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SEXUALITIES

Abstract Informed by narratives provided by self-identified South African transsexuals, whose lives span different periods of South Africa's political and social history, this article seeks to explore how South Africa's medical, legal and military establishments have exerted power over the transsexual body. A variety of studies outline the extent to which the apartheid state was a highly gendered state characterized by inflexible patriarchal norms and the dominance of violent and authoritarian forms of masculine expression. Hyper masculinization and militarization were explicit goals of the apartheid state. Deviance from the state's prescribed gender norms was not simply socially unacceptable, it was, in many cases, punishable. South Africa's post-1994 democratic Constitution, in contrast, explicitly outlaws discrimination on the basis of sexual orientation. But the democratic legal framework, which provides significant protections for freedom of sexual expression and freedom from discrimination for homosexuals has arguably had less of an impact on the lives of South Africa's transsexual community. The state, even the post-apartheid state, has been loathe to move beyond the idea of a necessary correlation between the physical make-up of the body and the gender identity of a person in the way in which it has treated the idea of transsexualism.

Keywords gay; gender; military; South Africa; transsexualism

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Putting the 'T' into South African Human Rights: Transsexuality in the Post-Apartheid Order

In South Africa the transsexual[1] body has historically been the site of direct state surveillance, control and manipulation. Core state institutions including the legal system, the medical establishment and the military have played a defining role in the way in which transsexualism has been understood and experienced over the last 60 years. Drawing on narratives

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provided by self-identified South African transsexuals, whose lives span different periods of South Africa's political and social history, this article seeks to explore how South Africa's medical, legal and military establishments have exerted power over the transsexual body. In doing so state power is revealed as highly gendered in its manifestation and based on narrow heteronormative binary assumptions concerning the nature of bodies, of desire and of gendered embodiment.

The article draws on life stories provided by three self-identified South African transsexuals in interviews conducted in October 2007. Two were biologically born male; one was born female. Two have undergone surgery, although all have expressed a desire for surgery at one point in their lives. The non-operative is a MTF (Sue), while the post operatives are MTF (Sasha) and FTM (John), respectively. All three consider themselves to be specific genders regardless of their assigned sex. With regards to sexual orientation only the FTM views himself as explicitly homosexual – a gay man. Both MTF's view themselves as women, the one heterosexual the other gay – a lesbian. All the participants vary in age and thus came to understand who they are and to form their perceptions of who they are, during different periods in South Africa's history. The participants were aware of the purpose of the research process and names have been changed to preserve anonymity.

Burr (1995) suggests that identity is 'constructed out of discourses culturally available to us and being achieved by a subtle interweaving of many different threads' (1995: 51). Language is the tool we use to pull together these variant threads of social interactions, shape and interpret them in order to create stories about our 'lives through which our identity is constructed' (1995: 51). Because they varied in age, the life stories of the three narrators helped to provide an understanding of identity and the prevailing climate for transsexuals in South Africa in different historical periods. Analysis of the detailed life-stories of the three participants suggested the common themes that thread through each and therefore formed the conceptual framework for the article: medicine (access to, and responses from, health professionals); law (the legal framework, law enforcement) and, finally, the effects of the militarization of South African society and the role of the military establishment in shaping the state's response to the transgendered body.

The narratives were gathered through interviews both in person and electronically. Although it is not suggested that the experiences of these particular participants are 'representative' of all those who lived during the same periods of South African history, it is reasonable to assume that their life experiences speak to the wider functioning of society at the time. The first hand accounts were supplemented with information from the Gay and Lesbian Archives (GALA) – an extensive documentary archive of

South African transsexual history. GALA were also the coordinators of the aVersion project – a key study in the understandings of the South African state's approach to sexuality in the 1980s, specifically that of the military establishment.

While narratives are written from a very specific vantage point, that of the narrator, a narrator not only tells the story from his or her own point of view but also places that story in a particular social, cultural or political context (Fraser, 2004: 186). The truths of narrative accounts lie in the associations they are able to draw between the past, the present and the future (Riessman, 2001). As Anthony Paul Kerby (1991) suggests, 'narratives are a primary embodiment of our understanding of the world, of experience and ultimately of ourselves' (1991: 3). Accordingly narrative provides the capability to structure the disparate events of a life, drawing meaning from how the narrator interprets the connectedness of memories. While the coherence that is experienced in memory is undoubtedly imposed by the narrator, that imposition gives us a sense of what is important for the narrator and suggests ways in which a life can be interpreted (Gergen and Gergen, 2003).

Stories, in other words, provide us with the opportunity to access the impact of cultural and political shifts over time. In this case the life stories recounted are about experiences of a single phenomenon during different periods of South African history. Riessman (2001) has referred to the way in which the use of narrative research to foreground the stories of 'members of historically "defiled" groups' has the potential to reveal how, for instance, shifts in language over time, both shape and are shaped by, these actors. In this way what we might otherwise understand as merely 'personal troubles' can come to be situated and understood within specific political and social contexts. Thus, for Riessman, an individual's narratives about their troubles 'are works of history as much as they are about individuals, the social spaces they inhabit, and the societies they live in'. Personal narratives are capable then, of illuminating something more than a personal biography; they illuminate also the social context within which the personal is lived and experienced (Laslett, 1999).

