Designing Safe Physical Activity for Transgender Communities: Implications for Primary Care

HARC
Health and Research Collaborative

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Foreword

Physical activity matters. For many people, it is a source of joy, connection, and wellbeing. Yet for trans people in Aotearoa New Zealand, access to that joy has too often been blocked — not by a lack of desire, but by environments that were not designed with us in mind.
I have had the privilege of leading the *Counting Ourselves* survey — the largest study of trans and non-binary health and wellbeing in Aotearoa New Zealand. The data from that work tells a striking story about physical activity and sport. While similar proportions of our trans participants reported exercising or training on their own as in the general population, stark disparities emerged the moment sport became organised or social. Only 13% of our participants had taken part in competitions, events, or other organised activities, compared with 24% of the general population. The gap is not about motivation or capacity. It is about safety and belonging.

When we asked participants whether being trans or non-binary had affected their ability to exercise or participate in recreational sport, the responses were clear and consistent. Fifty-one percent said they would be more likely to participate if gender was not an issue. Forty-five percent had avoided gender-segregated exercise or recreational sport because they didn't know whether trans and non-binary people were welcome, and 43% had stayed away due to concerns about accessing a bathroom or changing room. Thirty-nine percent chose not to disclose being trans or non-binary, or deliberately selected solo activities, simply to avoid having to navigate others' attitudes. Only 23% of our participants felt able to be themselves around others when engaging in sport or active recreation.

These findings remind us that participation is not only about motivation, fitness, or opportunity. It is about safety. It is about belonging. It is about whether people can enter a space and know they will be respected, affirmed, and able to participate without fear. The numbers reflect a community that has learned, through hard experience, that participation comes at a cost that is not asked of others.

What makes this report particularly important is that it moves beyond identifying problems and instead asks communities what safe participation actually looks like. Through collaboration with transgender community members, Health Improvement Practitioners, Health Coaches, and local partners in Whanganui, this project centres lived experience and places trans people's voices at the heart of designing solutions.

The findings reinforce what many trans people have long known: safety is multi-dimensional. It includes physical environments, social relationships, identity affirmation, practical access, and trust. Physical activity is not simply exercise; it can also be a pathway to connection, confidence, healing, joy, and community.

This report offers an important contribution by shifting the focus from asking trans people to adapt to existing systems, toward designing environments that support participation from the outset. It provides practical guidance for creating safer and more inclusive opportunities not only in Whanganui, but across Aotearoa New Zealand.

I commend the research team, the Transgender Working Group members, and everyone who contributed their time, trust, and expertise to this kaupapa. I hope this work contributes to a future where trans people can engage in movement, sport, and recreation not despite us being trans, but as valued members of our communities.

Jaimie Veale
Principal Investigator, *Counting Ourselves*
Senior Lecturer in Psychology and Rutherford Discovery Fellow
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Acknowledgements

We would like to acknowledge the Health Improvement Practitioners and Health Coaches from two Whanganui primary care services, whose time, insights, and openness to sharing their experiences of working alongside transgender patients have contributed meaningfully to this work. Their reflections provided important context for understanding how safe physical activity can be supported within primary care.

We extend our sincere thanks to Pride Whanganui and its subsidiary, Gender Care Whanganui, for their support in connecting with and recruiting members of the transgender Working Group. Their ongoing commitment to the wellbeing of the local transgender community has been central to enabling this project.

We also acknowledge Sport Whanganui for their early engagement and contribution to the development of this work. Their input regarding local physical activity options, the potential role of Green Prescriptions, and opportunities for service-level support helped to shape the practical considerations explored within the project.

Most importantly, we acknowledge the members of the transgender Working Group. This work would not exist without their time, honesty, openness, and commitment. Participants shared personal experiences, insights, and reflections with generosity and courage, often going beyond what could reasonably be expected in a research setting. The findings and outcomes presented in this report are a direct result of their lived experience, collective knowledge, and commitment to supporting their community. We recognise and deeply value the trust placed in this process, and the contribution made to advancing safer, more inclusive physical activity opportunities.

Executive Summary

Transgender people in Aotearoa New Zealand experience significant inequities in both physical and mental health. While physical activity is widely recognised as beneficial for wellbeing, many transgender people are unable to access or participate in existing opportunities due to safety concerns, a lack of affirming environments, and limited appropriate services—particularly in rural and semi-rural settings such as Whanganui.

This project was developed in response to both national and local research identifying unmet needs in mental health support, social connection, and access to safe, inclusive spaces. It aimed to explore how safe physical activity opportunities could be designed to better support the health and wellbeing of transgender communities.

A two-phase, community-informed approach was used. Phase 1 involved interviews with Health Improvement Practitioners (HIPs) and Health Coaches (HCs) working in primary care. These interviews explored current practice, strengths, and system-level challenges in supporting transgender patients. Phase 2 involved a co-design process with a Transgender Working Group (TWG), bringing together community members to define safety, identify barriers and enablers, and develop practical solutions.

The project was also informed by early engagement with key regional stakeholders to support implementation and ensure the findings could be translated into practical, sustainable physical activity opportunities.

Across both phases, a consistent and important finding emerged: **safety is the foundation of participation**. Safety was understood as multi-dimensional, encompassing physical, social, emotional, and practical factors. Without these conditions in place, participation in physical activity is unlikely to occur.

The Transgender Working Group provided detailed, lived-experience insights into what safe participation requires. Key findings included:

- Participation is **conditional**, shaped by environment, people, and context—not motivation
- Safety is **relational**, built over time through trust, consistency, and connection
- Entry into new environments is a critical barrier and requires **supported, gradual engagement**
- Physical activity is valued not only for physical health, but as a space for **social connection, identity affirmation, and rebuilding trust in the body**
- There is a need to carefully balance **visibility and safety**, using layered and controlled communication approaches
- Sustainable initiatives require **shared ownership and integration into existing systems**

Primary care insights strongly aligned with these findings. Health Improvement Practitioners and Health Coaches described providing relational, holistic care and recognised safety as a key barrier to engagement. However, they also identified significant system constraints, including a lack of clear referral pathways, limited knowledge of safe local options, and insufficient resources to support access. Providers frequently relied on informal workarounds,

highlighting a gap between understanding community needs and being able to respond to them within current systems.

Together, these perspectives demonstrate that improving access to physical activity is not simply about increasing availability, but about creating the **conditions required for safe participation**.

In response, this project developed a **stepped, practice-oriented framework** for designing safe physical activity opportunities for transgender communities. This approach includes:

1. Establishing safety as the foundation
2. Designing for those with the highest barriers
3. Building relationally safe environments
4. Supporting entry into participation
5. Reframing activity around connection and flexibility
6. Creating clear and trusted referral pathways
7. Managing visibility carefully
8. Integrating initiatives for long-term sustainability

This framework provides a practical and transferable model for services, particularly in rural contexts where access is limited and visibility carries additional risk. Importantly, the framework is designed around the needs of those facing the greatest barriers to participation, recognising that improving access for those with the highest support needs creates safer and more inclusive environments for everyone.

Overall, this project demonstrates that safe, affirming physical activity spaces can play a critical role in supporting transgender health and wellbeing. When designed in partnership with communities and supported by primary care, these initiatives offer a meaningful pathway to reduce isolation, strengthen connection, improve physical and mental health outcomes, and reduce inequities in participation. The framework developed through this project provides a practical model that can guide implementation within Whanganui and inform similar rural communities across Aotearoa New Zealand.

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The Research Team

This project was led by **Dr Katie McMenamin** *(she/her)*, from the **Health and Research Collaborative (HARC)**, who undertook the role of lead researcher and co-facilitator of the Working Group. The co-design process was supported by a transgender co-facilitator, **Kelvin Sasse** *(he/him)*, ensuring that the development and direction of the work remained grounded in lived experience. Theming of interviews with Health Improvement Practitioners and Health Coaches was supported by **Debra Smith** *(she/her)*, from **HARC**.

The Working Group was made up of nine transgender people from the Whanganui community who contributed as active partners in the co-design process. Their role extended beyond participation, involving the sharing of lived experience, shaping of discussions, and collective development of the findings and outputs presented in this report.

In recognition of individual preferences, some members of the Working Group have chosen to be named in acknowledgement of their contribution, while others have chosen to remain anonymous. These preferences have been respected.

We acknowledge the following Working Group members who have chosen to be named:

Eden Sibbald *(they/them)*
Cyn Willis *(he/him/they/them)*
Lynda Carlton *(she/her)*

We also acknowledge the contributions of the remaining Working Group members, who have chosen not to be named. Their collective knowledge, insight, and commitment have been central to this work.

Introduction

This report uses the terms transgender to refer to anyone whose gender differs from their sex assigned at birth. While there are many terms used to describe gender diversity, including Māori and Pasifika terms, the term transgender is used for consistency, while recognising the diversity of identities and terms people use for themselves. These terms include, but are not limited to, transgender, transsexual, non-binary, irawhiti, whakawahine, fa'afafine, and genderqueer.

Context of Transgender Health Inequities

Despite resilience and community strength, transgender people in Aotearoa New Zealand continue to face significant health inequities. These are driven by discrimination, restricted access to affirming care, and health systems that are not yet fully responsive to their needs. As a result, transgender people experience inequitable physical and mental health outcomes than the wider population, with high levels of distress, self-harm, and suicidality reported, alongside strong community resilience and support networks (K. E. McMenamin, 2024; Yee et al., 2025).

1. Mental Health Inequities

People from the transgender community are disproportionately affected by mental health challenges (K. E. McMenamin, 2024; Tan, Ellis, Schmidt, Byrne, & Veale, 2020; Veale et al., 2019; Yee et al., 2025). The *Counting Ourselves* survey reported that 77% of participants experienced high or very high psychological distress, compared with just 12% of the general population (Yee et al., 2025). Over half had deliberately injured themselves or seriously considered suicide, and 10% had attempted suicide in the past year. These findings highlight the urgent need for accessible, affirming, and culturally safe mental health support, particularly those who belong to multiple minority or marginalised groups or who face additional challenges such as discrimination and harassment.

Access to appropriate services, however, remains a major barrier. One in four *Counting Ourselves* participants reported an unmet need for counselling or psychological support, citing cost, lack of information, and long waiting times as key barriers (Yee et al., 2025). Whanganui-based research echoes these findings, identifying limited service capacity as the primary barrier to accessing mental health care (K. E. McMenamin, 2024). Even when support is available, transgender people often face further challenges. Some are referred on due to therapists' limited knowledge or reluctance to engage with transgender-specific issues. Others describe feeling unsafe or unable to discuss their gender identity in contexts such as ACC-funded therapy—where funding often excludes gender-related care—or with therapists whose religious backgrounds create discomfort.

A further barrier is the absence of Whanganui-based mental health professionals with lived transgender experience. Participants in local research strongly preferred access to transgender or gender-diverse therapists, viewing lived experience as crucial to creating a safe, affirming environment (McMenamin K. E. & Enoka, 2025; K. E. McMenamin, Enoka, & Meates, 2025). Such providers were seen as uniquely able to support the complex challenges

of both social and medical transition. At present, however, lived experience therapists are only accessible online, which remains a significant limitation for those who prefer face-to-face care.

2. Discrimination and Harassment

High rates of discrimination and harassment compound these inequities, contributing to social exclusion, isolation, and reduced quality of life. In the *Counting Ourselves* survey, 44% of participants reported experiencing discrimination in the past year—more than double the rate of the general population—and 35% said this was directly related to their gender identity (Yee et al., 2025). Discrimination frequently restricted daily activities, with many transgender people avoiding public transport, bathrooms, and other public spaces due to safety concerns, with 19% reporting being threatened with physical violence in the past four years.

These findings reflect the very real safety concerns faced by transgender communities and highlight the need for safe, inclusive spaces where people can participate fully without fear of exclusion or harm.

3. Minority Stress and Health

The Minority Stress Model (Meyer, 2003) provides a useful framework for understanding how discrimination and stigma affect mental health. It explains how minority status creates unique stressors—including prejudice, harassment, microaggressions, and exclusion—that are not typically experienced by the broader population (Testa et al., 2012; Veale et al., 2019). These external stressors are compounded by internal stressors, such as internalised transphobia and the pressure of concealing one's gender identity, which together contribute to elevated rates of anxiety, depression and suicidality among transgender people (Tan et al., 2020; Veale et al., 2019).

While this model highlights the harmful effects of minority stress, it also points to opportunities for change. By addressing external discrimination and reducing internalised stigma through affirming environments, it is possible to foster resilience, strengthen belonging, and improve both mental and physical health outcomes (McMenamin, 2024; Tan et al., 2020).

4. Neurodiversity and Physical Activity

Emerging evidence suggests that autism and attention deficit/hyperactivity disorder (ADHD) are more common among transgender and gender-diverse people than in the general population, although the reasons for this association are not yet fully understood (Gratton et al., 2023; Rea et al., 2026; Warrier et al., 2020). This overlap has important implications for physical activity participation because many neurodivergent people experience sensory sensitivities, require greater predictability, or prefer clear communication and structured environments. These factors may interact with gender-related concerns to further influence whether physical activity settings feel accessible, manageable, and safe. Considering neurodiversity alongside gender diversity, therefore, supports a more inclusive understanding of the conditions that enable meaningful participation.

5. Policy and Social Context

The broader policy and social environment also influences perceptions of safety within physical activity settings. Internationally, public debate regarding transgender participation in sport has intensified in recent years, with increasing attention given to policies governing inclusion in both competitive and community sport (Coleman et al., 2022). In Aotearoa New Zealand, this has included the Government's 2025 direction to Sport New Zealand to withdraw its *Guiding Principles for the Inclusion of Transgender People in Community Sport* (Sport New Zealand, 2025a, 2025b). Although the effects of these policy changes on participation have not yet been evaluated, the removal of nationally endorsed guidance may contribute to uncertainty among organisations seeking to create inclusive environments and reinforce existing concerns about safety and belonging for transgender people.

6. Summary

Together, these findings highlight the urgency of creating safe, affirming, and inclusive environments where transgender people can thrive. Transgender participation is shaped not only by individual and interpersonal experiences, but also by broader health system, policy, and social contexts that influence perception of safety and belonging. Addressing inequities, therefore, requires not only removing barriers but also building on community resilience and strengths, while supporting organisations to create environments that are welcoming, inclusive, and affirming. The current project responds to these needs by co-developing safe physical activity opportunities in Whanganui that actively support health, wellbeing, connection, and participation.

Health Benefits of Physical Activity

Physical activity is widely recognised as a cornerstone of health and wellbeing. Regular participation reduces the risk of chronic disease, enhances cardiovascular and musculoskeletal health, and contributes to improved sleep, energy, and cognitive functioning (Warburton & Bredin, 2017). Beyond these physical benefits, physical activity has strong protective effects on mental health, helping to reduce anxiety, depression, and stress while building confidence, resilience, and social connection (Holder, Morris, & Spreckley, 2022).

For the transgender community, these benefits are particularly important given the heightened rates of psychological distress linked to discrimination and systemic inequities. Research shows that participation in physical activity can help buffer the impacts of minority stress, providing both immediate relief from distress and longer-term improvements in mood, confidence, and coping capacity (Holder et al., 2022; Lightner et al., 2024).

