See All of Me - Transcript

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Tammy Kremer:

Transgender affirming care goes far beyond pronouns. In this both personal and professional conversation, Dr. Tatyana Moaton and Zami Hyemingway share stories about how healthcare can alienate transgender folks, as well as concrete steps we must take to create equitable and nourishing environments for all.

Welcome to Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Speaker 2:

For most of us, having sex is easier than talking about it.

Speaker 3:

This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Speaker 4:

What can I do? What can I learn that impacts change for the people that are in my sphere of influence?

Speaker 3:

This is so, so, so preventable.

Tammy Kremer:

These conversations are brought to you by the California Prevention Training Center at the University of California, San Francisco. It's time. Let's Come Together for Sexual Health.

My name is Tammy Kremer. Just a note, all views expressed are those of the persons speaking and not of the CAPTC or their employer.

Welcome to Coming Together for Sexual Health, Zami and Tatyana. I'm so excited to have you here today to talk about the recent summit that I fortunately was able to attend, called See All of Me: The Intersections of Medical Mistrust and Distrust and its Impacts on Transgender Health, HIV Care, and Prevention. Today, we have Zami Tinashe Hyemingway. Zami is the capacity building assistance gender affirming project manager at the Denver Prevention Training Center, where he leads a team of identity consultants that provide technical assistance to clinics, health departments, and community-based organizations. Zami has over 10 years experience in developing and implementing health behavior and health promotion programs. And he also hosts personal wellness workshops via his organization, Spiritus Wellness. Welcome, Zami.

Zami Hyemingway:

Thank you. I'm excited to be here.

Tammy Kremer:

And Dr. Tatyana Moaton is the CEO and principal consultant for Envision Consulting, one of the first black trans led consulting firms in the country. She's also a senior capacity building specialist with San Francisco Community Health Center. Tatyana is a veteran of the US Armed Forces serving honorably as an intelligence officer. She recently obtained her doctorate of philosophy in management science. Congratulations.

Dr. Tatyana Moaton:

Thank you.

Tammy Kremer:

She has worked with the American Civil Liberties Union, LAMBDA Legal, the US Center for Disease Control, AIDS United, NMAC, Gilead, Merck, Elton John AIDS Foundation, and the Black AIDS Institute. Welcome, Tatyana.

Dr. Tatyana Moaton:

Thank you so much. It's an honor.

Tammy Kremer:

I'm so excited to get to talk with you both. Before we started recording, I was just saying how much I enjoyed this summit. I felt it was full of so much great information, so much commitment to the cause and to each other. I felt that community amongst the speakers and it was just really powerful. I wanted to start off by asking Zami, can you share what your role was with the summit and give us an overview of the impetus and content?

Zami Hyemingway:

Yeah, absolutely. The summit was led by Denver Prevention Training Center. The Summit Committee was a collaboration amongst different prevention training centers, educational training centers, and other CDC and HRSA funded organizations. And so as a member of the Denver Prevention Training team, my role was to help the committee but also do a lot of the background foundational work. And then, the impetus of the summit is gender affirming care, transgender and gender expansive identities are a hot topic right now and have been for the past several years.

And we're seeing a plethora of anti-trans laws popping up all over the nation. And historically, whenever transgender identities, particularly when it comes to medical or clinical fields is being discussed, it's often by non-transgender people and through this lens of pathologizing or othering trans and non-binary folks. And so, this summit was to really create a platform where we as transgender and non-binary people could speak to not only the harm, misconceptions and reasonings behind the medical mis- and distrust in our community, but to also speak to our resiliency, our creativity, our ability to not only survive in very hostile, oppressive and stigmatized systems, but to also cover ways that these systems can be more affirming.

And so all of our speakers, panelists, MCs, facilitators, identified as transgender, non-binary or someone of trans experience, which is the first time to my knowledge, that a medical summit on transgender health only had transgender non-binary subject matter experts. And we were able to discuss the decolonizing transgender health and making it more accessible to non-binary, two-spirit and other gender diverse community members. We're able to take a deep dive with an ecological discussion on transgender health from a clinical perspective and administrative perspective and a harm reductive lens.

And then not to mention the brilliant plenary from my counter, Dr. Tatyana Moaton, that allowed us to look at trans health at the intersections. And then, we offered resources on how to create gender affirming system. We were able to acknowledge the history, including present day of medical mistrust. What pieces of the system are broken? And then offered ways to begin to not fix this system, but to build a new one where we can thrive and we are leading it.

Tammy Kremer:

Yeah. Thank you for that an amazing breakdown of those two days. And Dr. Moaton, the first plenary was yours, you set a strong foundation for I think all of the conversations that followed. The name of your plenary was titled similarly to the name of the conference as a whole. If you could tell us about how you chose the title for your plenary, See Me As I Am and Not How You Want Me To Be.