Researching transsexual experience poses significant challenges. Few people would still choose to label themselves as transsexual post-surgery, with many post-operation transsexuals either referring to themselves as transgendered or simply identifying as their chosen gender post operation. Most transsexuals desire full integration into society as members of their chosen sex rather than continually identifying as transsexuals and are therefore loathe to talk about their 'other' life. In South Africa the transsexual community lacks visibility. Where interaction does take place it is usually in virtual spaces rather than physical locations. This reality informed the research process which entailed the gathering of narratives

using one-to-one electronic and face-to-face interviews. There are many difficulties with electronic interviews. On the one hand, while face-to-face interviews provide the opportunity for the establishment of rapport, probing for further or fuller answers and the reading of non-verbal cues, electronic communication lacks these advantages. On the other hand, in the context of the subject explored in this particular article, electronic communication provided the research subjects with the possibility of communicating without being physically scrutinized.

The participants were asked to reflect back on experiences in their lives. Their accounts are no doubt subject to the usual distortions from which any retrospective account might suffer. But what is important for the purposes of the present study is precisely how that past is remembered, which particular features of memory are isolated as being of particular significance and how past experiences are reflected upon and reinterpreted through the lens of the present. Although it cannot be expected that the experiences of these particular participants will mirror exactly those others who lived during the same time periods, it is reasonable to assume that the life experiences of the participants speak to the political and social context in which they took place. In particular, the narratives are employed to highlight shifts in the access to information, education and medication on the part of transsexuals and how these shifts have imprinted themselves on the experience of being transsexual in South Africa since 1950.

The apartheid state and the transsexual body

Internationally the emergence and history of transsexualism has been relatively well recorded with the term 'transsexual' first being coined by sexologist, Magnus Hirschfeld, in 1910. One of his clients, Lile Elbe (formally Einar Wegener), is considered the 'first' recognized transsexual after her operation in 1930. Hormones, such as Di-Ethyl and Premalin, became widely available in 1938. Nevertheless, transsexualism remained largely unknown, until the advent of the first fully fledged 'media transsexual': Christine Jorgensen (formally George Jorgensen, an American GI) in 1953 (Brown and Rounsley, 2003: 229–30). These ground-breaking figures notwithstanding, the term 'transsexual' is relatively recent, arising in the context of enabling technological and medical procedures which began to be developed from around the mid-20th century (Brown and Rounsley, 2003: 230). It is in this sense that the transsexual body is sometimes said to have come into existence in the mid-1950s – which is not to say that people desiring a change in the physical manifestation of their sex did not exist before this time but rather that it is from this time that this form of body modification became literally possible.

The 1950s represent an important decade in South African history. The National Party had won the election of 1948 with its policy of apartheid and during the following decade embarked on a programme of consolidating its power both legally and politically.

Key was the Population Registration Act (no. 30) of 1950, which classified all South Africans as either white, coloured or 'native'. The Group Areas Act (no. 41) of 1950 provided the basis for South Africa to be divided into separate areas for blacks and whites and the Bantu Authorities Act (no. 68) of 1951 set up separate local authorities in regions that had been set aside for black occupancy. The limited franchise that had existed for some black South Africans was abolished with the 1956 Separate Representation of Voters Amendment Act (no. 30). Segregated public amenities such as swimming pools, parks and park benches, public toilets, beaches and clubs were institutionalized with the Reservation of Separate Amenities Act (no. 49) of 1953 while separate and unequal education systems for black and white citizens were created by the Bantu Education Act (no. 47) of 1953. Giving muscle to the ideology of apartheid was the security legislation that accompanied the enactment of these laws in the 1950s. The Suppression of Communism Act (no. 44) of 1950 defined 'communism' as anything that brought about a disturbance or a disorder in Union and paved the way for the banning of a wide variety of anti-apartheid organizations and individuals. In 1953 the Public Safety Act (no. 3) and the Criminal Law Amendment Act (no. 8) further augmented the state's power to suspend democratic processes and to jail opponents.

From the outset, sexual and gender relations were a focal point of attention for apartheid law-makers. One of the first apartheid laws to be enacted was the Prohibition of Mixed Marriages Act of 1949, which made marriage between black and white South Africans illegal. It was followed by the so-called Immorality Act, which attempted to ban all sexual relations across the colour bar. This legislation made it possible for the state to intrude into the most private parts of peoples' lives, literally invading homes and bedrooms, seizing underwear as evidence and photographing couples having sex. The Immorality Act of 1969 was one of the first pieces of South African legislation that came close to dealing with transsexualism. It was the first Act to 'explicitly acknowledge governmental hostility to female masculinity and lesbians by banning dildos' (Keenan, 2006: 20). The Act criminalized 'any act by a male person . . . with another male person at a party . . . which is calculated to stimulate sexual passion or to give sexual gratification' with a party defined as 'any occasion where more than two persons are present' (Hoad, 2005: 17). The age of consent for male homosexual acts was also raised from 16 to 19 (Gevisser and Cameron, 1994: 35).

Apartheid legislation was met with heightened political protest so that the decade came to be known in popular parlance as the 'fighting fifties'. Inevitably, mass resistance was met with government repression marked initially by the Sharpeville massacre in 1961 and followed by the banning of political organizations and the jailing of leading figures in the anti-apartheid movement. With popular protest temporarily quelled the 'silent sixties' was a time of economic boom and prosperity for white South Africa. But the situation began to shift in the 1970s with rising international oil prices, a newly emergent highly organized and militant black trade union movement and an increasingly disenchanted youth whose voice was most memorably heard in the Soweto uprising of 1976.

