UNIT 3 HEALTH CARE AND NON-NORMATIVE SEXUAL IDENTITIES

Structure

3.0 INTRODUCTION

This Unit discusses the concept of non-normative sexual identity in relation to health care services. It defines what is understood as non-normative sexual identities and introduces different categories which explain non-normative sexual identities. As the title of the unit suggests, we will try to deconstruct and contest the medicalized notion of heterosexuality which is normalized and accepted in the society. Further, this unit will help you to examine certain kind of gender biases that exist in the practice of culture of health care systems.

3.1 LEARNING OUTCOMES

After studying this Unit, you would be able to:

- Understand the various concepts related to non-normative sexuality and health;
- Discuss the challenges faced by the non-normative population in relation to health; and
- Engage in the rights of non-normative population and their health access.

3.2 CONCEPTS OF NON-NORMATIVE SEXUAL IDENTITIES

The sexual identities are primarily assigned on the basic differences of anatomy between male and female sex organs. This creates confusion for lot of other gender categories who do not fit into the binary or assigned sex/gender at birth. The social and political structure reproduce masculine and feminine behavior in accordance to their structures and it becomes

aligned with normative gender roles and heterosexuality (Butler, 2006). The study of sexuality with LGBTQIA as an umbrella term is a recent phenomenon and its manifestations are still regarded as taboos and stigmatized category as it challenges the hegemonic norms of the society. There is a movement of convergence and emergence of non-normative sexual identities to challenge the dominant language and culture of the binary classification. According to **A. Fausto Sterling** in the article, **the *Five Sexes. Why Male and Female are not enough* (1993),** the medical model that has the assumptions that there are only two senses and heterosexuality alone is normal is a contested agenda; one true model of psychological health has gone unexamined.

3.2.1 The Normative: Tracing the Conceptual Formulations

This sub-section is adapted from Unit 4: Feminism and Non-Normative Relationships of the course MWG 001: Theories of Women's and Gender Studies. In order to understand the categories that define the non-normative, we will first look at issues of sexuality while trying to understand non-normative sexuality and its relation to feminism.

Homosexuality

It is interesting to note that the term 'heterosexual' comes into being only after the term 'homosexual', when 19th century sexologists began to construct theories that explored 'normal' and 'abnormal' sexualities. **Richard von Krafft-Ebing** in his **Psychopathia Sexualis: A Medico-Forensic Study** (1886) pathologized homosexuality in his work, seeing it and other 'perversions' like it as a sign of individual illness of a larger depraved society. It was in the 1892 translation of Krafft-Ebing's work that the term 'homosexuality' came into general usage. Sexuality, as seen by these sexologists was constructed in terms of the binaries of heterosexuality and homosexuality, where one was seen as inherently positive, normal and desirable; while the other, homosexuality, was only defined in terms of negativity. Discussing the emergence of the category of homosexuality, Michel Foucault in his book, The History of Sexuality says:

Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphrodism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species. (Foucault, 1976, p.43)

For Foucault, the sexual classification of individuals is the result of the development of a regime of power. According to Foucault, power structures operate through classification and categorization. The sexual classification of individuals, become possible by relying on the medicalization of the sexually peculiar. This implies that those who are seen as sexually normative are treated as a separate category from those who are seen as sexually peculiar. These sexual categories, especially those of 'homosexual' and 'heterosexual', also became new and empowering ways for individuals to identify themselves. It made possible what Foucault calls, "a 'reverse' discourse", wherein, "homosexuality began to speak on its own behalf, to demand that its

legitimacy or 'naturality' be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified" (Foucault, 1976, p.101).