Dr. Tatyana Moaton:

Absolutely. And I mean, first and foremost, I wanted to give honor and thanks to Zami, although he talked a little bit about his role. He was conference planner, speaker, handler extraordinaire. I appreciate Zami for that. In my role as a senior capacity building specialist with San Francisco Community Health Center, I had offered up some expertise surrounding the centering of trans people. If trans persons are a priority population within this country and within the context of prevention and providing services, then that should be the main focus. There is a great tendency from clinicians and providers to immediately start pathologizing trans people on encounter, as opposed to allowing them to be the experts of their own experiences. And I say this both in a professional and a personal capacity, although pronouns and language are very, very important. They're critically important. That cannot be the end point or the stopping point for clinicians and providers. Because the issues that I face as a trans person and those people like me within my community who look up to me are so far beyond pronouns. The needs, the disparities, all of these things.

And we only have so far as COVID 19 to look to the lessons that we're learned and the opportunities that were missed and particularly a lot of the disparities within trans communities. And so coming up with the title, as Zami explained earlier about meeting at the intersection. There are a lot of concepts and themes that are foreign to people who say, "I don't have experience with working with trans people, particularly treating trans people." And so, I was in a training earlier and someone had quoted Dr. Maya Angelou and the quote said, "Nothing that is done by humans is alien to me." And so when you approach it in that way, a human is a human as a human being. There are intricacies in there. Even through the plenary itself, I wanted to provide a foundational basis of how medical mistrust and distrust is built, particularly from public institutions of health and even the health systems itself, how they are built and the foundations that people don't know that history.

And so then coming through and helping clinicians and providers understand its impacts on communities. And so, people who are coming in receiving services and they're not always as open to provide that critical information that you need to develop a care plan. And even those instances where a person may fall out of care, how you handle that and reengage them back into care. It was important for me to provide a lot of those clinical tips and tools. But then also towards the end, helping them to see how the value in seeking out further education.

It was important for me to provide a central focus of why are we here? And in that make a powerful statement. See me as I am and not how you want me to be. I already know how I am, so there's no pathology needed here. But also allow me to tell you that. And see that when I tell you that story, there are a lot of experiences that led up to this. I'm distrustful of you, and that is not solely on the basis of

you being you. But there's a lot of stuff that I did getting up to this point. And sometimes even those interactions and those negative experiences could be right at the front desk.

Tammy Kremer:

And your talk really did open up one interaction, say, a patient and a provider opened up that much bigger picture looking historically at medical mistrust and abuse against the black community. And I thought that was a really powerful way to also be focused on intersectionality, which was such a theme of the conference that, like you said, the trans community doesn't get equal treatment within the community. And recognizing that when you're seeing a patient, they're coming to you from all kinds of aspects of their life experience, identity, heritage. So yeah, I definitely felt those points really being driven home and we'll also link in the show notes to some of those SIBA resources as well as some recordings from the conference so that folks could check those out. And I wanted to ask Zami too, is there anything you want to add about the title of See All Of Me? What did that mean for you?

Zami Hyemingway:

Transgender folks, we aren't just our bodies. We aren't just our trans identity. There's so much to us. And so in order to actually treat us, address mistrust and distrust, then you have to see all of us and see who we are. And also understand that every time I come into your office, it's not because I'm trans. Sometimes I just need a flu shot maybe. And so, can I get that vaccine and then go about my day?

Tammy Kremer:

Yeah, that's something that came through a lot in some of the panels where people were talking about their personal experience seeking care and being over and over again seen for just this one aspect of who they are, as opposed to seeing for what the reasons were that they were coming in for care. I wanted to dive in a little bit to some of the sources and impacts of medical mistrust and distrust. And I was hoping we can start with you, Dr. Moaton.

Dr. Tatyana Moaton:

There's this misconception within healthcare settings oftentimes that if we build bigger, bigger, brighter, more technologically advanced, in that same vein that people says, "If you build it, they will come." But if people are not affirmed in who they are, I will never come back. That is applicable beyond just trans people. If people are not affirmed in who they are, that impacts all other areas of their healthcare. And so of particular importance with trans people, just as Zami shared earlier. If I am not centered and affirmed in who I am as a person first, everything else doesn't matter. I could come into your clinic seeking HIV care, but if we are not addressing the other cares, particularly trans-affirming care. I use that term particularly because people get it confused. When they say, "Oh, we provide transgender care." But it is not trans-affirming care, then it is not authentically trans care.