The 1950s also marked the beginning of a process of comprehensive militarization of South African society, which would culminate in the appointment of the Minister of Defence P.W. Botha as Prime Minister in 1978. The Defence Act of 1957 saw the augmentation of the South African Defence Force (SADF) budget and the introduction of a limited system of conscription for white South African men (Seegers, 1987). With Botha's rise to power in 1978 the militarization of South Africa's socio-political landscape was to accelerate. It was from this point that the apartheid regime put forward its understanding, first articulated in the White Paper on Defence of 1977, that the Republic was subject to a 'total onslaught': a comprehensive and multifaceted assault from the combined forces of local and international communism. In this context, the appropriate response, the government averred, was one of 'total strategy' (Cawthra, 1986; Mills, 1996). The rhetoric of total strategy in response to the total onslaught came to dominate the 1980s and was used to justify government policies ranging from the military occupation of black townships to lengthy compulsory military conscription of white South African men.

A variety of studies has outlined the extent to which the apartheid state was a highly gendered state characterized by inflexible patriarchal norms and the dominance of violent and authoritarian forms of masculine expression (see for instance Cock, 1991; Morrell, 2001). 'In militarised societies', writes Daniel Conway, 'where masculinities become intertwined with the performance of military service, the state's gender regime is constructed in ways that serve . . . to discipline men and women to support the status quo' (2006: 21). In this context, the safeguarding of rigid gender binaries comes to be associated with preserving social order. Sexual identity is policed as a central manifestation of the logic of a gender order premised on heteronormativity. As Conway points out, 'it is no coincidence that men who object to military service are frequently portrayed by the state . . . as cowardly, effeminate and homosexual' (2006: 21).

South Africa in the 1950s then, was hardly a conducive climate for transsexualism which had just begun to establish itself as a fragile and uncertain category of identity. State repression, hyper masculinity and constant state surveillance of sexuality in the context of a state structured around ideas of racial purity ensured that, at least at the level of public visibility or acknowledgement, non-conforming sexual and gender identities were as Sue recalls, 'a very hidden thing' (Interview, 6 October 2007). Invisibility in a climate of justifiable fear meant that there was little opportunity to find others who experienced their identity in similar ways so that transsexuals were isolated and often believed that there were no others like them. Sue can remember only one chance meeting in a bookshop and, on another occasion, coming across a group of women selling themselves to sailors on the docks which served to suggest that her experience was shared by others. She recalls how she experienced her identity at a time of state repression of marginalized sexual identities:

> I knew I wanted to be a woman and dressed in woman's clothes, but had very little idea of who or what I was . . . it was something to be coped with and hidden and feel guilty about . . . even gay people used to hide themselves . . . In those days police used to actively try and hunt out homosexuals, there was no concept of consenting adults in private . . . there was no consenting adults and there was no privacy. It was just not allowed; they were caught, they were charged and they were sent to prison . . . so then . . . I thought my god if they do that to two guys pulling one another's wire . . . what will they do to me if they catch me in girls' clothes? They will line me up against the wall and shoot me. (Interview 6 October 2007)

Transsexualism and the apartheid military

The military was a central source of authority and power for the apartheid state (see Enloe, 1983: 11). Hyper masculinization and militarization were explicit goals of the apartheid state which pursued and enforced them by way of the compulsory conscription of its white male population. As Conway has argued, 'conscription underpinned and perpetuated gendered binaries: binaries that encouraged men and women to support the social preparation for and actual prosecution of military warfare' (Conway, 2006: 7) and served as a 'disciplinary mechanism for a white elite whose unity was by no means assured' (Conway, 2006: 8). Conway (2006) makes the argument that conscription played the role of entrenching and perpetuating the state's heteronormative gender regime, ensuring that the ideal typical South African citizen was constructed as white and necessarily heterosexual. This in turn implied that those (black, gay, transsexual) who did not fit this prescription were stigmatized and subject to a variety of shades of state brutality. Deviance from the state's prescribed

gender norms was not simply socially unacceptable it was, in many cases, punishable.

But it was from the 1970s that the apartheid state's most sustained and intrusive intervention in the bodily existence of those who did not conform to its prescribed gender norms began. In late 1969 a psychiatry unit was established by South African Medical Services at One Military Hospital Voortrekkerhoogte (in what was then Pretoria). Rather than focusing simply on the combat-related medical and psychological problems of recruits, the centre become what one commentator has termed 'a dumping ground for conscripts who dissented with apartheid ideology and traditional views of masculinity' (van Zyl et al., 1999: 31). Any form of homosexuality in South Africa was considered taboo and in most cases a punishable crime. Homosexuals were treated as social deviants and a threat to the dominant gender order. Rather than simply exempting gay conscripts, the military approached homosexuality as a disease, which it attempted to 'treat'. Gay men and women were encouraged to confess their desires and submit to various forms of treatment, such as electro shock therapy in the psychiatry unit (van Zyl et al., 1999: v).

