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2026 Survey Report on the Living Conditions of Transgender People in Chinese Online Communities

Analysis-eligible records n=900 · Valid age responses n=899 · Report version v1.2 · August 2026

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Chapter 1 · EXECUTIVE SUMMARY

Executive Summary

The survey recruited respondents through an online questionnaire and describes their self-reported experiences of identity awareness, everyday expression, medical needs, family relationships, campus experiences, employment circumstances, mental health, and social support. The summary below condenses the key findings and directions for action; full data and methods appear in later chapters.

43.5%

Aged 18–22 · largest age group in the sample

Three youngest age groups combined: 73.1% · n=899

16.8%

Can live fully as their gender identity

Expression concentrated online: 87.7%

71.9%

Currently on HRT

Another 14.6% want to start but have not · n=859

73.7%

At least one negative campus experience

Verbal discrimination 49.3% · n=749

88.4%

Frequent emotional distress in the past six months

Self-reported: frequent anxiety 61.8% · frequent depressive moods 61.1%

68.2%

History of self-harm

Evidence of safety support needs, not identity attribution

Important note

The survey used non-probability sampling, and the sample is dominated by young respondents (43.5% aged 18–22). All results describe only the respondents of this survey and cannot be generalised to transgender and gender-diverse people across China. All "associations" or "correlations" are statistical and do not imply causality.

1.1 Key Findings

Sample characteristics

A notably young sample

Among respondents with a valid age answer (n=899), 43.5% were 18–22, 20.6% were 16–17, and 9.0% were 12–15; the three youngest age groups together accounted for 73.1%. Gender identity was diverse (women 70.3%, non-binary 28.3%, men 11.7%, still exploring 11.6% — multiple choice). Residence was concentrated in urban tiers: tier-1 and new tier-1 cities together 44.0%, tier-2 cities 17.1%, tier-3 and below plus county/town 29.6%, and overseas plus Hong Kong, Macao and Taiwan 9.3%. The medical needs, family dependence, campus experiences, and economic circumstances in this report must be read against this young sample structure.

Identity awareness and expression

Aware early, expression constrained

More than 80% of respondents (84.8%) noticed their gender identity difference at or before age 17 (13–17: 36.5%; 7–12: 33.9%; before 6: 14.3%). However, the share able to live fully in line with their gender identity is not high (16.8%); expression is heavily concentrated in online spaces (87.7%) and trusted friend circles (55.3%), while rates in formal settings such as family, school, healthcare, and employment are notably low (all ≤16%). Well-being distributions differ by expression status (Cramér's $V=0.144$, adjusted $p<0.001$).

Healthcare access and voice needs

HRT common, channels informal, barriers multiple

71.9% of respondents who answered the HRT-status question (n=859) are currently on HRT, and 14.6% want to start but have not. Among respondents reporting how they obtain HRT (n=716, multiple choice), online informal sellers account for 66.6%, while regular hospital/clinic prescriptions in China account for 29.3%. Medical barriers include family opposition (59.9%), cost burden (51.7%), fear of discrimination (40.0%), resource shortage (35.4%), and insufficient professional supply (33.6%). Those more satisfied with medical care tend to also report higher well-being (rho=0.370, adjusted $p<0.001$, n=855).

Monitoring gaps

Only 20.4% of respondents undergo regular HRT health checks; 28.7% would like to but have no access.

Widespread voice anxiety

65.8% of respondents find it difficult or impossible to use a satisfying voice, and 56.9% are dissatisfied with their current voice. Voice is a significant source of gender-expression pressure.

Family

Awareness is not support

36.6% came out voluntarily; 29.6% said their family does not know; 20.1% were outed passively. Among respondents whose families know (multiple choice), silence/avoidance 58.2%, blame/accusation 48.4%, non-understanding 48.4%, support/acceptance 25.3%. Currently 26.9% describe "completely unsupportive"; among the 312 respondents who directly reviewed family attitude change, 49.4% report improvement, 36.9% report no real change, and 13.8% report deterioration. Those with more family support also tend to report higher well-being (rho=0.321, adjusted $p<0.001$).

Family restrictions and violence

Among respondents answering the family restriction/violence question for the past year (n=474, multiple choice), 39.7% experienced verbal/psychological violence, 33.3% medical interference, 20.0% economic violence, and 14.3% physical violence. Family harm involves medical autonomy, economic control, freedom of movement, and bodily safety.

Campus environment

Negative experiences widespread, institutions absent

73.7% of respondents answering the campus-experience question (n=749, multiple choice) reported at least one clear negative experience: verbal discrimination/ridicule 49.3%, isolation by classmates 44.6%, being required to dress as their assigned sex 36.0%, physical harassment/violence 27.2%. Those reporting more negative campus experiences also tend to report more psychological distress (rho=0.149, adjusted $p<0.001$).

More than 70% of respondents report almost no support or only sporadic support at school; the share of schools with overall supportive environments is under 20%. School policies that explicitly cover gender diversity and are effectively implemented are extremely rare (5.6%). Those with more school support also tend to report higher well-being (rho=0.278, adjusted $p<0.001$).

Employment and economy

Concealment is a primary cost

Among respondents with work experience (n=267, multiple choice), 52.1% had to hide their identity because it was not disclosed, 36.7% had to maintain an expression inconsistent with their gender identity, 23.2% were questioned because their documents did not match their appearance, and 21.3% were rejected for a job due to gender expression. 50.5% believe their transgender identity negatively affected their financial situation (n=283).

Mental health and safety support

Distress widespread, pressure multi-layered, support insufficient

Nearly 90% of respondents (88.4%) experienced at least one high-frequency emotional distress in the past six months (frequent anxiety 61.8%, frequent depressive moods 61.1%, emotional turbulence 58.0%). Pressure sources involve gender identity/body anxiety (83.7%), schoolwork (59.6%), family (58.6%), finances (56.7%), public policy/public opinion (41.4%), and healthcare access (32.9%). 45.5% find it difficult to obtain psychological support.

Self-harm and suicide-related experiences widespread

68.2% have a history of self-harm (had it but stopped 47.8%, still engaging in it 20.4%). On suicide-related experiences, lifetime self-reports show ideation without attempt 51.3% and attempt 37.6%; under that question's classification, at least one category was reported by 88.9%. These figures are evidence of safety support needs, not evidence of danger posed by transgender identity, and should not be attributed to the identity itself.

Well-being skewed low

47.1% rate their overall well-being negatively (n=896); only 20.7% say they are fairly or very happy.

Documents and public space

Document difficulties alongside public services

Nearly half of relevant respondents (48.8%) encountered questioning or inappropriate treatment in public affairs at least occasionally in the past six months. Those who face more document difficulties also report more difficulties with public services (Cramér's V=0.173, adjusted p=0.013).

Only 14.7% can comfortably use public facilities matching their gender identity; 35.3% are forced to use facilities for their assigned sex; 25.8% try to find alternatives; 22.9% avoid using them whenever possible.

Harassment fairly common

71.3% report some form of harassment experience (n=855). 21.2% frequently experience gender stereotypes or verbal bias; 72.1% at least occasionally (n=900).

Social support and desire for change

Inner resilience and peer support are the main protective sources

Their own inner strength 59.9%, friends in the transgender community 49.4%, cisgender friends who understand them 39.4%. Family support ranks low (11.6%). Those with more support sources also tend to report higher well-being (rho=0.179, adjusted $p<0.001$). 12.7% still say they currently draw strength and support from none.

Desire for change broad and diverse

83.7% would like to change body characteristics, but desire for change in voice (68.3%), finances (65.3%), mental health (63.5%), legal documents (55.6%), and family relationships (50.2%) is equally common — all above half. 80.0% express a strong desire for change (strongly want 43.5% + somewhat want 36.5%).

1.2 Cross-chapter threads

01

A young and diverse sample, aware early, but severely constrained in everyday expression: formal settings (family, school, healthcare, employment) lack safe conditions for expression.

02

Healthcare, family, campus, employment, documents and public space form interwoven practical barriers: for example, family opposition is reported alongside barriers to healthcare access, economic support, and identity expression; document-mismatch difficulties also appear across employment, public affairs, and public facilities.

03

Psychological distress must be interpreted within multi-layered external pressures, not attributed to identity itself: reported pressure sources involve body, schoolwork, family, finances, and institutional environments; distress should be read alongside multi-layered pressure, insufficient support, and safety needs — and cannot establish causal direction.

04

Inner resilience and relational networks protect, but coverage is uneven: structural responsibility should not be shifted onto individual resilience; services must actively reach the groups with the least support.

05

Desire for change spans body, voice, finances, psychology, law, and social environment: this is not a single medical issue.

1.3 Directions for action

The directions below draw on the survey findings and are intended as reference for service providers, policy discussions, and community organisations — not finalized policies that have passed cost-benefit or feasibility review:

Medical services

- Expand regular, affordable HRT assessment, prescription and follow-up services; integrate HRT health monitoring into the service chain.
- Provide harm-reduction information during the transition period where formal services do not yet sufficiently cover.

- Treat voice support as a standalone service: offer informed-consent, non-conversion-based training and referral.
- Improve privacy protection and professional training in medical services.
- Review potential accessibility barriers related to age and guardian-consent requirements, and explore institutional paths that balance individual autonomy, informed consent, and minor protection.

Family support

- Provide long-term family education and support programmes that can be entered repeatedly.
- Offer families accurate, non-pathologizing information that addresses misconceptions, traditional values, and social pressure.
- Build low-threshold safety plans, legal and psychological referrals, and emergency economic support.

Schools

- Explicitly include protection of gender identity and expression in anti-bullying policies.
- Establish support mechanisms with accountable staff, confidential procedures, and complaint channels.
- Provide professional training for teachers.
- Gradually reduce social stereotypes through systematic gender education, and promote gender education for students and families.

Employment and economy

- Drive inclusive redesign of recruitment, dress codes, document verification, name use, and anti-harassment processes.
- Offer more flexible, privacy-respecting alternatives in identity-verification processes.

Mental health and safety support

- Provide trauma-informed, non-pathologizing psychological services covering a range of distress, not a single diagnosis.
- Build low-threshold crisis support and long-term psychological services.

- In presentations of self-harm and suicide-related content, connect directly to support resources and handle the topic neutrally, without sensationalism.

Documents and public services

- Simplify document-change procedures and improve accessibility; reform front-desk identity-verification processes.
- Increase the supply of gender-neutral public facilities and push for gender-neutral redesign.

Social support and resource visibility

- Expand peer networks, partner and family support, while respecting individual resilience without transferring responsibility onto individuals.
- Make local support resources more visible and expand actual supply.
- Proactively reach the groups with the least support.

Cross-cutting principles

- Design support around diverse needs for change, covering body, voice, finances, psychology, law, and social environment.
- Respect individual autonomy: respond to desire for change while respecting those who are unsure or do not want to change.

1.4 Research limitations

- **Non-probability sampling and a young sample restrict generalisation**: the results cannot be generalised to all transgender and gender-diverse people in China.
- **Self-report and cross-sectional design limit interpretation**: all data are self-reported and collected at a single point in time; associations are not used to infer temporal order or causality.
- **An unexamined item is not "no association"; an item short of adjusted significance is not "no relationship"**: some pre-specified tests may fall short due to sample size, measurement, or analysis limits.
- **Passing technical QA does not establish representativeness, validity, external validity, or scientific conclusions**: technical QA only verifies the accuracy of numeric processing.
- **Reporting bias on sensitive topics**: domestic violence, self-harm, and suicide content may be under- or over-reported.

- **Measurement limits of single items or multi-select proxies**: some core concepts cannot capture all dimensions.

Full research limitations and methods are in Chapters 2 and 11.

1.5 How to read this report

- This report has 12 chapters: Chapter 2 introduces methods and limitations; Chapters 3–10 present findings by domain; Chapter 11 synthesizes conclusions and directions for action; Chapter 12 provides the appendix.
- Every percentage and count is given next to its paragraph, so you can check the charts against the text directly. Public materials present aggregate results only and cannot be traced back to any individual response.
- This web edition deliberately leaves out the item-by-item results table, the technical check records and some appendix detail; those exist only in the PDF edition. The method notes and limitations remain complete here.
- This report recommends keeping three boundaries in mind: within-sample description, self-reported data, and statistical association.
- Sensitive content (domestic violence, self-harm, suicide) is presented neutrally, without sensationalism or pathologization; relevant chapters provide psychological support and crisis-intervention resources (Chapters 8 and Appendix E).

Acknowledgements

We thank every respondent who shared their real experiences in the questionnaire. This report rests on respondents' self-reports and provides an empirical starting point for improving the situation of transgender and gender-diverse people. Improvement requires systemic collaboration across healthcare, family, education, employment, law, and social environment — and respect for each individual's autonomy and diverse needs.

Chapter 2

02

Background, Sample Characteristics, and Methodological Boundaries

Barriers faced by transgender and gender-diverse people in healthcare access, family support, school environments, employment conditions, and public services have been widely documented in international literature. A cross-sectional study based on the Chengdu TREASURE cohort also reports a statistical association between traumatic experiences (including LGBTQ+-related adversity) and depressive symptoms, discussed within a framework of minority stress, social support, and coping (Yang et al., 2026; see Appendix F).

43.5%
Aged 18–22 · largest age group · 391 people

70.3%
Gender identity: women (multi-select) · 632 people

2.1 Background and purpose
2.2 Sample characteristics
2.3 Methods and research limitations
2.4 Terminology
2.5 Structure of the report

2.1 Background and purpose

This study uses a cross-sectional self-report questionnaire design and recruited respondents through online platforms. The survey covers age of identity awareness, expression settings, use and access to hormone replacement therapy (HRT), family awareness and support, campus and workplace experiences, mental health status, difficulties using public services and facilities, sources of social

support, and willingness to change the status quo. The survey makes no clinical diagnosis; prior diagnosis experiences reported by respondents are self-reports, unverified against medical records. Other experiences are likewise unverified by physiological measurement or third-party checks.

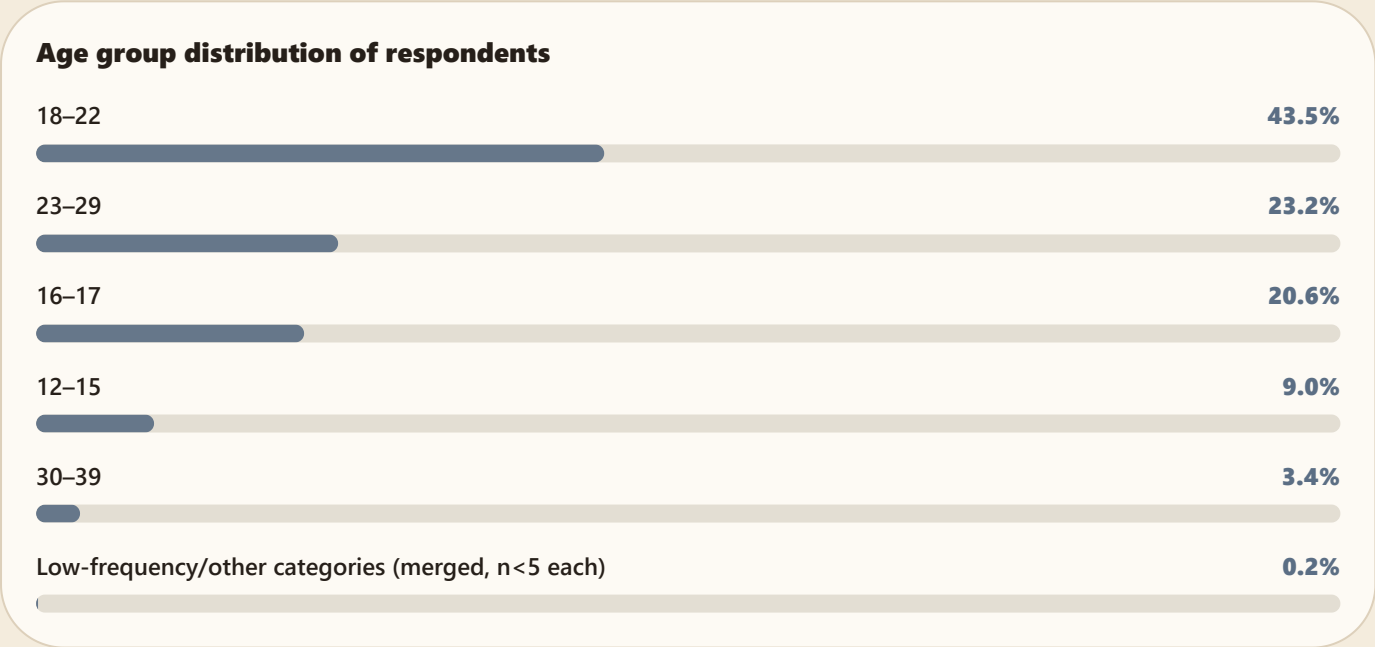
2.2 Sample characteristics

2.2.1 Age distribution: a notably young sample

The sample is notably young; 18–22 is the largest age group

Key finding

Among respondents who answered the age question (n=899), the distribution shows a clear youth bias.



18–22 accounted for 43.5% (391 people), the largest age group; 16–17 for 20.6% (185 people); 12–15 for 9.0% (81 people). The three youngest age groups together accounted for 73.1% of respondents with a valid answer. 23–29 accounted for 23.2% (209 people), 30–39 for 3.4% (31 people), and the remaining low-frequency categories together 0.2% (2 people).

This age structure is directly related to the recruitment channels (mainly online social platforms and community networks) and the sample type (non-probability convenience sampling). The high share of young respondents means that the medical needs, family dependence, campus experiences, and economic circumstances described here must be read against this age backdrop. Topics in later chapters — family conflict, enrolment status, minors' medical decision rights, and economic autonomy — are closely tied to this age structure.

Reading note: the findings describe only the respondents of this survey and cannot be directly generalised to all transgender and gender-diverse people across China. All percentages use valid respondents to that question as the denominator; the number of valid respondents may differ between questions.

2.2.2 Diversity of gender identities

Gender identities in the sample are diverse

Key finding

Among valid respondents to the gender-identity question (n=899, multi-select), women accounted for 70.3% (632 people), non-binary 28.3% (254 people), men 11.7% (105 people), still exploring 11.6% (104 people), genderfluid 10.1% (91 people), and agender 7.7% (69 people). Because this was a multi-select question, some respondents selected more than one category, so the percentages sum to more than 100%.

This distribution indicates clear diversity in gender identity among respondents: they should not be reduced to a single "transgender" category. When reading the medical needs, expression strategies, and support sources in later chapters, keep in mind that the experiences of people with different gender identities may differ. The analysis in this report is based on the records included in the main analysis and does not run formal statistical tests by gender-identity subgroup, so later findings should be read as overall patterns "among the respondents of this survey", not precise descriptions of a particular subgroup.

2.2.3 Residence: tier-1 and new tier-1 cities together largest share

Respondents live mainly in tier-1, new tier-1, and tier-2 cities

Key finding

Among respondents who answered the residence question (n=883), tier-1 cities (Beijing, Shanghai, Guangzhou, Shenzhen) accounted for 22.3% (197 people), new tier-1 cities (Chengdu, Hangzhou, Wuhan, Nanjing, etc.) 21.9% (193 people), tier-2 cities 16.9% (149 people), tier-3 and below 19.0% (168 people), county towns or townships 10.6% (94 people), overseas 7.2% (64 people), and Hong Kong, Macao and Taiwan regions of China 2.0% (18 people).

Tier-1 and new tier-1 cities together have the largest share, and tier-3-and-below plus county/town also has a meaningful share. This regional distribution is related to online recruitment channels and may run parallel to differences in medical resources, community activity, and information access

across city tiers, providing context for barriers such as "no relevant medical resources in my area" in later chapters.

2.2.4 Descriptive subgroup stratification: age, gender identity, and HRT direction

To complement the overall results, this section stratifies descriptively along three confirmed dimensions: age into under 18 and 18 or above; gender identity into mutually exclusive groups of transfeminine/female identity, transmasculine/male identity, non-binary, and other/multiple; and HRT direction into feminizing and masculinizing per V036. The indicators are: currently on HRT, "want bottom/genital surgery but currently lack the conditions", and positive well-being ("fairly happy" or "very happy"). Each indicator uses valid respondents to that question within the group as its denominator; stratification is descriptive only — no significance tests or causal interpretation.

- **Age**: among the under-18 group (n=266), 159/250 (63.6%) are currently on HRT; bottom/genital surgery "want but lack conditions" 98/148 (66.2%); positive well-being 42/265 (15.8%). For the 18-and-above group (n=633): 459/608 (75.5%), 253/434 (58.3%), and 144/630 (22.9%). One age record was excluded only in the age variable due to a logic conflict; the two groups together n=899.
- **Mutually exclusive gender-identity groups**: transfeminine/female-identity group (n=496): 376/478 (78.7%), 244/356 (68.5%), 103/494 (20.9%); transmasculine/male-identity group (n=80): 50/74 (67.6%), 5/21 (23.8%), 23/80 (28.7%); non-binary group (n=114): 68/103 (66.0%), 24/70 (34.3%), 26/113 (23.0%); other/multiple-identity group (n=209): 123/203 (60.6%), 77/134 (57.5%), 34/208 (16.3%).
- **HRT direction**: feminizing group (n=696): 550/696 (79.0%), 323/509 (63.5%), 139/693 (20.1%); masculinizing group (n=87): 63/87 (72.4%), 9/25 (36.0%), 22/87 (25.3%). Other directions without sufficient valid answers are not shown in public stratification. A variable-level logic anomaly in V036 was excluded before stratification.

2.3 Methods and research limitations

2.3.1 Survey design

The survey used a structured online questionnaire distributed through Tencent Survey and Google Forms. Submission dates recoverable from the current workbook run from 2 June to 30 July 2026 (workbook local time; the project materials do not save a separate timezone note). The questionnaire contains closed-ended choice questions (single and multi-select) and ordered rating

items, covering identity awareness, expression, healthcare, family, campus, employment, mental health, public services, and social support. The design drew on common frameworks of international transgender health surveys, with some wording and options adapted to the Chinese context.

Recruitment channels included transgender community social media accounts, online mutual-aid groups, social platforms of relevant non-profit organisations, and snowball forwarding by respondents. Participation was voluntary: the current questionnaire states the purpose, data-use approach, and privacy protections at the outset and requires confirmation of informed consent before proceeding. The project's surviving materials do not record formal inclusion criteria for recruits, minimum-age statements, or processes for minor respondents' own informed participation and guardian consent (or waiver), so this report cannot retroactively assume those processes; the age question does include a 12–15 option, and the sample includes respondents under 18. This material gap is listed as a research ethics and interpretation limitation.

2.3.2 Data processing

Raw questionnaire data were processed as follows:

1. **Consent eligibility screening**
   4 submissions with explicit refusal and no subsequent valid answers were excluded. The old questionnaire produced 13 submissions: 1 recorded "willing" in the consent field, while the other 12 lacked a structured consent field; all 12 were completed and submitted, with no explicit refusal recorded, so the main analysis followed the old questionnaire's flow and treated continued completion as an expression of willingness to participate and included them.

2. **Invalid entries and cross-platform duplicates**
   Apart from consent screening, no other record was excluded as "entirely invalid"; logic anomalies were excluded by affected variable. The only cross-platform duplicate pair was merged into one record — the primary version retained, the other filled in only blank fields — with 0 field conflicts verified.

3. **Merging synonymous options**
   Because wording differed across time periods and platforms, some synonymous options were standardised and merged to ensure comparability.

4. **Variable-level missing and logic exclusion**
   Valid respondents to each question are computed independently. Structural missingness, not-applicable skips, unanswered items, and logic conflicts are recorded separately; e.g. 1 record with an age logic conflict was excluded only from age analysis rather than removed from all analyses.

The main-analysis sample flow: 905 raw submissions; consent screening excluded 4 explicit refusals and kept 12 old-questionnaire submissions completed with no refusal; 901 source submissions remained; after merging 1 cross-platform duplicate, n=900 entered the main analysis; the age variable then excluded 1 logic conflict, valid n=899.

Sensitivity analysis: a stricter scope that kept only verifiable explicit consent records excluded the 12 old-questionnaire records, yielding analysis n=888 and valid age n=887. Comparing the 353 results cited in the text under both definitions, the largest difference in any descriptive percentage is 0.55 percentage points; no flip from "adjusted $p<0.05$" occurred among the 23 completed pre-specified tests. The n=888 scope is used only to test sensitivity to the consent-handling choice and is not the main analysis. Full aggregation differences ship with the public package.

Every number in the text is copied from the audited analysis table; nothing was recalculated while writing. Public materials also include an item-by-item summary table listing chapter, indicator, denominator, counts, percentages and calculation notes so readers can check the statistics — it contains no personal information and cannot be traced back to any response.

2.3.3 Statistical methods

Descriptive statistics mainly use frequencies, percentages, and medians for ordinal variables. Association tests use chi-square tests (categorical variables) or Spearman rank correlation (ordinal variables), reporting effect sizes (Cramér's V or Spearman's rho) and Benjamini-Hochberg adjusted p-values. All statistical tests are exploratory; adjusted $p<0.05$ is treated as statistically significant.

"Association" or "correlation" in this report means statistical association only, not causation. The cross-sectional design cannot establish temporal order or causal direction. Mental health, well-being, and support analyses are all based on self-report. The survey makes no clinical diagnosis; the prior-diagnosis question likewise records only self-reports, unverified against medical records. The psychological-status items are not a single validated clinical scale.

2.3.4 Research limitations

> ▲ **Non-probability sampling**
>
> Respondents were recruited voluntarily through online channels, not random sampling, so representativeness cannot be guaranteed. The results describe only the respondents of this survey and cannot be generalised to all transgender and gender-diverse people in China or to other countries and regions.

The study has the following important limitations, which readers should consider when interpreting results:

Young sample age structure

As noted in 2.2.1, respondents aged 18–22 hold the largest share (43.5%), while those 23 and above together account for 26.6% (23–29: 23.2%; 30–39: 3.4%). This age structure shapes the reading of medical needs, family dependence, campus experiences, employment circumstances, and financial conditions: younger respondents may more often be in school, dependent on family financial support, not yet in the labour market, or still in early stages of family conflict.

Self-reported data

All data are self-reported by respondents and unverified by third parties. Descriptions of emotional distress and mental health are based on subjective experience and are not clinical diagnoses. Reports of family reactions, campus experiences, and workplace discrimination reflect respondents' perception and memory, which may be affected by recall bias and personal interpretation.

Cross-sectional design

All data were collected at a single point in time, so temporal order or causality between variables cannot be established. For example, the statistical association between identity expression and well-being cannot determine whether expression affects well-being, whether well-being affects willingness to express, or whether both are influenced by third factors (e.g. family support, financial conditions).

Measurement instruments

Some concepts in the questionnaire (e.g. "family support", "school support", "well-being") are measured with single-item ordinal ratings or multi-select proxies that cannot capture every dimension of the concept. For instance, "family support" is measured by one rating item about overall feelings, without distinguishing emotional support, financial support, medical-decision support, and other layers.

Limits of interpretation of statistical associations

All "associations" or "correlations" passing statistical tests in this report are exploratory results, not preceded by sample-size calculations or effect-size estimation. An adjusted-significant p-value only indicates a statistical association observed in this sample; it does not imply truth in the population or substantive importance. Tests that fell short of adjusted significance (e.g. F024, F025, F026) cannot be read as "no association" — they may be limited by sample size, measurement instruments, or analytical methods.

Reporting bias on sensitive topics

Some questions touch on highly sensitive content such as domestic violence, self-harm, and suicide-related experiences. Respondents may under- or over-report out of privacy concerns, psychological defence, or worry about consequences. Choosing "no clear negative experience" or "never" cannot be inferred to mean complete absence of such experiences.

Limited historical comparison

The report's structure was informed by the 2021 national transgender health survey, but differences in questionnaire wording, recruitment channels, sample composition, and statistical methods mean the two surveys are not strictly comparable. This report performs no cross-year percentage comparison or trend inference.

