Urban Forum (2017) 28:91–110
DOI 10.1007/s12132-016-9286-8

Queering Mobility in Urban Gauteng: Transgender Internal Migrants and Their Experiences of "Transition" in Johannesburg and Pretoria

Nadzeya Husakouskaya[1]

Published online: 11 May 2016
© Springer Science+Business Media Dordrecht 2016

Abstract Migration studies in post-Apartheid South Africa have maintained a strong focus on cross-border mobility while often narrowing health-related research to HIV/AIDS concerns and framing gender in woman-oriented approach with a gradually emerging area of research on migrant sex workers. This article offers to bridge certain gaps in migration research on health, internal mobility, and gender. It revolves around experiences of black unprivileged transgender internal migrants accessing medical services in the public health sector in urban Gauteng, in particular, Johannesburg and Pretoria. The article explores their experiences of migration focusing on analysis of their "transition"—both "gendered transition" (different medical interventions that alter/modify gender-related attributes of the body) and "spatial transition" (diverse mobility patters, relocation, renegotiation of place of living and belonging)—and ways they negotiate belonging. The analysis outlines challenges that transgender individuals face in the public health sector and affects these challenges have on mobility of transgender South Africans. Further, the article delves into exploration of transgender internal migrants' experiences and understanding of "migration" that arises from sense of (non)belonging and ways to negotiate dynamic subjective sense of being (or not) part of physical (and sometimes imaginary) social groups and places, such as family/home, local ("host") community, lesbian, gay, bisexual and transgender (LGBT) community, and religion/spirituality.

Keywords Transgender individuals · Post-Apartheid South Africa · Public health sector · Internal migration and mobility · Experience of migration · Belonging

This article is based on my master thesis "Becoming a transgender/intersex internal migrant in Urban Gauteng: Challenges and experiences of transition while seeking access to medical services" (Husakouskaya, 2013a).

✉ Nadzeya Husakouskaya
nadzeya.husakouskaya@gmail.com

[1] Centre for Women's and Gender Research (SKOK), University of Bergen, Allegaten str. 34, room. 411B, 5007 Bergen, Norway

Introduction: Gender, Migration, and Health Non-intersections in Post-Apartheid South Africa

Over the last decade, migration studies in post-Apartheid South Africa have maintained a strong focus on cross-border mobility and related urgent issues: urbanization, "migration management," challenges posed by HIV/AIDS, xenophobic violence, and policy responses (Landau 2008, 2011; Misago 2009, 2011; Polzer and Segatti 2011; Amit 2010, 2011; Vearey et al. 2009, 2010, 2011). While cross-border migration is a relevant topic and concern for policy development and research, the statistics show that there are many more internal migrants than cross-border ones in South Africa. In particular, this tendency is well-reflected in Gauteng province. As Vearey (2013) points out, "[w]ithin Gauteng, the most migrant-dense and economically active province of South Africa, about 5 to 6% (around 580,000 people) of the population are estimated to be cross-border migrants; [i]n comparison, almost 3,9 million South Africans living in Gauteng have migrated from another province within the country." Currently, there is an emerging trend within South African migration studies to pay more attention to internal mobility and comparative research looking at different groups of migrants (Vearey 2013; Myroniuk and Vearey 2014). Nevertheless, the overwhelming majority of researchers are inclined to zoom in on cross-border movements.

Health-related research on internal migration in South Africa keeps its focus on return migration and urban-rural linkages pertaining to bi-directionality of HIV transmission (Lurie 2006; Vearey 2013), thus mirroring a broader field of migration studies in South African context where health is often scrutinized through HIV/AIDS pandemic anxiety and policy responses (Scheibe et al. 2011; Oluwafemi 2011; Vearey 2011; Richter and Vearey 2011; Nunez et al. 2011).

When it comes to gender and sexuality within South African migration research, these topics have been predominantly represented as a woman-oriented approach (Jinnah 2012; Nunez et al. 2011; Middleton and Palmary 2008) with a gradually emerging area of research on migrant sex workers (Richter and Chakuvinga 2012; Oliveira 2011; Richter et al. 2010). Although gender-based persecution in the South African asylum system has been properly examined (Middleton and Palmary 2008; Palmary 2008), variations of gender identities and sexualities related to and intertwined with *internal* migration remain a highly under-researched area. Transgender internal migrants in particular receive little attention if any within the field of migration studies in South Africa.

At the same time, neither needs of transgender people nor internal migration as a crucial variable are addressed by LGBT activism in South Africa. As my data gathered through the fieldwork in 2012–2013 suggests,[1] in the LGBT scene in Johannesburg, there were firmly voiced concerns of gay men, (black) lesbians, men who have sex with men (MSM), and to a certain extent women who have sex with women (WSW).[2] Transgender and intersex individuals were barely included as target groups in activities arranged by LGBT organizations in

[1] The data comprises 14 interviews conducted with 12 main actors in the field of LGBT activism in Johannesburg. It is important to notice that analysis of LGBT activism reflects the state of affairs as for June 2013 the latest. See more Husakouskaya 2012, 2013a.

[2] Terms "MSM" and "WSW" reflect sexual practices rather than sexual identities (such as "lesbian" and "gay").

Johannesburg. The main LGBT actors in Johannesburg did not consider issues of internal migration relevant to their constituencies. Although many of the organizations articulated rural-urban mobility within South African borders as a crucial factor for the LGBT community (especially for youth and students), most of them refrained from framing it within discourse of "migration." Health needs within the LGBT community and the LGBT sector echoing approach of South African migration studies were "overshadowed by HIV and AIDS and gender-based violence" (interview with Betsi Pendry, Sexual Health and Rights Initiative South Africa (SHARISA), 23 October 2012) with less attention to other health-related concerns such as mental health (Husakouskaya 2012).[3]

Taking into account outlined debates around migration, gender/sexuality and health in migration studies and LGBT activism in post-Apartheid South Africa, I am particularly interested to bridge certain described gaps by analyzing experiences of transgender internal migrants pertaining to mobility and "transition." The article aims to explore South African transgender internal movers' experiences of migration focusing on analysis of their co-existing and co-dependent transitions: "gendered transition" (different medical interventions that alter/modify gender-related attributes of the body) and "spatial transition" (diverse mobility patters, relocation, renegotiation of place of living and/or belonging). The analysis revolves around experiences of *black unprivileged transgender internal migrants*[4] accessing medical services in the *public* health sector in urban Gauteng, in particular, Johannesburg and Pretoria.

The article is grounded in the research conducted in Johannesburg and Pretoria in 2012–2013 (University of Witwatersrand, ethical clearance: H130218). The data gathered during intensive fieldwork (August 2012–May 2013) includes five focus group discussions followed by six semi-structured/narrative interviews with black unprivileged transgender individuals who were moving to and/or living in Johannesburg or Pretoria and accessing medical services pertaining to their transition in the public health medical sector. The fieldwork was done in close collaboration and with support of Transgender and Intersex Africa (TIA), Pretoria-based non-governmental organization (NGO). The data consists of almost 15 h of recorded material including focus group discussions and interviews. Overall, 22 transgender people with different mobility patterns participated in the study: 7 transmen and 15 transwomen. In addition, I draw on interviews and informal conversations with team members of TIA and on participant observation during the aforementioned focus group discussions, TIA's outreach programs in neighboring provinces, and diverse

[3] In 2012–2013, LGBT organizations in South Africa started tackling interconnected areas of migration and sexuality by launching a range of activities, projects, and research that dealt with very particular social groups—LGBT *refugees* and *asylum seekers.* Thus, LGBT activist arena mirrored approach of South African migration studies sidelining internal movers as well as transgender individuals (Husakouskaya 2012).

