

Settler Colonialism and Health Inequities:  
Contextualizing Religion and HIV among Transgender Women in the  
Philippines

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A thesis

submitted in partial fulfillment of the  
requirements for the degree of

Master of Public Health

University of Washington

2024

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Program Authorized to Offer Degree:

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**Abstract**

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The health inequities faced by transgender individuals in the Philippines are deeply intertwined with the historical impacts of colonization on Philippine society. This study examines the association between religiosity, socio-demographic factors, and HIV status among Filipino transgender women using an abolitionist framework. Quantitative data were collected between June 2018 and May 2019 through a cross-sectional survey conducted in Manila and Cebu. Data analysis involved multinomial regression to assess the relationship between religiosity and HIV status. Religious affiliation was significantly associated with HIV status ( $p = 0.011$ ), with non-Catholic respondents more likely to report being HIV positive compared to Catholics (Adjusted RRR = 9.835, 95% CI: 1.13, 61.72,  $p = 0.038$ ). Age, location, education level, and past year income were also significantly associated with HIV status. No significant associations were found between religiosity belief or practice and HIV status. There is a need for a nuanced understanding of the intersection between religion and health, considering not only protective aspects of religiosity but also potential negative impacts, such as historical trauma, social

exclusion, or rejection from religious communities. By contextualizing religiosity within a historical framework of colonization, this study sheds light on the nuanced intersections of religion, culture, and health, providing valuable insights for developing targeted interventions to address HIV inequities among transgender communities.

## Background

### *Overview*

While various studies on HIV health inequities among transgender women in the Philippines focus on structural barriers that negatively impact health outcomes, the historical and current impacts of colonization on Philippine society, particularly regarding HIV health outcomes, are less emphasized. The health inequities faced by transgender individuals in the Philippines are deeply intertwined with the historical impacts of colonization on Philippine society. The violent nature of colonization eradicated the existing beliefs and practices of this community, replacing them with Eurocentric structures and ideals, such as Catholicism. The introduction of this religion was just one structure of the new system imposed by colonialism in the Philippines. These historical impositions have significantly contributed to contemporary health inequities, such as the high prevalence of HIV among Filipinx trans women. The total HIV infections among trans women doubled during the COVID-19 pandemic, from 714 cases in 2019 to 1560 in 2022 (1). To understand the current scope of public health programming, there is a need in this field to contextualize the HIV health inequities among Filipinx transgender women from the lens of abolition, specifically using the framework of abolition medicine (2). This perspective emphasizes dismantling colonial systems and structures that perpetuate health inequities, even after a nation gains “independence.” In this thesis, I situate religiosity as a proxy variable to visualize the ways in which colonial practices and norms impact HIV outcomes. I aimed to pull literature from public health literature and works written by Filipinx scholars to document effects of colonialism and to contextualize this public health issue impacting this important group.

### *Anti-colonialism and abolition*

The destructive legacy of colonialism has deeply entrenched health inequities in the Philippines, necessitating an anti-colonial and abolitionist approach to address these patterns. Abolition medicine is a transformative framework that seeks to dismantle oppressive systems and reimagine healthcare through the lens of racial and social justice. It aims to abolish the remnants of colonial and racist practices within healthcare systems, replacing them with models that prioritize community well-being and self-determination (2). This approach not only addresses immediate health inequities but also challenges their structural roots by promoting practices that are equitable, liberatory, and culturally appropriate. Abolition medicine is inherently anticolonial as it confronts and seeks to eradicate the colonial legacies that perpetuate marginalization and health inequities. In the context of the Philippines, this involves breaking down the colonial structures that have historically and systemically marginalized transgender communities and advocating for an anti-colonized healthcare system that honors and integrates indigenous knowledge and practices.

