

Borderland Bodies:
Queering Intersectional Health Activisms

by

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*To Eleanor Miller, my patient mother
to whom I owe my feminist consciousness*

and

*To Margo,
my companion in transgression and in the long, ongoing journey of personal and
social decolonization*

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Introduction

To analyze the complexities of the struggle for reproductive health, bodily self-determination and social justice, an intersectional framework is absolutely essential. My Feminist, Gender and Sexuality Studies concentration, “Representation and the Social Control of Bodies,” has come together in a way that has illuminated my understanding of the body as a locus of intersecting status positions. The body is inseparably both physical and social. One both has a body and is a corporeal being. For healthcare practitioners, the body is seen primarily as an object of analysis, a physical being that at any point in time represents the interaction of anatomy, physiology, genetics and the environment. However, the health of the body is also differentially affected by social practices and statuses that give it meaning in social interaction and reflexively shape it. Thus, socially, the lived body develops in inseparable interaction with the physical body. At the same time, the body is always an intimately personal vehicle of self-expression and meaning-making. And yet, because the body is so centrally implicated in the meanings we attach to individual human differences and social, economic and political hierarchies of difference, it is simultaneously a site of social regulation, a site for the reinforcement of sex/gender norms and the sustained social stratification of race, class and sexuality, a site where labor is reproduced both in the physical form of new, docile laborers and in the reality of the laboring bodies essential to capitalist accumulation (e.g., Omi and Winnant 1986; Crenshaw 1996; Collins 1990, Glenn 1992; Fausto-Sterling 2000).

I have come to see the analytical power of viewing bodies through the lens of simultaneously intersecting vectors of domination. However, I have also become acutely aware of the challenges of analyzing the collective impact of these vectors in this honors thesis, where I attempt to parse the social position of stigmatized bodies and specify the necessary conditions of a social movement to ensure the health and vitality of all those whose bodies have historically been judged “deviant.” Still, intersectionality demonstrates the power of locating the analysis of the “deviant” body within a political field of power relations because it is here that institutions seeking to discipline the body, to render it docile and (re)productively and economically exploitable, and to sustain their hegemonic grip (Foucault 1998, 141).

I have come to believe that where there is oppression, there is an opportunity for empowerment. I have come to believe that intersectionally-sensitive queer and gender theory, grounded in a fierce political critique of the normative binary paradigms that produce bodies as hierarchically meaningful, are the basis for building a powerful post-essentialist argument in support of a social movement that valorizes the liberating assumption that without social discipline, bodies and identities are fluid. This conceptualization of identity, when embodied, offers a possible strategy for organizing for reproductive health care that undermines the assumption of universalism undergirding identity categorization. Finally, I believe that feminist and LGBT health collectives, clinics, activists, students, grassroots organizers, radical queer anarchists and “do it yourself” zinesters are politically positioned to lead and inspire a movement to explore the borderlands of identity implicated in the liberation of “deviant” bodies.

In this thesis, I examine how identity, privilege and power are implicated in identity-based feminist and LGBT movements for reproductive and sexual health and interrogate and historicize the issues and ideologies that have been and are prioritized and formulated by health activists of various social statuses. In addition, I investigate the role of the medicalization of “deviant” bodies in the production and naturalization of fixed, stigmatized identities that subsequently become the sole legitimate basis for making claims on modern medical practice and, thus, determine the shape, extent and quality of healthcare provision. I deconstruct the narrative that naturalizes this productive process and obstructs the quest for health, and therefore, social justice, for all. I argue that because intersectional and queer theory challenge normative constructions of identity as singular and essential, they offer the potential to move political praxis beyond fractured identity-based social movements toward broader coalition-based movements grounded body politics, and a “bottom-up” strategy of activism, working in parallel and joint efforts to wrest bodily control from agents of social control, medical and otherwise. My political goal is not modest, it is to take a step toward refocusing the struggle to end reproductive, sexual, and gender oppression by examining its roots in the capitalist ideologies of white supremacy, heteronormativity, and the criminalization of poverty, while laying the basis for the establishment of a new social movement built on self-determination and disidentification and the shared goal of undermining the social constructions that support the material realities of all vectors of domination. If I can take a theoretical step in that direction in the thesis, I will consider the effort a success.

Chapter 1

Feminisms in Flux:

The Body, Identity Politics, and Ideology in Reproductive Health Organizing

Power and Body Politics

The feminist truism that “the personal is political” may never be more apt than in body politics (Hanisch 1970). In a society where female difference naturalizes the social domination of women by men, where blackness connotes a body as poor, and where queerness marks a body as diseased, departures within medical research and practice from what Epstein terms the “standard human,” literally make people sick (2007, 277). The conditions for future instantiations of the deviance of bodies emerges historically with the Enlightenment idea of abstract individualism which ties the rights of citizens to a conception that supports the treatment of all humans as the same. But the same as what? Scott points out that this standard human was the prototypical white male (1995). This exclusionary conception of the standard human forms the basis of all modern legal claims rooted in citizenship. In the U.S., the production of deviant bodies through medicalization and criminalization has become a primary trope in theories of social control and physical discipline. In this regard, Foucault speaks specifically of “biopower,” that is, literally having power over other bodies through “numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (1998, 140).

The Women's Health Movement of the late 1960's and 1970's in its various incarnations identified patriarchy, defined broadly as the exploitation and oppression of women by men as a critical locus of political struggle. "Body politics," the dispute over the degree of individual (female) versus social (male) control of the body, thus, became a central theme in this movement, eventually providing the driving force behind the campaign for reproductive rights for women. The right for women to make decisions about their own bodies was the *sine qua non* of the movement. With regard to their own health, feminists believed that they would never be free and healthy if they did not have the right to reclaim their bodies from the sexual slavery of pregnancy and abuse, from the prison of patriarchal ideology (hooks 1994, 86). One goal of feminist activism has been to restore the female body as a site of power and possibility rather than of domination and subordination; thus, the focus on sexual liberation and reproductive rights, particularly the right to natural childbirth, contraception, and the right to abort an unplanned for or unwanted fetus were central parts of the feminist agenda because these issues represented the more general claim that the female body should be a site of (female) pleasure, power and health (hooks 1994, 85). "Body politics" came to denote the resistance to the oppressive effects of institutional and interpersonal power on those whose bodies were marked as different, inferior, and stigmatized. Thus everything personal came to be seen as very much political when agents of social control came to be understood as constantly trying to regulate personal lives, bodies and social hierarchies through biopower. The early and central importance of this analysis, rooted in earlier attempts by feminists to control their own bodies, is everywhere evident in descriptions of the Women's

Movement of the 1960' and 70's. Thus, it is not surprising that an effort to wrest health care from the medical establishment emerged as a feminist issue as early as 1971 when 800 women attended a feminist health conference. By 1973 there were dozens of feminist health centers around the country that provided women with services and referrals, and in 1975 the National Women's Health Network was established to monitor legislation that was being proposed that might affect women's health and relevant actions of government agencies (Davis 1991, 228-229).

By the end of the twentieth century a new generation of feminists shifted their focus to the exploration of subtler, often invisible hegemonic modes of bodily discipline and control. At the same time, there was a concerted move to theorize the body in all its complexity (See, for example, the work of Butler 1990, 1993). This was a reaction to the conception of the body operative in the discourse of the women's movement of the '60s and '70s, which was an essentialist one that assumed that gender is a social manifestation of sex, the body given in nature. The proponents of this movement sought sisterhood in their status as women; however, they tended to extrapolate from their experience as women, which was very much the limited experience of women whose bodies were shaped by their race and class status (Kessler and McKenna 1978). Only since the 1970s has the body been seen as a social construction with a specific history. That understanding emerged from the realization that the body has not been viewed and experienced always and everywhere in the same way (Gallagher and Laqueur 1987, vii).¹

¹ As early as 1970, Douglas noted that the body could be viewed from two perspectives, physical and social, but it wasn't until the 1980's that the body began to be theorized from at least three

While appreciating the struggle that came before, and continuing to recognize how gender and sexuality act as planes of contact between bodies and society, many contemporary feminists critiqued the gender ideals of second-wave predecessors as heterosexist and essentialist. There is sometimes a fine line between arguing semantics and actual exclusion, but the language used seemed to be explicitly excluding a new conceptualization of feminism that had formulated a new standpoint from which to view gender as well as the individuals living between or outside of gender borders. Without questioning the power that comes from speaking from certain gender locations and identities, this new transfeminist ethic questioned the usefulness of the category “women” as the foundation of all feminist politics, the universalism implicit in limiting the discourse about gender exclusively to men and women and considerations of patriarchy, and the stability of the sex/gender binary (Stryker 2008, 3). Questions were also raised about the viability of a social movement locked in essentialist notions of sex and gender and characterized by divisive identity politics (Grant 1993). Rooted in gender and queer theory, this critique has broadened and reconceptualized definitions of gender justice and resulted in a body politics within which a wide range of gender performances, gender techniques and body modifications are supported as acts of self-determination and self-creation, including butch and femme gender roles, gender-blending and genderfucking, transgender lifestyles and families, transition-related surgeries and hormone treatment, binding, tucking, body piercings, and tattoos. All of these bodily practices are informed by a

perspectives: in terms of “first, individual body experience (e.g., the phenomenological body); as a symbolic system for thinking about culture, society and nature (i.e., the social body); and third, as an object that is subject to either social or political control (i.e., the body politic)” (Scheper-Hughes and Lock 1987, 7-8 as cited in Cromwell 1999, 31-2).

new political landscape in which body politics, self-determination and a radical critique of capitalism and social control are central and that demands a refocused feminist health care agenda that is not necessarily centered on the reproductive. A brief attempt to trace the history of the feminist health movement as it was forced to confront the full complexity of gendered bodies, sexual expression, reproduction and, thus, body politics, the pressures and temptations of identity-based politics, and problems in mobilizing coalitions for effective, inclusive, affordable and identity sensitive health care follows prefatory to an exploration of an alternative model of both subjectivity and activism.

Mainstream Feminism and Privilege: The Reproductive Rights/Pro-Choice Movement

Historically, women's rights advocates have linked the regulation of, and control over, reproduction to limitations of freedom and quality of life. They courageously resisted reproductive oppression for centuries, first, through their body practices and by word of mouth advice, and later via organized resistance, education, lobbying and grassroots health activism (Ehrenreich and English 1978). However, this long history has not provided a consensus for organizing a united front of feminist movements and coalitions for reproductive health (Davis 1981, 202). Rather, a common pattern of privileged representation has emerged among smaller, fractured identity-based movements each struggling to see that their own reproductive health needs are met. In the U.S., the feminist movement for most of the twentieth century consisted of a heterogeneous group of women activists, with only the most privileged having access to other social statuses that enabled them to legitimately

theorize about feminism, afford to become low-paid organizer/activists, and attract the serious attention of the media; thus, the privileged were the ones who had the power to define the movement and its dominant issues. In addition, as Davis notes, “as the media discovered the movement in 1969, they initially spotlighted the most colorful of the radical feminists . . . [but] as some feminist ideas were accepted by the public, the press began to seek out liberal feminists when they needed someone to speak for the movement,” thus “deradicalizing” the second wave (Davis 1999, 106). Thus, the mainstream feminist movement, abetted by the media, promoted a hegemonic representation of women and femaleness writ with whiteness, class privilege and heteronormativity. Moreover, as Brownmiller observes, “Women’s Liberation found its first unifying issue in abortion, and abortion became the first feminist cause to sweep the nation” (1999, 102). Although it may rather be that the struggle over abortion rights so predominated in national agendas that it has become better remembered today in popular historical accounts of feminist activism than other, broader aspects of feminist activism like workplace activism, which was much more cross-class and interracial at all levels, the result was what seemed then and now a single-issue “pro-choice” movement with overlapping offshoots dedicated to issues rendered less important. As a result the complexities of body rights were funneled into the single-issue of the legality of abortion (hooks 1994, 87). Radical or revolutionary feminist standpoints, standpoints from other status positions, were silenced in the process (Davis 1991).

In addition, predominantly white, middle-class Reproductive Rights Movement activists found it beneficial to use a framework of liberal rights discourse

to struggle for the right to abortion and contraception through the courts because their economic, social and racial status granted them access to a legal system denied to others. Rather than organize under the inclusive umbrella of humanist reproductive health, the pro-choice movement in the 1970's used a liberal ideology to fight for "special rights" as women, following in the footsteps of the relatively successful modern American movement for race-based rights that had recently (in 1964) had major legislative successes. Silliman explains that, "This conception of choice is rooted in the neo-liberal tradition that locates individual rights at its core, and treats the individual's control over her body as central to liberty and freedom. This emphasis on individual choice, however, obscures the social context in which individuals make choices and discounts the ways in which the state regulates populations, disciplines individual bodies, and exercises control over sexuality, gender, and reproduction" (2004, 5). For those who are not privileged, economic and institutional constraints may restrict their "choices." Still, using the constitutionally guaranteed protections of privacy and liberal rights' rhetoric, mainstream feminists, won a series of important battles in the fight for reproductive freedom. For example, in 1960, the FDA approved the contraceptive pill; in 1965 *Griswold v. Connecticut* upheld the right of married couples to have access to the pill, beginning to limit governmental intrusion into the private sex lives of citizens; in 1967 President Johnson approved a \$20 million initiative for contraceptive programs; in 1972, *Baird v. Eisenstadt* expanded the right to contraception to unmarried individuals; and in 1973 *Roe v. Wade* legalized abortion (Rose 2007, 63-64). Liberal feminist

organizations like the National Organization for Women (NOW) and the National Association to Appeal Abortion Laws (NARAL) were important in this fight.

Socialist feminist groups like the Redstockings and the Boston-based Bread and Roses Collective (1969) were critical of capitalism, imperialism and racism and connected those dimensions of oppression to patriarchy as the modal form of domination. Such organizations had an instrumental role in expanding the feminist focus beyond a moderate, liberal feminist ideology to include a consideration of the economic and political issues that complicate the interrogation of gender oppression. However, the focus on abortion rights remained primary, even for radicals who also at times invoked a liberal rights discourse. For example, radical feminists of the Jane Collective (1968-1973) performed 11,000 illegal abortions in the Chicago area. In 1964, Heather Booth started to help women seeking abortions find doctors willing to operate. In 1968 she recruited others to help and the collective was born. Jane learned how to counsel women, make contacts with doctors, negotiate prices, handle emergency situations, and follow up on their patients. Members became frustrated with doctors who charged large fees and even demanded sex from these women. A male abortionist agreed to teach the members of Jane to perform abortions, which turned out to be a relatively simple procedure. Women who could pay the full amount were urged to do so and any surplus went into an abortion loan fund for the many women who could not scrape together the fees. The ability to perform the operation themselves, in addition to the loan fund, allowed them to charge under \$100, just enough to cover supplies and operating expenses. Women who couldn't pay were

never turned away. Despite a police raid in May 1972, the collective continued to operate until *Roe v. Wade* prompted its dissolution (Knox 2008).

It is clear that the radical feminists of Jane were willing to step outside a liberal feminist agenda that sought legal remedies to address women's reproductive needs, but the emphasis on abortion and the dissolution of Jane with *Roe*, despite the fact that poor women would still have difficult obtaining abortions, demonstrates the centrality of abortion as an issue. Jane saw the right to control reproduction as integral to liberation. The laws that criminalized abortion were symptomatic of a society that viewed women as subordinate citizens. Jane operated as part of a larger self-care movement that emphasized reframing the public discourse on abortion within the context of women's health to reflect the complex "reasons for abortion and the impact that restrictions have on women's self-determination and social status" (Rose 2007, 189).

Jane, along with organizations like the Boston Health Collective (*Our Bodies Our Selves*), and the numerous feminist clinics popping up all over the country, led the fight to wrest control of the provision of reproductive healthcare from the primarily male, medical establishment. Through a critique of the patriarchal control of women's bodies, feminists began to demystify medical knowledge, redefine women's medical needs and disseminate reconceptualized, self-affirming and politically informed knowledge of women's health. The goal was to encourage women to take their sexual and reproductive lives into their own hands through promoting self-help, patient advocacy, community organizing, counseling services, providing safe illegal abortions, and establishing feminist clinics and birthing centers

(Morgen 2002; Silliman et al. 2004, 34), thus connecting reproductive and sexual freedom to the social freedom of women.

However, the attempts of liberal feminists to organize a movement aimed at the right not have a child involved an exclusionary politics that argued that *all* women were universally oppressed. This “gender universalism proved to be a new kind of monist political ideology” (Roth 2004, 196). Buechler argues that the eradication of difference was the result of the “unconsciousness” of white privilege (1990, 134). Roth however argues persuasively that the exclusive focus on the issues of white women was a deliberate strategy to emphasize feminism’s importance with the goal of forming viable feminist groups. Roth says, “to put it bluntly, white feminists did not ultimately need a discourse of racial oppression to organize as feminists” (2004, 196). At the same time, white feminists appropriated the narrative of slavery to promote the vision of themselves as an oppressed group. In response, Rene Neblett, Minister of Culture with the Black Panther Party in Boston, at the 1969 Cornell Conference on Women said, “It is my contention that there is no such thing as a universal feminist movement, because of the racist situation in this country. Historically and from a contemporary perspective we are in fact talking about two separate entities—the black woman and the white lady” (as cited in Roth 197). Black women were caught between their understanding of oppression as women and their allegiance to the economic and political issues of the Black Liberation Movement. At the same time, it was even more difficult for Chicana activists to claim their own legitimate organizing space relative to the multiple dimensions of their oppression in light of this Black/white political dichotomy (2004, 198-200). Roth argues that,

“Chicana feminists emerged into a multimovement milieu that conceived of race in dualistic Black/white terms,” but at least Chicana feminists did not have to hear white feminists appropriate the conditions of Chicana oppression to characterize white women’s oppression” (2004, 194). As Grant points out, because of its ethnocentrism, mainstream feminist attempts to organize on the basis of womanhood, “has led to a fragmented feminism, not merely in terms of hyphenated feminisms, but in terms of more pernicious kinds of exclusion around race, class, and ethnicity” (1993, 5).

Women of Color and the Reproductive Justice Movement

Despite the fact that privileged women were the high profile feminists sought out by the mass media and thus their issues received more public attention than those of working-class women, there were numerous less-recognized history-makers in the area of women’s health, including African slaves. Guy-Sheftall, for example, argues that, “An historical perspective on the evolution of feminist consciousness among African American women is usually thought to have begun with abolition . . . [H]owever, for 200 years enslaved African females had already been struggling for their freedom: protesting beating, involuntary breeding, sexual exploitation by white masters, having to bring slave children they couldn’t protect into the world, family separation debilitating work schedules, substandard living conditions, and demeaning stereotypes—the most persistent being that they were immoral and sexually insatiable. . . . Covert use of contraceptives, the practice of abortion, and daring attempts to control the fate of their children—including the desperate act of

infanticide—provided slave women some measure of control over their bodies and their reproductive capacity (2003, 177).

Before *Roe*, white mainstream reproductive rights activists frequently asked, “Where are the women of color in the struggle for abortion rights?” Women of color were engaged in the struggle for abortion and contraception, but the very question excludes women of color by erasing their historical involvement in the birth control and pro-choice struggle. The question assumes that because women of color are not in white organizations, they are not active in advancing these particular reproductive freedoms. Brenda Joyner suggests, “Perhaps the question is not really where are women of color in the abortion rights and reproductive rights movement. Rather, where is the primarily white, middle-class in our struggles for freedom?” (as cited by Silliman et al. 2004, 16).

