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Addressing Health Inequalities. Settings-based Health Promotion for Transgender and Non-Binary People in Germany

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Abstract: The World Health Organization has proclaimed health as a fundamental human right. This right is not equally available to all: transgender and non-binary (TNB) people have a high overall likelihood of encountering discrimination, minority stress, and norms imposed from without, leading to corresponding negative impacts on their health. Our project GeLebT* sought to identify ways of promoting health among TNB people. We used a qualitative research design to analyse data from three target groups. Our findings demonstrate the need for significant improvements in healthcare for TNB people due to the negative health impacts associated with their current experience of healthcare. Appropriate health promotion requires support for TNB people's resilience and health-promoting structural conditions in settings such as workplaces and sports. Healthcare professionals have a particular role due to their capacity to reduce discrimination and to help remove barriers to accessing healthcare.

Keywords: Equal Opportunities, Gender Identity, Health, Non-Binary, Transgender

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Introduction

Everyone has a right to good health, and all people deserve equal opportunities to “attain their full potential for health and well-being” (WHO 2023) and access healthcare at an adequate and appropriate standard (Krennerich 2020). In Germany, the Preventive Health Care Act (PHCA) sets out provisions to promote health both at the individual level and by shaping the structural conditions for health promotion at the systemic level. On both the individual and the systemic level, people find resources that support their health and meet barriers that restrict it. One explicit focus of the PHCA is the improvement of health promotion and disease prevention for population groups deemed vulnerable. Transgender and non-binary (TNB) people are one such vulnerable population (Tanenbaum/Holden 2023). The United States Department of Health and Human Services recognised TNB people as a high-risk group in 2012 (Fredriksen-Goldsen et al. 2014).

Historically, the medical profession has pathologised transgender identities, for example via the list of mental disorders in the International Classification of Diseases (up to ICD-10).

TNB people often find their identities in conflict with cis[1] or binary conceptions of gender, because they do not, or only partially, identify with the sex recorded and assigned to them at their birth (Appenroth/Castro Varela 2019a). The few studies on this in Germany as well as the much larger body of international research indicate that TNB people are exposed to above-average levels of discrimination (Saalfeld 2021). This discrimination affects their health across various life settings (LesMigraS 2012), including the workplace (Franzen/Sauer 2010), and is particularly extensive in healthcare, with almost one in two TNB people in Germany reporting negative experiences (LesMigraS 2012; Fütty 2019). Documented problems include barriers to accessing care (Bartig et al. 2021); gaps

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[1] Short for cisgender, referring to people who identify with their sex as it was recorded at their birth.

in professionals' knowledge of TNB people's life settings and healthcare needs (Sharek et al. 2015; Zeeman et al. 2017); pathologising assumptions about what being TNB entails (Appenroth/Castro Varela 2019b); and a lack of recognition of TNB people's specific situations and gender identities (Bartig et al. 2021). These experiences impact TNB people's health (Richter 2022) and may induce sequelae from various stressors such as "minority stress" (Smith/Robertson/Cotton 2021). The minority-stress model, which was first developed in reference to members of LGBTI+ communities, suggests that people's experience of stigmatisation, prejudice, and discrimination exposes them to greater levels of stress than the general population, with potential implications for their physical and mental health (Meyer/Frost 2013). TNB people who experience intersectional discrimination may be at even greater risk of health inequalities (Lacombe-Duncan/Kattari/Kattari 2021). For example, Black, Indigenous, and other People of Colour who are TNB are significantly more likely than white TNB people to experience discrimination when accessing healthcare services (Kattari et al. 2017). Overall, TNB people cannot enjoy their right to good health to the same extent as cis people and have unequal and therefore unjust health opportunities (Trautwein et al. 2023).

The context surrounding TNB individuals' accounts of their experience is the healthcare system that centres a cis/binary model of gender and imposes corresponding, and at times contradictory, norms. Most societies place significant restrictions on gender diversity. Normalisation and its counterpart, pathologisation, are clearly visible in healthcare institutions and help uphold the cis/binary mode of being as the norm for individuals and their health (Fütty 2019). In Germany, this results in a healthcare landscape that, from the perspective of TNB people, is at best fragmentary and problematic and, at worst, discriminatory, harmful to health, and injurious (Appenroth/Castro Varela 2019b).

