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Bachelor's project HGP:

A post-structural qualitative analysis of queer desired health and its effect on queer migration

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Abstract

This paper conducts a literature review of the theoretical intersections of research in migration, health, and queer geographies and identifies a lack of academic understanding in the intersection of all three bodies of research. In order to find a non-cisheteronormative post-structural agency-driven rationale that could explain the effect of queer identity on desired health, desired health's effect on queer migration, and the capability of queer migrants of attaining said health through healthcare, a set of semi-structured in-depth interviews with queer migrants was conducted. This paper makes use of a desire-production mechanism allowing participants to define their own conceptualization of health, within queer identity that constitutes agency in a structure-agency dialectic. Using Grounded theory inductive methodology, guided by the participant's voiced desire, various concepts of health, as well as desired healthcare and capabilities emerged from the data. Participants identified that queer identity has a determining role in their desired health, which includes mental and social health, as well as physical health including gender affirmation. Wanting to attain this desired health through healthcare, it either motivated their decision to migrate or played a role in destination choice. Finally, participants identified detriments to capability of achieving their desired health related to queer and migrant identities.

Introduction

The principal motivation behind this research is the desire to understand migration and health through a queer perspective. Even though feminist geographies and queer geographies are steadily becoming robust fields of study, more and more capable of reimagining and critically analyzing well-established theory through new perspectives built on egalitarianism, many salient concepts, theories, and entire areas of study within geography remain under-researched with regards to their intersection and reconcilability with feminist or queer values. Both migration and health are such areas of study, the mainstream of which has come under heavy criticism by feminist and queer scholars on account of the disregard for intersectional analysis, assumptions of heteronormativity, binary gender, binary sex, conflation of gender and sex, antiquated methods, etc. (Manalansan, 2018).

However, by studying migration and health within queer identity, new theories can emerge, which can help explain phenomena outside of heteronormativity and the aforementioned oft-fallacious assumptions. This manifestly carries significant societal relevance as well – understanding queer phenomena is paramount to creation of a society that is appealing, safe, and healthy for queer people. In addition to that, understanding the influence that queer identity may have on migration and health, amongst countless other societal phenomena, may help build a more all-round inclusive society as we step away from normativity and normalcy, and into diversity and communicative rationality.

Migration studies have for long been guided by implicit (cis)heteronormative assumptions, thus whenever sexuality is even remotely connected to the subject matter at hand (viz. family, marriage/partnership, reproduction, etc. as determinants of migration), the theory that attempts to explain human migration and mobility suffers from guiding its conclusions into reinforcement of these same assumptions. The same can be said about the study of health, albeit to a different extent and manifested in different ways. For decades, mainstream scientific literature about health has explicitly aligned itself with biodeterministic and cis-heteronormative assumptions (binary sex, binary gender, etc.). It should then come as no surprise that in an academic setting like this, the knowledge gained falls short of explaining the phenomena of the population that indeed does not adhere to these norms, and in a clinical setting, the care that they should receive (so as to achieve health 'equal' to the norm) either does not exist, because it has not been substantiated by sufficient research, or exists, but is difficult to access due to a multitude of barriers (Clark et al., 2018; Kumar et al., 2022; Puckett et al., 2017).

In order to a) 'bridge the gap' between mainstream research in migration and health and a queer perspective on sexuality rid of heteronormativity, and b) examine the accessibility of healthcare desired by queer people and their actual capability of accessing it, the following main research question (MRQ) is proposed, along with specific sub-questions (SQ1, SQ2):

MRQ: *How does the desired health of queer migrants determine their mobility, and to what extent are queer migrants capable of achieving their desired health as a result of their mobility?*

SQ1: *How does queer identity shape desired health in the first place?*

SQ2: *How does queer and migrant identity impact capability (with respect to health)?*

Next, a theoretical framework that underpins and guides this research will be outlined, including a conceptual model, followed by a methodological chapter on the methods used during this research, results of analysis of the gathered data, a discussion of results, and finally a conclusion including recommendations for further research as well as application of the knowledge gained.