From the outset, the feminists struggled between committing to a reformist model of liberation, which basically demands equal rights for women within the existing class system, and committing to a more radical and/or revolutionary model, which calls for fundamental change in the existing socio-economic structure so that models of mutuality and equality can replace old paradigms (hooks 2000, 101). At a meeting of twenty feminist women from various cities in Sandy Spring, Maryland in August, 1968 arguments between liberal feminists and radical feminists erupted again and again. As the group began to plan a larger conference in November, there was debate about whether or not to invite some radical black women who were involved in the civil rights or welfare rights movements, but not women’s liberation. One group wanted to understand how all women were oppressed, while another pointed

out that the black women were often disdainful of the women's movement. Still another group argued that they needed time to analyze their own oppression. When 200 women met over Thanksgiving weekend, the black women's groups had not been invited and were not represented. (Davis 1991, 79-80)

Yet white mainstream feminists were almost entirely absent from activism in support of issues affecting lower income women and women of color, and initiatives promoted by white mainstream feminists at times actually limited the reproductive freedom of women of color and the poor.² Silliman explains, "pro-choice organizations perceived restrictions on sterilization as infringing on women's choices, not enhancing them" (2004, 12) and any criticisms women of color had of the safety and efficacy of dangerous contraceptives were dismissed by pro-choice activists as playing into the hands of the anti-abortion movement (2004, 13). At the same time, for women of color, "resisting population control while simultaneously claiming the right to bodily self-determination, including the right to contraception and abortion or the right to have children, is at the heart of their struggle for reproductive control" (2004, 7). Moreover, the language used by mainstream feminists seemed to explicitly exclude certain women. While middle-class feminists were complaining about the economic and psychological dangers of "confinement in the home, a huge majority of women in the nation were in the workforce. And many of these working women, who put in long hours for low wages while still doing all the work in the domestic

² In fact, Tamar Carroll entitles her article on an exception to this case, the Brooklyn-based Congress of Neighborhood Women (NCNW), "Unlikely Allies" and argues that other organizations that worked for feminist causes across race and class divides, like the Young Lords party in New York City and the female members of Students for a Democratic Society in its Economic Research and Action Project, did not begin as specifically feminist in orientation, but "through consciousness raising and struggling against discrimination, like the NCNW [they] came to adopt a feminist perspective" (2008, 215).

household, would have seen the right to stay at home as ‘freedom’” (hooks 2000, 102). Furthermore, while white, wealthy women were concerned with fighting codes that enforced sexual modesty and thus liberating their own sexuality, women of color were fighting to counter harsh characterizations of themselves as promiscuous and sexually irresponsible. Overall, it seemed to women of color that the pro-choice movement was not concerned with their rights or with the conditions of their lives.

While the legalization and accessibility of abortion and contraception were important to women of color, after *Roe v. Wade* passed, the rift between the needs of mainstream white feminists and the needs of women of color grew as some celebrated the freedom to obtain abortions and use contraception, while many poor women and women of color felt their access to abortions and contraception remained limited despite legalization. As bell hooks argues, “Revolutionary feminism was dismissed by mainstream reformist feminism when women, primarily well-educated white women with class privilege, began to achieve equal access to class power with their male counterparts” (2000, 101). Furthermore, women of color continued to be forcibly sterilized, given dangerous contraceptives (like Norplant and Depo-Provera) to “fight against black poverty,” and have their children taken away, all because of their race and socioeconomic status (Silliman et al. 2004, 12, Roberts 1997). In addition, the white mainstream feminist movement did not respond with the same vigor to the Hyde Amendment (1977), which denied the use of Medicaid funds for abortion, as they did to the passage of *Roe v. Wade* (Silliman et al. 2004, 30). Rather, when abortion was legal and available to the rich and wealthy, their movement waned in strength. Furthermore, white mainstream feminists almost never opposed the

sterilization programs to which women of color were repeatedly subjected. In fact, dating back to liberal feminist Margaret Sanger (1879-1966) who founded the American Birth Control League (precursor of Planned Parenthood), many white birth control advocates were also pro-eugenics and believed, as the government did, that controlling the fertility of people of color was necessary to end their poverty (Roberts 1997, 57). Angela Davis notes that “arguments advanced by birth control advocates have sometimes been based on blatantly racist premises,” in attempt to prevent “undesirable” women from increasing their numbers (Davis 1981, 202).³

Black feminist thought and the activism of people of color has been informed by this history of reproductive oppression, inextricably linking the right *not to have* a child to the right *to have* a child. The Reproductive Justice Movement, which may rightly trace its roots to the resistance to patriarchy and racist ideology in the early history of the United States, emerges in the late 1960’s as part of, but distinct from, the Women’s Liberation Movement. The uniqueness of this movement stems from its intimate relationship to the efforts of the National Welfare Rights Organization and the Southern Poverty Law Center to connect particular women’s reproductive rights to their disadvantaged economic and racial-ethnic status. While they focused their critique on the policies of government and private population control organizations, they also criticized mainstream movements that did not link “policies and practices dressed in the benign language of family planning and welfare reform to

³ Although Margaret Sanger was an Irish working-class immigrant nurse, who because she was Irish was not even recognized as white by some, she allowed the birth control movement to veer from its radical, feminist origins toward a eugenics agenda clothed in family planning and poverty elimination rhetoric in order to secure funding from more conservative benefactors (Roberts 1997, 80-81).

restrictions on reproductive freedom” (11). In *Killing the Black Body*, Dorothy Roberts links the oppressive history of women of color and the reproductive justice struggle today by tracing a trajectory from slave masters’ economic stake in bonded women’s fertility to the contemporary campaign to bribe and threaten Black teenagers and welfare mothers to accept Norplant and Depo-Provera (1997).

The focus of black women’s health mobilization, then, was not primarily on abortion and contraception, but rather on the search for self-determination, highlighting how race and class shape reproductive choice. The movement for Reproductive Justice organized for the needs of women with intersecting identities and was thus, perforce, built independently from that of white feminists organizing for reproductive health. In the attempt to build a broader, explicitly anti-racist and multi-issue movement for Reproductive Justice, women of color emphasized the relationship of reproductive control with human rights and economic justice. Grassroots groups and feminist clinics promoted this broader message of radical and direct-action strategies in order to mobilize larger numbers of people alienated by the mainstream’s politics. Going directly into neighborhoods, workplaces, schools, churches, and the streets, the Reproductive Justice activists raised awareness about how the pro-choice movement undermined the reproductive freedom of many women. Barbara Smith and the Combahee River Collective (1970), a black lesbian feminist organization states, “...our particular task [is] the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking.” (2000, 264) And, as bell hooks further argues, “the only genuine hope of feminist liberation lies with a vision of social change that takes into consideration

the ways interlocking systems of classism, racism, and sexism work to keep women exploited and oppressed” (2000, 109). At the same time, many reproductive justice activists did not see abortion rights themselves as a problematic goal, nor were they actively antiabortion; rather they were critical of the inability of white feminists to conceptualize their activism with an awareness of the interlocking institutions of power/change that would have allowed the interests of women of color to have been attended to.

At the same time that it is correct to argue that the rift between Black and white women that emerged because of the “collision between the limitations of organized feminism and the imperatives of racial unity expressed by the Black Liberation Movement” and that it “extended to the area of abortion, where, in the words of one historian, campaigns for reproductive rights were ‘in many ways racially defined’” (Valk 2008, 138), it is important to note that there were examples of coalitions formed across the racial and class divides that sought to advance the health concerns of differently situated women. For example, in 1975, the National Women’s Health Network (NWHN) was founded with the explicit mission of responding to the health issues of women of different races and classes (Davis 1991, 228; Rosen 2000, 180). In addition, in the 1980’s women of color began to organize to promote an understanding of their unique health needs and establish self-help groups. The National Black Women’s Health Project, founded in 1981 by Byllye Avery, was the first of these organizations. It emerged not out of any connection to the Reproductive Rights Movement, however, but from Avery’s observation that the women she worked with in a CETA (Comprehensive Employment Training) Project

were plagued with conditions like breast cancer, cervical cancer, high blood pressure and diabetes. In 1989 the National Black Women's Health Project issued a powerful statement written by Marcia Gillespie, then editor of Ms Magazine, but signed by numerous black feminist activists, to challenge the Webster decision, which allowed individual states to restrict access to abortion. In it they stress the importance of choice to any definition of freedom and tie the right of black women to protect their health, take charge of their own personal lives and control their own bodies to basic human rights. Their statement clearly relates their demand for access to abortion for all women to numerous aspects of the material conditions that differentially impact poor women of color (1989, <http://www.ourbodiesourselves.org/book/>).

Sistersong, a women of color reproductive health collective, formed in 1997. It is now a leading organization in the struggle for Reproductive Justice, declares that reproductive health isn't just about the legalization and accessibility of abortion. The Collective originally included 16 organizations, representing African American, Asian American and Pacific Islander, Latina and Indigenous women of color. Strategically, Sistersong mobilizes at the grassroots level while promoting a public policy agenda. Loretta Ross, founder of Sistersong, declares,

“Reproductive Justice is the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights. For women of color, it is important to fight for (1) the right to have a child; (2) the right to not have a child; and (3) the right to parent the children we have, as well as to control our birthing options, such as midwifery. We also fight for the necessary enabling conditions to realize these rights” (Ross, www.sistersong.net/reproductivejustice).

Tackling issues like HIV/AIDS services, midwifery, services for incarcerated women, health screenings, abortion and contraceptive advocacy, clinical research, teen pregnancy programs, cancer screenings, drug and alcohol treatment programs, and programs for the treatment and prevention of STIs, the Reproductive Justice movement broadened the focus of reproductive health to a scope and depth that can account for more of the issues oppressing women than the pro-choice movement ever imagined (Silliman et al. 2004, 42). In addition, because the Reproductive Justice Movement is a grassroots movement, intimately tied to changing community issues, it is capable of constantly renewing the meaning of reproductive health in light of these evolving community concerns.

However, rather than mobilizing to fight along side feminists of color, predominantly white pro-choice feminist organizations merely relegated the responsibility of fighting against sexist racism to the activists organizing specifically around race and class. Most mainstream feminists were at least partially aware of the variety of ways in which patriarchy oppresses women of color, but absolved themselves of responsibility to join the fight (Koyama 2006, 703). Most privileged white feminists were clearly not able to comprehend the complexities of intersectional identity that were beginning to emerge from the Reproductive Justice Movement, and could not understand the implications in health organizing that is alluded to when, for example, Rita Mae Brown says, “Class is much more than Marx’s definition of relationship to the means of production. Class involves your behavior, your basic assumptions, how you are taught to behave, what you expect

from yourself and others, your concept of a future, how you understand problems and solve them, how you think, feel, act” (as cited by hooks 2000, 103).

The Reproductive Justice Movement, then, stands as a critique of liberal rights-based activism rooted in a discourse of reproductive oppression and human rights. The concept of reproductive justice involves examining the ways “women, girls” are controlled and exploited through their bodies, sexuality, labor, and reproduction, rather than narrowly focusing on the protection of the legal rights to abortion and contraception. By examining these issues within the context of economic and racial discrimination, reproductive justice activists take on issues of sustainability, economic justice, the environment, as well as, discrimination based on race and sexuality, all of which may interfere with the ability for someone to attain full autonomy in their choices. Using this sort of intersectional analysis of the experiences of women allows for the integration of multiple issues while bringing together constituencies that are multi-racial, multi-generational, and multi-class, thus building a more powerful and relevant grassroots movement. (Ross, www.sistersong.net/reproductivejustice).

Organizing for Lesbian, Gay, Bisexual, and Trans (LGBT) Reproductive and Sexual Health

Since mainstream feminist movements organized around the “reproductive” in the heterosexual sense, and thus were, at best, ambivalent to the inclusion of LGBT health issues in their organizing platforms, the gay and lesbian health movement had no choice but to develop its own agenda and grassroots health care services. Post World War II, the Homophile Movement of the 50’s, including organizations like the

Daughters of Bilitis and the Mattachine Society, as well as the Gay Liberation Front of the 1960's-1970's, were not specifically concerned with issues of gay and lesbian reproductive health, but rather with issues related to community, sexual liberation, homophobic discrimination and personal safety (D'Emilio 2002, 80). However, the Stonewall Rebellion (1969), "instigated by low-income people, people of color, transpeople like Sylvia Rivera, and other sex/gender outsiders who were the most common and easiest targets (like they still are) for homophobic and transphobic cops" (Spade 2008, 46), represented a shift in gay politics, allowing for gays and lesbians to draw the connection between their own status as homosexuals and a larger political critique formulated by other civil rights activists at the time (D'Emilio 2002, 82). Combating stigma and the medicalization of homosexuality became another target for organizing. A *mélange* of scientific studies emerged, postulating some innate link between the body, homosexual desire and abnormality (Foucault 1998; Terry 1995). Groups like the Radicalesbians Health Collective began to express discontent with their doctors and gynecologists, saying they knew little about women's bodies and neither knew nor cared about deviant sexuality past the notion of it as a pathologized category. All lesbian medical problems were deemed a result of their deviant sexual identity; to doctors, being a healthy woman meant having sexual relationships with men (Radicalesbians 1992, 122).

The organizational structure the homophile movement established became important when, with the advent of HIV/AIDS in the 1980's, it became clear that gays and lesbians needed large-scale mobilization in support of health issues (Epstein 1996). Having been shunned by both the Reproductive Health and Reproductive

Justice Movements, the gay/lesbian health movement worked to meet the challenge of HIV/AIDS by building, where possible, on the organizational infrastructure of the Gay Rights Movement and the culture of “gay pride.” The stigma of HIV/AIDS and the sensationalized and false purported etiology of HIV/AIDS, the promiscuous “gay lifestyle,” forced activists to bond fiercely in opposition to medically-produced knowledge of their lives, bodies, and HIV/AIDS. Although initially described as a “gay disease” by scientists, the discovery that the medical establishment’s claims that lesbians or women who have sex with women could not contract HIV/AIDS from their partners were erroneous, led to a political response bringing lesbians into active coalition with gay men (Epstein 1996; Hollibaugh 2000, 185). Amber Hollibaugh argues that the health of lesbians suffer because they had to navigate their “health, sexuality and social existence in an environment committed to imagining all women as heterosexual” (2000, 188-189). The female risk for HIV was contained inside a heterosexual landscape that kept lesbians ignorant and uninformed about their own risks for HIV (2000, 189). The discovery that those who share needles and heterosexuals married couples were also susceptible to infection resulted in a health movement around inclusivity and in support of education and organized demands for proper research and treatment of the disease.

In an effort to establish an invigorated and effective gay/lesbian sexual health movement amidst the AIDS crisis and ignorance in the medical establishment, gays and lesbians situated their struggle in the economic, gender and racial diversity of queers and in a fierce critique of the medical establishment and of the federal government’s response (or lack thereof) to the HIV/AIDS crisis. Thus, much

gay/lesbian organizing has strategically mirrored that of the civil rights and feminist movements of the 1960's and 1970's, and, in the United States these movements have a history of utilizing racial, ethnic, gender and sexual orientation identities as community-organizing tools (Joyner, 9). Gay/lesbian health activism, thus, also has deep roots in identity-based health organizing, as well as reclaiming the medical establishment through grassroots knowledge production (Epstein 1996, 234). However, organizations like ACT UP have employed more radical and visible techniques to demand resources to combat HIV/AIDS and have challenged the more accommodationist tactics of liberal gay/lesbian health activists.

Connecting reproductive freedom to sexual freedom and bodily autonomy, gay and lesbian health activists have included pro-choice concerns in their organizing, affirming the rights of individuals to control over their own bodies, especially their reproductive and sexual lives. Doing so is consistent with an affirmation of the right to have intimate engagement with members of any sex. Although gay/lesbian health issues were not taken very seriously by the Reproductive Rights or Reproductive Justice Movements, gay, lesbian and trans health activists included pro-choice concerns in their organizing, supporting the right to safe and accessible abortions since some lesbians and FtMs have sex with male-bodied people, and rape, incest and sex work can all result in unwanted pregnancy. However, recognizing that the term “pro-choice” does not only denote a position on abortion, the gay/lesbian health movement “encompass[es] a much broader advocacy of sexual life liberated from reproductive function. It includes the right to choose whether or not to have children as well as the right to a life free from governmental scrutiny and intrusion in our

sexual and reproductive lives” (Joyner, 8). Furthermore, drawing on the Reproductive Justice Movement’s imperative to claim the right to reproduce, the gay and lesbian health movement advanced struggles for the right of all people to safe and affordable reproductive technologies as well as assistance and access to adoptive services (5).

Despite the reservations of both the Reproductive Rights and the Reproductive Justice Movements, it is a fact that gay liberation is intimately tied to reproductive and sexual freedom. One is impossible without the other. The freedom and legitimacy of sexual activity without reproduction as an outcome is as fundamental to the liberation of LGBT people as it is to heterosexual women and their male partners. The protection of privacy secured by *Roe v. Wade*, was important for advancing the rights of LGBT people, illustrating that the feminist and LGBT causes are inseparable. Thus, early struggles for reproductive freedom laid the groundwork for legal arguments that an individual has a right to decide how and when to engage in consensual sexual activity (*Lawrence v. Texas 2003*).

Although *Lawrence v. Texas* (2003) legally recognized that all persons who identify as lesbian, gay and bisexual are entitled to the right to sexual lives free from government intrusion and that same-sex relations between consenting adults would no longer be criminalized, the extreme and systemic heterosexism in the U.S. continues to relegate gays and lesbians to a second-class citizenship. Gay and lesbian health movements recognized the need to eradicate the homophobia of medical providers, religious leaders, sex educators and reproductive counselors and confront discriminatory health insurance practices. Feminist and queer struggles, therefore,

are linked in their opposition to state-exercised biopower over their bodies and reproductive and sexual lives.

Neo-liberal policies that don't challenge the requirement that couples be married in order to be entitled to certain benefits, including health benefits, in the name of keeping taxes low, reducing poverty or making public assistance yet another entitlement of heterosexuals (those who are permitted to marry under the law) is clear and overt discrimination against LGBT people (Joyner 12), and, have the directly negative effort of making it more difficult for poor people to live sexual and economic lives of their choosing. Furthermore, Joyner asks, "what does 'abstinence until marriage' mean to a population that cannot legally get married?" (19). Clearly, proponents of abstinence only education are sending a message to same-sex partners that they ought never to have sex at all. In addition, homophobic adoption and in vitro fertilization (IVF) policies make it near impossible for gays and lesbians to exercise their right to reproduce. Health insurance policies that cover advanced reproductive assistance, like IVF, are applicable only in the event of infertility, which is defined as an inability to conceive through heterosexual intercourse. Thus, a variety of safe reproductive services become inaccessible to insured, fertile and infertile gays and lesbians, and unaffordable and completely inaccessible to those who are low-income and uninsured. Finally, the Food and Drug Administration (FDA) and the Centers for Disease Control (CDC) prohibit sperm banks from accepting sperm donations from men who have sex with men regardless of their HIV status or the informed consent of the woman receiving the sperm (15).

Just as the predominantly white pro-choice activists were blind to issues significant to women of color in the 1960's and 1970's, even though their causes overlapped, the health issues of gay men, lesbians and trans people were largely ignored by the Reproductive Rights and Reproductive Justice Movements because they framed feminist health as exclusively significant to the heterosexual, female and cis-gendered body. Beyond simple indifference to the reproductive and sexual health issues of gays, lesbians and trans people, homophobia, transphobia, and fear of stigma by association, certainly account for why the activists in the Reproductive Rights Movement were reluctant to include issues of sexual and gender health that might undercut their ability to move their agenda forward politically. In addition to this strategic concern, these activists sometimes confronted vigorous opposition from religious leaders in their own communities. That inclusion of health issues relevant to gay men and lesbians was problematic for the Reproductive Rights Movement is evident in the history of the production of early editions of *Our Bodies Ourselves*. In early editions, even though lesbianism was acknowledged, it was ghettoized by being confined to one chapter and health issues important to gay men and trans people were completely ignored or seen as irrelevant. Kline argues that for the Boston Health Collective, responding to the demands and complaints of lesbians about the heterosexism in the book was a divisive issue (2008, 77).