Overall, studies indicate that TNB people have substantial health promotion needs (Rasch 2019). A representative systematic review from the United States, which conceptualises health promotion as multifactorial (Johns et al. 2018), shows that robust social, family-based, peer, or community support networks have positive effects on TNB people's mental health. TNB individuals with such support showed higher self-esteem, had better access to resources for coping with life and with discrimination, made fewer suicide attempts, and reported lower rates of depression. However, few studies have examined how societies can support TNB people in mobilising these resources for their health (Johns et al. 2018), with particular gaps regarding mental-health promotion (Adams/Dickinson/Asiasiga 2013). Overall, resilience appears to be an important factor in promoting good health. In some studies, trans youth defined resilience as an individual capacity that allowed them to persevere through adversity. In all these studies, resilience also was understood by them to mean being able to self-define or define their own gender identity (Zeeman et al. 2017).

Currently, the evidence base on health promotion in TNB people's life settings is insufficient. Our project "Settings-based health promotion for transgender and non-binary people" (*Gesundheitsförderung in Lebenswelten von trans* Menschen*, abbreviated to GeLebT*[2]) aimed to reduce this research gap. Conducted between 2021 and 2024, the project sought to identify ways of promoting TNB people's health in the actual settings in which they live. The project addressed the following research questions:

- What helps TNB people maintain good health, and how can healthcare systems and services support their resilience?
- What health-promotion needs do TNB people have?
- What actions can help make TNB people's life settings health-promoting?
- What skills and awareness do healthcare staff need if they are to appropriately meet TNB people's health-promotion needs?
- What structural conditions can help TNB peer educators working in TNB people's life settings to support their clients in attaining optimum health?

Starting from the current state of international research on TNB health and health promotion, the GeLebT* project set out to provide a scientific evidence base for improving health promotion for TNB people in Germany. By centring TNB people's resources and resilience, we sought to counter deficit-oriented representations of this population group and to derive recommendations for action that help combat discrimination and strengthen their health. The following sections describe the GeLebT* study in its qualitative design, participating target groups, and analytic approach.

Methods

As a qualitative study, GeLebT* engaged both with participants' perspectives and with the social constructions operating in the surrounding societal context. We centred the subjective experiences of TNB people in interaction with structural conditions. This approach allowed us to remain as close and as open as possible to their lived realities and to gain a differentiated understanding of the societal conditions, processes, patterns of interpretation, and structural issues that affect them.

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[2] The abbreviation uses letters from the title and, in a figurative sense, refers to the positive experience of a life well-lived.

We constructed our sample around three target groups (TG1, TG2, and TG3). The first target group (TG1) comprised TNB people, whom we considered experts in their own settings. We aimed to centre their experiences in situations such as interactions with healthcare staff and to obtain a nuanced picture of their health promotion needs, in particular their actions and behaviours in response to these needs. The second target group (TG2) consisted of professionals who provide advice to TNB people or work on TNB issues in education and academia. Their professional roles qualify them to provide contextualising input on TNB people's needs and settings, including associated opportunities and risks relating to health promotion.

Our third target group (TG3) comprised two sub-groups. One sub-group (TG3a) included healthcare staff, such as physicians and nurses, as representatives of the German healthcare system and as professionals who have frequent contact with TNB people and thus the potential to deliver effective health promotion given the appropriate awareness. Within TG3a, we distinguished, following recommendations from our advisory committee, between professionals with considerable expertise on TNB health (TG3a1) and those with little or no expertise in this area (TG3a2). The second sub-group (TG3b) consisted of TNB peer educators who, on a volunteer basis, provide peer-to-peer support to TNB people on health issues and thereby contribute to health promotion in this group. We were particularly interested in potential ways of optimising the circumstances under which peer educators deliver this support.

In order to best grasp the distinctive perspectives provided by each target group, we used a variety of methods of data collection and analysis. With TG1, we conducted episodic interviews (Flick 2011) based on an interview guide that elicited both "semantic" and "narrative/episodic" knowledge. We asked TNB interviewees about their understandings of health and "being healthy" and invited them to describe concrete experiences, for example in interactions with healthcare staff, in which being TNB had been a particular factor. To avoid (re-)traumatisation, interviewees chose which situations they wanted to share and how to narrate them.