1. Barriers to participation

Despite these benefits, many transgender people face considerable barriers to participating in physical activity. National and international studies report that gyms, sports clubs, and public exercise spaces are often avoided due to safety concerns, fear of harassment, and the lack of gender-affirming facilities (Coleman et al., 2022; K. E. McMenamin, 2024; Yee et al.,

2025). The *Counting Ourselves* study reported that 45% of respondents avoided gender-segregated spaces, while 43% expressed concerns about bathroom access. Local research in Whanganui confirms that these barriers are further exacerbated in regional areas, where fewer inclusive options are available (K. E. McMenamin, 2024).

2. Opportunities for Change

At the same time, evidence demonstrates that inclusive, affirming environments can transform these barriers into opportunities. Safe physical activity spaces—where people feel welcomed, respected, and free from discrimination—support not only physical health but also mental wellbeing, social connection, and a sense of belonging. Creating such spaces is a practical and achievable strategy for advancing equity and improving overall health outcomes for transgender communities.

This project was designed as a direct response to these identified needs and opportunities. By working alongside the transgender community and other community partners, the initiative aimed to create safe, gender-affirming physical activity spaces in Whanganui. In doing so, it sought not only to reduce barriers but to actively promote resilience, connection, and holistic wellbeing.

Project Response to National and Local Recommendations

Both the *Counting Ourselves* survey (Yee et al., 2025) and the *Whanganui Needs of Transgender Adults, Youth, and Parents of Transgender Children* study (K. E. McMenamin, 2024) called for safe, affirming, and inclusive spaces that support the health and wellbeing of transgender people. Key recommendations emphasised: (1) reducing barriers to participation in physical activity, (2) addressing mental health challenges through supportive environments, and (3) fostering social connection and access to gender-affirming services.

The current project was designed as a direct response to these recommendations. By working with local partners, it aimed to create safe physical activity opportunities where transgender people could participate without fear of harm, reduce the isolation linked to discrimination, and promote both physical and mental wellbeing. In doing so, the project positioned physical activity as a practical and community-led strategy for advancing equity.

The following section describes the project's implementation, insights from both primary care providers and those from the transgender community, the physical activities identified for trial, and the resources needed to sustain these initiatives in the Whanganui region. The project was undertaken in two complementary phases, designed to bring together both primary care perspectives and community lived experience to inform the development of safe physical activity opportunities for transgender people in the Whanganui region.

Phase 1: Primary Care Insights (HIP/HC Interviews)
The first phase involved semi-structured interviews with Health Improvement Practitioners (HIPs) and Health Coaches (HCs) working within Whanganui general practices. This phase aimed to understand current practice, including how primary care providers support transgender patients with mental health and wellbeing, the role of physical activity in care,

and the barriers and limitations faced within existing systems. Findings from this phase highlighted key gaps in referral pathways, uncertainty around safe and appropriate options, and challenges supporting patient engagement.

Phase 2: Community Co-Design (Transgender Working Group)
The second phase involved the establishment of a Transgender Working Group (TWG), bringing together community members with diverse lived experience. Through a series of facilitated sessions, participants explored barriers and enablers to physical activity, co-developed a shared understanding of safety, and identified and refined potential activity options for future implementation. This phase focused on generating community-informed solutions and defining what safe, accessible participation looks like in practice.

Integration of Phases
The two phases were sequential and complementary. Insights from both phases provide a comprehensive understanding of both system-level challenges and community-defined solutions, forming the foundation for the project's recommendations and next steps.

Method

Study Design and Ethical Approval

This project used a two-phase, community-informed design to understand and address barriers to safe physical activity for transgender people in the Whanganui region. The approach combined insights from primary care providers (Phase 1) with community co-design through a Transgender Working Group (Phase 2).

Phase 1 explored how transgender patients are currently supported within primary care, including existing practices, challenges, and gaps in referral pathways. Phase 2 built on these findings by working directly with community members to define safety, identify barriers and enablers, and co-develop practical activity options for future implementation.

Together, these phases provide a comprehensive understanding of both system-level challenges and community-defined solutions (Figure 1).

Ethical approval for the project was obtained from the Health and Disability Ethics Committee (HDEC), and all participants provided informed consent prior to taking part.

Stakeholder Engagement

Prior to engagement with HIPs, HCs, or the Transgender Working Group (TWG), early engagement was undertaken with key regional stakeholders. The lead researcher and a representative from Pride Whanganui, met with senior staff from Sport Whanganui, including the Chief Executive, Diversity and Inclusion Lead, and Active Wellbeing Manager.

The purpose of this engagement was to introduce the project and its aims, and to connect with organisations already working to support an active, healthy, and connected Whanganui community. This initial discussion provided an opportunity to share the kaupapa (what the project was about), seek feedback on proposed approaches, and explore opportunities for alignment and collaboration.

Sport Whanganui's involvement was particularly valuable given their established networks, leadership within the regional sport and recreation sector, and role in promoting inclusive participation. This early engagement helped to strengthen potential pathways for implementation and begin conversations around the longer-term sustainability of project outcomes.

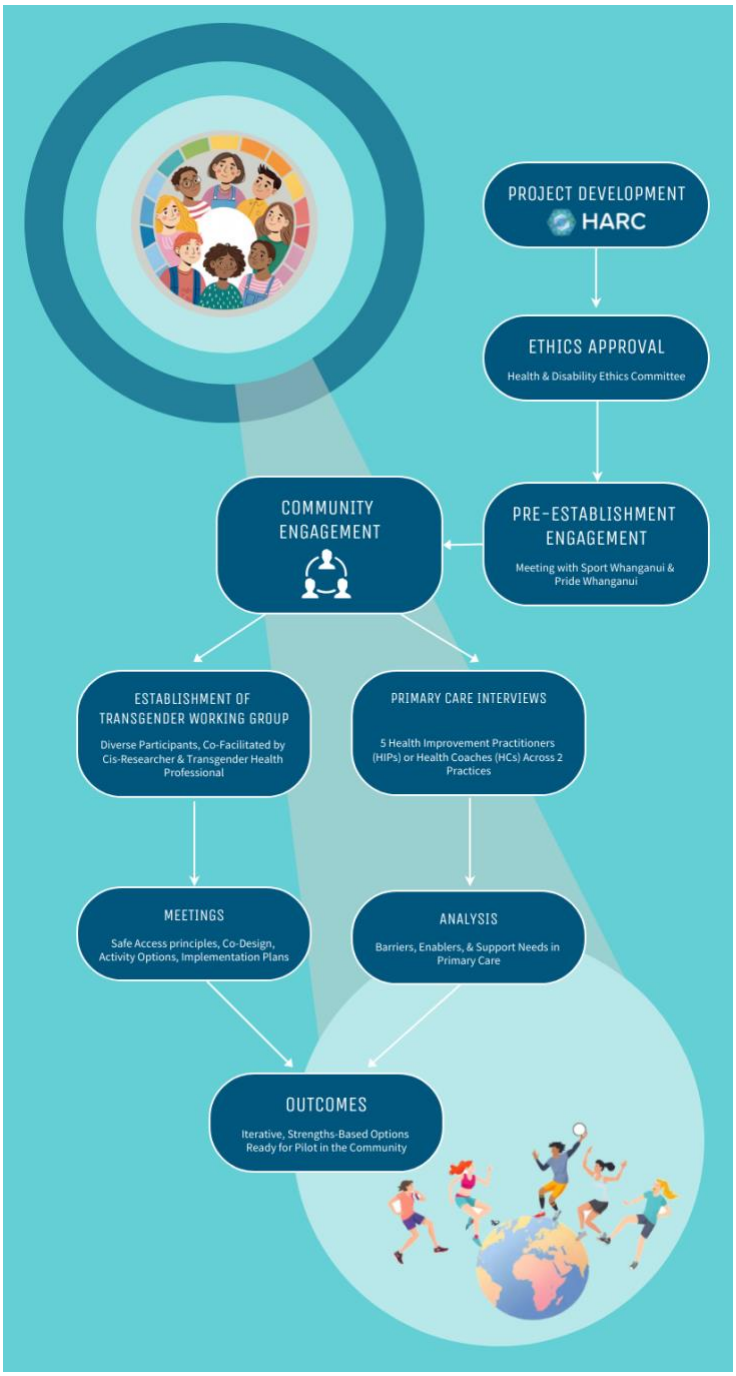

Figure 1. Transgender Safe Physical Activity Project Flow Diagram.

Phase 1: Primary Care Interviews (HIPs/HCs)

Participants
Semi-structured interviews were conducted with five primary care providers working in HIP and HC roles across two Whanganui general practices. All participants had experience supporting transgender patients, although this experience varied. While multiple other primary care practices were invited to participate, they either did not respond or were unable to take part (e.g., recent addition of HIP/HC role to the practice).

Procedures
HIP and HC interviews were guided by a semi-structured interview schedule (Appendix 1). Interviews explored current approaches to supporting transgender patients, including mental health and wellbeing, the role of physical activity in care, and perceived barriers and enablers to engagement. Participants were offered flexibility in interview format, and all interviews were conducted in person, as a team, at participating practices.

Analysis
Interviews were recorded, transcribed, and analysed thematically to identify common practices, challenges, and opportunities for improving support for transgender patients, particularly in relation to physical activity and wellbeing.

Phase 2: Transgender Working Group (Community Co-Design)

Participants
Participants were recruited through community networks, including Pride Whanganui. Recruitment posters were displayed at primary care services known to provide gender-affirming care and at the Pride Whanganui hub, and were promoted through Pride Whanganui's social media channels. Pride Whanganui staff also informed community members who they considered may be interested in participating. Interested individuals contacted the lead researcher directly by email or text message. All individuals who expressed interest were invited to participate, and no one was excluded. Prior to closing recruitment, participants completed a brief demographic questionnaire (including age, gender, ethnicity, neurodivergence, and disability experience) to ensure the group reflected a diversity of perspectives.

The Transgender Working Group (TWG) comprised 10 community members with diverse lived experience, including transgender men, transgender women, non-binary, and agender individuals. Participants ranged in age from late teens to their 70s and included people who identified as neurodiverse and/or living with disability. Ethnicities included Māori, Samoan, New Zealand European, and Other.

The group was co-facilitated by the lead investigator and a transgender allied health professional, ensuring both research and lived experience perspectives were integrated throughout.

Procedures
The TWG met regularly over six sessions at Pride Whanganui, a recognised safe space for the LGBTQI+ community. Prior to the first meeting, the cisgender lead researcher and transgender co-facilitator jointly developed an outline for the six sessions, informed by the study aims and previous discussions with community partners during project planning. Each session had a broad objective rather than a fixed interview guide, allowing discussions to evolve in response to issues raised by the group. Sessions were intentionally iterative and responsive, with each meeting building on insights from previous discussions.

Sessions were structured to:

- Explore barriers and enablers to physical activity
- Define what safety means in this context
- Identify and prioritise potential activities
- Co-design approaches for implementation

Each participant received a koha (gift of appreciation) for their time and expertise, in recognition of the significant contribution made. Meetings were held at Pride Whanganui, a recognised safe space for the LGBTQI+ community.

Attendance
Attendance remained high throughout the study. Two sessions were attended by all 11 TWG members, three sessions were each missed by one participant (a different person each week), and the final session was attended by six members because the remainder were unavailable. The consistency of attendance supported continuity of discussion and the progressive refinement of ideas across meetings.

Analysis
Data from the TWG were analysed using Braun and Clarke's reflexive thematic analysis approach (Braun & Clarke, 2021). Audio recordings were transcribed verbatim and managed using NVivo 15 to support data organisation, coding, and identification of preliminary themes. Coding was undertaken by the lead researcher, with emerging interpretations discussed with the wider research team. Preliminary themes were then presented back to the TWG during subsequent sessions for discussion, refinement, and challenges. This iterative process ensured that the final themes reflected both researcher interpretation and participants' collective understanding, consistent with the co-design approach adopted throughout the study. A strengths-based, equity-focused approach was used throughout to ensure findings reflected both challenges and opportunities for change.

Phase 1: Health Improvement Practitioner/Health Coach Insights

Interviews with HIPs and HCs across the two general practices highlighted a number of consistent themes regarding current practice, strengths, and gaps in supporting transgender patients. As an initial step, participants were asked to describe their roles and how these function in practice.

The roles were described as overlapping, complementary, and flexible, with both HIPs and HCs working together to support the diverse needs of patients. While some distinctions were identified, there was a strong emphasis on collaborative, team-based care.

HIPs were generally described as focusing on short-term behavioural change and addressing emotional or psychological barriers, while HCs were more likely to support longer-term condition management and practical goal-setting:

> "Generally, it's… HIPs who deal with like, short-term behavioural changes, goal setting… and health coaches would do more like long-term conditions… but… we just kind of all work together… to get the best outcome for that person." [KI104]

In practice, however, these distinctions were fluid, with participants describing themselves as "generalists [working across] mental health and wellbeing" [KI105].

This flexibility allowed primary care providers to respond to patient needs in a coordinated way. For example, HIPs described focusing on identifying and addressing barriers, while HCs could provide more structured support such as exercise planning:

> "If someone was wanting… 'oh, hey, can you help set me up with an exercise program?' I would be like, [Health Coaches] straightaway… whereas [HIPs] would probably be more looking at what are the barriers and the things that are stopping you, maybe emotionally, to try to help you get to do it, not necessarily set it up." [KI101]

Within this collaborative and flexible model, primary care providers described working with transgender patients in ways that were highly responsive to individual circumstances. Presentations were described as highly varied and "fluid," requiring a flexible and person-centred approach:

> "They come for different things… it's so individual about what they need… it's so kind of fluid, really." [KI104/KI105]

Building on this, participants described the range of reasons why transgender patients engaged with HIP and HC services. These reasons reflected the diverse and evolving needs of individuals, often shaped by their identity journey and broader life context.

A key area of support involved identity development and the day-to-day realities of being transgender, including navigating disclosure, healthcare interactions, and social environments:

> "A lot of it's to do with them finding their niche in the world and dealing with day-to-day challenges of coming out and doing all of those things that you know, seeing the doctors and having those conversations, and redefining themselves as the person that they feel that they are, rather than how they've just been portrayed..." [KI104]

Primary care providers also supported patients with broader life challenges, including family and relationship dynamics, as well as practical stressors such as housing and finances:

> "[It's about] unpicking… family relationship dynamics… romantic relationships… and sometimes even social stuff, housing, finances, WINZ. And yeah, it's just about being affirming, as much as possible." [KI103]

In addition, there was a strong focus on building skills to help patients navigate complex or unsafe environments, including developing boundaries and communication strategies:

> "Just boundaries… helping them know what boundaries they want to put in place and how to do that." [KI105]

> "Different things come up… there might be some communication skills like some assertiveness… especially if the family, you know, might be navigating rejecting family. [KI103]

Moments of disclosure were recognised as particularly significant, requiring careful, affirming support:

> "And I think when people come out, it's such a special time, like moment to be able to share with people, you know, creating that safety." [KI103]

Within this context, seven key themes emerged from the interviews: 1) Holistic, relationship-based care as a strength, 2) Mental health needs are high and context driven; 3) Physical activity is valued but difficult to access safely; 4) Lack of clear pathways and resources; 5) Importance of supported and relational access; 6) Social isolation and disconnection; and 7) Need for system-level changes and training.