[4] All participants self-identified (strongly) as "black" and offered a term "unprivileged" during one of the focus group discussions to describe their collective identity pertaining to class while discussing the social and economic challenges they face. In this article, "internal migrant" refers to an individual moving within the borders of her/his/their country. For definition of "transgender," see the footnote 6 in this article. For further discussion on subjective understanding of "internal migration," see a separate section of this article.

academic and activist LGBT-related events held in Johannesburg and Pretoria between August 2012 and May 2013.

Contextualizing Transgender Health in Post-Apartheid South Africa: (Public) Health Sector and Medical Framework for Transgender Individuals

The Apartheid system strengthened and reinforced segregation and fragmentation that existed in the South African health sector since the late 1800s. During the Apartheid, the public health sector suffered from fragmentation, unequal distribution of infrastructure and financial and human resources between different geographical areas, and inefficient distribution of resources between levels of care (only 11 % of spending were devoted to non-hospital primary care services) (Coovadia et al. 2009: 828). The public facilities were segregated along racial lines with separate services (or even entire facilities) for the non-white population (Department of Health 2002: 10). The private health sector was developed in the late 1880s due to corporate capital, and it aimed to cater for the health needs of white mine workers. Therefore, expansion of the private health sector benefited first of all the middle class white population. Noteworthy, by 1960, almost all whites in South Africa had shifted to the private medical sector. At the same time, 95 % of non-whites relied on free services provided by the public sector when more than half of financial and human resources were allocated to the private sector (Department of Health 2002: 19; Coovadia et al. 2009: 828).

The post-Apartheid health system in South Africa has been marked by important changes and improvements: 14 health administrations have been reorganized into one national and nine provincial health departments; primary health care became one of the key foci; clinic infrastructure has been significantly developed and improved with 1345 new clinics built and 263 upgraded; the essential drug lists and standard treatment guidelines were introduced; and two HIV and AIDS and STI Strategic Plans for South Africa (2007–2011; 2012–2016) were developed and implemented (Coovadia et al. 2009: 828). Despite some achievements in the domain of health, the health system is still very much constrained due to (1) limited access and affordability of health services along racial lines caused by persistent poverty, unemployment, sexism, and socioeconomic inequity; (2) lack of integration and coordination between public and private sectors of health care and persistent non-engagement of these sectors with civil society; (3) inadequate human resource capacity and planning, poor leadership, and management; and (4) lack of statistics and information

(Coovadia et al. 2009; Mayosi et al. 2012).[5] As the following analysis will show, all these shortcomings have direct impact on challenges, mobility patterns, and experiences of transgender individuals who access gender affirmation treatment in South Africa.

Transgender people[6] in South Africa *usually* would express their desire and/or need to undergo full or partial gender affirmation treatment: hormone replacement therapy[7] and one or more gender affirmation surgeries. All my informants emphasized their need and desire to opt both for hormone replacement therapy and one or more gender affirmation surgeries. At the same time, most of them stressed that they did not have proper access to these medical services and/or they struggled afford them financially (particularly, surgeries). Noteworthy, the need for surgeries is not imposed by South African legal framework. The Alteration of the Sex Description and Sex Status Act, No. 49 of 2003 that came into effect in 2004 explicitly secured transgender people's

[5] It is important to mention that along with the public and private sectors of the medical system in South Africa, there are traditional health practitioners. According to AIDS Foundation South Africa (2010; quoted in Kim 2011), there are more than 185,000 traditional health-care practitioners in South Africa. It is estimated that around 80 % of South Africans use traditional health practitioners' services and consult with them on a regular basis (Mafisa 2010, referred in Kim 2011).

[6] Based on my 10-month fieldwork, I use the term "transgender" in its narrow meaning referring to people whose gender does not match the sex category they were placed into at birth and who therefore *usually* opt for medical interventions (hormone replacement therapy and/or gender affirmation surgery/surgeries) to align body with gender identity. None of my 22 participants identified as "queer," "non-binary," or "gender non-conforming." Therefore, I am not using "trans*" or "queer" as ostensibly more encompassing terms (see, for example, Klein 2008, 2014). The term "transman" refers to those who were assigned female sex at birth and have male gender identity; "transwoman" is used for those who were assigned male sex at birth and have female gender identity. Even though I do not have enough space in this article to go into discussion over the terminology I would like to acknowledge that I am aware that my use of a term "transgender" (as well as its usage by the participants) has been deeply influenced by vocabulary that TIA deploys as an organization that works with constituencies in Gauteng. In turn, their choice of terminology has been largely defined by discursive framework of donors' agenda (based on informal talks with members of TIA and other LGBT organizations in Johannesburg).

[7] Hormone replacement therapy for transmen includes intake of testosterone that causes a process of bodily masculinization (deepened voice, clitoral enlargement, growth in facial and body hair, cessation of menses). Transmen can opt for all or some of the following gender affirmation surgeries: mastectomy/chest reconstruction aims to remove breasts and create a male-looking chest; hysterectomy removes a womb; oophorectomy removes ovaries; vaginectomy removes a vagina; and genital reconstructive surgery aims to transform genitalias associated with female sex to those associated with male sex. Transwomen are prescribed two types of hormones—estrogen and anti-androgen (blockers). In case of transwomen, hormone replacement therapy leads to breast growth (variable), decreased libido and erections, and increased percentage of body fat compared to muscle mass. Gender affirmation surgeries for transwomen include mammoplasty (breast enlargement), penectomy (removal of a penis), orchidectomy (removal of testicles), and vaginoplasty (creation of vagina) (WPATH 2011). Hormonal treatment for transgender individuals is individually prescribed by an endocrinologist (excluding cases of self-medication which are not rare) and may last for their whole life, especially, when due to biological conditions and/or surgeries performed the body does not produce its own hormones. Transgender person can opt for full or partial transition (different scales of medical interventions); the choice depends on desire/need for a certain scale of body modifications, health conditions, doctors' advice, accessibility, and availability of medical services, and financial situation (affordability of treatment).

right to get the legal adjustment of their sex description without need to undergo genital surgery. Nevertheless, implementation of existing laws and services provided by the Department of Home Affaires have been widely criticized (Klein 2008; Moloi 2012; Husakouskaya 2013a).

Along with hormone replacement therapy and gender affirmation surgeries, other medical services intrinsically linked to and entailed by transition have to be taken into consideration while conceptualizing transgender people's experiences. These medical services and issues include (but are not limited to) reproductive health, mental health, HIV vulnerability, specific health challenges (as, for example, diabetes, hypertension, embolism for transwomen), necessary recurrent tests, and checkups (for example, to exclude breast/cervical/prostate cancer and prevent any damage hormonal intake can cause) (Newman-Valentine and Duma 2014; Klein 2008, 2014; Muller 2012; Husakouskaya 2013a, b).

Globally, medical treatment of transgender people is regulated by three main documents: International Statistical Classification of Diseases and Related Health Problems (ICD), 10th edition, the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (APA 2013), and the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (SOC), 7th edition (WPATH 2011). The latest version of ICD offers "gender identity disorders" (F64) as a label for a set of diagnoses that transgender people can be diagnosed with. The newest edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, replaced the diagnostic term "gender identity disorder" with ostensibly less pathologizing term "gender dysphoria". The 7th version of the Standards of Care (SOC) released in 2011 provides clinical guidance to medical and mental health providers who serve transgender, transsexual, and gender non-conforming people worldwide. Despite controversies and debates around the SOC, there have been crucial changes and amendments in its last 7th edition including (1) recognition that gender non-conformity is not a disorder; (2) firm position that transition-related treatments (hormone therapy and surgery) should be covered by insurance since they are medically necessary for many individuals; (3) removal of the 3-month requirement for either "real life experience" (living in a congruent gender role) or psychotherapy before access to hormonal care[8]; and (4) attention to lifelong preventive and primary care.

