accepting the former leads logically to the latter."[276] He thus feels that group-differentiated rights are needed if people want to foster the feeling of belonging in society at large.

All this suggests that the notion and practice of universal citizenship, while historically served to promote the exclusion and marginalisation of various populations, can be reframed and recalibrated in a more inclusive manner. We shall now look at how gender and sexuality figure in this particular debate.

2.4.3. Gender in the rights framework

TH Marshall's influential work differentiates between different types of rights while also placing them in a specific timeframe. According to him, civil rights, such as rights to property, rights to free speech, etc. were born in the 18th century; political rights, such as the right to vote, to run for office, etc. emerged in the 19th century; and, finally, social rights, such

[273] Kymlicka, *Multicultural Citizenship*, 7.
[274] Faulks, *Citizenship (Key Ideas)*, 89.
[275] Kymlicka, *Multicultural Citizenship*, 124.
[276] Kymlicka, *Multicultural Citizenship*, 124.

as the right to health and education, gained prominence in the 20th century, in the aftermath of WWII[277]. The first two variants are institutionalised in the law, whereas social rights include a certain level of economic welfare and security as well as general conditions to allow a certain standard of living. While Marshall's approach is helpful in unpacking the evolution of rights in their many manifestations, he falls short of discussing "the different degrees of citizenship obtained by different social groups at different times"[278].

In this regard, Michael Mann critiques Marshall negatively and calls him out on his Anglocentricism and evolutionism, and while he highlights the significance of military and geopolitical contexts in the genealogy of citizenship, he too ignores gender[279]. Yet, he refers to it only implicitly, in his mention of the white male working class as exemplary "insiders" of the paradigm of citizenship developed in the US. For Mann, this group was normalised as citizens by default, and tended to overlook the "others" excluded from citizenship. However, Mann has a tendency of conflating categories of "labour" with "white adult males"[280], thus ignoring the significant contributions of African-American people and women in general to the development of the working class. White adult males were recognised inside the regime, whereas others were not.

Bryan Turner draws on Marshall to typify different types of citizenship, while paying particular attention to social rights[281]. In doing so, he suggests that there are several types of citizenship versus a single type, and discusses different time periods of citizenship in history, from the ancient Greek to revolutionary France. He is interested in the social forces under which specific regimes of citizenship arise, which gives rise to two questions: first, where is the pressure for citizenship coming from, and secondly, is it relegated to the private or the

[277] Thomas H. Marshall, *Citizenship and Social Class*, vol. 11 (Cambridge, 1950). Marshall.
[278] Walby, 'Is Citizenship Gendered?', 381.
[279] Michael Mann, 'Ruling Class Strategies and Citizenship', *Sociology* 21, no. 3 (1987): 339–354.
[280] Mann, 'Ruling Class Strategies and Citizenship', 342.
[281] Bryan S. Turner, 'Outline of a Theory of Citizenship', *Sociology* 24, no. 2 (1990): 189–217.

public spheres? Turner criticises Mann for not recognizing the difference between public and private spheres, especially when the private is political. This is especially important when considering the relationship of the rights of the individual and private life to the State and totalitarianism.

While Turner seems to be on the right track, he does conflate the individual with the family as a unit, thus not considering the variety of positions at play within the family, and, thereby, erasing women (or gendered identities for that matter). For him, the private sphere relates to both the autonomy of the individual as well as freedom from state interference. His extension of the private to the family by conflating the individual with the family ignores the fact that women are not free from interaction with, and dominance by, men within the family structure. Here, he, too, falls short of producing a combined analysis of gender and citizenship and, while he talks of the public/private partnerships, he ignores how this specific divide also fuels the exclusion of women from the public sphere.

As explained above, intellectual and political debates have interrogated the universal and abstract notion of citizenship by focusing on cultural and ethnic difference. Along with civil, political and social rights, cultural rights are a new concept which theorists are keen to develop, seeking to establish cultural prerogatives and obligations as a new set of citizenship claims[282]. Social exclusion, in this context, may be understood in terms of the denial or lack of access to cultural spaces for certain groups in society. This is important because citizenship is not just about the legal membership in a nation-state, but also about social membership. In many contexts, as David Taylor remarked, "socio-economic and ideological practices […] amount to mechanisms of exclusion and inclusion of particular groups and categories of

[282] Diane Richardson, *Rethinking Sexuality* (SAGE, 2000), 74.

individual, [amongst which] most notably, those without property, women, racialised groups and the differently abled, children and lesbians and gay men"[283].

This suggests that debates on cultural rights need to be articulated to the question of gender and sexuality as well. As argued above, gender should not be overlooked because, in its universal and abstract form, citizenship regimes take the white male and the paradigmatic citizen even when claiming to be gender and colour blind. Indeed, feminist criticism has also pointed out that citizenship is both gendered and racially constructed. Here, the myth of nationhood serves to reinforce the lines between full and second-class citizens, especially as the terms of belonging into the nation are, too, gendered and racialised in particular ways. In this context, the quest for inclusive cultural rights also begs the question of how the dominant patriarchal and heteronormative order marginalises subcultures that are gendered and sexually defined. This is most clearly the case of queer and transgender people. As Diane Richardson has argued, the "definition of citizenship in terms of cultural citizenship also raise questions about the sexualised, as well as gendered nature of social entitlements"[284]. Citizenship needs, thus, to be understood in sexualised terms as well. This means that the space of articulation of citizenship is not only the public sphere, but also the realm of private and intimate life.

2.4.4. Sexual and Intimate Citizenship

Moving beyond the Marshallian notion of citizenship, which essentialises civil or legal rights protected through the law, political rights exercised through the parliaments or councils, and social rights embodied in a certain level of welfare, contemporary debates and struggles over citizenship often focus on gender and sexuality. Within the Marshallian framework, gays

[283] David Taylor, 'Citizenship and Social Power', *Critical Social Policy* 9, no. 26 (1989): 19–31.
[284] Richardson, *Rethinking Sexuality*, 83.

and lesbians – and, by extension, transgender individuals – are only "partial citizens"[285]. In its struggle to achieve what is generally referred to as "equal rights" (and equality here relates to those rights enjoyed by the heteronormative heterosexual citizen), the LGBTQI community have been campaigning for the right to marry, right to have a family, etc. However, beyond these initiatives, the Marshallian notion of citizenship, by focusing primarily on legal rights, i.e. protection through the law, is still a fragile notion and does not do justice to the challenges faced by individuals associated with non-heteronormative genders and sexualities.

Another contribution in this regard is found in the work of David Evans, who speaks of different forms of "sexual citizenship" based on the lived experience of male homosexuals, bisexuals, transvestites, transsexuals and children[286]. For him, there is a both consumerist and a moral dimension to this notion. It is consumerist because, as he states, "sexual citizenship involves partial, private and primarily leisure and lifestyle membership"[287]. It also relates to moral judgments about what is fit behaviour and what is not, and therefore raises the issue of the legitimacy of the non-heteronormative identity. Thus, for Evans, rights and privileges of sexual citizenship are defined by the citizen's relative moral worth and status as a consumer. One must also take into account, however, that in many contexts non-heterosexual behaviour is socially condemned for being considered immoral, or even criminal in some cases. In this situation, Evans argues that male homosexual citizenship is predicated on the intersection of "consenting adult freedoms" and the "reinforced stigma of immorality". This coupling bans the individual from "moral community" and instead "polices him into privacy"[288].

Diane Richardson's work gives us another approach to sexual citizenship, which, in her view, involves sexual rights being granted or denied to individuals or groups. Richardson is particularly interested examining the dynamic relationship between democratic norms and

[285] Richardson, *Rethinking Sexuality*, 75.
[286] David Trevor Evans, *Sexual Citizenship: The Material Construction of Sexualities* (Routledge, 1993), 64.
[287] Evans, *Sexual Citizenship*.
[288] Evans, *Sexual Citizenship*, 100.

sexuality, chiefly because, as other theorists have suggested, "social reform and sexual liberation" are deeply interconnected[289]. Taking this point forward, she explains that civil and social rights are only partially given to homosexual persons, who in many contexts still suffer from stigmatisation and denial of rights (such as marriage and child adoption). This particular situation leads her to conclude that gays and lesbians enjoy only partial citizenship, meaning that their sexual identity is restricted to the private sphere. This proves problematic because the language and practice of citizenship is centred on the public role of the individual, from political participation to civic action. The queer person remains an outsider insofar as he or she is disallowed from laying a too public role. Instead, their space of belonging is restricted to the private sphere. In other words, they might be granted the right to be tolerated so long as they do not disturb already existing boundaries[290]. Perhaps because of this marginalisation some Lesbian and Gay movements have campaigned towards assimilation and adherence to the "hegemonic regime of heterosexuality" by demanding equality with heterosexuals rather than putting forward a "particularistic claim based on difference"[291].

Another pertinent contribution of Richardson's work is to acknowledge the difference in experiences of citizenship among gays and lesbians, which has not been sufficiently stressed by earlier theorists, including Evans, whose work is silent on lesbians. Richardson notes that because male homosexual acts tend to be more criminalised than female, citizenship for gays and lesbians manifest differently[292]. Yet, in intellectual and political debates alike, lesbians are dangerously close to being subsumed in the "gay" category and all other non-heterosexual sexualities and non-binary gender variations under the universal gay. Once again, this brings us back to male-dominated sexual and gender politics.

[289] Richardson, *Rethinking Sexuality*, 89.
[290] Richardson, *Rethinking Sexuality*, 76.
[291] Richardson, *Rethinking Sexuality*, 94.
[292] Richardson, *Rethinking Sexuality*, 95.

Likewise, feminist theorists also emphasise how women have been kept away from accessing full citizenship because of the role the public/private structuring of social relations have played out. The private arena, as already mentioned, is not considered to as important to citizenry as the public sphere is, and its political importance is often dismissed. Hence, the befitting citizen cannot be anything other than a heterosexual able-bodied male – citizenship is, thus, associated with naturalised heterosexuality. This can also be seen in the exclusion of gay identities from the very definition of families and marriage, which still remains restricted to heterosexuality in several countries around the globe. Even within the heterosexual norm, one finds the construction of an ideal that again overlooks the diversity of social positions: the middle-class able-bodied man, marrying a woman, having children, and conforming to sexual and social norms emerges as the ideal citizen.

Sexual citizenship, as mentioned, disturbs the private-public binary underlying liberal paradigms. Looking at the private domain as a deeply political space invites us to consider the question of intimacy as well. Here, Ken Plummer adds a fourth dimension to the Marshallian framework, referring to intimate, rather than sexual, citizenship. He defines the intimate aspect of citizenship as "a cluster of emerging concerns over the rights to choose what we do with our bodies, our feelings, our identities, our relationships, our genders, our eroticisms and our representations"[293]. It is difficult not to draw a parallel with sexual citizenship here due to the similar concerns at play. However, using a framework of intimacy might be helpful insofar as it allows us to move away from sexuality, strictly speaking. Focusing on sexuality and sexual orientation as a way to understand intimate desires and pleasure may prove reductive or even essentialist, particularly when we look at those people who do not fit neatly into boxes.

[293] Ken Plummer, *Telling Sexual Stories: Power, Change and Social Worlds* (Routledge, 2002), 17.

The contributions mentioned above highlight how crucial the private, sexual and intimate domains are in experiences of citizenship. They also point out to the great diversity of positions and individualities even within the non-heteronormative pattern. With this in mind, we must now look at the question of transgender citizenship.

2.4.5. Transgender Citizenship

The feminist challenge to patriarchal citizenship is based on the idea of an unequal gender-binary system that needs to be righted/corrected[294]. When transgender people enter this equation, they disturb the very binary structure, creating several categories between the male and the female, as well as going beyond them [295]. Because of the particularity of their experience and the demands arising from there, the transgender movement is not necessarily at ease with feminism. In fact, certain feminists have gone as far as criticizing the transgender agenda for reinforcing patriarchal stereotypes (i.e. a transwoman being "hyper-feminine" or a transman being "hyper-masculine")[296]. Surely, this criticism does not account for the variety of positions relating to gender fluidity, queerness, androgyny and third gender categories.[297]

Even then, perhaps feminist models of citizenship are the most important when it comes to navigating transgender citizenship, because of their emphasis on gender equality (which can be read as including all genders and in-between genders). In addition, transgender citizenship also draws from other differentiating citizenship movements, such as those based on ethnicity, conditions of disability, etc.[298] The diversity of influences relates to the fact that

[294] Surya Monro and Lorna Warren, 'Transgendering Citizenship', *Sexualities* 7, no. 3 (August 2004): 348,354, https://doi.org/10.1177/1363460704044805.
[295] Such as Drag queens or Drag kings, explained in the glossary.
[296] Janice G. Raymond, 'The Transsexual Empire', 1980; Mary Daly, 'Pure Lust Elemental Feminist Philosophy', 1984.
[297] Surya Monro, 'Theorizing Transgender Diversity: Towards a Social Model of Health', *Sexual and Relationship Therapy* 15, no. 1 (2000): 33–45.
[298] Several aspects of differentiated citizenship are covered in John Swain et al., *Disabling Barriers-Enabling Environments* (Sage, 2013); Kymlicka, *Multicultural Citizenship*.

transgender movements are relatively less homogeneous than other movements, the gay and lesbian included. In a simplistic manner, while the latter focuses on decriminalising same-sex behaviour and legitimising same-sex relationships, the transgender agenda is built on the intersection of gender and sexuality politics.

Not only does sexual orientation give rise to different agendas and politics within the transgender community, but also the diversity of positions in the sexual transitioning process plays a role in shaping people's needs and aspirations. There is a marked difference, for instance, between the "pre-op" and "post-op" individual, which speaks to the centrality of surgery as an identity marker. This relates to the fact that transgender people are expected to remove all traces of the gender they were assigned at birth while taking on a new role within the binary system, and medical intervention helps in this regard. But what is the place of those people who identify as beyond the gender binary spectrum, that is, the third gender category – who and what does a person belonging to the third gender desire? Are they straight, gay, bisexual, pansexual or asexual? These identity boxes do not suffice, because if the people concerned do not identify with being either men or women, how does one fit into boxes based on gender binaries in the first place? It is important, thus, to keep in mind the normative *telos* generally assigned to the term transgender, whereas, in reality, this umbrella grouping covers several groups of people with different notions of identity.

Moreover, in order to develop a model for transgender citizenship, it is important to treat transgender people not as mere objects of law, but as "equal citizens" worthy of being heard. To be sure, transgender identities are pathologised and medicalised, but that is not to say that they are devoid of agency[299]. In fact, transgender people navigate within and across the boundaries demarcated by the citizenship regime to which they were assigned at birth. As I will show below in relation to healthcare, in their interactions with the state and society at

[299] Isaac West, *Transforming Citizenships: Transgender Articulations of the Law* (NYU Press, 2013), 6.

large, transgender people are commonly denied services because of their gender identity and appearance.

At the same their relationship to the state remains nebulous: their former identity does not cease to exist as far as the state is concerned, yet their contemporary predicament requires specific engagement with state structures, which are generally not well equipped to cater for them. Law and public medical policy often go hand in hand in constructing the transgender body and experiences. In many instances law leads to medical policy, and in others, vice versa. Legal documents often reflect the name assigned at birth, as well as sex assigned at birth. However, with a visual appearance differing in the normative gender lines set in the documents required in day to day activities such as opening bank accounts, buying transport passes, etc. people are often questioned and harassed beyond necessity. All this prevents the full participation of transgender people in society as full citizens.

As Isaac West points out, however, to merely adjust state policies to encompass all genders, or to go into "definitional chaos" by increasing the number of definitions will not necessarily bring about equality or the collapse of the gendered system of policy. Citizenship is not just given by the state, and does not just enact itself in a court or in policy, but also in daily lives, outside government offices. In his research with activist groups and transgender people themselves, West found the law "to be a set of unstable signifiers continually modified […] as trans people [performatively enact citizenship] through their quotidian practices"[300].In this regard, if citizenship is understood as a "fluid, dynamic, discursive resource available for rearticulation", then we must remember that "practices of citizenship may be more complex than complicity with or rejection of normativities"[301]. Thus, transgender citizenship may be achieved, performed and experienced through a complex navigation between the sexual and the gendered aspects of citizenship.

[300] West, *Transforming Citizenships*, 183.
[301] West, *Transforming Citizenships*, 35.

2.5. Conclusion

If we expand our notion of citizenship to mean becoming a member of humanity, the ideal citizen remains the heterosexual white male as the embodiment of the "universal, natural and normal"[302]. As my debate of social theory has shown, the human is not a neutral biological term, but a social construct that involves the exclusion of the non-human, or less than human. The monster, the abnormal, and the abject, are historical examples of the social and discursive constructions of non-humans who are considered inferior, often perceived as animalised outsiders and incapable of integration into society, polity and citizenry. This mode of marginalisation, as stated earlier, has been translated in relation to both gender and sexuality. Women, especially particular groups such as black and working-class women, were "closer to nature" than to the world of culture and politics, and were to be excluded from it. Likewise, gender non-confirming bodies and non-normative sexualities were considered to be unnatural.[303] While one was excluded as too close to nature, the other was excluded as outside nature. This complex construction of exclusion can be extended to the transgender identity as well – an identity excluded on the basis of being understood as not natural, yet close to nature, associated with behaviour too close to nature (or primal), yet outside nature, and even more so when the transgender person happens to profess an alternative sexuality.

In this chapter, I have looked at intellectual debates on gender and sexuality to better understand the discursive and political practices preventing sexual minorities from exercising full citizenship rights. Here, it is important keep in mind that the binary gender order and the dominant hetenormative matrix are social constructions of legal and political implications. As mentioned earlier, as regimes of truth they shape identities and social perceptions, but also,

[302] Geoffrey Hosking and Recorded Books, *The Modern Scholar*, 80–81.
[303] Geoffrey Hosking and Recorded Books, *The Modern Scholar*, 82.

they set the boundaries of what groups and identities had to be recognised as part of the citizenry and who is to be excluded from it. Likewise, they also structure the ways in which individuals and groups can relate to institutions, the state, and the law. The chapter has also looked at the longer genealogy of citizenship across history to demonstrate that practices of exclusion and denial of rights and belonging have been a recurrent affair, with various forms of "othering" taking place based on perceptions of gender, racial, and bodily inferiority. As I have showed, women and racialised others have been particularly excluded from citizenship regimes even in times of great advancement towards equality as a political ideal. Indeed, the white, heterosexual, able-bodied male has remained the epitome of the universal citizen.

The chapter proceeded to looking at more contemporary recalibrations of citizenship by looking at the Marshallian framework and re-readings of it. To political, civil and social rights as the backbone of modern citizenship, scholars have added the gendered, sexual and intimate dimensions of life as preconditions for a more expansive, and inclusive, theory and practice of citizenship. In this context, the debate moves away from abstract universality as the condition for equality before the law, to focus instead on how to address and respond to the differences existing between and within groups in society.

Differentiation in terms of gender, sexuality, race, disability, and so on, all shape the ways in which people and groups relate to the state and to each other, and therefore is consequential to how citizenship itself is enacted and lived. The chapter concludes by examining the challenges and possibilities underlying transgender citizenship as both a theoretical construct as well as a practice whereby transgender people are able to claim their rights against the state. In what follows, I shall look at how such practices have been taking place in the three case studies at hand.

3. South Africa

3.1. Introduction

It's complicated, it's complicated, it's complicated.

- Zanele Muholi[304]

In 2009, Caster Semenya, a South African middle-distance runner soared to fame at the Berlin World Championship in Athletics[305]. However, her reason for becoming famous overnight wasn't her prowess on the running track, but her appearance – which brought along controversies of the sort where her being a woman was questioned. She had short corn-rowed hair and a muscular body, making people speculate that she might be a man in the guise of a woman, which in their opinion would explain her tremendous speed and strength on the track. Thus, the International Association of Athletics Federation (IAAF) subject Caster to a "gender test", which, in actuality, was a sex determination test – to find out whether Caster was biologically a male or a female[306].

The test results, despite being supposedly confidential, were leaked out and published by the Sydney Daily Telegraph[307], and many questions about the ethics of such a publication were raised. The South African media did not fall behind after this, using this case to create an "other"ing discourse. While several athletes across the world have often been subject to such tests, seldom has it received such publicity. In time, the IAAF cleared her gender test and stated that she could compete in sports as a woman.

[304] Zanele Muholi in Gabeba Baderoon, "'Gender within Gender": Zanele Muholi's Images of Trans Being and Becoming', *Feminist Studies* 37, no. 2 (2011): 390–416.
[305] 'Caster Semenya Wins 800m Gold but Cannot Escape Gender Controversy | Sport | The Guardian', accessed 10 October 2017, https://www.theguardian.com/sport/2009/aug/19/caster-semenya-800m-world-athletics-championships-gender.
[306] David Smith, 'IAAF Wants to Talk to Caster Semenya about Gender Test Results – Report', *The Guardian*, 10 September 2009, sec. Sport, http://www.theguardian.com/sport/2009/sep/10/caster-semenya-gender-iaaf.
[307] 'Semenya Could Face Athletics Ban', 11 September 2009, http://www.dailytelegraph.com.au/z-redesign/archive-sport/semenya-could-face-athletics-ban/news-story/947f46669a076d98dbd1177da00b3f10.

This incident brought to light an intersection of aspects – the interaction of being a strong woman in the sports arena versus being a "freak". The masculinity attributed to her on the running track challenged different notions of femininity and masculinity in sports, This, in turn, served to stigmatise her, and consider her as deceitful till she was cleared of such charges.[308] Her physical strength and power was considered to be abnormal as it was a masculine trait in a woman, and thus questioned to the point of having her sex verified. Instead of her performance being considered to be outstanding, it was seen as an abnormal accident, produced by an anomaly of nature[309].

On the other hand, the outpouring of public support for the Semenya who was perceived to be a woman was overwhelming. This was, however, not rooted in mere support for an athlete of the nation – it was as a reinforcement of her female sex and gender and the notion of brushing her masculine performance on the tracks under the carpet. The question that comes up here is "[w]hy do we need to have our biologically allocated sex in sync with our gender performance?"[310]

The side-lining of "feminine masculinities and masculine femininities" in South Africa is common, with women like Semenya being subject to corrective rape, to being pushed to feminisation, and to be made to submit to patriarchal norms. This is why there was a tremendous insistence by the overall South African rhetoric on casting Semenya as a woman who shouldn't have to undergo ill-treatment – to remind her and the nation of the vulnerability of the woman and her body, which is open to scrutiny, and the recasting of her image from a strong sports woman challenging the boundaries of masculinity to a woman

[308] Tavia Nyong'o, 'The Unforgivable Transgression of Being Caster Semenya', *Women & Performance: A Journal of Feminist Theory* 20, no. 1 (2010): 98.
[309] Neville Hoad, '"Run, Caster Semenya, Run!" Nativism and the Translations of Gender Variance', *Safundi* 11, no. 4 (October 2010): 397–405, https://doi.org/10.1080/17533171.2010.511785.
[310] Antje Schuhmann, 'Taming Transgressions: South African Nation Building and "Body Politics"', *Agenda* 24, no. 83 (2010): 98.

who is stereotypically feminine[311] - in other words, "a thoroughly Westernized young woman – from power girl to glamour girl".[312]

This type of "othering" carries on through South African society in various aspects of transgender people's lives. The moment something unknown is encountered, it is common to have a witch-hunt to throw down the savage, the freak of nature, the abnormal, and if possible, to "normalize" the freak. This has been the norm through the history of South Africa through the Apartheid Era, and its shadows are still cast today, as I explain later in the chapter.

This chapter shall briefly consider the history of the transgender body in South Africa within the realm of law. It shall further shed light on the medicalised gaze towards the transgender body within South Africa and the interaction between the fields of mental health and pathology and the creation of the diseased "other" who needs to be normalised and pushed within the boundaries of heteronormativity. From this, it shall go on to the transgender individual's interaction with the law in South Africa with special attention to Act 49 of 2003 and anti-discrimination legislation. It shall also consider the medical aspect of being transgender in South Africa, with attention being paid to the clinical aspects of various studies conducted over the past years looking at this seeming need to manage the transgender body.

When it pertains to sex and gender, there are different aspects to be taken into consideration, as there is a high level of intersectionality between race, ethnicity, culture, tradition, language, class, religion and education, not to mention medical and legal aspects. All these categories interplay in daily interactions within the queer community[313].

[311] Schuhmann, 'Taming Transgressions', 100.
[312] Hoad, '"Run, Caster Semenya, Run!" Nativism and the Translations of Gender Variance', 402.
[313] Liesl Theron, '"This Is like Seeing a Human Body Totally from a Different Angle": Experiences of South African Cisgender Partners in Cisgender-Trans* Relationships' (University of Cape Town, 2013), 14,20,85, http://137.158.155.94/handle/11427/13926.

This chapter intends to give an overarching view of the situation regarding transgender populations and the right to health currently existing in South Africa. After a historical overview, the chapter will investigate the current nature of the health system, and what narratives have been used to make the transgender population fit into the health system.

In order to ascertain my findings from the literature, I conducted seven qualitative interviews to support my findings through my interviewees' personal experiences and supported by informal discussions with other key informants. The interviewees include transgender people as well as transgender allies and all of them have been associated with the queer rights movement in South Africa over the last few decades, either through non-governmental organisations or by themselves. I interviewed one activist at his home in Cape Town, and the rest of them at different NGOs – OUT in Pretoria and Gender Dynamix in Cape Town. The findings from the interviews shall be interspersed as and where required.[314]

The transgender body has been a site of "state surveillance, control and manipulation"[315]. Almost all the institutions of the State have been involved in defining the transgender experience over the period of apartheid South Africa as well as after. Also, unlike the gay movement, which did encompass transgender people as an overarching issue, most of the changes that have taken place to give transgender people their place in society and law were made on the side-lines, away from the public eye. Through a lot of advocacy, instead of public interest litigation, various acts and amendments of existing acts were passed, and a quiet storm was created to reach the few changes that have been achieved till date. To understand how it came to a place where transgender people were considered within any

[314] It is important to note here that none of my respondents had ever accessed public healthcare services with the exception of one person (who had accessed it just once as a child) who I interviewed, and thus had never personally faced any bias against them within the public healthcare sector. The final version shall have all the transcripts of the interviews attached to it.

[315] Louise Vincent and Bianca Camminga, 'Putting the "T" into South African Human Rights: Transsexuality in the Post-Apartheid Order', *Sexualities* 12, no. 6 (December 2009): 678–700, https://doi.org/10.1177/1363460709346108.

framework at all, it is important to consider the birth and development of apartheid in South Africa.

3.2. The Scramble for South Africa – colonising the lands

South Africa is a country with a very tumultuous colonial past. The written history of South Africa before colonization is somewhat sketchy. Several African languages did not/do not have scripts, which means documentation of the histories of the clans remains unwritten. However, there are several military records of wars and skirmishes between the ruling clans themselves as well as with colonisers after the first European settlers entered. The primary starting point of colonialism would probably be the establishment of a permanent post at the Cape of Good Hope by the Dutch East India Company. However, this also meant engagement with the local tribes and clans. This led to several bloody battles, especially with the settlers and the colonisers coming on heavily with superior armaments. cattle.

With every battle and war in Europe, various colonies would change hands in Africa. The Cape area was no exception. Colonisation brought the suppression of local tribes and clans, and sometimes wiping out entire villages thanks to the bringing in of diseases like small pox. Along with that came slavery and racism. Slaves were brought in from other places to make up for the labour force shortfalls.

The Cape area was a colony of the British Empire, and after the abolishing of slavery, the Boer population fled from there and established their own states, Transvaal and the Orange Free State. However, this transition wasn't peaceful, and culminated the first and second Anglo-Boer Wars in the 19th Century. The second war was primarily because of the financial power Transvaal and the Orange Free State had started wielding, due to the discovery of gold in Witswatersrand and diamonds in Kimberley. By 1910 these areas were

under British dominion. However, when it comes to the starting of apartheid, scholars consider the starting point of apartheid as 1948, when the African Nationalist Party came into power. The move to segregate became stronger in the 1960s with various event happening, such as the Sharpeville Massacre in 1960, the South African Republic being formed in 1961 and the withdrawal from the Commonwealth. From this moment on, "[a]ll Africans, irrespective of their place of birth or length of employment, were entitled to remain in white areas only as long as they ministered to white needs".[316]

3.3. "Trans"ing history – a brief overview of Transgender people in South Africa

In 1948, the National Party of South Africa won the national elections with their apartheid agenda, and in the decade that followed, consolidated their position. One of the main instruments utilised for bringing to fruition the apartheid agenda was the Population Registration Act (no. 30) of 1950. This classified all South Africans into categories based on race[317]. This was followed by the Group Areas Act (no. 41) of 1950, which gave the legal basis for the geographical area segregation for blacks and whites. The Bantu Authorities Act (no. 68) of 1951 created local governments for black settlements. Public amenities such as clubs, swimming pools and even public toilets were segregated according to race under the Reservation of Separate Amenities Act (no. 49) of 1953. The education system too was segregated and made unequal with the Bantu Education Act (no.47) of 1953.

Notions of democracy and equality were further attacked as apartheid progressed into a political system with the Separate Representation of Voters Amendment Act (no.30) of 1956, which disenfranchised black voters from their already limited franchise. Prior to this,

[316] Deborah Posel, *The Making of Apartheid, 1948-1961: Conflict and Compromise* (Oxford University Press, USA, 1991), 235.
[317] Instead of using "black" or "negro", official terminology used the term "native", along with "coloured", "white" and "Asians" categories.

several security-oriented laws had been promulgated – the Suppression of Communism Act (no.44) of 1950, the Public Safety Act (no. 3) of 1953, the Criminal Law Amendment Act (no. 8) of 1953 were brought into being and used later for quelling anti-apartheid organisations and acting against any voice of dissidence.

When it came to policing sexual and gender relations, right after the apartheid government came to power, the Prohibition of Mixed Marriages Act of 1949 was promulgated, banning marriages between black and white South Africans. However, the legislation that came the closest to dealing with transsexuality, was the Immorality Amendment Act 57 of 1969[318]. The Act not only went to the extent of being used to police the bedroom (where underwear would be snatched and copulating couples would be photographed), but also, it "was the first Act to 'explicitly acknowledge government hostility to female masculinity and lesbians by banning dildos'"[319]. This act also criminalised any behaviour which could be construed as giving rise to sexual passions between two males at a party, meaning any situation where more than two people were present[320]. While there was consent on male homosexual acts already, the age of consent was raised from 16 to 19.[321]

The 'fighting fifties', so known due to rising protest and political mobilisation against apartheid legislation, culminated in the Sharpeville massacre in 1961, a repressive move by the then-government, which temporarily quelled the protests by instituting a state of emergency and significantly enlarging the police apparatus. This decade was also a period of economic boom. In the 1970s, however, the protests soared up again, most marked by the Soweto uprising of 1976.

[318] It was an amendment of the Immorality Act of 1957, subsequently renamed the Sexual Offences Act of 1957. While the Immorality Act of 1957 prohibited sex or "immoral or indecent acts" between white and non-white people, the Amendment Act of 1969 expanded several sections to include sodomy as a statutory crime for men under 19, and prohibited the manufacturing or sale of any "article intended to be used to perform an unnatural sex act".
[319] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 682.
[320] The infamous Section 20A of the Immoral Amendment Act of 1969
[321] Vincent and Camminga, 'Putting the "T" into South African Human Rights'.

It was also from the 1970s that the apartheid government brought policing the human body to its height. People who had anti-apartheid sentiments and went against "traditional views of masculinity" were interred in the psychiatry unit at One Military Hospital in Voortrekkerhoogte[322]. Thus, instead of exempting military conscripts, at the time all male, who confessed their homosexuality, the apartheid state treated it as a disease to be cured. Being made to declare their homosexuality at the risk of punitive measures, many of the conscripts were hospitalised not just for psychiatric treatment, but for sexual reassignment surgery as well, which was then seen as a cure for homosexuality. The idea behind it was creating a heterosexual woman out of a homosexual man by assimilating his body into the ranks of women. 1980 onwards, it is estimated that over 900 such surgeries were carried out, not just in 1 Military Hospital at Voortrekkerhoogte, but also in other facilities. While not all the people made to undergo surgeries were unwilling, there were many who were homosexual and unwilling.[323]

Many queries, surprisingly, used to come from homosexual men to the doctors specialised in sexual reassignment surgeries. This is because while homosexuality was seen as a deviance from the normative, transsexuality allowed for a way out of the deviance and to align the body with social norms – a chance to fit back into the binary model.[324] Despite homosexuality being removed from DSM2 as a mental disease as early as 1973, the then South African government kept treating it as a disease. Many people who were coerced into undergoing surgery and hormonal treatments were unable to maintain their expensive treatments post-surgery, and often passed away (some even during surgery).[325]

[322] Mikki Van Zyl et al., '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 on Behalf of Gay and Lesbian Archives Health and Human Rights Project, Medical Research Council, National Coalition for Gay and Lesbian Equality,* 1999: 31.
[323] Van Zyl et al., 31,32; Vincent and Camminga, 'Putting the "T" into South African Human Rights', 690.
[324] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 690.
[325] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 690.

In the 1970s, there were two roads for accessing medical services for transgender people in South Africa – one was sexual realignment surgery, and the other, aversion therapy through electric shocks. A transgender person who was interviewed about her experiences at the time stated that there was a major lack of support in the entire process. The process itself was frightening enough without adding the medical service provider's apathy towards her.[326]

When the first South African "medical transsexual", Elize van der Merwe, appeared in media spotlight in the early 1980s, the focus was less on her being a transsexual, and more about a heterosexual woman being in the wrong body, and how she had all the attributes of a woman.[327]

Medical and cosmetic interventions are a part of the lives of transgender people – whether its hormonal therapy, laser hair removal, body transformation, psychological and/or psychiatric counseling, they have always been there. However, such interventions are often used as a tool to police and control the transgender body.

With the fall of apartheid, South African laws saw a distinct change. Before the laws changed though, the new DSM of 1994 omitted transsexualism and instead used the term Gender Identity Disorder. However, medical professionals did not move on from the binary aspects of gender that they were always used to when dealing with transsexual patients. A male to female transgender person who visited the Pretoria Academic Hospital's Gender Clinic in the mid 1990s recalled being told by a panel of psychiatrists to feminise her attire, something she was quite uncomfortable with. She felt the doctors were too keen on sticking to the narrow dimensions of the gender binary.[328]

[326] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 688.
[327] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 689.
[328] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 691.

3.4. Changing narratives in the Rainbow nation

With the new 1996 constitution, which outlawed any discrimination on the basis of sexual orientation at the very outset, came a new wave in legislation making and removal. In 1998, the anti-sodomy law was repealed, along with the 1957 statute that prohibited sexual contact between men when more than two people were present. Other laws followed, including gay couples being allowed co-adoption of children and same sex partnerships.[329]

For the first time, transgender people stopped viewing themselves as a social problem that needed rectification and fit into the gender binary, and started viewing themselves as an oppressed minority. However, while the gay and lesbian movements gained greater legitimacy as acceptable forms of sexual expression, the same context did not translate into such an acceptable scenario for transgender people. Granted that this wave of new legislation made it easier for transgender people to come out and consequentially to organize, legal change did necessarily transform into a widespread rights-oriented approach.

To be sure, gay and lesbian movements have often embraced transgender issues as a part of their movements, but this relationship has often been fraught with difficulties and misunderstandings. For example, there was an incident where a transgender man who identifies as being gay was a part of the Triangle Project Transgender Support Group. When he felt the need to interact with gay men in general and reached out to a gay support group also run by the Triangle project, he was told that he couldn't join them as he was transgender.[330]

Thus, while cis-gendered people were gaining momentum in creating a positive legal space for them, and lesbian and gay movements had adopted transgender issues as part of their cause, their experiences are quite different from sexual minorities. Despite this,

[329] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 691.
[330] Vincent and Camminga, 'Putting the "T" into South African Human Rights', 692.

lawmakers, too, have often conflated their issues and problems with those of cis-gendered sexual minorities[331].

Transgender men have different experiences in social interactions as opposed to transgender women. Transgender men seem to be more invisible in transgender spaces, and apparently blend in with heteronormative society more easily. It may be because they do not seem to upset the heteronormative power structures in society, unlike transgender women, who call out to attention their transition from being classified as male to wanting to be considered female, challenging patriarchal norms with a male-bodied person taking on a traditionally non-male (submissive) role[332].

Within these structures, the interaction of transgender women with cis-gendered women and the exclusion felt by them is unsurprising. Just as the transgender man who came out as gay and wanted to interact with cis gay men was considered unacceptable (stated above), the transgender woman's foray into a cis woman's fight might not be taken in the same manner. For instance, when it comes to corrective rape in South Africa, statistics do not cover transgender women at all. That does not mean that transgender women do not face the same discriminations as faced by cis-gendered women – over HIV statuses, gender-based violence, sexual health, employment, discrimination (which may be an intersection of other social factors such as race and class along with gender). Instead, it goes above and beyond, given their transgender status compounding all aforementioned factors. While the transgender man has the dubious privilege of stepping into and getting absorbed into patriarchy, transgender women enter the arena of women, but in the shadow-lines.[333]

[331] I repeatedly point out the cis-gendered sexual minorities as being different with a different spectrum of needs from (though sometimes overlapping with) transgender people as, when transgender people identify as men or women, it is often assumed that they are taking heteronormative and heterosexual roles. However, in situations where they identify with being homosexual, they face issues trying to gain acceptance beyond just being transgender. Vincent and Camminga point this out repeatedly in their paper.
[332] L. A. Van der Merwe and T. Padi, 'Transgender Feminism', *New Voices in Psychology* 8, no. 2 (2012): 113.
[333] Van der Merwe and Padi, 'Transgender Feminism', 113–15.

3.5. Creating the legal body of the South African Transgender citizen

South African gender and sexual identities cannot be understood in purely Eurocentric or Western-centric terms. Gender binaries are challenged by identities like Moffies, *Skesana* and *istabane*[334], female *Sangomas* with ancestral wives and women (including monarchs[335]) living in relationships with other women, but assuming the role of the man.[336]

While it would be erroneous to say that there are no shared histories and concerns between the sexuality and gender structures and concepts of the Global North and South Africa, to equating the two would be equally faulty. A case in point is the plethora of languages existing in the country (11 official languages), with each of them having a pattern of signification with its terminologies on gender non-conforming people, including some being considered derogatory by locals.[337]

However, in order to ascertain an identity in law, given that local identities mentioned above are not taken into account, the South African legislations have resorted to using gender binaries, with even the intersex body being coerced into admitting either one way or another. There is no room for being anything other than male or female.[338]

When analysing the situation, the intersectionality of various socio-economic factors also need to be taken into account. White transgender people, hailing from middle class and

[334] Swarr, '" Stabane," Intersexuality, and Same-Sex Relationships in South Africa'.Swarr. The author talks about how the role of the *Istabane* or *Stabane* would be seen as the conflation of two things – lesbian identities with intersexuality. People who are called *Stabane*, are thought to have both male and female genitalia. When the notions of transgender identifications are not clear, more often than not, clarifications are required that same-sex desire in women need not be ascribed to having a penis instead of a vagina. The family of one of her interviewees would never talk about homosexuality, but instead talk about *Stabane*. The author also talks about the intricate fabrics of non-urban South African sexual behavior identities.

[335] Extrapolated from my interview with Busisiwe Kheswa, South African interviews, where I learnt about the Venda Queen who would take on a male role and marry multiple wives, and where the monarch could only be a woman.

[336] Thamar Klein, 'Necessity Is the Mother of Invention: Access Inequalities to Medical Technologies Faced by Transgendered South Africans', *Technology & Innovation* 15, no. 2 (2013): 167.

[337] Klein, 'Necessity Is the Mother of Invention', 167.

[338] Klein, 'Necessity Is the Mother of Invention', 169.

upper middle class backgrounds address less abuse than their coloured or black counterparts. Individuals transitioning from one gender to another have vividly varied accounts of their experiences – primarily because of the intersection of several factors as mentioned earlier, some which give privilege and some which create social subordination – skin colour, ethnicity, religion, gender (to which the person is transitioning), class, education, citizenship, and so on and forth. An intersection of merely two of these factors is enough to create waves in a person's life, but in the case of the South African transgender citizen, it is often the interaction of several of these factors.[339]

This specificity of experience is expressed in the fact that the South African Transgender movement took on a different journey from the LGB movement. Instead of embracing the Court and the Parliament, they took to the streets, and mobilised people, till very recently, as we shall see. Activists, too, played up the constant notion of South Africa being the blue-eyed boy of rights and being the exception in all Africa. While they did share some of the goals of the LGB people, they were keener on legitimizing their very existence as well as linking it to a larger global rhetoric. LGB mobilization played on the South African Constitution's promise of a rainbow nation through the Equality Clause[340]. However, transgender activism played a role in linking the progressive constitution to the more progressive transgender rights regimes in different parts of the world.[341]

As already mentioned, the legal and healthcare system in the country is essentially designed to serve the heteronormative South African. To start with the most mundane, South

[339] Klein, 'Necessity Is the Mother of Invention', 169.
[340] Discussed later in the same chapter.
[341] R. Thorenson, 'Beyond Equality: The Post-Apartheid Counternarrative of Trans and Intersex Movements in South Africa', *African Affairs* 112, no. 449 (1 October 2013): 656, https://doi.org/10.1093/afraf/adt043. It is to be noted that transgender right have often been disconnected in the way they have been perceived from LGB rights in certain countries, such as India, Iran and Sweden.

Africa has a system of identification cards under the Identification Act[342] that a citizen must bear and present for the simplest of activities to the most important – from getting a driver's license to opening a bank account to voting, it is a mandatory requirement. All the information regarding the person on the card is reflected in the population register of the country.

While it was possible to go for a sex-change operation, for the longest time, it was not possible to change the gender marker on the card. This was the scenario decided on by the South African judiciary in the judgment passed on the 1976 case, *W v. W* (2) SA 308 (WLD), wherein the court held that sex could not be altered merely through surgery, and that it was obtained at birth and was unalterable[343]. In 1992, the Births and Deaths Registration Act carried on the same legacy of gender assignment as was decided in the case.