Emergence of Lesbian and Gay Communities

Forging the links between the emergence of a specifically homosexual identity in the latter part of the 19th century with the new patterns of social organization that were being formed at the time, **John D' Emilio** in his path breaking essay, **"Capitalism and Gay Identity",** explores the ways in which capitalism facilitated the articulation of such an identity. According to him, the reorganization of the family structure, propelled by capitalism's spread of wage labour and capital, allows for the conditions that foster the separation of sexuality from what he calls, "the 'imperative' to procreate" (D'Emilio, 2009, p.104). This, in turn, made possible the rise of urban communities of lesbians and gay men. Thus, by the time of the Stonewall Riots in New York City in 1969, which sparked off the Gay Liberation Movement, huge crowds of lesbians and gay men could be mobilized. D'Emilio recognizes that while it became significantly easier at the time for men and women to construct a personal life away from the constraints of the family, it was nonetheless more difficult for women, as they were still economically dependent on men. This recognition gestures towards a nuanced understanding of the lesbian movement, wherein instead of it being willingly brought under the general rubric of the Gay Liberation Movement, it is acknowledged in terms of its own politics and struggle. Historically, lesbians have occupied a somewhat uneasy position in social movements that organized protests on issues of gender and sexuality. The international women's and gay and lesbian movements were instrumental in raising awareness about concerns regarding the inequality of the sexes and the sidelining of gay issues. Both the women's movement and the gay rights movement questioned and sought to defy traditional beliefs regarding sexuality to destabilize the hegemony of heterosexuality. However, as Nitza Berkovitch and Sara Helman point out, "challenging heterosexuality did not inevitably lead to a critique of patriarchy" (Berkovitch & Helman, 2005, p.271). The gay movement largely privileged male sexuality and there were very few exceptions to this sort of gender hierarchy. Lesbian feminists argued for the specificity of the lesbian experience as an experience specific to women and criticized the assumption that lesbians and gay men share characteristics simply by virtue of being same-sex relationships. Thus, feeling estranged from both these movements, lesbians felt the need to create a distinctively feminist lesbian politics, one that interrogated the creation of heterosexuality as the normative model of sexuality. Lesbianism then, was seen as being more than a sexual preference, it was a political choice. It defied the power equation that always existed between men and women, and in doing so, lesbianism posed the most radical challenge to the established order.

Transsexuals

While discussing non-normative relationships, it is essential to mention non-normative sexualities other than those of lesbians and gay men, such as transsexuals. For a long time, transsexuals were either relegated to the field

of abnormal psychology or were seen as fascinating because of their cross dressing. As part of the advocacy for gender expression, the term 'transgender' was coined in the 1980s. It was used by **Virginia Prince** to refer to individuals whose identities fell between 'transvestite' and 'transsexual'. However, 'transgender' as defined by **Leslie Feinberg,** came to signify a term for all those people who embodied different genders from what was normative and those who were marginalized or oppressed as a result of it. It stood for, "an imagined community encompassing transsexuals, drag queens, butches, hermaphrodites, cross-dressers, masculine women, effeminate men, sissies, tomboys, and anybody else willing to be interpolated by the term, who felt compelled to answer the call to mobilization" (Stryker, 2006, p.4). Several feminists tended to see transsexuality as a "false consciousness" (Janice Raymond in Stryker, 2006), as they were adopting masculine or feminine stereotypes and altering their bodies in order to do so. It questioned some very basic assumptions—how can a person born with male genitalia claim to be a woman, when it defies the biological basis for being a woman? So, the basic belief of feminists, of there being two sexes and two genders, is thrown into question by the presence of transsexuals and propelled them to be seen as, "the visible symptoms of a disturbed gender system" (Raymond in Stryker, 2006, p.4).

In India, according to the Transgender Persons (Protection Of Rights) Act, 2019; there is a clarification for the definition of transgender as a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such persons have undergone sex reassignment surgery or hormone therapy or laser therapy or such other therapy), person with intersex variation, gender queer and person having such socio-cultural identities as *kinner* (term used in the west and northern India , *hijra* (universally used for eunuch), *aravani* (term used in Tamil Nadu) and *jogta* (term used in Maharashtra an Karnataka).

Again, the definition of person with intersex variation is also mentioned as a person who at birth shows variation in his or her primary sexual characteristics, external genitalia, chromosomes or hormones from normative standard of male and female body. There is also a queer culture of acknowledging plural sexual behaviors, sexual identities and liberation movement (Ana Garcia-Arroyo, 2010).

3.2.2 Origin of the term 'queer'

This sub-section is adapted from the **Unit 2: Literary and Cultural Perspectives of the course MWG 001: Theories of Women's and Gender Studies**. It may be interesting for you to know that the term "queer" is recent in origin and the genesis of queer theory is heavily influenced by several theoretical and identical movements such as feminism, black movement, poststructuralism and postmodernism.

Lesbian/gay studies thus attempts to foreground social and political issues concerning queer people, and the marginalization of queer persons who find themselves in an 'oppositional' stance vis-à-vis mainstream society, due to existing prejudices and hostility towards them. While in recent years, the

term 'queer' has been chiefly associated with lesbian and gay subjects, the scope of the term extends to issues such as cross-dressing, hermaphroditism, gender ambiguity, gender-corrective surgery, intersex persons, gender queer, and non-conforming and transgender persons as well. The term 'queer theory' was coined by **Teresa de Lauretis**; several writers such as Eve Kosofsky Sedgwick, Judith Butler, Adrienne Rich and Diana Fuss have positioned the queer and queer theory in the light of culturally marginal sexual self-identifications. It was in the year 1869 that the term 'homosexuality' appeared in print for the first time in a German pamphlet written by **Karl-Maria Kertbeny (1824-1882).** In 1886 with the Criminal Law Amendment Act (1885), sexual relations between men (not women) were given Royal Assent by Queen Victoria. And further, it was in 1892 that the word 'bisexual', in its current sense, was used in Charles Gilbert Chaddock's translation of Kraft-Ebing's Psychopathic Sexualism.

