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LEONARD DAVIS INSTITUTE of HEALTH ECONOMICS

Testimony from Amy Hillier, PhD, MSW

I am an associate professor at Penn's School of Social Policy & Practice. I live in West Philadelphia with my wife and two teenagers, one of whom is transgender. Over the past ten years, my research has focused on the needs of transgender children and their families. I want to share some of the relevant takeaways from that research.

Systems must support parents so they can support their children. Parent support is a key protective factor for transgender and gender diverse children who disproportionately face mental and physical health challenges. Parents need social and emotional support and access to accurate, scientifically based information to help their transgender and gender diverse children navigate the complicated landscape of school and health care. This was true before the nation-wide political backlash against gender-affirming medical care, and it is even more true today given the misinformation and anti-trans sentiment pervasive in the media and public policy. Peer support groups provide one important form of this support.

Gender and sexuality are important to the health of all people. While transgender children and their parents face many vulnerabilities, all parents and children must navigate challenges relating to gender. This includes discussions and decisions about gender roles, gender expression, puberty, and supporting friends and relatives who identify as LGBTQ+. All parents would benefit from the opportunity to speak with pediatric staff during well visits about questions or concerns they have about their child's gender identity. Pediatric staff are in the best position to reassure parents and children that gender exploration is an important part of healthy child development. We need to normalize talking, thinking about, and challenging gender norms, including the gender binary, because they have a negative impact on the health of all of us.

Violent and discriminatory systems put LGBTQ+ communities at risk. Too often, researchers focus on individual behavior to explain health disparities characterizing queer and trans communities. Much of this research points to risky behaviors—drug and alcohol use, risky sex, and avoiding preventive care—as the cause of the health disparities. While nominally intended to direct more resources to promote queer and trans health, this line of scholarship contributes to the dominant risk narrative without interrogating the systems, practices, and attitudes that put queer and trans people at risk. The focus of our attention should be on addressing cisnormativity and heteronormativity, interpersonal violence and rejection, institutional discrimination, and structural violence. Those are the conditions that put queer and trans people at risk.

Access to Competent Health Care. We live in a city full of world-class health care institutions. Even here, though, as elsewhere in the U.S., queer and trans people have limited access to competent healthcare. Health care professionals still lack appropriate training to serve LGBTQ+ communities. Medical, nursing, and dental students report positive attitudes about serving LGBTQ+ communities, but they don't feel adequately prepared to serve queer and trans patients. On the one hand, queer and trans people may experience "erasure" from intake forms, life history protocols, and computer information systems that fail to leave room for their identities and experiences. On the other hand, they may receive too much attention and be pathologized by healthcare professionals who are curious and unprepared to serve them. Either situation is dehumanizing. We all deserve better.

Demanding accountability. Isolating the sources of stigma, stress, discrimination, and violence that cause physical and psychological harm makes it possible to identify points of intervention. If we identify faulty systems as the root cause, we need to intervene at the systems level. What would be possible if we all hold government officials and institutions accountable for actively,

explicitly promoting the health and well-being of queer and trans people? What would healthcare systems look like through a justice lens? What would families, religious institutions, schools, housing, employment, and the child welfare system look like if we reimagine them, centering health equity for queer, trans, and multiply marginalized people? To do that, we need all educators, researchers, funders, and clinicians to see themselves as people with gender and sexual identities and to critically examine how their positionality influences their knowledge and their practices. Alongside queer and trans leaders, they must also interrogate the policies and practices within our systems to root out heteronormativity, cisnormativity, and transphobia. Focusing on queer and trans health equity also means finding a place for gender identity and sexuality within our conception of health, something that is not only relevant but also precious for all of us.

In closing. I am deeply grateful to the School District of Philadelphia for standing strong in support of Policy 252 and the rights of transgender students. That has made a difference for my family. I am also deeply grateful to City Council for its leadership on supporting the rights of LGBTQ+ children and adults. I say with pride that we can and must continue to build on this record to ensure the health and wellbeing of queer and trans people in Philadelphia and beyond.