Despite early queer activists of color, like The Combahee River Collective (1970), who wrote about experiences of Black, lesbian women, and specifically emphasized the importance of interlocking forms of domination, including sexuality (Smith 2000), it wasn't until the HIV/AIDS crisis of the 1980's that the Reproductive

Justice Movement began to reconsider its inattention to health issues important to gay and lesbian people. This stand changes when it became undeniable that people of color with HIV/AIDS were disproportionately low-income queer people of color, many of whom contracted HIV from gay partners or shared needles. Today, Loretta Ross in *INCITE! The Color of Violence*, insists that white supremacy is an “interlocking system of racism, patriarchy, homophobia, ultranationalism, xenophobia, anti-Semitism, and religious fundamentalism that creates a complex matrix of oppressions faced by people of color in the US” (2006, 54). In *sistersong’s* activist briefing book, Ross states that the Reproductive Justice Movement is committed to opposing those seeking to control sexuality, gender conformity, reproductive choice and the legal definitions of family (www.sistersong.net/reproductivejustice). However, neither mainstreamed feminist health movement often addresses the health issues most important to gay and lesbian communities when they do not overlap HIV/AIDS, and there is still a strong resistance to activism on this issue from some with religious ties.

Furthermore, much of the feminist movement that was launched in the 1970s in the U.S. articulated a vision of liberation and women’s identity either ignorant of or decidedly opposed to the inclusion of certain forms of gender experience, most notably that of transsexual women and men and butch and femme lesbians. While butch and femme people were certainly involved actively in the remarkable organizing in support of women’s liberation that took shape through the 70s, their presence was increasingly dismissed, maligned and erased as the movement became more bureaucratized (O’Brien 2003, 2 trans lib). Similarly, drag queens and butch

lesbians were the instigators of Stonewall, that monumental event that sparked a truly energized gay and lesbian movement and yet, as I will show later, their needs are often overlooked in gay and lesbian health organizing.

Because heterosexual white people have not recognized themselves as an identity group, they assume their identity to be the norm. Institutional racism, heteronormativity, and the hegemonic power of whiteness are clear factors in the failure of white reproductive health activists to recognize how their lives are shaped by their whiteness and other social locations of privilege (Ross 2006). However, it is clear from the history, that in its concerns, membership, and political strategies, the Reproductive Health Movement is fractured into smaller identity-based movements. Although the movement for reproductive justice brings women of color “from margin to center,” promoting a broader multi-issue vision for reproductive health rooted in the material realities of poor women and women of color, it too is identity-based, circumscribed by the essentialized category “woman,” even if more complexly so.

Janice Raymond’s *The Transsexual Empire: The Making of The She-Male* (1979) marked a central event in the conceptualization of a feminist political stand that justified the hatred of trans women within feminist politics. Raymond’s book was celebrated as an advance in feminist theory and praxis by many famous radical feminists at the time, including Andrea Dworkin, Mary Daly and Robin Morgan. Patrick Califia’s book *Sex Changes* argues that transphobic feminist politics directed against butch and femme people and against trans people share with other currents of feminism certain crude and unhelpful tenets. Raymond depicts MtF transsexuals as male conspirators trying to replace women as sex objects and invade women’s-only

spaces and characterizes FtMs as “traitors and as women who literally become the enemy” (Halberstam 1998, 149). Raymond’s assumptions about gender rest on essentialist and narrow ideas of proper women’s identity and expression, a deeply naturalized romanticization of women’s bodies as female. From this point of view, women’s unity was assumed to be built on some essential sameness, some core experience of one’s body and oppression, that all women shared. It rested on the destructive idea that policing other people’s gender identity was the way forward in challenging systemic patriarchy. Essentialist feminists like Raymond who regarded trans people as dupes of the patriarchy and mentally ill, also characterized feminist pornography, feminist sex work and feminist practices of S&M as rooted in internalized misogyny rather than expressions of autonomy. Like earlier disputes within feminism about heterosexism, class, and color, these essentialist and universalizing views of womanhood prove to be feminism’s worst enemy, further fragmenting a movement that was never as homogeneous as some feminists wanted to believe (Stryker 2008, 129).

The notion that trans people pose a threat to the feminist movement is extremely problematic because it supports the notion of feminism as primarily struggling for women’s rights where “woman” is explicitly defined as a biologically-based category that unites *all* females, rather than as a hierarchically-constructed social construction that is used to oppress women. In denying the importance of utilizing an intersectional framework that exposes how multiple forms of domination construct identity, it robs these feminists of the duty and opportunity of collaborating with and supporting the struggles of the socioeconomically disadvantaged, the

racialized and the gender transgressive, who may or may not identify as women, but nonetheless whose bodies are oppressed by the hegemony of patriarchy, white supremacy and capitalism and are regulated through the medicalization of deviance.

Koyama argues that, “The very existence of transsexual people, whether or not they are politically inclined, is highly threatening in a world that essentializes, polarizes and dichotomizes male and female in order to benefit from the understanding of patriarchy as the oppression of women-born-women. Trans identities destabilize essentialist definitions of gender and expose the unreliability of the body and genitals as a source of identity as well as the fallacy of some universal female experience and oppression (Koyama 2006, 704). At the same time, feminists often accused FtMs and MtFs of cementing notions of binary sex. And yet, trans people, even when they identify with a binary sex cannot be considered gender normative, especially not more so than a cis-gendered female. Yet, Janelle L. White of San Francisco Women Against Rape argues that trans inclusion does not mean that organizations built to prioritize experiences of women of color are at risk of deterioration. She asks, “what about trans people who identify [or used to identify] as women of color?” (2008). “If identity politics isolate you and make you unable to see connections with people, it’s not useful....Bernice Reagon wrote in *Home Girls: a Black Feminist Anthology* that if you really want to make comprehensive social change, you can’t just stick with people just like you. You have to open yourself up to working in spaces that might be new, that might scare you or push your buttons....People need to go back to those old women-of-color feminist roots” (White 2008).

Critiques of Gay/Lesbian Health Organizing

Although identity-based in organizing, the queer community has never been a monolithic entity. The fight for gay equality and equal treatment in the domain of health has been “rocked by internal conflict over assimilationist versus confrontational tactics since the emergence of the homophile movement in the 1950’s” (Duggan 2003, 51). There have always been divisions along racial, gender, age and class lines. Mecca says, “As far back as I can remember—and I came out in 1971—there were gays who lived in mansions and those who lived in the streets, gays who worked for Wall Street and those who sold their bodies to pay the rent. There were gays of all colors, but black gays hung out in one section of the city and whites in another. There were gay Republicans and gay Socialists, but they seldom sat in the same room together” (2008, 30).

But during the last decade, nearly every national organization that previously fought exclusively for the rights of gay/lesbian people changed its mission to include bisexual and trans people (Davidson 2008, 149). And, while trans activists supported inclusivity, the principle of trans inclusion has not translated into a practice that dedicates resources and support to ensure the health and rights of trans people (2008, 250). There are a lot of organizations that purport to provide LGBT services that really just provide gay and lesbian health care. If they are going to label themselves LGBT, they need to understand LGBT in all its complexity. An organization can only really say it is committed to trans issues when it has staff, programming and services by and for trans people. Adding T to LG was a result of an era of trans organizing that

linked homophobia to transphobia; yet the privileged constituencies of gay/lesbian activists, in an effort to assimilate and avoid stigma, often left behind the issues important to that trailing T, as well as to those identifying explicitly and politically as queer⁵.

Many do not understand the relationship between queer people and trans people. They ask “where were trans people 20 years ago?” To this, Riki Ann Wilchins responds, “They were there, but they were gay” (2002). In the past, gender transgression could only be conceived of as within the binary—there wasn’t a place to go with gender except to be gay or undergo full sex reassignment. This older generation of thought, as well as the medical profession, conceptualized transsexualism as a total crossover process. Now there are many people living outside the gender binary. This has made the linkage between queer and trans experiences more apparent. First of all, it is only through gendered behaviors that people make themselves attractive to others, are attracted to them, and make love. Furthermore, many LGBT people are oppressed simultaneously because of their sexual desires and because of their gender expressions. Sexual minorities are oppressed for their sexual desires and, many believe, for failing to conform to gender roles and normative gender expression. Gays and lesbians targeted for harassment or assault are almost always targeted because their gender transgressions make them visibly queer.

Feinberg elaborates, “Many butch females and feminine males have been asked

⁵ Queer in this sense is not used as an umbrella term for those identifying as gay, lesbian, bisexual or trans; rather, it is distinct from gay, used as a term representing a sexuality that is fluid or uncategorizable using LGB language because they imply notions of immutable binary genders and sexuality, limiting the possibilities of identities and bodies one could be and to which one could be attracted.

repeatedly why they seem to attract problems that other lesbians and gays do not... ,
But the rise of transliberation has given us the language to say, ‘I am oppressed
because of my gender expression, as well as my sexuality’” (1998, 97). In a society
in which heteronormative ideologies of dress and behavior are constantly under
surveillance, LGBT people are all gender transgressors (1998, 98). In addition, in the
case of gender deviant people, when gender is hard to define, it becomes hard to
choose a gendered word like heterosexual, or even gay, lesbian, or bisexual, and have
it describe you and your partner accurately, especially when many gender
nonconforming people like to have sex with those that are nonconforming as well.
Feinberg says, “When the borders of sex and gender are not fixed, neither is the
definition of what constitutes gay or lesbian or bisexual” (1998, 101). Thus, it’s not
so much a question of trans inclusion as it is of recognizing that gender has always
been a part of the gay agenda and always will be. Gender, body politics, and self-
determination are all intertwined, and, together, these topics should have been the
quintessential issues for both gay rights and feminism. However, this was and is not
the case, and even in gay and lesbian organizations, gender health issues are
compartmentalized when it come to trans people to hormones and surgeries for sex
reassignment.

Over the last decade, the mainstreaming of queer identities with the advent of
treatments for HIV/AIDS, has resulted in a focus on issues, including health issues, of
specific interest to mainstream-oriented, middle-class and wealthy, white queers, such
as gay marriage, adoption, and a political praxis that is decidedly neo-liberal and
assimilationist. Dean Spade, the founder of the Sylvia Rivera Law Project (SRLP), a

nonprofit organization that provides free legal services to low-income trans, intersex and gender-variant people of color, criticizes the “LGBfakeT” movement for exclusively supporting a privileged and single-issue gay reproductive health politics. Primarily focused on inclusion in institutions like marriage and adoption, and claiming the right to serve openly in the military and access IVF procedures, social security benefits and private health insurance, wealthy gay and lesbians have been ignored issues such as Medicaid, welfare rights, affordable housing, police brutality, the incarceration of queer and trans youth and universal health care. Instead, they rally around passing hate crimes laws, thus putting more punishment power in the hands of an overtly racist criminal justice system (Spade 2008, 51). In addition, sometimes unwitting racist and classist representations of the LGBT movement erase the very existence of poor, working-class, trans and queer people of color whose social statuses prevent them from receiving the social benefits afforded white, middle-class gays and lesbians. Spade asks, “What does it mean for activists that we see wealthy gay and lesbian people setting an agenda that excludes and/or harms low-income queers, trans people and queers of color?” (Spade 2008, 48).

For example, the Human Rights Campaign, the most powerful LGBTQ organization in the US, has supported non-trans inclusive legislation; implementing a version of the Employment Non-Discrimination Act that does not explicitly include protections for gender identity and expression. The National Gay and Lesbian Task Force, although it has a trans civil rights project, lacks any trans-identified employees or lawyers, and there is no account of gender fluidity in the critiques most gay and lesbian organizations are creating (Spade 2008, 250-252). Furthermore, as Duggan

points out, prioritizing “same-sex marriage” at the expense of nearly all other organizing made it clear that national gay and lesbian organizations were not interested in fighting for the trans right to marriage because, while it should have been framed as the right for any type of couple to marry, they particularly chose “same-sex” marriage, a term that is really ambiguous for trans people. In addition, the economic role of marriage and its relation to the free market impose discipline and privatize dependency among the poor. In their adoption of assimilationist politics, gay/lesbian organizations only fight for the rights of traditionally gendered people and fail to challenge the structural inequalities built into society (Davidson 2008, 245-252).

Identity-Based Organizing

Women of color have brought crucial theoretical criticism and tools to feminist and LGBT reproductive and sexual health activism. The notion of intersectionality allows for the illumination of reinforced subordination within identity-based political movements and for the visualization of how converging trajectories of domination are commonly constructed and reinforced in capitalist society. Providing a basis for reconceptualizing identity as a subject position occurring at the points of intersection in a multidimensional web of power relations, intersectionality unites various hierarchies previously construed as distinct. Knowledge of intersectional politics, thus, lays the groundwork for strategies that can mediate tension among movements and suggest how coalitions might be forged among identity-based groups. These movements can then make common cause not

because their systems of domination overlap, but because these systems are interdependent and similarly constructed and executed. Feminism needs to be about power dynamics, about the struggle against all oppression, not just about the singular and essentialist oppression of women by men and patriarchy, but also about how these other social-status-based power dynamics inform and interact with gender to form the realities of oppression.

In all these battles over dualistic oppression, white/black, rich/poor, man/woman, heterosexual/homosexual, the groups battling oppression are using “the master’s tools” to do so. Although it is empowering to reclaim identity, Audre Lorde asks, “What does it mean when the tools of a racist patriarchy are used to examine the fruits of that same patriarchy? It means that only the most narrow perimeters of change are possible and allowable” (1984, 111). The historical record has shown that identity-based ideology, by definition, reaffirms difference and privilege what they define as their own rights. For example, although not explicitly self-identified as identity-based, the hegemonic white feminism of the Second Wave frequently conflated intragroup differences, privileging a single representation of one vector of dominance (sex/gender) over others (race, class, sexuality), falsely and sometimes unknowingly universalizing the notion that *all* women have the same reproductive oppression based in biology: the illegality and unavailability of abortion and contraception. This example is symptomatic of white, heterosexist privilege that seems to pervade Western culture. In “Mapping the Margins,” Kimberle Crenshaw observes that women of color are situated within at least two subordinated groups, and, as a result, are historically marginalized in both feminist and anti-racist

movements. She says, “The failure of feminism to interrogate race means that feminism’s resistance strategies will often replicate and reinforce the subordination of people of color; likewise, the failure of anti-racism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women” (1996, 360). In the case of women of color, race-based political movements claim to be the voice of women of color oppressed by racism, while gender-based political movements claim to be the voice of all women oppressed by sexism. In fact, the inability of each dominant representation to accommodate intersectional identity reproduces the subordination operative in the other dimension by privileging, for example, the representation of Black bodies as male and female bodies as white. When social movements represent identity as singular and unitary, as an either/or proposition, they “relegate the identity of women of color to a [social] location that resists telling” (Crenshaw 1996, 357). Intersectionality thus exposes social relations usually obscured by more generalized social categories. By denying the importance or existence of difference within its own identity-based group, white Second Wave Feminists in unmarked positions of privilege and power gained the ability to falsely universalize their own experience and exclude those in less privileged circumstances from their movement (Koyama 2006, 698). And, as Paulo Freire insightfully professed, “the true focus of revolutionary change is never merely the oppressive situations which we seek to escape, but that piece of the oppressor which is planted deep within each of us, and which knows only the oppressors’ tactics, the oppressors’ relationships” (as quoted by Lorde 1984, 123).

The Reproductive Rights Movement used privacy laws to secure the right to abortion and contraception, freeing some bodies from the slavery of unwanted pregnancy and motherhood. The Reproductive Justice Movement expanded the notion of reproductive health to include a consideration of how race and class contextualizes the experiences of women, transforming the fight for reproductive health into a broader agenda of issues that affect the reproductive health of women of color and poor women, especially the right to have children and to raise them in an affirming way. *Roe v. Wade* served as precedent for *Lawrence v. Texas*, demonstrating the deep connection between feminist and LGBT struggles. The gay and lesbian reproductive health movement began to expand the definition of “reproductive” freedom to include the freedom of sexuality free from heterosexist discrimination. The freedom to have consensual sex free from discrimination was shown to be inseparable from the right to control fertility, sparking the emergence of a sexual health not necessarily focused on reproduction. Transsexual health activists, fighting for the right to change their bodies to fit their gender identity, further redefined the notion of reproductive autonomy, although unprotected by law, to a broader one of reproductive, sexual and bodily self-determination. This trajectory seems to move to an all-encompassing coalition for reproductive and sexual health around the right to an incredibly intimate and personal bodily autonomy and self-determination, free from governmental intrusions of ideology. Yet, identity politics keeps these struggles separate, parceling identity into mutually exclusive categories of interrogation and preventing the articulation of a common basis for united political action to secure Reproductive Rights in its broadest definition. They say, “let us win

our demands first, and then yours will be more easily won later on.” But this is employing a trickle-down theory of reform that is rarely productive.

Movements for reproductive health have been consciously or unconsciously rooted in identity politics because identities are empowered by and realized in their accumulated group and personal histories. In the case of identity-based groups, people with common interests based on similar positions in society (similar privileges and subordinations) come together to organize based on these interests. Identity and selfhood are so cathectic they often feel innate. Thus, identity politics is usually the primary motivator for action in organizing; its emotional connection energizes the movement. Furthermore, as Simone de Beauvoir argues, “It is in the knowledge of the genuine conditions of our lives that we must draw our strength to live and our reasons for acting” (as quoted by Lorde 1984, 113). Identity-based politics can give meaning to people’s own experiences and self-interest while providing social supports, community, safe spaces and a definition of need. People who work in identity-based movements do so because they are provided a sense of cohesion and community, of safety and perhaps hope. Reform movements of all kinds are thus often based on identity politics rather than around common social statuses. The need for a recognizable identity, and the need to belong to a group of people with a similar identity—these are the driving forces in our culture because it is through organizing through one identity or another that one may claiming rights, like, for example, to healthcare, since constitutional guarantees of equal protection are established relative to protected categories of disadvantaged citizens (see, for example, Rimmerman 2002).

Despite the extremely powerful lure of identity as an organizing tool for social change, movements based on identity run the risk of creating barriers to coalition-building. They can become focused narrowly on self-interest rather than on the systemic political changes and cultural evolution necessary for creating enduring social change. Because identity-based organizing binds activists to a smaller, more exclusive group of people with similar statuses, they run the risk of limiting, rather than expanding, the vision of what is possible. The association of identity-based groups with issues specific to a privileged narrative of identity that is gendered, racialized and classed, dehistoricizes identity while immutably defining it, often in a complex interplay with its medicalized category. Moreover, the larger political effects of identity-based organizing are limited. Rarely radically challenging status hierarchy, identity-based groups produce competition among similarly disadvantaged groups for incremental change in policy. So, while it may be the case that one set of social conditions produces dominance and subordination across all these categories (like capitalism—which produces and perpetuates the conditions for racial, gender, sexuality and age stratification) positions in society are intersectional and complex and the notion of identity or selfhood connects with individual experience rather than a uniting principle regardless of difference. Although identity-based politics has been the basis of organizing in support of reproductive health, it reinforces a binary, psychosocial self that limits the discovery of uniting principles that, if supported in unison, could radically alter the current regimes of power. Foucault insists that categories of social identification are merely utilized by higher social powers to disperse and, thus, splinter, minority power among smaller movements. This results

in incremental change that can be easily managed and deliberately misinterpreted by agents of social control as forms of biopower (1998). As Patricia Hill Collins argues, “Given the tendency of state power to manipulate groups that rely too heavily on narrowly defined identity politics, it is especially important to keep intersectional analyses of group construction in mind” (1998, 204). It’s not just that civil rights laws are more conservative than they should be, but rather, to grasp at a protective identity category like women, African American, or gay, is necessarily to place one’s identity under regulation by an inherently conservative legal system (Kirkland 2004, 183).

