A Qualitative Study on the Health Perceptions and Needs of Queer and Transgender Pacific Islanders

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Abstract

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Background

The historical trauma of colonization and of epistemicide of Pacific Islander knowledge systems may cause Queer and Transgender Pacific Islanders (QTPI) to experience greater health disparities compared to non-QTPI Pacific Islanders. Although little is known about QTPI health disparities, the "Indigenist" Stress and Coping Model suggests that cultural determinants of health could be utilized to promote QTPI Health. Although interventions utilizing these determinants exist and demonstrate efficacy, the mechanisms by which they can improve QTPI health have yet to be explored.

Methods

Using semi-structured qualitative interviews and Community Based Participatory research principles, the study aimed to examine: the health issues experienced by QTPI community, ways to collect health information from QTPI populations, and identify mechanisms by which culturally-rooted health interventions can produce better health for QTPI people. 12 interviews

were conducted with Queer and Transgender Pacific Islander adults who spoke English. Data collection was constrained by COVID-19 and more data is needed to achieve inductive thematic and data saturation. Common and unique themes were identified in relation to QTPI's health experiences.

Results

QTPI views of their health were related to harmonious relationships between their mind, body, and spirit that were shaped by cultural and social norms. Cultural responsiveness, and a simultaneous understanding of a QTPI's culture; gender; and sexuality, creates comfort and greater ability to talk about their health with providers. Agofli'e and alofa ("Visibility and Love") were identified as important cultural mechanisms to improve QTPI mental health and the relationship between their mind, body, and spirit.

Conclusions

Culture is critical to understanding and improving QTPI Health. Providers should consider utilizing culturally responsive practices when discussing health with QTPI. Pacific cultural values that embody visibility and love for QTPI should be included in future models and culturally rooted health interventions that seek to improve QTPI health.

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Dangkolo' Saina Ma'ase,

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Introduction

Indigenous, Queer and Transgender Pacific Islander (QTPI) people in the U.S. may have unique health disparities compared to non-QTPI Pacific Islanders. In many Pacific Islander cultures, gender and kinship practices have existed outside of the Western gender binary and sexuality norms; Māhu, Fa'afafine, Gela' and many other identities and roles continue to persist in many Pacific Islander cultures. Moreover, the suppression of traditional gender roles and kinship practices through the assimilation of systemic oppression – like homophobia, transphobia, transmisogyny, and heterosexism – in Pacific Islander and other indigenous cultures is rooted in heteropatriarchy and colonialism, (Camacho, 2015; V. M. Diaz, 2010; Driskill, 2010; Kauanui, 2018; Kerekere, 2017; Smith, 2016). The "Indigenist" Stress and Coping Model proposed by Walters and Simoni (2002) suggests that colonization creates ecosocial stressors like historical and current trauma that negatively impact indigenous peoples' health. The historical trauma of cultural erasure may render QTPI identities invisible when examining broader Pacific Islander health disparities and in the design and implementation of culturally-rooted health interventions. Project Isa, or "Project Rainbow", aims to accomplish the following:

1. To better understand the health issues experienced by QTPI community.
2. Identify ways to collect health information from QTPI populations.
3. Study the mechanisms by which culturally-rooted health interventions can produce better health for QTPI people.

The Need to Study Pacific Islander Health Experiences

Although Pacific Islanders were reported by the U.S. Census Bureau (2017) to be the third fastest growing racial group in the United States in 2017, there is a limited amount of research that examines the unique health experiences of QTPI. The Executive Director of

UTOPIA Seattle – a grassroots non-profit organization founded and led by QTPI that provides culturally grounded social, civic, and health services to QTPI and other Pacific Islanders– enthusiastically emphasized that 12 UTOPIA chapters have opened in major US cities over the past 25 years (Maene-Johnson, 2019). QTPI's may experience greater health disparities in STIs/HIV, mental health, and barriers to accessing healthcare services. As this population rapidly grows, there is a dire need to research the health experiences of QTPI.

