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Institutional Inconsistencies: The Case of “Transgender”

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By V Varun Chaudhry

The CDC’s recent attempt to dictate and regulate possibilities for funding and research included attention to broad swaths of people, including those deemed “vulnerable” and/or receiving “entitlements,” as well as anyone who might fall under the category of “diversity.” The inclusion of “fetus” and “transgender” alongside the other words on the list suggests a specific attack on gendered bodies: “fetus” might be used in reference to abortion rhetoric (on either side of debates about reproductive rights), while “transgender” is often mobilized in reference to a broader question of LGBTQ populations, health risks, and civil rights. The Obama administration made progress on women’s and LGBTQ rights, the story goes, and the current administration is attempting to roll back said progress. The case of the category “transgender,” however, cannot be lumped in with “women’s and LGBTQ rights,” but rather viewed on its own. Understanding transgender as one of the CDC’s forbidden words requires examining not only fraught institutional and medical(ized) histories of the category, but also recognizing just how transgender-identified and gender nonconforming people have continued to work within and resist the institutions that attempt to apprehend them.

The CDC list of words came just a couple of months after the National Institute for Health released a [funding opportunity announcement](#) calling for research on transgender and gender nonconforming populations. The inconsistencies across these two national health institutions raise crucial questions, which advocates, service providers, and gender nonconforming people themselves are already quite attuned to: *what does it mean for “transgender” to be both forbidden and fundable?* Are we seeing a transphobic administration unevenly implement detrimental policy and budget reflections (which will soon be realized in full), or is something more complicated taking place? Transgender as a category evokes a myriad of images in the public imagination: from the glamorous, i.e., figures like [Caitlyn Jenner](#) and [Laverne Cox](#) to the terrifying, i.e. the [“man in a dress”](#) preying on young girls in the women’s bathroom. An audience more attuned to the realities for transgender people might be sure to name the [violence and marginalization](#) faced by transgender and gender nonconforming people, particularly transgender women of color. These different conceptualizations of transgender identity and gender

nonconformity in general indicate an uncertain at best, precarious at worst, climate for gender nonconforming people (of color). Given this context, inconsistencies between the CDC and NIH are not surprising, but in keeping with the uneven institutionalization of an already-confused category.

As scholars have drawn out more extensively elsewhere (Stryker 2008; Valentine 2007), transgender as a category initially emerged within medicalized, specifically psychiatric, contexts, primarily in Western Europe. The emergence of the category in this way makes sense given deeper histories of gendered, sexualized, and racialized bodies being marked (ab)normal through scientific institutions (Laqueur 1990 and Somerville 2000). Where transgender differs, however, is the ongoing reliance upon medical institutions for legitimacy and legibility: health institutions like the CDC and NIH, as well as local and national funds from Department(s) of Health have continued to fund crucial transgender-specific advocacy and programming. The philanthropic response to the early HIV/AIDS prompted a number of lesbian and gay organizations to form and grow within the confines of nonprofit structures; many of these organizations continue to serve LGBTQ populations today. Funding for transgender-specific programming, both within and outside of LGBTQ-focused organizations, has historically relied on this HIV/AIDS money, which often marks transgender and gender nonconforming (hereafter TGNC) people, particularly women of color, as vulnerable and at-risk. In fact, one of the few spots on the CDC website that still includes the supposedly forbidden word “transgender” is in reference to HIV/AIDS risks and rates, specifically among black transgender women. Health-related funding and support for trans-specific programming has continued to come from [funders](#) like AmFAR Foundation for AIDS Research, the Elton John AIDS Foundation, and MAC AIDS Fund.