We analysed the resulting episodic material using the documentary method by Arnd-Michael Nohl (2017), an established approach in qualitative reconstructive research. Originally developed by Ralf Bohnsack (2007) as a method of analysing data from group discussions, it has been adapted by Nohl for documentary analysis of solo interviews, including narrative interviews. In this framework, we reconstructed TNB people's practical experiences and the principles and strategies guiding their actions. To this end, we interpreted selected interview excerpts in relation to our research questions and identified their "documentary meaning", that is, *how* participants narrated their experiences. Using comparative sequential analysis, we reconstructed implicit patterns or "frameworks of orientation" in these narratives. We understand these frameworks as attitudes and practices that TNB people adopt to navigate their life settings, which in turn illuminate the structural conditions of these settings (Nohl 2017; 2005). The semantic knowledge was analysed using qualitative content analysis (Mayring 2015), supported by coding in MAXQDA, in order to reduce the material to its essence, that is, to *what* our participants were fundamentally saying.

We collected data from TG2 and TG3 via focus-group discussions (Krueger/Casey 2015) as planned, specific, and facilitated group conversations exploring participants' views on a particular topic or topic area (Kitzinger 1994; Pelz/Schmitt/Meis 2004). In healthcare research and health education, focus groups can assist in the process of creating policies, programmes, and plans of action. In our context, they brought together diverse TNB healthcare stakeholders (Liamputtong 2011; Krueger/Casey 2015), enabling us to construct shared meanings arising from the interaction of different perspectives and to deepen our understanding of TG1's settings and needs. The focus groups with TG2 addressed settings-based TNB health, TNB-specific needs in health promotion, and the design of health-promoting services for TNB people. TG3a discussions focused on the skills and awareness required by healthcare professionals, and TG3b discussions on the structural conditions needed by TNB peer educators to promote health in their settings. We analysed all focus-group data using qualitative content analysis (Mayring 2015), supported by coding in MAXQDA.

The research questions (see above) guided all interviews and focus groups and were answered from different perspectives and experiences. For the interviews, we used a structured questionnaire that was open in terms of narrative content. For the focus groups, we created discussion questionnaires and moderation concepts tailored to the respective expertise. The data were collected by the project's research staff. The interviews lasted between 30 minutes and 3 hours, while the focus groups lasted an average of 2 hours.

In addition, we conducted participatory workshops with members of all target groups (including but not limited to previous interviewees) to jointly identify priorities for action. The five-hour workshops were held after our data analysis was completed. They were open to anyone who identified with one or more of the three target groups. Two workshops were held: one for trans and non-binary participants only, and one for both cis and TNB participants, in which we presented and discussed key study results. Though the outcomes of these workshops are not analysed in detail in this article, they informed the development of the practice and policy implications presented below.

Our research met the standards set out in relevant institutional, national, and international ethical frameworks. These include criteria for the quality of qualitative research (Steinke 2017), the four basic principles of biomedical ethics (Beauchamp/Childress 1983), the World Medical Association's Declaration of Helsinki (WMA 1964) and the German Federal Data Protection Act (BDSG). The study was approved by the Ethics Commission at Hamburg University of Applied Sciences. We included only adults who were able to give informed consent and were not experiencing an acute physical or mental health crisis (Schnell/Heinritz 2006).

Given TG1's self-identifications as TNB and the highly personal, sometimes discriminatory experiences discussed, we paid particular attention to the principles of non-maleficence and beneficence. After receiving comprehensive information about the study, interviewees assessed their own stability and vulnerability and thus the risks involved in participation, which supported informed consent (Schrems 2017). To minimise risks further, all interviews with TG1 were conducted by TNB members of the research team, who also made their own situational assessment of whether to proceed. An advisory committee of TNB community members and experts on TNB issues and health provided critical input throughout the research process. All interviewees' names mentioned here are pseudonyms; the excerpts have been lightly edited for readability (for example by removing filler words) and translated from German into English.

Demographics

The evaluated sample for TG1 consisted of 35 TNB individuals (*n*=35). Based on self-identification, participants located themselves on the non-binary spectrum (*n*=13), the transfeminine spectrum (n=10), or the transmasculine spectrum (*n*=12). One transmasculine person additionally identified as intersex (*n*=1).

Twenty-eight individuals reported characteristics potentially associated with the experience of intersectional discrimination. These included neurodiversity or autism (n=5), physical impairment or long-term physical conditions (*n*=9), mental-health conditions (n=9), experience of addiction/substance abuse (*n*=3), and experience of being subject to racism and/or antisemitism (*n*=4).

The age distribution of the participants was as follows: 17% were aged between 18 and 24 years (*n*=6), 46% were 25 to 34 (*n*=16), 11% were 35 to 44 (*n*=4), 11% were 45 to 54 (*n*= 4), 11% were 55 to 64 (*n*= 4), and one was over 65 at the time of the interviews (*n*=1).