With the 1996 Constitution coming into power, a certain change emerged. The Constitution of South Africa mandates two things in its body quite clearly:

> **Section 9** [also known as the Equality Clause]: The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth".
>
> **(…)**
>
> **Section 27**: Everyone has the right to have access to health care services, including sexual and reproductive health care.

[342] This act has had many forms, and the current rendition is the 'Identification Act (No. 68 of 1997)', Polity.org.za, accessed 9 March 2018, http://www.polity.org.za/article/identification-act-no-68-of-1997-1997-01-01.
[343] *W v. W,* 2 SA 308 (1976).

However, these directives are difficult to materialise for gender non-conforming people, given the tendency of the legal and the health system to be heteronormative in their function.

The Promotion of Equality and Prevention of Discrimination Act 4 of 2000, while not exactly pointing out gender non-conforming people in its purview, has left room for interpretation by stating that "harassment" would include any conduct which creates an unfriendly environment on the basis of "sex, gender or sexual orientation" and "a person's membership or presumed membership of a group identified by one or more of the prohibited grounds or a characteristic associated with such group". It includes intersex within its definition of sex (through an amendment in 2005). Section 8 specifically prohibits "unfair discrimination on ground of gender" but essentially talks about women, which may be presumed to mean cis-gendered women, but the lack of specification means that it may be, through judicial interpretation, extended to transgender women as well. Section 11 prohibits harassment of any person by any person, thus covering all humans. Section 28 assures that the State shall take measures in eliminating discrimination and promoting equality in respect of gender. These sections may be used in a court of law to create a non-discrimination framework to aid transgender people.

After much procrastination on the matter, the department of Home Affairs promulgated the Alteration of Sex Description and Sex Status Act (No. 49) in 2003[344]. The original draft required sexual reassignment surgery in order to get an alteration in documentation, and used archaic and outdated terminology. The Act, in its current form, focuses primarily on genitalia versus hormonal divide. For an Act that has such epoch-making effect on its stakeholders, it is surprisingly short, and the definitions include intersex while not

[344] Hereafter referred to as the Alteration Act. This was the culmination of a report submitted by the South African Law Commission to the Ministry of Justice and Constitutional Development in 1995, when a draft legislation had been created on altering sexual organs to alter gender assignment on documents, which had languished behind closed doors for seven years before being brought out again.

going into any other gender category. Moreover, the entire language of the Act uses the gender binary and does not leave any space for a non-binary gender marker[345].

When this Act came up as a Bill, the arguments presented were an amalgam of fundamental human rights and socio-economic rights. Legal recognition was connected with access to "employment, physical safety, health, use of public amenities, relationships, social interaction, gender expression, self-worth, emotional well-being and travel"[346]. The South African Human Rights Commission went beyond this and connected it directly to the equality clause, stating that the "inability to change one's sex 'constitutes a violation of many rights including privacy, dignity and equality, which are enshrined in [their] Bill of Rights"[347]. In order to do away with the mandatory sexual reassignment surgery as stated in the initial draft, transgender activists presented that this forced transgender or intersex people to undergo hazardous and risky procedures, infringing on their right to bodily autonomy, as well as weighing down in a discriminatory manner on all those transgender and intersex people who were incapable of accessing such surgeries due to the financial costs involved.

The National Health Act of 2004, while seen to be an extension of Section 27 of the Constitution, does not encompass transgender people within its purview *per se*. It does mention that within its reach come women, children and other vulnerable groups. However, it has very specific guidelines as to what constitutes a vulnerable group. It lays out the grounds

[345] The inclusion of intersex was a small but very important victory. It is to be noted here that activists secured the position of transgender people further by seeking protection under the Judicial Matters Amendment Act of 2005 wherein they managed to amend the terms "human being" and "natural person" to go beyond the male and female binary. Without this, intersex people would have been a legally non-existent population. I have gone deeper into the Alteration Act later in the chapter as it is pivotal for understanding the notion of transgender citizenship in South Africa.

[346] 'Request by the Cape Town Transsexual/Transgender Support Group to the South African Home Affairs Portfolio Committee for an Extended Submission Period for the Alteration of Sex Description and Sex Status Bill, 2003', in Thorenson, 'Beyond Equality', 662.

[347] Thorenson, 'Beyond Equality', 663.

for medical confidentiality, which is something that several transgender interviewees across researches have stated to have been breached[348].

Health policies have often seen transgender needs being conflated with the needs of MSM and WSW. However, what did bring the transgender population into the foreground was when the third National Strategic AIDS Plan was being unrolled in 2012 and it specifically mentioned "transgender". Also, the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014-2019) makes it a point to mention transgender and intersex people, along with lesbians and gays, as "underserved"[349] populations. It also underlines the lack of "comprehensive material around SRHR for all target groups"[350].

3.6. The Alteration Act No. 49 of 2003 – law and implementation

South African legislations around transgender people and gender marker changes have gone through several fluctuations. For instance, during the Apartheid Era, the now-repealed Births, Marriages and Deaths Registration Act No.81 of 1963 allowed post-operative transgender and intersex individuals to change their sex markers on their birth certificates. The same act was amended in 1974 to include Section 1(1):

> "The Secretary may on the recommendation of the Secretary for Health alter, in the birth register of any person who has undergone a change of sex, the description of the sex of such person and may for this purpose call for such medical reports and institute such investigations as he may deem necessary."

[348] For instance, Douglas D. Newman-Valentine and Sinegugu E. Duma, 'Transsexual Women's Journey towards a Heteronormative Health Care System: Gender and Equity', *African Journal for Physical Health Education, Recreation and Dance* 20, no. Supplement 1 (2014): 385–394. At the same time, a must-mention is the South African Health Professionals Act, 2006, which provides ethical guidelines for healthcare providers and to take care that they "do no harm".

[349] Marion Stevens, 'Transgender Access to Sexual Health Services in South Africa: Findings from a Key Informant Survey', *Cape Town: Gender Dynamix*, 2012, 6.

[350] Stevens, 7. This lack of information also translates into risky behavior by transgender people due to the lack of knowledge and access to knowledge and knowledgeable health care providers.

This act was repealed entirely and replaced by the Births and Deaths Registration Act No. 51 of 1992. This Act provided for a gender marker change under Section 7(b) of the repealed Act if a person was already transitioning before the adoption of the new Act. However, as mentioned above, the influence of the decision in *W v. W* was felt when this facility was withdrawn.

This absolute repeal was like a death knell to the self-realisation of gender, and biological determinism was given precedence over the stigma and discrimination faced by transgender and intersex people. Moreover, the fact that *W v W* and *Corbett v. Corbett* were cases that retroactively nullified existing marriages on gender-non-recognition added to the oppression.

Thus, when the Alteration Act came about, it was a tremendous boost to the legitimacy of transgender citizens in South Africa. This Act 49 of 2003 highlights particular definitions in Section 1:

> "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;
>
> "gender reassignment" means a process which is undertaken for the purpose of reassigning a person's sex by changing physiological or other sexual characteristics, and includes any part of such a process;
>
> "intersexed", with reference to a person, means a person whose congenital sexual differentiation is atypical, to whatever degree;
>
> (…)

> "primary sexual characteristics" means the form of the genitalia at birth;
>
> "secondary sexual characteristics" means those which develop throughout life and which are dependant upon the hormonal base of the individual person;
>
> "sexual characteristics" means primary or secondary sexual characteristics or gender characteristics."

What is noteworthy is that there is a differentiation between sexual and gender characteristics, which is quite a departure from *W v. W*.

Under Section 2(1), three categories of people can apply for alteration of sex description, that I call gender markers. The first category is for people who have altered their sexual characteristics through medical or surgical treatment, the second category is for people who have reassigned their genders by "evolvement through natural development", and the third category is for intersex people.

Under the first category, the implication is that there has to be some type of intervention to qualify for a gender change. The second category was controversial because it implied towards a particular type of intersexuality that is very rare. With the introduction of the third category as an umbrella for all types of intersexuality, the second category becomes redundant.

Section 2(2) also establishes the requirements to apply for a gender marker change. While all applicants have to submit their original birth certificates and a report from a medical practitioner who has examined the sexual characteristics of the applicant, the first category of applicants need to submit detailed medical reports of the processes they have undergone. This report needs to be from a different medical practitioner than the one who examined the sexual characteristics. The second and third categories of applicants, that is intersex people, need to

submit a report confirming their intersex status. However, the Act is silent on whether it is an additional requirement to the sexual characteristics report and whether it is required to be a different medical practitioner from the one giving that report. Given that both reports would be the same, this ambiguity seems easily resolved.

Currently, there is no regulation to accompany the Act, which makes the accompanying letters quite arbitrary in their format. The fact that there is no clear guideline on what to include makes it confusing for all parties concerned.

Section 2(3)-(10) lays out the procedure post-granting of application as well as grounds for refusal and how to appeal a negative decision. Should the application be granted, then the Director-General is ordered to proceed under Section 27A of the Births and Deaths Registration Act, and the markers are changed in the birth certificate.

Should an application be refused, the Director General of the Department of Home Affairs is supposed to give a detailed explanation of refusal. However, given that there is no timeframe to supply such reasoning, the wait may get tedious. An appeal against the refusal may be made to the Minster of Home Affairs within 14 days of the refusal. Also, there is no guideline as to what added documents need to be provided. Even after this, should there be no relief, it may be taken up with the Magistrate's court. If there is a refusal at the level of the Magistrate's court, there is no guideline provided. Yet, with a constitutionally entrenched right to access courts, it may be assumed that it can be taken up to a higher level.[351]

Most importantly, Section 3 orders the Director General to act per Section 27A of the Births and Deaths Registration Act, which allows for the gender marker changes in the following manner:

[351] The Constitution of the Republic of South Africa, Section 34.

(1) If the Director-General grants an application, made in the prescribed manner, or a magistrate issues an order in terms of section 2 of the Alteration of Sex Description and Sex Status Act, 2003 (Act No. 49 of 2003), the Director-General shall alter the sex description on the birth register of the person concerned.

(2) An alteration so recorded shall be dated and after the recording of the said alteration the person concerned shall be entitled to be issued with an amended birth certificate.

While, on the face of it, the Alteration Act seems to have broken hitherto unknown ground, and paved the way for much sought-after relief, the fact of the matter is that ground level implementation is difficult to say the least. For instance, there were several complaints about delays in processing the applications.[352] Consequentially, this acts as a barrier from accessing services such as medicare, educational facilities, exercising one's voting rights, or any other activity that brings to the forefront the gender identity mismatch on the visual front with the one recorded in the identity documents[353].

Significantly, several people are rejected a gender marker change on the grounds that they have not had surgery. This is in direct contravention of Section 2(1) of the Alteration Act. Worse still, some of the applicants were not even given any explanation on the refusal, once again going against the Alteration Act[354].

These rejections on the grounds of no surgery have led to other consequences such as doctors also refusing to give a letter of support for gender marker changes, despite the applicants being people who have undergone other medical procedures for gender

[352] 'Gender Dynamix on Alteration of Sex Description & Sex Status Act Implementation; Lawyers for Human Rights on Statelessness; CoRMSA on Closure of Refugee Reception Offices in Metro Areas | PMG', 1, accessed 7 March 2018, https://pmg.org.za/committee-meeting/15305/.
[353] 'Gender Dynamix on Alteration of Sex Description & Sex Status Act Implementation; Lawyers for Human Rights on Statelessness; CoRMSA on Closure of Refugee Reception Offices in Metro Areas | PMG', 1.
[354] 'Gender Dynamix on Alteration of Sex Description & Sex Status Act Implementation; Lawyers for Human Rights on Statelessness; CoRMSA on Closure of Refugee Reception Offices in Metro Areas | PMG', 1.

realignment[355]. Several transgender and intersex people often opt to not go for the highly invasive surgeries like vaginectomy, phallectomy, phalloplasty and vaginoplasty – not only are these surgeries invasive, they are also highly risky and expensive[356]. However, given the circumstances, some people brave the risk.

By not implementing the Alteration Act as it should be, or interpreting it in an arbitrary manner, one would be inclined to agree with Thamar Klein who feels that the Department of Home Affairs is not just acting against the word of the Act, but also against the Equality Clause of the constitution. This is because of their arbitrary demands for sexual reassignment surgery, given that the Act has space for both sexual and gender characteristics.[357] However, this could be an inadvertent consequence of the fact that the Alteration Act only has room for gender binaries. There is no gender marker space for someone who does not identify with either male or female.

3.7. The Case of KOS – challenging the notion of marriage and union

Gender binaries have often inadvertently come up when trying to push through pro-equality legislations. For instance, when the Civil Union Act 17 of 2006 was still a Bill, it was exclusively meant for same-sex unions, and spoke about men and women. The South African Human Rights Commission made a submission to include intersex people, and thus, the Civil

[355] 'Gender Dynamix on Alteration of Sex Description & Sex Status Act Implementation; Lawyers for Human Rights on Statelessness; CoRMSA on Closure of Refugee Reception Offices in Metro Areas | PMG', 3.
[356] Chris Bateman, 'Transgender Patients Sidelined by Attitudes and Labelling', *SAMJ: South African Medical Journal* 101, no. 2 (2011): 92. I speak of the waiting lists of the public health system later in the dissertation.
[357] Thamar Klein, 'Who Decides Whose Gender? Medico-Legal Classifications of Sex and Gender and Their Impact on Transgendered South Africans' Family Rights', *EthnoScripts* 14, no. 2 (2012): 23–24.

Union Act came to be written in gender-neutral terms, thus encompassing room for gender non-binary people to get married[358].

This gave rise to two serious contradictions in law. Firstly, under Section 8 (6), the couple asking for a union must be of the same sex (despite the removal of determinate gender markers earlier in the Act)[359]. Secondly, if a person is married under the Marriage Act 25 of 1961 or Customary Marriages Act[360], which presume marriage to be a heterosexual institution, between a man and a woman, and if the person comes out as transgender and undergoes a gender identity change, the person's marriage ceases to be valid under the Marriage Act or Customary Marriages Act. They must remarry under the Civil Union Act. This is in direct contradiction of the premise of the Alteration Act.

In 2017, a pivotal case on transgender recognition was brought to the Western Cape Court[361]. Certain transgender people, who had been married under the Marriage Act 25 of 1961, were facing difficulties getting their gender markers changed under the Alteration Act without getting a divorce from their respective spouses.

Six people were applicants for the case, along with Gender Dynamix. Three of them were the transgender spouses of the other three. The transgender spouses, for the case, were referred to as KOS, GNC and WJV, and their cisgender spouses, were referred to as MMC, HA and HJV (in the respective order). The transgender spouses were biological males at birth, and after they married, decided to go in for treatment either medical or surgical to align their bodies to their gender. The respondents were the Minister of Home Affairs, the Director-

[358] Thorenson, 'Beyond Equality', 663.
[359] This makes it complicated for people identifying as intersex in this equation, as having a cis-gendered partner would basically mean that both persons are not of the same sex. In Sally Gross, 'De-Gendering Unions - Civil Union Act & the Intersexed', in *To Have & to Hold - the Making of Same-Sex Marriage in South Africa*, ed. Melanie Judge, Anthony Manion, and Shaun De Waal (Fanele, 2008).
[360] The Recognition of *Customary Marriages* Act 120 of 1998, referred to as Customary Marriages Act in short.
[361] 'KOS and Others v Minister of Home Affairs and Others (2298/2017) [2017] ZAWCHC 90; [2017] 4 All SA 468 (WCC); 2017 (6) SA 588 (WCC) (6 September 2017)', accessed 8 March 2018, http://www.saflii.org/za/cases/ZAWCHC/2017/90.html hereafter referred to as the *KOS* case.

General, Department of Home Affairs and the Deputy Director-General, Department of Home Affairs, Civic Services.

Section 3(3) of the Alteration Act reads as:

> Rights and obligations that have been acquired by or accrued to such a person before the alteration of his or her sex description are not adversely affected by the alteration.

Thus, according to this section, altering one's gender markers under this Act does not adversely affect any person's contracts, etc. that the person entered before changing his/her gender markers. By the same logic, a marriage entered into before a sex/gender alignment procedure or legal marker change should stand as it is.

In *KOS*, the transgender applicants had initially applied to alter their sex descriptions in their respective birth registers with the Department of Home Affairs, entirely supported by their spouses. They considered that the fact that their marriages would now be same-sex marriages was irrelevant for their official marital status.

In two of their cases, KOS and GNC, they were refused the alteration of their gender markers. In the case of the third applicant, WJV, the Department of Home Affairs, they changed the gender marker, but at the same time, deleted his/her marital status with the sixth applicant from the records, that too unasked. At the same instance, the Department also reverted the sixth applicant's surname to her maiden name. This happened because the Department's view of the situation around marriage was guided by the understanding that the applicants could not be granted an alteration in their gender markers due to their marriages being solemnised under the Marriages Act, which is in contravention to the Alteration Act. It must be noted here that the Department did tell them that they would facilitate a marriage

under the Civil Union Act for them.[362]

In *KOS*, the Court took cognizance of the basis of the Civil Union Act as a legislative response to the *Lesbian and Gay Equality Project and Ors. v. Minister of Home Affairs and Ors*[363] to make up for the omission in the definition of marriage in the Marriage Act, which disallowed same-sex couples to get married[364]. It also pointed out that while the case was specifically about gay and lesbian couples, sexual preference or orientation is often conflated wrongly with gender identity, as has been done by the Department of Home Affairs.[365]

The Court also pointed out that marriage is not defined in either the Marriage Act or the Civil Union Act. This omission was because marriage is accepted the way it is found in common law. However, while a union under the Marriage Act is always termed a marriage, under the Civil Union Act, parties, both heterosexual and non-heterosexual, have the option of calling it either a civil union or a marriage. However, that, in no way, takes away the equivalence for the two for all rights and purposes. Even marriage officers are the same for officiating unions under both Acts. The primary difference is that under the Civil Union Act, a marriage officer reserves the right to object on grounds of conscience, religion or belief to officiating on a same-sex union. Thus, *KOS* became pivotal in trying to resolve this legal anomaly that is creating many issues for specific members of society from exercising their rights.[366]

The Department of Home Affairs' defence was "inconsistent". Firstly, the Department

[362] The irony of the matter is that no divorce proceedings were ever sought or carried out. This kind of an annulment

[363] 'Lesbian and Gay Equality Project and Eighteen Others v Minister of Home Affairs (CCT 10/05) [2005] ZACC 20; 2006 (3) BCLR 355 (CC); 2006 (1) SA 524 (CC) (1 December 2005)', accessed 8 March 2018, http://www1.saflii.org/cgi-bin/disp.pl?file=za/cases/ZACC/2005/20.html&query=equality%20project hereafter referred to as the *Equality Project* case.

[364] "[A] union of one man with one woman, to the exclusion, while it lasts, of all others" was found to be discriminatory as it specifically prevented same-sex unions from publicly formalising their unions.

[365] '*KOS* Case', paras 17–21.

[366] '*KOS* Case', paras 22–25.

said that, although the Alteration Act did lay out that all rights and duties that the applicants had before the alteration would remain the same and that the marital status of the applicants should not have any bearing on the gender-marker change, the Act cannot be read in isolation. The respondents went further to say that the State had promulgated the Civil Union Act understanding that the Marriage Act could not be amended to include same-sex couples. Thus their understanding in the matter was that a once-opposite sex married couple can no longer be officially married under the Marriage Act as they are now a same-sex couple, and this is not allowed in the Marriage Act. The inconsistency came about when the Director-General said that WJV and her/his wife's marital status change in the records was a mistake and not based on the notions followed by the Department of the difference in accommodation between the two Acts in question.

In his discussion on the matter, Binn-Ward JJ, the judge adjudicating the case, called out the inconsistency, and how this anomaly can lead to an inaccuracy in the population register under the Identification Act and an inaccurate identity card for the applicant, given WJV's gender alignment procedures. He points at the obvious confusion caused between the different legislations and the authorities meant to implement them, but says that the notion of this differentiated treatment was influenced by socio-religious prejudice, and that the Department was falling short of its constitutional responsibilities "that statutes must be interpreted in a manner consistent with the promotion of the spirit, purport and object of the Bill of Rights" and that the Department is obliged to diligently carry out its constitutional obligations.[367] More so, given that the Department itself had pointed out the lack of necessary regulations to deal with the anomaly, it had taken no step to create supplementary regulations or provisions.[368]

[367] '*KOS* Case', para. 70.
[368] '*KOS* Case', para. 68-70.

Binn-Ward JJ repeatedly pointed out that the primary requirement of the alteration of the gender marker is to ally with the Identification Act, so that a population database may be maintained and identity cards and certificates required for administrative purposes may be issued with correct details. He also acknowledged the need for such an identity card for day-to-day activities such as obtaining bank accounts, driving licenses, and traveling. Not reflecting the correct details on such cards can lead to a major barrier in accessing services, as was submitted by the applicants.

Section 8 of the Identification Act reads as:

> 8. *There* shall in respect of any person referred to in section 3, be included in the population register the following relevant particulars available to the Director-General, namely -
>
> (a) his or her identity number referred to in section 7;
>
> **(b) his or her surname, full forenames, gender, date of birth and the place or country where he or she was born;**
>
> **[…]**
>
> **(e) the particulars of his or her marriage contained in the relevant marriage register or other documents relating to the contracting of his or her marriage, and such other particulars concerning his or her marital status as may be furnished to the Director-General;**
>
> […][369]

Referring to the sub-sections highlighted above, Binn-Ward JJ opined that no amendment to the particulars, being provided under Section 8(e), needs to be carried out. All that is required is for an amendment in the particulars under Section 8(b).

[369] Emphasis added.

Regarding the Marriage Act, the respondents particularly relied on Sections 29A and 30(1), viz.:

29A. Registration of marriages

(1) The marriage officer solemnizing any marriage, the parties thereto and two competent witnesses shall sign the marriage register concerned immediately after such marriage has been solemnised.

(2) The marriage officer shall forthwith transmit the marriage register and records concerned, as the case may be, to a regional or district representative designated as such under section 21(1) of the Identification Act, 1986 (Act No. 72 of 1986).

(Section 29A inserted by the Schedule of Act 51 of 199

30. Marriage formula

(1) In solemnizing any marriage any marriage officer designated under section 3 may follow the marriage formula usually observed by his religious denomination or organization if such marriage formula has been approved by the Minister, but is such marriage formula has not been approved by the Minister, or in the case of any other marriage officer, the marriage officer concerned shall put the following questions to each of the parties separately, each of whom shall reply thereto in the affirmative:

"Do you, A.B., declare that as far as you know there is no lawful impediment to your proposed marriage with C.D. here present, and that you call all here present to witness that you take C.D. as your lawful wife (or husband)?'"

and thereupon the parties shall give each other the right hand and the marriage officer concerned shall declare the marriage solemnised in the following words:

"I declare that A.B. and C.D. here present have been lawfully married."[370]

These sections in no way preclude any person from undergoing sex/gender reassignment or an official gender-marker change. Section 29A provides for registering of the marriage so that it may be entered into the public administrative system more than anything else. The fact that there is no prohibition on any party changing his or her gender/sex was pointed out by the judge, and that a small additional form to cater for required amendments to the particulars in the records ought to be enough. Thus, he ruled that this wasn't a sufficient ground to rely on.

In a similar manner, the respondents' reliance on the Civil Union Act was on false premises, as both Acts consider civil unions and marriages as the union of two persons, not specifying sex/gender. Binn-Ward JJ pointed out that the respondents' understanding that this was because there are two parallel systems of marriage in South Africa – one under civil law and one under common law- was incorrect, and that their forwarding of pushing for a change of marriage registration under one Act to another is premised on a misconception.

Thus, the Court decided in favour of the petitioners and that the Department had acted unlawfully and had infringed on the rights of the applicants – even the cisgender spouses had had their dignity and equality infringed upon, and that they were to be granted administrative relief. Also, specifically, the deletion of the marital status of WJV from the registers and converting her/his spouse's name to her maiden name was held to be an unlawful move which was to be unconditionally changed back to its original status.

[370] This is also the same in the Civil Union Act Section 11(2), except for the addition of civil union to the words.

3.8. Conclusion

South Africa has had a tumultuous past. The Apartheid Era has left an indelible mark on the jurisprudential and socio-economic face of the country. Having said that, with the new constitution, it has tried to make amends for the wrongs of the past. It has tried to make the constitutional tenets as inclusive as possible. In fact, today, it is considered to be the most progressive country in the entire African continent, with a functioning democracy and a strong constitutional framework.

Yet, as seen above, certain segments of the population are still finding it difficult to engage with the State as equal citizens. Despite there being economic growth and opportunity, many sections of the population who were poorly off during the Apartheid Era, continue to be so. Transgender people are no exception. Although the narratives of their struggle under the "never again" constitution changed, it has been an uphill legislative battle.

This is probably because of the lack of general engagement with transgender people, as well as the insistence of normativising the transgender body, there has been little understanding around them. For instance, the way Semenya's unnatural strength was considered to be anomalous for a woman is not a unique phenomenon – it is just that this was a reported incident because of the high profile of the person involved.

South Africa has a unique interplay between its colonial past, race, ethnicity, and gender. The Equality Clause in the constitution has tried to right the negative impacts of these interplays, and has also been the basis for many a sexual and gender minority movement. Few constitutions around the world have such a clause for sexual and gender inclusion.

While the journey for transgender rights wasn't primarily through litigation, activism and advocacy brought about the Alteration Act. While it was limited in scope, it definitely

seemed to be a step in the right direction. Yet, as we saw, there have been more than a few issues with its implementation.

The legal journey to getting the Alteration Act off the ground was tough. To see its implementation being mired in constant delays and controversies makes life for its stakeholders unbearable at times. Starting with the gender binary being pushed forward in the Alteration Act, thus making it difficult for anyone who considers her/himself to be fluid to get a non-binary marker, to constant administrative delays in getting the markers changed, the problems have been manifold. The latter makes it difficult for stakeholders to access several rights and services, and also leaves them open for more stigma and discrimination.

The tensions between the administrative bodies and the citizens who go to claim their rights was highlighted in the *KOS* case, as seen above. While this was in 2017, such adverse experiences around transgender lives have been the norm. Standing at the intersections of race, gender, ethnicity, transgender people have many battles to fight.

Several laws have come together to form a strong corpus to help transgender people in their battles against discrimination. Many of these laws, however, need to be interpreted expansively in order to include transgender people. Also, at the ground level, if socio-economic improvements are not seen, those laws will fall flat. As we shall see later in the dissertation, the South African transgender person's battles don't end with getting their gender markers changed in their identity cards. The healthcare sector becomes a site of battles for many of them, before they can even get their gender markers changed.

As noted above, the lack of specific guidelines has led to several incidents of deprivation of rights, and the worst part is that there was little to no relief possible. This is also aggravated by general societal ignorance around transgender people. Advocacy around transgender people has been scant in South Africa so far. These issues become more visible on public platforms such as state-run healthcare setups, banks and other administrative

departments. The *KOS* case was one of the first to highlight the issues that transgender people face when interacting with a system that makes their recognition so difficult. While it has been a victory for transgender people, as to how long it will take for a larger application of the case leaves to be seen.

This chapter's primary aim was to encapsulate the way the South African state has been interacting with non-normative genders. As we shall see later, this interaction has more frictions when transgender people try to exercise their citizenship in public spheres such as healthcare units.

4. Brazil

4.1. Introduction

The travesti has a place in legitimizing LGBT misery

- Majorie Marchi[371]

In 2016, the Olympic games, held in Rio de Janeiro, was opened in true carnival style. The famous Brazilian fashion model Lea T. introduced the Brazilian team in the parade of the nations. While this might not seem to be anything out of the ordinary, Lea T made history by being the first identified transgender person to present a country's team at an Olympics the opening ceremony[372].

However, despite all the pomp and circumstance around the Olympics, it repeated a controversy that had surfaced in years before in the sports-world. It was around Caster Semenya from South Africa once again, the runner mentioned in the previous chapter, but this time it also involved her co-runners, Burundi's Francine Niyonsaba and Kenya's Margaret Wambui. They took the top three positions in the 800 meters race. While Caster Semenya was directly questioned about being hyperandrogenic, the other two were subject to remarks about their so-called masculinity[373].

While the above events showcase two incidents on how transgender people are perceived in different circumstances at the same occasion, all the people involved have a

[371] Translated from an interview of Majorie Marchi, in Mario Felipe Lima Carvalho and Sergio Carrara, 'Em Direção a Um Futuro Trans? Contribuição Para a História Do Movimento de Travestis e Transexuais No Brasil', *Sexualidad, Salud y Sociedad-Revista Latinoamericana*, no. 14 (2013): 334. She is referring to the notion of the *travesti* being perceived in general as discarded lumpen, whose disempowerment gives wind beneath the wings to the LGBT movement as there is a general perception of cis gays and lesbians of being gentrified and educated, thus having more access to rights and services.

[372] Al Donato, 'Transgender Supermodel Lea T Made Olympic History At Rio Opening Ceremony', Huffington Post, 6 August 2016, http://www.huffingtonpost.ca/2016/08/06/trans-model-rio-olympics_n_11361316.html.

[373] During this particular Olympics, yet another athlete, Dutti Chand from India, had a similar experience, having not cleared the heats, her story wasn't highlighted by the media in a similar manner. I shall speak about her in the Chapter on India.

degree of public exposure and privilege that is not generally available to the average Brazilian transgender person.

Brazil has its own indigenous transgender movement that has culminated in great progress in transgender rights and empowerment, as we shall see. However, before engaging with the current situation, it is important to get a historical overview of the country to understand the heavily ingrained social barriers which are applicable on some parts of the population, and more so when it comes to transgender people.

The way we perceive Brazil today is a product of a chequered history. It is a mix of Portuguese colonisation, of exterminated indigenous people, of populations of mixed ethnicity, of military dictatorships and the exoticism associated with the carnival, the latin body, and the sexualised other.

This chapter will start with a brief understanding of the creation of Brazil as a country, as this affects the way minority populations are perceived there today. From there, I shed light on how the transgender identity is perceived in Brazil and how the articulation is different from the internationally understood terms of trans* and transgender. Thereon, the chapter shall show how the transgender identity is perceived in the socio-legal context through the medicalised viewpoint, and how the pathologised transgender person is treated within the government service systems. This chapter shall draw extensively from field research conducted in Brazil, from qualitative interviews conducted with seven people, including psychologists, professors, researchers, some cis gendered and some openly identifying as transgender. Only one of the transgender people identified herself as *travesti*.

4.2. Brazil, from a colony to a federal republic

Brazil is widely believed to have been first claimed for the Kingdom of Portugal by Pedro Alvares Cabral in 1500 AD. Once sugarcane plantations started, Portugal started

importing slaves from Africa into Brazil (having failed to enslave natives). Some communities set up by runaway slaves exist till date. Their descendants form a large part of the population in modern Brazil. Along with sugarcane, coffee too became a major export. As with the sugarcane plantations, coffee plantations were also built on the backs of slaves and native workers.

Brazil became the seat of the Portuguese crown in 1807 during the Napoleonic wars, when Napoleon ordered the invasion of Portugal. It was at that time that Dona Maria I, the Queen Regnant of Portugal declared the United Kingdom of Portugal, Brazil and the Algarves. When the wars in Europe had subsided, her son King Dom Joao VI was forced to return to Portugal because of an uprising against the monarchy. The people of Portugal wanted him to rule Portugal from Portugal instead of from across the oceans.[374]

The regent, the King's son, Dom Pedro I, put in charge of Brazil, decided to secede from Portugal in 1831. Thus, he became the first emperor of Brazil in a constitutional monarchy, and Brazil, by itself, became an empire. However, from the time of its independence from Portugal, it was fraught with internal strife. Dom Pedro's rule was short-lived, and he was forced to abdicate and flee to Portugal in 1840, with his son, Dom Pedro II, being made Emperor under a regency, and put on the throne immediately. During this period, there were several military actions, such as the Uruguayan and Paraguayan wars and the Silver war. Importantly, during his reign, in 1888, after a lot of external pressure, primarily from the United Kingdom, slavery was abolished in Brazil. In 1889, Dom Pedro II was forced to abdicate in favour of a constitutional democracy, and thus, through a military coup (one of many to follow), was born the Federal Republic of Brazil.[375]

[374] Darlene J. Sadlier, *Brazil Imagined: 1500 to the Present*, 1st ed, The William & Bettye Nowlin Series in Art, History, and Culture of the Western Hemisphere (Austin: University of Texas Press, 2008).
[375] Sadlier, *Brazil Imagined*.

The first republican constitution denied voting rights to women and illiterate people – keeping in mind that the Portuguese settlers were probably the only people who were educated in the sense the new government wanted, this excluded the majority of the population. A presidency was established, with elections to take place every four years. However, after 1894, a new sort of polity emerged, called "*política café com leite"* or coffee with milk policy. Essentially, this was a wordplay on the fact that, for the next few years, the Presidency was shuttled between coffee barons. This led to dissent both in the military and the civilians, with several movements taking place between the years 1893-1926.[376]

In 1930, a revolution led by Getulio Vargas, backed by the military junta, overthrew the coffee plantation oligarchs, and restored the control of the state to a broader base of people. However, even during this period, there were rebellions of different sorts.[377]

After the Second World War, Brazil was restored to a proper democracy for almost two decades that followed. This period saw an economic boom, and this was also the period when Brazil's capital was moved to Brasilia[378]. However, the last few years of this period was marked by the rapid increase of the military in democratic matters, and there was growing unrest amongst the military about the bureaucratic delays and negotiations with different factions which generally go hand in hand with every democracy.[379] The demise of the Brazilian democracy came about in 1964, when a military coup took over the reins of governance. This ensured two things – unbridled economic growth in the face of civilian discontent, and securing power for people who were already at the top of the political set up. Thus, there was no real transfer of power – instead it led to absolute power.

[376] Sadlier, *Brazil Imagined*.
[377] Leslie Bethell, ed., *The Cambridge History of Latin America* (Cambridge [England] ; New York: Cambridge University Press, 1984).
[378] Brasilia was a planned city, built to become the new capital. For more about the plan and how it fared, refer to David G. Epstein, *Brasilia, Plan and Reality: A Study of Planned and Spontaneous Urban Development* (Univ of California Press, 1973).
[379] Bethell, *The Cambridge History of Latin America*.

The vast economic reforms brought about intense growth for a while, but in the latter years of the dictatorship, it led to economic strife, along with politically motivated murders, disappearances, tortures and deportments. Around this time, several indigenous peoples were rooted out from the Amazons in order to set up roads – this perhaps was not as bad as the extermination of the indigenous peoples that took place in the first half of the 20th Century. Along with this, the services that were to be provided by the State were less than desirable, with the healthcare system in shambles, barely any notion of welfare, and high mortality rates.

In 1985, democracy was once again restored in Brazil. However, this did not end strife for the population. Brazil has one of the largest income gaps in the world[380], and it continues to be a struggle for oppressed minorities, despite having a robust constitution, promulgated in 1988. Today, Brazil is once again on the cusp of the democratic process being questioned, with a gradual rise in the power of corrupt politicians, and the constant conservatism-oriented counter movements initiated by several people in power on the basis of their religious, evangelical beliefs[381]. Throughout my interviews, as well as my internship at the *Associação Brasileiro Interdisciplinar de AIDS* in Rio de Janeiro, I was warned about the State's situation, and what one of my interviewees, Professor Guilherme Almeida of the State University of Rio de Janeiro, called "*neopentecostalismo*"[382]. Regional governments were changing state-run programmes around LGBT inclusivity and diversity issues with every change of regime. In fact, this happened in the year that followed after my field research.

[380] 'Brazil: Extreme Inequality in Numbers | Oxfam International', accessed 6 March 2018, https://www.oxfam.org/en/even-it-brazil/brazil-extreme-inequality-numbers.
[381] For a glimpse into this counter movement, refer to Omar G. Encarnación, 'Amid Crisis in Brazil, the Evangelical Bloc Emerges as a Political Power', *The Nation*, 16 August 2017, https://www.thenation.com/article/amid-crisis-in-brazil-the-evangelical-bloc-emerges-as-a-political-power/; 'Brazil's Evangelicals Become a Political Force to Be Reckoned with | World News | The Guardian', accessed 6 March 2018, https://www.theguardian.com/world/2014/oct/01/brazil-evangelicals-politics-presidential-election.
[382] Professor Guilherme Almeida is a transgender man, and is also involved in the running of the Ambulatory for Transgender people at the University. He was talking about this surge in religious fervour because of a new-wave evangelists in Brazil. Translated from Portuguese. Brazilian interviews, Rio de Janeiro, June 2016.

4.3. Realising the notion of transgender in Brazil

The Brazilian Constitution does not recognise minorities *per se*. However, it does guarantee equality between men and women, and the right for indigenous people to inhabit the land of their ancestors– this excludes the right to ownership of the land. Several affirmative action programmes run across the country at various levels. Educational institutions at different levels have controversial quota-based systems for people who self-identify as coloured, as well as seats for indigenous people. However, despite having such programmes running across the length and the breadth of the country, the systemic violence, the military presence, the overall abuse meted out to several non-white people have allowed little progress to happen in these regards. The transgender citizen is no exception in this regard. In fact, probably due to the social stigma around transgender identities, there is a larger presence of violence and killing with impunity in transgender lives than with other minorities.

4.4. Creating the vocabulary

The notion of transgender is not new in the Brazilian context. However, to allow them a societal and legal space is new. Moreover, keeping in mind that the dominant language, Portuguese, doesn't have any neutral identifiers/pronouns, this has had a pronounced effect on how transgender identities are perceived.

Transgender, transsexual, intersex and transvestite take on very different meanings within the borders of law and pathology in Brazil, and as will be explained later, are all fit into the discourse around a phenomenon unique to Brazil and Latin America, and transsexuals. Transgender identities, in the way they are articulated on a global level, is a

relatively new phenomenon in Brazil. Being only recently imported into the vocabulary, it has led to frictions between groups.

The articulation of the word *travesti* can be seen first in the 1960s, when sexual liability was lain at the woman's door – and all those who fulfilled a woman's role. Thus, a dichotomy is sexual roles designated the "*bicha*" (slang for gay male) and "*bofe*" to the female roles. A third category of persons who became visible, beyond the cis male and female heterosexuals, formed the notions of the modern Brazilian homosexual male. The *bofe* or *bicha* would perform at parties in cross-dress. This aspect of cross-dressing started articulating itself more exclusively in the late 1960s, because of the friction between effeminate males who were challenging the more masculine ideas of homosexuality. According to some masculine gay men, referred to as "*ententidos*", this stigmatised homosexuality, thus leading to a break in the way homosexual men were socialising.

This notion of gentrifying the male homosexual persevered in the 1970s and was probably most forcefully articulated in the constitutional building process of 1987-88 when there was a push to include the term sexual orientation, thus creating a separation from performative gender identities as well as from people wanting to be the opposite gender. The current move of separating the homosexual from the *travesti* is reminiscent of the earlier break between the *ententido* and *bicha* or *bofe*[383], Thus, the identity category of the *travesti* seems to have been officialised at this moment, gaining a separate visibility – that of disgust and pollution, and different from the masculine homosexual male.[384] This was also suggested in other scholarly works, where a shift was noticed between the *travestis* who would perform drag (thus being attributed as males in feminine clothing) at parties in the 1960s to the

[383] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 322.
[384] João Antônio de Souza Mascarehas, who was a member of the Triângulo Rosa, an NGO, spoke in the plenary sessions of the Subcommittee on Individual Rights and Guarantees, and in Blacks, Indigenous Populations, Persons with Diabilities and Minorities, respectively, on May 20 and June 24, 1987, and on two occasions dileanated the homosexual from the travesti, the latter being mostly associated with prostitution, thefts and drugs. In Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 323.

travestis who were walking the streets of Rio de Janeiro and Sao Paolo in the 1970s soliciting for sex (thus taking on a separate embodiment), creating the main project around the gay male, and the *travesti* becoming the "other".[385]

While the construction of the *travesti* being frozen as a type came about with the constitution-making exercise, the construction of separations between the *travesti* and the transsexual is a much later phenomenon, of the late 1990s, early 2000s[386].

4.5. Transgender-oriented movements

Transgender people in Brazil started organising themselves in the 1980s out of necessity. It took on two forms – one born out of police violence, the other born out of HIV/AIDS. These were support groups to help each other more than to take a stance against the State or injustice. However, in the 1990s, activism started taking root. In 1992, the first such organisation in Latin America was formed – the *Associação das e Liberados do Rio de Janeiro* (ASTRAL) took root thanks to the high levels of police violence faced by who were involved in sex work in city of Rio de Janeiro[387].

With the growth of several bodies of action based on STD and HIV/AIDS prevention, suddenly the *travesti* became a subject of interest and consideration – albeit as a diseased "other", a carrier, but nevertheless, it was a starting point for social legitimacy[388]. Also, at the time the programmes started, it was barely a few years after Brazil had been restored to a

[385] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 324.
[386] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 339.
[387] As has been the case in several places around the world, LGBT rights organisations are often based in Health issues – ASTRAL was no exception. Its inception was supported by a AIDS and STD project "Saúde na Prostituição" or Health in Prostitution, organized by the Instituto Superior de Estudos da Religião (Higher institute of Religious Studies - ISER). Other similar organisations which came about are Grupo Gay da Bahia (GGB), GAPA-RS and RedTrans – while the bouncing board was HIV/AIDS and STDs, they were essentially looking into mitigating violence against.
[388] Later, I explain how the right to health and access to healthcare becomes a platform for social legitimacy for transgender people.

democracy. NGOs, by themselves, had little legitimacy. With governmental HIV/AIDS prevention programmes, these NGOs gained ground[389].