2.3.5 Ethics and privacy

The survey followed these principles in design and implementation:

- The current questionnaire requires reading and confirming the informed-consent statement before answering; the 12 old-questionnaire records lack a structured consent field but were all completed with no explicit refusal, so the main analysis treats continued completion under the old flow as willingness to participate, with sensitivity analysis under the strict explicit-consent scope n=888.
- Data analysis in this report uses only the closed-question workbook. The analytic flow did not access or use contact fields; the separate workbook containing contact information or open-text content did not enter the analysis. Public report and analysis artefacts contain no raw contact information, open-text originals, raw record IDs, or information directly identifying individuals.
- The surviving project materials contain no verifiable institutional ethics-review documents, minimum-age rules, or records of minor participation/guardian consent (or waiver). This is not to assert that the project was never reviewed, but to explain that the public report cannot confirm it from available evidence; the report lists this as an explicit limitation and does not substitute technical QA for ethics review.
- Where verifiable materials are insufficient, data-minimisation and alternative protections at the analysis stage include: read-only raw inputs, isolation of contact information and open-text answers, aggregate-only reporting, merging of low-frequency categories, neutral language for sensitive content, and provision of crisis-support resources.
- Presentations of sensitive content — self-harm, suicide, domestic violence — use neutral, non-sensational, non-pathologizing language, and relevant chapters list contact details for psychological support and crisis-intervention resources.

2.4 Terminology

For ease of reading, the report defines the following core terms:

- **Transgender**: people whose gender identity differs from the sex assigned at birth. In this report "transgender" is used broadly, covering trans women, trans men, and other people whose gender identity does not fit the binary framework.
- **Gender diverse**: including but not limited to transgender, non-binary, genderfluid, agender, and other gender identities.
- **Sex assigned at birth**: the sex assigned at birth based on physical characteristics, usually "male" or "female".
- **Gender identity**: an individual's inner sense and experience of their own gender.
- **Gender expression**: external presentation of gender through clothing, behaviour, manner, voice, and the like.
- **Hormone Replacement Therapy (HRT)**: medical measures using hormonal medication to move secondary sex characteristics toward the recognized gender. In this report "HRT" covers feminizing HRT (oestrogen and anti-androgens) and masculinizing HRT (testosterone).
- **Gender affirmation**: the umbrella of medical, social, and legal measures supporting an individual to live in line with their gender identity, including but not limited to HRT, surgery, document changes, and social support.
- **Coming out**: voluntarily disclosing one's transgender identity to others. This report distinguishes "voluntary coming out" from "passive coming out / passive discovery".
- **Cisgender**: people whose gender identity matches the sex assigned at birth.

2.5 Structure of the report

The report has 12 chapters:

- **Chapter 1 Executive Summary**: overview of key findings and directions for action.
- **Chapter 2 Background, sample characteristics, and methodological boundaries** (this chapter): survey design, sample description, and research limitations.
- **Chapter 3 Identity awareness, disclosure, and everyday expression**: age of gender-identity awareness, identity-expression status, and settings where expression is possible.
- **Chapter 4 Body, HRT, healthcare access, and voice needs**: HRT use, access channels, medical barriers, health monitoring, and voice satisfaction.

- **Chapter 5 Family awareness, changes in support, and safety**: how families learned, their reactions, support levels, and family restrictions or violence.
- **Chapter 6 Campus environment, institutions, and educational continuity**: negative campus experiences, school support, and policy coverage.
- **Chapter 7 Employment, identity concealment, and economic circumstances**: workplace experiences, document questioning, and financial situation.
- **Chapter 8 Mental health, well-being, and safety support**: emotional distress, pressure sources, access to psychological support, self-harm and suicide-related experiences, and overall well-being.
- **Chapter 9 ID documents, public services, and public space**: impacts of document mismatch, difficulties in public affairs and public facilities.
- **Chapter 10 Social support, resilience, and desire for change**: current sources of strength and support, visibility of local resources, willingness to change, and priorities.
- **Chapter 11 Key findings, directions for action, and research limitations**: cross-chapter syntheses, policy and service recommendations, and future research directions.
- **Chapter 12 Appendix**: figure directory, notes on how the numbers were derived, and technical notes.

Later chapters present the findings by domain; see section 1.5 and Appendix C for how to check a number against its source.

Chapter 3

03

Identity Awareness, Disclosure, and Everyday Expression

This chapter presents respondents' experiences of becoming aware of their gender identity, disclosing it, and expressing it in everyday life. The findings sketch the complex path from inner awareness to outward expression, and how different life settings support or constrain it.

36.5%
Became aware of the gender difference at 13–17 · 328 people

42.8%
Live as their gender identity only in some settings · 375 people

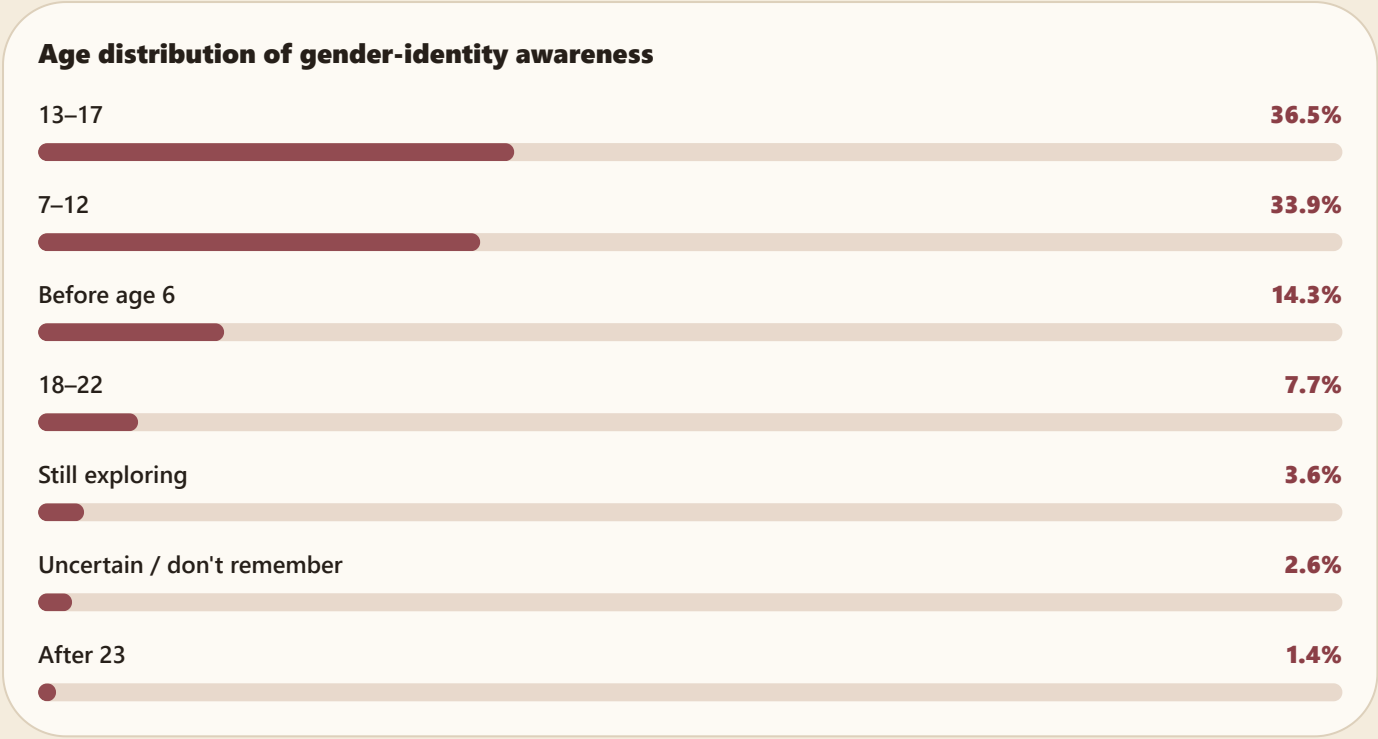
3.1 Age of gender-identity awareness
3.2 Identity-expression status and settings
3.3 How and how widely identity is disclosed
3.4 Identity expression and other experiences
3.5 Chapter summary

3.1 Age of gender-identity awareness

Many respondents began to notice their gender identity difference in childhood or adolescence

Key finding

Among respondents who answered the awareness-age question (n=899), quite a few became aware early that their gender identity did not match their sex assigned at birth.



36.5% (328 people) became aware at 13–17, 33.9% (305 people) at 7–12, and 14.3% (129 people) before age 6. These three early stages together account for 84.8% of all valid respondents. Those who became aware at 18–22 account for 7.7% (69 people), still exploring 3.6% (32 people), uncertain/don't remember 2.6% (23 people), and after age 23 1.4% (13 people).

This finding suggests that gender-identity awareness often emerges while family and school still shape daily life heavily. For individuals who became aware in childhood or early adolescence, family reactions, school inclusivity, and age-appropriate information and support become especially critical. Note also that these data rest on retrospective self-reports, which may be affected by memory bias, and do not represent the awareness-age distribution of all transgender and gender-diverse people.

Reading note: the awareness-age distribution is related to this sample's age structure. As described in Chapter 2, the sample is dominated by respondents aged 18–22 (43.5%); younger respondents are closer in time to their awareness point, so recall may be clearer, but they may also be more likely to attribute awareness to a specific age band.

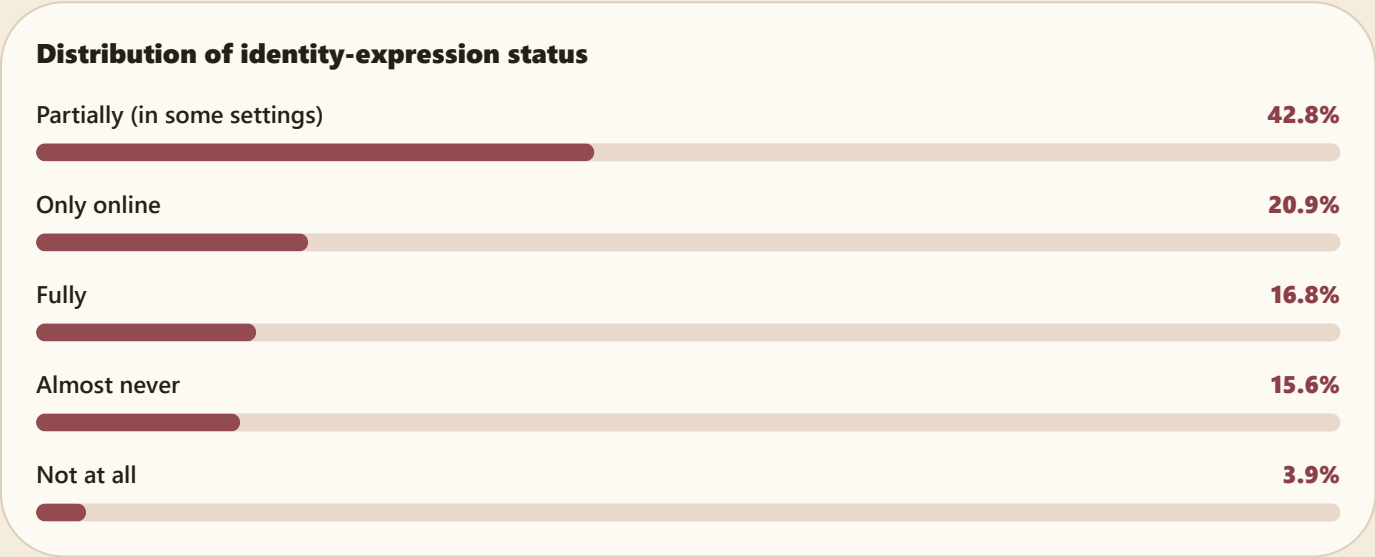
3.2 Identity-expression status and settings

3.2.1 Overall status of identity expression

Fully living as one's gender identity is not common; expression status and well-being are statistically associated

Key finding

Among respondents who answered the expression-status question (n=876), the share able to live fully as their gender identity is not high.



42.8% (375 people) can live as their gender identity only in some settings, 20.9% (183 people) only online, 16.8% (147 people) fully, 15.6% (137 people) almost never, and 3.9% (34 people) not at all.

Combining "almost never" and "not at all", nearly 20% of respondents can barely express their gender identity in daily life. Combining "only online" and "some settings", more than 60% of respondents face clear setting-based limits on expression.

Well-being distributions differ by expression status. The two are statistically associated (Cramér's $V=0.144$, adjusted $p<0.001$, $n=872$).

Among these respondents, those able to live as their gender identity in more settings differ from those whose expression is constrained. However, family support, financial conditions, and social environment may also influence both expression and well-being.

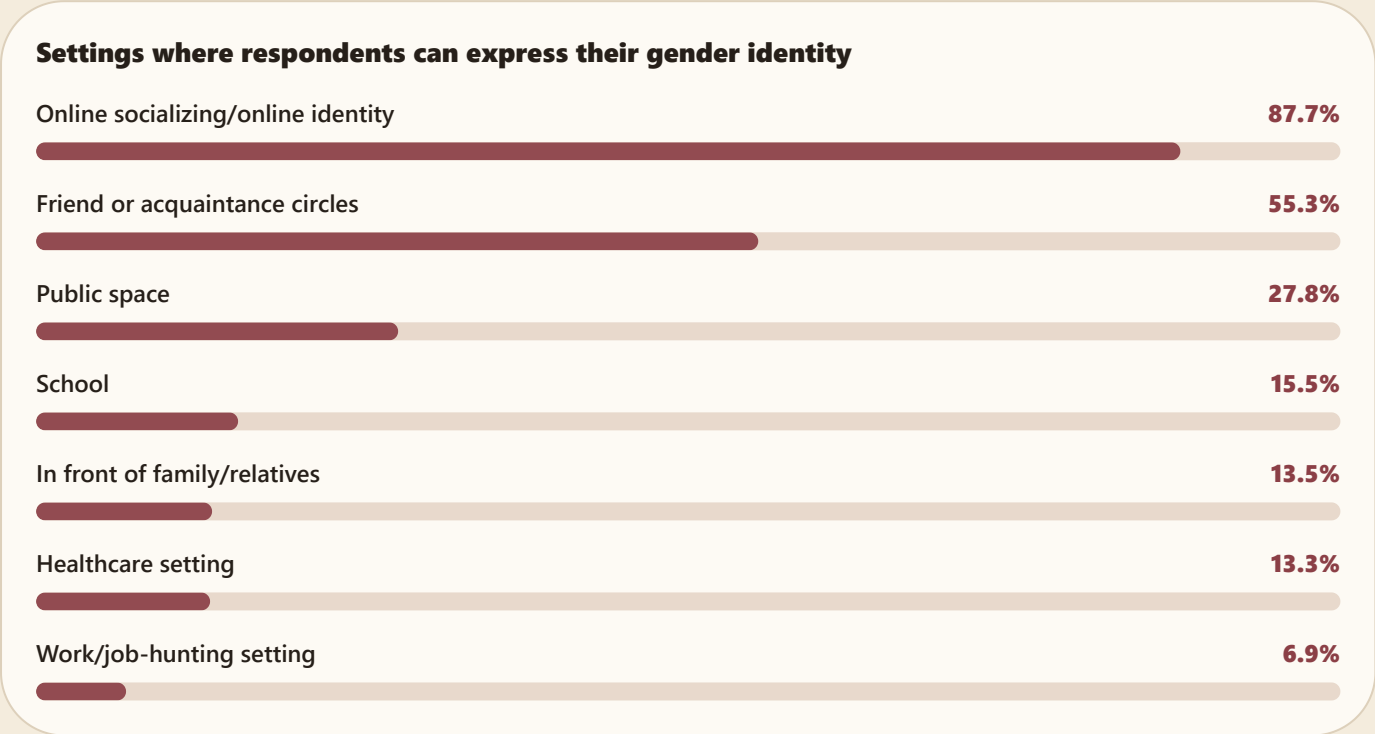
The questionnaire records identity expression and well-being over the same period; it cannot determine which came first, nor prove that fuller expression directly raises well-being.

3.2.2 Settings where respondents can express their gender identity

Online spaces and friend networks carry identity expression; formal settings fall clearly short

Key finding

Among respondents who answered the expression-settings question (n=579, multi-select), identity expression is heavily concentrated in informal settings.



Online socializing/online identity 87.7% (508 people), friend or acquaintance circles 55.3% (320 people). By contrast, expression in formal settings is clearly lower: public space 27.8% (161 people), school 15.5% (90 people), in front of family/relatives 13.5% (78 people), healthcare 13.3% (77 people), and work/job-hunting only 6.9% (40 people).

Possible mechanisms / interpretive discussion (not directly measured by this question): this pattern suggests that informal support networks (online socializing and trusted friend circles) provide relatively usable expression space, while gaps in formal settings — family, school, healthcare, employment — are more pronounced. The high online share may relate to anonymity, selectivity, and the community's online clustering, but it also reflects insufficient support in offline formal settings. These mechanism explanations draw on community experience and existing research and cannot be treated as direct measurements from this question.

Reading note: this was a multi-select question, so percentages sum to more than 100%. It was open only to respondents able to express themselves "in some settings" (n=579), excluding those who "almost cannot" or "cannot at all" — so results cannot be compared directly as percentages against all records in the main analysis (n=900).

3.3 How and how widely identity is disclosed

3.3.1 The layered nature of disclosure

Disclosure mostly happens within a few trusted relationships and online spaces

Key finding

Among respondents who answered the disclosure-audience question (n=900, multi-select), disclosure is clearly stratified. Telling a few trusted friends 62.8% (565 people), only online 39.6% (356 people), telling family (voluntary coming out) 32.9% (296 people). By contrast, disclosure to wider groups is rarer: passively exposed due to physical changes or other reasons ("blown out of the closet") 11.1% (100 people), fully hidden 9.0% (81 people), disclosed at school/workplace 7.7% (69 people), and fully open 6.8% (61 people).

This distribution shows that disclosure is not a binary "out or not" state but a contextual, layered process. Most respondents selectively disclose to trusted individuals or small groups rather than to all social relationships. The high online share matches F004 and underscores the role of online space in expression and community connection.

3.3.2 Passive exposure and continued concealment

Passive exposure and full concealment are both real identity-management experiences

Key finding

Besides voluntary disclosure, some respondents experienced passive exposure or chose continued concealment. In the disclosure-audience question (n=900, multi-select), 9.0% (81 people) chose "not disclosed to anyone at all" and 11.1% (100 people) reported passive exposure ("blown out of the closet") due to physical changes or other reasons; 5.7% (51 people) do not voluntarily disclose at school/workplace but may be detected. In the supplementary passive-exposure options, 4.3% (39 people) reported passive exposure.

Possible mechanisms / interpretive discussion (not directly measured by this question): passive exposure (having one's identity disclosed by others without consent) can bring safety risks, broken relationships, or forced encounters with unprepared reactions. Continued concealment may carry long-term psychological costs, limited expression, and the strain of maintaining a double identity in social interaction. These mechanisms draw on community experience and existing research; they cannot be treated as direct measurements from this question.

Reading note: the percentages above come from different question versions and options and cannot be directly summed or compared. "Passive exposure" and "continued concealment" may co-occur in the same person (e.g. exposed once, then worked to re-conceal).

3.4 Identity expression and other experiences

3.4.1 Expression and negative campus experiences

The pre-specified test between expression and negative campus experiences fell short of adjusted significance

Key finding

This analysis found no clear statistical association between identity-expression status and negative campus experiences (Cramér's V=0.108, adjusted p=0.118, n=729).

This does not mean expression and campus experience are unrelated. Expression is recorded with a single five-level item, and campus negative experiences are compressed into a simplified indicator, which may miss specific settings, frequency, and severity. These data can only show that evidence is not yet clear-cut; they cannot prove "no relationship".

This finding also implies that even among respondents able to express their gender identity fully, negative campus experiences may still occur for other reasons — expression not matching stereotypes, being seen as "not masculine/feminine enough", or simply because of transgender identity itself. Campus support must cover all gender-diverse students, not only those "unable to express".

3.4.2 Attraction and exploration

Attraction is diverse; pansexual and femininity-oriented attraction are relatively common **Key finding**

Among respondents who answered the attraction question (n=878, multi-select), women/femininity 49.2% (432 people), everyone (pansexual) 34.2% (300 people), men/masculinity 27.4% (241 people), non-binary/genderfluid people 24.5% (215 people), still exploring 21.6% (190 people), and attracted to no gender (asexual) 8.5% (75 people).

This distribution indicates attraction is not concentrated on a single gender expression; a fair share report pansexual (33.8%) or still exploring (21.7%). This diversity suggests support services and community discussions should not assume a single attraction pattern — identity expression and intimate relationships are likewise diverse.

3.5 Chapter summary

The findings in this chapter sketch a complex picture of identity awareness, disclosure, and expression:

1. **Early awareness**: more than 80% of respondents noticed their gender identity difference at or before age 17; family and school reactions during this period are crucial for individual development.
2. **Constrained expression**: the share living fully as their gender identity is not high (16.8%), and over 60% face clear setting-based limits. Well-being distributions differ by expression status — a link, not proof of causation.
3. **Setting divergence**: online spaces and trusted friend circles are the main settings for expression (87.7% and 55.3%), while formal settings — family, school, healthcare, employment — are clearly lower (all ≤16%).
4. **Layered disclosure**: disclosure is stratified; most respondents selectively disclose to close friends, online communities, and a few family members rather than to all social relationships.
5. **Privacy risks**: passive exposure and continued concealment are both real identity-management experiences; support for privacy protection and safe expression must cover voluntary disclosure, passive exposure, and continued concealment alike.

These findings suggest that supporting gender-diverse individuals' expression and disclosure requires more than "how to come out" information: it requires improving safety and inclusivity in formal settings — family, school, healthcare, workplace — while respecting each person's autonomy over the scope, timing, and manner of disclosure.

Later chapters present experiences in healthcare, family, campus, employment, and mental health, all of which are closely tied to the conditions and costs of identity expression.

Chapter 4



04

Body, HRT, Access to Healthcare, and Voice Needs

This chapter presents respondents' experiences with hormone replacement therapy (HRT) use, access channels, health monitoring, and voice needs. The findings reveal multiple barriers to healthcare accessibility and the shortfall in formal medical service coverage.

71.9%
Currently on HRT · 618 people

66.6%
Get HRT through online private sellers · 477 people

4.1 HRT use and unmet needs
4.2 HRT access channels
4.3 Barriers to healthcare
4.4 HRT health monitoring
4.5 Voice needs and satisfaction

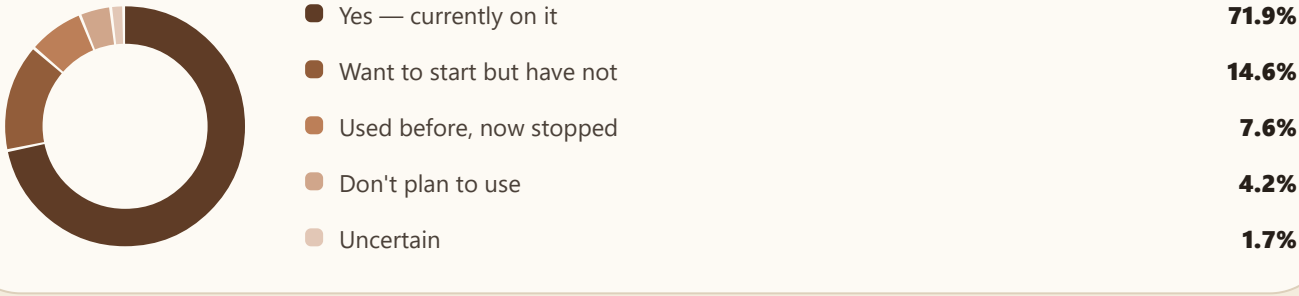
4.1 HRT use and unmet needs

HRT use is common among respondents, with clear unmet needs

Key finding

Among respondents who answered the HRT-status question (n=859), HRT use is fairly common, but unmet needs are clear.

Current status of hormone replacement therapy (HRT)



71.9% (618 people) are currently on HRT, 14.6% (125 people) want to start but have not, 7.6% (65 people) used it before but have stopped, and 4.2% (36 people) do not intend to use it.

The "want to start but have not" share (14.6%) suggests that about one in seven interested respondents in this sample remains unable to start HRT. This unmet need likely relates to the multiple barriers presented in later chapters (family opposition, cost burden, resource shortage, fear of discrimination). Those who used but stopped (7.6%) may have faced supply interruption, side effects, financial pressure, or family interference; their ongoing medication needs also deserve attention.

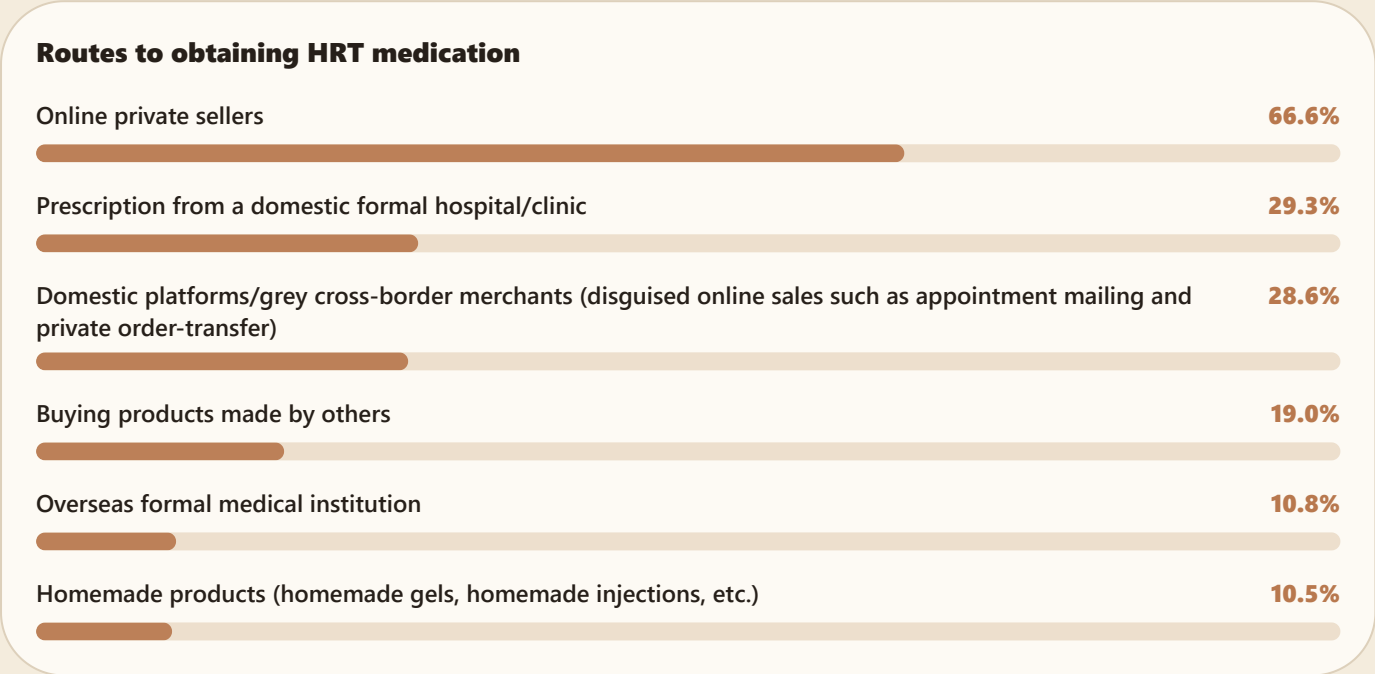
Reading note: this question has n=859 valid answers, close to all main-analysis records (n=900), but due to questionnaire-path design and sample composition, HRT-related percentages may still be higher than for the broader transgender and gender-diverse population. This report does not extrapolate them.

4.2 HRT access channels

HRT access relies heavily on private and informal channels; formal medical coverage is limited

Key finding

Among respondents who answered the HRT-access question (n=716, multi-select), formal healthcare is not the main route.