### *Impact of colonization on gender roles*

Prior to the colonization of the Philippines, gender roles were more fluid, as exemplified by the babaylans - spiritual leaders who embodied feminine traits irrespective of their biological sex (3). Babaylans held a revered and unique position, transcending conventional gender roles to seamlessly navigate between the realms of the mundane and the mystical. As spiritual

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guardians of their communities, babaylans were entrusted with maintaining harmony between the physical and supernatural domains, communicating with ancestral spirits, nature deities, and the unseen forces that influenced everyday life (4). Their role was deeply intertwined with shamanic practices, which formed the core of their spiritual duties. These practices included divination through dreams, the use of medicinal plants, and ecstatic dancing aimed at inducing altered states of consciousness. In these states, babaylans would commune with spirits, diagnose illnesses, and provide guidance to those in need, demonstrating their profound connection to both the spiritual and earthly realms. However, Spanish colonization in the Philippines disrupted these norms. Babaylans became targets of persecution, and their traditions were driven underground, leading to the suppression of native mythology and the rise of social stigma against gender-diverse identities.

With the arrival of the Spanish in 1565 came the proselytizing of Catholicism to the Philippines, a religion that continues to shape the nation today. Spanish colonization continued for over three centuries, driven by both economic and religious interests, as the Spaniards aimed to establish trade routes and spread Christianity in Asia. A significant portion of these arrivals comprised religious priests, whose portrayal of priestesses and transgender priests tended to be disparaging. Early Filipinx religious figures posed a challenge to the status of Catholic priests in the region, as their roles diverged from the male-centric Catholic hierarchy (5). The community possessed a rich history and culture prior to the arrival of the Spaniards, but earlier records were destroyed due to their pursuit to control the land. This period of Spanish colonization marked the demise of traditional Filipinx mythology, diminishing the societal standing and rights of transgender women in the Philippines (6).

### *Religiosity, Law, and Impact on trans communities*

The influence of the Catholic Church on Philippine laws is systemically powerful. Laws such as the Family Code of the Philippines, which restricts marriage to "between a man and a woman," reflect the moral doctrines propagated by Catholic missionaries (7). The Constitution of the Philippines neither prohibits nor legally recognizes same-sex marriage. The Filipinx LGBTQ+ community continues to lack legal protection against abuse and discrimination. The Church's influence continues to shape public policy and societal norms, reinforcing Eurocentric gender roles and heteronormative standards, which have significant implications for health equity, particularly for transgender individuals. Religious institutions also express concerns that distributing condoms may encourage promiscuity and are therefore restricting the availability of condoms only to health clinics and convenience stores (8). Additionally, the lack of condom- and HIV-related curricula in schools is partly due to the Church's influence on the school system (9). Despite initial introduction in 2000 by then-Senator Miriam Defensor-Santiago, the SOGIE Equality Bill - which seeks to outlaw discrimination based on sexual orientation, gender identity, or expression - remains unpassed in the country (10), leaving the trans Filipinx community without essential legal protections.

Despite ongoing efforts to enact the SOGIE Equality Bill aimed at addressing health-related inequities, this policy has encountered strong opposition from religious and conservative groups, resulting in its failure to pass in Congress for over the last two decades (11). This historical context laid the groundwork for increased barriers to key health services including HIV prevention, testing, and treatment among transgender communities (12). These barriers manifest through workplace discrimination, medical distrust, and harm inflicted on transgender individuals, compounded by their lack of representation in health settings. Beyond access to health services, these barriers also impact broader determinants of health, such as economic stability, education, and social support. Consequently, these factors contribute to poor health outcomes, culminating in a higher prevalence of HIV among Filipinx trans women compared to the public. While this thesis explicitly focuses on health service access, it is important to recognize that these conditions permeate all systems and aspects of life, reinforcing the need for comprehensive approaches to health equity.

#### *Religiosity, Healthcare access, and HIV*

Religiosity significantly influences health outcomes and healthcare access in various ways. In its benefits, religiosity fosters strong community networks that provide emotional, social, and financial support, enhancing overall well-being (13). One study concluded that formal religious practices may reduce sexual risk-taking behaviors and subsequently HIV risk among young trans women (14). A study among Christian youth in Wakiso district in Uganda have also found lower religiosity has been associated with higher HIV infection rates (15). Alternatively in its detriments, religiosity can also contribute to stigma and discrimination against marginalized groups, hindering their access to healthcare services. One example being religious opposition to preventive measures like condoms limits their availability and acceptability, complicating HIV prevention efforts (8). Additionally, research has found that self-identifying as religious, particularly as Christian, is associated with increased transprejudice (16).