Chapter 2

Queering Reproductive Health Self-Determination and the GenderQueer Revolution

“In a society where femininity is feared and loathed, all women are genderqueer. In a culture where masculinity is defined by having sex with women and femininity by having sex with men, all gay people are genderqueer”

-Riki Ann Wilchins, founder of GenderPAC

Medicalization

The medicalization of gender nonconformity illustrates well the powerful ability of social institutions to use narrowly defined identity categories to regulate the ability of particular social groups to access social goods, while at the same time reinscribing those very social identities in the process, leaving preexisting power relations unchallenged. The medicalization of gender deviance constructs a narrative of intersex, trans, and queer experiences that is firmly entrenched in heteronormative ideology. As in the cases examined in Chapter 1, here, too, identity-based activism is involved in a feedback loop with the medical establishment that sustains a narrative of immutable, natural corporeally-given identity. But, culture does not in any mechanical way create particular roles for naturally-gendered people that are somehow automatically determined by their bodies; culture and the social institutions it shapes, in fact, first creates acceptable gender categories and in failing to foreground the fact or process of their creation, reifies them, naturalizes them, and integrates them into the epistemological moral life of the “taken for granted”

(Bornstein 1994, 12). As a result, gender identity categories, informed by class and race statuses, become sites or locations of self-knowledge with which their occupants identify, through which they understand themselves and their relations to others, and through which they act. This interactive process naturalizes identity categories and makes them seem both inevitable and impervious to change. The medicalization of gendered bodies and naturalization of dichotomous gender identity has resulted in the physical modification of bodies such that they support a hegemonic ideology of differential sex/gender norms (Kessler & McKinnen 1978, 162-164).

Such naturalization of gender dimorphism can partially explain the focus of feminism on essentialized womanhood and LGBT on dimorphically-gendered sexual categories like gay, lesbian, bisexual and transsexual. Both have been primarily interested in improving their options for healthcare while challenging hegemonic notions of their bodies as inherently pathological or diseased, and identifying the role of the social, political, and economic conditions associated with health and wellness and access to health care provision. Similarly, the medicalization of gender nonconformity is the context in which intersexuals, trans, and queer experiences were understood, suggesting the challenges of achieving an effective movement for responsive change. In addition, however, I hope that analysis of the regulation of gender begins to chart a course for a more effective movement that might advance the healthcare rights and claims of all subordinated peoples by opposing the regulation of bodies by the state and its institutions of social control.

Intersex

Sex assignment at birth is assumed to dictate gender for life. The medicalization of pregnancy has bestowed the power of gender assignment primarily to medical practitioners. However, when confronted with “ambiguous genitalia,” the decision to designate a child a boy or girl is a social rather than a medical decision (Greenberg 2006, 52). When determining whether a baby is a male or female, doctors focus primarily on penis size in the case of a prospective boy and reproductive abilities in the case of a potential girl: men have sex, women have babies (Chase 2002, 209). If a child is born XX, with oviducts, ovaries, and a uterus, but also a penis and scrotum, doctors declare the child a girl because of the potential to give birth, and intervene using surgery and hormones to biologically “decide” (Fausto-Sterling 2000, 5). When asked why standard practice assigns 90% of intersex infants as female, surgically “correcting” nature by trimming or removing the “enlarged” clitoris, one prominent surgical specialist reasoned, “you can make a hole, but you can’t build a pole” (Chase 2002, 209).

Early on, medical professionals argued that the accepted standard of care just described was necessary, successful, and justified, even going so far as to recommend lying to former patients about their medical histories. Today, the American Association of Pediatrics, American Medical Association, and American Urological Association designate ambiguous genitals a “social emergency” that necessitates an immediate medical response (AAP 2000).

Cheryl Chase, founder of the Intersex Society of North America (ISNA), argues that it is difficult for physicians and parents to consider infants as complex and fully agentic adult sexual beings. For example, in assessing newborns for surgical intervention, physicians describe adequate intercourse as successful vaginal penetration, failing to consider pleasure as important to female sexuality. The few follow-up studies that have been done on intersex surgeries, do not examine the psychological well-being of the subjects in any real depth; most simply report on the status of the postsurgical anatomy (Dreger 1998). Yet, many intersex patients who have received normalizing surgeries report feelings of inadequacy and freakishness as a direct result of their parents' and doctors' attempts at normalization, in part because gender assignment surgeries all too frequently leave scarred, insensate, painful and infection-prone genitalia (Dreger 1998). Those who report lack of sexual function are silenced because, as the same surgeon reasoned, “some women who have never had surgery are anorgasmic” (Chase 2002, 209). Allowing such phallogocentric social beliefs about gender and sexuality to inform medical and surgical care demonstrates how definitively a naturalized heteronormative gender binary constructs medical practice in this area (Bornstein 1994, 22).

Beginning in the late nineteenth century, a small percentage of adult patients with intersex conditions started to ask for—and some surgeons started to offer—surgical reconstruction of large clitori, small vaginas, and hypospadiac penises (where the urethral opening does not extend to the tip of the penis). Most of the genital surgeries performed for cosmetic reasons in the nineteenth century were performed on adults at their request. Before the nineteenth century, the vast majority of intersex

people went unnoticed by legal, religious, or medical establishments and only a few cases per year came to the attention of authorities. Presumably other people with so-called “abnormal” sex anatomies lived average lives, either because their anatomical variance was undetectable or because it was not considered especially important (Fausto-Sterling 2000, 10). However, with the rise of gynecological sciences and military medical examinations in the twentieth century, doctors gained a much better sense that “abnormal” sex anatomies were actually quite common. Indeed, late-nineteenth century doctors began reporting dozens of cases a year of “hermaphroditism” and “pseudo-hermaphroditism.”

In the 1950s, Johns Hopkins University created a team to deal with intersex conditions, one that sought to essentially eliminate intersex in early childhood. The approach developed there came to be known as the “optimum gender of rearing” model. The basic idea was that each child’s potential for a “normal” gender identity should be maximized by making each child’s body, upbringing, and mind align with normative standards as much as possible. Because of the belief that it was harder to engineer a boy surgically than a girl, most children with intersex were made as feminine as possible, utilizing surgery, endocrinology, and psychology. A “successful” patient was one judged to be stable and heterosexual in the assigned gender (Fausto-Sterling 2000, 12). There was little investment in the ideas of informed consent or of studying outcomes in a systematic way. Today, in the United States, approximately five “normalizing” surgeries are performed on infants each day (2000, 11).

Normalizing surgeries transform the diversity of sexes that actually exist in nature into pathologies, medically constructing and surgically producing “botched” males and females and, simultaneously naturalizing sex and gender dimorphism. But why should society care if a “woman” having breasts, vagina, uterus, ovaries and menstruation, has a “clitoris” large enough to penetrate the vagina of another woman? What is the essential sexual difference between a clitoris and a penis anyway? And, as Fausto-Sterling asks, “why should we care if there are individuals whose ‘natural biological equipment’ enables them to have sex ‘naturally’ with both men and women? Why must we amputate or surgically hide that ‘offending shaft’? The answer is: to maintain gender divisions, we must control those bodies that are so unruly as to blur the borders” (2000, 8).

Designed to normalize bodies in accord with crude male and female stereotypes, these surgeries have had a deeply destructive impact on the physical, psychic and sexual lives of many people. Nonconsensual surgery “cannot erase intersexuality and produce whole males and females; it produces emotionally abused and sexually dysfunctional intersexuals” (Chase 2002, 213). In response, a social movement has arisen; intersexuals and their allies have started organizing to end unnecessary and damaging surgeries that alter the bodies of infants and to fight for the right of all adults to determine their sex and gender once they have reached the age of consent. The intersex political stand with respect to reproductive health is thus intimately related to queer and trans politics because it also challenges medical definition, hegemony and authority and calls for the reform of powerful social institutions in the name of human rights. In this instance, however, the practice of

normalizing surgery is visceral evidence in support of the argument that beliefs about the gender binary actually produce the sex of the body (Stryker 2008, 139).

In 2004, the San Francisco Human Rights Commission declared that “normalizing” interventions done without the patient’s informed consent are inherent human rights abuses. It argued that the fate of a child’s sexual anatomy should not primarily rest on the needs of others or the “needs of society,” but should be left to that individual to decide when they are of consenting age. “Normalizing” interventions were seen as depriving intersex people of the opportunity to express their own identity and to experience their own intact physiology. The commission stated unequivocally that it is unethical to disregard a child’s intrinsic human rights to privacy, dignity, autonomy, and physical integrity by altering genitals through irreversible surgeries for purely social and aesthetic rationales. They condemned infant genital surgeries and sex hormone treatments that are not performed for the treatment of physical illness, such as improving urinary tract or metabolic functioning, and have not been shown to alleviate pain or illness. Evidence presented to the commission also suggested that clitoral surgery can have negative outcomes: it risks a reduction or loss of sensation in the genital region; it may create painful sensations upon arousal or erection; and it may not be consistent with a child’s gender identity. Vaginoplasty can have negative outcomes as well: it can cause infertility; vaginal dilation is often painful and humiliating; the constructed vagina can release odors from the bowel; it can necessitate constant use of sanitary napkins; it may require repeated surgical revisions. In addition, no testimony presented to the commission indicated that intersex children benefit from “normalizing” interventions

and many intersex adults reported dissatisfaction with the sex hormone treatments and/or the surgeries they were subjected to as infants and children, including dissatisfaction with physical appearance, scarring, pain, and diminished or absent sexual function, as well as psychological problems such as depression, poor body image, dissociation, sexual dysfunction, social anxiety, substance abuse, suicidal ideation, shame, self-loathing, difficulty with trust and intimacy, and post-traumatic stress disorder. Finally, evidence was presented that adults with small phalluses and large clitorises can and do learn to be sexual in ways that satisfy both themselves and their partners (2004).

In general, then, there is at least anecdotal evidence that adults with atypical genitalia usually would not choose the procedures to which intersex infants and children are subjected, such as the removal of a small penis or the removal, reduction, or recession of a large clitoris (San Francisco Human Rights Commission, 2004). As Alice Dreger notes in a *New York Times Magazine* article, “when I ask people with dark skin if they would change their color, they tell me no, and when I ask women if they would rather be men, they tell me no, and I get the same response when I ask people with unusual anatomies if they would take a magic pill to erase their unusual features” (1998). Ambiguous genitalia can be a sign of metabolic concerns that may need urgent treatment; however, ambiguous genitals themselves do not need urgent surgical or hormonal treatment to “normalize” or “correct” their appearance. Instead of constantly enhancing the norm with new technologies, Dreger suggests that maybe society “should work on enhancing the concept of normal by broadening appreciation of anatomical variation” (1998). Specifically, Dreger recommends showing parents

contemplating sex assignment surgery for their children, medical students and genetic counselors representations of lives lived by those with unusual anatomies that are not deeply pathologized ones and allowing those with unusual anatomies to describe their own lives in full and rich detail, including letting them communicate the forbidden narratives of enjoying their deviance (1998).

Trans

Susan Stryker notes that, “People may move away from their birth-assigned gender because they feel strongly that they properly belong to another gender in which it would be better for them to live; others want to strike out toward some new location, some space not yet clearly defined or concretely occupied; still others simply feel the need to get away from the conventional expectations bound up with the gender that was initially put upon them” (2008, 1). Although the meaning of trans⁶ is, by definition, in constant flux and may have various meaning to different people, Stryker defines it as “the movement across a socially imposed boundary away from an unchosen starting place—rather than any particular destination or mode of transition” (2008, 1).

There are trans people whose gender identity lies strictly within the binary, who identify with the gender “opposite” the gender assigned at birth and who refute the notion that they are not “real” men and women. Some of these individuals desire complete physical transition and to pass, others desire only some medical procedures but still desire to pass and others do not feel the imperative to change their bodies or

⁶ Because all gender nonconforming people are impacted by trans politics, I will be using “trans” as an umbrella term for those who identify as transsexual, transgender, genderqueer, gender nonconforming, and any other terms used by gender variant people to describe themselves.

to pass. Some transfolk identify as transwomen or transmen. Some just identify as “trans,” flexibly in between or completely outside of the gender binary and may or may not want to alter their bodies to look more gender-ambiguous. Some trans people live their lives in deliberately constructed gender-ambiguous bodies while others desire complete transition and desire to pass. Many do not even identify as trans. What is important to recognize is that surgery and hormone treatment is not what defines trans identity; self-identification is at the heart of gender.

The medicalization of transsexualism in the 1930’s set the stage for how all trans experiences were to be understood for decades later, establishing forms of bodily regulation of gender that kept both non-transsexuals and transsexuals in adherence to binary gender roles. Medical discourse has been largely confined to discussions of trans as a deviant or pathologized state, studied in the context of medical or psychiatric anomalies. Medical and psychological texts treat transgenderism as pathological deviations from social norms of “healthy gender expression” (Stryker 2008, 2). Researchers occupied, and continue to occupy, themselves with finding a biological cause of and cure for trans pathology. Cures included various violent interventions into the bodies and psyches of trans people. In nearly every instance, trans bodies and brains were perceived as inherently diseased, disordered, and deviant (van den Wijngaard 1997). For those unable to be cured therapeutically, in their book *The Transsexual Phenomenon*, American researchers Harry Benjamin, John Money, and Richard Green outlined surgical protocols and hormone treatments that mirrored the procedures used for more than fifty years in Europe to improve the quality of life for trans people who desired to change their

bodies (1977). Reed Erikson, millionaire transman and benefactor of the ONE Institute, a homophile activist organization of the 60's, provided much of the funding for Benjamin's work at Johns Hopkins as well as for the establishment of clinical research programs to study the trans experience at UCLA, Stanford, and the University of Minnesota (Stryker 2008, 80). Although the use of these procedures in the U.S. was celebrated in many trans communities, especially for those who felt "trapped in the wrong body," they were developed to produce the stereotypical appearance of one sex or the "other," generally situating trans experiences within a category of "transsexual," exclusively within a clinical context and strictly within the gender binary; in this system, trans people were either FtM [Female to Male] or MtF [Male to Female]. Dean Spade argues that the result of the medicalization of the trans experience was the construction of, "a fictional transsexual, who just knows in hir gut what a man is and what a woman is and knows that ze is trapped in the wrong body" (2003, 25). Kate Bornstein, a trans theater activist, further argues that the public was only interested in trans people to the extent that they provided stories by and about themselves as people who had lived their lives "hiding deep within a false gender—and who, after much soul-searching decided to change their gender, and spent the rest of their days hiding deep within another false gender" (Bornstein 1994, 12-13). The institutionalization of trans experiences as deviant has, thus, contributed to the naturalization of two discrete gender categories by implying that these categories usually encompass everyone's experience of gender, but occasionally people, intersex or trans, are wrongly assigned and require physical correction to reestablish the norm (Spade 2003, 26).

People have a “multitude of goals when they seek gender-related body alteration, such as access to different sexual practices, ability to look different in clothing, enhancement of a self-understanding about one’s gender that is not entirely reliant on public recognition, public disruption of female and male codes, or any number of other things” (Spade 2003, 28). In some ways these goals are similar to those of people who seek other kinds of cosmetic surgery. Those seeking surgeries like breast enhancement, pectoral implants, or laser vaginal reconstruction that enhance the femininity of birth-assigned women and the masculinity of birth-assigned men are accessed with relative ease while doctors and policies ferociously guard technologies that aid in gender transgression (Spade 2003, 28).

Perhaps the single most erroneous misconception about trans people is that sex reassignment consists of a single “sex-change operation” that transitions a trans person from one gender to “the other.” In fact, even though doctors usually assume transsexuals pursue a linear trajectory of hormone treatment, top and bottom surgery to transition from one to “the other,” there are several different kinds of treatment that people seeking sex reassignment choose from, including bilateral mastectomy, breast implants, orchiectomy, phalloplasty, hysterectomy, vaginoplasty, brow reduction, facial implants, vaginal closure, voice surgery, metaodioplasty, augmentation mammoplasty, tracheal shave, liposuction, electrolysis, hormone therapy, group or individual counseling, and psychotherapy (Spade et al. 2007). Thus, a “complete” transition is somewhat subjective. For example, some birth-assigned females might want to take hormones and become “sexy bearded ladies” who are interpreted a variety of ways but feel affirmed in how they look. In the end, body alteration is all

about empowerment. However, when medical gatekeepers employ dichotomous gender standards, they eliminate the possibilities of norm-resistant gender/body expression (Spade 2003). This is not to deny that when medical practitioners are not well-trained in the art and science of their craft, their interventions may have the same negative effects as those performed on intersex infants and children. Here the issue for trans people is not so much informed consent per se, but rather, being able to find physicians with the training and broad, non-judgmental social knowledge required to inform patients of possible treatments, risks and complications and well as benefits, to treat patients sensitively, safely and effectively, and to help them secure the auxiliary services they may require to live their lives in the way they choose.

There is a huge gap between the trans community's understandings of their bodies, experiences and sources of liberation, and the medical establishment's interpretations of their lives. According to standard medical practice, trans people must seek and obtain medical treatment in order to be recognized as trans in the first place. But the converse is also true, in order to obtain a medical intervention, trans people need to prove psychological and emotional membership in the category "transsexual" by proving they are diseased and in need of treatment. They must prove that they have some variant of gender identity disorder (GID). In order to be diagnosed with GID, one must have the symptom of life-long and childhood participation in stereotypically gender inappropriate behavior. According to the stereotypical psychosocial profile, boys with GID "particularly enjoy playing house, drawing pictures of beautiful girls and princesses, watching television or videos of their favorite female characters ... [t]hey avoid rough-and-tumble play and

competitive sports and have little interest in cars and trucks.” Girls with GID “do not want to wear dresses, ‘prefer boys’ clothing and short hair,’ and are interested in ‘contact sports, and rough-and-tumble play’” (Spade 2003, 24). Despite the disclaimer in the diagnosis that this disorder is “not to be confused with normal gender non-conformity found in tomboys and sissies, no real line is drawn between ‘normal’ gender non-conformity and gender non-conformity which constitutes GID” (Spade 2003, 24). Thus, normative gender is defined in opposition to the created and pathologized category of deviants in which non-GID kids play with gender appropriate toys and enjoy fictional characters of their own sex. Gender deviance is thus created as a disorder that requires medical regulation/intervention. Foucault describes this phenomenon as informal governance—the invention of a category of deviance, described as an illness to be resisted or cured that creates an opportunity for increased surveillance and speculation, a biopower that has the ability to “qualify, measure, appraise, and hierarchize, rather than display itself in its murderous splendor,” silently rendering the deviant subordinate, disadvantaged and powerless in society (1998, 144). Therefore, in order to appear worthy of the body alteration sought by many gender-transgressive people, they must convince doctors and psychiatrists that they identify as “transsexual” and have been suffering from GID since early childhood and throughout their lives. Their quest for body alteration needs to be legitimized by a medical reference to, and belief in, a binary gender system, a system that many trans people seek to disrupt, dismantle or destroy. It is clear that some fake a desire for gender normativity (wanting to be either man or woman) and nothing in between, because they know that without adhering to this

narrative, their desires for body alteration and physical gender transgression will be declined (Spade 2003, 24). No one should be required to conform to false identities or stereotyped models in order to access the medical care they need to improve their health, well-being, quality of life, and length of life.