The activist movement gained momentum over the past two decades, and has culminated with the formation of the *Articulação Nacional de Transexuais e Transgêneros* (The National Organisation for Transsexuals and Transgenders – ANTRA), which currently has at least 80 affiliated organisations with it working on the rights of transgender people. Also, it wasn't till 1997 that gay and lesbian movement started working in synergy with transgender people. Initially it only made room for the inclusion of *travesti,* but gradually, it incorporated transsexuals within its paradigm. Thus, for the first time, gender identity became a part of the larger vocabulary along with sexual orientation. However, this incorporation of transgender and transsexual people into a unified movement under the rainbow flag was, if anything, politically conflicting, given the very different social experiences of the people in question.[390]

Within this situation arose a dichotomy between the transsexual and the *travesti*. 1997 onwards, male-to-female genital reassignment surgery was no longer considered to be experimental[391]. Thus, the transsexual body had access to surgery, which would help align the body within the gender binary constructions. "Adequacy" of the genitalia to suit the normative gender binary – in sync with the rhetoric around medical terminology of ambiguous genitalia[392] - was thought to help transsexual people gain the social legitimacy they so desired. However, the problem that remained was that, despite aligning the body to the suited gender, political access was still limited – the rejection of transsexuality and the

[389] The Public Health in Brazil is under the *Sistema Único de Saúde* (SUS), which enabled the use of social and economic determinants of health, as was revealed in my interviews.
[390] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 330–33.
[391] 'Council Resolution 1482/97 CFM' (Conselho Federal de Medicina, 1997). This was ONLY for vagina construction, and not penis construction, which is still considered to be experimental.
[392] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 333.

socio-legal acceptance of womanhood was still missing.[393] There was also an added fear – that once the international idea and terminology of transgender was established, it would render the *travesti* invisible.[394]

Over the past decade and a half, there has been a concerted movement to garner force under the larger umbrella of "trans" in vocabulary, as opposed to having separate notions of *travesti* and transsexual. The discussion around expanding the vocabulary came about in 1997 at the 5th ENTLAID meeting[395], where there were several foreigners, and the notion of internationally acceptable terminology came about. There were several disagreements around it, and till date there are discussions about foreign imposition in trying to assimilate Brazilian gender identities into international terminology. While the T in LGBT was incorporated to be understood as transgender, there is a rejection of the term in itself, as it is argued by several people within the movement that it is about people transiting between genders, versus the Brazilian experience of the *travesti* already having a "defined gender".[396]

4.6. Exercising citizenship rights for transgender people in Brazil

The problem with transgender recognition in Brazil is that the entire notion of accepting transgender bodies is through medical protocols, not through legislative or judicial action. From a target population to a political group – the LGBT movement, given its roots in the health arena, has treated transgender people differently – from a voiceless group who

[393] I shall not go into the details of further fissures and frictions of the movement, as it is for an entire dissertation by itself.
[394] Tathiane Araujo in Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 335.
[395] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 347.
[396] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 338–39. The authors also bring out the confusion caused in the Brazilian press around transgender and transgenic, the latter being an organism that contains genetic material into which DNA from an unrelated organism has been artificially introduced, which as is understandable, caused a great deal of alarm. Given the nature of the movement for articulating transgender rights in Brazil, it is important to understand the macro aspects of the Brazilian Health System before looking at the way people, especially minorities with specific healthcare needs manage to access it.

needs to be given preventive care and medication, to a group reclaiming their position as citizens and articulating their rights jointly and severally. These relations of tension and rapprochement gradually built up a demand for "political protagonism" and "empowerment" within the *travesti* and transsexual movement, a concept popularised through policies related to the AIDS epidemic.[397]

Pelucio[398] takes the term "*cidadanizaçao*",[399] and replaces the "c" with "s" into "*SIDAdanizaçao*" to condemn the way HIV/AIDS has become the way of repathologising non-heterosexual identities. and, ironically, making them visible subjects of the State machinery at the same time. Thus, in order to be granted citizenship, it is important to fall in line with State programmes and their assumptions on sexual behaviour of groups, including those with non-normative gender identities. It creates citizenship through the biomedical gaze.

Riding on that, the advent of the *travestis* into the citizenry was through the Brazilian Ministry of Health's programmes, which created the campaign "*Travesti* and Respect: It is time for the two to be seen together. At home. In the club. In school. At work. In life", launched on January 29, 2004.[400] This campaign was created in conjunction with the Department of STD/AIDS and Hepatitis in the Ministry. For the first time, there was a movement away from the biomedical health-only narrative around *travestis*. This was the first of many such campaigns. This marked a move of the *travestis* from being the subjects of a preventive healthcare mechanism to the protagonists of their own political voice.[401]

[397] The ALGBT included a *travesti* on their board only in 2010, and not before that. While this move was pivotal in the acceptance of a joint voice versus the LGB voice dominating over the T, it doesn't mean that this was the end of the conflicts between the cis and non-cis members of the groups.
[398] Larissa Pelúcio, 'Nos Nervos, Na Carne, Na Pele: Uma Etnografia Travesti Sobre o Modelo Preventivo de Aids. 2007' (Tese (Doutorado em Ciências Sociais)–Programa de Pós-Graduação em Ciências Sociais, Universidade Federal de São Carlos, São Carlos, 2007).
[399] Portuguese for citizenship, and SIDA is *Síndrome da imunodeficiência adquirida* or the equivalent of Acquired Immono-Deficiency Syndrome (AIDS) in English.
[400] Translated from "*Travesti e Respeito: já está na hora dos dois serem vistos juntos. Em casa. Na boate. Na escola. No trabalho. Na vida*". The 29th of January is celebrated as the Trans Visibility Day in Brazil, a day not of victory against, but of acknowledgement by, the State.
[401] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 347–48.Carvalho & Carrara, 347-348.

However, given the frictional politics between the multiple narratives on transgender identities and concepts in Brazil[402], an organization called RedTrans came about – *Rede Nacional de Pessoas Trans* or the National Network of Trans People – in 2009, which, for the first time saw an organised movement under the umbrella term "trans". However, the problem envisaged by several Brazilian transgender activists was that the idea of the Brazilian *travesti* is not within the paradigms of the internationally imagined trans or transgender. While the term "trans" can make access visibility on an international platform easier, the Latin American and Brazilian idea of the transgender body remains quite a specific type, attuned to a particular acculturation, and born out of oppression (somewhat parallel to the Indian *Hijra*).[403]

The Brazilian political and administrative setup is divided along the federal, state and municipal lines. For instance, health is a federal issue, whereas education is set up along different lines – syllabi for fundamental schooling is decided by the municipality, high school by the state, and universities generally by the federal government. However, there are several universities which are state-owned as well. Each state has a varied syllabi and programmes across its different schools even at the same level, due to the different notions of each ruling party in the concerned state, and their priorities. Thus, exposure to the idea of transgender identities or, for that matter, sexual orientation, is not something which is covered by fundamental educational institutions. Also, anti-discrimination regulations must be enacted at every level, not just the federal level. States and cities need to pass separate laws – currently Rio de Janeiro has laws which are in consonance with Article 50 of the Brazilian constitution,

[402] The friction between the *travesti* and the transsexual becomes apparent especially when accessing healthcare, as we shall see later in Chapter 6.
[403] Carvalho and Carrara, 'Em Direção a Um Futuro Trans?', 347–48. It is important to note that within the travesti community itself, there is also the idea of adequacy – as in the operated-on transgender.

thus forbidding discrimination of any sort. This has led to disciplinary boards for medical personnel, making it possible for people to complain in case they face any discrimination.[404]

Moreover, going beyond the social name aspects, to get an official gender change is an expensive judicial process. There are no legislations regarding this, no uniform laws around it, and much like what used to happen before the 2010 CFM protocol on gender reassignment surgeries[405]. Judges need the person applying to "pass" per their personal notions of how masculinised or how feminised the person ought to be to get an official gender change.

Several judges often push for genital reassignment surgery, despite what they might perceive externally of the plaintiff. For transgender women who do not necessarily want to carry out a highly invasive procedure, this becomes a major deterrent. In the case of one of interviewees, Daniela Murta's former patients, who is highly educated and wants to teach, she wanted to get her name and gender changed through the judiciary, but instead, "the [judge] changed her name but not her gender. So, she has a female name but she has man on her documents. What does [judge] say? That she doesn't have a vagina! That she can't be a woman. They give her name because she needs a name to work." Another transgender person who came to her had the following story: "she says, I want my penis, I love my penis, I have sex with my penis, and I am not scared or have any disgust about it. But I will make this surgery because of work. And I tried and insisted to convince her that I understand that it is difficult, but she wants to make a big surgery on her body that she doesn't want, it's a big problem and that she cannot come back from that." Ironically, a transgender man can get his gender changed without any requirements of surgery, as, per the Brazilian medical protocols, neophalloplasty is covered under "experimental surgeries", thus not covered under SUS.

[404] From my interview with Daniela Murta, Rio de Janeiro, July 2016.
[405] 'Resolution No. 1955' (Conselho Federal de Medicina, 2010).

4.7. Conclusion

Brazil's volatile political past is something that the country is still dealing with today. Yet, people the world over seldom associate Brazil with anything other than the larger-than-life *carnaval* and football. A powerhouse of the Latin American countries, it is a key player in global south politics, and with a highly miscegenated society, while on one hand it is possible to be of any ethnicity and be Brazilian, on another hand, because of a rise in evangelism and political extremism, non-normative sexualities and genders are coming under scrutiny.

Brazil's own indigenous transgender movements have often been at friction with identities that they consider are foreign to them. The *travesti*, the transsexual and the transgender, while all under the same outreach umbrella, have specific class distinctions and categories, which has led to questions of legitimacy of each group, as seen above.

However, at the same time, *travestis*, transsexuals, and all people who identify with the more westernised, international notion of transgender and trans categories have one thing in common – they are all viewed through an askewed medicalised lens in Brazil, and have no legal foundation. Because of the way these identities are pathologised, it leaves the door open for people to look at transgender people as less than normal. More so, because of the associations people have about *travestis*, they are viewed negatively, and at times, are seen as nothing more than dispensable creatures there for viewing and sexual pleasure.

Beyond the social aspect of recognition, given the legal lacuna, transgender people are at the mercy of judges who seem to be the last arbiter of whether they can get their gender markers changed on paper. Thankfully, the social name tradition of Brazil gives some amount of respite, but as seen above, it is definitely not enough.

While several things such as hormonal therapy (for menopausal and intersex women) are generally available, it becomes inaccessible for people who identify as transgender in any form without getting a certification of gender dysphoria. The same goes for neophalloplasty – it is considered to be a requirement to "treat" intersex people, but becomes an experimental surgery, not covered by SUS, in the case of transgender men. Moreover, *travestis* are treated differently because of their social standing more than anything else, depriving them of treatments which they go to quacks for, such as getting industrial silicone, and often lose their lives.

This lack of cohesion and double standards of the treatment of transgender people create more barriers than not. Unfortunately, many transgender people feel that pathologising is necessary for them to be able to access treatment and gender alignment surgeries. However, there is a movement to try and move it from a disease perspective to a general occurrence such as pregnancy – a naturally occurring physical phenomenon, which is not treated like a disease, yet covered by the medical system.

While the Brazilian transgender movement's internal articulation has not come to a specific understanding of the international paradigms of transgender identities, it has used its own understanding, albeit within a pathologised context, in order to exercise the citizenship rights for its constituents, and externally, it has embraced the term transgender in order to be able to access international visibility and funding for various programmes run by civil society organisations for empowering transgender people in Brazil. This dichotomy is not going to go down in a hurry, especially if the State continues using a pathologised viewpoint to grant full rights of citizenship to its transgender constituents.

5. India

5.1. Introduction

In 1998, a historic incident took place in the state of Madhya Pradesh. For the first time since India's independence, a transgender woman[406], who refers to herself as a *Hijra*[407], stood as a candidate in state by-elections, and won a seat in the Legislative Assembly of the state. Her name was Shabnam Banu. This was barely four years after transgender people were given voting rights in India. This created waves, but not the sort one might expect – there were no objections to her taking an office as a Member of the Legislative Assembly. Rather, the waves were formed in the idea that, finally, the transgender people of India had a political voice. By the year 2000, as many as five transgender women had been elected into various municipal offices, including one as a mayor.[408]

On the other hand, the stories of Dutee Chand, Santhi Soundarajan and Pinki Pramanik, all track athletes who won several national and international accolades for India, Dutee being one of three Indian women ever to make it for the Olympics hundred meters' track, are things nightmares are made of. Dutee Chand was disqualified from the 2014 Commonwealth Games based on a test revealing that she had hyperandrogenism, something which Caster Semanya has also been said to have. Apparently, as this would give her an added advantage in the women's race, she was disqualified by the authorities.[409] In 2015, the Indian government took the matter on her behalf to the Court of Arbitration for Sport. The

[406] In Chapter 2, I have mentioned how transgender people incorporate eunuchs. In this situation, various international news agencies described her as a eunuch as the word *Hijra* is often synonymous with eunuch, but that may not be the case. Hence, I specifically refer to her as transgender.
[407] Refer to glossary. Also, detailed later in the chapter.
[408] 'BBC News | SOUTH ASIA | Eunuch MP Takes Seat', accessed 10 March 2018, http://news.bbc.co.uk/2/hi/south_asia/668042.stm.
[409] 'Indian Sprinter Dutee Chand Disqualified After Failing a So-Called Gender Test', accessed 10 March 2018, https://www.bustle.com/articles/33066-indian-sprinter-dutee-chand-disqualified-after-failing-a-so-called-gender-test.

Court decided that, since there was insufficient evidence at the time about the link between high androgen levels and improved athletic performance, Dutee was free to compete again. In 2006, Santhi Soundarajan was hailed as the first Tamil woman to win a medal at the Asian Games. However, her joy was shortlived as she was stripped off her medal – a silver – after failing a sex verification test. This failure disqualified her to compete as a woman. Humiliated and feeling defeated, Santhi returned home to her village in Tamil Nadu but did not give up fighting for her rights. However, till 2015, she had not received much reprieve. In 2012, Pinki Pramanik did not face trials by the sports authorities, but instead was accused of being a man, and "raping" a neighbour of hers, both of which she vehemently denied. She was subject to several gender tests, one stating that she was a male pseudo-hermaphrodite[410], another stating it was inconclusive[411]. In 2014, she was finally cleared of the rape charges[412].

India's interaction and struggle with transgendered bodies and with social space for the transgender person is not new. However, to understand the status of transgender people in modern India, we need to go through the understanding of the transgender population in the historical context of the subcontinental area. Recent times have seen a variety of concerted moves toward transgender empowerment in India, but it started in little splashes. There are multiple aspects to transgender identities in India, which at the outset might seem like the global transgender movement. However, the differences lie in the fact that there are several indigenous transgender identities across the subcontinent, many of whose members do not ascribe to the westernised notion of transgender, much like the Brazilian narrative around *travestis*. Also, several complexities arise in trying to derive one cohesive narrative from the

[410] 'Medical Report Claims Pinki Is a "Male Pseudohermaphrodite"|Scientific Indians', accessed 10 March 2018, http://www.scientificindians.com/life-sciences/genetics/medical-report-claims-pinki-is-a-male-pseudohermaphrodite.
[411] 'Pinki Pramanik Gender Test Inconclusive|Kolkata|Hindustan Times', accessed 10 March 2018, https://www.hindustantimes.com/kolkata/pinki-pramanik-gender-test-inconclusive/story-wP9oY02i3uD56fJWwsjBUI.html.
[412] 'Calcutta High Court Drops Rape Charge against Athlete Pinki Pramanik| Off the Field News - Times of India', accessed 10 March 2018, https://timesofindia.indiatimes.com/sports/off-the-field/Calcutta-high-court-drops-rape-charge-against-athlete-Pinki-Pramanik/articleshow/42372971.cms.

vividly varied experiences of the different indigenous transgender identities. Having said that, they do have some commonalities, such as being marginalised and stigmatised. The indigenous transgender population in India exists as a parallel culture, and has gleaned from different religious customs and traditions around it. As we shall see, it has managed to survive several sanctions against their very existence.

It wasn't till as recently as 2014 that transgender people in India were acknowledged as citizens in their own identity. However, this is not to say that there is an absolute agreement between all transgender groups in India, as we shall explore later in the chapter. The reason for this is the transgender body in India has been subject to the travails of conquering forces, coercive cultures and the development and proselytising of several world religions within the region, each viewing the body corporal through a different prism.

With this chapter, I attempt to tie together the historic existence of transgender people in India to their current status. I explain various aspects of the indigenous transgender populations and how they differ from westernised transgender identities.

5.2. A brief history of India

The Indian subcontinent has been the home of several civilisations, especially those who invaded the subcontinent, and made it their home. From the Aryans, thousands of years ago, to the establishment of Islamic rule in the eastern parts of the subcontinent as early as 800 AD, it has seen the propagation of several religions and sects of existing religions. It has been the home of several empires – Hindu, Buddhist, Islamic, before being colonised by European powers. Through the hands of several Islamic empires, the Mughals came and settled down for a few hundred years, ruling vast areas of the subcontinent, all the way into Afghanistan. However, with several princes, both Hindu and Muslim, being vassals of a

Muslim Emperor, whose religious allegiance was with the Baghdad caliphate, to say that there was a national Indian identity at the time would be farcical. Each of them had their own rules and legislations. While some regions of India had a common cultural identity, to say that any of the religions of the rulers was practiced uniformly across the principalities would be wrong as well. For instance, thanks to the several gods of the Hindu Pantheon, almost each and every Hindu kingdom had a primary deity who was venerated through various festivals. Sometimes the same deities would be worshipped in different forms with different associated festivities in other kingdoms. With the rise and fall of particular clans and dynasties, the primary deities would also undergo changes.

Several European powers attempted to colonise the subcontinent – the Portuguese had Goa and Bombay[413], the French had Pondicherry[414], the Dutch were stationed at various points at various parts[415], including Bengal. However, none of them were as pervasive as the British. With the advent of British rule came a new situation – for the first time, there were vast areas of the subcontinent that were being ruled by a foreign power, the head of which had never set foot on Indian shores – their understanding of the new lands was limited to the notion of what wealth could be amassed - if the tropical weather did not carry them into the grave first.

[413] Vasco da Gama established Portuguese colonies in India in 1502, six years after the first trade links had been established. Bombay was passed to the British in the dowry of Catherine of Braganza when she married the King of England, Scotland and Ireland, Charles II in 1661. The final stand was part of the colonial wars of 1961, with Goa, Daman and Diu being the last possessions to be handed over to the Indian Government – viewed by the Indian Government as Goa's Independence, and controversially by several Goans as India's forceful takeover of an overseas Portuguese State.

[414] Initiated under the French East India Company in 1642 by Cardinal de Richelieu, the French were the last colonial powers to arrive in India among the Europeans. Despite having several possessions in the subcontinent, France could not hold onto all of them throughout its colonial history. In 1950 and 1954, the last French possessions of Pondicherry, Yanaon and Karikal on the Coromandel Coast, Mahe on the Malabar Coast and Chandernagore in Bengal were handed over to the Indian Government.

[415] The Dutch East India Company was set up in 1602, and lasted only till 1825. There was no single political or ruling identity of the different geographical locations they were in – they were essentially trading outposts, and considered to be separate governorates. They lost all their possessions on the basis of the Anglo-Dutch Treaty of 1824.

The British East India Company was set up in 1600 AD, and was a trading outfit with its own militia. They set up factories in various parts of Mughal India, as well as in the Vijayanagar empire in the south of the subcontinent. In 1757[416], the army of the Company defeated the Nawab of Bengal – a decisive victory, which secured them the *Diwani* (revenue-collection) of the Bengal Province[417] and later the *Nizamat* or governorship, and planted them securely onto the subcontinent for the next two hundred years. Thus, came a mix of legislations – with local princes using their own, derived from old customs, both Hindu and Muslim, and with the Company, and later, the Crown of the United Kingdom bringing forth their own. With such a variation of laws and legislations, populations were differently treated – and that included transgender people. They went from being treated as sacred to being treated as criminal outcastes, as we shall see in the following sections. This specific history played a crucial role in the way the Indian judiciary finally legitimised the claim of transgender people to be acknowledged and accepted.

It wasn't till the East India Company's quelling of the revolts in 1857[418] that the British Government started taking a more conscious look into what was hitherto a cash-cow and a back-yard property of a multi-national corporation. With this, though, came the need to administrate from the top. To help rule the new colony, the British colonial masters created long lists of names, provinces, castes, tribes, systems, thus aiding them to rule a massive population of which they had very little understanding. A new legal system was put into place, paying respect to traditional personal laws for Hindus and Muslims (regarding

[416] Battle of Plassey between Lord Robert Clive against Siraj-ud-daulah, the Nawab of Bengal. A tributary to the Mughal Court, by the time the battle of 1757 happened, the Mughals had already started losing control over the small kingdoms in the empire, Bengal being one of them.
[417] The Bengal Province included modern-day Bangladesh, the Indian states of West Bengal and Odisha and was one of the wealthiest provinces of the Mughal Empire.
[418] Sipoy Mutiny, also referred to by several scholars as the first war of independence against the British occupation of the sub-continent.

marriage, inheritance, etc.), but creating a law criminalizing everything that did not fit into their notion of sexual behaviour and gender binaries.

Within these limited categories, the transgender body had no space. Also, since they did not exist in the political imaginary of the new colonisers, transgender people were seen as a troublesome, category-defying group. The colonial masters, with little understanding of the subcontinental values and cultures, had stepped out to "civilise" the natives of their colonies in the 18th and 19th Century[419]. In turn, they, inadvertently, criminalised a full section of society with legal sanctions against them.

The British imposed two legislations, of which one is used against sexual and gender minorities even today - the Criminal Tribes Act[420], criminalising various bands of people including nomads and the transgender communities who identified themselves as *Hijras*, and Section 377 of the Indian Penal Code of 1860[421] (which is discussed later on). While the former successfully marginalised the *Hijras* almost immediately, the latter carries on haunting them (and others as well) till date.

5.3. Placing the Transgender person in the history of the subcontinent

Apparently, no one knows when Hinduism got structured into the religion we know it today. What we do know is that many spiritual leaders of the past and the present have impressed upon Hindus that Hinduism is a philosophy, not a religion (despite what Hindu

[419] While the subcontinental region was colonized not just by the British, but also by the Portuguese and the French, it was the British domination which left a far more lasting mark on the peoples of this area, including the law.

[420] Promulgated originally in 1871, covering many tribes of people, including traveling salesmen, gypsies and the indigenous transgender groups or tribes referred to as the *Hijras* (who were identified as eunuchs). This Act went into great details about what made these tribes dangerous and criminal in nature – either through "inborn" criminal tendencies or nurturing. It was repealed in 1949 after the independence of India, and in 1952, this Act was replaced with the Habitual Offenders' Act, and many tribes were de-notified (de-criminalised), including the *Hijras*. This would probably be the best example of the imperial need to regulate and classify everyone and everything seen as the colonized.

[421] Several colonies of the British Empire were subject to similar provisions of the Imperial Penal Code.

fundamentalists would have us believe). It is an amalgamation of several religions and cultures that existed in the region.

As the mythology in Hinduism developed, going beyond the gods of the Aryans to include the several indigenous gods of the Indian subcontinent, the advent of the deity who is half-man and half-woman or *Ardhanarishwar* came about. The *Ardhanarishwar*, a depiction of Lord Shiva,[422] gave a special status to hermaphrodites, who are often mistaken as eunuchs in India, due to colloquial language barriers. However, what is most interesting is the myth around Lord Iravan (or Aravan)[423], who is the god of the *Alis* (or the *Aravanis*, a sect of the indigenous transgender people in Southern India).

One of the primary epics of the subcontinent, the *Mahabharata*, is a story around two warring princely families, where one side has five brothers, the *Pandavas*, and the other side a hundred, the *Kauravas*[424]. The avatar of Lord Vishnu as Lord Krishna also features in this epic, and is on the side of the five brothers. According to legend, to let the five *Pandavas* win, Lord Iravan was willing to sacrifice himself. To honour this self-sacrifice, Lord Krishna granted him three boons. One of them was Iravan's wish to be married before his death. Lord Krishna turned himself into Mohini[425], the only female form of Lord Vishnu, and was married to Aravan. This is celebrated today in an eighteen-day long festival by the *Alis* and *Aravanis*[426].

Mohini's marriage to Aravan aside, she also enchanted Lord Shiva that led to the rise of several other legends. According to legend, Shiva was so taken by Mohini's beauty and

[422] One of the Holy Trinity of Hinduism – Brahma is the Creator, Vishnu the Preserver, and Shiva the Destroyer.
[423] Found in the epic, *Mahabharata*, he is discussed in Wilber Theodore Elmore, *Dravidian Gods in Modern Hinduism* (University of Nebraska (Lincoln campus)–1915., 1915).
[424] Son of Kuru, thus *Kauravas* and Son of Pandu, thus *Pandavas*.
[425] Mohini appears several times in Hindu mythology. The name itself is derived from the Sanskritic word meaning to enchant, ergo, the enchantress. The earliest reference to her is in the Mahabharata, but is seen subsequently in various books of Hindu religious mythology, generally in roles of active enchantment of male demons, who are then vanquished by her.
[426] Delliswararao Konduru and Chongneikim Hangsing, 'Socio–Cultural Exclusion and Inclusion of Trans-Genders in India', *International Journal of Social Sciences and Management* 5, no. 1 (n.d.): 10–17.

allure that he abandoned his wife, Parvati, for a while, and chased Mohini through hills and vales. From his consummation (or non-consummation, in some retellings) was born the god, Shasta, who is generally venerated in Kerala under the name of Lord Ayappa[427]. A particular legend around Ayappa's birth says that as Mohini, being the female form of a male god, did not have a womb, he was born from her thigh.

One of the *Pandavas*, Arjun, was cursed to be a eunuch due to some misdeeds by him. In this form, he went into hiding and became one of the servants of a princess, Chitrangada. Chitrangada, on the other hand, had various so-called masculine traits. She wasn't interested in finery, was a fine warrior, and raised more like a son than a daughter. However, when Arjun falls in love with Chitrangada, his curse is lifted, and he becomes masculine once again, and Chitrangada is feminised, and they marry each other.

There are several such legends around people with non-binary genders in India. However, it is rare to find mentions of women with masculine traits as with Chitrangada – and, in fact, the indigenous transgender person in India is almost invariably male-to-female. Every region in India has its own folklore, which has given birth to different stories around the transgender people, and from where the indigenous communities of transgender people in India draw their historic and religious legitimacy[428]. In fact, since the ancient times, *Hijras* have been a part of everyday socio-religious culture as well as in politics.

This religious and ritualistic significance continued in the era of the Islamic empires, but during this time, there came a twist in their roles – eunuchs were made guardians of the harems, and were also the messengers between the *zenana* and the outside world. The chief eunuch in the Mughal courts was referred to as the *Khwaja Sara* and enjoyed the privilege of entering both the harem as well as the court. This meant that they were in the confidence of

[427] Ayappa is celebrated as Ainar in Tamil traditions, and is also considered to be the classical gods Hanuman and Skanda, whose births are from a similar telling of the tale.
[428] For more such tales, refer to Chapter 2 of Serena Nanda, *Neither Man nor Woman: The Hijras of India*, 2nd ed (Belmont, CA: Wadsworth Publ. Company, 1999).

the king and his various queens. They even managed to rise to the level of advisors in the courts of the Islamic emperors. For instance, in the court of Alauddin Khalji, a eunuch slave, Malik Kafur, became a close confidante and a very powerful general of the Emperor[429]. Within the larger Islamic world, eunuchs were also entrusted with guarding Mecca and Medina.[430]

The word "*Hijra"* is rooted in Arabic and Persian, and in the subcontinent, is part of the *Urdu* vocabulary[431]. Culturally, the *Hijras* assimilated themselves as a parallel movement, breaking away from the different religious backgrounds they came from, and absorbing several rituals from different religions into their own practices. This parallel cultural placement of the *Hijra*[432] has helped them gain a foothold in legal recognition. Generally biological males, they give up their masculine identity and often identify as either women, "not-men", "neither man nor woman", or "in-between man and woman" (which gives strength to the notion of the third gender[433]). They have cultural practises unique to them, which I shall refer to later. A UNDP report on Transgender Issues in 2010 noted that "[i]n India, people with a wide range of transgender-related identities, cultures, or experiences exist - including *Hijras, Aravanis, Kothis, Jogtas/Jogappas*, and *Shiv-Shakthis* […]. Often these people have been part of the broader culture and treated with great respect, at least in the past, although some are still accorded particular respect even in the present" [434] (emphasis added). Thus,

[429] Refer to "Ziauddin Barani: The Khaljis in love (Persian)" in Ruth Vanita and Saleem Kidwai, eds. *Same-Sex Love in India: Readings in Indian Literature*. Springer, 2000.
[430] William Dalrymple, *City of Djinns: A Year in Delhi* (Penguin UK, 2004), 169–83. Even today, in certain instances, if an intersex child is born in rural areas, the parents take it as a blessing, but at the same time, hand the child over to the local *Hijras*.
[431] Derived from the Semitic word *hjr* that means leaving one's tribe. This gender identity is not to be confused with the Jihadi movements associated with this word.
[432] As stated above as well as in the context of the *NALSA* decision
[433] The Kamasutra refers to people of a third sex or third nature - "*tritiyaprakriti".*
[434] To start with regional specificities, the *Alis/Aravanis*, mentioned above, are prevalent in Tamil Nadu, and also go by the term *Thirunangi*. Many of them believe they are women trapped in men's bodies. *Hijras* from Delhi often refer to themselves as *Kinnars*. *Jogtas/Jogtis* and *Jogappas* are those people who dedicate themselves to Goddess Renukha, who is often referred to as Yellamma. Her temples are situated in Karnataka and Maharashtra. *Jogtas/Jogtis* are the male/female variations of the worshippers of Yellamma. The worshippers might be heterosexual and cis-gendered, and sometimes the male worshippers dress in women's clothes when

while the communities are known by different names with regional specificities and variations in different parts of India, the term *Hijra* is commonly used to refer to all of them as a larger group.

Hijras, not just in India but across the subcontinent, are organised under *Gharanas* (or houses/clans)[435] where they are under a hierarchical system, at the head of which is a *Guru* (or leader), and then everyone else comes below the *Guru* as the *Chela* or *Shishya* (follower or devotee), and pays allegiance to him/her. There are seven such *Gharanas* across India, and many of them host annual festivals along religious lines, but specific to the *Gharanas*. People who identify with the more westernised notion of transgender do not necessarily participate in these cultural aspects of being a *Hijra*. This has also given rise to the question of which transgender type is more legitimate in the Indian cultural setting, and has led to several controversies ever since the transgender rights movement took off in India beyond the gaze of HIV/AIDS.

In western terms, the word *Hijra* has been equated in English with being a eunuch. *Hijras* in the original sense would have primarily referred to hermaphrodites and eunuchs (through a ritualised by a *dai)*. However, the *Hijra* today is like Brazil's *travesti* and is used as an overarching term referring to transvestites, hermaphrodites, eunuchs, and intersex people. They embrace the *Hijra* culture, and enter one of the seven *Gharanas*. The term *Hijra* is acknowledged all over the subcontinent, but is predominantly used in the north, with different regions having their own terms, as mentioned earlier.

worshipping. The female worshippers are akin to *devadasis*. Male-to-female transgender persons who are worshippers refer to themselves as *Jogta, Jogti, Jogappa* or *Jogti Hijra*. They follow a similar cultural pattern to *Hijras*. Another sect of the *Hijras* are the *Shiv-Shakthis* (another term for the *Ardhanarishwar)*, who consider themselves to be males possessed by a goddess, and follow similar rituals to the *Hijras* with slight variations. In Chakrapani and others, 'Hijras/Transgender Women in India', 13. Beyond this, it ought to be remembered that given the plethora of languages in India, each language has several terms to refer to local transgender people

[435] Currently, seven *Gharanas* exist – they are Laskarwallah, Chaklawallah, Lalanwallah, Bendi Bazaar, Poonawallah, Ballakwallah and Adipur. In Nanda, *Neither Man nor Woman*, 39.

Hijras are supposed to give up their sexuality, and be ascetic, and their power to curse and bless is rooted in this notion of letting go of their carnal desires. However, it is a common fact that several *Hijras* are engaged in sex with men, both recreationally as well as for sex-work. While the number of *Hijras* in India are supposed to be around five hundred thousand, it is impossible to put a cap on it, primarily because there is a high level of social stigma to identifying as a transgender person or as a *Hijra*, especially the latter.

Beyond these identities and clans, the more westernised identities and variations of transgender men and transgender women are also used. There is a definite class aspect connected to the connection or disconnection with different identities – the more educated transgender people of India tend to label themselves per western norms as opposed to local terms. Even within the *Hijras*, the ones who are better educated often refer to themselves as *Kinnars*. Also, while the male-to-female indigenous transgender people are more visible, indigenous female-to-male indigenous transgender identities also exist, but are far less visible and often get usurped into butch lesbian narratives. Some terms they use are *bhaiya*, *thirunambi*, *gandabasaka*, and *babu*[436].

Several members of the *Hijra Gharanas* lead dual lives. As my interviewee Anupam Hazra recalled from his experience,

> [i]n the case of trans women and *Hijras* what we have seen is there is portion of some *Hijra* population who are married [to women]… what we have seen is that they are married at a very young age, before they came to the *Hijra* profession, or before they realised their trans identity, or family members forced them to marriages, or they were in such situations that they had to marry- may be for reasons of dowry, or for having a life partner, or maybe for reasons of finding someone who can take care of you, or maybe family members have forced you and

[436] 'Shiv Shakti | KJ (Katy Jon Went)', KJ (Katy Jon Went), accessed 16 October 2017, http://www.katyjon.com/world-press-freedom-day-journalism-is-essential-to-political-accountability-personal-liberty/journalism-is-not-a-crime-amnesty/.

maybe many of them felt that marriage is a done thing , or they want children - so there are N number of reasons for why they get married.[437]

The *Hijras* who do embrace the *Gharanas* are presented to a parallel social hierarchy within the *Gharanas*, which gives the highest respect to those who are emasculated. It is thought that those who have gone through the emasculation process have gone beyond carnal desire and renounced their sexuality. Everyone else is offered lesser degrees of respect. Professionally, they are associated with entertaining through dancing and singing at social ceremonies, begging and sex-work. The aspects of entertainment also go hand in hand with blessings which are considered auspicious, and according to some scholars, it is "a common trajectory for all *Hijras*: everyone starts out as a sex worker, and when their bodies or desires change, they become 'ascetic' *badhai Hijras*."[438]

It was not till the late 20th Century that *Hijras* were decriminalised as a group in India – almost 40 years after the independence of India and Pakistan. However, decriminalising did not give them the social recognition they required – of being acknowledged as equal citizens, and a gender marker of their choice. Thus, with a few exceptions, they keep on living on the fringes of the socio-political fabric. Social acceptance of a transgender person in India is still a distant reality.[439]

Given their social situation, employment options are few and far between even today. It is not unusual to see several of them associated with sex work. The commodifying and fetishizing of the transgender body carries on in this way, and at the same time, as Serena Nanda puts it, while "it is considered a low calling, offensive to the Mother Goddess, one

[437] Interview with Anupam Hazra , Kolkata, July 2015.
[438] Gayatri Reddy, *With Respect to Sex*, 53,56, accessed 12 April 2017, http://www.press.uchicago.edu/ucp/books/book/chicago/W/bo3534006.html.
[439] A report by the United Nations' Development Programme states that "[a] primary reason (and consequence) of the exclusion is the lack of (or ambiguity in) legal recognition of the gender status of Hijras and other transgender people" in Venkatesan Chakrapani and Arvind Narrain, 'Legal Recognition of Gender Identity of Transgender People in India: Current Situation and Potential Options', *Policy Brief*, 2012. However, while the legal reality may have changed, social realities are often hard to evolve.

undermining of the *Hijra*'s ritual role in society, [...] it is far too lucrative a source of income for it to be prohibited by *Hijra gurus*" who get a share of their *chelas*' income[440].

5.4. The partition of the subcontinent and the birth of the Indian nation

Both India and Pakistan are more unions of states, much like the United States of America, but the idea was to bring them under a more unitary constitutional system than federal. Born out of the politics of the time, they had a common start with the Indian Freedom Movement.

From the very start, the idea of the Indian nation[441] was fraught with unrest. It was a fragile entity, fuelled on primarily by the hedonistic freedom movement more than anything else. The ask of a separate Islamic state not only brought about a fissuring of the figure of Mother India, but also a significant saffronising of the imagery[442].

The British Indian Empire had been carved up along religious lines, with majoritarian religious interests being given primacy. Several princes of the realm felt they were being made to join the wrong side, and unfortunately, given their geographical locations, it made it impossible for them to accede to the union of their choice[443]. This led to the transfer of

[440] Nanda, *Neither Man nor Woman*, 54.
[441] The Indian National Movement was a manufactured movement – firstly, to give a singular national identity to several nations co-existing under one offshore colonial ruler, secondly, to give a unified voice to the voice of dissent against colonial rule. At the crux of the Indian National Movement was the evolution of the new national identity, that of "Bharat Mata" or Mother India, a deified woman who needed to be worshipped, protected and fought for. The earliest pictorial depiction of Mother India by Abanindra Nath Tagore shows a four-armed woman clad in a saffron saree with several ritualistic icons in her hands. This depiction was not only meant to invoke the feeling of the national mother, but also persuade the Hindus of the subcontinent to take it on as their religious duty to fight for the mother. Although the depiction changed over a period of time and became more an amalgamation of the several goddesses of the Hindu pantheon, with a generous take from the Goddess Durga, a warrior goddess who vanquished the Bull-Demon, Mahishasura, the Indian National Movement had a figure to defend, a religion to uphold, and oust the people who trample the goddess. This was the perfect stepping stone for actually propelling caste, gender prejudices, regional and religious politics into the 20th Century.
[442] This saffronising or pro-Hindutva stance had a significant role to play in the acceptance of the transgender body by the Indian polity and judiciary as I shall showcase later on.
[443] The Principality of Hyderabad wanted to join Pakistan, but the Indian government, through a peaceful coup, took over the state. The *Nawab* of Junagadh wanted to join Pakistan, but being unable to do so, fled with his

massive populations, like the Balkans after the fall of Yugoslavia. With the transfer came tremendous amounts of violence and cold-blooded slaughter on all sides.

Out of this tremendous bloodshed came two things – the Indian national identity was secured on a very flimsy level, and at the same time, the Islamic national identity of Pakistan was established (as written in their constitution itself), perhaps giving it a stronger basis to act as a united front[444].

5.5. Citizenship and the Indian State

The Indian Constitution was brought into effect on the 26th of January, 1950, three years after the independence of India. It was drawn up to bring together several native princes, minority groups, and *prima facie*, equality was at the core of the creation of the constitution – everyone was an equal citizen now[445]: the upper-caste Brahmin, the former untouchable, the Muslims, the Christians, the Jews, the Zoroastrians, and other religious minorities. Beyond this were the tribes of the various tribal belts of India – they are treated, in a manner of speaking, as ethnic minorities. The constitution making "defines arenas of struggles to de-symbolise ritual hierarchy, based on notions of purity and pollution"[446].The constitutional dream was in process - democracy was the rule of the day, and the republic was

dogs and servants to the new dominion. The King of Kashmir wanted to remain independent but when Pakistan started attacking its borders, he was coerced into acceding to the Indian Union in exchange for military help.

[444] The primary problem with the formation of Pakistan, at the outset, was that they inherited 1/3rd the army of the British Indian Empire, but only 17% of the GDP, thus creating the base for a military regime in the future, and history proved it so. For more information, refer to Craig Baxter, *Pakistan on the Brink: Politics, Economics, and Society* (Lexington Books, 2004).

[445] In theory. See Upendra Baxi, 'Outline of a "Theory of Practice" of Indian Constitutionalism', *Politics and Ethics of the Indian Constitution*, 2008, 92–118. He points out that the notion of republicanism wasn't an alien concept, but the notion of equal citizenship was. Especially in the context of empire, where colonial subjects were unequal citizens of the empire, where two sets of rights existed for the colonisers and the colonized, the notion of equal citizenship became very important.

[446] Baxi, 'Outline of a "Theory of Practice" of Indian Constitutionalism', 104.

formed. However, dreams seldom become realities in such severely contested political situations.

With the advent of the constitutional right of equal citizenship for everyone, came the need to consider the harder realities of social inequalities, which wasn't an easily resolved situation. Thus, going into different types of categorisations was thought to be the only way out to keep everyone on board with a unified constitution – from religious categorisations in majorities and minorities, to castes, sub-castes, scheduled castes and tribes, backward castes, and to pushing forward one body of law, the formal Indian citizen emerged as the amalgamation of all of the above, and started pushing an agenda of equality by law, but in reality, the fissures in society continued. While the motto of "unity in diversity" stands firmly with the Indian nation, the fact that the nation itself is still so heavily divided along several lines that the Constitution has striven to abolish has been the undoing of the Indian State in a way.

The freedom movement was based on the notion of *Swaraj* (self-rule), thus laying the foundation for one of the primary human rights, which we still fight for today, almost all the time, especially when it comes to the rights of minorities' self-determination. While the movement focused on political self-determination, the new age of constitutionalism given rise to by the independence of India moved away from political self-determination to the prevention of such, the new Indian state looked down on anyone wanting to secede from the union. Thus, Habermas's notion of Constitutional Patriotism[447] plays out - it becomes the new benevolent despot. All rights enumerated in the constitution of India are conditional to them not being used in any manner that may be construed as sedition or treason.

[447] Jurgen Habermas, *Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy* (Mit Press, 1996), http://14.139.206.50:8080/jspui/bitstream/1/2333/1/Habermas,%20J%C3%BCrgen%20-%20Between%20Facts%20and%20Norms.pdf.

The Constitution of India, while showcasing itself as a jewel of enumerated rights and duties, also shows a tendency of confiscating the rights of the citizen, or policing the citizen, which, several times, has been upheld by the Supreme Court of India. As Baxi states, "[t]he militarized practices of governance continuously reproduce patterns of confiscation of Indian citizenship; those whom the Indian state apparatus can successfully stigmatize as constitutional outlaws stand thus wholly denied of their rights as citizens and as human beings"[448].

5.6. Placing Transgender in Modern Indian History

Modern India is still shackled by the Hindu caste system. Although officially abolished under the Constitution of India, it carries on from strength to strength[449]. Historically, several Hindu people converted to Islam and Christianity to relieve themselves of the ignominy of being treated badly because of being from a lower caste[450]. Transgender people are not the only groups who have had to bear the brunt of being marginalised. Even the notions of pollution associated with untouchability is something that is associated with the indigenous transgender groups of India in many senses. They are religiously revered and worshipped in several areas of India, but, at the same time, feared as well as looked down upon – many people want their blessings, but wouldn't want to associate with them otherwise.

[448] Baxi, 'Outline of a "Theory of Practice" of Indian Constitutionalism', 107. From this notion of constitutional outlaws, I take my starting point for sexual and gender minorities.

