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"Being trans intersects with my cultural identity": Social determinants of mental health among Asian transgender people

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ABSTRACT:

Purpose: While studies on the relationship between social determinants and mental health among transgender people in Asia are increasing, there is a paucity of research on Asian transgender people living in Western countries. This study aimed to examine how social positions (gender, ethnicity, and migrant status) and social determinants of mental health were inter-related for Asian transgender people in Aotearoa/New Zealand.

Methods: We analyzed both quantitative and qualitative data from Asian participants (n = 49) who responded to the 2018 Counting Ourselves: Aotearoa New Zealand Trans and Non-Binary Health Survey.

Results: Overall, 35% reported a very high psychological distress level. There were high levels of unmet needs for gender-affirming care, and participants reported a range of negative experiences at health care settings. About two-fifths had been discriminated because of their transgender (42%) or Asian (39%) identities. Fewer than half of participants felt that their family members were supportive of them being transgender (44%), and most reported they had supportive friends (73%). More than two-thirds of participants (68%) had a strong sense of belongingness to the transgender community and 35% reported this for the Asian community. Qualitative findings revealed specific challenges that participants experienced; these included barriers to accessing health care due to their migrant status and language barriers, influences of Asian cultures on mental health experiences, and rejection by family and people in Asian communities.

Conclusion: Our study provides evidence for health care providers, researchers, and policy makers to employ a culturally appropriate lens to improve knowledge about the intersectional experiences of being Asian and transgender.

KEYWORDS: social determinants; mental health; Asian; transgender; migrant

Introduction

Transgender mental health has been recently described as a ''public health crisis,''[1] as international studies have reported large mental health inequities faced by transgender people, including psychological distress, non-suicidal self-injury (NSSI), and suicidality.[2–5] Based on a health equity perspective that explores social determinants of health,[6] international studies have found that mental health issues among transgender people are associated with enacted stigma (overt experiences of discrimination, rejection, and gender nonaffirmation), unmet need for gender-affirming care, and negative interactions with health providers.[3,4,7–9]

Transgender people in Aotearoa/New Zealand (hereafter referred to as Aotearoa) share a different gender-affirming care provision in context to other countries, and only a handful of studies have examined gender-affirming care as a social determinant of health for transgender people in this country.[10–12] In Aotearoa, gender-affirming care such as top surgeries (e.g., breast augmentation and chest reconstruction) and hormone therapy (except genital surgeries) can be accessed through primary care clinics or local District Health Boards (DHBs), although not all DHBs provide comprehensive gender-affirming care.[10,11] Transgender people who wish to be referred to publicly funded genital surgeries are required to undertake a readiness assessment from a health professional (e.g., endocrinologist or sexual health physician) who has gender-affirming health care expertise.[11] While overseas studies have uncovered negative health care experiences among transgender people of color due to prejudices and assumptions made about their transgender and race/ethnic identities,[13,14] we could not locate any studies specifically exploring this topic among Asian transgender people.

At present, there is a paucity of research specifically examining the social determinants of mental health among Asian transgender people living in Western countries. The lack of research focusing on this vulnerable population meant that the specific needs of Asian transgender people may be obscured within studies that recruited predominantly European (or White) transgender participants.[3–5] Moreover, existing (limited) studies that have looked at mental health differences across ethnic/racial groups of transgender people often housed Asian within the broader ethnic minority groups,[14,15] except for one recent U.S. study that explored the relationships between violence exposures and mental health outcomes for Asian transgender people.[16] While research on transgender people in Asia is beginning to flourish,[9,17,18] there needs to be careful consideration when extrapolating these findings to Asian transgender people in Western countries such as Aotearoa/New Zealand which have unique migration contexts.

Maori are the indigenous people of Aotearoa having migrated from eastern Polynesia in twelfth and thirteen centuries.19 The

European settlement in Aotearoa began with the arrival of James Cook in 1769, and subsequent colonization efforts involved land confiscation, assimilationist policies, and the imposition of European cultural and social practices.[19] Asian groups such as Chinese and Indian were also early settlers in late nineteenth century, although as a marginalized minority who were subjected to racist legislations.[20,21] Active recruitment of skilled and entrepreneurial Asian migrants began after the government abolished immigration policies that favored European migrants in 1986, and there has been a large increase in Asian migration since then.[20,21] The 2018 Aotearoa Census found that 15% of the population identified with at least one Asian ethnicity such as Chinese, Indian, and Filipino.[22] Although a majority of the Asian people in Aotearoa were born in countries in Asia, 23% were born locally.[2]

Despite Asian people constitute the third largest, as well as one of the fastest growing ethnic groups in Aotearoa,[22] Aotearoa findings on Asian transgender people have been previously restricted to youth.[5,23] This study drew data from the 2018 Counting Ourselves survey, a large nationwide Aotearoa survey of transgender people. Building on a health equity perspective,[6] this study filled in the current literature gap by understanding how social positions (gender, ethnicity, and migrant status) of Asian transgender people determine their access to social determinants. Specifically, we were interested in social determinants of health that are crucial to empower Asian transgender people in attaining full health potential; these comprised of enacted stigma experiences, gender-affirming and general health care access, interaction with health providers, and protective factors such as family, friends, transgender communities, and ethnic communities.