1. Holistic, Relationship-Based Care as a Strength

Across both practices, care for transgender patients was characterised by a strong emphasis on relational, person-centred approaches. Establishing trust and creating a safe, affirming environment were seen as foundational, and in some cases, reflected the primary form of support:

> "For me, the emphasis at first was like a positive and supportive relationship... that's accepting... sometimes that's all it is." [KI103]

Primary care providers described their roles as providing a consistent and accepting space where patients could feel comfortable to express themselves:

> "A lot of it's just them having somebody that's safe to go and be themselves." [KI105]

This relational foundation enabled broader, holistic care, with support extending across mental, social, and practical domains. Rather than focusing on a single issue, care often reflected the interconnected nature of wellbeing:

> “It’s kind of mental health and wellbeing… it’s a little bit of everything that you might encounter in general practice.” [KI103]

2. Mental Health Needs Are High and Context-Driven

Primary care providers collectively reported high levels of mental distress among transgender patients, including anxiety, low mood, and social isolation.

> “Anxiety or low mood or relationship struggles with the people that I've seen, those would probably be the main areas of concern.” [KI101]

However, they noted that these experiences are often rooted in real world challenges, shaped by broader social and systemic factors (e.g., stigma, rejection, discrimination):

> “There's been some real significant trauma.” [KI103]

> “Some people are affirming in a genuine felt sense kind of way. And some people can be affirming in a, in a way that the words are right, but it doesn't *feel* very safe.” [KI103]

There was recognition that distress cannot be separated from broader social realities and that care must acknowledge these lived realities, rather than attempting to “normalise away” distress that is grounded in real-world experiences.

> “There was a young female… that I'd been working with for a while and had mentioned organisations a few times and she was just like, ‘no’… She didn't want to be going down that road… It was a lot of looking at ‘how do I continue doing the things that are important to me, even with the uncomfortableness that's showing up for me when I get stares from people?’… I think that tackling that can be even a little bit harder, because normally I would look at people going, ‘well, what's the reality of that? Is that actually real? Is that not real?’ And it is! And it is real! So it's looking at it going, well, yes, that is a real concern that they have and does really happen… ‘How do you want to keep yourself safe in that respect?’” [KI101]

3. Physical Activity Is Valued but Difficult to Access Safely

Primary care providers consistently recognised the importance of physical activity for mental wellbeing. However, in practice, supporting transgender patients to engage in physical activity was often complex, with safety emerging as a central concern.

Many patients did not feel safe or comfortable in typical environments such as gyms or public spaces. Experiences or fears of judgement, misgendering, and harassment were commonly described, and these concerns significantly limited participation:

> “They didn’t feel comfortable at the gym… they felt that people were looking at them… they didn’t find it a safe space.” [KI104]

As a result, primary care providers often found themselves adapting recommendations to prioritise safety over ideal activity types. This meant working collaboratively with patients to identify alternatives that felt more manageable and less risky.

Common strategies included:

- Exercising at home
- Walking in safer or more populated areas
- Attending activities with trusted others

> "We come up with plans for exercise at home… or safe people to go with." [KI103]

Despite these adaptations, primary care providers described feeling limited in what they could offer. There was a clear sense of uncertainty around what safe, affirming options actually existed locally:

> "Any information that you've got around safer spaces… would be brilliant because I was at a bit of a loss." [KI104]

This highlights a **key gap between recognising the value of physical activity and having practical, safe options to recommend.**

4. Lack of Clear Pathways and Resources

Building on this, primary care providers described a broader systems issue: the lack of clear, trusted pathways for referring transgender patients to appropriate services.

Across both practices, there was uncertainty about:

- Which services are genuinely safe and affirming
- What local options exist for physical activity or wellbeing
- How to confidently refer patients without risking harm

> "There's not really any specific pathways that I know to be affirming… it's not clear." [KI103]

Even when services existed, primary care providers lacked confidence in recommending them. This was compounded by:

- No central directory of inclusive services
- Limited awareness of existing initiatives (e.g. Green Prescription)
- Inconsistent communication between services

Participants highlighted the value of **simple, practical tools**, such as:

- A directory of safe and affirming options
- Clear referral pathways
- Guidance on which services are appropriate for transgender patients

> "A directory… it would be cool to know which of them are gender affirming." [KI103/KI104]

Without this, primary care providers were often left relying on guesswork, which reduced confidence and limited their ability to connect patients to external supports.

5. Importance of Supported and Relational Access

A consistent theme across interviews was that **access is not just about availability — it is about support**.

Primary care providers described how many transgender patients were unable to engage with services independently, particularly when experiencing anxiety, past trauma, or neurodiversity. Simply providing information or referrals was often not enough:

> "Even connecting them… is a real battle… you give them all the info… and they'll come back and say, 'no, I didn't do it.'" [KI102]

Instead, successful engagement often relied on **relational and supported approaches**, where primary care providers played an active role in facilitating access.

- Attending activities with a trusted person
- Gradual, supported entry into new environments
- Primary care providers facilitating initial contact (e.g., making calls together)

> "We might ring together… if they've made that plan… then they're more likely to get it done.'" [KI101]

This reinforces that **intermediary support is critical**, and that traditional self-referral models are often insufficient for this group.

6. Social Isolation and Disconnection

Social isolation was described as a significant and ongoing challenge for many transgender patients.

Primary care providers frequently encountered individuals who had lost connection with family, friends, or previous support networks:

> "A lot of them have got dislocation because basically they've moved from family. I've got a couple, but they've both come from outside Whanganui... But they have sort of, just haven't got anyone. Their mates, their friends, whatever supports they had, have gone." [KI102]

This disconnection not only impacts mental wellbeing but also creates additional barriers to engaging in activities that are inherently social, such as group exercise or community programmes.

Importantly, primary care providers also highlighted that **not all patients want transgender-specific spaces**, reinforcing the need for flexibility:

> "She was just like, 'no, I don't want to [be] in a space of other people who are transgender.'" [KI101]

This points to the importance of:

- Diverse options (not one-size-fits-all)
- Choice in how and where people engage
- Both transgender-specific and general inclusive environments

7. Need for System-Level Changes and Training

While individual primary care providers were working hard to provide affirming care, there was a strong sense that broader system-level changes were needed to support this work.

Across both practices, participants identified several key areas for improvement:

- Training for clinical and administrative staff
- More inclusive physical environments (e.g. gender-neutral facilities)
- Better patient management systems (e.g. correct names and gender markers)

> "I'd love for us… to have the training… for our whole team." [KI101]

> "Toilets… because at the moment, we've only got male and female toilets… little things like that… would be great." [KI101]

There was a clear desire for further training and development, with primary care providers recognising that **creating safe, affirming care requires a whole-practice approach**, not just individual effort.

Conclusion

Conversations with HIPS and HCs highlighted both the strengths and limitations of primary care-based support for transgender patients in a regional Aotearoa New Zealand context (Figure 2). HIPs and HCs demonstrated provision of highly relational, flexible, and holistic care; however, it was evident that they are operating within systems that lack the structure, resources, and pathways needed to fully support this population. Together, these findings point to a clear need for practical, accessible, and affirming options that extend beyond traditional healthcare services and are developed alongside the transgender community and the local services that support them.

Figure 2. Key Challenges & Key Areas to Strengthen Within Primary Care to Support the Transgender Community Around Safe Physical Activity.

Phase 2: Transgender Working Group Insights & Outcomes

Phase 2 comprised six two-hour co-facilitated meetings with the Transgender Working Group, at approximately fortnightly intervals. Each meeting created space for grassroots insights and, while there were defined goals for each session, the process was intentionally flexible and iterative. Discussion and activities built on outcomes from previous meetings, allowing ideas to be refined and developed over time.

Insights from Meeting 1

Goal: To gain insights and perspectives around physical activity in the transgender community and identify a range of physical activity options available in the Whanganui region.

1. Establishing Foundations for Safe Engagement

The first meeting primarily focused on establishing a **safe, ethical, and relational foundation** for the working group. This included completion of consent processes, introduction to the kaupapa, and development of shared expectations for participation (Appendices 2–4).

Participants reviewed and signed consent forms, including agreement to voice recording, and were provided with supporting documentation (Working Group Expectations Agreement, wellbeing guidance, and support services). This process ensured that participation was:

- Informed
- Voluntary
- Supported

Importantly, this session also enabled participants to begin **building familiarity and trust**, which would underpin later discussions.

2. Understanding Baseline Physical Activity

An anonymous activity profiling exercise was introduced to understand the **current physical activity levels** of participants.

Participants were invited (voluntarily and anonymously) to describe their weekly activity. This served two purposes:

- To establish a **baseline understanding of engagement**
- To inform future discussions about **realistic and accessible activity options**

This information was collated between Meetings 1 and 2 for later reflection, signalling an iterative, data-informed co-design process.

3. Expanding the Possibility Space

A key focus of Meeting 1 was generating a **broad, unconstrained list of physical activity options** available in the Whanganui region.

Participants were explicitly encouraged to:

- Think beyond personal ability or interest
- Ignore cost, access, or skill barriers
- Contribute freely without judgement

This resulted in a wide-ranging list (Table 1), spanning:

- Individual and group activities
- Indoor and outdoor options
- Low- and high-intensity activities

This approach ensured that early-stage thinking was **expansive and unrestricted**, preventing premature narrowing of options.

Table 1: Potential Physical Activity Options in the Whanganui Region, as Identified by the Transgender Working Group.

POTENTIAL ACTIVITIES

Walking/Running	Hiking/Tramping
Weights	Rowing/Kyaking/Waka Ama
Squash	Martial Arts
Swimming	Normal Gyms
Skating/Derby	Cycling/Mountain Biking
Skateboarding	Archery
Soccer	Equestrian
Rugby	Gymnastics
Tennis	Skiing/Snowboarding
Pickleball	Parkour
Ping Pong	Yoga
Hockey/Roller Hockey	Pilates
Badminton	Surfing
Volleyball	Paragliding
Netball	Cricket
Softball	Gardening
Dancing	Climbing

4. Early Recognition of Barriers & Enablers

Although detailed analysis occurred in Meeting 2, initial discussions began to surface the idea that:

- Activities themselves are not inherently unsafe
- Safety is shaped by **context, environment, and social dynamics**

Participants began identifying **common barriers and enablers across activities**, rather than treating each activity as distinct. This marked the beginning of a shift toward:

- Thematic analysis
- A cross-cutting understanding of safety

Participants were encouraged to continue reflecting on barriers and enablers between sessions, reinforcing the **ongoing and participatory nature of the process**.

Figure 3. Key Learnings Week 1

Summary

Meeting 1 laid the foundational groundwork for the project. Rather than focusing on solutions, the session prioritised **relationship-building, shared understanding, and expansive exploration**. This created the conditions necessary for deeper, more critical discussions in subsequent meetings.

Insights from Meeting 2

Goal: To identify barriers and enablers for each potential physical activity option and begin to define 'safety' from transgender, neurodiverse, and disability perspectives.

1. Moving From Possibilities to Lived Experiences

Building on the broad activity list from Meeting 1, Meeting 2 shifted focus toward **lived experience**, exploring what enables or prevents participation.

Rather than analysing each activity individually, participants quickly identified that:

- Many activities share **common barriers and supports**
- Understanding these patterns is more useful than activity-by-activity analysis

This continued the thematic approach.

2. Patterns of Participation and Avoidance

Participants described how their current engagement in physical activity is shaped by safety considerations. Many spoke to the deep emotional and physical risks of participating in public activity spaces.

> A repeated theme to emerge was that ***"what makes an activity unsafe is the people around us—not the activity itself."***

Unsafe environments, untrained staff, stares, misgendering, and being told they were "in the wrong place" left some members disengaging from activity altogether, or only exercising alone at home.

Strategies used to manage risk included:

- Choosing **indoor or controlled environments** (e.g., weights)
- Attending at **low-traffic times** (e.g., early morning)
- Avoiding public or highly visible settings

These patterns reflect **adaptive behaviours**, where individuals modify participation to maintain safety.

3. Distinction Between Social and Competitive Contexts

A clear distinction emerged between:

- **Social, community-based activity**
- **Competitive or formal sport environments**

Competitive contexts were widely perceived as unsafe due to:

- Increased visibility
- Gendered structures
- Risk of exclusion or discrimination

This led to a shared agreement that the project should prioritise:

- **Non-competitive, community-based activities**
- Locally controlled environments

4. Defining Safety as Multi-Dimensional

Participants described safety as comprising three interconnected dimensions, referred to by the Working Group as the **3 Ps of Safety** – Physical Safety, Personal Safety, and Practical Safety (Figure 4) – creating a framework expanding the concept of safety beyond solely physical risk.

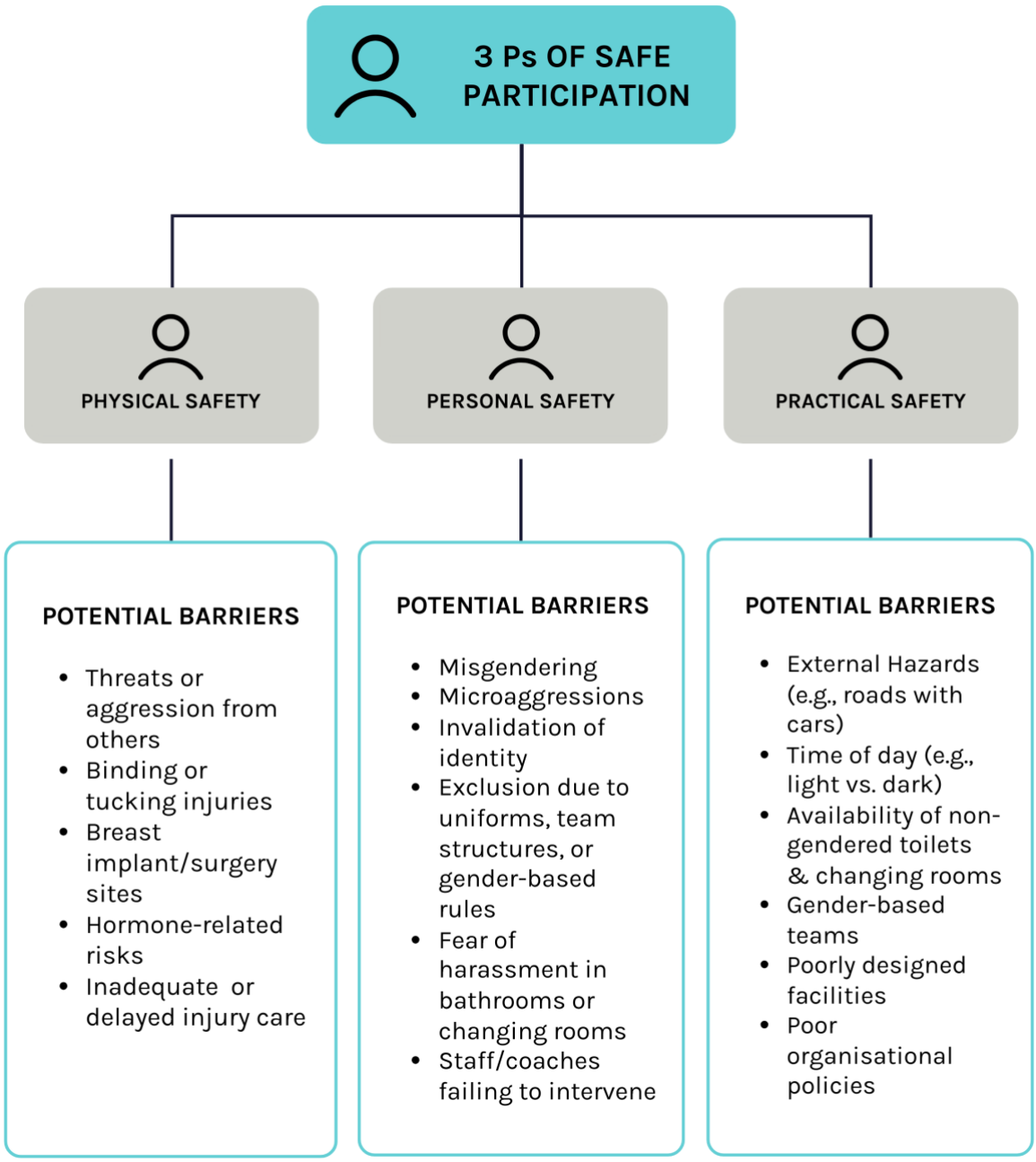

Figure 4. Safety Risks for Transgender & Gender-Diverse People When Engaging in Physical Activity in the Community.