[449] Unfortunately, it is integrated into Hindu practices and rituals. Being a Hindu myself, I am all too aware of what my last name denotes – not just my caste, but also my sub-caste, and in particular contexts, my lineage. To see how it works on a daily basis, one merely has to log onto matrimonial web sites such as BharatMatrimony.com to see how "brides wanted" and "grooms wanted" are segregated by castes. Caste atrocities over the centuries has made several people who were considered untouchable (Gandhi referred to them as *Harijans* or God's people) to break away from mainstream Hinduism, convert to Buddhism, and call themselves Dalit (or Trodden), following in the footsteps of Doctor B. R. Ambedkar, who himself came from such a caste, but fought his way up to becoming one of the founding fathers of the Indian Constitution.

[450] For instance, 'Caste Atrocities Have Hastened Religious Conversions | Forward Press', accessed 1 March 2018, https://www.forwardpress.in/2017/05/dalits-atrocities-have-hastened-religious-conversions/..

The kind of discrimination that would be associated with being transgender or a *Hijra* aside, given the structure of India's society, the discrimination that comes with being from a particular caste or religion often intersects. Thus, joining a *Gharana* is often a gateway into a safer space, where one is with other like-minded people, and one can leave behind their previous socio-religious identity.

5.7. From Section 377 to the Transgender Persons Bill 2016

After the de-criminalising of transgender people came about, there was a concerted movement in trying to become more mainstream. With the overall LGBT community in India, despite the political fissures, as are wont to be in such large countries with diverse populations, coming together in a concerted effort to do away with an archaic law that criminalizes any non-procreative sexual behaviour. This includes sodomy, something that is more often associated with gay men and transgender women than with heterosexual people. Codified under Section 377 of the Indian Penal Code, 1860, it reads as "[w]hoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine."

In 2001, Naz Foundation, a legal NGO based in New Delhi that works with people living with HIV/AIDS, decided to file a writ petition (a public interest litigation) to change Section 377[451]. The Naz Foundation stated that the section as it was violated several fundamental rights of the Constitution of India, including Articles 14, 15, 19 and 21 viz.:

Article 14. Equality before law.

[451] Naz Foundation v. Government of NCT of Delhi and Ors., No. WP(C) No. 7455/2001.

The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

Article 15. Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.

(1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them.

(2) No citizen shall, on grounds only of religion, race, caste, sex, place of birth or any of them, be subject to any disability, liability, restriction or condition with regard to-

(a) access to shops, public restaurants, hotels and places of public entertainment; or

(b) the use of wells, tanks, bathing ghats[452], roads and places of public resort maintained wholly or partly out of State funds or dedicated to the use of the general public.

(3) Nothing in this article shall prevent the State from making any special provision for women and children.

(4) Nothing in this article or in clause (2) of article 29 shall prevent the State from making any special provision for the advancement of any socially and educationally backward classes of citizens or for the Scheduled Castes and the Scheduled Tribes.]

(…)

Article 19. Protection of certain rights regarding freedom of speech, etc.

(1) All citizens shall have the right-

(a) to freedom of speech and expression;

(b) to assemble peaceably and without arms;

(c) to form associations or unions;

(d) to move freely throughout the territory of India;

(e) to reside and settle in any part of the territory of India;

(g) to practise any profession, or to carry on any occupation, trade or business.

(…)

[452] An area next to a pond or on the banks of a river where people go to bathe.

Article 21. Protection of life and personal liberty.

No person shall be deprived of his life or personal liberty except according to procedure established by law.[453]

The grounds for bringing about the public interest litigation was that people of sexual and gender minorities, primarily the MSM, transgender and *Hijra* communities in India (who are considered to be at-risk communities under HIV prevention programmes), were being discriminated against on the basis of this law. Thus, this law not only hampered combatting and preventing HIV/AIDS as it drove these communities underground, but also affected these communities' right to equality, non-discrimination, privacy, life and liberty and the right to health.

The Government of India was represented by two ministries but on opposite sides of the case. The Ministry of Home Affairs presented their opinion on why this section should be kept in its entirety, which would otherwise disallow prosecution of child sexual abuse, fills a gap in rape laws, open the "flood gates of delinquent behaviour" and that Indian society wouldn't condone such behaviour and that law needs to reflect the society's values. On the other hand the Ministry of Health and Family Welfare (together with the National AIDS Control Organisation) submitted in favour of reading down Section 377 as it felt it was counter-productive to the HIV/AIDS prevention efforts, and increased chances of high-risk sexual behaviour.

In what was felt to be a landmark judgment at the time, handed down by Chief Justice of the Delhi High Court, Ajit Prakash Shah and Justice S. Muralidhar, the Delhi High Court ruled in favour of reading down Section 377 as it felt that Section 377 unfairly targets a particular community, thus violating Article 14. It also interpreted the word "sex" in Article

[453] 'The Constitution of India', Part III-Fundamental Rights. Part III, Fundamental Rights, Constitution of India. I have left out the sections of the articles that do not immediately relate to the context.

15 to include sexual orientation and that Article 21 was to be expansively read to include the right to privacy. The two-judge bench concluded that Section 377 in its current form was unconstitutional, and said:

> "If there is one constitutional tenet that can be said to be underlying theme of the Indian Constitution, it is that of 'inclusiveness'. This Court believes that Indian Constitution reflects this value deeply ingrained in Indian society, nurtured over several generations. The inclusiveness that Indian society traditionally displayed, literally in every aspect of life, is manifest in recognising a role in society for everyone. Those perceived by the majority as 'deviants' or 'different' are not on that score excluded or ostracised."

It further stated that the application of Section 377 would continue to govern non-consensual peno-non-vaginal sex both for adults and minors.

However, this victory was short-lived. It was challenged in 2013 at the Supreme Court of India, presided over by a two-judge bench of the Supreme Court, comprising of G. S. Singhvi and S.P. Mukhopadhyay JJ. Unfortunately, Section 377 was held to not suffer from any unconstitutionality and the Court overruled the Delhi High Court decision. The Court further ordered that the Parliament should debate the matter and it wasn't for the Court to decide. Moreover, the Court stated that while the Delhi High Court's expansive reading of Article 21 to include privacy was allowed, a "minuscule fraction of the country's population, lesbians, gays, bisexuals or transgenders and in last more than 150 years less than 200 persons have been prosecuted (as per the reported orders) for committing offence under Section 377 IPC and this cannot be made sound basis for declaring that section ultra vires the provisions of Articles 14, 15 and 21 of the Constitution". The fact that the Court had had stated that a minority needs to bow in front of the majority when it came to constitutional rights did not go

unnoticed by critics globally, as well as fellow members of the court[454]. As we shall see, it was brought up in a later case. A curative petition has been filed since, and is still pending in front of the Supreme Court.

In the meantime, in 2012, a case was filed on behalf of transgender people by the National Legal Services Authority (henceforth referred to as NALSA). This wasn't to address Section 377, but to reclaim the socio-legal space transgender people have been denied for centuries as equal citizens and to be granted the recognition of the "third gender" category. NALSA was set up as a statutory body[455] to aid people who were incapable of hiring legal help for themselves. In this case, NALSA brought a public interest litigation as the primary petitioner, representing the transgender people of India, especially the *Hijras*, asking the Court to give recognition to their plight, and their unengaged existence within the constitutional set-up of India. The other petitioners were Poojya Mata Nasib Kaur Ji Women Welfare Society and Laxmi Narayan Tripathi, more famously known as Laxmi, a *Hijra* activist. The matter was filed directly at the Supreme Court of India[456] in September 2012, as a civil Writ Petition.[457] The judgment was passed in favour of the petitioners in April, 2014. It was decided by a two-judge bench, the judges being Justices K.S. Panicker Radhakrishnan and Arjan Kumar Sikri[458].

---

[454] Suresh Kumar Koushal and another v NAZ Foundation and others, Civil Appeal No. 10972 of 2013 (The Supreme Court of India (Civil Appellate Division) 2013) hereafter referred to as *Koushal*.

[455] The National Legal Services Authority Act, 1994. For the full text of the Act, please go to http://nalsa.gov.in/actrules.html (last accessed on 09-09-2014).

[456] The Supreme Court of India is the highest Court of the land, and a court of original jurisdiction if any person wants to raise an issue of constitutional importance. Otherwise it acts as an appellate court for all the High Courts of the various states, who also have a limited original jurisdiction, and act as an appellate jurisdiction for all lower district-level Courts. The decision of the Supreme Court of India is binding across the country, and the Legislature is expected to follow it up with legislations to help strengthen it.

[457] The Indian Judiciary has been very proactive in initiating public interest litigation, especially under the aegis of the former Justice P N Bhagwati. This was a way for the judiciary to react against the high-handedness of the Prime Minister, Indira Gandhi, and her actions during the period of "emergency" she had declared in India between 1975-77. This period saw the absolute derogation of fundamental rights (aka human rights). For more information on the emergency, and its aftermath, refer to Kuldip Nayar, *The Judgement: Inside Story of the Emergency in India* (New Delhi: Vikas Publishing House, 1977).

[458] National Legal Services Authority v. Union of India, No. WP (C) No. 604 of 2013 (Supreme Court of India 15 April 2014) hereafter referred to as the *NALSA* Case. The main body of the decision was drafted by

5.8. Salient features of the decision

The decision acknowledges the marginalisation of the transgender community in India, and considers the non-recognition of their gender identity as a constitutional violation of articles 14 and 21. It took cognizance of the different experiences submitted before the court by transgender people of specific communities. The petitioner invoked Article 21 multiple times[459] and the Court acknowledged that. It also read the Yogyakarta Principles[460] alongside the decision.

Crucially, the Supreme Court of India gave the Indian Judiciary a working definition of transgender as:

> [An] umbrella term for persons whose gender identity, gender expression or behaviour does not conform to their biological sex. TG may also takes [sic] in persons who do not identify with their sex assigned at birth, which include *Hijras*/Eunuchs who, in this writ petition describe themselves as "third gender" and they do not identify as either male or female.[461]

Radhakrishnan J., with Sikri J. agreeing with every aspect of it, adding to the critique of the historical discrimination faced by Transgender people in India. Instead of taking the name of the justices individually, for the sake of brevity, I have referred to the judgment as that of the Supreme Court of India.

[459] *NALSA* Case at 5.

[460] "In 2006, in response to well-documented patterns of abuse, a distinguished group of international human rights experts met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender identity. The result was the Yogyakarta Principles, *Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (Recuperado de: http://www. yogyakartaprinciples. org/principles_en. htm, 2007). Its a universal guide to human rights which affirm binding international legal standards with which all States must comply. They promise a different future where all people born free and equal in dignity and rights can fulfil that precious birthright." – these principles are considered to be the first of its kind wherein sexual and gender minorities are expressly spoken about in a highly inclusive manner, and specific issues faced by them due to non-recognition, mis-recognition by multiple countries are outlined and the need to prevent atrocities arising out of them is also given out.

[461] *NALSA* Case at 9.

The Court's decision also differentiated between pre sexual reassignment surgery and post sexual reassignment surgery gender identification and transsexuals[462].

The Supreme Court of India gave the following directives pertaining not just to civil and political rights, but also socio-economic rights. I have analysed this previously in another publication, and have reached the following conclusions:

1. The Central and State Governments are to grant legal recognition of gender identity as chosen by the individual, be it male, female or the Third Gender.
2. The "third gender" category has been officially acknowledged and recognised as the Court understands the need of fundamental rights to be available to every citizen, and considers the non-recognition of the third gender in all civil and criminal statues pertaining to marriage, divorce, adoption, etc. as discriminatory.
3. The Court gives the basis of the psyche of a person to determine the alternation between the gender binaries of male and female, and does not consider sexual reassignment surgery as a precondition for gender reassignment.
4. Measures need to be taken by the Central as well as State governments to mete out medical care to transgender people in the hospitals as well as provide them with facilities specifically built for them. Within this scenario, it is also important that transgender people be given targeted and tailor-made measures regarding HIV interventions *vis a vis* cis gendered men and women.
5. Reservations are to be created in educational institutions and public appointments for transgender people as a socially and economically backward class, and other social welfare schemes are to be instituted.[463]

[462] The Supreme Court of India hastens to state that it is deciding only on the matters of the Indian transgender people, notably the *Hijras*, and not the umbrella term of transgender as generally understood globally. I have delved into this later in the dissertation.

[463] The state of Tamil Nadu instituted a pension programme for transgender people, which was announced in September 2012, and has been launched since. For the press release, please go to http://www.tn.gov.in/advanced_search/pension?page=12&set=1.

6. The community at large needs to be sensitised and made aware of transgender people and their need to regain their status and respect in society, and create a more inclusive environment, so that they may feel more at home with mainstream society and not live in exclusion on the fringes of humanity. Moreover, many psychological illnesses, which follow from social stigmatisation, the inability to deal with gender dysphoria and exclusion, need to be dealt with, such as self-stigmatisation, depression and suicidal tendencies.[464]

5.9. Placing the decision in a regional comparative perspective

Importantly, the Supreme Court of India gives descriptions of the indigenous transgender communities in India, who have existed throughout the history of the subcontinent, and have parallel communities in Pakistan, Nepal and Bangladesh. It examines the report of United Nation's Development Programme, "Hijras/Transgender Women in India: HIV Human Rights and Social Exclusion", published in December 2010, which looks at the specific populations of sexual and gender minorities as well as statistical details of HIV prevalence.

In this context, it outlined various recommendations for lowering HIV prevalence rates, which the Supreme Court of India looked into, while at the same time acknowledging that there are community-specific issues faced by gender non-conforming people:

1. Address the gape [sic] in NACP-III: establish HIV sentinel serosurveillance sites for Hijras/TG at strategic locations; conduct operations research to design and fine-tune culturally-relevant package of HIV prevention and care interventions for Hijras/TG; provide financial

[464] Debjyoti Ghosh, "The Categorical Other: Going Beyond the Gender Binary in Law in India", *Journal of Constitutionalism and Human Rights*, 3-4, no. 8 (2015): 89.

support for the formation of CBOs run by Hijras/TG; and build the capacity of CBOs to implement effective programmes.

2. Move beyond focusing on individual-level HIV prevention activities to address the structural determinants of risks and mitigate the impact of risks. For example, mental health counseling, crisis intervention (crisis in relation to suicidal tendencies, police harassment and arrests, support following sexual and physical violence), addressing alcohol and drug abuse, and connecting to livelihood programs all need to be part of the HIV interventions.

3. Train health care providers to be competent and sensitive in providing health care services (including STI and HIV-related services) to Hijras/TG as well as develop and monitor implementation of guidelines related to gender transition and sex reassignment surgery (SRS).

4. Clarify the ambiguous legal status of sex reassignment surgery and provide gender transition and SRS services (with proper pre-and post-operation/transition counseling) for free in public hospitals in various parts in India.

5. Implement stigma and discrimination reduction measures at various settings through a variety of ways: mass media awareness for the general public to focused training and sensitization for police and health care providers.

6. Develop action steps toward taking a position on legal recognition of gender identity of Hijras/TG need to be taken in consultation with Hijras/TG and other key stakeholders. Getting legal recognition and avoiding ambiguities in the current procedures that issue identity documents to Hijras/TGs are required as they are connected to basic civil rights such as access to health and public services, right to vote, right to contest elections, right to education, inheritance rights, and marriage and child adoption.

7. Open up the existing Social Welfare Schemes for needy Hijras/TG and create specific welfare schemes to address the basic needs of Hijras/TG including housing and employment needs.

8. Ensure greater involvement of vulnerable communities including Hijras/TG women in policy formulation and program development.[465]

[465] Chakrapani and others, 'Hijras/Transgender Women in India', 12.

As seen above, the Supreme Court tried to fill out several lacunae that the body of Indian law and policy has had so far. It also acknowledged the fact that gender non-conformists face social exclusion and discrimination, and while there may be a growing space for different gender narratives when it comes to male-to-female transgender people in India (including *Hijras*), female-to-male transgender people lack visibility. However, the fact that their visibility is low does not mean that they face lesser violence, social exclusion or discrimination.

Among the Fundamental Rights in the Constitution of India[466], the Supreme Court based its decisions on the right to equality[467], comprising of equality and equal protection before the law, non-discrimination on any grounds, including caste[468] and sex. This

[466] 'The Constitution of India', Part III.
[467] Articles 14 and 15, already mentioned above, and Article 16, viz:
16. Equality of opportunity in matters of public employment.
(1) There shall be equality of opportunity for all citizens in matters relating to employment or appointment to any office under the State.
(2) No citizen shall, on grounds only of religion, race, caste, sex, descent, place of birth, residence or any of them, be ineligible for, or discriminated against in respect of, any employment or office under the State.
(3) Nothing in this article shall prevent Parliament from making any law prescribing, in regard to a class or classes of employment or appointment to an office _11[under the Government of, or any local or other authority within, a State or Union territory, any requirement as to residence within that State or Union territory] prior to such employment or appointment.
(4A) Nothing in this article shall prevent the State from making any provision for reservation in matters of promotion to any class or classes of posts in the services under the State in favour of the Scheduled Castes and the Scheduled Tribes which, in the opinion of the State, are not adequately represented in the services under the State.]
(4B) Nothing in this article shall prevent the State from considering any unfilled vacancies of a year which are reserved for being filled up in that year in accordance with any provision for reservation made under clause (4) or clause (4A) as a separate class of vacancies to be filled up in any succeeding year or years and such class of vacancies shall not be considered together with the vacancies of the year in which they are being filled up for determining the ceiling of fifty per cent. reservation on total number of vacancies of that year.]
(5) Nothing in this article shall affect the operation of any law which provides that the incumbent of an office in connection with the affairs of any religious or denominational institution or any member of the governing body thereof shall be a person professing a particular religion or belonging to a particular denomination.
[468] Caste is a unique feature of the social scenario in India and Nepal, which is followed by the Hindus. What was essentially a relatively fluid system of social demarcations became rigid over the warping of the system over many millennia and has often been abused by the upper castes. This plays a dual role in the context of transgender people, especially *Hijras*, as caste issues often engage with gender issues, and dual discrimination can play a vital role in marginalization. While caste was constitutionally abolished, the Constitution guarantees special treatment as affirmative action to specific castes who have historically faced marginalization, thus creating a justification for upper castes to keep on propagating it socially. For more information, refer to R. K. Pruthi, *Indian Caste System* (Discovery Publishing House, 2004).

constitutional provision also gives the Parliament the authority and power to provide affirmative action where required.

The Constitution of India often uses the word "person" as opposed to the gender binary, which gave the Supreme Court the scope to expand on the inclusiveness of the Constitution. To mitigate the extreme discrimination faced by the non-recognition of transgender people in India, the Supreme Court read them with the Directive Principles of State Policy asking for social equality[469].

The Supreme Court also considered Articles 19(1) and 21[470], which guarantee the right of freedom and the right to life and liberty to all citizens respectively. The right to freedom includes freedom of speech and expression, assembly and unionization and the right to practice any line of work as long as it is lawful – something which is particularly pertinent for transgender people, given that they are socially shunned, thus making it difficult for them to attain mainstream employment.

Acknowledging the fact that Pakistan and Nepal have already upheld the recognition of local transgender people in their own chosen identity, and that various states within India have taken measures to alleviate the plight of transgender people already, the Supreme Court of India gave legal recognition to the need for a "third gender" and directed the government to make necessary changes across all laws so as to not infringe on any right, especially to

[469] 'The Constitution of India', Article 38, Part IV.
[470] Right to Freedom
19. Protection of certain rights regarding freedom of speech, etc.-
(1) All citizens shall have the right-
(a) to freedom of speech and expression;
(b) to assemble peaceably and without arms;
(c) to form associations or unions;
(d) to move freely throughout the territory of India;
(e) to reside and settle in any part of the territory of India;
(f) (removed by amendment)
(g) to practise any profession, or to carry on any occupation, trade or business.
21. Protection of life and personal liberty.
No person shall be deprived of his life or personal liberty except according to procedure established by law.

equality, privacy and family[471] and spoke of gender identity as one of the most fundamental aspects of life and defines it in detail:

> "Gender identity is one of the most-fundamental aspects of life which refers to a person's intrinsic sense of being male, female or transgender or transsexual person. A person's sex is usually assigned at birth, but a relatively small group of persons may [be] born with bodies which incorporate both or certain aspects of both male and female physiology. At times, genital anatomy problems may arise in certain persons, their innate perception of themselves, is not in conformity with the sex assigned to them at birth and may include pre and post-operative transsexual persons and also persons who do not choose to undergo or do not have access to operation and also include persons who cannot undergo successful operation. Countries, all over the world, including India, are grappled with the question of attribution of gender to persons who believe that they belong to the opposite sex. Few persons undertake surgical and other procedures to alter their bodies and physical appearance to acquire gender characteristics of the sex which conform to their perception of gender, leading to legal and social complications since official record of their gender at birth is found to be at variance with the assumed gender identity. Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body which may involve a freely chosen, modification of bodily appearance or functions by medical, surgical or other means and other expressions of gender, including dress, speech and mannerisms. Gender identity, therefore, refers to an individual's self-identification as a man, woman, transgender or other identified category."[472]

[471] *NALSA* Case at 70 para.70.
[472] *NALSA* Case at 16 para.19.

To base its decisions in the context of India[473], the Supreme Court looked into the historical background of the transgender people in India. It deliberated over religious texts that speak of transgender people, such as the epics of *Ramayana* and *Mahabharata*[474], while also considering the *Puranas*[475].

The Supreme Court also considered the role of transgender people in more recent times, in the courts of the Ottomans and the Mughals, and then regarded the British Colonial Empire in the subcontinental region, where the first criminalisation of transgender people started as a specific group - the Criminal Tribes Act, 1871- which allowed arrest without warrant of any of the people listed in the Act. The Act was repealed in 1949, but at the time, there was no debate on the need to step out of the sexual binary in the newly formed Parliament of India, for they were still trying to put together the Constitution. At the same time, the Supreme Court of India briefly considered Section 377 of the Indian Penal Code of 1860,[476] but declined to opine on it.

However, for the first time in the judicial history of independent India, the Supreme Court of India gave a highly comprehensive non-legalistic definition of gender, and is being viewed most optimistically by lawyers and activists alike. The optimism wasn't unfounded

[473] By doing this, the Supreme Court of India managed to do two things – one is to satisfy the necessity of placing the transgender body in a time before the colonisation by different religions and by European powers came about, and the other, in my opinion, was to satisfy the saffronised context for the transgender body by not considering Section 377 of the Indian Penal Code all over again, something which is highly relevant for transgender people as well, especially if they are to exercise their rights as per the judgment, but does not fit into the rhetoric of the ruling polity, the Bharatiya Janata Party, a centre-to-right party which looks at homosexuality as un-Indian and till now has not legislated in favour of repealing or reading down Section 377 of the Indian Penal Code.

[474] The *Ramayana* and the *Mahabharata* are two epics of the subcontinent in which the heroes are supposed to be incarnations of the Hindu God Vishnu, and characters (also often tied to various Hindu Gods) in the epics are seen to change their gender as well as act as transvestites. These epics are considered to be not just of mythological significance, but also of religious significance, given that they are tied to the Hindu pantheon. For more information through a non-religious ontological account on the Hindus, please read Wendy Doniger, *The Hindus: An Alternative History* (Penguin, 2009).

[475] The *Puranas* are ancient Indian texts eulogising various divinities of the Hindu Pantheon, and often refer to various Gods and Demi-Gods taking of the form of the opposite gender as characters in stories.

[476] *Koushal*, Civil Appeal No. 10972 of 2013. Discussed earlier.

when both the *NALSA* judgment and *the Koushal* judgment of the Supreme Court came up in a 2017 judgment on the Right to Privacy[477].

In 2012, a case was filed by a retired judge against a move by the Indian Government on biometric identification requirements and how it infringed on privacy under Article 21. In 2017, a nine-judge bench of the Supreme Court of India decided on the matter and declared that the right to privacy is intrinsically a part of Article 21. Justice D.Y. Chandrachud, while delivering the main judgment, on behalf of the Chief Justice J.S. Khehar, Justice R.K. Agarwal, himself and Justice S. Abdul Nazeer, has held that privacy is intrinsic to life, liberty, freedom and dignity and therefore, is an inalienable natural right. Justices Chelameswar, Bobde, Sapre and Kaul have also agreed with Justice Chandrachud's judgment. Most importantly, in the context of LGBT rights, it frowned upon the decision of *Koushal*. The judgment says:

> The test of popular acceptance does not furnish a valid basis to disregard rights which are conferred with the sanctity of constitutional protection. Discrete and insular minorities face grave dangers of discrimination for the simple reason that their views, beliefs or way of life does not accord with the 'mainstream'. Yet in a democratic constitution founded on the rule of law, their rights are as sacred as those conferred on other citizens to protect their freedoms and liberties. **Sexual orientation is an essential attribute of privacy.** Discrimination against an individual on the basis of sexual orientation is deeply offensive to the dignity and self-worth of the individual. Equality demands that the sexual orientation of each individual in society must be protected on an even platform. The right to privacy and the protection of sexual orientation lie at the core of the fundamental rights guaranteed by Articles 14, 15 and 21 of the constitution… [LGBT] rights are not so-called but are real rights founded on sound

[477] *Justice K. S. Puttaswamy (Retd.) and Anr. vs Union Of India And Ors.* WP (C) No. 494 of 2012, hereafter referred to the *Right to Privacy* Case.

> constitutional doctrine. They inhere in the right to life. They dwell in privacy and dignity. They constitute the essence of liberty and freedom. Sexual orientation is an essential component of identity. Equal protection demands protection of the identity of every individual without discrimination.[478]

It went further to say that:

> NALSA indicates the rationale for grounding of a right to privacy in the protection of gender identity within Article 15. The intersection of Article 15 with Article 21 locates a constitutional right to privacy as an expression of individual autonomy, dignity and identity. NALSA indicates that the right to privacy does not necessarily have to fall within the ambit of any one provision in the chapter on fundamental rights. Intersecting rights recognise the right to privacy. Though primarily, it is in the guarantee of life and personal liberty under Article 21 that a constitutional right to privacy dwells, it is enriched by the values incorporated in other rights which are enumerated in Part III of the Constitution.[479]

Thus, although the *NALSA* decision created room for negotiating various transgender identities into mainstream society, it hadn't allowed for the sexual expression of transgender people. With the above judgment on the right to privacy, it may be hoped that Section 377 shall be read down appropriately, thus decriminalising non-procreative sexual acts. The *NALSA* decision did bring about many changes, albeit a bit slowly. One of the first things to happen was the tabling of the Transgender Persons (Protection of Rights) Bill.

5.10. The Transgender Persons (Protection of Rights) Bill

[478] *Right to Privacy* Case at 123-124, paras. 126, 127. Emphasis added.
[479] *Right to Privacy* Case at 85, para.84.

The Transgender Persons (Protection of Rights) Bill, 2014, was introduced in the Lower House of the Indian Parliament on August 2, 2016, by the Minster of Social Justice and Empowerment. This bill has been two years in the making, ever since the decision by the Supreme Court of India to legalise a third gender category as well as spell out all civil and political rights and liberties of the transgender citizen.

The bill incorporates several positive aspects, but has left way too much room for ambiguities and exclusion by the community itself. Some of the salient features of the bill are:

- It gives a definition of a transgender person, which is far from the internationally accepted definitions of transgender, and has even gone to the extent of mentioning transgender people to be part-male, part-female, thus showing a tremendous amount of ignorance and a snub to the *NALSA* decision.

- It prohibits discrimination against a transgender person, including denial of service, fair treatment, employment opportunities in both public and private spheres, tenancy as well as healthcare and all other services generally available to the public. However, it does not specify what the discrimination should entail to be redressable or how to redress.

- It establishes the right to reside in his or household, and if the family is incapable of caring for the transgender person, then the person can be placed in a rehabilitation centre on the orders of a competent court. Crucially, however, this does not include the concept of the right to marry or found a family as envisaged in the decision of the Supreme Court.

- It stipulates that all educational institutions, both governmental and non-governmental, have to create an inclusive atmosphere to welcome transgender students.

- With regard to healthcare, the government should take steps to provide separate health facilities for transgender people, including sero-surveillance centres, sexual reassignment surgeries, etc. while also reviewing medical curriculum to address health issues of transgender people, as well as provide comprehensive medical insurance schemes for them. The latter part

is the more surprising since the State does not have comprehensive medical insurance schemes for its cis-gendered citizens.

- Identity certification of transgender people as transgender may be done through an application to the District Magistrate for a certificate of identity, indicating the gender as "transgender". This certificate will be issued on the recommendations of a District Screening Committee, comprising of the Chief Medical Officer, District Social Welfare Officer, a psychologist or psychiatrist, a representative of the transgender community and an officer of the government. Herein lies a problem – when a representative of the transgender community is chosen, who will be the representative? Will it be a person from one of the indigenous transgender communities of the region, or will be it be a person who identifies more with the western ideas of trans-ness? Would this lead to discrimination as to who is transgendered enough to be given the certification?

- The government shall also undertake create inclusive policies and environments for transgender people, and to rescue and rehabilitate, create vocational training and schemes of self-employment, etc. and promote more cultural participation. Essentially this extends the directive principles of social, economic and cultural rights to transgender people.

- Various offences have been put under this act – begging (something which several transgender people in India are forced to do in order to make ends meet), forced or bonded labour, unless it is compulsory service for public purposes, denial of the use of a public place, denial of residence in a household, village, etc., physical, sexual, verbal, emotional and economic abuse – which are punishable with a fine and imprisonment between six months to two years. Sexual abuse is categorised under several other laws, such as the Indian Penal Code, and have varied punishments according to their severity. This might make interpreting this particular aspect more complicated than necessary.

- A National Council for Transgender Persons will be formed, chaired by the Union Minister of Social Justice, with the Minister of State for Social Justice as the vice-Chairperson, Secretary of the Ministry of Social Justice; (iv) one representative from ministries including Health, Home Affairs, Minority Affairs, Housing, Human Resources Development, etc. Other members include representatives of the *NITI Aayog*[480], National Human Rights Commission, and National Commission for Women. State governments will also be represented. The Council will also consist of five members from the transgender community and five experts from non-governmental organisations. The Council will advise the central government on the formulation and monitoring of policies, legislation and projects with respect to transgender persons.

The Bill, while a step in the right direction, when read closely, is felt to be inadequate and riddled with contradictions, including poor definitions of transgender and no protection from Section 377 of the Indian Penal Code. Once referred to the Standing Committee of Social Justice and Empowerment, in July 2017, these deficiencies came to light, and currently, a different version of it was tabled in December 2017.[481]

5.11. Socio-economic conditions and the divisions within

With the *NALSA* decision, several universities have started accepting students identifying as transgender or third gender. With more and more advocacy programmes by NGOs gearing towards legal literacy and gender identity issues, in general, the private sector seems to have become more open to accepting people of all genders based on equal opportunity employment. While this seems to paint a rosy picture, the chief problem lies in

[480] The *NITI Aayog* (Hindi for Policy Commission), also National Institution for Transforming India, is a policy think tank of the Government of India.
[481] For a full understanding of the report, please refer to Priyanka Rao, 'Standing Committee Report Summary on The Transgender Persons (Protection of Rights) Bill, 2016' (PRS Legislative Research, 1 August 2017).

the fact that, all this while, most transgender people in India were neither accepted in mainstream educational institutions, nor were they gainfully employed beyond the NGO sector.[482]

Pawan Dhall, a renowned queer rights activist of India, said that,

> when it comes to a part of this visibility and social attitudes towards this community, it is one of a mixture - you have disdain and disgust and you have certain amount of reluctant or hesitant reverence because they have somewhat a mysterious aura around them. This has probably, with more information, with coming out in media slowly, been changing, but by and large people would still have a mixture of reverence and fear for them and disgust for them." With many of them joining the indigenous *Hijra* groups, they go about dancing from village to village, looking for homes where there have been weddings or child-births recently. Being blessed by a Hijra is considered to be very auspicious[483]. [It is perceived that] they might have special powers so they may curse, they may bless, and that also gets reinforced by their popular occupation which is *chhalla* or *badhai*, *badhai* is like giving blessing during wedding or a child birth and *chhalla* or *mangti* is something like begging for alms on street corners or in shops or at the traffic crossings […] and at the moment I am still talking about the *Hijras*, the reality is that socioeconomically they are still quite marginalized.[484]

When this doesn't suffice, they resort to begging in trains, at traffic crossings, and prostitution. Sex work is a tremendously tough affair, because condom-negotiation is far tougher than with cis-gendered sex workers. Their clients are often under the impression that condoms are only for controlling pregnancy risks, and not necessarily associated with

[482] This does not hold true for the north-east of India, which, much like Thailand, has a culture of transgender women who are very visible in society, and are gainfully employed outside the civil society circuit.
[483] The corollary applies here – their curses are considered to be highly inauspicious, with their biggest threat being to show their castration wounds to anyone who angers them. This is considered to bring down the wrath of the gods onto anyone who views it.
[484] Interview with Pawan Dhall, Kolkata, July 2015.

sexually transmitted diseases. Also, chances of sexual abuse are as high as they are with women sex workers[485].

Hijras, as opposed to westernised transgender people, are associated with a type of negative visibility, similar to the Brazilian *travesti*. Begging at street corners, sex work in clandestine and lonely areas, getting aggressive if not paid the ransom demanded by them when going to collect alms at blessing ceremonies and other social occasions, and threatening to show their pubic area to show their emasculation – which is associated with the worst possible luck – if their demands are not met. They are also associated with a hollow resounding clap, and people fear it if they hear it, thinking they will be accosted and forced to give alms. However, this association with a type of aggressive behaviour is not to be interpreted as occupying a space that is not theirs, but rather, forcefully re-entering the space taken away from them. In a situation where the society has shunned them for decades and centuries, they have had to survive, and today, with the Supreme Court of India's decision, discussed above, they have rights on paper, but to actually navigate through bureaucracy in order to ascertain rights against the State in India is a hassle for a cis gendered able-bodied upper caste male, let alone a person who is considered in many ways to be lumpen.

The aggressive behaviour associated with *Hijras*, while it has been intrinsic to their survival, has begotten them a lot of flak from the more gentrified sectors of the LGBT movement. There is a disconnect between the educated, western-identity oriented transgender people of India versus the more indigenous, grassroot, village-level *Hijra* and other sub-cultures of transgender – while both populations have faced discrimination, there is an indignation amongst the *Hijras* about whose rights ought to be in the forefront.

[485] According to Pawan Dhall, transgender sexworkers often hear from abusive customers: "if you want to be a woman, I shall show you what it is like to be a woman". Interview with Pawan Dhall, Kolkata, July 2015.

People who identify with the more western notion of transgender and the *Hijras*, while being a part of the same movement, are running more parallel than together. As Anupam Hazra mentioned in his interview with me,

> For trans people who are [from] a middle class or upper middle class family [and] have access to some sort of education and resources, their problems are slightly different from the people who come from the lower income families or from very poor backgrounds. What we usually see is that people who are born males who identify as women, or want to consider themselves as transgender but are from a very poor background and want money, they take up the *Hijra* profession. So, for them, it's a profession which also helps them be in the gender role that they want. For other transgender who are from upper class or middle class more educated background, for them, they try to find their financial independence and then they gradually start to express their gender identities. For each of them there are different sets of problems.[486]

The *NALSA* judgment took cognizance of what he mentions, and spoke particularly about the plight of the Indian transgender within a specific framework, and primarily highlighted the plight of those who consider themselves to be of the third gender. This has also led to sporadic moves at the state levels to include transgender people within their frameworks.

5.12. Affirmative Action in India

Different communities in India were given representational voices in Colonial India. This acted as somewhat of a precursor for the incredibly complex affirmative action

[486] Interview with Anupam Hazra, Kolkata, July 2015.

programmes that are in India right now. While blind equality prevails in a court of law under the Constitution of India's auspices, social inequalities are addressed through the affirmative action programmes, and are often tested at the doors of the judiciary for their constitutional veracity.

The affirmative action programmes are designed to benefit very specific minority groups: Scheduled Castes, Scheduled Tribes[487] and women. There is another grouping of Other Backward Classes, which looks at economically and educationally deprived groups. Currently this itself has over 2000 groups[488]. India practices affirmative action through employment and educational reservations in all governmental and government-aided institutions. Based on this practice, the Supreme Court, in *NALSA*, ordered for such reservations for transgender people as well.

However, the problem herein is that while caste, class, religion is mostly decided at birth, to be declared transgender requires medical supervision. Even if the medical authorities give the required certification, transgender people will face a fresh battle of choosing their pathways in the intersection of caste-based reservations, class-based reservations, religion-based reservations, and gender-based reservations. Also, given the limited understanding of gender fluidity in India, once the gender markers are changed on paper, it won't be possible to revert to the original, or change to anything else.

Amrita Sarkar, a transgender woman and a rights activist stated:

[487] Refer to Karuna Chanana, 'Accessing Higher Education: The Dilemma of Schooling Women, Minorities, Scheduled Castes and Scheduled Tribes in Contemporary India', *Higher Education* 26, no. 1 (1993): 69–92; Harish C. Jain and C. S. Venkata Ratnam, 'Affirmative Action in Employment for the Scheduled Castes and the Scheduled Tribes in India', *International Journal of Manpower* 15, no. 7 (1994): 6–25; Aparna Mitra, 'The Status of Women among the Scheduled Tribes in India', *The Journal of Socio-Economics* 37, no. 3 (2008): 1202–1217.

[488] Refer to Andre Beteille, *The Backward Classes in Contemporary India* (Oxford University Press, USA, 1992).

> [T]he problem is we are now legally recognized according to the NALSA judgment 2014…but still there is a gap…people who are service providers they don't have this information at all…that this people can get services as OBC [other backward castes] and they have to be taken care of…but unfortunately you know yourself that nothing important has come through except for [our] status…I think problem is [greater] if you go to the rural part of the Country like Orissa where people have no information and that actually indulge more kind of discrimination against such people….I mean the first questions have to face are actually how can you identify yourself even if you are going to a hospital…even about social entitlement…when I wanted to renew my passport last year after the judgment…they showed me "madam there is only male or female option…so I can't help you"…even there is a judgment there is discrimination.[489]

Moreover, Anupam Hazra mentioned that the inadequate sensitisation initiatives and education on transgender people can create confusions with affirmative action programmes. For instance,

> in many small towns and places we have come across government officials who say that, so what is the way? How do you identify a person? Is there a certification process is there a medical process through which you would know definitely that this person is a transgender person? We have also seen top government officials at the level of Additional Secretary say that oh, if it is about self-determination, then a lot of non-transgender people will come in and access these services[490].

[489] Interview with Amrita Sarkar, New Delhi, July 2015.
[490] Interview with Anupam Hazra, Kolkata, July 2015.

Additionally, when the population that the Supreme Court is addressing is composed of people of highly varied educational backgrounds, some being borderline illiterate, to explain the notion of self-determination itself is a challenge. Anupam Hazra also mentioned,

> working in this sector, for me understanding this judgment, there are some areas I am not completely aware. Then a person who has not even studied up to class 3 that person is absolutely lost! […] [T]his understanding gets complicated when *Hijras* were like that Supreme Court stand on self determination that a person can say what he or she is - sort of some *Hijra* leaders are not happy with that completely of this judgment .The *Hijra* leaders first thought that this is for *Hijras* and transgender women. Then they realised it was about self-determination, and for transgender women and transgender men. We have come across some *Hijra* leaders who are not happy with this aspect of the judgment. We have also come across some transgender women leaders are also not happy that transgender men are included in this judgment. We had other people who are like, what is this self-determination? what does it mean? So, it would take us some time to make all this people come together on a platform and arrive at a consensus on this is what the judgment means and this is what we need to do next.[491]

Different states in India have set up welfare boards for transgender people, and have different ways of coming to the conclusion of who is transgender enough to qualify for the benefits enumerated under the decision of the Supreme Court. As Anupam Hazra pointed out,

> [T]he district level transgender board's idea of certifying a transgender person is different. In Bihar they are talking about certification in a very different process. I would not go into specifics, but there is ambiguity across the country which may lead to more troubles for the community […]. And also, self-determination is one aspect but the other aspect is your exhibiting or expressing

[491] Interview with Anupam Hazra, Kolkata, July 2015.

> your gender identity. I may be [a] trans woman but I may be wearing moustache and pants and shirts and consider myself a trans woman but some community leaders may consider that, no, then you are not a trans woman[492].

5.13. Conclusion

India is a large country, with a literacy level of around 74%, but with areas of very high literacy coexisting along with areas of zero literacy. It also battles poverty with over 22% of its population under the poverty line – and most transgender women in India are within or just above this category of poverty. However, at the same time, it has one of the highest GDPs of the developing world, and one of the world's fastest growing economies. At the same time, it severely lacks a cohesion of knowledge within the service delivery sectors. Given its vast size and its amalgamation of cultures, while a one-size-fits-all policy seems fine on paper, the ground level realities are different in every corner of the country.

The Indian judiciary has played a pivotal role in securing the status of transgender people in India. However, it has been a long time coming, given the interaction of the sub-continent with gender non-binary populations. Yet, the judiciary has not managed to overthrow the colonial shackles entirely that had once outlawed all transgender people. Section 377 of the Indian Penal Code is still there to haunt several MtF transgender people and gay people.

While the judiciary has taken a step in the right direction, the Transgender Bill seems to renege half the rights granted through jurisprudence. From its narrow tailoring of the term transgender, to the understanding of third gender, to the exclusion of the right to marry, etc. it seems like a document in much need of a revision. Should it be passed in its current form, it

[492] Interview with Anupam Hazra, Kolkata, July 2015.

will lead to administrative ambiguities and legal lacunae that the stakeholders themselves will have to resolve.

The health system is no exception within this scenario. When it comes to transgender people trying to access anything in the system, there has been sporadic moves by governments of states earlier on, and currently, with the order of the Supreme Court, there is hope for a more consolidated approach to transgender rights. While all this is in limbo, the transgender population still has to access basic services such as healthcare. Beyond just dealing with several people across cultures and different notions of fear and religiosity playing around the transgendered body in India, it becomes a challenge both for the service provider, who has had little to no training on how to interact with someone who doesn't fit into the gender binary, as well as the transgender patient who comes to receive the services, fearing discrimination at every step of the way, as we shall see later in the dissertation.