Check Your Progress Exercise I

Note: I. Use this space given below to answer the question.

II. Compare your answer with the Course material in this Unit.

1. Define the term 'Queer'.

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2. How do you define the concept of sexuality?

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3.3 NON-NORMATIVE GENDER AND HEALTH CARE: RIGHTS AND ISSUES

There is a delay in getting urgent medical attention within the Queen Community due to the historic discrimination. The discrimination is due to the structural ignorance and negligence as the non-normative gender does not fit into the category of binary male and female. 70% of transgender and gender non-confirming individuals are subjected to discrimination in health care setting (Lambda Legal, 2009). Studies have revealed that care was being refused to around 19% of the transgender (Hollenbach et.al 2014). Again, coming to the historic 'The Transgender Persons (Protection of Rights) Act, 2019', chapter II 3d (d), reveals that no person or establishment shall discriminate a transgender person on the ground of denial or discontinuation

of, or unfair treatment in, healthcare services. Under the same Act Section15 (b), (c) and (d), provides the medical care facility of sex reassignment surgery and hormonal therapy. It also brings the purview of before and after surgery; hormonal therapy counselling, bringing out a manual in accordance with World Professional Association for Transgender Health guidelines. The sections 15 (f) and (g) of the Transgender Persons (Protection of Rights) Act, 2019 facilitates access to health care institutions and centres and most importantly covering medical expenses for wide range of health issues such as hormonal therapy, Sex Reassignment Surgery and laser therapy.

3.3.1 Health Issues and Sex Reassignment Surgeries

According to World Professional Association of Transgender Health (2012), there are certain health issues confining to feminizing hormones therapies such as: hypertriglyceridemia, gall stone, thrombolic disease, and weight gain. Male hormonal therapy creates issues of polyethemia, sleep apnea and acne.

According to **Wiley et.al. (2016),** in the article "*Serving transgender people clinical care consideration and service delivery models in transgender health"*, the operative procedures undergone by transgender women are breast reconstruction, orchiectomy, penectomy, vaginoplasty, labiaplasty, clitoroplasty, urethral meatus, reconstruction; others include facial feminization therapy. For transgender men, it involves mastectomy, hysterectomy, oophorectomy, vaginectomy, scrotoplasty, metoidioplasty, phallioplasty; others are vocal deepening, body hair growth, increased musculature, cessation of their menstrual cycle (hormonal therapy). **Jeftovic** et.al (2018), also includes the same operative proceedings removal of female genitalia (hysterectomy with bilateral salpingo-oophorectomy and vaginectomy), chest masculinization (bilateral mastectomy), and genital reconstructive surgery (metoidioplasty or phalloplasty, urethral lengthening, and scrotoplasty with testicular implants). Hysterectomy could be both transvaginal and laparoscopic. There are hormonal issues which can severely affect female to male transgender population, hence, specific aspects must be considered including effects of testosterone treatment, gynecological malignancy, thromboembolic events and operative bleedings (Winkler 1996; Ose et.al 2017). For surgical necessity, before two weeks, it is important to stop testosterone administration. It helps to avoid excess intra-operative bleeding. Also, some prefer laparoscopic hysterectomy for better visualization of tissues and controlling haemorrhage (Ott, et. al. 2010; O'Hanlan, 2007). It is easier and comfortable for sex reassignment (also known as gender affirmation (confirmation) surgery with transvaginal hysterectomy. New age robotic single-port access hysterectomy and laparoscopic can be a future alternative as there are limited current experiences (Bogliolo et. al, 2014; Lazard et.al, 2013). In a study conducted for sex reassignment surgery for 124 female-to male transsexuals it was found that there is an increased risk of bleeding. Increased operative time can also increase the risk for the life of patients for instance, repositioning the patient, removing equipments (Gomes da Costa et.al, 2016). The laparoscopic approach is associated with a longer operative time and higher cost. The scars

in the anterior abdominal wall may also compromise abdominal phalloplasty. These characteristics make transvaginal hysterectomy with bilateral salpingo-oophorectomy as the optimal choice in transsexuals. The clear advantages of transvaginal approach are especially important in our setting of one-stage gender affirmation surgery, where a fast and the least invasive procedure with minimal blood loss, is highly appreciated (Sheth, 2014; Sheth et.al , 2011)

3.4 CASE STUDIES

Let us read some case studies to understood the breath care issues faced by the non-normative gender categories.