5. Physical Safety: The Complexity of Body-Affirming Supports

Participants highlighted the dual role of body-affirming supports (e.g., binding, tucking, packing):

- These supports can **enable participation and affirmation**
- But also introduce **physical risk and psychological distraction**

Key issues included:

- **Health risks** (e.g., restricted breathing, discomfort)
- **Financial barriers** leading to unsafe alternatives
- **Anxiety** about visibility or failure of supports

Of note, participants highlighted the potential risks associated with body-affirming supports (i.e., binding, tucking, or packing). Some shared stories of overuse—or incorrect use—of binders, despite knowing the medical risks associated with using them during physical activity—such as respiratory strain, circulation issues, or skin irritation.

> "If you're binding, you are heavily advised not to do anything because you will hurt yourself and, you know, other methods that we have to use aren't super fitness friendly… You can walk for a little while, but… you can't just take your binder off to have a break."

Others described how tucking raises concerns for both physical wellbeing and sense of safety. It was noted that physically, tucking can cause discomfort or strain, while psychologically it introduces anxiety about whether it will remain secure during movement. Together, these factors influence confidence to participate fully in physical activity and can limit enjoyment of the experience.

> "What people can afford [affects] the method that you're able to use… people are using duct tape and that kind of thing."

Importantly, group members highlighted a duality in the use of body-affirming supports during physical activity. While these supports can provide affirmation and comfort, they also create anxiety about shifting or becoming noticeable to others. Participants described this as a "distracting risk," where:

- Participants must constantly monitor their bodies
- Focus is diverted away from the activity itself

> "Packers falling out. I haven't had that happen to me, but it sounds horrifying. And so, if that was a risk, I just would go without my prosthetic, but then I'm distracted because I don't have my prosthetic… It's just very distracting… I can't really focus on the sport."

This duality influences engagement in two key ways: either people avoid participation due to perceived risk, or they experience distraction and on-going self-monitoring related to body-affirming supports. Both outcomes reduce focus and enjoyment, limiting the benefits of physical activity.

6. Personal Safety: Visibility, Harassment, and Identity

Personal safety emerged as a major determinant of participation.

Participants described:

- Fear of harassment or violence
- Experiences of misgendering and microaggressions
- Anxiety related to bathrooms and changing spaces

Team and gendered activities were particularly challenging:

- Requirement to "choose a side" for non-binary participants

> "For NBs [Non-binary people], it is still a little bit, when you're not, which side do you go?.. I think it can be affirming for some but not for others. Yeah. And so, I watch. That totally puts you off joining just because of picking a team."

- Increased exposure and scrutiny

> "I'd just be scared that someone's going to see the poster around town, and they know where all the trans people are at this time and this day, and they're going to show up with a gun or something."

- Uniforms that conflict with identity or comfort

> "I think if you get to choose what you want to wear and that kind of thing. It can give you more options to kind of, you know, present yourself in a way that feels more comfortable."

This reinforced that **social environment is a primary driver of safety**.

7. Practical Safety: Facilities, Cost, and Environment

Practical factors were identified as critical to participation, including:

- Availability of gender-neutral bathrooms
- Privacy in changing facilities
- Lighting, layout, and environmental design
- Financial barriers (equipment, fees)

The most notably and recurring theme was the availability of gender-affirming bathrooms and changing rooms. When facilities are limited to 'male' and 'female' spaces only, participants described heightened anxiety about whether they could safely go, with many avoiding facilities altogether. The absence of non-gendered or private options therefore directly restricts participation, while access to gender-neutral toilets or single-user cubicles was consistently described as enabling and affirming.

Participants emphasised that:

- Lack of appropriate facilities can completely prevent participation by increasing feelings of vulnerability

- Well-designed environments can significantly reduce anxiety, allowing people to enjoy the activity itself

Across these discussions, participants identified a consistent set of supports and barriers that shaped their ability to engage in physical activity. These were not specific to individual activities, but operated across contexts, highlighting the structural and relational nature of safety. Table 2 summarises these cross-cutting enablers and constraints.

Table 2: Supports vs Barriers to Physical Activity Engagement for the Transgender Community, as Identified by the Transgender Working Group.

Supports	Barriers
Community / Trans-centred: supportive people, safe queer environments	Clothing challenges: binders, tucking, packers, implants (cost, safety, distraction)
Choice in clothing and uniforms (style, size, options)	Distraction from focus on appearance and presentation
Safe Space sticker on door	Lack of safe paths (visibility, safety from others, traffic, body safety with clothing/binders)
Age – reaching a point where others' opinions matter less	Time of day – safety issues (day vs night)
Regular activities (weekly, consistent)	Voice changes required in different settings
Non-gendered toilets & cubicles; gender-neutral facilities list; safe access	Expense: high one-off (gym fees, shoes) and ongoing costs (swim, lessons)

Building on these supports and barriers, participants then explored what 'safe' participation would look like in practice, identifying key conditions required to engage in physical activity.

8. Safety as a Set of Conditions, Not an Outcome

Through individual reflection and group discussion, participants articulated detailed **conditions required to feel safe** (Table 3).

Table 3: Collated Personal Requirements to Feel Safe to Engage in Physical Activity, as Identified by the Transgender Working Group.

Category	Safety & Inclusion Needs
Environment & Facilities	Non-gendered bathrooms Neutral changing room Access to gender neutral facilities Access to exits or safe area Familiar environment Away from general public
Social & Community	Support from a friend Being with those who are accepting Inclusive

	Queer spaces Community of peers and allies Safe community – trans/allies Having loved ones involved
Identity & Belonging	Sense of belonging Knowing my wellbeing matters Opinions and feelings acknowledged Gender identity not an inconvenience Sex at birth irrelevant Having my gender validated Feeling welcome and accepted Feeling like you belong Correct pronouns used
Safety & Freedom	Generally free from threat Not feeling in danger Free from violence and coercion No threat of violence No cameras out
Expression & Comfort	Access to right clothing Control over clothing Wearing comfortable clothes Relaxed and not serious environment Free from gendered expectations
Participation & Inclusion	Mixed teams Not forced to choose gender side Not the only trans person Gender neutral teams/competitions Team that cares Passing No judgement Non-gendered No staring Being anonymous
Personal Strengths & Knowledge	Strength (physical, emotional, psychological) Knowing your rights Being understood/respected Body, mind & spirit respected
Practical Conditions	Time of day (light/dark) Correct information

These conditions spanned:

- Environment (e.g., private, familiar spaces)
- Social context (e.g., supportive peers)
- Identity (e.g., affirmation, correct pronouns)
- Participation (e.g., non-gendered teams)

This marked a shift toward understanding safety as:

- **Relational**
- **Contextual**
- **Actively created**

9. The Role of Physical Activity in Healing and Identity

Despite extensive discussion of barriers, participants also described the **positive potential of physical activity**, particularly when safety is achieved.

One participant reflected:

> "Having started at the beginning of my transition and having battled dysmorphia and dysphoria, what it taught me while I was creating strength to do a crow pose or a headstand or a handstand… it was actually body appreciation."

This highlights that physical activity can support:

- Gender affirmation
- Confidence
- Reconnection with the body

It also highlights that for many transgender individuals, the value of physical activity is not just fitness—it is reclaiming a relationship with their body on their own terms. However, these benefits are **conditional on safety being present**.

Summary

Meeting 2 marked a critical shift from identifying activities to understanding **what makes participation possible or impossible**. The session established safety as a **complex, multi-layered construct**, laying the foundation for the development of a structured Safety Framework in subsequent meetings. Overall, members called for options that centre connection, affirmation, and autonomy—where physical activity is shaped around *what feels safe and meaningful*, not just what is offered.

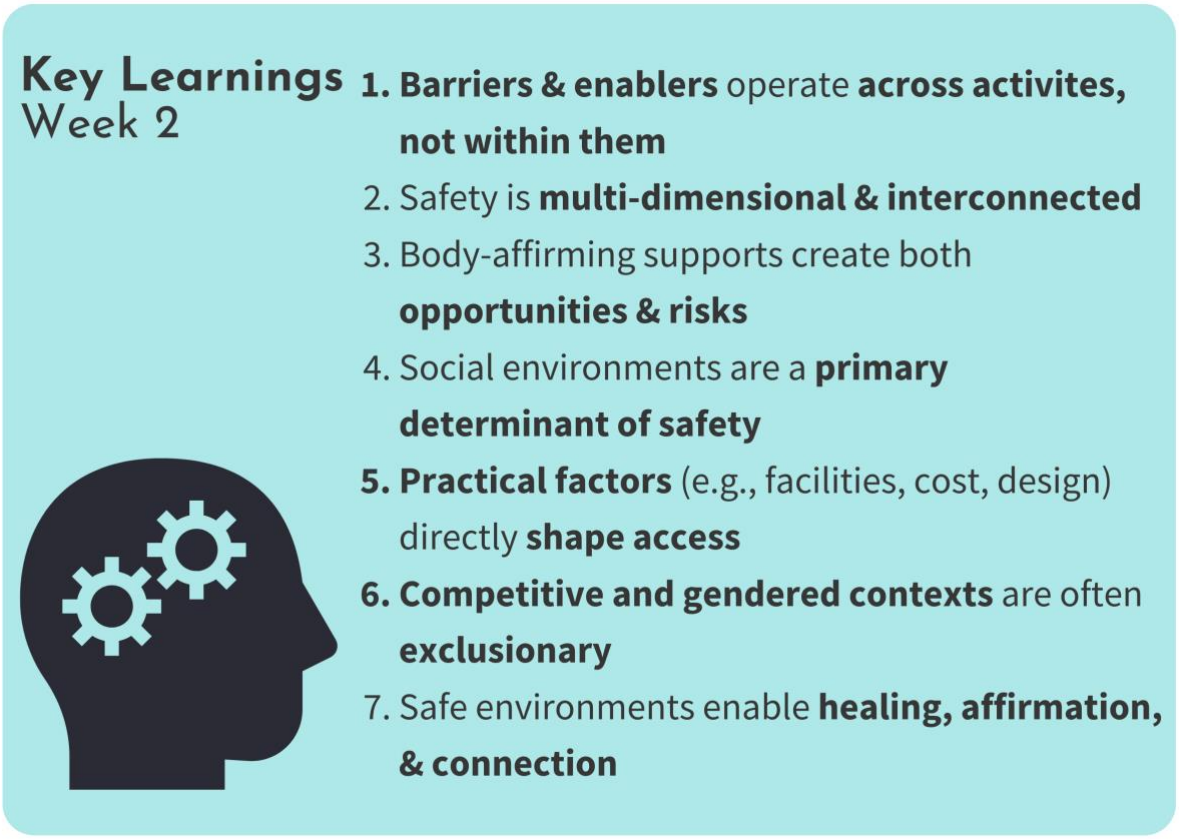

Figure 5. Key Learnings Week 2

Insights from Meeting 3

Goal: To integrate safety principles with lived experience and begin applying the Safety Evaluation Framework to prioritise activities.

1. From Understanding to Application

Meeting 3 represented a transition from **exploration to application**, bringing together:

- Lived experience insights from earlier sessions
- Baseline physical activity data
- The draft Safety Evaluation Framework

The session focused on translating these elements into **practical decision-making tools**.

2. Embedding Intersectionality and Accessibility

A critical reframing occurred early in the session, with participants emphasising that:

- Transgender experiences cannot be understood in isolation
- Accessibility must include disability, neurodiversity, age, and other intersecting identities

As one participant noted:

> "We really need to have [activities] that are able to cope with disabled people, because disabled LGBTQI+ community, we are the least important of all of it… everything is catered towards the young, the middle, but the old or disabled don't get a look in."

This led to a more complex understanding of inclusion as:

- Multi-dimensional
- Context-dependent
- Requiring deliberate design

3. Meeting the Community Where It Is

Review of participants' anonymised weekly activity data (Figure 6) highlighted low engagement in vigorous activity, predominance of low-intensity activity (e.g., walking), and high sedentary time.

Figure 6. Outcomes from the Voluntary, Anonymised Review of the International Physical Activity Questionnaire (IPAQ).

4. Safety as a Precondition for Participation

A key insight from this session was the **centrality of safety—not just physical safety, but emotional, cultural, and relational safety—as a necessary foundation** for participation. Safety was not seen as an enhancement, but foundational.

Participants described avoiding activity entirely when environments were unsafe, reinforcing that:

Without safety, participation does not occur!

5. Applying the Safety Evaluation Framework

Participants engaged with the six-domain Safety Evaluation Framework (Appendix 5), a tool developed from insights that had emerged during previous sessions, to assess activities across:

- Environment
- Clothing and expression
- Social safety
- Psychological safety
- Practical barriers
- Body comfort

Each domain was rated on a Likert Scale between 0 (Completely Unsafe) and 5 (Completely Safe). The exception was the 'practical barriers' domain, which was reversed—0 = No Barriers and 5 = Excessive Barriers (Appendix 5). Once completed, the rating scales were collected by the co-facilitators for review over the coming weeks.

This structured approach enabled:

- Systematic comparison of activities
- Identification of modifiable barriers
- More transparent decision-making

Through guided kōrero, the group provided the following feedback:

- **Affirming social spaces** are as important as physical adaptations. The presence of other trans/queer people or trusted peers greatly increased the likelihood of participation.
- **Walking and dance** emerged as the most feasible starting points for group-based options. These activities were low-cost, flexible, and adaptable to a wide range of bodies, energy levels, and expressions.
- **Uniforms and changing rooms** are consistently problematic. Any proposed group or partnered activity must ensure alternatives to binary uniforms and provide private or gender-neutral changing facilities.

- **Activity framing** matters. Gentle movement described as “healing,” “restorative,” or “fun” felt more welcoming than terms like “fitness” or “performance.”