Further testimony to this is that fact that surgery and hormone treatment both require demonstration of an ability to pass as the “other” gender—sometimes with disastrous consequences for the person seeking a medical intervention. In almost all circumstances, trans people in pursuit of body alteration must have completed either three months of Real Life Experience (RLE) or a period of psychotherapy (of at least three months), or both, before hormones are provided. During the RLE, patients are supposed to live “full time” in their “new” gender identity. However, fulfilling these requirements may not be possible or safe for all trans people. For many trans people, a meaningful RLE experience before treatment may not be possible given the limitations of their bodies or their finances. For patients who must pay out of pocket, the cost of three months or more of psychotherapy may be prohibitive. In addition, RLE may place some patients at significant risk of violence and even death if they are discovered to be trans. Trans Specialist Dr. Nick Gorton of the Lyon-Martin Health Clinic argues that RLE may in fact, “represent a violation of the medical ethics principle of maleficence to require some patients to fulfill a three month RLE as a condition of receiving hormonal therapy” especially since the provision of hormones may be the least harmful and potentially most helpful way to address trans patients’ concerns (2005, 14-15). Furthermore, those already living in accord with their desired gender presentation full-time, such as those who live betwixt or outside of

gender normative presentations, who find no meaning in such “real life experience” tests and yet must lie and say they have been living as the “other” gender. Moreover, the only medical research done on these preconditions suggests that, “there may be no differential benefit or reduction in risk or regrets in patients who undergo a RLE versus those who do not” (Gorton 2005, 15).

Those living between or outside of normative gender categories, may, of course, question the passing imperative and live full-time in their “deviant” genders, but this leaves them “unreal” and thus medically inappropriate for transition in the eyes of psychiatrists, doctors and other professionals who determine whether they receive surgery or hormones. Because the ability to be perceived by non-trans people as a non-trans person is valorized, normative gender expressions are again reinforced. This may result in the medical production of stereotypical clones of hyper masculine or hyper feminine bodies with the risk that such presentations affect the actual treatment and follow-up prescribed and distort the ability of the trans person to determine freely a vision of their future embodied selves. Gender disruptive behavior is thus at the very least discouraged, leaving “many feminist genderqueer trannies with the question, why bother?” (Spade 2003, 28). In the end, the medical establishment seems to hold all the cards when the very access to and “success” of transition is measured by normative definitions of “real” femininity and masculinity.

The politics of transition

The heteronormative and gender-binary-naturalized narrative that constructs the medicalization of the trans experience is also deeply implicated in the claims of

trans people to basic civil rights in the liberal tradition. Feminist legal scholars have repeatedly demonstrated that the legal claims of citizenship are not often made without gender framing (Kessler & McKinnen 1978). In the case of trans people, the myriad regulatory institutions of the state and the criminal justice system often have a discriminatory effect on those who actually live trans lives (Arkles 2007, 8). Moreover, in a reenactment of the epistemological and praxis feedback loop described, the inability to be seen as a legitimate claimant of the rights of citizenship before the law undermines the ability of trans people to also make claims upon health care providers for services and upon the insurance carriers for the payment of medical costs.

In order to be legitimately recognized as trans by the legal system, and, thus to appeal for rights as a trans person, medical proof of having completed physical genital gender transition must be provided; to the courts, genitals are, thus, gender's essential sign (Kessler & McKenna 1978, 119). Yet, there is no medical rationale for linking the legal recognition of a trans person's gender identity to genital reconstructive surgery or any other specific treatment that is not medically appropriate or possible for all trans people. For example, the majority of trans people never have surgery, because many don't want it or need it to express their gender, and, for transmen, the most common sex reassignment procedures are hormone treatment and chest surgery. Fewer than 10% of transmen undergo any reconstructive genital surgery, like phalloplasty, because of the limitations and severe medical risks associated with the current available surgery (Spade 2003, 31). As a consequence, even after hormone treatment and mastectomy, FtMs are prejudiced against in the

courts because they cannot as yet receive genitals that look and function perfectly (Kessler & McKenna 1978, 119).

Furthermore, transitioning is expensive, and insurance companies do not cover it (nor can they be compelled to because trans people have no federal and limited state level constitutional protections), so many who seek surgery or hormones cannot afford to pay for them. Because trans identities are legitimized or delegitimized by the legal system based on the medical care they receive, those of low-income face the most severe discriminatory effects of the medicalization of the trans experience (Arkles 2007, 8). The refusal of Medicaid to cover transition-related health care reproduces hierarchies of race and class because these exclusions disproportionately affect low-income people, since Medicaid is usually their only health insurance option, and people of color, since they are more likely to have low income as a result of racial discrimination (Arkles 2007, 7-8). SRLP activists Pooja Gehi and Gabriel Arkles say, “for low-income trans people, this legal catch-22—being required to show proof of medical care for legal recognition of their identities but being denied that care by Medicaid—places them in a perpetual state of illegitimacy” (Arkles 2007, 8). Especially in a context where medical care and the realization of proper rights as citizens remains inaccessible to most, and particularly to low-income, gender-transgressive people, it seems counter-intuitive that gender-related body surgeries are still allocated through expensive, gender-regulating processes that reinforce oppressive and sexist gender binaries. Thus, the exclusive focus of much LGBT organizing in the area of trans-relevant healthcare on surgical and hormonal transition may itself be reproducing racist, classist modes of healthcare

activism and outcomes in addition to perpetuating an immutable version of the trans experience that must be replicated and thus reinscribed physically and epistemologically. The law and medicine have thus both shaped LGBT activism and, intertwined as it is with heteronormative and essentialized medicalization, undermines its transformative effect.

The central role of surgery and hormones in LGBT and trans-specific health activism also supports the myths that trans people all have or want surgery, and that their identities are defined by those surgeries. And because these myths are so widely accepted as true (and so frequently sensationally exploited in the media), those seeking physical transitions are often required to legitimate trans identities in the process and to appeal for rights as trans people. For example, “if a trans person can’t prove ze has had reconstructive surgery, ze can’t change hir state-issued identification card, passport, driver’s license, and birth certificate” (Spade 2003, 16). In fact, it is a felony to check the “M” box on identification papers if you were birth-assigned “F” (Feinberg 1998, 21). Changing one’s name to a name typically associated with the “other gender” requires medical evidence of all surgical procedures to be presented (Spade 2003, 16). Without genital surgery, these policies prevent people from having proper gender placement and thus relatively safer havens in prisons, homeless shelters and group homes (Spade et al. 2007). Even the ability to use a gendered bathroom without getting harassed or arrested may be dependent on the ability to produce identification of the “correct” gender, which will only indicate the new gender if one has successfully submitted medical evidence to the right authorities (2003, 17). The legal status “of a trans person’s marriage, the custody of hir children, hir right not to

be discriminated against in employment, his right to wear gender appropriate clothing in school or foster care, his rights in prison, for all of these medical evidence will be the cornerstone of the determination of his rights” (2003, 18).

The result of the complicated and fraught gatekeeping with respect to health care particular to trans people is that the numerous other possible healthcare problems they have that are in need of attention are often left unattended (like the health effects of using binders for flattening the chest, gaffs for tucking, as well as post-operative care). In addition, trans people who do not undergo body modification often do not pass and are routinely denied primary health care due to transphobia. The inaccessibility of transition-related care can result in the purchase of hormones in underground economies and use without medical supervision. The lack of information about trans health and the inaccessibility of clean needles and proper medical advice results in many unsafe hormone injections in unregulated amounts. Using the wrong doses can severely damage the liver and using and sharing unsterilized needles has given trans people a higher risk for HIV/AIDS and hepatitis. Silicone injections for body contouring is another transition-related treatment often obtained on the black-market, but that is so dangerous that ethical medical practitioners will not administer them. When bought on the street, silicone is not medical-grade. It has the potential to migrate to other areas of the body and cause infections; yet, many desperate trans people seek them out anyway and put their bodies at risk (Spade et al. 2007). Finally, the almost complete absence of trans-sensitive sex education materials and educators results in a higher risk of STI's and the complications they give rise to if left untreated.

Queer

Just as the medical categories that frame trans experiences influence the delivery of effective health care so does the history and epistemology of queer sexuality and reproductive and sexual health activism. Queer reproductive (or sexual) health has been divided into two relevant categories: women who have sex with women (WSW) and men who have sex with men (MSM). While this model may indeed take into account the social effect of being sexually deviant on health, it almost completely overlooks the importance of sexual practices in the study of disease transmission. Numerous assumptions are involved in determining the risk of “WSW” or “MSM” for disease including essentialized notions of what their bodies look like, what their sexual practices are, what sexual practices they have participated in in the past, and what they will participate in in the future. Basing healthcare needs assessment and delivery on identity categories that make the categories of lesbian and gay both essentialized and immutable are certain to fail. Instead of determining what diagnostic tests to run or care to give or what educating or follow-up or referral is necessary based on a person’s sexual identity, acknowledging the complex interactions between the body, the social identity and sexual behavior and providing sex education that is relevant to those of diverse bodies, sexual practices and identities would facilitate a more effective and respectful healthcare practice.

For example, in the HIV/AIDS crisis, the representation of the disease as a “gay male disease” was a result of the construction and assumption of sexual practices associated with being a gay male, as well as those associated with being a heterosexual, and those with being a female-born lesbian. Amber Hollibaugh argues

that assumptions about the sexual practices of lesbians as nonpenetrative or docile has led “to many erroneous and tragic conclusions and confusions when each of us tries to understand our own personal risk for HIV” (Hollibaugh 2000, 194). The denial of a lesbian risk for HIV is often supported by a constructed narrative of lesbianism that refuses, “to acknowledge or accept that we sleep with each other in many, many different ways. We are butch/femme women; we are queer or androgynous; we are lesbian feminists; we don’t believe in labels; we practice s/m; we use our hands, our mouths, our bodies, sex toys, to pleasure and please each other; and we may also sleep with men, whether we call that bisexuality, coming out, economic necessity, or we don’t dare talk about it” (Hollibaugh 2000, 190). The Radicalesbian Health Collective wants “every gynecologist we go to to know all aspects of lesbian sex with relation to gynecology” (1992, 139), and yet little substantial information about what lesbians do in bed with each other, including what might put them at risk for HIV and other STIs is rarely addressed in sex education or even by LGBT gynecologists (Hollibaugh 2000, 190). In ignoring the existence of heterogeneous behavior within identity categories, the medical categories of sexuality that attempt to contain and characterize queerness impede the administration of effective reproductive and sexual health.

Challenging Heteronormativity and Homonormativity: Avoiding the Pitfalls of Neo-liberalism and the Cooptation of Diversity

Consistent with this view with respect to trans and queer healthcare, Ward argues with respect to identity politics more generally that, “Challenges to single-identity or gay-only politics have transformed LGBT organizing in many productive

ways. LGBT organizations across the country have indeed become more racially and gender diverse and organizations established by and for queer people of color, in particular, have become more common” (Ward 2008, 135). However, “even as the organizations diversified and engaged in multi-identity activism, their emphasis on the institutional functions of diversity helped to preserve middle-class, male-centered, or white-normative ways of ‘doing difference’” (Ward 2008, 133-134). The deployment of identity normative logics may be strategic, on the one hand, or intentionally put to work for the good of the larger struggle, on the other. Either way, Ward argues, it is important to determine whether activists are achieving greater visibility and access to resources by undermining normativity or by uncritically colluding with it, using their privilege to gain resources as an oppressed subject with the possibility that they are excluding or even stigmatizing others via their effort or framing (Ward 2008, 134).

Lisa Duggan’s homonormativity is “a theory that deciphers the ways in which conservative and assimilationist gays and lesbians contribute to the privatization of mass culture” (Munoz 1999, xii). In *The Twilight of Equality*, Duggan defines “homonormativity” as a neo-liberal sexual politics that “does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption” (2003, 50). Examining a few nonprofit LGBT organizations, Ward observes that the adoption of “corporate diversity speak and diversity management practices helped diminish the stigma associated with being a lesbian and gay organization” while enhancing their

professional authority because other professional organizations, like universities and corporations, also focus on inclusion because, today, diversity is a central part of doing good business (Ward 2008, 137). In the search for funding, LGBT nonprofits often lose transformative queer politics and the acknowledgement of interactions of race and class with sexuality in such assimilationist strategies because it involves privileging the most visible and ostensibly knowable or predictable forms of difference, ultimately containing diversity while valorizing neo-liberal identity-based civil rights claims and “marking boundaries between respectable and unrespectable forms of identity activism” (Ward 2008, 138). As even intersectional frameworks of diversity are normalized and privatized in businesses like clinics, Ward found that the diversity rhetoric espoused by the state and its institutions was replicated, while persistent forms of dominance were masked. The mainstreaming of diversity rhetoric and LGBT activism has thus demonstrated that “Normalcy is therefore not constituted as strictly endemic to heterosexuality” (Munoz 1999, xii).

Multi-identity politics can be rescued from co-optation and commodification; however, it is important to distinguish these forms of neo-liberal multi-identity organizing, steeped in homonormative politics and tokenization, from what might be termed “queer intersectionality” (Ward 2008, 135). The intersectional framework is commonly used to refer to interlocking systems of oppression—particularly race, class, gender, and sexuality. Used to identify both theoretical subject positions and actual models of multi-identity activism emerging within contemporary movements, intersectionality, in theory, allows for the transcendence of singular and self-interested understandings of priorities in organization and has worked to promote

more diverse movement leadership and expanded forms of social change. However, many LGBT organizations fail to consider the relationship between grassroots multi-identity activism and the widespread attention to diversity and equality characteristic of corporate, pop-cultural, and political realms (Ward 2008, 135-136). Queering intersectionality implies using this same intersectional framework, but avoids economic and cultural co-optation and commodification by professionalism because at its roots, queerness implies anti-normativity, a necessary component to dismantling capitalism and its interlocking systems of social control (Ward 2008, 136). As Ward points out, the mainstreaming of diversity culture has worked to “catalog differences and rend them more manageable, predictable, and profitable,” while “queer feminist theorists of color have pointed to the value of a far more groundless and unpredictable identity politics” (Ward 2008, 144).

Disidentification: Historical Challenges and Possibilities

Disidentification is one tactic that poses a challenge to the mainstreaming and co-optation of difference. Diversity projects tend to strengthen ties to fixed identity categories and encourage identification with predictable markers of cultural difference while disidentification escapes definition. The question is whether or not it is a viable anti-identity around which a new health movement might emerge?

All identity-based appeals for rights and healthcare perpetuate an immutable vision of identity and the body. In contrast, queer and trans interrogations of, and challenges to, naturalized, dualistic “we-them” identities rooted in gender and race dichotomies, like notions of man/woman, gay/lesbian, MTF/FTM, white/black, form

the basis for a conceptual of identities as fluid constructions, that depend on the social, but are self-determined in their essence. Such a conception would make it particularly difficult to navigate institutions that have used these immutable narratives of identity as organizing and operating principles for healthcare provision. For example, queer bodies that do not limit themselves to narrow definitions of gay and lesbian, automatically interrogate medicalized categories like “men who have sex with men (MSM) and women who have sex with women (WSW)” that have become barriers to providing good healthcare to queer, gay and lesbian people. In addition, the medicalization of nonconforming bodies makes it difficult for those who do not adhere to the institutionally-sanctioned definition of transsexual to benefit from an array of public and privately funded shelters and welfare services as well as to access reproductive health care related to expression of gender identity and medical care more generally. In a parallel way, those of mixed race get erased in the provision of healthcare where seemingly progressive efforts to provide “culturally competent” healthcare reduces the complexity of an interrelated nexus of concerns that are simultaneously class-related, genetic and social to essentialist racial/ethnic considerations divorced from considerations rooted in bodily self-determination. Because more people are in the borderlands of identity than those who can be easily positioned exclusively in one identity category, intersectional and queer theoretical knowledges can serve as a fulcrum for challenging identity-based definitions that disadvantage people at the margins, like intersexuals, queer, trans and those of mixed race and may provide a powerful, new basis for organizing in support of reproductive health and bodily self-determination.

Challenging Categorization, Medicalization, and Social Control in Search of Anti-Oppression Health Care

There is also an argument to be made that identity-based health care is inherently inferior health care and that challenging its basic assumption might lead to better health care for all people. The mainstreaming of diversity and the reformation of medicine to include “culturally competent” medical care has used what Epstein describes as “the inclusion-and-difference paradigm” to emphasize the key principles of inclusion of members of diverse groups as research subjects and the measurement of outcome difference across subgroups (2007, 278). This “biomulticulturalism,” advocated by federal health officials, and often the result of activism in the neo-liberal tradition has been realized through categorical alignment, the unspoken assumption that categories of identity politics and state administration can also function as categories of biomedical differentiation (Epstein 2007, 278). Public health officials took ideas about group inequality and group classification used elsewhere in government (such as in the census) and transposed them onto the biomedical research domain, inscribing the categories into policies and surveillance systems that prescribe biomedical practices. Therefore, other ways of classifying populations, such as by social class, or by at-risk behavior, and the question of “why categories of political mobilization and administration should be viewed as the categories of greatest biomedical relevance” were bypassed (Epstein 2007, 278). Although this model challenges the standardization of healthcare to a generalized, once-size-fits all, wealthy, white, male, and, as such, has brought needed attention to groups that historically have been disadvantaged in the medical domain, the emergence of social

categories as targets of scientific inquiry have resulted in the formation of “niche standardization,” creating a new “standard human” for each social category or group and “displacing standardization to an intermediate level...between individuality and universality” (Epstein 2007, 279). This “substandardization” of healthcare reserves the definitional power of categories of identification to the medical establishment without truly challenging neo-liberal notions of individualism or universalism. Thus, in attempt to create monolithic and biological “facts” about certain identities, and by analyzing them as discrete, singular units, the medical establishment naturalizes their version of identities, recapitulating and naturalizing the problems characteristic of identity-based politics, leaving no room for intersectional identities, variation or transgression. All is once again given in nature. Surrendering definitional control to medicine may also result in relegating, for example, queer sexual health to queer-identified people, when everyone, straight, queer, or questioning, should be exposed to a broader sexual health education based in a knowledge of body parts and sexual behaviors rather than the limited heterosexual and gender-essentializing health education available. The inclusion-and-difference approach is thus a “biopolitical” paradigm in Foucault’s sense because it promotes ways of defining, knowing, and governing populations. Because categorization has become a broad tendency of the state, the law, and medicine, phenomena such as race and gender are placed at the heart of the state’s maintenance of social order (Epstein 2007, 282). In this way, the very meaning of concepts such as race, sex, gender, and sexuality are historical outcomes of repeated feedback loops, operating between expert labeling and the self-assertions of those being labeled (Epstein 2007, 295).