A large majority of participants lived in a city (*n*=29); four in towns of various sizes (*n*=4), and two in rural areas (*n*=2).

The sample for TG2 consisted of 14 TNB experts (*n*=14) organised into three focus-group discussions. TG2 participants, some of whom held multiple professional positions, were active in advisory services (*n*=4) and networks (*n*=3) for TNB people, anti-discrimination work (*n*=2), TNB-related professional trainings in the area of health and nursing care (*n*=4), legal representation (*n*=1), psychotherapy (*n*=1), educational work (*n*=1), as well as sexual health and bodywork (*n*=1). Most of TG2 participants were themselves transgender. As the focus groups focused on work expertise rather than personal experiences, there were no ethical implications in this regard.

The healthcare staff in TG3a (*n*=15) were professionals working in nursing (*n*=3), midwifery (*n*=4), physiotherapy (*n*=2), gynaecology (*n*=1), psychotherapy (*n*=1), general medicine (*n*=1), psychology (*n*=1), Traditional Chinese Medicine (*n*=1), and nursing science (*n*=1). The TG3a participants were divided into two focus-group discussions, one with those with considerable expertise in TNB health (TG3a1; *n*=8) and one with those with little or no expertise in this area (TG3a2; *n*=7).

The TNB peer educators for TG3b (*n*=4) were involved in volunteer peer-to-peer advisory services (*n*=3) and a youth organisation (*n*=1). By definition, this target group consisted predominantly of TNB people, who were interviewed in their capacity as peer educators with a focus on their work expertise.

Results

Our findings cast light on healthcare services and a healthcare system that are distinctly deficient in their ability to meet TNB people’s needs. At the same time, TNB health is shaped not only by healthcare but also by other environments in which TNB people live. In the interviews, these environments emerged as providing structural resources for health but also as creating barriers.

In the following, we first focus on the interviews with members of TG1, illustrating how they navigate interactions with (a) healthcare services and (b) other life settings. Using the documentary method, we reconstruct distinctive implicit patterns, or “frameworks of orientation” (Nohl 2017), that structure how TNB people respond to the healthcare system and everyday environments. We then complement these reconstructed orientations with the semantic knowledge generated through our qualitative content analysis of the focus-group discussions with TG2 and TG3.

Healthcare services

Can TNB people turn to healthcare professionals for help and support?

Our data show that TNB people in Germany do not automatically regard healthcare systems and services as useful or helpful points of contact in matters of their health. Interviewees who nevertheless interact with healthcare services – in order to receive advice and guidance on issues around transitioning or for other reasons – often perceived these services as limited in their approachability, even when they had, in some cases, experienced the healthcare system as helpful overall. Participants articulated clear expectations of healthcare services: they should convey reliability and trustworthiness, support patients in their transition processes, respect patients' privacy, maintain professionalism in the healthcare encounter, and be knowledgeable about patients' specific situations and needs. In many accounts, these expectations stood in marked contrast to participants' actual experience with current healthcare services.

When describing situations in which they had been discriminated against by healthcare staff, interviewees clearly distinguished appropriate behaviour from unprofessional actions, such as intrusive questions about relationships and sexuality or evaluative, racialising comments on their bodies. In various instances, they resisted stigma, intrusive attitudes, and imposed norms and constructions of identity, creating their own distinct ethics and practices in response. One example is Sam, who spoke about an encounter with a doctor who had taken notes on Sam's responses to questions about relationship status and gender identity, although the appointment had concerned blood tests (related to Sam's transition):

> "'Ah, okay, so I'm guessing you're single.' And I went, no, I'm married […] the instant response was, 'But to a man, right?' So I said, no, to a woman. […] 'Ah, I'll just note that down' […] Then, […] I asked, just purely out of interest, what relevance it has to my treatment that I have found myself outing myself as a lesbian before I've had my coming-out." (P29:11)

Knowledge about TNB health

Some TNB people in our sample sought to compensate for gaps in knowledge they perceived among healthcare staff by acquiring information themselves or drawing on resources provided by TNB communities. This knowledge enabled them to retain a degree of autonomy over their care, to understand and, where necessary, resist bureaucratic procedures, and to evaluate the expertise of the professionals treating them. It informed their decisions on whether to push for further or different forms of treatment or to request to be treated by a different member of staff.

