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Care in Transit: The Political and Clinical Emergence of Trans Health

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Care in Transit: The Political and Clinical Emergence of Trans Health

by

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ABSTRACT

Care in Transit: The Political and Clinical Emergence of Trans Health

Christoph Hanssmann

Care in Transit examines the transnational emergence of transgender health care as an institutionalizing field and public entitlement. Clinical care for trans people has been classically framed as a pitched struggle between providers and patients, but coordination and negotiation increasingly characterize this relation. *Care in Transit* thus turns to examine sites of local and transnational collaboration (in addition to conflict), specifically in trans health's public provision and regulation. Looking ethnographically to activists and health care providers in Buenos Aires and New York City, the project seeks to explain how these groups work together to assemble, intervene on, and refigure the infrastructures through which trans health care takes shape. While such cooperation may seem to signal an increased standardization and stabilization, I propose that it instead signals the protraction of a period of ambiguity within which a multitude of care practices and political claims can proliferate. I call this set of dynamics and practices "transmutable care," and explore it analytically through classification, racialized citizenship, statistical politics, and feminist politics of care.

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PROLOGUE

The past decade was rife with extraordinary transformations in the set of practices known as "transgender health" or "trans health," a burgeoning field in health care. Trans health thus encompasses patients and providers, but also incorporates scholars, activists, advocates, policymakers, and many others.[1] It both springs from and pushes against the classificatory, diagnostic, and legal conditions of its emergence, with "revision" materializing as synecdoche for the state of the field. For those of us invested in formations of trans health since the early 2000s or before, the rapid shifts in this emergent field appear as a deluge after a drought: sudden, surprising, welcome, troubling, restorative, and destructive. The new arrangements, organizations, and practices that have sprung forth are still proliferating. But while novelty and growth tend to adhere to notions of evolution and advancement, they may also accompany more sinister processes, such as metastasis, decomposition, suppression.

This dissertation aims to describe the emergence of trans health in a transnational sense. What practices and actors comprise it? Where is it articulated and in what forms? Does it travel, and if so, how? What has it ushered in or enabled? What has it supplanted, amended, or effaced? Alongside the broader set of changes that *Time Magazine* (Steinmetz 2014) recently named the "transgender tipping point," how has trans health become a vital site through which trans life, value, and politics are fashioned and circulated?

This project looks to New York and Buenos Aires—two cities in which trans health "leaders" or proponents (activists, advocates, and providers among them) presently work to (re)fashion trans health locally and transnationally. I ask how providers and activists are working together to "fix" problems with recent historical iterations of trans health and to develop "dignified," "respectful," "just," and "effective" forms of care.

In the shift from what Ben Singer (2006) characterized as "pathologizing models" to "trans-health" models of care, providers and activists have slowly moved from positions of antagonism to negotiation, and occasional cooperation. Given this, it might seem as if trans health practices could begin to settle and stabilize. Why, then, can trans health can convincingly be defined and described in such a plethora of ways, perhaps even more than ever? And if, as I argue, trans health is increasingly looking outward to the *environments* within which trans people dwell, rather than only looking inward to subjective gendered experiences or diagnostic classifications, what kinds of trans health practices accompany this shift in orientation? How do these new forms of trans health care reclassify, revise, repurpose, and reimagine the field, and with what effects?

Present forms of trans health seem to comprise a more mobile, mercurial, and expansive field than prior instantiations. Designated clinic nights and health fairs bear its name (Antón 2011; Department of Public Health n.d.). International summits and conferences convene practitioners, policymakers, advocates, and trans people—usually organized as "experts" and "community members"—to engage topics ranging from surgical techniques to police violence (Center of Excellence for Transgender Health n.d.; World Professional Association for Transgender Health [WPATH] n.d.). International human rights-based organizations are increasingly concerned with health—writ broadly—in these communities, both in terms of access to medical care and freedom from violence (Open Society Foundations 2013; United Nations Development Programme 2013).

Yet despite its increasingly ubiquity, it remains unclear just what "trans health" describes in practice. Some think of it as a set of etiological or diagnostic assessments, or procedures that partially facilitate certain forms of gendered embodiment or enactment and care practices. These varied processes go by many names: gender or sex reassignment surgeries or procedures, gender confirming or gender affirming care, or (usually derisively) "sex change."[2] Others see trans health as the general practice of caring for patients and clients who are varyingly interpellated as "trans" (or trans*, gender nonconforming, gender variant, or any number of other shifting descriptors). They therefore conceptualize trans health as a set of capacities and practices that meet the varied health needs of trans patients as they interact with all facets of health care.

Some consider trans health to include all factors contributing to conditions of health and survival for gender non-normative people, and understand it as a political objective or imperative, a matter of justice, or a "human right." Dominant conceptions of trans health generally center on the practices that, through high- and low-tech biomedical or perimedical practices, enable certain shifts in gendered corporeality.[3,4] (See Figure 1 for a graphic representation of these different domains of trans health). Yet as I will demonstrate, broader notions of trans health are gradually widening the lens of what politics and practices people understand to comprise the field.

The many practices of trans health interpenetrate significantly. Sonya (Interview, August 7, 2013), a New York nurse practitioner regarded as an expert in trans health, described the many kinds of interactions she might have during a visit at the clinic at which she worked. Some of these included prescribing or managing hormones, and trying to convince people not to take too many or too much at once. They also involved doing Pap smears and prostate exams, checking breasts for lumps, talking to patients about their illnesses, prescribing medicines, doing STI checks, trying to convince people not to inject silicone even when surgeries are inaccessible,[5] and negotiating with patients to find "trans diagnoses" that they could live with—or figuring out ways around them. Sonya also described what she saw as her political obligation to "write whatever paperwork people need…and be…flexible about it." (Sonya Interview August 7, 2013). She described her political work—she is a non-trans[6] and self-described queer woman of color who has long been involved in leftist activist work—as giving her an "affinity" for many of her patients. She recognized the gauntlet of problems that her patients, who were mostly low-income and often undocumented trans women of color in New York City, had to navigate within institutions, in health care settings and benefits systems, at home, in public, and in shelters, jails, prisons, or detention centers. As a provider in the field of trans health, she understood her role to include diagnostic, bureaucratic, legal, and political facilitation, bridging, and advocacy. She felt strongly that trans people did not have access to anywhere near the level of resources to which she thought they were entitled, and she felt it her professional and political duty to eliminate any barriers to care that she possibly could. She also described how she worked towards these goals in broader ways by collaborating with activists and advocates, particularly using her standing as a medical professional to influence the distribution of health resources and to increase trans people's access to health care. While Sonya was not necessarily characteristic of all the providers with whom I spoke, the multiple registers through which she described the practices that she bundled together as "trans health" illuminates the complexity of the borders and boundaries of trans health.

The "where" of trans health matters as much as the "what": it comprises the difference between Sonya's low-income community clinic in a relatively impoverished borough of the New York City and an upscale surgical suite in downtown Manhattan. It also differentiates the legal advocacy networks of New York State from groups involved in the provincial politics of Buenos Aires; and the fragmented, mainly private insurance systems of the U.S. from the more centralized and largely public systems of Argentina. It distinguishes the Lacanian Buenos Aires psychotherapist from the New York psychiatrist invested in brain-based notions of gender, and the Argentinian post-dictatorship left from the U.S. civil rights-oriented left. Questions of place and space, mobility and site-specificity, and universality and particularity are thus also central to examinations of trans health.

In this chapter, I frame the orienting questions of this dissertation, and describe the "formalized curiosity" (Hurston 1942:143) that motivated them. In so doing, I situate my research questions and central findings within ongoing discussions and debates across the sociology of health, illness, and disability; science, technology and medicine studies (STMS); and theories of race, gender, sexuality, and citizenship. This introduction concludes with a brief overview of the three substantive chapters that follow, and describes the overall trajectory of the dissertation.

Locating Trans Health

My own work in the field of trans health was as an activist and health educator. I conducted periodic trainings for health care providers and health professional students, drawing from a combination of formal and informal knowledge as a trans patient and as a credentialed health educator. Navigating the awkward spaces carved out by the discomfiting affinity for "cultural competency" in medical pedagogy in the late 1990s and early 2000s, I joined various upwardly mobile trans people who somewhat inadvertently and in patchwork fashion assembled the "Trans Competency Training."[7] Such trainings aimed to intervene in the quotidian indignities and harms experienced in navigating health care systems as gender non-normative people. As a loosely assembled and almost wholly uncoordinated group, we tried to right the wrongs of medical pathologization, abandonment, and phenomena such as "trans broken arm syndrome"[8] through a multitude of approaches.

However, the more I became involved in such trainings, the more skeptical I became about their effects. Racialized, gendered, and classed stratifications shaped the kinds of "professional" trans people likely to be hired as trainers. This then influenced what kinds of trans people—typically white and trans-masculine—were invested with (at least limited) authority and credibility by both providers and students. The structures of health professional education were highly resistant to the efforts of (some) trainers to frame transness more broadly, and to discuss the simultaneity of varying and interlaced forms of subjugation.

As such, trainings often missed the crucial point that Ehrenreich and Ehrenreich (1978) raised in the late 1970s: in medicine subjugation works in different ways on different people. Embodied, political, racialized, and material differences matter profoundly in precisely how subjugation plays out. But instead, trainings often collapsed these differences into a near-monolithic "trans population." This "population" was most often presumed to dwell within the U.S., and when trans and gender non-normative people outside of the U.S. were invoked, it was often through a wildly colonialist or culturalist lens.[9]

Moreover, the time-limited expectations of groups seeking trans trainings, combined with the identitarian parochialism of many trainers, precluded serious discussions about trans health from simultaneously discussing other groups of people or forms of health care closely linked to the needs or demands of trans people. Many people may encounter similar "barriers to care," in public health parlance, as do many trans people. For example, people with disabilities, people with intersex conditions, non-trans women, people who are pregnant, people seeking abortions or contraception, and poor people are each and all systematically excluded from adequate health care, or may be aggressively absorbed by it against their wishes. In fact, "trans patients" are represented among nearly all of these groups. Yet trainings could only gesture towards these imbrications, and rarely did even that.

These concerns then led me to wonder about other ways people were intervening in medical practices regarding trans health, and whether and how health care providers were shifting their practices. The more I considered this, the more I realized that despite being a mobile and oft-repeated term, "trans health" was scarcely a discernible field. Rather, it was a set of shifting practices that we as activists, advocates, providers, and many others were dynamically and emergently fashioning.

Instead of continuing to contribute to the relatively anemic strategies enabled by competency trainings, I decided to take a step back and consider just what we were engaged in producing. I became increasingly curious about where these projects were taking place, who was at work on them, and to what effects. I wondered what kinds of objectives and politics were debated and hashed out in the varied processes of developing these strategies, and how people decided to undertake specific strategies over others.

As guidelines for trans health care and diagnostic classifications became sites for broad debate at varying geographic levels, I wondered how these ideas, practices, and definitions were and were not traveling. Even as I ruminated, trans health kept changing: the term "depathologization" moved from protest signs to professional meetings about diagnostic revision, often with vigorous debate. Trans activists articulated wider ranging demands for everything from employment protections to decriminalization to free health care. Nations, states, provinces, and cities across the world developed and sometimes passed laws relaxing requirements for surgery prior to gender reclassification. Professional associations and medical experts increasingly threw their weight behind legitimating gender confirming care's increasing legitimation, while some experts still held fast to previous models and approaches.[10] Laws and regulations changed, some of them enabling broader forms of trans health care, and others restricting their use or development. But while trans health remained a charged site of contestation—about the meanings of gender, desire, autonomy, recognition, citizenship, state governance, sexuality, race, resource distribution, and the boundaries of medicine—the signs of a sea change also were increasingly evident.

This became especially apparent during the first few years of my research. I started interviewing providers in 2012. Within two years, the APA had published its new "depathologized" diagnosis of social distress-based gender dysphoria, the World Health Organization had initiated a process to eliminate "Gender Identity Disorder" and replace it with a non-psychiatric diagnosis of "Gender Incongruence," Argentina had passed the "depathologized" Gender Identity Law, and New York State had removed its blanket Medicaid exclusion. Key themes thus began to emerge that would seem to characterize the present landscape of trans health: revision, depathologization, incongruence, environment, and so on.

Transnational politics were also putting pressures on the ethnocentric hubris of U.S.-centered classifications, guidelines, and professional organizations. The World Professional Association of Transgender Health (WPATH), based largely in the U.S., encountered criticism for presuming to issue guidelines of care that traveled well and effectively. In response, they adapted their standards somewhat, but not before a collection of other regionally-based "PATHs" proliferated. In addition, Argentina's Gender Identity Law enabled sweeping changes in the nation: it ushered in free and streamlined legal gender reclassification without medical or judicial support, guaranteed coverage for gender confirming care across the health system, and eliminated diagnostic requirements for access to gender confirming care ("self-expressed desire" now suffices). Bloggers and reporters referred to these as groundbreaking changes, and a multitude of other regions and nations worked to replicate the law. But the story barely broke the surface in the U.S. news media. While these actions seemed to resonate with familiar global relations of power, I wondered how increasing pushes to "provincialize" the U.S.'s place in trans health were affecting the field's formation more broadly (Chakrabarty 2000).

These musings ultimately condensed into several distinct kinds of questions: What kinds of practices are central to emerging formations of trans health? What are the classifications, regulations, and policies that are central to trans health's formation and practice? How do these travel and take shape in different places and within different infrastructures? What can these reflections reveal about the shifting commitments of biomedical practices and technoscience, the shifting investments of states and nations, the changing relations between care providers and activists, and transformations in how health care intersects with politics of difference?

While Stone (1992) aptly described trans people and providers as opponents on a "battleground" of health care access and provision, by 2012, twenty years later, I saw a different set of struggles playing out in contemporary formations of trans health. "Trans-supportive" providers occasionally identified themselves as such, sometimes joining trans activists in street protests or inviting them to participate as "community experts" in classificatory revision processes. They innovated ways to get around regulatory exclusions and to connect patients with the "care they needed." Attorneys filed lawsuits on behalf of trans clients seeking access to care, becoming conversant in the lexicon of biomedicine as much as in the broad and specific demands of trans activists. For their part, self-identified trans activists moved between a multitude of spaces and fashioned various partnerships, tense and otherwise, with providers and professional advocates. This increasing degree of collaboration and negotiation was accompanied by a decreasing clarity of the boundaries demarcating these groups. Activists went to nursing school or law school and became providers or advocates, or routed their activism through existing professional affiliations. Health care providers became politicized in their interactions with trans patients and occasionally lost credibility among colleagues. The position of the "advocate"—the paid professional who works on behalf of an individual or group—further confused divisions between "providers," "activists," and other actors. Local, regional, and national politics also further blurred the divisions between these ostensibly different "social worlds" and "subworlds."[11] How did each of these itinerant groups work on, and work to assemble, trans health? In what domains and at what scales did they imagine their work to have an effect? What kinds of practices did they define as being within the bounds of trans health, and how were these differentiated from practices they might understand as beyond its domain?

I also sought to learn about how expertise, credibility, power relations, and authority inhere in the classificatory and regulatory work of trans health activism and provision. The assemblage of expertise and knowledge production that shapes trans health involves actors—both human and non-human—from heterogeneous geographic regions in the global North and South.[12] I thus followed these actors to track the rapid shifts in formal and informal classification systems on the one hand, and regulatory changes in the public provision of gender confirming care on the other. Noting a series of classificatory and regulatory "revisions," I began to read this term doubly, as Clarke and Olesen (1999) do in developing a diffractive optics in accounting for practices of women's health and healing. How did debates around classificatory changes shift when concerns about what certain classifications could *do* partially subsumed concerns about ontology or diagnostic accuracy? How did certain forms of gender non-normativity move from "psychopathology" to "healthy variation?" What accounted for these shifts in thinking about classification, diagnostics, and the formation of a "trans population?" With regard to regulations, especially those relevant to the public provision of health, what enabled the possibility of state investment in trans health (to the small degree that legal and regulatory shifts allow)? How are notions of membership, recognition, and citizenship "revisioned" in these processes, and in what ways do their accordant stratifications, exclusions, or absorptions take new shape? How do national and transnational politics play out in such projects, and with what effects?

Finally, I was interested in the mobility of trans health, and how it takes shape in distinctive ways across different sites of practice. I therefore grounded my study in two geographically disparate ethnographic sites, each of which comprises sites within which important claims to trans health vis-à-vis the public provision of care were in struggle. While this enabled a multitude of comparisons (between clinical and activist sites, across the global North and South, between privately and publicly-subsidized structures of care, etc.), it also enabled me to trace what elements of trans health practice traverse each of the boundaries, which remain less mobile, and which tend to shift and mutate more as they move. Such an approach also made possible an understanding of how trans health practices (in their many forms) were articulated across scales and with ranging objectives. Ostensibly "local" work was sometimes undertaken as a transnational strategy, while highly geographically situated work was also imagined to translate across a multitude of sites. I sought to learn about how the politics and geopolitics of mobility are articulated in part through trans health's contested field formation.

INTRODUCTION

In this section, I begin by broadly summarizing some of the key formations that preceded and led to trans health's present, especially transsexual medicine and HIV/AIDS treatment and prevention. I then outline some of the central theoretical discussions within which I situate my work, and how key concepts guide my inquiries. Next, I describe conceptual and empirical questions examined in each dissertation chapter and summarize the overarching arguments of the dissertation. In so doing, I describe what trans health—in an empirical, situated, and transnational sense—is, does, and aspires to be in the U.S. and Argentina.

Changes in the realm of trans health, while they have doubtless seemed plodding to those involved, appear to be unfolding with stunning velocity in the past few years. These changes accompany and produce new and different accounts of trans health. Its emergent field is populated by themes of "facilitating health" rather than "treating illness," and characterized by a contingent embrace of (often delimited) political commitments within biomedicine. This dissertation strives to account for and explain these shifts. These are not only tales of ascendance, justice, and triumph—but also tales of the retrenchment of racialized stratifications, investments in dubious forms of recognition, and the tamping down of wilder and broader activist demands. As the U.S. and a voraciously neoliberalizing Argentina[13] consider and reconsider their national health politics, health care is also more broadly being asked to consider what, beyond cellular, molecular, genetic, or organic processes, "makes us sick."[14] "Inequity" has been forcefully offered up as one answer, reverberating from laboratories to street protests (Loyd 2014; Nelson 2011; Williams and Mohammed 2009). Trans health brings to the surface otherwise submerged political debates about resource distribution, stratification, and injustice in health and biomedicine. The fact that "transness" itself does not bring with it a straightforward politics makes these debates all the messier and more revealing (Hsu 2013; Irving 2008; Najmabadi 2013).

This dissertation thus contributes not only to scholarly and political discussions about transness, health, and transnationality, but also to ongoing struggles over who may be included within the embrace of "health" and "health care." It offers empirically-grounded reflections about the persistence of stratification, the openings through which power relations might be partially reconfigured, and the relationships through which different arrangements might be imagined or articulated. I engage sensitizing concepts from theoretical discussions from various scholarly fields, as guides to follow certain lines of inquiry, or "directions along which to look." (Blumer 1954:7).

I draw on reflections from science, technology, and medicine studies (STMS) to analyze the negotiated power dynamics of classification and to foreground the questions of infrastructure throughout my analysis. Also mobilizing feminist STMS alongside the medical social sciences (sociology and anthropology), I center questions of care politics and the figure of care.[15] In addition, I engage early and contemporary insights from the medical social sciences in discussions about the formation of expertise, the figure of the "population," and various notions of structural or necropolitical violence. Finally, I draw on insights from critical studies of race, gender, sexuality, and citizenship; social movements; and trans, queer, and disability studies to foreground how politics of difference are inseparable from infrastructures, state governance, and other shifting structures of "population management"—and how various groups respond in more or less coordinated ways to these conditions.

THEORETICAL FRAMEWORKS

Trans Health and its Predecessors: Pathologization, Revision, and Regulation

Trans health, as Singer (2006) suggests, has superseded the "pathologizing" models of transsexual medicine (Meyerowitz 2002). It also far exceeds the domain of transsexual medicine. "Trans health" may refer to several interpenetrating domains that connote 1) gender confirming care practices; 2) basic or specialty care for trans or gender non-normative people more broadly (including but not limited to gender confirming care); and 3) a political orientation or imperative to meet or prioritize the health needs and survival of trans people (see Figure 1 below). Amidst the ambiguity of what trans health is or does, an intensity of action swirls around various classificatory terms, meanings, and regulatory implications of trans health.

Ascertaining who counts as "legitimately" trans—a designation with social, biomedical, and legal ramifications—is primarily accomplished through appeals to diagnostic criteria. As clinical diagnoses, medical notions of gender non-normativity have taken many forms and names: Transsexualism, Gender Identity Disorder, Gender Dysphoria, and Gender Incongruence, as well as other similar diagnoses that invoke the specificity of age, sexual orientation, and other forms of difference (American Psychiatric Association 1980, 2000, 2013; World Health Organization 1979, 1992, 2004). Most are still defined as psychiatric conditions, but activists and providers (among others) are working to establish non-psychiatric classifications. Shifting definitions range in scale from localized clinical policies to international classification systems and treatment protocols, often under revision. The effects of their revisions are manifest discursively and materially: in addition to ontological shifts, they bring about reprinted manuals, revised coding schemas, new human rights imperatives, and changes in gender reclassification laws. Finding a relatively stable and "universal" diagnostic classification—or at least one that can work "well enough"—seems to be a primary objective of the restless redefining.

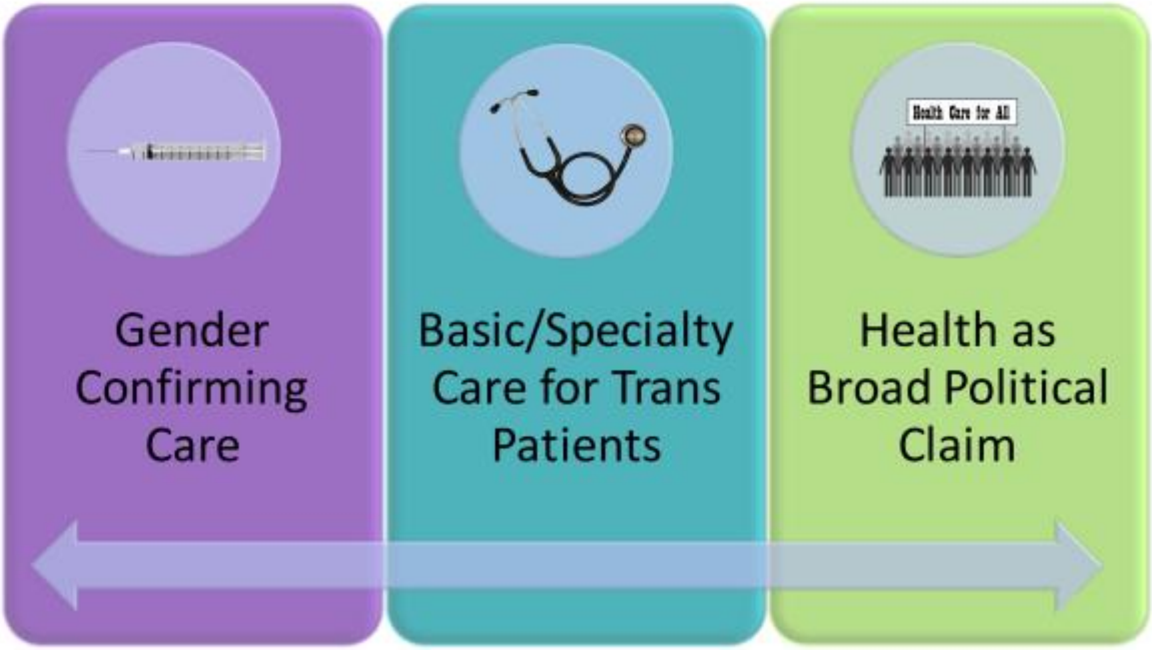


Figure 1. Interpenetrating Domains of Trans Health (Hanssmann 2014)

Trans health appears as an assemblage of varying care practices both related and unrelated to gender confirming care. As Singer (2006) suggests, trans health's orientation around gender confirming care springs in part from "transsexual medicine" practices converging in the mid-twentieth century. This marginal field involved a scattered set of relatively novel and specialized practices centered largely in metropolitan and university-based clinics in the U.S., Denmark, Germany, the Netherlands, and Morocco, and centered in the fields of surgery, psychiatry, and endocrinology (Meyerowitz 2002).[16] Its current and historical technologies owe to innovations in other specialties and recently emergent fields, including post-war reconstructive surgical techniques and reproductive medicine (Franklin 2013; Meyerowitz 2002).

Trans health in a broader sense also grows out of varying health-based social movements. Its infrastructures (particularly in the U.S.) build on those of feminist and women's health, gay and lesbian health, community clinics, and disability activism (Garland-Thomson 1997; Loyd 2014; Murphy 2012; Nelson 2011; Ruzek 1980). "Trans depathologization"—a key orienting approach in emergent models of trans health—is often traced to U.S.-based activism in the 1970s, when gay and lesbian depathologization movements successfully lobbied to remove "homosexuality" from the DSM, which itself can be traced to transnational anti-psychiatry and mental health liberation movements of the 1950s and 1960s. (Deleuze and Guattari 1972; Laing 1964; Szasz 1966). Yet such accounts of trans depathologization may not be sufficient to understand the implications of trans health's relationship to rejecting pathologizing regimes. I therefore ask what other dynamics also contribute to trans depathologization commitments, and what accounts for their complex relations to clinical and surgical care.

My dissertation thus builds on the work of scholars who have begun to parse the distinctions between medicalization and pathologization. Medicalization scholars account for how phenomena come to fall within the "jurisdiction" of medicine (e.g., Conrad and Schneider 1992; Zola 1972). They generally focus on how medicine gains or retains the power to define and control specific conditions, often drawing on sociological labeling theory (e.g., Becker 1963; Goffman 1963). Here medicine is viewed largely as a moral authority and agent of social control, operating in an "imperial" to pathologize specific kinds of bodies (e.g., Ehrenreich and Ehrenreich 1978; Klawiter 2008; Riessman 1983; Ruzek 1978). Yet other scholars more recently note that medicalization may be a goal, pursued through "bottom-up" currents (Brown et al. 2004; Dumit 2006). Pathologization—the process of defining practices, social positions, and/or bodily states as simultaneously anti-normative and ill—thus may be part of medicalization, but they are assuredly not synonymous processes (Burke 2011:189).

In addition to building on Burke's (2011) reflections on this distinction, I interrogate how biomedicalization (Clarke et al. 2003, 2010) shifts attention away from concepts of "control" and towards those or "transformation" and "reconfiguration." Rather than focusing on definitional jurisdiction, inclusion, and the ostensibly "positive" or "negative" effects of medicalization, Clarke and colleagues instead center on broad and transformative reorganizations of bodies, subjectivities, knowledge production and distribution, financing, risk, and the technoscientization of biomedicine both organizationally and clinically. I ask how these reconfigurations may also be at play in the emergence of trans health transnationally and collaboratively, within and across uneven economies of knowledge, technoscience, financing, and practice.

In addition to transsexual medicine, HIV/AIDS treatment and prevention infrastructures are also historically important to present instantiations of trans health, particularly in what is now taking shape as "global trans health." (Aizura, forthcoming). For some time, epidemiological surveillance in global health has statistically folded trans-feminine people who have receptive sex as "Men who have Sex with Men," or MSM. These surveillance mechanisms produced data that were linked to certain funding streams in domains of international development and aid. Following significant push-back against this classificatory elision, "trans women" were gradually identified as a specific "risk group" distinct from "MSM." Though these shifts, trans health also gained broader transnational legibility in some measure through new funding streams, forms of clinical care, and programs of research,[17] as well as through widespread social movement activism (Cohen 2005; Dutta 2013; Stryker 2008; Swarr 2012).

These reflections about the centrality of financing and funding streams also link with recent analyses of what Lewis and Irving (2017) call "trans political economy," or TPE. TPE builds on feminist political economy to attend simultaneously to free market and neoliberalizing economies and gendered and sexualized dynamics of labor and capital accumulation (Bezanson and Luxton 2006; Ferber and Nelson 2003). Lewis and Irving (Lewis and Irving 2017:4) describe TPE as focusing on "how contemporary 'architectures' of power differentially and unequally affect trans and sex/gender-diverse people across the globe—and how we all… become implicated in those architectures… across different local and global geopolitical spaces and scales." This informs my examination of how economic inequity is engaged (or not) by the politics organizing contemporary forms of trans health and its travels. How do distinct forms of national health financing play out in various instantiations of trans health? How do funding streams enable the ascendance of certain conceptualizations of transness, and how do these "matter" to trans health formations? How do critiques of racialized economic stratification get taken up or excluded from discussions about "trans communities" or "trans populations," and what are the consequences for classifications and regulations?

Regulatory domains—especially public provision of care—also comprise sites of contestation. The legitimacy of gender confirming care for trans people is often in question, and public and private hospitals, clinics, and third-party payers have long defined such forms of care as "cosmetic" or "experimental" (Baker and Cray 2013). In Argentina, the 2012 Gender Identity Law legitimized gender-confirming care, formally resulting in nationwide coverage. In the U.S., Medicare—the federal program funding care for people over 65 or disabled—formally lifted a 33-year ban on gender confirming care in 2014. Medicaid is a federally funded safety-net program that covers some low-income individuals, families, and children. Rather than being coordinated centrally, though, Medicaid is administered by states in the U.S., and does not have an enforceable policy about gender confirming care. Medicare policies tend to inform state policies, but they are rarely identical. Presently, U.S. state Medicaid programs have wildly different policies regarding gender confirming care. In 2015, New York State's Department of Health formally lifted its 16-year exclusion clause for gender-confirming care.

These changes have taken place through different avenues of actions. For example, while the Argentinian law passed legislatively, changes to U.S. Medicare and state Medicaid programs stemmed from legal challenges in federal and state court systems. I am concerned less with these laws as objects, and more with the conditions of possibility that enabled them.[18] What made these transformations possible? What compromises did activists, advocates, and providers reach in their negotiations to attain them? How did these processes encode certain infrastructural arrangements, relations of power, and political commitments?

Trans Studies and Transformations in Health and Medicine

From its inception, the interdisciplinary field of trans studies has theorized surgical, psychiatric, and clinical care, and one of its major strands of inquiry problematizes gender non-normativity as an object of medical and/or psychiatric classificatory work and scrutiny (Aizura 2010; Burke 2011; Cabral and Viturro 2006; Namaste 2011, 2011; Prosser 1998; Singer 2006; Stone 1992; Stryker 2008; Suess, Espineira, and Walters 2014). With notable exceptions, many critiques from trans studies have tended to flatten or underanalyze "medical authority" as monolithic and/or geographically untethered.[19]

To address these elisions, I integrate social science debates about contemporary transformations in health and medicine that interrogate situated specificities and stratifications of trans health in various places, asking questions including: How are trans health formations in metropolitan Argentina distinct from those in metropolitan U.S.? How do ostensibly transnational trans activist movements (e.g., trans depathologization movements) coordinate, and how do they conceptualize broad versus situated objectives? How do concepts of "medical authority" range within and between different geographic sites?

My geopolitical focus in the U.S. and Argentina also engages one of the pressing matters emerging at the forefront of trans studies: the question of transnationality and situated forms of medico-legal governance. Aizura and colleagues (2014:314) write of the imperative to broaden trans studies' Anglophone and North American foci and partiality by "interrogating the logic of smooth circulation that mobility denotes in progress narratives of globalization". While the notions of "transgender" and "trans health" appear to be mobile, they are far from seamlessly so, and many disparate currents are at play in their uneven and contested movement and uptake. I thus interrogate how shifts in trans health—particularly those hailed as on the political "cutting edge," such as Argentina's Gender Identity Law—invite broader critiques of globalization and mobility.

These reflections join a growing number of transnational interrogations of so-called transgender subjectivities in studies that consider health care formations (Aizura 2010; Cohen 2005; Dutta 2013; Hsu 2013; Najmabadi 2013; Ochoa 2014). My dissertation builds on these to ask how and where health care providers and activists assemble and define this field in contemporary regimes of practice—described as "healthscapes" in Clarke's (2010) extension of Appadurai (1996). Clarke (2010:105) defines healthscapes as

> ways of grasping, through words, images, and material cultural objects, patterned changes that have occurred in the many and varied sites where health and medicine are performed, who is involved, sciences and technologies in use, media coverage, political and economic elements, and changing ideological and cultural framings of health, illness, healthcare, and medicine.

This view enables an engagement with health care not as a discrete institution or industry, and rather as a broad, diffuse, and ever-changing set of political, social, economic, religious, cultural, and symbolic relations and interactions. As such, I look across multiple fields of knowledge and cultural production—diagnostic classification, regulatory policy, artistic production, activist culture, and advocacy strategies—to ask how collaborative relations and geopolitics of trans health develop and travel.

Examining formations of health and health care also builds on scholarship in trans studies on differential distribution of life chances along lines of race, class, gender, sexuality, and, to some degree, disability (e.g., Aizura 2014; Clare 1999; Gehi and Arkles 2007; Krieg 2013; Lamble 2008; Snorton and Haritaworn 2013; Spade 2011). For example, Snorton and Haritaworn (2013) describe "trans necropolitics" as manifesting in how trans women of color are often memorialized and their deaths are mobilized to bring about state protections, rights, and resources that benefit white, economically-mobile gender non-normative citizen-subjects. Irving (2012:154) similarly argues that economic relations produce an "active/proper/worthy/deserving neoliberal citizen, a construction that disrupts and further devastates the lives of trans people for whom the systemic barriers to emulating these ideals are insurmountable." My analyses thus ask how activist demands of health systems, novel epidemiological approaches to population formation, and certain positions on depathologization may demonstrate or exceed these dynamics.

Classification, Infrastructures, and the Vexing Problems of Ill Fit

Classification and its "intended" and "unintended" consequences has long been a focus of STS scholarship (Bowker and Star 1999; Clarke and Casper 1996). Engagement with trans subjectivities focuses in large part on ontologies and classifications, with much attention trained on classificatory revisions of "trans diagnoses" (Burke 2011; Drescher, Cohen-Kettenis, and Winter 2012; Valentine 2007; Winters 2011). Trans studies and activism also center classifications within phenomena of erasure (Namaste 2000), "administrative violence" (Spade 2011), legal impasses (Currah and Moore 2009), and formal exclusions (Cabral and Viturro 2006). Each of these strands also engages social movements and the push-pull relations of medical and legal bureaucracies on one hand and trans people on the other. The figure of the "norm" looms large, with states, medical and scientific institutions, and legal bodies as primary producers of normalizing knowledge within projects of preservation, security, containment, management, absorption, or abandonment.

In my dissertation, I work to synthesize these critiques with perspectives from STMS that posit classified objects as specifically, contingently, and multiply enacted (e.g., Mol 2002). This focuses attention on the classificatory practices and the negotiations integral to these processes of classificatory formation and revision. It asks what kinds of classifications one winds up with—diagnostic, regulatory, identitarian, and so on—when they are expected to do specific kinds of work (and especially when various actors want them to do *different* kinds of work).[20]

My analytic focus is on how constellations of regulation and resistance or counter-conduct

(Murphy 2012) shape and are shaped by people and practices encountering varying infrastructures. Scholars in STMS center the background work of infrastructure, describing this as "something that other things 'run on,' things that are substrate to events and movements" (Star and Ruhleder 1996:17). Turning infrastructures on their heads, exposing their embedded workings, and unearthing their politics comprises a distinctly STMS project. Bowker (1994) and Bowker and Star (1999) call this "infrastructural inversion." I draw on these theorizations and methodological demands of infrastructure studies to attend the particularities of how distinct forms of trans health manifest in different places. For example, I look to public infrastructures of care because people are quite economically and racially stratified, though they are often regarded as a somewhat monolithic "community."[21] Furthermore, forms of care are not evenly distributed across these groups. To train attention on public health care infrastructures enables me to ask a set of questions about differential valuations of life and resource distribution in two different situations.

In their discussion of shifting racial classifications during South African apartheid, Bowker and Star (1999) discuss the notion of "torque" to illustrate how classificatory systems are politically interested, contingent, and unevenly implemented. When biography and classification processes "are aligned," they explain, "there is no sense of torque or stress; when they pull against each other over a long period, a nightmare texture emerges" (Bowker and Star 1999:27). Those on borders of classification boundaries may be particularly torqued, especially during shifts in classificatory criteria. Torque, in some regard, might provide an apt description for trans existence across a multitude of domains, including in medicine. However, in my dissertation, I ask how the concept of torque may transcend the dynamics of *individuals* encountering classificatory systems. Might torque also be forcefully twisting at broader scales: between different classificatory systems and national formations, or across different groups, for example?[22]

STMS scholars have long argued that producing and maintaining categories involves a great deal of work to stabilize meanings, contain disagreements, and establish boundaries. This brings about relatively fragile ostensible stabilities that are often subject to pushback.[23] As Shim (2014), Epstein (1996), Dumit (2006), Jutel (2011) and others have shown, the content and legitimacy of scientific and medical authority can be contested, modified, and even radically transformed by patient experience and "lay expertise." Alongside work on "embodied health movements," these literatures offer a means of accounting for the co-constitutive production of biomedical knowledges by assemblages of actors that far exceed "official groupings" of physicians and researchers (Brown et al. 2004; Brown, Morello-Frosch, and Zavestoski 2011; Klawiter 2008). In this dissertation, I ask whether "lay expertise" is sufficiently capacious to describe the rapidly institutionalizing dynamics of trans health's emergence and its production of technoscientific and clinical knowledge. Who counts as what kind of expert? I also question whether, in concrete practices, such stabilities that are achieved, however transient, may not also be highly local—situated in specific space and time.

Politics of Place and Difference in Trans Health

In addition to drawing on STMS to synthesize classificatory theories and social movements, my dissertation also looks to how STMS theorizes the "where" and "how" of shifting knowledge formations. While feminist and postcolonial STMS scholars attend deftly to marginality as theoretically and empirically important (e.g., Harding 2011; Medina 2014; Star 1991), my dissertation also necessitates thinking precisely about how embodied social and political difference are produced and deployed, often as identitarian projects (Ferguson 2004; Muñoz 1999; Wiegman 1995). Even the limited theoretical work on trans health rarely asks about its conditions of possibility as a practice organized by identity, and even more rarely asks how racialization, sexualization, and questions of ability may be at play in how this identitarian organization (Warner 2000:167) is imagined.[24] Yet it is through complex arrangements of various politics of difference that forms of knowledge—

particularly the privileged knowledge of biomedicine—take shape, circulate, and are reproduced (e.g., Berg and Mol 1998; Bowker and Star 1999; Latour and Woolgar 1979; Medina 2014).

I analyze these dynamics in part by engaging critical studies of race, sexuality, gender, and disability. These are distinct but interrelated theoretical fields that emphasize processes of valuation with regard to differences (e.g., Crenshaw 1995; Grzanka 2014; Kafer 2013; McRuer 2006; Omi and Winant 1994; Reddy 2011; Schulz and Mullings 2006; da Silva 2007; Somerville 2000; Spade 2011; Stoler 1995). Without overstating the similarity of these various explorations of race, sexuality, gender, and disability, I draw empirically on scholars who analyze these modes of difference and subjugation as deeply intertwined (Chen 2012; Cohen 1997; Ferguson 2004; McRuer 2006; Muñoz 1999; Puar 2012; Schweik 2009). "Trans"—even in the delimiting reach of the very term—enfolds, produces, and reproduces hierarchies of race, sexuality, gender, disability, nationality, pathology, and criminalization. In this dissertation, I ask how knowledge production, authority, and credibility circulate in these shifting but persistent hierarchies.

A transnational scope is critical to this project, training analytic focus on power dynamics between people, and between nations. Among others, I draw on Kaplan and Grewal's (1994) transnational feminist methods and analyses (see also Mani 1990). Contesting ethnocentric so-called "global" feminisms, they aim instead to "link diverse feminisms without requiring either equivalence or a master theory" and they strive to "make these links without replicating cultural and economic hegemony" (Grewal and Kaplan 1994:19). Here, I look to relations within and between geographic sites to foreground questions about nationalism, economic power, and knowledge economies.

A limited number scholars outside of Latin America reflect on how "transgender" amends, differs from, and incorporates gender non-normativity in this global region, and even fewer focus specifically on health and medicine in so doing.[25] But Latin American scholars increasingly engage these questions (Berkins and Fernández 2005; Cutuli 2011, 2013b; Fernandez, D'Uva, and Viturro 2004;

Hernández-Rosete Martínez 2008; Páez Vacas 2010; Silva and Ornat 2014; Zambrini 2007). However, most of these publications do not circulate in the U.S. Exceptions include Argentina-based scholars and activists Cabral and Viturro (2006), Litardo (2013), and Cutuli (2013). Several U.S. or Australia-based scholars also engage various Latin American formations of gender non-normativity in Brazil, Mexico, Venezuela, and Chile, such as Kulick (1998), Lancaster (1998), Lewis (2010), and Ochoa (2014). Economies of knowledge and politics of language shape how the latter literatures travel more readily in the U.S. than do the former. Nonetheless, the theorizing of Argentinian (and some broadly Latin American) scholars are crucial to generating robust accounts of, for example, *travesti* political organization in Argentina.[26] As Lewis (2013) points out, these formations are most robustly theorized through relations of state violence, political economy, and situated laws and regulations, against culturalist anthropological accounts such as Kulick's (1998) and Lancaster's (1998).[27] Drawing on these critiques, I position my analyses of gender non-normativity and social movements within a broader political field in Argentina and in the U.S.