Stigmatization within HIV services is a critical issue influenced by religiosity. In the Philippines, where approximately 79% of the population identifies as Catholic (17), the Catholic Church's influence significantly impacts healthcare access and public health policies. Stigma against HIV is driven by religious beliefs that associate HIV with moral failings, which prevents individuals from seeking testing and treatment (18). This stigma is particularly pronounced for transgender individuals, who face multiple layers of discrimination and bias from healthcare providers influenced by religious beliefs. These barriers exacerbate issues like homelessness, unemployment, lack of health insurance, and avoidance of HIV services due to gender identity or the absence of LGBTQ+ anti-discrimination policies (9).

Research highlights that transgender communities in the Philippines experience significant barriers to healthcare access, including limited HIV knowledge and avoidance of HIV services due to discrimination (19). This stigmatization, driven by religious and societal norms, impedes their ability to receive necessary care and prevention services. Addressing these challenges requires comprehensive strategies that consider the intersection of religiosity, stigma, and healthcare access to improve health outcomes for transgender individuals in the Philippines.

## Specific Aims

The primary aim of this study is to examine the association between religiosity belief/practice and HIV prevalence, healthcare access, PrEP awareness, and HIV stigma among transgender women in the Philippines. Using the #ParaSaAtin survey, the exposure is defined by those who believe in the Catholic religion. The outcome is defined as a positive self-report HIV outcome. I hypothesize that those who rated their religiosity belief as high will have a relative risk ratio (RRR) of HIV.

The second aim of this study involves a stratified analysis of the primary association by age, employment status, and income level. I hypothesize that this association will be stronger among participants of younger age, those who did not have employment, and were classified as low-income status.

## Significance

A gap exists in research exploring the intersection of colonial history, transgender rights, and health inequities in the Philippines. Understanding the historical impact of colonization on transgender individuals in the Philippines is necessary for grasping contemporary health inequities and societal norms. By placing health inequities within the framework of colonial history, we uncover how colonial ideologies have molded present-day societal standards and perpetuated systemic injustices. This examination underscores the necessity of acknowledging colonial legacies to drive social change and tackle health inequities among marginalized communities. It is imperative that we recognize the effects of colonization post-independence and understand health inequities within the historical context of colonization, as it acknowledges existing injustices holistically. The persistent influence of colonial ideologies underscores the ongoing struggle for anti-colonization and sovereignty. By acknowledging these colonial systems, we can advocate for initiatives that reclaim land and end Western colonization of foreign territories, fostering self-determination and justice for formerly colonized peoples. This imperative extends beyond the Philippines, emphasizing the enduring impacts of colonialism on marginalized communities worldwide.

## Methods

### *Study design*

We utilized quantitative data from Project #ParaSaAtin, a community-informed study on the health and wellness of transgender women in the Philippines. Data was gathered using a cross-sectional survey, informed by the qualitative data from the same study, to quantitatively examine access and characterize access to HIV prevention and treatment services among this group. This study only focuses on the quantitative data.

### *Study setting*

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Data was collected between June 2018 and May 2019, in Manila and Cebu, the two highest HIV burden areas in the Philippines metropolitan cities (20).

### *Study subjects*

Project #ParaSaAtin participants eligibility requirements reflected criteria that were pertinent to understanding the epidemiology of HIV in the Philippines, based on HIV surveillance trends that reflected sexual behaviors and demographics that showed trans communities of highest risk (21); the criteria included the following: (1) being 18 years old or above, (2) identify as a trans woman, (3) had condomless anal sex in the past year with a cisgender male partner, (4) currently living in Metro Manila or Cebu, and (5) demonstrated English and consent comprehension via a brief cognitive screening tool consisting of true/false questions about the consent form.

### *Data collection*

Between June 2018 and August 2019, data collection took place, with the research team adhering to recommended procedures for conducting online surveys, described more in detailed elsewhere (22). Individuals were recruited through venue-based sampling, distribution of study flyers, and snowball recruitment methods facilitated by three community-based organizations (CBOs) catering to transgender communities. Best practices for web-based online surveys were utilized; these practices included the integration of a "captcha box" to sift out non-human participants or automated bots (23). A cross-validation system was methodically applied to identify and block repeated IP addresses, ensuring that each participant provided a unique response (24). Any instances of duplicate IP addresses resulted in the disqualification of the associated survey submissions.