Several members also noted that **consistency and routine** are vital for those managing mental distress, neurodivergence, or complex trauma histories. Weekly, predictably scheduled, and relationship-based options were seen as more valuable than one-off or competitive events.

Participants described avoiding structured exercise due to anticipated misgendering, stares, clothing expectations, or unsafe facilities. Swimming emerged as a key example. While physically accessible in theory, participants noted that public pools are often dysphoria-inducing or socially unsafe:

> “Something I hear from trans people is that something a lot of trans people miss since transitioning is swimming… it feels completely impossible to go to a public pool.”

Another participant added:

> “Everything else might tick all the boxes, but *that* one [clothing]… unless they’re with other pre- and post-op trans ones who understand, that would be the only time you’d actually get them in the pool.”

This reinforced that **physical accessibility does not equal psychological or social safety**.

Safety domains discussed included:

- Facilities and gender-neutral bathrooms
- Private or flexible changing options
- Clothing and binder/tucking safety
- Time of day and visibility
- Social environment and trusted peers
- Cost and transport

Discussions highlighted the toll and high level of ongoing emotional labour involved when constantly having to focus on risk management in unsafe environments.

> “Wanting to be able to be in the moment instead of spending all your time focused on how you look, what might happen...”

6. Identifying Feasible Entry Points

Walking and gentle movement emerged as the most feasible starting points due to:

- Low cost
- Flexibility
- Alignment with current activity levels

However, feasibility (particularly when focused on inclusivity) remained conditional on:

- Environmental factors (e.g., shelter from wind/sun)
- Accessibility (e.g., seating, terrain, parking proximity)
- Perceived safety (e.g., time of day, visibility)

For example, from lived experience of disability, one participant stated:

> "I need to research the location – where's the parking, where's the seating, what's the terrain like… so I know whether I can go."

Walking activities with older people or people with disabilities were discussed:

> "We would choose our locations [around] is there going to be seating?"

Participants also emphasised flexibility and responsiveness:

> "Maybe the activity needs to be responsive to whoever shows up?"

The group discussed tiered options (beginner/intermediate), inspired by local tramping groups that pre-classify walks by difficulty and send targeted emails.

These insights reinforced that:

- Even "simple" activities require **intentional design**

7. Neurodiversity and Sensory Considerations

Participants highlighted sensory barriers as distinct but overlapping with physical accessibility.

Key issues included:

- Noise
- Lighting
- Overstimulation
- Unpredictability

To address this, participants suggested:

- Advanced written information
- Simple rules
- No multi-tasking instructions
- Regular scheduling (e.g., same times, days of the week, etc.)
- Reminder texts/emails

8. First-Contact Barriers and Social Anxiety

Initial engagement was identified as a major barrier.

Participants described:

- Anxiety entering unfamiliar spaces
- Fear of being observed or judged

One participant described walking into closed-door environments as intimidating:

> "You stand there and you're like, I don't know how many people are going to be in there… I don't know how many eyes are suddenly going to be on me."

Suggested solutions included:

- Meeting outside first
- Having a designated contact/liaison person
- Providing supported entry (e.g., an option for someone to "walk in with you")

As one participant suggested:

> "Can you contact them first and see if someone will meet you outside and walk in with you so you're not walking into a room of eyes?"

This reinforced that:

Participation is relational, not just logistical.

9. Reframing Physical Activity as Social Connection

During this session, a key conceptual shift emerged:

- Physical activity is not the only goal
- **Connection is an equally important goal**

> "A big part of it [is] to increase ability to socialise in a safe place."

The group distinguished between formal sport and social movement. Competitive framing was described by many as alienating:

> "As soon as it got to competition, it wasn't fun anymore."

The preferred model was:

- Non-competitive
- Fun-focused
- Flexible engagement (sit and chat, light participation, higher intensity if desired)

One participant described ideal conditions as:

> "Just having a football kick around rather than a game of soccer."

This reinforced that movement does not require competitive structure and highlighted the benefit of **movement creating contexts in which relationships could form organically** — walking side by side, stretching together, sitting and talking before or after an activity. The shared kaupapa of safety and inclusion provided a foundation from which community could grow.

Movement was seen as a vehicle for:

- Building relationships
- Reducing isolation
- Creating community

This aligns with relational models of wellbeing, including *whakawhanaungatanga* – the intentional building of relationships through shared experience and time spent together. Rather than focusing solely on individual fitness outcomes, the group emphasised connection, mutual understanding, and *manaakitanga* (care for one another) as central to participation. This reiterated that **safety is relational**, not merely structural.

There was emerging insight that safe, consistent physical activity spaces could function as relational hubs — places where people first connect, then build confidence, and eventually initiate their own activities together. As one participant reflected, once connections are formed, people may begin to organise informally:

> "Even if it turns out to be coffee… it might be like two people that like to cycle… 'oh, we can go cycling together because that's safer as a pair.'"

10. Trust, Consistency, and Community Formation

Participants discussed how trust develops over time, reflecting on increasing trust within the group itself throughout the first three meetings. They noted:

- Greater openness over time
- Increased willingness to share

> "This group… everyone has just gelled so well… Honestly, like last week was just the things that people talked about, I was like, they've probably never talked to anyone except very close friends about…real vulnerable."

This shift was not accidental. It reflected the **power of repeated gathering in a shared space**, under a shared kaupapa. Participants described how the first session carried uncertainty — not knowing who could be trusted, how much could be said, or whether others would understand. By the third meeting, however, there was a noticeable ease in conversation,

humour, and openness, demonstrating a shift from cautious participation to relational connection.

This highlighted that:

- Safety is built through **consistency and repetition**
- Regular, predictable sessions are essential

Over time, making a safe space, or 'relational hub' (e.g., for the TWG meetings, extrapolated to future physical activities) was seen as representing:

- Catalysts for informal connection
- Foundations for community-led activity

This highlights an important learning: the initiative is **not simply about delivering structured sessions, but about seeding relational networks**. Regular, affirming physical activity becomes both a protective factor for individual wellbeing and a catalyst for collective resilience. Over time, involvement in these safe movement spaces is hoped to strengthen confidence, expand social networks, and grow community from within — grounded in shared safety, shared purpose, and shared presence.

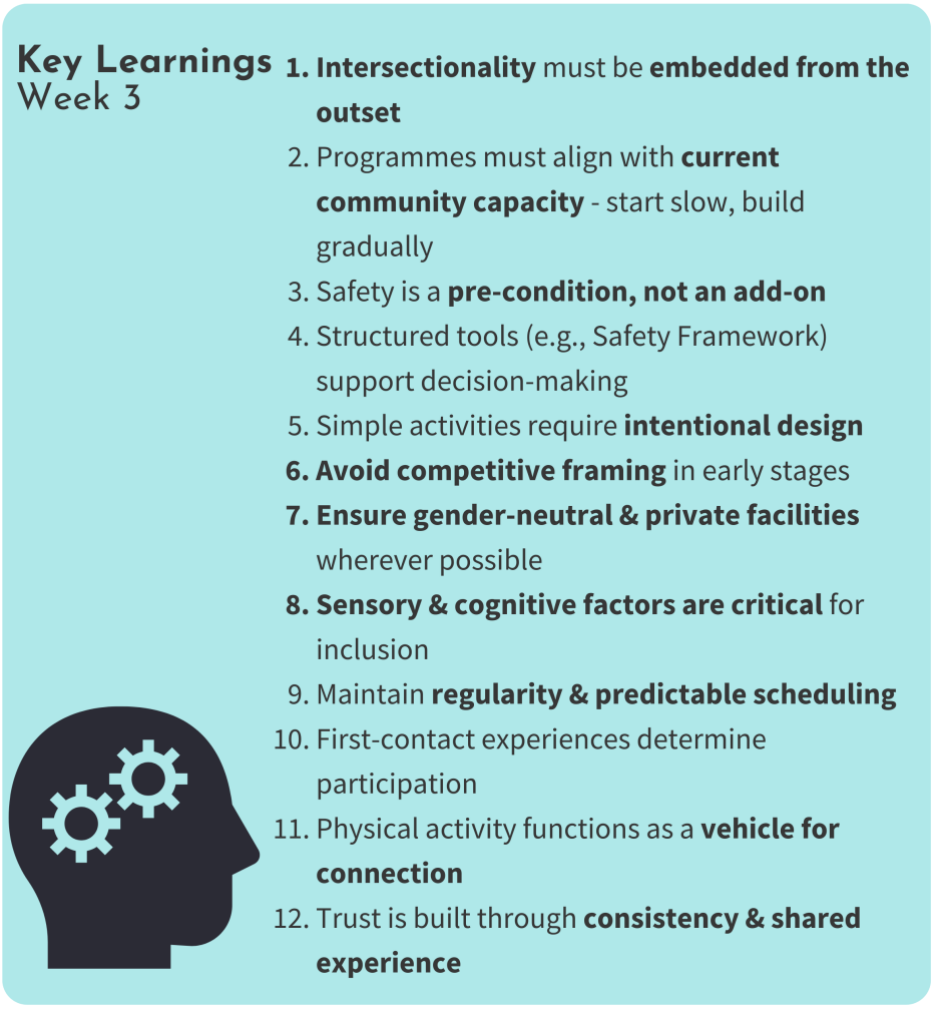

Figure 7. Key Learnings Week 3

Recommendations Emerging from the Session:

From this discussion, several community-led priorities were highlighted:

- Trial a **queer/trans walking group** with a clear safety policy, optional whānau/support person attendance, and inclusive language in all promotions.
- Explore **partnerships for gentle movement** activities such as yoga or dance, with facilitators trained in gender-affirming practice.
- Use the **Safety Evaluation Framework** to assess any new physical activity initiatives before promotion through health providers or community channels.
- Continue to refine the framework with lived-experience input, using it as a **tool for advocacy and education** with providers and funders.

Summary

Meeting 3 marked a pivotal shift toward **implementation-oriented thinking**, supported by structured tools and deeper understanding of participant needs. The session reinforced that safe physical activity initiatives must be **accessible, relational, and intentionally designed**, with connection and community at their core. Moreover, it demonstrated that, with the right conditions, physical activity can be a powerful vehicle for healing, connection, and strength-building.

Insights from Meeting 4

Goal: To solidify at least 3 options to pursue as safe physical activities within the region and to brainstorm next steps and logistics (e.g., staffing, etc.)

Week 4 marked a transition from broad exploration to focused decision-making. The session had three key aims:

1. Confirm a shared definition of "safe" in the context of transgender physical activity.
2. Integrate disability and neurodiversity considerations into planning.
3. Narrow down potential activities to a smaller number for deeper feasibility assessment.

1. Reaffirming a Shared Definition of Safety

The session opened with review and discussion of the 'working' safety definition developed from previous meetings. Based on co-development to this point, the definition of being ***"safe"*** in terms of physical activity for transgender and gender diverse people was acknowledged to encompass much **more than just the absence of harm**. Safety means being able to participate in ways that uphold dignity, affirm identity, and remove barriers across the physical, social, and emotional environment. A safe activity is one where facilities, clothing, and social dynamics are inclusive; where people are free from judgement, threat, or coercion; and where an individual's identity is validated and respected (Figure 8).

Key Elements of Safety for Transgender & Gender Diverse People in Physical Activity:

- **Environment & Facilities** – gender-neutral bathrooms and changing rooms, safe exits, familiar or private environments, and accessible facilities.
- **Social & Community** – support from friends and allies, inclusive and queer-friendly spaces, and communities that are safe and accepting.
- **Identity & Belonging** – being addressed with correct pronouns, knowing one's gender identity is valid and not an inconvenience, and having a sense of belonging and value.
- **Safety & Freedom** – freedom from threat, violence, coercion, surveillance (e.g., cameras), or unwanted attention; feeling generally at ease rather than in danger.
- **Expression & Comfort** – choice and control over clothing and uniforms, ability to manage binders/tucking safely, and spaces that are relaxed rather than rigidly gendered.
- **Participation & Inclusion** – opportunities to be part of mixed or gender-neutral teams, not being the only transgender person, and inclusion in activities without judgement or pressure to choose sides.
- **Personal Strengths & Knowledge** – respecting participants' body, mind, and spirit; ensuring rights are known; and supporting physical, emotional, and psychological wellbeing.
- **Practical Conditions** – safe times of day, clear and accessible information, and regular scheduling to build trust and routine.

Co-Developed Working Definition of Safe Physical Activity:

Figure 8. Transgender Working Group Co-Developed Definition of Safe Physical Activity.

Figure 9. Creating Safe Spaces in Physical Activity Poster.

Participants confirmed that safety extends beyond absence of harm and includes dignity, affirmation, belonging, and freedom from judgement.

The group affirmed that safety must encompass social, environmental, and identity-based dimensions — not simply physical protection. This reinforced earlier learning that safety is relational and experiential.

2. *Embedding Disability from the Outset*

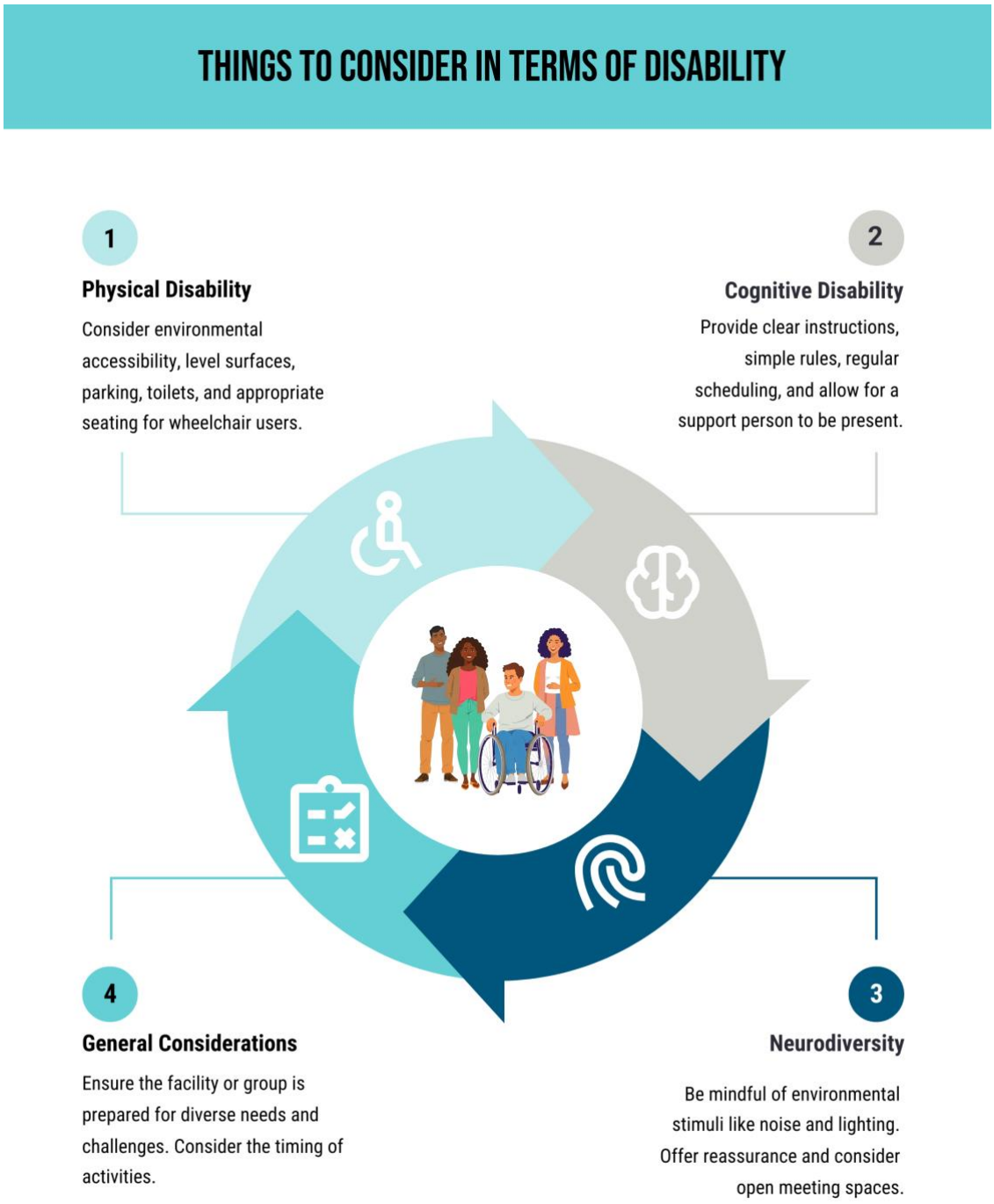

Figure 10. Things to Consider in Terms of Disability Poster.