Sites of Knowledge Production: Clinics, Diagnostic Manuals, and Streets

While the site of the clinic is familiar empirical territory for medical social sciences, classical STMS studies tend to focus on the production of biomedical knowledge in the lab (Callon 1986; Knorr Cetina 1981, 1995; Latour 1988; Latour and Woolgar 1979; Traweek 1992). Contemporary studies have since dispersed from the lab as a gravitational center, exploring clinical trials (e.g., Petryna 2009), or technological applications (e.g., Casper and Clarke 1998; Clarke and Casper 1996), biotechnological or pharmaceutical development (e.g., Dumit 2012; Sunder Rajan 2006), scientific economies (e.g., Cooper and Waldby 2014; Vora 2015), and other sites of inquiry. Even in its present forms, though, STMS studies more commonly follow scientists than health care providers.[28]

Yet recently, Löwy (2011:116, emphasis added) describes the clinic as a "unique site of the *production* of knowledge." My dissertation therefore interrogates how classificatory and diagnostic knowledge production are engaged and amended in actual practice, especially within clinical practices. Latimer's (2013) study of clinical genetics vividly demonstrates that the clinic can be a central, rather than distal element in biomedical knowledge production, clearly disrupting the presumptive linearity of "lab to bedside" of "translational" biomedical discovery and practice.

Hence I examine how providers (and some activists) occupy an epistemological and ontological "front line" of knowledge production. For example, the emergence of "trans science"—brain-based or genomic accounts of transness—has largely followed rather than preceded transformations in trans health. These burgeoning projects take place largely in the U.S., Australia, and Europe (e.g., Case and Ramachandran 2012; Hare et al. 2009; Zubiaurre-Elorza et al. 2013).

Such projects and have been enabled in part by what Hess (2016) calls "undone science," the gaps, or the "knowable unknowns" and "unknowable unknowns" of more or less interest to certain parties to pursue or repress (Hess 2016:30). "Knowable unknowns," he suggests, can be leveraged as sites for developing more extensive scientific knowledge depending on changes in resource allotment, increasing attention or priority, act. "Trans science" appears presently to be following the path carved out by a biologically essentialist "gay science" from the 1990s (e.g., LeVay 1993), working to establish organic bases for transness as an anticipatory rejoinder for the opponents of "trans rights" that center rhetorics of "choice."[29]

Also relevant to undone science, an entirely different version of trans science is emerging in novel engagements of transness in population health sciences. Epidemiological research concerning transness has taken shape in HIV/AIDS treatment and prevention and in methodological work to establish estimates of trans "populations." These, as well as the community-based health disparities-focused studies that preceded them, involved greater or lesser degrees of trans groups' collaboration with population health and social scientists. Brown (1987, 1992) describes such partnerships as "popular epidemiology." Here, social movement groups who are concerned with health-based phenomena collect data and enroll scientists to transform biographical and anecdotal experience into epidemiological data.

Extending Latimer's (2013) argument and building on Hess (2016) and Brown (1987, 1992), I also examine how the actions and definitional work of health-based social movements shape and are shaped by clinical practice (e.g., Banaszak-Holl, Levitsky, and Zald 2010; Brown et al. 2011; Epstein 1996; Gould 2009; Klawiter 2008; Nelson 2011). These works posit that science, medicine, and social movements exist in mutual and generative, if hierarchical, relation. Health-based social movements organize around a variety of projects: to inhabit or change diagnostic criteria (Dumit 2006), to shift practices of care or redirect interest in specific research questions (Epstein 1996; Klawiter 2008), to organize around specific forms of embodied illness experience (Brown et al. 2004), or to engage biomedical projects on different and identitarian terms (Murphy 2012). Most focus on activists' influence on scientific or medical experts to change how they do their work. In trans health, this has certainly taken place. In addition, I explore how trans health has also necessarily enrolled providers in order to politicize their approaches to knowledge production and care provision. I ask what fissures emerge from the uneven enrollment and politicization of providers. In so doing, I ask if the camps described in Stone's (1992) account of the "battleground" scene have shifted alliances, and if so, how these reconfigurations have played out. Regarding trans population health science, I ask what new statistical conceptions of "trans populations" enable, and possible consequences.

Biopolitics, Citizenship, and Biomedicalization

Health, recognition, inclusion, and survival are central themes clustering around the topic of trans health, even as trans studies has begun to inch away from questions about medicine and its enmeshment with law and state governance. Nevertheless, the convergence of embodiment, biomedicine, and state governance involved in trans lives and health demand renewed examination of the interconnections among these broad themes. Recent engagements with diverse forms of biopolitical citizenship provide rich analytics regarding how these may be linked, and how various actors might converge. João Biehl (2007:302–3), for example, discusses "patient citizenship" vis-à-vis embodied biomedical and technoscientific interventions in relation to nation-making projects. Adriana Petryna's (2002) "biological citizenship" in post-Soviet Ukraine after Chernobyl centered on how people cultivated relationships with the state *through* disease, leveraging demands on the state from this position (Petryna 2002). In Epstein's (2009) "biopolitical citizenship," "inclusion" in a biomedical paradigm signals recognition and metaphorical enfranchisement in the broader polity. Such analyses emphasize the social, cultural, and broadly political dimensions of "belonging" in citizenship.

Nevertheless, these analyses do not always focus centrally on legal and administrative categories of citizenship. Trans health raises questions about how providers are implicated in decisions about care that relate directly to formal citizenship and the state (Cabral and Viturro 2006; Currah and Moore 2009; Spade 2011). In what Cabral and Viturro (2006) position as an exclusion from citizenship, and Spade calls "administrative violence" (2011[2015]), the imbrication of medical and legal classifications and regulations often produce trans subjects as "impossible people" (Spade 2011[2015]:19). While I share with other scholars a degree of skepticism about citizenship as a central domain of analysis (Brandzel 2016; Ochoa 2014), it remains a key analytic for theorizations of national membership, collective fashioning, and stratified exclusion (e.g., Anderson 2006; Nguyen 2010; Roberts 2012; Shah 2011). Thus, it is necessary to take up questions of formal legal and administrative citizenships (and the way these categories are differentially mobilized across groups) alongside broader notions of inclusion.

In so doing, I draw on critical studies of race, sexuality, and citizenship, which position citizenship as a symbolic set of racializing relations that engenders conditional inclusions and exclusions in a biopolitical register through formal laws and regulations (e.g., Canaday 2009; Kandaswamy 2010, 2012; Luibhéid 2002; Reddy 2011; Shah 2001, 2011). In addition, I interrogate how notions of citizenship—both formal and less so—are among the domains included in the broad transformations of biomedicine (Clarke et al. 2003, 2010).

Once again, biomedicalization is relevant. As Clarke and colleagues (2003, 2010) suggest, this signals "increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through new social forms of highly technoscientific biomedicine." Biomedicalization thus speaks to how broad social and political shifts suffuse and transform life vis-à-vis biomedicine (Clarke et al. 2003:161–62). They assert that the "bio" prefix bundles bioscience, medical research, and clinical practices, and indicates the extent to which "medicine" and "technoscience" have become essentially inseparable. The prefix also evokes *bio*politics and the administration and governance of life and populations. Mobilizing these reflections with critical studies of race, sexuality, and citizenship, I interrogate trans health's varied investments in reconfigurations of regulatory and administrative landscapes. In particular, I examine novel engagements with statistical and epidemiological knowledge, new engagements with "risk" and "population," and how biomedicine and states conceptualize transness (or fail to do so).

Politics of Care

Analyses and explorations of care have in the past several decades been at the center of feminist STMS, feminist social sciences, and sociological and anthropological work on medicine, health, and illness (e.g., de la Bellacasa 2011, 2012; Held 2007; Hochschild 1997[2012]; Kaufman 2006; Kleinman, Das, and Lock 1997; Martin, Myers, and Viseu 2015; Murphy 2015; Ruddick 1995). Care as a figure and analytic centers questions of relation, reciprocity, and moral or ethical politics (Borneman 1997; Cohen 2008; Kaufman 2006; Mol 2008; Taylor 2008). As feminist STMS scholars argue, it also "an affective state, a material vital doing, and an ethico-political obligation" (de la Bellacasa 2011:90). Whether figured as ethical imperatives, as reflections of economic modes of production, or as iterative and contingent processes, modes of clinical care comprise rich ethnographic and theoretical sites for reflection. Care inhabits biomedical discourse, inciting questions about fostering life, conducting triage, and reducing harm (Kaufman 2006; Nelson 2011; Petryna 2002; Taylor 2008; Thompson 2013).

My dissertation explores not only confrontations the limits of care, but also how care indexes relations of power and obligation, in addition to (and sometimes within) dynamics of support or nurture (Murphy 2015:732). In trans health, care practices dovetail with notions of structural violence (Farmer 1997)—the uneven distribution of illness, harms, and life chances—that materialize in what Clarke et al. (2010) call "stratified biomedicalization."[30] I ask how varying politics of care produce different notions of trans health, and how these bring about distinct arrangements of resource distribution, recognition, and valuation. I engage these questions centrally in my discussions of depathologization, and ask how activists (and some providers) make different kinds of demands with regard to health care and the state. How has trans health directed its attention in prior and contemporary instantiations? How have contemporary constructions of "health disparities," for example, affected how trans individuals and "trans populations" are regarded and conceptualized? How are concepts of structurally-produced harms relevant to emerging forms of trans health, and to what effects?

METHODS

My dissertation is a multi-sited ethnography, combining ethnographic interviews and observations with a multitude of other data sources. Between 2012 and 2017, I collected ethnographic data as well as regulations, laws, diagnostic manuals, web sites, images, and activist publications. My ethnographic research spanned multiple sites and spaces of interest—clinics, organizations, protest sites, news and online media, and conferences. Nearly all of these were concentrated in two metropolitan cities: New York City and Buenos Aires.[31] Although there were many other locales in which I might have grounded the work that would have been just as generative, I selected New York and Buenos Aires because: 1) each of these cities is home to self-identified trans health "leaders," many of whom are also involved in transnationally-coordinated work; 2) each was in the midst of an important set of regulatory and legal transformations regarding public provision of trans health care; and 3) these sites spanned the global North and South. Between 2013 and 2016, I interviewed 34 health care providers and activists, evenly split between each of these locales. Over the course of the study, I spent three non-continuous months conducting fieldwork in each city, becoming acquainted with the trans health landscapes in each site.

In so doing, I traveled to a multitude of clinical spaces in each geographic site: hospitals, community clinics, therapists' offices, and academic departments. I attended clinical trainings, went to provider conferences, and tracked changes to diagnostic classifications, care guidelines and protocols, and regulatory policies concerning trans health. In addition, I followed trans health activists and advocates to work, to political actions, to summits, and to films and artistic performances. I collected advocacy materials, activist editorials, blog posts, ad campaigns, and videos.

Given the rapid transformations in the field, I struggled to maintain an up-to-date archive of these materials, as debates and material shifts seemed to careen in all directions with lightning speed. Over the course of field work, I took detailed fieldnotes during and after observations and interactions with informants, and wrote reflective and analytic memos across the full trajectory of data collection and analysis. Using ATLAS.ti qualitative analysis software, I thematically organized and coded transcripts, field notes, and other key data sources. In addition, I drew from Clarke's

(2005) situational analysis to develop multiple maps to chart and track the shifting "situations" of trans health's emergence.

It is difficult, particularly in sociological symbolic interactionism, to parse methodology from epistemology. This field has historically refused a stark separation between these (Blumer 1959; Strauss and Corbin 1998). Feminist interactionist Star (1989) referred to the co-constitutiveness of ontology, epistemology, and practice as "theory/methods packages." Star (1989) and Clarke (2005) extended the perspectives of Straussian grounded theory and its methodological rooting in symbolic interactionist and philosophical pragmatist epistemologies (e.g., Strauss and Corbin 1998). As Jenks (1995:12) observes, "method…is not the servant of theory: method actually grounds theory."[32]

Situational analysis thus mobilizes a post-structuralist account of grounded theory to enable iterative theorization of empirical data across a range of interrelated sites (Clarke 2005). This study combined situational analysis with ethnographic methods. Drawing also on the nimble methodologies of feminist science, technology, and medicine studies (STMS), I examined to human and non-human actors to interrogate how biomedical, regulatory, and activist currents converged as trans health care materialized in distinct geopolitical sites. While some actors and phenomena I observed are marginal (for example, explicitly "trans-supportive" providers are certainly the exception rather than the rule in medical practice), I assume that they remain crucial in "defining the situation" of trans health.[33] This approach thus revealed a complex, multi-layered, and shifting set of landscapes that do not reduce trans health to a "thing" or a neatly contained field. Grounded theory methodologies center *action* and *interaction* rather than "subjects," and this makes demands on researchers to attend to a broad and often messy field of inquiry, which perpetually exceeds the capacity of the project. Indeed, to treat the assemblage of trans health as anything but unruly and uncontainable would be a mistake and an unfaithful rendering. While I do not presume to represent trans health in its fullness—all research, after all, is partial—I strive to answer the question that Strauss and Glaser (1967) framed as a primary provocation of grounded theory: What is going on here?

OVERVIEW: TRANSMUTABLE CARE

Several major—and wholly incomplete—transformations currently characterize shifting conceptualizations of trans health care: from psychopathology to difference; from diagnostic accuracy to health disparity; and from taxpayers' burden to state-supported benefit. These thematic shifts cohere around several major events. Two of them are classificatory: 1) The diagnostic change from Gender Identity Disorder to Gender Dysphoria in the *Diagnostic and Statistical Manual* (DSM); and 2) the proposed introduction of Gender Incongruence in the *International Classification of Diseases* (ICD). The other two are legal or regulatory: 1) The passage of the 2012 Gender Identity Law in Argentina; and 2) the elimination of New York State's Medicaid exclusion for gender-confirming care in 2015. These classificatory and regulatory transformations were both produced by and profound had effects on landscapes of trans health, but they had particularly marked significance for questions of insurance reimbursement, state subsidies for care, and the public provision of gender confirming care. Given the sustained stratifications in the provision of trans health care,[34] these shifts demanded direct engagement with questions of resource distribution and political economy.

The classificatory changes I discuss are some of the most palpable forms of evidence of the departure from "transsexual medicine" (among other genealogically-linked fields) to "trans health" (Singer 2006). Diagnostic classifications have sparked protests, caused tense schisms, and become centers of gravity for trans health activism. While questions of representation circulate at the center of these debates, questions of practice are never far afield. In fact, providers and activists seem decreasingly interested in what diagnostic classifications actually *mean* in contrast to what practices they enable or preclude. Yet the economies of attention devalued by different diagnostic classifications, classificatory manuals, codes, and subcodes take shape within familiar power relations of geopolitics, race, class, and criminalization.

The regulatory changes I analyze are to some degree more peripheral in their public notoriety, but no less characteristic of trans health's field formation. These also become charged sites of debate, conflict, and negotiation. These regulatory shifts also set precedence and join a growing archive of traveling "policy packages" (e.g., Reid 2005) that providers, activists, advocates, and policymakers continue to draw on throughout the world—with varying and sometimes unanticipated effects.

Both classificatory and regulatory transformations have taken shape in large part through increasing coordination and negotiation among providers, activists, and advocates. In contrast to earlier antagonisms, present formations of trans health seem to indicate an increasing degree of cooperation. While such cooperation often takes places *without consensus* (Star 1993), many tense and polarized conflicts are presently playing out in the form of compromise and collaboration. This is not to imply that antagonisms do not remain, but to indicate that they have shifted and (at least for some people) diminished with the increasing formation of collaborative relationships, accompanied by trade-offs achieved through negotiations.

It might seem as if such coordination would have a stabilizing effect on the field of trans health. Instead, I found it opened up a space within which multiple practices and politics are convincingly defined and mobilized as trans health. I characterize these dynamics through the relations of "transmutable care." I elaborate on this phenomenon through several domains: classification and standardization, racialized citizenship, and depathologization—considering each through politics, place, and practice.

Transmutable care produces the contestations and partial shifts that characterize present forms of trans health. It does so through the conditions of possibility produced through cycles of classificatory breakdown and revision; through insistence on the salience of the "external environment" and structural violence as serious concerns; and through the ranging politics of depathologizing regimes of trans health. The relations of transmutable care also arise from and reshape trans health's confrontations with its situated parochialisms, demanding a flexibility and multiplicity that pull against the entrenchment of trans health as a potentially standardized or universalizable field. Yet the appeal of standardization and universality looms large for many providers and their desires for credibility and institutionalization when it comes to trans health. As such, it remains an open question how transmutable care will persist in shaping transnational landscapes of trans health. It also remains to be seen how these proliferations may settle into material and discursive forms that might be undesirable or unrecognizable to trans health activists. At this point, though, the field is characterized by its very openness, multiplicity, and increasing utility in terms of achieving improvements in trans health care.

CHAPTERS

Chapter 1: Containing Unruliness: Classification and Negotiation of the "Trans Diagnosis"

Here, I explore the place of diagnostic forms of classification in trans health. Tracing the "trans diagnosis" across its relatively brief life, I show how these terms, definitions, and classifications have become central sites of contestation over time and across geographic sites. Drawing on diagnostic manuals and activist writings, I interrogate how shifting terms and meanings have rarely if ever gained a modicum of stability when it comes to trans health and other related fields. As I describe, present revisions have transferred focus from "internal pathologies" of gender non-normativity to more social concepts of "distress" or "gender incongruence." Such shifts, while they continue to rely on an anchoring "norm," pivot away from the pathologizing problematization of *individuals'* psychic development, and turn instead toward the subjugating social relations that suffuse the environments within which they live. This turn away from the "disordered individual" to the "dynamic social" is partial, but comprises one important dimension within which present iterations of trans health take shape. This shift resonates with turns in the U.S. and more broadly to "health disparities," "global inequities," and "social determinants of health." Yet the fact that trans diagnoses remain *diagnoses* reflects how it remains caught up in the "inertia" of infrastructural change (Bowker and Star 1999:14): health care financing bureaucracies cannot code for structural inequity, and thus the code remains.

I empirically show how this perpetual process of breakdown and revision also characterizes less formalized identitarian classifications. Further, I suggest that the practices of delivering and financing care, legal regulation, and negotiating daily life and health are at the center of classificatory debates. Ontology and diagnostic accuracy are, for most actors, in the background if they are even of concern. Ongoing revision exemplifies the emergent field of trans health through its iterative, multiplicative, and diffractive effects. Negotiations around classification are thus one crucial domain through which trans health maintains a lack of closure with regard to trans health's "proper" ontologies, epistemologies, and practices.

Chapter 2: Epidemiological Rage: Population Biography, Biomedical Expertise, and the Quantified Politics of Recognition

This chapter draws on ethnographic and other empirical data to show how trans health-based social movements strategically redefined notions of "risk" and "reduced life expectancy" to bring about major regulatory shifts in the public provision of trans health care. Focusing on Argentina's Gender Identity Law and New York State's elimination of a Medicaid exclusion prohibiting reimbursement for gender confirming care, I show how the shift from "individual pathology" to "structural inequity" was further retrenched through a turn to statistical sciences. I develop the notion of "population biography" to describe community-based studies that activists produced in the absence of epidemiological studies tracking health disparities among trans and gender non-normative people. Focusing in particular on a series of studies produced in Buenos

Aires by *travesti* activists, I describe how biographical narratives are combined with statistical data to foreground sexualized, gendered, and racialized subjugation and state violence as health risks. These studies—particularly in their efforts to estimate an overall trans life expectancy—proved important in the passage of the Gender Identity Law. New York activists and advocates similarly mobilized biographical narratives alongside descriptive statistics to make a case for the necessity of state coverage for gender confirming care. These differed, though, in that they foregrounded a cost-benefit analysis, arguing not for formal inclusion into citizenship on moral grounds, but rather on economic grounds. Nonetheless, I show how epidemiological thinking and the "statistical turn" in trans studies have become crucial to present forms of trans activism and trans health. As a biopolitical project, I demonstrate how these activist interventions are then enfolded into aspirations for inclusion into both biopolitical and formal citizenships.

Chapter 3: Diagnosing Wellness: Relations of Care in Feminist and Trans Health Politics and Practices

The third chapter moves back to questions of diagnostics and "wellness" (contra psychopathology), but through an analytic of care politics. By mobilizing ethnographic interviews and observations, alongside web archives of recent debates, it explores the wildly varying dimensions that constitute different forms of trans depathologization. Here, I discuss how trans health in the US and Argentina have taken two distinct approaches to depathologization, and also how activists within each site differ markedly in their orientations to and objectives around such projects.

I situate these discussions within a rehistoricization of "depathologization" movements in general. For example, although gay and lesbian depathologization projects in the U.S. in the 1970s would seem to form the blueprint for trans depathologization efforts, other social movements' engagements with health care formations may align more closely with those of trans health activists.

Drawing on feminist health and disability activism, I show how trans depathologization—though not gay and lesbian depathologization—works through a dynamic I call "care without illness." I expand on this concept to demonstrate some of the broader stakes of trans health and depathologization regimes and their close relations with other forms of care that turn on notions of "self-determination."

Against previous accounts that treat "depathologization" as a monolithic set of politics, I show how distinct commitments to resource distribution, representation, and access to care shape trans depathologization's many forms. Here, I build on work that has begun to parse these differing positions (e.g., Burke 2011). I extend these reflections on social movement strategies to describe how distributive politics, governance, and nation also matter in depathologzation debates, demonstrating how strategies crystallize through health infrastructures. In so doing, I map out the varying positions that trans depathologizationists take up, and explore the stakes vis-à-vis questions of stigma, infrastructure, geopolitics, stratification, and coalitional solidarity. Lastly, I explore how trans health has taken up regimes of depathologization within its formal practices. I discuss the terms and stakes of this contingent uptake, and consider how these shifts reconfigure the relations of power and dynamics of care in trans health as an emergent field.

Conclusion

I conclude the dissertation by discussing the thematic shifts that trans health has brought about: a reconceptualization of individual pathology into difference; a shift in attention from diagnostic accuracy to health disparity; and a partial change from "individual choice" to "medical necessity," accompanied by demands on state-subsidized medicine. I summarize the theoretical contributions enabled by reflections on trans health, particularly in its public provision and its transnational forms. I also outline some of the implications of this work as it articulates more broadly with transformations in medicine, debates about classification and citizenship, and the entanglements brought about by the various politics of care that shape these discussions. While the dynamics of transmutable care render it difficult to say precisely *what* trans health is, the very multiplicity of its enactments, as well as the stratifications it encodes and reproduces, tell us a great deal about its practice.

CHAPTER 1: CONTAINING UNRULINESS: CLASSIFICATION AND NEGOTIATION OF THE "TRANS DIAGNOSIS"

INTRODUCTION

Classifications have been the lightning rods of trans health for a quarter century or more. This chapter explores the most salient classifications and standards shaping the landscape of trans health, and examines how both controversy and collaboration have brought about shifts in their meanings, arrangements, and effects. I describe how different terms, definitions, and diagnostic requirements have become central sites of debate and negotiation in trans health practice over time and in different places. Much research in science, technology, and medicine studies (STMS) and beyond focuses on how classifications seem common-sense, static, natural, and universal—even though they in fact are situated, contingent, unruly, and often hotly debated. By contrast, classifications central to trans health appear to be in a state of near constant contestation, and change.

This chapter examines how the character of trans classification controversies have shifted over time as pitched struggles between providers and activists have given way to diverse collaborations and negotiations. I assert that providers, activists and advocates,[35] and other actors have focused on diagnostic classifications as primary sites through which to cooperatively hash out the terms of trans health practice. The very process of defining "trans" in trans health care practices has thus been in an extended period of openness. Within this protracted period, conflicts, contingencies, and differing objectives have foregrounded rather than foreclosed the wild multiplicity of transness with respect to health. Many studies of classification analyze instances of breakdown to articulate the ethics, contingencies, and politics involved in classification and standardization processes. But breakdown—or perhaps more appropriately, short cycles of breakdown and revision—are trans health's constant state. This chapter looks empirically to 1) diagnostic revisions, and 2) the competing demands of local practice and transnational relevance to reflect on classification issues in trans health.

The chapter begins with a discussion of perhaps the foundational classificatory problem of trans health: classification practices relevant to gender. I draw from diagnostic manuals to examine the classifications most frequently mobilized in trans health. I then define the classifications and diagnoses that are central to various forms of trans health, especially those most relevant in the U.S. and Argentina.[36] Very briefly, I explore histories of these classifications, and discusses how activists, health care providers, and others understand classificatory stakes. I then outline how various classifications have been at the center of field-defining conflicts in trans health.

Subsequently, the chapter focuses on three events relevant to classification in trans health: 1) the diagnostic change from "Gender Identity Disorder" to "Gender Dysphoria" in the Diagnostic and Statistical Manual (APA 2000; 2013); 2) the work to develop "Gender Incongruence" in the International Classification of Diseases; and 3) the emergence of "trans*" ("trans asterisk") in the global South. In describing the dynamics leading up to and following these changes, the chapter demonstrates how activists and providers have increasingly come to collaborate in multiple endeavors to reclassify, redefine, and restandardize trans health. In so doing, I show how the boundaries differentiating activists, advocates, health care providers, policymakers, and other advocates have become increasingly permeable. Within this, I discuss how the knowledge demands of "expertification" (Epstein 1996) become strongly multidirectional in the case of trans health.

Through these examples, I empirically explore how, over recent decades, classifications have shifted from sites of antagonistic conflict to sites of negotiation and collaboration. In the 1990s and early 2000s, trans activists pushed back on health care professionals (among others) to criticize pathologizing classificatory processes associated with accessing gender confirming care (see Chapter 3). One of their major criticisms, consistent with other health activist agendas, was that trans people were not included in making the decisions that would drastically affect their lives. Through a variety of avenues, trans people were gradually enrolled in projects of classificatory revision and development. These positions, perhaps unsurprisingly, remained subordinated and/or minoritarian. Nonetheless, once activists and advocates became increasingly involved, marked shifts took place in diagnostic descriptions of trans people, as well as how trans health care was imagined and arranged.

While classificatory debates may appear to be definitional, empirical data suggest that these may be understood more robustly as debates over actual practices. This chapter explores some of the major collaborations between activists and health care providers to examine the dominant concerns within and across involved social worlds. Mobilizing a social worlds/arenas analysis and positional maps (Clarke 2005), it shows how varying definitional and trans care practice concerns are formulated and hashed out through negotiation and "cooperation without consensus" (Star 1993).

While conflicts over the universality and mobility of “transgender” with respect to health care suffuse the field, these are especially palpable in debates at a transnational scale. For example, I describe how “Gender Incongruence” in the ICD and the identitarian/communitarian intervention of “trans*” in the global South each work to critique the limits of “transgender,” and also to make more mobile the enabling apparatuses of trans health and activism.

The chapter concludes by positing that trans health is characterized by ongoing collaborations among multiple actors, generating perpetual cycles of breakdown and revision. Such processes open up spaces within which ongoing revisions—even more than specific kinds of patients or practices—exemplify the emergent field. As one site of exploring the concept of “transmutable care,” negotiations around classification and standardization are central in maintaining a potential openness with regard to trans health’s ontologies and practices. I suggest that such negotiation processes at least potentially maintain a responsiveness to changes and shifting conditions of possibility in the politics and practices of both health care and trans politics. Perpetual revision seems to strike a balance between flexibility and containment vis-à-vis the unruliness of classifications.

CLASSIFICATION AND RELATIONS OF POWER

A growing array of embodiments and enactments of gender non-normativity are articulated through the lexicon of "transgender." "Trans," and to some degree "trans*" are increasingly common descriptions of gender non-normativity. Like nearly all terms describing gender non-normativity, these remain contested. In the past quarter century, they have been taken up across a wide variety of socially, politically, and culturally situated groups and places. "Transgender" also organizes an increasingly intelligible "patient population"[37] (Aizura 2010; Cohen 1995; Dutta 2013). Thus the figure of the transgender patient has also gained transnational salience and visibility over recent decades, and comprises the presumptive center of trans health.

The "transgender population" has also emerged in the past decade as of interest to human rights advocates (Open Society Foundations 2013; United Nations Development Programme 2013), lawmakers and policy advocates (Boudou et al. 2012; Department of Health, New York State 2015), activists (Berkins 2008; Burke 2011), and of course health care providers (Alegria 2011; Coleman et al. 2012). Trans individuals (among others) put considerable pressure on extant classifications of sex and gender (legal, biomedical, and social, to name a few). Contemporary biomedicine constitutes an important arena in which these classifications and their consequences are worked out.

Various forms of classification are relevant to each different conceptualization of trans health, and diagnostic classifications are only one set of these. For the sake of brevity, in this chapter I focus mainly on diagnostic classifications though I briefly engage several others. Many studies of trans health—most originating in public health, medicine, nursing and social work—focus on the problem of classification (e.g. Israel, Tarver & Shaffer 2001; Kenegy 2005; Gorton 2007). However, with a few notable exceptions, there is a dearth of analyses that engage broader theorizing of classification.[38] Drawing on feminist STMS analyses, this chapter demonstrates how stratification is reproduced and contested through the very processes of classificatory revision.

Classification shapes, encodes, and enacts relations of power. Bowker and Star (1999:10) define classification as "a spatial, temporal, or spatio-temporal segmentation of the world," and "a classification system" as "a set of boxes (metaphorical or literal) into which things can be put to then do some kind of work." Significantly, scholars of classification do not take such orderings to be "natural" nor "universal," but see them as constructed, using specific organizing principles that seek some degree of mutual exclusivity between categories within a system—whether formal or informal (Bowker and Star 1999:10–11). In their discussion of classification and Pap smears, Adele Clarke and Monica Casper (1996:601) highlight how "different entities (people, animals, plants, diseases, etc.) are organized into classificatory groups," and how this "reveals something of the social, cultural, symbolic, and political contexts within which classifications occur."

As Foucault (1994 [1966]) also argues, historically and geographically situated modes of distinguishing entities from each other encode specific relations of power. Bowker and Star (1999:26, emphasis added) describe how classificatory power dynamics manifest empirically, as "lives of individuals are broken, twisted, and *torqued* by their encounters" with "the cage of classification systems." Spade (2011[2015]:11) further asserts that such a classificatory and regulatory landscape of "administrative violence" characterizes states' stratified management of trans existence. He asserts that classifications not only produce meaning, they also differentially distribute vulnerability and security. The contingency of classifications is thus most apparent in instances of ill-fit. Depending on position, stakes, and material consequences, classifiers and the classified usually experience such instances of ill-fit quite differently. Yet in the case of trans health, each actor is expected to understand and in a sense bridge these distinct experiences. This chapter shows how such "torqueing" takes place not only between classifications and individual biographies, but also between particular classificatory schema and national formations—with people and specific "populations" also caught, squeezed, and twisted.

Many of the central debates in trans health hinge on the "trans diagnosis," its validity, its ability to capture gender non-normativity, and its ability to bring about specific outcomes for both providers and patients. The "trans diagnosis" does not exist in the singular, but is rather a gloss on the many distinct and shifting diagnoses that appear in varying psychiatric and medical classificatory systems throughout the world. The very notion of gender non-normativity as relevant to and appropriately managed by medicine springs largely from early- to mid-twentieth century sexology, centered primarily in Europe and the U.S. (Meyerowitz 2002). The varying classificatory diagnoses that have emerged since this point carry the vestiges of sexualized, gendered and implicitly racialized codifications of "deviance" found in their origins.[39] The pathologizing impulse of these classificatory genealogies—discussed further in Chapter 3—become a central site of tension in some of the conflicts defining trans health as an emergent field. These struggles became broadly apparent not only through the emergence of trans health, but also in related fields, such as HIV/AIDS treatment and prevention and feminist health.

Two thematic figures haunt the historical imagination vis-à-vis trans diagnosis, and remain perpetually present in debates about classification vis-à-vis geopolitics, classification, culture, medicine, and difference. Conceptualizations of the "historical trans subject" draw at once from the gender non-normative anthropological object and from the medical/psychiatric object.[40] These two figures are opposed along a variety of axes: pre-modern/modern (APA 1980; Nanda 1999); East/West (or global North/global South) (Boellstorff 2004; Kulick 1998); and "tradition"/technomedical intervention (Käng 2012; Ocha 2012). Far from being distinct, however, Skidmore (2011), Aizura (2011), and Hsu (2013) point out that these historical figures are produced in tandem. As Hsu argues, colonized and "racialized bodies are crucial to the intelligibility" of the medically-imagined trans body (Hsu 2013, paragraph 4). Stoler (1995), Somerville (2000), and Terry (1999) describe how various national projects of sexual and gendered normalization depend on implicitly—and sometimes explicitly—racialized dynamics of power and subjugation. Such relations take on a different form in contemporary classificatory debates, but perpetually circulate (even if more subtly).

Classification also involves processes of formalization and standardization. In this chapter, I discuss mainly formalized classifications—specifically, diagnoses. But I also touch on less formalized classifications, like "trans*," which are not similarly standardized. While classification and standardization remain "two sides of the same coin" (Bowker and Star 1995:15), I focus here on classification.

At some level, the distinction between classification and standardization is awkward. As Bowker and Star (1999:33) suggest, "[s]ystems of classification (and of standardization) form a juncture of social organization, moral order, and layers of technical integration." Bowker's (1994) methodological approach of "infrastructural inversion," later taken up by Bowker and Star (1999), suggests "recognizing the depths of interdependence of technical networks and standards, on the one hand, and the real work of politics and knowledge production on the other" (Bowker and Star 1999:34). To examine classification on its own sidesteps its inextricability from modes of standardization. Even simply to follow the process of a male-to-female trans person deciding to change the gender classification marker on her legal identification documentation is revealing of the inseparability of diagnostic classifications, medical and legal standardization, and other infrastructures including insurance, judicial, administrative, and medical.

Spade (2011[2015]) and other scholars and activists describe the tangle of apparatuses and regulations that such a process involves in the U.S. Prior to the passage of the Gender Identity Law in Argentina, Cabral and Viturro (2006) describe a distinct but similarly entangled web of challenges to obtain a similar administrative change. Gender reclassification in Argentina is presently more streamlined, but the infrastructures through which people attempt to accomplish such work remain entangled. While these and other entanglements of standardized practices and infrastructures are highly relevant to classificatory analyses, for the sake of clarity and focus, I presently leave to one side a more thorough discussion of standards.

While it would seem that classification defines entities ontologically, Mol (2002) suggests otherwise. Ethnographically examining a Dutch hospital, she focuses on atherosclerosis. She argues that multiple actors—patients, pathologists, surgeons, radiologists, and others— interact with the disease in different ways as to produce a multiplicity of objects that would seem deceptively to condense as a singular thing: "atherosclerosis." Mol (2002:33) writes, "in practices, objects are enacted," reflecting not on what atherosclerosis *is,* but rather on how it is *done.* Different kinds of actors also enact "transgender" in ways that reveal its multiplicities. Yet unlike atherosclerosis, the multiplicities of transgender are far more evident and explicit: there is less consensus in defining or describing the state of being transgender. These multiplicities circulate through naming practices, scientific studies, diagnostic classifications, social service programs, care standards, legal categories, and activist formations. Furthermore, while atherosclerosis involves what can fairly unequivocally be called a disease, there is less consensus about what "transgender" describes with regard to illness, biological and psychic phenomena, cause, and biography. Thus, even as the sites within which atherosclerosis is enacted spill over from the hospital into homes and multiple publics, at some level it remains a phenomenon that happens in and to certain bodies and that affects veins. Transgender is more loosely constructed, arguably less biomedically anchored, and with less agreement even among those who would describe themselves as "transgender" as to what it is *or* how it is done.

The politics of classification comprise a central matter over which activists and providers have historically clashed (see Chapter 3). Cromwell, Green, and Denny (2001)—all trans activists or advocates and professionals[41]—discuss some of the struggles over the proliferation of language to describe "gender variance." Presenting findings from a survey about trans people's use of language, they included a schema of certain terms and their origins (reproduced below):

Transgender Community Terms	Medical Community Terms
Crossdresser	Transvestite
Transgender	Transsexual
Transition	Sex Reassignment
Gender Variance	Gender Dysphoria, G.I.D.
Transsexual Woman	Male Transsexual
Transman, FTM	Female Transsexual

Table 1: Adapted from "Terms and their Origins," from Cromwell, Green, and Denny (2001).

They introduce their survey results with a brief discussion of language usage: "[W]e are seeing the emergence of terms originating within the transgender community[,] which seem to be replacing terms which originated from the psychological and medical communities" (Cromwell, Green, and Denny 2001:Paragraph 4). These authors echo the conventional wisdom that transgender's origins are bottom-up and "community-based." "Transgender," in this sense, is cast as a collective community rejoinder that confronts the "medical community's" diagnostically-focused taxonomies, which are expressed largely through "transsexuality." Classificatory language thus becomes a site of community-based resistance against the diagnostic and often pathologizing impetus of medical practice. Indeed, "transgender" is presently treated as an "umbrella term" (Currah 2006) that generally incorporates multiple forms of gender non-normativity, and that foregrounds collective identity over diagnostic likeness.

Since this presentation (2001),[42] many of the terms these authors characterize as originating in "transgender community"—and indeed, many more—have been taken up by medical providers and within various classifications and standards relevant to trans health**.** This is one of the transformations that Singer (2006:615) locates in describing a shift from a "pathological" to a "community-based" model of care provision for trans people. As Singer (2006) and Meyerowitz (2002) both indicate, transsexual medicine exercised a near-complete refusal to collaborate with activists. Entering the 2000s, though, Singer (2006) describes how "community members" worked with providers in the shift to trans health, largely in the ambit of "competence trainings," which focused on linguistic and other pragmatic suggestions to providers from community trainers. As I will show, this has to do in large part with the increasingly collaborative relations and permeable boundaries between providers and activists. The results of these cooperative interactions are often figured by medical providers as enlisting community advisory members, community input, or other expressions of community partnership.

Yet as Valentine (2007) argues in *Imagining Transgender*, to presume that a "trans community" (let al.one "medical community") is a discernible, self-evident formation would be an error. He writes, "I realized that a transgender community does not exist outside the contexts of those very entities which are concerned to *find* a transgender community: social service organizations, social science accounts, and activist discourses" (Valentine 2007:68). His "ethnography of a category" thus explores the "imagined unity" of "transgender," focusing on the racialized, classed, and gendered fissures and hierarchies that are obscured in its ostensible unity and identifiability. This account invokes different modes of torqueing than medical or diagnostic modes, but these remain important to questions of trans health—especially given the increasingly "expertified" position of the "trans community member."

However, as Valentine (2007) notes, “transgender” has conferred markedly uneven material changes and benefits among the “community” it claims. Spade (2011[2015]) concurs, asserting that legal equality approaches to trans politics, for example, violently reinforce such hierarchies rather than dismantling the classificatory and regulatory systems that produce the differential valuation of life. At stake are questions of how well “transgender” fits for different people, how it is institutionalized, and who it organizes, as well as familiar questions of representation and claims to “speak for” a community.

While Valentine shares one of my ethnographic sites of New York City, his reflections focus squarely on U.S.-based classificatory struggles. To examine classificatory struggles at a transnational level is to introduce another scale through which ontological and political debates are waged. The extent to which “torqueing” is at play at this level is evident in early appearances of the term “trans*” in the global South in the early 2000s. These claimed that U.S. and European accounts of gender non-normativity dominated the ostensibly “international” field of trans health and other fields of trans politics. Funding streams, they asserted, also followed what Chakrabarty (2000:6) and other postcolonial scholars (e.g., Hall 1992) characterize as the historicist logic of “first in the West, and then elsewhere.”[43] Global South activists, cognizant of the potential ill fit of “transgender” to describe the breadth of their political allies and constituents, thus appended an asterisk to funders’ language of “trans” and “transgender.” The asterisk worked to modify “trans,” and therefore to cheekily and implicitly reject its universal reach. Activists maintained the terminology of “trans” to enable the possibility of accessing funding streams, but their addition of the asterisk troubled the presumptive relevance of “trans” to *travestis* and other groups that do not use the language of “transgender.” Political economy and frames of “development” thus also shape classificatory debates, and inform how torqueing takes place at varying scales.

At times, activist responses to problems of ill fit and torque appear as the diverse actions of an "unruly public," as de Saille (2014) describes in analyzing public participation in the development of technoscientific research agendas. These paired forms of "unruliness"—classificatory and political—might be theorized together in the case of trans health. Such multi-dimensional unruliness also gestures to what Khanna and colleagues (2013) call "unruly politics." While they use this term to describe recent mass social movement uprisings, I suggest that "unruliness" also comprises some of the conditions to which trans health is perpetually responding—in terms of classificatory torque as well as certain activist demands. Unruly politics, for Khanna and colleagues (2013:14), "draws its power from transgressing…the rules of the political game" while coordinating actions based on a sense of "what is right and just." In practice, negotiation between providers and activists is far less unruly than the politics that Khanna and colleagues (2013) describe, given that proponents of classificatory changes who gain a place at the table are willing to negotiate within the terms of biomedicine. But the underlying unruliness that persistently destabilizes classificatory efforts remains at play, at times pressing against the very foundations of diagnostic classification and hierarchical provider-patient relations. Furthermore, stratified forms of ill fit become a central issue for social movements that are more inclined to reject the rules of the game (discussed in Chapter 3).

GENDERING THE PROBLEM LIST

Clarissa, a newly practicing nurse practitioner, describes the conundrum of charting when it comes to caring for transgender patients: "There's no template for a trans person…There's not even a question, it's just male/female. And all the providers, they're like, just write it in the notes. Or in the *problem list*, is where it would go" (Clarissa Interview, July 25, 2013). This literal and figurative space of the "problem list" frames one of the foundational problems for trans health: how to classify patients' sex or gender?

Analyzing classification—particularly in the realm of medical nosology and clinical practice—forms one of the theoretical and empirical cornerstones of transgender studies (e.g., Stone 1992; Hines 2007; Burke 2011). But these tend to focus squarely on how gender non-normativity is *clinically* defined and described—centering largely on questions of diagnosis. These interests remain centrally relevant to my reflections. But I suggest that other elements of classification also matter: the systems within which they are embedded; how people work around them; and how they coordinate action.