Most interviewees did not have medical backgrounds; their accounts of the laborious process of finding, understanding, and contextualising medical and other information highlight the considerable time, energy, and effort they invested in order to make up for healthcare professionals' limited knowledge and awareness, as Agnes shows in her interview:

> "And I just tried to inform myself and didn't find the information in Germany but outside […] and tried to check it so that it was a bit more solid and not just someone writing something. To look at various publications and draw my own conclusions or, let's say, find a common ground in what various publications think about it." (P31:2–3)

Educating the professionals

Some interviewees reported using this knowledge, their own experience, and, above all, information from TNB communities to educate healthcare staff about TNB health and the necessary gender-related competence. This led to an effective "role reversal" in healthcare encounters: TNB patients saw their expectations of professional attitudes disappointed and found themselves not only educating but also reassuring healthcare staff. As Sam notes:

> "Either I ascribe too much competence and authority to doctors […] But somehow, ever since I came out as trans, I've often found myself sort of calming down the doctors who have never worked with trans people before and educating them on things to do with the healthcare system or the situation of trans people in Germany." (P29:11)

Ready to fight

Some participants responded to discrimination on the part of healthcare staff by confronting them directly or by actively advocating for their interests and needs. They described this strategy as empowering, because it allowed them to maintain a sense of agency instead of feeling helplessly exposed to the situation. Many interviewees anticipated challenges and discrimination in healthcare settings; one example is Luiz:

> "Every type of [health] appointment is a challenge for me, really. So, I prepare for every appointment. So, I make a list of terms, of symptoms, then I go in and I'm always in this position, okay, I need to defend myself now, I mean, I have to talk in a way that'll get me listened to." (P36:44)

Participants also described similar confrontational strategies in other areas of life outside healthcare. For example, they insisted on the use of their preferred names and pronouns at work or reported discrimination to the relevant departments.

Flight response

While some of the TNB people we interviewed responded to anticipated discrimination with a combative approach, others sought to avoid confrontation by minimising their encounters with health services or disengaging from them altogether. Some focused on preventing being outed or protecting themselves from conflict by “flying under the radar”.

This was evident in accounts of no longer going to the doctor’s or of putting measures in place to avoid being outed or needing to out themselves. Some participants described conforming to, or performing, specific notions of being TNB that are widespread among healthcare professionals in order to obtain the treatment they desired. Others, undergoing the course of psychotherapy currently required of TNB people in Germany before accessing gender-affirming treatment, found that the therapists they consulted for recommendations for hormone therapy espoused binary gender norms and normative concepts of transition processes.

Strategies of avoidance also appeared in other areas of participants’ lives in which they navigated discriminatory or potentially dangerous situations. Some sought to “fit in” by keeping their TNB identity to themselves at work or responded to discrimination by focusing on doing their job especially well.

Perspectives of TNB experts, healthcare professionals, and TNB peer educators on healthcare services

The interviews with TG1 enabled us to reconstruct implicit, experience-based orientations towards healthcare and health promotion, whereas the focus-group discussions with TG2 and TG3 yielded more explicit and reflective accounts of these issues. From this perspective, TG2 and TG3 took up similar thematic fields to those reconstructed as frameworks of orientation in the TG1 interviews.

The focus groups with TG2 articulated an urgent need for change in healthcare services. Participants felt that healthcare staff required more thorough knowledge of TNB issues, including specific health matters relating to TNB people, and competencies such as greater diversity awareness and sensitivity in their interactions with this group. They also called for quality standards and quality-management processes for evidence-based TNB-affirming healthcare; acknowledgement of TNB people’s distinctive expertise and their needs in relation to settings-based health promotion; as well as general and transition-specific healthcare services that are easy to access and attuned to the issues and potential discrimination that TNB people face.

Both lived-experience experts/advisors (TG2) and healthcare staff (TG3a1 and TG3a2) observed a need for improvement in awareness of discrimination and power relations in interactions with TNB people, in gender-aware communication with this group, and in the development of open-minded attitudes towards the expertise arising from TNB people's lived experience. Interviewees in TG2 and TG3 alike felt that healthcare staff should engage with colleagues from other specialties and areas of healthcare on TNB health issues. They also highlighted the need for networks linking TNB communities with healthcare professionals and researchers as a way forward, towards optimum support for this group.

Across all three target groups, participants attached particular importance to straightforward access to both general and transition-related healthcare as a basic precondition for maintaining their health, and to the assurance that providers possessed adequate knowledge of TNB issues. TG1 interviewees described their struggles in obtaining transition-related care. Similarly, one TG2 advisor emphasised:

> "I perceive a very substantial lack of knowledge in general and trans-specific healthcare […] and, across the board, knowledge and awareness are almost completely missing. [… Health professionals] are not fulfilling their mandate to provide TNB people with good healthcare." (TG2:24).