Resisting Essentialism and Queering Intersectionality: Identity as a Process

Historically, feminist reproductive health activism has claimed its moral strength on a concept of essentialized womanhood to be recovered or restored from the taint of patriarchal pollution, prioritizing the oppression of “women” by “men” as individuals and by patriarchy as a system. Linking femaleness to womanhood and womanhood to the biological capacity for motherhood became a common trope in the discourse around reproductive oppression. However, identity-based politics and the institutionalization of identity perpetuate notions of essentialized, immutable identity and sex/gender congruency that render the diversity of races, classes, sexualities, sexes and genders that actually exist, invisible (Cromwell 1999, 11). Just as the black/white binary fails to include the range of experiences of other people of color and those of mixed racial identities, the man/woman binary fails to include the experiences of other genders (Smith 2006, 70). Moraga and Anzaldúa found power in the hybrid identity, in the uncategorizable nature of the intersectional identity. Intersectionality, thus, provided the basis for deconstructing immutable notions of identity, race, and the sex/gender binary (Munoz 1999, 22). Queer studies discarded older feminist notions that women were the only victims of gender oppression, that they were the only ones suffering under a system that exploited their labor, and controlled their reproductive capacities, turning them into second-class citizens (Stryker 2008, 127). Without denying that gender systems indeed created systematic inequalities for women, the queer take on gender also emphasized the importance of the productive power of gender socialization—how the categories of woman and man

were in fact produced through the mutually reinforcing practices of media, gendered bathrooms, clothing, housing shelters, prisons, parental and peer pressure and violence.

The phenomenon of sustained gender inequality is rooted in the construction of binary relationality (Derrida 1982, 15). Domination is formed out of hierarchy; the maintenance of hierarchy requires difference; and difference requires categorization and definition. Therefore, in order for the category of man to be dominant, in fact in order for it to exist, the category of woman must exist in relation to it, as a derivative of it. Because hierarchy is necessary for capitalism to function through exploitation, this economic system benefits by systematically naming sets of binary social relations so one may dominate over the other. Spivak says, “ideology reproduces the social relations of production” (1988, 274); it also functions to regulate the formation of the social body in a way that maintains social stratification and furthers capitalist domination (Foucault 1998, 140). Gender is articulated as natural through culturally hegemonic ideology, through the interpellation of the body into the binary categories of male and female, allowing for the reproduction of the social relations of production. Since “the relations of production in their totality constitute what are called the social relations, society”, the binary categorization of gender is related to the maintenance of patriarchy and the systematic exploitation of “gender deviants” through capitalism and the process by which capitalism reinscribes the binary (Marx 1978, 207).

Exploitation, a fundamental process of capitalism, is a system that can only be fully utilized once domination has been fully articulated and set in self-perpetuating

motion. If domination has not been established, exploitation is not possible. Since domination has been established by white, wealthy men, the promise of capitalism is only accessible to this group precisely because they developed definitions of citizenship to serve their needs as the dominant class. All “others” who enter the work force in an effort to improve their everyday lives are necessarily exploited for profit. Strict gender role stratification based in biological difference is necessary, then, to sustain a capitalism where men are the dominant sex class. Consequentially, it is in patriarchal capitalism’s best interest to stratify gender into two distinct categories, one being man, and one the derivative of man, in order to systematically disadvantage and exploit the derivative for the promotion of man’s needs.

The constant classification, naming, and devaluing of identity is imperative to this power structure; power needs identity to be repeated, to be identifiable in order to control those so identified. Thus, in the medicalization of gender nonconformity, deviance became the defining characteristic of the person’s identity in order to regulate behavior and status, to label the person as a sinner, a patient, an outlaw, simultaneously to discipline, stigmatize and disempower the deviant and reinscribe the binary. Institutional discourse on gender deviance is ironically associated with the “transsexual” precisely because gender identity must be fixed in a category; fluidity must be extinguished because it confounds the very basis of exploitative relations. However, this also means that, it is possible to refuse repetition, to refuse to be named, to resignify the meaning of gender, to evade categorization, to evade gendered exploitation. Roles can be reinterpreted, and thus carry new meaning, rather than replicated, rewriting powerful capitalist scripts (Butler 1997).

The Genderqueer Revolution refers to the revolutionary idea that people can and should be able to determine and express their own gender identities and bodies in the way they see fit. Genderqueer as an identity has been linked to a particular political critique of binary gender systems. Although “queer” is often used as an umbrella term for LGBT identified individuals, queer-identified people often understand themselves as neither heterosexual nor homosexual, both heterosexual and homosexual, or flexibly playing between them. Similarly, genderqueer-identified people often understand themselves as neither man/male nor woman/female, both man/male and woman/female, or flexibly playing between them (O’Brien 2003, trans lib). “Queer Theory,” as a theoretical concept, was coined in 1991 by Teresa de Lauretis, challenging the idea that sexual orientation and gender identity can be neatly categorized with fixed labels (gay, straight, transsexual, man/woman, etc.).

Proposing a spectrum of individuality, to be queer meant to have the freedom and pride of self-creation, independent of the expectations or limitations of society. Being queer particularly “resonates with young folks who are frustrated with the increasingly assimilationist politics, attitudes and identities of many gay and lesbian organizations, as well as with those who generally see the proper project to be subverting boundaries and norms rather than reifying them” (Ritchie 2008, 261).

Over the past fifteen years, many who identify as LGBT have embraced the word ‘queer’ as a self-affirming umbrella term, inclusive of all people who do not fit into, or politically oppose abiding by, traditional sex/gender/sexuality norms. Especially because of its gender-neutrality and the connotation of social non-conformity, many see “queer” as a term that is both personally positive and politically empowering.

Together, Intersectional and Queer Theory have the potential to inform social movements, especially identity-based movements that are constantly battling intragroup privilege and difference. Cherrie Moraga's *This Bridge Called My Back: Writings by Radical Women of Color* and Gloria Anzaldua's *Borderlands/La Frontera: The New Mestiza* gave critical insights into intersectional analyses of race/class/gender/sexuality oppressions. In the special attention given to hybridity of identity, no one status could be privileged over the others in the material lives of women or anyone else. Like Gloria Anzaldua's *New Mestiza*, queer, trans and mixed race people occupy the borderland where notions of gender and sexuality are constantly shifting. Anzaldua wrote, "A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary. It is in a constant state of transition... Los atravesados live here: the squint-eyed, the perverse, the queer, the mongrel, the mulato, the half-breed, the half dead; in short, those who cross over, pass over, or go through the confines of normal" (2007, 25). Borderland bodies occupy in-between spaces because they are sites of multiple and ambiguous meanings and continuously evade description, but that may allow for the reworking of coalitions around difference that do not imply hierarchy and domination (Jakobsen 1998, 14). These borderland struggles elucidate how ambiguity must be tolerated and celebrated in order to transcend oppressive duality. Intersectional and Queer critiques of normativity, or conventional forms of association, belonging, and identification have, thus, "helped to highlight the limitations of identity politics, including the ways that identity activism can work to sustain hegemonic ideas about gender, sexuality,

race, and class—even as activists make successful strides toward equality at the local level” (Ward 2008, 134).

Queer intersectionality combines intersectional politics that simultaneously struggle for racial, gender, class and sexual analyses of identity and queer politics that resist the institutional forces seeking to contain and normalize differences or reduce them to a profit value (Ward 2008, 136). This queer analysis is not being used as a means of privileging sexuality or sexual identity within multi-identity politics, but rather, as a political metaphor for a reconceptualization of identity without fixed referent, a metaphor that describes various modes of challenging the institutional and state forces that normalize, categorize and commodify difference; it is anchored in a broad critique of the mechanisms that tie people to fixed identity categories (Ward 2008, 143). Thus, queer intersectionality potentially offers an intervention into this cycle of categorization perpetuated by both identity politics and the institutionalization of identity that construct social statuses and identity as immutable and natural.

Butler argues that, “Gender is a kind of imitation for which there is no original” (1991, 21), but becomes naturalized by being viewed as essential (1991, 28). Thus, gender is a process, as is all identity, rather than something naturally possessed. Norma Alarcon’s “subject-in-process” describes the construction of an individual identity as continually unfolding without origin or end, as an act of becoming that ever ceases (Ward 2008, 145) and can never fully be described or categorized. Juana Maria Rodriguez explains that, “no single term of construct can fully inscribe the historically marginalized subject” (2003, 6). It is in this tradition that a basis for a

new health movement may find its source. Although intersectionality paved the way for reconceptualizing identity as fluid, when used, it is often thought of in terms of intersecting and interplaying categories of identification, rather than fluid states constantly informing each other, at times stable and at other times volatile. Hence, intersectional politics must not only enable multiple and interlocking identifications, but must also allow for identity to be a site of opposition in which identities are understood to be spastic and unpredictable. Jose Munoz's post-structural theory of disidentification may more precisely describe this reconceptualization of identity as a process (1999).

Munoz argues that although the binary is maintained by multipronged strategies that involve stigmatizing and punishing those whose gender performances undermine categorization, gender disidentification can be a powerful tactic for evading social control and manipulation in organizing. By "disrupting the connection between identification and normativity, disidentification acts a strategy that works on and against dominant ideology...a failure of interpellation (1999, 11).

Disidentification opposes assimilation within a structure, without countering it, so for Munoz, even to identify with a category is an unstable situation, one is constantly identifying and disidentifying with the category's historical and personal meaning. But, to explicitly disidentify with identity categories is to extricate identity from the nexus of normalization, deconstructing the power relation dominating that identity (Crosby, Notes 10/18/07). Enacted through reinterpretation, disidentification offers the potential to recapitulate personhood neither outside nor within the confines of societal rules (Munoz 1999, 31), but "offers a lens to elucidate a minoritarian politics

that is not monocausal or monothematic, but rather, one that is calibrated to discern a multiplicity of interlocking identity components and the ways in which they affect the social” (1999, 8). In other words, disidentification claims the borderland. Gender disidentification, thus, has many forms, but this is not to say that those who disidentify with it are countering gender. Rather, where gender and meaning is concerned, there are lots of little truths: “The way you understand your hips, your chest, your hair. How you feel when your lover holds you, gets on top, makes you come. The rush when you dress up, dress down, put on silk or leather. These are immensely small and private experiences. They are among our most intimate experiences of ourselves in the world. And they are precisely what is lost when we propound and pursue singular and monolithic Truths about bodies, gender and desire” (Wilchins 2002, 39). As D. Travers Scott asks, “How can a rigid Gay Male identity cope with that really cute guy, who used to be a baby butch dyke, and is still involved in a primary relationship with a woman, but considers herself basically a gay man?” (as quoted by Kirkland 2004, 183). Sexual desire is the conduit that leads across all restraining boundaries and border crossing is the primary site of freedom, knowledge, power (Kirkland 2004, 183).

Because disidentification is a survival strategy that the minority subject utilizes in order to negotiate a phobic majoritarian public sphere that has the privilege of easy access to the fiction of identity, and that “continuously elides or punishes the existence of subjects who do not conform to the phantasm of normative citizenship” (Munoz 1999, 4-5), disidentification, coupled with a kernel of utopian possibility, opens up the promise of queer world-making (1999, 25) outside of the socially

encoded ideologies that function to regulate bodies in the name of capitalism. Disidentification with mainstream identities, indeed, requires culture-making, requires meaning-making, requires self-determination and resistance. Zines have become an embodiment of this ethic and, as such, a central strategy in grassroots feminist and trans activism today precisely because they help people construct a social world in which they may be free to be themselves. They are a multipurpose transformative device created by an anti-normative political underground that has constructed an alternative culture that counters the co-optation of identities and desires by capitalism and its institutions of social control. Chapter three delves into the nature of the do-it-yourself health care zine as a potentially powerful vehicle of disidentification-based social activism more deeply.

Defining the Parameters of Genderqueer Health Activism: From Organizing for Reproductive Health to Organizing for Self-Determination

Historically, there has been a recursive relationship between identity-based activism in support of reproductive health, the nature and focus of the movements that result, and the privileging of divisive identity-based narratives. Although progress toward reproductive health has been made via such models, the challenge and complexity of the inclusivity of fluid identities and its potential power remains unrealized. Activist Loretta Ross is convinced that “we’re going to have to learn to unite people through diversity. Of opinion, of race, of gender, or sexual identity; we’ve just got to cross over all of these artificial boundaries that we who are oppressed live in” (2008, 1). However, we have yet to develop the activist tools for using human difference as a springboard for creative change within our lives. We

speak not of human difference, but of human deviance, spending lots of time saying there are insurmountable barriers or pretending they don't exist at all (Lorde 1984, 115-116). But, just how do we go from the cognitive differentiation of bodies, a category of difference, to moral categories like deviance? The current perception of difference seems necessarily infused with a negative moral valence that assumes all things positive of the standard from which difference departs and attributes all things dark and deviant to its opposite. The binaries that result are perpetuated on a personal, interpersonal, and institutional level, sustaining the "productive" hegemonies, both ideological and real, of maleness, whiteness, wealth and heteronormativity. But as bell hooks argues, "it is crucial to construct habits of seeing and being that restore an oppositional value system affirming that one can live a life of dignity and integrity in the midst of poverty" (1994, 199) and difference. To deconstruct these binary judgments and interrogate these value systems is to go in reverse and erase the stigma of deviance from the property of difference. Refocusing reproductive and sexual health organizing on the politics of the body has the potential to broaden the activist political base and thus the power of the movement; however, exactly this strategy circumscribed the outcome of prior identity-based movements. Thus, the body must be conceptualized in a queer, fluid, and intersectional way. Because the body is a primary site of social control enacted through techniques of biopower, it is central in the understanding of the mechanisms of capitalism and patriarchy. Ultimately, the multiple interlocking systems of control enacted on the body are experienced by the majority; thus, "the need to think across multiple modes of struggle and power is relevant to everyone" (O'Brien, tracing this body 11). To

acknowledge that many people occupy these same social statuses that render them powerless in today's society is to acknowledge the possibility of a larger struggle centered on self-determination and wresting control over bodies and health from the powerful. This movement includes reproductive capacities in its most literal sense, but also includes self-determination in sex, families, lifestyles, dress and body modifications. Halberstam posits that, "Queer uses of time and space develop in opposition to the institutions of family, heterosexuality, and reproduction, and queer subcultures develop as alternatives to kinship-based notions of community...their futures can be imagined according to logics that lie outside of conventional forward-moving narratives of birth, marriage, reproduction, and death" (2008, 27). Thus, queering the movement for health and social justice shifts the movement away from gender essentialisms implicit in the narrowly defined "reproductive" sphere and away from other assumptions that reinforce the idea that difference is deviance or disease that are involved in creating identity-based healthcare. Refocusing the movement on bodily self-determination also means refocusing on grassroots organizing rather than national, monolithic representations. Involving communities in the production of medical and social knowledge about their bodies given their material circumstances could work to empower individuals and communities, wresting individual control of the body back from the white supremacist and heteronormative ideologies, institutions, and neo-liberal policies that infuse bodies with hierarchical meaning, thus producing inequality and fueling capitalism.

In *The Second Sex*, Simone de Beauvoir wrote that "the body is a situation," deeply related to individual subjectivity. Wilchins goes further to argue that the body

is a political situation, one that ties it into a web of rules and expectations regulating how to look, act, dress and desire that are deeply entrenched in ideologies that reinforce and are reinforced by white supremacy, capitalism, heterosexism and patriarchy (Wilchins 2002, 12). Western notions of bodily materiality have been constructed through a gendered, racialized and classed matrix. But the social infrastructure of bodies does not have to be represented by stagnant group identities. The experiences of queer and trans people demonstrate that the body and identity can be conceived of and theorized as materially and socially fluid. Fausto-Sterling suggests that, “As we grow and develop, we literally, not just ‘discursively’ (that is, through language and cultural practices), construct our bodies, incorporating experience into our very flesh.... We must erode the distinctions between the physical and the social body” (2000, 20). “Where’s the boundary of an individual human body? Is it skin? Clothes?... The body is a generator of symbolic exchange” (Stone as quoted by Stryker 2008, 127). Since the mind and body are inseparable, the body must be thought of in both its physical and social manifestations. The technologies of gender, the way we hold ourselves, dress, speak, touch, look, are influenced by our race, class and sexualities. Thus, uniting the physical and social body is important theoretically, politically and personally. In this way, the body is not limited by its physicality and the social need not be thought of as limited by the body. Many feminists organizing for reproductive health have defined reproductive freedom as the cornerstone for attaining rights for women. But their definition of “reproductive freedom,” although founded in notions of bodily rights, inherently link reproductive capacities to females, to women, and often to heterosexuality. This linear trajectory

of thought needs to be dismantled because it creates a monolithic and essentialized notion of womanhood at the same time that no one can really define “female” or “woman.” For example, in the case of infertility or menopause, not all females have the capacity to reproduce; in the case of (trans)women, not all women have the ability to reproduce; in the case of (trans)men and individuals who identify as genderqueer, no-gender etc., not all who possess the ability to reproduce identify as women. At the same time, this fluidity suggests that reproductive freedom is essential for attaining rights for all people, not just “women.” Maybe it is the descriptor “reproductive” in “reproductive health” that is holding the movement in a stagnant position as seeking “special rights.” Although maybe the term reproductive was appropriate in describing heterosexual cis-gender female oppression, it now seems to separate reproductive health from overall primary health care for women, separating necessary gynecological services from the basic healthcare needed for survival. The same may be true of LGBT health services, which often prioritize STI tests and cancer screenings but occasionally ignore the necessity of basic survival healthcare (Mananzala 2008).

So, how can such structuralist gender categorization be evaded? Feinberg answers: by “defining ourselves in ways that honor our self-expression, our very beings” that eventually help to change the “way people think about what’s ‘natural’ and ‘normal’” (1998, 72). Through representing your own life in your own words, through resignifying the meaning of gender, through disidentification, through the elimination of a fixed meaning of gender. And yet, self-determination isn’t just about making individual decisions; it’s about communities, classes and nations seizing

control of their own destinies from the grips of the domination of capital, state violence and colonization. This allows for legitimate world-making possibilities that is unique to each individual, and to each community.

In response to the medicalization of gender nonconforming bodies, Spade says, “A commitment to gender self-determination and respect for all expressions of gender” (2003, 23) would be a better basis for describing identity than the dehumanizing requirements of the ability to “pass” full-time or the amount of cross-dressing one did as a child. Many must lie and adhere to the transsexual narrative to cheat their way through the medical roadblocks like two surgery-authorizing letters from psychiatrists, “to get the opportunity to occupy their bodies in the way they want” (Spade 2003, 23). A bodily justice model should call for demedicalization of what are truly social statuses and an end to practices that coerce people into expressing gender identity through a narrowly defined binary. This includes the end of involuntary “corrective” surgeries for intersexed babies. We should be fighting for the freedom of people to determine their own gender identity and expression and not to be forced to declare such an identity involuntarily or pick between a narrow set of choices. No person should be required to show medical or psychiatric evidence to document that they are who and what they say they are as gendered/sexed beings, especially when non-trans people never have to. Self-identification should be the determining factor for a person’s membership in a gender category to the extent that knowledge of this category is necessary (2003, 29). Fighting for this is to fight for a world in which diverse gender expressions and identities exist and are freely expressed. Kate Bornstein asks, “Do we have the legal or moral right to decide and

assign our own genders? Or does that right belong to the state, the church, and the medical profession? If gender is classification, can we afford to throw away the very basic right to classify ourselves?” (1994, 23). Self-definition allows for the reconceptualization of legitimate gender expressions and identities, moving away from fixed gender categories as normative (Cromwell 1999, 10).

Spade urges people to stop studying and medicalizing trans experiences, and start studying the institutional obstacles and systemic oppression trans people face that is so underdescribed and underdiscussed. People should stop asking why people are trans, how do trans people feel about themselves, what are trans people like. Stop asking about their bodies, sexualities, and life histories. Stop creating policies that demand trans people disclose genital status when non-trans people are never asked to do so. Move the focus away from childhood behavior, surgeries, makeup, and binders. Rather, given the premise of gender diversity, ask what the obstacles are to trans people’s health, survival and equality? What does discrimination look like? How can it be prevented? Trans people, never having to “prove” they are who they claim to be, should be able to lay claim to basic civil rights, receive funding through Medicaid and have access to primary care and transition-related medical care because they are human, and on these grounds as well be treated equitably in every social institution including prisons, universities, law offices and homeless shelters (Spade et al. 2007).