Materials and methods

Procedure

The Counting Ourselves: Aotearoa New Zealand Trans and Non-Binary Health Survey was the first comprehensive survey that examined the health of transgender people in Aotearoa/New Zealand. The survey was open for participation from June to September 2018, and it received a total of 1178 valid responses from transgender people aged 14 years residing in Aotearoa/New Zealand. Counting Ourselves used convenience sampling, with recruitment involving making connections with transgender community organizations, networks of health professionals working in trans health, and transgender people who were older and living in rural areas. The project team also invited transgender community leaders from parts of transgender communities that were likely to be harder to reach, including Asian transgender people, to share quotes about the importance of the survey of them. Illustrated images of these members and their quotes were used in the social media campaigns (see Supplementary Fig. S1 for an example).

Ethics approval for the survey was granted from the New Zealand Health and Disability Ethics Committee (18/NTB/66/AM01). For more details about the research design and recruitment strategy of the survey, see the published report.[24]

Measures

The Counting Ourselves survey incorporated questions from national population-based surveys such as the New Zealand Health Survey[25] and overseas transgender surveys such as the United States Transgender Survey.[3] Further questions on topics that were not covered in other national and international surveys were designed by the research team in collaboration with a community advisory group.

Sociodemographic variables included age, gender, race/ethnicity, birth country, refugee status, region, religion, education qualification, personal income, and employment status. Participants were allowed to select multiple options for ethnicity, allowing them to be counted as having more than one ethnic group.[26] We classified participants into one of the three gender groups (i.e., trans men, trans women, and nonbinary) based on their responses to two questions—sex assigned at birth and current gender(s). Trans men included those who identified as man, trans man, transsexual, or tangata ira tane, and were assigned female at birth. Trans women were participants who selected woman, trans woman, transsexual, tangata ira wahine, or whakawahine as current genders, and were assigned male at birth. Other participants who did not meet these criteria were classified as nonbinary.

Mental health of participants was examined using a range of variables such as psychological distress, binge eating, NSSI, suicidal ideation, and suicide attempt. All mental health variables were assessed using one-item questions except for the 10-item Kessler Psychological Distress (K10) Scale. The K10 demonstrated high internal consistency in the overall sample, and we used this scale to identify if participants had low or moderate (0–11), high (12–19), or very high (‡ 20) psychological distress.[27]

Participants were asked about their experiences accessing gender-affirming care and general health services. Unmet need for a gender-affirming care was defined as participants who wanted but could not access specific medical interventions.[24]

We examined enacted stigma experiences that occurred because of participants' transgender and ethnic identities; these comprised of discrimination, unfair treatment, verbal harassment, cyberbullying, and homelessness. Protective factors were explored in four domains: family, friends, transgender communities, and ethnic communities.

A general open-text question was provided at the end of each section in the survey for participants to elaborate on the issues that were not covered by the closed questions. In this article,

we analyzed responses of the open-text questions ''Is there anything else you would like to share with us about.'' from the following sections: gender-affirming care, general health services, mental health, discrimination, cultural connection, family and friends, and transgender identities and communities.

Participants

Participants were included in this study if identified with at least one Asian ethnicity, such as Chinese, Filipino, Indian, Japanese, and Thai. Overall, 4.4% (n = 49) of Counting Ourselves participants met this criterion. Table 1 presents detailed sociodemographic information on these participants. The mean age of Asian participants was 26.18 (range = 14–54; SD = 8.18), which was lesser than that of the overall sample.[24] While many Asian participants aligned their genders with Western identities such as nonbinary, trans man, and genderfluid, a few (n = 4, 8.2%) identified with gender-diverse identities within their cultures such as Chinese kua xing bie, Indian hijra, and ''Thai third gender.'' About three-fifths of Asian participants were born outside of Aotearoa/New Zealand, and one-tenth of participants had applied for refugee status. A majority of participants did not have a religion, and were living in urban regions such as Auckland and Wellington. Approximately three-fifth had a university qualification. Slightly more than one-third had personal income of < 5001 in the last 12 months, which was similar to the proportion of participants not currently employed.