Theoretical framework

Sexuality & Identity

In the work of Manalansan (2018), sexuality is rethought as a synthesis of individuals' agencies – negotiated and developed in situ, dynamic, mediated by culture and mobility. Varelas et al. (2015) posit that analysis of a structure-agency dialectic such as this one has great potential for addressing matters of equity and social justice. In order to operationalize sexuality for the purposes of this research, it will be regarded and treated as agency in a structure-agency dialectic in analysis, but participants will have the exclusive capacity to determine and characterize their own sexuality, whether it be through the usage of common labels of sexuality, or a vaguer, more or less nuanced characterization.

As far as the concept of identity is concerned, this research will take an intersectional approach to its analysis (Runyan, 2018), again allowing participants to determine what factors of (dis)advantage apply to them and how do they perceive them with regards to the oppression or empowerment. In addition, this intersectional identity will be placed in spatial structure, in line with 'politics of location' (Rich, 1994; Madhok, 2020), to facilitate spatial analysis.

As such, this research does not impose a central definition of sexuality, identity, and queerness, but rather lets participants conceptualize and characterize their own queerness.

Health

Since 'health' is a very broad concept that can be interpreted in many different subjective ways, it will be conceptualized in this research as an actual material manifestation of the desire of queer people (participants) for health; in other words, the material health external to one's desiring machine is here the product of the machine's desire-production to be attained through behavioral means (migration/mobility), thenceforth it is the subjectivity itself materialized. This conceptualization of health, desire, desiring machines and their desire-production is informed primarily by Deleuze & Guattari (1983), and the usage of such a post-structural interpretation of desire applied to health is precisely the author's intent of placing emphasis on (partial) decoupling of a) the participants' knowledge of health from their respective structures and b) the academic community's knowledge of health from their respective structures, seeing as it is, in both cases, desire itself that produces knowledge, although bi-conditionally interrelated with social machines, yet still subject to bias and misinterpretation that are in themselves inherent to knowledge that is not absolute, that is subjective. This departure from structurally defined health is then just as well an attempt to produce knowledge about health that is based on participants' agency – queerness/sexuality – in the structure-agency dialectic.

Migration & Mobility

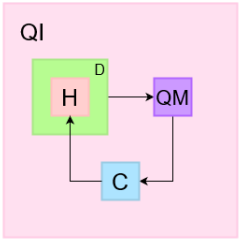
Research overlapping queer geographies and migration studies has been undertaken before: Gorman-Murray (2009) explains that queer migration can be motivated by affects of emotion, namely comfort and love, and especially in the case of paired movements. Queer migration in general can also be driven by the act or process of coming out (Gorman-Murray, 2007), which suggests that a life-course differentiation is also present within queer migration, albeit with different life-course events than that of cis-hetero migrants. Similarly, in this research, mobility will be analyzed through the perspective of queerness, so that these structural differences can stand out during analysis. Due to characteristics of the sample of participants and of the data, analysis will be applied to international migration specifically.

Capability

In order to understand the barriers in place that impede queer migrants' access to their desired health through healthcare, this research will make use of a health capability framework conceptualized by Prah Ruger (2010) and operationalized by Chiaperro-Martinetti et al. (2014). This framework will allow for an evaluation of structural imbalances in healthcare access, where an individual's agency to pursue health, which is here the fundamental unit of analysis, is facilitated or encumbered by factors internal or external to them. Since this research deals with intersectional identity and politics of location, it is expected that these will constitute the queer migrants' internal and external factors, respectively. In line with the efforts of escaping the structure and analyzing agency, just as with desired health, participants in this research will be able to present their own explanations on their capability, according to their lived experience of identity; nonetheless, these may be comparable to already existing definitions of determinants of capability, such as those outlined in Nussbaum (2011).

In order to investigate possible causality between desired health and queer migration, and subsequently evaluate the capability of queer migrants to achieve said health, all within queer identity, the following conceptual model (Figure 1) is proposed:

Figure 1 – Conceptual model



QI	queer identity
H	health
D	desired health
QM	queer migration
C	capability

Source: created by author

The model proposes that the desired health of migrants will influence queer migration, as per the research question, and upon moving the queer migrants will be able to access health, the symmetry of which with their desired health is to be subject to their capability as a queer person, as a migrant, and as a queer migrant, etc. The entirety of the conceptual model is framed within queer identity, so that the inner concepts are specific to queerness and thus detached from structure of normative theory.