Building on Week 3, Meeting 4 formally integrated the disability framework into decision-making (Figure 4). Rather than treating accessibility as a later adjustment, the group applied criteria such as:

- Level surfaces and parking proximity
- Toilets and seating

- Clear instructions and predictable scheduling
- Sensory considerations (noise, lighting, crowding)
- Not standing out or being singled out

This was reflected in discussion about archery venues, terrain, wheelchair access, and toilet availability. Participants noted practical barriers such as muddy access in winter and long distances from parking.

Importantly, the group recognised that inclusion may require separate session times or dedicated spaces to ensure comfort and reduce exposure to potentially unsafe dynamics. As one participant suggested:

> "If it was a separate time… completely just us… for a whole separate time… that would be more comfortable."

This reflects a growing confidence in designing for safety rather than adapting to existing norms.

3. Shortlisting Potential Activities

Participants reviewed results from the Transgender Safety Rating Scale and collectively identified five leading options:

- Archery
- Martial Arts
- Boats (e.g., kayaking, waka ama, rowing)
- Gardening
- Yoga

Rather than selecting solely on popularity, the group discussed and examined each option through the safety and disability lens.

Archery: Presence, Skill, and Meditative Focus

Archery emerged strongly, both in ratings and discussion. Participants described it as grounding and meditative:

> "It creates a sense of presence and breath."

> "It's meditative… you need to be quite still… it's all about breathing."

> "The secret to being successful is doing the same thing exactly the same each time."

However, practical considerations were explored — toilet access, parking terrain, wheelchair suitability, and clothing considerations (e.g., binders, sleeve safety). Rather than dismissing barriers, the group discussed potential mitigations, including separate session times and trial visits.

A strong learning from the archery discussion was that **an activity can feel safe conceptually, but operational safety requires deliberate planning**.

Martial Arts: Empowerment vs. Environment

Martial arts generated complex discussion. Participants noted interest in self-defence and empowerment:

> "It's so useful and so empowering… just to know that if you've got grabbed, you know how to break a hold."

However, concerns were raised about professional or competitive environments being exclusionary or hostile. The distinction between competitive sport and community-based, skills-focused learning became important. The group identified that context — not just activity type — determines safety.

Boats: Social Connection and Adaptability

Boat-based activities were valued for their inherently social structure:

> "You have six people in a [waka ama] boat and it's super social."

Participants noted that group boating allows variable intensity and collective pacing, making it adaptable to different ability levels. However, concerns around tipping, wetsuits, physical demands, and accessibility surfaced. This reinforced the need to evaluate equipment requirements, safety training, and perceived risk.

The discussion revealed a key insight: activities involving water may amplify anxiety if psychological safety is not assured and risks (e.g., to physical safety) needed to be mitigated.

Gardening: Relational and Practical

Gardening was framed not only as physical activity but as community building and food sovereignty. One participant described an ideal model:

> "If it was like a queer gardening group… swap seeds, swap stories, help each other out."

This reflected learnings from earlier weeks that physical activity can be a vehicle for relational connection and shared kaupapa. Gardening was seen as adaptable, low-cost, and flexible across ability levels.

Yoga: Indoor Accessibility

Yoga was considered valuable as an indoor, modifiable, lower-intensity option. Participants recognised its compatibility with the safety definition — particularly in relation to breath,

body awareness, and self-regulation — provided facilitators were affirming and environments were sensory-considerate.

4. Process Learning: How Decisions Are Made Matters

A significant shift in Week 4 was methodological. Rather than facilitators deciding the top three, participants were asked to research the five options through the agreed safety and disability frameworks at home for contributing to the next session. A shared collaborative document was proposed to gather reflections.

The facilitator emphasised psychological safety in the decision-making process:

> "The only rule is please be kind to each other… it's really important that everyone feels safe to put out anything they want."

This reinforced that co-design extends to how disagreement and critique are handled.

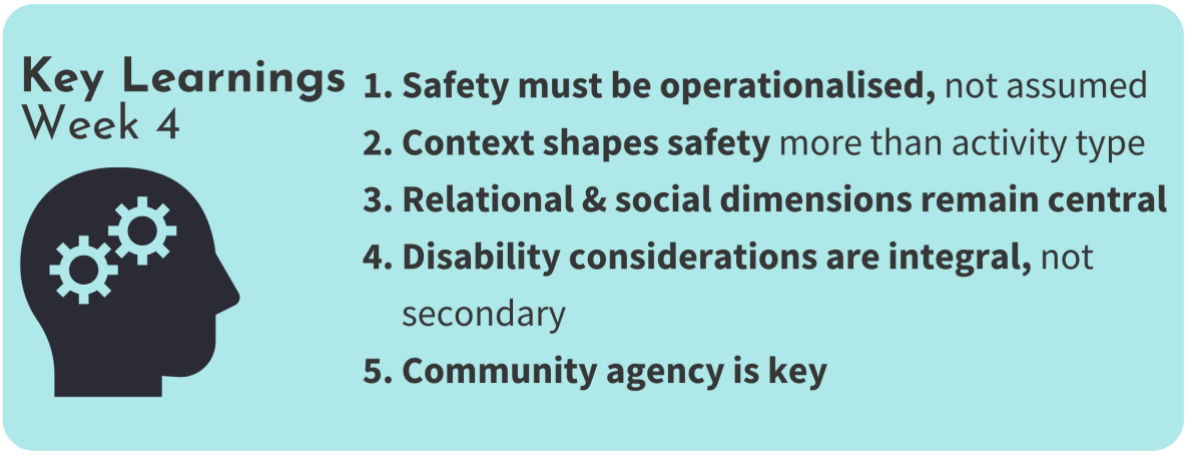

Figure 11. Key Learnings Week 4.

Summary

Week 4 moved the project from possibility to practicality. The group affirmed a shared safety definition, embedded disability considerations into planning, and identified five priority options for further exploration. The session demonstrated increasing confidence in co-design, critical reflection on existing systems, and a clear commitment to ensuring that any selected activity meets the community's own definition of safety, dignity, and belonging.

Insights from Meeting 5

Goal: To identify community connections that might facilitate the actualising of the chosen safe physical activities (e.g., around access to facilities, etc.) and to identify potential issues around cultural needs.

Week 5 marked a clear shift from planning and prioritisation to **practical implementation**. Building on the five shortlisted activities from Week 4, participants worked in small groups to

develop concrete plans for how each activity could be established, sustained, and delivered safely within the community.

The session focused on identifying:

- Requirements to get each activity "off the ground"
- Staffing, equipment, venue, and funding needs
- Promotion and recruitment approaches
- Safety and accessibility considerations in practice

These plans were intended to be sufficiently detailed to **hand over to a community organisation** (e.g., Pride Whanganui or Sport Whanganui) for delivery.

1. Reaffirming a Shared Definition of Safety

A key learning from Week 5 was that **feasibility depends not just on the activity itself, but on how it is introduced and integrated**.

For several activities (e.g., archery, waka ama), participants proposed a **staged approach**, beginning with introductory sessions before transitioning into existing community groups:

> "Maybe two intro sessions… and then… do people feel comfortable amalgamating into the club or would they prefer our own time?"

This reflects a growing understanding that **confidence and safety must be built gradually**, rather than expecting participants to immediately enter unfamiliar or potentially unsafe environments.

Participants also emphasised the importance of testing environments before committing:

> "It's also good to test whether the group… is a safe space to integrate into… If you get the bad vibes, then…"

This reinforces that safety is not assumed — it must be **experienced and validated**.

2. Sustainability and Reducing Reliance on Individuals

Across all activities, sustainability emerged as a central concern. Participants consistently sought models that would **minimise reliance on a single organiser** and instead integrate activities into existing systems or shared structures.

For example, integrating with established clubs was seen as beneficial because:

> "There's no reliance on one person to organise it every week… like it's set up."

Similarly, for yoga, a funded short-term block was proposed as a pathway to longer-term sustainability:

> "We could do a short burst… and then it is sustainable from there if people want to keep doing [it]."

This reflects a shift toward designing **self-sustaining pathways**, rather than one-off or facilitator-dependent initiatives.

3. Relational Safety As Central

Despite the increased focus on logistics, relational safety remained a dominant theme. Participants continued to emphasise the importance of **familiarity, gradual exposure, and social connection**.

The concept of introductory sessions again reflected this:

> "Just so you know what the space is and where things are… so you're not just walking into [it]."

This highlights that **first-contact experiences remain a key barrier**, and that reducing uncertainty is critical to participation.

In contrast, environments that required immediate immersion were described as challenging:

> "You go in, just hop on the boat… it's like, where am I? Who are these people?"

This reinforces earlier findings that **predictability and orientation are essential components of safety**.

4. Flexibility vs. Structure

Participants identified a tension between structured activities and more flexible, social models.

Some activities (e.g., waka ama, martial arts) were seen as **structured and skill-based**, while others (e.g., social activity groups) were intentionally flexible:

> "The point is to hang out with other trans and queer people and do something fun… whatever."

Flexible models were seen as:

- More adaptable to different energy levels
- Less intimidating
- More inclusive of varying abilities

However, they also carried risks of reduced engagement:

> "It could maybe lose steam… there's no goal, really."

This highlights a key learning: **activities require enough structure to sustain engagement, but enough flexibility to remain inclusive**.

5. Safety in Public vs. Private Spaces

Participants revisited the tension between **visibility and safety** when considering activity locations.

Private or closed spaces were perceived as safer:

> "If we rent out a space… who cares which bathroom we use."

Whereas public spaces introduced additional risks:

> "You've got people observing what we do, which bathroom we go into..."

At the same time, public spaces offered lower cost and accessibility. This reinforced the need to carefully balance:

- Cost and accessibility
- Visibility and safety
- Privacy and inclusiveness

6. Community-Led Models of Sharing and Collective Ownership

The gardening group highlighted a different model — one based on **distributed participation and shared resources** rather than a single fixed location.

Participants proposed:

> "Swapping seedlings, swapping tools… sharing knowledge… having a sense of belonging to a group."

This reflects a strong alignment with **collective, community-led approaches**, where value is generated through participation rather than formal structure.

At the same time, risks to sustainability were acknowledged:

> "You end up with just a couple of people running the thing… and other people turn up and want the rewards."

This reinforced the need for **light coordination and shared responsibility**.

7. Safety in Engagement and Outreach

When discussing the engagement of external organisations and potential partners, there was a strong emphasis that outreach must be **intentional and safe**, given that there is risk in visibility and participants must be kept safe for individual or group harm.

Figure 12. Key Learnings Week 5.

Summary

Week 5 represented a critical shift from **co-design to implementation planning**. Participants demonstrated increased confidence in translating ideas into practical models, while continuing to centre safety, accessibility, and community connection. The session reinforced that successful physical activity initiatives for transgender communities must be **intentionally designed, relationally grounded, and sustainably structured** — not simply offered.

Insights from Meeting 6

Goal: To determine safe and effective ways to advertise activities and establish pathways for access and coordination.

Week 6 marked the **final transition point from planning into real-world implementation**, with a specific focus on **how to safely connect people to activities** without compromising privacy, safety, or sustainability .

Rather than refining activities themselves, the group shifted attention to:

- Safe advertising strategies
- Managing access and information flow
- Supporting safe, self-directed engagement (e.g., minimising harassment and unwanted exposure)
- Clarifying roles in coordination and delivery

This session highlighted that **how activities are communicated is as critical as the activities themselves**.

1. Safety as the Central Driver of Design

A key finding was that **traditional advertising approaches were not considered safe** for this context. Participants explicitly identified risks associated with publicly advertising time, location, and target population:

> "What I'm envisaging… what we really don't want is to advertise something and then have a group of picketing people standing out in the front..."

This reflects a strong awareness that visibility can increase vulnerability, particularly for transgender communities.

As a result, the group consistently prioritised **controlled, layered access to information**, rather than open promotion.

2. Layered and Indirect Access Pathways

The group co-developed a **multi-step access model**, where information is gradually disclosed rather than immediately visible.

This included:

1. **Public-facing, non-specific promotion**
2. **Secondary step requiring contact (QR code, email, or Pride)**
3. **Targeted sharing of detailed information (time, location, facilitator)**

Participants described this as a way to filter engagement:

> "Instead of being like, 'come to this place at this time'… it's gonna be a bunch of gay people there… if it's like… 'go to this Facebook page or email…"

> "If they suck *[sic]*, they won't do it. And if they are cool, they'll do it."

This reflects a deliberate strategy of **self-selection**, where unsafe individuals are less likely to engage due to the additional steps required.

3. Balancing Visibility and Discretion

A central tension emerged between **being visible enough to reach the target community**, while not being so visible as to attract harm.

Participants proposed subtle signalling approaches:

> "Queer people know to look out for the hidden detail… a rainbow QR code would be like… 'let's find out'."

> "It's kind of like, if you know, you know."

This reflects a nuanced understanding of **coded visibility**, where:

- Signals are recognisable to the intended audience
- But not overtly obvious to others

This approach aligns with community-led strategies of **quiet signalling and selective visibility**.

4. Centralised Coordination as a Safety Mechanism

Another key learning was the need for a **central point of contact** to manage access and enable safe, supported engagement.

Rather than multiple facilitators being directly contacted:

> "We pretty much need a central person that… all this is getting directed to."

This role (likely Pride or a designated coordinator) would:

- Receive initial enquiries
- Provide appropriate information
- Connect participants with facilitators
- Maintain oversight of who is attending

Participants recognised that this adds workload but improves safety:

> "It's probably better that the middle person contacts you… rather than people just contacting… willy-nilly."

5. Protecting Activities from Liability & Risk

The group demonstrated a strong awareness of **legal and safety responsibilities**, particularly for activities like kayaking.

> "We have to be really careful about saying this is something we've set up… and then something [bad] happens… [and it turns to] who was in charge?"