The problem list was developed in the last 1960s as an area in the medical chart that "helps [physicians] to define and follow clinical problems one by one and then systematically to relate and resolve them" (Weed 1971:3) Intended as a less-standardized space for clinical reflection and synthesis, its uses are multiple, and it does not always work as intended. For Clarissa (Interview, July 25, 2013), the problem list was simply a space in an electronic record that she knew providers would look at. As a provider who was personally and politically committed to caring well for her trans patients, she thought that letting other providers know right away that a patient was trans was of the utmost importance. She thought this might prevent some of the frequent awkward moments that trans people experience in health care settings.[44]

Even with a plethora of diagnostic options on the chart to describe the medical or psychiatric condition of gender non-normativity, providers face a peculiar and remarkably mundane problem when it comes to charting basic patient demographics: Is the "male" or "female" box most appropriate? Clarissa (Interview, July 25, 2013) notes the absurdity of this situation as she describes her efforts to more effectively chart patients' gender by pushing for changes in electronic charting capabilities with Epic, an electronic medical charting vendor in the U.S.: "I have been inquiring…'do you just have to ask this company to give you another button? …Has this company not invented this button?...What is the story on this?'"

“Residual categories” and the persistently defiant category of “Other” vex classificatory systems that aspire to stability and closure. Residual categories serve multiple functions: they distribute uncertainty; they do the “good enough” job of partially categorizing that which would otherwise resist categorization; and they signal ambiguity while eluding uncertainty on the part of the classifier (Bowker and Star 1999:149). In some cases, they serve a “bootstrapping” function by locating where more explicit categories should exist. Ad hoc categories often emerge from these (Bowker and Star 1999:276). In fact, “transgender,” “other,” or a blank space in which to write one’s sex/gender[45] increasingly appear on intake forms and in medical charts. This is likely partly attributable to the collaborative work of providers, activists, and advocates, and several groups have published recommendations about how to best chart for trans patients (e.g., Deutch, Green, Keatly et al. 2013; Tate, Ledbetter, & Youssef 2012; Cahill & Makadon 2013).

Clarissa (Interview July 25, 2013) struggled to find a way to identify trans patients’ self-identified gender to her colleagues. Beyond wanting patients to be able to access gender-confirming care, she was worried about how other providers would treat her patients for health issues irrelevant to gendered enactment or embodiment. In this concern, Clarissa identifies how the imperative for sexed/gendered legibility spans the whole of health care practice. The proliferation of new boxes, two-question methods for assessing gender categories, and ad hoc practices like Clarissa’s use of the problem list are just some of the strategies that people use to intervene in the conundrums produced by this imperative. But the elusiveness of sexed/gendered legibility is far from a new problem in medicine—in fact, many argue that it is medicine’s techniques of power that in large part *produce* this problem. As Foucault (1990), Stoler (1995), and others argue, medicine is a key (though certainly not sole) site through which processes of normalization are articulated and hierarchies of existence are instantiated.

The following sections draw on ethnographic, textual, and web-based data to outline and analyze the classifications and standards most relevant—both presently and in recent history—to trans health. I highlight several struggles that show how classification and standardization have become central sites of meaning-making with regard to both ontology and practice. In contrast to Stone's (1992) characterization of trans health as a "face off' between providers and trans people, I suggest that conflicts have shifted from professional to political lines of division.[46] Some providers hold fast to diagnostic descriptions of transness that define it as pathological or problematic, and are most concerned with diagnostic accuracy when it comes to classificatory debates (e.g., McHugh 1992; 2012). In contrast, an increasing number of providers—many politically aligned with trans people if not trans-identified themselves—are more interested in providing what they see as "good care" to trans patients (Lev 2004; Deutsch 2012; Karasic and Drescher 2005; Coleman et al. 2012). In this regard, classificatory debates can become a site through which to work with "trans communities" to identify what comprises "good care" in *practice*—even as they may inadvertently hold certain professional, racialized, classed, and gendered hierarchies stable.

SHIFTING CLASSIFICATIONS

A variety of classification systems and standards converge in the landscape of trans health. Specific diagnoses mean and do different things for medical billers, physicians, patients, epidemiologists, support group members, and activists (to name a few), and vary from place to place as well. Due in part to these ranging stakes, categories emerge and shift iteratively, and different actors resist when classifications are not sufficient for the work that they do. Several providers I interviewed in New York, for example, referred to the "creative" practice of diagnosing trans patients with endocrine disorder to facilitate insurance coverage. Ultimately, formal classificatory changes depend on the ability to leverage authority, expertise, cooperation and some degree of cooperation (Bowker and Star 1999; Clarke and Casper 1996; Latour 1990). Informal classificatory changes may require far less cooperation, but may later influence institutionalized shifts. In all such iterations the cooperation may or may not bring about genuine consensus (Star 1993). A new classificatory formation may be acceptable or possible through negotiation without being viewed as ideal or even close to it.

This section provides an overview of the classifications most relevant to trans health practice, both historically and presently. Table 1 below charts the shifts in two of the major classificatory systems within which the "trans diagnosis" has been administered in the U.S. and Argentina (as well as many other geographic sites): The *Diagnostic and Statistical Manual* (DSM) and the *International Classification of Diseases* (ICD). Having entered the ICD in 1975 and the DSM in 1980, the "trans diagnosis" has moved between these classificatory systems itinerantly.

The DSM is published by the U.S.-based American Psychiatric Association, but its circulation and consequences are much broader. In fact, its diagnoses comprise most of the mental health chapter of the World Health Organization's International Classification of Diseases (the ICD), the diagnostic system used in most of the world. Yet the appearance of "Trans-sexualism" in the ICD-9 *predated* the entry of "Transsexualism" in the DSM-III. Subsequently, the ICD took up the language of "Gender Identity Disorder." Recently, the DSM has reconceptualized the "trans diagnosis" as "Gender Dysphoria," and the upcoming ICD-11 revision is slated to adopt "Gender Incongruence," as of 2018. The extent of continuities and distinctions between classifications in each "bible" of classification is matched by shifts within each source.

In addition, the trans diagnosis migrates between chapters, and there are other shifts in description, emphasis, essential features, and differential diagnoses (APA 1980; 1987; 1994; 2000; 2013; ICD 1975; 1990; 2000). Through structuralist analysis, it might be possible to read the meaning of the trans diagnosis through its diagnostic neighbors, which range from exhibitionism to tic disorders. Yet the distinctively and rapidly iterative character of its placement seems to elude rather than stabilize its definability.

Table 1.

Medical Classifications and "Trans Diagnoses"

Source	**Classifications and Subtypes**	**Chapter**	**Neighbor Classifications**
DSM III (1980)	**Gender Identity Disorders** 302.5 Transsexualism 302.60 Gender ID Disorder of Childhood 302.85 Atypical Gender ID Disorder	Psychosexual Disorders	Paraphilias (e.g., Fetishism, Transvestism, Zoophilia, Pedophilia); psychosexual dysfunctions (Inhibited sexual desire, Inhibited sexual excitement, Premature ejaculation); Other psychosexual disorders (e.g., Ego-dystonic homosexuality)
DSM-III-R (1987)	**Gender Identity Disorders** 302.60 Gender ID Disorder of Childhood 302.5 Transsexualism 302.85 Gender ID Disorder of Adolescence or Adulthood, nontreanssexual type (GIDAANT) 302.85 Gender ID Disorder Not Otherwise Specified	Disorders Usually First Evident in Infancy, Childhood, or Adolescence	Disruptive behavior disorders; Anxiety disorders of childhood or adolescence; Eating disorders; Tic disorders; Elimination disorders; Speech disorders
DSM-IV (1994)	**Gender Identity Disorders** 302.6 Gender Identity Disorder in Children 302.85 Gender Identity Disorder in Adolescents and Adults 302.6 Gender Identity Disorder Not Otherwise Specified	Sexual and Gender Identity Disorders	Sexual dysfunctions (e.g., Sexual Desire Disorders, Sexual Arousal Disorders, Orgasmic Disorders), paraphilias (e.g., Exhibitionism, Fetishism, Pedophilia, Transvestic Fetishism)
DSM-IV TR (2000)	Gender Identity Disorders 302.6 Gender Identity Disorder in Children	Sexual and Gender Identity Disorders	Sexual dysfunctions (e.g., Sexual Desire Disorders, Sexual Arousal Disorders,

	302.85 Gender Identity Disorder in Adolescents or Adults 302.6 Gender Identity Disorder Not Otherwise Specified		Orgasmic Disorders), paraphilias (e.g., Exhibitionism, Fetishism, Pedophilia, Transvestic Fetishism)
DSM-V (2013)	302.85 (F64.9) Gender Dysphoria	Gender Dysphoria	No others, only diagnosis in chapter
ICD-9 (1979)	302.5 Trans-sexualism (Excludes 302.3 Transvestism) 302.50 With unspecified sexual history 302.51 With asexual history 302.52 With homosexual history 302.53 With heterosexual history	Mental disorders, (under heading "302 Sexual Deviations and Disorders")	Homosexuality; Zoophilia; Pedophilia; Transvestism; Disorders of psychosexual identity; Psychosexual dysfunction
ICD-10 (1992)	F64 Gender Identity Disorders F64.0 Transsexualism F64.1 Dual-role transvestism F64.2 Gender identity disorder of childhood F64.8 Other gender identity disorder F64.9 Gender identity disorder, unspecified	Mental and Behavioral Disorders	Habit and impulse disorders; Enduring personality changes; Specific personality disorders; Disorders of sexual preference; Psychological and behavioural disorders associated with sexual development and orientation
ICD-11 (Forthcoming)	Gender Incongruence Gender Incongruence in Childhood (?)	Conditions Related to Sexual Health	Sexual dysfunctions; Sexual pain disorders; Changes in male genital anatomy; Changes in female genital anatomy; Paraphilic disorders; Adrenogenital disorders; Predominantly sexually transmitted infections

Much controversy has marked each of these shifts. Moreover, in the 1990s, trans activists loudly rejected the need to be diagnosed as having Gender Identity *Disorder* to be eligible for gender confirming care. Accordingly, Stone (1992) described the relations between trans people and providers around this time as a "battleground." For many trans people, "the letter"—or the diagnostic confirmation that psychiatrists and psychologists drafted for surgeons, endocrinologists, and primary care doctors to confirm a person's "medical need" to seek biomedical care—came to signify a site of coercion and normalization. Standardized treatment regimes, such as those issues by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) (now the World Professional Association for Transgender Health (WPATH)) recommended that people undergo extended mental health treatment prior to such a letter being issued.[47] Such often polarized struggles persisted through the 1990s and early 2000s. Many trans people and those who considered themselves their allies began organizing online to respond to invitations for public comment and joining professional associations and advisory groups. Providers—many emerging from HIV/AIDS health care practice and feminist women's health care settings—joined these efforts as "trans-supportive" or "trans-affirming" providers.

Presently, trans health is a field that focuses on relieving "distress" and is conversant in what might be described as "structurally stratified" aspects of health care. For the most part, trans health providers seem to place far less stake in diagnostic accuracy, and are more concerned with trans people being able to access care. They advocate describing the negative effects of "transphobia" (Bockting & Ehrbar 2006) and "institutionalized social control" (Lev 2005:38). Many of these providers describe themselves as trans, or align themselves politically or personally with trans or LGBT people.

This period of relative calm should not however be interpreted to imply that trans health practice has achieved consensus in its views on classification and its uses. Kenneth Zucker, for example, is a psychiatrist who advocates so-called “reparative” therapy for young people for whom their gendered enactment or embodiment does not align with normative expectations. For Zucker and others, the ostensible accuracy of the DSM diagnosis enables providers to work to therapeutically alter “disordered” expressions of gender prior to recommending what they see as the last resort: the biomedical techniques of gender confirming care. Zucker remains an important figure in psychiatry, and he served as the chair of the Sexual and Gender Identity Disorder Work Group for the DSM-5 revision—an appointment that was met with much alarm and criticism from both activists and trans-supportive providers.

While many of these debates have centered in the U.S., diagnostic classifications remain relevant in Argentina, despite the Gender Identity Law having obviated the need for diagnoses to access gender-confirming care. Classifications still matter in two main ways. First, many activists and some providers engage in transnational collaborative work. Argentina’s law has become a model for a spate of new “Gender Identity Laws” throughout Latin American and beyond, and people who worked as part of the coalition have been asked to consult with groups working on such projects elsewhere. Given that many nations use ICD or DSM codes for diagnosing trans people, transnationally-oriented Argentinian activists remain affected by and interested in transformations in both diagnostic systems. Second, even though the Gender Identity Law eliminates the requirement for diagnosis, some Argentinian providers continue to use it and to insist on its validity and importance. For example, one Buenos Aires provider who positioned himself as an expert in caring for trans*[48] patients insisted on the relevance of psychiatric diagnoses, and continues to use them several years after the law’s passage (Jaime Interview, July 28, 2015). In contrast, Argentinian activists, like Antonio (Interview, July 25, 2015), describe feeling frustrated by the “U.S. psychiatric imperialism” that dominates transnational conversations about trans health and questions of access. He and others view DSM debates with some measure of exasperation. This in part influenced

Antonio's decision to work with the World Health Organization in the revision of the ICD (discussed below).

The positions of advocates and activists range even more broadly vis-à-vis their desired objectives for trans diagnosis. On the one hand, they agree with each other and with trans-supportive providers that questions of access should drive how the trans diagnosis is defined and situated. Yet on the other, they differ markedly about how to achieve broad access to gender-confirming care for trans people. "Depathologizing" projects figure centrally in activists' and advocates' collaborative work with trans-supportive health care providers (Chapter 3 discusses their range of positions in more detail). Objectives range along multiple lines and, perhaps unsurprisingly, differ by geopolitical location. Activists in Argentina developed the Gender Identity Law—which had a profound effect on how gender-confirming care is organized in the nation—with minimal participation from health care providers. The only participating providers were themselves already members of the activist organizations working with the coalition that drafted the law (Nico Interview, August 3, 2015). Activists in the U.S. expressed various concerns about potential effects and consequences of the shifting diagnoses. Some worried about stigma while others were concerned that less "pathologizing" diagnoses would disproportionately benefit those who were already likely to have greater access to care (see Chapter 3).

Roberto (Interview, July 29, 2013), a nurse practitioner in New York, described how the clinic where he worked—a large LGBT health clinic in the city—had developed a workaround to insulate patients from the "stigma" of a mental health diagnosis while helping them obtain coverage for hormones.[49] The clinic had adopted the policy of using "Endocrine Disorder, Not Otherwise Specified"—an ICD code, but not a DSM one—as a diagnosis for trans patients needing coverage for hormones. He was concerned, though, that insurance companies were beginning to catch on:

> Author: Are there any problems with that, with people's insurance and gender markers?

> Roberto: There hasn't been any yet but there's a concern there will be. I guess they're changing the ICD-9 codes soon and they're worried that is going to be a problem. I think [with] Endocrine Disorder, Not Otherwise Specified, you don't have to attach a sex to it like [with] Gender Identity Disorder. I have started getting more denials. Some insurance companies are asking for prior authorization for hormones and they ask flat out if it's for hormone therapy or cross-gender hormone therapy or something along those lines, which treat gender-identity disorder, and if you say "yeah," they deny it. (Roberto Interview, July 29, 2013)

Tina (Interview, August 8, 2013), a nurse at the same clinic, was a bit more concerned with the ethics of this workaround (Knorr Cetina 1999; Bowker and Star 1999), though she felt it was ultimately justified:

> Tina: [M]y understanding is that we use endocrine disorder because it's very vague and does not "out" somebody as being trans, and there's more likelihood that insurance will cover the labs, visit and medication.
>
> Author: What are your thoughts on [using] Endocrine Disorder?
>
> Tina: It's slightly dishonest… But I get why it's done because again, it's pragmatic, but duplicitous, yes. But you sometimes have to be duplicitous, and it's better than gender dysphoria which is so "mental health-y" and gross.

Another New York provider (Fieldnotes, July 25, 2013) mentioned to me during an ethnographic observation that the classification did not seem dishonest to her at all. In fact, she said that it is simply a fact that trans people have Endocrine Disorder: their bodies produce the "wrong hormone," she reasoned, and the diagnostic criteria formally included for Endocrine Disorder diagnosis simply had not caught up yet. She joins an increasing number of "trans-supportive" providers, advocates, and activists who strive to redefine gender non-normativity as a biological phenomenon. These reterritorializations of diagnosis are, in fact, supported by a growing body of research that investigates trans brains, genes, and other anatomical, hormonal, or molecular systems (e.g., Case and Ramachandran 2012; Hare et al. 2009; Zubiaurre-Elorza et al. 2013).

As such, medical diagnoses beyond the parameters of what might be regarded as "trans diagnoses" are also significant for trans health. Such diagnoses that arise among New York providers I interviewed and observed were restricted to endocrine-related diagnoses. It is likely, though, that providers elsewhere have found other means to establish workarounds congruent with health and insurance infrastructures within which they work. Alternatively, some providers may use diagnoses more convergent with emergent conceptions that transness is best understood as a partially biological (rather than a solely psychological) phenomenon.[50] Thus, Table 2 shows what is likely an incomplete list of non-psychiatric diagnostic classifications currently relevant to trans health practice.

Table 2.

Medical Classifications as Workarounds for "Trans Diagnoses"

ICD-9 (1975)	259.9 Endocrine Disorder Not Otherwise Specified	Endocrine, Nutritional, and/or Metabolic Disorders	Disorders of the thyroid; Disorders of the pancreas; Disorders of the pituitary gland; Disorders of the adrenal gland; Disorders of the gonads
ICD-10 (1990)	E34.9 Endocrine Disorder, unspecified		

Below, Table 3 broadly maps some of the work that different social worlds in the U.S. seek to accomplish through trans diagnosis (this mapping was also relevant to Argentina prior to the passage of the Gender Identity Law, but has become less relevant since its passage in 2012). This table draws from Clarke's (2005) methodological approach of mapping positions as separable from actors.

In Table 3, I combined early versions of my positional maps with a social worlds/arenas analysis, which Clarke cartographically extends from Strauss (e.g., 1987). These demonstrated how social worlds agreed and differed about the objectives of trans health, and how each moved between positions between diagnostic revisions. Given the dominance of DSM classifications in the U.S., the positions articulated generally center around mental health diagnoses. Positions change somewhat with the emergence of "Gender Dysphoria" in 2013 for reasons I explore below.

Table 3. Positions on the Utility of the "Trans Diagnosis"

OBJECTIVE	SOCIAL WORLD
FOR DIAGNOSES BEFORE 2013	
Providing access to care	Activists, advocates, "trans-supportive" providers
Diagnosing patients accurately	Providers (excluding "trans-supportive" providers)
Informing etiological analyses	Providers
Social control/subjugation	Activists, advocates, "trans-supportive" providers
FOR DIAGNOSES AFTER 2013	
Providing access to care	Activists, advocates, "trans-supportive" providers
Diagnosing patients accurately	Providers (including "trans-supportive" providers)
Informing etiological analyses	Providers, some advocates, some activists
Social control/subjugation	Activists, some advocates

Regardless of the geographic differences between my sites, diagnostic classification in trans health—whether its use in the U.S. and elsewhere, or its declassification in Argentina—is squarely focused not on ontology, but on action and practice.

Non-Diagnostic Classifications

Non-diagnostic modes of medical classification have also shaped the landscape of trans health and influenced it as a formation. For example, HIV/AIDS treatment and prevention became concerned with the high prevalence and incidence rates increasingly found among trans people in the late 1990s and early 2000s (Baral, Poteat, Strömdahl et al. 2013). Epidemiologists initially classified trans women as "men who have sex with men," or MSM—a classificatory decision that raised much ire for trans advocates and activists (Parker, Aggleton, & Perez-Brumer 2016). In addition to the identitarian erasure of defining women as men, activists and advocates argued that the prevention needs of both groups were distinct. Epidemiologists had been more focused on what body parts were involved in fluid transmission, but they eventually responded to the pushback, and began to focus on trans women specifically as a "high-risk population" (e.g., Poteat, Reisner, & Radix 2014).

This set of debates, alongside other non-diagnostic classificatory debates, such as women's health clinics including trans men and women (Boston Women's Health Book Collective and Norsigian 2011, Chapter 4), contributed to the emergence of a common-sense presumption that 'trans health needs are unique.' This "uniqueness" was, however, accompanied by an implication of the sameness of "trans health needs." A growing number of scholars now argue that this has tended to collapse and erase some of the marked racialized, classed, sexualized, gendered, national, and other differences among gender non-normative people worldwide (Dutta 2012; 2013; Spade 2011 [2015]; Hanssmann 2012; Aizura 2011; Thompson 2015).

At some level, identitarian classifications at some level resist this collapse, and some actors have worked to integrate distinctions into the structuring of trans health formations. Some theorize that the very intervention of "trans health" as a terrain distinct from "transsexual medicine" significantly expands its reach across distinct forms of gender non-normativity by centering "transgender" (Singer 2006). Yet, as Valentine (2007) notes, transgender's provenance is not so uncomplicated as to be a strictly "community-based" term—and it indeed performs some of the same erasures of difference as does trans health. The shift is nonetheless indicative of the growing partnership between activists, advocates, and certain providers in developing "trans-supportive" trans health. Another identitarian classification—trans*—has also worked to intervene in the collapse and erasure of difference, particularly in Argentina. It does so by troubling certain ontological presumptions and suggesting a lack of universally mobile meaning in expressions of gender non-normativity. In so doing, it links up to trans health practice, implicitly claiming that trans health—much like distinct modes of being trans*—cannot be based in notions of sameness, but rather must be articulated within frameworks that explicitly acknowledge, center, and support difference.

From Disorder to Distress

The DSM's most recent revision (APA 2013), finalized and published in 2013, eliminated "Gender Identity Disorder" from the Manual, and introduced in its place "Gender Dysphoria." Several key distinctions subsequently emerged between these diagnostic classifications. Most notably, its authors touted the new classification as a tool to diagnose distress springing from gender non-normativity, rather than diagnosing an inherent psychological or developmental problem. Publicizing highlights of notable changes, the APA (2013b:14) wrote, "Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of 'gender incongruence' rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder" (APA 2013b:14). Proponents of this shift to a distress-based diagnosis suggest that it turns attention from individual pathology to the dynamic social environment within which transphobia and other forms of systematic subjugation bring about distress (APA 2013).

In addition to this change, Gender Dysphoria is now included in a chapter of its own, rather than in the chapter on sexual dysfunctions and paraphilias as was Gender Identity Disorder. Lastly, the language describing the diagnosis shifts from "sex" (as in "cross-sex identification") to "gender," following the lead of activists and advocates who proclaim distinctions in meaning among between gender, sex, and sexuality.

The lead-up to DSM-5 began in 2006 through the appointments of a DSM-5 Task Force, which in 2008 grew to encompass 13 Work Groups. These corresponded with each of the DSM-IV groupings (Zucker 2010). Kenneth Zucker chaired the Sexual and Gender Identity Disorders Work

Group, and members of the Gender Identity Disorder subgroup included Peggy Cohen-Kettenis, Jack Drescher, Heino Meyer-Bahlburg, and Friedemann Pfäfflin.[51] Drescher in particular positions himself as a trans-supportive provider, and works closely with mental health providers, advocates, and activists to foreground questions of access in the provision of care for trans people.

Subgroup members also solicited certain advisors for the process, and eventually in 2011 presented preliminary diagnostic descriptions to the public. Activists and advocates were thus included, albeit in subordinated ways, as advisors in the process. Activists and advocates also broadly circulated the call for public comment in the summer of 2011. Kelly Winters (2011), who heads GID Reform Advocates, published a lengthy blog post in the weeks leading up to the comment submission deadline, proclaiming that the draft diagnostic criteria "fall short." After detailing what she regarded as shortcomings, she encouraged people to register a user account with the APA and submit commentary. She also encouraged readers to ask LGBTQ organizations to "clarify that nonconformity to birth-assigned roles and being victims of societal prejudice are not, in themselves, mental pathology," and urged them to ask trans-supportive professionals to "voice their concerns to the APA" (Winters 2011). The Work Group indeed made several changes to the final version of the diagnosis, including incorporating an "exit clause" that Winters (alongside others) had proposed: "Gender Dysphoria" as a diagnosis would not remain with an individual in perpetuity as GID had, but would no longer apply after patients sought care that would presumably resolve dysphoria.

The new diagnosis was broadly regarded as a compromise between "old guard" defenders of GID and activists, advocates, and providers who sought to "depathologize" trans health care (discussed in Chapter 3). Trans-supportive mental health providers were largely content with the compromise (Fiona Interview, January 11, 2016). But the shift was met with mixed response by activists and advocates, as well as some trans-supportive medical providers. Overall, most of the providers with whom I spoke felt that it offered some degree of improvement and that it at least potentially improved non-stigmatizing access to care. Some were enthusiastic about the "depathologizing" tone of the diagnosis, while others were frustrated that it remained in the DSM as a mental health diagnosis. Miranda (Interview, August 10, 2013), a nurse practitioner, commented:

> "[I]t's still in the DSM, as far as a mental health… [T]he good news about that is it allows medical intervention, but I think that most proponents that I'm aware of would like it to be a medical diagnosis so we can get away from the stigmatization of mental illness, and pathology. I mean, I think it's good, it's better. But I just hate the DSM really. I hate all of it. I don't think it's useful. And yeah, maybe I'm like throwing out the baby with the bath water but it doesn't have to be the only way that we do things.

Some activists and advocates were displeased about the change for other reasons. Some concurred with Strangio's (2012) concern that for certain people, access to treatment depended on GID *as* a pathology. In a blog post following the DSM revision, he argued that among incarcerated people—with whom he was working as an attorney at the time—gender confirming care was often only accessible though 8th Amendment lawsuits against prisons and other carceral institutions for failing to provide adequate health care. These, he asserted, hinged on medicalized diagnoses, not on less clearly defined assessments of "distress." Similarly, certain advocates and trans-supportive providers who worked closely with low-income and trans people of color described how diagnostic classifications were of less immediate concern to many of their clients and patients. Advocates were less interested in diagnostic classifications and more interested in the regulations and classifications relevant to accessing state benefits plans, such as Medicaid. As a New York advocate named Gia described (Interview, January 12, 2016), their clients and patients were most interested in the classificatory systems that affected their public lives: namely, how they were likely to be targeted by police based on criminal classifications.[52] Issues of racialized, classed, gendered, and geopolitical stratification manifest most markedly in debates about depathologization regimes and activism (discussed in Chapter 3).

While DSM-5 contributors frame "dysphoria"—which originates from the Greek term for "distress"—as a novel intervention, it is in fact far from a new concept. In 1973, following the growth of university-based gender biomedical centers offering surgeries, Stanford psychiatrist

Normal Fisk suggested "gender dysphoria syndrome" as an improved means to assess patients' *degree* of non-normativity. "As originally intended," he writes, "the term *transsexual* was to specifically identify a person who was not to be confused with a homosexual or a transvestite" (Fisk 1974:387). He recounts his work with Stanford University Medical Center's clinical research on the efficacy of "surgical sex conversion" (Fisk 1974: 387) in an editorial published in the *Western Journal of Medicine*. Based on these reflections, he asserts,

> there was indeed a great deal of diversity and deviance from what had been defined as the symptoms of "classical transsexualism." Moreover, the overtly present common denominator was the high level of dysphoria concerning the individual's gender of assignment or rearing. It became readily apparent that people presenting with gender problems actually made up a spectrum of gender disorders ranging from the mildest to the most severe forms of this affliction. (Fisk 1974:388)

Fisk (1974) describes how the existence of this broad "spectrum" should guide providers to broaden indications for surgeries. "We are far more interested in the patient's status here and now and in the recent past, than we are in establishing a differential diagnosis" (Fisk 1974:389). However, he and his contemporaries were not interested in reconceptualizing transsexuality "as benign variation rather than as illness or disorder," as some activists in gay liberation and feminist movements desired (Meyerowitz 2002:254).

The repackaging of "gender dysphoria" in the contemporary moment aims to bridge Fisk's "spectrum" model with activists' notions of non-pathological plurality—the former as an index of a range of pathology, and the latter describing the non-pathological stress of social subjugation. This seems to hinge on dysphoria's reclamation and recirculation as a novel intervention.

From Distress to Incongruence

Miranda was not the only provider who wistfully expressed a desire for a solely "medical" and non-psychiatric diagnosis. Beth (Interview, July 25, 2013), another New York provider, wanted a way diagnose patients without the "stigma" that accompanies mental debility, and wished for a "neutral," which she then corrected to say, "I mean a *medical*" diagnosis. These expressions have in part to do with the diagnostic awkwardness that providers experience given the strange positioning of trans health care: unlike other conditions, the diagnosis is psychiatric but the "treatments" are hormonal, surgical, or other medical interventions on the physical body (Plemons 2010).

As New York-based nurse practitioner, Talia (Interview, August 3, 2013) said, "I still don't really think that as a nurse practitioner—[a] medical provider—I should really be diagnosing people with things out of the DSM…" This concern, however, undergirds a broader assumption: that psychiatry is a moral and moralizing domain, while the rest of medicine, in sharp contrast, remains at least potentially value-free: "neutral." Critiques of this supposed conventional wisdom are familiar in the medical social sciences (e.g. Metzl & Kirkland 2010). This ostensible schism also animates certain debates in psychiatry, promoting its "biologization" and compelling its alliance with neuroscience and other biologically-based endeavors of research and practice instead of the less "scientific" realms of psychoanalysis (e.g., Pickersgill 2011).

While several providers mentioned a "medical" or "neutral" trans diagnosis, few were anything but vaguely aware of the ongoing efforts in the World Health Organization (WHO) to update the ICD-based designation for the trans diagnosis. This process is part of the overall revision of ICD codes, which the WHO's World Health Assembly oversees. Within this, an ICD-11 expert working group was convened by WHO staff, comprised of medical providers, psychiatrists, and some non-medically trained advocates from across the globe. This was called the Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) Several members of this group asserted that it was:

> now appropriate to abandon the psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services. (Drescher, Cohen-Kettenis, Winter 2012: 575)

The WGSDSH also incorporated experts from the WHO Department of Mental Health and Substance Abuse as well as the WHO Department of Reproductive Health and Research. It was tasked with reviewing evidence and revising classifications, descriptions, and guidelines for conditions in the ICD-10 chapter on Mental and Behavioral Disorders relavant to sexual behavior, dysfunction, and orientation, as well as gender identity (Krueger, Reed, First et al. 2017). Strikingly, the group was also asked to review the APA's proposals for the DSM-5 revision.

The WGSDSH's working process progressed through several stages: First, members conducted literature reviews and compiled evidence. After developing a draft diagnosis, they entered a "Beta phase," during which they gathered public comments.[53] Subsequently, they initiated field-testing in several international sites, including in Mexico, Brazil, France, India, Lebanon and South Africa. Presently, the group has finalized the proposed diagnosis—Gender Incongruence. The WGSDSH recommends that it be placed in a chapter apart from the Mental Health and Illnesses chapter (within which "Gender Identity Disorder" appears in the ICD-10). These proposals will be voted on by the World Health Assembly in 2018.

In 2016, Geoffrey Reed, a member of the WHO Secretariat in the Department of Mental Health and Substance Abuse led the field testing in Mexico and co-authored results in the *Lancet Psychiatry* in 2016. His team used statistical modeling to analyze whether psychological distress or dysfunction was the result of "gender incongruence" or "social rejection and violence" (Robles, Vega-Ramírez & Cruz-Islas 2016). They found that social rejection and violence overwhelmingly predicted distress, while gender incongruence in and of itself did not. In a press release issued about the article, lead investigator Rebeca Robles (2016) commented: "Our findings support the idea that distress and dysfunction may be the result of stigmatization and maltreatment, rather than integral aspects of transgender identity."

Some U.S.-based providers discussed having heard about a group working to develop a "solely medical" diagnosis, but none with whom I spoke were directly involved. Nor did they mention having contributed to the public comments, though several had submitted feedback during the DSM's revision. Only two advocates with whom I spoke in New York were aware of the proposed changes to the ICD. In Argentina, by contrast, activists were broadly familiar with the process—even though the resulting diagnosis would not apply to trans health practice in that nation given the provisions of the new Gender Identity Law.

Antonio, a Buenos Aires-based activist and advocate with longstanding connections with providers and policymakers, was an adviser to the WHO working group, as were a number of other activists and advocates from a variety of locales. While diagnoses were no longer relevant in Argentina, he felt that establishing a non-mental health trans diagnosis would be possible outside of the confines of U.S. health infrastructures, and that this would benefit emergent transnational trans health networks. Jack Drescher (U.S.) and Peggy Cohen-Kettenis (Netherlands)—two of the four members of the DSM-5's Gender Identity Disorder subgroup—were also members of the ICD working group. Sam Winter (Singapore, now in Australia), another member of the WGSDSH, describes his classificatory positions as being shaped in part by trans activists with whom he is in contact (Winter 2014).

Activists and advocates also worked more indirectly on the ICD revision. Anticipating its arrival and hoping for a less pathologizing and more useful diagnosis for its constituents, one global activist organization held an international gathering in The Hague in 2011. Convening a group of multidisciplinary experts—most of them trans—they strove to provide early recommendations to the WHO as they anticipated the ICD revision. Intricately detailing codes, groupings, and chapters, they outlined a highly technical proposal of decentralized codes that could be tailored to localized needs—termed a "starfish model," for its decentralized nervous system and capacity to exist in separation. In the report, authors wrote:

> At the Experts' Meeting the starfish was used as a metaphoric model that could give answer[s] to differentiated possibilities in terms [of] access to health care, including its coverage. In this sense, combining different chapters, blocks and codes (the starfish's legs) could exponentially increase trans* people['s] opportunities of accessing health care under very different circumstances without recurring to a single and potentially repathologizing diagnosis (a Spider Model). (GATE 2011:10)

Ultimately, the Deleuzian "starfish model" was not adopted, but a number of the provisions and suggestions set forth in the report were considered and in many cases integrated into the currently proposed diagnosis of "Gender Incongruence."

While the Working Group seems to have come to a consensus that this new iteration of the trans diagnosis is not a mental illness, new fissures have formed around the question of whether or not "Gender Incongruence in Childhood" is a necessary diagnosis. Members and former members of the Working Group who say it should not further assert that such a diagnosis only prompts stigmatization of early gender variance, and it does not bridge to access (since hormone treatments are not used until just prior to adolescence). These members align with activists and advocates who soundly reject the classification. Other Working Group members, however, thought the diagnosis could be useful to bring about research funding and to justify specialty clinics. In a rather scathing guest post on Kelley Winters' blog, Sam Winter dismissed these arguments, and characterized the WHO's development of GIC as "transphobic hypocrisy" (2014).

ACTIVIST-PROVIDERS AND EXPERT-ACTIVISTS

The dynamics that emerge in the DSM revision and to an even greater extent in the ICD revision demonstrate how the boundaries among activists, advocates, and providers are increasingly permeable—often to the extent that it may be difficult to differentiate among work, position, and role based on what I previously framed as distinctive "social worlds." Instead, schisms now tend to take place along political lines—seen, for example, in Winter's adoption of activist critiques of transphobia not only as a phenomenon in the world, but as shaping current diagnostic classifications. Further, as Epstein (1996) has discussed, activists and advocates became highly conversant in technical aspects of diagnostic classification and practice. Yet most analyses of such "lay-expertise" center on how non-professionals become integrated in the production of knowledge. While this may include activist appeals to professionals to consider the quotidian needs and experiences of laypeople, studying trans health shows that in this instance, "expertification" (Epstein 1996) also involves certain providers building language, integrating knowledge, and orienting politics based on activist guidance. In this regard, activist inculcate providers with a concept of health care based on both experiences of trans existence and certain orientations to trans politics. Yet certain providers take this "activist inculcation" more seriously or incorporate it more deeply than others, bringing about varying levels of engagement with what might be called "provider-activism."

The WGSHSD drew from activist's accounts to define "social rejection and violence," rather than "gender incongruence" as those tightly linked to distress. This manifests a turn outward toward the social, rather than inward toward the individual (discussed in Chapter 2). While the WGSHSD attended carefully to questions of mobility and transnationality, however, more outward questions of racialization rarely arose in discussions about diagnostic revision (at least those documents to which I had access). Based on my ethnographic work, it was clear that diagnostic practices in the U.S. are (and in Argentina had been) markedly stratified and racialized. Several activists and advocates also discussed how apparent this was in their work.[54] As such, it remains curious that discussions about race and racialization were apparently given such short shrift in the DSM and ICD revision processes. This absence is the more notable because racialized (as well as sexualized, classed, and gendered) violence against gender non-normative people was increasingly reported in the media across the globe during the very years that the Working Group was assembled (BBC News 2015;

TGEU 2015). In fact, the whiteness of both of the working groups and the activists and advocates involved in diagnostic revision is rather striking. Chapter 3 discusses some of the racialized and classed power dynamics at play in trans depathologization activism.

In Epstein's (1996) description of AIDS treatment activists, the contributions of trans "community experts" are also highly stratified by race, class, gender expression, nation, and political objective. "Community expertise" in trans health advocacy and activism has involved imparting wisdom to providers about what trans life is like and how providers can help rather than hinder the possibilities of a good life. But in these collaborative interactions, both "trans life" and "a good life" are conceptualized in racialized, classed, ethnocentric, and otherwise specifically situated ways. Thus, even as the resulting changes in both classification systems and standardized practice guidelines "democratize" the scaffolding of trans health, they also encode and materially circulate marked stratifications.

TRANS-ASTERISK (TRANS*)

The ethnocentric terms of trans health's field of formation are increasingly contested as it emerges as a transnational field, and the ICD's revision process reflects some of these debates. Outside of a diagnostic framework, "trans*" (with an asterisk appended) has surfaced as one of many interventions on what some view as the US- and European-centered notion of "transgender." This classificatory innovation works to both critique the limits of "transgender" and to make the enabling apparatuses of trans health and activism more mobile. Such linguistic interventions contest domination of trans health's institutionalization by the global North.

Several years after its appearance in Latin American and Caribbean activism, trans* was also taken up in the U.S. However, it developed along a wholly different trajectory, not at all in conversation with its emergence in Latin America and the Caribbean. This diminutive typographical symbol, the asterisk, has come to stand in for an intense set of debates in both geographic sites. However, the debates differ markedly in each locale, revealing a great deal about the politics of transnationality, identity, mobility, and temporality at stake in trans health.

In the inaugural keywords issue of *Transgender Studies Quarterly,* Avery Tompkins (2014), describes the multiple registers of the asterisk in "trans-star." Working as either a "wild card" Boolean search term or a typographical footnote indicator, the asterisk *amends* "trans," expanding the groups of people to whom it applies. He wrote, "Proponents of adding the asterisk to trans argue that it signals greater inclusivity of new gender identities and expressions and better represents a broader community of individuals." Such *expansion* work has also been a theme of early as well as contemporary trans health activists wishing to contest the medical gatekeeping of health care providers vis-à-vis eligibility requirements for gender-confirming surgeries or hormones. A concern for such corporeal and identitarian pluralism similarly drives work to reform broader health care infrastructures to "include diverse trans identities, bodies and experiences" (as one set of guidelines describes) (Planned Parenthood Toronto 2016).

But in the US, the asterisk is a symbol now somewhat past its zenith. Tompkins places its online emergence around 2010. However, after a pitched and somewhat confusing battle on Tumblr, online communities—based largely, though not exclusively in the US—came to a consensus that the asterisk was either unnecessary, exclusionary, or delegitimizing (e.g., Trans Student Educational Resources n.d.; Gabriel 2014). Following these debates, some organizations removed the recently-added asterisk from their websites and materials, resulting in its rather abbreviated institutional life in the US.

While these exchanges included many discussions of the asterisk's origin, none that I could find mentioned a group of *travestis,* trans, and intersex activists that met under the auspices of an international LGBT NGO in Córdoba, Argentina in 2005. The training—in which various activists from Latin America and the Spanish-speaking Caribbean participated—employed the asterisk as what they called a "textual strategy." In the institutional report following the training, conveners wrote the following about the asterisk:

> How to avoid, while at the same time undermining, the generic determination that language places not just upon the subjects and their possibilities to find themselves in language but also on the way we conceive and name the world? One strategy that might be used is the one we have set at work while writing this Memoir, through using the asterisk (*) (IGLHRC 2005:2).

They described choosing the asterisk for several different reasons. For example, it enables a means of speaking about identities—both in the plural and individually—that do not necessarily condense as "transgender." There is also an implicit critique of "transgender" as an importation of the global North. Given the epidemiological revelation of high HIV transmission rates among what general global North-based NGOs define as "transgender women," some funding streams for targeted prevention were awarded to NGOs working on "transgender issues" in Latin America and the Caribbean. However, as a distinctly classed and racialized term, "transgender"—or in Spanish, *transgénero,* carries a set of connotations that was somewhat removed from the social position of *travesti.* Trans* thus became somewhat of a cheeky rejoinder to the ethnocentric presumption of equivalency. As the institutional report continued,

> We prefer the asterisk because of how it looks, almost suspended over the sentence, as a star in the horizon or a point through which it might be possible to fly away. Of course, the asterisk cannot be pronounced, and we also like that because, when our tongue comes there, and staggers, it becomes quite an accurate expression of the status enjoyed by those whose existence gender ignores (IGLHRC 2005:2).

The historical and regional erasure of the asterisk and its history in the context of U.S. trans politics does not come as a surprise given geopolitical power dynamics and the flows along which knowledge as well as capital flow. Nevertheless, it illuminates how identity categories, population health classifications, funding streams, linguistic debates, and geopolitics shape the landscape of trans activism across the global North and South.

CONCLUSION

Diagnostic classification is a primary site through which trans health is conceptualized, defined, practiced, and rendered mobile. The process of diagnostically defining "trans" is not so much punctuated by periods of breakdown as much as it is in a process of perpetual breakdown and revision per se. Within this process, closure becomes a challenge not only due to the ranging and changing objectives of involved actors, but also because of the geographic mobility that is either emphasized or ignored in classificatory debates. Unruliness is at work in the uncontainable and always-proliferating character of the trans diagnosis (as well as other trans classifications and their hybridizing forms). In addition, unruliness—albeit a rather tame version of it—it at play in activist practices to mobilize health providers and the field of biomedicine to adopt a politicized reorientation to the outward environment. Political unruliness—though still somewhat "disciplined" in its manifestation—also condenses in community-based population health projects I discuss in the next chapter.