As to whether this situation will improve with the rolling out of the Supreme Court's decision, or when the Transgender Bill becomes a legislation with its new amendments remains to be seen. Right now, all that can be done is try to bring about a cohesion in the sporadic efforts seen all over the country to include transgender people within mainstream society.

6. Implementing the Laws and Regulations – Healthcare in practice

6.1. Introduction

> "Everything involving *travestis* or transsexuals is linked to health […]. To a travesti or transsexual to access health is a very painful thing, nobody wants to go [to a hospital], because the health system does not cater for the trans population, there is a great difficulty when you even suggest that one of them go to a hospital, they are frightened, people are prejudiced and do not like to attend transsexuals."
>
> - *Tais Azevedo*[493]

This quote above, from one of my interviews, is perhaps the most all-encompassing statement to form the basis of why the implementation of rights through laws and regulations need to be examined, and more so within the right to health. As discussed above, the right to health has multiple layers to it, and must be implemented through improving various social determinants and implementation at the ground level. Primarily, this takes the form of service-delivery by the government through the healthcare sector. When it comes to transgender people though, while they are considered mainly through the medicalised gaze – the diseased "other", who needs to be cured (or controlled) – ironically, their access of the medical system remains limited thanks to the systemic barriers in place, from ambiguities in legal inclusion to the lack of knowledge on the part of healthcare service providers.

The International Classification of Diseases 10 (ICD10)[494], which has been in force since 1990, classifies gender identity disorders under sub-section F64 in Section V of mental and behavioural disorders. In the past nearly three decades, much has developed on the area

[493] Interview with Tais Azevedo, São Paulo, July 2016.
[494] 'ICD-10 Version:2016', accessed 11 March 2018, http://apps.who.int/classifications/icd10/browse/2016/en.

of healthcare as well as the legal front when it comes to the acceptance of transgender citizens across the world. With a view of addressing the changes taking place, the WHO called for a High-Level Revision Meeting in October 2016 in Tokyo, and invited countries to submit their domestic treatment guidelines about gender realignment. A new international classification system, the ICD 11, was to be presented in 2017 as a test. On the question of the transgender experience, the idea was not only to replace "disorder" with "dysphoria", but also to move it away from disease and situate it parallel to conditions like pregnancy and childbirth,[495] which the DSM 5 had already done in 2013[496], The WPATH guidelines also had a vital role to play in bringing about this change, with the WPATH7 (or SOC7) guidelines[497].

However, despite these global advancements, India, Brazil and South Africa are still far from having standardised domestic protocols, both legal and medical, to protect and recognise the rights of their transgender citizens and communities. Moreover, as discussed earlier, transgender people are highly diverse, but are often reductively put into one large group, without necessarily taking regional and personal specificities into account. From a health perspective, beyond general healthcare, transgender people may require some or all of the following: gender alignment surgery, hormonal therapy, other medical and psychological interventions. All these services, in part or whole, enable transgender people to pursue their gender identity, and are thus critical to their mental and physical health and well-being. Here, access to healthcare plays a key role.

[495] Mauro Cabral, 'Critique and Alternative Proposal to the "Gender Incongruence of Childhood" Category in ICD-11' (Global Action for Trans* Equality/GATE Civil Society Expert Working Group, 4 April 2013).
[496] Megan M. Campbell, Lillian Artz, and Dan J. Stein, 'Sexual Disorders in DSM-5 and ICD-11: A Conceptual Framework', *Current Opinion in Psychiatry* 28, no. 6 (November 2015): 435–39, https://doi.org/10.1097/YCO.0000000000000197; Trevor A. Corneil, Justus H. Eisfeld, and Marsha Botzer, 'Proposed Changes to Diagnoses Related to Gender Identity in the *DSM* : A World Professional Association for Transgender Health Consensus Paper Regarding the Potential Impact on Access to Health Care for Transgender Persons', *International Journal of Transgenderism* 12, no. 2 (20 September 2010): 107–14, https://doi.org/10.1080/15532739.2010.509205.
[497] 'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People' (The World Professional Association for Transgender Health, August 2016).

Drawing from the previous chapters and the promises made in the constitutions and legislations (or the lack of them) of the three countries, this chapter examines the actual implementation of the public health aspects of the right to health, and then works upwards to transgender peoples' interactions with the public health system. I discuss each country individually before comparing the three cases together. Within the discussions, I aim to give an overview of the healthcare setup in each country before shedding light on transgender specificities in the programmatic aspects of healthcare implementation as well as accessing healthcare. For this, I shall lay out my findings in a tabled format in order to make my findings more easily accessible to the reader. The aspect of looking at healthcare provisions within a country is important because it is necessary to showcase the situation at hand in general before setting it in context for the population whose accessibility, or lack thereof, is being analysed.

6.2. The right to healthcare – is it a human right?

The right to health must not be conflated with the right to healthcare. As we have seen, the right to health, while being a part of human rights unto itself has several components, of which healthcare is a large part.

Going beyond public health, the right to healthcare needs to ensure that quality health services are available to everyone without discrimination, where they are treated with respect and dignity, with transparency and public accountability. Health services also need to take into account the diversity of people and different needs. Thus, several civil and political rights get intertwined on one platform, a platform whose access is also barricaded for many people on the basis of their group belonging, their financial situation and their social positioning.

In all three countries in question, as seen above, constitutional provisions have varied as to how the right to health as well as the right to healthcare has been treated, and how it has

fared in jurisprudence as well. As we shall see, the healthcare systems are partly public and partly private. The former is accessed primarily by those who cannot afford the latter. This is in part because of the lack of resources of the three developing countries, in part because of their historical trajectories out of systems entrenched in inequality and discrimination, such as colonialism and apartheid. Also, with burgeoning populations, much of state-based healthcare is focused on primary disease and epidemic prevention, and the rest is focused on curatives, rather than focusing on other determinants of health that might help prevent physical health deterioration.

In the private sector, where healthcare becomes a commodity to be bought and sold, and not a right to be claimed, care is easier to access for those who can afford medical aid or insurance. In this arena, discrimination is more on the basis of finances as opposed to group belonging, which does not mean that the latter does not take place. However, in order to keep the answerability of private healthcare enterprises alive, given that lives may be at stake, a constitutionally entrenched right to healthcare may lead to specific justiciability.

6.3. The Indian healthcare system

As mentioned earlier, the healthcare system of a country is one of the primary areas where one can exercise one's right to health. The Indian Constitution guarantees the right to life and considers the right to health as a progressive right, as discussed in an earlier chapter. However, the Indian public healthcare system is a far cry from the rights guaranteed on paper and in principle. As the country is partly unitary and partly federal in nature, the responsibility over the Indian healthcare system is split between the central and the state governments. The first oversees the quality of medicine and drug manufacturing, national disease control, national health policy, medical education, international health treaties and the regulatory

framework for guiding the medical facilities in the states. Each state is responsible for the organisation and delivery of healthcare and medical services to the citizens residing in the state.

The Indian healthcare system, as such, provides primary and secondary medical care, preventive care, diagnostic services, inpatient and outpatient services, as well as vaccinations and immunisations for various diseases under national disease eradication campaigns. The public healthcare system, furthermore, implements one of the largest anti-retroviral treatment programmes in the world for HIV/AIDS infected/affected populations.[498]

There are a few government-run schemes that allow for a high level of accessibility for some of the population. For instance, the Central Government Health Scheme and the Employees State Insurance Scheme ensure several free services, including some that are highly expensive, such as cancer treatment and organ transplants. A new scheme launched in 2008, the *Rashtriya Swasthya Bima Yojana* (RSBY) or the National Health Insurance Scheme was introduced to provide health insurance coverage to people below the poverty line, and in 2015-2016, over 41 million families were enrolled under it[499].

The structure of the healthcare system is three-tiered, including primary, secondary and tertiary facilities. Rural areas have primary health care services being given out by primary health centres, community health centres and sub-centres. The sub-centre has the lowest capacity of looking at patients between 3-5,000 people and the community health centre between 80-120,000 people. Every district has a district or sub-divisional hospital or

[498] For detailed reports by the National AIDS Control Organisation, refer to Susan D Cochran et al., 'Proposed Declassification of Disease Categories Related to Sexual Orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11)', *Bulletin of the World Health Organization* 92, no. 9 (1 September 2014): 672–79, https://doi.org/10.2471/BLT.14.135541; Megan M. Campbell, Lillian Artz, and Dan J. Stein, 'Sexual Disorders in DSM-5 and ICD-11: A Conceptual Framework', *Current Opinion in Psychiatry* 28, no. 6 (November 2015): 435–39, https://doi.org/10.1097/YCO.0000000000000197.

[499] For a detailed explanation on this scheme, please refer to ::'::RSBY':, accessed 9 October 2017, http://www.rsby.gov.in/about_rsby.aspx. It is a small amount of Rs.30,000 per annum on a floating family basis for all ailments requiring hospitalization. It also comes with a transport allowance of a maximum of Rs.1000 per annum. While this gives a certain amount of financial leverage, the amount is paltry in the current Indian market.

community health centre. They are intended to act as secondary service providers and as blood banks. While there are over 600,000 government beds available, over 190,000 of them are in rural areas. Surprisingly, the rural health sector is better organised than the urban sector, and the urban poor often find it highly difficult to access free medical services.[500]

Because of the federal nature of the Indian union, however, several states that are socially and economically underdeveloped have a deficient public healthcare sector, which leads to an overall slowdown of medical betterment nationally. As mentioned earlier, India's expenditure on the health sector is one of the lowest in the world per capita. Thus, while in principle the governmental healthcare system - which is state-funded - should be accessible for all citizens, the reality of public health access is that demand is far higher than supply, compelling several people to seek private healthcare. Given the poor per capita income rate, private healthcare often turns out to be an unaffordable luxury for many. This holds true for the transgender people of India as well, primarily the *Hijras* because of their social marginalisation.

Based only on the sheer numbers of India's population, its healthcare system is, by far, the one with the largest burden to bear among the three jurisdictions examined here. It serves over 1.2 billion people and, with a doctor-patient ratio of 1:1674[501], it suffers from a severe shortage of staff. In addition, primary healthcare infrastructures, while widely spread, are still highly insufficient, and it is common for healthcare units to become heavily burdened and unable to meet the patient demand. As each of them is branched out into mandatory child vaccination services, anti-retroviral treatment, and several-bedded hospitals for all types of diseases, public hospitals tend to have long waiting queues, sometimes lasting for days, weeks or even months. The most dramatic staff-shortage scenarios commonly found in many of such

[500] Indrani Gupta and Mrigesh Bhatia, 'The Indian Health Care System', The Commonwealth Fund, accessed 9 October 2017, http://international.commonwealthfund.org/countries/india/.
[501] Gupta and Bhatia, 'The Indian Health Care System'.

hospital include patients admitted due to urgent treatment requirements, but who are nonetheless left lying in the aisles attended by their relatives rather than trained nurses[502].

In addition, when a government is more focused on defence-building and economic infrastructure[503], certain public services are often left in the hands of private actors. This is true of healthcare as well, particularly tertiary healthcare. In India, the private healthcare sector is only partly regulated, and does not necessarily prevent private organizations and poorly trained doctors to deliver faulty services to a section of the population. Be that as it may, the private hospital sector is the best-regulated area of private care, and has expanded exponentially over the last few years, partially fostered by the increase in government-sponsored schemes of public-private partnerships. Indeed, today the private sector holds about 63% of the total number of hospital beds available in India. With the rise of medical tourism – from knee replacement to liposuction – private hospitals continue to grow and proliferate, but as entirely for-profit enterprises. Yet, because of the low-income average in the country, private medical services remain highly expensive for the lower middle classes.[504]

Despite the challenges faced and its overstretched nature, there have been certain milestones and successes in the healthcare sector in India. In 1985, for instance, the central

[502] In 2009, called in for a discrimination case, my colleagues and I were rushed across to one of the largest government hospitals of Kolkata, where one of the admitted patients (who happened to be HIV positive) had been refused treatment by a ward-boy. We found him lying on a bed in the corridors, along with several other patients in similar situations because of overcrowding in the wards. Upon investigation, it turned out that the wardboy wasn't an employee of the hospital in the first place, but because of a severe shortage in staff, outside people were allowed to contract out their services to the patients who weren't getting immediate attention. On our bringing this particular case to the notice of the authorities, the matron of the ward took up the patient herself, and he faced no further discrimination. However, this case was reported primarily because the patient was an employee of a rights-based organisation. Several such cases go unreported.

[503] Indian healthcare is a state-based affair. However, the Central budget pays for around 30% of it. On top of that, as the central budget also decides on how much money is allocated from the overall budget, it is disheartening to see that only 1.3% of the budget of 2017 was allocated to the healthcare sector. However, in March, 2017, the government announced that it would increase the budget to 2.5% of the GDP. In Special Correspondent, 'Health Spending to Be 2.5% of GDP: Centre Announces New Policy with an "Assurance" of Health Care for All', *The Hindu*, 17 March 2017, http://www.thehindu.com/news/national/centre-cleared-the-long-awaited-national-health-policy-2017/article17487845.ece.

[504] Several hospitals in the public-private partnership deals were given land to build on, with the understanding that a few beds will be provided free of the daily charge. However, it does not consider the charges for the services. Also, the beds are seldom publicized.

government introduced a Universal Immunisation Programme against tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, measles and Hepatatis B. Since then, immunisation is conducted at outreach centres even in every rural area, with the number of children and adults attended to growing every year. Since 1992, India has also been the host of one of the largest anti-retroviral treatment campaigns in the world, run by the National AIDS Control Organisation (NACO), as mentioned earlier. In fact, it is because of the interventions run by NACO that alternative genders and sexualities finally came to the forefront in public policy and debate, albeit through the medicalised gaze.

6.3.1. The "Third Gender" and the transgender in Indian healthcare

While transgender people have been accessing healthcare in India for many years, it has generally been through private healthcare providers, where they resort to both trained medical professionals, if they can afford it, as well as quacks, when they cannot. When forced to use the public healthcare settings, transgender patients have tended to present themselves as cis gendered in order to avoid unnecessary attention. Thus, public healthcare specifically targeted to the needs of transgender people, if at all existent, is still in the nascent stages in India. Social movements around sexual and gender identity started in the 1980s, but official cognizance of a transgender population and a "third gender" categorisation happened as late as 2014, when the Supreme Court of India decided the *NALSA* case[505]. Since then, there have been several moves by various state governments in collaboration with NGOs to improve and reform the local healthcare systems per the *NALSA* case decision, as I discuss later.

[505] Discussed in Chapter 5.

There is considerable confusion around the applicability of the *NALSA* case judgment in all sectors of the general life of transgender people.[506] More importantly, when it turns to the highly specialised medical needs of the transgender population, public hospitals are yet to have any centralised regulation around gender affirming services such as hormonal therapy, counselling and sexual reassignment surgeries. Some private clinics do practice it, but at exorbitant rates that render it practically prohibitive to many[507]. The Transgender Bill that was tabled in 2014 has provisions for laying down the path for medical professionals to follow as far as ethics committees and rules are concerned, but is yet to be passed as of 2017.[508] Some states, however, have taken up isolated initiatives to provide sexual reassignment surgery at government hospitals, while others are yet to follow suit.

Given the high pressure the medical staff is already under in governmental hospitals, as described above, sensitising service providers on transgender issues can become a trying affair. Moreover, with each state having a different stance on the prioritisation of the transgender population[509], fear of discrimination or even experiences of discrimination by transgender people run rife, especially in the case of the more visible male-to-female transgender people. At the same time, owing to the core health necessities of preventing the spread of HIV/AIDS and tuberculosis, several programmes are running parallel, including separate programmes for MSM and transgender patients. This differentiation is, in itself, a sign that over the past few years a greater understanding of transgender and *Hijra* health needs have come about at the field level.

[506] Discussed in Chapter 5.
[507] One such clinic is Designer Bodyz, run by Dr. Parag Telang, based in Mumbai. Some transgender people I have interacted with, including Amrita, went to the clinic and were extremely satisfied with the sensitive behaviour they received, along with the pre-operation counselling. However, their services are not inexpensive. For more information, refer to: http://www.designerbodyz.in/index.php
[508] Discussed in Chapter 5.
[509] Given the fact that the Bill is yet to be passed, there is no centralised procedure for integrating the third gender category in official systems. Each state is pursuing it in an individualised manner in implementing the *NALSA* judgment, and some states are working more efficiently than others.

Despite the *NALSA* decision's requirements in expanding legislations and healthcare to include transgender people as referred to earlier, the Central Government remains largely indifferent, and has avoided any strong action in this area – this includes the fact that the bill is yet to be tabled, that no particular medical protocol has been developed and that there has been no major change to the medical syllabi in India. This leaves transgender people looking for gender affirming treatment at the hands of private medical practitioners. As Simran Sheikh puts it,

> The doctors … have one or two chapters which speaks broadly about sexuality and gender but hardly goes deep on terms…hence taking advantage of non-availability issues, there are private practitioners, there are surgeons who have ample knowledge and have performed on such kind of SRS… they charge double or triple [the price] which is very expensive…but the result is good…[510]

Given that most transgender people in India are socio-economically backward, gender affirming services become a luxury that few can afford.

Most commonly, it's the transgender people in India identifying as *Hijras* who face the most difficulties in accessing hormonal replacement therapy and antiretroviral drugs. Anupam Hazra, an activist working with one of the leading NGOs in India in the field of HIV/AIDS and sexual and gender minorities, mentioned that

> [l]ast year [2015] we had an event in one of the suburban hospitals very near Kolkata. A male transgender person had gone to a hospital in Kolkata, possibly for a STI or something similar… the doctors in the hospital said, its fine that now you have the

[510] Interview with Simran Sheikh, New Delhi, July 2015.

> NALSA law and all that, but I can't treat people like you, you go to those hospitals where you have transgender doctors – so that was an outright refusal to treat a patient."[511]

The possibility or likelihood of discrimination or refusal of treatment leads to several transgender people avoiding governmental medical services, including basic care such as inoculations and anti-retroviral treatment.

In a documentary made by Hazra, which she referred to during the interview, she spoke of a transgender woman's (referred to as *Kinnar*[512]) experience with a doctor

> [The] problem is the definition and the identity of who we are, people don't have any idea….they have their preconceived notion when they have to serve the trans people or a *Hijra* person they are involved only in sex work and don't have anything other thing to do in life…that actually creates more problem…[…] a *Kinnar* in the film, she was from Jaipur…she was telling me that she had some problem after a surgery [of an unrelated illness] but the doctors told her to open her blouse and all so he can examine her [breasts]…when she told that, 'my problem is not there', he said 'then you become the doctor'.[513]

In situations like this, when medical service providers themselves go beyond discrimination and verge into sexual abuse, the vulnerability of the group becomes specially pronounced, the more so due to the lack of protections and security mechanisms for transgender people. For instance, several *Hijras* who access the public medical system are afraid of reporting or filing a complaint about abuse in case it goes against them[514], given the

[511] Interview with Anupam Hazra, New Delhi, July 2015.
[512] Refer to glossary.
[513] Interview with Anupam Hazra, New Delhi, July 2015.
[514] *Hijras* are often considered to be a nuisance by many, as discussed earlier. Because of this, their complaints are often dismissed by counter-complaints by the service providers. When it comes to sexual abuse too, it is

fact that the *NALSA* judgment is yet to be translated into proper legislation, and that the position of the Indian *Hijra*, while strengthened through the judgment, is still socially ambiguous at best.

Currently, Tamil Nadu and Kerala are the only states that offer state-sponsored sexual reassignment surgery. Tamil Nadu's programme was started even before the *NALSA* decision acknowledging the presence of people who do not fit into the gender binary was passed. In 2016, Kerala decided to include it as a part of the government health scheme[515]. However, the lack of qualified medical personnel is an issue that not only plagues the public health system, but also the private sector. According to Hazra,

> there are hardly [any] people who can help us in terms of body modification or HRT or any kind of surgery. How many doctors have those skills? So, most of the times, when we have to go for sexual reassignment surgery we have to actually take help from [a] private clinic, [a] private doctor, and because most of the trans don't have money for that, sometimes they have to go for castration process to the quacks, that actually creates harm for them.[516]

Because of a lack of proper medical protocols around sexual reassignment surgery, several transgender people do not know that sterility is a necessary side-effect of proceeding

seldom taken seriously. Many a time, they are refused by police officers when it comes to recording their complaints, and instead harassed.

[515] T. K. Devasia, 'Why Kerala's Free Sex-Change Surgeries Will Offer a New Lifeline for the Transgender Community', Text, Scroll.in, accessed 9 October 2017, https://scroll.in/article/804496/why-keralas-free-sex-change-surgeries-will-offer-a-new-lifeline-for-the-transgender-community.

[516] Interview with Anupam Hazra, New Delhi, July 2015. Several Indian states also have Transgender Welfare Boards, with Tamil Nadu setting one up in 2013. Other states such as Kerala, West Bengal, Maharashtra, Andhra Pradesh and the city of Chandigarh (which is a union territory) have also instated such boards. However, many of them have come under the scanner for not functioning properly, including the one in Tamil Nadu, the state which started as the pioneer in this sector. Many states, as mentioned before, also introduced quotas in their universities for transgender candidates. While a step in the right direction, it discounts the fact that transgender children drop out of school as they either feel like misfits or are treated poorly. Some are too poor to access the education system as well.

with genital realignment, as the counselling seldom includes this aspect of the treatment. As Hazra described it:

> If I have money I can go through a proper process…I can go through counselling…there is pre-operative counselling that happens for 3-6 months from a reputed psychologist…but if this process is not happening then I am not aware what are the consequences I have to face after the operation…and people who don't have the money don't go through this process and they suffer.[517]

Perhaps one of the most challenging aspects barring transgender people accessing the health system is the entrenched discrimination they experience at hospitals or other healthcare units, including by medical professionals who are poorly equipped to address the specificity of their situation. This question was clearly described in an interview with by Simran Sheikh, whose experience I will quote at length:

> [T]hey say everybody is so well behaved with this community but unfortunately if you go to the remotest district you will find discrimination…people are yet to understand what are you…you are an alien to them…you are feminine but your voice is masculine…it can be anything…let's talk about anal STI… the doctors sitting in the government hospital [think], how did you get it? If you say, I had unprotected sex, or whatever reason, the doctor comes to [the] conclusion that anal STI has happened only and only because you are getting yourself [penetrated] from a wrong thing, and that's the perception. Doctor will not even understand what is right now troubling.... Rather they jump [to] conclusions….those are the stigmas that the community faces, and due to that, the community does not open up. Suppose there is some boils near my genitals - I will never

[517] Amrita, Indian interviews, New Delhi, July 2015.

> show it to the doctors because I know how uncomfortable he will get - I will say there is some itchiness or there is something happening….That's why I will hide it, and then I will get wrong medicines for it ad that will complicate the case more….Today when we look at HIV prospect in a trans person it is around 8.82% at a national HIV prevention level…and if you are talking about men having sex with men it is around 4.4%....you can imagine out of 100 people there are almost 9 people who are HIV positive [amongst transgender people] so you can [see that] the epidemic is growing fast because of health care systems which we are not able to focus [properly].[518]

Thus, despite the *NALSA* decision and moves instituted by states to integrate transgender people into the public systems, perhaps the lack of cohesion in the advances, coupled with the lack of a central legislation, keep affecting the transgender population adversely. This gets magnified when it comes to trying to access public services, especially services where people feel physically and emotionally vulnerable. While legal barriers are slowly overturned, the social barriers still prevent transgender patients to exercise their rights. The situation has changed wherein, earlier, they were visible but treated as invisible, but now, it has made people sit up and start talking.

6.4. Brazil's Healthcare Network

Brazil is an enormous country, with over two hundred million people spread over a little more than eight million square kilometres. In itself, this geographical and demographic constitution presents specific challenges and difficulties to the smooth functioning of public services across the country. Moreover, during the decades of military dictatorship, the lack of democratic accountability meant that several aspects of service provisions by the state were

[518] Interview with Simran Sheikh, New Delhi, July 2015.

abysmal. Most of resources towards the public health system were concentrated in the richer and more urbanised regions of south and southeast, while preferential access was awarded to certain professional groups, such as public servants[519]. The situation was such that in 1979, for instance, a New York Times article noted that in the country "disease from vermin is rampant among children."[520]

In the 1970s, several opposition groups to military rule – from social movements to trade unions – started to mobilise around demands for universal care by advocating the principle of "health for all"[521]. Indeed, universal health became an important aspect of a broader public debate about social rights and democratization which culminated in the 1988 Constitution, as already outlined above[522]. With democracy, many changes occurred in public administration and services, including higher levels of spending on social welfare, reduction of overall mortality rates, and increasing standards of living. Healthcare became a federal subject and a constitutional right. To be sure, states and the municipalities still maintained their roles and responsibilities towards citizens and residents as major providers of healthcare facilities and services. Yet, nationwide medical protocols are passed by the *Conselho Federal de Medicina* – the Federal Medical Council or CFM – as the primary decision making body in the sector[523].

Democratisation alone did not reverse the deeply rooted inequalities between social classes and different regions across the country, to a point in which "health inequality" in

[519] Ahmed Mushfiq Mobarak, Andrew Sunil Rajkumar, and Maureen Cropper, 'The Political Economy of Health Services Provisions in Brazil', *Economic Development and Cultural Change* 59, no. 4 (2011): 723–51, 726.
[520] Olga Khazan, 'What the U.S. Can Learn From Brazil's Healthcare Mess', The Atlantic, 8 May 2014, https://www.theatlantic.com/health/archive/2014/05/the-struggle-for-universal-healthcare/361854/.
[521] National Center for Biotechnology Information et al., 'Flawed but Fair: Brazil's Health System Reaches out to the Poor', *Bulletin of the World Health Organization* 86, no. 4 (April 2008): 248, https://doi.org/10.2471/BLT.08.030408.
[522] Valeria Guimarães de Lima e Silva, 'Public Health in Brazil | Carnegie Council for Ethics in International Affairs', Carnegie Council for Ethics and International Affairs, 15 December 2014, https://www.carnegiecouncil.org/publications/articles_papers_reports/0236.
[523] Decisions issued by CFM are supposed to be carried out by the national health system – SUS – which is described below.

terms of regional disparities in access and infrastructure was deemed relatively recently as Brazil's "most serious disease"[524]. As of 2014, there were 6706 hospitals in Brazil, with over 50% of them being concentrated in São Paulo, Minas Gerais, Bahia, Rio de Janeiro and Paraná. As of 2012, over 66% of the hospitals were private, whereas 73% of the ambulatory services (referred to as *ambulatórios*) were in the public sector.

Nonetheless, democracy brought about many changes. For instance, in 1990, the Brazilian government initiated a State-run unified healthcare system or the SUS[525]. While free for every citizen or permanent resident of Brazil, in its first decade of implementation the SUS reproduced regional inequalities, since the distribution of resources and equipment remained concentrated in state capitals, major cities and regional poles[526]. In 1994, the *Programa Saúde da Familia* (PSF) or the Family Health Programme was initiated to partially revert this trend and concentrate on the poorest areas of the country. The idea behind the programme was to focus on primary healthcare and make the family the main receiving unit, as opposed to the individual. Families are then attended by "health teams", i.e. teams of medical professionals who look into every aspect of medical care. Considered a highly effective programme, the PSF is running till date. It employs several thousand people, including community organizers and social workers, known as "barefoot doctors".

Brazil has a strong HIV prevention programme, with free testing and counselling, along with free anti-retroviral treatment available for all. For the treatment to reach HIV infected populations, there are seven hundred centres dedicated to the distribution of the medication across all the states.

[524] 'Health Inequities in Brazil: Our Most Serious Disease (Document Presented at the Launch of the Brazilian National Commission on Social Determinants of Health (NCSDH))' (Commission on Social Determinants of Health, World Health Organisation, March 2006).
[525] Referred to earlier.
[526] Mariana Vercesi de Albuquerque et al., 'Regional Health Inequalities: Changes Observed in Brazil from 2000-2016', *Ciência & Saúde Coletiva* 22, no. 4 (2017): 1055–1064, in 1056.

While the SUS has the duty to provide universal health coverage, it has often been the site of conflicts and lawsuits that are filed based on availability of high-end medications for specific diseases and needs. In 2008, for instance, Rio Grande do Sul spent twenty-two percent of the drug budget of the state to comply with 19,000 of such court orders. As already mentioned earlier, litigation in Brazil is still a lengthy and costly process, many times only accessible to those who can afford it. Indeed, the majority of the legal cases against the SUS were brought about by claimants belonging to privileged socio-economic backgrounds[527].

Besides the socially selective aspect of judicial conflicts, universal access to public healthcare is hindered by the State's inability to meet the high demand. Medical treatments may become a rather lengthy and laborious process, from patients struggling to make a simple doctor's appointment to long waiting lists to certain procedures. Consequently, those who can afford it opt for private healthcare and medical insurance services. Even then, however, the process can be difficult and quite time-consuming. [528] Moreover, although several local clinics and other healthcare providers are sufficiently equipped to meet the patients' demands, many people still opt to receive treatment in the larger cities, where, they believe, medical standards are higher or simply more practical or expeditious.

Thus, the general healthcare system is often a site for contestations, not in the least legal, and creates a situation of general discord, thus making it hard for people who need it the most to access it. Unfortunately, transgender people bear the biggest burden in this situation.

6.4.1. Transgênero ou Travesti? Alternative genders in the SUS

[527] Cesar G. Victora et al., 'Health Conditions and Health-Policy Innovations in Brazil: The Way Forward', *The Lancet* 377, no. 9782 (2011): 2042–2053, Ferraz (quoted earlier).
[528] In my own experience, when I was there to collect data in the Brazilian winter of 2016 in Rio de Janeiro, I had private insurance for the period I was there, but despite paying a large amount of money as premium, to avail services was arduous.

Transgender people have been acknowledged as a part of the Brazilian health system even before democratisation. In December 1971, a plastic surgeon, Roberto Farina, conducted the first recorded genital change surgery in Brazil to Valdir Nogueira, now Waldirene, at Oswaldo Cruz Hospital, in São Paulo. After changing her name with the permission of a Family Court Judge, Waldirene went back to her hometown of Lins in the interiors of São Paulo, where she led her life as a woman. A few years later, Dr. Farina was prosecuted in a criminal case, after he publicly presented the results of his surgery at a medical congress, in 1975. The state prosecutor, Luís de Mello Kujawski, claimed that the surgery Farina had performed was a crime of bodily mutilation under the Brazilian Criminal Code, Article 129 § 2, III, due to the irreversibility of the amputation of a healthy bodily part, therefore inducing the loss of the reproductive functions of the body. While Kujawski pushed for the conviction of the doctor in the criminal case, Waldirene's name change was revoked. On appealing the judgment, Farina was acquitted by two out a three-judge bench, which decided that his act had not been to cause harm, but, in fact, had intended to cure the patient.[529]

In 1977, the same Doctor Farina operated on Joana Nery, a psychologist. At the age of 26, Joana transitioned to João. On transitioning, João discovered that he could no longer practice as a psychologist as the law refused to recognise him as a male. Thus, began his journey of creating a new life altogether. Given the limits of the legal system at the time, when such transitional surgery was illegal, he could not get his name changed at the courts. Finally, he procured a male birth certificate, and currently has two social identification numbers – one of his past life as a woman, and one of his current self as a man. This came at a huge cost – as a man, he has no educational records, which means he cannot work as a

[529] For more information on this, refer to Aureliano Biancarelli, 'Transexuais querem direito a RG e cirurgia', *Folha de São Paulo*, 8 September 1996, http://www1.folha.uol.com.br/fsp/1996/9/08/cotidiano/29.html

psychologist any more. He makes ends meet working sometimes as a manual labourer or doing odd jobs.[530]

As these cases illustrate, at the time the CFM first brought up the discussion of "sexual conversion surgery", in 1979, it was still considered as bodily mutilation under the Brazilian Criminal Code as well as the Code of Medical ethics. However, the medical community seemed to favour the idea of the genital reassignment surgery, which was considered the most important step in the treatment of transsexualism, due to the possibility of integrating the body with the psyche of the person. The procedure was justified on the basis of two principles: autonomy, i.e. the right of self-determination and disposition of the body itself; and justice, i.e. the right of the person not to be discriminated against in surgery. These premises were included in the Opinion and Proposal of Resolution PC/CFM/N° 39/97, of 1997, the first comprehensive resolution on the medical, ethical, and social aspects of transsexualism and genital reassignment surgery in the country.[531]

Together with Resolution PC/CFM/N° 39/97, the CFM passed Resolution N° 1.482, which, for the first time, authorised and advised genital reassignment surgery for transsexual people, even if on an experimental basis. The CFM based the decision on both ethical and professional grounds, but also considered it imperative to secure the medical wellbeing of the individuals concerned. Indeed, the Resolution considers that "the transsexual patient carries a permanent psychological deviation of sexual identity, with the rejection of the phenotype and

[530] João W. Nery, Erro de pessoa: Joana ou João? (Editora Record, 1984) - its an autobiographical account by João of his journey through the first few years.

[531] The Proposal reads: "The principal motive for this surgery is the intention of aiding in (…) the search for the integration between the body and the sexual and psychological identity of the individual, while other principles involved in the ethical examination of this question are autonomy and justice: autonomy because it refers to the right of self-determination, including disposing of one one's body (…), in whole or in part (…); justice because it involves citizenship, the right of the person to not be discriminated against when seeking surgery, which is already available to the medium and upper classes."; 'Resolution PC/CFM No. 39/97' (Conselho Federal de Medicina, 1997), http://www.portalmedico.org.br/pareceres/cfm/1997/39_1997.htm.

tendency to self-mutilation or self-extermination."[532] While a step forward in its recognition of the possibility and desirability of medical realignment of the body, this framing of the issue remains problematic because it positions gender identity disorder – or *Transtorno de identidade de gênero* (TIG) – as the medical instrument through which to gain access to legal rights. As its critics have already pointed out, the idea of basing transgender identity in psychiatry, and that too as a disorder, fails to remove the stigma and discrimination around a person who, even in this context, is considered otherwise healthy[533].

Even considering this setback, the position assumed by the CFM prompted significant changes. Following the passing and publication of the Resolutions, the late 1990s saw a sharp increase in the demand for specific treatments, with an ever-increasing number of patients identifying as transsexual, seeking public healthcare[534]. To meet the rising demand, from the early 2000s, several university hospitals in the country launched initiatives to provide distinct medical programmes catering to the transgender population specifically[535]. At the same time, the question of access to medical treatment was further judicialised in 2001, when the Federal Public Ministry (*Ministério Público Federal*) moved, an action against the Health Ministry, demanding that the procedures involved in sexual reassignment surgery be made available to

[532] The Resolution considered ethical and medical grounds, considering that medicine has the ethical duty of working for the benefit of the patient, as well as the professional obligation of keeping up with new methods, research and technologies. 'Council Resolution 1482/97 CFM'.
[533] Translated from Márcia Arán, Daniela Murta, and Tatiana Lionço, 'Transexualidade e saúde pública no Brasil.pdf', *Ciência & Saúde Coletiva* 14, no. 4 (2009): 1142.
[534] Translated from Márcia Arán, Sérgio Zaidhaft, and Daniela Murta, 'Transexualidade: Corpo, Subjetividade e Saúde Coletiva', *Psicologia & Sociedade* 20, no. 1 (2008): 70, http://www.redalyc.org/html/3093/309326454008/.
[535] In 2006, the following institutions offered such services: *Hospital de Clínicas de Porto Alegre, Hospital Universitário Pedro Ernesto-UERJ, Hospital das Clínicas da Faculdade de Medicina da USP, Hospital das Clínicas de Goiânia, Hospital Universitário Clementino Fraga Filho-UFRJ, Instituto Estadual de Diabetes e Endocrinologia Luiz Capriglione (IEDE), Hospital das Clínicas da UFMG, Serviço de Urologia da Faculdade de Medicina de São José do Rio Preto, Hospital Universitário de Brasília*, and *Instituto Paulista de Sexualidade*. See: Márcia Arán and Daniela Murta, 'Relatório Preliminar Dos Serviços Que Prestam Assistência a Transexuais Na Rede de Saúde Pública No Brasil', 5, accessed 10 October 2017, http://pfdc.pgr.mpf.mp.br/atuacao-e-conteudos-de-apoio/publicacoes/direitos-sexuais-e-reprodutivos/direitos-lgbtt/Relatorio_Preliminar_set_20092.pdf. Because it was authorized on experimental basis, the Resolution No 1482 stipulated that genital reassignment surgery should only be available in University hospitals or hospital with research facilities. While this directive was later lifted, throughout most of the 2000s treatment to transgender patients was mostly limited to university hospitals.

transgender patients under the aegis of SUS. Because these procedures were already available to the general public under specific circumstances but not to transgender patients, the action posited that the Health Ministry was promoting discrimination on sexual grounds[536]. On this occasion, the experimental nature of sexual reassignment surgery, as defined by the CFM, was raised as an impediment to its inclusion in the list of services offered by the SUS, given that the latter only covers those treatments whose medical efficacy and safety are already well-established.[537]

Partially in response to this conundrum, in 2002 the CFM passed a revised medical protocol[538] whose main innovation was to lift the "experimental" character of male-to-female genital reassignment surgery, authorizing public and private hospitals to perform it regardless of their research activities or affiliation to a university. Female-to-male reassignment surgery remained "experimental", for, according to the Resolution, it still faced technical difficulties and had not yet achieved satisfactory results, both aesthetically and functionally[539]. Another relevant change was the more detailed definition of transsexualism, including: "discomfort with one's natural anatomical sex; the expressed desire to eliminate one's own genitals […] and to obtain the primary and secondary characteristics of the opposite sex; permanence of these disturbs in a continuous and consistent fashion, and for a minimal of two years; and the absence of other mental disorders".[540] The new CFM Resolution, once again, quite clearly reiterated the notion of transsexualism as a permanent psychological deviation of sexual identity, or more specifically as a diagnosable mental disorder. Thus, as many critics have

[536] Many of the medical procedures involved in sexreassignment surgery were available through SUS to cisgender patients as treatment to genital injury or malformation, but the same procedures were not offered as treatment to transgender patients. More on this context, see: Tatiana Lionço, 'Atenção Integral à Saúde e Diversidade Sexual No Processo Transexualizador Do SUS: Avanços, Impasses, Desafios', *Physis-Revista de Saúde Coletiva* 19, no. 1 (2009): 49–50.
[537] Lionço, 'Atenção Integral à Saúde e Diversidade Sexual', 50.
[538] 'Resolution No. 1625/02' (Conselho Federal de Medicina, 2002).
[539] 'Resolution No. 1625/02'.
[540] 'Resolution No. 1625/02' Article 3.

already noticed, the definition provided by CFM medicalizes the trans identity by making the pathologisation of the patient as the prerequisite for access to treatment.[541]

Despite these setbacks, by the mid-2000s public programmes specifically designed to the transgender public were already well established and serving a relatively large number of patients, such as in the Hospitals and Clinics of the Federal University of Rio Grande do Sul and the Faculty of Medicine at the University of São Paulo[542]. As a general rule, the standard treatment must be carried out by an interdisciplinary team[543] and must involve several stages, including: psychiatric evaluation with a follow-up period to confirm the diagnosis; group psychotherapy; hormonal therapy; genetic evaluation; and, finally, surgical intervention. Moreover, medical care occurs parallel to legal counselling in order to proceed with the name change and other formalities. The entire process is intended to deconstruct the previous identity entirely, while constructing a new self[544].

The 2000s also witnessed a sharp increase in the public visibility of Transgender and LGBT activism in Brazil. At the same time – and despite much institutional resistance to change due to the homophobia, prejudice and discrimination underlying various sectors of public service in Brazil – the State itself undertook various initiatives that demonstrated a sensible openness to the aspirations of LGBT groups[545]. These included the launching of national campaigns against Homo and Transphobia and the creation of a Technical Committee on Health for the LGBT Population, both in 2004[546], as well as several

[541] Pablo Cardozo Rocon, Francis Sodré, and Alexsandro Rodrigues, 'Regulamentação Da Vida No Processo Transexualizador Brasileiro: Uma Análise Sobre a Política Pública', *Revista Katálysis* 19, no. 2 (September 2016): 262, https://doi.org/10.1590/1414-49802016.00200011.
[542] Arán, Murta, and Lionço, 'Transexualidade e saúde pública no Brasil.pdf', 1142.
[543] As per Resolution No 1625/02, the team must be formed by a psychiatrist, a surgeon, an endocrinologist, a psychologist, and a social worker.
[544] Arán, Murta, and Lionço, 'Transexualidade e saúde pública no Brasil.pdf', 1142.
[545] Rocon, Sodré, and Rodrigues, 'Regulamentação Da Vida No Processo Transexualizador Brasileiro'.
[546] Ordinance of the Ministry of Health, no. 2.227, 14 October 2014.

conferences whereby activists and pressure groups could have a say in the formulation of public policy.[547]

In 2005, the question of transgender health came to the spotlight when the Ministry of Health, in collaboration with the State University of Rio de Janeiro's department of Social Medicine, organised a national conference to map out the current state of affairs on public policies on "Transsexuality and Health". Scholars, public servants, and representatives of social movements agreed on the need "to debate the question of transsexualism in all its aspects in order to foster a national, regional and local ethical compromise to improve the coordination and intensify the local and national initiatives for the treatment and assistance of transsexualism."[548] The Conference's recommendations included the incentive of research and organization and systematization of knowledge on transgender health across the country, the need to promote public sensitization campaigns, the expansion of SUS' coverage to certain medications and procedures, and the facilitation of the legal process of name and sex change in identification documents[549]. As these directives indicate, over the last years the medical and the legal started to converge in order to ascertain the citizenship rights of transgender people, or, in this case, specifically transsexual people.