Methodology

Drawing on the existing research of

a) the relationship between migration and health,

b) queer migration, and

c) the relationship between queer geographies and health,

carrying out a literature review, this research synthesizes theory subject to critical analysis into an intersection of these disciplines, and subsequently tests the provisional results by collecting qualitative data on queer migrants' health, mobility, capability, identity, and their interrelations.

Data collection

In order to answer the research questions, an in-depth semi-structured interview was used as a data collection method. This method is considered most suitable in this context, because it allows for the collection of rich and nuanced relevant qualitative data that is open-ended and thus allows for application of inductive reasoning in subsequent analysis, that leads to the emergence of a theory examining the causal relationships investigated by the MRQ and the SQs. The interviews are structured according to a pre-written interview guide (Appendix A), but eventually follow the pace and direction of the participant, in order to gain as

much understanding of their experiences as possible, and to inhibit their expression of them as little as possible. In the same vein, in order to escape the structure and center the data on participants' personal experiences and agency, they were asked questions that pertain to their selves specifically, rather than to external definitions of concepts used.

Participants were gathered through instant messaging channels and word of mouth, and this constitutes convenience sampling. All of the selected queer migrants were university students, which will reflect in the data with respect to life-course impact on mobility. All of the participants were interviewed in person, except for one, who was interviewed through videocall.

Analysis

After gathering data from participants in the form of audio recordings of interviews, the speech was transcribed into text and the documents produced analyzed systematically using grounded theory methodology - available data will be assigned codes, and synthesized into concepts, categories, hypotheses and finally a theory that will be the answer to the research question. It is important to note that since prior research has already been done in the form of a literature review on the topic of queer migration and health, a certain degree of path dependence will be evident in the analysis, but since the research focuses on examining these particular causal relationships, that will in fact become one of its acceptable limitations.

Positionality

The research may be influenced subject to my own positionality, as the author: I am myself a queer non-binary trans migrant, and have (had) experience with queer health and healthcare, which might introduce a certain degree of determinism into my analysis of this topic. My relationship with the participants may also play a role – as most of them were acquainted with me before the start of this research, and some of them my close personal friends, they may or may not espouse the same notions as me about the subject matter. Nonetheless, they have been given free rein to express their own opinions and experiences, without any direct interference by me.

Ethics

Before the start of participation, the participants were informed about the topic and purpose of this research, their rights with regards to participation, how their data will be processed, stored, analyzed, etc. by an information sheet (Appendix B). Subsequently, they were asked to sign an informed consent form, stating that they willingly participate in this research (Appendix C). All of the data gathered from the participants has been stored safely and anonymized. The audio recordings have been deleted to protect participants' identities.

Results

As expected according to the theoretical framework of this research, certain concepts and patterns of concepts emerged from the qualitative data, that have the potential to answer the RQs.

Identity

The overarching context of the participants' desires, mobility, and capability are their respective identities. In order to investigate the nature of these identities, participants were asked to express what queerness and/or sexuality mean to them. One participant considered ***sexuality*** an important part of their identity, because, just as conceptualized in the theoretical framework of this research, it is

embodied by the individual's ***agency*** in interpersonal contexts:

"Surely, sexuality, I would say is part of my identity. It's an important part of your life. Your sexuality is related to life - relationships, sex… are important elements." (I1)

Multiple participants outright reject the gender binary, and identify as non-binary:

"I identify myself as a non-binary person, I'd say, because I don't really care if I'm a woman or a man." (I2)

"I use she/her and they/them pronouns, I would see myself as transgender, sitting somewhere on the non-binary spectrum on the gender spectrum leaning more towards feminine. I am pansexual and have had relationships in the past with many different genders." (I3)

One participant rejected gender altogether

"I identify as pansexual. And with gender, I don't know, I don't really agree with societal gender norms, but I am femme presenting. I guess that's like, I don't mind being called the girl. I don't really care. But yeah, I don't really believe in gender that much." (I4)

All participants, however, identified as queer, that is, non-cishetero. In addition to that, all participants were migrants – from China, Russia, England, and Romania. Other intersectional factors of (dis)advantage were not directly identified by participants.