In order to protect its ranks from the perceived threat of homosexuality, the military screened all conscripts for any signs of homosexuality (Kaplan, 2004). To ensure compliance, those who were suspected of being homosexual were threatened with punishment should they be unwilling to come forward. A large majority of those who came forward confessing their homosexuality were admitted to the Military Hospital at Voortrekkerhoogte. Here a key 'cure' for homosexuality was sex reassignment surgery. From 1980 it is estimated that as many as 900 sex-change operations were performed at this hospital and others in South Africa. Smit (2006: 251) suggests that not all of those who obtained sex reassignment or access to hormones through the South African military were unwilling or unknowing victims. There were those for whom the military offered the opportunity to fulfil an intense desire for physical change by providing access to rare and expensive surgery and other forms of medical treatment. The largest proportion of operations was performed on homosexual recruits despite the fact that homosexuality had been removed from the DSM[2] as a mental illness in 1973 (Kaplan, 2004). In the majority of cases treatment was enforced without any consent on the part of the 'patients' or their guardians. Moreover coercion was often used in the attempt to make 'patients' submit to therapy (van Zyl et al., 1999: 90). Casualty rates were high; some died during surgery, others were discharged from the army before their operations were completed and still others were discharged, unable to maintain their expensive hormone regimes and therefore unable to maintain their new appearance (Kirk, 2000).

In addition to those who underwent surgery, an unknown number of officers were prescribed hormones, often without their knowledge (Kaplan, 2004). Adam was a gay conscript who was surreptitiously given hormones during his time in the SADF. Through the intervention of sympathetic university lecturers he was submitted to evaluation in the hopes that he would be discharged early. After being evaluated he was given some tablets which, in retrospect, he presumes were a form of hormonal tampering:

> I was given tablets to drink which had no name on them. I believed they would conduct tests on me later on whether I had really taken the stuff and whether I was a co-operative patient . . . I do not know what the substance was . . . all I know is that it changed my life forever . . . After two days of torture they were too scared to carry on with that and sent me home. By that time I was psychologically and hormonally and physiologically damaged. (GALA IV 5, 1998: 3)

There are many other recorded incidents among both male and female recruits that echo Adam's experience. The treatment of gay and lesbian people in the South African military by medical workers has been documented by the aVersion Project – a report commissioned by gay rights groups and the South African Medical Research Council and conducted between 1998 and 2000 (McGreal, 2000).

Access to treatment in the military during the 1980s was subject to harsh conditions such as severing ties with one's former life. Denny, (2004: 30) argues that this was typical of gender programmes around the world which often expected transsexual clients to 'divorce, change their names, quit their jobs, dress and behave in stereotypically masculine or feminine ways'. Nevertheless, and ironically, access to rare surgery afforded at One Military Hospital literally gave rise to the phenomenon of the transsexual body in South Africa on a far larger scale than would otherwise have been likely. For many, this was an imposed identity based on the state's insistence on the maintenance of a gender binary in which to be male was to desire women. Within this logic the only conclusion that could be reached about a man who desired men was that he was a woman and surgery provided the physical means to create this desired fit. For others, those who themselves regarded their physical bodies as out of step with their desired identity, surgery was a welcome opportunity to transition to a new body.

Transsexuality and the medical establishment

The South African Medical Services (SAMS) was the medical arm of the South African Defence Force (SADF). It fell under the administration of the Department of Defence, alongside other units such as the navy and

air force. The medical staff of the SAMS was drawn from the Special Forces and conscripts. Medical personal were expected to obey commands even when orders from superiors contradicted personal or professional ethics (see van Zyl et al., 1999: 41). But medical officers in the army itself were not the only medical personnel to be involved in the abusive and inappropriate treatment of transsexuality in South Africa. Kaplan (2004) refers to the collusion of medical personnel with the apartheid state as a 'notorious example of medical complicity in state abuse'.

The medical establishment has always played a central role in the control and surveillance of the transsexual body. Mental health care practitioners (psychologist and psychiatrists) the world over are key figures in the lives of transsexuals. Medical intervention is required by transsexuals who wish to change their bodies and medical personnel have the power to decide who will and will not be allowed privileged access to treatment. They control access to surgery, hormones and in some cases classification of oneself as transsexual. Most often they are understood in pejorative terms as gatekeepers or key holders, blocking transsexuals from achieving their goals. Moreover, the requirement of medical intervention means that transsexualism is frequently constructed as a disease or mental disorder which in turn means that those who claim the label are also opening themselves to being stigmatized as sick or perverse (see Hausman, 1992: 275).

For the most part, the medical establishment's understanding of how to identify and treat so-called sexual and gender identity disorders relies on the definitions and assumptions provided by the DSM (Smit, 2006: 251). The DSM's approach to transsexuality has been criticized for being rooted in stereotypical, heteronormative understandings of transsexuals attempting to access hormones and surgery. Harry Benjamin, for instance, suggested that any deviation from heterosexuality disqualified one from being a 'true' transsexual (Smit, 2006: 261). Benjamin, often referred to as the 'father of transsexualism', played a central role in making sex reassignment surgery a legitimate, accessible and acceptable medical practice (Smit, 2006: 255–60). When the first gender clinics were established in the USA in the 1960s, Benjamin's book, *The Transsexual Phenomenon*, was the standard reference guide on transsexualism. In it transsexualism was explained as an opportunity to examine 'deviations from the norm in hope of better understanding normal processes' (Green, 1999).