Large surveys that contain health information of QTPI are sparse in the United States. In fact, the first effort to collect a national sample of Pacific Islander health data, during the 2015 National Health Interview Survey (NHIS), excluded non-Lesbian, Gay, and Bisexual gender and sexuality demographics (Wu & Bakos, 2017). Both the 2020 U.S. Census and NHIS will once again miss another opportunity to collect critical data on sexuality and transgender identity (Center for Disease Control and Prevention, 2020; U.S. Census Bureau, 2020). Collecting and analyzing these data are critical to understanding the health disparities experienced by the QTPI community is critical to developing health interventions. The systemic prejudice in exclusion of indigenous queer and transgender populations – including QTPI's –within national surveys like the US Census and NHIS, continues to erase not only the QTPI population, but their health issues as well.

QTPI Health Issues

Although there is limited academic literature that examines specific causes of health disparities in QTPI communities, research in other Indigenous Queer and Transgender and Two-spirit people found an association between poor health and experiences of interpersonal and historical trauma (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Fieland, Walters, & Simoni, 2007). For example, Queer and Transgender Indigenous people's experiences of

heterosexism and homophobia within their indigenous communities have been associated to poorer mental health in both Pacific Islander and Non-Pacific Islander populations (Fieland et al., 2007; Lawson-Te Aho, 2016). Additionally, among Two Spirit people, those who experience racial discrimination also had a lower associated odds of self-reported overall health compared to heterosexual American Indians (Chae & Walters, 2009). The "Indigenist" Stress and Coping Model, attributes these health disparities in indigenous Two-Spirit[1] populations to historical trauma and current trauma related to colonization (Fieland et al., 2007; Walters & Simoni, 2002). Although little is known about QTPI health disparities, their experiences may be similar to Native Two-Spirit populations. Therefore, ecosocial stressors related to colonization may drive health disparities for QTPI.

For centuries, indigenous gender and kinship practices, existing outside western gender and sexuality norms, have persisted despite the epistemicide of these cultural roles. For example, Māhū are Kānaka Maoli (Native Hawaiians) that exist in the middle of masculinity and femininity and Āikane are Kānaka Maoli who have a close kinship (sexual or non-sexual) with someone of the same gender (Kauanui, 2018). These ways of being are similar to the lived experiences of CHamoru Gela' and Pinalao'anan people, Sāmoan fa'afafine and fa'atane, and many more Queer and Transgender indigenous people from the Pacific. These roles hold cultural significance compared to Western Queer and Transgender identities. For example, in Guåhan (Guam), Queer and Transgender CHamorus practice poksai, where they become caregivers of children in their families whose parents are unable to care for them (Camacho, 2015). Kumu Hinaleimoana Wong-Kalu, a prominent Māhu Kumu Hula and cultural leader, has also recounted that Māhū have historically been the "caretakers, healers, and teachers of ancient traditions"

[1] Indigenous term roughly equated to American Indian/Alaska Native people who identify as Gay, Lesbian, Bisexual, or Transgender (Fieland, Walters, & Simoni, 2007).

(Hamer, Wilson, & Wong, 2014). Although these identities have existed for centuries, western colonialism's indoctrination of Christian beliefs and western values into indigenous cultures impacts how Pacific Islander communities treat QTPI (Camacho, 2015; V. M. Diaz, 2010; Fieland et al., 2007; Kauanui, 2018; Kerekere, 2017). Indoctrination led to the epistemicide[2] of indigenous gender and kinship practices, instilled heteronormativity and heteropatriarchy into Pacific cultures, and cemented the norms, biases, and systems of oppression (i.e. heterosexism, transphobia, racism) that we see in indigenous and Pacific Islander communities today (V. M. Diaz, 2010; Kauanui, 2018; Kerekere, 2017; Smith, 2016). Experiences of gender and sexual oppression and their intersections with racism have been amply linked to health disparities in Queer and Transgender populations (Center for Disease & Prevention, 2014; Center for Disease Control and Prevention, 2019b; R. M. Diaz, Ayala, & Bein, 2004; Frost, Lehavot, & Meyer, 2015; Sutter & Perrin, 2016). Colonization, epistemicide, and structural oppression contribute to health disparities in QTPI populations.