This led to distinctions between:

- **Formally organised activities** (with oversight and responsibility)
- **Informal, peer-led connections** (e.g., 'come kayaking with me')

This reflects a growing understanding of **risk governance**, including:

- Liability
- Safety protocols
- Organisational responsibility

6. The Role of Trusted Gateways (Health & Community Services)

Participants reinforced the importance of **trusted intermediaries**, particularly within primary care.

Health Improvement Practitioners (HIPs) and Health Coaches (supported by the primary care service) were identified as key pathways:

> "[Primary care providers] are seeing people anyway… let's give them options [to suggest to their transgender patients]… currently they have none."

These roles enable:

- Targeted referrals
- Safe, one-to-one conversations
- Matching individuals to appropriate activities

This aligns strongly with the broader aim of **integrating pathways into existing systems**, rather than relying solely on public advertising.

7. Addressing First-Contact Barriers

Consistent with earlier weeks, **initial engagement remained a major barrier**.

Participants highlighted the importance of support for first attendance:

> "Just having someone that will go with you for the first couple of times… [Lack of support is a] huge barrier."

Solutions included:

- Peer "buddy" systems
- Health service support (e.g., youth services accompanying participants)
- Allowing participants to bring a trusted person initially

> "You could bring someone along for the first time… once the ice has broken..."

This reinforces that **access is not just about information — it is relational and supported**.

8. Managing Inclusion & Boundaries

A complex discussion emerged around **who activities are for**, and how to maintain safe spaces while being inclusive.

Participants expressed concern about activities becoming diluted if opened up to transgender allies as well as the transgender community:

> "It might just become like… a gay bar that's been taken over… and not there's not a gay bar anymore."

As a result, a staged approach was proposed:

- Initial focus on transgender individuals
- Limited inclusion of "plus ones" for support
- Potential expansion later if appropriate

> "It is open to other people, but it's not… if you're an ally, come along."

This reflects careful navigation of **inclusion vs protection of safe space**.

9. Practical Advertising Strategies

The group identified a range of **low-risk, community-based advertising approaches**, including:

- Posters with QR codes (without explicit details)
- Placement in trusted locations (e.g., medical centres, cafés, Pride)
- Use of social media and closed groups
- Word-of-mouth and peer networks

There was recognition that some of these methods might not reach the targeted audience, or, potentially, any audience at all:

> "Within a few hours… somebody came down and ripped them all [posters] down."

This reinforced the need for **multiple pathways** rather than reliance on a single method.

10. Use of "Taster Sessions" as Engagement Strategy

Participants proposed **taster sessions** as a way to:

- Build interest
- Assess demand
- Reduce commitment barriers

> "On these dates, there are these things… click the QR code if you would like to come along..."

These sessions also allow:

- Real-time co-design of ongoing schedules
- Testing of safety and accessibility
- Building early group cohesion

Figure 13. Key Learnings Week 6.

Summary

Week 6 consolidated the group's work by addressing one of the most critical and complex challenges: **how to safely connect transgender individuals to physical activity opportunities**. The session demonstrated a sophisticated understanding that **access is not just about availability, but about safety, trust, and controlled visibility**.

The resulting approach — **layered access, subtle signalling, central coordination, and relational entry points** — provides a practical and transferable model for safely implementing community-based initiatives in contexts where visibility carries risk.

Discussion

Safe, affirming environments are fundamental to enabling participation in physical activity among transgender people. Participation is shaped by multidimensional, conditional, relational, and negotiated factors that extend beyond the availability of opportunities. A safe activity is one where participants can access appropriate and gender-neutral facilities, wear clothing that supports comfort and expression, and engage without fear of judgement, exclusion, or violence. Safety is also shaped by supportive peers and allies, clear and accessible information, and opportunities for meaningful participation without being forced into gendered categories. Ultimately, being safe means feeling welcome, respected, and able to belong fully while engaging in physical activity.

Conceptual agreement on safety, however, is insufficient; logistics, facilities, timing, and equipment must align with this definition. Findings from both the Transgender Working Group and primary care providers demonstrate that safety must be **designed, enacted, and experienced**—not assumed.

Equity Framing: From Access to Conditions for Participation

An equity lens requires shifting from asking *"what is available?"* to *"who is able to participate, and under what conditions?"*. Across this study, it was evident that transgender people are not excluded from physical activity due to lack of interest, but because the **conditions required for safe participation are often absent**.

These conditions are shaped by:

- Structural factors (facilities, cost, service design)
- Social environments (acceptance, visibility, risk of harm)
- Identity-based experiences (affirmation, dysphoria, belonging)

A central finding of this project is that safety underpins participation in physical activity, rather than representing simply another barrier to overcome. Previous research has largely focused on obstacles such as discrimination, exclusion, concerns about changing facilities, and fear of harassment (K. E. McMenamin, 2024; Yee et al., 2025). The findings from this study suggest a broader perspective: before deciding whether to participate, transgender people evaluate whether an activity provides the conditions needed to feel safe, comfortable, and affirmed. Decisions about participation, therefore, were shaped less by willingness or motivation than by the interaction of physical, practical, personal, and relational factors that can be influenced through thoughtful programme and service design.

Importantly, inequities are compounded for those at the intersections of marginalisation, including disabled, neurodiverse, low-income, and rurally located transgender individuals. It was explicitly highlighted that accessibility cannot be treated as an add-on; rather, **equity**

requires designing from the margins inward, ensuring those with the greatest barriers are considered first.

Within a semi-rural/rural context, such as Whanganui, these inequities are further intensified by:

- Limited service-availability
- Reduced anonymity and increased visibility
- Greater reliance on informal networks

Taken together, this positions safe physical activity not as a "nice to have," but as a **necessary, equity-driven intervention** to support mental health, reduce isolation, and enable participation in everyday life.

Key Insights from the Transgender Working Group

The TWG provided critical, practice-oriented insights into what safety actually requires.

1. Safety is Multi-Dimensional and Foundational

Rather than being an inherent characteristic of physical activity environments, safety emerged as something negotiated through the interaction between individuals, social relationships, organisational practices, and the physical environment. This shifts the focus from asking whether an activity is available to whether it provides the conditions required for safe participation.

Safety was consistently understood as extending beyond physical protection to include social, emotional, and practical dimensions. It is shaped not only by the activity itself, but by the environment, the people present, and the broader context in which participation occurs.

Importantly, safety was not seen as an added benefit, but as a **precondition for participation**. Without it, engagement is unlikely. This reframes physical activity from something individuals choose to do, to something that must first be **made possible through safe conditions**.

2. Participation is Conditional, Not Universal

Participation was described as highly dependent on whether the right conditions are in place. Decisions not to engage were often grounded in careful consideration of safety, comfort, and previous experiences.

These findings challenge assumptions that participation is primarily influenced by motivation or interest. Instead, participants consistently described participation as contingent upon environmental conditions. Interventions that simply encourage exercise or increase programme availability are therefore unlikely to reduce inequities unless they also address predictability, identity affirmation, accessibility, and the broader conditions that enable people to feel safe engaging in physical activity.

3. Safety is Relational and Built Over Time

Safety was not described as something that can be established immediately, but rather as something that develops through **consistency, familiarity, and trust**.

Regular, predictable opportunities to engage were seen as essential, allowing people to build confidence gradually. In this context, relationships—both with facilitators and peers—play a central role in creating environments where people feel able to return and continue participating.

The findings suggest that relational safety may be as important as physical safety. Trust, familiarity, and affirmation developed progressively through repeated positive experiences, highlighting that physical activity environments can contribute to wellbeing through social connection as much as through movement itself.

4. Physical Activity as a Space for Connection and Affirmation

While the physical health benefits of activity were acknowledged, the group placed greater emphasis on its role in supporting **social connection, identity affirmation, and reconnection with the body**.

Participants described physical activity spaces as having the potential to evolve into relational hubs where people could build confidence, establish supportive relationships, and initiate activities independently. This suggests that the value of physical activity extends beyond physical health to include opportunities for connection, belonging, and community formation.

5. Entry into Spaces Matters

Initial engagement was identified as a critical point in shaping participation. The group highlighted the importance of supportive entry into new environments, noting that confidence can be impacted by uncertainty, including:

- Entering unfamiliar spaces
- Awareness of being observed or evaluated
- Limited clarity about what to expect

These insights reinforce that **how people enter a space is as important as the space itself**, and that thoughtful, supported entry can significantly influence whether participation occurs.

Supported entry, therefore, represents more than a practical introduction to an activity. It functions as a transitional stage between interest and sustained participation, enabling individuals to establish trust, assess whether an environment feels affirming, and develop confidence before participating independently.

6. Visibility is Both Necessary and Risky

There is an inherent tension around visibility. On one hand, there is a need for transgender people to know that safe, affirming opportunities exist. On the other, increased visibility can carry real risks, including unwanted attention, exposure, or harm.

Visibility, therefore, cannot be approached as an unqualified good. Instead, it requires **careful and intentional management**, with attention to how information is shared and accessed.

Visibility was not viewed as something to maximise or minimise, but as something to be carefully managed. Participants valued opportunities to control how and when they were visible, suggesting that layered approaches to communication—where general information is publicly available but more detailed information is shared through trusted contacts—may better balance awareness, privacy, and safety.

7. Sustainability Requires Shared Ownership and System Integration

Sustainability was a consistent theme, with recognition that safe physical activity options cannot rely on short-term effort or individual champions alone.

Discussion highlighted the importance of building approaches that are **shared, supported, and integrated into existing systems**, such as primary care or community organisations. This not only strengthens continuity, but also reduces reliance on any one individual.

There was also recognition that engagement may evolve over time. For some, beginning in smaller, safer environments is essential, while others may later choose to participate more broadly. Supporting this **gradual progression** was seen as an important part of creating sustainable and inclusive pathways.

Overall, this reflects a move away from one-off initiatives toward **ongoing, connected approaches** that can grow and adapt within the wider community.

8. Safety as a Precondition for Participation

Taken together, the findings suggest that participation should be understood as dependent on the conditions that enable people to feel safe, affirmed, and able to engage. Rather than reflecting individual choice alone, participation emerged from the interaction of physical, personal, practical, and relational conditions. This reframing moves the focus away from encouraging participation towards creating environments that make participation possible.

Key Insights from Health Improvement Practitioners and Health Coaches

The primary care provider findings reinforce and extend the insights generated through the Transgender Working Group, situating them within the realities of primary care practice.

Across interviews, HIPS and HCs described delivering **relational, holistic, and highly responsive care**, often acting as trusted entry points for transgender patients navigating

complex and intersecting challenges. In many ways, their accounts mirrored the TWG emphasis on safety as relational, conditional, and shaped by context.

1. Safety and Participation as Clinically Recognised Barriers

Consistent with TWG findings, care providers recognised that safety is not a peripheral issue, but a **central determinant of whether participation occurs at all**. Patients were understood to avoid physical activity environments not due to lack of motivation, but because of **real and anticipated risks**, including judgement, visibility, and exclusion.

HIPs and HCs also described mental health needs as deeply connected to these experiences, reinforcing the TWG framing that distress is often a **logical response to unsafe or unaffirming environments**, rather than something inherent to the individual.

2. Working Relationally to Enable Access

The importance of relational safety, strongly emphasised by the TWG, was also evident in care provider accounts. HIPs and HCs described their role not simply as providing advice, but as **creating safe, affirming spaces where individuals feel able to engage, disclose, and explore next steps**.

This relational approach was particularly important in supporting participation. Care providers noted that access is rarely achieved through information alone. Instead, engagement often depends on:

- Gradual, supported entry
- Shared problem-solving
- Ongoing encouragement and follow-up

These insights align closely with TWG findings around the importance of **first-contact experiences**, reinforcing that how someone enters a space is critical to whether they engage at all.

3. Adapting Within System Constraints

While HIPS and HCs demonstrated strong alignment with community-defined needs, they also highlighted the **limits of what can currently be achieved within existing systems**.

A consistent theme was the lack of **clear, trusted pathways** to safe and affirming physical activity options. They described uncertainty about:

- What options exist locally
- Which environments are safe
- Where it is appropriate to refer patients

As a result, care providers frequently adapted their approach, suggesting lower-risk or more controlled options such as walking or home-based activity. However, these adaptations were described as **pragmatic workarounds**, rather than solutions that fully meet patient needs.

This reflects a key tension: while primary care providers understand what is required for safe participation, they are often **unable to operationalise this within current service structures**.

4. Primary Care as a Bridge Between Insight and Implementation

Taken together, these findings position primary care teams as a critical bridge between **community-defined needs and system-level implementation**.

Where the TWG provides detailed insight into what safety requires in practice, care providers highlight:

- The absence of pathways to deliver this
- The need for structured, visible, and trusted options
- The importance of embedding these options within existing care relationships

This reinforces that primary care is not only a point of identification, but a **key mechanism for enabling access**, particularly when supported by appropriate community-based options.

Alignment and Divergence

There is strong alignment between community and primary care provider perspectives in recognising that safety is foundational, participation is conditional, and current systems are insufficient to support engagement.

Importantly, which TWG members primarily described participation through lived experience and HIPs/HCs discussed it through clinical practice, both groups converged on the same central finding: physical activity recommendations alone are insufficient. Participation depends on creating conditions that enable people to engage safely, highlighting the importance of collaboration between healthcare, community organisations, and activity providers.

The key difference lies in perspective. The TWG articulates **what is needed for safety and participation**, providing detailed, lived experience insight into the conditions required. Care providers, in contrast, highlight **what is currently missing**, identifying gaps in pathways, resources, and system support.

Importantly, these perspectives are complementary rather than contradictory. The TWG offers specificity and depth that cannot be accessed through clinical perspectives alone, while primary care providers identify the **practical and structural levers required to translate these insights into action**.

Together, they provide a comprehensive foundation for designing safe, accessible, and sustainable physical activity options.

Summary of Key Findings

This study highlights that improving access to physical activity for transgender communities is not simply a matter of increasing availability, but of ensuring the **conditions required for safe participation are in place**.

Across both the Working Group and clinician findings, safety emerged as **multi-dimensional, relational, and foundational**. Participation was shown to be highly conditional, shaped by the interaction of environmental, social, and personal factors, rather than individual motivation alone.

Physical activity was also reframed beyond its physical health benefits, with important roles identified in:

- Supporting **social connection**
- Enabling **identity affirmation**
- Facilitating **reconnection with the body**

At the same time, significant system-level gaps were identified. Primary care providers described limited pathways, uncertainty around safe referral options, and reliance on informal knowledge, while the TWG provided detailed insight into what safe, accessible environments actually require in practice.

Together, these findings demonstrate that **safe participation must be intentionally designed**, and that primary care has a critical role in enabling access through trusted, relational pathways.

Strengths of the Project

This project has several key strengths. First, it draws on **co-designed, community-led insight**, ensuring that findings are grounded in lived experience rather than assumptions about need. The TWG provided detailed, practical, and context-specific knowledge that is rarely captured through traditional research approaches.

Second, the integration of **clinical perspectives alongside community insights** strengthens the relevance of the findings. This dual perspective allows for both:

- A clear articulation of what is needed (TWG)
- An understanding of what is currently possible within systems (primary care providers)

Third, the project is strongly **practice-oriented**, moving beyond description to provide actionable insights. The development of a structured, stepped approach offers a clear pathway for services seeking to respond to identified needs.