The dominant interpretive model of transsexualism that emerged then was one that defined transsexuals as desperately unhappy because they felt that they did not fit their birth assigned sex and felt that they belonged to the other sex (Denny, 2004). Transsexuals did not only feel that they 'belonged to the other sex, they wanted to be and function as members of the opposite sex, not only appear as such' (Smit, 2006: 260). According to Benjamin true transsexuals felt a deep disgust towards their sexual

organs seeing them as 'disgusting deformities' (Smit, 2006: 260). Benjamin believed that unlike homosexuals, all transsexuals were attracted to their birth sex and, post-surgery, would function as heterosexual members of society. When the first transsexuals were evaluated for their suitability for surgery, their 'behaviour matched up gratifyingly with Benjamin's criteria' (Smit, 2006: 261) thus giving further credence to his views. It took several years for researchers to realize that Benjamin's book was being passed from hand to hand in the transsexual community, and that transsexuals were only too happy to evince whichever behavioural traits would be most likely to give them access to surgery (Shefer et al., 2006: 261). A rigid model of transsexualism emerged which became entrenched in the medical community and mirrored in the way in which transsexuals began to speak about and understand themselves. Inevitably these interpretations reflected the very specific gender norms and assumptions that were dominant in North America and Europe at the time (Smit, 2006: 261).

In South Africa access to medical services for transsexuals was much more limited than in the developed world. When Sue turned to a psychiatrist for help in the mid-1970s she was offered two options: surgery or electro shock therapy. At this time there were as yet no concrete international guidelines outlining how to work with transsexuals. Sue recalls her experience of being isolated and the far from adequate psychiatric treatment that was available to her at the time:

> I didn't really have anybody to discuss these things with except this not too sympathetic psychiatrist . . . The aversion therapy was a bit sort of frightening because he explained that I would be required to bring girls' clothes in and then I could touch the girls' clothes and he would give me an electric shock. This would stop me from wanting to touch girls' clothes. I said 'but what's going to happen in my mind?' He said 'oh well you will get over it'. That, I felt, was a bit sort of freaky. I would be left wanting to do things and then my own body not allowing me to do them. Well the other option was well could I sign up . . . get an operation . . . I thought well that was perhaps something and I need to investigate further. Then he wasn't there to investigate it with. He was gone. You know there was no follow up from him . . . there was never a call from him . . . it wasn't really very sympathetic . . . it was confusing . . . I think there was a lack of general support it was a big thing . . . it was all so frightening. (Interview, 6 October 2007)

Transsexualism appeared for the first time as a disorder, in the DSM III, released in 1980. It was considered a far more ambitious and thorough text than the APA had ever released before, but its analysis of sexual maladies continued to attract criticism. Culver and Gert (1982: 105) argue that individuals who enter into the paraphiliac fantasies or behaviours (such as transsexuals) described by the DSM may not even have a

mental disorder, according to the DSM's own definition. They suggest that the reason for the DSM's including issues such as transsexuality in the 1980s was because the authors seem to have adopted the psychological theory that heterosexuality between consenting adults was the ideal and that any deviation from this was 'ipso facto a mental disorder . . . thus it is deviance that defines disorder' (Culver and Gert, 1982: 105).

While the debate over the DSM III classification continued within medical circles, South Africa's first 'media transsexual' Elize van der Merwe, formerly Pierre, hit the headlines of newspapers across the country (*Daily Dispatch*, 1982). Van der Merwe had grown up in Graaff-Reinet in the Karoo and was referred to in news reports as a *plattelandse Afrikaner-seun* (Afrikaner country boy – see *Rapport* 14 January 1982). She underwent gender reassignment surgery in 1975. Of all the newspaper and magazine reports on the story only one refers to her as a transsexual, the rest refer to a woman in the wrong body. The reports are at pains to extol her womanly interests including baking, house-keeping and her life-long search for a husband (van der Merwe, 1982). Van der Merwe described herself (1982) as wanting to be with men but knowing that rather than being homosexual what she wanted was to be a woman (*Sarie Marais*). Eventually her searching took her to the Transsexual Clinic at the then H.F. Verwoerd Hospital (today the Pretoria Academic Hospital). It was here that she came into contact with the term 'transsexual' for the first time. This gave her a way of describing herself and the consoling knowledge that there were others like her (van der Merwe, 1982) and that she was not gay.

In South Africa, in order to access surgery, a transsexual must go through four stages and fulfil the specific requirements of each. These stages are referred to as assessment, psychotherapy, real life experience and hormonal therapy. Van der Merwe described her six months real life experience during which she was required to live 'as a woman' in order to qualify for surgery; this, despite the fact that at this time 'impersonating a woman' was illegal in South Africa:

> It was a compete revolution, to suddenly live life as a woman. Physically you are not yet a woman, but you have to go to work as a woman, you have to look like one and behave like one. At work I had to apply for a transfer to another branch, I had to buy women's clothes, shoes, make up . . . All of a sudden I had to be aware of what I did and what I said . . . I had to stop myself from opening doors for women . . . I had to choose a new name and hardest of all I had to try and go out with heterosexual men. I had never been out with a man before . . . What would I do if he made friendly advances and found out I was a man? Is there anything that gives me away? Did I say the right thing? It was a nightmare. Luckily I had one consolation: in my handbag was always a letter stating that I was under the care of doctors. (van der Merwe, 1982, translated from Afrikaans)

Having passed her six months' 'real life' test, van Der Merwe was permitted to undergo surgery and was pronounced by her doctors 'one of their best products yet' (van der Merwe, 1982).