Table 1. Demographic details of Counting Ourselves Asian participants

	n (%)
Age groups (n = 49)	
14-19	10 (20.4)
20-24	14 (28.6)
25-34	18 (36.7)
35+	7 (14.3)
Gender group[a] (n = 49)	
Trans men	22 (44.9)
Non-binary AFAB	22 (44.9)
Non-binary AMAB	3 (6.1)
Trans women	2 (4.1)
Gender[b]	
Non-binary	19 (38.8)
Trans man	19 (38.8)
Genderfluid	15 (30.6)
Transgender	14 (28.6)
Man	14 (28.6)
Genderqueer	8 (16.3)
Woman	7 (14.3)
Trans woman	3 (6.1)
Agender	3 (6.1)
Others	4 (8.2)
Ethnicity[b]	
Chinese	17 (34.7)
New Zealand European/Pākehā	16 (32.7)
Filipino	11 (22.4)
Indian	9 (18.4)
Māori	4 (8.2)
Japanese	4 (8.2)
Others such as Thai, Korean, and Lao	12 (24.5)
Birth country (n = 49)	
Aotearoa/New Zealand	20 (40.8)
Philippines	8 (16.3)
United States of America	4 (8.2)
China	3 (6.1)
Singapore	3 (6.1)
Others such as Australia, Taiwan, and Thailand	11 (22.4)
Applied to be a refugee[c] (n = 29)	3 (10.3)
Regions (n = 48)	
Auckland	29 (60.4)
Wellington	12 (25.0)
Other North Island	3 (6.3)
South Island	4 (8.3)
Religion (n = 32)	
No religion	22 (68.8)
Christian	4 (12.5)
Buddhist	3 (9.4)
Other	3 (9.4)
Education qualification (n = 32)	
None	2 (6.3)
Level 1 to 6 Certificate	11 (34.4)
Level 7 or Bachelor degree	13 (40.6)
Level 8 and above Postgraduate degree	6 (18.7)
Personal income in last 12 months (n = 31)	
NZD <$5,001	11 (35.5)
NZD $5,001 to $25,000	9 (29.0)
NZD $25,001 to $50,000	7 (22.6)
NZD $50,001 or over	4 (12.9)
Median income	NZ$20,001 to 25,000
Current employment (n = 31)	
In paid employment including self-employment	20 (64.5)
Not in paid work and looking for job	4 (12.9)
Not in paid work and not looking for a job (e.g., retired, homemaker, or full-time student)	7 (22.6)

[a]Participants were categorised into one of the four gender groups based on their responses to sex assigned at birth and current gender identification

[b]Participants could select multiple options

[c]Among participants who were not born in Aotearoa/New Zealand
AMAB = assigned male at birth; AFAB = assigned female at birth; NZD = New Zealand dollars

Data analysis

Descriptive analyses were carried out in IBM SPSS Statistics v26. Not all participants completed the whole survey, as questions in the later part of the survey had a lower number of participants due to participant attrition over a long survey (330 questions).[24] Thirty-two Asian participants completed the last section of the survey, giving a completion rate of 65.3%. The presented frequencies and proportions excluded missing responses except for the psychological distress variable, where data were imputed if participants completed at least some of this scale. The missing responses of 10- item Kessler

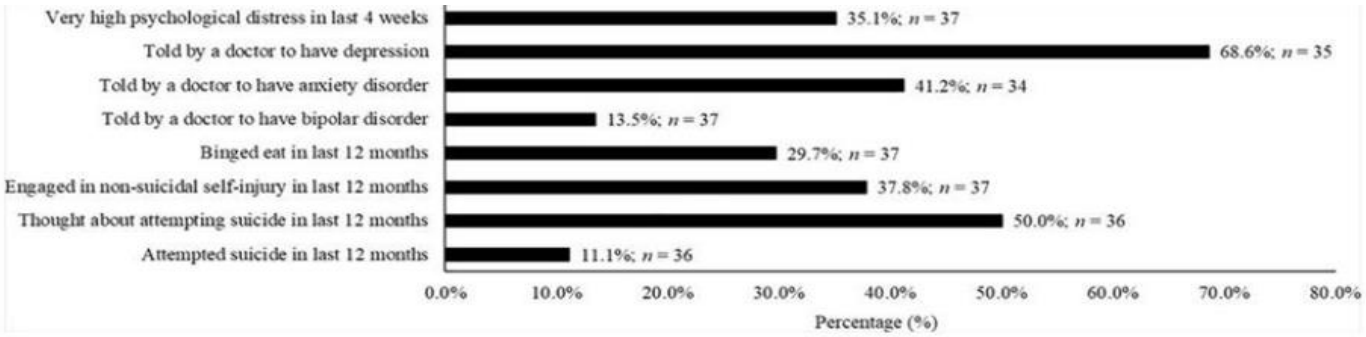

Figure 1. Mental health of Counting Ourselves Asian participants. *n* indicates the total number of participants responded to the questions.