Practices figure centrally in each of these debates—indeed, it seems as if questions of diagnostic accuracy fade nearly into oblivion though ongoing iterations of diagnostic revision. Not only advocates and activists but also providers seem to "work backwards" from their practice objectives to the classifications that will enable their desired actions. This perhaps decreasing regard for diagnostic accuracy also contributes to a sense of openness and play within the classificatory brackets of diagnostic systems and manuals. Lastly, the degree to which the APA's DSM revision almost exclusively centered on U.S.-based providers and advocates stands in contrast with the WHO's focus on transnational relevance. Nonetheless, both projects, nonetheless, reproduced as well as countered various forms of stratification and subjugation.

These processes signal a lack of foreclosure about the purposes and content of the trans diagnosis in health care. Similarly, they signal a lack of foreclosure in how people understand what trans health *does*—or at least should do—in practice. As such, classification is one domain through which *transmutable care* takes shape: perpetual revision yields a protracted period of openness within which many things can be diagnostically encoded, or diagnoses can be made to do very different things. The wild multiplicity of formations of transness, trans health, and trans politics proliferates in diagnostic debates. One can trace the changing politics of trans health not only through the published versions of revised diagnostic manuals, but through the minutiae of blog posts, acknowledgement sections, position statements, and by-lines in working group publications.

In the company of trans advocates and activists, providers have to a varying degree been enrolled in provider-activism via “activist inculcation.” For many providers, that has meant turning away from debates about diagnostic accuracy. Instead, they turn towards the concerns articulated by activists and advocates about the environments within which trans people live. Within these, providers have come to believe, many trans people encounter varying degrees of harm, subjugation, immiseration, and/or violence. Such concerns are embedded in classificatory debates. They also set the stage for what I discuss in the next chapter: a continuing shift of focus from individuals to external environment in the form of community-based epidemiology.

CHAPTER 2: EPIDEMIOLOGICAL RAGE: POPULATION BIOGRAPHY, BIOMEDICAL EXPERTISE, AND THE QUANTIFIED POLITICS OF RECOGNITION

In 2014 in Argentina, a trans and travesti[55] organization called ATTTA[56] and an HIV prevention organization called Fundación Huésped launched a campaign for the International Day Against Homophobia and Transphobia. Called *"Expectativas,"* which translates to "expectations," the campaign foregrounded the shortness of trans and *travesti* lives. Thus its name also connoted *"expectativas de vida,"* one translation of "life expectancy." The publicity campaign generated and aired a TV spot and posted large ads in the style of the image in Figure 1.

Figure 1. Poster from *Expectativas* campaign, sponsored by Fundación Huésped and ATTTA.

The campaign's visual images play on the sensationalism of "before and after" photos of gender transition, presumably from male to female. The typically masculine name on the left shows a date of birth. On the right is a feminine name, and under it a set of dates indicating that for the trans-feminine subject of the photo, death arrived at age 35—the life expectancy for trans people and *travestis* estimated by several community-based studies of life expectancy.[57]

In this chapter, I show how trans and *travesti* activists in Buenos Aires and New York City leveraged arguments that braided statistical and economic rationalities with affectively charged narratives to argue for political change. Activists in each locale defined early trans and/or *travesti*[58] death as directly linked to state or interpersonal violence, exclusion from health care, and/or marginalization from formal labor economies. These explanations stand in marked contrast with dominant epidemiological studies—though few in number—that define trans populations through behavioral risk, focusing largely on HIV transmission. I discuss how trans and *travesti* activists effectively redefined "risk" as a descriptive critique of sexualized, gendered, and racialized subjugation. Specifically, I show how these groups mobilized hybrid modes of epidemiological thinking, sometimes by adopting concrete epidemiological methods.

This chapter has three related aims. First, it describes the importance of epidemiological thinking to trans health advocacy and activism. Second, it proposes and explains "population biography" as a specific form of political and health-based knowledge production. Third, it discusses how these activist interventions are marshaled into contingently effective citizenship claims. I begin by outlining two legal and regulatory shifts: one in each of my ethnographic sites. While distinct at many levels, these transformations specifically addressed gender-confirming care as a public entitlement, and linked this to political recognition. I trace how trans health activists in part brought about these changes by drawing on quantitative methods, epidemiological thinking and what Biehl (2010:182) calls the "pharmaceutical discourse of life-saving."

The first regulatory shift took place in Argentina, with the passage of the Gender Identity Law. The second took place in New York State, with the elimination of the Medicaid exclusion for reimbursement of gender confirming care. In both sites, I describe how activists leveraged these regulatory changes through a strategy that I call *population biography.* By developing and circulating population biographies, activists in Buenos Aires and New York called for new regulations, expanded legal provisions, and economic redistribution to address the profound and distinctly racialized and classed foreshortening of *travesti* and trans people's lives. For these health activists, biomedical, epidemiological, and political recognition are closely intertwined. Dynamics of citizenship—formal, biopolitical, and so on—suffuse the field of political claims-making in the realm of trans health. The imperative for trans activists to engage notions of citizenship, to the degree that these comprise a *lingua franca* of distributive governance, thus enables certain demands while constricting others.

Relevant to these legal and regulatory changes, I demonstrate how trans health activists mobilize the political discourse of citizenship to expose either systematic neglect or targeted state violence towards gender non-normative people. In addition to potentially revealing contradictions in regimes of liberal equality, these strategies also open up debates about "proper" citizenship and which subjects may be considered deserving by state care apparatuses. The chapter thus engages several examples of political claims-making on the part of trans health activists to interrogate the stakes of varying approaches to political action and social movement mobilization. In so doing, it examines how "trans health"—mobilized metonymically as gender-confirming care—has in part been reimagined and refashioned by social movement activists' interactions with each other, with health care providers, and with policymakers.

Within the distinct political dynamics that circulate in each of my ethnographic sites, the language and logics of epidemiology and population health both thematically and materially assemble risk, health, violent death, recognition, devaluation, and citizenship claims. These converge in a strategic political deployment of what I name "population biography." "Population biography" methodologically merges narratives of embodiment, collective politics and praxis, and encounters with state and other forms of violence (among others) with quantitative methods informed by population health. In addition to engaging Brown's (1987, 1992) notion of "popular epidemiology," this concept also draws on Traweek's (1999:189, 199) insights about the centrality of "intimate knowledges" in how people 'embody theories' and 'theorize bodies' in research on biomedicine and technoscience. This chapter explores how citizenship and other political claims for recognition, remuneration, and reparation are leveraged through a lexicon of health—and specifically through quantitative population health methods. In examining such reversals of expertise and the diffusion of knowledge, the chapter shows how trans activists and *travestis* not only made the statistical personal, but also produced a *population* that compelled recognition and political action in ways that individual-level claims could not—a phenomenon that resonates with Chatterjee's (2004) "politics of the governed". In conclusion, I describe how such political claims confound, remake, and reiterate gendered, sexualized, racialized, and abled hierarchies of human valuation.

STATISTICAL TURNS AND THE RELEVANCE OF VIOLENCE

Argentina's and New York's legal and regulatory changes mark shifts in how gender confirming care is conceptualized with respect to public forms of health care financing.[59] First, Argentina's unusually expansive Gender Identity Law passed in 2012, was buoyed in part by claims that the nation's ongoing subjugation of gender non-normative people comprised a "debt to democracy" (*deuda de la democracia).*[60] One of the more persuasive arguments for legislators on this point was the potential for the law to mitigate the enduring threat of violence and proximity of death for trans people and *travestis*. The activists involved in drafting the initiative sought to eliminate or limit administrative barriers to health care access and legal gender reclassification by identifying these as primary obstacles to social and political recognition and extended life chances.[61] The law's relatively easy passage turned in large part on the effective politicization of a drastically reduced life expectancy for trans people in the nation, pointing in particular to state and other forms of violence contributing to lives being cut short.[62]

Several years later, New York State eliminated a sixteen-year blanket exclusion for gender confirming care for trans people who are recipients of Medicaid.[63] New York State's Department of Health became the target of a series of direct action protests and a 2015 class action lawsuit that eventually overturned the provision. Activists who protested to the Insurance Commission and Offices of Medicaid and Medicare, as well as the attorneys and advocates involved in the lawsuit, framed their demands baldly as a question of survival. Appealing to empirical studies, they asserted that lack of access to health care results in "increased suicidality, higher rates of drug and alcohol abuse, and higher rates of unemployment." (Kinkead 2015:Paragraph 6).[64] Prior to this, a series of lawsuits and proposals had been unsuccessful in overturning the exclusion, begun in 1998.

One of the major effects of trans activists' involvement in shaping trans health alongside health care providers has been that violence, murder, and suicide have been defined as issues central to trans health and well-being. This is true in both the U.S. and Argentina, and has been advanced through a series of community-based studies (e.g., Xavier, Hitchcock, Hollinshead et al. 2004; Bockting and Avery 2005; Berkins and Fernández 2005; Berkins 2008). In these studies, violence is described not only as a public health problem to be publicized and addressed, but also as a central reason for leveraging changes to insurance plans and legal regulations that prevent trans people or *travestis* from changing legal identification or accessing hormones or surgeries.

Activists and advocates also argue that having a physical appearance that does not align with gender normative self-presentation of increases one's likelihood to be targeted for violence. Therefore, they assert, affordable gender-confirming health care must be available as a preventive measure. Activists also argue that having a legal ID with a gender marker that does not seem to comport with their gendered embodiment increases the possibility of being targeted, harassed, or detained by police. To mitigate these outcomes, activists assert that gender reclassification must be made easier to achieve through policy simplification and innovation. By defining what is at stake for trans health in these expansive ways, activists thus rendered violence legible through the epidemiological lexicon of health disparities. At least theoretically, violence and death became the discernible health outcomes that demonstrated excess death among trans people—which could be mitigated through robust trans health care provision and shifts in legal and regulatory policies and practices.

Producing statistical evidence of health disparities and negative health outcomes has proven to be an important advocacy instrument for trans and *travesti* activists. Adams (2016: 16-17) calls this "metrical forms of accountability" and Porter (1995) calls it "trust in numbers." Both are distinctive signs of neoliberal assessment and audit strategies in which what *counts* must be both quantifiable and quantified. Many of these trans and *travesti* activists had long described anecdotal accounts of violence and exclusion, and they had worked to leverage these narratives into provisions that would support trans and *travesti* survival. However, the activists I observed describe encountering pushback from law- and policymakers, funders, and some health care providers about whether or not they could credibly demonstrate the patterns of violence and exclusion that they described narratively. As such, some activists and organizations prioritized the production of quantitative data to support the claims they had already been making (e.g., National Center for Transgender Equality and National Gay and Lesbian Task Force. 2010; Berkins and Fernández 2005; Berkins 2008).

However, statistical analyses to demonstrate excess mortality have been elusive. As the handful of health researchers working on what they define as "transgender populations" have asserted, several factors make it difficult to produce quantitative analyses. For one, they assert that it is a "very small" population compared with the general population of the U.S. Many of the central tools for public health researchers, such as the national Census or national longitudinal studies, do not track gender identity or sexuality. As such, researchers have tended to use non-probability samples to draw conclusions.[65] They nonetheless draw from data to speculate that trans people experience disproportionate exposure to violence (Bockting, Miner, Swinburne et al. 2013; Nemoto, Bödeker, Iwamoto 2011; Berkins and Fernández 2006; Berkins 2007).

Regardless of statistical analyses, the frequency of violent death among trans and other gender non-normative people is regarded as common knowledge among activists and others, and narrative memorialization has played an important part in trans politics in the U.S., Argentina, and elsewhere. Internationally, November 20th is the Transgender Day of Remembrance (TDOR), during which trans people and supporters gather in vigil and read names of trans people who have died violently over the past year. In Argentina, a group of trans and *travesti* activists and supporters have developed a campaign calling for an end to *travesticidios*—"travesticides," or murders of *travestis*. This campaign parallels and at some level joins feminist anti-violence movements in Argentina and beyond (for example, *Ni Una Menos,* or "not one [woman] less") in their call to stop the gendered violence of femicides (Fregoso and Bejarano 2009). Both TDOR and *Ni Una Menos* focus on foregrounding specific names and sometimes brief narratives about people who died from gendered and/or anti-trans violence.

Significantly, both population health and narrative memorialization define transgender identity as the primary condition of exposure to violence. And yet some have contested these narrative practices, pointing to their failure (or at least TDOR's failure) to account for racialized and classed trans death. For example, Lamble (2008) argues that "by focusing on transphobia as the definitive cause of violence, this [TDOR] ritual potentially obscures the ways in which hierarchies of race, class, and sexuality constitute such acts." Lamble (2008) further explains that through these dynamics, victims "emerge… as the product of an individual hatred or fear rather than the result of the accumulative effect of social institutions… that are founded on, and perpetuate, complex hierarchies of power and violence."

Others have contested the production of knowledge about trans death more broadly, including statistical iterations. In their work on trans necropolitics, Snorton and Haritaworn (2013) assert that feminized gender non-normative subjects who are racialized as non-white, and who are generally marginalized from formal labor markets and administrative citizenship, are uniquely marked for death. They suggest that while the deaths that are memorialized and statistically mobilized to bring about state protections, rights, and resources are primarily those of trans women of color, such provisions primarily benefit white, economically-mobile gender non-normative citizen-subjects. Snorton and Haritaworn (2013) name this as an insidious form of "value extraction" from trans of color death. It is precisely this extraction of surplus value, they assert, that enables a "newly professionalizing class of experts" to produce population health and other studies about (deracialized and declassed) excess trans death (Snorton and Haritaworn 2013, 67). I draw on Snorton and Haritaworn's (2013) mobilization of necropolitics to discuss how racialized, classed, and other stratifications take shape along lines of life chances, exposure to violence, knowledge production, and resource distribution. However, I also engage empirical evidence to demonstrate how the multiple dimensions of value and the persistent but non-deterministic dynamics of knowledge economies can both stabilize and occasionally destabilize such hierarchies.

While there is increasing statistical focus on patterns of violence, the statistical life of trans death is probably more visibly represented by larger-scale HIV prevalence and incidence studies and review articles[66] that define transgender populations as "high risk" for HIV transmission through sexual "behavior" (e.g., Baral, Poteat, Strömdahl et al. 2013; Herbst, Jacobs, Finlayson et al. 2008). Varying degrees of explanation accompany these forms of knowledge production. Some researchers caution that that these results must take into account the conditions within which sexual "decision-making" unfolds. Others claim that statistical methods misrepresent the actual disease burden of HIV in trans populations. Some assert that economic conditions and the survival imperative of working in informal economies (including sex work) constitutes an important consideration, and should be a domain for future research. Significantly, in all of these studies, "risk" is generally constructed as an *individual-level analysis of decision-making*, constrained or not.

This stands in stark contrast with certain community-based studies, which redefine "risk" *not* through individual behavior, but through group-differentiated exposure to violence, marginalization, and exclusion from social spheres, employment, and health care access. This difference in perspective and orientation is at the center of the "epidemiology wars" (Poole & Rothman 1998). As Shim (2014:71) asserts, introducing "group-level data" into epidemiology has been nothing short of controversial. Looking beyond individual-level data "challenges many of the discipline's standard operating procedures and assumptions about the scientific validity and legitimacy of different types of research and data" (Shim 2014:72). While the subfield of social epidemiology strives to achieve scientific validity while integrating group-level data, this remains somewhat marginal to hegemonic epidemiology practice.[67]

Community-based studies of trans subjects have implicitly argued against individual "behavioral" models of health, illness, and by translation marginalization. In the U.S., community-based studies centered on trans subjects have tended to be published by non-profit organizations or by health researchers in collaboration with trans advocates or "community members" (e.g., Clements-Nolle and Bachrach 2002; National Center for Transgender Equality and National Gay and Lesbian Task Force 2012).[68] Some are peer-reviewed (and thus at least admissible, if contested, in population health research), but some are not. In Argentina, community-based studies have largely been conducted by *travesti* and trans organizations, sometimes in collaboration with scholars, and other times not (Berkins 2007; Berkins and Fernández 2006; Borgogno with REDLACTRANS 2009). While there are a number of Argentinian manuscripts that publish health-based data on trans and *travesti* people, I have not to date located epidemiological articles on this topic in Argentina.

While community-based studies in both locales focus on distinct questions and forms of data presentation, they tend to define what might be called “structural problems” as primary in producing situations of risk or imperilment to trans people. Such studies vary in the extent to which they present racial and class difference as central to these dynamics, but they uniformly reject—usually implicitly, and sometimes explicitly—the “individual responsibility” implications of standard epidemiological behavior-based risk paradigms.

Next, I combine ethnographic data with legal and regulatory document research to describe statistical claims about trans health that, combined with narratives, brought about significant and somewhat surprising transformations in Buenos Aires and New York.

LEGAL CHANGES IN THE PUBLIC PROVISION OF TRANS HEALTH CARE

Policy and infrastructural landscapes of trans health care have shifted significantly in the past 20 years, especially vis-à-vis the availability and coverage of gender-confirming health care. As I discussed in Chapter 1, both biomedical and psychiatric understandings of gender non-normativity have shifted. Alongside them, dominant paradigms for treatment and reimbursement have shifted as well. This section focuses on two legal and regulatory transformations—one at the level of the nation and one at the level of the state—within which key controversies about trans health have recently condensed.

Argentina’s “Groundbreaking” Gender Identity Law

In 2012, Argentina passed the federal Gender Identity and Health Comprehensive Care for Trans People Act. The resulting Gender Identity Law has received remarkably and curiously little attention in the US, although it has inspired legislative actions in several other nations.[69] The Gender Identity Law greatly reduced bureaucratic barriers and surgical requirements for legal gender reclassification in the nation. Previously, people who wished to change the gender marker on their national ID cards had to get a psychiatric diagnosis, surgical treatment, and medical approval, and had to plead their case before a judge--a lengthy, expensive, and often very arduous experience.[70] Policies were inconsistent, and the process often took several years. The Gender Identity Law converted this to a two- to three-week streamlined administrative process requiring only expressed desire on the part of those requesting this change.[71] Furthermore, the law required gender-confirming health care to be covered or reimbursable across the three-tier medical system, including in public hospitals (which subsidize the care of people without employer-based or private health insurance).[72] In addition to this, the law did away with the necessity of establishing a Gender Dysphoria diagnosis (described in Chapter 1). Again, only an expression of desire on the part of those seeking hormone or surgical treatment is necessary.

While various forms of the law had been introduced to the Argentinian legislature since 2007, the Gender Identity Law passed in 2012 is notable in several regards. First, it was conceived and drafted by a coalition of activists, and was provided to legislators in its final form only after protracted internal debate among coalition members. Second, it combined administrative gender reclassification with access to gender-confirming health care within the same law. Third, it eliminated the use of the psychiatric diagnosis that had previously been requisite to initiate gender-confirming care and legal gender reclassification (and that generally remains so in most other nation-states). Fourth, the act passed by a very wide margin.[73] Fifth, it was the first national law based on the Yogyakarta Principles (2007), which reconceptualized sexual orientation and gender identity through international human rights law. Finally, the law applied health care coverage for gender-confirming care in a less economically-stratified manner than is typically the case.[74]

The activists who conceptualized the Argentinian law prioritized the gender reclassification provision in part because legal gender markers on ID documents have been a pretext for police harassment, violence, and arrest among gender non-normative people, alongside other forms of systematic exclusion. They also stressed the importance of access to diagnosis-free gender-confirming care in public as well private hospitals, at once rejecting medical gatekeeping and reducing economic stratification of care. Nico, one of the attorneys and activists with whom I spoke, explained that CHA (Homosexual Community of Argentina, or *Comunidad Homosexuál de Argentina*)[75] struggled with coalition members from other organizations who wanted to separate these two legal provisions (gender reclassification on one hand and depathologized medical access on the other). In our interview, he said, "[i]t was another aspect of our bill that…we included the right to health and…the ID amendment stuff all together. The other organizations did it separately" (Nico Interview, August 3, 2015). Nico (Interview, August 3, 2015) further described how he thought some of the coalition members who opposed combining the provisions had arrived at their position:

> Well, during the discussion of the law, I think that the other organization that had this decision of dividing the two bills, I think…they got in advance some sort of advice from someone that knew about laws and about lobbying from healthcare companies, because I remember the day the law was approved [that I heard] from some Senators, saying, "This law is stupid because I told them many times that the health part should be in another bill. The implementation of the law is going to be very difficult. Blah blah blah."

Thus, certain activists argued that the combined law was unfeasible and unlikely to pass, largely due to anticipated organized resistance from health care providers and insurers. Nonetheless, it passed Argentina's Congress by a landslide.

Indeed, the law seems to diminish medical authority in a manner that many anticipated would be problematic for health care providers. Significantly, Nico (Interview August 3, 2015) noted that providers (save for those already involved in LGB or trans*/travesti activism) were not part of the coalition developing the law:

> I don't remember having doctors in the discussion. It was organizations and [was] very politicized, it was a very active political campaign of "we want this law." "We want it now!" was part of the slogan. "Gender identity law now." The organizations were very hurried. They pushed the discussion a lot.

After its passage, the health care provisions of the law have been challenging to implement at several levels. For example, Nico (Interview, August 3, 2015) and others mentioned certain providers who resisted the law's imperative not to use psychiatric diagnoses in the delivery of gender-confirming care. In fact, one provider who considered himself a trailblazer in trans health care continued insisting that patients come to him for regular psychiatric treatment. Other providers were less recalcitrant, but nonetheless found themselves unprepared to meet the needs of patients. Some surgeons sought guidance from practitioners outside of the country, while others anxiously awaited guidance from the Ministry of Health about how to conceptualize trans health care provision.

Yet despite its easy passage, the law remained unregulated by the Ministry of Health for three years following its passage. Nico and others explained that this delay caused providers and insurers to express confusion about what treatments and procedures would be included and standardized. In the absence of governmental guidance, a trans advocacy community-based organization called Capicüa (2014) published a trans health guide. This guide acquainted providers with terms, medical facts, and narrative experiences of transition, as well as including a social and political history of medical power in regulating and normalizing gender. In 2015, the Ministry of Health finally issued explicit regulations to implement the law, which up to that point had been enacted in an ad hoc manner by varying hospitals and insurance systems based on their own interpretations of the law. But even the formally issued regulations issued few concrete guidelines about reimbursement rates and qualified treatments. Its vagueness caused Nico to describe the regulations as "a legal joke," and to compare it to other symbolically important but ill-regulated health care laws. Following the law's regulation, the National Program for Sexual Health and Responsible Reproduction (Programa Nacional de Salud Sexual y Procreación Responsable et al 2015) published a health guide to educate providers about implementing the law's provisions. While this guide served as the official expert resource, it drew extensively from Capicüa's (2014) document, basing its first two chapters almost entirely on that community-based organization's resource.[76] In a reversal of the conventional wisdom of expert knowledge production, activists thus provided the expertise that produced both the Gender Identity Law and the guidelines for its biomedical implementation.[77]

The law—whether or not it delivers on all of its promises—aims to address conditions of life and survival, and to facilitate the reduction of state violence and biomedical coercion. At this level, it can be distinguished from some of the legal anti-discrimination advocacy in the U.S. and elsewhere that aims to enroll state actors (including police) to supposedly to *protect* gender non-normative people as an identitarian class from bad transphobic actors. Notably, Argentina's federal anti-discrimination laws do *not* explicitly include gender identity or sexuality, although a 1988 anti-discrimination law could be broadly interpreted to apply to anyone who "prevents, obstructs, restricts or in any way undermines the full exercise on an equal basis of the fundamental rights" (Ministerio de Justicia y Derechos Humanos, Presidencia de la Nación 1988).[78] However, while "race, religion, nationality, ideology, political or trade union opinion, sex, economic status, social status [and] physical characteristics" are specifically protected, gender identity and sexuality are not. Presently, activists are working to pass anti-discrimination laws in Argentina (Buenos Aires passed one in 2015), but they describe prioritizing laws that pertained specifically to access concrete entitlements and administrative rights.[79] Meanwhile, activists elsewhere in the world strive to attain a law "like Argentina's" (e.g., International HIV/AIDS Alliance 2014: 53). As mentioned, the "coattail" effects of this law are already becoming manifest in Latin America, Europe, and beyond. Even in the reporting on these shifts, the "West and the rest" (Hall 1996) dynamics that postcolonial scholars describe are notable. For example, a recent article (Russo 2017: Paragraph 1) erroneously described Denmark—which in 2017 passed a law replicating some of Argentina's Gender Identity Law's provisions—as "the first country to declassify [transgender] as a mental illness."

New York State's "Medicaid Victory"

In 1998, New York State's Department of Health added a specific exclusion for state Medicaid payments for any treatments—surgical, hormonal, or psychological/psychiatric—related to what they called "gender reassignment." It appeared in the state's social services regulations without a hearing (Spade 2010), around the time when trans health activism had begun to gain some degree of visibility in the US.[80] Many state Medicaid programs had no explicit policies governing gender confirming care for trans people, although some had (and continue to have) limitations or exclusions on such care (Spade 2010: 500). Such policies have often been justified by defining gender confirming care for trans people as "experimental" (or sometimes "cosmetic")—which was the case in New York. Professional organizations have begun to contest these claims, and trans-supportive researchers have aimed to address any perceived gaps in evidence-based research.

Despite New York's exclusion, many trans Medicaid beneficiaries were able to access coverage for hormones in the first few years after its implementation. This changed in the early 2000s, when advocates at Sylvia Rivera Law Project (SRLP)—a collective grassroots organizing project and legal agency that provides legal representation for low-income trans people and trans people of color—began to hear from clients that their hormone coverage was being cut off. The Department of Health had evidently begun flagging those records where gender markers and hormone prescriptions were ostensibly "mismatched."

Meanwhile, grassroots and direct action strategies[81] for health care access were gaining momentum in New York and throughout the US. Some of these advocated depathologizing care—discussed in Chapter 3. Others protested discrimination in health care settings, while still others engaged organized labor to address insurance coverage (e.g., Wilson 2013). In New York City in particular, direct action strategies embraced broad demands for justice, and folded health activism into a larger political program. TransJustice, "a political group formed by and for trans and gender-nonconforming [TGNC] people of color," (TransJustice 2006: 227) organized the first "Trans Day of Action for Social and Economic Justice" in 2005. Lack of basic health care for trans people of color was defined as part of a bevy of marginalizing forces confronted routinely. A 2005 statement asserted:

> The specific issues that TGNC people of color face mirror those faced by broader communities of color in NYC: police brutality and harassment; racist and xenophobic immigration policies; lack of access to living wage employment, adequate affordable housing, quality education, and basic healthcare; and; the impacts of US imperialism and the so-called US "war on terrorism" being waged against people at home and abroad. These issues are compounded for TGNC people of color by the fact that homophobia and transphobia is so pervasive in society. As a result, our community is disproportionately represented in homeless shelters, in foster care agencies, in jails and prisons. (TransJustice 2006:228)

TransJustice's Trans Day of Action responded directly to the city's 2002 vote to prohibit transgender discrimination—a commitment that the group pointedly noted was slow to be regulated, as the law lacked guidelines for implementation for two and a half years. In their 2005 statement, Day of Action organizers explicitly connected trans discrimination with broader racialized economic marginalization, including the lack of health benefits. The city's action to pass the anti-discrimination law and the state's decision to restrict hormone benefits for trans people were ostensibly unrelated. Nonetheless, it reveals how formal legal protections—specifically in the realm of employment and housing—do not necessarily extend to health care access and benefits.

In 2007, a team of attorneys (including those at SRLP) brought a federal lawsuit to challenge the statute that excluded gender-confirming care for trans people. The team argued that the statute discriminated on the basis of diagnosis, since hormone treatments and gender-confirming surgeries were reimbursable for other diagnoses. A judge dismissed the suit without granting a hearing, and the claimant and representing attorneys decided not to appeal to avoid a setting what they considered a negative precedent if they lost. In 2011, attorneys—again, led in part by SRLP—tried a different course of action. Governor Cuomo had just come into office and assembled a "Medicaid Redesign Team" (MRT) to save money and improve health outcomes. Several advocates looked to this process as an opportunity to reverse New York State's blanket exclusion. Several advocates submitted a proposal for consideration to one of the MRT's subgroups, the Health Disparities Working Group. While advocates retained a position that the regulation was unfair and unethical, this time advocates also focused on the savings in mental health crisis costs, as well as the health-supportive benefits of lifting the exclusion. The Working Group thus decided to issue the proposal to the Governor's team.

In the course of this process, however, reporter Carl Campanile from the New York Post learned that lifting the exclusion was on the MRT's agenda. He wrote an article entitled, "Let Taxpayers Foot Sex-Op Bill: Panel," reporting that the Working Group advising Cuomo wanted "taxpayers to foot the bill for transgender residents to get 'sexual-reassignment surgery[.]'" (Campanile 2011a). He continued, "New York's costliest-in-the-nation Medicaid program would cover the tab." (Campanile 2011a). Greta (Interview, January 9, 2016), an attorney and advocate in New York City, explained that this caused an uproar within the MRT and Governor's office. While the process was supposed to be "transparent and public," the MRT and Cuomo's team was concerned with the negative press. Greta (Interview, January 9, 2016) explained that the state insurance commissioner, Nirav Shah, met privately with some of the people involved in submitting the proposal. When the Health Disparities Working Group compiled their final list of proposals for Cuomo, the proposal to lift the exclusion was pulled from consideration. Two days after the initial Post story ran, Campanile ran a second story, salaciously titled, "Cuomo Chops Off Sex-Change Funds" (Campanile 2011b).

Sara (Interview January 14, 2016), a New York City activist and media advocate, described how a SRLP members and attorneys, as well as other local activists and advocates, regrouped following this. She explained:

> I think what they were taking away from that is that this work behind the scenes or even this work out in public like a lawsuit which becomes public knowledge when the media gets a hold of it, it's kind of a disaster… [T]he New York Post scooped [the 2011 proposal] so that had a really big impact, and SRLP…didn't want to go through this work and have it happen again. So what was the other option? Was it to just continue to try to

> keep things under the radar as much as possible and be careful about who you talk to and that kind of thing, which is very hard? Or was there another way of actually using the media this time, particularly as trans stuff was finding its way into the mainstream a little bit more here and there which…could have been useful.

Sara said that despite concerns about public reception, a team of activists, advocates, and media specialists—from SRLP, GLAAD and TransJustice—came together to develop a public campaign about trans health in support of lifting the Medicaid exclusion. SRLP, Legal Aid, and a group of other attorneys were already gearing up to try litigation once again. They planned to file a class action lawsuit on behalf of two Medicaid beneficiaries (*Cruz v. Zucker* 2015*)* Prior to this, the group decided to "lay the groundwork" for this, as Sara described, by producing PSAs with trans people, health care providers, and family members discussing the importance of trans health.

The resulting education and media campaign embedded several arguments in its materials: first, trans people lack access to care in part based on economic marginalization; second, health care for trans people is not exceptional or "special"; third, non-medically supervised care is unsafe, and that it leads to emergency room costs (Sara Interview January 14, 2016); fourth, despite public rhetoric, health care for trans people is affordable; and last, health care access leads to improved outcomes, reduced mortality and morbidity, and hence cost-savings. Sara said that one of the objectives was to cultivate support through finding points that non-trans people could relate to:

> The messaging… was that this isn't special healthcare, that it's the same healthcare that many people access every day. [T]hat came out of this idea again from the report of drawing other people in, so it didn't seem [like] some care that they couldn't relate [to]… The hormone therapy that I receive is the same that some cis woman in menopause receive or at other points in their life for whatever reason and same goes for testosterone. There are cis men that access that as well. [S]urgeries often can be similar to things that cis people receive as well. So we wanted to get that point across so people didn't feel so… Because trans healthcare has been sensationalized for everyone in the media so we wanted to just challenge that and question that.

Each of the campaign points is represented below in one of the infographics circulated by the campaign (see Figure 2). The graphic below was circulated both as a composite and in various component parts. Throughout the campaign, figures and statistics about the improvement of mental health outcomes and the reduction in suicidality were repeated frequently.

EVERYONE NEEDS ACCESS TO SAFE, RELIABLE HEALTHCARE

MEDICAID PROVIDES CRUCIALLY NEEDED CARE TO LOW-INCOME PEOPLE ACROSS THE COUNTRY, INCLUDING NEW YORKERS.

DID YOU KNOW?

- 15% OF TRANSGENDER PEOPLE ARE LIVING IN POVERTY

COMPARED TO

- 4% OF THE GENERAL POPULATION

19% OF TRANSGENDER PEOPLE REPORT LACKING ANY FORM OF HEALTH INSURANCE, INCLUDING MEDICAID

SELF-MEDICATION IS DANGEROUS

UNSUPERVISED HORMONE USE CAN LEAD TO SERIOUS LIVER PROBLEMS, BLOOD CLOTS, STROKE, AND INCREASED HIV AND HEPATITIS RISK.

HEALTHCARE FOR TRANS PEOPLE IS NOT 'SPECIAL' CARE

IT'S JUST REGULAR HEALTHCARE THAT NON-TRANS PEOPLE ACCESS EVERYDAY – BUT THAT IS SPECIFICALLY DENIED TO TRANS PEOPLE.

COVERING THE HEALTH CARE NEEDS OF TRANS PEOPLE IS AFFORDABLE

MANY INSURANCE PROVIDERS COVER TRANS HEALTH NEEDS – WITHOUT RAISING PREMIUMS.

WHEN TRANS PEOPLE GET THE CARE THEY NEED

OVERALL MENTAL HEALTH IMPROVES

78% OF TRANS PEOPLE HAD IMPROVED PSYCHOLOGICAL FUNCTIONING AFTER RECEIVING GENDER-CONFIRMING TREATMENT.

SUICIDE RATES DROP DRASTICALLY

FROM A RANGE OF 29% TO 19% BEFORE GENDER-CONFIRMING TREATMENT, TO A RANGE OF 6% TO .2% AFTER TREATMENT.

MEDICAID MONEY IS SAVED

TRANS PEOPLE WHO RECEIVE GENDER-CONFIRMING TREATMENT HAVE FEWER MENTAL HEALTH AND SUBSTANCE ABUSE COSTS, WITH HIGHER RATES OF EMPLOYMENT.

HELP REPEAL MEDICAID EXCLUSIONS FOR TRANSGENDER PEOPLE IN NEW YORK. VISIT SRLP.ORG

glaad glaad.org

SYLVIA RIVERA LAW PROJECT

Figure 2:
Infographic by GLAAD and SRLP circulated in 2014

In addition to the infographic and PSAs, the coalition also engaged in direction actions against the State Insurance Commissioner Shah and his successor, Howard Zucker. On Valentine's Day in February 2014, a group of activists protested the Medicaid exclusion in from of the New York State Department of Health office. Members of SRLP and TransJustice, as well as other organizations such as Make the Road, Trans Women of Color Coalition, and Trans Latinas, organized and attended the march. They held banners and signs with images of hearts on them that read, "Hey, Shah: Where's the Love? Trans People Need Safe + Affordable Healthcare Now!" Protestors also carried a bunch of red mylar balloons in the shape of hearts. In May, activists targeted Zucker, who had recently replaced Shah. Zucker was delivering a keynote speech at a health care technology and design conference in New York City. SRLP members took the stage and unfurled a large banner that read, "NY Needs #TransHealthcareNow: End Medicaid Exclusions." Two activists held the banner while Reina Gossett, SRLP's membership director, spoke from the stage. Reflecting in a media interview on the five minutes she spent speaking from the stage, Gossett (2014:Paragraph 4) said:

> I talked about why this regulation is so harmful – it's not just a policy issue, it's about who can go to the doctor, who can access medically necessary care, and who can live. And right now the message that the Department of Health is sending to transgender New Yorkers is that they don't care if we live, they don't care about our health.

Attendees at the conference—which had nothing specifically to do with trans health—used the Twitter hashtag prompted by the banner to tweet and post photos of the protest using the conference's name and the #TransHealthNow tag.

Attorneys filed the class action lawsuit a few months later. The defendants filed a motion to dismiss, which they were granted for several provisions of the lawsuit. However, the motion was denied for a number of the articles outlined by the team representing the plaintiff. As a result of this, New York State agreed to repeal the exclusion, though they maintained exclusions for covering hormones for people under 18, as well as surgeries for people under 21. They also excluded surgeries and procedures that they defined as "cosmetic," including breast augmentation, electrolysis, facial feminization surgeries, tracheal shaves, and (oddly) voice therapy.[82,83] The case was thus heralded as a victory for trans health, but an unfinished one. As such, the legal team filed another lawsuit, and in 2016, New York's Medicaid program further relaxed its restrictions on coverage, including by extending covered care for surgeries to people under the age of 21.

LIFE EXPECTANCY

The *Expectativas* campaign arrived at 35 as an estimate of average trans/*travesti* lifespan through data presented by community-based studies conducted in Argentina over the late 1990s and early 2000s. The original statistics and methods of data gathering that produced this estimate are difficult to locate, but the number travels widely and is often repeated in these studies. Several community-based reports cite the statistic, citing other reports, sometimes elliptically. One study asserts that "The average life expectancy, according to data that some possess, yield an estimated minimum of 35.5 and a maximum of 41.25 years" (*Los promedios de esperanza de vida esperanza de vida según los datos que poseen algunas referentes arrojan un mí nimo de 35,5 y un máximo de 41,25 años*) (Borgogno with REDLACTRANS 2009: 54). The same study decries the lack of epidemiological data that would enable more robust conclusions, noting the absence of data as one of its primary limitations (Borgogno with REDLACTRANS 2009: 8). In noting this broader gap in data, study authors thus indict government and international surveillance agencies for perpetuating trans "invisibility." They further assert that the absence of these data—the "undone science" (Hess 2015) of large-scale epidemiological research on trans and *travesti* people—forces community-based researchers to use methods and make estimates that might be limited in their scientific validity. These authors thus implicitly defend the findings of community-based studies, even if their methods may be distinct and/or less "rigorous" than hegemonic epidemiology might require.

A variety of community-based health studies have been conducted in Buenos Aires and beyond since 1999 (e.g., (Adjuntía en Derechos Humanos de la Defensoría del Pueblo de la Ciudad de Buenos Aires and Asociación de Lucha por la Identidad Travesti y Transexual (ALITT) 1999; Berkins and Fernández 2005; Berkins 2008; Borgogno with REDLACTRANS 2009; ATTTA and Fundación Huésped 2014). Most tracked rates of employment, education, and violence—including police violence. Some studies also discuss average life expectancy, sometimes with quantitative estimates (e.g., Borgogno with REDLACTRANS 2009). These assert that the average life expectancy for trans "populations" is about half that of the nation's aggregated life expectancy. These statistics—as well as the particular framing of what might be called "structural violence" (Galtung 1969; Farmer 2004)—proved particularly important to the legislative debates that preceded the landslide passage of Argentina's Gender Identity Law.

Claims about reduced life expectancy and structural violence played a major role in legislative debates leading up to the law's passage. Vilma Ibarra, a former senator and National Deputy of Argentina, argued for the passage of the Gender Identity Law in a special legislative session late in 2011.

> Trans community members are generally people with the lowest life expectancies, and with the most difficulty completing schooling, and they are expelled, in general, from the labor sectors. They suffer enormous discrimination and social violence.
>
> *Los integrantes de la comunidad trans son en general personas con las más bajas expectativas de vida y con mayor dificultad para la escolarización, y son expulsados, en general, de los sectores laborales. Sufren una enorme discriminación y violencia social.*

Discussions of violence and marginalization have long been part of the analysis of trans and *travesti* people, advocates, and organizations (e.g., Global Action for Trans Equality n.d.; Asociación Travestis Transexuales Transgéneros de Argentina n.d.; Berkins n.d.; Fernández 2005). These assertions have been advanced through both narrative testimonials and statistical representations.

However, arguments gained serious traction in a legislative and policy sense when linked to an epidemiologic vernacular of "reduced life expectancy."

While the problem of foreshortened lives was also central to New York's Medicaid campaign, there was not so strong a focus on the quantification of life expectancy. The strongest claim that activists and advocates made in circulating data from community-based and other studies were about cost-savings. Interesting, cost-savings were rarely quantified, but rather they were convincingly projected by linking the failure to cover gender confirming care to a host of expensive problems about which states are already concerned: substance abuse, mental health treatment, and employment. In this campaign, then, trans people were positioned not as a "taxpayers' burden," but rather as *potentially* productive citizens (see Irving 2008). U.S. discourse about public provision of care included claims about mortality and reduced life chances (though it was suicide rather than murder that figured as the primary site of bodily violence). However, this was merged with discourses of economic efficiency and cost-benefit analysis.

While it appeared particularly significant to have a numerical estimate of foreshortened life expectancy in Argentina's work to pass the Gender Identity Law, New York activists seemed to be able to leverage just the *promise* of cost-savings alongside reduced mortality. Differences in the scale, scope, and objective of each campaign and legal or regulatory shift is also significant here, so a direct comparison between each site may not be merited. Nonetheless, the foci of these community-based studies—whether emphasizing mortality or economic efficiency—are each indicative of a set of shifts that redirects attention away from individuals and towards the relevance of collective or structural formations.

