

**KEYNOTE ADDRESS: Peter Hyndal**

**Queensland Transgender, Sistergirl and Gender Diverse Conference**

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**The position from which I speak**

I've been involved with A Gender Agenda (AGA) for the last ten years. The first seven of those years we focused all of our energy of fairly traditional lobbying for legal reforms. We put an awful lot of effort into this lobbying. We wrote submissions, responded to public consultations, and engaged in meetings with key members of the Legislative Assembly.

But despite this, in those seven years we achieved, quite frankly, very little. In terms of meaningful legislative change – we achieved nothing at all.

Three years ago we decided to try something different – we re-assessed our priorities, and most importantly, we changed our strategies. Since then, we have achieved, I think, some pretty mind blowing things – certainly far more than we ever achieved in our 7 years of hard work using traditional lobbying techniques. For example, in the last three months - since June this year - we have secured premises, received \$70,000 worth of funding for our third health promotion project, and secured recurrent funding of \$150,000 per year.

These are outcomes that all seemed so ludicrously out of reach back in 2009.

I value very highly the opportunity I have had to work with AGA in achieving these things. It is from this position that I speak today.

**The sex and gender diverse community**

I wanted to talk a bit about the sex and gender diverse community. But before I do that, it would be worth acknowledging that the use of the word 'community' is, in and of itself, seen by some as quite contentious

Last year I wrote an email to an interstate trans activist in which I made passing reference “our community”. This person responded immediately and very clearly by saying “There is no community – just disparate groups of isolated individuals”.

This is, in fact, a true reflection of how it is for many people. The few stats that we have all make reference to the incredibly high levels of social isolation experienced by sex and gender diverse people.

But when I read those stats, I think ‘What is the one thing that all of those individuals have common? What is it that probably every single one of them wants, possibly more than anything else in the world? *They want to be less isolated.* They, like every other human being on this planet, want to feel like they are part of a community.

Our experience in the ACT supports this. We didn’t have to track down individuals and bring them kicking and screaming to community events. We provided a space, and terms of engagement which were respectful and inclusive. People found us – and in doing so, they found each other.

Over the course of a year we watched a community quite literally materialize before our very eyes.

So, as an aspirational kind of person - as someone who believes in occupying the space we want to occupy and of creating the things we want for ourselves by speaking them into existence - I am going to insist on continuing to use this word “community”.

### **What do we know about our community?**

So, who exactly, is this community? How many people could be part of it?

The truth of the matter is: we don’t know.

The Australian Bureau of Statistics and the Australian Institute of Health and Welfare produce no population based research about our community. Apart from Tranznation, and a few footnote type references in Gay and Lesbian research reports, there is no large scale Australian based social research.

It's worth noting, I think, that our inclusion combined in LGBTI statistics is not actually always helpful. It has a tendency of making our own needs more invisible than they might otherwise be.

Because of the lack of good social data, we often end up using medical or psychiatric based texts to inform our discussions about sex and gender diverse experiences – including those experiences that are not actually related to medical or psychiatric issues.

The problem with this, is not just that these texts are written from a medical, and often pathologising framework – but also that they only represent a particular sub-group of the sex and gender diverse community.

When I look at the community we serve – a community that includes transsexuals, transgender people, intersex people, cross-dressers and other gender variant or gender non-conforming people - only a very small proportion of that population group accesses medical, surgical or psychiatric services.

The important point here is that any research, no matter how good, that originates from a sample group who are accessing medical treatment, is simply not addressing the issues or experiences of a rapidly growing proportion of our community.

### **The conflicting roles of medical profession**

So now let's start talking about specifically about health...

The starting premise in talking about health services is that men and women “pre-exist” their interaction with these services.

I actually want to challenge this position – because in my view, the medical profession plays an active and critical role in “creating men” and “creating women” and in maintaining the illusion of binary sexes.

Here’s a bonding moment that every single person in this room can share... In the first few minutes of each of our lives, a doctor picked us up, physically examined our genitals and then ticked a box on a form. Declaring to the world that we were either male or female. Why? Who was the patient? The mother? The newly born child? And what health need was being met by performing this examination? The answer is that there was no medical purpose at all – the only purpose was a legal one. And the examination itself was not performed on behalf of a patient, but on behalf of the state.

In the case of newborn intersex babies, doctors sometimes find it difficult to assign a sex. This “problem” has often been “fixed” by undertaking surgery to more clearly align their bodies to what we culturally consider to be a more ‘male’ or ‘female’ physicality.