Psychological Distress Scale were imputed using the expectation maximization method.[27] We undertook a conventional content analysis on the qualitative responses to the open-text questions. This inductive analytic approach was useful to describe common issues identified through the contents of the data.[28] All open-text responses were initially read multiple times by the first author to achieve immersion. The first author was responsible to create a coding schema, and select exemplars for each code and category. The exemplars used were jointly discussed, and a consensus was reached among all authors. We provide information on age group and gender group for each exemplar, but not the specific ethnicity as it would risk leading to deductive disclosure.

Results

The mental health experiences of Asian transgender participants are presented in Figure 1. About one-third had experienced very high psychological distress in the last 4 weeks. More than two-third had been confirmed by a doctor for depression, and more than two-fifth for anxiety disorder. Close to one-third of participants had a large amount of food in a short period of time that they felt out of control (binge eating), and more than one-third reported NSSI. In the last 12 months, half had thought about attempting suicides and one-tenth had attempted suicides.

Table 2 details health care access enablers and barriers reported by participants. An exceptionally high proportion of participants reported unmet need for voice therapy, chest reconstruction surgery, hysterectomy or oophorectomy, and genital reconstruction surgery. More than half felt uncomfortable or very uncomfortable discussing about their genders with a doctor, and one in twenty had experienced at least one negative interaction with doctors, nurses, and administrative staff as a transgender person. It was common for participants to report that staff in health care settings knew very little or only some things about providing care to transgender people, and that they had to teach staff about this. Half of participants were confident and had trust in the health professionals that they visited for gender-affirming care. Most participants had a doctor that they commonly visited for general health care, and more than two-fifths had confidence and trust in their doctors.

Participants' experiences of enacted stigma and protective factors are shown in Table 3. About two-fifths of participants had experienced discrimination because of their transgender or ethnic identities, and were unfairly treated for their genders. Due to being trans, at least one-fifth were exposed to verbal harassment, cyberbullying such as being sent threatening and sexual messages, and rejection by a religious community. A smaller number of participants had been denied a home, evicted from home, or were homeless because of violence from family members.

Some participants (n = 7) did not disclose their transgender identity to their family, but more than two-fifths of those who did felt that their family members were supportive of their genders. Some of the common positive experiences that participants reported were being told that they would be supported and used preferred name. More than two-thirds had friends who cared about them and had a strong sense of belongingness to transgender community. Only about one-third felt a strong sense of belongingness to their ethnic group, and this was reflective of limited opportunities to attend cultural events and difficulty in finding someone to help with cultural practices. Nonetheless, more than twothirds agreed that they had spent time to learn more about their ethnic backgrounds.

Open-text responses of participants for mental health and social determinants (general-affirming care, general health services, enacted stigma, and protective factors) are summarized in Table 4. About half (49.0%; n = 24) voluntarily left at least one qualitative comment in the open-text questions that we examined. Due to the low number of responses and categories in each section, we chose to discuss the findings of the qualitative analysis alongside quantitative results in the discussion section.

Table 2. Health care access enables and barriers among Counting Ourselves Asian participants

	n (%)
Gender-affirming Care	
Unmet need for gender-affirming care services[a]	
Counselling (*n* = 40)	14 (35.0)
Mental health assessment (*n* = 37)	18 (48.6)
Hormone treatment (*n* = 32)	9 (28.1)
Voice therapy (*n* = 16)	15 (93.8)
Chest reconstruction surgery[b] (*n* = 28)	23 (82.1)
Hysterectomy or oophorectomy[b] (*n* = 23)	19 (82.6)
Breast augmentation (*n* = 2)[c]	1 (50.0)
Orchidectomy (*n* = 2)[c]	1 (50.0)
Genital reconstruction surgery (*n* = 13)	12 (92.3)
Comfortable discussing being trans with a primary care doctor[d] (*n* = 42)	
Comfortable or very comfortable	11 (26.2)
Neither comfortable nor uncomfortable	8 (19.0)
Uncomfortable or very uncomfortable	23 (54.8)
Negative health care experiences as a transgender person[e] (*n* = 43)	
Had to teach someone about trans	17 (39.5)
Asked unnecessary or invasive questions	14 (32.6)
Told that they didn't know enough about gender-affirming care to provide it	10 (23.3)
Knowingly used an old name	10 (23.3)
Referred to you by the wrong gender	8 (18.6)
Discouraged from exploring gender	6 (14.0)
Tried to stop you from being transgender	5 (12.8)
Physically rough or abusive	3 (7.0)
Refused care or had care ended because of trans	2 (4.7)
Provider knew about providing health care for transgender people[f] (*n* = 21)	
Very little or Some things	9 (42.9)
Most things or Almost everything	12 (57.1)
Confidence and trust in medical specialist[f] (*n* = 21)	
Yes, definitely	11 (52.4)
To some extent	8 (38.1)
Not at all	2 (9.5)
General Health Care	
Have a general practitioner clinic or medical centre that usually go to (*n* = 40)	36 (90.0)
Confidence and trust in general practitioner (*n* = 39)	
Yes, definitely	17 (43.6)
To some extent	20 (51.3)
Not at all	2 (5.1)