A Transgender Female: She is involved in dancing profession and initiation ritual (during the birth ceremony where blessings are required by the new-born family). Jeena is from Assam. She moved to Delhi when there was a discovery of fondness towards femininity, and it was not accepted by the family members. Delhi has a better acceptance of transgender community and soon she was initiated in a transgender circle. After gaining professional and personal experiences, she returned to her home state. She shared her life experience – 'We have lots of problems. We have lot of struggles. In public spaces, we are judged and mistrusted. If someone is unwell, we go to a private hospital. Our disciple (chela) was unwell, haemoglobin was low. People do not accept us easily. Four people helped us financially and we donated and arranged for blood. I also have nerve problem. I have consulted doctors in public and private hospitals and treatment is very expensive. Since I have less awareness level in hospital setting, I wait in queue for two/ three hours. On reception counter too, the employees do not help. The dilemma is, there is no alternative queue for third gender as I do not belong to male and female standing place for Outpatient Department (OPD). Even if I complain, they ask me to wait in the last place. Some nurse and doctors are good. Private hospital and private chambers have good accessibility. Atal Amrit Card was used in Private Hospital only for partial facility as some components were not covered like MRI and operation. I am an elder in my group and I look after the group. I have a daughter. In Delhi, situation is different; here people are much aware of the community therefore my health issue is prioritized' (Primary data from the field).

Let us look into the perspective of a psychiatrist to give a perspective on mental health issues and non-normative gender categories. For a very long period of time, non-normative sexual identities were stigmatized. Recently, there is a change of definition and meaning as well. According to Diagnostic and Statistical Manual- DSM-V, gender dysphoria is psychological distress associated with gender non-confirming a marked incongruence between ones experienced/exposed gender and assigned gender of at least 6-month duration (Reisman, 2019, p. 284). Hence, it is the counselling for gender dysphoria that is sought by the non-normative sexual identities.

Box No. 3.1: A Psychiatrist's Account who Works for an NGO

The present health care system is not equipped for non-normative sexual identity population. Still many medical personnel are not much aware about the problems faced by the community. Many times they are discriminated on the basis of their gender identity. On few occasions I have counselled patients with gender dysphoria. Even many mental health workers are well informed or experienced about counseling for gender dysphoria but many patients come for counseling quite late due to stigma, shame and lack of awareness. Main problems faced by them are having a strong feeling of guilt and trapped/caged in opposite gender body. Many people cannot bare this caged feeling which ultimately pushes them to severe symptoms of depression. Most of the time family support is lacking for the community of LGBTQ+. They along with the family also undergo severe trauma of what society and family members will think about them. A few people opt for surgery but it is not affordable for many. Overall, in medical curriculum least importance is given to the issues of LGBTQ+.

Source: Primary Data from the field

Non-normative sexual identities need to be an integral part of an inclusive and patient-centered care advocacy approach. Health disparities and unique health care needs of the LGBTQ+ community must be considered at all levels of health policy development (Daniel & Butkus, 2015). Furthermore, eliminating hetero-normativity assumptions, developing person-centric approaches, and improving communication strategies in preparatory programs are crucial changes for addressing deficits in the health care delivery system. Developing an inclusive existing health care and community services for LGBTQ+ community along with public communication, documentation, representation of images, and language choices and terminology used in various forums remain critical for development of the community (HCC, 2019).

Check Your Progress Exercise II

Note: I. Use this space given below to answer the question.

II. Compare your answer with the Course material in this Unit.

1. Write short note on sex reassignment surgeries and its health implications.

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2. Explain the concept of non-normative sexual identities.

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3.5 LET US SUM UP

As every child matter when they grow, it is not important to enforce the binary gender identity as there are more than two. It is the lack of cultural representation and norms that enforces non-normative identities invisible. The need is to challenge gatekeepers of medical community for the language used in the medical community influences and reflects societal perceptions of non- normative identities. The health sector must move beyond bodies and gender identities towards the innate experience of the community to change the whole dynamic of gender dysphoria and homophobia. As non-normative sexual identities face homelessness, impoverishment due to societal ostracization like social stigma, domestic abuse, cultural apathy and victimization; the issue of health suffers due to the lack of expertise and exposure on medical fraternity. There should be Inclusion of family, adolescent counselling, sensitive to the health needs of the people to uncover their bodily shame and comfort.

3.6 UNIT END QUESTIONS

1. Define the concept of Non-normative sexual identities with examples.
2. Discuss the in-section between gender and health in relation to non-normative sexual identities. Give examples and case notes to substantiate your answer.
3. How does access to health care differ in the context of non-normative community? Critically analyse.

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3.8 SUGGESTED READING

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