And so a part of that is focusing on the importance of pronouns, focusing on expanding provider knowledge surrounding these things, even terms surrounding body identification. Those things are important and can be very traumatic in a clinical experience with a trans person because as I talked about earlier about intersectionality and these experiences that oftentimes shape these power imbalances between patient and provider. If these things are not addressed even in the moment, it becomes a part of the culture of the way things are done. And these will come across to their patients and clients as this is just the way it is here. That reputation will get out amongst community. That is not a place that we go to. And to even understand that means taking a deeper dive and to understand how trans communities are formed, how we maintain and how we should be incorporated?

A part of our chosen family members is Care Team. And it's critical for providers and even health systems to understand that oftentimes the way that you provide care may not always be appropriate for certain cultures and communities. It is no longer enough to say that I'm culturally competent. It is time for us to move to the next step of being culturally responsive. What trans looks like in Chicago, Illinois is not what it's going to look like even in Milwaukee, Wisconsin, which is only an hour and a half away from here. And so if I go with this cookie cutter approach to all things trans, then I will never get a full breath and understanding of the needs of my patient or client. And even in that, I say to people, don't truncate names or terms until a person has told you that they allow that. Truncating trans from transgender until someone tells you that because even the identification of that term becomes a part of that person's affirmation.

And so until I give you that kind of, "Oh yeah, you can just go ahead and do away with those pleasantries, trans is totally fine." And even something like that, that is a part of people's dysphoria. I am a black female, respect that. But if you go with this cookie cutter approach that I know all things for trans people and that's going to be applicable to every trans person, you are going to do more harm than you will good. And so again, I say allow people to be the experts of their own experiences.

Tammy Kremer:

As I'm listening to you, I'm thinking about the difference between those postures. The posture of being receptive and of learning from the person in front of you versus the posture of being like, "I've taken a class." And recognizing also the work that it can take for providers to maintain the posture of curiosity, of openness, of connection in the systems that they're working. But that's what we need our providers to do. One thing I loved, I'm trying to remember who said this in the conference, we need our providers to be allies to help us navigate a system that isn't built to serve us and to be willing to take risks and provide care in ways that maybe are different from ways that they have been taught to provide care, because those ways actually don't meet the needs of the people in front of them.

Dr. Tatyana Moaton:

And I think that as we move and create plans in this country ending the epidemic. If those are not inclusive of the people who they're most critically impactful for, then it's not going to be effective. Like you said, if a person said, "Oh, I took the training. I know those things." But you actually haven't put them into practice. And then even when putting them into practice, if you're not approaching it with that openness to say, "I am committing to being a lifelong learner." And this experience may change from day to day. A person may come into you and say, my pronouns are she/her/hers today; tomorrow, I'm just not with all that. And we should be respectful of that. Empower people to take control over their own health and their own encounters with you.

Tammy Kremer:

Something else that you spoke about was minority stress and the intersections between the kinds of pressures put on people based on the variety of identities that they have. Can you speak to that a little bit about how minority stress plays a role in this conversation?

Dr. Tatyana Moaton:

Absolutely. And you hit a point earlier when talking about the medical system. I mean, I am a black woman of trans experience. I walked through a foundational perspective of medical mistrust in the institutions of medicine and to see that it has been built upon the backs of blacks and African Americans, I have an identification a part of that group. Black is who I am. Trans is who I discovered I was because

the world told me that. I never had to question whether I was black or not. There became a point in time where through self discovery of the term, trans itself is like, "Okay, that's what I can call it." And so, there's a stress that is created because of all of these disparities that I face. And so, we will find ourselves playing oppression Olympics. But the reality of it is that we are all experiencing disparities.

Equality dictates that we all get the same thing on the same level. Equity teaches us, "No, you get what you need until you are successful." That's where the difference come in. And so where the intersections meet at is that we are all going through something. As providers and professionals, we have a duty to figure out where is the dise? Because most times people say, "Oh, we meet people where they are." If meeting people where they are dictates to you we're open from nine to seven, do you provide non-traditional entry points into care? And particularly for trans persons where we see that sex work and a lot of other different things that we may experience throughout life happening.

A reality for me, coming into your appointment at nine, and I just finished working at six. I'm still sleep at seven because I had two clients earlier in the day. That is not affirming care. Thinking about those non-traditional entry points to care, having your care team think of non-traditional ways of outreach and testing. Those are of critical importance. And when you start to look at it from an economy of scale perspective, it's not just a focus on trans people. This should be a part across the board of providing culturally competent and responsive care of recognizing that my day-to-day and the issues that I face don't exist from nine to five only in the month of pride. No, they go a little bit deeper and longer than that.

Tammy Kremer:

Absolutely. And like you said, changing systems to really meet the needs of transgender people opens up systems that work better for so many people. As I said earlier, I found the panels where people shared about their personal experiences, super, super powerful. The stories really drove home the need for trauma-informed care and holding clinicians and systems accountable. And I'd like first to start with defining trauma-informed care.