In these scenarios, the medical profession is actively engaged in perpetuating the myth that all people are unquestionably either male or female. This time, by surgically removing or altering the very body parts that *prove* that there is a great and naturally occurring variation in human biology.

Under current laws, many people in Australia are unable to change their legal sex from the one assigned to them at birth. But for those who are able to apply for such a change, the new legal sex will only be recognised upon producing ‘medical proof’. Here the medical profession plays the role of ‘gatekeeper’ not just to the medical services provided to sex and gender diverse individuals, but also to what legal rights their patients will have recognised by the state.

And what is it that the medical professional must provide ‘medical proof’ of? Although phrased differently in different jurisdictions, there is commonly a

requirement for the 'surgical alteration of reproductive organs'<sup>1</sup>. What this rather innocuous sounding phrase actually means, in practical terms, is surgical sterilization.

After ten years of being pressured by my GP to have a hysterectomy I finally agreed to see a specialist. I asked him why he thought I should have a hysterectomy. He didn't miss a beat – he looked me straight in the eye and said, “well, so you can get a passport of course”.

The rules around passports have since changed – but the rules around amending birth records have not.

We talk a lot in our community about “informed consent”. I actually don't understand how consent can ever be truly given, when an individual's legal rights are contingent upon agreeing to such surgery. Under such circumstances - who exactly is this surgery being performed on behalf of? The patient? Or the state?

So many times I hear people say that the two most pressing needs for our community are legal recognition and better health services. I don't believe that these are completely separate issues. For as long as the medical profession is being asked to fill so many conflicting roles, they are in my view, simply not in a position that allows for the provision of good health care to sex and gender diverse individuals.

Changing ID recognition laws will resolve this conflicting role of the medical profession. This is not only good for us – it's also good for medical professionals. It clarifies their position, and allows them to get on with the work they presumably love doing – which is assisting their clients to achieve better health and wellbeing outcomes.

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<sup>1</sup> After the 2011 High Court case *AB & AH v State of Western Australia*, surgical proof of sterilization is no longer required in WA. Given South Australia's legislation has similar wording to Western Australia, it is possible that surgical sterilization may no longer be required in South Australia.

## **Health outcomes for sex and gender diverse people**

A report we released in 2011 called *Gender Diversity in the ACT: A Survey of Trans Experiences* reported on the findings from a survey of 83 sex and/or gender diverse people. It shows that:

- 80% of respondents experienced “difficulty” in accessing appropriate health care services
- 65% reported predominately poor experiences when accessing health care
- 61% reported predominately poor levels of knowledge from health care service providers
- Although 50% had accessed mental health services, only 7% stated that they had received any ‘support’ from these interactions
- When asked where they would seek medical information related to gender identity issues, only 7% said that they would ask a medical health practitioner.

For those in our community who seek hormonal or surgical interventions, there are a range of other issues related to PBS and MBS coverage. Any of us who take hormones have issues about the lack of pharmaceutical testing in relation to our particular circumstances. There are also issues related to a lack of research about the effects of long term hormone usage – intersex people who may have been prescribed hormones very early in their life are particularly affected by this issue. For transmen who would like to pursue lower surgery options, the issue is not one of public coverage, but about a complete inability to access this surgery within Australia. For young trans people the issues are about a denial of access to desired treatment. For intersex people, the issues are about being subjected to surgical intervention that is unnecessary and often unwanted.

These are just some of the direct clinical based health issues.

There are many more issues affecting the broader health and wellbeing of our community. Social isolation and marginalization, the effects of stigma and discrimination: all of which produce the significantly higher rates of anxiety, depression and suicide that are found within our community.

There are clearly some issues here that need to be addressed.

And here we all are... A whole lot of sex and gender diverse community members sitting alongside medical practitioners and mental health service providers.

I'm assuming that everyone in this room has chosen to be here. That we are all here because we care about the same issues. Because, from whatever position we occupy, we recognize that we can improve our understanding of the issues and improve the interactions that we have with each other.

This is not a one-way interaction – I think sex and gender diverse people often assume, in these kind of interactions, that that it is only medical practitioners who need to learn. But we have huge amounts to learn as well. Not just about doctors, but about our own community.

The lack of social research, in combination with the social isolation of individuals and groups, mean that most of us know very little about the entirety of the community we seek to serve or represent. I am very conscious about the gaps in my own knowledge – gaps around understanding the different cultural context experienced by my indigenous sisters and brothers, gaps around intersex issues, gaps about the changing landscape in which we are seeing exponentially larger numbers of younger people who are identifying in an exponentially growing number of ways.