Transsexualism understood and treated in this way posed no threat to the prevailing heteronormative orthodoxy in which not only was sexual attraction the attraction of 'opposites' on the gender binary, but gender roles and behaviours were understood in highly stereotypical terms. It is perhaps not surprisingly then, that despite the fact that van der Merwe's treatment took place in a very conservative social and political context, far from being shunned, she enjoyed a brief time of celebrity. Letters – at one point as many as between 40 and 60 a day – which arrived from all over the country were for the most part highly supportive of her transition and her new life as a woman. Many were from men and women who wanted to know more about accessing surgery and treatment (van der Merwe, 1983). A considerable number were not from transsexuals at all but from homosexuals who saw in surgery the potential for living a 'normal' life rather than having to accept an identity as homosexual (Marais, 1982; Solomon, 1982; van Tonder, 1982). While homosexuality was understood as deviance, transsexuality offered a mechanism of fitting back into the binary and thus the possibility of an interpretation of the self as normalized.

From 1994 the term transsexualism was omitted altogether from the DSM and replaced with the term Gender Identity Disorder (GID) (Bullough and Bullough, 1998: 22). Health care practitioners have argued that the existence of GID within the DSM gives those involved with caring for trans people, particularly psychiatrists, validation within their profession (Bolin, 1988: 54). Nevertheless, semantic shifts notwithstanding, the medical profession's understanding of transsexualism continues largely to be defined within the rigid binary of two sexes and two genders which are thought to ideally map neatly onto one another along with the associated assumption of heterosexuality as the norm for sexual expression. Gender roles are understood within narrow stereotypical and prescriptive boundaries and the source of explanation and 'cure' for sexual maladies is sought strictly within the individual rather than looking to the social context within which the definition of 'normal' and 'deviant' arises. As Clarke remarks 'we are asked to believe transsexuals are unhappy because men are not meant to bake cookies and not because transsexuals get rejected and isolated' in society (1995).

Far from being a neutral diagnostic instrument then, the DSM's prescriptions of normality and pathology continue to reflect specific cultural beliefs, philosophical approaches and social values (Smit, 2006: 252). Sasha recalls attempting to access treatment at Pretoria Academic Hospital's Gender Clinic in the mid 1990s:

> The first thing they [the board of psychiatrists] said to me is that I need to start dressing like a woman and I was like what? I am unfortunately not the most feminine person on the earth. I just couldn't see myself wearing a dress every day and high-heeled shoes, with make up on. I mean I had grown my hair but I was like this is as fem as I get this is it . . . I mean you had to wear make up every day . . . and I was like I just can't do that . . . and I was like no I don't want to do that, that's not me. They were like, well if you don't want to do that then we can't help you. You have to make up your mind if this is what you want to do then do it. It was stereotyping . . . not all woman wear high heels every day not all woman wear dresses every day . . . not all woman wear make up . . . to me that's not what makes a woman a woman, it's the way you feel inside. (Interview, 4 October 2007)

To defy narrow gender role prescriptions is to risk being diagnosed as an unsuitable candidate for surgery. In this way the medical establishment has historically wielded considerable power not simply to define who is and is not a 'true' transsexual but to define what is and is not a proper way to behave as a man or a woman. Together with the state's legal machinery and military apparatus, South Africa's medical establishment formed an important lynchpin in a tripartite power structure whose activities included the surveillance, stigmatization, imprisonment, torture and brutalization of those whose sexual or gender expression was deemed to deviate from its understanding of [hetero] normality.

Transsexuality and the law in contemporary South Africa

Largely as a result of the concerted lobbying efforts of gay and lesbian organizations in the country during the period in which South Africa's democratic settlement was negotiated, South Africa's Constitution of 1996 broke new legal ground in explicitly outlawing discrimination on the basis of sexual orientation in its equality clause. Other legal victories followed. In 1998 the Sodomy Law in terms of which homosexual sex was illegal in South Africa was declared unconstitutional along with the 1957 statute which made any form of sexual contact between men illegal when more than two people were present. Same-sex couples were afforded the right to co-adopt children and same-sex partnerships were recognized for the purpose of awarding state pensions and other employment benefits and immigration rights.

Sue experienced the shift from one legal order to another:

> post 1994 . . . the country was becoming much more liberal and there was a lot of gay movement and gay marches and things that there had never been before. You know they would have been mown down . . . by the nationalist government if there was a whole gay march with everybody in pink and wearing

> dresses and this sort of thing . . . so really it happened quite suddenly I'm inclined to say almost like one day . . . you know . . . and of course then the internet was available and the internet has been a major spreader of news and contacts for all sorts of people, including or not least transsexuals . . . So I then thought, well I started actively to look for others . . . I was amazed, amazed at what I found out there. (Interview, 6 October 2007)

Arguably, however, this altered legal context that recognizes homosexuality as a legitimate form of sexual expression and protects homosexuals from discrimination has had fewer far-reaching consequences for South Africa's transsexual community. While the overall social climate has shifted to provide greater opportunities for transsexual people to find one another, to form organizations and to seek treatment without fear of retributive state action, victories for gay rights cannot simply be read as victories for transsexuality.