Likewise, TG1 participants' accounts of healthcare professionals' limited knowledge of TNB people's situations and needs – illustrated, for instance, by Sam's and Luiz' descriptions of having to prepare for and "manage" medical encounters – were mirrored in the focus groups. A member of TG3a1 reflected on their experience that "the topic of transition has practically no space in medical school; there is no such thing as trans medicine. […] Everything that one learns there is oriented towards cis normativities." (TG3a1:2), echoing TG1 interviewees' reports of frequently having to explain basic aspects of TNB health to their providers.

Beyond the healthcare setting

Beyond the healthcare setting, members of TG1 also pointed to a range of other contexts in which they experienced crucial forms of support. These included TNB communities, their local neighbourhoods, workplaces, sports and exercise environments, as well as intimate and other relationships, including families of origin and of choice. At the same time, these same settings could also constitute sites of exclusion, stress, and harm. In the following, we therefore examine how such everyday settings can act both as important resources for health promotion and resilience, and as contexts in which significant barriers to health and wellbeing are produced for TNB people.

The problem of binary spaces

The TNB interviewees reported day-to-day experiences of encountering public spaces organised by binary conceptions of gender, such as toilets and changing rooms. They found that these structures subjected them to stress and restricted their capacity to engage fully in society. Some participants had adapted their everyday routines and actions to the existence of binary spaces. Particularly in relation to sports and exercise, a central area of health promotion, the gendered designation of spaces such as toilets presented a fundamental, continually occurring structural issue. The inaccessibility of some settings due to prevailing binary-gendered norms is evident in the interview with Sam, who describes sporting activities as an area of life:

> “Where I’m sort of forced to put myself in a binary category and where it suddenly feels like my body is a big thing. […] That both sort of makes everyday situations more difficult and, well, that I sort of can’t do one of my main hobbies anymore that I’ve been doing for years.” (P29:18)

TNB identity as accepted normality

The interviews with TG1 point to TNB people’s desire for their identities to be accepted in all their life settings. Participants expressed their need to be regarded not as deviations from the norm but as legitimate in their identities and as of equal value to cis people. Their ideal reality is for others not to see TNB identities and bodies as something out of the ordinary and not to make them a subject of conversation via, for instance, intrusive questions about transition surgery scars. Interviewees felt that experiencing the visibility of TNB people as entirely ordinary in settings such as their workplaces would enable them to perceive connections between experiential spaces that they otherwise regarded as separate, thereby promoting their wellbeing. One example of this is Agnes’ account of unexpectedly encountering another trans woman in a work context:

> “[I] sat there […] and then almost had tears in my eyes […] It was like, I’m not alone … Dammit, it was like a whole other level […] I’m not in my local TNB self-help [group …], but I’m in a business space and it’s becoming something normal. And I see that as something very liberating. And now I’m nearly crying again, because my experience is just that it’s not like that [otherwise].” (P31:35)

TNB people living as their authentic gender identity

Participants described the authentic expression of their gender identity in their day-to-day lives as an important practice, a key resource for good health and, at times, a survival strategy. The process of medical and legal transition and the performance of gender in everyday life had a dual potential to either support or damage their health. Some interviewees sought to boost their wellbeing by making use of clothing and other products that affirmed their gender.

They encountered barriers to the expression of their gender identity in the ambivalent relationship between their self-perception and the ways in which their communities and mainstream society viewed them, as well as in the pressure to align with various conceptions of "norms". Alex, referencing an intersectional perspective, is a case in point:

> "I sometimes felt too disabled […] to be trans […] at least in terms of what is considered the standard […] in the trans* community […] Not being able to medically transition yet, but maybe simply not being able to at all […] because of such a physical impairment that, theoretically, binding just isn't possible. And then asking: yeah, am I still trans, just because I don't bind? […] So there are also […] these double standards that you have to meet. And of course, that also affects your mental health." (P24:22–23)

In Alex's narrative, intersectional discrimination, "double standards", and individual needs or difficulties all impact the degree to which someone can express and live their gender identity. TNB people may regard gender-affirming products, such as binders, as health-promoting and adopt their use on this basis. Due to a disability, however, Alex cannot fully access such resources, despite regarding them as markers of TNB practice, leaving Alex struggling with self-doubt over Alex' status as part of the TNB community.