Finally, the **rural/semi-rural context** is an important strength. Much of the existing literature is urban-focused; this project highlights the unique challenges and opportunities within

smaller communities, where visibility, access, and service availability are experienced differently.

Limitations of the Project

There are also important limitations to consider. The study is based within a **single regional context**, and while many findings are likely transferable, local dynamics (e.g., service availability, community networks) will influence how they apply elsewhere.

The TWG, while rich in insight, represents a **small and engaged group**, and may not capture the full diversity of transgender experiences, particularly those who are more isolated or not connected to community networks.

Similarly, clinician perspectives were drawn from a limited number of practices, and may not reflect variability across different service models or regions.

As a co-design and exploratory project, the findings are **practice-informed rather than outcome-evaluated**. While the proposed approaches are grounded in strong qualitative evidence, further work is required to assess their impact on participation, mental health, and wellbeing over time.

Implications for Practice: A Stepped Approach to Safe Physical Activity

Drawing together insights from both the Transgender Working Group and primary care providers, a clear, layered approach emerges for designing safe physical activity opportunities for transgender communities. Importantly, this *Transgender-Safe Physical Activity Framework* reflects not only what safe participation requires, but also what is needed to **enable access within real-world systems**.

1. Establish Safety as the Foundation
Safety must be defined broadly, including physical, social, and practical dimensions. Without this, participation is unlikely to occur. This also requires **confidence from referring primary care providers** that environments are genuinely safe and affirming, not assumed to be so.

2. Design for Those with the Highest Barriers
Equity requires designing from the margins inward. This includes considering neurodiversity, disability, financial barriers, and rural context from the outset. Clinician insights further highlight that without this level of intentional design, options are unlikely to be **clinically appropriate or referable**.

3. Build Relationally Safe Environments
Small, consistent, and predictable group settings support trust and belonging. Relationships are central to sustained engagement. This aligns with primary care approaches, where primary care providers can act as **trusted connectors**, linking patients into environments that feel safe and familiar.

4. Support Entry into Participation
Initial engagement should be actively supported through clear information, reduced uncertainty, and, where possible, facilitated introductions. Clinician findings reinforce that **access is a supported process**, often requiring active facilitation, shared problem-solving, and encouragement, rather than passive referral.

5. Reframe Physical Activity
Activities should prioritise connection, flexibility, and enjoyment over performance, allowing for varied levels of participation. This increases relevance for individuals presenting in primary care, where needs are often complex, evolving, and not centred on fitness goals.

6. Create Clear and Trusted Pathways
Safe physical activity options must be visible and structured in ways that primary care providers can confidently refer into. This includes:

- Clear information about safety and inclusivity
- Defined referral processes (e.g., through primary care)
- Trusted intermediaries or points of contact

Without this, primary care providers are left relying on informal knowledge, limiting access despite recognised need.

7. Manage Visibility Carefully
Communication and access should balance reach with safety, allowing individuals to engage without unnecessary exposure. This includes layered or indirect communication, as well as pathways that allow individuals to engage through **trusted services rather than public-facing entry points**.

8. Integrate for Sustainability
Initiatives should be integrated into existing systems, such as primary care and community organisations, to ensure continuity and reduce reliance on individuals. Integrating these options into referral pathways strengthens both **uptake and long-term viability**, while supporting gradual transitions into broader participation where appropriate.

Conclusion

Safe, affirming environments are fundamental to enabling participation in physical activity among transgender people. Participation is shaped by multidimensional, conditional, relational, and negotiated factors that extend beyond the availability of opportunities. Transgender communities require a shift from **availability to accessibility and from intention to implementation**. Safety must be actively designed, participation must be supported, and approaches must be grounded in both lived experience and system realities.

By bringing together community insight and clinical perspective, this work provides a clear, practical framework for moving forward. In doing so, it positions safe physical activity not only

as a health intervention, but as a **critical pathway for connection, affirmation, and wellbeing**, particularly within rural and resource-constrained settings.

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Appendix 1: Semi-Structured Interview Schedule for HIPS/HCs

1) Can you share some of the ways you currently work with transgender and gender diverse clients around their mental health and wellbeing?
   [Prompt: What approaches or tools have you found work well with transgender clients?]

2) Have you had opportunities to talk with transgender clients about physical activity as part of your mahi (work)?
   [Prompt: What kinds of activities do you usually suggest, and how are they received?]

3) From your experience, what seems to help transgender clients feel safe or motivated to engage in physical activity?
   [Prompt: Are there any local options you've seen work particularly well, or any gaps you've noticed?]

4) What are some of the barriers you face when trying to support transgender clients to be physically active—whether those are system-related, confidence, or resource-based?
   [Prompt: What makes this work easier, and what makes it harder?]

5) If there was one thing that could be put in place to support you in promoting safe, affirming physical activity options for transgender clients, what would it be?
   [Prompt: Training, referral tools, networks, inclusive spaces, etc.]

Appendix 2: Working Group Expectations Agreement

WORKING GROUP EXPECTATIONS AGREEMENT

Working Group on Safe Physical Activity Options for Transgender and Gender Diverse People
Thank you for volunteering to be part our working group. This form helps us ensure that everyone understands what's involved and agrees to shared group values.

What You're Being Asked to Do:

You're being invited to take part in 6–10 meetings with a small group of people to help co-design safer and more inclusive physical activity options for transgender and gender diverse people.

What You Can Expect:

Your participation is voluntary, and you can stop at any time.
You'll be treated with respect, and your identity will be protected.
You don't have to share anything personal unless you want to.
You'll help shape ideas, give feedback, and contribute to something that could make a real difference.

Group Agreements:

I will respect other people's privacy and keep what is shared in the group confidential.
I will use the names and pronouns people ask me to use.
I will speak kindly and listen with care.
If I don't feel safe or want to raise a concern, I know who I can talk to.

Please Tick:

☐ I understand what this group is about.
☐ I agree to take part voluntarily.
☐ I agree to keep other people's stories private.
☐ I know I can stop participating at any time.

Your Name (print): _____
Signature: _____
Date: _____

Appendix 3: Looking After Your Wellbeing in the Group

Looking After Your Wellbeing in the Group

We want this working group to be a safe and respectful space for everyone. Sometimes, talking about experiences can bring up strong feelings. Here's what will happen if you feel overwhelmed, upset, or triggered during a session:

You can take a break at any time — no need to explain.

You don't have to share anything personal unless you want to.

A support person will be available during and after each session if you'd like someone to talk to.

You can use a discreet signal (e.g., raising your hand or note card) if you'd like a pause or to step out.

If you become distressed, the facilitator may gently check in to see what support you'd like — but there's no pressure to talk.

What happens in the room stays in the room. Confidentiality and kindness are key.

We're here to support you. Let us know what you need to feel safe and heard.

Support contact:

Dr Katie McMenamin – Project Lead
Email: katie.mcmenamin@harc.org.nz
Phone: xxxxxxxxxx

Appendix 4: Support Services in Whanganui and New Zealand

Support Services in Whanganui and New Zealand

These topics can sometimes be difficult to think about. You can skip questions, take a break, or stop answering at any time. If you would like to talk to someone about your feelings, the following resources may be helpful:

Intersex Youth Aotearoa (IYA)
Intersex Youth Aotearoa is a place for all people with intersex variations, and their whānau and friends to share information, find support and network with each other.

InsideOUT
InsideOUT works with youth, whānau, schools, community groups, youth services, government agencies and other relevant organisations to provide safer schools and communities for young people of minority sexualities, sexes and genders. Phone 027 331 4507.

Gender Minorities Aotearoa
Gender Minorities Aotearoa is a cross-cultural, transgender-led organisation that operates on a kaupapa Māori public health framework. Its activities include research, providing information and resources, advocacy, education and training, operating services for gender minorities and providing support for takataapui, transgender and intersex people, and referrals to other services.

Transgender and Intersex NZ
The Facebook group is the largest online transgender community support group with a New Zealand-based membership. This group is primarily for sharing information between people of diverse genders and sex characteristics, and has a secondary focus on supporting parents and whānau as well as those who work with trans people and supportive others.

NZ Trans Guys
A group for people born or living in Aotearoa/New Zealand, assigned female or intersex at birth, but who identify outside of that, including but not limited to transgender, transsexual, ftm, f2m, tangatairatane, mtm, male, taane; genderqueer, trannyboy, transman, 3rd gender, bi-gendered. Contact NZTG at nztg@gmail.com

Portal support for NZ parents of transgender and gender diverse children
A Facebook group offering support for parents with children who are gender questioning or gender diverse. Email contact at nzparentsoftransgenderchildren@gmail.com.

Rainbow Path NZ
Rainbow Path is a refugee-led advocacy and peer support group for the rights of refugees and asylum seekers living in Aotearoa New Zealand who are lesbian, gay, bisexual, trans or gender diverse, intersex, queer, questioning or asexual (LGBTIQA+). Email contact at rainbowpath@protonmail.com.

OutLine Aotearoa

Phone 0800 688 5463. An all-ages rainbow mental health organisation providing support to the rainbow community, their friends, whānau, and those questioning. We provide a nationwide, free and confidential 0800 support line for people who want to speak to a trained volunteer from the rainbow community.

PFLAG Palmerston North

A support group for lesbian, gay, bisexual, transgender, takaatapui, fa'afafine and intersex people, and their families and friends, in the lower North Island. Keep you updated with news and events coming up in the lower North Island with our group and other queer groups. Look up Parents and Friends of Lesbians and Gays Palmerston North on Facebook.

Pride Whanganui

A registered charity that is striving to create an inclusive Whanganui for the LGBTTQIA+ community that live in and visit Whanganui. Aim to establish more resources, create better healthcare processes, encourage regular events, project a sense of understanding and an eradication of ignorance. Located at 64 St Hill Street (back right of the carpark next to The Brickhouse Restaurant). Open Tuesdays, Wednesdays & Thursdays from 10am till 4pm. Outside of these hours, you can message via Facebook, Instagram or Email: info@pridewhanganui.co.nz.

Whatever! Whanganui

A free Health care centre for 10-24yrs. Whatever! have a general practitioner (by appointment only) & nurses (appointments recommended), as well as counsellors, a psychologist who specialises in transgender-related care, and a social worker available. Whatever! also works with other service providers in the region to offer youth-specific support groups and workshops.
Contact at 06-348 9935 or https://www.whatever.org.nz/get-in-touch.

1737

Free call or free text 1737 any time, 24 hours a day. You'll get to talk to (or text with) a trained counsellor or talk to a peer support worker. The service is completely free. Offer brief 1:1 counselling support, focusing on one or two key things you need support for. Find out more about the service 1737 provides. Recruit a culturally diverse team. Mainly provide support in English but there may be cases where they can connect you with someone from your language of origin.

Appendix 5: Safety Evaluation Framework for Transgender & Gender Diverse Physical Activity

1. Facilities & Environment

- **Changing rooms / Bathrooms**:
  - Need gender-neutral or private options (not forced to choose a binary space).
  - Safe, accessible, and close to activity areas.
- **Visibility & Observation**:
  - Safety from being stared at, photographed, or outed.
  - Ability to participate without spotlight or unwanted attention.
- **Physical Environment**:
  - Familiar, consistent, and predictable spaces reduce stress.
  - Safe walking/cycling paths to and from the activity.
  - Parking availability and proximity.

2. Clothing, Equipment & Gender Expression

- **Freedom of Clothing Choice**:
  - Ability to adapt uniforms (e.g., looser options, non-gendered outfits).
  - Non-revealing, comfortable clothing options.
- **Gender-Affirming Gear Considerations**:
  - Risks and discomfort with binders, tucking, packing, or prosthetics during exercise.
  - Activities that allow participation without compromising safety (e.g., swimming gear alternatives, loose sportswear).
- **Equipment Accessibility**:
  - Adaptive gear available (wheelchair sports, modified bikes, etc.).
  - Costs for special equipment should be minimised or subsidised.

3. Community & Social Safety

- **Inclusive Culture**:
  - Mixed or gender-neutral teams where possible.
  - Peer and coach acceptance; no tolerance for transphobia.
- **Queer/Trans-Centred Spaces**:
  - Activities run by or in partnership with queer-friendly organisations.
- **Support Networks**:
  - Being able to bring a friend, whānau, or support person.
  - Building community bonds and peer encouragement.

4. Psychological & Emotional Safety

- **Sense of Belonging**:
  - Feeling valued as part of the group regardless of skill level.
  - Opinions and feelings respected and acknowledged.
- **Affirmation & Validation**:
  - Correct pronouns consistently used.
  - Gender identity not treated as an inconvenience.
- **Low Pressure**:
  - Non-competitive, relaxed, and fun environments.
  - Avoid activities where skill gaps or rigid gender roles exclude newcomers.

5. Practical Barriers

- **Affordability**:
  - High cost (e.g., memberships, equipment, transport) is a major barrier.
  - One-off subsidies or community grants can make participation possible.
- **Scheduling & Timing**:
  - Daylight options for safety when travelling to/from activities.
  - Regular and predictable schedules help with routine and wellbeing.
- **Transport Access**:
  - Local facilities more inclusive than activities requiring travel (skiing, equestrian, etc.).

6. Health, Safety & Body Comfort

- **Physical Risks**:
  - High-contact or high-injury sports (rugby, combat sports, skateboarding) carry added risk when distraction from dysphoria or gear issues is present.
- **Body Connection & Confidence**:
  - Activities that help people feel proud of, and in control of, their bodies (e.g., yoga, swimming, dancing).
- **Entry-Level Accessibility**:
  - Low-skill entry points (e.g., walking, gardening, social dance) are more inclusive than advanced/elite sports.

How to Use this Framework

Rate each potential activity across the six domains using the scales below. Reverse the Practical Barriers score (0=5, 1=4, 2=3, 3=2, 4=1, 5=0), then sum the six domain scores to calculate the Safety Alignment Score. Higher scores indicate greater overall alignment with the conditions identified by the Working Group as supporting safe.

1. Facilities & Environment	0 = Completely Unsafe 5 = Completely Safe
2. Clothing/Equipment & Gender Expression	0 = Completely Unsafe 5 = Completely Safe
3. Community & Social Safety	0 = Completely Unsafe 5 = Completely Safe
4. Psychological & Emotional Safety	0 = Completely Unsafe 5 = Completely Safe
5. Practical Barriers	0 = No Barriers 5 = Excessive Barriers
6. Health, Safety & Body Comfort	0 = Completely Unsafe 5 = Completely Safe

Safety Evaluation Framework
(Example)

Activity	Facilities/ Environment	Clothing/ Equipment/ Gender Expression	Community & Social Safety	Psychological & Emotional Safety	Practical Barriers	Health Safety & Body Comfort	SAFETY ALIGNMENT SCORE
Archery	3	4	3	3	3 **(2)**	4	**19**
Boating	3	3	2	2	4 **(1)**	3	**14**
Martial Arts	2	1	1	2	3 **(2)**	1	**9**
Swimming	1	1	1	2	5 **(0)**	1	**6**
Walking/Running	5	4	3	4	1 **(4)**	4	**24**
Yoga	4	4	4	4	2 **(3)**	3	**22**