EPIDEMIOLOGICAL FURY: DEFINING DEATH'S PROXIMITY

My field work in Buenos Aires occurred both before and after the launch of the *Expectativas* campaign. In 2015, a year after it circulated, I attended the opening of a photography exhibition called *Furia Travesti,* or "*Travesti* Fury." A bustling crowd of more than one-hundred people filled the Tierra Violeta community center in Buenos Aires where the show was held. On the weathered brick walls hung photographs taken or collected by *travesti* photographer Agustina García, documenting several decades of marches, events, and mundane moments in the lives of Buenos Aires *travestis.* At one point, a voice spoke loudly over the din of the crowd. "I am death!" A figure dressed in black had taken the microphone. "I am death!" she repeated, as the crowd fell silent and gathered around her.[84] It was Agustina, and she spoke with a palpable urgency. "I follow you wherever you go," she continued. "I follow you as you walk and work on the streets. I follow you everywhere. "Enough!" she began to shout from behind her black lace mourning veil. "Enough with the murders, enough with the travesticides![85] Enough with lives cut short too soon, like Laura Moyano's! Enough!"[86]

Indeed, the pace of violence and death I observed was unbearably relentless. Moyano, a 35-year-old *travesti* from the city of Córdoba had been murdered two weeks before. This was followed by protests in Buenos Aires, Córdoba, and elsewhere that demanded "*Ni una menos*" and *"Basta de travestidios"* ("No More Travesticides").[87] At the event, I chatted with Diana Amancay Sacayán. A high-profile *travesti* activist, she had been the first Argentine citizen to receive a new national identity card from President Cristina Kirchner de Fernández after the passage of Argentina's Gender Identity Law. Diana had worked with the coalition that drafted the initial law, and at that point was working as an activist on several other legislative projects. Three months later, at age 40, she was also murdered. By all accounts, neither of these deaths had an explicitly political motivation, but were caught up in the classed, gendered, racialized, and sexualized violence that condenses into death's perpetual haunting of *travesti* life in Argentina.[88]

As mentioned previously, death—whether by violence or suicide, by state or interpersonal violence, by sudden death or infirmity—is regularly invoked as a condition of trans existence. The extent to which these dynamics are analyzed as racialized, classed, and sexualized violence varies greatly. Nonetheless, the particular racialized, classed, and sexualized locations stand as qualitative data in the narrative representation of trans and *travesti* deaths.

Some of these stratified differences, however, are subsumed in data investigating the health conditions of "transgender" populations. While certain community-based studies increasingly point out these marked stratifications, they also maintain some slippage. Snorton and Haritaworn's (2013) reflections on trans necropolitics may be instructive here, as they analyze policy changes as largely beneficial to white, upwardly-mobile trans and gender non-normative people. However, as in the case of Argentina, in some cases racialization and class specificity are underemphasized in data to bring about legal changes that might be argued to focus benefit on those most exposed to state violence (as I would argue the Gender Identity Law, at least in theory, accomplishes to some degree).

When it comes to gender non-normativity, it may be the case that "population" can comprise a more urgently deserving set of subjects than "individuals." However, it may be the very interplay of these that builds the case for establishing trans people and *travestis* as legitimate national subjects, and indeed as human. This conditional admittance to "humanness" is starkly racialized, sexualized, abled, and classed (e.g., da Silva 2007; Hua 2011; Spillers 2003; Weheliye 2014). Thus, the very collapse of *travestis* into "trans population" writ large may have an effect of statistically "rendering human" (and therefore rendering worthy of life) those gender non-normative people who—through racialized necropolitics—have otherwise been marked for premature death (Snorton & Haritaworn 2013). It is the material evidence of the survival-enhancing possibilities of this slippage, alongside the ethical and political repugnance of its necessity, that leads to the "epidemiological rage" that names this chapter and that echoes the affectively charged intensity of *furia travesti*.[89]

POPULATION BIOGRAPHY: FROM INDIVIDUALS TO POPULATIONS AND BACK

The Statistical Turn

In Fundación Huésped's (2014) article about the Expectativas campaign, Juan Frontini, the creative director of the project, said the following (my translation): "The data on life expectancy for trans people were quite astonishing to me. For this reason, I looked for a campaign that would have the same impact." Such excess death, Frontini is asserting, is exceptional in its sensationally-inflected political persuasiveness. That such death is highly concentrated among trans-feminine subjects seems scarcely to require specific mention.

Trans population health studies increasingly turn to statistical methods to frame and make claims about trans health and medicine in what might be called "the statistical turn" in transgender studies. In the introduction to the special *TSQ (Transgender Studies Quarterly*) issue, "Making Transgender Count" (2005: 4), the editors explain some of the tensions related to quantification and trans people:

> On one hand, one makes trans count (in the sense of having its importance recognized) by counting it (making it visible through quantification). On the other hand, one *makes* (i.e., compels) trans count by forcing atypical configurations of identity into categories into which they do not quite fit—the proverbial square peg in a round hole. In this way, the *imperative to be counted* becomes another kind of normativizing violence that trans subjects can encounter and hence another problematic to be critically interrogated by the field of transgender studies.

The form, method, and focus of precisely *what* is counted or measured about trans people (and of course where) may range greatly—as may the credibility of those who do the counting, and the dispersed effects—anticipated or not—of quantification. For instance, well-funded and typically global North HIV prevention networks and research agencies have established trans women as a global priority and a "very high risk" population, aiming to intervene on "health behaviors."

University-based professional researchers in the U.S.—many driven in part by questions about resource allocation—recently published a national trans population estimate. Smaller-scale community-based studies focus on data-collection about the structural features of health and survival: for example, medical access, education, and employment, and violence.

This economy of knowledge production is certainly shaped by hierarchies of "scientific" expertise. It is also shaped by academic economies—including the dominance of English-language journals and peer-review systems—that geopolitically structure what counts as valid, mobile, and "universal" knowledge and expertise. It remains quite notable, however, that the evidentiary arguments that held significant sway in the 2011-2012 debates in the Argentine legislature, as well as those that comprised the education campaign preceding *Cruz v. Zucker*, were *not* produced by biostatisticians or epidemiologists, but rather by small-scale community-based research studies.

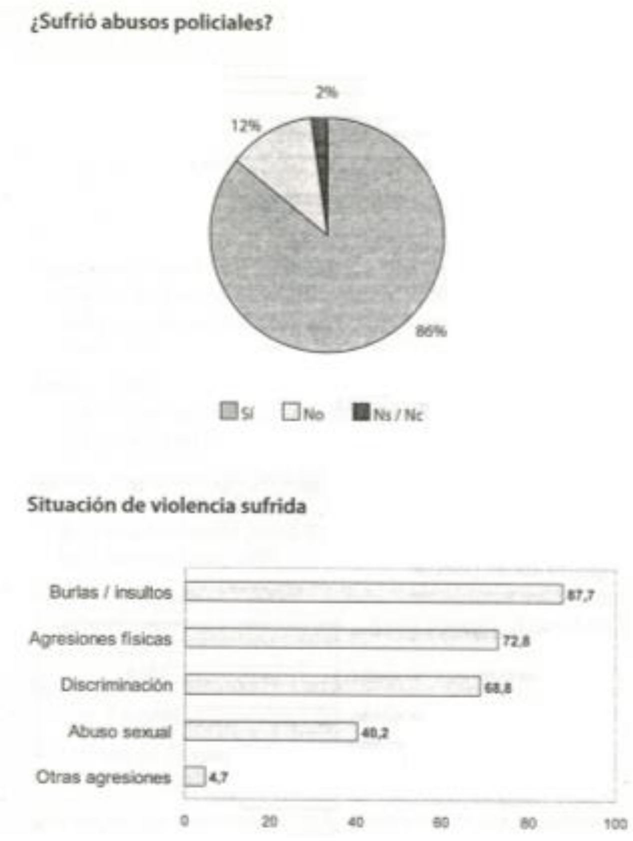
As Epstein (1996: 257, 314) and others demonstrate, it remains possible to effectively contest the authority of statistical analysis as the apotheosis of accurate representation. This does not necessarily require discrediting statistics as such. Rather, it involves reframing scientific assertions by pointing out what they exclude or elide, often in scientific terms and on methodological grounds through an epistemological bridging (Epstein 1996). Shim (2014: 14-17) describes an instance in which this bridging work did *not* occur. On one side of what she describes as an epistemological "lay-science divide," epidemiologists mobilized reductionist ideas about the stability and separability of race, class, and gender. On the other side, laypeople brought a systemic, intersectional, and relational view of these factors as relevant to the health inequities they experience.

The community-based studies I describe in this chapter seek to span this divide. Activists engaged some "epistemological bridging" at some level by bringing a population health-oriented view to their work. However, they also managed to retain a conceptualization of marginalization that did not comport with epidemiology's reductiveness. Further, activists did not demand that epidemiologists worked *differently*, but rather identified and defined as a problem the lack of statistical data on trans mortality, and worked to address this "undone science" (Hess 2016) through their own epidemiological efforts. Adams (2016) locates a similar challenge to statistical knowledge in the broader domain of disease research within which some patients have pointed out the lacunae in knowledge related to their "orphan diseases." She writes (2016: 228), "these patients have begun to make arguments for quantification strategies using an "n of 1," such that their own bodies become the site for the production of metrics."

When it comes to life expectancy studies, trans activists have both embraced and deflected the statistical turn, at least vis-à-vis standard epidemiological methods. Instead, through community-based studies, they focus outward on structural factors they implicitly argue are causative of abbreviated lives. This work converges in some ways with certain forms of population health inquiry, such as social epidemiology. Further, they draw from fairly small-sized samples, but make claims about generalizability that are aided by the addition of narratives that emphasize representationally the widespread phenomena of violence, marginalization, and exclusion.

The Emergence of Population Biographies

These community-based epidemiological studies coming out of Argentina (and to some extent the U.S., though they are not precisely parallel) both reflect and at some level push against some of the familiar stratifications of knowledge production. For example, these studies are often mobilized and at least co-authored by *travestis* and *travesti*-led organizations. As I mentioned, the racial and class positions of most *travesti*-identified people would not align with the white, upwardly mobile "professionalizing class" that Snorton and Haritaworn (2013) (generally rightly) describe as taking up trans-related population health research. In addition, the content of the community-based studies that I have mentioned is presented in a form that foregrounds *narratives* alongside population-based data. *La gesta del nombre propio,* or *The Struggle for One's Own Name* (2005)*,* for example, contains graphs, bar charts, and tables that track a range of variables. Also included are photos of protests and meetings, as well as a long list of names of some of the *travestis* who died during the course of the study. See samples of these in Figures 3 and 4.



Celeste
Abril
Micolosa
Daniela
Lourdes
Estrella
María José
Marisa
Karina Ferguson
Rosalinda
Cecilia
Romi
Vivi
Mary/Martin
Yiyi
Cristal

Rubí
Karen
Heidi
Cher
Andrea de Lugano
Marisa de Lugano
Daniela de Lugano
Stefanía de San Martín
Mónica de San Martín
Sasha
Carla Kustnier
Judith
La Rata
Silvana
Mariana
Barbi

Margarita
Jorgelina
Wendy
Jackeline
Princesa
Miriam
Yanina
Pamela
Andrea
Ángela
Flavia
Marcela
Agustina La Pedro
La Verde
Grisel
Giselle

Figure 3 **Figure 4**

Figure 3: Sample image of data display about experiences of police violence
Figure 4: Sample image of names and a protest photo

From *La Gesta del Nombre Propio* (Berkins and Fernández 2006:29-30;129)

Once again, like many community-based studies, these figures do not frame problems in terms of individual risk factors (such as so-called "risk behaviors" for HIV transmission). Instead they imply what might be described as *structural* risk, such as being subject to police violence or educational exclusion. In so doing, they embed arguments about some of the specific *causes* of foreshortened life, prominently featuring state violence, rarely a focus of standard public health research. Through this mode of empirical presentation, they insist on the *collective* and not just the aggregate, and promote specific kinds of social and political change.

I describe these community-based studies as "population biographies." This notion extends Phil Brown's (1987, 1992) work on "popular epidemiology" from the realm of environmental health. Brown (1992: 269) describes popular epidemiology as "the process by which lay persons gather data and direct and marshal the knowledge and resources of experts." He advanced this concept to examine how non-scientist political actors (he call them "citizens") use scientific authority to identify and solve health-related problems. Such lay or community actors thus transform "biography" into "population health."

Population biography also mobilizes scientific population surveillance and life expectancy data. While data collection is a central part, the process of directing and marshaling expert research and knowledge is partially supplanted by *claiming* a sort of bridging expertise to bring data into conversation with collective trans and *travesti* life. In so doing, population biographies explicitly tether collective narratives and political life to figures of population, rendering them inextricable. Population biographies thus engage the thought styles (Fleck 1976) associated with epidemiology without capitulating to the reductiveness of aggregate data, and insist on a simultaneity of scale.[90] In short, they project epidemiological affect where they lack robust methods, and where they lack robust methods, they explicitly point out that gaps in data are produced by the very exclusions that they seek to represent.

Population biographies, at some level, contest certain hierarchies of knowledge production. Snorton and Haritaworn (2013) incisively identify the conventional hierarchies of knowledge production as a necropolitical site through which racialized, classed, gendered, and sexualized subordination is reproduced. They assert that these dynamics take shape in part through expert professionalization. However, in the case of population biographies (particularly those based in Buenos Aires), *travestis* are not only the privileged subjects of such research, they also at least in part *drive, shape,* and *author* it to some degree. In both Buenos Aires and New York City, population biographies addressed issues like gender reclassification and health rather than formal discrimination protections or anti-"hate crime" legislation. The latter are examples of the types of provisions that Snorton and Haritaworn (2013), Spade (2011), and others describe as primarily benefiting white and upwardly mobile trans subjects. Many *travesti*-led organizations in Buenos Aires and some activist and advocacy groups in New York have articulated these "survival-oriented" strategies as more pressing than "state protections-oriented" strategies. Partly in response to this prioritization, Argentina's Gender Identity Law focused more strongly on provisions that would best be described as "survival-oriented." Here, stratifying necropolitical dynamics still shape notions of "deservingness," but at some level diverge from the notions of expertise that Snorton and Haritaworn (2013) discuss. This seems to complicate their theorizations of the value extraction involved in trans necropolitical production of expertise and rights regimes.[91]

The extent to which population biography disrupts the hegemonic relations of power that shape Snorton and Haritaworn's (2013) account of trans necropolitics, however, is limited. The activism leading up to Argentina's Gender Identity Law is scarcely regarded in the U.S. The fact of the passage of the law itself—of which even experienced trans health advocates in the U.S. are often unaware—is often condescendingly viewed as both remarkable and aberrant. Thus, even though community-based studies from Argentina were cited in national government-produced documents and on the congressional floor, they did not or have not yet penetrated the geopolitical hierarchies of knowledge production.

Further, in Argentina, the notion of "expertise"—even experiential expertise—remains tightly linked to a proximity to death by state actors. For example, a trans man and activist I interviewed told me that state actors only give credence to the expertise of *travestis* who can claim to be authentically near death, *or* to the non-trans professionals who claim to represent them. He explained that his expertise as a trans activist and professional, whose classed and racialized exposure to early death was far more distal, was regarded as being "too political" to offer credible expertise. As such, a persistent hegemonic politics of knowledge—while provisionally mutable—still suffuses what forms of (necropolitical) expertise can count.

Activists and advocates in New York, in contrast, had to mobilize their economic value in the form of efficiency, productivity, and cost-savings. Life expectancy (in the form of suicide risk rather than state or interpersonal violence) was important, but not the primary object of attention. Nonetheless, the PSA-style videos and campaign materials produced leading up to *Cruz v. Zucker* still framed the necessity of trans health as a public benefit by bridging narrative and statistics. While still engaged in "upstreaming" work, population biographies in New York were different from those in Buenos Aires at several levels. They were largely produced by activist/advocate partnerships, and often took a less confrontational approach, leaving out critiques of state violence and using rhetorics of cost-saving and preventive health.

The effects of population biographies have been notable, particularly in the Buenos Aires and Argentinian contexts. As noted, the low life expectancy estimate was frequently and powerfully mobilized to promote passage of the Gender Identity Law. Yet the legitimacy of professional expertise remains somewhat stable. For example, Argentina's trans health guide, *Atención de la Salud Integral de Personas Trans* (or "Comprehensive Health Care for Trans People) (Programa Nacional de Salud Sexual y Procreación Responsable 2015) contains varying references to peer-reviewed research, as well as drawing directly from population biographies. It notes: "The importance of these [legal] changes [are] central, since at this point the estimated life expectancy of trans people is 35 years" (Programa Nacional de Salud Sexual y Procreación Responsable 2015:41). A footnote reads, "For lack of official statistics, these data were estimated in organization-based studies, such as those by ALITT, ATTTA, and others" (Programa Nacional de Salud Sexual y Procreación Responsable 2015:41). In the absence of "official" data, the use of population biographies seemed justified regardless of potentially diminished scientific rigor.

FASHIONING STATISTICAL CITIZENSHIP

Rigor, however, is the name of the epidemiological game. "Official data" are gradually being produced within a global economy of knowledge, and are being taken up to mobilize a wide variety of objectives. Interestingly, my research revealed that despite the recurrent geopolitical hierarchies of knowledge production, the numerical estimate of trans life expectancy—specifically 35—traveled, although the studies from which it emerged did not. As such, this figure has appeared in a number of U.S.-based blog articles, sometimes without citation, other times with citation to another page that did not provide an original citation (e.g., Vincent 2015). I note this not to criticize citational practices. Rather the obligation to utilize to statistics, however challenging and elusive they might be to generate, is characteristic of the field of debate within which these bloggers find themselves. "Trust in numbers" permeates widely, and the statistical imperative generates a peculiar rhetorical form. Activists too must think epidemiologically to make persuasive political claims. These numbers then take on a mobile life of their own.

While local debates about trans health are distinctive, the emergence of trans health is very much a transnational phenomenon. Local debates thus travel, albeit unevenly. One of the longest-standing debates in trans medicine concerns the "appropriateness" of surgeries or sex hormone provision for gender non-normative people. Paul McHugh is an important figure in these debates, as the former psychiatrist-in-chief at Johns Hopkins Hospital who led the closure of the University's gender identity clinic in 1979. In an op-ed in the *Wall Street Journal* entitled "Transgender Surgery Isn't the Solution," McHugh (2014:Paragraph 10) cites a 2011 Swedish study from the Karolinska Institute (Dhejne et al. 2011) to assert the ineffectiveness of gender confirming care:[92]

> The study revealed that beginning about 10 years after having the surgery, the transgendered began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable nontransgender population. This disturbing result has as yet no explanation but probably reflects the growing sense of isolation reported by the aging transgendered after surgery. The high suicide rate certainly challenges the surgery prescription.

His representation is methodologically unfaithful, since the study set out to compare how trans people's mortality outcomes compared with those of non-trans people, not the effectiveness of gender-confirming surgeries. Indeed, the study's authors publicly disputed what they characterize as a "misuse" of their results. Lead author Dr. Cecelia Dhejne with Cristan Williams (2015:Lines 104-7), said in an interview: "What we've found is that treatment models which ignore the effect of cultural oppression and outright hate aren't enough. We need to understand that our treatment models must be responsive to not only gender dysphoria, but the effects of anti-trans hate as well. That's what improved care means."[93]

But despite Dhejne's objections, the study focuses on what public health practitioners would call "downstream" individual measures of health effects—specifically, direct causes of death. While the article's conclusions gesture explicitly towards what public health researchers call "social determinants of health," its mortality measures cannot quite statistically extend to the realm of "proof" regarding these speculations.

This is precisely where population biographies differ from "official" studies. They effectively bring together the "downstream" measure of mortality with "upstream" concerns regarding social subjugation—in part by merging quantitative and narrative data. Moreover, population biographies also present statistical analyses of housing, education, income, and state violence (rarely engaged in public health) to make claims about what social epidemiologists Link and Phelan (1995) would call the "fundamental causes" of travesti and trans mortality. Population biographies thus take up what Alondra Nelson (2011) calls "social health" in her work on the Black Panther Party's health and research programs. This signals practices that are "oriented by an outlook on well-being that scale[s] from the individual, corporeal body to the body politic in such a way that therapeutic matters were inextricably articulated to social justice ones" (Nelson 2011:10).

I propose that one means through which population biographies are translated into political action is through linking social health to a notion of *investment* in travesti and trans lives. But the fact that such demands have gained political traction when the investment is in the *aggregate* population is not incidental. In his analysis of squatters excluded from formal citizenship, Chatterjee (2004:57) describes how a "politics of the governed," necessitates "investing their collective identity with a moral content" to leverage means of survival from states. For Chatterjee (2004:34), this involved an active collective fashioning into a "population," but not simply as a descriptive of empirical concept, but as a moral one. Building on Chatterjee's reflections, I argue that it is possible to understand the work that population biographies perform as a means of fashioning "statistical citizenship" that simultaneously produces a population and invests it with a moral or ethical imperative. Here I am extending Hannah's (2000: 515) initial mobilization of "statistical citizenship," defined as the "strategic active participation in the construction of the statistical representations by which individuals are constituted as political actors, objects of social policy, and/or consumers."

Certainly, population biographies and political investments in their findings may be analyzed through Hannah's lens of "active participation." However, I am also drawing attention to a means of *rendering statistical* the forces that hegemonic epidemiology cannot readily define as causally valid.[94] As these forces—violent policing, exclusion from labor, racialized and sexualized violence—are made plain through both stories and numbers, the political and ethical imperative to act is (at least potentially) heightened. I argue that it was this bridging, along with Argentina's distinctive political history, that made it possible for the Argentina legislature to concur with the claim that the nation had a "debt to democracy" when it came to trans and *travesti* subjects.

Statistical citizenship thus involves what might be called "upstreaming mortality" by focusing on structural cause, which clarify the necessity of intervention at this level rather than at the usual individual "behavioral" level so favored by public health. For example, in 2015, the province of Buenos Aires passed the Employment Quota law. This stipulates that 1% of all public-sector job hires must include travesti and trans people. This provincial law came about in the wake of publicity about the national Gender Identity Law, and also took up arguments about life expectancy and mortality.[95]

Here, we can observe how trans claims on the state and demands for social justice are intertwined with questions of economy. Michelle Murphy (2013; 2017) calls this the "economization of life," which she posits as a post-eugenic set of entanglements that increasingly examine aggregate life through the joining together of population and macroeconomies. The "calculative infrastructures" of the economization of life "offer… a way to calibrate human worth, but also forms of human waste, human surplus, unproductive life, and life in excess of economic value." (Murphy 2013:144).

In this regard, population biographies produce *valuable* individuals and populations in terms of life chances. But such strategies are also inevitably tied to questions about value to and for the nation state. That such interventions are beneficial is difficult to contest. However, such shifts also, and perhaps inevitably, produce scenarios in which non-incorporation into state economic infrastructures—such as participation in informal economies—becomes equated with "unproductive life." This raises questions about what trans and *travesti* life *is* to the state as a site of investment, and about what kinds of governance (and governabilities) are implied in and through the production of "vulnerable" populations. As Aren Aizura (2014) writes, "we cannot theorize a trans necropolitics without exploring the mobility of gender variant bodies and the circuits of capital they/we exploit and are exploited by." Given the novel ways that statistical citizenship and the economization of life are taking shape, it remains to be seen how these questions of value and exploitation will materialize in the future. Assuredly, this will remain a generative area for analysis moving forward, in both sites I studied and beyond.

This imbrication of population, economy, and investment vis-à-vis trans lives raises many questions. To think about how relations of economy also animate necropolitical questions of population is to think differently with population health. What kinds of productive lives are state actors and institutions interested in cultivating by recognizing and *knowing* these "populations" ? What are the anticipated returns on investment, as Murphy asks of the other "risky subjects" of state investment? Might we view these interests as being about assimilation or compliance? About containing unruly actors by, for example, containing practices of sex work and political unrest? To the extent that *costliness* is uniquely mobilized when it comes to trans people, how do these concerns enter the universe of concerns about citizenship, protection, health care access, and human value? What other dynamics do economized trans lives animate when comes to the ostensible knowability of gender non-normative populations?

While these are merely starting points, I am arguing that to thoroughly grapple with the stakes of trans health and politics, it is critical also to center such questions of financialization and capital. My provocations must remain preliminary, but can be productively engaged in the future through reflections on neoliberal subject-making (e.g., Irving 2008), with a thorough empirical grounding in the emergent phenomena of increasingly robust trans care infrastructures.

CONCLUSION

It matters that population biography has provided some of the most *persuasive* work leading to administrative and bureaucratic transformations in both Argentina and New York. This may be due to its novel form. It could also be attributed to its scientific commensurability, or to the sheer shock value of the mortality estimates. Regardless, it seems that such studies defined problems in ways that led to openings rather than closures in terms of centering trans survival. One of the ways that this has taken shape in the emergence of trans health is through activists' development of methodological innovations, for example through efforts to "upstream mortality." Brown (1987, 1992) describes how "citizens" produce new forms of knowledge when there is a gap in expertise, and how relations of power are negotiated within these processes. Population biography extends this to discuss how trans and *travesti* activists created new knowledge not only through methodological innovation, but also through the absolute refusal to parse narrative biography from population health data. Epidemiological methods routinely fail to capture both nuance and the dynamism of the social field, which accounts for some its major limitations in engaging the stratified and stratifying currents in health research and provision (Shim 2002; 2014). Population biographies turn epidemiology and its methodological constraints against itself, as did the HIV/AIDS treatment activists that Epstein (1996) described.

But in the case of population biographies, interwoven biographical narratives provided an alibi for any potential methodological inadequacies in quantification of trans death and violence. This move rejected the very objectivizing thought styles of epidemiological practice and state governance in which it simultaneously also engaged. Through this hybrid methodology, activists foregrounded the relevance of structural violence and its extended history as a primary, rather than secondary or background means through which to understand health and health care. This resonates with Nelson's (2011:3, 19) reflections about "social health," and how Black Panther Party health activism was inextricably linked up with notions of how “bondage, racism, and segregation affected the well- being of black communities.” It also resonates with Chatterjee’s (2004) reflections on how “population-making” is involved in fashioning demands on the state, even in the ambit of persistent exclusion or marginalization.

Of course, it also matters that “population” is inescapable in the production of knowledge mobilized by population biography—and that the active *formation* (or perhaps *invention)* of a specific population of need is one of its many effects. Such modes of quantification are inevitably caught up in forms of governance that operate in and through the figure of the “population”. Population health is, after all, profoundly and inextricably linked to racialized population control and the political economic investment in certain forms of life over and above others (Murphy 2013; 2017). Further, with the ascendance of “official” or hegemonic epidemiological data about trans populations, the figures as well as the meanings of mortality measures may shift. This may affect the allocation of resources and the possibilities of political demands on the state and beyond.

Resource distribution is a central theme in the provision of trans health, especially in its public forms. Public health logics generally take two forms when it comes to intervention: 1) what is the largest group that will be affected, and 2) what intervention will have the most profound effect on a group regardless of its size. Trans communities are in part characterized by their exceptional status, and this “population” is perpetually described as being very small. Thus, trans activists and advocates have recognized that they must demonstrate the necessity of the profound effect size when it comes to justifying coverage for gender-confirming care. In the next chapter, I discuss how activists and providers have partnered to leverage state (as well as private insurance) coverage while simultaneously “depathologizing” the diagnostic practices associated with transness vis-à-vis biomedical treatment.

In conclusion, I suggest that population biography is a deftly inventive strategy that at once enlists epidemiological thinking even as it rejects its reductiveness, and exposes hegemonic epidemiology's inherent non-neutrality. In refusing to capitulate wholly to population-level abstraction, these community-based studies framed problems distinctly and produced highly convincing evidence to bring about unusual administrative and bureaucratic shifts in Argentina. Yet this tactic remains intractably tethered to problems of "population." Here, life cannot count as life except in and through the data. And death—however profoundly apparent in daily existence—cannot count as death without the calculative infrastructures of mortality measures.

CHAPTER 3: DIAGNOSING WELLNESS: RELATIONS OF CARE IN FEMINIST AND TRANS HEALTH POLITICS AND PRACTICES

Talia, a nurse practitioner in a New York City hospital, talked with me about diagnostic classification of her trans patients. Her raised eyebrows registered disapproval of the injunction to use a psychiatric code to facilitate her patients' ability to procure hormone treatments and surgeries. "I still don't think that as a nurse practitioner, I should really be diagnosing people with things out of the DSM" (Talia, Interview August 3, 2013). She shrugged, leaning back in her chair. Our conversation took place while New York State's Medicaid program still prohibited Medicaid from covering gender-affirming care. After a brief pause, she conceded that if this provision were lifted, she might use that psychiatric diagnosis to "help billing." She explained that currently, she regularly risked her license by using a work-around common among health care providers treating transgender Medicaid patients: "For billing purposes, I just use Endocrine Disorder-NOS [Not Otherwise Specified] 259.9"[96] (Talia Interview August 3, 2013). However, this was *not* her vision of ideal care. "We actually view people as being generally healthy. Diagnosis means there's something wrong with you. [Why do] we still have to assign a code to health? Why can't we just use V70.0—the code you use for a well visit—for all of our trans health and have that cover everything?" (Talia Interview August 3, 2013).

Talia's comments contest the requirement for a diagnosis that pathologizes transgender patients. Aligning with trans depathologizationists broadly speaking, this position is enabled by a mode of organizing care politics that I call "care without illness." This chapter explores depathologization as a multifaceted set of practices and principles organizing trans health care across multiple sites. Studies of trans health activism are still a developing area of research. Some of these have focused specifically on trans depathologization, but it remains an understudied domain,[97] and many recent engagements with it treat depathologization as an undifferentiated phenomenon.

Instead, I show in this chapter that it indexes a range of practices, targets, and objectives. I thus advance “care without illness” as an analytic that joins together some—but not all—forms of depathologization activism.

Depathologization movements in general (including trans depathologization, anti-psychiatry, gay and lesbian depathologization, and some forms of feminist health and disability activism) work to refigure expertise and contest medicalizing and normalizing power.[98] Some projects aim to refashion rather than entirely disengage from clinical relations of care. Instead of contesting medical power via demedicalization, proponents of care without illness work to level the relationship between provider and patient by foregrounding self-determination. The concept of care without illness affords a nuanced examination of depathologization by attending to the embedded politics of care that shape its distinctive forms. It enables theorizing how trans health activism resonates with other depathologizing projects working to transform care relations while retaining access to biomedical care.

In this chapter, I show how activists and some providers are working to refigure what they view as pathologizing diagnostic models comprising hegemonic health infrastructures. Trans depathologizationists[99] comprise a large, vocal, and loosely assembled group asserting that access to medically-based gender confirming health care is critical for many trans people to support health rather than to “correct” a problematic corporeal or psychic state. Accordingly, this means that trans people are not “ill” but ought to be able to access care based on self-expressed need to facilitate and support wellness. Most trans depathologizationists maintain that sex hormones and/or surgeries should be available if people feel they need them, but that clinicians’ main role is to provide information and facilitate access, not to authorize care or obstruct access to it.[100] Activists and scholars who argue for trans depathologization thus do not view biomedicine as problematic per se.

Rather, they condemn the hubris of its presumptive authoritative expertise and the manifold infrastructural obstacles — legal, regulatory, billing, bureaucratic — it presents for trans people.

DEPATHOLOGIZATION AND POLITICAL DIAGNOSTICS

Social scientists and other scholars have long critiqued medicalization[101] and pathologization,[102] particularly in the new subfield of the sociology of diagnosis (Jutel 2009; McGann and Hutson 2011). However, as sociologist Mary Burke (2011:203) points out, these are not identical, and "the former does not always lead to the latter." Burke asserts that medicalization—the process of defining a bodily state, social position, or set of practices as jurisdictionally within the domain of medicine and health care—carries a range of possible consequences. She argues as others do that certain outcomes might be highly desired by medicalized subjects, such as enhanced allocation of resources and access to care (Burke 2011:188). However, such forms of medicalization differ from pathologization—the process of defining practices, social positions, or bodily states as being at once anti-normative and ill. Burke notes, "activists can simultaneously embrace medicalization while rejecting pathologization," characteristic of trans depathologization movements (Burke 2011:204).

This assumption that care need not be faithfully tied to pathologization is shared in large part by many feminist health and disability rights activists, and forms the basis of care without illness as a distinct mode of organizing care relations. In developing this analytic, I draw especially on feminist theorizing about care, particularly its insistence that care indexes relations of power and obligation, in addition to (and sometimes within) dynamics of support or nurture (Murphy 2015:732). Feminist technoscience scholars thus define "care" as "an affective state, a material vital doing, and an ethico-political obligation" (Puig de la Bellacasa 2011:90).

I extend reflections on care by asking how care politics, as modes of attention and attachment, produce distinct visions of trans health that generate different possibilities for recognition, valuation, and resource distribution. In so doing, I show how social stratification shapes not only relations of care, but the ways that depathologizationists recognize and define problems in assembling trans health. In elaborating how some depathologizationists *care differently* from others, I demonstrate how the concerns of some gender non-normative subjects are favored while those concerns of others may be sidelined.

In what follows, I invite consideration of "depathologization" not solely as a set of processes that contest diagnostically-based treatment practices, but also as a *political* diagnostic in and of itself. Empirically examining trans depathologization therefore enables an analysis of how politics of care organize and are in turn shaped by infrastructures, power dynamics, racial and economic conditions, and other facets of care relations. Alongside feminist health and disability activists, trans depathologizationists advance diffractive concepts of wellness and access that decoupled "health" from gendered, racialized, sexualized, and abled "norms." Nonetheless, I found that even while many activists attended fastidiously to questions of differential access, certain depathologizationists' emphasis on stigma and destigmatization at times displaced attention to deeply stratified practices of care.[103] Other activists instead foregrounded questions of distributive health politics, at times leaving definitional struggles to one side. These reflections on the ranging care politics of depathologization highlight new questions about how to define, address, and transform the distributive problems of health access, inequitable power relations, and politics of subjugation that suffuse health care provision transnationally.

Empirically, I draw on interviews and observations among providers and activists in New York City and Buenos Aires to discuss how clinical relations and broader politics of care converge in practice vis-à-vis trans depathologization. Some analysts have taken for granted depathologization as a mode of pulling away from the structures of medicine. In contrast, these empirical observations make clear that depathologization strategies in fact incorporate many concrete clinical practices and enroll many health care providers, and are therefore not synonymous with demedicalization projects. In addition, few studies engage depathologization's contestation of power relations beyond the domain of biomedicine. This chapter addresses each of these lacunae by detailing how depathologization movements view the broad stakes of their work, how depathologization projects unfold both within and beyond clinical spaces, and how activists and providers work collaboratively on such projects. I show how, for some, depathologization comprises a political imperative within which the pathologizing dynamics of health care and medicine are only a single point of departure among many.

Depathologization is often advanced as a putatively singular political strategy. I argue instead that it incorporates wildly diffracted and sometimes dissonant orientations, projects, and politics that are observable in the multiplicity of objectives that its proponents articulate. Dimensionalizing these nuances—both as they inhere in depathologization projects more generally, and in trans depathologization specifically—enables analyses of how care infrastructures and broader care politics are rarely in stable relation. Through asking what care without illness actually *does* across differing sites and for different actors, I offer a more robust account of what is at stake for varying actors. In this regard, I build on the work of other ethnographic scholars who engage the multiplicity of trans activism's approaches to depathologization (e.g., Burke 2011). I extend these conceptually and geographically by considering trans depathologization through the lens of care politics and stratification, and by methodologically undertaking a transnational ethnography.

I begin by using Clarke's (2005) analytic strategy of positional, social worlds/arenas and project mapping to analyze these several distinct positions and genres of depathologization in relation to each other. These broadly outline the distinctive positions, collective actors, and genres I encountered in my fieldwork vis-à-vis trans depathologization. The distinct genres I identified include *declassificatory, medicalized, revisionist psychiatric, depscyhopathologization, consent-based,* and *coalitional.* After broadly situating these, I loop back to ground trans depathologization in broader social movements, and define the central terms of depathologization and care relations. Next, I situate trans depathologization within the theoretical frameworks of medicalization, pathologization, and normalization, focusing on feminist and disability activism's concerns with the subjugating figure of the "norm."[104] In this regard, I argue, trans care without illness arises in large part from feminist health infrastructures and epistemologies in both the US and Argentina (e.g. Brown 2013; Clarke and Olesen 1999; Murphy 2012) and modes of care developed by disability activists and scholars (Garland-Thomson 1997; Krieg 2013; Shakespeare 2006) in their multivalent notions of autonomy. Subsequently, I draw on ethnographic data to illustrate how actors asserted these varying positions—often articulating multiple and sometimes conflicting positions. I argue that a more nuanced and capacious accounting for trans health care is possible, in sharp contrast with accounts that focus solely on medicalization and stigma.

This chapter thus contributes to ongoing engagements with care in transgender and feminist studies, social sciences, and disability studies by drawing connections between clinical practices of care and the range of political commitments and positions from which they emanate. In exploring care infrastructures and the "truth" of diagnostic classification as intimately linked to politics of care, the chapter further brings feminist technoscience studies' reflections to bear on these provocative debates.

This chapter also extends discussions in medical sociology, especially the sociology of diagnosis, in detailing how diagnostic practices, depathologization, notions of autonomy, and relations of care are distinctly mobilized in trans health. Moreover, I argue that these reflections are highly germane to other modes of health care that foreground questions of "self-determination," including sterilization, surgeries for intersex infants and children, euthanasia, abortion, varying forms of plastic surgeries or elective surgeries, genomic diagnostic practices, HIV treatment-as-prevention, and so on.

MAPPING TRANS DEPATHOLOGIZATION

Clarke (2005) advocates positional maps as a cartographic analytic approach to "understand, make known, and represent the heterogeneity of positions taken in the situation under study and/or within given…discourses in that situation" (p. 25). Trans health activism has not yet been robustly studied, and in all but the most attentive accounts, "trans depathologization" is treated as an undifferentiated phenomenon, rather than a ranging set of practices, targets, and objectives. The positional map in Figure 5 below displays the relationships and variations among these differing positions in trans depathologization.

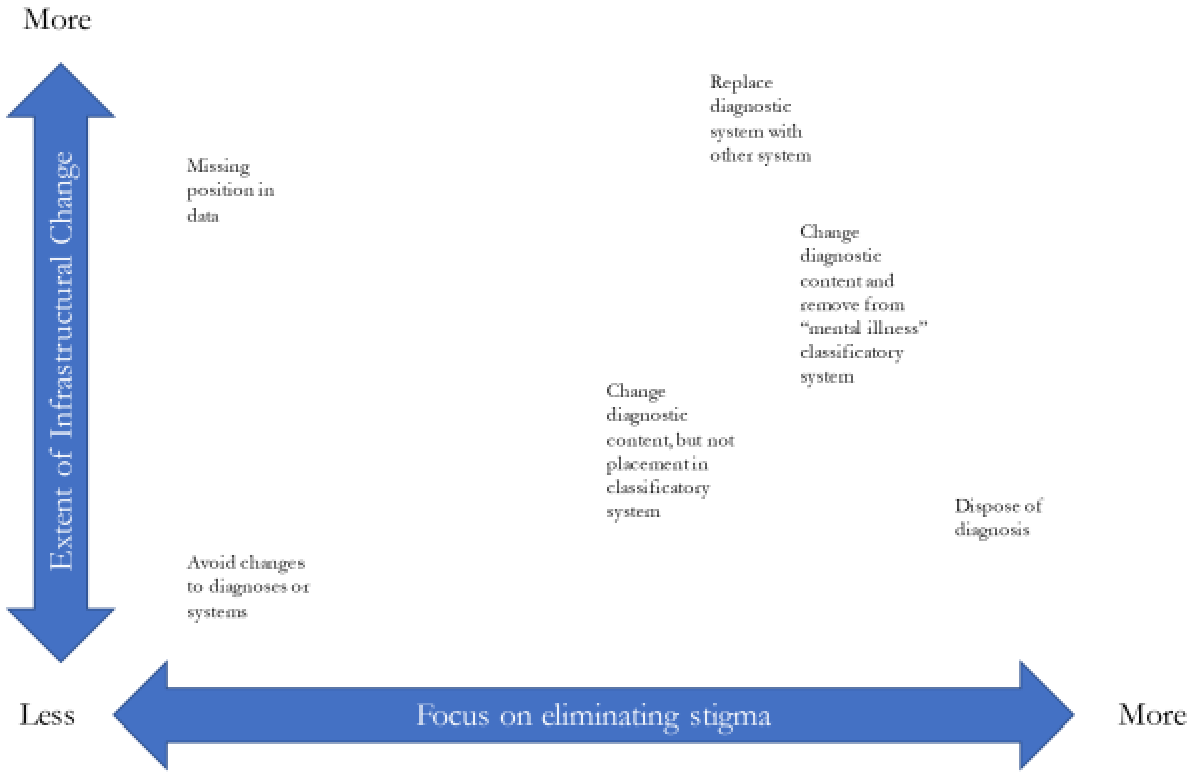


Figure 5. Positional Map: Extent of infrastructural change and importance of eliminating stigma in depathologization activism

Clarke also proposes using social worlds/arenas maps to "lay out the collective actors, key nonhuman elements, and the arena(s) of commitment and discourse within which" negotiations take place (Clarke 2005:xxii). Figure 6 is a social worlds/arenas map that represents the collective actors that are invested in different ways in trans depathologization.[105]

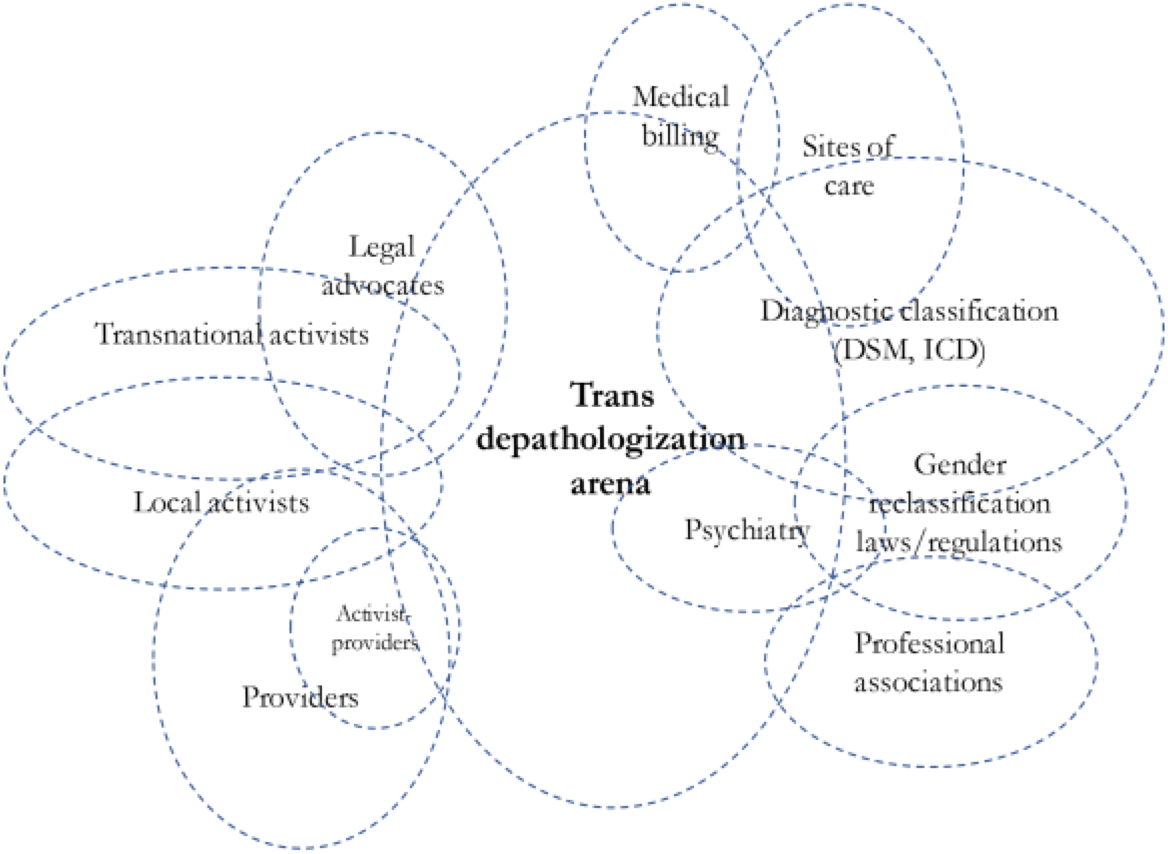


Figure 6: Social World Map of Trans Depathologization

Project maps synthesize analytic findings and "big picture" relationships (Clarke 2005:136-9). Figure 7 is a project map showing how different genres of depathologization differ from each other.