[a]Unmet need was defined as participants who wanted but could not access specific medical interventions.
[b]Among trans men and non-binary participants assigned female at birth
[c]Among trans women and non-binary participants assigned male at birth. Due to the low number of participants among these gender groups, we chose to not elaborate on these findings in the discussion section.
[d]Among participants with a primary care doctor
[e]Among participants who had discussed gender-affirming care with a health professional
[f]Among participants who had a main health provider for gender-affirming care

Table 3. Enacted stigma and protective factors among Counting Ourselves Asian participants

	n (%)
Enacted Stigma	
Ever been discriminated against because of being trans (*n* = 33)	14 (42.4)
Ever been discriminated against because of race or ethnic group (*n* = 33)	13 (39.4)
Ever been discriminated because of being trans and race/ethnic group (*n* = 33)	6 (18.2)
Any discrimination experiences in last 12 months	21 (60.0)
Ever been unfairly treated in social settings because of being trans[a] (*n* = 29)	11 (37.9)
Ever been verbally harassed in social settings because of being trans[a] (*n* = 29)	6 (20.7)
Ever been sent threatening messages through phone or internet because of being trans (*n* = 32)	9 (28.1)
Ever been sent unwanted sexual messages through phone or internet because of being trans (*n* = 32)	7 (21.9)
Ever left a religious community due to rejection for being trans (*n* = 32)	7 (21.9)
Denied a home or apartment because of gender (*n* = 33)	4 (12.1)
Evicted from home or apartment because of gender (*n* = 33)	2 (6.1)
Homeless because of violence from a partner or family member due to gender (*n* = 33)	2 (6.1)
Protective Factors	
Family being supportive of being transgender[b] (*n* = 25)	
Most or all were unsupportive	9 (36.0)
About half were supportive	5 (20.0)
Most or all were supportive	11 (44.0)
Experiences growing up with family members (*n* = 33)	
Told me that they respect and/or support me	14 (42.4)
Used preferred name	13 (39.4)
Used correct pronouns	10 (30.3)
Stood up for me with family, friends, or others	8 (24.2)
Did research to learn how to best support me (such as reading books, using online information, or attending a conference)	6 (18.2)
Lent or gave me money to help with any part of my gender transition	5 (15.2)
Helped me change my name and/or gender on my identity documents (ID), such as doing things like filling out papers or going with me to court	2 (6.1)
Have a friend or friends that can talk about anything (*n* = 33)	28 (84.8)
Felt that friends care a lot (*n* = 30)	22 (73.3)
A strong sense of belongingness to trans or non-binary community[c] (*n* = 34)	23 (67.6)
Ways socialise with other trans people (*n* = 34)	
In person	26 (76.5)
Online	26 (76.5)

Support groups	13 (38.2)
Political activism	13 (38.2)
A strong sense of belongingness to ethnic group[c] (n = 34)	12 (35.3)
Spent time to find out more about ethnic background, such as its history, traditions, and customs (n = 34)	
Somewhat disagree or strongly disagree	5 (14.7)
Neither agree nor disagree	3 (8.8)
Somewhat agree or strongly agree	26 (76.5)
Number of times attended an event that celebrated cultural identity in last 12 month (n = 32)	
None	19 (59.4)
Once	9 (28.1)
3 to 5 times	4 (12.5)
Ease of finding someone to help with cultural practices, such as going to a ceremony, speaking at a celebration, or blessing an event[d] (n = 27)	
Easy or very easy	8 (29.6)
Sometimes easy or sometimes hard	9 (34.6)
Hard or very hard	10 (27.8)

[a]Among participants who had accessed services such as drug or alcohol treatment program, driver licensing service, Work and Income service, gym, legal services, court, bank, aged care, public transport, retail store, and restaurant.

[b]Participants who had not disclosed their transgender identities were excluded (n = 7)

[c]Participants were asked to rate their belongingness from 0 (no sense of belongingness) to 10 (strong sense of belongingness) and those who rated a score of 6 or higher were classified as having strong sense of belongingness

[d]Participants who responded "This does not apply" were excluded (n = 5)

Discussion

To the best of our knowledge, this is one of the few studies to employ quantitative and qualitative data to examine mental health, as well as relevant social determinants, among Asian transgender people living in Western countries. Similar to the 2015 US Trans Survey that uncovered high prevalence of mental health difficulties among Asian transgender people,[16] participants in this study exhibited high levels of mental health difficulties, ranging from psychological distress, binge eating, NSSI, suicidal ideation, and suicide attempt. When compared with Aotearoa population estimates,[25] our findings revealed that Asian transgender participants had a 9 times increased likelihood than the overall general population (64.9% vs. 7.4%), as well as 16 times increased likelihood than the Asian population (64.9% vs. 3.9%), to manifest high or very high psychological distress level.