For Wilchins, the early 1990s marked a moment of political recognition for transsexuals who for the first time began to see themselves as an oppressed minority rather than merely a social problem (Wilchins, 2004: 23). This has been challenging not only for the heterosexual orthodoxy but for the gay rights movement as well. While a number of LGB (Lesbian, Gay and Bisexual) groups have adopted the 'T' (Transgendered/Transsexual) as part of their cause, their embracing of the 'T' remains far from complete. Historically many transsexuals have been sheltered within the gay community but the relationship has always been fraught and continues to be, as John's experience in contemporary South Africa suggests:

> A few months after I started living full time as male I came to terms with the fact that I was gay. I had been attending the Triangle Project Transgender Support Group on a monthly basis. During this time I felt a need to interact and connect with other gay men who where the same age as me. I had gotten quite involved within the transgender community yet felt a desperate need to chat to gay men my age. I knew that Triangle Project had a young gay men's support group and one day I phoned them . . . I was told that due to the fact that I was a transman they didn't think I would be able to join the group and instead I should join the transgender support group, I told them that I was already a member of that group yet specifically wanted to join the men's group and was once again told that I couldn't join as I was a transman. I was really angry and upset, as I felt that if a support group wouldn't accept me as a gay man then no gay man or group would. (Interview, 8 October 2007)

While the state often lumps transsexual rights together with gay and lesbian rights this is not necessarily reflected in the way in which members of these different identity categories experience themselves or others. Moreover, beyond the question of a general climate of discrimination or

anti-discrimination, the social and legal issues facing trans people are often quite different to those confronting the gay and lesbian community. For transsexuals, questions of how one is legally defined and what the law is prepared to recognize one as being play a determining role in the intricate and private details of life including which bathroom one may use, which change room to enter, which sports team to play on, which cell to occupy – and in multiple daily interactions, literally, which box to tick.

In a judgement of far-reaching import from this point of view, in the 1976 case of W v W (2) SA 308 (WLD), the court held that in South Africa, sex could not be medically changed (Swartz, 1997). This ruling effectively meant that for legal purposes a person's sex is fixed at birth and cannot be altered.[3] This has severe implications for transsexuals because it implies that a person's sex is legally unchanged even after undergoing surgery, let alone merely as a result of choosing to identify as one gender rather than another.

South Africans are issued with an identity document (ID) which they must produce, for instance, for purposes of voting, obtaining a driver's licence, opening a bank account and so on. According to Section 7 of the Identification Act (68/97) the 'Director-General shall assign an identity number to every person whose particulars are included in the population register'. Section 19 of the Act instructs the Director General to cancel and replace any identity document that does not correctly reflect 'the particulars of the person to whom it was issued'. In short, a person's identity number, which encodes their date of birth and their sex, must correlate with what is perceived to be the actual sex of that person, which is the sex assigned to the person at birth and recorded on their birth certificate. This number forms part of a person's personal information entered into the population register.

As a result, someone who undergoes sex reassignment surgery is able to change their Identity Document to reflect their new name and new photograph but the barcode would still record their previous sex. This has potentially far-reaching consequences for the status of post-operative transsexuals under the law. Identity documents are not simply used to open bank accounts and the like but can have more consequential implications. As an interviewee pointed out to the South African Human Rights Commission (2003):

> What are my rights? Do I have any? What would happen if I were raped or if my partner were to physically abuse me? What would happen when I went to the police station to report such a crime? I sometimes feel that I do not have any rights . . . Which cell would I be placed in if I were arrested?

In an attempt to rectify this situation, the department of Home Affairs put forward The *Alteration of Sex Description and Sex Status Act* in 2003.

In a number of ways this Act points to a general understanding on the part of the state of what transsexualism is. The Act employed out-dated terminology, had a strong focus on sexual organs and was seemingly written with the underlying assumption that one could have a complete sex change. The Cape Town Transgender/Transsexual Support Group made a presentation to the National Council of Provinces in 2003, highlighting these issues and further stating that a Bill that required people to undergo invasive, painful and sometimes unsuccessful surgery in order to change their sex was against international standards and required the impossible, essentially that full sex change was possible.

The group argued that:

> [b]y using the expression 'sex change' the Bill also seems to demand that we undergo every possible surgical procedure before allowing us to change our sex description. This is a human rights violation. It is positively inhumane to require us to undergo surgical alteration of sex organs given the immense risks involved, the number of hospital stays, the immense amount of physical pain, and the frequently unsatisfactory results and debilitating consequences. There is no medical rationale for linking legal recognition of a trans person's new sex to genital reconstructive surgery or any other specific treatment that is not medically appropriate or possible for all transsexual people. For example, for female-to-male transsexuals (FTMs), the most common sex reassignment surgery is chest surgery. In contrast, fewer than 10% of FTMs undergo any reconstructive genital surgery, due to the severe limitations and medical risks associated with this surgery. (Cape Town Support Group, 2003: 6)

The Act also required that in every application for legal documents to be changed, medical documents be furnished stating that the applicant had undergone some sort of surgery or medical treatment in order to have their sex description changed. The support group argued that these requirements continue to pathologize transsexuals and furthermore do not allow for self-identification. This continued control on the part of the state highlighted its need to:

> enforce on all human beings a very rigid concept of what it means to be female or male. It wants to deny us our very sense of self on the basis of the external appearance of our bodies, on the basis of what hangs between our legs or what the shape of our chest is. On the basis of how our bodies look it makes us outcasts, stigmatises and sensationalises us. It clings to absolutes that do not exist and feels extremely threatened by those of us who cross those artificially imposed boundaries. It seeks to regulate us, track us and require our bodies to fully fit one of the two tiny boxes it constructed before allowing us the legal and social existence we yearn for. (Cape Town Support Group, 2003: 9)

When the President assented to the Act on the 15 March 2004, some of the changes with regard to wording and requirements were made. Most

importantly, thanks to the intervention of the Cape Town Transgendered/Transsexual Support Group, the Act provides for those who live successfully as another sex utilizing non surgical means such as changing clothing, body language, vocal expression and body appearance (hair removal or breast binding). The Act now allows for the changing of documents and legal sex status but still requires medical documentation in order to do this. The continued requirement is that citizens remain within the disciplining orderliness of the gender binary which is itself produced, policed and maintained by the state's medical proxies.