I'm excited by the opportunity this conference provides for me to broaden my own understanding of these issues.

## The process of achieving change

I used to have a view that achieving change was a very linear process. That first you collected evidence, then you wrote submissions, then you met with members of parliament... and then you got change.

Over the last ten years I've developed a much more organic understanding of the way change is created.

I remember, probably back in 2007, having a meeting with the ACT Attorney General, where we presented all of our quite compelling arguments for why ID law reform was needed. We did well... when he responded he had no compelling arguments about why it shouldn't happen. He just sat there and said "the time wasn't right", that we "needed more consultation", that the "issues were complex", and that he wasn't prepared to make changes now because "the community wasn't ready for change",

I was furious when I left that meeting. I remember thinking to myself 'the only reason we're not getting what we want is because *he* doesn't want to do it. It seemed so unreasonable. So impossible to engage with. Such a complete dead end. Until I calmed down and started to think about the whole thing a bit differently.

It's one of those fundamental lesson in life isn't – finally realizing that you can't actually make *anyone* do something they don't want to do.

Bullying or hassling someone to do something they don't want to do, creates relationships between us and people in power, that are built on the foundations of resentment and mistrust.

These are not, in my view, the kinds of relationships that will do us any favours in our future lobbying activities.



Although you can't make people do things they don't want to do, by reframing discussions and providing tools, you can encourage other people to discover for themselves, that they genuinely care about (at least some) of the same issues that we do.

This concept informs all the work we do at AGA now – our strategy is no longer about identifying 'the enemy' and negotiating on adversarial ground, but rather is about identifying the contested ground and putting it to one side. It's about focusing on the things that we actually do have in common, and positioning ourselves to be as helpful as possible to anyone who wants to make changes in the right direction.

These are strategies that I think will help us to frame constructive dialogue – not only over the next two days, but more importantly, long into the future.

In any discussion between sex and gender diverse people, and health practitioners – there are going to be areas of disagreement. We come from different perspectives. We operate from different frameworks. We have different social, legal and political pressures placed upon us. But we actually don't need to all agree, on absolutely everything, to be able to find a way to work together constructively.

One of the many things I've changed my mind about over the last 10 years is the relative importance of end outcome vs process.

My starting position was entirely focused on end outcome – on achieving legislative reform.

I now believe that the processes we use to try and achieve that reform are at least, if not more, important than the desired outcomes themselves.

## **What strategies should we use?**

So let's have a look at some of the processes or strategies that we could choose to use...

### **“Just the same as you”**

In this scenario, you produce evidence of trans people who are intelligent, articulate, in happy relationships, earning good money in well-paid jobs: highly functioning members of our society. And you say “Look, these people deserve access to better health care because, apart from being trans, they're just like us”.

### **“Tragic Tranny”<sup>2</sup>**

At the other end of the spectrum, there is, what I call the “tragic tranny tactic”. Where someone, most commonly someone who is not trans, produces evidence of trans people who are struggling, unemployed, on low incomes, socially isolated and experiencing any number of associated, or completely unrelated, mental health issues. And you say “Look, these people need our help to access better health care, because they are clearly incapable of helping themselves”.

There are a range of other strategies that have been adopted by various groups within our community - strategies that privilege those people who have undertaken surgical intervention, strategies that try to frame some people as being ‘more trans’ than others. Strategies that privilege a trans experience over the experiences of intersex people.

The problem with all these tactics is that, although each of them may, to a greater or lesser degree, accurately represent a part of our community; and although each of them may, to a greater or lesser degree actually be effective

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<sup>2</sup> I want to be categorically clear that I find the terminology “tragic tranny” to be highly offensive. I have used the term in this particular context, because I think it is important to overtly name *exactly* what it is about this lobbying strategy that is so offensive.

in achieving the desired change; the very process of achieving that change unnecessarily divides our community.

The process used to achieving the outcome is based on an assumption that really, *only some of us* are legitimately entitled to the outcome that's been achieved.

I think that human rights based lobbying provides a much better process by which to achieve change.

I am entitled to be legally recognised, and to be able to access appropriate healthcare – not because I'm 'just like you', not because 'I deserve your pity', not because I've had more or less surgery than someone else, not because I was born this way and therefore 'had no choice'... I am entitled to be legally recognised and to be able to access appropriate health care *because I am a person*.