In South Africa, there are no unified specific guidelines for medical treatment of transgender individuals: each hospital (and sometimes each doctor) has its own interpretation of existing globally recognized guidelines. It contributes to unnecessary complexity of different paths and ordeal transgender South Africans face while navigating the medical system to get trans-related treatment. Most of black unprivileged transgender people opt for public health services due to poverty, unemployment, and socioeconomic inequity. This situation reasserts existing segregation and fragmentation of health services along racial as well as class lines mentioned above. In my study sample, only one participant out of 22 went for private health services (hormone replacement treatment and mastectomy) being able to keep good relationship with his

[8] Psychotherapy as an absolute requirement for hormone therapy and surgery was introduced in previous versions of SOC (5th and 6th). In the 7th edition of SOC, it is stated: "A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement" (WPATH 2011: 28).

family and cover his expenses through health insurance of his father (the case was exceptional among my respondents).

The official statistics of transgender individuals in South African is absent. This lack of the statistics not only reflects one of the shortcomings of the post-Apartheid South African health system, but it is grounded on and stems from institutionalized heteronormativity of the census data (Newman-Valentine and Duma 2014). Approximate number of transgender people in South Africa is available through data provided by non-governmental organizations and activist groups (in case they keep databases). Thus, as for June 2013, TIA had a list of 380 transgender constituencies who resided in Gauteng and neighboring provinces. According to Nthabiseng Mokoena, an advocacy coordinator of TIA that time, this number reflected mostly those who had reached the organization in search for information and support to overcome the challenges experienced in the public health medical sector.

Challenges of Transition: Access to Medical Services and Its Effect on Mobility of Transgender South Africans

There are four public hospitals that aim to assist transgender individuals in South Africa. Three of them are located in urban Gauteng: the Steve Biko Academic Hospital in Pretoria, the Chris Hani Baragwanath Hospital, and the Charlotte Maxeke Johannesburg Academic Hospital in Johannesburg. The fourth hospital—the Groote Schuur Hospital Transgender Clinic—operates in Cape Town. Only two hospitals—Steve Biko and Groote Schuur—provide comprehensive services, and the other two offer surgeries only. While there are three hospitals that offer trans-related treatment in Gauteng, there is only one non-governmental organization, Transgender and Intersex Africa (TIA), that explicitly targets transgender constituencies in Gauteng and neighboring provinces providing them with support in medical settings. There are two organizations that assist transgender individuals in (or closer to) Cape Town: GenderDynamiX (GDX) operates in Cape Town and the Social, health, and empowerment feminist collective of transgender, and intersex women of Africa (S.H.E.) is based in the Eastern Cape.[9]

In South Africa, the path for transgender individual to get through medical settings is quite similar to that one in other countries: psychologist → medical panel → endocrinologist → surgeon. Discrimination and mistreatment in the medical settings is a common challenge that transgender South Africans share with their fellows across countries (see, for example, reports from the EU, Russia and Ukraine: Being Trans in the European Union, 2014; Sitnikova 2015; Insight and Husakouskaya 2015). Even though the South African Constitution (1996) has been well-known for its progressive entrenchment of gender, sex, and sexual orientation into the Section 9(3) of the Bill of Rights, abusing power and discriminating against transgender people in the medical (institutional) settings (and far beyond these settings) is quite prevalent in South Africa.

[9] As Nthabiseng Mokoena, an intersex and trans* activist, clarified as for current development in transgender activism in Gauteng: "Iranti has taken up a lot more trans* work and they have become more visible with trans* work ever since they hired Joshua Sehoole as their Human Rights Coordinator. What is more interesting though is that there are more smaller non-NGO based groups and people that are organizing support groups by themselves and that seems to be working for most people, it is great to see people organize outside of the NGO industrial complex" (correspondence from 31 June 2015).

Thus, psychologist (or psychiatrist) holds a powerful position since she or he makes a mental assessment and provides a transgender person with referrals to further doctors. In South Africa, as in many other countries, there are still instances of reinforcing heteronormative gender stereotypes on transgender individuals and practice of "doing gender" (West and Zimmerman 1987) performed by some psychologists/psychiatrists (Stevens 2012; Newman-Valentine and Duma 2014; Klein 2008, 2014; Moloi 2012; Husakouskaya 2013a, b). Some of the doctors keep following previous editions of the Standards of Care (6th and 5th) with its strict unnecessary requirement of long-term experience living in preferred gender. These outdated excessive requirements can result in prolongation of psychological/mental assessment and lead to unnecessary mobility. In South African context, it can also heighten the probability of violence towards transgender individuals while they are traveling to hospital to access medical services (especially if they are not on hormones yet waiting for a referral letter from the very same psychologist and therefore are not passing[10] well) (Husakouskaya 2013a). In case of transgender people in South Africa, discrimination, misunderstanding, and mistreatment are among the most pivotal factors not only for movement from one hospital to another but also for deferring and postponing necessary medical treatment (Stevens 2012; Moloi 2012; Husakouskaya 2013b).

The shortage of medical specialists working with transgender individuals is still common across the country. Especially, it concerns surgeons who would be able to perform gender affirmation surgeries. As the Desmond Tutu HIV foundation's report emphasizes, "only two South African public specialist centers provide gender reassignment surgery, and these do not meet the demand" (Scheibe et al. 2011). Possible transfer from one public clinic to another becomes very intricate transition in itself and usually requires to start all assessment and treatment from scratch with(in) a new hospital (Husakouskaya 2013a). The availability of "bottom" surgeries (i.e., genital reconstructive procedures) is very relative since quality of the surgeries is deemed to be very low. Thus, transwomen who can afford it prefer to travel to Thailand for getting their surgeries done (informal talk with Nthabiseng Mokoena, January 2013).

Other limited capacities of the public health sector include insufficient medication and theater time allocated for surgeries. Insufficient medication can lead to irregularity of treatment that has to be regular (tests, hormonal intake) and/or self-medication such as usage of contraception pills instead of prescribed hormones in case of transwomen (based on discussion during TIA's outreach program in Mpumalanga, February 2013). Limited theater time allocated for surgeries (in case of the public health sector with free services offered) entails long waiting lists for transgender individuals to be registered in the system and assisted. As GenderDynamiX claims, there is 25 years waiting list for transgender people in South Africa to receive transition surgeries.[11]

The localization of public hospitals that can provide transgender related medical services in Johannesburg and Pretoria along with lack of medical resources and professional capacities in rural areas induce transgender people (especially from five neighboring provinces) move permanently, temporarily, or repeatedly towards

[10] "Passing" in case of transgender individuals refers to one's ability to be perceived by others as the gender one identifies as (for example, as a cisgender man or a cisgender woman).

[11] See http://www.news24.com/Live/SouthAfrica/News/25-year-waiting-list-for-transgender-people-in-SA-to-get-transition-surgery-20150604. Accessed 10 August 2015.