Online private sellers 66.6% (477 people), the most common channel. Domestic formal hospital/clinic prescriptions 29.3% (210 people), domestic platforms/grey cross-border merchants (including disguised online sales like appointment mailing and private order-transfer) 28.6% (205 people), buying others' homemade products (e.g. homemade gels hawked within the community) 19.0% (136 people), overseas formal medical institutions 10.8% (77 people), and homemade products (homemade gels, homemade injections, etc.) 10.5% (75 people).

This distribution shows online private sellers are the most common channel. Among valid respondents on the cross-recomputed V038 question path (n=512), 35.4% (181 people) chose at least one of domestic formal hospital/clinic prescription or overseas formal medical institution, with 21 people choosing both; that union share cannot be obtained by adding 28.7% and 10.7% directly. Because this was a multi-select question, each percentage uses its own valid denominator. Use of e-commerce platforms, others' homemade products, and homemade products each falls in the 10%–30% range, suggesting that some respondents turn to less transparent channels of harder-to-guarantee quality and safety when formal healthcare is unavailable.

Reading note: this question merges HRT-access items across question versions; its specific paths and sample composition mean it is not open to all main-analysis records, so n=716 represents only valid respondents to this question, not all HRT users or all respondents. This report does not blame channel use on individual choice; it reads it as the result of insufficient accessibility and continuity of formal medical services.

4.2.1 Main sources of medical information: the wiki community is the most important

Medical information depends heavily on wikis and community; formal medical channels inform a limited share

Key finding

Among respondents who answered the information-source question (n=810, multi-select), MtF.wiki/FtM.wiki/RLE.wiki 45.7% (370 people), transgender communities (QQ groups, WeChat groups, etc.) 15.7% (127 people), social media (Twitter, Weibo, Xiaohongshu, etc.) 11.1% (90 people), AI tools 8.8% (71 people), doctors or professional consultation 6.9% (56 people), friends or other transgender people sharing 4.7% (38 people), and self-study of medical papers/clinical guidelines 4.6% (37 people).

Wikis are the leading source (45.7%), far ahead of transgender communities (15.7%) and social media (11.1%). Project Trans's wiki community plays a key role in this sample's medical literacy: it synthesizes procedures, risks, and cautions for HRT, surgery, diagnosis certificates, and related topics in a structured format, becoming the first stop for many respondents to obtain basic medical information when formal medical consultation is limited. The share citing doctors or professional consultation as an information source is only 6.9%, indicating limited formal involvement in information provision.

This distribution echoes 4.1: when formal channels under-cover information, community-maintained resources like wikis fill the gap. Support strategies could consider collaborating with wiki and community information sources to ensure accuracy and currency, while increasing formal channels' informational accessibility.

4.2.2 Medication-supply difficulties

Supply difficulties include high-premium purchasing, withdrawal reactions, and opaque order-transfer

Key finding

Among respondents who answered the supply-difficulty question (n=781, multi-select), forced to buy at a high premium on the black market 26.4% (206 people), severe physical or psychological reactions from running out of medication 19.2% (150 people), forced to switch to more opaque purchasing methods such as appointment mailing or private order-transfer 14.6% (114 people), defrauded by online sellers or dealers 8.2% (64 people), and bought counterfeit or ineffective medication 5.2% (41 people).

These experiences indicate that supply-channel instability and opacity sit alongside financial burden, withdrawal experiences, and medication predictability concerns. The questionnaire does not test causal paths between price, switches, withdrawal, and specific physical or psychological outcomes.

Reading note: the question stem mentions "policy changes or platform crackdowns", but the data cannot establish causality between policy and individual experience. These difficulties should be read within channel characteristics, supply chains, regulatory environments, and market behaviour; this survey cannot judge each factor's independent effect or causal direction.

4.2.3 Use of non-pharmaceutical-grade preparations and unconventional substitutes

Some feminizing-HRT respondents have used or still use non-pharmaceutical-grade preparations or unconventional substitutes

Key finding

Among respondents who answered the unconventional-preparation question (n=731), 14.1% (103 people) used them before, 12.3% (90 people) still use them, and 73.6% (538 people) never used them.

Combining "used before" and "still using", 26.4% of respondents have experience with non-pharmaceutical-grade preparations or unconventional substitutes. This aligns with the access channels in F006 — others' homemade (19.0%) and homemade (10.5%) products — suggesting that when formal prescriptions are unavailable, private channels are unstable, or financial pressure is high, some respondents turn to less standardized alternatives.

This distribution should not be read as faulting individuals; it flags the accessibility gap in formal medical services as the issue to address. Responses include expanding affordable formal prescription and follow-up services, and providing harm-reduction information during the transition period where formal services do not yet cover, helping users understand risks of different preparations, how to spot quality problems, and when to seek care.

Reading note: this question did not ask preparation names, dosages, or usage, so specific risks or health harms cannot be inferred. "Used but stopped" may reflect switching to formal channels, financial reasons, side effects, or other personal considerations — one size does not fit all.

4.3 Barriers to healthcare

4.3.1 HRT-related spending and surgery intention

HRT-related spending is most commonly ¥100–300/month; about 20% report no current spending

Key finding

Among respondents answering the monthly HRT medication/check-up/related-spending question (n=545), ¥100–300/month 36.1% (197 people), no current spending 19.1% (104 people), ¥300–600/month 14.7% (80 people), ¥50–100/month 13.6% (74 people), unstable/hard to estimate 6.4% (35 people), below ¥50/month 5.9% (32 people), and ¥600–1000/month 2.8% (15 people).

After merging synonymous tiers across questionnaire versions by amount band, monthly spending clusters at ¥100–300; about 20% report no current spending. HRT-related spending is a fixed financial burden for some respondents, forming the background to affordability — along with the disposable-income distribution in Chapter 7 and the cost barrier (51.7%) in this section.

Gender-affirming surgery intention: "want bottom/genital reconstruction but lack conditions" is the largest category; completed rates are extremely low

Key finding

Among respondents answering the bottom/genital reconstruction (bottom surgery) intention question (n=582), want but currently lack conditions 60.3% (351 people), not planning 17.5% (102 people), planning/recent surgery 8.8% (51 people), uncertain 8.4% (49 people), and completed 4.6% (27 people).

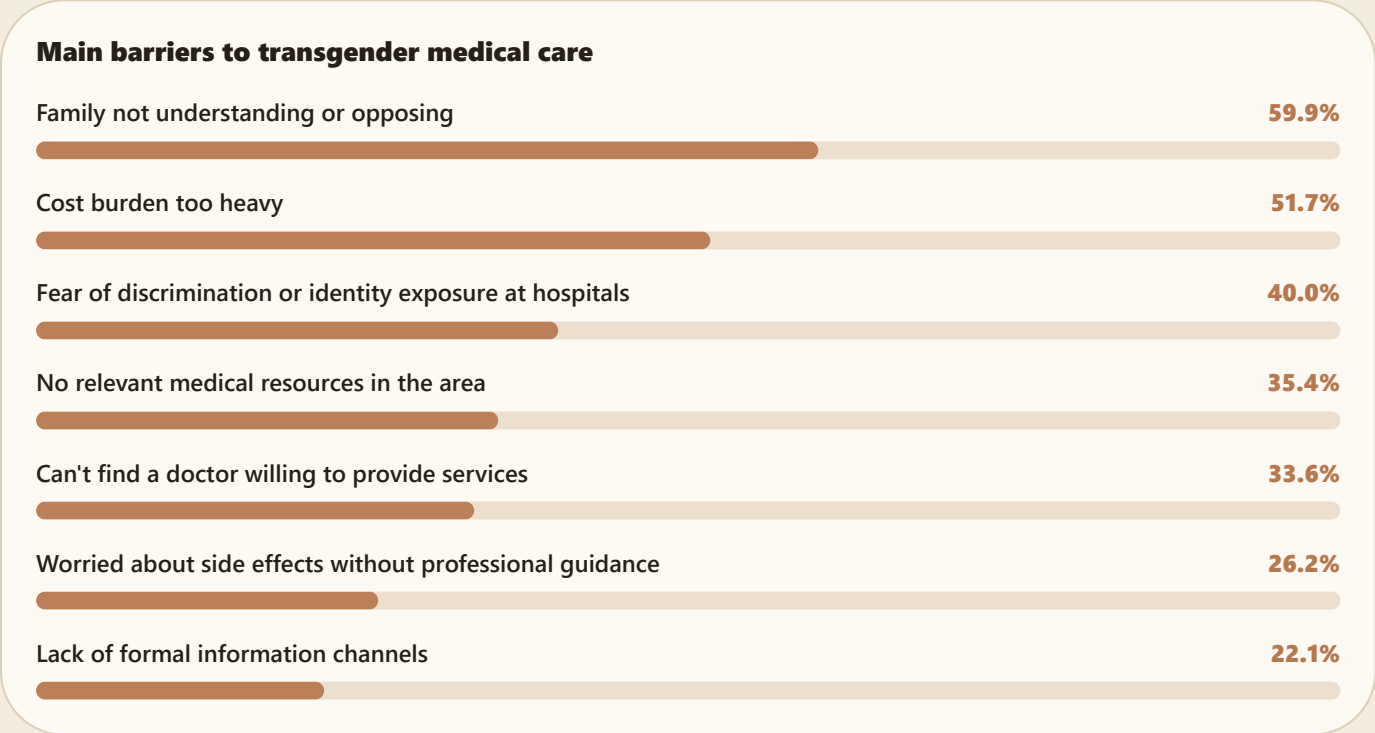
For facial gender-affirming surgery (FFS/FMS) intention (n=572): want but currently lack conditions 54.9% (314 people), completed 1.0% (6 people). For chest surgery intention (n=563): want but currently lack conditions 40.3% (227 people), completed 0.9% (5 people).

For all three surgery types, "want but currently lack conditions" is the dominant category while "completed" is extremely low (≤4.6%). Together with the medical barriers in this section (cost burden 51.7%, family opposition 59.9%), this shows a clear gap between surgery intention and accessibility: unmet needs extend beyond HRT to gender-affirming surgery.

Barriers come from family, cost, discrimination concerns, and resource shortage alike

Key finding

Among respondents who answered the medical-barriers question (n=806, multi-select), barriers show multiple sources.



Family not understanding or opposing 59.9% (483 people), cost burden too heavy 51.7% (417 people), fear of discrimination or exposure at hospitals 40.0% (322 people), no relevant medical resources in the area 35.4% (285 people), cannot find a doctor willing to provide services 33.6% (271 people), worried about side effects without professional guidance 26.2% (211 people), and lack of formal information channels 22.1% (178 people).

Family opposition (59.9%) and cost burden (51.7%) are the two most reported barriers, both above half. Discrimination concerns (40.0%), resource shortage (35.4%), and insufficient professional supply (33.6%) each sit around one third. This distribution calls for simultaneous attention to family

relationships, economic conditions, institutional environments, regional resource distribution, and professional supply; the questionnaire cannot judge how layers interact or confirm causal direction.

Those more satisfied with medical care tend to also report higher overall well-being. The association is comparatively clear (Spearman rho=0.370, adjusted p<0.001, n=855).

Among these respondents, the link between medical experience and well-being is fairly visible. Healthcare accessibility, whether services are respectful, and economic and family conditions may all affect both.

The questionnaire records medical satisfaction and well-being over the same period; it cannot determine which came first, nor prove that improving medical care directly produces an equal change in well-being.

4.3.2 Overall distribution of medical satisfaction

Satisfaction ratings cluster at lower and middle levels

Key finding

Among respondents who answered the medical-satisfaction question (n=859), very dissatisfied 21.8% (187 people), level 2 32.5% (279 people), level 3 32.1% (276 people), level 4 10.9% (94 people), and very satisfied 2.7% (23 people).

Combining "very dissatisfied" and "level 2", over half (54.2%) hold negative or somewhat negative views of current transgender medical services. Only 13.6% report level 4 or very satisfied. This distribution suggests substantial room for improving medical-service experience.

Reading note: this is an ordered-rating issue; the percentages describe the distribution of rating levels. A mean may be computed as a summary statistic, but ordinal ratings should not be treated as interval measures — respondents may understand "average" or "fairly satisfied" differently.

4.3.3 The dual role of cost and family opposition

Cost and family opposition are the two most common barriers

Key finding

As noted, in the medical-barriers question (n=806, multi-select), family not understanding or opposing accounts for 59.9% and cost burden 51.7%. Both exceed half, clearly above other barrier types.

Possible mechanisms / interpretive discussion (not directly measured by this question): family opposition may appear as direct prohibition of medical care, refusal of financial support, blocking minors' guardian consent, or indirect interference through verbal pressure and emotional control. Cost burden covers HRT medication, check-ups, surgery, and transport/accommodation for cross-region care. For young respondents still economically dependent (as in Chapter 2, 18–22 account for 43.5%), family opposition and cost burden may intertwine: even with personal will, family refusal of financial support can block care. These mechanisms draw on community experience and existing research; they are not direct measurements from this question.

Improving medical accessibility therefore requires addressing family knowledge and attitudes, affordability (insurance coverage and low-cost services), and the legal/ethical framework of minors' medical decision rights.

4.3.4 Obtaining a diagnosis certificate

> **"The largest share want a 'transsexualism' or 'gender dysphoria/gender incongruence' diagnosis certificate but meet difficulties"** Key finding

Among respondents who answered the diagnosis-certificate question (n=801), want but meet difficulties (e.g. age, cost, family objections) 37.3% (299 people), already obtained 30.3% (243 people), trying to obtain 17.4% (139 people), and not planning to obtain 15.0% (120 people).

About 30% already obtained one, while "want but meet difficulties" (37.3%) is slightly higher. Combining "trying to obtain" and "want but meet difficulties", over half (54.7%) are in a state of wanting but not yet having. Diagnosis certificates serve practical purposes in some settings (medical processes, document changes), and difficulty obtaining them interweaves with the barriers described earlier (age limits, cost, family objections). Meanwhile, "not planning to obtain" (15.0%) shows not everyone treats the certificate as necessary — some may decline out of privacy concerns, questions about the diagnostic framework, or other reasons.

4.4 HRT health monitoring

> **Monitoring is insufficient; "want check-ups but lack conditions" is a key gap** Key finding

Among respondents who answered the HRT check-up question (n=711), the share with regular check-ups is low.

HRT-related health check-up status



Check occasionally	**33.1%**
Want to but lack conditions	**28.7%**
Yes — regular check-ups	**20.4%**
Never checked	**17.9%**

33.1% (235 people) check occasionally, 28.7% (204 people) want to check but lack conditions, 20.4% (145 people) check regularly, and 17.9% (127 people) have never checked.

Combining "never checked" and "want to but lack conditions", nearly half (46.6%) have unmet monitoring needs. The "want to but lack conditions" category is especially notable: respondents already recognize the importance of monitoring, yet cannot do it due to cost, geographic distance, lack of a trustworthy medical institution, or fear of identity exposure.

The gap between ongoing medication needs and monitoring conditions suggests HRT support should not stop at drug access — check-up accessibility, result interpretation, and referral mechanisms belong in the same service chain. The questionnaire only records monitoring experiences and difficulties; it cannot confirm specific health consequences or risk changes.

Reading note: this question was open only to respondents on a particular HRT path (n=711) and does not represent all HRT users or all respondents. Not checking or checking occasionally does not equal existing health harm, but it does mean fewer opportunities for risk monitoring and early intervention.

4.5 Voice needs and satisfaction

Voice is a prominent source of gender-expression pressure; satisfaction is generally low

Key finding

Difficulty using one's voice: among respondents who answered the voice-use question (n=798), voice causes significant anxiety for many.

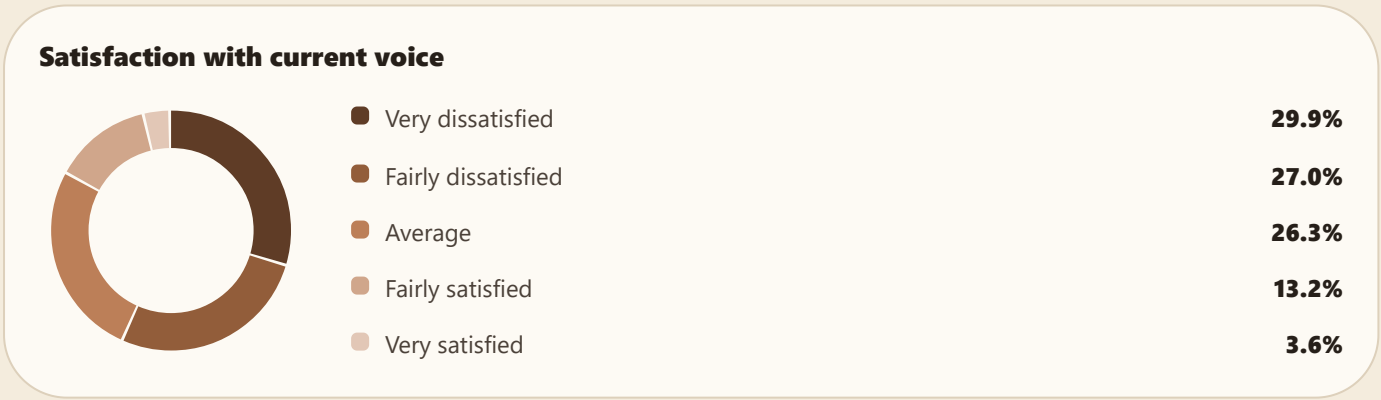


"Very hard; my voice is one of my main anxiety sources" 46.2% (369 people), and "impossible" 19.5% (156 people). Together, 65.8% face great difficulty or complete impossibility in using a satisfying voice.

Those dissatisfied with their voice clearly outnumber those satisfied

Key finding

Satisfaction with current voice: among respondents who answered the voice-satisfaction question (n=840), dissatisfaction clearly outweighs satisfaction.



Very dissatisfied 29.9% (251 people), fairly dissatisfied 27.0% (227 people), average 26.3% (221 people), and very satisfied 3.6% (30 people).

Combining "very dissatisfied" and "fairly dissatisfied", over half (56.9%) hold negative views of their current voice. In contrast, "fairly satisfied" 13.2% (111 people) plus "very satisfied" 3.6% (30 people) total only 16.8%.

The uniqueness of voice needs: voice is not merely an aesthetic preference — it is directly tied to daily expression, exposure concerns, and psychological stress. In phone calls, face-to-face conversations, job interviews, and medical consultations, voice can become a cue that outs a

transgender identity, bringing discrimination risk or expression constraints. Voice training and support services (speech therapy, voice feminization/masculinization training, voice-surgery information and referral) should be treated as a standalone need, not an appendix to the medical chapter.

Reading note: the voice-use question (n=798) and the voice-satisfaction question (n=840) have different denominators and measure different dimensions (difficulty versus satisfaction evaluation); percentages are not directly comparable. Voice status should not be pathologized, nor should it be assumed everyone wants a different voice — but the prevalence of voice anxiety in this sample should be recognized.

4.6 Tests with no clear association in these data

The unmet-HRT-need vs. distress association fell short of adjusted significance

Key finding

This analysis found no clear statistical association between "want to use HRT but not yet started" and psychological distress (Spearman rho=-0.070, n=822, adjusted p=0.087).

This does not mean HRT accessibility is unrelated to mental health. Here "unmet HRT need" is simplified to "want but not started", without distinguishing waiting reasons, waiting length, or previous use then stopping; psychological distress is likewise a simplified record in the questionnaire. Because the report tests many relationships, statisticians raise the bar to avoid treating chance differences as real findings. These data did not clear the bar — evidence is not yet clear, not proof of no relationship.

4.7 Chapter summary

This chapter's findings reveal multiple barriers to healthcare and unmet needs:

1. **HRT use and gaps**: over 70% are on HRT (71.9%), but 14.6% want to start without having, and 7.6% used and stopped — clear unmet needs.
2. **Channel distribution**: among valid respondents to the cross-version-merged HRT-access question (n=716), online private sellers 66.6%; the de-duplicated formal-channel union from cross-recomputation is in 4.2. Domestic platforms/grey cross-border merchants, others' homemade, and homemade products each run 10%–30%, reflecting insufficient formal service access.
3. **Multiple barriers**: family opposition (59.9%), cost burden (51.7%), discrimination concerns (40.0%), resource shortage (35.4%), and insufficient professional supply (33.6%). Those more satisfied with medical care also tend to have higher well-being (rho=0.370) — a link, not proof of causation.
4. **Monitoring gaps**: 20.4% check regularly; 28.7% want to but lack conditions; 17.9% never checked. A clear gap between ongoing medication needs and monitoring conditions persists.
5. **Voice anxiety**: voice is a prominent gender-expression pressure; 65.8% face great difficulty achieving a satisfying voice or cannot at all; 56.9% are dissatisfied with their current voice. Voice support deserves standalone presentation.

Improving transgender healthcare accessibility thus requires simultaneously addressing family support, affordability, regional resource coverage, professional training, privacy protection, and continuity of health monitoring. Voice support should be included in the gender-affirmation support system as an independent service. During the transition period where formal services are not fully covered, harm-reduction information and safe-medication guidance matter equally.

Later chapters present experiences in family, campus, employment, and mental health — domains deeply intertwined with the barriers and costs of healthcare access.

Chapter 5

05

Family Awareness, Changes in Support, and Safety

This chapter presents respondents' relationships with their families: how families learned, the reactions after they did, how support changed, and the restrictions or violence some respondents experience at home. These findings show family as a complex environment — at once a possible source of support and of pressure and risk.

36.6%
Came out voluntarily · 309 people

33.3%
Family attitude somewhat improved · 104 people

5.1 How family learned and initial reactions
5.2 Overall family support and its change
5.3 Attributions of family non-support
5.4 Family restrictions and violence
5.5 Chapter summary

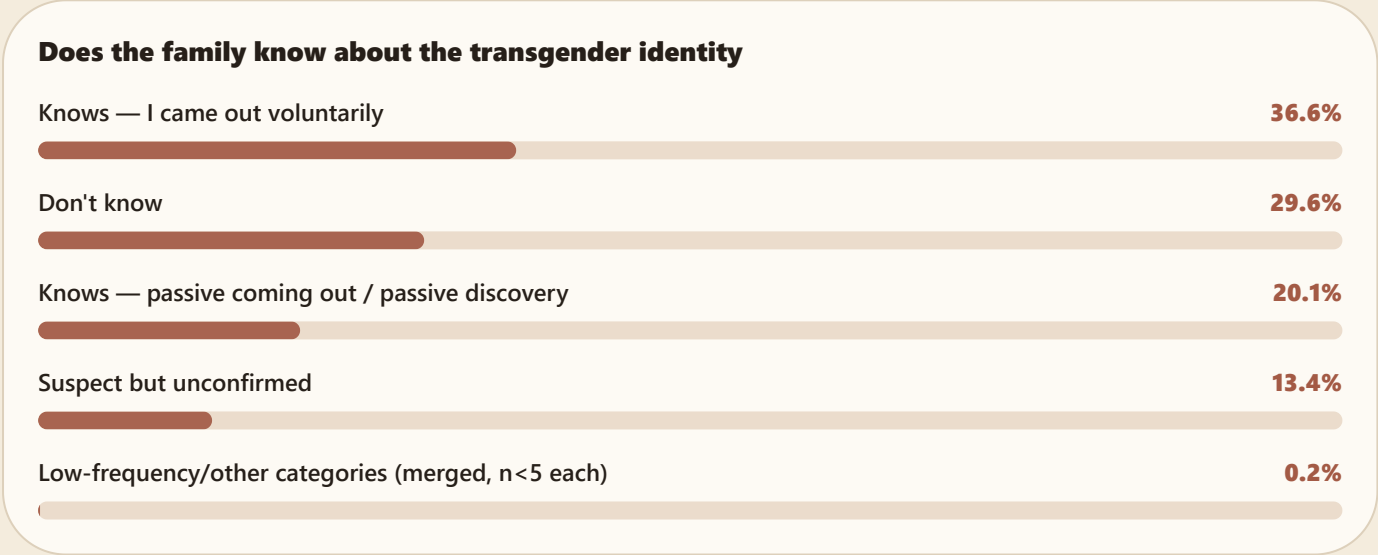
5.1 How the family learned and their initial reactions

Awareness is not support — silence, blame, and non-understanding are common

Key finding

5.1.1 How the family learned

Among respondents who answered the family-awareness question (n=844), the ways families learned are diverse.



Know — I came out voluntarily 36.6% (309 people), don't know 29.6% (250 people), know — passive coming out/passive discovery 20.1% (170 people). Additionally, suspecting but unconfirmed 13.4% (113 people), and the remaining low-frequency categories together 0.2% (2 people).

Voluntary coming out is the largest category (36.6%), but nearly 30% (29.6%) have families who still do not know, and another 20% (20.1%) were learned via passive coming-out or passive discovery.

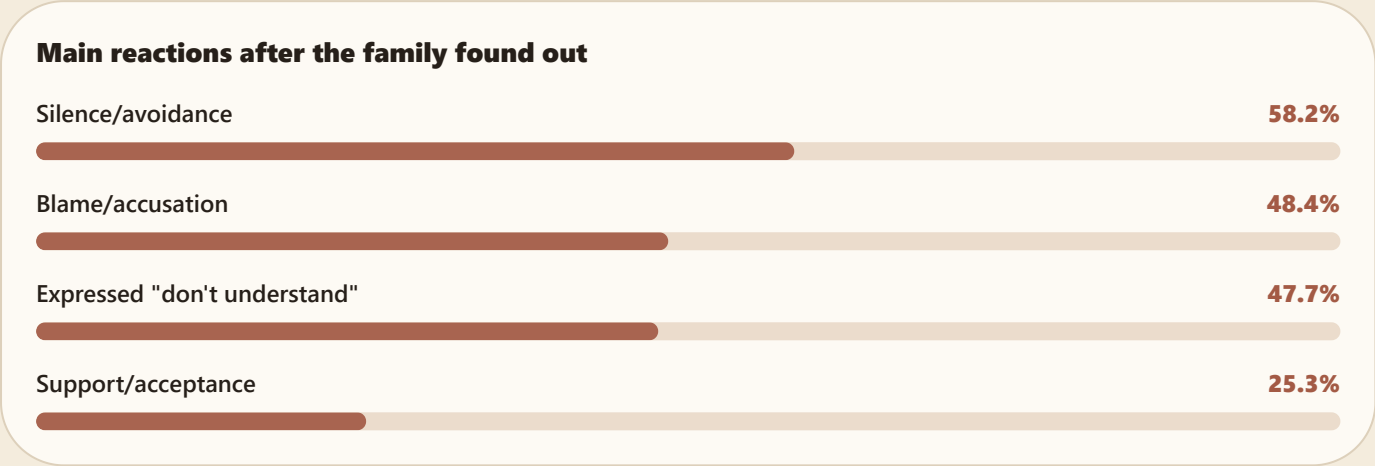
Possible mechanisms / interpretive discussion (not directly measured by this question): passive coming out may mean respondents had to face family reactions unprepared, or were discovered through external cues (medical records, delivered parcels, social-media leaks). These mechanisms draw on community experience and existing research; they are not direct measurements from this question.

This distribution shows family awareness is a complex process that cannot be reduced to a binary "out or not". Nearly 30% of families not knowing means a substantial share still hide their identity at home — possibly delaying disclosure out of fear of family reactions, economic dependence, or

safety risks.

5.1.2 Main reactions after the family found out

Among respondents whose families know (n=486, multi-select), reactions after learning are mainly negative or neutral.



Silence/avoidance 58.2% (283 people), blame/accusation 48.4% (235 people), "don't understand" 47.7% (232 people), and support/acceptance 25.3% (123 people).

Negative reactions (blame/accusation, non-understanding) and passive responses (silence/avoidance) are both clearly higher than support/acceptance (25.3%).