Trusting in TNB communities

The interviewees were unanimous in their perception of TNB communities as crucial settings that they could draw on as health-promoting resources in a range of contexts – always on the basis of shared experience, as Sam explains:

> "For instance, a community is just seven or eight people where there's a kind of intersection, okay, what about queer Asian German people in Germany […] What are [their] experiences […] that they share [in the community]? We meet up once a month and just talk, really. And really, we just support one another, and that's the main thing about meeting up. And I've had moments so often where I thought, wow, okay, I didn't know that other people have had these sorts of experiences, too. It's

> helped so much to have a place I can go to with [these experiences].” (P29:30–31)

The primary function of these communities for TNB people is to provide them with an initial point of contact for information on health matters and for assistance in navigating the healthcare system, and to act as a place they associate with a low, or lower, risk of encountering discrimination than non-community services might pose. Communities might also serve as a form of replacement family or family of choice, giving people a sense of belonging that improves their wellbeing and – as the excerpt from Sam’s interview illustrates – as a space for sharing experiences, which can combat feelings of isolation. TNB people may find positive role models within communities, helping them see past distorted conceptions that may prevail in wider society and regard their own experiences as normal. Alongside all this, communities can be a space of empowerment for TNB people’s activism, for meeting community needs, and for helping themselves and others, thus providing them with a health-promoting sense of agency.

Perspectives of TNB experts, healthcare professionals, and TNB peer educators on health beyond the healthcare system

The focus groups we conducted with TG2 highlighted close links between participants’ health and wellbeing across all their life settings and others’ willingness, or unwillingness, to acknowledge their gender identities. The focus-group findings resonated with the frameworks of orientation reconstructed from the TG1 interviews, which showed how acceptance and access in everyday settings shape TNB people’s wellbeing. As one TG2 participant explained:

> “Removing barriers [in society] simply means enabling social participation, whether it is going to the swimming pool or going to the sauna. So, access to places where bodies are visible also needs to be guaranteed so that social participation can take place there, and the same goes for sports […] These are the kinds of barriers that also affect other people but of course place an even greater burden on trans people in particular.” (TG2:1)

Another TG2 participant underlined that acceptance, or its absence, in key life settings is decisive, asking:

> “How does acceptance look in school […]? What is acceptance like in the workplace? Is the chosen name respected, accepted? Is it an environment in which one can live being trans or is it an environment where being trans is sanctioned through […] bullying, non-acceptance, discrimination, experiences of violence?” (TG2:7)

Data from both the interviews with members of TG1 and the focus groups emphasised the crucial role of people’s living environments – particularly whether they live in urban or rural communities – in shaping their access to healthcare and other services. In this context, peer-to-peer advisory schemes and TNB communities were described in both interviews and focus groups as the only actors that approached clients with a consistently affirming and supportive attitude, and therefore as a key form of provision for TNB people. As one TG3b participant summed up:

> “There are many people who are so withdrawn that they internalise incredibly harmful things which would be resolved very quickly if one simply talked to a real trans person. […] I think a major aid for mental health is to have this network, to have connections, to have friends, and simply to get out of one’s room.” (TG3b:2)

Building on this central role of TNB communities and peer-to-peer schemes as health-promoting spaces, the focus-group discussions with TG3b pointed to the need for comprehensive funding for the peer-to-peer support services provided by TNB peer educators, which at present are mostly delivered by volunteers. Participants called for paid positions in these services, full geographic coverage, and specific additional expertise in areas such as intersectionality, as well as a stronger voice for TNB issues in policy as a catalyst for change.

Discussion

Our findings point to a healthcare system that provides care to TNB people that is so precarious that it currently fails to meet their fundamental needs. A significant proportion of healthcare staff lacks not only basic knowledge of TNB lives and the specific health challenges faced by this group but also the skills to critically reflect on cis- and binary norms in the context of their work. The various responses of our interviewees that pointed out common challenges in their healthcare highlight how everyday professional behaviour can either facilitate or obstruct health-promoting care. In this respect, our findings are consistent with previous studies that have shown that non-discriminatory, TNB-affirmative healthcare can make a crucial difference to TNB people’s health when patients are approached with appropriate diversity awareness and the informed ability to address their needs (McCann/Donohue/Brown 2021). This underlines the central role of healthcare staff in reducing TNB people’s experience of minority stress (Smith 2020).