From a health equity perspective, the mental health inequities between Asian transgender people and general populations occur due to the unequal distribution of social determinants of health.[6,29] Despite the wide recognition of gender-affirming care as a social determinant for transgender people who require it,[4,9,17,30] international studies have shown that transgender people were more likely to experience unmet health care needs than their cisgender counterparts.[31] Compared with the overall proportions of Counting Ourselves participants,[24] we found more substantial unmet needs for gender-affirming care among Asian participants, especially for chest reconstruction (82.1% vs. 73.7%) and genital reconstruction surgeries (92.3% vs. 86.2%).

In addition to the health care barriers shared by non-Asian transgender participants in Counting Ourselves, such as the inconsistent provision of gender-affirming services across regions and gatekeeping practices,[24] qualitative findings shed light on the specific barriers faced by Asian transgender participants. For instance, our migrant participants noted the unavailability of publicly funded care for noncitizens of Aotearoa and language barriers when English was not their first language. Similar to international research on transgender people,[7,17,31] a high proportion of our participants reported that health professionals had limited knowledge about gender diversity, and that they had to educate staff about their health needs. The lack of transgender-specific training in Aotearoa is likely the reason for the gaps in competency in health care provision for Asian transgender people,[32] and our findings support a need to upskill health professionals to provide trans-affirmative care that is inclusive of the identities and mental health experiences of this population.[30]

Our participants commonly reported experiencing discrimination, unfair treatment, and cyberbullying due to being transgender. Relative to the overall Counting Ourselves cohort,[24] we found that Asian participants were less likely to report being discriminated because of their transgender identities (51.2% vs. 42.4%) but more likely to feel discriminated for their race/ ethnicity (6.7% vs. 39.4%). When compared with the prevalence of any discrimination experiences in the last 12 months among Asian population,[33] our participants were twice more likely to report being discriminated against (25.8% vs. 60.0%).

Numerous international studies have found associations between these enacted stigma experiences and heightened levels of mental health problems.[3,4,8,9] Such studies included the 2015 US Trans Survey that documented higher risks of psychological distress and suicidality among Asian transgender people who had experienced partner abuses and enacted stigma when accessing bathrooms.16 Our findings of the overlapping prevalence of being discriminated against because of transgender and ethnic identities provided a direction for future studies to consider the multiple and intersecting prejudices that shape the enacted stigma experience of Asian transgender people through an intersectionality framework.[34] The high rates of enacted stigma among our participants endorse the Human Rights Commission's call to explicitly mention transgender people within the Human Right Act 1993,[35] as this was also mentioned by one participant who felt transgender rights were not safeguarded under the current law especially in regard to covert discrimination.

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Table 4. Participants' categories and quotes

Section	Question	Categories	Exemplar quotes
Gender-affirming care	Is there anything else that you would like to share about your experiences of accessing gender-affirming healthcare through the New Zealand public health system (i.e., DHB services)? (*n* = 17)	Access: It was common for participants to experience barriers in accessing gender-affirming care, which included long waiting time and barriers due to migrant status.	It's too much frustration. My referral for top surgery was around 4/5 months ago. I am continuously requesting my doctor in the sexual health clinic to re-reply. She is not doing it. I am feeling so much helpless and stress. (Trans man, Adult)
			Immigrants to NZ (non-residents) often have no access to affordable gender affirming health. We have to either go back to our countries of citizenship or pay out of pocket. This is extremely frustrating and debilitating for me. I have been in years of gender therapy in the USA, had top surgery in the USA but still was faced with jumping through hoops to get access to hormones in NZ. (Non-binary, Youth)
		Mental health assessment: Participants reported low competency of mental health professionals in delivering gender-affirming care and gatekeeping practices.	Psychiatrist was unaware of why I felt a rush to start hormone therapy (worried about effects of testosterone being unopposed causing virilization of my body) and caused me to wait almost one year refusing to write my referral letter to endocrinology. (Trans woman, Adult)
			If they are going to make a psychological assessment compulsory, it should be provided at no cost. (Trans man, Adult)
		Information: Insufficient and inconsistent information on gender-affirming care led to delayed in access.	There doesn't seem to be a lot of information available to either patients or healthcare providers that is up to date and relevant. Some of the information seems contradictory and confusing. There are different option for different District Health Board areas. (Non-binary, Adult)
	If you would like to share more about any experiences of accessing gender-affirming healthcare services as a trans or non-binary person, please do so here. (*n* = 8)	Access: Participants noted the limited access to public gender-affirming services and the costly private services.	It was not easy to find information. A lot of GP's are really uninformed of the availabilities. I initially paid for private treatment that was costing an arm and a leg through the fertility clinic then went public. I paid for my own psychiatrist to sign my letter. Again that cost an arm and a leg. Going through private was not necessarily the best option but it was quicker. (Trans man, Adult)
		Differential access: Participants brought up differences in provision of gender-affirming care across regions in Aotearoa.	When I tried getting hormone replacement therapy in Wellington I had to wait quite a while just to hear back from anyone but I moved to Auckland before anything happened. Response in Auckland was way faster. (Trans man, Youth)
General health services	Is there anything else you want to share about the level of support or respect you have received, as a trans or non-binary person accessing healthcare? (*n* = 7)	Negative experiences: Some participants experienced negative interactions with health care providers.	Once I had a counsellor who just kept asking me about transitioning (when my issues were related to a relationship breakup) and kept asking me what it was like. (Trans woman, Adult)
		Migrant: One participant shared their difficultly in accessing health service as an international student.	As I'm a person of color, an international student who speaks English as my second [language], I feel uncomfortable to disclose my gender identity to a health care provider who I don't know. (Non-binary, Adult)