Johannesburg and Pretoria. Due to discrimination, mistreatment, and shortage of available services, there is also mobility occurring on microlevel (movements from one doctor to another and shifts from one hospital/clinic to the other). Based on my data, I suggest two types of mobility patterns that transgender South Africans prefer to pursue while considering access to medical services. The first pattern is a permanent/temporary (for a year or longer) movement from “home” place to Johannesburg or Pretoria when a person can be considered an *internal migrant*. The second pattern is a circular repetitive routine movement from “home” to Johannesburg or Pretoria and back. This type of a mobile pattern can be attributed to an *internal traveler*. In this case, a person does not consider moving or staying in Johannesburg or Pretoria longer than a day or two though mobility plays out a crucial role in a person’s life due to the need to access medical treatment pertaining to transition on a regular basis. In both mobility patterns, difference between urban (“townships” are included in urban settings) and rural homes a person is moving from is an important variable defining challenges and experiences one is facing. Therefore, four types of transgender South Africans who move internally can be derived: urban-urban internal migrant, rural-urban internal migrant, urban-urban internal traveler, and rural-urban internal traveler. Transgender South Africans who participated in my research had diverse mobility patters: among them, there were rural-urban travelers (7), rural-urban internal migrants (4), urban-urban internal migrants (6), and non-migrants (5).

Transgender Internal Migrants in Urban Gauteng: Experiences of Transition and Sense of Belonging

The growing concern with “belonging” in South Africa converges its colonial past and post-colonial realities. Under British colonial and Afrikaner nationalistic rules belonging was part of denaturalization “processes through which black people in South Africa came to be considered as “foreigners” – that is, migrant labour who belong elsewhere” (Pillay 2004, 216). As Thomas Blom Hansen remarks, “Black South Africans were defined as “foreign natives” within the country, guests of the white South African Republic, visiting from their designated homelands (Bantustans) that had been set up along lines of “tribe”, custom and language” (Hansen 2014, 280). In post-Apartheid South Africa, belonging has been heavily deployed (probably similar to European context) through diverse socio-political mechanisms to distinguish “insiders” and “outsiders” (“us” and “them”) (Amit and Bar-Lev 2014). Thus, in 2008 and 2015, these tensions and renegotiation over belonging lead to burst of xenophobic violence in South Africa.

Within migration studies, belonging as a concept is conventionally employed to approach experiences of cross-border migrants who negotiate their meaning of home and build relations through which they “can make claims to reside in and possibly access means of livelihood” in the host country (Rutherford 2011, 1305). In the global North, much of migration research on belonging has been combined with implicit or explicit discussion on (better) integration and challenges of multiculturalism (Orton 2012; Alleyne 2002; Weingrod and Leỵi 2006). This approach traces back to politico-economical concerns and moral panics over immigration that have been rampant over the last decade in wealthy Western/Northern European countries. Moreover, this way of

analyzing belonging resides in a very clear division between host and migrant population. As Madhavan and Landau (2011) point out, recent vast and fast urbanization in Africa having migration and mobility as its critical variables is characterized by blurred boundaries between so-called host and migrant communities (Madhavan and Landau 2011: 473). In many instances, the host community can be considered as not self-evident and unidentifiable. In addition, comparing to the global North, there is a different dynamic and balance at play among various groups of migrants in many African countries. For example, it is recognized that the predominant mode of migration in southern Africa is circular migration when young men move to urban area periodically returning home (Lurie 2006: 650). Also, as it was discussed in the very beginning of the article, internal migrants in South African context outnumber international movers. Importantly, as Madhavan and Landau note "there may be little difference between domestic and international movers in terms of livelihood strategies and institutional relations" (Madhavan and Landau 2011: 474).

In the following section, drawing on my field data gathered in 2012–2013, I explore experiences of migration of transgender internal migrants focusing on analysis of their transitions (both spatial and gendered) and ways they sense and negotiate their belonging while going through these transitions.

Becoming a Transgender Internal Migrant in Urban Gauteng: Subjective Meaning of "Migration"

Transgender internal migrants' narratives occasionally highlight the similarity of challenges that internal and cross-border migrants encounter in South African context. Based on my data, I argue that in some instances, there is little difference between cross-border and transgender internal movers in South Africa, in particular, when we take into consideration their reason to move and their sense of linguistic belonging.

Many transgender participants underlined language barrier as a predicament in forging sense of belonging ("being from here") and in navigating urban spaces. The South African context is linguistically distinctive. There are 11 official languages (English, Afrikaans, Zulu, Xhosa, Tswana, Tsonga, Sotho, Swati, Northern Sotho, Venda, and Southern Ndebele) with particular geographic distribution of languages and intense mix in urban areas (in particular in multicultural urban Gauteng). Thus, in North West, a predominant language is Tswana (63.4 %); in KwaZulu-Natal—Zulu (77.8 %); in Limpopo—Sotho (52.9 %); in Mpumalanga—Swati (27.7 %) and Zulu (24.1 %); and in Gauteng—Zulu (19.8 %) with Johannesburg being predominantly Zulu speaking and Pretoria Sotho speaking cities (Census 2011). This linguistic diversity makes experience of internal migrants close to one of cross-border movers when language becomes a matter of concern. An account from a transman, urban-urban internal migrant, sums up this experience: "And also the language barrier… most people could speak Zulu and Zulu is predominantly spoken in Joburg and KwaZulu Natal, but I am seTwana and I can only speak Tswana… in Pretoria I can walk in shop and ask for something and I know the other person will understand me. In Joburg the first couple of weeks just getting the taxi was a nightmare because I am speaking to this taxi drivers and they very insistently only speak Zulu. I don't understand what they're saying. And getting around was a bit problematic… The language barrier especially

without family it could be felt like to be in a foreign place" (March 2013). Noteworthy, none of the participants mentioned language barrier as an obstacle *within* the medical system, experience often referred to in case of cross-border migrants in South Africa (Vearey and Nunez 2010; Crush and Tawodzera 2014).

Cross-border migrants in South Africa are often portrayed as those who move in order to access health care when in fact, they look for employment and usually have better health than so called host population (Vearey 2011). Similarly, my data suggested that in many instances for internal migrants (not travelers), access to health care was not the main (or the only) concern for relocation. Transgender participants who considered temporal or permanent move to urban Gauteng were looking for job opportunities that would allow them to secure sustainable access to medication and give the possibility to opt for the private medical sector if needed. As it was discussed, being South African citizen does not necessarily provide an advantage for internal migrants when it comes to integration and job seeking (Madhavan and Landau 2011; Myroniuk and Vearey 2014). Similarly, transgender internal migrants mentioned high costs of living, scarcity of available jobs, and lack of support networks among the reasons they would migrate from one area to another within urban Gauteng, return home, or stay/become internal traveler.

At the same time, experiences of transgender internal migrants differ from those of cisgender and/or heteronormative internal or cross-border movers[12]. The major challenges mentioned in the narratives of transgender participants who moved to (or within) urban Gauteng were tied to their gender identities and gendered transition: discrimination based on their gender non-confirming appearance (in public transport, medical settings, local communities, job market); broken or loose ties with their families and communities back home; and difficulties to build comprehensive sense of belonging and sustainable support networks in a new place of arrival (urban Gauteng) either through religious institutions or within LGBT communities.

In fact, for majority of the participants, the very possibility to call themselves "internal migrants" stemmed from hardships they had endured due to co-dependent and co-existent transitions—gendered and spatial. At first, all participants (during interviews and focus group discussions) unanimously attributed the category of "migrant" to experiences of cross-border movers. This perception mirrored popular media discourse, widespread understanding of migration in South African LGBT movement, and echoed predominant occupation of migration studies with cross-border migrants in post-Apartheid South Africa. After discussions, "internal migrant" as an identity was unpacked and taken up by some of the participants based on their subjective adjustment of the term to their experiences of mobility, gendered transition, and settlement (even though sometimes temporal) in new settings in urban Gauteng.