Zami Hyemingway:

I'll use my social work background a little bit here. Trauma-informed care is seeing the person as a whole person. Understanding that when a client, regardless of identity, comes in that they're coming in with the history, they're coming in with different aspects of their lives that we are not going to be able to see. And it's important to build that rapport so that the individual is willing to open up and share that with you. And that includes holistic consent. Consent before touching a client. Consent to perform whatever exam you need to perform. And even explaining this is what is going to happen throughout this exam. All is a part of trauma-informed care. Really coming from this heart and person-centered experience. Understanding that we're in positions in power, which can be very scary for the client. And putting the power and the agency back into their hands so that they know that this is their body, this is their mind, this is their experience, and we're here to really support, affirm and make this the best possible experience that they can have.

Tammy Kremer:

One of the sharings that really stuck with me was that so many of us are not just survivors, but multiple time survivors. And just recognizing we just don't know what someone is walking in with. What can we do to create settings and interactions that are affirming? I want to share a couple quotes that I wrote down during the summit, and I'd love to hear you respond to them however you'd like to. And of course, you're welcome to pass. The first one came up multiple times throughout, and people were talking

about their own experiences, which was having medically unnecessary and often forced pelvic exams, being expected to disrobe when they're coming in for care that has nothing to do with their genitals.

Dr. Tatyana Moaton:

I've shared this for, I guess later on in my professional life, it was like, "Wait a minute. That was a traumatizing event." Particularly, where I already have trust relationships with providers and clinicians because I was sexually assaulted by a mental health provider at the age of 13. It's one of those things that when you, after coming from something like that. And then you go into a medical setting where it's like, "I just got bronchitis." And this turns into one provider, the provider leaving out. And then that transitions into, now there's three more coming in and, "Oh, we just have these students." And I'm just like, "What is going on here?" "Oh, we need you to completely disrobe, so we can do an examination." The examination, it's a very, very narrow area that you need to examine. Why and what entails you to have a full disrobing?

And so those experiences, although are alarming, they're not unique and they are not uncommon within healthcare settings, particularly for trans people. And the scary part of that is that we as a society have gotten to a place where it's seen like, "That's not really a big thing. It's a part of the exam." That is not a part of the exam. When people are making those excuses about, "Oh, you need to disrobe." How about you get robes that just snap from the top, that doesn't require a complete disrobing. And so, it is the way to push away the harm that has been done. But I am one of those people that will continue to speak out about these things and raise the alarm of what happens within clinical settings and in those exam rooms, that once that door closes, it's you and the provider. And some of those stories that we may never even get to hear because they were so traumatizing.

Zami Hyemingway:

Thank you. Thank you so much, Dr. Moaton. And just really holding space for you and so many of us who are survivors in so many ways and multiple survivors. Now, I want to take a breath. For me, there's really two things that I want to say around this. And so, the first thing is that Dr. Moaton said this practice of forced exams is not uncommon. And it's not just not uncommon for trans folks, but it's not uncommon to have forced exams when you live in a non-white body, when you're a person of color. And when you're a person who's just coming from communities that often get marginalized, so whether you're from the disabled community, refugee community, et cetera. And we've seen this happen, as Dr. Moaton, pointed out in her plenary. We've seen this happen on black women throughout history. We've seen this happening to Guatemalan women and we see this happen to transgender folks.

And so, Dr. Moaton talked about how providers, they justify it. They justify as saying they want to learn that they want to advance medicine, that they have a curiosity, and then they force us to be in these positions to where we have to cure that curiosity and be those subjects for that curiosity. Never acknowledging and pausing that we're human beings. I think that this speaks to a larger problem of white cisgender heteronormativity. That says that if you are not a white, cisgender, heterosexual male, then you are a subhuman. You're not seen as a full human being if you are not a part of that dominant culture. And when we look at who dominates the medical field, it is white, cisgender, perceived heteronormative men. We have to get providers to actually see transgender people as people and acknowledge our humanity and not see us as experiments for them to advance medicine.

And so that's the first thing that I want to say about it. And then the second thing is I feel this is why it is so important for us as transgender people to know what our rights are when we are seeking out medical care; know that we can say no; know that we can bring someone to the exam with us; know that we can say, "Before you actually perform this exam, you need to explain to me why this exam is necessary and

what are the steps that you're going to take to do this exam." Before I allow any medical provider to do anything to me, I ask them, "Okay, why is this a part of the reason why I came in? Is this something that you practice on non-transgender folks? Is this a part of the standard procedure? Okay, what implements are you going to use in this procedure? Why is that implement necessary? Okay, I consent to this part, but don't consent to that part."

And I feel that I'm in a position where I'm lucky because I have a mother who works in a hospital and has my entire life. And so I grew up in those settings and I know what should happen and what should not happen. And I've been taught my entire life to advocate. And so, I feel more of us need that help and that many of us do feel powerless because we're afraid that if we say no, we're not going to get what we need. And a lot of providers will hold that against us.