Research on other indigenous populations have illuminated that Queer and Transgender indigenous people have a greater risk for health issues compared to non-Queer and Transgender indigenous people (Balsam et al., 2004; Fieland et al., 2007). QTPI, as compared to the general Pacific Islander population, may be at elevated risk for health issues. For example, QTPI may be at higher risk for STIs compared to non-QTPI pacific islanders. Pacific Islanders generally have a higher likelihood of HIV diagnosis and a higher prevalence of gonorrhea and syphilis compared to Whites (Center for Disease Control and Prevention, 2019a; Office of Minority Health, 2020). This risk for STIs and HIV can be amplified by QTPI people's exposure to heterosexism, homophobia, and transphobia; which have all been shown to elevate Queer and

[2] Epistemicide - Epistemicide is defined as the systematic destruction, devaluation, and erasure of indigenous and non-western knowledge systems through colonial practices. (Hall & Tandon, 2017)

Transgender peoples risk for HIV and STD infection in comparison to straight and cisgender populations (Ayala & Diaz, 2001; Center for Disease & Prevention, 2014; Díaz, Ayala, Bein, Henne, & Marin, 2001; Herbst et al., 2008; Schulden et al., 2008). QTPI may also be at higher risk for mental health disparities compared to non-QTPI Pacific Islanders. Although Pacific Islanders have lower rates of depressive episodes compared to whites (Office of Minority Health, 2020), QTPI may experience higher rates of suicidality and depression than cisgender and straight Pacific Islanders. This is evident as other Queer and Transgender populations have been found to experience elevated rates of suicidality and depression (Mustanski, Garofalo, & Emerson, 2010). Finally, Transgender Pacific Islanders may also experience greater barriers to healthcare compared to non-Transgender Pacific Islanders. Over half of the respondents of the 2015 U.S. Transgender Survey reported being denied insurance coverage for transitioning surgeries and one fourth of respondents were denied insurance coverage for hormone therapy (James et al., 2016). This serves as a barrier to accessing care but also a determinant of their mental health as these services have been demonstrated to be critical to supporting Transgender people's mental health (Olson, Durwood, DeMeules, & McLaughlin, 2016). Existing epidemiological literature on Pacific Islander, Queer and Transgender health suggests that QTPI may experience higher rates of illness and more barriers to healthcare compared to Non-QTPI Pacific Islanders.

The inability of epidemiological research to accurately represent indigenous peoples health is a form of colonization (Houghton, 2002). Current epidemiological and health services research suggest that QTPI have greater health disparities compared to the non-QTPI Pacific Islanders. However, current epidemiological research methods do not capture the historical trauma, discrimination, culturally specific coping tools, or cultural taboo that impact health

disparities faced by many indigenous populations (Lehavot, Walters, & Simoni, 2009; McGrath & Ka'ili, 2010; Walters et al., 2011), including Queer and Transgender indigenous people (Fieland et al., 2007). Exploring protocols for collecting and researching QTPI health information may create foundations to identify their health disparities. Though the health disparities experienced by QTPI have not been well documented, there is still a need for health interventions to improve their health.