In 2006, the Technical Committee on Health for the LGBT Population organised a meeting to discuss the integration of sexual reassignment procedures in the SUS framework. Attended by scholars and representatives of social movements, the event was of great importance because it helped pushing public debate away from the narrow focus on the medico-surgical aspects of sexual reassignment, and shed light on the broader process of

[547] A detailed account on all these initiatives can be found in: Lionço, 'Atenção Integral à Saúde e Diversidade Sexual No Processo Transexualizador Do SUS'; Luiz Mello et al., 'Políticas de Saúde Para Lésbicas, Gays, Bissexuais, Travestis e Transexuais No Brasil: Em Busca de Universalidade, Integralidade e Equidade', *Sexualidad, Saludy Sociedad-Revista Latinoamericana*, no. 9 (2011), http://www.redalyc.org/html/2933/293322075002/; Jaqueline Gomes de Jesus and Hailey Alves, 'Feminismo Transgênero e Movimentos de Mulheres Transexuais', *Revista Cronos* 11, no. 2 (2012), https://periodicos.ufrn.br/index.php/cronos/article/view/2150.

[548] Arán, Murta, and Lionço, 'Transexualidade e saúde pública no Brasil.'.

[549] Arán, Murta, and Lionço, 'Transexualidade e saúde pública no Brasil'.

gender transitioning, with all its social and psychological implications.[550] As Tatiana Lionço has noted, at this point the depathologisation of the transsexual identity was defended as a strategy to promote health, while the debate was more focused on the integral right to health than on the medicalised gaze[551]. Indeed, following the meeting, the late 2000s witnessed two ground-breaking steps in the realization of transgender rights.

Firstly, in 2008, the Health Ministry formalised directives for the integration of sexual reassignment treatment in the SUS framework[552]. The decision reiterated the principle that sexual orientation and gender identity are social determinants of health, and therefore require specific attention from the state. It also set technical and ethical standards by establishing that the treatment offered should be humane, non-discriminatory and integral, that is, involving the process of gender transition and the patient's health in its entirety, and not only in its medico-surgical aspects[553]. Secondly, in 2010, the CFM passed a new medical protocol revoking the expression "absence of other mental disorders" as a criterion of eligibility for sexual reassignment, replacing it by "absence of mental disorders"[554]. This was a significant semantic step, for the CFM explicitly, and for the first time, moved away from a definition of

[550] The Meeting was titled "*O Processo Transexualizador no SUS*", meaning, literally, "The Transexualizing Process in SUS". The term "*processo transexualizador*" has since been widely used in public discourse, public policy and in the academic literature as the broader process of gender transitioning, which includes but is not limited to sexual reassignment.
[551] Lionço, 'Atenção Integral à Saúde e Diversidade Sexual No Processo Transexualizador Do SUS', 51. Lionço Atenção integral à saúde, p. 51.
[552] Ordinance no. 1.707. Since female-to-male sexual reassignment surgery remained labelled as experimental as per CFM's Resolution, only male-to-female patients are contemplated in this policy. In addition, this ordinance was restricted to transgenital surgery, not including mastectomy, hysterectomy, or hormonotherapy. Therefore, it was also not applicable to travestis. See Rocon, Sodré, and Rodrigues, 'Regulamentação Da Vida No Processo Transexualizador Brasileiro', 263.
[553] Guilherme Almeida and Daniela Murta, 'Reflexões Sobre a Possibilidade Da Despatologização Da Transexualidade e a Necessidade Da Assistência Integral à Saúde de Transexuais No Brasil', *Sexualidad, Salud y Sociedad-Revista Latinoamericana*, no. 14 (2013). The decision by the Health Ministry in 2008 was greatly based on the Charter of Rights of Users of Health (*Carta de Direitos de Usuários da Saúde*), promulgated by the Ordinance no. 675, of 31 March 2006, which explicitly mentions the rights to humane and non-discriminatory treatment to all users of SUS.
[554] 'Resolution No. 1955'.

transsexualism itself as a mental disorder[555]. This resolution is applicable across the country, irrespective of private or public hospitals, clinics and ambulatories.

Following the Health Ministry's directives, the healthcare system under SUS initially started four *Ambulatórios Transexualisadores* – gender reassignment ambulatories – spread across the country, in different university hospitals.[556] They opened the doors for *travestis* and transsexuals to be diagnosed as suffering from TIG, undergo hormonal therapy, and proceed with the various modalities of plastic and genital surgery involved in the gender transitioning process (the *processo transexualizador*). Today, there are nine such installations, out of which five offer sexual reassignment surgery[557]. The services rendered by them cover psychiatry, hormonal therapy, endocrinology and plastic surgery.

Moreover, following the principle of integral treatment laid out by the Ministry of Health, several state governments have launched specific ambulatories to treat transgender and travesties patients on a variety of medical, psychological and social matters – and not only issues directly involved with sexual reassignment or HIV/Aids. The *Ambulatórios TT* (*Travesti* and Transgender Ambulatories) generally count on a multidisciplinary staff that includes medical specialities such as urology, endocrinology, dermatology, psychiatry, as well as psychologists and social workers. They fill an important gap by providing the transgender population a safe space where their needs can be attended to without any fear of

[555] The resolution still keeps female-to-male reassignment surgery as experimental.
[556] Initially, the institutions authorized to offer this service were: *Programa de Transtorno de Identidade de Gênero* (Protig), of the Hospital de Clínicas of Porto Alegre/UFRGS; the *Unidade de Urologia Reconstrutora Genital do Hospital Universitário Pedro Ernesto/UERJ*; the *Ambulatório de Transexualidade – Projecto Sexualidade* (Prosex) of the *Instituto de Psiquiatria do Hospital das Clínicas da Faculdade de Medicina/USP* and *Project Transexualismo* of the *Hospital das Clínicas* of Goiânia. Márcia Arán, 'A Saúde Como Prática de Si: Do Diagnóstico de Transtorno de Identidade de Gênero Às Redescrições Da Experiência Da Transexualidade', *ARILHA, Margareth; LAPA, Thaís de Souza; PISANESCHI, Tatiane Crenn. Transexualidade, Travestilidade e Direito à Saúde. São Paulo: Oficina Editorial*, 2010, 80.
[557] Besides the 4 hospitals the *Hospital das Clínicas of Universidade Federal de* Pernambuco also offers sexual reassignment surgery. In early 2017, other four clinics have been accredited by the Ministry of Health to provide different services within the SUS, including hormonal treatment and the pre- and post-surgery monitoring of the patient: *Hospital das Clínicas de Uberlândia, Instituto Estadual de Diabetes e Endocrinologia do Rio de Janeiro, Centro de Referência e Trainamento DST/AIDS de São Paulo*, and the *CRE Metropolitano*, in Curitiba. Source: http://portalsaude.saude.gov.br/index.php/o-ministerio/principal/secretarias/sgep/sgep-noticias/27154-ministerio-da-saude-habilita-novos-servicos-ambulatoriais-para-processo-transexualizador

discrimination or ill treatment, as it often occurs in general clinics or hospitals[558]. The first *Ambulatório TT* was created in 2009 in São Paulo, in the framework of the Programme of STD/Aids of the State Secretary of Health (*Secretaria Estadual de Saúde*)[559]. Since then, many other states followed suit, and now *Ambulatórios TT* exist around the country[560].

Yet, despite the many advances in the medical and legal fields as well as in the formulation of public policy, implementation has been consistently deficient. The passing of laws and regulations over the years, for instance, does not mean that clinics, hospitals and health professionals became informed and well-prepared to receive the growing numbers of transgender patients. One of my informants, Daniela Murta, a famous psychologist and researcher on transgender rights in Brazil, reminisced that

> [i]n 1997, a person who knew about the [CFM] resolution and [went] to the hospital and said, I want to make the surgery, now I can do it, and none of the professionals there - everyone was [a] psychiatrist - no one knew about that, and they looked for it, what happened, what CFM decided, because they didn't know, and then they started the programme, without any formality, any paper, anything, just the psychiatrist started the consulting and looking at what was defined in the CFM constitution, that this girl needs to be two years assisted by him … After two years, this girl, [she] looked for reassignment surgery, as [she] wanted to do that, so [she found an] endocrinologist and a urologist and they make the surgery.[561]

[558] Mello et al., 'Políticas de Saúde Para Lésbicas, Gays, Bissexuais, Travestis e Transexuais No Brasil', 19-20.
[559] A detailed description of the work of the *Ambulatório TT* in São Paulo is provided in Maria Clara Gianna, 'CRT DST/Aids-SP Implanta Primeiro Ambulatório Para Travestis e Transexuais Do País I', *BIS. Boletim Do Instituto de Saúde (Impresso)* 13, no. 2 (2011): 182–189. Gianna describes how the *Ambulatório TT* works in cooperation with the *Hospital das Clínicas* of São Paulo, which remains the main institution to provide sexual reassignment surgery (p. 99). The *Ambulatório TT* provides a variety of services, from psychological evaluation and social service to various medical modalities.
[560] Today, *Ambulatórios TT* exist in Florianópolis, João Pessoa, Belém and Piauí, among others.
[561] Interview with Daniela Murta, Rio de Janeiro, July 2016.

However, this caused the patient to become a source of conjecture and ridicule. As Murta recalled, "it was a big confusion in the hospital because everybody wants to know who is the girl who made the surgery and take pictures."[562]

Murta's research on transgender health involved setting up a psychotherapy group among the various transgender patients who were visiting the hospital in Fundão. The hospital authorities and staff were not particularly aware about the specifics of her project. In fact, many of them conjectured that she might be investigating on behalf of the government, and, accordingly, were careful not to misbehave with the transgender patients at least in front of her. However, she realised that this special care should be part of the treatment being offered, and not something a researcher ought to be doing on the margins. She told me: "I woke up and I thought, I am the reflection of their invisibility. […] While I was staying there, they were taking this place of invisibility, […] it's not fair to them."[563] Murta became particularly aware that the hospital was not looking into the special needs of the transgender patients specifically. At the end of the day, she was not an employee of the hospital, but an absolute outsider who was volunteering her help unbeknownst to the authorities, which should have set up the support group in the first place.

Murta and her colleagues uncovered other deficiencies when conducting research to map out the situation on the ground in 2008-2009. They found a predominant inconsistency in medical protocols, with each doctor or therapist proceeding differently, even though they all claimed to be closely following the dictates of the CFM. For instance, Murta told me:

> [T]he psychologist from Goiânia used a test, what we call personality test, that we use for understanding [if] the person is psychotic, [if] that the person has any kind of personality

[562] Interview with Daniela Murta, Rio de Janeiro, July 2016. In this quote, Murta was talking about a transgender woman, who had gone to the Fundão Hospital in the state of Espirito Santo.
[563] Interview with Daniela Murta, Rio de Janeiro, July 2016.

> disorder, for understanding if someone is transgender or not because … you should see a psychologist or a psychiatrist … to know if you are a transgender or if you are a transsexual, but … the instruments that were being used are not the instruments that indicate it. In São Paulo, […] the psychologists and psychiatrists use another word – psychodrama – that I found is a good way, and the other psychologist was trying to validate a test to know if someone is transgender or not... In Porto Alegre, the psychiatrist worked with interviews. In Sergipe, the psychiatrist who's also a psychoanalyst is working with psychoanalysis. You hear people, and he always says that, I don't know what I am looking for and, sometimes in the analysis, I have the real impression that I am talking to a woman, so for me, I make my diagnosis like that – this I decided. So it was very strange for me when I saw a lot of services working with the same people [but each in their own way], but saying that they were using the same reference from the CFM resolution.[564]

This makes the confusion around the medical resolution very apparent, with each healthcare provider using his/her own methods to come to their own conclusions and going more by gut instinct than by approved rules.

Moreover, as is the case in South Africa, there is a very long waiting list for all services being rendered. According to Murta, the current health protocol requires that "they need to be 2 years in treatment, to be sure about 'your transition', so this law in Brazil for the public health system took psychologists and psychiatrists as the main professionals […] in this process"[565]. However, as Murta points out, the waiting period can often become years, "because the service [doesn't] have space, they don't have conditions to have the surgery. So people stay around 7 years 10 years waiting for surgeries."[566] The Pedro Ernesto Hospital

[564] Interview with Daniela Murta, Rio de Janeiro, July 2016.
[565] Interview with Daniela Murta, Rio de Janeiro, July 2016.
[566] Interview with Daniela Murta, Rio de Janeiro, July 2016.

with the UERJ, for instance, opened their doors for a mere four years before being declared full. While the people who are already in the system keep going through the therapies required, there is little if no room for new patients. Unfortunately, Murta's research revealed that this is the situation for all the ambulatories in question.

Moreover, several transgender individuals who want to undergo gender affirming surgery feel frustrated as the waiting time is often quite lengthy. In those cases, they often end up scraping together money to go abroad for surgeries in places like Thailand. On their return, however, in several instances these individuals have to visit the ambulatories to care for post-surgery issues or complications, which at times includes further surgeries. This has resulted in a change in mindset to an extent. According to LGBT activist Mário Carvalho,

> [P]eople … want[ed] to travel go to Morocco or Thailand, but nowadays many trans people prefer to do it here. Mainly trans women that went to Thailand they had really big problems after surgery and they had no support, and they had to end up fixing the problems of their surgery here in Brazil, … which made many trans people say, I am going to do in Brazil, I prefer to wait 2-3 years in Brazil than do it outside[567].

Moreover, while there is the constitutional right against discrimination for transgender people, the transgender citizen in Brazil remains a highly pathologised person. As Professor Marco Aurelio Prado puts it, "if you are a transgender, you have a crime before you have a crime, you know what I mean? The social pressure – you are socially criminalised even before you are an actual criminal."[568] This has resulted in several instances of transgender people being shunned in public service settings, from being refused service to being ill-treated overall.

[567] Interview with Mário Carvalho, Rio de Janeiro, June 2016.
[568] Interviews with Marco Aurelio Prado, Rio de Janeiro, July 2016.

Institutional resistance to enforce legislation accounts for a great part of the problem. A relevant case in point pertains to the use of the "social name", that is, the name with which transgender people identify and by which they present themselves socially, regardless of their biological sex or civil name (e.g. the name assigned at birth and figuring identity documents). For years, the right to use their social name has been at the forefront of transgender advocacy in Brazil. The evident mismatch between people's appearance and gender identity, on the one hand, and their identity documents, on the other, is too frequently a cause of embarrassment, anxiety and a trigger for discrimination, thus imposing serious restrictions to the realization of citizenship rights to transgender people.[569] While many have attempted to change the name in their identity documents through adjudication, the dominant jurisprudence tends to attach the possibility of legal name change to the completion of gender transition, including sexual reassignment surgery.[570] The Charter of the Rights of the Users of Health, passed in 2006 by the Ministry of Health, guarantees the right of any patient to use whatever name they "prefer to go by, irrespective of their civil documents"[571].

However, there are many challenges to the realization of this directive, which remains largely ineffective[572]. Particularly considering that health services function rather differently at different levels, various state-run and city-run clinics and hospitals tend not to follow this rule[573]. Fearing the possible discrimination and ridicule resulting from their inability to use

[569] de Jesus and Alves, 'Feminismo Transgênero e Movimentos de Mulheres Transexuais', 11.
[570] Bento, Berenice, 'Carta Potiguar - Identidade de Gênero: Entre a Gambiarra e o Direito Pleno', accessed 7 October 2017, http://www.cartapotiguar.com.br/2012/05/29/identidade-de-genero-entre-a-gambiarra-e-o-direito-pleno/.
[571] Third Principle, I. Ordinance 675, 30 March 2006. More recently, on 28 June 2017, the Federal Decree no. 8.727 guaranteed the right of *travestis* and transsexuals to use their social names in all aspects of public federal administration, and banishes the use of any pejorative or discriminatory expression to refer to them.
[572] Mello et al., 'Políticas de Saúde Para Lésbicas, Gays, Bissexuais, Travestis e Transexuais No Brasil', 15.
[573] The right of a transgender person to use their social name does not excuse them from having to present proof of their civil name per their identity documents as well. The legislation requires that hospitals and medical professionals refer to patients by their social names, as well as provide them with registration forms that allow them to introduce their social name in addition to the civil name. Yet, these directives are often not followed.

their social name, several transgender people prefer to stay away from clinics and hospitals. As Murta told me,

> [E]verybody says, I won't go there, the doctor never call[s] me the name that I asked; I go there, they call me 'he' all the time. I don't want to be there, or they don't know, they use the social name, and they didn't see that the person uses her social name, and they call the male name and the person must stand up and go when they are called.[574]

Another serious obstacle is that, given that several general clinics and hospitals do not have transgender-specific wards, transgender patients who might require treatment for minor ailments are often shunted about from department to department. Murta recalled her days at the *Fundaçao Oswaldo Cruz*, when "one volunteer who was trans [was unwell and needed to be hospitalised] and […] the only vacancy she could find was in Infectology […] She [didn't] have any kind of infectious disease, but this was the only place which would accept her!"[575].

As already mentioned above, this problem has been partially addressed by the creation of *Ambulatórios TT*. However, the very existence of this niche service may serve as an excuse for refusal of treatment elsewhere. Indeed, a transgender person going to a general family clinic or to specialist doctor may be refused service and redirected to a transgender-specific ambulatory. While such practices have the adverse effect of overburdening the ambulatories, they also expose the pervasiveness of discrimination within the public health system. Moreover, given the stretched nature of the health system, not every ambulatory is capable of performing all the services at the rate required. As a consequence, patients often have to travel extensively to the nearest facility where the necessary procedure is available. Fortunately, the

[574] Interview with Daniela Murta, Rio de Janeiro, July 2016.
[575] Interview with Daniela Murta, Rio de Janeiro, July 2016.

SUS covers travel costs, but the inconvenience and related costs are a deterrent to many patients.

Within the transgender population, *travestis* are particularly marginalised given their non-conformity with the legal and medical framework around which Brazilian public policy has evolved in the last decades. As mentioned above, according to the CFM, transsexualism requires the "desire to eliminate one's own genitals", while acquiring the genital characteristics of the opposite sex.[576] This definition automatically excludes *travestis*, whose identity, sexual practices and medical needs do not necessarily involve genital surgery, but often remain rooted in their desire to keep the penis[577]. When the Ministry of Health drew on CFM's directives to define its public policy on gender transitioning under SUS in 2008, it tacitly excluded *travestis*. In 2013, when the Ministry widened its coverage of the sexual reassignment process by increasing the number of medical procedures offered, it also explicit recognised *travestis* as eligible patients[578]. Yet, because surgical procedures are still dependent to the diagnosis of transsexualism, *travestis* are effectively denied all procedures except hormonal therapy.

Similarly, in the same year, a bill was tabled at the Congress that looks at the amendment of the name and gender-change laws in Brazil, and legalises the right to one's own gender identity. Following in the footsteps of the Argentinian legislation, the bill provides clauses for persons to self-identify their names and gender and be acknowledged

[576] 'Resolution No. 1955'.

[577] As the coordinator of the *Ambulatório TT* of Uberlândia, Flávia Teixeira pointed out: "Travestis claim a different place than transsexuals. Travestis seek a place that is very uncomfortable. That is, they claim that penis, they speak about that penis, they have pleasure with that penis… This is what makes everyone uncomfortable. (…) It is not a problem for the travesty to be (sexually) a top with their husband."(self-translated) Quoted in: Anibal Guimarães, 'Ambulatório de Saúde Integral de Travestis e Transexuais Do Estado de São Paulo: Relatório de Duas Visitas (2010-2012)', *Bagoas-Estudos Gays: Gêneros e Sexualidades* 7, no. 10 (2013): 274, http://ufrn.emnuvens.com.br/bagoas/article/viewFile/5387/4402.

[578] Ordinance No. 2.803, 19 November 2013. The services offered are: monthly appointment to monitor patient for at least two years before surgery and one year after; hormonal treatment; male-to-female sexual reassignment; and related or complementary plastic surgeries (e.g. voice change, reduction of Adam's apple, etc.). An important change is that this regulation includes various procedures to aid the female-to-male transition (except phalloplasty), such as mastectomy and hysterectomy.

accordingly in all legal instruments. While this was passed through till the plenary session of the Chamber of Deputies with only one amendment about the right of minors (i.e. below 18 years of age) to change their names and gender identity, as of 2016 it was yet to be passed, and had received the approval of only the Commission of Human Rights and Minorities. In Murta's words, "the status that we have now is that [a] transsexual woman can do everything, a trans man can do some of the procedures and *travestis* can only do hormones."[579]

Therefore, while the system has gone a long way to acknowledge the existence of *travestis*, their inclusion is still on marginalised terms. Indeed, for a *travesti* to be able to access further surgeries under SUS, she has to assimilate under the transsexual discourse. Furthermore, *travestis* are particularly vulnerable to suffer prejudice and discrimination from medical professionals, given their common association with sex work and drug abuse[580]. As a consequence, when confronting a psychologist or psychiatrist for evaluation, a *travesti* will seldom identity as such for the fear of being judged or being denied access to treatment. In fact, because desirable procedures such as breast implants are harder to access for *travestis*, many resort to precarious and unsanitary implants of cheap industrial silicon, which often results in serious, potentially deadly, health complications[581].

There is one loophole in the situation, and in the most unlikely of places, which shows how the Brazilian legal administrative system is a contradiction in terms: the prison system. While prisons are state-run mechanisms, the Federal Government has instituted grants for states who comply with making their prisons more LGBT friendly. Should a person declare himself or herself as homosexual, they are generally put in what is known as "Ala LGBT" or

[579] Interview with Daniela Murta, Rio de Janeiro, July 2016.
[580] For instance, from the patients registered at the *Ambulatório TT* of São Paulo, sexwork was the single most common occupation (48), followed by hairdresser (31), unemployed (15), student (10), seller (5), and domestic worker (5). In Guimarães, 'Ambulatório de Saúde Integral de Travestis e Transexuais Do Estado de São Paulo'.
[581] Health complications related to usage of industrial silicon remains one of the major problems the travesty population seeks the *Ambulatórios TT* to treat. In Guimarães. 'Ambulatório de Saúde Integral de Travestis e Transexuais Do Estado de São Paulo'.

the separate LGBT prison cells[582]. This follows for people who identify as transgender and transsexual. While the cells themselves are little different from the ordinary prison space, it is still preferable as LGBT inmates often face violence and abuse when placed with the general population. Based on his research of the prison system, Marco Prado mentions that a common statement from individuals incarcerated in special cells is: "I was in the normal prison before and it was violent every day, and people treat[ed] me [badly] but now I have these friends here, it's a LGBT prison… they call you with your social name, they cannot cut your hair."[583]

While in theory the health system should extend to prisons as well (as seen in a case with AIDS medication in South Africa), unfortunately in Brazil the reality is much different. Speaking from his observations, Prado reported that HIV-positive LGBT inmates, including transgender women, often do not receive treatment during incarceration. Yet, as he notes, "the laws say they should get treatment. The law is very beautiful in Brazil, […] but institutions are bad. So, we have this gap between the law and the real life."[584] In a similar observation about the gap between policy and implementation, or between the law and social conditions in Brazil, Professor Guilherme Almeida stressed that "the human rights policy for transgender people of this country is a farce, but it is the best farce that we have so we adore it and we are trying to safeguard it"[585].

[582] The *Pacto Federativo*, or the Federal Pact – it is not an obligation for the state, but on the basis of the pact, they may be persuaded to create more inclusive prisons. Minas Gerais has such prisons. Also, the arrests attributed to drug trafficking by is disproportionately high primarily because of the ambiguity of drug trafficking laws, where the peddler and user are often confused.

[583] Interview with Marco Aurélio Maximo Prado, Rio de Janeiro, July 2016.

[584] Interview with Marco Aurélio Maximo Prado, Rio de Janeiro, July 2016. Prado also mentioned that there is a great disparity in sentencing of cis gendered and transgendered people, with transgendered people getting harsher sentences for the same crimes. The judges seem to thrust a criminality on the transgendered person merely based on being transgendered.

[585] Interview with Guilherme Almeida, Rio de Janeiro, June 2016.

The Brazilian gaze towards *travestis* is of suspicion. General people consider them to be "*malandragem*"[586]. This attitude towards them keeps *travestis* from accessing public services, especially healthcare, even when they really need to access it, as they fear discrimination. Because of this, *travestis* seek out self-medication, even in times of great distress. This often leads to severe health complications, and even death. In an interview with Taís Azevedo from São Paulo, who happened to be the only person amongst my interviewees who proclaimed herself to be a *travesti*, she mentioned that the life expectancy of an average travesti is less than 40 years. She was about 62 at the time of the interview, being, in her own words, an anomaly.[587] This might seem to be a stretch, but the kind of violence and general stigmatisation that comes with being a *travesti*, this did not come a surprise.

6.5. South Africa's Healthcare System

The current South African healthcare system was set up on the ashes of what was left behind by the crumbling apartheid state. Throughout the many decades of white rule, for the most part the health of the black population was only prioritised when it came to maintaining a sizeable labour force. Moreover, due to restrictions in the education sector, only a few black people were educated as doctors or any type of healthcare service providers. The exception was the Second World War period, when black women were trained as nurses due to a shortage of professionals in the sector[588]. Still, during the Apartheid Era, public health was fragmented and compartmentalised: there were fourteen separate health departments, one for each racial group – black, coloured, Indian and white – and one for each nominally

[586] Carvalho talks about this character from folklore who is referred to as a "*malandro*" or a person who has ill intentions and cons people through disguises. The *travesti* is often treated the same way: as a man masquerading as a woman, who is disreputable, involved in crimes. Brazilian interviews, Rio de Janeiro, June 2016.
[587] Brazilian interviews, São Paolo, July 2016.
[588] Hoosen Coovadia et al., 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges', *The Lancet* 374, no. 9692 (2009): 829.

independent apartheid homeland.[589] This created unequal situations for each group, both with respect to quality of the service as well as funding opportunities, and the best healthcare providers and facilities were concentrated in the predominantly white areas[590].

In 1994, full reforms were instituted to dismantle this racial departmentalisation and to create a unified health system, propelled by the constitution of South Africa guaranteeing health for all. Thus, the National Health Plan commenced, which focused on overall health (drawing from the Constitution) as opposed to just medical care. It took a long time to dismantle the old system in its entirety given the disparate way it was set up, not to mention the financial implications involved. Despite its inadequacies, the National Health Plan is the primary go-to for a very large part of the South African population. South Africa spends 11% of its annual budget on healthcare, but it is yet to meet up with the outcomes expected from middle-income countries, primarily due to the high levels of inequity, poverty and inequality still existing in society. Much of the budget concentrates on HIV and tuberculosis treatment, which is no surprise given the large number of HIV infected and affected people in Southern Africa in general, and in South Africa in particular[591]. The budget is spread across nine provincial governments. However, each province has a different level of development, which also creates a larger burden of poverty-related afflictions in the underdeveloped states' medical setups[592].

As of 2015, there were 4200 public health facilities with each of them catering to over 13000 people. Since 1994, 1600 clinics have been built new or upgraded, while there are 376 public hospitals and 265 diagnostic and health research services under the National Health

[589] For information on the homeland and Bantustan policies, refer to Henry J. Richardson III, 'Self-Determination, International Law and the South African Bantustan Policy', *Colum. J. Transnat'l L.* 17 (1978).
[590] Coovadia et al., 'The Health and Health System of South Africa', 825; Dr. Marjorie Jobson, 'Structure of the Health System in South Africa' (Johannesburg: Khulumani Support Group, October 2015), 4.
[591] Salim S. Abdool Karim et al., 'HIV Infection and Tuberculosis in South Africa: An Urgent Need to Escalate the Public Health Response', *The Lancet* 374, no. 9693 (2009): 921–933.
[592] Coovadia et al., 'The Health and Health System of South Africa', 826–27.

Laboratory Service. However, despite this, on an average, a person has to travel around five kilometres to access a health clinic[593].

While there are over 165000 qualified healthcare providers including over 38000 doctors and 5500 dentists, 73% of them are part of the private sector, thus putting an enormous amount of pressure on the doctors in the public sector – 1:4219.[594] A 2012 audit found that several community health centres were understaffed, and often did not have a visiting doctor[595]. Part of the reason for having such an overwhelming gap between delivery requirements and service providers is the looming shadow of the apartheid past. Given that transition to non-discrimination and majority rule has occurred quite recent, several members of the population are still very much impoverished to a point where education is a luxury, thus making it more difficult for black people (who still make up the majority of the poor people[596]) to enter the medical profession. Despite all this, the private healthcare sector is flourishing, and is considered to be one of the best in the Global South. There are several health insurance companies, but restricted to those who can afford it[597].

Post-apartheid South Africa, therefore, is invested in creating a more equitable health system for everyone with several new strategic plans such as fast-tracking the National Health Insurance Scheme, development of the HIV/Strategic Plan to reduce the number of new HIV infections and the related stigma around it. Yet, for economically disadvantaged citizens till date it remains difficult to fully access healthcare services. The situation is further complicated when it turns to the transgender population, because of a great amount of racial and religious prejudice that there is in South Africa in general.

[593] Jobson, 'Structure of the Health System in South Africa', 3.
[594] Mafika, 'Health Care in South Africa', *Brand South Africa* (blog), 2 July 2012, https://www.brandsouthafrica.com/south-africa-fast-facts/health-facts/health-care-in-south-africa; Jobson, 'Structure of the Health System in South Africa', 3.
[595] Mafika, 'Health Care in South Africa'.
[596] Jobson, 'Structure of the Health System in South Africa', 10,11.
[597] My own experience of using private medical services in Cape Town, ZA, was seamless and queer-friendly.

6.5.1. The problematic body of the South African transgender person

South Africa's healthcare system has been built to provide primary health care to everyone, thus not taking into account the different needs of different populations, or the inequities in accessing the services. In other words, "[c]urrent healthcare practices are often based on an assumption of sameness, rather than ensuring equal access to services while taking into account the needs of different people and groups"[598].

Such differences exist on a variety of issues. For instance, a study was conducted at the University of Natal, Paediatric Surgery Unit, where seventy-one children over a 16-year period were diagnosed with hermaphroditism, with a a disproportionately high level of black South Africans being affected. Moreover, the study aimed to try and create a protocol for "the management for children with true hermaphroditism", as the researcher feels that leaving "ovotesticular tissue"[599] in the bodies of these children can have complications in the future[600].

Another study carried out in the abovementioned unit reviewed 85 patients retrospectively over 18 years set out to investigate the "management dilemmas associated with true hermaphroditism in a Third World population". This study brought to the forefront the problems faced by doctors when assigning a gender to a child in a situation where upbringing is entirely gender-based. While the researcher states that the gender of the older child (and parental wishes) needs to be taken into consideration, the black South African society's bias towards male children is also taken into account. However, despite the bias, several intersex children were treated as female instead of male because the basis of

[598] 'Sexual and Gender Diversity Position Statement' (Psychological Society of South Africa, 2013), 2 http://www.psyssa.com/documents/PsySSA_sexual_gender_position_statement.pdf.
[599] Where the tissues of ovaries and testicles have fused with each other, and are inseparable.
[600] Rinus Wiersma, 'Management of the African Child with True Hermaphroditism', *Journal of Pediatric Surgery* 36, no. 2 (2001): 397–399.

identifying the gender was the descendance of the scrotum (or the absence thereof) and not the existence of the penis.[601]

The reasons laid out for surgical intervention at an early stage on the intersexed body are mainly pragmatic. While chances of malignancy are low, it is considered desirable to remove ovotesticular tissue for the lack of poor follow-up by the parents[602]. The different types of management in surgery can be either early interventional where an infant is made to "fit" into an assigned gender, or a cosmetic surgery where the child "is able to determine the child's own gender". This can be further managed during puberty by an endocrinologist and psychological management by the parent of the child.[603]

Throughout these medical procedures described above, what stands out is the supposed propensity of the intersex or hermaphrodite child to appear among black South Africans, and the need to remove such tissues in order to make the child fit into the gender binary. This is not only race-based eugenics, given the propensity to focus these studies on the black population, but also the need for corrective surgery to make human beings conform to the medically normative. While the research might show a pragmatic concern about complications that might arise later, such as underdeveloped gonads during puberty, or something like the lack of access to healthcare due to poverty, medical determinist tendencies are in full flow across the three researches mentioned above.[604]

[601] Rinus Wiersma, 'True Hermaphroditism in Southern Africa: The Clinical Picture', *Pediatric Surgery International* 20, no. 5 (2004): 363–368.

[602] The subjects across Wiersma's research have been referred to the Paediatric unit at the University of Natal from peripheral hospitals across Kwazulu Natal. This involves traveling to the city for treatment, thus making socio-economic factors very important in the ability to leave the intersex body undisturbed.

[603] Rinus Wiersma, 'The Clinical Spectrum and Treatment of Ovotesticular Disorder of Sexual Development', in *Hormonal and Genetic Basis of Sexual Differentiation Disorders and Hot Topics in Endocrinology: Proceedings of the 2nd World Conference* (Springer, 2011), 101–103, http://link.springer.com/10.1007/978-1-4419-8002-1_21.

[604] Swarr, '"Stabane," Intersexuality, and Same-Sex Relationships in South Africa'. Swarr also talks about race-based eugenics which developed in the mid-19th Century, and how they influenced the gathering of data in apartheid South Africa where lowering medical interventions with the black population was a method of population control, and data on physical anomalies from that period cannot be strictly relied on.

For a person to undergo gender change in South Africa, the state requires that the transgender person go through four stages as a precondition to be given permission to access and undergo sexual reassignment surgery. The stages are assessment, psychotherapy, real-life experience and hormonal (or surgical) therapy[605]. This is in keeping with the WPATH 7 Guidelines. However, in reality, while these services might be availed from the public health system by getting onto the waitlists, to get a gender change on paper from the Home Affairs' Ministry can be an uphill battle, such as in the case of Nadia Swanipoel.[606]

Universal access to public health services is important primarily due to the lack of affordability of private health care by the general black transgender person in South Africa[607]. However, governmental health services discriminate against transgender people and lack a human rights based approach towards their clients. Moreover, health providers are frequently ill-prepared to deal with patients who come in with HIV-related complications (this goes for cis-gendered patients and patients of alternative sexual identity). Accessing post-exposure prophylaxis is often a problem for transgender people, and situations have arisen where instead of being given the PEP patients have been shamed by the healthcare professionals[608]. In one instance, a lesbian woman was repeatedly told by healthcare providers that she could not get HIV as she had a girlfriend and that they both had vaginas[609].

According to Newman-Valentine et al, there is a disproportionate relationship between the service giver and the service taker in a public health care setting in South Africa. For

[605] D Wilson et al., 'Transgender Issues in South Africa, with Particular Reference to the Groote Schuur Hospital Transgender Unit', *South African Medical Journal* 104, no. 6 (15 May 2014): 449, https://doi.org/10.7196/SAMJ.8392.
[606] 'Transgender Woman Battles with Home Affairs for True Identity', accessed 7 October 2017, https://www.enca.com/south-africa/transgender-woman-battles-home-affairs-true-identity.
[607] Martine Collumbien and A. Qureshi, 'Sexuality, Power Dynamics and Abuse among Female, Male and Transgender Sex Workers in Pakistan', in *Poster Presented at the 19th World Congress for Sexual Health, Goteborg, Sweden, June*, 2009, 21–25, https://assets.publishing.service.gov.uk/media/57a09de7e5274a27b2001adf/WAS_poster_Collumbien.pdf.
[608] 'Silenced and Forgotten: HIV and AIDS Agenda Setting Paper for Women Living with HIV, Sex Workers and LGBT Individuals in Southern African and Indian Ocean States', Open Policy Paper (Johannesburg: UN Women and Open Society Initiative for Southern Africa, 2011).
[609] Stevens, 'Transgender Access to Sexual Health Services in South Africa', 12.

instance, the service giver has the power to refuse treatment and surgery for gender realignment. One service taker used the metaphor of "playing God" for the doctor who refused her treatment. Some service providers, in addition, overstep the ethical boundaries of their medical position by insisting on proselytizing to their transgender patients about the needlessness of their actions in wanting gender realignment[610].

In certain instances, the spectacle of a transgender person coming into a clinic takes precedence over providing treatment, often resulting in embarrassing and humiliating situations for the patient. For example, a transgender woman who had gone to a public clinic for general treatment was asked by the nurse to take off her clothes. Seeing her genitalia to be not something she expected, the nurse got two other nurses in to see the body of the patient. This kind of a situation was repeated in another case where a transgender woman refused to have a pregnancy test and when she told the doctor why, she was subject to being looked at by another doctor who was brought in to see the anomalous body. [611]

While this might have been a case of curiosity, albeit demeaning for the transgender person, in other situations service providers' treatment of transgender patients demonstrates a fear of the unknown at best, and complete lack of professional preparation at worse. At first glance, service providers are not always well equipped to identity and address transgender women who appear to be cis-gendered, and can ask them inappropriate questions on their periods or birth control techniques[612]. Transgender women have also reported to suffer a degree of bad treatment upon disclosure of their gender identity status. This leads to many

[610] Newman-Valentine and Duma, 'Transsexual Women's Journey towards a Heteronormative Health Care System'.
[611] Newman-Valentine and Duma; Stevens, 'Transgender Access to Sexual Health Services in South Africa', 11.
[612] Stevens, 'Transgender Access to Sexual Health Services in South Africa', 11.

transgender people trying to access healthcare in the private sector, which is often expensive and unaffordable[613].

Because of all this, the lack of a transgender-specific ward in hospitals is a burning issue[614]. One transgender woman stated that she had been first put in the female ward, and after her operation, was taken out of the female ward, and put in a side ward. There, the doctor did not even come to visit her. This kind of neglect or being overlooked seems to be a common phenomenon. Another transgender woman who had suffered a stroke stated that she was just given medication and left to her own devices. She had no support from the healthcare providers on her road to recovery – whether it was the physiotherapy required or speech therapy.[615]

The tertiary healthcare sector has always taken care of gender reassignment in South Africa. However, for the smallest of ailments, transgender patients are referred to the tertiary healthcare centres, irrespective of whether they could have been treated easily at the primary healthcare centre[616].

A study conducted by Gender Dynamix in 2012 in Kwazulu-Natal[617] revealed that there was a major dearth in the understanding of transgender people and their needs by healthcare professionals. More often than not, they conflated transgender people with gay and lesbian people, thus confusing one's needs with the other. While some of the health service providers interviewed in the study mentioned that they would be comfortable talking about sexual health with their patients, they were ignorant about the sexual needs of non-

[613] Newman-Valentine and Duma, 'Transsexual Women's Journey towards a Heteronormative Health Care System'.
[614] Extrapolated from my interviews with Catlehoe Of Gender Dynamix and Arnaud de Villiers, South African Interviews, Cape Town, June 2015.
[615] Newman-Valentine and Duma, 'Transsexual Women's Journey towards a Heteronormative Health Care System'.
[616] T. Nkoana and M. Nduna, 'Engaging Primary Health Care Providers in Transgender Community Health Care: Observations from the Field', *New Voices in Psychology* 8, no. 2 (2012): 120–129.
[617] Lebohang Moloi, 'KwaZulu Natal Transgender and Gender Non-Conforming Needs Assessment Report 2012' (Gender DynamiX, September 2013).

heterosexual and non-cis gendered people. Moreover, with the influence of the church in various rural areas, they don't want to come across like people who are "fuelling bad behavior"[618], that is encouraging people to step away from normative stances of sexuality and gender. Overall, they admitted that there is a dearth of information or guidelines on medical treatment to gender non-conforming people.

An interview-based case study found that Primary Healthcare professionals tend to believe that gender reassignment is a luxury and a cosmetic change. In certain instances, service providers even try and dissuade transgender patients from undergoing gender reassignment surgery by claiming that the procedure is frequently unsuccessful. This type of approach invariably deprives poor transgender people from an important medical intervention for their well-being. Given that gender reassignment in private hospitals is highly expensive, it puts them in a financially precarious position should they try to access privates services[619].

Psychiatrists and psychologists are considered to be the "gatekeepers" of access to healthcare facilities for transgender people, not only in South Africa but elsewhere as well. They get to decide who is gender-nonconforming enough and who is not, in order to be able to access medical services designed for gender realignment or reassignment. The whole process leading to diagnosis is about managing the gender-dysphoric body, and making it conform to specific norms and not necessarily looking at the transgender person's betterment. However, the entire notion of going to a psychiatrist can be stigmatised. For a person who does not receive any psychiatric treatment, or has no other psychiatric need requiring the attention of a mental health specialist, the entire notion of going to such a person can be abhorrent and socially stigmatising[620].

[618] Moloi, 'Needs Assessment Report',11.
[619] Nkoana and Nduna, 'Engaging Primary Health Care Providers in Transgender Community Health Care'.
[620] Wilson et al., 'Transgender Issues in South Africa, with Particular Reference to the Groote Schuur Hospital Transgender Unit'.

Mental health professionals, thus, can make or break possibilities for transgender people to access the type of care they want or require. In many instances, mental health professionals have been noted to thrust their personal, sometimes even religious, beliefs onto their patients when it came to gender reassignment. For instance, one transgender male patient was denied gender reassignment when he showed that he knew how to hold a baby, as in the psychiatrist's eye this was something that was not a male characteristic. Moreover, in other cases sexuality and gender are confused, as when a psychiatrist told his transgender male patient that by transitioning to male, he could only have relationships with females, and that by not wanting to do so, he proved he was not transsexual[621].

Besides an apparently complete lack of training and knowledge on issues of gender, sexuality and transsexual health by service providers, many still spouse archaic and outdated notions. For instance, in one of the largest hospitals of Johannesburg, healthcare providers were still using Harry Benjamin Principles and SOC7[622], while there was no specific guideline on how to treat transgender patients.

There have also been many reported cases of transgender people being refused treatment until they sought a private (and consequently expensive) psychiatrist for evaluation and assessment of their transgender identity. The reason behind this is a dearth of psychiatrists and psychologists at primary health care centres who are trained in evaluating and diagnosing transgender people. Also, those who do end up receiving treatment often get different qualities of behaviour from the service providers on their subjective belief on whether the transgender patients fit into either the male or female binaries, and how well they

[621] Klein, 'Necessity Is the Mother of Invention', 171.
[622] Harry Benjamin was a German-American endocrinologist and sexologist who was one of the first people to pen down an understanding around transsexual people. One of his most famous patients was Christine Jorgensen, who brought the issue to the international limelight. The Harry Benjamin International Gender Dysphoria Association is now known as WPATH.

play their role.[623] This kind of attitude is not just a lack of training in transgender specific psychology and treatment but also a lack of professionalism on the part of the medical service providers[624].