[12] Cisgender as a term describes a type of gender identity when one's experience and self-realization of own gender matches the sex one was assigned at birth. Cisgender is usually used in opposition to transgender experience. Heteronormativity refers to the system of beliefs that involves alignment of biological sex, sexuality, gender identity, and gender roles. It is characterized by firm believe that (1) people fall into two distinct and complementary genders (man and woman); (2) man and woman have natural roles in life; (3) heterosexuality is the only sexual orientation and/or only normal sexual orientation; (4) sexual and marital relations are most (or only) fitting between people of opposite sexes.

A transwoman who had relocated from a township of Johannesburg to Pretoria had a tough time trying to access medical treatment and was routinely discriminated against in the area where she lived in Pretoria. Therefore, on my question whether she would consider herself an internal migrant, she gave a positive answer. A transman who had moved from a township of Pretoria to Johannesburg, on the contrary, was quite reluctant to the idea of "becoming" an internal migrant. Firstly, he used an argument that "[he hadn't] left the country, [he hadn't] even left the province." Afterward, he specified that the reason he felt uncomfortable being labeled as migrant was that he still stayed with (part of) his family in Johannesburg and he had a choice to move back to Pretoria. As he explained it to me: "If I didn't have family in Joburg and my family all lived in Pretoria and I moved to Joburg where I had no support base and I was coming there because I had to do surgery and had to live in Joburg because of surgery and then to come back home or travel between places may be I would say 'yes'. But because I am moving from a place where I have family support and structure to another place where I have the same family support and structure I don't feel like it's migration, because it's still a whole and I've still got family there [in Pretoria – N.H.] and I have support in Joburg" (transman, urban-urban internal migrant, February 2013).

Thus, the movement itself (i.e., relocation to a new area) was not indicative and sufficient for the transgender participants to adopt the term "internal migrant." In case of transgender internal migrants in urban Gauteng, experience of migration, or rather the possibility to frame their experience of movement as migration, was tightly linked to sense of (non)belonging, i.e., to dynamic subjective sense of being (or not) part of a physical or imaginary social group and/or place (Black 2002). Those participants who upheld this identity emphasized their struggle to negotiate their belonging in/to multiple interconnected spaces: family/home, local ("host") community, LGBT community, and religion/spirituality.

Envisioning Home, Re-inventing the Family

In transgender internal migrants' narratives, "home" was envisioned ambiguously. On the one hand, some participants pictured "home" as a place that could grant feeling of being safe and protected. This experience of home as a place familiar and easier to navigate was highlighted many times by travelers when they explained why they would not consider making a permanent move to cities (Johannesburg or Pretoria). As one of my respondents, rural-urban internal migrant, described it: "That's the other issues about the rurals that I love so much: we are all interlinked and interconnected. Everybody knows who you are, everybody knows whose child you are, where your house is… so you are safe… even though my gender was questioned all the time I never felt unsafe, because – 'fine this is this child we don't know what she is but we know she is a child of so and so and we respect and by the way her uncle is so dangerous don't mess with him'…And you go to a tavern and you talk and you can talk to anyone and you can get drunk as much as you want and we walked all the way at our homes you know… it was fine… I can't do that in [name of the township in urban Gauteng] … and you can never feel safe… and as a migrant again when I do not know anyone at the area it is a major challenge for me, it has major psychological impact on my life…" (April 2013).

On the other hand, some transgender internal migrants conceptualized distance ("being far from home") as one of the ways they could come to terms with and ascertain their identities, align their gender expression with preferred gendered mode of being ("be who they are"), reduce psychological pressure they had been enduring at home, and balance their relationships with family members (especially in cases when families were not supporting/accepting). Some of transgender internal migrants stated that one of the key triggers for their movement was to avoid further tensions within family and/or community. One of transwomen shared her experience: "I guess I can say that distance made them [family – N.H.] feel comfortable because I wasn't there anymore always in their face. And people were not talking about them, may be not seeing them as parents that cannot discipline their child…" (urban-urban internal migrant, April 2013).

"Home" can be conceptualized as "an imagined or desired locus of belief and yearning" (Amit and Bar-Lev 2014, 2), a real place and/or an imagined space that encompass emotional, spiritual, patriotic loci of subjectivity (Sigmon et al. 2002; Duncan and Lambert 2004). Within this conceptual and semantic framework, the participants repeatedly mentioned "home" referring to "family" (i.e., being part of and belong to the family) and Africa (being African, sometimes also "being black").

Family (not only parents and siblings but also community as an extended family) was a starting point of narratives and the most emotional part of the stories. Family acceptance, its structure, and socio-economic background had huge influence on mobility patters of transgender internal migrants, their mental health, level of accessibility and affordability of medical services, degree of their psychological comfort, and also on ways they voiced importance of reproductive choices.

Transgender internal migrants prompted to reconfigure and redefine how they saw and perceived "family" and whom they could turn to for support, advice, and shelter while considering access to medical services and/or movement. Such non-biological understanding of belonging/kinship was perfectly depicted by a transgender participant living in extended family with his step-mother and step-sister: "I think with my family I've learnt that a family isn't created by bond of blood… so I don't feel like you have to be biologically related to be a family. And I think this one of the things that you kind of learn and it kind of supports you when you are queer, especially if you're coming from a family which is not accepting of what you are going through. The community becomes a family. Like people that you meet that are going through the same things, you become like family" (transman, urban-urban internal migrant, April 2013). A transwoman, rural–urban traveler, echoed this idea of transgender community becoming a family: "I think accommodating trans people to my place when they come and visit me is my family – give them the love which they don't have" (February 2013).

In South Africa, transgender people share with gay and lesbian individuals experience and fear of discrimination and gender-based violence stemmed from prevalent sexism, homophobia, transphobia, and prejudice that being gay/lesbian/trans/gender non-conforming is unAfrican (Western) pattern of behavior (Human Rights Watch 2011; Naidu and Mkhize 2005). Paradoxically, transgender participants indicated that they often felt excluded from so called LGBT spaces and, therefore, could not establish strong support networks or develop profound sense of belonging to gay and lesbian communities. Their reflections supported evidences of systematic sidelining of transgender constituencies by the main LGBT actors in Johannesburg and Pretoria (Husakouskaya 2012). Moreover, their

narrated experiences unpacked everyday transphobia and sexism occurred *within* so called LGBT community (not just outside of it). In interview, a transwoman outlined how gender identity of transgender individuals was often contested, misinterpreted, and misunderstood by gay and lesbian people: "I felt that they really dismiss who you say you are. You'll have a gay person who would ask you – 'but why you have to change yourself?' And you are like – 'no, I am not changing myself, I am just aligning myself, I am just making inside and my heart and mentally to one with what's in outside'… A lesbian woman would say – 'I can't see you as a woman until you fully have transitioned, as long as you have parts of a male you are male'. And a gay guy would say – 'the chromosomes would always be XY you know you are never be a woman in my eyes, you just another gay guy with breasts'…" (transwoman, urban-urban internal migrant, March 2013).

During the focus group discussion in February 2013, a transman caught this frustration over non-belonging to neither homosexual nor heterosexual spaces through "in-betweeness" which was common in narratives of many transgender participants: "There are always these empty spaces. Even when you are with lesbians you never belong. And you don't belong to straight people. So it's that loss in always being in-between."