In the end, reproductive freedom is really about bodily freedom and bodily freedom is really about physical and social self-determination. Refocusing feminist health activism on bodily self-determination as the road to health and rights rather than

“reproductive” health in fact has roots in black feminist thought. For Patricia Hill Collins, a key trope of black feminist thought is self-definition and self-evaluation because it is a challenge of the political knowledge-validation process co-opted by the state and its institutions of social control (1991, 37-38). In 1832, Maria W. Stewart, a Black woman from Connecticut with abolitionist and feminist impulses, delivered four public lectures in Boston at the Afric-American Female Intelligence Society. She spoke on a variety of issues like literacy, self-determination, abolition, economic empowerment (Guy-Sheftall 2003, 179). The fight for self-determination has been an underplayed trope in the struggle for social justice, lost in rhetoric of “reproduction,” but it has been there all along. DuBois’ dream of libratory self-determination was at the heart of his radical commitment to social justice for all (hooks 2000, 100). hooks argues that a “revolutionary struggle for black self-determination must become a real part of our lives if we want to counter conservative thinking and offer life-affirming practices to black folks daily wounded by white supremacist assaults” (1994, 213). In the week-long African American holiday, Kwanza, first celebrated in 1966, the first principle is Umoja, which means unity, the decision to strive for and maintain unity in self and community, the second principle is Kujichagulia—self-determination—the decision to define ourselves, name ourselves, and speak for ourselves, instead of being defined and spoken for by others, and the third principle is Ujima—collective work and responsibility—the decision to build and maintain ourselves and our communities together and to recognize and solve our problems together (Lorde 1984, 43). It is clear that a long history of struggle for self-determination grounded in countering racism already exists. This is because, as Audre Lorde observes, “For

Black women as well as Black men, it is axiomatic that if we do not define ourselves for ourselves, we will be defined by others—for their use and to our detriment” (1984, 45). Many feminist sex workers and porn makers have been pushing for a feminist politics rooted in honoring the self-determination of women making their own choices around sexuality, sexual expression and employment. While still recognizing the potentially coercive dynamic in any commercial relationship, these activists have shifted the attention of feminist politics towards defending and standing beside sex workers in struggles over workplace conditions, health care and safety rather than chiding them, turning sex work and porn from a site of domination to one of empowerment.

Radicalism and the Bottom-Up Strategy

The feminist and gay and lesbian movements for health have adopted a civil rights, identity politics model with “integration into the status quo, or mainstreaming as the guiding principle and most widely shared ideal of the movement, but this is a strategy that will not deliver genuine freedom or full equality because the goal of winning mainstream tolerance differs from the goal of winning liberation or changing social institutions in lasting, long-term ways” (Davidson 2008, 245). As bell hooks says in *From Margin to Center*, “just as our lives are not fixed or static but always changing, our theory must remain fluid, open, responsive to new information” (1984, xiii)

Dean Spade asks, “What kind of analysis do we need to make sure that we don’t replicate the mistakes of the gay and lesbian rights [and generally identity-based rights] movements? In order to create a praxis by which trans activism operates, the

needs of those suffering from multiple points of oppression need to be addressed” (2008, 49). A queer intersectional framework applied to health activism would focus on thinking about the numerous ways institutions are systematically structured to perpetuate the gender binary, white supremacy, and the criminalization of poverty. Since transpeople face “unaddressed and mostly legal discrimination in education, employment, health care and public benefits, trans activism must be rooted in simultaneously fighting racism and poverty” (Spade 2008, 49). Trans people have a particularly difficult time accessing the entitlements that exist to support poor people, as many housing facilities and bathrooms are gender segregated and welfare, workfare job sites, law services and Medicaid offices commonly turn down clients on the basis of gender identity (2008, 49). And, many identity-based nonprofits have separated the provision of direct, survival-based services from their health activism (Mananzala 2008, 56). Therefore, many survive through sex work and drug trade—two highly criminalized survival crimes (Arkles 2007). Incarceration is, of course, also gender segregated (Arkles 2008). Spade observes that, “Almost every institution designed to house, exploit the labor of, and control low-income people and people of color is gender-segregated” (2008, 50). Furthermore, because the fluidity of gender and identity is “inherently resistant to a rigid, bureaucratic way of viewing people, and so it follows that such a trans consciousness is opposed to the state, whose centralization necessitates rigid categories for the purpose of social control” (Ritchie 2008, 270). Thus, the trans reconceptualization of identity as fluid and as a process of construction, has illuminated how the movement must reorganize its priorities and connect with more radical politics to form a cohesive movement for health that may

include, but should not be limited to identifying genderqueer health needs (a trans health not so focused on surgery and hormones), ending essentialist gynecological care and sex education (O'Brien 2003—transsafesex), discrimination in employment (Spade 2008), Medicaid (Arkles 2007) and housing: a health movement that would recognize gendered prisons (Arkles 2008), shelters (Mottet 2003), bathrooms (Spade 2003), pronouns (Spade 2003) and welfare (Arkles 2007) programs as tools of reproductive oppression that have significant impacts on healthcare and social justice for gender non-conforming people, but not just for them, for everyone.

Because many mainstreamed national organizations working for social justice have been prioritizing issues that disproportionately affect people who are more privileged at the expense of working with the people with the greatest need, activists in the New York City-based organization FIERCE!, founded in 2000 and self-described as a community organizing project for trans, lesbian, gay, bisexual, two-spirit, queer and questioning youth of color, argue that activists must adopt a “bottom-up” approach to organizing, prioritizing issues important to people who have the greatest number of disadvantages as a result of experiencing multiple, overlapping oppressions (Davidson 2008, 253). Fueled by direct experiences of racial, economic, sexual, gender and age oppression, FIERCE! works to build bridges between these movements, tackling issues like preserving safe spaces, police brutality, the homophobia and transphobia of juvenile detention centers, and the criminalization of homeless youth (35% of which are trans and/or queer in NYC because they are kicked out, abused, and/or run away from their homes) (Davidson 2008, 247).

Committing to ally work and finding meaningful solidarities in an effort to position queer and trans activism within a larger social context is to acknowledge that many people occupy the same social statuses that render them powerless in today's society (Davidson 2008, 257). It is to acknowledge the possibility of a larger coalition of struggles centered on the notion of self-determination as at the core of health. Since "people in other social justice movements that are currently not aware of queer and trans issues are willing to become aware of them," it may be more fruitful to convince allies to join causes than it is to convince Republicans to vote gay (Davidson 2008, 257). The implications of such an organizing praxis include the reconstruction of national organizations for health to support grassroots, local organizing. This would recognize that "the base of any political movement is where people live, work, congregate and make family," and would help actualize a multi-issue grassroots activism that is needs-based and community responsive, by and for the people most affected (Davidson 2008, 259). Spade says, "I want us to reach out to find new coalitions, merge our analysis in new ways with people who are already prioritizing the rights of low-income people, people of color, people with disabilities, HIV-positive people, old people, and youth. There are more of us suffering under capitalism and imperialism than benefiting" (2008, 53). Fighting with other groups that are not necessarily organizing around identity, but rather, against state violence is also an attractive option; such a coalition would work against police brutality and gentrification, find alternatives to incarceration, work to establish trans and queer sensitive shelters and drop-in centers, work to end discrimination and overcome the barriers that low-income people and people of color face in accessing healthcare,

housing, employment, and public benefits. Davidson says, “If we help the people on the bottom first, this guarantees to help the people at the top,” but the other way around, as has been shown, does not” (2008, 254).

Over the past decade, there has been a surge in radical grassroots queer and trans activisms that situate themselves in a history of radical queer resistance to heterosexism while linking their oppression as sexual and gender deviants to feminism, anarchism, anti-capitalism, anti-racism and dismantling neo-liberalism. Because trans consciousness requires a collective transgression of normative politics, even the rebellion is in constant flux due to its decentralization (Ritchie 2008, 274). Ideas and tactics are swapped across oceans, over the internet and through zine networks. Bash Back, Gay Shame, Queer Fist, Tranzmission, the Gender Mutany Collective, and the Pollinators, all formed to resist the rigidity and hierarchy of leftist resistance movements, emphasizing decentralism and collective structures and recognizing that the revolutionary potential of many identities lies in their resistance to fixed definition (Ritchie 2008, 262-263). Many activists involved in these organizations easily go from their meetings to prison books programs, food not bombs chapters, infoshops that distribute cheap and beautiful zines, art/music shows and grassroots environmental groups like Earth First! Tranzmission’s stated goal is to end the socially enforced, non-consensual gender tyranny perpetuated by heteronormative and homonormative institutions alike (Ritchie 2008, 268), but from Asheville, to Philly, to Oakland, to Burlington, this growing queer culture, built on the consciousness of gender and identity fluidity, and a commitment to grassroots organizing, has united many forms of social justice activism. All of these

organizations need to be working together on this local level to expand HIV/AIDS social services, counter police brutality, teach self-defense, organize tenant unions and workplaces, expropriate and renovate abandoned buildings for the homeless, set up free food programs, and create health collectives and DIY clinics that are truly trans and queer inclusive. Ritchie says, “Imagine the potential intersection of DIY queer health clinics and the self-determination of poor people” (2008, 276). A new visioning is in order and is slowly reaching its roots into the dirt.

However, even these radical groups have their faults. The Queer Fist mission statement states, “We are a group of radical queer and trans identifying people who oppose the gay mainstream’s agenda of assimilation. The inclusion of gays in institutions such as marriage, the military, or a (mis)representative democracy will only further legitimize these systems of domination. The politics of fitting in serves those in positions of power and excludes people including but not limited to people of color, trans folks, immigrants, women, the working class, the poor, and sex workers” (Ritchie 2008, 264). Although it is true that fitting into organizations as a strategic goal may not be the fight of most significance to queer and trans people, it is important not to dictate the actions, desires and identities of individuals. To do so is to be so radically queer and trans in activism that one reinvents a “we-them” dichotomy and interferes with the search for full self-determination. Who is Queer Fist to say who should and should not want to get married? Who is Queer Fist to say that yes you can be queer, but this means you can’t fulfill your life-long dream of being in the army? This is just another version of identity-based politics. It fuels reactionary responses and instills fear in people that the concept of trans inclusion

means they'll lose those trusty lesbian and gay borders, or they will no longer be able to identify as a woman without being criticized. But if we stay true to self-determination, rather than rigid anarchist politics, it becomes clear that resisting categorical identities is an organizational tool, and does not strip people of the right to define themselves. No one's fluidity of identity threatens the right to self-identity and self-expression. On the contrary, the trans struggle bolsters the right to self-identity and opens up more avenues for self-definition. Feinberg explains, "My right to be me is tied with a thousand threads to your right to be you" (1998, 101). In the end, organizing cohesively is all about self-determination.

The trans community has always had its own factions and fissures: between suburban white heterosexual cross dressers and inner-city African American trans sex workers, between young white punk transmen and femme queen vogue dancers, between successful professionals and trans people in prisons, in inpatient facilities or on the streets. It has grappled (and failed to grapple) with racism and classism within the group (O'Brien 2003—Race War). Although the concept of gender fluidity has the potential to unite, the same practices of identity politics have arisen even among gender variant people. Genderqueers, some argue, are a radical vanguard challenging the most basic oppressive systems of gender. Transsexuals, meanwhile, have occasionally been dismissed as politically reactionary, conforming and reproducing the oppressive system of gender dualism (O'Brien 2003, 6 trans liberation; Raymond 1979). Furthermore, dismissing genderqueers as shallow opportunists, uncommitted, confused people appropriating transsexual identity, transsexuals charge genderqueers as not being authentic. Genderqueers, some transsexuals have argued, are a

privileged collection of people superficially fooling around with issues, words and identities with deep, life-threatening and liberating implications for transsexuals. But the knowledge based in identity that “the personal is political” that is often a bridge to political activism, sometimes involves a misstep when it leads to seeing one’s own identity or system of linking identities as more radical, more liberating, more legitimate, more authentic or more substantive than another. Both genderqueer activists, privileging gender transgression, and transsexuals, privileging binary gender identities, have engaged in this destructive form of identity politics. But, it is important to move beyond destructive identity-based claims making and attributions of ideological purity and say let it be, allow for self-determination. As Gandhi insightfully noted, no one is free when others are oppressed.

This new generation of combinatorial feminist, queer and trans radical grassroots activisms are challenging the categories of societal knowledge and in doing so the very structure that allow us to see a particular, reified social form as a society. They also recognize the significance of each movement to one another. In 2003, the annual Trans Health Conference held in Philadelphia was themed “Our Bodies, Our Selves Too” in homage to a feminism that, although has a history of exclusion of trans bodies, also laid the groundwork for powerful movements for radical healthcare reform and self-determination over bodies (O’Brien 2003). To them, it’s not about the right to be gay or lesbian, bi, trans, or even straight, but rather, the right to be who they are, whole and complete, and without omission, even if that means they don’t fit any preexisting categories and have to make up whole new names and pronouns for themselves on the spot. (Wilchins 2002). Justice can only be

won once these binaries are questioned and deconstructed. As Riki Ann Wilchins so eloquently put it, “We can stand on old ground, protecting 40 year old borders or we can throw open the gates and see what lies ahead in new thinking, new organizing, new narratives, new intersections between political, cultural, economic and gender/sex struggles. More than ever we have the tools for a deeper critique of gender both as a means of social control and as a promise of greater global freedom of gender and sexual expression” (2002, 9). This, I think, is the future of feminism.

Seeing trans as more than one category and a fluid category at that allows for acknowledging multiple possibility, infinite terms that express trans identities in individualized ways (Cromwell 1999, 26): transgender, transsexual, transsexual, FTM, F2M, MTF, M2F, trans, tranz, tranman, transwoman, tranny man, tranny woman, boy, fag, girl, lesbian man, dyke daddy, drag king, drag queer, new woman, new man, boi, tranzboi, tranny girl, baby butch, soft butch, butch dyke, stone butch, tryke, boy chick, boy dyke, genderqueer, transqueer, queer, cross-dresser, androgynous, transhuman, transfolk, transfolx, transpeople, man, woman, gender outlaw, genderfuck, transfaghag, genderbender, genderblender, no gender, gender-variant, omni-gender, pangender and finally some people believe their gender can only be described by their self-chosen own name. Many of these terms vary in meaning depending on who’s self-identified in relation to that particular concept, in other words in relation to their performativity. In life on the fringe, it’s not always possible to make clear distinctions and that’s the point. Rather than allowing society to dictate who and what they are, trans people define themselves (Cromwell 1999, 43). Perhaps, this is the true path to finding oneself outside the social regulations of

the state. Acknowledging the fluidity of identity, affirming the lives of those with borderland bodies, ultimately calls on us to be committed to abolishing the structures of social regulation, state violence, class exploitation and imperial white-supremacy that lie at the heart of America's capitalism.

Susan Stryker at the 2007 Fourth Annual Trans March in San Francisco remarked on what she saw: "I found the crowd a bewitching spectacle: brilliantly tattooed, biologically female queer femme women and the trans guys who used to be their dyke girlfriends; straight-looking male-to-female transsexuals with nail salon manicures sitting side by side with countercultural transsexual women sporting face jewelry, dreadlocks, and thrift-store chic; lithe young people of indeterminate gender; black bulldaggers, white fairies, Asian queens, Native two-spirits; effeminate trannyfags and butch transsexual lesbians; kids of parents who had changed sex and parents who supported their kids' rejection of the labels their society had handed them. Some people walked around in fetish gear, some in chain-store khakis or floral-print sundresses from the discount clothing outlet; most wore the casually androgynous style of clothing that is the cultural norm. *Vive la difference*, I thought as I stepped up to the mike and surveyed the beautiful range of human diversity spread out on the grass before me. *Live and let live*" (2008, 29).

Chapter 3

Transgress, Transcend, Transmit, Transform (Culture): Zines and the DIY ethic

Grassroots resistance and reclaiming the power of knowledge production about bodies isn't new. From English and Ehrenreich's pathbreaking analysis of the role of witches and midwives in empowering women to take control of their bodies to the Jane Collective and *Our Bodies Our Selves* to ACT UP, the idea of self-definition, of self-determination and of producing one's own culture was key to spreading the message of early radical feminists and queer activists (Schilt & Zobl 2008, 173). Radical feminists of the 60's and 70's published many small pamphlets and magazines about their political ideas and DIY "women's" health, creating alternative spaces outside of dominant culture in which to create self-knowledge. However, contemporary radical queers and feminists are itching for alternative spaces outside dominant feminism and LGBT activism, movements somewhat co-opted by neo-liberal assimilationist models of equality.

Over the past decade, or so, these radical queer and feminist activists have taken up strategies used by their predecessors, but have tried to avoid their mistakes by using queer intersectionality as their theoretical tool and linking it to bottom-up strategies as their organizing tools, to create a subculture all their own. I would like to conclude by discussing one particular manifestation of this new organizing tactic, the world of zines.

The History of Independent Publishing and Zines

Zines are non-commercial, non-professional, small-circulation magazines that their creators, “zinesters,” produce, publish and distribute themselves (Spencer 2008, 17). One could argue that zines have existed since people began to write, copy and self-publish, tracing back as far as 1517 when Martin Luther published the “Ninety-five Theses” and Johannes Gutenberg had just invented the printing press (grrrlzines.net/overview). Self-publication spread as a political medium, frequently used to express resistance to the mainstream culture, political figures or politics of the time. Zines are, therefore, joined with independent magazines and newspapers, in that they were all created with the ambition to simply put words into print, words that might not have been in print if it were up to more mainstream outlets. While shaped by the long history of underground presses in the U.S., zines as a distinct medium were born in the 1930s. Fans of science fiction produced “fanzines,” short for fan magazine, like *The Comet*, as a way of sharing science fiction stories, critical commentary and communicating with one another (Duncombe 2008, 10-11). The dada art zine, the chapbook by beat writers in the 50’s, and music zines created by punks of the 70’s ignored by and critical of the mainstream music press, all started as fanzines about their own cultural scene (2008, 10-11). Because the most recent version of zines have their roots in punk culture, many zinesters defined themselves in opposition to a society predicated on consumption; they privileged “the ethic of DIY, do-it-yourself: make your own culture and stop consuming that which is made for you” (2008, 7). The very idea of profiting from a zine would be an abomination to

the adherents of the zine subculture (2008, 16). With a critique of property and privatization in mind, many “copyleft” their zines, stealing copyrighted material and offering information free to reprint and distribute as any individual sees fit. Zines are, then, as an anti-capitalist form of self-expression, began to boom some time after Xerox machines and before the internet. People realized they could create their own rudimentary publications on copy paper, fasten the pages with staples and distribute them along the thoroughfares that coursed across the country, with barely any money and without any permission, censorship, or guidance whatsoever (Bleyer 2004, 44). Refusing to live in the mainstream and resisting conformity, zinesters do not produce zines to fill some market niche, but to speak about something, to create a community and a culture that doesn’t valorize conformity and profit, but is assembled in the margins, respecting values like personal connection, authenticity, progressive politics and creativity (Duncombe 2008, 7). Thus, zinesters often write about their personal takes on the world while addressing political and social issues implicated in their lives.