Such a situation can be traced back to elementary stages such as medical schools themselves. A curriculum mapping exercise[625], for instance, found that the University of Cape Town's health sciences curricula were inadequately equipped to deal with the health issues faced by LGBT people. For instance, in their medical course, MBChB (Bachelor of Medicine and Bachelor of Surgery), teaching on LGBT health issues is optional and mostly haphazard. However, at the same time, in comparison with the US and Canada, the curricula does cover a large portion on sexual reassignment surgery and transitioning. This may be directly linked to the existence of the Groote Schuur Hospital's Gender Reassignment Unit[626]. However, as the cases show, access does not necessarily guarantee humane treatment.

When it comes to psychologists and psychological professionals, depathologisation and respect for individuality puts forth a path for better interaction between them and their patients. Thus, the Psychological Society of South Africa issued a statement in 2013, ten years after Act 49 of 2003 came into power, stating that psychology professionals acknowledged the differential treatment meted out to non-heterosexual people in the past, and affirmed their respect for gender and sexual diversity and individual self-determination[627]. This is seen as a positive step forward in keeping with global trends. Moreover, they are to

[623] Nkoana and Nduna, 'Engaging Primary Health Care Providers in Transgender Community Health Care'.
[624] Thamar Klein, 'Querying Medical and Legal Discourses of Queer Sexes and Genders in South Africa', *Anthropology Matters* 10, no. 2 (2008), http://www.anthropologymatters.com/index.php/anth_matters/article/view/37, 170-171.
[625] Alexandra Müller, 'Teaching Lesbian, Gay, Bisexual and Transgender Health in a South African Health Sciences Faculty: Addressing the Gap', *BMC Medical Education* 13, no. 1 (2013): 174.
[626] The University of Cape Town, as of 2014, had decided to update its undergraduate curriculum and include transgender issues. Several professors had also promised to update their curricula to include transgender issues, and one Dr. Adele Marais encourages students to research trans health. Liesl Theron and Moly Egerdie, '2nd Trans Health Advocacy and Research Conference: Rooted in the Past, Reaching for the Future' (Gender DynamiX, December 2014), 6, http://www.genderdynamix.org.za.
[627] Theron and Egerdie, 'Rooted in the Past, Reaching for the Future', 8–10.

take into account the "impact of multiple and intersecting forms of discrimination against sexuality and gender diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical sensory and cognitive-emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality"[628].

In the whole of South Africa, as of 2016, there were two hospitals where transgender people feel the staff and procedures are transgender friendly, e.g. the Chris Hani Bharagwanath Hospital (CHBH in short) of Johannesburg, and the Groote Schuur Hospital (GSH), located in Cape Town. The latter is the only provider of transgender-specific health care at a tertiary level. Its transgender clinic was opened in 2009, and has a multidisciplinary team including an adult psychiatrist, endocrinologist, gynaecologist and, among others, a social worker. Due to the harsh realities of limited primary and secondary healthcare available for transgender people, they admit patients in requirement of all types of care. The clinic works within a depathologisation framework, and follows WPATH recommendations on gender issues. Patients often have to travel extensively to reach them, which creates a considerable financial burden on them[629].

A third hospital, the Steve Beko Academic Hospital in Pretoria, also has a trans-specific clinic, but it has been cited by several transgender service users as being unfriendly and negative towards them. In addition, it has a tendency of referring patients to expensive private psychiatric clinics for evaluation on being trans. Given that many of the patients going to public hospitals are economically underprivileged, this puts a severe burden on them.

[628] 'Sexual and Gender Diversity Position Statement', (Psychological Society of South Africa, 2013), 9.
[629] Theron and Egerdie, 'Rooted in the Past, Reaching for the Future', 29–30.

Moreover, the hospital staff refuses to interact in local bantu languages, which often acts as a massive barrier for patients to be able to communicate their health dilemmas.[630]

With merely two hospitals offering gender reassignment surgery and complementary procedures, the vast majority of transgender people are virtually prevented from access to treatment. Moreover, given the paucity of resources, each hospital is incapable of doing more than five surgeries a year, resulting in incredibly long queues. The waiting list at the GSH, for stance, goes as far as twenty-five years ahead[631]. An ongoing joke in the activist circles states that one should put one's new-born child on the waiting list, in case in twenty-five years' time, the child would want a gender reassignment surgery![632]

Because of this deficiency in service, those transgender patients who can afford it opt to seek treatment in Thailand, where many doctors have far more experience and expertise in gender reassignment surgery[633]. Indeed, in South Africa there are organisations which raise money for transgender people to get their surgeries done in Thailand[634]. While different surgeries are required for different people with varying budgets and needs, this option is still more financially accessible than to seek treatment with of a private South African doctor.

6.6. Comparing IBSA

The right to health and healthcare cannot be examined in isolation. Legislations and medical protocols give the framework to investigate the implementation of healthcare and other components of the right to health, but without seeing its interaction with its beneficiaries, measuring its efficacy will fall short.

[630] Extrapolated from my interviews with Johann Meyer and Dilene Van Dyk, Cape Town, June 2015.
[631] Wilson et al., 'Transgender Issues in South Africa, with Particular Reference to the Groote Schuur Hospital Transgender Unit'.
[632] Extrapolated from my interview with Dilene Van Dyk, Cape Town, June 2015.
[633] Klein, 'Querying Medical and Legal Discourses of Queer Sexes and Genders in South Africa' 176-177.
[634] Interview with Dilene Van Dyk, Cape Town, June 2015.

In this context, for a better understanding of the situation, a comparative table with information drawn from above might lay the situation in front of us in a clear light:

6.6.1. Table: Factors affecting the access to healthcare for Transgender people

Factors	**India**	**Brazil**	**South Africa**
Historic acknowledgement of transgender population	Yes: from ancient times with roots in mythology	Yes: but more in the form of the feminised drag queen, called *travesti*	Not as such, but there are records of women taking on male roles, such as the *sangoma*
Socio-legal acknowledgement of transgender population today	Yes: as "third gender", *Hijras, Kinnars*, etc. (in the indigenous categories) and transgender	Yes: as *travesti* and transsexual, more than transgender	Yes: as transgender man or transgender woman
Constitutional provisions for the right to health	Yes, but as a directive principle	Yes	Yes
Constitutional provisions for healthcare systems	Yes, but as a directive principle of state policy	Yes, under Social Rights	Yes, in the list of rights without any demarcation as a social right
Constitutional provisions for the right to a healthy life	No, but the Supreme Court of India has expanded various constitutional rights to include the right to a healthy life	Yes, but under workers' rights, and not under the right to health.	Yes, but indirectly.
Legislations around transgender acceptance/gender change	None yet, but Supreme Court decision is there, and a bill is pending. HOWEVER, several government documents allow for "other" or "third gender" as categories now.	No, but medical protocols from the Ministry of Health, and the ability to change the social name. HOWEVER, there is no fixed judging criteria about the social name change. Documents are all	Yes: Alteration of Sex Description Act, which DOES NOT require surgical intervention. HOWEVER, there is no fixed criteria on changing gender markers, whether the person has

		according to gender binary.	transitioned or not, despite medical interventions. Documents are all according to gender binary.
Health programmes available nationally that target the transgender population as a key group	HIV prevention and ART access programmes	HIV prevention and ART access programmes	HIV prevention and ART access programmes
Provision for gender reassignment/hormonal therapy under private insurance	No	No	No – only one company has paid for sexual reassignment surgery
Curriculum change/inclusion for primary medical studies	None yet	None yet	None yet
Gender marker change dependent on hormonal replacement/surgery	Unsure due to lack of legislation till now	No, but judges insist on surgery at times	No, but judges insist on surgery at times
Special provisions in the health system for transgender clients	None yet, but sporadic moves by different states have taken place	Several Ambulatories to deal with everything regarding gender realignment, but limited to hormone therapy for travestis. Male-to-female transitional surgery allowed, female-to-male considered experimental. Requires psychiatric evaluation and sign-off.	Two hospitals in the entire country dealing with gender realignment. Male-to-female female-to-male transitional surgery allowed. Requires psychiatric evaluation and sign-off
Waiting lists	Unknown	Yes, as much 20 years – lack of funds, due to provincial funding	Yes, as much as 25 years – lack of funds, due to provincial funding,

		as opposed to national	as opposed to national
Barriers faced by transgender people in trying to access public healthcare (including transgender-specific services)	Lack of education, lack of services, class-related stigma from service providers, superstition-related stigma from service providers (multiple minority status), stigma associated with curiosity of the unknown from medical staff.	Lack of education, lack of services, racial and religious stigma from service providers, class-related stigma from medical staff (multiple minority status).	Lack of education, lack of services, racial and religious stigma from medical staff and from service providers (multiple minority status).

As we can see above, India is still grappling with the implementation of judicial decisions when it comes to transgender-specific healthcare. The public healthcare system is still essentially looking at transgender people through the specific health intervention programmes running to prevent HIV and other associated maladies, except where states have set up their own facilities. On the other hand, Brazil and South Africa have defined healthcare measures for transgender people. However, when it comes to being able to access it, several factors act as barrier to them.

Moreover, in all three cases, the public healthcare system is heavily burdened. Thus, with a utilitarian approach, it might not look at transgender-specific issues as highly necessary. Given that both South Africa and Brazil have fewer service providers than required for transgender people, while the services are available, access by sheer numbers and length of time become a problem.

Across these contexts, curricula for medical students have to undergo a drastic change, along with alternative gender and sexuality sensitisation at the training level for all service providers. It takes a tremendous amount of courage for a transgender person to come into a setting where her or his body is under scrutiny. To face ridicule in settings where the person is

already vulnerable makes it difficult to openly discuss several health issues. Sexual reassignment surgeries are often the least of the medical needs of transgender people. Other than the general diseases associated with age, with unregulated hormone replacements, several transgender people run a higher risk of various ailments. Also, where sexual and reproductive health is seldom discussed with transgender people in mind, risky sexual behaviour might lead to further complications.

As mentioned earlier, to avoid social complications and interactions with prejudiced service providers, several transgender people resort to going to quacks who administer hormones and even industrial silicone for getting feminine curves, with often devastating results. Those who can afford it try to go to countries where gender reassignment surgery is relatively easy and cheap. However, the post-operative care is seldom of the intensity it needs to be, which leads to several health complications.

In this situation, given India's nascent stage in healthcare practices, there is a chance to create an improved model of transgender healthcare which is more inclusive than exclusive, and learn from the failures of fellow global south countries. However, as to whether that will come to pass remains to be seen.

6.7. Conclusion

India, Brazil and South Africa are racing towards economic greatness within the trajectory of the Global South. However, this kind of greatness often comes at the cost of the rights of minority populations, especially with a one-size-fits-all policy being operated in various sectors. This chapter examined the way healthcare is implemented as a public good in India, Brazil and South Africa. It investigated the way they have grown in their respective countries, and what challenges they have faced along the way in building their systems.

Thereon, it led into how transgender people fit into the existing systems and what changes have taken place in order to make healthcare more accessible for them, and what still hinders their achieving their right to health, such as misidentification, non-identification, etc.

As the table in the section above shows, while India is doing somewhat worse in terms of inclusivity in the healthcare sector, overall, the three countries have severe loopholes between law and policy and implementation. This lag seems to only grow worse with poor budgeting at the centre for all countries concerned.

Transgender people are often denied services and access to services because of their gender identity and/or expression. While many service sectors behaving in this manner might not affect the quality of transgender lives directly, when it comes to the health sector, it is crucial to the basic minimum that human beings need for their existence, as they are often high on the lists of people at high risk for various diseases. Thus, when transgender people are denied access to health services, it affects them disproportionately, because, given their already marginalised situation, it pushes them towards self-medication, fear of health-service providers and further marginalisation.

Denial of access to health services is not the only barrier that many transgender people face, but often experience abuse and harassment, both mental and physical in medical settings. Sometimes, even if they come across a transgender friendly service, they might not be able to afford it. Many a time, even if they have private health insurance, it does not cover transitioning costs. This situation is not just prevalent in the jurisdictions covered in this dissertation, but in various places across the world. The gap between law (and policy) and reality is vast. It has taken several years of activism for transgender visibility to reach where it has.

Many transgender people do not want to go through the entire invasive surgical procedure of gender reassignment, and opt for some of the non-invasive procedures. First and

foremost, medical service providers often aren't aware of the anxieties that transgender people feel about their body being medically examined by them, and they are often treated like a spectacle since transgender people are not commonly found. In various cases, people often dress to suit their biological gender when going to a medical service provider in order to not be ridiculed. In other situations, they opt to not go to medical service providers at all.

Physicians who are more experienced with transgender-specific care are hard to locate, especially in public hospitals. However, wherever the governmental health departments have set up transgender ambulatories or clinics, transgender people often go there with the most minor ailments that should be taken care of at the local clinics. The fear of being ridiculed and harassed, as well as the healthcare providers immediately redirecting them to the ambulatories, makes this happen. In many instances, where transgender people opt for private healthcare, insurance schemes do not cover gender reassignment surgeries or hormonal replacement therapy.

Law and medical policy often go hand in hand in constructing the transgender body. In many instances law leads to medical policy, and in others, vice versa. Legal documents often reflect the name assigned at birth, as well as sex assigned at birth. However, with a visual appearance differing in the normative gender lines set in the documents required in day to day activities such as opening bank accounts, buying transport passes, etc. people are often questioned beyond necessity.

With all the progress that these countries are making, in many ways, their expenditure on public goods is lagging, especially in the area of healthcare. Despite having universal healthcare within their public structures in some form, to say that most of the population in any of these countries is covered would be a tenuous claim. If this is the case for cis and able bodied people, it gets severely aggravated when it comes to a minority population that is veering between misidentification and criminalisation. So long as the transgender population

is not considered important enough to take them into account when making changes, so long as their voices are not heard out loud and clear at the very top, it will be difficult for them to be able to access healthcare per their needs.

7. Conclusion and recommendations

> I'm transsexual, and I'm not sick. And I'm not going to listen to you say that about me, or people like me, any more.[635]
>
> – *Susan Stryker*

7.1. Introduction

The primary aim of this dissertation was to try and encapsulate the highly varied transgender experience of exercising citizenship rights – especially the right to health – in three of the most important countries of the Global South – India, Brazil and South Africa. In order to substantiate my research, I interviewed people from the transgender communities or associated with transgender advocacy and organizations in all three countries. What I found out on the ground was in many ways more hopeful than what I had initially anticipated or expected.

In order to give a legal, theoretical and historical underpinning to my dissertation, I explored the right to health in international and domestic legal and jurisprudential contexts, intellectual debates on gender and sexuality, citizenship and its historical evolution into how we exercise it today, the background of the countries of India, Brazil and South Africa, and how the identities of transgender people evolved within their domestic contexts. Finally, I looked at how the right to health plays out for transgender people when trying to access health determinants and healthcare. I shall summarise my findings and conclude with what I hope may be a useful framework to fall back on for various institutions and organisations in order to become more inclusive and empowering.

[635] Susan Stryker and Stephen Whittle, *The Transgender Studies Reader* (Taylor & Francis, 2006), 1.

7.2. The Right to Health – its evolution and application in India, Brazil and South Africa

As seen in Chapter 1, the right to health is a highly complex right that has gained primacy because of its interrelations with civil and political rights despite it being seen as a socio-economic right. A contextualised approach to the tight to health is the only way to realise the "highest attainable standard of health". This can only be achieved through a combination of factors because, as described earlier, the social determinants of health play an interconnected and pivotal role. In other words, each of the social determinants play a particularised role in achieving health and creating access to various aspects of health.

International covenants and conventions have been crucial in shaping the right to health in both domestic and international contexts. Here, the push from the Latin American countries during and right after the Second World War paved the way for the UDHR. This in turn helped to bring about the ICCPR and the ICESCR. After several decades of struggles for implementation and human rights advocacy around the globe, today there are organisations specifically trying to report on various social determinants of health, from international bodies such as WHO and UNDP to local NGOs virtually everywhere. As I have pointed out above, it has become increasingly evident that when those determinants suffer, human rights in general suffer, and consequentially health suffers.

While the voluntary aspect of international covenants and conventions means that these documents are not strictly enforceable, they are not irrelevant either. Indeed, they have had the effect of persuading and encouraging countries to promote domestic legal change and improve their performance in what regards to implementation. In addition, the accountability of governments before their citizens has increased, sometimes as a result of the naming and shaming of state policy in reports and studies. The right to health is no exception to this.

The importance of mitigating life-threatening diseases was not unknown before the setting up on international conventions. However, perhaps no other infection or affection has mobilised the world as much as HIV/AIDS did. It was internationally felt that people infected or affected by HIV/AIDS have a higher level of vulnerability from a both social and medical perspective and, therefore, require specific protections against the violation of their rights. Moreover, the recognition of gender differences and inequalities by the global human rights movement brought about several changes in policies across the world. Because of the high vulnerability of HIV/AIDS infected and affected people, the connection between the right to health and civil and political rights also became strikingly evident.

India, Brazil and South Africa were no exceptions to these states of vulnerability and change. Perhaps these countries are theatres on which the association of human rights and the right to health have become ever more complex, especially because of the postcolonial nature of each of these societies and the challenges they have faced in recent decades, from apartheid to dictatorship and economic strife. Social stigma and discrimination on various grounds still carry on. When one adds a physical or a medical vulnerability to this, it only serves to take stigma and discrimination even further. Also, the fact that all three countries are developing countries with sizeable populations means that the resources available, while large, are still scant per capita.

All three countries in the IBSA triangulation have strong constitutions, given their past histories, embedded in more or less recent social struggles for equality, rights and democracy, with Brazil having its current constitution passed in the 1980s and South Africa in the 1990s, after moments of particularly intense popular mobilization. The wordings of the constitutions, in these situations, helped pave the way for the judiciary to exercise checks and balances on the actions of the state. However, the judiciaries in question, as explained above, have often

changed their stance towards the government – sometimes being supportive of their policies, and at other times, going wholeheartedly against them.

As seen above, litigation on the right to health has been from multiple standpoints – from the very direct Brazilian cases of individualised claims to South Africa's HIV/AIDS pandemic remedying, to India's litigation on compulsory licensing for generic medicine manufacturing, housing and water. This dissertation has made an intervention in this field by grounding intellectual and legal debates on gender identities, human rights and the right to health to the actual experience of citizenship rights by transgender people on the ground. In what follows, I shall briefly go through the most relevant lessons learned.

7.3. Transgender citizenship – from the abject to the citizen

The question of citizenship and social belonging are necessarily entangled to the ways in which certain sexual behaviour and non-normative gender identities are rendered abnormal, excluded from society at large, and sometimes even criminalised. As I have stated above, this is so important because rights are exercised within the parameters of a state and mediated by the experience of citizenship. When one is not identified, or given recognition as a full-fledged citizen due to a disruptive gender identity or a non-normative body, the process of asserting and claiming one's rights before the state becomes a struggle for survival there is sometimes difficult to win. Yet, the Foucauldian monster is not only a silent outsider: its constitution and positioning at the margins of society and the state speaks to the prevalent regime of truth and constantly challenges it. By exposing the arbitrary line between inside and outside, inclusion and exclusion, normal and abnormal, the monster holds the potential of effecting change in the direction of a more inclusive politics, including in matters of citizenship.

Indeed, intellectual and political debates alike have only recently fully considered the need of recognizing social difference and cultural diversity as a defining mark of citizenship in contemporary societies. While much debate on how different groups relate to an otherwise universal model of citizenship has been going on for decades, gender and sexuality remained marginal until recent articulations of feminist and queer theorising and political mobilization brought them to the spotlight. This includes global advocacy for gender equality and LGBT rights.

As mentioned above, notions of binary gender identities and normative sexuality are essential to the law, and become a primary significator for demarcating legal personhood, for defining who is a legitimate citizen and who is to be excluded from full citizenship. Here, the illegitimate citizen is sometimes rendered invisible. The non-normative person is thus pushed into adopting a normative identity and to fit into a normalised category, often through medical procedures leading to legal recognition. This is the case of transgender people in the situations where legal gender exists only along binary lines. They are forced to enter the gender binary, or are doomed to fight all battles within private spheres as they lack public legitimacy.

Yet, as my discussion of the various forms of recognition of the transgender identity in India, Brazil and South Africa shows, through advocacy and legal change, the former monster can be assimilated into citizenship with the recognition that it has some specific qualities and needs the state must care for. In all three countries, transgender identity has been given indirect cognizance through the law and specific public policy set up to cater to the needs of the group. Because in these contexts the transgender population is highly diverse, coming from various backgrounds in what relates to race, class, and social status, political grouping tends to emphasise what is a common ground, that is, the experience of non-normative gender identity. Transgender, thus, operates as an umbrella term to bind a social group upon which the state must act upon and to which rights and protections must be granted.

As this dissertation has showed, the terms of this inclusion can prove problematic at times, especially when it invariably adopts a medicalised gaze. Moreover, legal recognition often carries with it a different type of identity politics, for instance by raising the question of who qualify as member of the group and thus is eligible to access specific rights and public policy. Given the many differences amongst the members of the group, this at times involves rivalry and competition for resources. All these issues demonstrate the complexity underlying the practice and experience of transgender citizenship in diverse and shifting societies. At the same time, they also offer a hopeful note, one of increasing inclusion and empowerment, even if not devoid of challenges.

7.4. IBSA and the transgender person

India, Brazil and South Africa are powerhouses of the Global South. Yet, they are still to come to terms with poverty, inequalities and the marginalisation of various sections of their population. Transgender people, in their different manifestations across these three countries, are no exception. Structural inequality and a certain precariousness of state services are marks of these postcolonial societies still struggling to overcome the legacies of the relatively recent past in what relates to issues of citizenship and human rights. Yet, another common ground is the robust and progressive constitutionalism that, in these three contexts, followed the political transition to what was to be a more egalitarian society. While gender-based discrimination is outlawed in the three constitutions, the everyday experiences of transgender people are far from satisfactory.

As seen above, while South Africa does not allow transgender individuals to legally identify with a third gender or as non-binary, it has legislation that allows for the change of name and sex description. However, public medical services are ill-equipped. Moreover, there is a communication gap between the different departments of government that make accessing

name-changes and gender marker changes highly difficult. Additionally, a waiting list of around 25 years is a formidable challenge for any medical system, and is telling of the difficulties in implementation and accessing rights. Regional inequalities also play an important role. With a federal system, the implementation is strong in certain parts of the country and poor in others.

Brazil, as explained above, while not having any legislation recognizing transgender identity as such, has used medical protocols to enhance the access to health for transgender people. However, societal discrimination and the stigmatised image of the *travesti* ensure discrimination remains a pervasive reality on a variety of fronts. The lack of a centralised legislation legitimising the transgender identity has created barriers in every walk of life. In addition, there is a distinct lack of consistency to the advancements made, as public policy has been largely dependent on the disposition of elected administrations rather than on legal or social change. Consequently, many of the rights and protections put in place lack the strength to inspire true confidence in the transgender community, as they can easily be stripped away if there is a change in administration or in the political climate of the country.

India, despite having a prolonged history of interaction with transgender people, has only now stepped up to the challenge of creating a more inclusive environment mostly thanks to public interest litigation for them. However, the Transgender Bill is yet to be passed into an Act, and the socially stigmatised image of the *Hijra* has not been yet alleviated. Moreover, the third gender category is not universally applied throughout governmental administrative and identity documentations, despite the judicial decision for it.

7.5. Barriers in achieving and exercising full citizenship

Despite significant progress in the fields of democratisation and rights affirmation, as seen above, transgender people have been a much-neglected population. Till date, their needs, not just in the field of healthcare but also in society at large, are barely understood. There is a dearth of proper information on transgender populations including their tremendous diversity, which is in many ways occluded by their grouping as transgender in the first place. Coupled with misinformation, stigma and prejudice against them, therefore leading to discrimination, transgender people find it even more difficult to access their rights. As stated earlier, this gets magnified when exercising their right to health – from trying to find information to accessing the actual service, they face barriers throughout.

There is clearly a lack of public education on transgender population. Indeed, seldom does a school book contain a story with a transgender character or, for that matter, seldom does a school curriculum include notions of gender identity beyond gender binaries. In fact, education tends to work for the reification of binaries rather than for the elucidation over the diversity of gender identities. As I could verify through interviews, when positive steps do occur, they are often expressions of a limited and precarious endeavour, and do not reach the level of a consistency nationwide policy.[636] This leads to an invisibility of the population, and coupled with societal pressures and prejudices, it creates more harm for them.

Because transgender people are discriminated against in employment and education sectors, they are disproportionately affected by scarcity of resources and opportunities, when not simply doomed to a life of poverty when devoid of family or financial support. Access to housing, basic services or even public places at times are affected negatively because of their gender identity and appearance. In addition, because of the exclusion from most avenues for

[636] In a conversation with a government employee at the Ministry of Education, I was told public schools in the Brasilia area were allowing transgender students to go by their "social name." It was mentioned that this was merely a directive that could easily be reverted after the next elections, depending on the views of the new cabinet. I was also told that this kind of initiative tends to receive much opposition from parents, which is a symptom of the gap between progressive policy change and social conservatism.

employment, primarily for transgender women, the range of possibilities available for them is drastically narrowed down, and generally translates into some variety of sex work. This once again reinforces the social stigma against them and places the entire population in a high risk category in HIV intervention programmes, with studies showing that transgender populations worldwide are 49 times more prone to HIV infection.

Western psychiatry has classified transgender people into the disordered category, thus allowing their entire identity and experience be defined through the medicalised lens. While this, on one hand, has helped transgender people in accessing gender affirming medical treatment, on the other hand, it has helped propagating a stigma against them, dehumanising them. Here, the combination of the invisibility in society along with the medicalising of the transgender person translates even more poorly in social policies and legal measures. When such policies are not gender inclusive, they necessarily curtail the possibility of recognition of any non-normative gender identity. In the juncture of medicalisation, social invisibility and poor implementation, and it is a recipe for barrier to any type of access.

Moreover, the constant threat of violence facing transgender people, both physical and emotional, puts additional difficulties and stress when accessing services of any sort. The socio-legal invisibility of this population, which makes them navigate the public systems and services through the margins, works to accentuate the group's vulnerability. This often leads to transgender people leading hidden lives, and carrying on in their public lives in the garb of cis gendered people as they fear discrimination. Medical settings, where many of the services are divided along binary gender lines, is one of the primary areas where transgender patients feel the need to disguise their gender identity. This disguising also leads to misinformation about their condition relating to sexual behaviour, drug usage, hormone therapies, etc., and at times patients fearing discrimination do not feel comfortable to be straight and forthcoming. The troubled relationship between patient and doctors often leads to misdiagnoses.

In situations where transgender people can undergo gender affirming surgery, many a time, they come across ill-equipped facilities or, as seen above, waitlists running into decades, in addition to inadequately trained doctors. These problems are also present even in the cases where special units have been specifically set up to care for the transgender community. As my interviews have showed, special treatment units often suffer with limited or inadequate supply of materials and fewer doctors, thus resulting to constant delays. The lack of adequate and accessible medical treatment leads frustrated patients to resort to alternative and at times rather dangerous options, such as buying hormones over the counter and self-medicating.

As this dissertation has emphasised at several times, the right to health, as any other right, cannot be seen and exercised in isolation. Rather, it is a right that requires the freedom of expression, freedom of speech, and virtually every other civil and political right for its full realization. In the case of sexual minorities in general and transgender people particularly, given that their rights and freedoms are curtailed on every front, exercising the right to health in a holistic manner becomes a very difficult task. Despite the various advances, protections and stances of direct or indirect of recognition put in place in India, Brazil and South Africa, this dissertation found that there is still much room for improvement. Hopefully, the struggle for protection of human and constitutional rights through social mobilization, public interest litigation and NGO advocacy is dynamic enough to accommodate the aspirations of the trans population in the years to come. Even when faced with incredible challenges and barriers, I have found that practitioners, advocates, and members of organizations and of the community themselves do not lose track of the way forward.

7.6. Recommendations

In the previous chapter, the comparative table highlighted in a succinct manner the shortcomings of the three countries when it comes to transgender people – from legislative shortfalls, to the lack of medical facilities leading to waiting lists of over two decades. An important point one must stress is that, given the diversity of transgender people within their political groupings, one must understand the range of identities and not try to push them all into a box of one-size-fits-all. This suggestion goes for all the actors and organizations that directly or indirectly have a voice in shaping policy addressing this group, from activists, policy-makers, both medical and legal, and governments. There is much to be done in order to revert the marginalisation of non-normative gender identities and create the conditions for the empowerment both individuals and the group. In my view, perhaps the most pressing question relates to greater legitimacy and social inclusion. In what follows, I will spell out suggestions and recommendations, with a view of facilitating our way forward.

7.6.1. Eliminating the medicalised gaze

Despite much of the movement towards the recognition of transgender personhood being medically defined, the medicalised gaze needs to be reformed, shifted away from the focus on non-normative gender identity as a disorder that needs to be fixed. Rather, a more inclusive approach would suggest that the transgender phenomena is an expression of humanity and, therefore, of the diversity of desires that are inherent to the human condition. By removing the mantle of abnormality and disorder implied in the medicalised gaze, we would be one step closer to fighting social stigma and provide a more supportive and patient-friendly medical service.

7.6.2. Ending transgender invisibility through inclusive gender policies and markers

Law and policy are often demarcated around gendered lines, as I have explained. The limitation of the legal system and public services to the gender binaries pushes gender-non-conforming people into boxes that they are uncomfortable with and that which often makes them lead dual lives. In the three countries researched above, only India has managed to bring about a partial insertion of the third gender category in its administrative system. While this might seem like a step in the right direction, unless it is applied in all areas and departments of the state, from the very basic governmental offices, it will not bring about much change. At any rate, the requirement of forcing transgender women to identify as women, not trans women and transgender men to identify as men, not trans men (if they do not necessarily want to) must cease, for it forces the individual into an uncomfortable position. South Africa follows this regime of gender identification, which is reductive in itself.

While legislations and policies might not be able to make room for every identity and sub-identity in its wordings, keeping transgender definitions open-ended and expansive can allow for greater inclusivity while also minimising the potential of divisive politics within the group.

7.6.3. Creating better inclusion by understanding social exclusion

As stated above, transgender people are excluded from mainstream society in various ways – from not being legally recognised to being deprived of livelihoods to being shunned in community settings. Many a time they are thrown out of their own homes because of social stigma and a general lack of acceptance and understanding. In addition, there are cases of in community exclusion based on one's non-adherence to local or vernacular understandings of transgender identities. This leads to unequal access to resources and unequal access to rights and justice. If these exclusions are studied properly in their varied contexts, they will offer us

the tools and necessary knowledge to mitigate these circumstances, therefore creating scope for inclusive practices that can be implemented at different levels.

7.6.4. Better population mapping

Till date, there has been no comprehensive mapping of the transgender population of the three countries analysed in this dissertation. Mapping is only indirect, and involve people who are openly transgender and who either have gone through gender reassignment treatment or those who are registered for anti-retroviral treatment. The other institutional space where transgender individuals are mapped is at maternity wards where children who are born with indeterminate gonads are often either "fixed" or assigned the intersex label.

The lack of precise data on the volume and needs of the transgender population undermines the efficacy of existing public policy and prevents the development of better interventions in the future. The mapping needs to be throughout the entire population of the countries, preferably through census interviews asking questions more closely. This will not only be beneficial when it comes to earmarking budgets for specialised service delivery in the healthcare sector, but also allow a higher degree of visibility for transgender men, a sub-group that is particularly left out of public debate and policy.

However, prior to any of this, there needs to be a series of legislations in each country assuring transgender people identity legitimacy and the assurance of minimum security from harm and prejudice. In addition, the mapping of transgender people should be carried out with regional specificities in mind. For instance, the Indian transgender community have vividly different regional identities within the country, which can be confusing for a mapper who has little knowledge or cognizance about these aspects.

7.6.5. Vulnerability mapping

Transgender people have vulnerabilities that go beyond what lesbian and gay people face because of their socio-economic situation. The fact of being visibly different often leads to stigma and discrimination. Frequently, they are impoverished and forced into drug peddling and sex work as sources of income. In these circumstances, the mapping and documenting of the social determinants of transgender vulnerability is crucial to understanding and meeting the needs to the community. Moreover, transgender men and women face several different vulnerabilities, and mapping these might help point to resolutions in the right direction.

7.6.6. Participatory involvement of transgender people in policies and curriculum concerning them

Research undertaken by transgender NGOs and CBOs often shape policies and work to push forward social changes. Yet, there is an obvious tendency of specialised knowledge being produced by cisgendered people as they have better access to research institutions and think thanks, because of their better placing due to their gender and education. Despite their poorer education levels, transgender people have their lived experiences behind them. No one knows their needs better than they do. Having them as the primary participatory stakeholders in research, policy-making and matters that involve them seems to be a very basic thing to do, but is often not done.

In addition, some improvement is needed in the university curricula and training for occupations that affect transgender people the most. For instance, medical curriculum is still lagging behind in what regards gender realignment surgery and other transgender-specific needs. The same is true of other areas whose professionals work in state services targeting the trans population, such as social servants, psychologists and lawyers. Lack of specific training

on issues of gender and sexuality often translated into poor services being offered to the target population.

7.6.7. Dissemination of rights related and health related information to transgender communities.

Transgender communities who live on the fringes of society are often poorly informed about better health practices. Audio-visual media as well as written media (depending on the education level of the stakeholders) can be used to disseminate the knowledge out to them so that they can seek out the assistance they require. In such diverse societies as the three cases analysed here, it is also important to spread out geographically to both urban and rural areas, and preferably in the many languages used by the population of these areas.

7.6.8. Transgender-friendly healthcare setups

Transgender healthcare is frequently sexual health-oriented, with special focus being placed on HIV/AIDS as this group is marked out as at higher risk. However, research has revealed that transgender people feel it is more urgent to remove discrimination in public healthcare settings and creating access to quality appropriate transgender-friendly healthcare. While Brazil has transgender-specific ambulatories in many states, South Africa has scant services, and India has some state-based facilities, but few and far between as it is in a very nascent stage of transgender-related development projects.

Medical needs of transgender people are not limited to gender realignment. They suffer from everything else that everyone suffers from. Yet, as seen above, they often resort to going to the transgender-specific clinics or ambulatories, where available, as they feel safe there. Thus, general primary healthcare setups need to be made transgender-friendly, so that

transgender people going in for a general check-up do not have to fear being discriminated against.

The recommendations given above are far from exhaustive. However, at the very outset, if these aspects are met, perhaps it would become easier for the next generation of transgender people to be on a better footing with cisgender people.

7.7. Conclusion

The right to health has had a complex journey into becoming what it is today. Yet, many segments of the human population still find it difficult to exercise their right to living with dignity, in a healthy environment, where it is possible to thrive. Non-normative people have always gone through trials and tribulations in order to fit into an already-ordered society. Their presence has often been felt to be objectionable and thus criminalised. Unfortunately, transgender people have often been at the receiving end of this treatment.

Today, several parts of the world are opening up to become more inclusive of sexual and gender minorities, both socially and legally. Transgender people started being acknowledged in many parts of the world through the viewpoints of disease and infection. Struggling within that recognition, transgender people have been forging a new road ahead – of recognition through human rights, through citizenship, through gender justice. Exercising their right to health through accessing various social determinants is still a distant reality. However, with the backing of civil society organisations and empowered voices from within the communities as well as allies, transgender people will soon gain equal citizenship, equal rights and equal access to resources and justice.

Bibliography

Organization Reports, Case law and Legal Texts

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).

African People's Charter (1981).

American Convention on Human Rights (also known as the Pact of San José) (1969). www.hrcr.org/docs/American_Convention/oashr.html.

'Annual Reports | National AIDS Control Organization | MoHFW | GoI'. Available at: http://naco.gov.in/documents/annual-reports.

Assembly, UN General. 'Universal Declaration of Human Rights'. *UN General Assembly*, 1948.

'Basic Principles for the Treatment of Prisoners'. United Nations, 1977.

Bayer Corporation v. Natco Pharma Ltd., No. 45 (Intellectual Property Appellate Board, Chennai 2013).

Byrne, Jack. 'Transgender Health and Human Rights'. United Nations Development Programme, December 2013.

Cabral, Mauro. 'Critique and Alternative Proposal to the "Gender Incongruence of Childhood" Category in ICD-11'. Global Action for Trans*Equality/GATE Civil Society Expert Working Group, 4 April 2013.

Case of Juan Humberto Sánchez v. Honduras, Ser. C No. 99 2003 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2003).

Charter of the United Nations (1945).

'Constitution of the World Health Organization'. WHO Basic Documents, Forty-fifth edition, Supplement, October 2006, 1948.

Convention C169 - Indigenous and Tribal Peoples Convention, 1989 (No. 169), C169 §. Accessed 5 March 2018.

Convention on the Elimination of All Forms of Discrimination against Women (1979).

Corbett v. Corbett (otherwise Ashley), 33 All England Reporter 48 (England and Wales 1970).

'Council Resolution 1482/97 CFM'. Conselho Federal de Medicina, 1997.

De Villiers, A. 'Statement of Motiviation to Medical Aids and Medical Scheme Administrators: Medical Cover and Reimbursement for Transgender Adults'. GenderDynamix, October 2013.

EN and Others v Government of RSA and Others, 6 SA 575 (D) (2006).

Francis Coralie Mullin v. Union Territory of Delhi, 2 SCR 516 (Supreme Court of India 1981).

'General Comment 3: On the Nature of States Parties' Obligations by CESCR'. *UN Doc E/1991/23*, 1991.

'General Comment 9: The Domestic Application of the Covenant by CESCR', 1998.

'General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12) by the CESCR'. *Adopted at the Twenty-Second Session of the Committee on Economic, Social and Cultural Rights*, 2000.
Government of the Republic of South Africa and Others v Grootboom and Others, 1 SA 46 (CC) (SACC 2001).
'Health Inequities in Brazil: Our Most Serious Disease (Document Presented at the Launch of the Brazilian National Commission on Social Determinants of Health (NCSDH))'. Commission on Social Determinants of Health, World Health Organisation, March 2006.
Hussainara Khatoon & Ors. v. Home Secretary, State of Bihar, AIR 1369 (Supreme Court of India 1979).
'ICD-10 Version: 2016'. Available at: http://apps.who.int/classifications/icd10/browse/2016/en.
'Identification Act (No. 68 of 1997)'. Available at: http://www.polity.org.za/article/identification-act-no-68-of-1997-1997-01-01.
Information, National Center for Biotechnology, U. S. National Library of Medicine 8600 Rockville Pike, Bethesda MD, and 20894 Usa. 'Flawed but Fair: Brazil's Health System Reaches out to the Poor'. *Bulletin of the World Health Organization* 86, no. 4 (April 2008): 248.
'International Guidelines on HIV/AIDS and Human Rights, U.N. C.H.R. Res. 1997/33, U.N. Doc. E/CN.4/1997/150 (1997)'. Available at: http://hrlibrary.umn.edu/instree/t4igha.html.
International Labour Organisation Convention No. 155 on Occupational Safety and Health (1981).
International Labour Organisation Convention No. 161 on Occupational Health Services (1985).
International Labour Organisation Convention No. 169 on the Indigenous and Tribal Peoples (1989).
Justice K. S. Puttaswamy (Retd.) and Anr. vs Union Of India And Ors. WP (C) No. 494 of 2012.
'KOS and Others v Minister of Home Affairs and Others (2298/2017) [2017] ZAWCHC 90; [2017] 4 All SA 468 (WCC); 2017 (6) SA 588 (WCC) (6 September 2017)'. Available at: http://www.saflii.org/za/cases/ZAWCHC/2017/90.html.
'Lesbian and Gay Equality Project and Eighteen Others v Minister of Home Affairs (CCT 10/05) [2005] ZACC 20; 2006 (3) BCLR 355 (CC); 2006 (1) SA 524 (CC) (1 December 2005)'. Available at: http://www1.saflii.org/cgi-bin/disp.pl?file=za/cases/ZACC/2005/20.html&query=equality%20project.
Mazibuko v City of Johannesburg, 4 SA (CC) (2010).
'Medical Report Claims Pinki Is a "Male Pseudohermaphrodite" | Scientific Indians'. Accessed 10 March 2018. http://www.scientificindians.com/life-sciences/genetics/medical-report-claims-pinki-is-a-male-pseudohermaphrodite.
Minister of Health and Others v Treatment Action Campaign and Others, 5 SA 721 (CC) (SACC 2002).
Moloi, Lebohang. 'KwaZulu Natal Transgender and Gender Non-Conforming Needs Assessment Report 2012'. Gender DynamiX, September 2013.
Murphy, Thérèse. *Health and Human Rights*. A&C Black, 2014.
National Legal Services Authority v. Union of India, No. WP (C) No. 604 of 2013 (Supreme Court of India 15 April 2014).
Naz Foundation v. Government of NCT of Delhi and Ors., No. WP(C) No. 7455/2001 (n.d.).

Pharmaceutical Manufacturers Association of SA (PMA)v. President of the RSA (TAC as the amicus curiae) Case No. 4183/98 (n.d.).
Pinker, Steven. 'The Blank Slate: The Modern Denial of Human Nature'. *New York, NY, Viking. Popper, K.(1974). Unended Quest. Fontana, London,* 2004.
Principles, Yogyakarta. *Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity*.
Rao, Priyanka. 'Standing Committee Report Summary on The Transgender Persons (Protection of Rights) Bill, 2016'. PRS Legislative Research, 1 August 2017.
Raymond, Janice G. 'The Transsexual Empire', 1980.
'Resolutiion 1999/49 on The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)'. The UN Commission on Human Rights, 1999.
'Resolution 2002/31, The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health'. The UN Commission on Human Rights, 2002.
'Resolution No. 1625/02'. Conselho Federal de Medicina, 2002.
'Resolution No. 1955'. Conselho Federal de Medicina, 2010.
'Resolution PC/CFM No. 39/97'. Conselho Federal de Medicina, 1997. Available at: http://www.portalmedico.org.br/pareceres/cfm/1997/39_1997.htm.
Rural Litigation and Entitlement Kendra, Dehradun and Ors. V. State of UP and Ors., 2 SCC 431 (Supreme Court of India 1985).
Sawhoyamaxa Indigenous Community v. Paraguay, Ser. C No. 146 2006 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2006).
Sawhoyamaxa Indigenous Community v. Paraguay, Ser. C No. 146 2006 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2006).
'Silenced and Forgotten: HIV and AIDS Agenda Setting Paper for Women Living with HIV, Sex Workers and LGBT Individuals in Southern African and Indian Ocean States'. Open Policy Paper. Johannesburg: UN Women and Open Society Initiative for Southern Africa, 2011.
'Social Determinants of Health Discussion Paper 2 - A Conceptual Framework For Action on the Social Determinants of Health'. World Health Organisation, 2010.
Somerset v. Stewart, 98 ER 499 (King's Bench 1772).
'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People'. The World Professional Association for Transgender Health, August 2016.
State of Punjab v. Mohinder Singh Chawla, (1996) 4 SCC 37, 4 SCC 37 (Supreme Court of India 1996).
Statute of the International Court of Justice (1945).
Stevens, Marion. 'Transgender Access to Sexual Health Services in South Africa: Findings from a Key Informant Survey'. *Cape Town: Gender Dynamix*, 2012.
STF, Petition No. 1246-1, Relator Sepulveda Pertence, 10.04.1997, 64,65 (Supremo Tribunal Federal 17 April 1998).
STF Recurso Extraordinario (Extraordinary Remedy), Relator: Min. Celso de Mello, 12.09.2000, No. 271.286-8 (Supremo Tribunal Federal 24 November 2000).
'Street Children' Villagrán Morales et al. vs. Guatemala, Ser. C No. 63 1999 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 1999).
Subhash Kumar v. State of Bihar, AIR SC 42 (Supreme Court of India 1991).
Suresh Kumar Koushal and another v NAZ Foundation and others, Civil Appeal No. 10972 of 2013 (The Supreme Court of India (Civil Appellate Division) 2013).
'The Constitution of India'. Accessed 28 February 2018. http://lawmin.nic.in/olwing/coi/coi-english/coi-indexenglish.htm.