Health

From the very beginning of data collection and simultaneous analysis, it was apparent that complex subjective definitions of health emerge. The use of a desire-production mechanism successfully enabled participants to center material expectations of health on self, thereby - with guidance from the structure of the interview – on identity, in particular queer identity. This is why the results of participants' conceptualization of health should be regarded as post-structural, defined by their agency, as per the theory discussed above. Nonetheless, they relate to structure, as such: the first notion of health that participants espoused is what would best be described by the umbrella term 'environmental health' (not to be confused with ecosystem or ecological health). Multiple participants stress the importance of ***safety***, often in relation to ***personal authenticity***, and ***queer acceptance*** in their environment:

"*Sometimes if you're too sensitive, you can overstate it and you just feel like there's always a trust issue between you and the majority. Yeah, but it also tells that many people actually don't feel safe sharing [queer identity]."* (I1)

On one occasion, a participant recalls an emotionally charged news story about a hate crime victim – a person being assaulted in public space because of their 'effeminate' looks – and relates this to her own experiences of ***misogyny***, ***queerphobia***, and ***normalcy***:

"And they just, without his consent, touch his fucking hair and shave it and... just the poor guy. Nobody says anything, because other people agree and are also threatened by this type of behavior. It's very, very aggressive. For example, when you walk on the street, even like in a skirt, if you decide to express yourself, you can be catcalled, you can also be harassed. That happened to me before, not even once. And it's such a bad thing, not comfortable, I need to pretend to be someone else, or I can't express myself, I can't color my hair, I can't wear the things I want to, I need to be somebody else, I need to always pretend to be somebody to be accepted by the community I would live in. So not to get hurt… you need to always suppress yourself." (I2)

Participants often mention that such environmental effects are closely related to politics and the political environment in their countries of origin and abroad. Those from highly authoritarian countries are cognizant of this, they speak of experiences with ***censorship***, and what one participant termed '***political violence***':

"In China they have this cultural restriction, for example, if you have gay films, you are not allowed to show them in cinemas, and you basically couldn't organize things like pride month, or pride parades..." (I1)

"It's still forbidden to be gay in Russia." (I2)

The participants explicitly relate this to their health outcomes, primarily in terms of mental health effects. Symptoms such as ***depressed mood*** and ***overt worrying*** have been noted by multiple participants as a result of their misfit with their respective environments. On the other hand, spatial environments that are characterized by higher perceived queer acceptance and ipso facto safety, have been observed to have a comparatively positive effect on the mental health of participants. The importance of ***community*** in this matter also cannot be understated. Oftentimes, this very difference has been cited as either a motivation to migrate or a determinant of destination decision:

"[I moved here] because of my studies, and I've also been here already twice. And since I've been here, for the first time in my life, I compared this with the world that I was living in, and I decided that I have never seen a more supportive and beautiful place… here, I can speak, so I feel much more comfortable and open, and I don't need to pretend to be somebody else." (I2)

Apart from queer acceptance, ***queer liberation*** has also been cited as a determinant of health outcomes, especially in relation to ***activism*** and ***homonormativity***:

"I got the sense that in the Netherlands, the queer community has been neutered in terms of activism. I think activism as a trans person is inescapably important. Because particularly when you are in an environment where transgender identities are politicized, and you are visibly transgender, your existence is a form of activism. I definitely felt that in Britain. And I was almost inspired by that because I had other friends who were doing the same. But in the Netherlands, sometimes I feel a little bit like activists or people who are seen as 'rocking the boat' a little bit... It's frowned upon, even within queer communities. If you go on and on about queer liberation and the necessity to like, push for better, right? People get annoyed at you." (I3)

The participant explained that she feels that the queer community has become complacent with issues concerning specifically trans activism. While participants who did not explicitly identify as transgender during the course of data collection rarely include ***physical health*** as a main focus in their conceptualization of health, and rather opt for mental or social health, a participant that did explicitly identify as trans, considered bodily health a priority:

"I think that, as a queer person, I want to feel happy in my body that my body can do what I want it to do. I want to be in a society, which doesn't put pressure on my body to be a certain way." (I3)