### *Measures*

This study explored the following measures:

- **Main Exposure:** Religiosity was assessed in three dimensions: religious affiliation, religiosity belief, and religiosity practice. Religious affiliation was determined by self-identification, with response options including Catholic, non-Catholic, non-religious, and other. Participants who selected "other" were prompted to specify their religious affiliation. Religiosity belief and practice was dichotomized into 'high' and 'low' based on mean responses. High religiosity belief was defined as >7, while high religiosity practice was defined as >6.
- **Covariates:** Demographic factors include age, current living location (Cebu, Manila), education level (high school or below, some college, college or beyond), past year income (less than P10,000, P10,000-P20,000, P20,000-P30,000, above P30,000, no income), sexual orientation (gay, bisexual, straight, not listed), and gender identity (trans, MSM, other). Participants who selected "other" were prompted to specify their gender identity. Social marginalization factors include experience of homelessness and current unemployment. Healthcare and Health Policy Indicators include the avoidance of HIV services due to gender identity, avoidance of HIV services due to lack of LGBTQ+ anti-discrimination policy, and HIV knowledge.

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- Main Outcome: HIV status was determined by self-identification with response options including positive, negative, and unknown.

### *Data analysis*

To begin analysis, we restricted the analyses based on gender identity such that the data set only included participants who reported their gender as transgender. To examine the association between religiosity belief and HIV status among transgender folks, descriptive analyses will be conducted to first characterize the study sample for Table 1. Missing values will be excluded. A multinomial regression was conducted to explore the relationship between religiosity belief and HIV status among Filipinx transgender women. The model included HIV status as the outcome variable with categories for HIV-negative, HIV-positive, and unknown status. Religiosity belief was the main independent variable of interest, where participants rated their belief on a scale of 1-10, indicating the strength of their belief in their religion's teachings and the frequency of their religious practices.

### **Results**

The study sample consisted of 139 Filipinx transgender women respondents. Among them, 54 reported being HIV negative, 36 reported being HIV positive, and 49 reported unknown HIV status.

#### Religiosity

110 of participants identified as Catholic, 21 as non-Catholic, and 8 identified as non-religious. Religious affiliation was found to have a statistically significant association with self-reported HIV status ( $p = 0.011$ ). Among the respondents, 23.6% of Catholics reported living with HIV, while 47.6% of non-Catholics and 0% non-religious individuals reported living with HIV. Relative to living without HIV, Non-Catholic respondents had a significantly higher likelihood of reporting living with HIV compared to Catholic respondents with the adjusted Relative Risk Ratio (RRR) = 9.835 (95% CI: 1.13, 61.72), and  $p = 0.038$ ). Relative to living without HIV, no significant associations of reporting living with HIV were observed between non-religious and non-Catholic individuals compared to Catholic respondents. The analysis of religiosity belief revealed no significant association with self-reported HIV status ( $p=0.438$ ). There was also no significant association between religiosity practice and self-reported HIV status ( $p=0.618$ ).

Other Demographic Factors and HIV Status: There was a significant association between age and HIV status ( $p=0.038$ ). Relative to those who are living without HIV, Respondents aged 25-29 had a significantly higher likelihood of reporting being HIV positive compared to those aged 18-24 (Adjusted RRR = 13.93,  $p=0.013$ ). Similarly, relative to those who are living without HIV, Respondents aged 30-34 had a significantly higher likelihood of reporting being HIV positive compared to those aged 18-24 (Adjusted RRR = 65.48,  $p=0.001$ ). No significant associations were observed between age groups and self-reported HIV unknown status relative to those who report living without HIV.

Relative to those living without HIV, those living in Manila had a significantly higher likelihood of reporting being HIV positive compared to those in Cebu (Adjusted RRR = 8.95,  $p = 0.030$ ). No significant associations were observed between current living location and self-reported HIV unknown status relative to those who report living without HIV.

Education level showed a significant association with HIV status ( $p=0.001$ ) at the bivariate level. No significant associations were observed between current living location and self-reported living with HIV, as well as self-reported HIV unknown status, relative to those who report living without HIV.

Education was significantly associated with HIV status at the bivariate level ( $p=0.001$ ). Respondents with high school education or below had a higher prevalence of HIV compared to those with higher education levels.