Supporting Yourself: Social Networks and Spiritual Transition

In case of transgender internal migrants, tensions and negotiations over their gender identities with families and gay and lesbian communities are often exacerbated by lack of social circles, social capital, and support networks in a new place of living. Putnam (2000) conceptualizes social capital through level and strength of engagement of an individual in formal groups in the community and degrees of trust among community members. The cause-and-effect relations between social networks and health have been well-theorized in migration studies showing how social networks and social capital impact health and health behaviors (Berkman et al. 2000; Carpiano 2006). Transgender respondents' narratives in many instances supported the idea that absence of trustful and stable social networks while in transition (both gendered and spatial) had direct impact on their health since it decreased ability to cope in challenging situations (including going through medical transition), prevented from building trustful relationships (in the community and with intimate partners), increased psychological vulnerability, and in some cases impeded accessing medical services. A transman eloquently described his ordeal of going through hormonal replacement treatment coupled with the move to Johannesburg: "I started hormones <…> and it was difficult because I had to learn new things by myself. I didn't have friends. I was in isolation… even those things were exactly what I wanted, but the process itself it was hard, it was not easy" (urban-urban internal migrant, February 2013).

Based on formal and informal interviews and focus group discussions, I argue that the main predicament for building up ties with the new community for my participants was not necessarily spatial otherness ("being not from the area") but rather gender non-conformity and the fear of gender-based violence which has been highly prevalent in South Africa (Human Rights Watch 2011; Naidu and Mkhize 2005). There is one of many accounts of impossibility to strengthen social ties and build friendship due to caution, fear of being discriminated against, and threat of physical violence: "[Back

home] I had a friend who was always there for me and no matter what understood me. And in Pretoria I had to be careful for who I friend and what I tell people about me… I have to be very careful who I make friends with. So it was still very hard for me to socialize, personally I felt like – ‘okey I can be myself but there is a certain line I have to draw’ which is something I never really imagined for my life you know” (transwoman, urban-urban internal migrant, April 2013). Troubling relations with gay and lesbian communities and exclusion of trans-related concerns from LGBT organizations’ agenda contributed to insecurity and intensified isolation of transgender individuals in move.

Religion (religious beliefs) was another important locus of desired belonging expressed by participants. All the participants—in interviews, focus group discussions, and literally in their drawings—placed “God” as one of the key elements of their life narratives. While unpacking meaning of “God” the participants referred to spectrum of senses from religiously dogmatic to fluid and spiritual. Religion has been explored within migration studies mostly tackling international migrant flows to reveal discursive mechanisms that constitute religion as one of the facets of otherness (along with physical appearance and culture) occurring when migrants meet the host society and to prompt incorporation of religious and ethnic minorities into societies in Western/Northern Europe and North America (Hansen 2014). Other strand of migration research has been examining how religion contributes to place making in the diaspora stimulating debates on role of the religion in shaping and mapping migrants journeys, “constructing their identities and facilitating their embeddedness at multiple scales across transnational social fields” (Vásquez and Knott 2014, 344). Migration shapes religious beliefs, practices, and discourses of those in the move, while in turn, “different religious traditions provide different resources for making sense of and validating the migrant journey” (Wong 2014, 308).

Transgender internal migrants perceived religious groups as one of the social and spiritual spaces that can provide smooth integration into a new community and pave ways for maintaining sense of belonging and building support networks. The term of “spiritual transition” was proposed by one of the participants—a transman, urban-urban internal migrant—to capture the need for transgender/gender non-confirming person to negotiate spirituality while undergoing gendered transition (either through medical procedures or through coming out to the community).

Spiritual transition (and spiritual belonging) occurred during discussions and interviews as desire to be accepted into chosen church/religion. The participants from families with dogmatic religious background noted intense tensions accompanied their coming out as transgender people to their families. The very process of coming out was described as stressful, challenging, and emotionally draining due to fears of being denied, disowned, and humiliated. In many cases, reaction of family members (if based on religious grounds) and members of religious community were very negative, and in some instances, it incited transgender people to move to urban Gauteng in search for more accepting communities. Although only one participant was able to find supportive religious network by shifting to another religion (from Christianity to Reform Judaism): “I feel very at home in my religion and my Synagogue. I don’t feel judged or anything. When I told my rabbi I was transitioning and I was gonna change my name, he was like ‘we should probably have like a naming ceremony’. They wanted to be it like the thing when community kind of involved so that they can understand when I don’t use the

female bathroom. And also Tswana is very gender neutral and Hebrew is very gendered language, and the way I would be referred to and the way I'd be quoted in the Tora will change as well… So it makes sense kind of to have public **spiritual transition** as well. Big thing about Judaism is the community – it's not just about my relationship with God, it's my relationship with the community you know… You have just like **spiritual family** as well – it's nice" (transman, urban-urban internal migrant, March 2013; highlights are mine – N.H.)

Other, more common, path to negotiate spiritual belonging was to leave organized religion as such and figure out one's own spirituality, to find "a special place with God." As one of the participants explained it to me: "I believe in God and I believe in Jesus, in other words I am Christian, so I pray to God, I pray to Jesus, but I chose to stay away from organized religion in any form, I chose not to go to church, and I've come to this point in my life when I can criticize what the Bible says and I am not guilty about it. I believe that at the moment I've chosen a spiritual path and this path is Christian, but that is my spiritual path and I don't have a right to enforce it on anyone and I don't want anyone to enforce theirs on me…I am simply spiritual…" (intersex person, rural–urban internal migrant, April 2013).

Another crucial site of spiritual transition (and spiritual belonging) was expressed through the need to be (re)introduced to ancestors under a new name and new (affirmed) gender (according to traditional African beliefs). One of the hottest discussions during the Mpumalanga outreach program was centered precisely on anxiety of being left without ancestors' protection and becoming lost/invisible in intergenerational family history. Even though quite a number of transgender people are accepted in the community as sangomas (traditional healers), the problem of being denied the chance to reconnect with ancestors through particular rituals reoccurred as a great matter of concern. This did not apply only for rural areas. A transman living in urban settings (non-migrant) describes a painful situation being disowned by his father and left without spiritual protection: "…if you believe that how it goes. Like we believe we have ancestors, and ancestors, they can plead on your part to God if something is going on… That what we do: we go to the grave side, speak to our grandparents, and we slaughter an animal you know, and we go home… I mean it makes sense, it makes sense for me, you have to go and tell them as it is, like – 'look, you see this person that you've always known this way, this was about to happen and with your blessing.'… you know … so I thought my father would wanted to do that. He didn't… I mean if you really believe in it you as a parent you are supposed to like (*crying*)… you must make your ancestors meet your children and you make sure they have protection over their lives … and my father, he never did it" (March 2013).

This importance and different forms of spiritual belonging found in narratives of transgender internal migrants widens understanding of belonging and transition and shows how (internal) migration can be interlinked with negotiations (both with oneself and with family/community) over spirituality, sexuality, and gender identity.

Conclusion

This article reflected on experiences of black unprivileged transgender internal migrants in urban Gauteng and thus aimed to bridge certain gaps in South African migration

studies pertaining to (non)intersection of health, (internal) mobility, and gender. Specific medical framework for transgender individuals along with shortcomings of the public health sector in South Africa results in challenges in accessing medical services that prompt transgender people to take up different mobility patterns (permanent/temporal move to urban Gauteng or traveling pattern). In case of transgender internal migrants, experience of migration, or rather the possibility to frame their experience of movement as migration, is tightly linked to sense of (non)belonging, i.e., to dynamic subjective sense of being (or not) part of a physical or imaginary social group and/or place (Black 2002).