Healthcare & Capability

This ties in closely with participant's perceptions of queer healthcare - a central concept that permeated through all of the participant's stories, albeit with drastically different ideas from participant to participant, subject to their intersectional identity. Those who did not explicitly identify as trans lacked the desire for gender-affirming care, and when asked what healthcare they and/or other queer people needed to achieve their respective desired health, they referred overwhelmingly to ***mental healthcare***, namely psychotherapy and psychiatry, but also aforementioned community, as well as ***organizational support*** from initiatives, NGOs and universities, such as providing information to queer migrants about pertaining issues. A majority of the participants agreed that they were not sufficiently capable of achieving this part of their desired health because of the interplay between their queer identities as endowments and the lack of support, acceptance, etc., and the socio-political environments in their countries of origin, as

discussed in the previous section, as conversion factors. Upon moving, however, their capability profiles gained a much more nuanced structure – the most often cited barrier to their access to healthcare was ***bureaucracy*** and a ***bureaucratic culture*** in Dutch healthcare. Participants complained about the necessity of obtaining permits, documents, referrals, etc. in order to access even the most basic treatments, as well as the exacerbation of this systemic problem in the area of mental healthcare:

"I was waiting for three months for the first appointment to a mental clinic. And it was horrible. Like, I needed it right now. But they just had a queue…" (I2)

Their migrant status, especially with respect to insurance, has also been cited as a significant detriment to access. Furthermore, a lack of ***anonymity*** within such highly bureaucratic system has been brought up as an issue on multiple occasions – privacy within healthcare can be extremely important for queer people, especially those who may be persecuted for their identity by authoritarian regimes, such as governments. While not explicit in the recounts of the participants, this can be closely connected to the concept of (mutual) ***trust***, which more of them hold in high regard with respect to healthcare ***professionalism***:

"I think I would garner support here. I wouldn't be afraid to talk to doctors about this, to ask questions that I'm interested in. And I would be afraid to ask these questions in like, my original country. I would be because even the doctors are very conservative and they try to change your mind all the time." (I2)

"If you don't believe me when I go to you with an issue as the doctor, then you cannot do your job as a healthcare professional adequately. So, then you're already failing at your task." (I4)

From the accounts of the participants, professionalism, especially within, but not limited to, mental health professionals, is an important determinant of access to healthcare – on multiple occasions, participants complain that healthcare professionals suffer from a ***lack of information*** on queer health, and sometimes even refusal to learn, borne of ***conservativism***:

"I was talking about polyamory with my Russian doctor. And he was so shocked. And he judged me a lot about me even talking about this. And he was like, "you know, you could just maybe read some articles, and it's like, completely written everywhere that it is just evolutionary good that we have one partner and don't even think about polyamory," …he refused to even believe that I can feel this way." (I2)

"They're not updated. They're kind of closed from the outer world. Russian doctors, sometimes they just refuse to read anything written even in English, and they read like, only like Russian journals. And it's so bad…" (I2)

One participant drew a link between conservativism and ***religious belief***, drawing an explicit disjunction between religion and queerness:

"They're very heteronormative and very 'judgy', and will call you names. And they'll talk about how religiously this is wrong. Here, religion is a bit different. I've heard it multiple times that they're like, 'I'm religious, and I'm okay with queer people', but at home, religion and queerness do not mix at all. So, you cannot be both." (I4)

For reasons mentioned, all of which pertain to the interaction of queer identity with spatially differentiated environments, participants expressed a desire for improved solutions to ***queer mental health*** in the form of healthcare tailored to queer experiences. This manifested as a desire for not only acceptance of queer struggle in social and clinical settings, but also its understanding through openness, awareness, and education:

"I did have a hard time lying to my therapist, but also, I feel like I would love to talk to my therapist about these societal imbalances, at least that I experienced in my home country. And again, I couldn't, because my therapist was also part of

that environment that was toxic towards queer people altogether. And, yeah, I would just like to talk to a professional that understands the implications of this environment on a queer person and the effects that it can have." (I4)

"I would like better tailored mental healthcare provisions for queer people. I guess what I would like is supportive workers and supportive staff within healthcare providers." (I3)

One participant noted that "*lack of [queer] acceptance goes hand in hand with a lack of education"* (I4)

Conversely, physical healthcare was considered a larger concern by a participant that identified as trans. Her desired health included outcomes that are only attainable by provisions of ***gender-affirming care***, such as ***hormone replacement therapy (HRT)*** and ***gender-affirming surgery***. The participant in question is undergoing HRT at this time, and by her account, this was a part of healthcare that suffers from many issues, resulting in trans people being less capable of accessing it:

"I started off in the UK, which I think is the worst-case scenario… in the UK, you go to a doctor, you hope that doctor puts you on to a waiting list for a gender identity clinic or GIC, your local one. And then the average time... it turns out, in 2023, they had only just started accepting patients who got onto the waiting list in 2018... a five-year waiting list." (I3)

Same as with providing mental healthcare to queer people, the issue with gender-affirming care is ***lack of education*** in the profession, according to the participant:

"I think there needs to be a lot of fact checking when it comes to gender-affirming healthcare, because we see these horror stories of people who did it, and then regretted it. And those are very, very marginal cases. And if you look at it, in actuality, on the macro level, the vast, vast, vast majority of people who take gender-affirming healthcare… it noticeably improves their quality of life. And I'm one of those people." (I3)

According to Turban et al. (2021), less than 1% of transgender and gender non-conforming people pursuing gender-affirming care detransition, with a vast majority of them citing external factors, such as societal pressure, as the reason.

With regards to gender-affirming care, an interesting dynamic emerged from the gathered data – participants who did not identify as trans perceived the accessibility of gender-affirming care as reasonable, and considered themselves capable of accessing it, should they wish to do so. Conversely, a trans participant pointed out the inaccessibility of gender-affirming care and the false belief of many queer people, who do not have experience with it, that it is accessible:

"I think if I would now go for hormones, for example, if I will decide to change my sex, I think that would be no problem." (I2)

"I have this sense in the Netherlands, that some people are very complacent with queer liberation. Particularly among queer people who aren't pursuing a medical or social transition. So, for people who perhaps present within their assigned gender or aren't in a medical transition, there is a sense that everything is great. We're a good country, everything's legal, you can get married, you can adopt kids and all this kind of stuff, everything's great. And I think there's actually a willful ignorance to the plight of Dutch trans people. Particularly with healthcare-related things… and the almost tacit support for the level of bureaucracy that trans people in the Netherlands have to go through to get healthcare." (I3)

With regards to HRT specifically, this participant continued to explain that an ***informed consent*** model of access to HRT would benefit trans people:

"I think another thing that needs to be done, and I really hope this is adopted across Europe, is the idea of informed consent to HRT. The way I would describe it is - I'm an adult, I can get a tattoo, I can legally cut a finger off if I want to. Why am I not able to take this medication which changes my body? If I'm sound of mind and I read the

information and consented, but why do I need to see so many doctors? Why do I need to go through so many bureaucratic hurdles just to get this medication to affirm my gender?" (I3)

According to her, because of this inaccessibility of HRT, many trans people are opting for self-medication, also known as ***DIY HRT***. This, of course, introduces additional risk, as it is illegal in the Netherlands under the Dutch Medicines Act. The amount of people undergoing DIY HRT in the Netherlands is unknown, but Stepwork, formerly the largest provider of gender-affirming healthcare in the Netherlands, once estimated that up to one third of its patients have a history of self-medication (nltimes.nl, 2020).

Migration decisions

All of the interviewed participants agree that queer identity played a significant role in their decision to move or destination choice, albeit in different ways. All of them, however, had to do with queer acceptance and the spatial political context of queerness. Participants describe their destination countries as better places to live as a queer person, than their countries of origin. Queerphobia, conservativism, political violence, and discrimination, on the other hand, seem to constitute the push factors. Accessibility of gender-affirming care has been noted as a motivation to migrate by a trans participant.

Discussion of results

The data gathered from participants is in line with the theoretical framework: participants confirm that their queer identity shapes their desire with regards to health, and identify what they consider important for queer health. Curiously, at least one participant spontaneously conceptualized their queerness/sexuality as agency, in line with Manalansan (2006).

By allowing participants to define health according to their desire-production, new conceptualizations of health were created, which pertain specifically to queer (and) migrant intersectional identity, and are non-adherent to the structure of mainstream health and migration research by virtue of being based in individuals' agencies. This new concept of health includes not only physical health, but also mental, social, and environmental health, with participants assigning different value to each of them subject to their desire. Thanks to this approach of redefining health to be suitable for analysis of populations marginalized from mainstream research, it is permissible to conclude that desired health of queer migrants indeed does influence their mobility, in that the desire to access respective healthcare motivates migration or determines destination choice.