### **Using diversity as a strength**

Many people consider the representation of diversity within a lobbying context as a deficit. I don't. I think are ways we can reframe the diversity of our community and turn it into a great lobbying asset.

Diversity in lobbying is problematic when lobbying is done on single issues. When members of parliament are approached by twenty different people each arguing for a single issue that addresses their personal concerns, and each saying different things.

But if we group together and combine those single issues and take the ones that we can *all* agree are important – even if they don't impact personally on us - then there is great strength. Strength that springs from the very fact that we *are* so diverse: we come from such different places, and yet we can all agree on what we want.

In the ACT we've decided that we won't start lobbying for change on any issue until our own community can agree on exactly what change it is that we want. What we've found, is that we have *always* been able to reach agreement. And the united position that we've taken to government has almost always been more far-reaching, more simple in its structure, and far more radical, than anything we would have come up with individually.

The fact that a diverse community can present a united position makes a very compelling argument for government to act.

And even if the end outcome isn't achieved – the process that is used is one that forms connections between people, one that is based on finding common ground. A process, that in and of itself, helps to build our own community.

This is a concept that applies equally both within and outside of our community. If we are able to define the common ground between us, and medical practitioners, and if we were to approach government jointly, asking for the same things, supporting changes that each of us want, even though not all of those changes may directly benefit us – then all of us – our own community, and health professionals - have a far more compelling argument than either of us do on our own.

Which brings me neatly to the issue of partnerships. And the need to choose these partnerships carefully.

### **The power of good partnerships**

There is a tendency for sex and gender diverse organisations to just assume that they should operate from within the LGBTI umbrella.

It may have made perfect sense, fifteen years ago, to build this alliance. But the huge progress that has been made on gay and lesbian issues over the last decade or so, means that the gap between the GLB and the TI is

widening. This, on some levels at least, means that we have fewer and fewer points of commonality.

I'm not trying to suggest here that we should completely separate ourselves from LGBTI. All I'm saying is that we shouldn't assume that there "just is" always going to be a good fit. And we certainly shouldn't assume that we don't have an equal or better fit with other types of organisations.

Through our work in the ACT over the last three years, we have forged amazing connections with a wide range of different mainstream organisations. Mainstream health providers, health consumer groups, mental health organisations, disability groups, women's services and men's services, youth services, housing providers...

Our interactions with these organisations have been easy. They are engaged, enthusiastic, honest about their levels of knowledge, genuine in their desire to improve, motivated to incorporate the stuff we talk about into the daily work that they do. Our engagement with these organisations is undertaken in an entirely uncomplicated way – as two equal partners working together on identified common ground to have a conversation, or to achieve an outcome, that provides benefits to us both.

Our experience in the ACT has proven that if you adopt that approach of 'focusing on the common ground' then there are lots of potential partnerships.

On issues related to marginalization, stigma and discrimination, we have common ground with indigenous groups, multicultural groups, minority religious groups – and many others.

On issues related to informed consent, pressure to undergo surgical sterilization, pre-natal testing and "treatment" or eradication of intersex babies – we have common ground with mental health consumer groups, disability groups, and a range of feminist organisations.

To the degree that we are a group of people whose bodily reality often doesn't match society's gendered expectations – we have common ground with men who find their 'male identity' threatened after testicular cancer, or women who have their 'female identity' questioned after breast cancer.

These are partnerships that, as a movement, we haven't put a great deal of energy into pursuing. But they are partnerships that I think have great potential – not just in terms of outcome, but also because in and of themselves working jointly on issues means that we multiply exponentially both the knowledge, and the number of voices that are speaking about sex and gender diversity issues.

Community education is delivered, not as a completely separate outcome in its own right, but as a *part of the very process* of working together.

There is so much work to be done, and so many people we could be positively engaged with to make progress. Whenever I find myself putting energy into just fighting to be heard – I remind myself of what I could be achieving if I chose to put this energy into more constructive partnerships.

### **Taking the next step**

I think this conference provides us with a fabulous opportunity. An opportunity to start a conversation between community members and health professionals that is long overdue. A conversation, if we start it well, that holds great promise for affecting real changes of mutual benefit.

There is clearly some work – work about specific legislative reforms - that we absolutely need to do in a nationally co-ordinated way.

But all that other stuff – the finding common ground, forging alliances, building allies, changing minds – this is work that is fundamentally important and work that each one of us can do, after we leave this conference, individually or in groups, wherever it is that we are.