Past year income was significantly associated with HIV status ( $p=0.022$ ). Respondents that reported earning less than P10,000, had a higher prevalence of HIV. No significant associations were observed between past year income and living with HIV, as well as self-reported HIV unknown status, relative to those who report living without HIV.

Sexual orientation was not significantly associated with HIV status at the bivariate level. No significant associations were observed between sexual orientation and living with HIV, as well as self-reported HIV unknown status, relative to those who report living without HIV.

At the bivariate level, current employment, having current health insurance, having avoided HIV services due to gender identity and due to lack of LGBT anti-discrimination policy, and HIV knowledge, were significantly associated with HIV status (all  $p$ 's  $<0.05$ ). Notably, A high proportion of respondents without health insurance reported being HIV positive. Respondents who avoided HIV services were more likely to report being HIV positive. However, no significant associations were observed between these variables and living with HIV, as well as self-reported HIV unknown status, relative to those who report living without HIV.

## **Discussion**

The study findings unveil meaningful relationships between various demographic factors, religiosity, and HIV status among Filipinx transgender women. Notably, religious affiliation demonstrated a noteworthy correlation with self-reported HIV status, indicating that non-Catholic respondents were more likely to report being HIV positive compared to Catholics. This aligns with previous studies findings that suggest religiosity, in general, may be protective against HIV risk due to associated moral teachings and community support. However, it is essential to avoid attributing causation solely to religious affiliation. Instead, a deeper exploration into the reasons why transgender women may not identify as Catholic is warranted. Factors such as historical trauma, social exclusion, or rejection from religious communities may influence religious identity among this population. Therefore, understanding the complexities of religious affiliation and its

intersections with HIV risk requires a nuanced examination of broader socio-cultural and historical contexts.

The association between socio-demographic factors—such as educational level, income, and health insurance status—and HIV status provide compelling evidence that health inequities are deeply rooted in the governmental, economic, and social systems that have been historically influenced by colonization. Inequities in educational attainment and subsequent limited access to employment opportunities contribute to lower income status among Filipinx transgender individuals. This inequitable access to education and employment negatively contributes to their vulnerability to HIV infection by impeding their ability to secure insurance coverage, consequently restricting access to essential healthcare services and the adoption of preventive measures. Employment opportunities may also be further hindered by stigma and discrimination against transgender individuals in the job market, leading to systemic exclusion from mainstream employment sectors. In the face of limited employment options, many Filipinx transgender individuals may turn to sex work as a means of survival, further exacerbating health inequities. Sex work, often driven by economic necessity and lack of viable alternatives, exposes individuals to increased risks of HIV transmission due to factors such as inconsistent condom use, limited access to healthcare, and heightened vulnerability to violence and exploitation (25).

Avoidance of HIV services due to gender identity and lack of LGBTQ+ anti-discrimination policies also showed an important relationship with HIV status, highlighting the barriers faced by transgender individuals in accessing necessary healthcare services. Avoidance of HIV services due to gender identity reflects the stigma and discrimination transgender individuals often experience within healthcare settings. Fear of judgment, mistreatment, or rejection may lead transgender individuals to avoid seeking HIV testing, treatment, and prevention services, ultimately exacerbating HIV inequities. Restructuring healthcare systems to address stigma and discrimination and promoting culturally relevant care are essential for improving healthcare access and reducing HIV risk among transgender populations. The lack of LGBTQ+ anti-discrimination policies contribute to healthcare inequities among transgender individuals. The absence of legal protections against discrimination based on gender identity and sexual orientation leaves transgender individuals vulnerable to mistreatment and denial of care. Implementing and enforcing comprehensive anti-discrimination policies is crucial for ensuring equitable access to healthcare services and promoting the health and well-being of transgender communities.

While previous research has stressed the critical role of socio-demographic factors in HIV prevalence among transgender populations, this study's emphasis on colonialism's influence on health inequities among Filipinx transgender women offers a unique contribution to the field. By contextualizing religiosity within a historical framework of colonization, this study sheds light on the nuanced intersections of religion, culture, and health, providing valuable insights for developing targeted interventions to address HIV inequities among transgender communities.