Possible mechanisms / interpretive discussion (not directly measured by this question): silence/avoidance (58.2%) as the most common reaction may reflect family members not knowing how to respond, avoiding conflict, or refusing to acknowledge reality. The high shares of blame/accusation and "don't understand" (both near half) suggest that awareness does not automatically bring support — a substantial share of families show denial or confusion initially. These mechanisms draw on community experience and existing research.

Reading note: this was a multi-select question; the same family may show several reactions at once (e.g. some members support while others blame). Support/acceptance at 25.3% does not mean one quarter of families fully support — it may mean at least one family member expressed support.

5.2 Overall family support and its change

Family support remains limited; some respondents retrospectively report improvement; support relates to well-being

Key finding

5.2.1 Retrospective direction of family attitude change

Among respondents who answered the attitude-change question (n=312), retrospectively reported improvement is the most common direction, but not universal.



Somewhat better 33.3% (104 people), much better 16.0% (50 people), no clear change 36.9% (115 people), much worse 8.7% (27 people), and somewhat worse 5.1% (16 people).

Combining "somewhat better" and "much better", nearly half (49.4%) retrospectively report family attitude improvement. However, over a third (36.9%) report basically no change and 13.8% report deterioration. This is the one question directly asking about change direction, so it is the primary basis for the conclusion here; it remains a retrospective self-report rather than a two-wave tracking measurement.

5.2.2 Snapshot of support right after the family found out

In the support-level question about when the family first learned (n=476), completely unsupportive 37.2% (177 people), neutral or uncertain 25.6% (122 people), little support 23.3% (111 people), more support 10.9% (52 people), and very supportive 2.9% (14 people). Combining "completely unsupportive" and "little support", 60.5% felt no support on that question; "more" and "very" support together 13.9%.

5.2.3 Snapshot of current support level

Among respondents who answered the current family-support question (n=324), completely unsupportive 26.9% (87 people), neutral or uncertain 26.5% (86 people), little support 21.3% (69 people), more support 17.6% (57 people), and very supportive 7.7% (25 people).



"More" and "very" support together 25.3%; the remaining 74.7% sit at little support, neutral, or completely unsupportive.

Reading boundary: the two questions — right-after-learning and current — have different respondent sets (n=476 and n=324); the percentages describe two cross-sectional snapshots and cannot be subtracted into "decline", "increase", or "net change". Conclusions about attitude change rely on the n=312 direct-change question.

Some families improved after learning

Key finding

As noted, 49.4% report family attitudes somewhat or much better. This suggests family attitudes can change; continuous, re-entrable family education and support programmes may fit actual needs better than one-time persuasion.

Retrospective reports also show no change or deterioration

Key finding

As noted, 36.9% of respondents report basically no change and 13.8% report deterioration (much worse 8.7%, somewhat worse 5.1%). This shows improvement cannot be assumed for all families; as the questionnaire captures change from a single time point, it cannot determine how long an attitude persisted.

5.2.4 Differences between fathers' and mothers' support

Fathers and mothers differ descriptively in awareness status and support distribution

Key finding

Alongside overall family support, the survey further examined support from each parent (mother and father) at the two stages — right after learning and currently.

In the mother-support question for when she first learned (n=308): completely unsupportive 37.3% (115 people), neutral or uncertain 23.1% (71 people), little support 22.7% (70 people), more support 10.4% (32 people), very supportive 4.2% (13 people), and 2.3% (7 people) had not told the mother. In the mother's current-support question (n=305): neutral or uncertain 26.2% (80 people), completely unsupportive 21.6% (66 people), little support 20.0% (61 people), more support 18.0% (55 people), very supportive 9.2% (28 people), and not told 4.9% (15 people).

In the father-support question for when he first learned (n=299): completely unsupportive 43.1% (129 people), neutral or uncertain 16.7% (50 people), little support 16.7% (50 people), not told 16.1% (48 people), more support 6.0% (18 people), and low-frequency/other merged (n<5 each) 1.3% (4 people). In the father's current-support question (n=294): completely unsupportive 29.9% (88 people), neutral or uncertain 19.4% (57 people), not told 17.7% (52 people), little support 15.3% (45 people), more support 11.2% (33 people), and very supportive 6.5% (19 people).

Two descriptive features appear. First, the share of fathers "not told" is descriptively higher than mothers in both stage questions: fathers 16.1% and 17.7%, mothers 2.3% and 4.9%. This report ran no formal paired test on this difference, so only the descriptive difference is reported, without inferring communication causes. Second, mothers' and fathers' support distributions differ across the two questions; but denominators and respondent sets differ, so these percentages cannot be written as individual-level rates or longitudinal change.

5.2.5 Parents' educational attainment distribution

Parents' education is concentrated at bachelor's level and high school/secondary vocational

Key finding

Among respondents answering parents' education, mothers' and fathers' attainment distribute as follows.

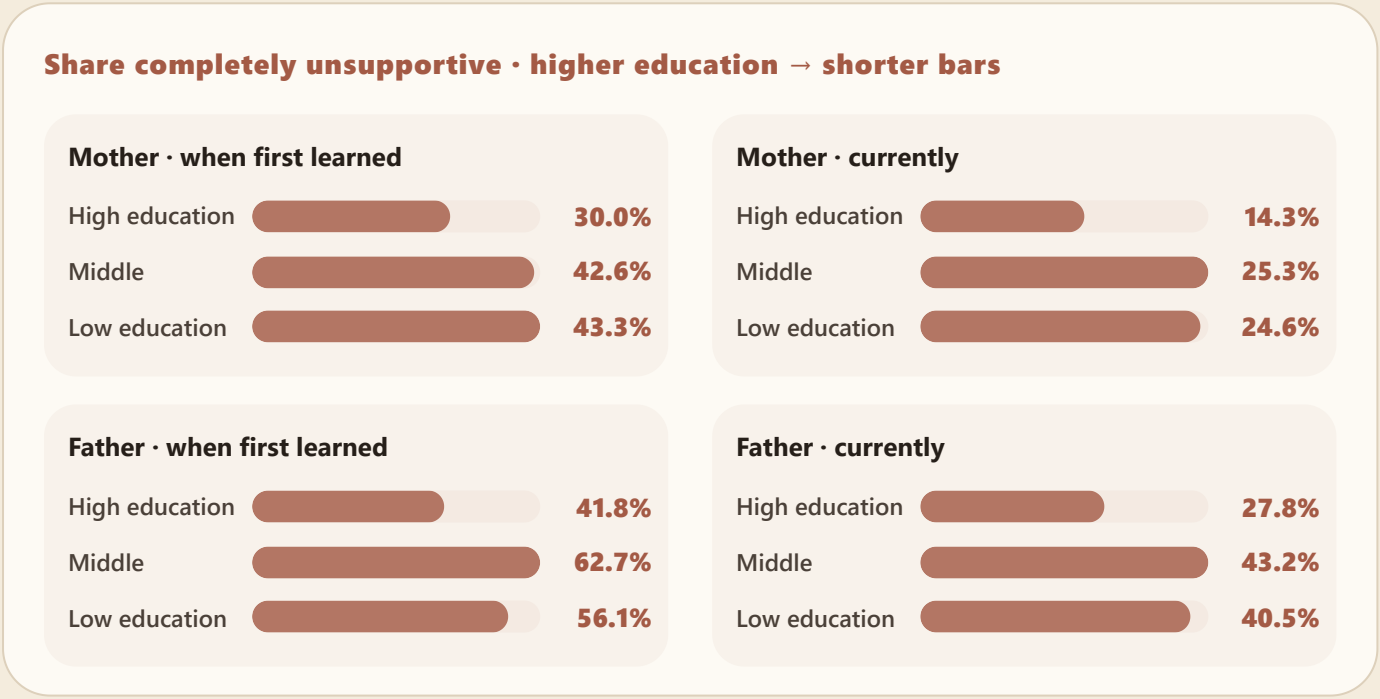
Mother's education (n=530): bachelor's 25.8% (137 people), high school/secondary vocational/vocational high 23.6% (125 people), middle school 17.2% (91 people), junior college 11.7% (62 people), primary school and below 10.6% (56 people), graduate and above 7.7% (41

people), and don't know 3.4% (18 people).

Father's education (n=501): bachelor's 27.9% (140 people), high school/secondary vocational/vocational high 22.6% (113 people), middle school 15.6% (78 people), junior college 13.8% (69 people), graduate and above 8.6% (43 people), primary school and below 7.8% (39 people), and don't know 3.8% (19 people).

It should be noted that the pre-specified analysis did not include the cross-relationship between parental education and support; the following is an exploratory statistical examination and description (recomputed from individual data, Spearman rank correlation + Benjamini-Hochberg correction; not a pre-specified test; not a causal conclusion).

5.2.6 Parental education and support level



Among respondents with valid education and support, parental education was grouped into three tiers: high (bachelor's and above), middle (junior college / high school / secondary vocational / vocational high), and low (middle school and below). Within each tier, parent support distributes as follows.

Mother: in the when-she-first-learned support question, the high tier (n=100) shows 30.0% completely unsupportive, below the middle (n=94, 42.6%) and low tiers (n=67, 43.3%). In the current-support question, the high tier (n=98) is 14.3% completely unsupportive (middle n=91 at 25.3%, low tier n=65 at 24.6%), with "more support" + "very supportive" totaling 38.8% (middle 24.2%, low 23.1%). The two questions are stage snapshots of different respondent sets.

Father: in the when-he-first-learned support question, the high tier (n=91) shows 41.8% completely unsupportive, below the middle (n=75, 62.7%) and low tiers (n=41, 56.1%). In the current-support question, the high tier (n=90) is 27.8% completely unsupportive (middle n=74 at 43.2%, low tier n=37 at 40.5%), with "more support" + "very supportive" totaling 27.8% (middle 17.6%, low 10.8%).

In this sample, mother's education and current support show a weak positive correlation (Spearman rho=0.178, p_adj=0.0181, n=254), reaching the pre-set adjusted $p<0.05$ threshold. Father's current-support result (rho=0.157, p_adj=0.0519, n=201) approaches but does not reach the threshold, so it is not judged significant. The when-first-learned results likewise do not reach it: mother rho=0.123, p_adj=0.0623 (n=261); father rho=0.104, p_adj=0.1356 (n=207). All four Spearman tests use two-sided Student-t p-values (df=n−2) with BH correction within the same family.

Within-tier proportions show the higher-education tier usually has lower complete non-support and higher more/very support. For the mother's high tier, complete non-support is 30.0% (first learned) and 14.3% (current), with mean support 2.42 and 3.07; because the two questions have different valid-respondent sets, these numbers cannot be read as longitudinal decline or rise for the same people. The father's current near-threshold-but-not-significant result cannot be called a confirmed association either.

5.2.7 Family support, well-being, and identity expression

Those with more family support tend to have higher overall well-being (Spearman rho=0.321, adjusted $p<0.001$, n=324). Family support and identity-expression status are also statistically associated (Cramér's V=0.170, adjusted p=0.0059, n=316).

Family support and expression status show an adjusted-significant statistical association

Key finding

In this sample, the link between family support and well-being is fairly visible, and people with different family support differ in expression status. Improving family environments has real-world relevance, but these results alone cannot say which side changed first.

Reading note for this subsection: the survey records family support, well-being, and expression at the same time; it cannot prove family support directly causes changes in well-being or expression. Age, economic conditions, regional culture, and family dynamics may also influence these outcomes. The parental-education analysis is exploratory; because multiple relationships are tested together, the statistical bar is raised to avoid mistaking chance differences for real findings.

5.3 Attributions of family non-support

Non-support is mainly attributed to knowledge misunderstandings, traditional values, and social pressure

Key finding

Among respondents who answered the non-support-reason question (n=462, multi-select), attributions concentrate on knowledge, values, and social pressure. Lack of understanding or misconceptions about transgender people 79.2% (366 people), traditional values (carrying on the family line, gender roles) 78.8% (364 people), worry about social opinion or pressure from relatives and friends 74.2% (343 people), worry about HRT side effects or health risks 71.9% (332 people), and concern about economic burden 27.1% (125 people).

Knowledge misunderstanding is the most cited attribution (79.2%). The high shares of traditional values (78.8%) and social opinion/relative-friend pressure (74.2%) suggest family reactions are shaped not only by individual attitudes but also by cultural norms, social expectations, and external judgment.

Reading note: these data reflect respondents' judgments about family reasons, not a direct survey of family members. Attributions may be influenced by respondents' understanding, family communication styles, and psychological defences. One family may combine several reasons (e.g. knowledge misconceptions plus worries about carrying on the family line).

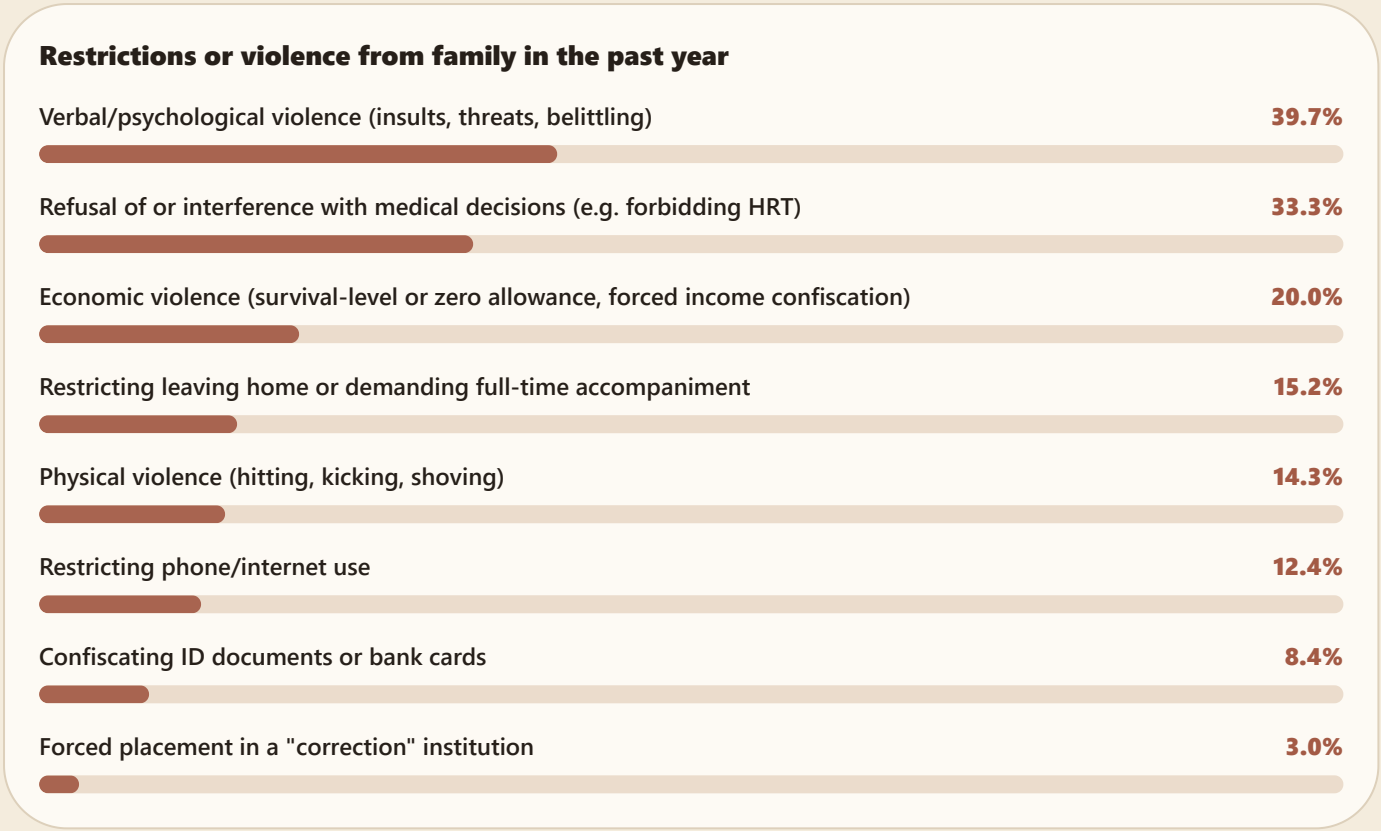
This suggests family-facing support services need to address knowledge misconceptions (accurate, non-pathologizing information), value conflicts (the balance between traditional values and individual autonomy), and social-pressure concerns (supporting families in dealing with external judgment and privacy protection) at once.

5.4 Family restrictions and violence

Some respondents experience verbal, medical, economic, and personal restrictions at home

Key finding

Among respondents who answered the past-year family restriction/violence question (n=474, multi-select), a share experienced multiple forms of substantive restriction and harm.



Verbal/psychological violence (insults, threats, belittling) 39.7% (188 people), refusal of or interference with medical decisions (e.g. forbidding HRT) 33.3% (158 people), economic violence (survival-level or zero allowance, forced income confiscation) 20.0% (95 people), restricting leaving the home or demanding full-time accompaniment 15.2% (72 people), physical violence (hitting, kicking, shoving) 14.3% (68 people), restricting phone/internet use 12.4% (59 people), confiscating ID documents or bank cards 8.4% (40 people), and forced placement in a "correction" institution 3.0% (14 people).

Verbal/psychological violence is the most common family harm (39.7%), followed by medical interference (33.3%). Economic violence (20.0%), restricting leaving home (15.2%), and physical violence (14.3%) each sit at 10%–20%. More extreme controls — confiscating documents, restricting phone/internet, forced "correction" institutions — are also reported (8.4%, 12.4%, 3.0%).

This distribution shows family harm is not only attitudinal or verbal: it involves medical autonomy (refusing or interfering with HRT), economic control (withholding allowance, forced income surrender), freedom of movement (restricting leaving home, full-time accompaniment), and bodily safety (physical violence). For young respondents still economically dependent, these restrictions can severely impair access to healthcare, education, employment, and social support.

Family restrictions extend to economic, movement, network, and document control Key finding

As noted: economic violence 20.0%, restricting leaving home or demanding accompaniment 15.2%, restricting phone/internet 12.4%, confiscating ID documents or bank cards 8.4%. These controls may make it hard to seek medical care, education, jobs, or external support independently.

Reading note: this multi-select question touches highly sensitive content and should be presented neutrally, without dramatization. Selecting an option means the respondent experienced it within the past year; not selecting does not mean complete absence (it may be unreported out of privacy concerns, psychological defence, or differing understanding of "violence"). These experiences should not be attributed to transgender identity itself; they can be read within family power dynamics, generational conflict, and social environment, but the questionnaire cannot determine specific causes.

This suggests safety support must go beyond emotional comfort and information provisioning to cover practical resources and action capacity: low-threshold safety planning, legal and psychological referral, emergency economic support, temporary-housing information, and protection mechanisms for minors.

5.4.1 Exploratory comparison: economic independence vs. family support and restrictions/violence

People with different economic-independence levels show some proportional differences in family support and restrictions/violence, but this analysis found no clear statistical association. In the current family-support question (n=292), the family-dependent group (n=219) shows 22.8% completely unsupportive and 27.9% more/very supportive; the independent group (n=54) shows 33.3% and 14.8%. In the family restriction/violence question (n=444), the dependent group (n=332) reports any violence at 57.5%, the independent group (n=85) at 45.9%. Adjusted p-values for economic independence vs. current family support (rho=-0.127, n=292) and the 9 restriction/violence tests all exceed 0.05. Medical interference shows a weak negative association before correction (rho=-0.120, raw p=0.011) but does not reach the adjusted threshold.

These proportional differences warrant further study, but the data are insufficient to confirm stable relationships. Because several restriction/violence experiences were tested together, the statistical bar was raised to avoid mistaking chance differences for real findings.

5.5 Chapter summary

This chapter's findings reveal the complexity of family relationships:

1. **Diverse ways of knowing**: 36.6% came out voluntarily; 29.6% of families do not know; 20.1% were passive coming-out/passive discovery. Family awareness is a complex process, not a binary "out or not".
2. **Awareness is not support**: after learning, silence/avoidance (58.2%), blame/accusation (48.4%), and non-understanding (47.7%) all exceed support/acceptance (25.3%).
3. **Limited support and inconsistent retrospective change**: in the direct-change question (n=312), 49.4% report improvement, 36.9% basically no change, 13.8% deterioration. In the two support snapshots with different respondent sets, complete non-support was 37.2% right after learning (n=476) and 26.9% currently (n=324); no longitudinal subtraction is made. Fathers' "not told" share is descriptively higher than mothers', with no corresponding formal paired test.
4. **Support relates to well-being and expression**: those with more family support tend to have higher well-being (rho=0.321); groups differing in family support differ in expression status (Cramér's V=0.170). These results show association, not proof that family support directly causes change.
5. **Attributions of non-support**: lack of understanding or misconceptions (79.2%), traditional values (78.8%), and social opinion or relative-friend pressure (74.2%) are the main attributions, suggesting family-facing support must address knowledge, values, and social pressure at once.
6. **Restrictions and violence**: 39.7% experienced verbal/psychological violence in the past year, 33.3% medical interference, 20.0% economic violence, 14.3% physical violence. Family harm touches medical autonomy, economic control, freedom of movement, and bodily safety.

Family is both a potentially important protective factor and a source of pressure and risk. Support strategies should include: accurate family-facing knowledge, conflict de-escalation and long-term education; safety planning, legal and psychological referral, and emergency economic support for respondents; and for minors, protection mechanisms and discussion of the legal/ethical framework of medical decision rights.

Later chapters present campus, employment, mental health, and public-service experiences — domains interwoven with family environment to form respondents' living conditions.

Chapter 6

06

Campus Environment, Institutions, and Educational Continuity

This chapter presents respondents' campus experiences: types and frequencies of negative experiences, levels of school support, and the state of institutional coverage. These materials show campus conditions as reported by young transgender and gender-diverse respondents.

49.3%
Verbal discrimination/ridicule · 369 people

51.3%
No break or dropout from school · 462 people

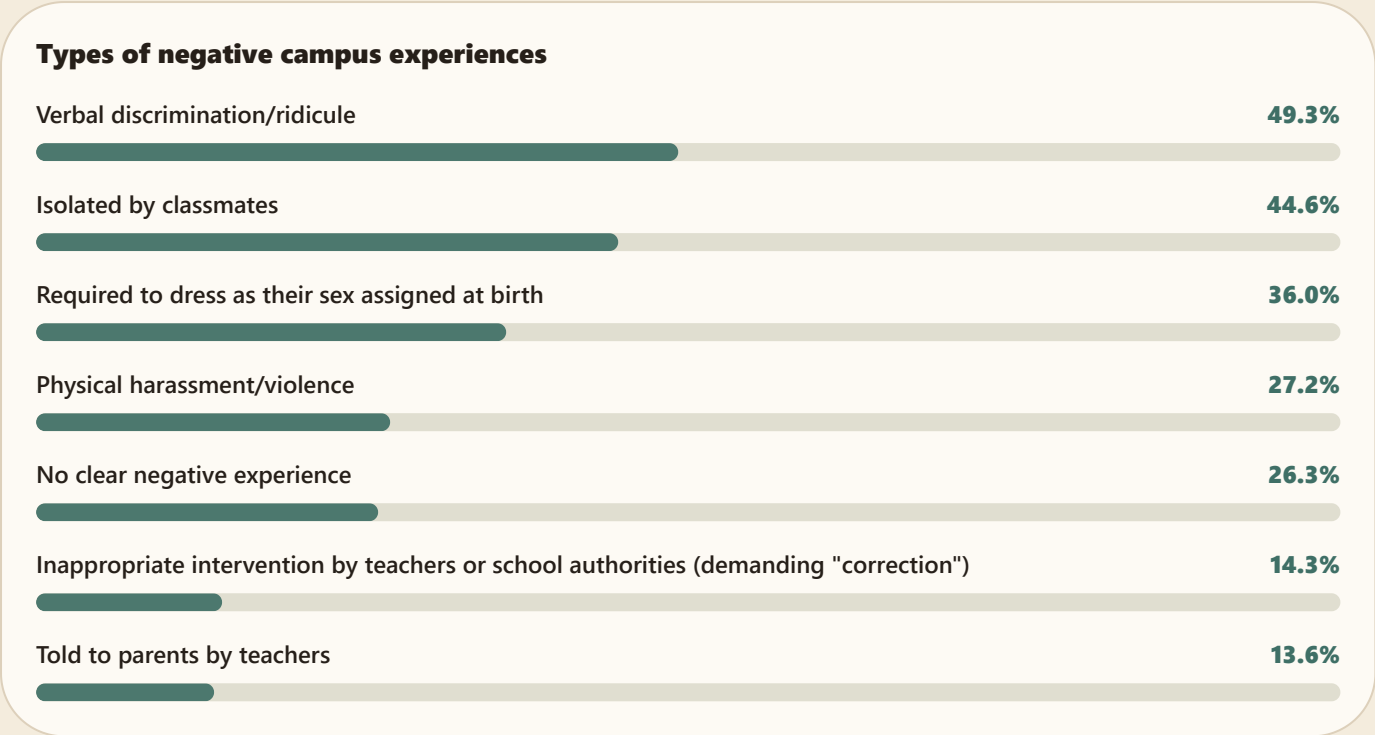
6.1 Negative campus experiences
6.2 School support and institutional coverage
6.3 Chapter summary

6.1 Negative campus experiences

Negative campus experiences span verbal abuse, isolation, dress requirements, and physical harassment, and correlate with distress

Key finding

Among respondents who answered the campus-experience question (n=749, multi-select), negative experiences are fairly widespread.



Verbal discrimination/ridicule 49.3% (369 people), isolated by classmates 44.6% (334 people), required to dress as their sex assigned at birth 36.0% (270 people), physical harassment/violence 27.2% (204 people), no clear negative experience 26.3% (197 people), inappropriate intervention by teachers or school authorities (demanding "correction") 14.3% (107 people), and being told to parents by teachers 13.6% (102 people).

More than 70% (73.7%) report at least one clear negative experience; only 26.3% say none. Verbal discrimination/ridicule (49.3%) and isolation by classmates (44.6%) are the most common, each near or above half. Being required to dress as their assigned sex (36.0%) directly reflects gendered rules at the institutional level. Physical harassment/violence (27.2%) shows campus safety cannot be ignored. Inappropriate teacher/school intervention (14.3%) and being told to parents (13.6%) indicate educators sometimes act as sources of pressure rather than protection.

Those reporting more negative campus experiences also tend to report more psychological distress. The association is positive but not strong (Spearman rho=0.149, adjusted $p<0.001$, n=724).

Campus ridicule, isolation, forced dress codes, and violence co-occur with respondents' current mental state, so campus safety and psychological support should be considered together.

Reading note: multi-select question, so percentages sum over 100%. It was open only to respondents with school/enrolment experience (n=749), not all main-analysis records (n=900). "No clear negative experience" (26.3%) does not equal "no experience at all", and may be affected by reporting tendencies and subjective definitions of "clear".

6.1.1 Common peer isolation and gendered dress requirements

Peer isolation and gendered dress requirements are fairly common on campus Key finding

As noted: isolated by classmates 44.6%, required to dress as their sex assigned at birth 36.0%. The former reflects rejection at the peer-relationship level; the latter reflects schools enforcing the gender binary at the institutional level.

The 36.0% share of dress-code conflicts shows respondents' reported school dress requirements directly clash with their gender identity. The questionnaire did not test whether this leads to identity exposure, peer isolation, or teacher intervention, so these experiences cannot be chained causally.

Isolation by classmates (44.6%) appears in the same question alongside verbal discrimination and dress requirements, but the survey did not measure the specific causes of isolation or test the sequence and pathways between these experiences. Explanations such as gender expression, peer norms, and dress codes require further research.

6.1.2 School breaks or dropout among some respondents

Some breaks/dropout are attributed by respondents to their transgender identity Key finding

Among respondents who answered the educational-interruption question (n=900), 51.3% (462 people) had no break or dropout, 21.9% (197 people) had one but consider it unrelated to their transgender identity, 13.6% (122 people) consider it directly related, and 13.0% (117 people) consider it partially related.