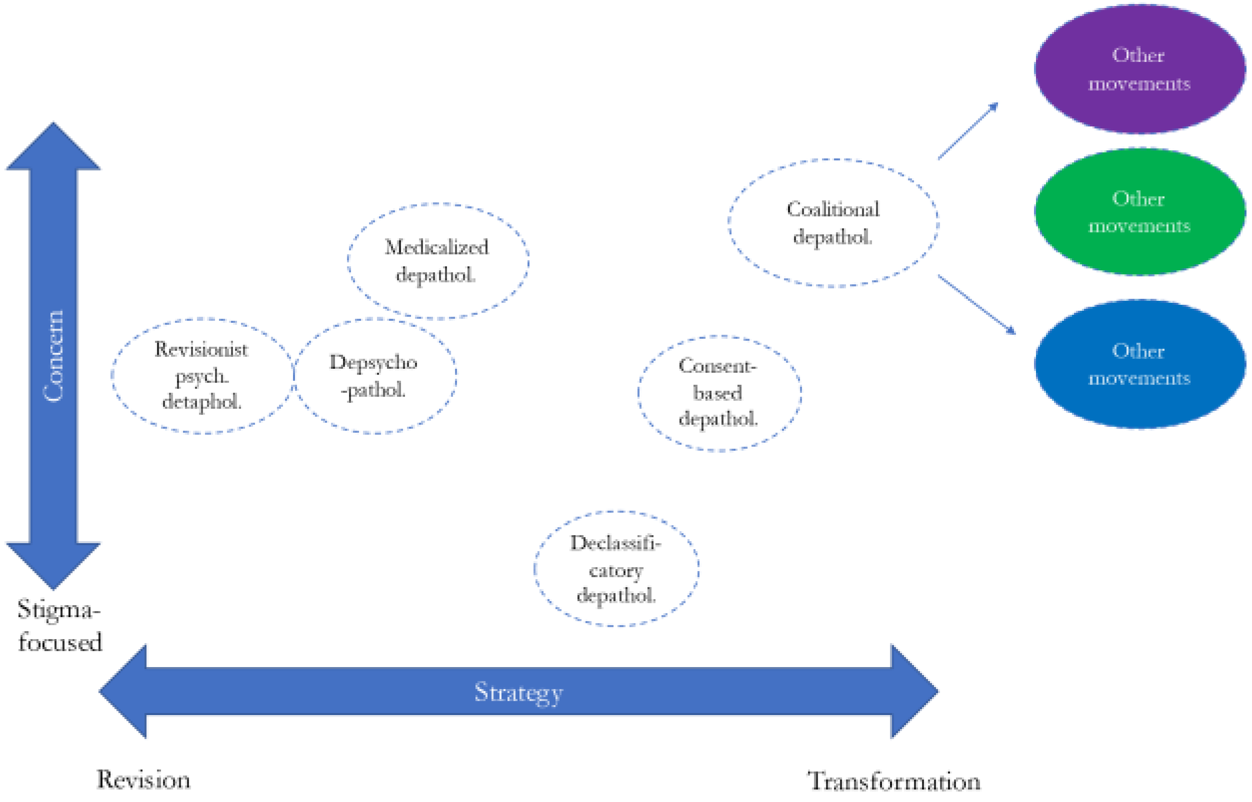


Figure 7: Project Map of Trans Depathologization Projects

Figure 5 tracks differences in the positions that study participants took vis-à-vis trans diagnoses in the realm of trans depathologization. These positions generally ranged along two major axes: the extent to which positions sought to change systems or infrastructures, and the degree to which they focused primarily on the problem of "stigma" (often over and above issues of access, which I expand on below). The positions outlined in Figure 5 are not linked to specific persons. Rather, these represent the permeable positions taken (or not taken) in interaction and negotiation that emerge in my data (Clarke 2005:25). Any particular individual may assert multiple and even conflicting positions—and this positional mobility arose frequently as activists and providers negotiated trans depathologization.

The social worlds/arenas map in Figure 6 shows some of the major groups, organizations, and systems involved in trans depathologization. This is non-exhaustive, but represents the social worlds (e.g., activists and providers), non-human elements (e.g., classifications and financing structures, and care guidelines), and discourses (e.g., psychiatry and other movements) that are implicated and involved in trans depathologization. It shows the broad range of actors and elements that are part of negotiating trans depathologization. As I discuss my ethnographic findings below, these actors and elements are varyingly present as activists (and others) work to navigate the landscape of work to change how the trans diagnosis is conceptualized in biomedical practice, law, and beyond.

Although individual actors were highly mobile in the positions they took on within the arena of trans depathologization, several "types" of depathologization took analytical shape. These, too, were not static and individuals moved between them. The project map in Figure 7 shows these distinctive genres of depathologization, and represents how they varied along two primary axes. The x-axis maps strategic commitments, and tracks whether depathologizationists take revisionist strategies (seeking to shift existing standards) or transformational strategies (re-envisioning or eliminating standards). The y-axis maps primary concern, and evaluates whether the focus is primarily on issues of stigma or infrastructure, which form the two primary depathologizationist concerns.

While most people are interested in addressing both of these, tensions arise between and among depathologizationists who focus primarily on stigma versus infrastructure and access. These debates play out vis-à-vis questions about economic privilege, how to best facilitate access to care, how stratification matters to depathologization, and how biomedically-defined diagnoses matter to broader forms of representation. Of course, the positions and genres of depathologization I discuss are far more contingent, mobile, and mutually imbricated than a static map can adequately capture.

CARE WITHOUT ILLNESS BEYOND TRANS HEALTH

Care without illness both underpins and draws together many forms of depathologization. While it is possible to bring a broad set of health social movements under this banner, my focus here is on feminist health and disability social movements and scholarship. Neither field readily deploys the term "depathologization." Nonetheless, critiques of normalization and pathologization advanced by both fields—barring a wholesale rejection of biomedical care—resonate clearly with trans depathologization imperatives. Next, I draw briefly on feminist and disability scholarship in sketching how care without illness organizes some of the major theoretical interventions of these two fields. Most discussions of trans depathologization persistently and insufficiently compare it to gay and lesbian psychiatric depathologization. Precisely because of this analogical reflex, it is important to examine these seemingly more elusive connections.

Feminist Health: Politicizing Pathologization

Feminist scholarship and activism is central to trans depathologization regimes in *both* New York and Buenos Aires.[106] Feminist analysts and activists have long pointed out that sites of medical practice can be elaborated as sites of social control and therefore as targets for politicization. Decades ago, Ehrenreich and English (1973) discussed how the US medical establishment historically regarded women as inferior on the basis of their corporeal and mental constitutions. They further pointed out distinct stratifications within this dynamic: the pathologization of wealthy women's bodies and minds involved a different set of illnesses and maladies than those of poor women.

Such stratified pathologization produced different modes of inclusion and exclusion vis-à-vis medical management.[107] Other scholars have shown how medical power produces and reproduces social norms and hierarchies of so-called "natural" orders—at once gendered, racialized, and abled—by exercising both coercive and violent power (Cutuli 2012; Rapp 1999; Roberts 1997; Ruzek 1978; Samuels 2014; and Stoler 1995). Writing about the US feminist health movement in the 1970s, Murphy (2012:29) recently argued that the politicization of health and indeed specific forms of life (what she calls "sexed living-being") took shape through a "feminist reassembly of the terms of health care"—focused on "seizing the means" of medical practice rather than demedicalization. One manifestation of this "self-help" approach to care was a refiguring of the concept of the "norm." Murphy (2012:97) discusses how feminists disputed the notion of the "normal" menstrual cycle relative to a population standard, and instead conceptualized a highly individualized "norm" based on specific women tracking their cycles over time.[108] These analyses bridge with assertions from trans health activists that embodied knowledge forms the basis for health and wellness rather than statistical or ideologically coercive norms.

Disability Activism: Displacing the "Norm"

Trans depathologization also stems from efforts of disability scholars and activists. Some trans health advocates, activists, and providers have explicitly engaged disability studies and activist rubrics in their framing of trans health, but most did not. Nevertheless, even when not specifically engaged, contributions of disability scholars and activists were palpable.[109] Like feminist interventions, these foreground the notion that the disciplinary and biomedical norm is ineluctably produced *against* the figure of the disabled subject. As Schweik (2009) and Garland-Thomson (1997) point out, gendered, racialized, and health norms converge in both regulatory governance and medical care for people with disabilities. Dolmage and Lewiecki-Wilson (2010:24) further link disability and feminist analysis, insisting that each field must "investigate the history of bodily norms in order to unmask the powers and processes of 'norming' and the construction of 'normality.'" As

Mel Chen (2012:43) argues, disability and feminist studies each take up such investigatory projects by "rais[ing] biopolitical questions about certain living states of being that have been marked as equivalent to death" or as otherwise dehumanized, subordinated, or objectified.

Disability scholars do not generally aim to abrogate the availability of biomedical care. Nonetheless, they insist that conceptualizing disability must not take place solely in the realm of biomedicine. To this end, Dolmage and Lewiecki-Wilson (2010:30) further argue that "disability is a complex political and cultural effect of one's interaction with an environment, not simply a medical condition to be eliminated" or managed. This relates to disability activists' and scholars' discussions of the "social model" of disability, which contrasts with both "individual" and "medical" models. The social model proposes that disability springs not from embodied, neural, emotional, or psychic atypicalities, but rather from the failures of society to accommodate different capacities (Hall 2011; Oliver 1990; Shakespeare 2006). Taken together with feminist reassemblies of medicine, this notion forms one of the major blueprints for care without illness. As in feminist health care formations, the social model of disability presumes the possibility of accommodation or capacitation (not limited to but likely inclusive of biomedical technologies and interventions) *without* the attribution pathology or deficiency to states of atypicality.

In the next section, I draw on my ethnographic data to show how these intertwined political analyses and commitments take shape in practice with respect to trans health. I demonstrate how the broad implications of care without illness shape the objectives of trans depathologization, even as its politics and foci vary, revealing how trans depathologization draws from feminist health and disability activism and scholarship.

PROLIFERATING DEPATHOLOGIZATIONS

Care without illness unites trans depathologizationists in their rejection of pathologization coupled with their desire to maintain access to biomedical interventions. However, despite this common link, empirical data show that stark differences remain among trans depathologization's distinctive forms. Burke (2011:192) also observed strategic distinctions among trans depathologization activists in the San Francisco Bay Area, and differentiated between those promoting "reform" and those proposing "demedicalization."

In this section, I extend Burke's (2011) insights to develop a more expansive positional typology that that also incorporates depathologization movements in the US and beyond. This both draws from and relationally positions some of the central debates among advocates and activists. The general genres of depathologization I present include: *declassificatory, medicalized, revisionist psychiatric, depscyhopathologization, consent-based,* and *coalitional* (Figure 7). Each of these might take on the varying positions outlined in Figure 5. Again, these genres and positions are by no means exhaustive, nor are their elements mutually exclusive. In fact, multiple genres of trans depathologization and multiple positions within it may be practiced by the same actors. For example, some activists slid between depsychopathologization and consent-based genres. Moreover, some may take on some positions as legal advocates or providers, for example, but might embed these within broader forms of depathologization (such as those who formally worked within medicalized depathologization, but who situated this work within coalitional forms of depathologization). Such complexities notwithstanding, these mappings provide useful schemas to examine what is at stake for different depathologizationists working in distinctive sites and for different objectives. Below, I explain the genres of depathologization I describe in the project map in Figure 7, and show how different positions (represented in Figure 5) were varyingly asserted. Throughout these ethnographic descriptions, the different actors, non-human elements, and discourses shown in Figure 6 arise as part of negotiating positions, claims, and compromises.

Genres of Trans Depathologization

Declassificatory depathologization

In a 2011 address to the Harvard University School of Public Health, trans activist Pauline Park argued for the declassification of what was then Gender Identity Disorder (GID) (discussed in Chapter 1). She said, "I personally find it outrageous that transgendered people in the United States and elsewhere have to have themselves declared mentally ill in order to access health care or to get or to keep a job" (Park, 2011). Arguing against what she called the "GID regime," she asserted, "We must commit to finding means by which transgendered people can access forms of medical intervention…without having to subject themselves to the degradation of being declared mentally ill simply by virtue of their gender identity" (Park 2011).

Park's (2007, 2011) conception of depathologization seeks primarily to remove GID from the DSM on the basis of social destigmatization. Her position exemplifies of a steadfast declassificatory depathologization. This genre of trans depathologization aligns most closely with demands made by US-based gay activists in 1974 to remove "homosexuality" from the DSM-II (American Psychiatric Association 1974). In her 2011 lecture, Park spoke to the specter of losing access to covered care with the eradication of the diagnostic code: "Very few transgendered people are getting hormones paid for and even fewer are getting SRS [sex-reassignment surgery] paid for anyway, so the ostensible 'loss' of coverage by embracing this concept of transgender health will be a small one for our community. In my view, the gain will more than offset such a loss" (Park 2011). In an earlier magazine interview, she riffed on an activist refrain: "I don't have a gender identity disorder. Society has a gender identity disorder…I think [GID] should be abolished. And I think it's disabling for the trans community and that it only serves to pathologize transgendered people"[110] (The Gully 2002: paragraph 23). According to this logic, if medicine produces a pathologized population through its diagnostic sorting, a depathologizing gesture requires divestment from this the classificatory frame of a "pathologizing" diagnostic model.

Declassificatory depathologizationists give primacy to concerns about social stigma over and above questions of infrastructure and access to care. Thus it is not a surprise that its proponents have come into conflict with other depathologization activists. Critics argue that declassification would inevitably result in demedicalization, and would lead to markedly stratified access to care (since access would wholly depend on ability to pay or pursue legal recourse). As such, many—including Mark, a New York activist and attorney—have decried this form of depathologization as "privileged," arguing that it fails to comprehend the power dynamics within which low-income and other marginalized trans people attempt to access care (Mark Interview, January 15, 2016). Other advocates and activists have expressed concern that, despite the roots of such a position in social models of disability, declassificatory depathologizationists trepidation about stigma relies on a disavowal and reification of mental debility as dehumanizing. Significantly, no participants in my US sample took a fully declassificatory position, but its predominance in broader debates led many to carefully articulate why they reject total declassification. In Argentina, participants pointed to the Gender Identity Law's health care provisions to demonstrate how declassification could be coupled with consent-based care as a means of formal and legal depathologization that still attends to access.

Medicalized depathologization

This genre of depathologization takes the pragmatics of access as a starting point, and partially sidelines concerns about stigma. Medicalized depathologization not only assumes but also anticipates the infrastructural constraints of health care. As one presenter I observed at a trans health conference commented, 'Philosophically and politically, the diagnosis feels stigmatizing. But in the health care system we have, everything has to have a diagnostic code—even a well visit."

Mark (Interview 2016:5) similarly commented:

> I always just think, well none of the stories we tell to the law accurately reflect who we are. We create these narratives to fit into the [existing] power structures to redistribute better opportunities for survival. So I just have a really hard time with the trans community sort of getting up in arms about the idea that we might be considered disordered or [that] being trans is a disability or …a mental illness when all of these things only have the meaning that we ascribe to them[.]

Here, depathologizationists separate the bureaucratic biomedical necessity of diagnostic classifications from political subjectivities. As Mark (Interview 2016:5) asserted, "[T]he entire medical and psychiatric paradigms are incredibly problematic and are used in the most problematic ways. So my approach…is always going to be in the lens of what's going to do the most to increase access to care that people need." Medicalized depathologizationists thus take as given that biomedicine has been and will continue to be a stratifying, pathologizing, and normalizing institution. As a result, they have little interest in tinkering with diagnostic classifications. It is not that they see these as performing accurate or adequate work, but rather their concerns that processes of diagnostic revision may open up debates that tend to destabilize already tenuous modes of access.

Medicalized depathologizationists are most likely to make explicit links to disability activism. Following up on his point about mental illness and disability having only the "meanings we ascribe to them," Mark (Interview 2016:5) commented, "So if having a disability means that the world doesn't understand or accommodate your needs, then that's precisely what [being trans] should be understood as…So I don't love the 'Oh get us out of [the DSM].'" As an attorney, he is also adamant that in the U.S. disability protections offer superior legal strategies than equality claims. Mark and other medicalized depathologizationists thus regard diagnoses—and laws—as imperfect and reductive, but ultimately as pragmatic instruments for achieving access for those who otherwise would not gain it. Their instrumental utility, however, is of course contingent on the particular medical and legal infrastructures in which diagnoses circulate.

Another key point for medicalized depathologizationists is their assertion that trans people who are also subjugated along lines of race, ethnicity, class, disability, and/or immigration status (among others) are least likely to benefit from efforts to destigmatize diagnostic classifications or practices. For example, the shift from Gender Identity Disorder to Gender Dysphoria (the latter as a "distress-based model") is not likely to be applied in institutional settings such as prisons or immigration detention facilities where "distress" generally does not register as requiring the intervention of medical administrative intervention (Hanssmann 2016:125–26; Strangio 2012).

Medicalized depathologizationists further assert that doctors, attorneys, and other actors adjudicate gender non-normativity vis-à-vis people being legible as properly productive citizens.[111] In short, they view diagnostic and biomedical practices as wedges. Bifurcating biomedical practices such as diagnosis split trans people into two groups: one which might be recognized as recuperable into citizenship, and the other outside of or excluded from citizenship.[112] The former group, according to medicalized depathologizationists, are admitted into citizenship contingently, while the latter becomes subject to increased barriers to entry. Simply revising diagnostic classifications is inadequate, they argue, because they would be applied in radically different and highly stratifying and marginalizing ways.

Thus, for medicalized depathologizationists, concerns about social control and subjugation are never simply or even predominantly enacted in the power field of biomedical practice. They are less concerned with scientific or representational accuracy, and focus instead on *effects*. As Strangio (2012:paragraph 3-4) writes:

> For many people, especially trans people of color and low income and incarcerated trans people, the diagnosis of Gender Identity Disorder has become a tool to resist medical and other forms of state control… [F]or incarcerated transgender individuals, the availability of a GID diagnosis creates an important framework for meeting Eighth Amendment and statutory requirements for challenging the deliberate indifference of prison medical staff.

In other words, at the same time diagnoses are subjugating, they may also be contingently employed strategically by trans people and advocates.

Medicalized depathologizationists with whom I spoke articulated concerns about centering gender non-normative subjects usually marginalized or excluded from recognition and care. However, in my study samples, addressing such marginalization *through* medicalization was unique to activists in the U.S. Mark (2016:19), for instance, had not heard about Argentina's Gender Identity Law.[113] When I shared with him its depathologizing provision, he said, "That would never work here." While he described his politics as being in line with this move, he commented that the US health care system would not accommodate distributing resources in accordance with desire rather than pathologization. In the US, he explained, a more equitable distribution of care could only possibly be enacted by engaging biomedicine on its own pathologizing terms. In a sense, this approach embeds a broader *politic* of care without illness into an extant pathologizing diagnostic regime, while also reading normalizing diagnostic classifications against the grain.

Revisionist psychiatric depathologization

Like medicalized depathologizationists, revisionist psychiatric depathologizationists are also largely concerned with pragmatic forms of access, but are more likely to *tinker* with diagnoses. Issues of stigma are also somewhat more prioritized in this group's practices compared with medicalized depathologization's square focus on infrastructure and access.

After fielding much controversy concerning the GID diagnosis, in 2008 the American Psychiatric Association convened the Work Group on Sexual and Gender Identity Disorders (WGSGID) to develop recommendations for its revised publication of the DSM-5 (American Psychiatric Association 2013). Some individuals appointed—mostly mental health providers and researchers—had ties to trans activists and advocates.[114] The group eventually struck a compromise among the demands three major constituencies: declassificatory depathologizationists, old-guard defenders of the Gender Identity Disorder diagnosis, and activists concerned with access to care. As a result, Gender Dysphoria became the revised diagnosis in the DSM-5 (American Psychiatric Association 2013). Fiona (Interview, January 11, 2016), a mental health provider in New York, reflected that the new diagnosis is "no longer a [classic] transsexual model. They're talking about gender diversity."[115] Thus, much like declassificatory depathologizationists, revisionist psychiatric depathologizationists center the notion of *wellness* over psychiatric pathologization. They implicitly critique psychiatry's normalizing power as they recast gender non-normativity as *human diversity* instead of pathological deviance. For such actors—many practicing mental health providers—it remains possible to undertake these changes *within* the realm of mental health and biomedical practice.

Like declassificatory depathologizationists, this group prioritizes the declassification of "pathologizing" diagnoses. Like medicalized depathologizationists, they foreground the importance of coding structures for health care access. However, some ambivalence remains about the unanticipated consequences of psychiatric diagnosis—even in "depathologized" forms.[116] Fiona (Interview, January 11, 2016) commented:

> I think the community and people certainly outside of mental health think that it's some kind of pathology that mental health people are imposing where really it's just like this is a coding book for billing. It's so incidental. Most therapists I know who do this don't even like using gender diagnosis. Now that we have so many insurance companies paying for things and they want a gender diagnosis more people will end up with one. Who knows what impact that's going to have on their future care. We know it could be bad, right?

Revisionist psychiatric depathologizationists ultimately strive to *retain a psychiatric diagnosis only for the explicit purpose of retaining access to care,* rather than maintaining an investment in defining gender non-normativity as a psychiatric illness. Some of the same people involved in revising the DSM are also active in developing a diagnostic classification within the ICD that dwells outside the chapter on mental health disorders (see Chapter 1). Nonetheless, striking the compromise that produced Gender Dysphoria to replace Gender Identity Disorder in the DSM was largely sufficient for revisionist psychiatric depathologizationists. It met their objectives of *both* facilitating access to health and removing the individually-based term “disorder” from the diagnostic classification. In this regard, diagnoses can work instrumentally, as for medicalized depathologizationists, but they need not be subjugating.

Depsychopathologization

Some depathologizationists, however, were unimpressed by the changes resulting in the altered Gender Dysphoria diagnostic classification, objecting specifically to its placement in the DSM. In shifting from a disorder- to a distress-based diagnostic model, they argued, little had changed in that it remained a psychiatric diagnosis. Depsychopathologizationists seek covered gender-confirming care without any reliance on a mental illness diagnosis. Like declassificatory depathologizationists, they strive for the elimination of a psychiatric diagnosis, and like medicalized depathologizationists, they train their attention on facilitating infrastructural access to care. This group also shares significant overlaps with revisionist psychiatric depathologization activists, but is more emphatic in rejecting psychiatry as the site for diagnosis.

For activists involved in Stop Trans Pathologization International (STP), “depsychopathologization” has become a potent call to action. For STP (2012) and other depsychopathologizationists, psychiatrization refers to the “practice of defining and treating transsexuality under a mentally disordered label.” Instead, STP favors establishing a “non-pathologizing” mention in the ICD-11. Significantly, this position shifted as STP grew from a relatively small group of activists in Spain to an informal transnationally-linked collaborative.[117]

Presently, STP and other activists, as well as health care providers (Drescher et al. 2012), presently aim to develop a non-psychiatric medical diagnosis. As part of this effort, a committee associated with the *International Statistical Classification of Diseases and Related Health (ICD-11)*, now in its full revision process, is addressing how to represent a diagnosis that defines and describes being trans in a "solely medical" non-psychiatric manner. Some participants called this a "neutral diagnosis." As with other conditions that one must "fight to get," (Dumit 2006) this diagnostic objective relies in part on the authorization of "medicine" as a potentially politically neutral terrain through which to diagnose and receive diagnoses, while psychiatry remains in the domain of speculation, moralization, and stigmatization.

In addition to the move away from psychiatric classification, more transnationally-focused depsychopathologizationists were also interested in contesting what they view as US epistemic dominance—or what one activist called "psychiatric imperialism." While the DSM has garnered much attention and controversy among trans advocates and activists in the US, certain depsychopathologizationists focus instead on the ICD as a more transnationally salient target. For example, Global Action for Trans* Equality (GATE), an NGO based in Buenos Aires, New York, and Bangkok, became involved at the inception of the ICD-11 revision process, as discussed in Chapter 1. While many of the US-based providers I interviewed were only marginally aware of this process, many had caught wind that there was a non-psychiatric diagnosis in development. Argentina-based providers were generally much more aware of this shift taking place through the ICD, though they also generally tracked the DSM changes.

Some depsychopathologizationists recognized the fine line between rejecting psychiatric imperialism and exacerbating the ongoing devaluation of people with mental illness. Antonio (Interview July 25, 2015)—the Argentinian activist involved in the ICD revision process (also discussed in Chapter 1)—notes that the WHO implored members of the working group to relinquish the position that the problem of stigmatized trans existence lies in the fact of the psychiatric illness per se. In debates about how to articulate an argument for moving the diagnosis outside the ICD's mental illness chapter, the group eventually strove to make this argument without rehashing the stigmatization of mental illness more broadly. As Antonio (Interview July 25, 2015) explained, one activist who attended a panel during which the WHO presented their work said, "We are not ill. We are human beings." He laughed sardonically when he reported this unintentionally but pointedly deprecating comment, which presumes that mental illness is synonymous with exclusion from humanness.

The WHO working group eventually argued that the stigmatization of mental illness remains a problem that requires work. Relative to their trans depsychopathologization-centered project, they assert that moving the proposed diagnosis of Gender Incongruence outside the mental health chapter does not comprise a reactionary disavowal of mental illness, but rather a bid for enhanced diagnostic accuracy.

Antonio (Interview July 25, 2015) also noted that Argentina's Gender Identity Law is caught in a similar conundrum in its disavowal of mental illness. He commented, "now, the law in Argentina has caused a complicated effect because it depathologizes. This means that people do not have to go through a process of psychiatric evaluation, but at the same time, what the discourse of depathologization produces is that it explicitly reinforces the stigma about mental illness and suffering" (Antonio Interview July 25, 2015).

In their strong demand for depscyhopathologization, these arguments also recall gay and lesbian depathologization paradigms. However, while gay and lesbian activists refuted psychiatric normalization, they lacked a distinctive impetus to remain engaged with biomedical practice. Trans depsychopathologizationists yoke the rejection of mental illness to demands for access to biomedical infrastructure through a different diagnosis (or through a law that removes the necessity of diagnosis for access to care, as in Argentina). In so doing, they assert that "self-determination" and "autonomy" must be at the center of the provision of trans health care.

Consent-based depathologization

This genre of depathologization reflects elaboration of some tenets of self-determination articulated through depsychopathologization. However, it moves away from diagnostic frameworks and towards contract-based models of elective care (while striving to maintain access to coverage). While definitions range broadly, informed consent in the realm of clinical medicine can be defined as "the core notion that decisions about the medical care a person will receive, if any, are to be made in a collaborative manner between patient and physician" (Applebaum, Lidz, and Meisel 1987:12).

With regard to trans health, informed consent models generally require a disclosure of risks associated with treatment or procedures rather than "an in-depth mental health evaluation and referral" (Deutsch 2012:140). To the extent that this genre of depathologization involves diagnoses, they are generally negotiated between patients and providers. In general, consent-based depathologizationists aim to enhance the agency of patients in accessing care and to prevent "paternalistic" dynamics of care (Caplan 1988). The contractual emphasis of informed consent models is increasingly regarded far more favorably than what advocates and activists call the "gatekeeping" practices of trans health that comprise the pathologizing diagnostic model of care.

Talia (Interview, August 3, 2013), the New York nurse practitioner whose comments opened the chapter, commented on her clinic's process of developing a clinic-wide protocol based on informed consent:

> [W]hen we wrote our informed consent protocol…part of what we wanted to do is not make people…jump through a bunch of hoops. [T]he whole purpose of [our] protocol was to make sure people had factual, high-quality, evidence-based information upon which to make their decision and that they had the cognitive ability to make a decision which most people do if they're already consenting for their medical care for everything else, they should be able to do this…So there was no gatekeeper anymore. It was really all up to that person to make that decision with guidance to make sure they understood what the consequences may be versus benefits versus unknowns.

Talia's (Interview August 3, 2013) experience describes one example of how informed consent-based projects aim to produce a collaborative model of treatment between health care providers and patients. For consent-based depathologizationists, informed consent models contrast with paternalistic diagnostic models that require psychiatric diagnosis, psychotherapy, and adherence to a specific trajectory of gender transition. However, Talia (Interview, August 3, 2013:8) also emphasized that informed consent models of care often fail to fit into diagnostic infrastructures:

> Talia: In my day to day, I never use [Gender Identity Disorder]. I never have to. I used to in a rare once in a while because a surgeon would require me to write a letter that said a person was diagnosed with GID so he could do the surgery. So I would tell the patient, like I'm going to have to put this in this letter but I'm not diagnosing you with this.
>
> Author: So it's in the letter, not the chart?[118]
>
> Talia: Yeah. Which I suppose wouldn't be good if the surgeon ever looked at the chart."

She emphasized that this was not without its risks, given the possibility of being charged with health care fraud—a common concern among health care providers who refuse what they see as pathologizing diagnoses.

In Argentina, no such risks exist, as the Gender Identity Law installed informed consent at the level of the nation, requiring only "expressed desire" on the part of trans people to obtain gender-confirming medical treatment. Discussing his transnational depathologization work, Antonio (Interview, July 25, 2015) expressed that he would have preferred Argentina's current approach to be the transnational standard: no diagnosis, and treatment based on self-referral. But he viewed the U.S.'s decentralized and rigidly diagnostic structure as making this unattainable. He said US-based insurance schemas structure the *need* for diagnosis.[119] In his mind, this "force[s] the rest of the world to accept a pathologizing category." He described this as "US psychiatric imperialism," and suggested that it prevented more sweeping changes to trans health as a transnationally standardizing field. This distinction accounts for why Antonio can move rather seamlessly between depsychopathologization and consent-based depathologization. In his transnational work, he advocated a "non-pathologizing" biomedical diagnosis, while in his activism within Argentina, he took a strong informed-consent position. While these positions are not incompatible, the former is more strongly constituted by diagnostic rather than contractual infrastructures.

In general, consent-based depathologization departs from dominant standards of trans health care by radically de-emphasizing assessment and diagnosis, and instead advancing "patient autonomy" and "informed choice." Informed consent advocates assert that this model ensures that gender non-normative people have the information they need (about the effects of hormone treatments or surgeries, for instance) to make considered and self-determined care decisions that best fit their needs.

Coalitional depathologization

While comprising a less distinctive strategic position, coalitional depathologizationists insist on foregrounding the stratifying elements of diagnostic classification. Like medicalized depathologizationists, they center on how diagnostic practices segment trans subjects into "deserving" or "undeserving" categories of care recipients (e.g., Aizura 2006; Irving 2008; Spade 2011; Strangio 2012). Further, they refuse to separate pathologization, racialization, sexualization, and valuation, instead advocating "self-determination" and "bodily autonomy" as embedded in broader transformative and redistributive politics. Moreover, they assert that economic and racialized stratifications and relations of power both constitute and are reproduced by the force field of biomedical practice (e.g., Araneta and Fernandez Garrido 2016; Arkles 2009; Berkins 2008; Fernandez, D'Uva, and Viturro 2004; Sylvia Rivera Law Project n.d.). This genre of depathologization thus comprises a more strictly epistemological position that seems to operate in tandem with strategic or pragmatic positions. But it also inevitably and strongly informs how advocates and activists define problems and imagine solutions, regardless of the specific form of depathologization that they adopt.

People with this view of care without illness frequently compare differing modes of embodied autonomy. For instance, several respondents made common-sense links between gender-confirming care, access to safe and legal abortion, coverage for *in vitro* fertilization and other reproductive technologies, freedom from forced sterilization, and the prevention of surgeries on intersex infants. Some respondents also mentioned how disability and euthanasia are connected to trans health, paralleling the central clinical relevance of patients' life conditions over and above diagnosis- and prognosis-driven care.

From this perspective, trans health is simply one among many forms of care that need not require a treatable illness. Even more important for this group, trans health is only one among many forms of care that places the subject of care—*not* the provider—at the center of decision-making.[120] Coalitional depathologizationists insist that racialization, sexualization, class, and other forces of marginalization shape the power relations between providers and patients to such an extent that "autonomy" requires far more than providers simply choosing to conduct their work differently. It is this position that distinguishing this group from other depathologizationists. Here, "self-determination" (*autodeterminación*) becomes a mode of demand that seems to invokes distinctive power relations that exceed those that presently shape institutions such as biomedicine. "Gender self-determination," in this regard, links to other modes of collective self-fashioning that explicitly reject the terms of a universal subject of care or rights.[121]

Coalitional depathologization activists thus view pathologization as far exceeding the realm of gendered or sexualized difference, and link depathologization efforts to a range of other desired social, political, and economic transformations. They orient around what Cathy Cohen (1997:444-45) calls "transformational politics," or "a politics that does not search for opportunities to integrate into dominant institutions and normative social relationships, but instead pursues a political agenda that seeks to change values, definitions, and laws which make these institutions and relationships oppressive." For instance, Ana (Interview July 31, 2015:18), a *travesti* activist in Buenos Aires, told me that she was fighting not just for depathologization, but against criminalization and abbreviated life chances, "and in favor of real economic, political, and social justice." Samantha (Interview January 9, 2016:6), a New York attorney and activist commented that she does not view biomedicine as a site of liberation. Rather, she sees it as an area where racialized, classed, gendered, and sexualized hierarchies are starkly instantiated. As such, she views depathologization as a way to intervene in the ideologies and practices that produce and stabilize these ranging and thickly interrelated hierarchies. Silvia (Interview, August 9, 2013), another New York activist, was skeptical about detaching depathologization activism from broader racialized class struggles. For her, care without illness was not a political endpoint, but was rather continuous with political and economic redistribution and revolution. She explained:

> Trans health was the starting point for beginning to think a lot about what it would take to turn back the tide on neoliberalism, to significantly increase taxation on the wealthy, to rebuild and expand the social wage, and to transform the provision of social services by this state into being more democratic, dignified, honoring the self-determination of particularly African-American communities and immigrant communities, and queer and trans people, and sort of rebuild [what a] democratic, egalitarian welfare state could look like (Silvia Interview, 2013:2).

Silvia distinguished LGBT freedom and rights projects from trans health activism, saying that while the former tend to be concerned primarily with issues of privacy and/or or non-discrimination, the latter can bring about the conditions to engage in class struggle. Specifically, she described how trans health advocates and activists must enter into explicit engagements and make demands on institutional infrastructures in ways that LGBQ advocates and activists do not need to take up.

> [T]rans health on a very clear level requires infrastructure of either the state or the market, [and] unlike LGBT freedom, where you could say, 'what we want is to be left alone in our bedrooms,' trans people require the actual acquisition of a material good that cannot be produced in one's own home…So it forces advocates and trans people into struggles around state provision and struggles around the shape of marketized and commoditized healthcare (Silvia Interview, 2013:3).

Ana (Interview 2015:14) took a similar stance, describing *travesti* politics as necessarily aligned with racialized class and labor struggles. We talked at a Buenos Aires restaurant. She criticized what she viewed as the racialized and classed subordination of *travesti* activists on the part of mainstream gay and lesbian rights organization. Gesturing to our server as he walked away from our table, she explained that *travestis* have more in common with him than with the well-off leaders of these organizations. For her, depathologization links to "proletarian struggle." Addressing biomedical pathologization without also mobilizing against economic marginalization and violence would be insufficient from this vantage point.

Ana was working with public hospital-based clinics in the lower-income outskirts of Buenos Aires on *consultorios inclusivos* –"inclusive" or "trans-friendly" clinic days. She appreciated the fact that Argentina had *diagnostically* depathologized access to gender-confirming care. But *pathologization,* she said, went much further than just medicine (Interview 2015). *Consultorios inclusivos* were specifically reserved for low-income trans people and *travestis,* as well as trans* and non-trans* sex workers, and people seeking abortions—which, while illegal, are often performed (e.g., McReynolds-Pérez 2017). *Consultorios inclusivos* aimed to connect patients with supportive providers and to insulate people from harassment that often occurred in standard waiting rooms. Ana asserted that the providers staffing these clinics needed to reject not only the pathologization of transness, but also medicine's broader racialized and classed pathologization. She did not think that clinic days would fundamentally shift the stratified dynamics of medicine, but she saw them as microcosms within which the possibility of a broader vision of depathologization could be materialized.

At one of the *consultorios inclusivos* that I visited, I spoke with a doctor named Adán. He worked in a clinic in one of the *conurbanos*—one of the districts in the province of Buenos Aires just outside of the city proper. I had spent most of the day in the clinic as I waited to speak with him. Every once in a while, Adán rushed out and delay our interview by another hour. As I waited, I spoke with the patients there. Chairs were arranged in a circle, and patients chatted and passed around snacks. In the afternoon, someone celebrated a birthday.

Auyero (2012), in his ethnographic work on state bureaucracies and welfare programs in the Buenos Aires *conurbanos*, reflects on this extended form of waiting. Arguing that people become "patients of the state," he suggests *waiting* as a form of social control. In a similar vein, Victoria Pitts-Taylor (2011) calls this "waiting to death." The wait was certainly long, but it did not seem immediately to have the stultifying effect that Auyero and Pitts-Taylor describe. This sense of "clinic as community" is one that accompanies both feminist and queer health formations. Without romanticizing this view or rehashing the notions of "good medicine/bad psychiatry" on which it partially relies, it was still difficult to ignore the fact that people seemed more or less content to be waiting there with each other. This—as well as the "structure of feeling" (Raymond 1954) that more generally accompanies the "trans friendly clinic"[122]—emerges largely as a collective sense of relief at the possibility (however minimal) of being able to access previously unattainable forms of facilitating the conditions of life and well-being. Of note here is the fact that this clinic is currently in danger of closure, having been swept up in the cuts to public medical programs in President Macri's neoliberalizing national policies since his election in late 2015 (*Página12,* 2016).

While I did not directly ask people in the *consultorio inclusive* why they were there, some volunteered that they had come for gender confirming care. Others were also there for a range of standard medical problems, even though they had to wait longer than on a regular clinic day. But they said they preferred to talk with Dr. Adán, and they liked the waiting room at the *consultorio inclusivo* anyway. I finally talked to Adán—a Marxist and physician—about an hour and a half after the clinic was set to close. He shared some of the other reasons that patients had come, including one who was seeking misoprostol for a pharmaceutical abortion (Adán Interview, July 24, 2015).

Abortion is illegal in Argentina. Yet, as one trans activist told me half-jokingly, they are now easier to access than gender-confirming care. Previously, abortion had only been accessible to wealthy people who could pay steep fees to private doctors. But in the past decade, feminist and lesbian organizing had made pharmaceutical abortion widely accessible. Adán described how his work was informed by collaborations with this network of feminists (see also McReynolds-Pérez 2017), as well as by his partnerships with *travesti* and trans* groups and organizations.

Coalitional depathologizationists are generally critical of revisionist politics that hold stable power dynamics between states, markets, providers, and trans people. New York activist Silvia (2013: 4) commented:

> A lot of trans advocates are very preoccupied with how legal categories don't include people or something. That's deeply baffling to me that we're not talking about socialism, that we're not about class war…that we're talking about how the state categorizes people. It's like that isn't actually that big a deal compared to poverty. The state could treat trans people just fine and we'd still all be dying of AIDS.

Silvia, Ana, and Adán, like several other respondents, saw depathologization as an important strategy for trans health. However, for them, contesting depathologization was not simply about a resistance to the normalizing forces of biomedicine or the state. Instead, they focused on its potential to contest wider power relations, and bind trans health activism to a broader Marxist praxis. When I asked Silvia (2013:9) about the end goals of trans health advocacy and activism, she responded, "Maybe it ends when we have a respectful, self-determined provision of medical services to trans people provided in a system of universal single-payer healthcare with a democratically controlled worker state. Maybe."