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### *Strengths:*

A major strength of this study lies in its incorporation of an abolitionist framework, which centered Indigenous communities and provided a lens through which to understand the fundamental causes of health inequities, contextualizing them within the historical framings of colonialism and oppression. Additionally, collaboration with community-based organizations (CBOs) ensured community engagement and participation in the research process, fostering a more inclusive and culturally sensitive approach. The study's strengths also lie in its comprehensive approach to analyzing multiple demographic factors and their associations with HIV status. The use of a community-based participatory research model also enhances the validity and reliability of the data, as it incorporates the perspectives and experiences of the community directly affected by the study.

### *Limitations:*

This study is limited primarily by its design as a cross-sectional observational study. Due to this, incidence cannot be assessed, and causal inferences cannot be made. Additionally, this study is also vulnerable to misclassification, recall bias, or social desirability bias, due to self-reporting of both exposure and outcome variables. HIV status was self-reported, with over one-third of participants reporting unknown HIV status, potentially biasing prevalence estimates. The small sample size further limits the statistical power and may not adequately represent the broader population of Filipinx transgender women. Additionally, the study's focus on religious affiliation, practice, and belief as primary variables may overlook other critical factors that may also play a significant role in shaping HIV outcomes. The exclusion of participants without cisgender male partners might result in an incomplete understanding of the diverse experiences within trans communities, potentially overlooking key differences in HIV risk and prevalence.

### *Implications:*

#### *The Need for Abolition and Anti-colonial Health Promotion*

The findings highlight the need for Integrating an abolitionist framework into public health practice to confront the fundamental causes of health inequities faced by oppressed communities, including trans Filipinx individuals. Abolition medicine provides a transformative approach to dismantling oppressive systems rooted in colonial legacies and advancing health equity through social justice. Deconstructing and reimagining global health initiatives begins with recognizing the history of coloniality in health outcomes. Colonialism established social, cultural, political, economic, and intellectual hierarchies that have shaped modern societies and education systems (26). Research and education in both current and formerly oppressed nations can be influenced by cognitive biases and prejudices inherited from colonial states. When we view settler colonialism as an ongoing system rather than something that happened in the past, and we connect this understanding to the way we now think about health inequities, we see a clear picture. This system of power continuously shapes the social and political structures that impact people's health (27). Abolition is a holistic approach to improving health outcomes. Dismantling colonial structures and imperial powers allows communities to comprehend the origins of their cultural beliefs and practices, enabling them to advocate for their self-determined needs rather than succumbing to externally imposed agendas. This serves

as a vital step toward healing intergenerational trauma, especially in contexts marked by transphobia and queerphobia. By reclaiming agency over their narratives and advocating for their self-determined needs, marginalized communities can initiate a process of healing that acknowledges past injustices while actively resisting ongoing systemic oppression.

### *Transforming Public Health Education*

Accreditation bodies overseeing schools of public health lack expertise in addressing colonization, trauma, and oppression as they relate to health. Consequently, this absence results in curriculum gaps, leaving public health students without exposure to essential topics such as colonization, particularly settler colonialism, and Indigenous values (28). Researchers may impose their own beliefs, that often stem from Eurocentric or Western academia, when these communities have their own priorities of needs. Unfortunately, global health initiatives often fail to address structural factors that contribute to poor health outcomes, especially in the ways in which colonialism has shaped and continues to shape the social, economic, and political landscapes of many communities. Shifting away from imperialistic programs perpetuating white saviorism is crucial in anti-colonial work. Recognizing the power of scientific research in addressing social injustice challenges America's White supremacist and capitalistic society, necessitating stringent control over the scientific narrative (29).

While external collaborations may offer potential advantages for certain communities by providing greater resources, it is crucial to understand the harmful implications involved. Relying on outside entities to address public health concerns, compromises the agency and autonomy of underprivileged communities. Power imbalances can persist even with collaborations, undermining the effectiveness of initiatives aimed at addressing public health issues. To effectively address public health issues, it is crucial to prioritize initiatives that are created by underprivileged communities. These communities must play a central role in the decision-making process to ensure their needs are adequately addressed at a systemic level. Placing them at the forefront of public health efforts and global initiatives can be more comprehensive and impactful in addressing the challenges faced by these communities. Practical steps include advocating for inclusive policies, challenging religious restrictions to improve condom availability, and incorporating comprehensive HIV-related education in schools to counteract the influence of the church.