Tammy Kremer:

Yeah. And that's such a position to be coming in because you need something. And then to be presented with a situation where you have to make a choice about how to engage with someone who has the power to either give or withhold what it is that you need and how much it takes to navigate that over and over and over again, not just one time, but over the course of a lifetime. As you were speaking, Zami, I was thinking about the presentation by Andrew Miller on Building an Affirming Healthcare System. One of the things that he spoke about was on the importance of sharing the hospitals or the systems' policies and procedures so that people really know what they can advocate for and where they can go if they are mistreated.

And thank you so much, Dr. Moaton, for what you shared. And I was thinking about something that Valerie Spencer shared. She used this phrase, "this spontaneous popup of perversion" and that is just such a biting phrase. And to me hearing that on a physical, emotional level. It brings up so much heat in my body. The vigilance that is required in order to fend off these spontaneous popups of perversion in a medical setting. And I'm sure in other settings as well.

Dr. Tatyana Moaton:

And even in instances of that, there are subtle ways that they do it. They will ask questions about body modifications and augmentations. And you immediately start to notice in the conversation that this is beyond a clinical curiosity. Immediately, there begins this building of medical distrust and mistrust because of those like, Reverend Spencer referred to, those spontaneous perversions. Just like, "Okay, I didn't come in here for a breast exam, so why are there questions surrounding the augmentation to my breast?" And so for trans people, these interactions are continually built. And so it becomes a part of the culture of the organization or even my perception of this is the acceptable culture here. And if those are not challenged, then I begin to internalize through my own personal processes that this is a distrustful place and I should not be coming here for care. And as you talked about a little bit earlier, Tammy, this is the place that I should be coming.

These are the people who have a duty. They took a hippocratic oath that says, "First do no harm." But everything that I've experienced in this moment or from this clinical interaction has made me mistrustful of not only the person but the institution of medicine. And so when those kinds of perversions and those things happen, it's internalized. And then what happens from there, as we know through culture and how culture is built, I'm going to go and I'm going to tell my friends and then they're going to tell their friends, and then they're going to tell their children, which is impacting of care because some of us are double and triple survivors. And so as we are speaking about these things even casually, we are encouraging or discouraging people from seeking that care from the people who have both the power and the duty to provide that. That's a perversion for me.

Zami Hyemingway:

I also think that what folks don't understand is that not only will we at times internalize it, but that also can create more dysphoria and dysmorphia for us. And so I think about how, for me, I had never intended on having chest reconstruction surgery until I was having a physical exam and the doctor flipped my breast and was like, "Are you getting these removed?" And I was a large chested person, and I was like, "Oh" immediately I was like, "Now I have to have top surgery." And I had not thought about that. I was okay with my chest. It was not a thing for me. But as soon as that happened in that exam room, I immediately start researching top surgeons. It gets in our mind to this place where we internalize it, and it can trigger dysmorphic thoughts for us. It can trigger our gender dysphoria even more so.

And so, I really think that the perversion in that curiosity, it is so hideous. It can have this impact that completely shifts the trajectory of our gender experience. Something that I never intended on having or wanted to have, became very important to me and what I hyper focused on because of what a doctor said while they were giving me a physical while I'm on their table in this vulnerable position. And I'm not going to even mention the other just completely inappropriate comments she made while doing my exams. But immediately it's like, "Oh, I'm disassociated in this space now as well." And so, there's so many levels of trauma and sometimes that survivorship is just multiple times in one exam.

Dr. Tatyana Moaton:

And even just piggybacking off of that, there's already a power imbalance that is created between the provider and the patient. But then you're going to double down on that and create a further body dysmorphia that I didn't have present prior to me coming into this clinical encounter because it was said by a person who was considered to be an authoritative figure. This person has the both power and the ability to change the entire trajectory of my transition. Is there an issue that is existing that I don't know about that has not been clinically diagnosed? And so even in that one encounter, I am a survivor of that. All of that. Not even counting all of the stuff I had to get to here just to come to this appointment.

Tammy Kremer:

And I want to bring in one more voice from the conversation here. Cecilia Gentili was talking about the decriminalization of sex work as a public health issue.

Zami Hyemingway:

I felt Cecilia brought up so many great issues from the immigration and the importance of what you should document and what you shouldn't document. And I feel that she is absolutely right. We need to decriminalize lots of things, but particularly sex work. And it is a public health issue because if sex work wasn't criminalized, then one people who engage in sex work would be able to obtain benefits, which includes healthcare and health insurance and be able to do so more easily as opposed to having to potentially lie on paperwork or just have access to the public healthcare system. And we know that when we have more options around our health, then that's how we begin to move towards health equity.