Analysis of transgender internal migrants' narratives proves certain similarities between experiences that internal and cross-border migrants encounter in South African context. At the same time, their experiences differ from those of cisgender and/or heteronormative internal or cross-border movers. There are distinctive challenges that shape migration (and its understanding) in case of those South Africans who undergo gendered and spatial transition. Many of these challenges stem from their gender identities, gender expression, and their attempts to negotiate belonging in/to multiple spaces: family/home, local (host) community, LGBT community, and religion/spirituality.

The undertaken analysis prompts to revise heteronormative and cis-sexist frameworks in current South African migration studies, to include sexuality beyond the discourse of medicalization, trafficking, sex work, and "vulnerabilities," and to explore further variations of gender identities and sexualities related to and intertwined with spatial transition/mobility.

Acknowledgments I would like to acknowledge the support of the African Centre for Migration and Society (ACMS) at the University of Witwatersrand where I was affiliated as a visiting researcher from August 2012 till June 2013. My deep appreciation goes to the Pretoria-based NGO Transgender and Intersex Africa (TIA) for all their efforts and arrangements that made the fieldwork possible. I thank my supervisor Dr. Joanna Vearey and my colleague and friend Nthabiseng Mokoena for being with me all the way in this journey. I pay tribute to all the amazing participants that shared their stories. Finally, I extend thanks to the anonymous reviewers for their valuable and thoughtful comments.

References

Alleyne, B. (2002). An idea of community and its discontents: towards a more reflexive sense of belonging in multicultural Britain. *Ethnic and Racial Studies, 25*(4), 607–627.

American Psychiatric Association (APA) (2013) Diagnostic and statistical manual of mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing.

Amit, K., & Bar-Lev, S. (2014). Immigrants' sense of belonging to the host country: the role of life satisfaction, language proficiency, and religious motives. DOI 10.1007/s11205-014-0823-3. Published on-line 19 November 2014. https://www.academia.edu/9483804/Immigrants_Sense_of_Belonging_to_the_Host_Country_The. Accessed 10 August 2015.

Amit, R. (2010) Protection and pragmatism: addressing administrative failures in South Africa's refugee status determination decisions, FMSP, research report. http://www.rcusa.org/uploads/pdfs/fmsp_protection_and_pragmatism_report_april_2010_doc_2.pdf Accessed 10 August 2015.

Amit, R. (2011). No refuge: flawed status determination and the failures of South Africa's refugee system to provide protection. *Internaional Journal of Refugee Law, 23*(3), 458–88.

Being Trans in the European Union. Comparative analysis of EU LGBT survey data (2014). http://fra.europa.eu/sites/default/files/fra-2014-being-trans-eu-comparative-0_en.pdf Accessed 10 August 2015.

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*(6), 843–857.

Black, R. (2002). Conceptions of "home" and the political geography of refugee repatriation: between assumption and contested reality in Bosnia-Herzegovina. *Applied Geography, 22*, 123–138.

Carpiano, R. M. (2006). Toward a neighbourhood resource-based theory of social capital for health: can Bourdieu and sociology help? *Social Science and Medicine, 62*, 165–175.

Census 2011 Statistical release – P0301.4. Statistics South Africa. Published on-line http://www.statssa.gov.za/publications/P03014/P030142011.pdf Accessed 27 April 2016.

Constitution of South Africa 108-1996. http://www.info.gov.za/documents/constitution/1996/a108-96.pdf. Accessed 15 June 2013.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *Lancet, 2009*(374), 817–34.

Crush, J., & Tawodzera, G. (2014). Medical xenophobia and Zimbabwean migrant access to public health services in South Africa. *Journal of Ethnic and Migration Studies, 40*(4), 655–670.

Department of Health, (2002). Inquiry into the various Social Security Aspects of the South African Health System. http://www.info.gov.za/view/DownloadFileAction?id=123928 and http://www.doh.gov.za/docs/reports/2002/inquiry/sahs.pdf. Accessed 10 August 2015.

Duncan, J. S., & Lambert, D. (2004). Landscape of home. In J. S. Duncan, N. C. Johnson, & R. H. Schein (Eds.), *A companion of cultural geography* (pp. 382–403). Malden: Blackwell.

Hansen, T. B. (2014). Migration, religion and post-imperial formations. *Global Networks, 14*(3), 273–290.

Human Rights Watch Report (2011). We'll show you you're a woman. Violence and discrimination against black lesbians and transgender men in South Africa. http://www.hrw.org/sites/default/files/reports/southafrica1211.pdf. Accessed 10 August 2015.

Husakouskaya, N. (2012). South African LGBT(I) movement today: sexuality, health and migration (non)intersections', ACMS, University of Witwatersrand: Johannesburg. http://uib.academia.edu/NadzeyaHusakouskaya/Internships. Accessed 10 August 2015.

Husakouskaya, N. (2013a). Becoming a transgender/intersex internal migrant in urban Gauteng: challenges and experiences of transition while seeking access to medical services. MA Thesis. https://uib.academia.edu/NadzeyaHusakouskaya/Thesis. Accessed 10 August 2015

Husakouskaya, N. (2013b). Rethinking gender and human rights through transgender and intersex experiences in South Africa. *Agenda*, 2013, 1–15.

Insight & Husakouskaya, N. (2015). Documentation of cases of discrimination in the field of access to health in the process of gender recognition procedure in Ukraine. Repost. http://www.insight-ukraine.org/wp-content/uploads/2015/07/reaserch_transgender_2015_eng.pdf. Accessed 10 August 2015.

Jinnah, Z. (2012). Entering sacred spaces: understanding the meanings of, and claims for sexual and reproductive health rights amongst Somali women in Johannesburg. http://www.migration.org.za/publication/conference-paper/2012/entering-sacred-spaces-understanding-meanings-and-claims-sexual-an. Accessed 10 August 2015.

Kim, H.L. (ed.) (2011) Indigenous comments on the standards of care for gender identity disorder, Sixth Version, GDX, Cape Town. http://www.genderdynamix.org.za/wp-content/uploads/2013/05/Indigenous-Comments.pdf. Accessed 10 August 2015.

Klein, T. (2008). Querying medical and legal discourses of queer sexes and genders in South Africa. *Anthropology Matters Journal, 10*(2), 1–17.

Klein, T. (2014). Who decides whose gender? Medico-legal classifications of sex and gender and their impact on transgendered South Africans' family rights. *EthnoScripts*, 2012, 12-34. https://www.ethnologie.uni-hamburg.de/forschung/publikationen/ethnoscripts/es-14-2/es-14-2-klein.pdf. Accessed 10 August 2015.

Landau, L. B. (2008). Regional integration, protection and migration policy challenges in South Africa. In Handmaker, J., de la Hunt, L.A. and Klaaren, J. (Eds.), *Advancing Refugee Protection in South Africa*, 27–46.

Landau, L. B. (ed) (2011). *Exorcising the Demons within: Xenophobia, Violence and Statecraft in Contemporary South Africa*, United Nations University Press.

Lurie, M. (2006). The epidemiology of migration and HIV/AIDS in South Africa. *Journal of Ethnic and Migration Studies, 32*(4), 649–666.

Madhavan, S., & Landau, L. (2011). Bridges to nowhere: hosts, migrants, and the chimera of social capital in three African Cities. *Population and Development Review, 37*(3), 473–497.

Mayosi, B. M., Lawn, J. E., van Niekerk, A., Bradshaw, D., Karim, S. A., & Coovadia, H. M. (2012). Health in South Africa: changes and challenges since 2009. *Lancet, 380*, 2029–43.

Middleton, J. & Palmary, I. (2008). Gender based persecution in the South African Asylum System. FMSP, Special Report №3, pp. 1 – 61. http://www.migration.org.za/report/middleton-j-palmary-i-2008-gender-based-persecution-south-african-asylum-system-fmsp-research. Accessed 13 June 2013.