With respect to the capability of queer migrants of accessing said healthcare in actuality, obstacles specific to queer and migrant identity are present in the participants. If these obstacles were to be integrated into Nussbaum's (2011) central capabilities, it could be said that the participants' capability is reduced in areas of:

1. *Life*, where concerns over mental or physical safety reach a level of threat to one's survival;
2. *Bodily health*, where especially reproductive health is insufficiently accessible;
3. *Bodily integrity*, where sexual or physical assault constitute a threat, or where sexual satisfaction is impeded by external forces;
4. *Senses, imagination, and thought*, where artistic and political freedom of expression is severely limited by 'political violence';
5. *Emotions*, where the ability to love is reduced by fear and anxiety;
6. *Practical reason*, where queer people might be denied liberty of conscience and observance;
7. *Affiliation*, where discrimination on the basis of sex/sexual orientation occurs
8. *Control over one's environment*, where the right to political participation qua queer politics is denied, or where

freedom of speech and/or association is not protected for queer people.

Figure 2 – Coding scheme

Source: Created by author

Figure 2 provides an overview of the codes discovered during inductive analysis, as well as higher-order categories that the codes were organized into.

NB: some codes feed into more than one category based on the data they refer to, but for simplicity of visualization only stand in the category to which most of the coded data pertains.

Limitations

Because of the relatively small and heterogenous sample of participants, the research might not reach data saturation and cover all of the topics necessary for understanding the complexity of the overarching theory. A larger sample of queer and trans migrants from different international contexts would maximize the explanatory power of an induction process driven by individual desire and agency. Time and space constraints played a significant role in choosing participants, thus they were chosen based on convenience, whereas a more purposeful sampling could bring about the diversity of ideas in participants required to cover the entire topic.

My positionality as the researcher, with regards to the subject matter and the participants, had a positive effect during the data collection process – with a preestablished rapport between us, the participants who were familiar with me spoke very openly about their opinions and experiences, without issues of trust. On the other hand, since I have my own experience in queer migrant struggle as well as queer healthcare, I may remain personally biased towards or exacerbating certain issues that were brought up by participants.

Conclusion

This research set out to examine the causal relationship between the desired health of queer migrants and their mobility, as well as the capability of queer migrants of achieving said health. It was found that:

a) queer identity bears influence on participants' conceptualizations of health through a desire-production mechanism, yielding concepts such as safety, authenticity, queer acceptance, community, associated mental health effects, as well as physical health as actuation of bodily image to desire,

b) participating queer migrants seek out healthcare to achieve said health, namely mental healthcare tailored to queer struggles, as well as organizational support, professionalism, trust, as well as gender-affirming healthcare,

c) this search for appropriate healthcare either drives migration at the decision-making stage or influences destination choice of queer migrants, seeing as the availability of such healthcare is unequally spatially distributed,

d) participating queer migrants identify obstacles in capability of achieving said healthcare, namely bureaucracy, finance, lack of

information and education on queer health, lack of professionalism, conservative societal pressures, etc. Both of the analyzed intersections of the participants' identities, i.e., queer and migrants, have obstacles in capability associated with them.

Based on the findings of this research, it is recommended that the information gathered from participants is incorporated into policy addressing conditions of queer health in a clinical setting. From the recounts of participants, there is an evident need for increased social acceptance of queerness, educated mental health provisions specifically for queer issues, as well as accessible gender-affirming healthcare, namely HRT. Further research is needed to examine the theory on a larger scale, with a larger representative sample, as well as to examine many more intersections of identity and their effects, as opposed to just queer migrants from a context- and age-specific sample.