And folks, again, who are often marginalized, including sex workers and particularly sex workers of color, particularly trans sex workers. When we see these folks who are pushed furthest to the margins start experiencing equity and start having more options, that means that they are able to experience more autonomy. That they're able to have more agency around their life and their health, which means when we're trying to end the HIV epidemic. When we're working towards that, that means they're having more access to comprehensive sexual health exams. They'll be more willing to give more information

around their sexual history. And then we can provide them the tools and resources needed for them to be able to make the best choices to optimize their health.

Dr. Tatyana Moaton:

For sure. When talking about the decriminalization of sex work, most of the impacts or the resulting consequences of sex work within the context of legal implications are oftentimes harshly impacting of those people, who are providing the service and less on the John. And so, we further force people into the recesses of life. This perpetual cycle of I have to go into hiding. And for all of the things that we are doing within healthcare and prevention particularly, we want people to be empowered to come in and get tested. We want to do outreach and testing at hotels where they are doing sex work. We also want people to feel open to be able to report when they have abuses. Sexual assault victims who are involved in sex work, they oftentimes go unreported because they feel I'm not going to be taken serious. Or there's some other legal implications there.

And so like I said, it impacts everything that we do from point of care to re-engagement to care. Even when taking a sexual history, I can't get a full and honest sexual history, if this person feels I'm going to go and report them. People will challenge the work that we are doing. Why do trans people need special spaces? Why do they need services provided in this way? And so when you think about its applicability, this goes beyond just trans populations. I've seen trans people who will report being raped, and then they go into the custody of the police, and then there's further harm done there than they experience even with this John who just wouldn't leave and decided to choke me or grab me. The harm that is experienced under the hands of law enforcement within this country, although they have been greatly challenged for communities of color, there are other communities that are still experiencing those things.

If I am experiencing intimate partner violence, I'm more against reporting this to law enforcement because the thing that is going to come out once that identification has been made about my identity that, yeah, this is not to be taken that serious. And as we've seen that this country, sometimes those result in trans people being killed by their partners. We have an opportunity here. We see this and we say that this is wrong. When are we going to move to that point of changing it? And opportunities like this with this summit. People who showed up and were participatory are speaking to that fact that this is not just some small thing, some little niche area that people are concerned with. No, people want to make these changes.

Tammy Kremer:

Absolutely. And to look for ways to create those changes that we need is just so critical. And I'd actually like to talk about some of the strategies, the tools, policies, procedures that were discussed that can actually make healthcare organizations and spaces more trustworthy. And I'm sure some of our listeners are feeling motivated to create some change. I'd love to share some of those ideas here too.

Dr. Tatyana Moaton:

For sure. And most of the work that I do has been in the HR space and particularly surrounding diversity, equity, and inclusion. And so when thinking about policies and procedures, most importantly, having gender affirming policies within your clinics or practices. But it is not just enough to say, we have a gender affirming policy. Where is it posted? Who knows about it? Who has access to it? How is it being implemented? Is this just something that is a part of the onboarding? And it's never revisited throughout the life cycle of a staff member being here? And so starting there, but doing the work of instituting or implementing these policies is not just enough, that has to be coupled with education. But then the

educating factor should, and I strongly recommend this as Zami was saying earlier, come from a trans person. It is shameful that I am sitting in an orientation and I'm having a cisgender person do the trans competency.

If I have a question, I want to take a deeper dive in that how are you going to approach that? Make it truly authentically, culturally competent. Allow that opportunity of education to come from a trans person within your organization. And even that, if you do not have trans people, hire them. Put people in front of the people that they are servicing. You're starting trans programming and you submitted a grant. I can't tell you how many times I've sat on grant review committees, and I've seen people submit applications. And you go into their staff demographics and it's like they have no trans people working here. But you're telling me you're going to provide services for 75 trans people as a community leader and stakeholder. No, I'm not going to recommend to fund, because I know that this is not, again, truly, authentic gender-affirming care. The issues that we face as a community are so far beyond pronouns that can't be the end point or stopping point of your education.

All of those policies, ensuring them up with hiring of trans people within your organization. Start there. Leverage those opportunities and that wealth of knowledge and diversity within your organization. But don't start to get into places where you're tokenizing trans people. Hire people for their expertise and their experiences and not just for their identity. Because you'll start to find yourself in places where you're getting performance pressures and a whole other cycle that did not exist for this person prior to you hiring them in. "Oh, we hired you to run our trans program because you're trans." It has to be a little bit more than that.

And even empowering trans people to see their value. Are you creating professional development opportunities beyond this person just coming in and being an outreach worker and tester? Is there a succession plan that has been created that can be this continuer frame of ad hoc things? "Oh, we decided to add a trans space," that should have been a part of the fabric of your organization. Looking at those things and building them into your strategic plan and let it truly be intentional from the top down. Have that be interwoven within your board of directors, your community advisory groups, all of those planning bodies. And stakeholders should have people that are representative of the communities that you are servicing.