NEGOTIATING DEPATHOLOGIZATIONS

Returning to the positional and project maps (Figure 5 and 7), I provide two ways to view what is at stake for a range of depathologization advocates and activists. Both show how simultaneous and sometimes competing concerns about infrastructure, access, and stigma are in play in trans depathologization and the varying positions that are taken in its negotiation. Taking a primarily stigma-focused approach, *declassificatory depathologization* activists, for instance, center questions of representation. As a result, they target what they see as devaluing elements of the diagnostic classificatory system as "stigmatizing." In contrast, infrastructure-focused *medicalized* *depathologization* are far more concerned with how to mitigate the structuring effects of stratified health care provision. They thus focus on how to address the inequities of biomedical infrastructures by adopting the lexicon of medicalization, even though it generally belies their broader political commitments. *Consent-based depathologizationists* work to reterritorialize the site of interaction between providers and patients from the frame of diagnostics to that of the contract. In so doing, they work (where and when possible) to maximize access to care while ostensibly mitigating stigma.

Depsychopathologization and *revisionist psychiatric depathologizationists* also attempt to take seriously the effects of stigmatization without compromising on the question of access. Each aims to change the name, the placement, and/or the descriptions of diagnoses to maintain access to care infrastructures without abandoning classifications altogether. *Coalitional depathologization*, while a more diffractive position, ultimately focuses somewhat more on infrastructures. However, it tends to understand biomedical infrastructures as intimately intertwined with a range of other infrastructures, and views its interventions as targeting ranging infrastructural sites: biomedical, economic, racialized, geopolitical, and so on. In each case, depathologizationists fashion a *political diagnostic* practice*,* and they then tailor varying strategies of depathologization to the ways they define the problem of pathologization.

The divergences between declassificatory depathologization, coalitional depathologization, and revisionist psychiatric depathologization illuminate some of the central debates between revisionist and transformational depathologization. Declassificatory depathologization envisions an abandonment of diagnostic frames altogether, in favor of a demedicalized but generally market-based model. Many coalitional depathologizationists instead envision mobilizing a redistributive politics combined with an imperative of "self-determination" that would also likely arise outside of a diagnostic framework. Attentive to the stratifying forces of the private market, however, coalitional depathologization is defined in contrast to advocates of declassificatory depathologization.

Revisionist psychiatric depathologizationists, in contrast with coalitional and declassificatory depathologization, view (if with some trepidation) psychiatric diagnostic frameworks as sufficiently elastic to enable access without disrupting dominant infrastructures of care. Medicalized depathologization and depsychopathologization is positioned more centrally along this continuum. While each genre is varyingly suspicious of diagnostic frameworks and while each may be accompanied by long-term political visions that do not rely on them, certain genres of depathologization focus on instrumentally mobilizing diagnostic frameworks. Medicalized depathologizationists strategically focus on DSM-based diagnoses as tools for access, while depsychopathologizationists focus on the ICD. These strategies rely on at least a provisional notion of either biological determinism or the "neutrality" of biomedicine in contrast with psychiatry (discussed in Chapter 1).

In all of these distinctive manners, trans health activists, advocates, and activist-providers engage the conundrum of "care without illness" by proposing or seeking changes in pathologizing diagnostic models of care. They seek arrangements of care in which trans people can opt for biomedical interventions without coercion, red tape, prior authorization, or even diagnosis. In a concrete sense, people undertake these objectives by tinkering with, shifting, or reimagining infrastructures that enable care without illness—each with distinct objectives, targets, and foci.

These varying interventions thus manifest in a range of infrastructural shifts and innovations (discussed in Chapter 1). Some are informal (such as providers' practices of "creative coding" for Endocrine Disorder-NOS), while some are implemented through formal changes to diagnostic classifications, guidelines, or standards.[123] Some are oriented to an urgent present, like medicalized depathologization, while others focus on bringing about a certain kind of future (like declassificatory depathologization and coalitional depathologization). Across different genres of depathologization, advocates and activists also attend to varying sites and scales of intervention: administrative regulations, expert committees, diagnostic classifications, treatment guidelines, clinic or medical system policies, and occasionally (though increasingly) national laws.

All of these positions and genres are in conversation, and to some degree, those who assert certain positions or mobilize within certain genres (however contingently and provisionally) counter what they view as the shortcomings of other positions and genres. These may converge in certain campaigns or political projects that are capacious enough to resonate with a range of positions.

CONCLUSION

While depathologization comprises a certain epistemological commonsense in transgender studies, elaborating precisely how it is articulated and instantiated in practice matters. This chapter examined different frameworks of depathologization. I argued for greater attention to the continuities between feminist women's health and contemporary trans depathologization (see also Hanssmann, 2016). Feminist health infrastructures have suffused the development of trans health formations (e.g., trans health clinics or community-developed care guidelines). Moreover, they provide a stronger analogy for care without illness than gay depathologization frameworks. Trans depathologization also refigures and at least ostensibly renders more horizontal clinical relations of care, characteristic also of disability scholars' and activists' analyses of biomedicine as both imperative and subjugating.

Regarding technologies and practices of trans depathologization (e.g., use of clinical informed consent guidelines rather than diagnostic classification), I argue that these too require attention as they take shape contingently in varying infrastructures and regulatory landscapes. My example here was the adoption of a legally mandated informed consent regime in Argentina, which seems both to facilitate broader access to care and to raise questions about the requisite conditions for such practices of consent (see also Casper and Clarke 1998).

Overall, my findings both corroborate and stand in contrast with the few extant studies of the broader politics of trans depathologization. For instance, Sekuler (2013:15) maintains that France produced itself as a "forward-thinking and rights-protecting nation" by depathologizing trans health. However, he argued that it did so by producing a "pre-modern and rights-neglecting non-French 'other'" (Sekuler 2013:15), thus unwittingly enrolling depathologizationists into the "racial policing of the French nation-state" (Sekuler 2013:27). Like Sekuler, I found that some genres and positions of depathologization engaged the power relations of destigmatization in ways that retrenched racialized and classed hierarchies. Others, however, adopted a care politics that expanded depathologization as a political diagnostic that far transcended trans health. Their view of medicine as only one of many institutions, infrastructures, and systems that instantiate broad forms of stratification in fact bridges trans pathologization and racial policing as paired problems, rather than pitting one against the other.

The objectives and foci of trans care without illness vary among advocates, activists, and providers. For coalitional and consent-based depathologizationists, depathologization constitutes a political imperative and a collective process of autonomy. In contrast, for depsychopathologizationists and medicalized or revisionist psychiatric depathologizationists, depathologization involves expanding, changing, or strategically using biomedicine to better meet the needs of trans people. For declassificatory depathologizationists, the main objective is destigmatization and recuperation into the embrace of "the normal." Last, for coalitional depathologizationists, depathologization is one means of addressing distributive justice, and is intertwined with broader projects that address power and subjugation. By elucidating these varying genres and positions of trans depathologization, as well as the relations between then, I demonstrated a range of different investments in trans health, each of which is accompanied by distinctive political, representational, and infrastructural objectives.

Depathologization as not only strategic interventions into health care but also *political diagnostics* thus foreground questions about care politics and their embeddedness in the relations of clinical, surgical, psychiatric and other forms of care. The distinctions among depathologizationists' positions and strategies reveal how differing politics of normativity, distribution, and autonomy profoundly shape how activists imagine depathologizing projects. Given the tendency in both transgender studies and medical sociology to collapse difference among depathologizationists and health-based activists, this dimensionalizing work reveals the immense range of politics that constitute and ground trans and other health activisms.

In sum, this chapter asks how care politics are both fashioned and revealed by activist practices of forging relations—infrastructural, professional, confrontational, historical, hierarchical, horizontal, collective, and strategic, among others. And indeed, it is through such processes that political objectives substantively materialize. As such, depathologization is not only a defiant rebuke of the pathologizing dimensions of medical practice, but also a particular set of orientations and demands that reshape—or at times retrench—extant relations and politics of care.

CONCLUSION: CIRCULAR REVISIONS

To conclude, I return to the theme of "revision." Revisions proliferate and condense in several major shifts that emerge as distinctive features of trans health: 1) from pathology to difference; 2) from individual to social; and 3) from choice to need. None are complete, nor are they wholly distinct from each other. Yet the shifts remain consistent across multiple geographic sites and widely ranging situations of practice.

Each shift materializes quite differently depending on where and how it is developed, elaborated, and institutionalized. Various combinations of actors (both human and non-human) work to accomplish these new processes of materialization through distinct actions, objectives, and strategies, and are situated within different infrastructural landscapes and political fields. Yet amidst this vast variation, trans health is consistent in its emergence as a set of correctives. Activists position these correctives across varying scales, from diagnostically attending to erroneous conceptions of transness to rebuffing the geopolitical dynamics of U.S. imperialism.

It is precisely this variation—in the midst of the consistency of the "corrective"—that I theorize as transmutable care. Problems of standardization, among others, produce space for the proliferation of various "trans healths." Transness is not singular, and the well-documented complications and failures of smooth travel and commensurate standards in care more generally also hold for trans health (e.g., Lakoff 1996; Livingston 2012). Nonetheless, trans health differs in that its plural forms are remarkable in their range and volume, and in the profound distinctions among their objectives, politics, and practices. This is true not only between geographic sites—such stark differences also emerge between sites of practices *within* each geopolitical location I studied: between the community clinic and the private hospital; the street protest and the courtroom; and across studies of disease burden and population biographies. This is in part due to the expanding set of actors involved in the broad revisions of trans health: not only do a wider range of providers now define its scope, so too do activists, advocates, policymakers, changing classificatory systems, and shifting regulations.

Yet even amidst this lack of standardization and commensurability, trans health certainly travels—and with astonishing speed. During my five years of research, a plethora of programs, laws, medical centers, and revision processes unfolded, not only in New York City and Buenos Aires, but much more broadly. Professional organizations grew and proliferated transnationally. Some of these have even begun to institutionalize trans health through credentialing and training programs. Today, transnational politics and infrastructures matter a great deal in just how trans health moves and instantiates, and mobility in this regard is caught up in complex currents of capital as well as those of knowledge.

REVISION AND CIRCULARITY

In 2014, Tierra Violeta Cultural Center—where Agustina García later portrayed the multilayered perils of racialized and classed subjugation among *travestis*—hosted a community seminar on depathologization. Led by an activist, the seminar explored "[t]he process of reform and revision of the ICD-10 as an historic opportunity for trans activism" (Centro Cultural Tierra Violeta 2014). Yet its tone was strikingly ambivalent: it described this revision as reflecting the "emancipatory struggle of depathologization," but conceded that "the very terms of that emancipation are also in dispute." *("El proceso de reforma y revisión de la CIE-10 representa una oportunidad histórica para el activismo trans comprometido con la despatologización como lucha emancipatoria –aunque los términos mismos de esa emancipación estén también en disputa.")* (Centro Cultural Tierra Violeta 2014)

The course's description continued in this vein, asking what it is to "depathologize." For some activists, it asserted, to depathologize is to grant access to rights and care without the need for diagnostic requirements. For others, it means eliminating diagnoses and "subvert[ting]…the medicalized ordering of bodies" (*"la subversión del orden medicalizado de los cuerpos"*) (Centro Cultural Tierra Violeta 2014). The catch in these different variants, it explains, is that *each carries a risk in its relation to biomedicine*. To put too much distance between trans*ness and biomedicine may be risk losing access to its modes of care. To fail to put enough distance between such subjectivities and biomedical regulation may perpetuate harmful biomedical ideologies (Centro Cultural Tierra Violeta 2014). The description thus likens depathologization's objectives to a "Möbius strip," and situated this conundrum as a framing question for the seminar.

This geometrical circularity of the Möbius strip seems also to mirror the transformative circularity in trans health's partial emergence out of transsexual medicine. As politics, practices, implications, nominal diagnoses, and objectives of contemporary trans health formations have shifted, the infrastructures on which it runs remain much more limited in their flexibility. Even in the case of "gender incongruence"—arguably the most substantively "depathologized" diagnostic classification, by many accounts—the implication remains that some notion of gendered "congruence" remains as its counter. This problematic is taken up in a range of critiques centering the gendering technologies of colonialism and slavery to the biologizing techniques of medical practice (e.g., Spillers 1987; Stone 1992; Stoler 1995; Davis 2015).

In this dissertation, I have focused on how the infrastructures that matter to trans health encode these knowledge technologies and politics, and thus remain at some level inescapable. I also discuss how activists rework notions of "risk" and "population" to produce different accounts of what is at stake in trans health: not the pathology of the psyche, but rather the varying and differentially violent social hierarchies within which gender non-normative people dwell. These partial transformations can never quite leave behind the elastic scaffolding assembled through the techniques of power that organize health formations in general. And indeed, the transformations that accompany biomedicalization (Clarke et. al 2003; 2010) scarcely leave an "outside" from which to contest medical power. Rather, activists engage in what Murphy (2012:29) calls "counter-conduct" to shift the politics, hierarchies, and terms of medicine without precisely resisting or divesting from its commitments. Trans health, as such, takes on the properties of the tail-eating serpent (Mehem or Ouroboros): recreation through return, or transformation through absorption.

FINDINGS

At the outset of my dissertation, I asked what trans health is—what is has been, what it is now, and from whence emerges. I also asked what actors and collaborations have been involved in its present instantiations, what currents it travels through (or fails to), and what politics are fashioned in its practices. Finally, I asked about the possibilities that it enables or effaces. Throughout my investigation, I have found that my primary question—what is trans health?—is the most elusive to answer. This is in large part due to its diffractiveness, its stratified and stratifying currents, the rapid pace of its shifts, and its distinct expressions and infrastructural embeddings across geopolitical times and spaces. Certain features of trans health are consistent, but such consistency inheres mainly in its malleability—or at least its perpetual state of being "under revision."

As such, I draw from Mol (2008) to reflect less on what trans health *is,* and more on what practices, people, things, politics, and processes it incorporates and mobilizes. In so doing, I found that these were also highly mobile and multiple. Even stories about the historical conditions of its emergence seem itinerant. While people tend to regard transgender health as a more humane successor to transsexual medicine, this also reflects engagements with feminist health infrastructures and imperatives, with the knowledge-making practices of HIV/AIDS treatment and prevention, and with the politics of disability activism, among others.

Present instantiations of trans health reenact all these relations, often implicitly, through their practices and varying commitments. I explored an example of such historical elision through analyzing trans depathologization. Scholars, providers, and activists alike position this transnational movement as following a path cut by U.S. gay and lesbian depathologization activists in the 1970s. While these are ineluctably connected, these links are partial. As a story about social movements, this account rehashes teleological trajectories of "progress" that represents trans politics as only and ever following victories of gay (and to a lesser degree, lesbian and other queer) politics. It also places a pin on global the map, geographically locating the origins of transnational trans depathologization movements in the U.S. Yet as I have shown, activists draw from a multitude of social movement blueprints that existed well beyond queer forms and U.S.-centered politics.

It is this conceptual and geographic expansiveness that makes it challenging to identify the various people and things that enact trans health in a broad sense. Nonetheless, my research shows that activists, advocates, and providers interact with each other as well as with classificatory systems, infrastructures, regulatory guidelines, and forms of knowledge to assemble and reassemble trans health. While historical accounts have traditionally placed activists and providers at loggerheads, my dissertation proposes three things: 1) that present modes of trans health have skewed towards collaboration and negotiation; 2) that the borders between "activist" and "provider" has become increasingly permeable; and 3) that diagnostic classifications, health financing procedures, and regulatory landscapes have become shared objects of intervention among activists and providers.

Forms of trans health practice travel in part through such classifications and regulations, but do not do so smoothly. In fact, it is often the failure of infrastructural features to "fit comfortably" in different places and within distinct practices that motivates processes of revision. I explored varying problems of "ill-fit" across dimensions of geopolitics, infrastructure, and site of practice. For example, Mark (2016) said of the Gender Identity Law's possibility in the U.S., "That would never work here." Further, Alejandro argued that the pathologizing terms of trans health, even transnationally, are primarily shaped by the terms of health care financing—which he emphasized was not inevitable (as Argentina had managed to dispose of such diagnostic practice). For *travesti* activists from across Latin America and the Caribbean, it was only with the addition of the asterisk after "trans" that the term could even be conceptualized as mobile, and this came with a cognizance of the geopolitical power relations that required its uptake. Finally, I showed how competing paradigms of knowledge, meaning, and practice were negotiated through such relations of power, both within and between the two sites under study. While such processes often retrenched or reified extant stratifications and modes of valuation, they also occasionally produced fissures in hegemonic practices, or brought about partial reversals of these dynamics.

These experiments have, at some level, reconfigured some of the relations of care that organize trans health practices. Even more than drawing on "community experts" to amend what trans health *is,* increasing collaboration between activists and providers has resulted in shifts in how the problems of transness are defined, and in what capacity biomedicine is made useful. Specifically, gender non-normativity-*as-pathology* as such is gradually fading from view. Instead, the problems of transness to which biomedicine can respond are increasingly deemed social and relational: "transphobic society" becomes the problem and, alongside it, the stratifications that materialize and uniquely imperil trans life and health.

The "turn outward" in trans health from individually-focused to socially-focused came early in its genesis. This situates it within a broader set of transformations in biomedicine, whereby the dynamic (and inequitably resourced) "environment" becomes the primary site of capacitation or limitation. Epigenetics, social neuroscience, and health disparities research are only a few expressions of these shifts. As in the case of these fields, trans health is embracing a notion of the "social environment" rather than the unit of the "individual" as problematic. This methodological and political shift is one that activists and some providers have welcomed, and it is eminently changing the diagnostic, regulatory, and clinical practices of trans health.

Yet such a turn is accompanied by a set of embedded presumptions, elisions, and collapses that yet again reproduce some of the very stratifications they strive to address. As I have demonstrated, epidemiological accounts—materialized in population biographies—foreground the racialized, classed, gendered, sexualized, and to some degree abled devaluations that lead to abbreviated lifespans for certain gender non-normative subjects. In so doing, though, they also perform an erasure of such differences in the production of the "trans population." While the encoding of stratified differences within these methodological interventions has sometimes directed an implicit focus on these dynamic and combinatory modes of subjugation, it does not *necessarily* have this result. As Haritaworn and Snorton (2013) argue, for example, such elisions may even have the opposite effect: "trans of color deaths" are instrumentalized into legalistic strategies that ultimately overwhelmingly protect and invest in white trans subjects and trans whiteness.

In addition, many institutionalizing forms of trans health at least presumptively embed the possibility of producing a "properly" gendered—and therefore, properly productive—citizen-subjects (e.g., Irving 2008; Spade 2011 [2015]). While there has been a partial departure from "passability" as a requirement for and major goal of gender-confirming care, the varying logics of biomedical "fixing" seem to remain a persistent undercurrent in present forms of trans health.[124] Such modes of intervention are mobilized within distinct political fields, and thus produce "trans citizens" differently—but almost invariably, there are winners and losers in the ambit of formal state inclusion and biopolitical investment (e.g., Spade 2011 [2015]; Najmabadi 2013, Hsu 2013, Snorton & Haritaworn 2013).

Finally, emergent forms of trans health rarely stray far afield from the established norms, lexicons, and boundaries of biomedical practice (even in its more "outward" view). This, too, is evidenced in the very impetus to route understandings of state and interpersonal violence, racialized immiseration, and labor politics through the language of "health." At some level, this may be a strategic enfolding: health care, after all, maintains a flexibility to marshal scientific authority and at the same time leverage ethical and/or political demands (e.g., Fassin 2012; Roberts 2012). At another level, however, this reflects what Aizura (2012: 146) describes as "an attempt to contain and domesticate [gendered] indeterminacy."

In my empirical work, the persistent forcefulness of varied health infrastructures (medical, legal, classificatory, technological, and so on) continually pull trans health's formations towards the status quo of biomedical practices and away from the unruliness of that which they work to stabilize. Writing against these currents of containment, Stryker and Aizura (2013:7) assert, "[w]ildness, even more than cultivation or care, should characterize the health of our gender ecologies." While some activists (and many fewer providers) would welcome such a lack of closure when it comes to the uncontainability of gender multiplicity, few outwardly claim such a "politics of unruliness" (Khannaet al. 2013) as their objective. The domain of health and medicine may flex, but wildness—or at least the desire for it—would scarcely align with its practices. Even in the face of formidable difficulties with standardization and classification (with which trans health providers are intimately and persistently familiar), practices of coordination remain the reflexive response in organizing practices of care. Trans health politics and formations certainly proliferate, but such proliferations remain bounded.

While such currents of containment and boundedness run through present forms of trans health, I have also shown that its practitioners—activists and providers alike—view health as a site through which politics (as well as care practices) can be refigured and refashioned. Activists and providers have worked to do so through a variety of techniques: coding creatively, developing regulatory interventions to redistribute resources, fashioning methodological innovations, and forging coalitions well beyond the realm of health and medicine. Some respondents were more insistent than others on the relevance of concerns beyond medicine that comprise "health."

Coalitional depathologizationists, for example, viewed health politics as wholly inseparable from a broader set of politics concerning subjugation, racialization, class and labor politics, migration, etc. Yet even those actors were impelled to navigate the proper terms of biomedicine, however apprehensively.

I have proposed the concept of "transmutable care" to describe the proliferative dynamics that spring from increasing relations of collaboration and coordination among multiple actors, particularly activists and providers vis-à-vis trans health. These dynamics take shape in classificatory and regulatory realms, instantiating distinctively depending on where and how they gain traction. Transmutable care is partially enabled by trans health's reckoning with its own situated particularities. As practices of negotiation slowly come to predominate, revision becomes the norm rather than the exception. Trans health thus perpetually cedes space for practices to morph and adapt to the multiplicity demanded by varying actors, infrastructures, sites of practice, and politics that pull continuously at its stabilizing efforts. However, the spaces within which multiple practices and politics can convincingly be defined as "trans health" are far from limitless, and even the openness that presently exists in emergent formations may not persist. Nonetheless, these dynamics demonstrate the elusiveness of stability in processes of field formation, and the point that contestation emerges through cooperation and collaboration at least as much as it does through antagonistic conflict.

In Chapter 1, I discussed the dynamics of transmutable care through shifting practices of classification, describing how diagnostic classifications previously formed polarized and polarizing sites of dispute between trans people and health care providers (Stone 1992; Meyerowitz 2002). I argued that presently, diagnoses comprise sites of negotiation and collaboration manifesting in continual cycles of breakdown and revision. Taking up recent theorizations of the clinic as a site of knowledge production (e.g., Mol 2003; Nelson 2011; Latimer 2013), I showed how these dynamics are brought about not only through pressure exerted by activists, but also through providers encountering the enduring failures of classification in practice. I showed how trans activists are (in limited ways) invited to contribute to processes of diagnostic revision, and certain "trans-supportive" providers bring the concerns of activists to the fore as working groups make classificatory decisions.

Focusing on the DSM and the ICD, I described how classificatory failures and shifting understandings of transness have over time repackaged gendered pathology as difference. Further, I described how this has enabled a turn to "distress" or "incongruence" that established the "environment" within which trans people exist—rather than a psychopathological state—as a crucial element of diagnostics. I demonstrated how such classificatory failures manifest in a less formalized mode in the identitarian intervention of "trans*" in Latin America and the Caribbean. In both formal and informal capacities, I discussed how concerns about practices—from health care financing regulations to stigma prevention to accessing funding streams—shaped such naming practices. Building on STMS theorizing on classification and infrastructure, I argued that these negotiations are only secondarily concerned with ontologies, and are organized more resolutely around what can be enabled or mobilized by certain classifications.

Chapter 2 began with the "turn outward" that accompanies the shift away from individual psychopathologies to "social environments." I discussed legal and regulatory projects in Buenos Aires and New York City that framed trans health access as an issue of structural inequity through what I called "statistical citizenship." I argued that activists and advocates brought about these changes by combining conventional epidemiological thinking with politically-inflected narratives in order to reconfigure notions of "risk." These new "population biographies" produced a simultaneous notion of a trans *collective* and a trans *population,* and they operated at a multitude of registers to bring about regulatory and other material shifts. I mobilized insights from studies of race, gender, sexuality, and citizenship alongside STMS reflections on biopolitics and biomedicalization to analyze the stakes and potential effects of marshaling political claims through the figure of the "trans population."

In Chapter 3, I returned to the question of diagnosis, but this time through the lens of "trans depathologization" movements. I argued that trans depathologization projects are widespread and varied, and that this is due not only to histories of gay depathologization, but also to intersections with feminist health and disability activist histories. I suggested that many—though not all—forms of depathologization are tied together by the impetus to retain access to care *without* resorting to notions of illness, infirmity, or debility. I called this "care without illness," and demonstrated how it is conceptualized and instantiated in distinct ways across different actors, sites of practice, and regulatory landscapes. Drawing on and extending theorization of care politics, I show how depathologization regimes have shifted the attention and objectives of trans health to at least partially reconfigure the relations of care encompassed in its practices.

IMPLICATIONS AND FUTURE DIRECTIONS

Overall, my analysis engaged the present dynamics of trans health to tell a story about contestations and transformations of health care practice. This story does not begin and end with the audacity and subsequent abdication of medical authority, nor with the extraordinary triumph of a social movement. It does not presume that changes in trans health have emerged solely through legal or organizational changes, or through structural dialectics. Rather, this story engages a complex set of forces, currents, and emergences—representational, methodological, political, economic, infrastructural, and geopolitical—that both reproduce and reconfigure stratified practices of care. Tracing the emergence of trans health provides an important instance of how health care formations grapple with politics of difference. As the "transgender tipping point" begins to recede into recent history, these analyses are relevant not only to trans health futures, but also to shifting commitments in health care and other biomedical practices more broadly.

In this regard, I suggest that trans health's turn toward "environmental" dimensions of trans life—and the reductiveness that remains embedded in this turn—resonates with a series of biomedical transformations looking to "environments" for answers about stratification. While the newfound relevance of social realms would seem to promise to (re)politicize biomedicine in different ways, these reformulations often retrench the very stratifications they strive to problematize (Rollins 2014; Bliss 2012; Pitts-Taylor 2016). In this dissertation, I provide an empirical account of how these retrenchments may take shape—even in the midst of creative methodological refigurations.

This work also speaks to present political economic transformations in the U.S. and Argentina grappling with distributive questions of health care in increasingly privatizing economies. My focus on the public provision of care thus foregrounds questions of both resource distribution and infrastructure. In addition, my reflections on how trans health is debated through questions of economic efficiency, national obligation, and/or taxpayer burden are highly relevant to wider reflections about distributive politics and state-subsidized care infrastructures.

The transnational scope of my project contributes to empirically-grounded research in trans studies, which to date remains overwhelmingly situated in the U.S. Looking to both Argentina and the U.S. not only contributes an account of how trans health instantiates very differently across two geographic sites, it also enables an engagement with geopolitical dimensions of trans health. The growing investment of states and nations in trans subjects is a rich area for study and a generative site for future research.

While this study sought to provincialize U.S. formations of trans health, it remains entangled in the knowledge economies that privilege U.S. accounts of transness and gender non-normativity.

Given its historical trajectory, neither U.S.-based trans studies nor U.S.-based trans health (both configured as ostensibly "global) are likely to shed their ethnocentrism. I therefore suggest that mobilizing the theoretical and methodological commitments of transnational feminism—in what might be called "transnational transfeminism"—offers one means of taking up trans studies differently.

One of the major directions I have identified for future research emerged out of my ethnographic work. In speaking with providers and activists, I found that the domain of reproductive health—specifically abortion, but also contraception, childbirth, and reproductive justice—arose repeatedly in discussions about trans health. While this was not a surprise, I was struck by how these were defined in relation to each other. At times, the links between trans and reproductive health were positioned as self-evident. At other times, these domains of practice were described as wholly distinct. What might account for these different understandings of the relations between reproductive and trans health? How do these accounts range, and along what lines? What is enabled or effaced in understanding them as tightly linked on one hand, and disconnected on the other?

Another area for future research is an examination of how labor politics—especially the specter of sex work—play into questions of both trans health and criminalization. While I touch on this lightly, my ethnographic data point to the critical importance of building a thorough account of how both labor and criminalization shape the landscape of politics and health. These dynamics appear vividly in the push to get trans women on PrEP, the racialized and classed politics of public space that disproportionately imprison trans women of color in the U.S. and *travestis* in Argentina, and the political deal-making that would seem to offer up citizenship in exchange for the abandonment of sex work. How do labor politics and processes of immiseration link trans people's relations to health and medicine? How are these dynamics attended to, made sense of, and expressed in processes of health care provision? How do “health” and “work” converge, especially vis-à-vis trans health, and how does biomedicine attend to this relation?

Another area for further study is standardization. While I attend closely to classification, the proliferation of protocols and guidelines of care, as well as the institutionalization of trans health through professional organizations (e.g. WPATH 2013) and legal recommendations (e.g., Yogyakarta Principles 2007) still necessitate a thorough analysis of how trans health grapples with standards. Classification and standardization are of course closely connected, and theorizing standards comprises another important dimension of infrastructure studies. Nonetheless, a fuller discussion of standards per se would contribute to a richer understanding of the currents at play in trans health’s shifts and contested proliferations. Specifically, such explorations should ask how standards connect with classifications in the infrastructures within which trans health is embedded. They would examine both the successes and failures of institutionalization to account for how standards are fashioned, negotiated, and revised. Through empirical framing, they might examine how the situated uptake of standards aligns with or departs from ostensibly “universal” standards.

Concepts of “human rights” lie at many edges of this dissertation. Many of the major consistent shifts enabled by trans health have been realized through appeals to human rights. Indeed, this may account in part for Argentina’s distinct uptake of trans health, given its national investments in international human rights law in response to its particular history of violence and political repression. Transnational forms of trans health have been built in and through infrastructures of AIDS/HIV treatment and prevention. Here in particular, the specter of human rights discourse suffuses the politics of health. While research that links “treatment activism” to global flows of development capital has been taken up in the medical social sciences (Patton 2002; Nguyen 2010; Biehl 2007), these reflections have not yet pursued the field of trans health. A burgeoning literature exists through which to engage human rights critically, and trans framings of human rights would be a generative site through which to take up questions of what human rights regimes enable and foreclose.

CONCLUDING THOUGHTS

While medicine has been producing and "working on" gender non-normativity for well over a century, the emergence of trans health is a relatively recent phenomenon, appearing unevenly in the first decade of the 21st century, and proliferating transnationally. As an assemblage, it has taken shape through a convergence of varying historical and contemporary health formations including transsexual medicine, feminist health, disability activism, and HIV/AIDS treatment and prevention. It has emerged in different ways in different sites, due in part to different infrastructures in the systems on which trans health runs. These distinctions produce both transnational and local differences in what trans health looks like. The low-income community clinic, the prison, the plastic surgery suite, the private therapist's office, and the hospital-based program instantiate different iterations of trans health, each with differing—as well as stratified and stratifying—effects.

In part, trans health emerges through a series of inadequacies and revisions. Pathologization is gradually falling out of failure, the focus on the "individual" is insufficient, and exclusion from the domain of "medical need" is no longer convincing. As trans health has confronted these failures—often producing new forms of knowledge through the flexible terms of patient engagement, insurance reimbursement processes, and diagnostic revision—trans health has also moved beyond the confines of the clinic, taking up positions fashioned through activist protests, editorials, blogs, and community-based studies. While such positions may previously have constituted the "outside" of clinical practice, today they are becoming enfolded with in it. The distinguishing shifts of trans health's field formation condense in foregrounding depathologized difference, identifying inequities in the environments within which trans people exist, and the medical "necessity" of gender confirming care (which works to bring about changes in the distribution of biomedical resources.

These changes should not be overstated. Trans health remains in significant flux, and even within the metropolitan spaces I studied, certain providers engaged in practices more closely resembling transsexual medicine. Yet the novelty and incompleteness of the shift indicates all the more strongly the effects of collaborative orientations on reconfiguring the very terms of trans health and medicine. I have suggested we might view the emergence of trans health not as solely a struggle between provider and activists, but rather as an unfolding of biomedical reckoning with itself. Providers, scientists, activists, advocates, and policymakers are asking how "environment" matters in trans lives. This resonates in debates in neuroscience and genomics as well as trans health. Here, biomedicine—unevenly and unsteadily—confronts the terms of subjugation, and begins to shift its focus away from "innate" or "inherent deficiency" models.

Yet as it does so, biomedicine also turns to some of the same tools (such as "populations") that produced these models in order to "fix" them. Thus, trans health may be reinventing itself as a new form of difference management that persistently rearticulates and reproduces various forms of stratifications. In contrast, as it engages in its perpetual cycles of breakdown and revision, trans health may alternatively continue to generate openings for providers like Sonya or activists like Ana, who work across multiple domains and forms of practice to refashion a new politics of care and distribution. Regardless, the field is caught up in dynamics that far transcend the ostensible boundaries of its practice: transnational politics, political economies, and labor politics, etc.

To conclude, there is no singular "trans health." This is no surprise as health care formations are ineluctably varied. Yet trans health seems surprisingly sudden in its widespread instantiation, and unusually open in its cycles of breakdown and revision. Its emergence provides a site for a multitude of analyses about trans embodiment, stratification, infrastructure, classification, negotiation, transnational politics, and shifting dynamics of power.

Trans health, in its different forms, is not foreclosed in the sets of practices it has to date bundled in its field formation. As such, this is a generative (if vexing) time to interrogate the conditions and stakes of its emergence. Its varied instantiations present opportunities to ask more broadly how biomedicine might otherwise engage stratified difference, even as it appears to be headed towards retrenchment and containment. Thinking with trans health offers strategies to think through health care dynamics at their most palpably politicized—vividly bringing to the surface the complex and conflicting politics that comprise biomedicine and trans people's lives more generally.

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NOTES

Prologue Notes

[1] I use the term "trans" with much apprehension throughout the dissertation. For reasons I will discuss in the following chapters, the term does not always travel as smoothly as some would assert. "Trans" also produces a set of collapses and oversimplifications that I aim to resist in these analyses. Nonetheless, "trans" remains a unifying object of trans health—even in sites that explicitly resist its ostensible universality (Valentine 2007). I join other trans studies scholars (Aizura 2006; Bhanji 2012) in mobilizing "trans" as a category under erasure (in other words, read this term henceforth as "~~trans~~"). When applicable, I use the terms that my study respondents mobilize, such as "trans*" or "*travesti.*" None of these terms is hierarchically positioned in relation to the others, nor is one strictly separate from or reducible to the others.

[2] I use the term "gender confirming care" here for several reasons, despite some reservations with it. Language encodes politics, and it is impossible to describe the set of biomedical and other practices involved in forms of health care that facilitate particular forms of gendered embodiment and enactment without making political claims in so doing. "Gender confirming care," though, is increasingly used by providers, activists, and advocates in New York. This description does not focus solely on surgery (like "sex-reassignment surgery"), not does it imply that transition is a solely medical process (like "transition-specific care"). Unlike "gender affirming care," "gender confirming care" is also used in regulations that govern such forms of care for non-trans people (such as gynecomastia surgeries for non-trans men). Using this term was thus a strategic choice for advocates who made a case that Medicaid was engaging in discrimination when it covered gender confirming care for non-trans but not for trans people (Spade 2015 [2011]). In Argentina, language tended towards "comprehensive care for trans* people" (*salud integral de las personas trans**),* including hormone prescription and use (*hormonización*) and "body modification surgeries" (*cirugías de modificación corporal*). Some providers, activists, and advocates in Buenos Aires used the term "health care related to processes of body modification" (*"Atención de la salud en relación con procesos de modificación corporal"*). This is not dissimilar from "gender-confirming care," though it centers the term "body modification," which in English tends to have associations that focus on artistic modifications (tattooing or piercing, for example). Using "gender confirming care" is less than ideal, however, as it seems to stabilize and reify an "internal gender" that would be externally confirmed (which may be the case for some, but not all, people who pursue these procedures and regimens).

[3] These practices are enormously varied, and including and number or combination of surgical procedures to remove, implant, or construct (many would say "reconstruct") gonads, organs, body fat distribution, cartilaginous or skeletal structures (facial feminization or masculinization surgeries), or genitals. They also many include the administration and/or use of varying hormones (such as testosterone, estrogen, or progesterone) and/or anti-androgens in different combinations, quantities, and forms. People might obtain these through formal prescriptions or through other routes. In addition to these, people may seek perimedical procedures such as electrolysis or laser hair removal, or engage in voice training therapies. Psychiatric or psychological counseling are also often included within trans health practices.

[4] Medical anthropologist Eric Plemons (2010) suggests that transsexualism (and perhaps trans health) produces a generative site through which to think about bodies as social and medical objects. Diagnosing "feelings" to perform medical intervention on the body, he argues, vexes the modernist mind/body split, troubling the way socially gendered bodies are taken up as medical objects. He describes how tensions between visibility practices and "invisible" connections (between feelings and treatable bodies, for example) can be "institutionally bridged" to make available certain subject positions through medical expertise and discourse (Plemons 2010:320).

[5] Injecting silicone, sometimes called "pumping," describes the process of injecting industrial-grade silicone into muscles and soft tissues such as breasts, hips, buttocks, and the face. The objective of such practices is to change (and usually "feminize") body shape. Scholars have framed silicone injection—which is associated with a number of potentially fatal health effects—as a problem related to the lack of affordable surgical options for body modification and transformation (e.g., Aizura 2014).

[6] Many people use the "cis" or "cisgender" to describe people who are not transgender. While it is also an inadequate term, I use "non-trans" in this dissertation to trouble what I view as the stabilizing tendencies of "cis." For more on the issues involved with this terminology, see Enke (2012).

[7] I have written elsewhere about racialized, classed, and gendered dynamics of these trainings that shape and are shaped by medical pedagogy (Hanssmann 2012).

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[8] This refers to the phenomenon of health care providers attributing a range of illnesses, injuries, or ailments to a patient's being trans. "Trans broken arm syndrome" refers to a reported instance of a provider asserting that a patient's broken arm was likely related to hormone therapy.

[9] With regard to indigeneity, the trainings occasionally discussed Two-Spirit people, but tended to do so in an ahistorical or cursory manner. None to my knowledge engaged Morgenson's (2011) description of Two-Spirit organizing as a critique of how settler colonialism shapes non-Native formations of gender/sexuality. With regard to transnationality, the rare trainings that engaged gender non-normativity outside of the U.S. often did so in a highly reductive manner that Stryker (2006:14) calls "around the world in eighty genders."

[10] For example, the American Psychological Association (Anton 2008; 2009) and the American Medical Association (2008) adopted resolutions in favor of insurance coverage for gender confirming care and other provisions in support of trans health's expansion.

[11] The concept of "social worlds" draws from symbolic interactionist sociology, and draws significantly from the Straussian tradition of social worlds/arenas analysis (Strauss 1978:119-128). This treats social worlds as a conceptual, mobile, and permeable grouping of people and things that generally coordinate around specific kinds of action, in particular sites, and often through shared technologies. For Strauss, debate and negotiation takes place between subworlds within each social world, and he describes these as "arenas."

[12] I employ the "North/South" mapping of the world to align with how informants have to date discussed the relations of transnational work within the collaboratives under study. This brings with it a set of politics about splitting up the world that is somewhat distinct from those mapping geopolitics through the East/West, or developed/developing/undeveloped schema (among others). While each of these performs various levels of reductiveness and erasure, the "North/South" mapping—alongside resonating with informants' descriptions—best aligns with what I presume to be the geopolitical dynamics of power as materialized through late capitalist forms of economics and politics best known as "neoliberalism."

Introduction Notes

[13] In 2015, businessman and former Buenos Aires mayor Mauricio Macri was elected as President of Argentina. Running on a neoliberal agenda to integrate Argentina into the international market, Macri was the first anti-populist (anti-Peronist) President popularly elected in Argentina in many years. At the time of writing, Argentina is rife with debates about privatization and the cost of public infrastructures. Public programs are on the chopping block, including LGBT-specific public health programs. These are ostensibly up for closure because of cost, rather than direct objection to the content of the programs—but commentators are skeptical about this reasoning (*Página12,* 2016).

[14] This turn of phrase comes from the subtitle of the U.S. film series, "Unnatural Causes" (2008), which asks "Is inequality making us sick?"

[15] Theoretical engagements of care appear across disciplines and interdisciplinary formations: philosophy (e.g., Heidegger 1927), feminist sociology (e.g., Hochschild 1983 [2012]) medical social sciences (e.g. Redfield 2013), and feminist, cultural, and ethnic studies (e.g. Hua 2011) and STMS (e.g. Vora 2015, de la Bellacasa 2011; 2013; Murphy 2015). In this dissertation, I draw from a broad set of literatures, but focus on the mobilization of care within feminist STMS. My conceptualization of the "figure of care" is indebted to discussions in Lawrence Cohen's 2011 "Care" course at UC Berkeley in the fall of 2011.

[16] The history of transsexual medicine continues to be largely undocumented and rife with methodological challenges, such as the secrecy with through which such work was pursued. Historians Meyerowitz (2002) and Stryker (2008), among others, have worked extensively with archival material to document histories of these emergences. Swarr (2012), Dutta (2012), Cohen (1995), Najmabadi (2013) and others have conducted situated work to identify medical practices among "gender liminal" (Roen 2001; Swarr 2012) subjects in South Africa, India, and Iran, among other particular geographic locations. A number of scholars extend Stoler's (1995) reflections about sexuality's construction in and through colonial knowledge production to foreground trans health's historical emergence through medico-ethnographic and colonial medical encounters (Aizura 2010; Palmer 2014). These and related texts form a burgeoning field of historical and contemporary inquiry regarding transnationality, gender non-normativity, and biomedicine. Continued exploration is merited and necessary.

[17] The CDC is presently revising their National HIV Surveillance System to collect specific information about transgender people, and is advising state and county health departments to do the same. Until recently, statistics about trans women and HIV prevalence and incidence were not disaggregated from those tracking the category of "men who have sex with men," or so-called MSM.

[18] This draws on perspectives from various legal studies fields, including Critical Race Theory (CRT) (e.g. Harris 2006; Delgado and Stefancic 2001), which examines how racialized subordination is legally encoded by interrogating its

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conditions of emergence and operation. This field (along with law and society, Latino critical race theory, and others) presumes that laws are not necessarily operationalized in such a way that they perform the work they claim to perform. Spade (2011[2015]) has broadly applied CRT, alongside Foucauldian analysis, to the field of trans politics, law, and activism.