Misago, J. P. (2009). Xenophobic violence in South Africa: reflections on causal factors and implications. *Policy Studies Bulletin of the Centre for Policy Studies, 10*(3), 3–9.

Misago, J.P. (2011). Disorder in a changing society: authority and the micro-politics of violence. In Landau, L.B. (Ed.), *Exorcising the Demons within: Xenophobia, Violence and Statecraft in Contemporary South Africa*, United Nations University Press.

Moloi, L. (2012) KwaZulu natal transgender and gender non-conforming needs assessment report 2012. Unpublished report, Gender DynamiX (GDX) project, Cape Town.

Muller, A. (2012). Sexual health for transgender & gender non-conforming people. A booklet, Gender DynamiX (GDX) project, Cape Town. http://www.genderdynamix.org.za/wp-content/uploads/2013/05/GDX-Safer-Sex-Bklt-Eng.pdf. Accessed 20 May 2013.

Myroniuk, T. W., & Vearey, J. (2014). Social capital and livelihoods in Johannesburg: differential advantages and unexpected outcomes among internal migrants, foreign-born migrants, and long-term South African residents. *International Migration Review, 48*(1), 243–273.

Naidu, E., & Mkhize, N. (2005). Gender-based violence: the lesbian and gay experience. *Agenda, 61*(1), 34–38.

Newman-Valentine, D., & Duma, S. (2014). Injustice to transsexual women in a hetero-normative healthcare system. *African Journal of Primary Health Care and Family Medicine, 6*(1), 1–5.

Nunez, L., Vearey, J., & Drimie, S. (2011). Who cares? HIV-related sickness, urban-rural linkages, and the gendered role of care in return migration in South Africa. *Gender and Development, 19*(1), 105–114.

Oliveira, E. (2011). Sex work and HIV. *Equal Treatment, 38*, 16–17.

Oluwafemi, A. (2011). HIV/aids health exclusion of forced migrants: a challenge to human rights. *Oxford Monitor of Forced Migration, 1*(2), 47–50.

Orton, A. (2012). Building migrants' belonging through positive interactions. A guide for policy-makers and practitioners. Connecting recognition, participation and empowerment to improve social cohesion. Council of Europe Policy Document. http://www.coe.int/t/democracy/migration/Source/migration/EnglishMigrantBelongingWeb.pdf. Accessed 10 August 2015.

Palmary, I. (2008). Gender, race and culture: unpacking discourses of tradition and culture in UNHCR refugee policy. *Annual Review of Critical Psychology, 6*, 125–133.

Pillay, S. (2004). Where do you belong? Natives, foreigners and apartheid South Africa. *African Identities, 2*(2), 215–232.

Polzer, N. T., & Segatti, A. (2011). From defending migrant rights to new political subjectivities: gauteng migrants' organisations after May 2008. In Landau, L.B. (ed.), Exorcising the Demons within: Xenophobia, Violence and Statecraft in Contemporary South Africa, United Nations University Press.

Putnam, R. D. (2000). *Bowling alone*. New York: Simon & Schuster.

Richter, M., & Chakuvinga, P. (2012). Being pimped out—how South Africa's AIDS response fails sex workers. *Agenda: Empowering women for gender equity, 26*(2), 65–79.

Richter, M. & Vearey, J. (2011). Submission to the global commission on HIV and the law. http://www.migration.org.za/publication/miscellaneous/2011/submission-global-commission-hiv-and-law. Accessed 13 June 2013.

Richter, M., Chersich, M. F., Scorgie, F., Luchters, S., Temmerman, M., & Steen, R. (2010). Sex work and the 2010 FIFA World Cup: time for public health imperatives to prevail. *Globalization and Health, 6*(1), 1–6.

Rutherford, B. (2011). The uneasy ties of working and belonging: the changing situation for undocumented Zimbabwean migrants in northern South Africa. *Ethnic and Racial Studies, 34,8*, 1303–1319.

Scheibe, A., Brown, B., Duby, Z., Bekker, L. (2011). Key populations, key responses. A gap analysis for key populations and HIV in South Africa, and recommendations for the national strategic plan for HIV/AIDS, STIs and TB (2012-2016), Desmond Tutu HIV Foundation. http://www.desmondtutuhivfoundation.org.za/documents/Key-Populations-Key-Solutions-report.pdf. Accessed 13 June 2013.

Sigmon, S. T., Whitcomb, S. R., & Snyder, C. R. (2002). Psychological home. In A. T. Fisher, C. S. Sonn, & B. J. Bishop (Eds.), *Psychological sense of community: Research, applications and implications* (pp. 24–41). New York: Kluwer.

Sitnikova, Y. (2015). Psychiatric abuse of transgender people in Russia. https://www.opendemocracy.net/od-russia/yana-sitnikova/psychiatric-abuse-of-transgender-people-in-russia. Accessed 10 August 2015.

Stevens, M. (2012) Transgender access to sexual health services in South Africa: findings from a key informant survey', report by Gender DynamiX (GDX) project, Cape Town. http://www.genderdynamix.org.za/wp-content/uploads/2012/10/Transgender-access-to-sexual-health-services-in-South-Africa.pdf. Accessed 10 August 2015.

The alteration of sex description and sex status act, no. 49 of 2003. http://www.info.gov.za/view/DownloadFileAction?id=68026. Accessed 13 June 2013.

The World Professional Association for Transgender Health (WPATH) (2011) Standards of care for the health of transsexual, transgender, and gender nonconforming people, 7th Version'. http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf. Accessed 20 May 2013.

Vásquez, M. A., & Knott, K. (2014). Three dimensions of religious place making in diaspora. *Global Networks, 14*(3), 326–347.

Vearey, J. (2013). Migration, urban health and inequality in Johannesburg. In Bastia, T. (Ed.), *Migration an Inequality*, (pp. 121–144) Routledge.

Vearey, J. (2011). Learning from HIV: exploring migration and health in South Africa. *Global Public Health: An International Journal for Research, Policy and Practice, 6*(3), 1744–1706.

Vearey, J., & Nunez, L. (2010). Migration and health in South Africa: a review of the current situation and recommendations for achieving the world health resolution on the health of migrants. FMSP, Report, 1-67. http://www.migration.org.za/report/vearey-j-and-nunez-l-2010-migration-and-health-south-africa-review-current-situation-and-reco. Accessed 10 August 2015.

Vearey, J., Nunez, L., & Palmary, I. (2009). HIV, migration and urban food security: exploring the linkages. Renewal regional network on AIDS, livelihoods and food security South Africa report. http://programs.ifpri.org/renewal/pdf/JohannesburgFinal.pdf. Accessed 13 June 2013.

Vearey, J., Palmary, I., Thomas, L., & Nunez, L. (2010). Urban health in Johannesburg: the importance of place in understanding intra-urban inequalities in a context of migration and HIV. *Health & Place, 16*(4), 694–702.

Vearey, J., Wheeler, B., & Jurgens-Bleeker, S. (2011). Migration and health in SADC: a review of the literature. FMSP. http://www.migration.org.za/publication/vearey-j-wheeler-b-and-jurgens-bleeker-s-2011-migration-and-health-sadc-review-literatur. Accessed 13 June 2013.

Weingrod, A., & Levi, A. (2006). Paradoxes of homecoming: the jews and their diasporas. *Anthropological Quarterly, 79*(4), 691–716.

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender and Society, 1*, 125–151.

Wong, D. (2014). Time, generation and context in narratives of migrant and religious journeys. *Global Networks, 14*(3), 306–325.