Mental health	Is there anything further about your mental health that you would like to share with us here? (*n* = 5)	Culture: One participant linked mental health to his Asian upbringing.	In my family and culture, I was always told not to show emotions and I grew up believing that showing emotions is weak. I became reclusive of my emotions and never talked about what I felt to anyone, even my family. As I grow older, I started to realize that not everyone was like that, so I tried talking to my family. It felt very uncomfortable and scary. My family tried to understand but still encourage me to control my emotions. I also did not like the overwhelming feeling of the different emotions in me, so I have chosen to push them back and not deal with the emotions. It gives me a clearer head space and allows me to think and make decisions. I know that bottling everything up is probably not healthy, but this is the way that I am familiar with and it is effective for me. (Trans man, Youth)
		Friends and family: One participant shared the importance of having supportive friends and family members in affirming their trans identity.	I'm fairly sure my poor mental health stemmed directly from being trans - I didn't know it at the time but I was very unhappy during high school and did consider suicide but could never bring myself to try. The only other time I have considered it was during the process of realizing I was trans, because it took me a long time to come to terms with it and I was scared of what I might have to deal with, but that improved with time and with support from friends and family. (Trans man, Youth)
Discrimination	Is there anything else that you would like to tell us about your experiences of acceptance or discrimination in Aotearoa New Zealand so we can better understand your experiences? (*n* = 4)	Law: Some participants described their low levels of confidence with current Aotearoa laws in protecting their human rights.	While I know we are protected legally against discrimination I don't think everyone knows this which is why I think it needs to be explicitly stated in our human rights act. Even though we are protected legally, it doesn't help against people discriminating if they are not overt. For example, if I feel I haven't gotten a job or house because I'm trans I can't do anything if the person hasn't stated outright that that is the reason. (Trans man, Adult)
		Inclusivity: Participants shared negative experiences navigating the social settings as a transgender person.	I wanted to join an anger issues program but would have felt very uncomfortable in a Women's group and was advised I would have made the men uncomfortable in a Men's group so I was left with one-on-one counselling. I was also denied inclusion in a support group for pelvic floor prolapse because it was for women and my inclusion would have made them feel unsafe. (Non-binary, Adult)
Culture	Is there anything else you want to share about your sense of connection to your cultural or ethnic background? (*n* = 8)	Intersectionality: Participants noted the difficulty in connecting to their cultures because of their trans identities.	As I'm Asian and Buddhist so I go to a Buddhist temple for cultural celebrations. Even though I enjoy the celebrations, I often feel out of place because I know I'm different from them. (Non-binary, Adult)
Family and friends	Is there anything else you would like to share with us about your interactions with friends or with whānau / family members? (*n* = 7)	Coming out: Disclosing trans identities to friends and family members was a challenge for our participants.	I came out to friends before family members and for the most part my friends have been extremely supportive and willing to learn and be open about my experiences. It was more difficult with my immediate family and I did not speak to my sister for over a year (even though we lived in the same house) because she did not 'believe I was trans'. (Trans man, Youth)
		Intersectionality: Some participants talked about the	As with many trans/non-binary people of color, me being genderfluid intersects with my cultural identity–while I may know several other trans and non-binary people,