Combining "directly related" and "partially related", more than a quarter (26.6%) link breaks or dropout to their transgender identity. The question does not separate "break" from "dropout", but this subjective attribution deserves attention. Campus pressure (negative experiences, parents being notified, dress-code conflicts) may relate to educational interruption; fuller understanding requires larger samples and more detailed cause tracking.

Although the sample is small, over half of those with break/dropout experience attribute it to their transgender identity; this subjective attribution deserves attention. Campus pressure may relate to educational interruption, but further research is needed.

Reading note: these data rest on subjective attribution and cannot prove that transgender identity directly "causes" breaks or dropout. Educational interruption may involve many causes (family conflict, mental health, economic pressure); transgender-identity-related factors may be one, potentially interwoven with others.

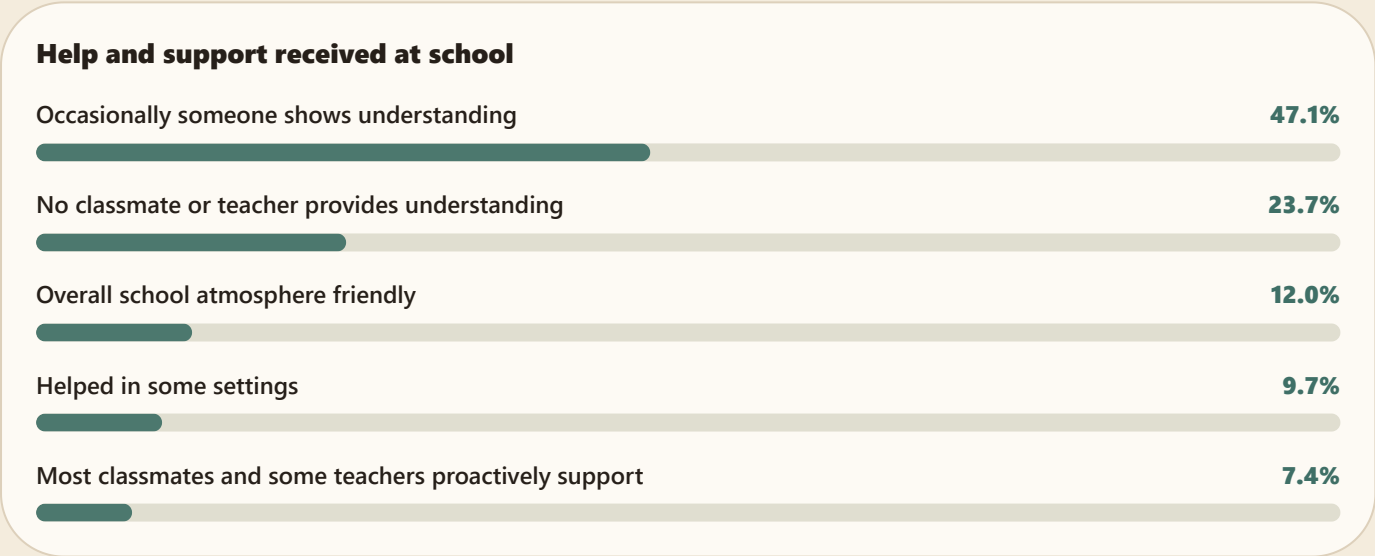
6.2 School support and institutional coverage

School support is generally limited, and more school support relates to higher well-being

Key finding

6.2.1 Support received at school

Among respondents who answered the school-support question (n=607), support is generally limited.



Occasionally someone shows understanding 47.1% (286 people), no classmate or teacher provides understanding 23.7% (144 people), overall school atmosphere friendly 12.0% (73 people), and most classmates plus some teachers proactively support 7.4% (45 people).

Combining "no support" and "occasional understanding", over 70% (70.8%) sit at almost no support or only sporadic individual support. Friendly overall atmosphere (12.0%) and most-classmate-plus-some-teacher support (7.4%) are low, suggesting systemic, institutional support remains rare.

Those receiving more understanding and support at school also tend to report higher overall well-being — a positive statistical association (Spearman rho=0.278, adjusted $p<0.001$, n=604).

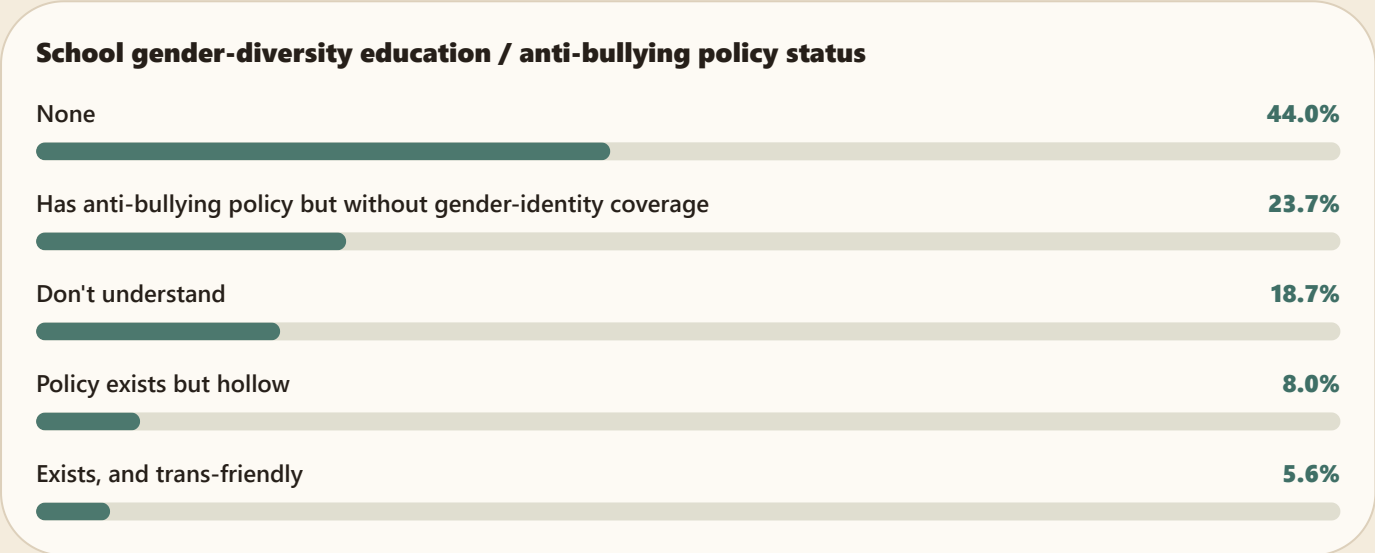
In this sample, the school-support and well-being link is more visible than the campus-negative-experience and distress link. Note that these are overall associations across different analyses; they cannot judge each person's specific experience.

6.2.2 Coverage of school policies

School policies explicitly covering gender diversity are very rare

Key finding

Among respondents who answered the school-policy question (n=823), schools with policies explicitly covering gender diversity are extremely rare.



No relevant policy 44.0% (362 people), anti-bullying policy without gender-identity coverage 23.7% (195 people), policy exists but hollow 8.0% (66 people), and exists and trans-friendly 5.6% (46 people).

Over 40% (44.0%) attend schools with no relevant policy; only 5.6% attend schools with explicit, trans-friendly policies. Notably, 8.0% report policies that exist but are hollow — policy existence is not equivalent to effective protection. Anti-bullying policies without gender-identity coverage (23.7%) suggest generic anti-bullying policies are often insufficient for transgender students; explicit protection of gender identity and expression needs to be added.

Reading note: respondents' awareness of policies may differ from actual existence; some may report "none" because they do not know, or describe policy content inaccurately due to incomplete knowledge. Results reflect perceived coverage, not measurable actual coverage.

Reading note on the association results in this section: the questionnaire records campus experiences, school support, and psychological state over the same period; it cannot prove one directly causes changes in the other. Negative campus experiences and distress are also simplified records that cannot cover frequency, duration, and severity.

6.3 Chapter summary

This chapter presents respondents' reports of campus negative experiences, support, and policy gaps:

1. **Widespread negative experiences**: 73.7% report at least one clear negative experience; verbal discrimination/ridicule (49.3%), isolation by classmates (44.6%), required dress codes (36.0%), and physical harassment/violence (27.2%) are the most common. More negative campus experiences correlate with more distress (rho=0.149).
2. **Scarce support**: over 70% sit at almost no support or only sporadic support; overall supportive schools are under 20% (19.4%). More school support relates to higher well-being (rho=0.278).
3. **Policy gaps**: over 40% attend schools with no relevant policy; explicit, effectively implemented gender-diversity policies are extremely rare (5.6%). Generic anti-bullying policies often omit gender-identity protection.
4. **Empty policies**: policy existence is not effective protection; 8.0% report hollow policies, highlighting the need to address policy content, enforcement mechanisms, and complaint channels together.
5. **Educational interruption**: 26.6% attribute breaks/dropout to their transgender identity (direct 13.6% + partial 13.0%); this subjective attribution deserves follow-up research.

Improving campus conditions for transgender students requires: explicit inclusion of gender-identity and expression protection in anti-bullying policies; support mechanisms with accountable staff, confidential procedures, and complaint channels; professional training for teachers; and converting individual goodwill into enforceable, accountable institutions. School support must not depend on individual teachers' kindness — it needs systemic policy support.

Later chapters present employment, mental health, and public-service experiences.

Chapter 7

07

Employment, Identity Concealment, and Economic Circumstances

This chapter presents respondents' experiences in job hunting and at work, along with identity-management strategies and economic impacts. Note that the sample is dominated by respondents aged 18–22 (43.5%): a substantial share may still be in school, not yet in the labour market, or at the first-job-hunting stage. The findings in this chapter therefore mainly reflect those with job-hunting or work experience.

52.1%
Must conceal identity at work · 139 people

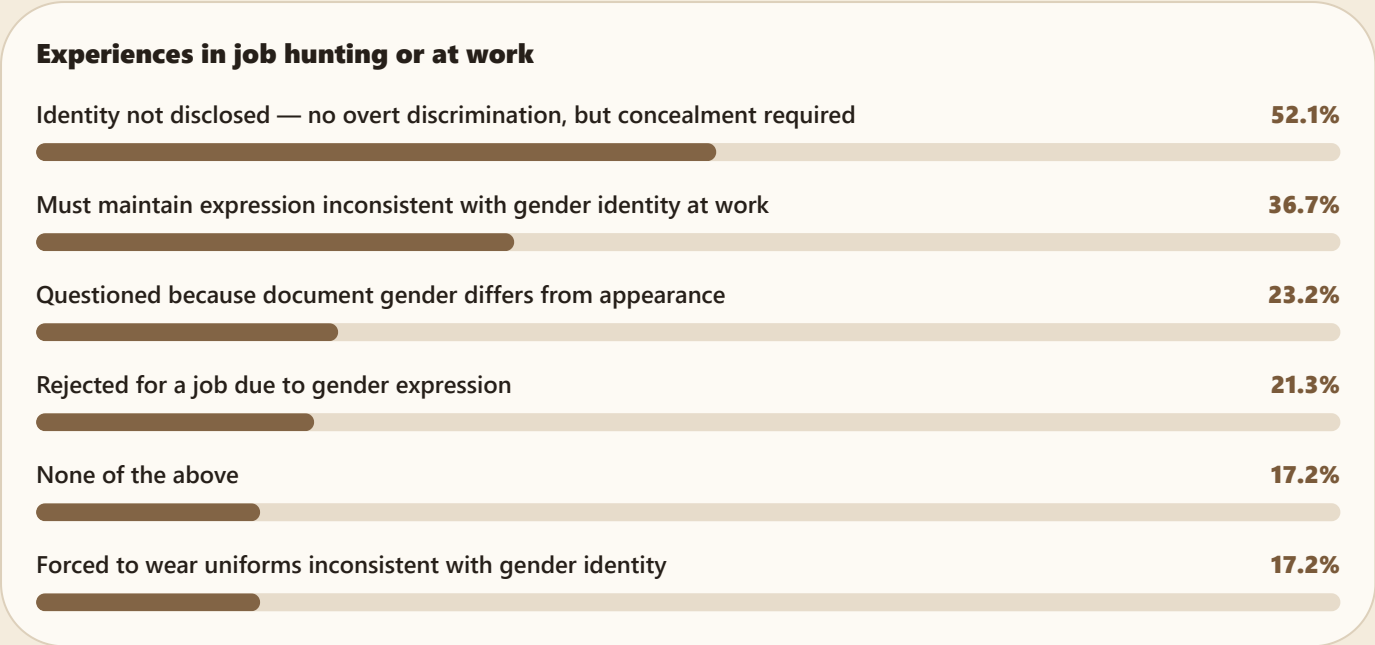
6.7%
Fired or forced to leave due to identity · 18 people

7.1 Identity management and negative experiences at work
7.2 Identity expression and employment experiences
7.3 Chapter summary

7.1 Identity management and negative experiences at work

The main costs at work are often identity concealment and maintaining inconsistent expression Key finding

Among respondents with job-hunting or work experience who answered this question (n=267, multi-select), overt discrimination and hidden costs coexist.



Identity not disclosed — no overt discrimination, but concealment required 52.1% (139 people), maintaining expression inconsistent with gender identity at work 36.7% (98 people), questioned because document gender differs from appearance 23.2% (62 people), rejected for a job due to gender expression 21.3% (57 people), none of the above 17.2% (46 people), and forced to wear work uniforms inconsistent with gender identity 17.2% (46 people).

Over half (52.1%) must conceal their identity because it is not disclosed. This share suggests sustained concealment is the most commonly reported workplace cost in this question. The questionnaire did not measure the specific manner or psychological consequences of concealment, so it cannot judge its relation to burnout, belonging, or other states.

Questioning due to document/appearance mismatch (23.2%) and rejection because of gender expression (21.3%) are more direct discrimination experiences, both over 20%. Forced to wear mismatched uniforms (17.2%) is an institutional enforcement of the gender binary, similar to campus dress requirements.

Only 17.2% say "none of the above", meaning over 80% of respondents with work experience report at least one negative experience or concealment cost.

Reading note: this question was open only to respondents with job-hunting/work experience who answered it (n=267), not all main-analysis records (n=900). Given the young age structure, the work-experience sample's representativeness may be below that of the school-experience sample. Multi-select question, so percentages sum over 100%.

7.1.1 Rejection and document questioning

> **Some with work experience report being rejected because of gender expression**
>
> Key finding

As noted, rejection for a job due to gender expression is 21.3%. In the same workplace-experience question (n=267, multi-select), fired or forced to leave because of transgender identity 6.7% (18 people), experienced salary discrimination or promotion barriers 6.7% (18 people).

> **Job seekers and workers with document-appearance mismatch report being questioned**
>
> Key finding

As noted, questioned because document gender differs from appearance is 23.2%. The question did not collect the specific settings or outcomes of the questioning, so it cannot be inferred whether rejection, job changes, identity exposure, or other consequences followed.

The interweaving of document systems and employment experience suggests improving workplace environments requires both anti-discrimination policy and more flexible, privacy-respecting identity-verification alternatives (e.g. confirming identity by name rather than gender marker).

7.1.2 Self-reported economic impact

> **Among those with work experience, negative economic impact clearly outweighs positive**
>
> Key finding

Among respondents who answered the economic-impact question (n=283), some negative impact 37.8% (107 people), no clear impact 20.8% (59 people), severe negative impact 12.7% (36 people), clear positive impact 2.8% (8 people), and some positive impact 2.1% (6 people).

Combining "severe negative" and "some negative", over half (50.5%) believe their transgender identity negatively affected their financial situation. In contrast, positive impact (4.9% combined) is extremely low. This distribution suggests employment and identity-related experiences may run parallel to economic vulnerability — but note this is respondents' subjective evaluation, not objective income change or causal inference.

The questionnaire did not measure the mechanisms behind this negative economic evaluation. Rejection, document questioning, family financial support, medical costs, and working conditions could be followed up; this report does not confirm any transmission pathway.

Reading note: this question asks respondents' subjective evaluation of "the impact of transgender identity on finances", not an objective measure of net income change. Respondents may synthesize overall economic pressure, interrupted family support, medical costs, and other factors, and may not cleanly isolate the identity's specific contribution.

7.1.3 Economic independence and disposable funds

Economic independence: fully/mostly family-dependent is the largest group; fully independent about one tenth

Key finding

Among respondents who answered the economic-independence question (n=883), fully dependent on family/guardians 46.4% (410 people), mostly dependent with a little own income 25.3% (223 people), fully independent 10.5% (93 people), mostly self-reliant with occasional family/guardian support 7.7% (68 people), and a mix of family/guardian and own income 5.5% (49 people).

Disposable funds: ¥1000–2000/month most common; a notable share report no income or no freely disposable funds

Key finding

Among respondents answering monthly freely disposable funds (n=863), ¥1000–2000/month 20.2% (174 people), ¥2000–3000/month 14.9% (129 people), below ¥500/month 13.0% (112 people), ¥500–1000/month 9.6% (83 people), unstable/hard to estimate 7.8% (67 people), no current income 5.4% (47 people), no freely disposable funds for now 5.3% (46 people), and ¥3000–6000/month 3.7% (32 people).

After merging synonymous tiers across questionnaire versions, fully/mostly family-dependent respondents form the largest group — consistent with the young sample structure noted at the start (18–22 at 43.5%) and directly relevant to reading Chapter 5's family restrictions/violence (economic violence 20.0%) and Chapter 8's economic pressure sources. Monthly disposable funds show a long-tail distribution: the ¥1000–2000 tier dominates, and "no income" plus "no freely disposable funds" together exceed 10%, suggesting a share of respondents lack free economic resources and have limited financial independence.

7.2 Identity expression and employment experiences

The pre-specified test between expression and negative employment experiences shows no statistical evidence

Key finding

This analysis found no clear statistical association between identity-expression status and negative employment experiences (Cramér's V=0.066, adjusted p=0.889, n=258).

This does not mean expression and employment experiences are unrelated, nor does it deny workplace discrimination. Fewer people entered this analysis, and employment experiences are affected by industry, region, position, and company size. Simplified questionnaire records may not separate these influences. These data only show insufficient evidence; larger samples and more detailed employment data are needed.

7.3 Chapter summary

This chapter's findings reveal multiple barriers and hidden costs in employment:

1. **Concealment is the main cost**: 52.1% must conceal their identity because it is not disclosed; 36.7% must maintain expression inconsistent with their gender identity. Sustained concealment and inconsistent expression are themselves the most common workplace burdens.
2. **Documents and rejection**: 23.2% were questioned because documents mismatch appearance; 21.3% were rejected for a job due to gender expression. Document systems directly intersect employment experience.
3. **Negative economic impact**: 50.5% believe their transgender identity negatively affected finances; positive impact is extremely low (4.9%).
4. **No clear association found**: this data shows no clear relationship between expression and negative employment experiences (adjusted p=0.889), but the absence of evidence is not evidence of absence. Sample size, simplified measurement, and multiple employment factors may affect the result.
5. **Sample limits**: with a young sample, those with work experience (n=267) are a small share, so findings mainly reflect job-hunting/work-experienced respondents, not the full sample or the broader working population.

Improving transgender employment environments requires: explicit anti-discrimination policies and complaint mechanisms; inclusive redesign of recruitment, dress, name use, and document-verification processes; and support services for the psychological costs of concealment and inconsistent expression. Beyond overt discrimination, sustained concealment and inconsistent expression are themselves significant burdens in the workplace and need to be visible in policy design and service provision.

Chapter 8

08

Mental Health, Well-Being, and Safety Support

This chapter presents respondents' self-reported mental health and well-being: emotional distress, pressure sources, access to psychological support, self-harm and suicide-related experiences, and overall well-being ratings. These findings must be read against multi-layered external environments, not attributed to transgender identity itself.

61.8%
Frequent anxiety in the past six months · 538 people

83.7%
Pressure source: gender identity/body anxiety · 503 people

8.1 Emotional distress and pressure sources
8.2 Access to psychological support and life motivation
8.3 Self-harm and suicide-related experiences
8.4 Overall well-being
8.5 Chapter summary

Content note: this chapter covers sensitive content such as self-harm and suicide-related experiences. If you are experiencing psychological distress or safety risks, you can contact the following verified support resources:

- **National unified psychological assistance hotline**: 12356
- **Beijing Psychological Crisis Research and Intervention Center hotline**: 010-82951332
- If in immediate physical danger, call 110 or 120, or go to the nearest emergency department.

This chapter presents data neutrally, in a research manner, without sensationalism; it infers no individual's current immediate risk, nor attributes distress to transgender identity itself.

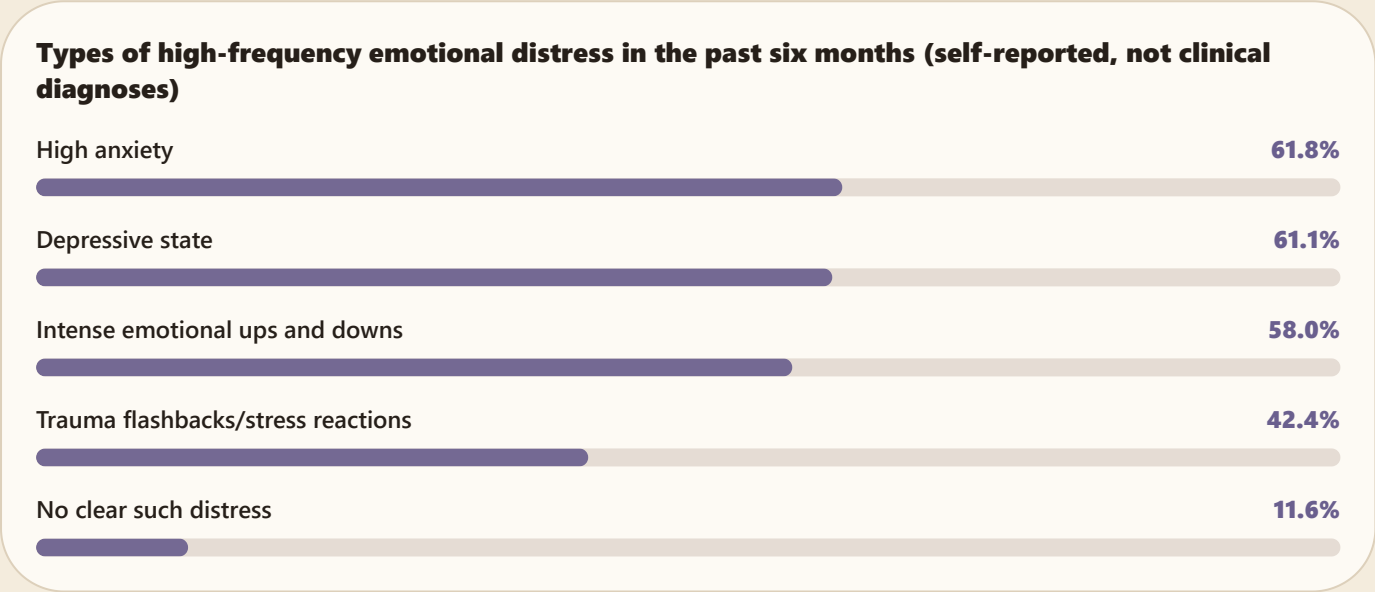
8.1 Emotional distress and pressure sources

High-frequency distress is widespread; pressure spans body, schoolwork, family, finances, and institutional environments

Key finding

8.1.1 High-frequency emotional distress in the past six months

Among respondents who answered the distress question (n=870, multi-select), high-frequency distress is fairly widespread.



Frequent anxiety 61.8% (538 people), frequent depressive moods 61.1% (532 people), intense emotional ups and downs 58.0% (505 people), trauma flashbacks/stress reactions 42.4% (369 people), and no clear such distress 11.6% (101 people). These categories reflect self-reported emotional experience, not clinical diagnoses or prevalence estimates.

Interpretive discussion (not directly measured by this question): frequent anxiety (61.8%) and frequent depressive moods (61.1%) both exceed 60%; intense emotional ups and downs (58.0%) approaches 60%; trauma flashbacks/stress reactions (42.4%) is also high, suggesting a substantial share may have experienced traumatic events or long-term stress. Only 11.6% report no clear distress, meaning nearly 90% (88.4% = 100 − 11.6%) experienced at least one high-frequency distress in the past six months; this mechanistic interpretation cannot substitute clinical assessment.

Anxiety, depressive states, and emotional turbulence are the most common high-frequency distress

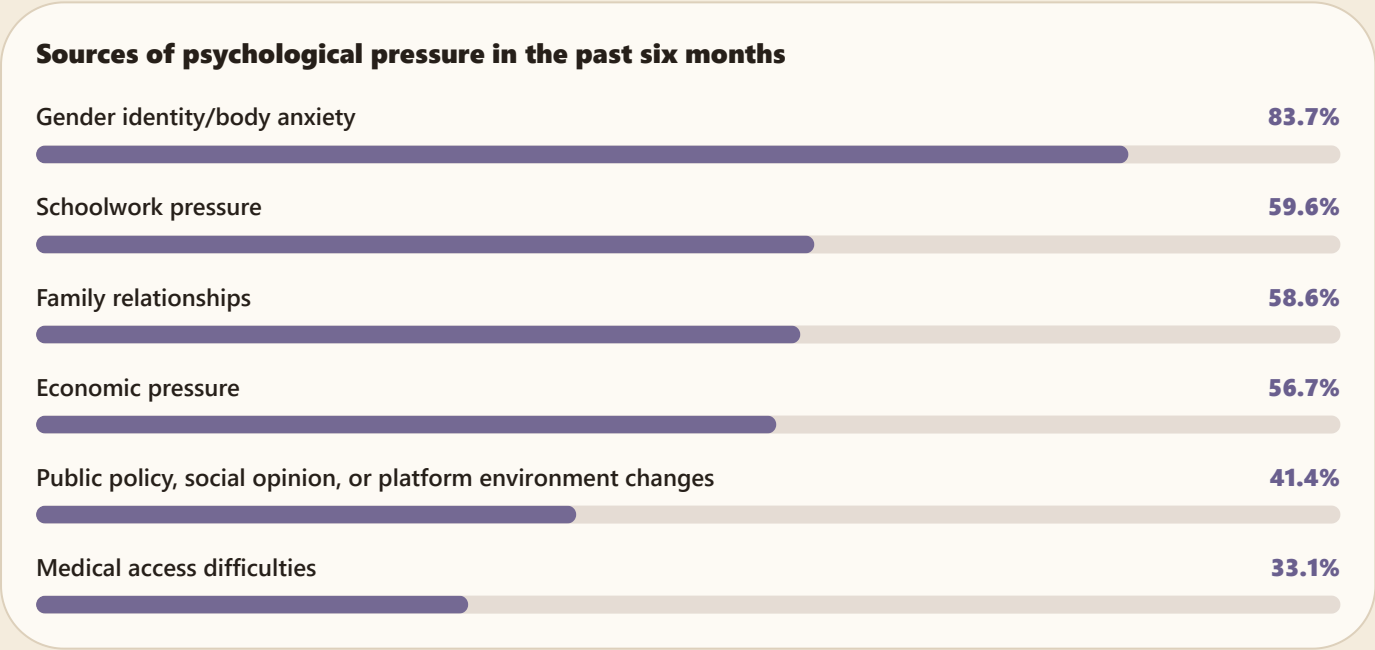
Key finding

As noted: frequent anxiety (61.8%), frequent depressive moods (61.1%), and intense emotional turbulence (58.0%) are the three most common, with close rates. This suggests psychological services need to cover multiple distress types, not a single diagnostic label.

Reading note: the question asks about "subjectively felt high-frequency, repeated affliction", not clinical diagnosis. Respondents may not have been to a doctor or formal assessment, or may differ in understanding "high-frequency" and "distress". These data describe self-reported experience and should not be read as disease prevalence.

8.1.2 Sources of psychological pressure

Among respondents who answered the pressure-source question (n=601, multi-select), sources show clear multi-layered environmental features.



Gender identity/body anxiety 83.7% (503 people), schoolwork pressure 59.6% (358 people), family relationships 58.6% (352 people), economic pressure 56.7% (341 people), public policy, social opinion, or platform environment changes 41.4% (249 people), and medical access difficulties 33.1% (199 people).