[19] The landmark inaugural issue of *Transgender Studies Quarterly* (2014) is an ambitious survey of the field through a set of keywords authored by contributors. While certainly in conversation with the question of biomedicine and psychiatry—contributed keywords include *biopolitics, depathologization, disability, psychoanalytic, sick,* and *surgery,* for example—"trans health" or "health care" do not appear. The concept of clinical care is of course engaged through the previously listed and other keyword passages, but it remains relatively undertheorized as such.

[20] These analyses pertain to diagnostic classifications (such as Mol's (2002) study about enacting diagnoses), and also link up with a robust literature in gender and sexuality studies about the iterative practices of materializing or "doing" gender West and Zimmerman 1987; Butler 2010). I do not intend to imply that such practices of materializing classifications are wholly instrumental—indeed, many times they would seem to defy what stands as logic or reason. Instead, I aim to foreground how the very leakiness and instability of classificatory processes become things or processes that are possible to "work on."

[21] The multiple infrastructures of concern in my study involve public health provision and financing, as well as federal, state, and provincial laws governing health care distribution beyond private insurance coverage. Argentina's health system is a partially universal health care system, which offers subsidized care through public hospitals to people without private or worker-based insurance. The three-tier system does not require low-income patients to pay, though its services are not always robust and there are long waits for care. The Argentinian Gender Identity Law required coverage for gender confirming care across the nation, including in public hospitals. New York State's Department of Health lifted a 16-year-old categorical exclusion of gender confirming care from Medicaid coverage. Criteria for Medicaid coverage ranges by state. New York enrolls a greater number of low-income individuals than do some Medicaid programs, but not all low-income people qualify for Medicaid. The lifting of New York's exclusion did not guarantee "access," but it brought an end to the long standoff between trans health activists and state bureaucrats, and reorganized some of the formal arrangements in the state with regard to the public provision of gender confirming care. There are many other public infrastructures of care in the fragmented health system of the U.S. (prison health care, local and state programs, etc.). I focus on Medicaid because it is one of the most widely recognized public systems (beyond Medicare) and because it is in the midst of changes when it comes to coverage for gender confirming care.

[22] I have chosen not to focus centrally on the classifications associated with criminalization, as others have analyzed these dynamics (Spade 2011[2015]; Snorton & Haritaworn 2013; Gehi & Arkles 2007; Yarbrough 2015). However, it remains an area for future exploration to attend to how classifications produced through criminal law (e.g., laws governing vagrancy and/or sex work) intersect with classifications produced in and through trans health (especially "depathologized" classifications).

[23] While the STMS literature critiquing scientific neutrality is robust, these analyses have tended to center on scientific and technological practice and processes far more than clinical practice. While there are notable exceptions to this, the "M" in STMS is less thoroughly analyzed in the field, despite the close relationship between the biosciences and clinical practice (hence the term "biomedicine"). My analyses will draw from critiques of scientific as well as biomedical neutralities from STMS (e.g., Latimer 2013).

[24] Exceptions include Namaste (2000), Spade (2011), and Valentine (2007), although only Namaste undertakes a sustained theorization of health care.

[25] Braiterman (1998) is one of several exceptions, as is the special issue of *Sexualities* (1998) within which his article is published. In the late nineties and early 2000s, *travestis* became an important object of study for "global sexualities" scholars, often to reflect on the presumptive separation between gender and sexuality. When scholars like Braiterman (1998) focused on health, rarely did scholarship take up consideration of issues outside of HIV or silicone injection.

[26] *"Travesti"* is a term of gendered and sexualized embodiment and enactment embraced by many trans-feminine people in varying parts of Latin America. The occasional translation of the term to "transvestite" is somewhat confusing, since in the US and Europe this connotes a distinct set of embodied practices and subjectivities usually associated with "cross-dressing." I will discuss the particular mobilization of "*travesti*" as a term of classed, racialized, sexualized, and gendered identification and political organizing in Argentina in Chapter 2.

[27] Kulick, with Lancaster (1998) edited a special issue of *Sexualities* called *Transgender in Latin America: Persons, Practices and Meanings*. While analyses of *travestis* have often focused on Brazil and Mexico, the tendency towards positioning gender non-normativity in Latin America as a phenomenon in the ambit of "machista" culture prevail across these accounts.

[28] Mol (2002), Latimer (2013), and Nelson (2011) are among the exceptions to this general current in STMS.

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[29] Jordan-Young (2010) describes how the methodological presumptions of such studies markedly embed social, political, and cultural notions of gendered and sexual difference, and thus empirically produce the differences they set out to measure.

[30] Here, Clarke et al. (2003;2010) build on Colen's (1986) concept of "stratified reproduction," later taken up by Ginsberg and Rapp (1995) to signal how "some reproductive futures are valued while others are despised." (1995:1)

[31] I also attended a trans health conference in Philadelphia with several providers from New York City. I also conducted early pilot field work in the Bay Area. While I do not draw on these data, they form some of the background of my analyses. In addition, while not part of the city of Buenos Aires proper, I visited some of the outlying areas of Buenos Aires. These are among thirteen districts that are a short distance from the Autonomous City of Buenos Aires, but are administered by their own municipal governments. Nevertheless, there is extensive daily travel and exchange between the city and these outlying areas.

[32] I am indebted to Adele Clarke for these insights.

[33] This draws theoretically from Foucault's (1994 [1975]) genealogies, Deleuze and Guttari's (1983) "minor literatures", and the methodological/theoretical foci on marginal knowledges in subaltern studies (e.g., Spivak 1988; Chakrabarty 1992; 2000).

[34] These forms of health are differentially available and of ranging quality both in terms of basic health care practice and gender confirming care.

Chapter 1 Notes

[35] In the prologue, I distinguished between "activists" and "advocates," describing trans advocates as paid professional who work on behalf of individuals or groups. In her recent book of leftist organizing, McAlevey (2016) contrasts "advocacy" methods of social change with broad-based, cross-class "organizing." Here, advocacy projects emphasize working *on behalf* of broader groups of people, holding stable an elitist relation of power. I draw on this distinction, especially to foreground the classed, gendered, and racialized stratifications constituting elite professionalism that at some level enable advocacy. However, I do not draw so rigid a distinction between advocates and activists, as there is significant slippage and permeability between "activists" and "advocates" in trans health. Many trans health advocates identify themselves as activists, and indeed became advocates through previous grassroots activism. Further, many unpaid activists are invested in advocacy models of social change rather than large-scale organizing models. As such, it is difficult to differentiate clearly between these groups. I do so when the distinction is important or evident. Otherwise, I tend to use the language of "activism," since this is how most people I interviewed and observed describe themselves.

[36] The passage of the Gender Identity Law eliminated the need for diagnosis prior to gender confirming care, so trans classifications are not required to do work in the same way they are in the U.S. As a result, classificatory debates have become far less important for Argentinian actors. Nonetheless, some Argentinian activists are focused on transnational trans health care formations, and thus remain invested in classificatory discussions. In addition, regardless of the law's passage, some providers have continued to use psychiatric classifications in practice. Therefore, classifications are far from irrelevant in Argentina, but their importance is less central.

[37] See Chapter 2 for a detailed analysis of some of the multiple processes involved in producing a "trans population."

[38] Notable exceptions include Thompson and King (2015), Spade (2015[2011], and Singer (2006).

[39] Valentine (2007) and Meyerowitz (2002) significantly assert that the very distinctions that separate "sex," "gender," and "sexuality" as discrete domains—a theorization that is central to both trans health and certain conceptualizations of transness in general—emerge from sexology. Other scholars reflect on how medical power is articulated through sexuality, nation, race, and imperial/colonial relations, which manifests not only in medical practice, but also in subject formation and identitarian arrangements (Foucault 1990; Stoler 1995; Somerville 2000; Terry 1999).

[40] The notion of retrospectively (and often anachronistically) interpellating historical subjects as "transgender" is circulated through texts like Feinberg's (1996) *Transgender Warriors: Making History from Joan of Arc to Dennis Rodman*. The

[41] The fact that these individuals are professionals—an anthropologist, and attorney, and a psychologist—is important given the fuzzy distinction between and frequent conflation of what might be called "grassroots activists" and "professional advocates." Often, self-identified trans activists draw on professional networks and practices through which to route activist agendas (whether or not they are technically paid as "trans advocates"). Yet professional status comes to matter in the production and circulation of knowledge in the emergent knowledge economies of trans health.

[42] The presentation is reprinted in full on Dallas Denny's website at http://dallasdenny.com/Writing/2014/04/23/the-language-of-gender-variance-2001 (accessed April 19, 2017).

[43] This builds on Hall's (1992) analysis of "the West and the rest."

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[44] Recently, trans people have begun circulating anecdotes on social media using the hashtag #TransHealthFail. These include videos and other posts describing uncomfortable, degrading, and sometimes dangerous interactions with health care providers.

[45] Here, I run into a classificatory problem that is not dissimilar from that of my respondents. They grapple with whether it is "sex" (which they define anatomically or biologically), or "gender" (which they tend to define as one's social and/or psychic identity) that is relevant to medicine and care. I find it difficult to conceptualize these as discrete, and thus struggle with how to describe this work without becoming caught in such "biological/social" dichotomies. While it is not the primary focus of this project to theorize the relation of "sex" to "gender" (and the relations of these to the production of difference in general) it remains embedded in these theorizations. Scholars deal differently with interrogating these in relation, and such engagements form a large part of the foundation of feminist, sexuality, and queer theory. I draw implicitly on concepts advanced by Murphy (2012); Hartman (1997); Puar (2007); Butler (1990); Salamon (2010); Ferguson (2004); and Samuels (2014) among others.

[46] For example, at the U.S. Professional Association for Trans Health (USPATH) symposium in Los Angeles in 2017, Kenneth Zucker's talk caused much controversy. Zucker is a prominent psychiatrist whose position on gender normativity as pathological has raised ire among both activists and providers, though he remains very engaged in revision projects. At the symposium, activists interrupted Zucker's talk to question his presence and reject his stances on trans health. This was followed by a highly politicized debate among providers and activists about the place of "pathologizing" providers in trans health, and resulted in an apology being published online by USPATH. The apology was removed soon thereafter (Chang 2017, personal communication).

[47] This mental health treatment process is often at least partially shaped by guidelines of care, the most popular of which is published by the World Professional Association of Transgender Health (WPATH). Up until the last revision, these standards recommended that therapists require trans patients to undergo a period of "real-life experience" (RLE), previously referred to as a "real-life test" RLT). This was an extended period of time—usually between six months and two years (and sometimes more)—during which people were expected to live in the "desired sex" without any medical intervention (Levine 2009). Levine (2009:186), a psychiatrist, describes this as a "fixture" in the "management of gender identity disorder," but strongly argues against its use. In arguing this case in the *International Journal of Transgenderism,* he points out that no clinical studies had ever been published on its efficacy. Describing this discovery as "unnerving," he recommended that revised guidelines of care eliminate the RLE requirements. The 2012 revision of the WPATH standards dropped this guideline.

[48] While I have used "trans" elsewhere, I include the asterisk when specifically describing gender non-normative formations in Argentina, given that most of the activists and some of the providers with whom I spoke increasingly tend to use this terminology.

[49] The Medicaid exclusion for gender confirming care was lifted in March of 2015, following a class action lawsuit that was filed against the State of New York by a group of attorney advocates (Department of Health, New York State 2015). Prior to this, codes with the DSM's "Gender Identity Disorder" diagnosis (now "Gender Dysphoria") would be rejected for reimbursement.

[50] Some of these debates assert that there is less distinction between this than previously assumed. This converges with recent turns in mental health professions to "biologize" certain "conditions." This is presumed to "reduce stigma," in addition to "scientizing" psychiatry (See Pitts-Taylor 2016).

[51] Cohen-Kettenis is a Dutch psychiatrist and researcher who has been a longtime member of WPATH. Drescher is a U.S. psychiatrist and psychoanalyst who has long advocated against the pathologization of gay identities in psychiatry, and who has worked as a provider-advocate in favor of trans depathologization. Meyer-Bahlburg is a professor of clinical psychology in the U.S., and studies intersex and gender dysphoria, often focusing on hypotheses pertaining to brain chemistry. Friedemann Pfäfflin is German psychoanalyst and retired university chair of forensic psychopathology.

[52] See, for example, Edelman (2011). In New York until 2014 (Hayoun 2014), the possession of multiple condoms could be grounds to arrest a person for sex work solicitation. The 2014 ban against the use of condom possession as evidence animated much discussion among respondents in my fieldwork.

[53] As an ethnographer, I signed up as a contributor, and was prompted to disclose any potential conflicts of interest. One of the questions included asked if I or members of my family have been diagnosed with any of the conditions on which I might comment. I checked the box.

[54] For example, Sonya (2013) described how some of her patients—particularly low-income trans women of color, as well as trans men of color—came to her after having had a difficult time accessing gender confirming care. At times, this had to do with the economic constraints imposed by public financing infrastructures not subsidizing gender confirming care, and other providers not being willing to work around Medicaid exclusions. Other times, she

explained, it had to do with what she saw as the racist tendency to diagnose people with other forms of "disruptive" mental illness and thus to refuse or delay treatment.

Chapter 2 Notes

[55] *"Travesti"* is mobilized in a specific way in Argentina, although people tend to identify with the term in other parts of Latin America (e.g. in Mexico, Chile, and Brazil). In general, *travestis* do not refer to themselves using the language of "transgender," though they politically ally with people who do. "*Travesti*" is generally applied to and used by working class, trans-feminine people, typically racialized as non-white, and often rural-to-urban migrants from the provinces. Significantly, many *travesti* organizations in Buenos Aires were initially formed in the 1990s to resist police violence and criminalization, especially related to how public spaces were regulated vis-à-vis sex work (Fernández et al. 2004).

[56] This acronym stands for *Asociación Travestis, Transexuales, y Transgéneros de Argentina* or the Association of Travestis, Transsexuals, and Transgender People of Argentina.

[57] It was not always clear from publications whether only *travestis* or also trans men or trans women who do not identify as *travestis* were included.

[58] In Argentina, activists argue that "trans" does not fully incorporate gender non-normative subjects, particularly *travestis* who as a group are central to these social movements. As such, they often append an asterisk (trans*) to signal the multitude of gendered positionalities incorporated by its reach. Latin American activists proposed this intervention in the early 2000s, and intended it specifically as a critique of the presumptiveness of global North funding agencies, who were newly investing funds in global HIV prevention for trans women (defined as such) as a "high risk population." Later, in the U.S., the asterisk was also adopted, but in a distinct manner: ostensibly to broaden the "umbrella" of the trans descriptor to include non-binary and other gender non-normative identifications that people did not explicitly describe themselves as "transgender." This latter use of the asterisk has become controversial through a series of online debates about its use and inclusiveness (or exclusiveness). I will not detail those here. But to avoid confusion, I do not adopt use of the asterisk in this work. Nonetheless, I am cognizant that "trans" remains a somewhat reductive way to describe gender non-normative social movements, particularly in Argentina, and aim generally to describe *travestis* specifically.

[59] I do not wish to overstate the equivalence of these legal and regulatory provisions; Argentina's national law and New York State's regulatory change differ across scale, process, and implementation. Furthermore, Argentina's Gender Identity Law implemented a series of legal changes that far exceed its provision about public financing to support hormone administration and surgeries related to gendered enactment and embodiment. Nonetheless, given the resistance—especially in the U.S.—to public programs supporting gender confirming care, these were important symbolic and material shifts.

[60] This phrase has been used by a variety of social movements in Argentina, including reproductive health activists, to contest what they define as marginalizing policies, institutions, and laws. It effectively invokes the nation's transition to democracy following the military dictatorship, and implicitly defines subjugating conditions as vestiges of illiberal regimes (Morgan 2015).

[61] Legal scholar Dean Spade (2011[2015]) asserts gender classification, as a site of persistent state surveillance, regularly catches gender non-normative people through their failure to fit a particular set of standards (e.g., conveying a gendered enactment or embodiment that comports with the gender marker on one's legal documentation). Spade shows—in the case of the U.S., but also relevant in other locales—that people who are marginalized along lines of race, class, sexuality, disability, and others are among those who most regularly come into contact with varying and more coercive forms of state administrative practices (e.g., welfare programs, prisons, or shelters). As a result, easing regulations for gender reclassification, for Spade and others, makes available a potential buffer in these interactions. While Spade is not particularly interested in "recognition" as an outcome, gender reclassification laws are often framed in these terms.

[62] One study (ATTTA and Fundación Huésped 2014) estimated a 35 year life expectancy for trans people, while another (Borgogno with REDLACTRANS 2009) study estimated a 40 year life expectancy for travestis.

[63] In 1998, New York State's Department of Health issued a regulation excluding all forms of gender-confirming care for Medicaid reimbursement (New York State 1998*).* Citing concerns about safety and efficacy, New York State's Medicaid program refused all forms of coverage and reimbursement for surgeries, hormones, and services for mental health in support of gender-confirming care.

[64] Accessed 4/20/17 at www.srlp.org/class-action-lawsuit-against-new-york-dept-of-health-on-behalf-of-transgender-new-yorkers-proceeds/?shared=email&msg=fail

[65] In population health research, these are modes of research recruitment that are not necessarily generalizable to the broader population. They might be spatially or programmatically defined (e.g., trans people at a specific clinic) or

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recruited in another manner that would be considered non-random for the usual purposes of research. Many are based on internet-based surveys, and there is some contention among public health researchers what might comprise "random sampling" when it comes to this form of research subject recruitment. Random sampling is considered a "gold standard" in population health research because researchers understand it to produce less error and therefore more generalizability of results.

[66] In population health, "prevalence" refers to the number of cases compared with the total number of people studied. "Incidence" refers to a probability of occurrence, represented as a proportion or a rate.

[67] Social epidemiology—a subfield that focuses largely on broader structural phenomena and their effects on health—is an important exception. Nonetheless, it, too tangles with epidemiology as a broader field over appropriate and legitimate methodologies.

[68] I include scare quotes here to frame "community" as a problematic. I will not include a detailed critique of formations of community, but concur with Joseph's (2002:xxii) concerns that notions of community often "elide and repress differences[.]" I use "community-based" to describe studies because this is the language mobilized by researchers. I do not want to obscure the power differentials at play in such collaborations among those designated as "experts" and those whose expertise lies in "community membership." Nonetheless, varying other power dynamics within these relationships remain underexplored and underemphasized in simply designating them "community-based."

[69] Malta's Gender Identity, Gender Expression and Sex Characteristics (GIGESC) Act (Caruana 2017), which was passed into law in 2015, is the most similar to Argentina's Gender Identity Law in structure, as it pairs legal document change, depathologization (discussed in Chapter 3), and the development of infrastructure for access to gender-confirming care. Other laws or proposed laws have also been modeled after part of Argentina's law, but have not necessarily coupled legal classification regulations with *both* depathologization and health care access as part of the same law (e.g., Colombia, Denmark, and Chile).

[70] Surgery was not explicitly a requirement, but was *de facto* necessary, since a state-employed medical panel was first required to assess that people's bodies comported with the gender which they wished to claim on their National Identity Document (called the *documento nacional de identidad,* or DNI).

[71] Based on scholarship in the US, even when gender reclassification guidelines and policies exist, they are only contingently and inconsistently followed. While it is generally useful to keep in mind that laws and regulations are not always enacted as expressed, most of the respondents with whom I spoke in Buenos Aires thought that these guidelines were generally being followed. They described what they thought were some provincial and regional variations. Nonetheless, with legal support through governmental agencies such as INADI (The National Institute Against Discrimination, Xenophobia, and Racism [*Instituto Nacional contra la Discriminación, la Xenofobia y el Racismo*]), most respondents who addressed this question thought that people were able to change their names and gender markers with relative ease.

[72] Despite its legal passage, however, the regulation and implementation of the law lagged for three years. Regulatory language was only issued with the 2015 arrival of a new health minister, Daniel Gollán, in Argentina. Gollán replaced Juan Luis Manzur, who some respondents claimed was personally opposed to the provisions of the law. While this is not empirically substantiated, several respondents speculated that the lag was in some regards a political rather than administrative. Ultimately, the regulations produced were rather vague and difficult to implement, causing a fair amount of confusion among providers, patients, and reimbursement offices alike about what procedures and treatments were to be covered.

[73] The bill was passed by Argentina's lower house of Congress (the Chamber of Deputies) in late 2011 by a vote of 167 in favor and 17 against (with seven abstentions). It later passed the Senate with 55 votes in favor and zero against (with one abstention and 12 absences). It is not within the scope of this project to demonstrate the reasons for such strong legislative support—which is certainly unusual among lawmaking bodies across the world. Nonetheless, respondents and commentators I interviewed in Buenos Aires speculated about the significance of the law's appeal to human rights rhetoric, and specifically to Argentina's legally enshrined "right to identity" (initially formulated after the dictatorship to re-establish kinship ties for children of the disappeared stolen during the Dirty War). This is a topic that certainly merits more study in terms of "coattail effects."

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[74] Argentina's health care system comprises two major forms of insurance: private and employment-based. For the 37.9% of people in Argentina without insurance (INDEC 2010), tax-funded public hospitals provide primary as well as specialty care. The Ministry of Health oversees all of these. In the U.S., scholars have pointed out that health coverage for gender-confirming care among private and large public employers has become more robust in the recent past, while Medicaid policies seem to have been eroding (Spade 2010), similarly to HIV care (Darling 2016).

[75] The CHA, founded in 1984 just after the military dictatorship, remains an active coalition of mostly leftist activists. Many members are also self-identified Communists or Marxists, and the organization tends to take political positions that are somewhat less influenced by mainstream "rights" politics and tend to privilege, to some degree, economic conditions in ways that other organizations do not consistently center. They contrast to some degree with more "mainstream" organizations, such as the Argentina LGBT Federation or FALGBT (Federación Argentina de Lesbianas, Gays, Bisexuales y Trans, n.d.), an NGO founded in 2006 and member of the the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA, n.d).

[76] This translation from politicized community resource to government-issued health care guide reflected a curious retention of Capicüa activists' scholarly and political affiliations, reproducing the original bibliography complete with citations of Michel Foucault, Judith Butler, B. Paul Preciado, and Gayle Rubin. Interestingly, while the Capicüa guide was mentioned in the government-published guide, it was not cited in its bibliography.

[77] This point is discussed by Steven Epstein (1996), Phil Brown (1987; 1992) and others. It also relates more generally to social science and STMS studies of lay knowledge and scientific expertise (e.g., Collins and Evans 2007).

[78] The 1988 *Anti-discrimination Act*, *Act* No. 23,592. Argentina. The Autonomous City of Buenos Aires presented similar legislation last year, which passed (Ley 5,261, La Ciudad Autonoma de Buenos Aires). María Rachid, General Secretary of the Argentine LGBT Federation (FALGBT) and a Buenos Aires legislator, helped to draft both pieces of legislation.

[79] See Matthew Smith (2016) "Will This be the Year Argentina Approves a New Anti-Discrimination Law?" *The Argentina Independent*, May 4th.

[80] The late 1990s and early 2000s saw a marked increase in trans activism in the US in general, and health was a salient domain within which this unfolded. Around the same time, gender-confirming care for trans people was increasingly defined by some policymakers as a problem of both ethics and cost. State auditors, legislators, and insurance commissioners seemed to take increasing note of public expenditures. Spade's (2010) interview with several Medicaid advocates documents some of the controversies leading to states adding exclusions for care. This recent history of publicly subsidized gender-confirming care for trans people in the US is not well-documented outside of legal and activist scholarship.

[81] The line between health care professionals, attorneys, trans-identified and supportive non-profit workers, and (typically unpaid) activists was often mobile and blurry.

[82] Accessed 4/20/17 from www.health.ny.gov/health_care/medicaid/program/update/2015/2015-03.htm, New York State Department of Health, New York State Medicaid Update (2015) 31(3), March.

[83] Plemons (2017) discusses how surgeons who do facial feminization surgeries (FFS) locate trans women's faces as particularly central as embodied sites of sexing/gendering, and describes how FFS is thus central to practices of gender confirming care. The vast majority of the surgeries and procedures that New York deemed "cosmetic" affected trans women rather than trans men, resulting in a gender-stratified *de facto* exclusion that was scarcely more expansive than the initial *de jure* exclusion. Furthermore, while coverage for genital surgeries was made possible by the law, low reimbursement rates and the lack of expert providers made such expensive surgeries nearly impossible to access.

[84] Again, *travesti* in Argentina and other regions of the southernmost region of South America comprise a loose social, economic, and political group. As Vek Lewis notes in an interview with Viviane Namaste (2011), identification with *travesti* identity is intimately tied to local economies and politics, municipal and national laws and surveillance practices, and varying flows of intercity and inter-region migration. Lewis also points out its potential misalignment with "gender identity," given its frequent articulation through object choice in erotic desire (citing Valentine on "transgender"). Furthermore, *travesti* is defined, embodied, and enacted in a wide range of ways in Argentina and throughout the Spanish-speaking Americas.

[85] "Travesticides," or "*travesticidios"* in Spanish, is a reconstruction of "femicides" (*"femicidios")* formally criminalized and/or informally protested in Argentina and in various regions of South America, Central America, México and beyond. Jill Radford and Diana Russell (1992) advanced the concept of "femicide" to describe gendered violence and murder, describing it as "the killing of women by men simply *because* they are women" (Radford and Russell 1992: xiv), other feminist scholars have extended the concept. Argentina has federal legislation specifically addressing gendered violence, but activists complain that it has not been budgeted for or implemented substantively. A movement

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organized under the banner “Ni Una Menos” (#niunamenos, meaning “Not One More,” in which the feminized “one” implies “not one more woman”) undertook coordinated protests in the summer of 2015. One Ni Una Menos organizer commented to a reporter (Rogers 2015), “Our country’s laws are beautiful and divine, but they’re not applied.” A prominent trans activist, Lohana Berkins (2015) published an opinion piece in the leftist paper *Página 12*, at the height of the coordinated Ni Una Menos protests in June of that year, asserting that “travesticide is also femicide” (*el travesticidio también es femicidio*). Feminist organizers of the nationwide protests were mixed in their reception to the presence and claims of *travesti* who asserted their inclusion in this coordinated movement, with some expressing concerns that *travesti* concerns were distinct. The political implications of femicides in Argentina is important to consider not only for the feminist and coalitional claim that *travesti* are making under the Ni Una Menos banner, but also because femicides are frequently linked in media reporting to sexualized and reproductive struggles around abortion, pregnancy, and sex work. Media frequently mention gendered intimate partner violence that occurs in response to women who are pregnant or intending to get an abortion, as well as violence against sex workers by their johns.

[86] The monologue was delivered in Spanish, and the translation is mine.

[87] Ni Una Menos, which translates to “Not One (Woman) Less” is also a loosely organized social movement. Its activists organize demonstrations and use the Twitter hashtag #NiUnaMenos to protest the murders of women. Such violence is typically also classed and racialized, although this is not always expressly articulated in protests. Ni Una Menos is described on its website as a “collective shout against macho violence” (“*un grito colectivo contra la violencia machista*”). (Ni Una Menos, n.d). During demonstrations, which frequently occur following gendered murders or violence, activists shout, “Basta de femicidios,” or “No more femicides!” In my research, it was clear that *travesti* murders were contested as femicides for many Ni Una Menos activists. As a result, *travestis,*many of whom were already active Ni Una Menos activists, specified “no more travesticides” (*“Basta de travesticidios”*) in response to violence against *travestis* and trans people. This became a rejoinder to both the exclusionary definition of feminized violence adopted by some Ni Una Menos activists and to the perpetrators of violence against *travestis*.

[88] *Travesti* and transgender identity differ along several important axes, but converge through certain forms of advocacy on various scales. While there is a frequent slippage between “trans” and “*travesti*,” and while “*travesti”* is at times seemingly incorporated by transgender’s “umbrella”, the particularities of *travesti* subjectivities at times subsume other forms of trans or gender non-normative embodiment or enactment. Violence—specifically its relation to policing and sex work—comes to stand as the unifying experience of gender non-normativity, though few middle- or upper-class trans Argentines are similarly, or at least as regularly, exposed to its effects. Trans men in Argentina also contend that they encounter differing types of violence.

[89] This resonates with Deborah Gould’s (2009:3) assertion that “feeling and emotion are fundamental to political life” and to social movements producing and working towards “political horizons.” Focusing on ACT UP and AIDS activism, she looks to affect as central rather than peripheral to the organization and action of social movements. These reflections inform my positioning of “epidemiological rage” in relation to *furia travesti*.

[90] This notion draws on Ludwig Fleck’s (1976) early engagements with the importance of shared communities of knowledge, or “thought collectives,” and their corresponding “thought styles.” These do not necessarily gesture to a shared set of beliefs, but rather what is *thinkable*—as well as what is *impossible* to think—for a particular (often professionalized) group.

[91] Aizura similarly discusses the imperative to theorize “value and racialization alongside necropolitics” and the sometimes contradictory dynamics that are produced within the articulation of trans femininity, labor, and exchange (Aizura 2014:133).

[92] Accessed 4/20/17 from www.wsj.com.

[93] Accessed 4/20/17 from www.transadvocate.com/fact-check-study-shows-transition-makes-trans-people-suicidal_n_15483.htm

[94] This law’s passage was also facilitated by an anti-sex work rhetoric that was taken up by both state actors and (at least conditionally) by some *travesti* activists. The scope of this project does not allow for an in-depth analysis of these dynamics, but this is a generative site for future research.

Chapter 3 Notes

[96] The Medicaid exclusion was in fact lifted in March of 2015, following a class action lawsuit that was filed against the State of New York by a group of attorney advocates (Department of Health, New York State 2015). Prior to this, any procedure code with the DSM’s “Gender Identity Disorder” diagnosis (now “Gender Dysphoria”) would be rejected

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for reimbursement. "Endocrine Disorder" because a standard workaround during this time, since it raised fewer flags for hormone treatment reimbursement.

[97] Sennott (2010), Burke (2011), Pyne (2011), Suess (2015), Suess, Espineira & Walters (2014), Kreig (2013), Sekuler (2013), and Puar (2015) are among those turning attention to this topic.

[98] "Depathologization" is not always the specific term under or around which groups organize, but refers to a mode of health activism that contests the terms on which certain bodies, social practices, subjectivities, or conditions are viewed as pathological or non-normative. These movements might seek to redefine sexed bodies or processes as healthy and non-pathological, for instance, in the case of feminist health activists who historically and presently strive to contest what they view to be the medical notion that the female body is inherently inferior, problematic, or ill (e.g., Ehrenreich and English 1973; Martin 1987; Murphy 2012). Relatedly, reproductive justice activists contest how racism shapes care provision as part of a broader social landscape, and how practices like forced sterilization are in part enacted through racialized pathologization (Luna 2009; Ross 2006; Silliman et al. 2004). Disability activists explicitly use the term "pathologization" with more frequency, and centrally critique notions of the "norm" in health care and medicine. They frame the "norm" as the falsely naturalized state against which people with disabilities are viewed to be ill, pathological, or deficient (Charlton 2000; McRuer 2006; Schweik 2009; Thomson 1997).

[99] An international coalition, Stop Trans Pathologization (www.stp2012.info), boasts a sweeping regional reach of member organizations throughout Africa, Asia, Europe, Latin America, North America and Oceania. Among these was the Spanish Network for the Depathologization of Trans Identities, which launched a campaign called "Stop Trans Pathologization 2012." This grew out of social media and Internet correspondence with a variety of transnational partners. This collaborative subsequently merged into the International Campaign to Stop Trans Depathologization (STP).

[100] In this regard, some depathologization activists compare medical care for trans people with that of pregnant people. For example, Krieg (2013:41) argues that both conditions are quotidian variations on standard human existence that may require biomedical care.

[101] "Medicalization" signals an important set of debates in medical sociology and beyond, initially articulated and elaborated in the 1970s. Generally positing that social problems or forms of difference are defined increasing as medical problems, these arguments held particular import at their inception for scholars of disability and gender. These critiques have traveled well beyond the confines of sociology. STMS-informed interventions have suggested that present social dynamics might be theorized less through medical control or dominance, and more through broad social and political shifts that suffuse and transform life vis-à-vis biomedicine (Clarke et al. 2010).

[102] Related to medicalization but not identical to it, studies of pathologization foreground the production of the norm in medicine and beyond (Burke 2011; Garland-Thomson 1997; Stoler 1995).

[103] "Stigma"—although presently part of the contemporary vernacular—was initially theorized by Erving Goffman (1963:3) in the early 1960s. Defining this as an "attribute that is deeply discrediting" and as a "spoiled identity" that "disqualifie[s people] from social acceptance," he emphasizing the social relations, within which certain elements of identity are scorned, devalued, or rendered undesirable.

[104] Trans depathologization projects differ from those undertaken by earlier gay depathologization activists in the US, as they *do not* seek demedicalization. Rather, trans depathologization strategies today draw from feminist and disability critiques—often implicitly—to reject definitions of gender non-normativity embedded in pathologizing diagnostic models of care while simultaneously demanding access to infrastructures of supportive clinical care.

[105] Here, Clarke (2005) builds on symbolic interactionist engagements with social worlds, commitments, perspectives, action, and negotiation (e.g. Strauss 1978). "Arenas," in this regard, are both "discursive sites" and "conceptual frames" (Clarke 2005:38) through which to analyze collective actors and action. These comprise part, though by no means the whole of situational analysis.

[106] While trans depathologization is deeply indebted to feminist activism, advocacy, and scholarship, the relations between these fields of practice have somewhat contentious histories. In the US and to a large degree in Argentina, there remain palpable antipathies towards trans and *travesti* people on the part of certain individual feminists and feminist organizations. This may manifest in exclusion from social and political participation (generally, participation of transfeminine people from feminist "women only" spaces and projects).

[107] Ehrenreich and Ehrenreich (1978) described these as medicine's "exclusionary" and "expansionist" currents. For some people—namely, wealthy white women—medical establishments encourage entry into medical management "in a variety of non-sick situations" (p. 49), while for others—primarily women of color and working class women—the "sick role" is out of reach, and "pathology" is addressed as a social, economic, and most significantly moral problem. These apparently conflicting modes of social control, they argue, are indeed two sides of the same coin.

[108] This notion of a norm as discontinuous with a population standard calls forth Canguilhem's (1966 [1991]) discussions in *The Normal and the Pathological* about the imperative for medical practice to differentiate between the statistical

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average and the norm. He writes, "in dealing with biological norms, one must always refer to the individual because this individual, as Goldstein says, can find himself 'equal to the tasks resulting from the environment suited to him,' but in organic conditions which, in any other individual, would be inadequate for these tasks. Laugier, Goldstein asserts that a statistically obtained average does not allow us to decide whether the individual before us is normal or not. We cannot start from it in order to discharge our medical duty toward the individual. When it comes to a supra-individual norm, it is impossible to determine the "sick being" (Kranksein) as to content. But this is perfectly possible for an individual norm" (Canguilhem 1991 [1966]:181). This "individual norm"—which is, he argues, the norm of pathology—takes shape within a specific social and biological environment, but is nonetheless not likely to fit with the statistical regularity of the non-medical sciences. In this regard, the "abnormal" is not necessarily equivalent to the "pathological."

[109] Trans and disability studies as well as activism, maintain a somewhat vexed relationship in the U.S., and to a large degree also in Argentina. Puar (2015) describes how the 1990s exclusion of transsexuality from the Americans with Disabilities Act (ADA) in part set the scene for trans ambivalence towards engaging disability. She also notes the curious schism between trans and disability studies' trajectories, describing their often unarticulated resonances as well as their general omission of engagements with racial difference.

[110] "Disablement" is far from an incidental connection here, given transgender's peculiar and troubled relation to disability. Barry (2013) discusses the historical exclusion of transsexuality from the Americans with Disabilities act, describing the ADA as "moral code, and people with GID its moral castaways." As Puar (2015), Strassburger (2012) and others point out, trans subjectivities are at times in alignment with though more often disavow such links. This was also the case historically, as a large degree of division characterized whether or not activists advocated trans exclusion in the ADA.

[111] Scholars such as Aren Aizura (2006) and Dan Irving (2008) have analyzed this particular dynamic as it unfolds within trans advocacy and rights discourses, emphasizing that those trans subjects who are most recognizable and/or who might be recuperated into a racially, economically, heteronormatively, and "properly" gendered transgender subjectivity become idealized trans subjects, while those who fail to fit such requirements are excluded from the medical treatment they seek, as well as from social/political spheres.

[112] This "wedge" also echoes the manner in which Ehrenreich and Ehrenreich (1978) describe social control in medicine. They argued that medicine is ideological and shaped by classed, racialized, and gendered stratifications. It thus operates in distinct ways by exerting social control through what they call "exclusionary" and "expansionist" modes, which either denied people admittance to care (exclusionary) or which undertook intimate management of aspects of people's lives that would seem to be beyond the concerns of appropriate medical care for illness (expansionist).

[113] On the whole, many US-based activists were unaware of Argentina's Gender Identity Law and its provisions.

[114] In a highly polarizing move, the APA also appointed Toronto-based psychologist and sexologist Kenneth Zucker to the work group. Zucker is infamous among trans depathologizationists for his use of "reparative" treatments for children and adolescents to discourage gender dysphoria in adulthood. He chaired the committee.

[115] The "transsexual model" sought to identify "the true transsexual" as defined in the mid-twentieth century by Harry Benjamin and other US- and European-based sexologists (Meyerowitz 2002). It typically excluded a large number of potential patients from treatment for reasons such as sexual object choice and physical appearance. This classic mode of diagnosis and treatment—while not entirely obsolete—has been sharply critiqued by trans activists, and has been expanded into less restrictive modes of diagnosis and treatment.

[116] Consequences may range from concerns about insurance coverage and pre-existing conditions (at least prior to the passage of the ACA in the US) to potential problems for trans parents associated with having had a psychiatric diagnosis in child custody disputes.

[117] Initially, the Spanish Network for Trans Depathologization focused on the legitimation of gender-confirming care, but soon shifted to forcefully confront medical hegemony (Araneta and Fernandez Garrido 2016). As it expanded into a transnational network, its focus moved from this broad critique of medical power to instead more narrowly contest depsychiatrization.

[118] As noted in Chapter 1, "the letter" refers to the generally compulsory document that a primary care and/or mental health care provider (or sometimes both) must provide to surgeons to ascertain trans people's qualifications for surgery. In the US and in many other locales, such documents are required prior to surgery, and stand as an expert assertions of the veracity of patients' claims to transness via a Gender Dysphoria diagnosis. The letter is unnecessary in Argentina's current health care system, given the legal codification of only expressed desire being satisfactory grounds for seeking surgical or other forms of gender-confirming care.

[119] The combined effects of the U.S.'s decentralization and diagnostic classificatory infrastructures are thus quite powerful. Argentina's health care system is not wholly centralized, as it is a tiered system that includes a robust private market in addition to government-run employment insurance and the subsidized public hospital safety net. However,

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while both systems are somewhat fragmented, the U.S.'s system is far more so, and it lacks the kind of coordination that the Ministry of Health in Argentina provides. So although Argentina's financing systems also link diagnostic codes and specific treatments, there is more flex and play in its system because the Ministry of Health sets standards for regulation. It was through the Ministry of Health, for example, that Argentina implemented the financing requirements of the Gender Identity Law. Even though rates of uninsurance in the U.S. are very high (and disproportionately so among people of color, low-income people, and young people) (Kaiser Family Foundation 2016), health insurance systems still have an outsized influence of what remains possible in terms of changing financing regulations and structures. As Antonio points out, this (combined with U.S. dominance in transnational politics) has implications for transnational efforts to standardize trans health, as well.

[120] This is of course linked to various discourses within the institutions of health care, biomedicine, and biomedical ethics. For instance, patient-centered care, family-centered care, and informed consent paradigms all center the notions of choice, autonomy, and patient-provider collaboration. Yet "autonomy" is not conceived or defined identically by those engaging in practices that might fall under any of these rubrics, *including those of depathologizationists.*

[121] Stanley (2014:89–90) describes "gender self-determination" as a "collective praxis" and a relational articulation of a "collective self" that rejects "constriction and universality." He writes, "Gender self-determination opens up space for multiple embodiments and their expressions by collectivizing the struggle against both interpersonal and state violence. Further, it pushes us away from building a trans politics on the fulcrum of realness (gender normative, trans, or otherwise) while also responding to the different degrees of harm people are forced to inhabit. As a nonprescriptive politics, its contours cannot always be known in advance — it is made and remade in the process of its actualization, in the time of resistance and in the place of pleasure" (Stanley 2014:90–91). Key to these insights are its claims to a non-domesticated multiplicity, changeability, and emergence that positions itself against the stablizing and universalizing currents of, for example, biomedical ethics.

[122] The recent film about the Tom Waddell Urban Health Clinic in San Francisco, "Transgender Tuesdays: A Clinic in the Tenderloin" (Freeman & Walters-Koh 2012), also traffics in this affective organization.

[123] As mentioned in Chapter 1, informal practices such as "creative coding" are also at times formalized, as when LGBTQ clinics adopt policies to diagnose patients with Endocrine Disorder to better facilitate coverage for hormone treatment cost.

Conclusion notes

[124] In her analysis of STS and critical race theorizing, Benjamin (2016:145) expansively considers "the carceral" by reflecting on the relationship between "innovation and containment." Here, she describes "fixing" as at once *purportedly helping* and *holding in place* (Benjamin 2016:150). This is also relevant to the racialized currents of containment in some aspects of biomedical treatment vis-à-vis transness (see Hsu 2013; Najmabadi 2013; Aizura 2009). Containment is by no means *equivalent* to biomedical treatment of transness. But neither are the curative and ameliorative impetuses of biomedicine—which weave through its disciplinary relations power—absent from discourses of gender-confirming care. I am indebted to Victoria Pitts-Taylor for pointing out Benjamin's analysis.

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