The Constitution of the Federative Republic of Brazil (1988).
The Constitution of the Republic of South Africa, 108 § (1996).
'The Standard Minimum Rules for the Treatment of Prisoners'. Economics and Social Council, 1977.
'The UN Declaration of Commitment on HIV/AIDS'. The United Nations, 2001.
'The UN Millennium Declaration'. The United Nations, 8 December 2000.
'The UN Principles for Older Persons'. The United Nations, 1991.
'The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'. The United Nations, 1991.
Theron, Liesl, and Moly Egerdie. '2nd Trans Health Advocacy and Research Conference: Rooted in the Past, Reaching for the Future'. Gender DynamiX, December 2014. http://www.genderdynamix.org.za.
Thiagraj Soobramoney v. Minister of Health, KwaZulu-Natal, 17 ZACC (South African Constitutional Court 1997).
TJRJ – 8, Ap. Civ. No. 1994.001.01749, Relator: Des. Carpena Amorim, 20.10.1994, DJRJ, 07.02.95, 1, No. Ap. Civ. No. 1994.001.01749 (Court of Appeals, Rio de Janeiro 2 July 1995).
Treatment Action Campaign vs Ministry of Health, 2002 (10) BCLR 1033 (South African Constitutional Court 2002).
'United Nations Millennium Development Goals'. Available at: http://www.un.org/millenniumgoals/.
Van Zyl, Mikki, Jeanelle De Gruchy, Sheila Lapinsky, Simon Lewin, and Graeme Reid. '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 on Behalf of Gay and Lesbian Archives Health and Human Rights Project, Medical Research Council, National Coalition for Gay and Lesbian Equality*, 1999.
W v. W, 2 SA 308 (1976).
Ximenes-Lopes v. Brazil, Ser. C No. 149 2006 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2006).
Yakye Axa Indigenous Community v. Paraguay, Ser. C No.125 2005 Inter-Am. Ct. H.R. (Inter-American Court of Human Rights 2005).

Literature

Ackerly, Brooke A. *Universal Human Rights in a World of Difference*. Cambridge University Press, 2008.
Adams, Abigail. 'Letter from Abigail Adams to John Adams, 31 March-5 April 1776'. *Adams Family Papers: An Electronic Archive*, 1776.
Agamben, Giorgio. *Homo Sacer: Sovereign Power and Bare Life*. Stanford University Press, 1998.
Albuquerque, Mariana Vercesi de, Ana Luiza d'Ávila Viana, Luciana Dias de Lima, Maria Paula Ferreira, Edgard Rodrigues Fusaro, and Fabíola Lana Iozzi. 'Regional Health Inequalities: Changes Observed in Brazil from 2000-2016'. *Ciência & Saúde Coletiva* 22, no. 4 (2017): 1055–1064.
Almeida, Guilherme, and Daniela Murta. 'Reflexões Sobre a Possibilidade Da Despatologização Da Transexualidade e a Necessidade Da Assistência Integral à Saúde de Transexuais No Brasil'. *Sexualidad, Salud y Sociedad-Revista Latinoamericana*, no. 14 (2013).

Arán, Márcia. 'A Saúde Como Prática de Si: Do Diagnóstico de Transtorno de Identidade de Gênero Às Redescrições Da Experiência Da Transexualidade'. *ARILHA, Margareth; LAPA, Thaís de Souza; PISANESCHI, Tatiane Crenn. Transexualidade, Travestilidade e Direito à Saúde. São Paulo: Oficina Editorial*, 2010.

Arán, Márcia, and Daniela Murta. 'Relatório Preliminar Dos Serviços Que Prestam Assistência a Transexuais Na Rede de Saúde Pública No Brasil'. Accessed 10 October 2017. http://pfdc.pgr.mpf.mp.br/atuacao-e-conteudos-de-apoio/publicacoes/direitos-sexuais-e-reprodutivos/direitos-lgbtt/Relatorio_Preliminar_set_20092.pdf.

Arán, Márcia, Daniela Murta, and Tatiana Lionço. 'Transexualidade e saúde pública no Brasil.pdf'. *Ciência & Saúde Coletiva* 14, no. 4 (2009): 1141–49.

Arán, Márcia, Sérgio Zaidhaft, and Daniela Murta. 'Transexualidade: Corpo, Subjetividade e Saúde Coletiva'. *Psicologia & Sociedade* 20, no. 1 (2008).

Baderoon, Gabeba. '" Gender within Gender": Zanele Muholi's Images of Trans Being and Becoming'. *Feminist Studies* 37, no. 2 (2011): 390–416.

Barrington, Richard. *The Magna Carta*. Encyclopaedia Britannica, 2017.

Bateman, Chris. 'Transgender Patients Sidelined by Attitudes and Labelling'. *SAMJ: South African Medical Journal* 101, no. 2 (2011): 91–93.

Baxi, Upendra. *Human Rights in a Post Human World: Critical Essays*. Stranger Journalism, 2009.

———. 'Outline of a "Theory of Practice" of Indian Constitutionalism'. *Politics and Ethics of the Indian Constitution*, 2008, 92–118.

Baxter, Craig. *Pakistan on the Brink: Politics, Economics, and Society*. Lexington Books, 2004.

Beteille, Andre. *The Backward Classes in Contemporary India*. Oxford University Press, USA, 1992.

Bethell, Leslie, ed. *The Cambridge History of Latin America*. Cambridge [England] ; New York: Cambridge University Press, 1984.

Bogdan, Robert. *Freak Show: Presenting Human Oddities for Amusement and Profit*. University of Chicago Press, 2014.

Breay, Claire. *Magna Carta: Manuscripts and Myths*. British Library Board, 2002.

Butler, Judith. *Gender Trouble: Feminism and the Subversion of Identity*. Routledge, 2011.

———. *Undoing Gender*. Psychology Press, 2004.

Campbell, Megan M., Lillian Artz, and Dan J. Stein. 'Sexual Disorders in DSM-5 and ICD-11: A Conceptual Framework'. *Current Opinion in Psychiatry* 28, no. 6 (November 2015): 435–39.

Carvalho, Mario Felipe Lima, and Sergio Carrara. 'Em Direção a Um Futuro Trans? Contribuição Para a História Do Movimento de Travestis e Transexuais No Brasil'. *Sexualidad, Salud y Sociedad-Revista Latinoamericana*, no. 14 (2013): 319–351.

Chakrapani, Venkatesan, and Arvind Narrain. 'Legal Recognition of Gender Identity of Transgender People in India: Current Situation and Potential Options'. *Policy Brief*, 2012.

Chanana, Karuna. 'Accessing Higher Education: The Dilemma of Schooling Women, Minorities, Scheduled Castes and Scheduled Tribes in Contemporary India'. *Higher Education* 26, no. 1 (1993): 69–92.

Chigwedere, Pride, George R. Seage III, Sofia Gruskin, Tun-Hou Lee, and Max Essex. 'Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa'. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 49, no. 4 (2008): 410–415.

Chris Alden and Marco Antonio Vieira. 'The New Diplomacy of the South: South Africa, Brazil, India and Trilateralism'. *Third World Quarterly*, Vol. 26, no. No. 7 (2005) (2005): 1077–95.

Colish, Marcia L. *The Stoic Tradition from Antiquity to the Early Middle Ages: Stoicism in Classical Latin Literature. I*. Vol. 1. Brill, 1990.
Collumbien, Martine, and A. Qureshi. 'Sexuality, Power Dynamics and Abuse among Female, Male and Transgender Sex Workers in Pakistan'. In *Poster Presented at the 19th World Congress for Sexual Health, Goteborg, Sweden, June*, 21–25, 2009.
Cooper, Carole. 'Health Rights Litigation: Cautious Constitutionalism'. *Litigating Health Rights…, Op. Cit*, 2011, 190–231.
Cooper, Frederick. 'Reconstructing Empire in British and French Africa'. *Past and Present* 210, no. suppl_6 (2011): 196–210.
Coovadia, Hoosen, Rachel Jewkes, Peter Barron, David Sanders, and Diane McIntyre. 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges'. *The Lancet* 374, no. 9692 (2009): 817–834.
Corneil, Trevor A., Justus H. Eisfeld, and Marsha Botzer. 'Proposed Changes to Diagnoses Related to Gender Identity in the *DSM* : A World Professional Association for Transgender Health Consensus Paper Regarding the Potential Impact on Access to Health Care for Transgender Persons'. *International Journal of Transgenderism* 12, no. 2 (20 September 2010): 107–14.
Dalrymple, William. *City of Djinns: A Year in Delhi*. Penguin UK, 2004.
Daly, Mary. *Pure Lust: Elemental Feminist Philosophy*, Beacon Press, 1984.
Day, Thomas. *Fragment of an Original Letter on the Slavery of the Negroes, Written in the Year 1776, by Thomas Day*. J. Stockdale, 1784.
Doniger, Wendy. *The Hindus: An Alternative History*. Penguin, 2009.
Edenheim, Sara. 'Bodies out of place: on Abjection, Exclusion, and Adaption of Intersexed and Homosexual Bodies within Legal and Scientific Discourses, 1919-1968', Paper Presented at the 5th European Feminist Research Conference, Lund University, 2003.
Edwards, Susan SM. *Sex and Gender in the Legal Process*. Oxford University Press on Demand, 1996.
Ellsworth, Jeffrey, and Johan ven der Walt. *Constitutional Sovereignty and Social Solidarity in Europe*. Bloomsbury Publishing, 2015.
Elmore, Wilber Theodore. *Dravidian Gods in Modern Hinduism*. University of Nebraska (Lincoln campus), 1915.
Epstein, David G. *Brasilia, Plan and Reality: A Study of Planned and Spontaneous Urban Development*. University of California Press, 1973.
European Social Charter (1961).
Evans, David Trevor. *Sexual Citizenship: The Material Construction of Sexualities*. Routledge, 1993.
Faulks, Keith. *Citizenship (Key Ideas)*. Routledge, 2000.
Feinberg, Leslie. *Transgender Warriors: Making History from Joan of Arc to Dennis Rodman*. Beacon Press, 1996.
Ferraz, Octavio LM, Siri Gloppen, Ottar M\a estad, and Lise Rakner. '7. Judging the Price of Life: Cost Considerations in Right-to-Health Litigation'. *Juridification and Social Citizenship in the Welfare State*, 2014, 121.
Ferraz, Octavio Luiz Motta. 'Harming the Poor through Social Rights Litigation: Lessons from Brazil'. *Tex. L. Rev.* 89 (2010).
———. 'Harming the Poor through Social Rights Litigation: Lessons from Brazil'. *Texas Law Review* 89 (2011): 1643.
———. 'Right to Health Litigation in Brazil: Why Are Collective Suits so Hard to Enforce?' University of Warwick, School of Law, n.d.
———. 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' *Health and Human Rights*, 2009, 33–45.

Finkelman, Paul. 'The Proslavery Origins of the Electoral College'. *Cardozo L. Rev.* 23 (2001): 1145.
Foucault, Michel. '1990: The History of Sexuality, Vol 1: An Introduction'. *Trans. Robert Hurley. London: Penguin*, 1976.
———. 'The History of Sexuality: An Introduction, Volume I'. *Trans. Robert Hurley. New York: Vintage*, 1990.
Foucault, Michel, Valerio Marchetti, and Graham Burchell. *Abnormal: Lectures at the Collège de France 1974 - 1975*. Lectures at the Collège de France. London: Verso, 2003.
Fraser, Nancy. '"Post-Socialist' Age'. *Feminism and Politics*, 1998, 430.
Fraser, Nancy, and Axel Honneth. *Redistribution or Recognition?: A Political-Philosophical Exchange*. Verso, 2003.
Gandy, Matthew. 'Zones of Indistinction: Bio-Political Contestations in the Urban Arena'. *Cultural Geographies* 13 (2006): 497-516.
Geoffrey Hosking, and Recorded Books. *The Modern Scholar: Epochs of European Civilization: Antiquity to Renaissance*. Recorded Books, n.d.
Ghosh, Debjyoti. "The Categorical Other: Going Beyond the Gender Binary in Law in India", *Journal of Constitutionalism and Human Rights*, 3-4, no. 8 (2015): 89.
Gianna, Maria Clara. 'CRT DST/Aids-SP Implanta Primeiro Ambulatório Para Travestis e Transexuais Do País I'. *BIS. Boletim Do Instituto de Saúde (Impresso)* 13, no. 2 (2011): 182–189.
Glendon, Mary Ann. 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea'. *Harvard Human Rights Journal* 16 (2003): 27–39.
Graham, Robert, Bobbie Berkowitz, Robert Blum, Walter Bockting, Judith Bradford, Brian de Vries, and H. Makadon. 'The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding'. *Institute of Medicine*, 2011.
Gross, Sally. 'De-Gendering Unions - Civil Union Act & the Intersexed'. In *To Have & to Hold - the Making of Same-Sex Marriage in South Africa*, edited by Melanie Judge, Anthony Manion, and Shaun De Waal. Fanele, 2008.
Guidotto, Nadia. 'Monsters in the Closet: Biopolitics and Intersexuality'. *Wagadu* 4 (2007).
Guimarães, Anibal. 'Ambulatório de Saúde Integral de Travestis e Transexuais Do Estado de São Paulo: Relatório de Duas Visitas (2010-2012)'. *Bagoas-Estudos Gays: Gêneros e Sexualidades* 7, 10 (2013).
Guimarães de Lima e Silva, Valeria. 'Public Health in Brazil | Carnegie Council for Ethics in International Affairs'. Carnegie Council for Ethics and International Affairs, 15 December 2014. Available at: https://www.carnegiecouncil.org/publications/articles_papers_reports/0236.
Habermas, Jurgen. *Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy*. Mit Press, 1996.
Hoad, Neville. '"Run, Caster Semenya, Run!" Nativism and the Translations of Gender Variance'. *Safundi* 11, no. 4 (October 2010): 397–405.
Jain, Harish C., and C. S. Venkata Ratnam. 'Affirmative Action in Employment for the Scheduled Castes and the Scheduled Tribes in India'. *International Journal of Manpower* 15, no. 7 (1994): 6–25.
Jesus, Jaqueline Gomes de, and Hailey Alves. 'Feminismo Transgênero e Movimentos de Mulheres Transexuais'. *Revista Cronos* 11, no. 2 (2012).
Jobson, Dr. Marjorie. 'Structure of the Health System in South Africa'. Johannesburg: Khulumani Support Group, October 2015.
Kahn, Kathleen. 'Population Health in South Africa: Dynamics over the Past Two Decades'. *Journal of Public Health Policy* 32, no. 1 (2011): S30–S36.

Karim, Salim S. Abdool, Gavin J. Churchyard, Quarraisha Abdool Karim, and Stephen D. Lawn. 'HIV Infection and Tuberculosis in South Africa: An Urgent Need to Escalate the Public Health Response'. *The Lancet* 374, no. 9693 (2009): 921–933.

Keener, Steven R., and Javier Vasquez. 'A Life Worth Living: Enforcement of the Right to Health through the Right to Life in the Inter-American Court of Human Rights'. *ColuM. HuM. RTS. l. Rev.* 40 (2008): 595.

Khan, Yasmin. *The Great Partition: The Making of India and Pakistan*. Yale University Press, 2017.

Kickbusch, Ilona. 'Global Health Diplomacy: How Foreign Policy Can Influence Health'. *BMJ: British Medical Journal* 342 (2011).

Klein, Thamar. 'Necessity Is the Mother of Invention: Access Inequalities to Medical Technologies Faced by Transgendered South Africans'. *Technology & Innovation* 15, no. 2 (2013): 165–179.

———. 'Querying Medical and Legal Discourses of Queer Sexes and Genders in South Africa'. *Anthropology Matters* 10, no. 2 (2008). http://www.anthropologymatters.com/index.php/anth_matters/article/view/37.

———. 'Who Decides Whose Gender? Medico-Legal Classifications of Sex and Gender and Their Impact on Transgendered South Africans' Family Rights'. *EthnoScripts* 14, no. 2 (2012): 12–34.

Konduru, Delliswararao, and Chongneikim Hangsing. 'Socio–Cultural Exclusion and Inclusion of Trans-Genders in India'. *International Journal of Social Sciences and Management* 5, no. 1 (n.d.): 10–17.

Kristeva, Julia. *Pouvoirs de l'horreur*. Columbia University Press, 1982.

Kulick, Don. *Travesti: Sex, Gender, and Culture among Brazilian Transgendered Prostitutes*. University of Chicago Press, 1998.

Kymlicka, Will. *Multicultural Citizenship: A Liberal Theory of Minority Rights*. Oxford Political Theory. Oxford : New York: Clarendon Press ; Oxford University Press, 1995.

Lemke, Thomas. 'Biopolitics and beyond. On the Reception of a Vital Foucauldian Notion'. *Frankfurt, Germany. Retrieved October* 14 (2005): 2013.

Lionço, Tatiana. 'Atenção Integral à Saúde e Diversidade Sexual No Processo Transexualizador Do SUS: Avanços, Impasses, Desafios'. *Physis-Revista de Saúde Coletiva* 19, no. 1 (2009).

Mamdani, Mahmood. *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism*. Princeton University Press, 1996.

Mann, Jonathan M. 'Human Rights and AIDS: The Future of the Pandemic'. In *Health and Human Rights: A Reader*, edited by Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, 216–26. Great Britain: Routledge, 1999.

Mann, Michael. 'Ruling Class Strategies and Citizenship'. *Sociology* 21, no. 3 (1987): 339–354.

Marshall, Thomas H. *Citizenship and Social Class*. Vol. 11. Cambridge, 1950.

Mello, Luiz, Marcelo Perilo, Camilo Albuquerque de Braz, and Cláudio Pedrosa. 'Políticas de Saúde Para Lésbicas, Gays, Bissexuais, Travestis e Transexuais No Brasil: Em Busca de Universalidade, Integralidade e Equidade'. *Sexualidad, Salud y Sociedad-Revista Latinoamericana*, no. 9 (2011).

Milliken, Jennifer. 'The Study of Discourse in International Relations: A Critique of Research and Methods'. *European Journal of International Relations* 5, no. 2 (1999): 225–254.

Mitra, Aparna. 'The Status of Women among the Scheduled Tribes in India'. *The Journal of Socio-Economics* 37, no. 3 (2008): 1202–1217.

Mobarak, Ahmed Mushfiq, Andrew Sunil Rajkumar, and Maureen Cropper. 'The Political Economy of Health Services Provisions in Brazil'. *Economic Development and Cultural Change* 59, no. 4 (2011): 723–51.
Mohanram, Radhika. *Black Body: Women, Colonialism, and Space*. Vol. 6. University of Minnesota Press, 1999.
Monro, Surya. 'Theorizing Transgender Diversity: Towards a Social Model of Health'. *Sexual and Relationship Therapy* 15, no. 1 (2000): 33–45.
Monro, Surya, and Lorna Warren. 'Transgendering Citizenship'. *Sexualities* 7, no. 3 (August 2004): 345–62.
Msibi, Thabo, and Stephanie Rudwick. 'Intersections of Two IsiZulu Genderlects and the Construction of Skesana Identities'. *Stellenbosch Papers in Linguistics Plus* 46 (2015): 51–66.
Müller, Alexandra. 'Teaching Lesbian, Gay, Bisexual and Transgender Health in a South African Health Sciences Faculty: Addressing the Gap'. *BMC Medical Education* 13, no. 1 (2013): 174.
Naish, Camille. *Death Comes to the Maiden: Sex and Execution 1431-1933*. Routledge, 2013.
Nanda, Serena. *Neither Man nor Woman: The Hijras of India*. 2nd ed. Belmont, CA: Wadsworth Publ. Company, 1999.
Nayar, Kuldip. *The Judgement: Inside Story of the Emergency in India*. New Delhi: Vikas Publishing House, 1977.
Nery, João W. *Erro de pessoa: Joana ou João?* Editora Record, 1984.
Newman-Valentine, Douglas D., and Sinegugu E. Duma. 'Transsexual Women's Journey towards a Heteronormative Health Care System: Gender and Equity'. *African Journal for Physical Health Education, Recreation and Dance* 20, no. Supplement 1 (2014): 385–394.
Nkoana, T., and M. Nduna. 'Engaging Primary Health Care Providers in Transgender Community Health Care: Observations from the Field'. *New Voices in Psychology* 8, no. 2 (2012): 120–129.
Nussbaum, Martha C., and Juha Sihvola. *The Sleep of Reason: Erotic Experience and Sexual Ethics in Ancient Greece and Rome*. University of Chicago Press, 2013.
Nyong'o, Tavia. 'The Unforgivable Transgression of Being Caster Semenya'. *Women & Performance: A Journal of Feminist Theory* 20, no. 1 (2010): 95–100.
Oldring, Lisa, and Scott Jerbi. 'Advancing a Human Rights Approach on the Global Health Agenda'. *Realizing the Right to Health. Edited by Zurich Uo*, 2009.
Parmar, Sharanjeet, and Namita Wahi. 'Citizens, Courts and the Right to Health: Between Promise and Progress?' *Litigating Health Rights…, Op. Cit*, 2011, 155–189.
Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 4 SCC 37 (1996).
Pelúcio, Larissa. 'Nos Nervos, Na Carne, Na Pele: Uma Etnografia Travesti Sobre o Modelo Preventivo de Aids. 2007'. PhD Thesis in Social Sciences, Universidade Federal de São Carlos, São Carlos, 2007.
Plummer, Ken. *Telling Sexual Stories: Power, Change and Social Worlds*. Routledge, 2002.
Posel, Deborah. *The Making of Apartheid, 1948-1961: Conflict and Compromise*. Oxford University Press, USA, 1991.
Price, Janet, and Margrit Shildrick. *Feminist Theory and the Body: A Reader*. Taylor & Francis, 1999.
Pruthi, R. K. *Indian Caste System*. Discovery Publishing House, 2004.
Rackham, Harris. 'Aristotle in 23 Volumes'. *Politics* 21 (1944).
Rakove, Jack N. *Original Meanings: Politics and Ideas in the Making of the Constitution*. 1st Vintage Books Ed edition. New York, NY: Vintage, 1997.
Richardson, Diane. *Rethinking Sexuality*. SAGE, 2000.

Richardson, Diane, and Surya Monro. *Sexuality, Equality and Diversity*. New York, NY : Palgrave Macmillan, 2012, n.d.
Richardson III, Henry J. 'Self-Determination, International Law and the South African Bantustan Policy'. *Colum. J. Transnat'l L.* 17 (1978): 185.
Riedel, Eibe. 'The Human Right to Health: Conceptual Foundations'. In *Realising the Right to Health*, edited by Andrew Clapham, Mary Robinson, Claire Mahon, and Jerbi Scott, 3:21–39. Swiss Human Rights Book. Rueffer & Rub, 2009.
Rocon, Pablo Cardozo, Francis Sodré, and Alexsandro Rodrigues. 'Regulamentação Da Vida No Processo Transexualizador Brasileiro: Uma Análise Sobre a Política Pública'. *Revista Katálysis* 19, no. 2 (September 2016): 260–69.
Rousseau, Jean-Jacques. 'Emile or on Education (A. Bloom, Trans.)'. *New York: Basic.(Originally Published 1762)*, 1979.
Rudolph, Lloyd, and Susanne Hoeber Rudolph. 'Redoing the Constitutional Design: From an Interventionist to a Regulatory State'. *The Success of India's Democracy*, 2001, 127–62.
Sadlier, Darlene J. *Brazil Imagined: 1500 to the Present*. 1st ed. The William & Bettye Nowlin Series in Art, History, and Culture of the Western Hemisphere. Austin: University of Texas Press, 2008.
Schmidt, Vivien A. 'Discursive Institutionalism: The Explanatory Power of Ideas and Discourse'. *Annual Review of Political Science* 11 (2008).
Schuhmann, Antje. 'Taming Transgressions: South African Nation Building and "Body Politics"'. *Agenda* 24, no. 83 (2010): 95–106.
Sen, Amartya. 'Why Health Equity?' In *Public Health, Ethics and Equity*, edited by Amartya Sen, Fabienne Peter, and Sudhir Anand, 21–33. Oxford: Oxford University Press, 2004.
Shorey, Paul. 'Plato, The Republic. 2 Vols'. *First Printed*, 1930.
Stark, Rodney. *For the Glory of God: How Monotheism Led to Reformations, Science, Witch-Hunts, and the End of Slavery*. Princeton University Press, 2003.
Stevenson, Douglas K. *American Life and Institutions*. Ernst Klett Sprachen, 1996.
Stryker, Susan, and Stephen Whittle. *The Transgender Studies Reader*. Taylor & Francis, 2006.
Swain, John, Sally French, Colin Barnes, and Carol Thomas. *Disabling Barriers-Enabling Environments*. Sage, 2013.
Swarr, Amanda Lock. '" Stabane," Intersexuality, and Same-Sex Relationships in South Africa'. *Feminist Studies* 35, no. 3 (2009): 524–548.
Taylor, David. 'Citizenship and Social Power'. *Critical Social Policy* 9, no. 26 (1989): 19–31.
Theron, Liesl. '"This Is like Seeing a Human Body Totally from a Different Angle": Experiences of South African Cisgender Partners in Cisgender-Trans* Relationships'. MA Thesis in African Gender Studies, University of Cape Town, 2013.
Thomson, Rosemarie Garland. *Freakery: Cultural Spectacles of the Extraordinary Body*. NYU Press, 1996.
Thorenson, R. 'Beyond Equality: The Post-Apartheid Counternarrative of Trans and Intersex Movements in South Africa'. *African Affairs* 112, no. 449 (1 October 2013): 646–65.
Turner, Bryan S. 'Outline of a Theory of Citizenship'. *Sociology* 24, no. 2 (1990): 189–217.
Turner, Ralph. *King John: England's Evil King?* The History Press, 2011.
Twist, Travers. 'The Extraterritoriality of Public Ships of War in Foreign Waters'. *The Law Magazine and Review: A Quarterly Review of Jurisprudence* 1, no. 219 (February 1876).
Uwimana, J., D. Jackson, H. Hausler, and C. Zarowsky. 'Health System Barriers to Implementation of Collaborative TB and HIV Activities Including Prevention of

Mother to Child Transmission in South Africa'. *Tropical Medicine and International Health* 17, no. 5 (2012): 658–665.
Van der Merwe, L. A., and T. Padi. 'Transgender Feminism'. *New Voices in Psychology* 8, no. 2 (2012): 110–119.
Vanita, Ruth, and Saleem Kidwai, eds. *Same-Sex Love in India: Readings in Indian Literature*. Springer, 2000.
Victora, Cesar G., Mauricio L. Barreto, Maria do Carmo Leal, Carlos A. Monteiro, Maria Ines Schmidt, Jairnilson Paim, Francisco I. Bastos, et al. 'Health Conditions and Health-Policy Innovations in Brazil: The Way Forward'. *The Lancet* 377, no. 9782 (2011): 2042–2053.
Vincent, Louise, and Bianca Camminga. 'Putting the "T" into South African Human Rights: Transsexuality in the Post-Apartheid Order'. *Sexualities* 12, no. 6 (December 2009):
Walby, Sylvia. 'Is Citizenship Gendered?' *Sociology* 28, no. 2 (1994): 379–395.
West, Isaac. *Transforming Citizenships: Transgender Articulations of the Law*. NYU Press, 2013.
Wiersma, Rinus. 'Management of the African Child with True Hermaphroditism'. *Journal of Pediatric Surgery* 36, no. 2 (2001): 397–399.
———. 'The Clinical Spectrum and Treatment of Ovotesticular Disorder of Sexual Development'. In *Hormonal and Genetic Basis of Sexual Differentiation Disorders and Hot Topics in Endocrinology: Proceedings of the 2nd World Conference*, 101–103. Springer, 2011.
———. 'True Hermaphroditism in Southern Africa: The Clinical Picture'. *Pediatric Surgery International* 20, no. 5 (2004): 363–368.
Wilson, D, A Marais, A De Villiers, R Addinall, M M Campbell, and The Transgender Unit. 'Transgender Issues in South Africa, with Particular Reference to the Groote Schuur Hospital Transgender Unit'. *South African Medical Journal* 104, no. 6 (15 May 2014): 449.
Winkel, Laurens. 'The Peace Treaties of Westphalia as an Instance of the Reception of Roman Law'. *Peace Treaties and International Law in European History: From the Late Middle Ages to World War One*, 2004, 222–37.
Yamin, Alicia Ely. 'The Right to Health Under International Law and Its Relevance to the United States'. *American Journal of Public Health* 95, no. 7 (2005): 1156–61.
Young, Iris Marion. 'Justice and the Politics of Difference'. *Princeton, NJ: Princeton*, 1990.
———. 'Polity and Group Difference: A Critique of the Ideal of Universal Citizenship'. *Ethics* 99, no. 2 (1989): 250–274.

Online Resources

'BBC News | SOUTH ASIA | Eunuch MP Takes Seat'. Available at: http://news.bbc.co.uk/2/hi/south_asia/668042.stm.
Biancarelli, Aureliano. 'Transexuais querem direito a RG e cirurgia', *Folha de São Paulo*, 8 September 1996. Available at http://www1.folha.uol.com.br/fsp/1996/9/08/cotidiano/29.html.
'Brazil: Extreme Inequality in Numbers | Oxfam International'. Available at: https://www.oxfam.org/en/even-it-brazil/brazil-extreme-inequality-numbers.
'Brazil's Evangelicals Become a Political Force to Be Reckoned with | World News | The Guardian'. Available at: https://www.theguardian.com/world/2014/oct/01/brazil-evangelicals-politics-presidential-election.

‘Calcutta High Court Drops Rape Charge against Athlete Pinki Pramanik | Off the Field News - Times of India’. Available at: https://timesofindia.indiatimes.com/sports/off-the-field/Calcutta-high-court-drops-rape-charge-against-athlete-Pinki-Pramanik/articleshow/42372971.cms.

‘Caste Atrocities Have Hastened Religious Conversions | Forward Press’. Available at: https://www.forwardpress.in/2017/05/dalits-atrocities-have-hastened-religious-conversions/.

‘Caster Semenya Wins 800m Gold but Cannot Escape Gender Controversy | Sport | The Guardian’. Available at: https://www.theguardian.com/sport/2009/aug/19/caster-semenya-800m-world-athletics-championships-gender.

Chakrapani, Venkatesan, and others. ‘Hijras/Transgender Women in India: HIV, Human Rights and Social Exclusion’, 2010. Available at: http://archive.nyu.edu/handle/2451/33612.

Devasia, T. K. ‘Why Kerala’s Free Sex-Change Surgeries Will Offer a New Lifeline for the Transgender Community’. Text. Scroll.in. Available at: https://scroll.in/article/804496/why-keralas-free-sex-change-surgeries-will-offer-a-new-lifeline-for-the-transgender-community.

Bento, Berenice. ‘Carta Potiguar - Identidade de Gênero: Entre a Gambiarra e o Direito Pleno’. Available at: http://www.cartapotiguar.com.br/2012/05/29/identidade-de-genero-entre-a-gambiarra-e-o-direito-pleno/.

Devasia, T. K. ‘Why Kerala’s Free Sex-Change Surgeries Will Offer a New Lifeline for the Transgender Community’. Text. Scroll.in. Accessed 9 October 2017. https://scroll.in/article/804496/why-keralas-free-sex-change-surgeries-will-offer-a-new-lifeline-for-the-transgender-community.

Donato, Al. ‘Transgender Supermodel Lea T Made Olympic History At Rio Opening Ceremony’. Huffington Post, 6 August 2016. Available at: http://www.huffingtonpost.ca/2016/08/06/trans-model-rio-olympics_n_11361316.html.

Encarnación, Omar G. ‘Amid Crisis in Brazil, the Evangelical Bloc Emerges as a Political Power’. *The Nation*, 16 August 2017. Available at: https://www.thenation.com/article/amid-crisis-in-brazil-the-evangelical-bloc-emerges-as-a-political-power/.

‘Free Healthcare: Betting on Brazil’. Pulitzer Center, 30 July 2012. https://pulitzercenter.org/reporting/free-healthcare-betting-brazil.

‘Gender Dynamix on Alteration of Sex Description & Sex Status Act Implementation; Lawyers for Human Rights on Statelessness; CoRMSA on Closure of Refugee Reception Offices in Metro Areas | PMG’. Accessed 7 March 2018. Available at: https://pmg.org.za/committee-meeting/15305/.

Gupta, Indrani, and Mrigesh Bhatia. ‘The Indian Health Care System’. The Commonwealth Fund. Accessed 9 October 2017. Available at: http://international.commonwealthfund.org/countries/india/.

Damerow, Harold. ‘International Politics, GOV 207 Global South’. Union County College, 27 August 2010. http://faculty.ucc.edu/egh-damerow/global_south.htm.

‘India Keeps Tight Rein on Public Health Spending in 2015-16 Budget’. Available at: https://www.reuters.com/article/india-health-budget/india-keeps-tight-rein-on-public-health-spending-in-2015-16-budget-idUSL4N0W20CA20150228.

‘Indian Sprinter Dutee Chand Disqualified After Failing a So-Called Gender Test’. Available at: https://www.bustle.com/articles/33066-indian-sprinter-dutee-chand-disqualified-after-failing-a-so-called-gender-test.

'India's Healthcare Sector: A Look at the Challenges and Opportunities Faced by $81.3 Billion Industry - Firstpost'. Available at: http://www.firstpost.com/india/indias-healthcare-sector-a-look-at-the-challenges-and-opportunities-faced-by-81-3-billion-industry-3544745.html.

Johari, Aarefa. 'Hijra, Kothi, Aravani: A Quick Guide to Transgender Terminology'. Text. Scroll.in. Available at: https://scroll.in/article/662023/hijra-kothi-aravani-a-quick-guide-to-transgender-terminology.

Khazan, Olga. 'What the U.S. Can Learn From Brazil's Healthcare Mess'. The Atlantic, 8 May 2014. Available at: https://www.theatlantic.com/health/archive/2014/05/the-struggle-for-universal-healthcare/361854/.

Krulwich, Robert. 'Non! Nein! No! A Country That Wouldn't Let Women Vote Till 1971'. National Geographic News, 26 August 2016. Available at: https://news.nationalgeographic.com/2016/08/country-that-didnt-let-women-vote-till-1971/.

'Kyoto Protocol'. Available at: http://unfccc.int/kyoto_protocol/items/2830.php.

Mafika. 'Health Care in South Africa'. *Brand South Africa* (blog), 2 July 2012. Available at: https://www.brandsouthafrica.com/south-africa-fast-facts/health-facts/health-care-in-south-africa.

'Mine Ban Treaty Text'. Available at: http://www.un.org/Depts/mine/UNDocs/ban_trty.htm.

Mohan, Pavitra. 'Health Budget Figures Tell a Sick Story'. *The Wire* (blog), 16 March 2016. Available at: https://thewire.in/24924/health-budget-figures-tell-a-sick-story/.

'Pinki Pramanik Gender Test Inconclusive | Kolkata | Hindustan Times'. Accessed 10 March 2018. Available at: https://www.hindustantimes.com/kolkata/pinki-pramanik-gender-test-inconclusive/story-wP9oY02i3uD56fJWwsjBUI.html.

Reddy, Gayatri. *With Respect to Sex*. Available at: http://www.press.uchicago.edu/ucp/books/book/chicago/W/bo3534006.html.

'RSBY'. Available at: http://www.rsby.gov.in/about_rsby.aspx.

'Semenya Could Face Athletics Ban', 11 September 2009. Available at: http://www.dailytelegraph.com.au/z-redesign/archive-sport/semenya-could-face-athletics-ban/news-story/947f46669a076d98dbd1177da00b3f10.

'Sexual and Gender Diversity Position Statement'. Psychological Society of South Africa, 2013. Available at: http://www.psyssa.com/documents/PsySSA_sexual_gender_position_statement.pdf.

'Shiv Shakti | KJ (Katy Jon Went)'. KJ (Katy Jon Went). Available at: http://www.katyjon.com/world-press-freedom-day-journalism-is-essential-to-political-accountability-personal-liberty/journalism-is-not-a-crime-amnesty/.

Smith, David. 'IAAF Wants to Talk to Caster Semenya about Gender Test Results – Report'. *The Guardian*, 10 September 2009, sec. Sport. Available at: http://www.theguardian.com/sport/2009/sep/10/caster-semenya-gender-iaaf.

Special Correspondent. 'Health Spending to Be 2.5% of GDP: Centre Announces New Policy with an "Assurance" of Health Care for All'. *The Hindu*. 17 March 2017. Available at: http://www.thehindu.com/news/national/centre-cleared-the-long-awaited-national-health-policy-2017/article17487845.ece.

'Transgender Woman Battles with Home Affairs for True Identity'. Available at: https://www.enca.com/south-africa/transgender-woman-battles-home-affairs-true-identity.

'WHO | 2016 Year in Review: Key Health Issues'. Available at: http://www.who.int/features/2016/year-review/en/.

Annex

Interviews

The interviews I conducted were in the countries of India, Brazil and South Africa. My first set of interviews were conducted in South Africa in June, 2015, after which I conducted my second set of interviews in India in July 2015. In June and July of 2016, I was given a Doctoral Research Support Grant to go to Brazil for my research, where I conducted my third set of interviews, added by ABIA. After visiting Brazil, I went to South Africa again where I was fortunate enough to meet several other people associated with transgender rights issues. I reconnected with several people in India after that as well.

All the people mentioned above had were associated with those organisations at the time, and referred to themselves with these names. Their recorded consent was taken for the interviews. All the people concerned have agreed to be named in my work.

My interviewees are grouped as follows:

South Africa:

- Tshepo Ricki Kgositau, Gender Dynamix, Cape Town – June 2015
- Johan Meyer, OUT NGO, Johannesburg – June 2015
- Dr. Arnaud de Villiers, Cape Town – June 2015
- Dilene van Dyk, associated with OUT NGO, Johannesburg – June 2015
- Catlehoe, Gender Dynamix, Cape Town – June 2015
- Busi Kheswa, Gender Dynamix, Cape Town – June 2015

The people who I met additionally in 2016 who influenced my research are Estian Smit, Gender Dynamix, Cape Town, Ronald Addinall, the Triangle Project, Cape Town, Dr. Alex Muller, University of Cape Town, and Dr. Kevin Adams, Plastic Surgeon, Groote Schuur Hospital, Cape Town.

India:

- Sudipa Rupsha Chakraborty, SAATHII, Kolkata – July 2015
- Simran Sheikh, India HIV/AIDS Alliance, New Delhi – July 2015
- Pawan Dhall, LGBT activist, Kolkata – July 2015
- Anupam Hazra, SAATHII, Kolkata – July 2015
- Amrita Sarkar, India HIV/AIDS Alliance, New Delhi – July 2015
- Abheena Aher, India HIV/AIDS Alliance, New Delhi – July 2015

Brazil:

- Dr. Guilherme Almeida, professor, Rio de Janeiro State University, Rio de Janeiro – June 2016
- Mário Carvalho, researcher and LGBT activist, Rio de Janeiro State University, Rio de Janeiro – June 2016
- Beto de Jesus, consultant on diversity in education, São Paolo – July 2016
- Cacau, Fundação Oswaldo Cruz, Rio de Janeiro – July 2016
- Daniela Murta, psychologist and Technical advisor to the Municipal Secretary for Health at the Prefectiture of the city of Rio de Janeiro – July 2016
- Dr. Marco Aurélio Maximo Prado, psychologist and professor, the Federal University of Minas Gerais, Belo Horizonte – July 2016
- Eduardo, social worker, Sao Paulo – July 2016
- Tais Azevedo, social worker, Sao Paulo – July 2016

My colleagues at ABIA connected me with several of the people mentioned above and made me abreast of the situation around HIV and the availability of anti-retroviral treatments.

The questions asked were generally open-ended. After introductions, the questions that were asked were:

1. How would you describe yourself?
2. Would you speak about your gender identity?
3. Can you tell me about your journey of self-realisation and how you came to terms with your gender identity?
4. Can you tell me more about yourself? (family/livelihood/community involvement, etc)
5. What are the perceptions about transgender people in your local community?
6. What, according to you, are the main problems faced by transgender people in your local community as well as in general?
7. Have you had any health issues related to your gender?
8. Have you ever faced any discrimination from health service providers because of your gender?
9. What are your thoughts on reproductive rights for transgender people? Do you know of any transgender people who have had problems exercising their reproductive rights?
10. Have you had problems in accessing government services? If yes, what kind of government services are you speaking of?
11. According to you, what is the best way forward to ending the problems faced by the trans* community?

Questions such as No.8 were changed according to the person's gender identity and adapted to get as much information as possible. The interviews were conducted in English in South Africa, in English and Portuguese in Brazil, and English, Bengali and Hindi in India.