Gender identity/body anxiety (83.7%) is the most reported source, but closely followed by schoolwork (59.6%), family (58.6%), and finances (56.7%) — all above half. Public policy/social opinion (41.4%) and medical access (33.1%) also exceed one third.

Pressure sources show clear multi-layered environmental features

Key finding

As above: sources span the individual level (gender identity/body anxiety), family (relationships), education (schoolwork), economy (financial pressure), service accessibility (medical access), and the macro environment (public policy, social opinion, platform environment).

This pattern suggests distress cannot be explained apart from external environments, nor reduced to a causal statement like "transgender identity causes psychological problems". Although gender identity/body anxiety is the most cited source (83.7%), it runs parallel to family, schoolwork, economic, and institutional pressures — with the latter also very high. Mental health support therefore needs trauma-informed, non-pathologizing services that respond to family, educational, economic, and medical barriers at the same time.

8.1.3 Neurodiversity traits and prior diagnosis experiences

Neurodiversity traits: over 40% report ADHD or ASD traits; a fair share report both

Key finding

Among respondents who answered the neurodiversity question (n=882, multi-select), neither 56.5% (498 people), ADHD (attention deficit hyperactivity disorder) 34.9% (308 people), and ASD (autism spectrum disorder) 25.4% (224 people).

Because it was multi-select, ADHD and ASD percentages are each computed separately; reading the two as mutually exclusive is unsupported — some respondents may report both. The relatively high neurodiversity share suggests psychological and support services should consider neurodiverse needs (information presentation, communication pace, sensory environments), not be designed only around gender-identity topics.

Among self-reported prior diagnoses, depressive and anxiety disorders are most common

Key finding

Among respondents who answered the prior-diagnosis question (n=886, multi-select), depressive disorder 52.6% (466 people), anxiety disorder 49.8% (441 people), none of the above 37.2% (330 people), bipolar disorder 19.9% (176 people), PTSD (post-traumatic stress disorder) 12.2% (108 people), and eating disorder 3.7% (33 people).

Over half self-report a depression or anxiety diagnosis from a formal medical institution/psychiatrist. These data are unverified against medical records and reflect reported diagnostic experiences, not current disease status or prevalence estimates; the parallel high shares of emotional distress (8.1.1: high anxiety 61.8%, depressive state 61.1%) and prior self-reported diagnoses further show the multi-layered mental-health support need.

8.2 Access to psychological support and life motivation

8.2.1 Difficulty accessing psychological support

Those who find support difficult outnumber those who find it easy Key finding

Among respondents who answered the support-access question (n=873), fairly difficult 27.3% (238 people), very difficult 18.2% (159 people), average 31.5% (275 people), fairly easy 17.5% (153 people), and very easy 5.5% (48 people).

Combining "fairly difficult" and "very difficult", 45.5% find it difficult to access psychological support. By contrast, "fairly easy" or "very easy" total only 23.0%. This suggests insufficient psychological service supply and accessibility is a common problem.

Difficulty may arise from many factors: cost burden, geographic distance, lack of professionals informed about transgender topics, fear of pathologization or identity exposure, family not supporting care, or not knowing how to find appropriate services.

8.2.2 Reduced life motivation

In the past six months, a share of respondents fairly frequently report reduced life motivation Key finding

Among respondents who answered the motivation-frequency question (n=872), often (multiple times a week) 26.4% (230 people), occasionally 25.1% (219 people), sometimes (about once a week) 23.4% (204 people), almost always 16.6% (145 people), and almost never 8.5% (74 people).

Combining "almost always" and "often", 43.0% fairly frequently reported reduced life motivation in the past six months. The questionnaire did not measure whether this predated the period, nor can reduced motivation be read directly as despair or immediate risk; this service need should not be attended to only in acute crises.

Reading note: the question asks the frequency of feeling "life has lost meaning or motivation has dropped sharply"; it is not a clinical diagnosis or immediate-risk assessment. These data describe self-reported experience and should be read as indicators of support needs, not disease labels or risk predictions.

8.3 Self-harm and suicide-related experiences

Difficulty accessing support alongside self-harm and suicide-related experiences signals urgent safety support needs

Key finding

This section covers highly sensitive self-harm and suicide-related experiences. The data below are presented neutrally, without sensationalism or pathologization; they infer no individual's current immediate risk and do not attribute these experiences to transgender identity itself. They should be read as evidence of safety support needs, not evidence of identity danger.

8.3.1 Self-harm experiences

Self-harm includes both those who stopped and those who report still engaging

Key finding

Among respondents who answered the self-harm question (n=873), had but stopped 47.8% (417 people), still do it 20.4% (178 people), and never 31.7% (277 people).

Combining "had" and "still do", more than two thirds (68.2%) report a self-harm history; 20.4% report currently engaging. This answer cannot directly establish frequency, severity, function, or immediate risk.

Support systems need to distinguish historical, current, and never experiences, providing trauma-informed, harm-reduction-oriented services; the question did not measure the function or motivation of self-harm, so psychological mechanisms should not be inferred.

Reading note: the question asks about existence and current status of self-harm, not frequency, severity, or specific method, nor the reasons for stopping. It cannot determine acute risk for individuals, nor why respondents stopped.

8.3.2 Suicide-related experiences

Suicide-related experiences should be presented cautiously and linked directly to support resources

Key finding

Among respondents who answered the suicide-related question (n=854), lifetime self-reports show ideation without attempt 51.3% (438 people), attempt 37.6% (321 people), and none 11.1% (95 people). Independent verification confirms the "attempt" category at 321/854 (37.6%), consistent with the main analysis.

By the question's mutually exclusive categories, 88.9% reported at least one category. This overall share serves only as background summary; more important is separately presenting the two lifetime self-report categories: ideation without attempt (51.3%) and attempt (37.6%). The high rates indicate suicide-related experiences are very common in this sample. It must be stressed that these data reflect historical experiences, not current immediate risk.

Key note

Reading boundary

1. **These data demonstrate safety support needs, not evidence of transgender-identity danger**; they should be read alongside the multi-layered pressure background seen elsewhere, without confirming causality.
2. **Historical experiences are not current immediate risk**. The question did not ask timing, continuity, or current status, so it cannot determine whether respondents are presently at risk, nor what changed.
3. **These experiences should not be attributed to transgender identity itself**. As noted (8.1.2), pressure sources include family, schoolwork, finances, medical care, and social environments; suicide-related experiences should be read in that multi-layered context.
4. **Support systems need low-threshold, accessible, non-pathologizing crisis support and long-term psychological services**, plus removal of barriers in family, campus, healthcare, and economy.

Reading note: the question asks only about existence, not timing, frequency, or current status. It must not be inferred as individual immediate risk or population extrapolation. These data are indicators of support needs and must not be dramatized, sensationalized, or used for stigmatizing campaigns.

If you are experiencing psychological distress or safety risks, please call the support hotlines listed at the start of this chapter, or reach out to a trusted adult, professional, or community member.

8.4 Overall well-being

Overall well-being clusters at average and lower levels

Key finding

Among respondents who answered the well-being question (n=896), average 32.1% (288 people), not very happy 30.8% (276 people), fairly happy 18.4% (165 people), very unhappy 16.3% (146 people), and very happy 2.3% (21 people).

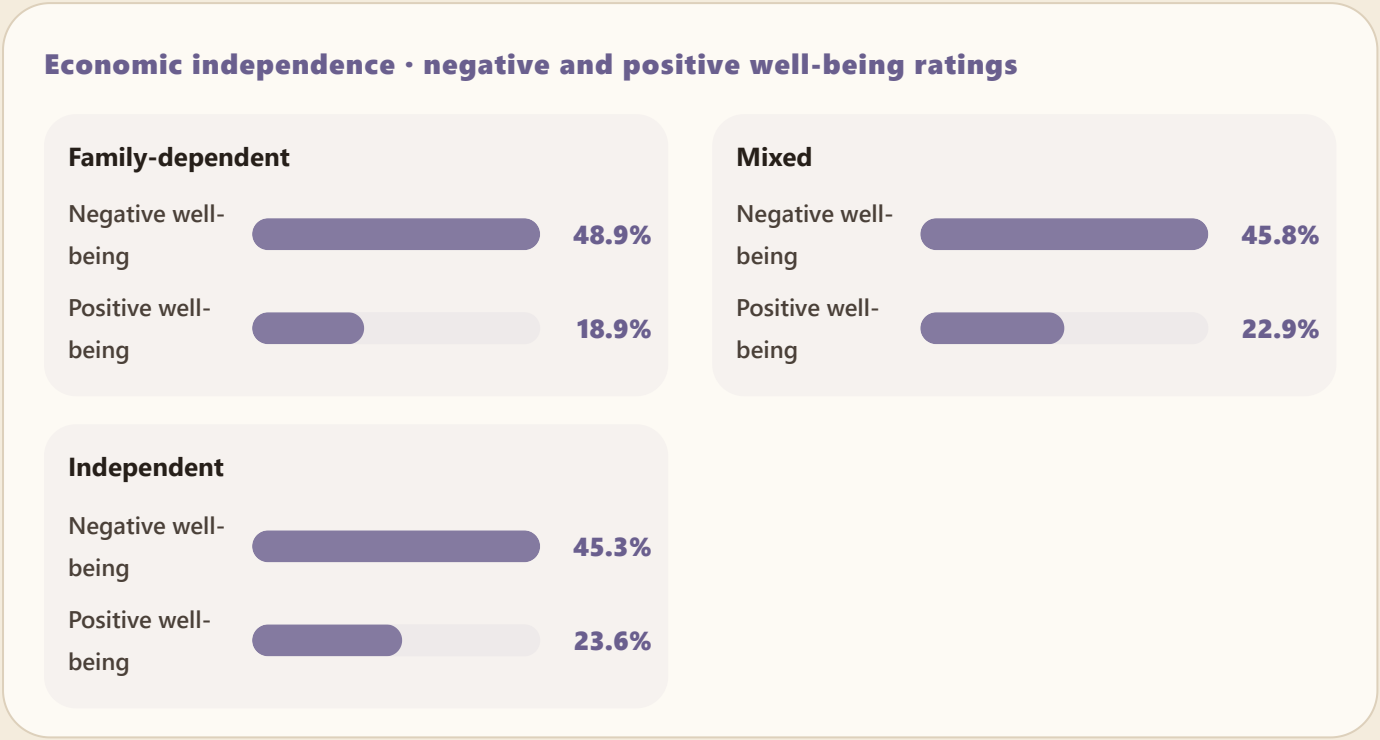
Combining "very unhappy" and "not very happy", 47.1% hold negative views of overall well-being. Only 20.7% report fairly or very happy. Nearly a third (32.1%) rate "average".

Well-being relates to many aspects of life. How one can express identity, how much family and school support one has, satisfaction with medical services, and the number of support sources all co-vary with well-being. The corresponding statistics: identity expression Cramér's V=0.144, family support rho=0.321, medical satisfaction rho=0.370, school support rho=0.278, support-source count rho=0.179.

These associations show well-being cannot be understood from individual psychological state alone. Family, school, healthcare, and support networks jointly form respondents' living environments, with medical satisfaction and family support showing relatively clearer links to well-being.

Reading note: this is an ordered-rating question; the distribution describes self-rated well-being. Ordinal ratings should not be treated as interval measures — respondents may understand "average" or "fairly happy" differently. This report does not compare well-being means to population norms or other groups; it only describes this sample's distribution.

8.4.1 Exploratory comparison: economic independence and overall well-being

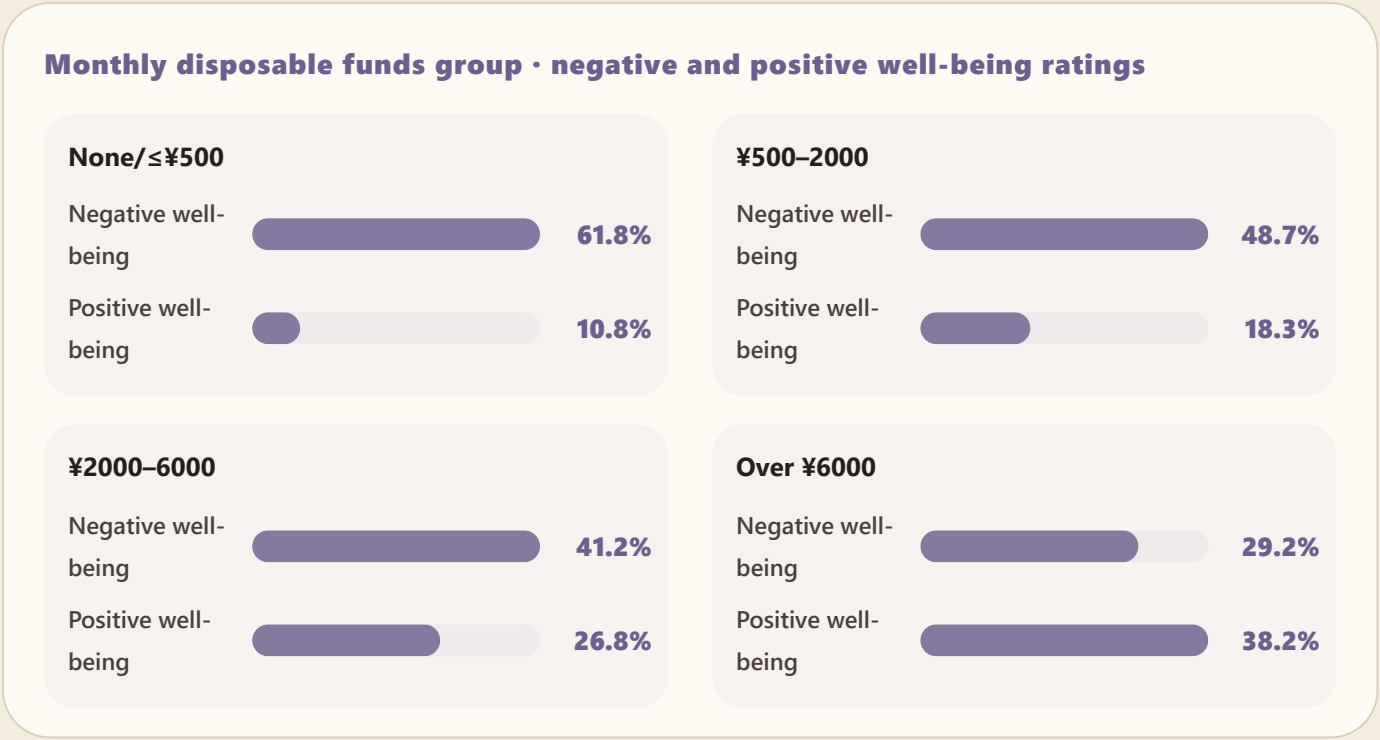


Among respondents valid on both economic independence and well-being (n=839), grouped by independence, well-being shows mild between-group differences. Family-dependent group (n=630): "very unhappy"+"not very happy" 48.9%, "fairly happy"+"very happy" 18.9%, mean 2.54; mixed group (n=48): negative 45.8%, positive 22.9%; independent group (n=161): negative 45.3%, positive 23.6%, mean 2.70.

The independent group rates slightly better, but this analysis found no clear statistical association between economic independence and well-being. The link is very weak (Spearman rho=0.077, n=839, adjusted p>0.05). Descriptively, the independent group has fewer negative and more positive ratings, but the difference does not reach the statistical threshold.

This does not mean economic conditions are unrelated to well-being. Employment status, age, and family relationships may all influence both. Because the report tests many relationships, the statistical bar was raised to avoid mistaking chance differences for real findings.

8.4.2 Exploratory association: monthly disposable funds and overall well-being



Among respondents valid on both monthly disposable funds and well-being with clearly mappable bands (n=760), four descriptive bands: none/≤¥500 per month (n=204): negative well-being 61.8%, positive 10.8%; ¥500–2000/month (n=273): 48.7% and 18.3%; ¥2000–6000/month (n=194): 41.2% and 26.8%; over ¥6000/month (n=89): 29.2% and 38.2%.

Mean well-being rating rises across the four bands: 2.24 (none/≤¥500, n=204), 2.56 (¥500–2000, n=273), 2.77 (¥2000–6000, n=194), and 3.10 (over ¥6000, n=89).

Groups with more disposable funds generally show fewer negative and more positive ratings; the corresponding exploratory Spearman rho=0.252, adjusted p<0.001 across 23 exploratory tests.

This is a cross-sectional association between resource conditions and well-being, not evidence that fund levels cause well-being change. The indicator is monthly disposable funds, not equal to personal salary; wide old intervals, unstable answers, and unmappable bands were excluded from this exploratory comparison, so the result should not be read as a full income effect.

8.4.3 Exploratory association: age and psychological conditions

To compare mental-health distributions across age groups directly, the charts show a fixed order: "under 16 → 16–17 → 18–22 → 23–29 → 30+"; "under 16" corresponds to the 12–15 group in analysis, "30+" to 30 and above. 30–39 and 40+ are merged to protect low-frequency cells. The

analysis is based on the main sample (analysis n=900); one age-logic-conflict record was excluded, so valid age n=899.

Age and mental health

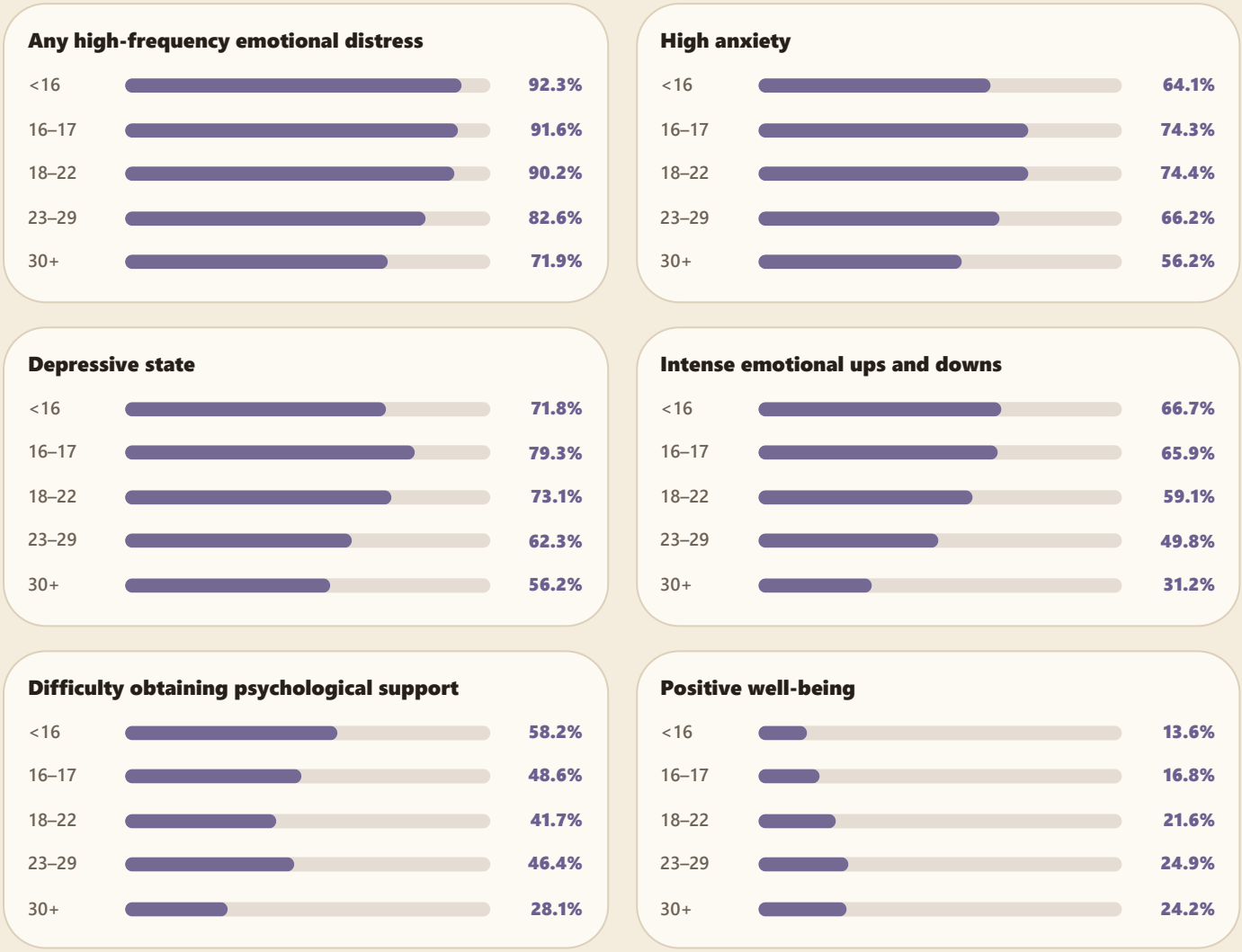


Figure note: overall tests across the five age groups and BH corrections are retained in the statistical verification records; the figure shows descriptive percentages only.

Descriptively: at least one high-frequency distress is 92.3% (under 16) and 71.9% (30+); depressive state is 79.3% (16–17), 73.1% (18–22), 62.3% (23–29), and 56.2% (30+); intense emotional ups and downs is 66.7% (under 16) and 31.2% (30+); positive well-being is 13.6% (under 16), 24.9% (23–29), and 24.2% (30+). These are cross-sectional descriptive between-group differences; they cannot show individuals changing with age, nor that age itself causes psychological changes.

Age groups do not fully match in psychological profiles. Across the five-group comparison, at least one high-frequency distress, depressive state, intense emotional ups and downs, and difficulty accessing psychological support show exploratory associations with age; high anxiety also reaches the adjusted threshold but with a weak effect; positive well-being does not reach it. With age coarsened into under-18 vs. 18+, the adjusted p-values for at least one high-frequency distress, high anxiety, depressive state, intense emotional ups and downs, difficulty accessing psychological

support, and positive well-being are respectively 0.02994, 0.65588, 0.02994, 0.00828, 0.02994, and 0.02994. The two-group and five-group analyses answer different questions; for example, positive well-being fails threshold in the five-group comparison but reaches it in the under-18 vs. 18+ split.

Age differences may reflect life stage, family support, economic conditions, medical accessibility, and recruitment channels simultaneously. A two-group split is a supplementary observation and does not replace the finer five-group results.

Reading note for this section: the psychological indicators are self-reported and not clinical diagnoses. The questionnaire records only one period and cannot prove age, economic independence, or any support factor directly causes psychological change; nor can this online-recruited sample's percentages be extrapolated to the whole transgender population. These cross-comparisons are exploratory and do not constitute new key findings.

8.5 Chapter summary

This chapter's findings reveal a complex picture of mental health and well-being:

1. **Widespread distress**: nearly 90% experienced at least one high-frequency emotional distress in the past six months; frequent anxiety (61.8%), frequent depressive moods (61.1%), and emotional turbulence (58.0%) are the most common.
2. **Multi-layered environmental pressure**: sources include gender identity/body anxiety (83.7%), schoolwork (59.6%), family (58.6%), finances (56.7%), public policy/social opinion (41.4%), and medical access (32.9%). Distress cannot be explained apart from external environments.
3. **Support access difficulties**: 45.5% find psychological support hard to access, clearly above those who find it easy (23.0%).
4. **Fairly frequent motivation decline**: 43.0% fairly frequently reported reduced life motivation (almost always or often) in the past six months — support should not be limited to acute crisis intervention.
5. **Self-harm and suicide-related experiences**: 68.2% report a self-harm history; 88.9% reported at least one suicide-related category. These are evidence of safety support needs, not identity danger, and should not be attributed to transgender identity.
6. **Well-being distribution**: 47.1% hold negative views of overall well-being; only 20.7% report fairly or very happy. Well-being is statistically associated with identity expression, family support, medical satisfaction, school support, and support-source count.

Mental health support therefore requires: trauma-informed, non-pathologizing services; low-threshold crisis support and long-term psychological services; simultaneous handling of family, educational, economic, and medical barriers; and harm-reduction-oriented, safety-planning, and referral mechanisms for self-harm and suicide-related experiences. Support strategies should not focus only on individual psychological intervention — external environmental conditions need improvement too.

Later chapters present public services, social support, and desire for change.

Chapter 9

09

ID Documents, Public Services, and Public Space

This chapter presents respondents' experiences with public affairs, public facilities, and the social environment. The findings reveal friction between document mismatch and gendered public facilities and services, and the widespread everyday prejudice and discrimination experiences.

39.6%
Public affairs: occasionally (1–2 times) · 164 people

35.3%
Forced to use facilities for their assigned sex · 267 people

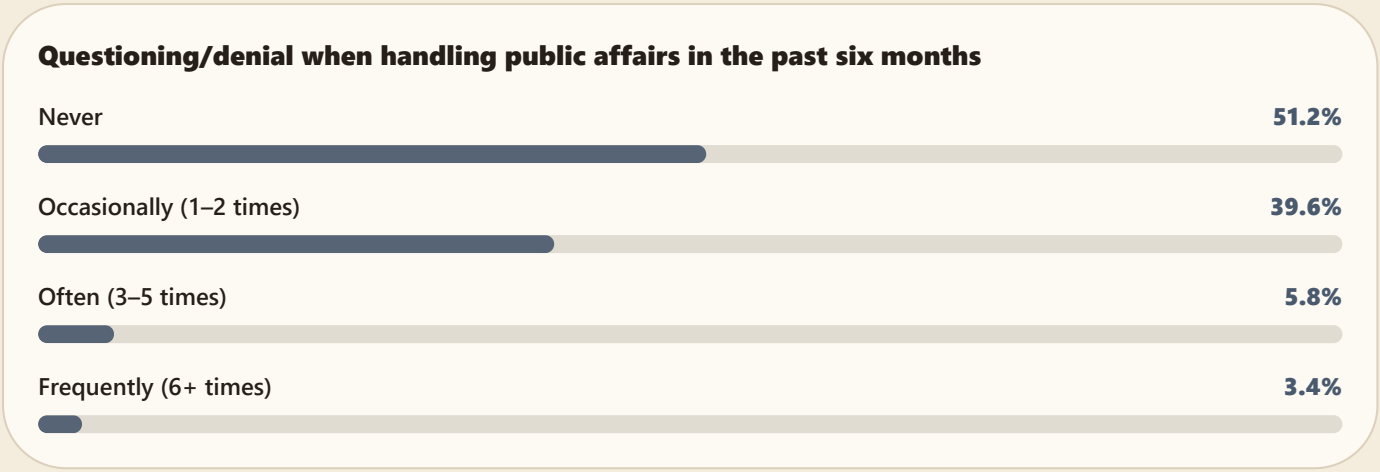
9.1 Documents and public affairs
9.2 Harassment and everyday prejudice
9.3 Visibility of local support resources
9.4 Chapter summary

9.1 Documents and public affairs

Document mismatch co-occurs with public-service and public-facility difficulties — Key finding

9.1.1 Questioning and inappropriate treatment in public affairs

Among respondents who answered the public-affairs question (n=414), experiences in the past six months of being questioned, denied, or sneered at while handling public affairs (bank account opening, hospital registration, high-speed rail/flights, hotel check-in) because gender expression does not match documents are fairly common.



Occasionally (1–2 times) 39.6% (164 people), often (3–5 times) 5.8% (24 people), frequently (6+ times) 3.4% (14 people), and never 51.2% (212 people).

Combining "occasionally", "often", and "frequently", nearly half (48.8%) encountered this at least occasionally in the past six months. Because the question applies only to those whose appearance mismatches their document gender, and many may actively avoid public affairs requiring document verification out of concern, the actual rate may be underreported.

> **Nearly half of relevant respondents at least occasionally encounter questioning or inappropriate treatment** **Key finding**

As above, 48.8% at least occasionally encountered questioning or inappropriate treatment in public affairs in the past six months. This suggests public-service difficulties are not limited to rare extreme events — they are everyday experiences for a substantial share.