Culturally Rooted Health Interventions

Public health and social science frameworks and indigenous worldview can be used to better understand approaches to promoting QTPI health. Bevacqua (2019) notes that Mo’na is a CHamoru worldview that blurs the boundaries between past, present, and future, and sets the premise for CHamoru’s spiritual connection to their ancestors. Duran, Heart, & Horse-Davis (1998) noted that historical trauma, including epistemicide, is a soul wound experienced through one’s ancestral lineage. Using this CHamoru worldview allows one to understand that QTPI may experience intergenerational trauma related to the suppression of their identities within their communities. Their proximity to trauma – specifically gender and sexual oppression; epistemicide; and colonization – and when this trauma is addressed determines the health outcomes of QTPI. The “Indigenist” Stress and Coping Model notes that cultural buffers exist that dampen the impacts of historical and current trauma on indigenous Queer and Transgender people’s health. This includes identity, enculturation, spirituality, and traditional health practices. Improving Queer and Transgender indigenous people’s health requires addressing the impacts of historical trauma, the erasure of indigenous morality, and the insertion of oppressive western and religious institutions. Health interventions that address the impacts of colonialism and

epistemicide through improving cultural buffers, like culturally rooted health interventions, may have the greatest impact on improving the quality of QTPI Health.

Although there is little research on culturally rooted health interventions designed to improve QTPI health, there is a growing body of research that has demonstrated the success of these interventions in facilitating better health outcomes for indigenous populations (Walters et al., 2018). Project Kā-HOLO's pilot of a hula intervention has been shown to improve hypertension among Native Hawaiians (Kaholokula et al., 2017). Tālanoas, a pan-Polynesian form of conversation that is grounded in balance, sacredness, and mana (potency) (Tecun , Hafoka, ʻUluʻave, & ʻUluʻave-Hafoka, 2018), have been effective in increasing Washington Sāmoan and Tongan youth's health literacy about risky sex behaviors and drug and alcohol consumption (McGrath & Ka'ili, 2010). Intertribal Talking Circles have been effective in preventing substance abuse in Native American populations (Walters et al., 2018). Many culturally-rooted health interventions, developed by indigenous communities in Oceania and around the world, seem to be effective in improving all indigenous people's health.

Although a growing body of research supports that culturally rooted health interventions have the ability to improve indigenous health, little is known about the mechanisms by which these interventions support the health and wellness of indigenous populations, especially those that are Queer, Transgender, and QTPI. Exploring these mechanisms are critical, as cultural practices are susceptible to colonial and western influences of homophobia, transphobia, transmisogyny, and heterosexism which harm QTPI health. Therefore, it is imperative to explore the mechanisms by which culturally rooted health interventions can improve QTPI health and alter the impacts of colonialism and epistemicide as a root causes of health disparities for QTPI.

Current Research

Little is known about the specific health disparities experienced by QTPI populations. Therefore, exploring the health issues that QTPI face and how to best collect their health information is necessary. Although a growing body of research is exploring the mechanisms by which culturally rooted health interventions improve indigenous peoples' health, very few bodies of work address these mechanisms for QTPI. To best support QTPI health, mechanisms by which culturally rooted health interventions can improve QTPI health must be examined. The current research seeks to use qualitative research methods to explore the health issues experienced by QTPI, ways health information can best be collected from QTPI, and the mechanisms by which culturally rooted health interventions can improve QTPI health.

Methods

Project Isa was an exploratory qualitative study utilizing semi-structured interviews that examined the health perceptions of QTPI. For this study, principles of community-based participatory research were used in the study's design and protocol. Data collection was impacted by Washington state stay home orders enforced during the COVID-19 pandemic. Human-subjects approval was granted by the University of Washington's Institutional Review Board before research activities began.

Participants

Twelve QTPI participants from Washington state were recruited using a combination of purposive and snowball sampling. Participants were recruited using posts on Facebook and Instagram, flyers, emails, and through word of mouth. Targeted recruitment was accomplished through ads sent via social media channels and email listservs of UTOPIA Seattle, the Associated Students of the University of Washington's Pacific Islander Student Commission,

and other Pacific Islander community leaders. Participants were asked to share the study recruitment ad with their networks once they completed the study. Participants included in our sampling frame self-identied as a Pacific Islander and Queer/Transgender, a non-cisgender indigenous gender, or non-heterosexual kinship practice; were 18 years of age and able to speak English. Participants who did not reside in Washington state were excluded from the sample.