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Appendix A: Interview guide

1. Identity questions
    1.1. Can you tell me about yourself?
        1.1.1.P: age, nationality/country of origin, queerness, sexuality, etc. if missing
2. Migration questions
    2.1. How long have you been living here?
    2.2. Do you like it here?
    2.3. Why did you move here?
    2.4. How is life as a queer person in your country of origin?
        2.4.1.P: Safety, social acceptance, political acceptance, family, etc.
        2.4.2.How does it compare to here?
            2.4.2.1. Did this influence your decision to move in any way?
3. Health and capability questions
    3.1. What do you consider important for your health?
        3.1.1.What healthcare do you want to achieve this?
    3.2. What do you consider important for your health for you as a queer person?
        3.2.1.What healthcare do you want to achieve this?
            3.2.1.1. P: Was <X> available in your country of origin? Is it available here?
                3.2.1.1.1. Did this influence your decision to move in any way?
            3.2.1.2. P: Have you ever received <X> healthcare? What were your experiences?
            3.2.1.3. P: How hard is it for you to access <X>?
            3.2.1.4. P: Do you feel like it is reasonably accessible to you?
            3.2.1.5. P: What kind of barriers are there for you?
            3.2.1.6. Do you feel like you are capable of achieving the kind of health you desire? Why?
    3.3. What do you consider important for the health of queer people in general?
        3.3.1.How difficult do you think it is for queer people to achieve this?

Appendix B: Information sheet

UNDERSTANDING QUEER MIGRATION AS A PRODUCT OF QUEER DESIRED HEALTH (working title)

Dear participant,
Thank you for your interest in participating in this research. This letter explains what the research entails and how the research will be conducted. Please take time to read the following information carefully. If any information is not clear kindly ask questions using the contact details of the researchers provided at the end of this letter.

WHAT THIS STUDY IS ABOUT?

- This study aims to examine the causal linkage between queer identity, health, migration, and capability of queer migrants to achieve said desired health.
- It is my bachelor's thesis, for the BSc programme Human Geography and Planning

WHAT DOES PARTICIPATION INVOLVE?

- Participation in this study entails expressing your own experiences in the form of a semi-structured interview – you will be asked questions that guide the overall structure of the interview, but are free to express yourself as freely as you like.

DO YOU HAVE TO PARTICIPATE?

- Participation in this research is completely voluntary.
- As a participant, you can also choose to withdraw from the study at any moment and choose not to answer questions without consequences or providing reasons

ARE THERE ANY RISKS IN PARTICIPATING?

- This research deals with highly personal and sometimes sensitive topics, but because all data gathered will be thoroughly anonymized, there are no immediate risks arising from participation.

ARE THERE ANY BENEFITS IN PARTICIPATING?

- There are no direct benefits to the participant, but the research they help create may contribute to further knowledge on the topics of the study, both academically and clinically.

HOW WILL INFORMATION YOU PROVIDE BE RECORDED, STORED AND PROTECTED?

- Data will be gathered by means of audio recording, then transcribed and stored on a cloud folder with end-to-end encryption and password protection.
- All data used and explicit in the final paper will be anonymized – names and other personal identifying information will be removed.
- The data gathered and stored will be deleted after successful completion of the study

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

- The results will be used in a bachelor's thesis in the form of a scientific article

ETHICS

- The researcher will uphold themselves to relevant ethical standards, namely the Netherlands Code of Conduct for Research Integrity 2018 (GDPR compliant)

INFORMED CONSENT FORM

- By signing the informed consent form, you confirm that you have the intention to participate, while still being able to withdraw at any time.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

- For any additional information, you can contact the researcher at:
  +31630122730 / s.durkac@student.rug.nl

Appendix C: Informed consent form

Title study: UNDERSTANDING QUEER MIGRATION AS A PRODUCT OF QUEER DESIRED HEALTH (working title)

Name participant:

Assessment

- I have read the information sheet and was able to ask any additional question to the researcher.
- I understand I may ask questions about the study at any time.
- I understand I have the right to withdraw from the study at any time without giving a reason.
- I understand that at any time I can refuse to answer any question without any consequences.
- I understand that I will not benefit directly from participating in this research.

Confidentiality and Data Use

- I understand that none of my individual information will be disclosed to anyone outside the study team and my name will not be published.
- I understand that the information provided will be used only for this research and publications directly related to this research project.
- I understand that data (c onsent forms, recordings, interview transcripts) will be retained in a secure cloud location and destroyed after completion of this research.

Future involvement

◯ I wish to receive a copy of the scientific output of the project.
◯ I consent to be re-contacted for participating in future studies.

Having read and understood all the above, I agree to participate in the research study: yes / no

Date

Signature

To be filled in by the researcher

- I declare that I have thoroughly informed the research participant about the research study and answered any remaining questions to the best of my knowledge.
- I agree that this person participates in the research study.

Date

Signature