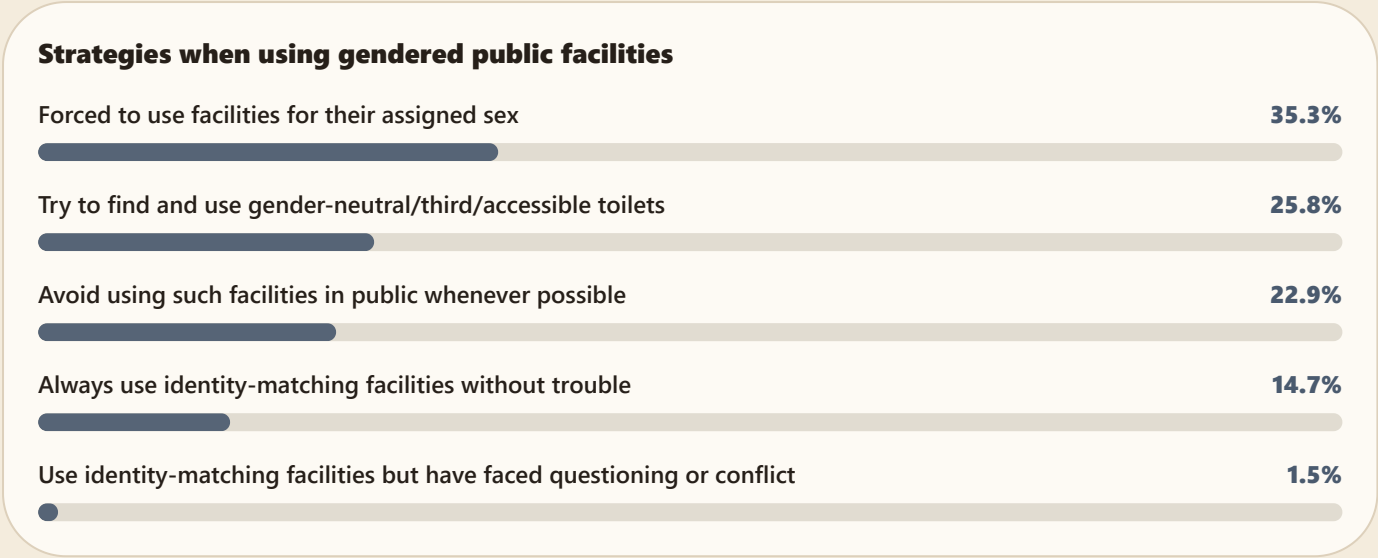
Those facing more document difficulties also more often report public-service difficulties — a statistical association (Cramér's V=0.173, adjusted p=0.013, n=407).

When document information does not match appearance or identity, processes may add risk of explanation, questioning, and inappropriate treatment. Public-service experience is also affected by region, institutional processes, and staff attitudes.

Reading note: applies only to specific respondents (those whose appearance mismatches document gender), not all main-analysis records (n=900). It describes actual encounter frequency in the past six months, not a complete record of all relevant public affairs; some may have avoided encounters.

9.1.2 Strategies for gendered public facilities

Among respondents who answered the public-facilities question (n=757), most use avoidance or alternatives rather than comfortable use of gendered facilities.



Forced to use facilities for their assigned sex 35.3% (267 people), try to find gender-neutral/third/accessible toilets 25.8% (195 people), avoid using such facilities in public whenever possible 22.9% (173 people), and always use facilities matching their identity without trouble 14.7% (111 people).

Only 14.7% always use identity-matching facilities without trouble. More than 80% (85.3%) cope with varying difficulty: forced to use mismatched facilities (35.3%), actively find alternatives (25.8%), or actively avoid (22.9%).

Avoidance (22.9%) and alternatives (25.8%) are adaptations to environmental constraints, not personal preference. Avoiding public restrooms may impede normal participation at school, work, shopping, and travel, bringing physical discomfort (reduced drinking, holding urine) and social limits.

A notable share cope with gendered facilities through avoidance or alternatives

Key finding

As above, avoidance (22.9%) and alternatives (25.8%) together 48.6%. Both are responses to environmental constraints and should not be read as personal preference or rejection of public facilities. Providing gender-neutral facilities, improving accessibility, and offering more flexible alternatives in identity-verifying public affairs are direct paths to reduce this barrier.

9.2 Harassment and everyday prejudice

9.2.1 Offline and online harassment

Offline and online harassment are both common; some also report sexual harassment or physical violence

Key finding

Among respondents who answered the harassment question (n=855, multi-select), all categories show relatively high shares. Offline verbal harassment/discrimination 26.1% (223 people), online harassment/doxxing/cyberbullying 25.5% (218 people), sexual harassment/sexual violence 18.8% (161 people), physical violence 6.1% (52 people), and none of the above 28.7% (245 people).

Combining all who reported at least one category, 71.3% reported some form of harassment. Online (25.5%) and offline verbal (26.1%) are close, indicating both environments carry substantial reported experience. Although lower than verbal harassment, sexual harassment/sexual violence (18.8%) and physical violence (6.1%) remain non-trivial in absolute numbers.

Reading note: multi-select, so percentages sum over 100%. The topic is highly sensitive and may be underreported. Respondents may understand option boundaries differently (e.g. between "verbal discrimination" and "harassment").

9.2.2 Frequency of gender stereotypes and verbal bias

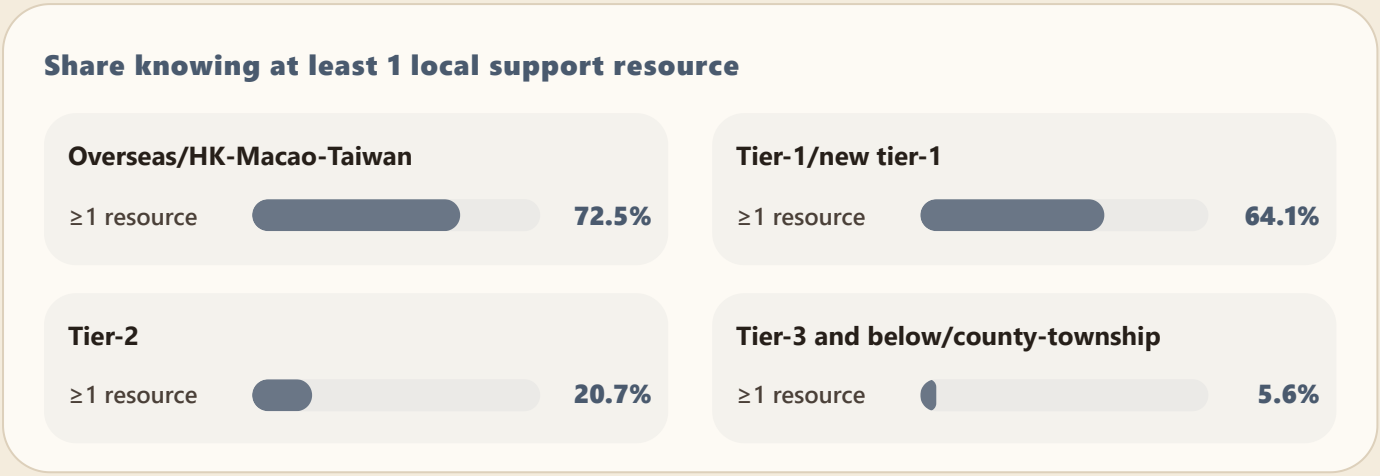
For some, gender stereotypes or verbal bias are frequent experiences

Key finding

Among respondents who answered the everyday-bias frequency question (n=900), occasionally (1–2/year) 31.2% (281 people), never 27.9% (251 people), sometimes (quarterly) 19.7% (177 people), often (monthly) 12.4% (112 people), and very frequently (weekly or more) 8.8% (79 people).

Combining "very frequently" and "often", 21.2% frequently experience gender stereotypes or verbal bias. Adding "sometimes" and "occasionally" (50.9%), more than 70% (72.1%) have such experiences. The distribution shows that low-intensity but repetitive bias is common in this sample; the cumulative impact should be reflected in reporting and service design.

9.3 Visibility of local support resources



Most respondents know very few local transgender support resources

Key finding

Among respondents who answered the local-resource question (n=628), almost none (know 0) 59.1% (371 people), know 1–2 24.4% (153 people), know 3–5 9.1% (57 people), and know 6+ 7.5% (47 people).

Combining "almost none" and "1–2", over 80% (83.4%) know very few local resources (0–2). Under 20% (16.6%) know 3 or more.

Mean resource visibility by city tier: overseas/Hong Kong–Macao–Taiwan 2.43 (n=69), tier-1/new tier-1 2.00 (n=273), tier-2 1.24 (n=106), tier-3 and below/county-township 1.06 (n=179).

"How many one knows" reflects both actual supply and informational visibility: there may simply be few local resources, or the resources exist but respondents do not know how to find them. Either way, raising visibility (integrated information platforms, community sharing, medical referrals) is as important as expanding actual supply.

The farther respondents live from tier-1 and new tier-1 cities, the fewer local resources they tend to know. In the tier-1/new tier-1 group (n=273), 35.9% say "almost none" and 26.0% know 3+; the tier-2 group (n=106) shows 79.2% and 2.8%; in the tier-3-and-below/county-township group (n=179), 94.4% say "almost none" and nobody reports knowing 3+ (0.0%). City tier and resource visibility show a comparatively clear negative statistical association (Spearman rho=-0.290, n=627, adjusted $p<0.001$).

In this sample, the resource-information gap in lower-tier cities and county towns is striking. Whether the cause is genuinely fewer local resources or existing resources being hard to find, service reach must not depend on users searching alone.

Reading note on association results in this chapter: the questionnaire records documents, public-service experiences, residence, and resource awareness in the same period; it cannot prove one directly causes change in another. "How many local resources one knows" is affected by both actual supply and informational visibility and cannot be read purely as local resource count.

9.4 Chapter summary

This chapter presents respondents' reported document, facility, and everyday-environment barriers:

1. **Documents and public affairs**: nearly half of relevant respondents (48.8%) at least occasionally encountered questioning or inappropriate treatment in public affairs in the past six months. Document difficulties and public-service difficulties are statistically associated (Cramér's V=0.173).
2. **Public facility use**: only 14.7% can comfortably use identity-matching public facilities. Avoidance (22.9%) and alternatives (25.8%) are common coping strategies, indicating demand for gender-neutral public facilities.
3. **Widespread harassment**: 71.3% report some form of harassment; offline verbal (26.1%) and online harassment/cyberbullying (25.5%) are most common. Sexual harassment/sexual violence (18.8%) and physical violence (6.1%) are also reported.
4. **Persistent everyday bias**: 21.2% frequently experience gender stereotypes or verbal bias; more than 70% (72.1%) have such experiences. Low-intensity, repetitive bias needs to be included in service design.
5. **Resource visibility gaps**: over 80% (83.4%) know very few local transgender support resources (0–2), indicating room to improve both supply and visibility.

Public-life barriers thus involve three layers: document systems, public facility design, and the social environment. Improvement paths include: simplified, accessible document change; reformed front-desk identity-verification processes; gender-neutral public facility supply; and inclusive education for society.

Chapter 10 presents respondents' social support sources, resilience resources, and desire for change.

Chapter 10



10

Social Support, Resilience, and Desire for Change

This chapter presents respondents' current sources of strength and support, the visibility of local resources, and the aspects they most want to change plus their willingness to change. The findings reveal the protective role of individual resilience and social support networks, alongside respondents' clear expectations for change.

59.9%
Own inner strength · 530 people

83.7%
Want to change body characteristics · 749 people

10.1 Sources of strength and support
10.2 Support sources and well-being
10.3 Desire for change and willingness
10.4 Chapter summary

10.1 Sources of strength and support

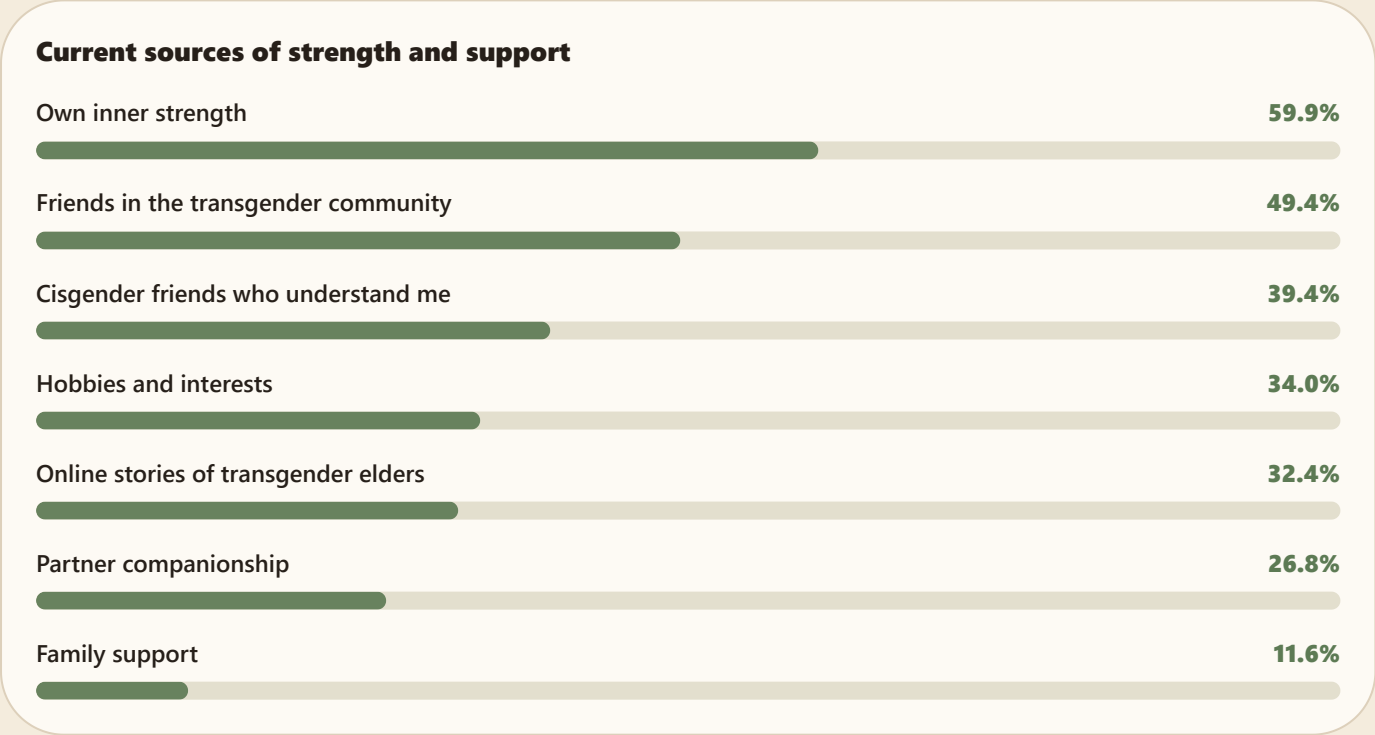
Inner strength, friends, and partners form the main protective network; diverse support sources relate to well-being

Key finding

Respondents' strength mainly comes from inner resilience and relational networks

Key finding

Respondents most often rely on their own inner strength, with many also supported by friends and community experiences. Among the 885 answering this multi-select question: own inner strength 59.9% (530 people), friends in the transgender community 49.4% (437 people), cisgender friends who understand them 39.4% (349 people). Hobbies and interests 34.0% (301 people), online stories of transgender elders 32.4% (287 people), partner companionship 26.8% (237 people), and family support 11.6% (103 people).



Sources of strength are rarely singular. Individual resilience, friends, community experience, and intimate relationships jointly form the support network; by contrast, few list family as a current source of strength — echoing the family-support gap in Chapter 5.

A share of respondents still report no current strength or support

Key finding

Some still feel they have no palpable strength or support. Among the 885 answering, 12.7% (112 people) chose "currently drawing no strength or support".

The existing support network does not reach everyone; service design needs to consider proactively reaching under-supported people.

Selecting this option does not mean a person is completely isolated in all life settings. The multi-select question also did not measure how much or how good the support is, or whether it is genuinely available when needed; percentages sum over 100%.

10.2 Support sources and well-being

10.2.1 Number of support sources

More support sources correlate positively with higher well-being

Key finding

In this survey, those with more support sources tend to have higher overall well-being — a positive statistical association (Spearman rho=0.179, adjusted $p<0.001$, n=882).

The focus is not a particular support type but whether a person has more sources to rely on. The association is real but not very strong; well-being is also affected by finances, family environment, health, and safety.

10.2.2 Partner and family support sources

Partner and family source proxies both correlate positively with well-being

Key finding

Those listing family or partner as a source of strength tend to have higher well-being; the family-support link is more visible than partner companionship. Family support rho=0.243; partner companionship rho=0.166; both adjusted $p<0.001$, n=882. For reference, the total-support-source count association is rho=0.179.

In this sample, the family-support and well-being link is more visible than partner companionship. These are overall associations and do not mean family support matters more than partner support for every individual. Both "family support" and "partner companionship" come from one multi-select question, without fully measuring relationship quality, support frequency, or actual availability.

10.2.3 Single-item proxies for friend and community support

Single-item proxies for friend and community support show no adjusted-significant association with well-being Key finding

This analysis found no clear statistical association between "listing understanding cisgender friends as a strength source" and well-being (Spearman rho=0.029, adjusted p=0.421, n=882), nor for "listing transgender community friends" (rho=0.008, adjusted p=0.853, n=882).

This does not mean friend or community support has no value. The questionnaire only records "selected/not selected", without measuring contact frequency, relationship quality, stability, or whether help is genuinely available in times of need. Because the report tests many relationships at once, the statistical bar was raised to avoid mistaking chance differences for real findings. This result is not inconsistent with "those with more support sources are typically happier": one looks at a single source, the other at how many sources a person has.

10.2.4 Exploratory comparison: city tier and strength sources



Among respondents valid on both residence and strength sources (n=880), grouped into four city tiers, the distribution of main strength sources is broadly similar, with some noteworthy descriptive differences. In the tier-1/new tier-1 group (n=388): own inner strength 58.5%, transgender-community friends 46.9%, understanding cisgender friends 39.2%, family support 13.9%, and no strength/support 12.9%.

In the tier-3-and-below/county-township group (n=262): inner strength 61.8%, community friends 49.6%, online stories of transgender elders 36.3%, family support 9.2%, and no strength/support 13.7%.

In the overseas/HK-Macao-Taiwan group (n=82): community friends 61.0%, inner strength 62.2%, understanding cisgender friends 48.8%, counsellors/doctors 24.4%, and no strength/support 8.5%.

Main strength sources are broadly similar across city groups, and this analysis found no clear association between city tier and any single strength source. All 10 sources have |Spearman rho| below 0.06 with adjusted $p>0.05$. Descriptively, the overseas/HK-Macao-Taiwan group has higher shares for community friends, cisgender friends, and professional support; the tier-3-and-below/county-township group has a higher share for "online stories of transgender elders". Mainland groups are close on "no strength/support" (12.8%–13.7%), with the overseas group at 8.5%.

These between-group differences can refine future questions, but the data are insufficient to confirm stable city differences. Because the report tests many relationships at once, the statistical bar was raised to avoid mistaking chance differences for real findings.

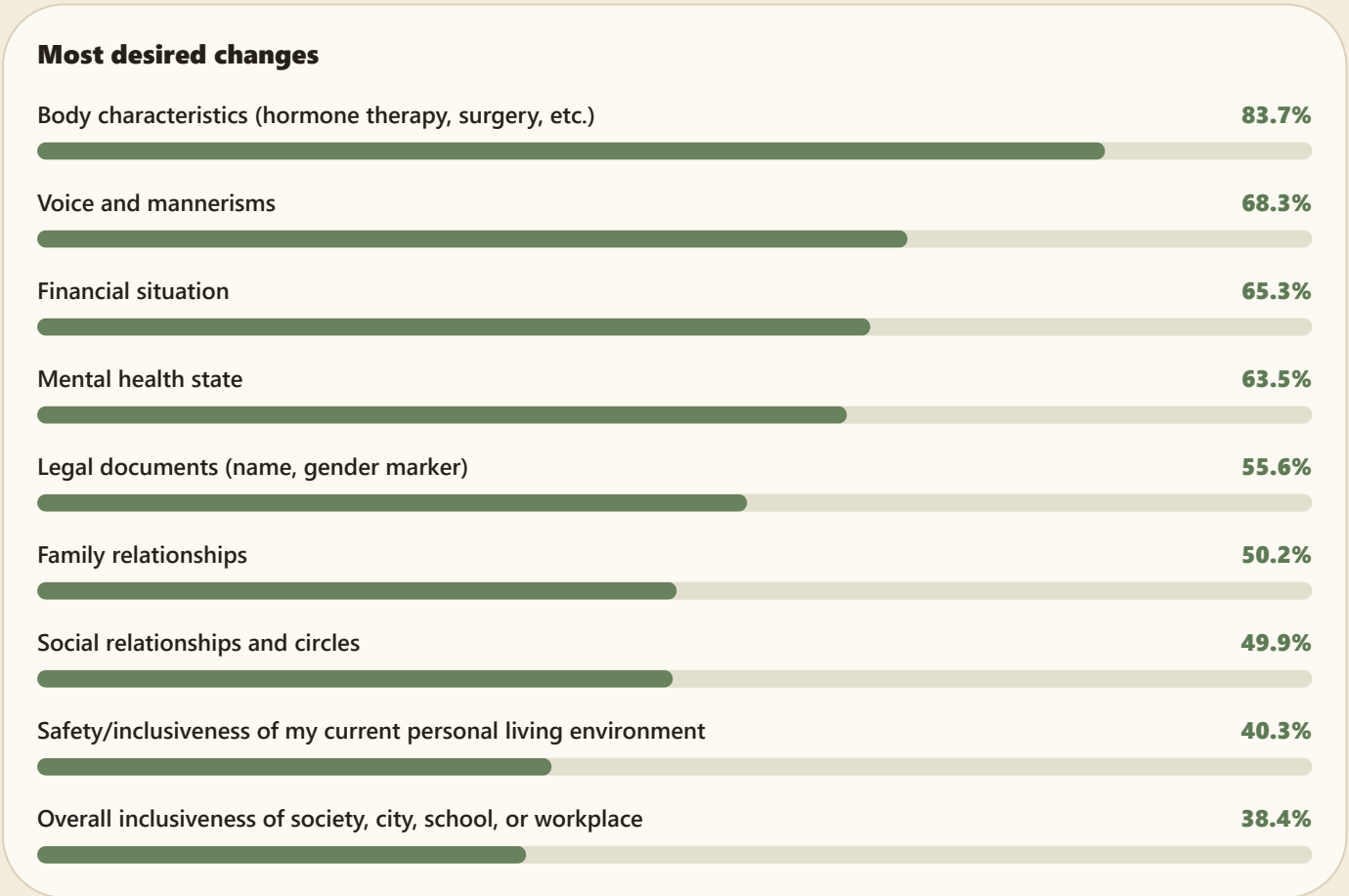
Reading note for this subsection: the survey records support and well-being over the same period; it cannot determine which came first, nor prove a specific support directly causes well-being change. "Whether a source was selected" is a simplified record, not a complete assessment of relationship quality. Not reaching the statistical threshold means these data provide insufficient evidence — it does not mean there is actually no relationship.

10.3 Desire for change and willingness

Respondents' desired changes span body, voice, finances, psychology, documents, and relational environments Key finding

10.3.1 Most desired changes

Among respondents who answered the desired-change question (n=895, multi-select), needs are broad and diverse.



Body characteristics (hormone therapy, surgery, etc.) 83.7% (749 people), voice and mannerisms 68.3% (611 people), financial situation 65.3% (584 people), mental health state 63.5% (568 people), legal documents (name, gender marker) 55.6% (498 people), family relationships 50.2% (449 people), social relationships and circles 49.9% (447 people), safety/inclusiveness of my current personal living environment 40.3% (361 people), and overall inclusiveness of society, city, school, or workplace 38.4% (344 people).

Body characteristics (83.7%) is the most-selected area but is closely followed by voice (68.3%), finances (65.3%), mental health (63.5%), and legal documents (55.6%) — all above half. Family relationships (50.2%) and social circles (49.9%) sit right at half. Safety/inclusiveness of the personal environment (40.3%) and overall societal inclusiveness (38.4%) are also selected by over a third.

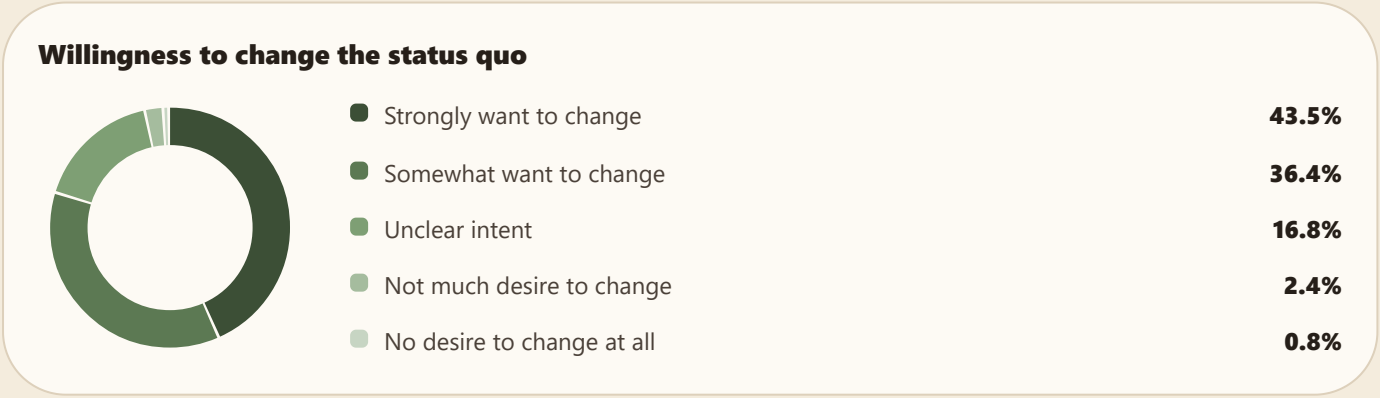
This distribution clearly shows that the desire for change is not a single medical issue. Although body-related changes (body characteristics, voice) rank highest, the desire for economic, mental-health, legal-document, family and social relationship, and societal-inclusiveness change is equally common and urgent — each selected by over a third.

10.3.2 Willingness to change the status quo

Most respondents express a strong desire to change the status quo

Key finding

Among respondents who answered the willingness question (n=898), strongly want to change 43.5% (391 people), somewhat want 36.4% (327 people) — 80.0% expressing a strong desire for change.



In the same question, unclear intent 16.8% (151 people), not much desire to change 2.4% (22 people), and no desire at all 0.8% (7 people). The strong desire of nearly 80% provides a clear needs backdrop for action recommendations.

Reading note: multi-select question (most desired changes), so percentages sum over 100%. "Wanting change" is not a value judgment on individuals or identities — it should be read as responses to current situational constraints. In the willingness question (FIG026), "strongly want" does not mean everyone prioritizes medical intervention; combined with FIG025, desired change spans medical, economic, psychological, legal, and social-environmental dimensions. The autonomy of the small minority — "not much" (2.4%) or "no desire" (0.8%) — must also be respected.

10.4 Chapter summary

This chapter's findings reveal the full landscape of protective factors and desire for change:

1. **Inner strength and peer support are the main protective sources**: own inner strength (59.9%) and transgender-community friends (49.4%) are the most common; family support (11.6%) is low. 12.7% still report no current strength or support.
2. **Diverse support relates to well-being**: more support sources relate to higher well-being (rho=0.179). Those listing partners (rho=0.166) or family (rho=0.243) as strength sources tend to have higher well-being. Single-item friend/community analyses show no clear association, but that does not mean they lack value.
3. **Desire for change is broad and diverse**: 83.7% want body changes, but voice (68.3%), finances (65.3%), mental health (63.5%), legal documents (55.6%), and family relationships (50.2%) are equally common and above half. It is not a single medical issue.
4. **Strong willingness**: 80.0% express a strong desire to change the status quo (strongly 43.5% + somewhat 36.4%).