Zami Hyemingway:

Dr. Moaton said everything that I have planned on saying as well to that. The only thing that I would add to that is, yes, you need to truly invest in trans folks and understand that when you are hiring trans folks from entry level through administrative. I feel we should receive more support at professional development because many trans folks, particularly trans folks of color, particularly trans women of color, do not have the same opportunities as other folks and don't have mentors the same way that other cisgender or other non-people of color have to help us, the young trans person, who their first job is an outreach worker at a nonprofit. They may not understand what's considered email etiquette. They may not understand why they can't pop off at that funder who just says something really transphobic. They might need you to sit with them and say, "Hey, we agree with you. Let me explain to you how to navigate this situation."

Often, I feel that trans folks are hired on and then are expected to just understand. But when we are working in the community as part of the community, there are certain things that come with that. Vicarious trauma comes with that. Different intercommunal dynamics come with that. And so, there really needs to be the support system built in and also understand that many of these agencies where we are being hired onto are agencies that need to acknowledge the fact that they engaged in harm. And instead of just saying, "Well, trans folks don't want to apply here." You need to understand why. And so

don't just hire us on and expect us to be in a violent environment. But say we have committed harm. These are the things that we are doing to hold our organization accountable. And this is our plan to not only hire, but invest in the development and the success of our trans and non-binary staff.

Tammy Kremer:

Yeah, thank you for adding that. And a point that came up a few times was that representation and access to care is increasing to some degree, but that also brings new problems with it. Like you're saying, if you just hire someone into an environment where they're not supported, you're creating new problems. If we give institutions commercial interests in providing surgery or other forms of care to transgender people, then commercial interests are creating new problems in terms of how people are being advised around their care. I wanted to ask, what can institutions and individual providers do to ensure that they're continually evaluating and improving the services that they're offering to the transgender community to make sure that they stay as far away from those new problems as possible?

Zami Hyemingway:

I'll kick this off. I really feel it goes back to what Dr. Moaton said. It's not just a language. It's not just we have these policies and procedures. It's not just we develop this new program. It really needs to be at the foundation of the organization. The organization needs to have trans folks and non-binary folks and other gender expansive folks as a part of their boards, their staff, their community advisory boards as well. And there needs to be a fine tooth comb review of that organization and how they, even in tiny microscopic ways, maybe engaging in transphobia. How are we engaging in it in passive ways as well as very blatant ways? And when that agency's able to pause and those groups are able to pause and do that examination and then do an overhaul, then part of that overhaul is continual training, is making sure that anyone who is missing from the table is at every single table.

And really how long has have these leaders been here? If you are a CEO or executive director of an agency that started 15 years ago and you're still that same CEO or ED, maybe we should start looking at new leadership and not hoard power because that is when we're able to continue to grow, is when we also see new leadership coming in and may even be a part of the community in what you're trying to serve.

Tammy Kremer:

I want to talk a little bit about the terms that we're using. Something that I took from the conference was that there was so much intentionality about having folks who identify in different ways within the whole umbrella of gender experience. Including non-binary folks, trans men, trans women, folks who may identify as two-spirit. There was a whole discussion about decolonization in trans health. And I wanted to ask about something that was stated, which is that transgender is a colonizing term. What makes transgender a colonizing term?

Dr. Tatyana Moaton:

The interesting thing about the systems in this country especially is that there is always a great push to identify, identify, identify, identify. Being a black woman of trans experience, I've always known that I was a woman. But the world taught me that I was trans. And so when there's the systems of othering, you've got to choose something. In the term transgender, it says that I am transitioning from one gender to the other. There has been a change. But if I am actually bringing my gender into congruence, where has been the change? There has been a path to self discovery along the way, but there has never been a change from the true essence of who I am. And so in that term, if you are not cisgender, you are

transgender. Why is it being so forced upon me in a way that I am now being forced to wear my diagnosis as my identity?

If in this country, we are saying a woman is a woman is a woman, why do we make the differentiation by saying transgender woman and transgender man? We have to take a true examination of terms and language justice and a lot of those things that the honest oftentimes fall on the people who are most oppressed by these systems. Why are trans people being forced to say, "Hey, I see this as being wrong." No, cisgender people saw that as being wrong too. But they were comfortable to exist in these systems which bought them opportunities of wealth and other things. And even enjoying the access because there has been a minimization of trans people that creates further space for those who don't have the identification of being trans.