Our data also highlight both the resources TNB people draw on for their health and the vulnerabilities they face. Interviewees responded to the challenges of their situations by creating various practices and strategies that affected their health and, in some cases, risked exacerbating existing health issues, particularly for individuals already experiencing social isolation or avoiding contact with health services. Conversely, numerous participants engaged in strategies that benefited their health, such as acquiring a high level of knowledge on health matters, gaining self-efficacy, and seeking support from TNB community members, including peer educators (TG3).

Nevertheless, TNB people – especially those exposed to intersectional discrimination – typically must expend significant resources on developing strategies to navigate the impact of cis/binary norms within healthcare systems and services (Fütty 2019) and in other key settings such as workplaces, educational institutions, and sports clubs (Schmechel 2019). While the shared experience that TNB communities provide is highly health-promoting, community-based services cannot cover all eventualities and may not fully meet the needs of those experiencing discrimination on the grounds of race, disability, or class.

Building on these findings, we held participatory workshops at the end of the project, in which concrete needs for action were identified. The work done in these participatory settings also informs the following implications for practice and policy:

First, closing the identified gaps requires mandatory, competence-based sensitivity and awareness training on TNB health, including social, structural, and clinical aspects. This training should be evidence-based, co-developed with TNB experts, and embedded in undergraduate curricula, continuing professional development, and quality management. In addition, training and continuing education programmes developed by TNB communities themselves should receive adequate funding and institutional support, ensuring that community knowledge is formally integrated into the healthcare system and cooperation between healthcare providers and TNB communities is strengthened.

Second, structural reforms are needed to ensure low-threshold, TNB-affirmative access to healthcare. In the German context, this includes ensuring reliable coverage of transition-related interventions, the rapid implementation of ICD-11 guidelines, implementing low-threshold local services as well as gender-inclusive documentation and procedures, creating clear pathways for transition, and offering effective complaint mechanisms. Statutory health insurance should explicitly support intersectional health promotion for TNB people, for example by funding peer education, community counselling, and community-based training programmes on a long-term basis.

Third, health promotion efforts must extend beyond the healthcare sector. In line with participants' accounts of discrimination in workplaces, educational institutions, and sports, community services and structures should be provided across the board, and accessible, non-binary, and safe spaces for TNB people should be established in key life environments such as work and sports clubs. Taken together, these measures would place healthcare staff and institutions in a better position to support TNB people in making autonomous – and thus ultimately health-promoting – choices regarding their transition and their health overall.

Statement on research design

The input from our advisory committee was crucial in ensuring that our work would be relevant to our target communities. The committee advised us on sampling strategies for TG1 so that we could incorporate a range of perspectives in the research. It also supported us in defining TG3, including distinguishing members of TG3a – healthcare professionals – according to the degree of their expertise on TNB issues.

Throughout the study, we sought to do justice to the vulnerabilities affecting our target groups. For the interviews with TG1, we minimised situational power differentials by ensuring that TNB members from our project team conducted them. Because the interviews involved discussing highly challenging experiences of discrimination and our interviewers had often been exposed to similar experiences themselves or knew of them from TNB communities, we held team debriefings and offered advice and support to help them manage their positionality and the emotional strain involved. Over the course of the project, we regularly reflected on our research methods and adapted them where necessary. This included, for example, refraining from asking certain questions and deciding not to analyse some particularly sensitive material.

Limitations

The selective nature of our sample, which persisted notwithstanding the diversity of the recruitment strategy we employed, represents a limitation of the study. For example, despite specific follow-up recruitment efforts in various communities, the sample that made up TG1 comprised mostly young, white adults living in urban areas. The views of TNB people exposed to intersectional discrimination, such as Black people, other People of Colour, and/or refugees, of older TNB people, and of those from rural areas were underrepresented in our study; it may have been possible, with a longer recruitment phase, to achieve a more diverse sample through more extensive, targeted, and individual approaches. The recommendations for action we derived from our findings are intended to inspire change; research on their implementation and impact will determine whether and how they meet this aim.

Conclusion

Our findings show that TNB people in Germany experience multiple forms of health-related discrimination and structural barriers across the settings in which they live. These patterns, together with interim results of this research project (Richter 2022; Trautwein et al. 2023), underline the need to address discrimination, reduce stressors, and strengthen structural resources that promote TNB people's health. Our findings gave rise to various recommendations for action to support TNB people in attaining optimal health; they include specific support for intersectional health promotion programmes aimed at TNB people, evidence-based training for healthcare professionals around TNB people's health needs, accessible medical transition pathways, and full information coverage on resources and services available in and via TNB communities.

Data availability statement

For ethical, privacy, and other reasons, the research data will not be published.

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