### *Future research*

Being in a privileged position pursuing higher education, it is crucial to acknowledge and address the problems associated with the field of public health, particularly the harmful effects of the white savior complex and colonialism (30). Historical context should always be researched and provided in scientific research otherwise the root structures and causes of health inequities will continue to be overlooked. This upholds white supremacy in the way that it erases the previous and continuous violence perpetuated by colonial powers. Further studies should examine the role of specific religious practices and beliefs in shaping health behaviors and outcomes to develop targeted interventions that address these dynamics. Research should prioritize community-based participatory methods to ensure that the voices of Filipinx

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transgender women are central to the research process. This approach can help ensure that the research addresses the actual needs and concerns of the community. Engaging community members as co-researchers can also help to mitigate the power imbalances that often exist in traditional research paradigms. The field of research needs to be dismantled and rebuilt in a way that supports the abolition of structures rooted in white supremacy and colonialism, instead of further perpetuating oppression. By focusing on these areas, future research can be reimagined to contribute to more effective and equitable public health strategies that address the unique challenges faced by Filipinx trans women.

### **Ethical Review**

The procedures for the study were approved by the Ethics Review Board of Brown University (IRB #1705001780). Written informed consent documents were obtained from all participants, and they were informed about the purpose of the study. Participants were also informed of their rights to confidentiality, withdrawal, and refusal to answer any questions. To ensure privacy, all transcripts have been stripped of any personally identifiable information.

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## Appendix

**Table 1. Sample Characteristics of Filipino trans women respondents (n=139) by self-reported HIV status.**

	Total	Self-reported HIV status			$\chi^2$ or Fisher's Exact <sup>^</sup> p-value
		HIV negative	HIV positive	HIV Unknown	
Total	139	54	36	49	
<b>Demographics</b>					
Age					
18-24	45	20	4	21	<b>0.038<sup>^</sup></b>
25-29	54	19	17	18	
30-34	20	7	9	4	
35+	15	5	4	6	
Current living location					
Cebu	29	21	4	4	<b>0.000</b>
Manila	110	33	32	45	
Education					
High School or below	55	11	14	30	<b>0.001<sup>^</sup></b>
Some College	23	12	6	5	
College or beyond	61	31	16	14	
Past year income					
Less than P10,000	39	12	9	18	<b>0.022<sup>^</sup></b>
P10,000 – P20,000	27	10	11	6	
P20,000 – P30,000	11	7	2	2	
P30,000+	24	15	5	4	
No income	38	10	9	19	
Sexual orientation					
Gay	77	28	20	29	<b>0.113<sup>^</sup></b>
Bisexual	18	8	7	3	
Straight	26	12	2	12	
Not Listed	18	6	7	5	
<b>Religiosity</b>					
Religious Affiliation					
Catholic	110	41	26	43	<b>0.011<sup>^</sup></b>
Non-Catholic	21	6	10	5	
Non-Religious	8	7	0	1	
Religiosity - belief					
Low	84	35	23	26	<b>0.438<sup>^</sup></b>
High	55	19	13	23	
Religiosity - practice					
Low	75	28	22	25	<b>0.618<sup>^</sup></b>
High	64	26	14	24	
<b>Social Marginalization Factors</b>					
Ever homelessness					
No	101	43	21	37	<b>0.121<sup>^</sup></b>
Yes	37	11	14	12	
Currently unemployed					
No	59	14	16	29	<b>0.003</b>
Yes	80	40	20	20	
<b>Healthcare and Health Policy Indicators</b>					
Current health insurance					

**Note: The findings of this thesis are preliminary and exploratory -- As they currently stand, the findings should not be utilized to inform any social or policy recommendations and decisions or guide medical and public health programming efforts for this population.**

No	94	30	21	43	<b>0.000<sup>^</sup></b>
Yes	45	24	15	6	
Avoided HIV services due to gender identity					
No	76	33	25	18	<b>0.006<sup>^</sup></b>
Yes	63	21	11	31	
Avoided HIV services due to lack of LGBT anti-discrimination policy					
No	76	33	25	18	<b>0.006<sup>^</sup></b>
Yes	63	21	11	31	
HIV knowledge					
Low	96	25	26	45	<b>0.000</b>
High	43	29	10	4	