Possibly one of the most hotly debated pieces of legislation in South Africa in recent years has been the Civil Unions Act which was passed by Parliament on 15 November 2006 and which made it possible for same-sex couples to marry. While heralded by some as a victory for the gay community, the law, it has been suggested, muddies the water for the transsexual community because by presenting it as a victory for that community, the implication is also made that marriage for a couple in which one member is transsexual is effectively same-sex marriage. On the one hand the law is positive in that it allows a transsexual person who has not had surgery but who identifies as male to marry a woman. On the other hand this is only possible because in the eyes of the law she would be considered to be in a homosexual relationship. This is to side-step the most crucial of questions for transsexuals, namely that of being recognized as being the sex that one says one is. This recognition needs to be afforded as a right rather than being dependent upon the identity that the state, or its medical surrogates, is prepared to afford an individual. Moreover, the state's approach to the instantiation of this right needs to be one of enabling rather than gate-keeping.

In contemporary South Africa this goal is far from having been realized. Currently the state sponsors seven sex-reassignment operations per year: one at Cape Town's Groote Schuur Hospital and six at Pretoria Academic Hospital (Klein, 2008). The waiting list is some 30 to 40 times this number. For many the high cost of the surgery means that without state sponsorship it is unaffordable. Medical aids do not typically make provision for sex reassignment surgery or other medical treatment such as the provision of hormones. Effectively then, the state and the medical establishment continue to hold the power to decide which seven people are annually granted the right to be, in their view, themselves (Keenan, 2006). As John's account of seeking treatment in 21st-century South Africa suggests, access to this right continues to be saturated with narrow gender assumptions and heteronormative prescriptions:

> 'If you could be in a relationship who would it be with?' he [the psychiatrist] asked. I replied without a second thought 'a guy'. Even more reason why you are not a transsexual. If you transition from female to male you have to be

> attracted to females. 'Huh, gender identity has nothing what so ever to do with sexual orientation', was my answer. 'They are intertwined', he said. (Interview, 8 October 2007)

Post-surgery heterosexuality continues to be used to determine who will have access to surgery. Homosexuality disqualifies one from being labelled a 'true' transsexual and thus from access to treatment. As Ruth Hubbard has pointed out, the medical community are major culprits in the maintenance of the idea that gender consists of two exclusive types mandated by biology and that sexuality, heterosexuality, flows from this (Hubbard, 1996: 6).

Conclusion

A political state is centrally concerned with the status of its citizens. Status includes legal concepts such as marriage, sex, gender and legislation. Accordingly the notion of sex change and the legal consequences of such an act, such as the determination of sexual identity are matters of considerable state concern (Taitz, 1988: 144). Sharon Cowan (2005: 72) argues that 'with transsexuality, law is forced into revealing the contingency of its claim to truth'. Transsexuality calls into question the idea that maleness or femaleness is determined by one's birth sex and that one can never be the other. Its very existence directly undermines the heteronormative assumptions to which law gives effect. The law assumes that gender matches biological sex; the figure of the transsexual suggests that gender and sex may be discordant (Pantazis, 1997).

Transsexuality demonstrates the problematic basis of the idea that maleness/femaleness is determined by birth sex and undermines the idea that one can never cross from one side of the sex binary to the other. However, transsexualism is challenging to the law not simply because it suggests that sex can change but because it questions the right of the state and its proxies to measure, define and pronounce on one's sex. The response of the law to transsexualism has been to embrace it to the extent that it reinforces heteronormativity and a binary understanding of sex and gender. A certain enthusiasm on the part of the patriarchal apartheid state for surgical reconstruction of the body to produce a fit between sexual desire and a heterosexual framework of assumptions reflects this. The state, even the post-apartheid state, has proven itself less able to adapt to transsexualism clothed in the language of choice, of self ascription and social, legal and political support for the self interpretation of the individual. The post-apartheid state, moreover, has been far from zealous from the point of view of influencing social mores in order to begin to create a climate in which the language of choice, preference and multiplicity comes to be socially understood and accepted. As a result, South African

society continues to be dominated by binary reasoning with regard to sex and gender and to demand hetereonormativity, punishing those who even transgress slightly.

Forcing subjects to live in a binary and dichotomous sex and gender system leads to a discourse of 'mistakes'. Transsexuality calls into question a heterosexuality which depends on discrete and immutable definitions of sex. For this reason it has the potential to subvert the binary logic underlying much of state, medical and legal discourse and, through this, to create the space for the emergence of counter discourses so as to multiply the available range of gender identities and decentre the prescriptive capacities of the state's legal and medical machinery.

Notes

1. The authors acknowledge and respect ongoing debates surrounding terminology including for instance the preference for the use of 'gender non-conforming expressions'. The choice that is made here was in part determined by the preference of the three key research participants.
2. The DSM (Diagnostic and Statistical Manual of Mental Disorders) is the influential handbook published by the American Psychiatric Association (APA) which details various types of mental disorder and the criteria that can be used to diagnose these. First published in 1952 it has gone through five major revisions, the last of which, DSM-IV was produced in 1994.
3. Given this approach it was an anachronism of South African law that between 1962 and 1992 it was possible to change one's sex in terms of the Birth and Deaths Registration Act of 1963 which was only repealed in 1992.

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