The mainstream media and systems of social control do not sustain their legitimacy by convincing people that the current system is the answer; rather, “what they must do and what they have done very effectively, is convince the mass of people that there is no alternative...Zines and underground culture offer that alternative, a way of understand and acting in the world that operates with different rules and upon different values than those of consumer capitalism.” (Duncombe 2008, 10). Thus, zines are often a deliberate attack on, and alternative to, consumer-based capitalism and mainstream culture, while what distinguishes zinesters from everyday

pamphlet makers is this political self-consciousness and desire to empower themselves and their communities. Today, there are queer zines, punk zines, feminist zines, poetry zines, art zines, film zines, gardening zines, bicycle repair zines, sex worker zines, anarchist zines, socialist zines, radical environmental zines, health-focused zines, self-defense zines, trans zines, smut zines, comics, vegan zines, freegan zines, zines about privilege, race and whiteness, and countless how-to zines, offering visibility to a varied world of marginalized underground voices and lifestyles, a culture of resistance, shouting out through the “cracks of capitalism and in the shadows of mass media” (Duncombe 2008, 8). Zinesters are deviant and marginalized, and their zines operate on the margins of society as well. As a result, the concerns addressed are often those of the marginalized: how to count as an individual, how to build a supportive community, how to have a meaningful life, and how to create something that is uniquely yours.

Since almost anyone can make a zine, most zines are ephemeral, many not surviving past the first few issues or changing title with relative frequency. Bleyer says, “sophomoric writing, lunatic ravings and bizarre obsessions are more common than not, yet there was something beautifully democratic about letting readers sift through it all on their own...[and] helped pave the way for a culture that would allow anyone with anything to say, to say it. Free speech on demand without apology” (2004).

Furthermore, because zines are self-published, they bestow an unlimited power of self-definition, literally personalizing politics (Duncombe 2008, 33). This is what makes zines a powerful form of resistance, allowing borderland voices to speak

for themselves and reach an international population of people who are politically engaged and want to hear what you have to say. Zines are the perfect outlet for expressing discontent and new beliefs. Never has there been a more fabulous way of engaging in democracy. Because zines gives a voice to the everyday anonymous person (Spencer 2004, 18), everyday oddballs, freaks and geeks can reject the status quo, speaking plainly “about themselves and society with an honest sincerity, a revealing intimacy, and a healthy ‘fuck you’ to sanctioned authority—for no money and no recognition, writing for an audience of like-minded misfits,” formulating “a radically democratic and participatory ideal of what culture and society might be...ought to be” (2008, 7). Zines also represent a powerful form of resistance because they can be used as a relatively quick, efficient and inexpensive means of distributing information and resources to others (Spencer 2004, 18).

In an era marked by mainstreaming, co-optation and the centralization of corporate media, zines are independent and localized, “coming out of cities, suburbs and small towns across the US, assembled on kitchen tables” (Duncombe 2008, 7). They connect people to a larger community of resistance absent in small-town U.S.A. Being young, fourteen or fifteen years old anywhere—rural, suburban, or urban, can be pretty dismal and isolating, getting zines in the mail was, for many, “roughly akin to receiving alien transmission from outer space confirming that they were not alone in the universe (Bleyer 2004, 47).

Queer Zines

The first queer “homocore” zine, *Faggots and Faggotry*, was introduced in the 1970’s by Ralph Hall, an influential gay activist in post-Stonewall New York. He reflected on love, sexuality and politics through homoerotic line drawings, poetry and political commentary (Spencer 2008, 42). Feeling excluded from both the mainstream consumerist gay community and the predominantly straight, macho and sexist punk community, the queer zine arose in the late eighties from *Queercore* and *JDs*, influential zines that sought to bring back the nonconformist roots of punk and queer culture that had been replaced by the sexual conservatism by the mid-eighties (Spencer 2008, 43).

Zines were an instigating factor in the formation of many movements and subcultures, from the Dadaists of the 1930’s, to the punks, to the queercore scene. The early queercore zines, “having opened the discourse on sexuality, gender and identity, have now been joined by thousands of queer, transgender, and genderqueer voices” (Spencer 2008, 48).

Feminist Zines

The significance of independent feminist media to feminist movements has been indispensable. Sci-fi fanzines, the independent anti-war press of the 60’s, and alternative punk music zines were primarily male produced, but feminists, interested in the potential power of independent media began to produce their own zines focused on feminist issues (Spencer 2008, 49). In the 1970’s, *It Ain’t Me Babe*, *Off Our Backs*, and *Ms. Magazine* all became well-known feminist zines. In the 1980’s and 1990’s, Riot Grrrl zines joined queer zines, emerging in response to the growing

sexism, sexual conservatism, and hypermasculinity of the punk/hardcore music culture (Bleyer 2004, 46). The number of zines produced increased exponentially, forming what is now referred to as the “cut-and-paste revolution” (Bleyer 2004). Thousands of young women began to produce zines with explicitly feminist themes. Original Riot Grrrl and zinester Jennifer Bleyer says, “From the late eighties to the mid-nineties, thousands of zines sprouted up like resilient weeds inside the cracks of the mainstream media’s concrete” (2004, 44), and although some zines maintained their “fandom,” of certain elements of pop or underground culture, many contemporary Riot Grrrl zines were derived from and inspired by anarcha-feminist pamphlets on DIY women’s healthcare and alternative newspapers of the 1960’s and 70’s like *Mother Jones* and *the Nation* (Gunderloy 1992), publishing explicitly political and feminist material. Furthermore, the development and exchange of contemporary feminist thought and action in the U.S. owes a lot to outlets like zine pioneer *Bitch magazine*, self-published zines, and an ever-expanding (and marvelously diverse) feminist blogosphere (Gatto et al. 2008). All the guerilla news reporting of today started with individuals sharing a similar DIY ethos: the urge to create a new cultural form and transmit it to others on their own terms (Spencer 2008, 14).

The Riot Grrrl Movement was born in Olympia, Washington in the early nineties and is often characterized as the advent of Third Wave Feminism. Zines were used an important tool with which to explain ideas, print manifestos, and call for other to join their growing culture. The term “riot grrl” was first used in zines by musicians and activists Kathleen Hanna from the band, Bikini Kill (and later Le

Tigre), and Alison Wolfe from Bratmobile (Spencer 2008, 49). Kathleen Hanna says, “Coming of age as an artist during the media heyday of ACT UP, Queer Nation, the Guerrilla Girls, and WAC (Women’s Action Coalition), allowed me to romanticize the confrontational, theatrical tactics I associated with such groups” (2003, 133). As a feminist who attempted to incorporate her politics about white-skin privilege, class and gender intersections and sexuality, Kathleen Hanna was easily mislabeled as Queen Riot Grrrl (2003, 132-134). Yet, she argues that Riot Grrrl wasn’t the cohesive political movement the media claimed it to be; rather it was an underground, anti-sexist, anti-conformity music and art scene that used feminist politics to shape songs, benefit concerts, parties and consciousness-raising groups. Riot Grrrl was amorphous and nonhierarchical with no elected leaders or central organization; it was a social movement born out of a sheer desire for an alternative culture (Schilt & Zobl 2008, 172). Yet, Hanna’s riot grrrl manifesto of 1988 is clearly feminist and political, if not policy-changing. She emphasized the importance of zines to feminism, stating, “because us girls crave records and books and fanzines that speak to us that we feel included in and can understand in our own ways. Because we wanna make it easier for girls to see/hear each other’s work so that we can share strategies and criticize-applaud each other. Because we must take over the means of production in order to create our own meanings. Because viewing our work as being connected to our politics-real lives is essential if we are gonna figure out how what we are doing impacts, reflects, perpetuates, or disrupts the status quo” (Spencer 2008, 50). Zines were vital in spreading the new feminist ethos to new audiences. *Bust Magazine*, *Bitch*, *Venus Zine*, *Chickfactor* and *Rockgrrrl* emerged, which were so popular, they

developed into glossy independent magazines but retained their underground ethos. *Bitch* started small, starting with just 300 copies in 1996 and grew to 45,000 by 2003 (Spencer 2008, 53-54). Riot Grrrl zines addressed topics like self-defense, sexuality, feminist parenting, music, popculture, women's health, and lesbian, queer and transgender issues.

Girls who wrote zines did so because “it was activism, it was therapy, and it was fun,” a unique blend of art, protest, confession and therapy, deeply, if unknowingly, informed by the old feminist dictum that the “personal is political” (Bleyer 2004, 48-49). Making a zine can be like literally constructing your own identity, writing your thoughts down can be personally and politically empowering, and reading zines fostered a renewed feminist consciousness and community in thousands of youth across the globe. If you have something different to say than the mainstream, it's feminist just by virtue of believing that what you have to say is important (Bleyer 2004, 60). Feminist zinesters knew they had to create avenues for their own voices, their own culture, or else continue to be marginalized, their dissent lost in the silencing thunder of the mainstream. Today, zines are a backbone to radical feminist activism, allowing zine makers to link personal experiences to broader activist work.

Trans Zines

The production of trans-focused zines has been increasing exponentially over the past 20 years. Queer and trans zinesters have criticized the exclusion of their viewpoints from the feminist movement and see zines as a way to speak about their

lives and experiences. Yet, Riot Grrrl feminists became increasingly devoted to supporting trans and genderqueer-inclusivity based on the concept of a “self-identified” feminist. Many have participated in the protesting of the Michigan Womyn’s Festival’s “womyn-born womyn” policy, which was enacted to exclude men and in so doing excluded transwomen. In addition, numerous rock camps for girls were born across the US from this movement to empower feminist youth to give themselves voice through music, but also with an ideology that promoted the acceptance of gender non-conforming individuals as counselors and as campers. Today, the grrrl community can be described as an international and geographically diverse network of culturally productive feminist-identified women, queer and trans youth (and aged youth) of complex and plural identities and backgrounds who aim at making an impact on their own and others’ lives (Schilt & Zobl 2008, 179). Riot Grrrl gardeners, rebels and anarchists in this way, have all become active agents of social change in the genderific world (Schilt & Zobl 2008, 185).

Red Durkin of the Tranny Roadshow, a traveling group of gender non-conforming performers, artists, and writers, says, “Zines are an almost perfect outlet for us. Being trans is personal. There’s no instruction manuals. I think the failing of any broad sweeping analysis is that it could never encompass all of us. The only way for all of us to be heard is for each of us to have our own voice, and that’s what the zine world offers” (as quoted by Schenwar 2006, not paginated). Given the tendency of mainstream media and culture to mutilate representations to fit their own agendas of maintaining boundaries, hierarchy and profit, zines offer a good alternative for representing interstitial identities, movements and ideas. Rather than reproducing

situations in which trans, queer and women have to defend their right to existence, zines provide a format outside of greater society in a forum under their own control (Schilt & Zobl 2008, 186). Co-founder of the Tranny Roadshow and creator of *Transcendence*, a zine by and for trans youth, Jamez Terry also notes that, “Zines are the ultimate DIY media, which means you’re totally free to define yourself and no one can challenge your right to identify however you want within your own zine...No one else is going to edit you and get your pronouns wrong” (as quoted by Schenwar 2006). The freedom of complete self-identification that zines offer is especially important to those constantly misrepresented by “allies,” the mainstream media and institutions. Furthermore, they are important for the empowerment of the creator as well as their community and as an educational tool for their allies. Within “the safe space of their zines, trans youth are engaged in an amazing variety of political and cultural strategies, mostly centering on identity construction, construction of sexuality, and the culture of queer-identified people in the United States” (Regales 2008, 87-88). For marginalized people, “cultural power is rare and limited, and thus zines become a crucial tool in their identity construction” (Regales 2008, 90). In addition, in certain situations, zines are practically the only way of overcoming isolating circumstances and uniting trans people. For example, Amanda Armstrong, creator of *Transsexuals in Prison*, began the zine as an attempt to reach trans people who are overrepresented in prisons, and who rarely receive books about trans issues, so they know that they are not alone in the world. Furthermore, especially since sex and sexual health education have historically been limited by anti-sex, neo-liberal, white, heteronormative, phallogocentric views of sexuality, the free distribution of

literature made by and for queer and trans folk has proven to be an especially valuable way to spread helpful, empowering information about healthcare to trans people, who deal with numerous health issues ignored by the mainstream healthcare industry. Zines like *Hot Pantz* that deal with DIY abortion and homeopathic gynecological techniques, zines on trans health, and “zines that educate about free or cheap community healthcare providers are all quite common” (Ritchie 2008, 266). Clinics focusing on trans primary healthcare incorporate reproductive, sexual and primary care together, treating the physical and social body, and also participate in zine-making while publishing their own trans health protocols on their websites. Tom Waddell Health Clinic, Lyon-Martin Health Services and the Callen Lorde Community Health Center all have participated in making information on trans health as accessible as possible.

Characterized by fragmentation, mixture, parody and ambiguity, trans-zines, as zine scholar Professor Doug Blandy describes them, throw all the identities and definitions we thought we knew into question, especially definitions of gender, and of magazines. As an example of post-modernism in practice and as a route to changing society, zines allow people, through their artistry, to participate in the public dialogue of democracy, radically defining and redefining an themselves and underground culture by sparking dialogue and discussion directly and indirectly in its community of readers. Thus, zines build a community of ideas constantly subject to change and transformation by community. It is in this way that zines represent a form of grassroots activism; the ideas and needs of the underground culture it fuels are constantly formed and reformed in response to the fluidity of the ideas that are

floating about in its community. Unlike mainstream forms of media that produce streams of “facts” and information that fuel a monopoly on knowledge-production, zines foster a dynamic forum for discussion. Today, zine distributors, anarchist infoshops, indy record stores and bookstores and some libraries carry racks of zines. Especially, with the advent of the internet, zines have come to be available worldwide, fostering an international underground culture of resistance. And, although libraries and internet cafes provide internet service, it is still a privilege to have access to computer technology. Many folks don’t have web access, especially those less privileged like low-income trans people, especially those in prison. Still, Elke Zobl, creator of the Grrrl Zine Network, an internet database of feminist, queer and trans zines, says that putting uncensored, marginalized voices into the world makes a political statement, beyond the personal nature of the zine: it is a “means of empowerment that is important personally, but also has a significant social and political function” (Zobl as quoted by Schenwar 2006) since it is a vehicle by which marginalized voices can reach the world. Kelly Shortandqueer, founded the Denver Zine Library, which has over 70 trans-focused zines and Milo Miller co-founded the Milwaukee-based Queer Zine Archive Project (QZAP) that collects hundreds of queer and trans related zines.

Historically it has been white, middle-class youth culture and its discontents that have informed zines since having the time and freedom to make a zine is a privilege in and of itself (Spencer 2004, 22). Bleyer says, “Participating in zine culture requires that one have the leisure time to create zines, a life generally uncluttered with the rudiments of survival, access to copy machines and other

equipment, money for stamps and supplies, and enough self-esteem and encouragement to believe that one's thoughts are worth putting down...all marks of a certain level of privilege" (2004, 53). Thus, despite the fact that many zinester feminists were earnestly concerned with issues of race and class, they are a predominantly privileged constituency. Yet many of these zinesters have since embarked on "careers of deviance that have moved them to the edges of society, embracing downwardly mobile career aspirations, unpopular musical and literary tastes, transgressive ideas about gender and sexuality, unorthodox artistic sensibilities, and politics resolutely outside the status quo" (Duncombe 2008, 10). Thus, zines are "an alternative fraught with contradictions and limitations...but also possibilities" (2008, 10).

People whose bodies lie in the borderlands attempt to reconceptualize themselves as new kinds of citizens by shifting citizenship from consumption to meaningful production, by trying to articulate new meaning, words, lives, and culture-world that break traditional frameworks. The potential of the participatory cultural production of zines can be remarkably beneficial for feminist, queer and trans health activists because they allow for the formation of networks and communities around diverse identities and health interests and allow for the self-representation of intersectional and interstitial bodies and identities (Regales 2008, 90). Spade asks, "If you don't engage with the media maker and you aren't producing media, how do you expect to influence representation?" (2007). In this way, zines allow for the reclamation of media, bodies, borderlands, communities and health, permitting the

creation of new cultural forms, a practical strategy for implementing the world-making possibilities of disidentification and identity fluidity.

Epilogue

Before I came to Wesleyan University, my experience as a transgressor of many borders was fraught with tension and discomfort. Constantly trying to categorize myself in a world where I didn't really fit, the concepts and language of identity, gender and sexuality to which Wesleyan exposed me, soon made it clear that I had to stop trying to fit into the boxes society had carved out for me. In the Midwest, I was constantly asked to what church I belonged. Before, I answered this question by going through a long family history of: well, my dad used to be Jewish and my mom used to be Catholic, but they're both atheists and their religion is kind of sociology and I don't really know what I am... Now, I can be comfortable saying I don't have a religion, or I that find religion in lovers and friends. Before, when asked to clarify my ambiguous tomboy appearance, I would decidedly answer, "Girl!" given the fact that I was a daughter and sister and sometimes my girl friends gave me make-overs and put me in dresses. Now that I comfortably identify with neither, both, or one or the other depending on how I feel that day, I can say "neither!" or "no!" or "yes!" contingent on how I feel that day or who I'm talking to. My queerness has also settled in the borderlands as well. Before, when accused of being "a lesbian" because I was too close with my best friend, I would vehemently deny homosexuality and stomp home. After all I was a lover of boys! (even though girls occasionally infiltrated my dreams). But now, I have the confidence to say, I don't discriminate lovers based on biology, they are not qualifiers for who I desire anymore. In fact, the

difference between sexes has lost the meaning it used to have. All I know is that I'm an anti-straight man sexual. Does that exist? Even when I do love boys, I'm not heterosexual, usually because the boy I'm with is also transgressing. And sometimes when I love girls, we're both faggots. No matter what I'm always queer, and to tell the truth, for me, love is only about who I connect with best. I don't force myself into absolutes anymore, and you know what, it feels great. It feels perfect. Living in the borderlands feels like home. I had been transgressing borders all my life, but I needed to cross from Midwest to East Coast to find the words and affirmation to be comfortable with that.

After four years of being a double major in Feminist, Gender and Sexuality Studies and Biology, and a pre-med student, I felt a strong pull to integrate my fields of study, characterized in such opposition, but between which I drew connections almost every day. In "Deviant Bodies, Healthy Lives," a DIY healthcare zine by and for those with nonconforming bodies, my objective was to create a zine on sexual and reproductive health that wasn't steeped in heterosexist and/or homonormative assumptions about identities, bodies, sexual practices, gender, race, and class. I wanted to resist the sex/gender script that all men have penises and all women have vaginas and reproductive capacities and that the only way to have sex is through penis-vagina intercourse. I tried to think of all the bodily techniques one may use to express gender and sexuality through their socio-physical bodies and researched health care strategies on those topics that could be done without professional help while demystifying the biology to those who may not have a strong biology background but who want to learn more about themselves as embodied deviants. I

also wanted to engage with healthy DIY alternatives to body modification and gender expression that sidesteps consumerism and the institutional attempts at the regulation of the public through their bodies.

In this thesis, I rely on a fierce critique of a capitalist-based medical establishment and mainstream identity-based movements, based on the fact that they both, together, produce naturalized and essential binary bodies, separated into the productive and the reproductive, and the economically exploitable, their bodies and identities rendered impenetrable to change. This zine critiques such regulation of bodies and lives in the name of capitalism, recognizing that without the disciplinary power of social control, identities and bodies are fluid. I tried to use queer intersectionality and the bottom-up approach to inform the issues I, and others, considered relevant to the healthcare of nonconforming bodies. However, it is clear that in order to truly take a bottom-up approach, gender//queer people must take control of as broad a swath of body politics, social justice and health issues as possible to empower themselves in healthcare. The zine is a step in this direction, but the construction of a healthcare for nonconforming bodies is an ongoing process, and, so, I'm sure this zine will have many incarnations, constantly in flux. Much like me.

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