Support strategies should be guided by diverse needs for change: covering medical (gender-affirming surgery, HRT, voice support), legal (document changes), economic (affordable services, employment protection), psychological (long-term support services), family (education and mediation), and social environment (anti-discrimination policy, public facilities, inclusive outreach). While respecting individual autonomy, action recommendations should respond to the diverse needs expressed, not make a single medical path the only exit.

Particular attention is also due to the 12.7% who report "no strength or support": services must proactively reach those in extreme support scarcity.

Chapter 11

11

Key Findings, Directions for Action, and Research Limitations

This chapter synthesizes the findings of the previous chapters, distils cross-cutting threads, proposes evidence-linked directions for action, and restates the limitations. All syntheses rest on the audited findings cited in earlier chapters and introduce no new statistical computations.

11.1 Cross-chapter core threads

11.2 Directions for action

11.3 Research limitations

11.4 Future research directions

11.5 Closing

11.1 Cross-chapter core threads

01

Young and diverse sample, early awareness, but severely constrained everyday expression

02

Interwoven real barriers across healthcare, family, campus, employment, documents, and public space

03

Distress must be interpreted within multi-layered external pressures, not attributed to identity itself

04

Inner resilience and relational networks protect, but coverage is uneven

05

Desire for change spans body, voice, finances, psychology, law, and social environment

Combining findings from Chapters 2 to 10, the survey presents five interwoven threads:

Thread 1: Young and diverse sample, early awareness, severely constrained everyday expression

The sample is dominated by respondents aged 18–22 (43.5%), and gender identities are diverse. More than 80% began noticing their gender identity difference at or before age 17. Yet the share able to live fully as their gender identity is not high (16.8%); expression is heavily concentrated online (87.7%) and in trusted friend circles (55.3%), while formal settings — family, school, healthcare, employment — are clearly lower.

Implication: gender awareness emerges in a life stage where family and school still heavily shape daily life, but formal settings lack conditions for safe expression. Support systems need both age-appropriateness and setting-specific targeting.

Thread 2: Interwoven real barriers across healthcare, family, campus, employment, documents, and public space

- **Healthcare**: HRT access relies heavily on informal channels (online private sellers 66.6%); barriers include family opposition (59.9%), cost (51.7%), discrimination concerns, and resource shortage.
- **Family**: awareness is not support; silence, blame, and non-understanding are common; some respondents experience verbal, medical, economic, and personal restrictions.
- **Campus**: 73.7% report negative campus experiences; school policies explicitly covering gender diversity are extremely rare (5.6%).
- **Employment**: concealment (52.1%) and maintaining inconsistent expression (36.7%) are the main costs; 50.5% believe their transgender identity negatively affected their finances.
- **Public space**: only 14.7% can comfortably use identity-matching public facilities; document difficulties accompany public-service difficulties.

Implication: these barriers are not isolated; they are reported across domains at once. For example, family opposition appears alongside healthcare access, economic support, and identity-expression barriers; document-mismatch difficulties likewise appear across employment, public affairs, and public facilities. Action requires cross-departmental, systemic collaboration.

Thread 3: Distress must be interpreted within multi-layered external pressures, not attributed to identity itself

Nearly 90% experienced at least one high-frequency distress in the past six months; pressure sources include gender identity/body anxiety (83.7%), schoolwork (59.6%), family (58.6%), finances (56.7%), public policy/social opinion (41.4%), and medical access (32.9%). Self-harm (68.2%) and suicide-related experiences (88.9%) are common in this sample, and 45.5% find psychological support hard to access.

Implication: distress runs parallel to external environmental pressure, insufficient support, and safety needs; cross-sectional data cannot confirm causal direction, and these experiences are not evidence of transgender-identity danger. Mental health support should be trauma-informed and non-pathologizing, responding at once to family, educational, economic, and medical barriers.

Thread 4: Inner resilience and relational networks protect, but coverage is uneven

The main protective sources are personal inner strength (59.9%) and transgender-community friends (49.4%), while family support is limited in coverage (11.6%). Diverse support sources correlate positively with well-being, but 12.7% still report no current strength or support.

Implication: protective factors include personal resources as well as peer, partner, and community connections. However, structural responsibility should not be shifted onto individual resilience — uneven network coverage means services must proactively reach groups in extreme support scarcity.

Thread 5: Desire for change spans body, voice, finances, psychology, law, and social environment

83.7% want body changes, but desire for voice (68.3%), finances (65.3%), mental health (63.5%), legal documents (55.6%), and family relationships (50.2%) is equally common. 80.0% express a strong desire for change.

Implication: the need for change is not one medical issue but a combination of body, financial, psychological, legal, and social-environmental dimensions. Action recommendations should respond to this diversity.

11.2 Directions for action

11.2.1 Medical services

- Expand regular, affordable HRT assessment, prescription, and follow-up services, reducing reliance on informal channels.
- Integrate HRT health monitoring into the service chain, offering affordable, bookable, privacy-protecting check-ups and referral.
- Provide harm-reduction information during the transition period where formal services do not yet cover, helping informal-channel users lower risk.
- Treat voice support as a standalone service: informed-consent, non-conversion-based voice training and professional referral.
- Improve privacy protection and professional training in medical services, reducing the barrier of discrimination concerns to care-seeking.
- Review potential accessibility barriers related to age and guardian-consent requirements, and explore institutional paths balancing individual autonomy, informed consent, and minor protection (see 4.3.1: bottom/genital reconstruction 60.3%, facial surgery 54.9%; diagnosis certificate "want but meet difficulties" 37.3%).

11.2.2 Family support

- Provide long-term, re-entrable family education and support programmes rather than one-time persuasion.
- Offer families accurate, non-pathologizing information that responds to knowledge misconceptions, traditional values, and social pressure.
- Build low-threshold safety plans, legal and psychological referral, and emergency economic support responding to family restrictions or violence.

11.2.3 Schools

- Explicitly include protection of gender identity and expression in anti-bullying policies, rather than relying on generic policies.
- Establish support mechanisms with accountable staff, confidential procedures, and complaint channels, converting individual goodwill into enforceable policy.
- Provide professional training for teachers, reducing cases where educators become a source of pressure.
- Gradually reduce social stereotypes through systematic gender education: bring gender-diversity knowledge into curricula, class meetings, and campus outreach, so stereotypes and verbal bias are no longer taken for granted.
- Promote gender education for students and families, helping them understand the diversity of gender identity and expression and respond to family and community misconceptions.

11.2.4 Employment and economy

- Drive inclusive redesign of recruitment, dress codes, document verification, name use, and anti-harassment processes.
- Offer more flexible, privacy-respecting alternatives in identity-verification processes.

11.2.5 Mental health and safety support

- Provide trauma-informed, non-pathologizing psychological services covering multiple distress types, not a single diagnosis.
- Build low-threshold crisis support and long-term psychological services covering those with historical, current, and no experience.
- In presentations of self-harm and suicide-related content, link directly to support resources and handle the topic neutrally, without sensationalism.

11.2.6 Documents and public services

- Simplify document-change procedures and improve accessibility.
- Reform front-desk identity-verification processes, providing alternative identity-confirmation methods.
- Increase the supply of gender-neutral public facilities and push for gender-neutral redesign.

11.2.7 Social support and resource visibility

- Expand peer, partner, and family support while respecting individual resilience without transferring responsibility onto individuals.
- Raise the visibility of local support resources (integrated information platforms, community sharing, medical referral) and expand actual supply.
- Proactively reach groups in extreme support scarcity, ensuring services cover respondents who report "no current strength or support".

11.2.8 Cross-cutting principles

- Design support around diverse needs for change, covering body, voice, finances, psychology, law, and social environment.
- Respect individual autonomy: respond to desire for change while respecting those who are unsure or do not want to change.
- Apply gender-neutral principles throughout public service and public-space design, reducing gendered assumptions in facilities, processes, and language.

11.3 Research limitations

All findings are constrained by the limitations below; readers should consider them carefully when interpreting and applying:

Non-probability sampling and young sample restrict generalisation

Respondents were recruited voluntarily through online channels; the sample is dominated by young respondents (18–22: 43.5%). The results describe only the respondents of this survey and cannot be generalised to all transgender and gender-diverse people in China.

Self-report and cross-sectional design limit interpretation

All data are self-reported and collected at a single time point. All "associations" or "correlations" are statistical and cannot establish temporal order or causal direction; synonymous options across questionnaire versions were merged under a unified scope.

An unexamined item is not "no association"; an item short of adjusted significance is not "no relationship"

The pre-specified tests of F024 (identity expression and negative campus experiences), F025 (expression and negative employment experiences), F026 (unmet HRT need and distress), and F058 (friend/community single-item proxies and well-being) all fell short of adjusted significance. These results should not be read as "no association" — they may be limited by sample size, measurement, or analysis methods.

Passing technical QA does not establish representativeness, validity, external validity, or scientific conclusions

The data went through technical checks (denominators, missing values, consistent numbering), but those checks only cover the accuracy of the arithmetic — not whether the sample is representative, whether the measurements are valid, or whether the conclusions generalise.

Reporting bias on sensitive topics

Items on domestic violence, self-harm, and suicide-related experiences may be under- or over-reported; choosing "none", "never", or "no clear negative experience" cannot be inferred as complete absence.

Measurement limits of single items or multi-select proxies

Some core concepts (e.g. "family support", "school support", "well-being", "community support") are measured with single-item ordinal ratings or multi-select proxies that cannot capture every dimension of the concept.

Interpretation limits of multi-select questions

Percentages of multi-select items may sum over 100% and cannot be added into an overall share. Different questions have different valid-respondent denominators, so percentages cannot be directly compared across questions.

11.4 Future research directions

01

Longitudinal tracking studies: collect data over multiple time points to explore temporal order and possible causal pathways among identity expression, family support, medical access, and mental health.

02

Finer measurement instruments: use validated standardized scales for mental health, well-being, and social support to improve measurement validity.

03

Subgroup analyses: with larger samples, stratify by gender identity, age, region, and economic conditions to understand differentiated experiences across subgroups.

Based on this survey's limitations, future research could deepen along the following directions:

11.5 Closing

This survey depicts the situation of respondents in identity awareness, expression, healthcare, family, campus, employment, mental health, public services, and social support. The findings reveal multi-layered interwoven real barriers, alongside individual resilience, community connection, and a clear desire for change.

Once more: all findings describe only the respondents of this survey and cannot be generalised; all statistical associations do not imply causation; distress should be understood within multi-layered external pressures, not attributed to transgender identity itself.

The value of this report lies in grounding service design, policy discussion, and follow-up research in respondents' real experiences as an empirical starting point. Improving the situation of transgender and gender-diverse people requires systemic collaboration across healthcare, family, education, employment, law, and social environment — and respect for each individual's autonomy and diverse needs.

Chapter 12

12

Appendix

This appendix provides the figure directory, a finding-number to chapter cross-reference, notes on where the numbers come from, and method notes, so readers can check the source of any figure.

Appendix A: Figure directory

Appendix B: Finding numbers by chapter

Appendix C: Number traceability notes

Appendix D: Technical QA records

Appendix E: Psychological support and crisis-intervention resources

Appendix F: References and source notes

Appendix G: Attitudes toward same-sex relationships and gender-role beliefs in the CGSS2023 sample

Appendix A: Figure directory

The report contains 32 numbered figures: 26 formal-result figures and 6 exploratory visualizations. Formal bar charts use horizontal track bars with direct value labels and semantic per-chapter colours; 6 share-structure questions use donut charts to show complete category shares; multi-select items keep the note that "percentages may exceed 100%". All figures appear inline; the reader edition does not list internal file paths.

Figure no.	Finding no.	Figure title	Chapter	Valid respondents
FIG001	F001	Age group distribution of respondents	Chapter 2	n=899
FIG002	F002	Age distribution of gender-identity awareness	Chapter 3	n=899
FIG003	F003	Distribution of identity-expression status	Chapter 3	n=876

Figure no.	Finding no.	Figure title	Chapter	Valid respondents
FIG004	F004	Settings where respondents can express their gender identity	Chapter 3	n=579 (multi-select)
FIG005	F005	Current status of hormone replacement therapy (HRT)	Chapter 4	n=859
FIG006	F006	Routes to obtaining HRT medication	Chapter 4	n=716 (multi-select)
FIG007	F007	Main barriers to transgender medical care	Chapter 4	n=806 (multi-select)
FIG008	F008	HRT-related health check-up status	Chapter 4	n=711
FIG009	F009	Difficulty using one's voice	Chapter 4	n=798
FIG010	F009	Satisfaction with current voice	Chapter 4	n=840
FIG011	F010	Does the family know about the transgender identity	Chapter 5	n=844
FIG012	F010	Main reactions after the family found out	Chapter 5	n=486 (multi-select)
FIG013	F011	Support currently felt within the family	Chapter 5	n=324
FIG014	F011	Family attitude change since they first found out	Chapter 5	n=312
FIG015	F012	Restrictions or violence from family in the past year	Chapter 5	n=474 (multi-select)
FIG016	F013	Types of negative campus experiences	Chapter 6	n=749 (multi-select)
FIG017	F014	Help and support received at school	Chapter 6	n=607
FIG018	F014	School gender-diversity education / anti-bullying policy status	Chapter 6	n=823
FIG019	F015	Experiences in job hunting or at work	Chapter 7	n=267 (multi-select)
FIG020	F016	Types of high-frequency emotional distress in the past six months	Chapter 8	n=870 (multi-select)
FIG021	F016	Sources of psychological pressure in the past six months	Chapter 8	n=601 (multi-select)
FIG022	F018	Questioning/denial etc. when handling public affairs in the past six months	Chapter 9	n=414
FIG023	F018	Strategies when using gendered public facilities	Chapter 9	n=757
FIG024	F019	Current sources of strength and support	Chapter 10	n=885 (multi-select)
FIG025	F020	Most desired changes	Chapter 10	n=895 (multi-select)
FIG026	F020	Willingness to change the status quo	Chapter 10	n=898
FIG028	—	Parental education × support (exploratory)	Chapter 5	mother n=261/254; father n=207/201
FIG029	—	Economic independence × well-being (exploratory)	Chapter 8	n=839
FIG030	—	Age × mental health (exploratory)	Chapter 8	per indicator n=870–883

Figure no.	Finding no.	Figure title	Chapter	Valid respondents
FIG031	—	City tier × local resource visibility (exploratory)	Chapter 9	n=627
FIG032	—	City tier × strength sources (exploratory)	Chapter 10	n=880
FIG033	—	Monthly disposable funds × well-being (exploratory)	Chapter 8	n=760

Appendix B: Finding numbers by chapter

The report cites 60 audited findings (20 primary key findings + 40 auxiliary findings). The full statistical content and limits of each finding remain in the research verification records.

Chapter	Primary key findings	Auxiliary findings
Chapter 2 Sample characteristics	F001	F021
Chapter 3 Identity awareness and expression	F002, F003, F004	F022, F023, F024
Chapter 4 Body, healthcare, and voice	F005, F006, F007, F008, F009	F026, F027, F028, F029, F030, F031
Chapter 5 Family relationships	F010, F011, F012	F032, F033, F034, F035, F036
Chapter 6 Campus experiences	F013, F014	F037, F038, F039
Chapter 7 Employment and economy	F015	F025, F040, F041, F042
Chapter 8 Mental health and well-being	F016, F017	F043, F044, F045, F046, F047, F048, F059
Chapter 9 Public services and public space	F018	F049, F050, F051, F052, F053
Chapter 10 Social support and desire for change	F019, F020	F054, F055, F056, F057, F058, F060

Appendix C: Number traceability notes

1. **Single data source for all figures in the text**: all percentages, frequencies, n-values, effect sizes, and p-values of this project's survey appearing in the body and Appendices A–F come from the audited unified results table, entering the text through audited findings and figure notes. No figures were recomputed during report writing. The CGSS2023 aggregate statistics in Appendix G are a separately bounded external supplement: they are not written into, do not modify, and do not become a downstream factual source for the existing unified results table.

2. **Checking the numbers**: public materials include an item-by-item summary table listing, for every figure in the text, its chapter, indicator, denominator, counts, percentages and calculation notes. This reader edition omits the inline labels to stay readable; the full table exists only in the

PDF edition. It contains no record-level identifiers, contact details or open-ended answers, and cannot be used to trace any individual response.

3 **Consent-scope sensitivity analysis**: the public sensitivity table compares the main-analysis scope (n=900) against the strict explicit-consent scope (n=888) item by item. The strict scope additionally excludes 12 old-questionnaire records lacking a structured consent field, serving only to test whether conclusions are sensitive to the consent-handling choice — it is not the denominator of the report's conclusions.

4 **Denominator principle**: all percentages use valid respondents to that question as the denominator. Valid counts (n) may differ between questions; every result in the report states its n. Percentages from different questions are not directly comparable.

5 **Multi-select principle**: percentages of multi-select items may exceed 100%, because respondents may pick several options. Multi-select shares cannot be summed into an overall share. Multi-select items are clearly marked "(multi-select)" in the text and figure notes.

6 **Statistical test principle**: every association test reports the effect size (Cramér's V or Spearman's rho) and the Benjamini-Hochberg adjusted p-value. Adjusted $p<0.05$ is treated as statistically significant. Tests short of adjusted significance are not interpreted as "no association".

7

Wording conventions

Method note

8 Associations from cross-sectional data consistently use "association"/"correlation", not causal terms such as "affect", "lead to", or "effect".

9 Results from a non-probability sample consistently use qualifiers such as "respondents of this survey", "within the sample", "respondents who answered this question", with no population extrapolation.

10 Self-reported data consistently use wording such as "respondents report", "respondents perceive", "self-reported", not assertions of objective fact.

11 Sensitive content (domestic violence, self-harm, suicide-related experiences) uses neutral, non-sensational, non-pathologizing language.

Appendix C.1 Original wording of the sensitive question

Original wording of the suicide-related experiences question: **Have you ever had thoughts of suicide or attempted suicide?**

This reflects the respondent's lifetime self-report; it does not ask when it happened, its frequency, or current status; results are not used to infer current immediate risk.

Appendix D: Technical QA records

The underlying data passed technical quality checks at the stages of input audit, version merging, descriptive statistics, cross-analysis, finding screening, and figure/text regression:

- **Raw data unchanged**: the original data file was checked before and after analysis and was identical (check passed).
- **Questionnaire versions merged**: options, skip logic, income bands, duplicates and consent rules were harmonised across versions and recorded (check passed).
- **Descriptive statistics**: 122 variables fully covered, 802 rows of descriptive results, denominators and three missingness types independently re-checked (QA passed).
- **Cross-analysis and statistical tests**: 23 of 25 pre-specified items completed, 2 retained with reasons; effect sizes, 95% CIs, and BH correction complete (QA passed).
- **Key-finding screening**: 20 primary and 40 auxiliary findings verified field by field, with an independent recheck confirming them (check passed).
- **Figure production**: 26 result figures and 6 exploratory charts are all numbered; before release every page was checked for overflow, clipping, text integrity and working navigation.

Important note: technical QA verifies the accuracy of numeric processing (denominators, missing values, calculation logic, tracking chains); it does not establish sample representativeness, measurement validity, or the general scientific applicability of conclusions. Passing technical QA does not mean conclusions are established.

Appendix E: Psychological support and crisis-intervention resources

If you or someone you know is experiencing psychological distress or safety risks, the following resources can help:

- **National unified psychological assistance hotline**: 12356
- **Beijing Psychological Crisis Research and Intervention Center hotline**: 010-82951332
- **Emergency**: if in immediate physical danger, call 110 or 120, or go to the nearest emergency department.
- Other regional psychological-assistance and mental-health resources verified by local health authorities.

Number verification date: 2026-08-09. Resource information

The national reachability of 12356 was verified against public information from the National Health Commission; the Beijing hotline was verified on the official page of the Beijing Psychological Crisis Research and Intervention Center. Numbers and service hours may change; please refer to the latest official releases. Data in this report about self-harm and suicide-related experiences reflect respondents' historical experiences and do not represent current immediate risk.

Appendix F: References and source notes

This report is written on the basis of this survey's self-reported data. Background statements in the text (e.g. Chapter 2's "widely documented in international literature", the questionnaire design's reference to "common frameworks of international transgender health surveys", and the structural reference to "the 2021 national transgender health survey") are industry background and design references at the time of writing and are not footnoted in the body. For rigour, the following is clarified:

1. This report **performs no literature review or cross-study comparison**; the items below only serve to verify background wording, questionnaire design references, and professional terminology — they are not sources of this report's statistical results.
2. WPATH Standards of Care Version 8: WPATH's official transgender healthcare standards, usable for checking gender-affirming care terminology and service context.
3. Hembree WC, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017;102(11):3869–3903. DOI: 10.1210/jc.2017-01658. Used to verify the professional-guideline background on HRT health monitoring; the text keeps the general wording "necessary health monitoring per professional guidelines".
4. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*. 2003;129(5):674–697. DOI: 10.1037/0033-2909.129.5.674. Used to verify the background concept of minority stress; the study population differs from this report's, and it is not used as direct evidence for this report's transgender-population statistics.
5. 《2021全国跨性别健康调研报告》(2021 National Transgender Health Survey Report): the national transgender health survey report recorded on CNLGBTDATA, used to verify structure and terminology in the Chinese survey field; this report does not substitute, extrapolate, or directly compare it with this survey's results.

6 Yang J, Wang Y, Liu L, et al. Association of traumatic experiences with depressive symptoms among LGBTQ+ population in China. *Nature Human Behaviour*. 2026. DOI: 10.1038/s41562-026-02518-0. Used to support background wording on traumatic experiences, LGBTQ+-related adversity, the minority-stress framework, and mental-health associations; its TREASURE cohort data are not a source of this report's statistics and are not directly numerically compared with this survey.

7 国家卫生健康委等部门《关于实施2025年卫生健康系统为民服务实事项目的通知》(National Health Commission and others, "Notice on implementing 2025 people-oriented health system service projects") and the transcript of the National Health Commission press conference of 20 May 2025: used to verify the 12356 national psychological assistance hotline's arrival arrangements and national coverage.

8 Official hotline page of the Beijing Psychological Crisis Research and Intervention Center: used to verify 010-82951332.

9 National Survey Research Center (CGSS Project Group), Renmin University of China. 《中国综合社会调查（CGSS）2023年度调查数据》(Chinese General Social Survey (CGSS) 2023 data), publicly released 21 June 2025. The official announcement states the data were executed, managed and released by the Center, with download via the China National Survey Data Archive (CNSDA; requires real-name registration). This item is the formal source of the Appendix G external data, not a source of this project's survey statistics.

10 All **data statements about this project's survey** in the text (percentages, n-values, effect sizes, p-values) come from the report's single data source (Appendix C) and are unrelated to external literature. The CGSS2023 statistics in Appendix G are separately identified external supplements.

11 Items 2–5 and their links were verified online on 2026-08-08; items 6–9 were verified on 2026-08-09. This document provides no clinical advice; for clinical-level guidance, consult a licensed physician.

Appendix G: Attitudes toward same-sex relationships and gender-role beliefs in the CGSS2023 sample

This appendix uses `a40`, `a421`, `a422`, `a423`, `a424`, and `a425` from the CGSS2023 raw data for independent unweighted descriptive statistics. It is not part of this project's questionnaire analysis chain, is not written into or modifying the existing unified results table, and cannot replace this report's findings on transgender and gender-diverse respondents' experiences.

G.1 Interpretation boundaries and statistical methods

- `a40` 's original wording is "Do you think sex between two people of the same sex is right or wrong?", measuring evaluation of that behaviour, **not respondents' sexual orientation** and not to be called "degree of understanding homosexuality" or "LGBTQ+ support level".
- `a421` – `a425` measure agreement with five gender-role statements, **not LGBTQ+ friendliness**.
- All percentages use valid answers coded 1–5 for that item as the denominator; `-2` (don't know), `-3` (refused), and Stata system missing do not enter the distribution denominator. The tables report full-sample, module-coverage, valid N, and missing counts alongside.
- Results describe only respondents in the CGSS2023 sample who answered the relevant items; they are not stated as "the current situation of all China".
- This appendix reports unweighted results only. The metadata list `weight1` (household weight; non-missing 5,583) and `weight2` (integrated weight; non-missing 11,326) as candidate weights, but provide no module-specific weight or module-selection mechanism for `a421` – `a425` ; nor does the coverage of `weight1` equal the module's 7,021 non-system-missing observations. Hence neither weight is automatically applied, and full-sample weights are not used to compensate for unknown module coverage or item missingness mechanisms.

G.2 Attitude toward same-sex sexual behaviour (a40)

Response category	Count	Share of valid answers
Always wrong	6,589	59.3%
Almost always wrong	867	7.8%
Neither right nor wrong	2,847	25.6%
Sometimes right	524	4.7%
Always right	288	2.6%

Denominator and missingness: CGSS2023 full sample N=11,326; no system missing on this item; module coverage N=11,326; valid N=11,115. Additionally, 197 "don't know" and 14 "refused" — 211 in total — were excluded from the percentage denominator. All statistics unweighted.

G.3 Gender-role beliefs (a421–a425)

Variable and statement	Valid N	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
a421 Men should focus on career; women on family	6,995	18.6%	23.9%	11.0%	28.1%	18.3%
a422 Men are born with stronger abilities than women	6,962	22.2%	30.5%	11.6%	23.2%	12.4%
a423 Better to marry well than work well (for women)	6,932	18.7%	23.8%	14.8%	27.6%	15.1%
a424 In a downturn, female employees should be laid off first	6,894	49.4%	29.3%	9.7%	8.1%	3.6%
a425 Husbands and wives should share housework equally	6,988	3.8%	7.0%	11.0%	34.7%	43.5%

Denominator, coverage, and missingness: the full sample is N=11,326 for all five items, each with 4,305 system missing; the non-system-missing module coverage is N=7,021 for each (62.0% of the full sample). Within module coverage, the following labelled missing were additionally excluded from each item's percentage denominator: a421: 22 "don't know", 4 refused; a422: 55, 4; a423: 83, 6; a424: 124, 3; a425: 27, 6. Because the existing metadata do not explain the specific module-allocation mechanism or ignorability of these 4,305 system missing, respondent distributions cannot be directly generalised to the uncovered sample. All statistics unweighted.

G.4 Data and verification notes

Data origin and citation: the data provider is the National Survey Research Center (CGSS Project Group), Renmin University of China; the dataset is titled 《中国综合社会调查（CGSS）2023年度调查数据》(Chinese General Social Survey (CGSS) 2023 data), publicly released on 21 June 2025. The official access channel is the China National Survey Data Archive (www.cnsda.org), downloadable after login and real-name registration. Official release notice: National Survey Research Center announcement, Renmin University of China; official pages accessed 2026-08-09.

On 2026-08-08 the project brought the local file `CGSS2023.dta` into read-only analysis. The original materials keep no separate version number or download receipt, so none is assumed; this report identifies the data file by dataset title, release date and file name. Suggested citation: National Survey Research Center (CGSS Project Group), Renmin University of China, Chinese General Social Survey (CGSS) 2023 data [dataset], publicly released 21 June 2025, obtained via the China National Survey Data Archive.

The analysis read-only extracted the six variables and two candidate weight fields above; raw numeric codes and value labels were preserved on read, and not all negative values were treated as missing — only the metadata-explicit `-2`, `-3`, and Stata system missing were handled separately per variable metadata. Output contains aggregate frequencies only, no raw IDs or row-level data.

Acknowledgements

This report extends thanks to the following communities, organisations, and platforms that helped with this survey during sample collection.



微光 (Weiguang)



兄弟盟猫哥 (Xiongdi Meng Mao Ge)



X MTF only community



X TransCircle chat group



Douyin trans cultural outreach group

The listing order carries no special meaning.

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We also thank every participant for their trust and support.

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KiraEqual is an independent research, public-knowledge, and digital-public-interest project focused on gender-diverse people

Let real experiences become the evidence that changes society