		unique intersection of their ethnic and gender identities.	sometimes even then they may not be able to understand what I am going through because they are not Asian/a person of color. (Non-binary, Adult)
		Rejection: Participants shared experiences of being rejected by family members due to their transgender identities.	I grew up with multiple families and all from conservative, religious backgrounds that have all rejected me being trans. (Trans man, Adult)
Transgender identity and communities	Is there anything else you would like to share about how you feel about being trans or non-binary, or your sense of connection to other trans or non-binary people? (n = 2)	Identity: One participant touched on his sense of being a trans person.	I'm not ashamed of being trans/non-binary but I do feel my life would be easier or better if I was born cisgender. (Trans man, Youth)
		Community: One participant shared his experience of connecting with other trans and non-binary people.	I have many trans and non-binary friends, and have been in two relationships with non-binary partners, and having people like that around me has helped a lot. I have close friends who can relate to my experiences on a personal level, who accept me (I'd say my cis friends do too, but there's something about having people who have literally lived it too). I have often been someone that other trans/non-binary friends felt safe coming out to and talking to about those experiences and feelings. As one of the first people in my social circle to come out this way, I found that by being out and existing as non-binary in my life that I was often a safe person to open up to for others. It has made me really happy to be able to be there for people I care about in this way. (Trans man, Youth)

DHB, District Health Board; GP, general practitioner; NZ, New Zealand.

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As observed from participants' responses and previous research,[2,9,14] supportive family environments could lead to affirmation of transgender people's identities and better mental health. It was also apparent in our qualitative findings that family members played crucial roles in influencing Asian transgender people's evolving sense of transgender and ethnic identities, which included their coping strategies for mental health issues.[14] We noted that some participants had not disclosed their transgender identities to their family members, which may be due to Asian cultures being relatively conservative toward gender diversity.[9,17,36] The high numbers of participants reporting having friends who cared about them also suggested that participants were more likely to turn to their friends for gender advice. However, further investigations are required into the specific types of social support offered by family versus friends for Asian transgender people.

In line with previous research that found lower level of mental health difficulties associated with transgender community connectedness,[2,8] our participants reported mental health benefits of having friends in the transgender communities. It appeared to be easier for participants to establish friendships with peers who shared similar life experiences to a transgender person, although one participant noted a lack of understanding of the intersectional ethnic and transgender identities among non-Asian transgender peers.

Our participants reported a lower sense of belongingness to their ethnic group than their sense of belongingness to transgender communities. Some participants shared that their transgender identities presented obstacles for them to connect with their ethnic communities as the results of prescribed social norms (i.e., cisnormativity) in Asian cultures that reinforce the normalization of cisgender identities and expression.[9,17,23,36] Due to the construction of transgender identities as a transgression of Asian traditional gender roles, studies in Asia found transgender people were likely to leave their families and communities for the fear of being shamed and discriminated.[9,17,23,36] Considering our findings, we recommend researchers to follow-up with a more in-depth investigation of the intersectional experiences of Asian transgender people in navigating ethnic communities as a protective factor.

Limitation

There are a number of limitations that should be borne in mind. Compared with the general population estimates of 15%,17 there was a lower proportion of Asian participants in Counting Ourselves (4.2%; $n = 49$). The relatively small sample size meant that we could not examine the mental health differences across Asian communities. The relatively high numbers of Asian participants assigned female at birth could be a limitation although a similar demographic profile has been reported in a population-based youth study in Aotearoa, the Youth'12 study.[5] We also noted a higher proportion of our participants born in Aotearoa (40.8%) relative to the Asian population (23.0%).[22] Lower number of migrants in our sample may suggest the underreporting of mental health difficulties and enacted stigma when accessing social determinants among those who faced additional barriers due to language issue and noncitizen status.

The use of convenience sampling also led to overrecruitment of participants who were younger, from urban regions, and more connected to transgender community organizations;[24] therefore, the generalization of findings to Asian transgender people who were older and from rural regions ought to be cautiously made. Finally, not all participants chose to provide qualitative comments, and the low number of qualitative responses reduced the richness of our content analysis. Another methodological limitation was the use of nondirective qualitative responses from a survey; such short responses often lack clarity around the context of the responses.[37] Despite the concerns mentioned, we deemed the inclusion of qualitative data as useful as it provided complementary findings that were not covered by the closed-ended questions.[37]

Conclusion

In response to the call to designate transgender identities as a social determinant of health,[29] this study has addressed an important literature gap on the social determinants of mental health among Asian transgender people. While our focus has been on Aotearoa/New Zealand, we believe that our findings may be relevant to Asian transgender people living in other Western countries, as we expect that there will be similarities in the way that this population navigates their genders, races/ethnicities, and migrant identities. Our findings strongly indicate a need to utilize a culturally appropriate lens to understand the social determinants of Asian transgender people, as our study has uncovered the specific barriers to access health care and social settings, influences of Asian cultures on mental health experiences, and challenges to establish supportive networks within family, friends, transgender communities, and Asian communities.

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Supplemental online material.

Online supplemental file 1. An example of illustrated images alongside quotes used to recruit Asian transgender participants