Zami Hyemingway:

This is actually one of my favorite topics is to talk about decolonizing trans health. Decolonization as a framework in transgender health is about one acknowledging that prior to global colonization, because this whole globe has been colonized. Prior to global colonization, there was not a widely practice of the gender binary. There was not a gender binary structure outside of white Western Europe. And what we now know as a United States, in Africa, in Thailand, in India, et cetera. All these places prior to colonization had a rich, diverse, multi-gender culture and practice where we just existed. We didn't have to say that we were trans or we were this or we were that we just existed and we were celebrated. The multi-gender folks, whether they were two-spirit, Hidra, Faʻafafine, muxes, and a part of the celebration of third and multi-gender communities was also a part of our spiritual traditions.

And so when we talk about decolonizing transgender health, we are talking about acknowledging our cultural practices. We're talking about how gender is not linear and that everyone regardless of if you are a transgender, cisgender, we all shift in our gender expression. We all shift in a way in which we experience our gender, express our gender, think about our gender. How we experience our gender at 10, is not how we experience it at 20. And so when we actually are decolonizing transgender health, we acknowledge that it's not this linear thing where you check box A and B and it makes it easier for you. And to enforce that on us is violent in many ways. The term transgender, I view it as being inherently colonizing because it limits us to be forced into this westernized binary structure. Anyone who is not white European, we all have come from some culture, some ancestral culture that had minimum three genders until society told us, like Dr. Moaton said, that's not a term that I would've identified with.

I would've never called myself transgender. And when we used the term transgender or put that onto our community, it just continues that violence, continues that erasure of our ancestral language or identity, et cetera. When I speak about decolonizing transgender health as a framework, it's acknowledging that my transition, my health, my practices, they always exist through my spirit, through my traditions, and who I know myself to be and away from this white supremacist domination lens that we are told we have to subscribe to in order to get care.

Tammy Kremer:

Well, there's so much in what both of you just said, and I'm just really appreciating what you're saying about how that identity becomes an imposed structure that reproduces those experiences of colonization over generations. I wish we could talk forever. And I'm just going to ask you this one final question, which is, this podcast is titled Coming Together for Sexual Health, and I like to ask guests, what would you like to create by Coming Together for Sexual Health?

Dr. Tatyana Moaton:

A psychological safety to even have the conversation. We are so adverse to having conversations about sex and people get all prudish. And there was a great push for a time in this country towards abstinence education and it did not work. The reality is that people are going to have sex, whether they are positive or negative or any of those things. Let's talk harm reduction techniques and a lot of that stuff, that's opportunities that are missed. Even in COVID, we saw a huge uptick surrounding STIs. And so why is there such this reluctance in this country to have those conversation?

What I want to create is that psychological safety for people to even have the conversation and this empowerment surrounding sex itself and sex positivity, body positivity, all of those things that people can bring to the table and say, "I'm here with my whole self." Let's talk about it. Ignorance is the absence of education. We will never get to zero in this country until we have everyone at the table to have that discussion. Unless it is inclusive of all populations and all people, even those indigenous to these land, then we can never have an effective conversation. It's no longer enough to say that the data, the numbers don't exist for trans people. They are there. You just have to go and find them.

Zami Hyemingway:

I just want to say ashay to everything you just said, Dr. Moaton. And then for me, I like to create a space or a place where healing happens. There's so much healing that needs to happen when it comes to sexual health and talking about sex, particularly for trans folks and folks of color and queer folks. I feel that sex, our sexuality, us being sexual beings have been used to harm in so many ways and so many people, we do internalize a lot of that shame. And so, my hope is to create a space where healing can happen. I want to create a space where we have autonomy over our bodies where consent is always engaged in. And where we are experiencing pleasure and talking about pleasure when it comes to sex, and not just how to prevent disease. And where we are liberated beings and we are all able to thrive and live happy, beautiful lives that has lots of great amazing sex because I don't believe in bad sex.

Tammy Kremer:

Well, thank you both so much for sharing those visions. I love connecting with good sex, not bad sex and this broader motivation, which is behind the work that we're doing. Big thank you again for taking the time to talk with me and for that amazing summit, and I look forward to continuing to learn.

Dr. Tatyana Moaton:

Thank you so much, Tammy. This has been an amazing conversation. Thank you for both the opportunity and the honor.

Zami Hyemingway:

Thank you. This is fun. Lots of fun.

Tammy Kremer:

Thanks for listening and check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show. Please follow and rate us wherever you get your podcasts. This will help more people find us. Connect with us on Instagram @comingtogetherpod and learn more about us and get in touch @comingtogetherpod.com. This podcast is brought to you by the California Prevention Training Center, where we build the capacity of healthcare professionals working in sexual health and emerging infectious diseases. Check us out at californiaptc.com and follow us on Twitter @CaliforniaPTC. This podcast is produced by me, Tammy Kremer with Laura Marie Lazar and Catalina Macdonald. It is edited by Layla Mohimani and Isaiah Ashburn with original music by Layla

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