The relationship between health-focused institutions and funders does not stop at the level of the organization: TGNC people must often work through and with health institutions to obtain necessary resources. In the case of medical transition (perhaps the more obvious, but certainly not the only, case of health “needs” for TGNC people), hormone therapy, gender-affirming surgeries, and other gender-affirming medical services require a [diagnosis](#) of “Gender Dysphoria,” a *Diagnostic Statistical Manual of Mental Disorders (DSM)* staple, which refers to the “conflict” or “discomfort” with the gender assigned at birth. Mental health institutions are quick to distinguish between “gender nonconformity” and “gender dysphoria,” noting that not all TGNC people experience the dysphoric piece. At the same time, however, the requirement of this diagnosis to access often-necessary medical resources keeps TGNC people and health institutions intertwined, not through a perfect glove-to-hand fit, but rather through what might be described as a kind of tentative partner

dance. Traditionally in a partner dance, one partner (often referred to as the lead) takes a step forward, while the other takes a step back, in order to keep both parties moving seemingly gracefully across the dance floor. For TGNC people and health-focused funders and institutions, while it might be easy to name the latter as the lead – an all-powerful, restricting force that keeps TGNC people tied to their every move – the reality looks a bit different. Both parties in this case take steps forward and back, responding to and working within the possibilities provided by the other.

Take, for example, the [Trans Equity Project](#), a grassroots organization in Philadelphia, Pennsylvania, which describes itself as the only “for trans, by trans” organization in the state of Pennsylvania, i.e., an organization led by TGNC people and serving TGNC people. Founded in 2001 as the Trans-Health Information Project (TIP) by a number of TGNC advocates of color in the city, the organization was initially supported using funds from the CDC. These funds supported harm- and risk-reduction programming, through one-on-one counseling and safe-sex education. Through this work, TIP became one of the primary resource sites for TGNC people, particularly people of color, living in Philadelphia. After some tumultuous funding and staff turnover, TIP became a program housed within GALAEI, a Latinx-focused LGBTQ advocacy organization initially founded as a Latino/a HIV/AIDS organization. Even housed within GALAEI, TIP program staff, always TGNC people of color, continued to apply for and utilize CDC funds to serve TGNC communities in Philadelphia.

In August 2017, TIP underwent a [name change](#) to the Trans Equity Project: formally, the name change was intended to reflect the “evolving mission, focus, standards, and overall energy of the program,” according to the organization’s press release. With a closer, ethnographically informed look at the name change, however, the shift away from health in name was intentional and strategic: in the words of organizational staff, “we’re fuckin’ working the system.” Due to changes in CDC funds and priorities, the funding that the program had relied upon would no longer be available. Moving away from direct (health and legal) services programming and funding and toward advocacy would allow the organization to tap into new kinds of funding. Shifting a focus to advocacy, equity, and overall wellness of TGNC people, then, is *strategic* in order to keep the organization alive, as well as to meet the needs of the clients who come to GALAEI and the Trans Equity Project in need of services, referrals, and resources. I draw attention to this example to point out something that TGNC people and their advocates working on the ground already knew: TGNC people, particularly people of color, already knew not to rely upon the health institutions that have continued to attempt to pull them into the dance, to dictate and regulate their every move, only to drop them on the floor to attend for themselves. There’s evidence, as well, that this strategy works: Trans Equity Project was recently [awarded](#) a \$25,000

grant to support its ongoing advocacy work, a sum that will make a tremendous difference for the program staff and the communities the program serves.

The Trans Equity Project demonstrates something that many anthropologists, particularly those of us working within marginalized communities (not to mention those of us who come from these communities), have already figured out: people on the margins are always-already “fuckin’ working the system,” and it would behoove ethnographers, social scientists, and others who aim to remain attuned “on the ground” to pay attention to their strategies. The CDC’s attempt to “forbid” transgender people from accessing services, funds, or legibility, then, falls on ears and bodies who saw it coming – and had already started running.

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[V Varun Chaudhry](#) is a PhD Candidate in the Department of Anthropology at Northwestern University. V’s research interests include the relationship between institutions and subjectivity; transgender studies; critical ethnic studies; language and materiality; and social movements. V is currently working on their dissertation project, tentatively titled: *The Price of Transgender Justice: Funding, Racial Politics, and Advocacy*, drawing on eighteen months of ethnographic fieldwork in Philadelphia, PA. V’s research has been funded by the Wenner-Gren Foundation, the Social Science Research Council, and the Sexualities Project at Northwestern, and draws upon over ten years of LGBTQ and racial justice advocacy work across the United States.

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