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\*p<0.05, \*\* p<0.01, \*\*\*p<0.001

***Note: The findings of this thesis are preliminary and exploratory -- As they currently stand, the findings should not be utilized to inform any social or policy recommendations and decisions or guide medical and public health programming efforts for this population.***

**Table 2. Results of multinomial regression of self-reported HIV status (HIV negative as base outcome).**

	Self-reported HIV status			
	<i>Base outcome: HIV negative</i>			
	HIV positive		HIV Unknown	
	Adjusted RRR (95% CI)	p-value	Adjusted RRR (95% CI)	p-value
<b>Total</b>				
<b>Demographics</b>				
Age				
18-24	Ref		Ref	
25-29	13.93 (1.75, 110.90)	0.013*	1.61 (0.33, 7.95)	0.560
30-34	65.48 (5.66, 757.56)	0.001**	1.01 (0.11, 9.54)	0.992
35+	4.79 (0.36, 63.79)	0.236	1.56 (0.17, 14.46)	0.696
Current living location				
Cebu	Ref		Ref	
Manila	8.95 (1.23, 65.05)	0.030*	3.78 (0.64, 22.23)	0.141
Education				
High School or below	Ref		Ref	
Some College	0.84 (0.78, 9.08)	0.888	0.31 (0.05, 2.02)	0.219
College or beyond	0.97 (0.13, 7.39)	0.982	0.35 (0.07, 1.69)	0.192
Past year income				
Less than P10,000	Ref		Ref	
P10,000 – P20,000	6.50 (0.69, 61.53)	0.103	1.39 (0.20, 9.83)	0.744
P20,000 – P30,000	0.29 (0.18, 4.67)	0.385	0.54 (0.04, 7.27)	0.639
P30,000+	0.26 (0.03, 2.37)	0.232	0.28 (0.04, 2.23)	0.231
No income	0.20 (0.02, 1.89)	0.161	0.31 (0.05, 1.95)	0.212
Sexual orientation				
Gay	Ref		Ref	
Bisexual	5.31 (0.77, 36.46)	0.089	0.72 (0.09, 5.56)	0.753
Straight	0.37 (0.02, 6.44)	0.496	3.89 (0.45, 34.01)	0.219
Not Listed	7.67 (0.81, 73.04)	0.076	0.38 (0.06, 2.49)	0.315
<b>Social Marginalization Factors</b>				
Ever homeless				
No	Ref		Ref	
Yes	2.08 (0.35, 12.51)	0.425	1.01 (0.22, 4.74)	0.988
Currently unemployed				
No	Ref		Ref	
Yes	9.29 (0.99, 87.17)	0.051	2.67 (0.44, 16.02)	0.284
Current health insurance				
No	Ref		Ref	
Yes	2.46 (0.51, 11.93)	0.265	0.69 (0.14, 3.35)	0.647
<b>Religiosity</b>				
Religious Affiliation				
Catholic	Ref		Ref	
Non-Catholic	8.35 (1.13, 61.72)	0.038*	3.39 (0.41, 27.87)	0.257
Non-Religious	3.03e-07	0.992	0.16	0.254
Belief				
Low	Ref		Ref	
High	1.17 (0.20, 7.01)	0.860	2.26 (0.49, 10.50)	0.298
Practice				
Low	Ref		Ref	
High	0.33 (0.06, 2.01)	0.231	0.90 (0.20, 4.14)	0.894

**Note: The findings of this thesis are preliminary and exploratory -- As they currently stand, the findings should not be utilized to inform any social or policy recommendations and decisions or guide medical and public health programming efforts for this population.**

### HIV Capacities

Avoided HIV services due to gender identity				
No	Ref		Ref	
Yes	0.17 (0.02, 1.31)	0.089	0.83 (0.14, 4.87)	0.836
Avoided HIV services due to lack of LGBT anti-discrimination policy				
No	Ref		Ref	
Yes	0.42 (0.07, 2.41)	0.333	3.74 (0.75, 18.74)	0.108
HIV knowledge				
Low	Ref		Ref	
High	0.29 (0.06, 1.37)	0.118	0.05 (0.01, 0.35)	0.600

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\*p<0.05, \*\* p<0.01, \*\*\*p<0.001

Note: RRR= relative risk ratios, ref=referent