Community Advisory Committee

Wilson (2008) suggests that indigenous research at its core must practice respect and reciprocity with the communities that participate in it and honor cultural protocols of that community. In practicing inafa'maolek – the CHamoru values embodying relationality, reciprocity, and respect – and community-based approaches to public health research, a community advisory committee (CAC) of two QTPI Sāmoan and two QTPI CHamoru leaders and elders was formed to advise the study. The leaders and elders were identified and selected based on their service and involvement with community-based organizations that serve QTPI in greater Puget sound area. Members were engaged with work at UTOPIA Seattle, the Guma Gela' Art Collective, Pacific Islander Community Association of Washington and other organizations serving the local Pacific Islander community. These relationships were used to build partnership with UTOPIA Seattle to recruit QTPI participants. The committee guided the study's ethical protocol by collaborating with the research team in the development of the study's procedures, interview guide, and cultural protocols used when interviewing participants. The interview guide and procedures were drafted by the research team then edited by the CAC. The recommendations from the CAC transformed the interview procedures and interview guide to include Pacific Islander cultural values and practices. Pacific Islander practices of story-telling were incorporated into the interview guide and practices of reciprocity were included in the changes.

For example, many of the questions that asked about QTPI's interactions with healthcare providers when discussing their health were deemed by the committee as too sterile and cold. They suggested asking participants to tell stories of their interactions with providers instead. The CAC also altered research protocol so that food be shared with participants during the interviews to help participants feel like they were having a conversation rather than feel like they were having their information extracted from them. The CAC explained that most Pasifika people hold conversations over sharing meals. Once interviews were completed, the CAC advised the development of the codebook. The codebook was initially drafted by the research team, then was presented to the CAC with deidentified interview excerpts that exemplified each of the codes. The CAC then recommended the inclusion Pacific Islander, Queer, and Transgender epistemologies into the framing of the codes. For example, agofli'e, a deep CHamoru understanding of visibility, understanding, and love, and alofa, the many ways in which Pasifika people express love, were added to the Visibility and Love code used to identify culturally rooted health intervention mechanisms (see Appendix C). The CAC will further guide and assist in the publishing of the study's results. As the study intends to explore ways to benefit the health and wellness of QTPI in Washington state and globally, the findings will be disseminated in the community upon completion of the research.

Social Location

The principal investigators of the study identify as a tenured Kānaka Maoli faculty member and a Queer CHamoru graduate student from the University of Washington. The remainder of the research team consisted of 3 undergraduate research assistants from Pacific Islander, Queer, and Transgender backgrounds. The research team received guidance from the CAC on stating these social locations when engaging in research with QTPI community. With

the assistance of the CAC's guidance, the research team was able to create self-reflective research protocol that facilitated trust and ethical practice with QTPI community members.

Procedure:

The study implemented exploratory semi-structured in person *(n=6)* and videoconference (*n=6)* interviews (*n=12*) on the UW Seattle Campus, the UTOPIA Seattle office in Kent, and over Zoom's web-based video conferencing. The interview guide includes questions (see Appendix A) aimed at exploring QTPI health concerns in relation to their QTPI identity, experiences of providers collecting their health information, and an interactive mapping activity utilizing a tree diagram (see Appendix B) to facilitate conversation on what QTPI perceptions of cultural facets are critical to improving their health. All interviews were recorded using a digital sound recorder or Zoom's recording software and were approximately one hour in length. Participants were compensated with a $20 or $25 visa gift card at the end of the interview. Participants received $25 visa gift cards as $20 visa gift cards were unable to be acquired by the research team during a second round of purchasing as they were unavailable from retailers. During in-person interviews light snacks were shared with the participants in accordance with the CAC's recommendation. Once interviews were completed, the audio recordings were transcribed using trint (Trint Ltd., 2020), an online automated speech to text transcription software, then edited for transcription errors by the researchers on trint and Microsoft Word. Transcriptions were then uploaded to Dedoose (SocioCultural Research Consultants, 2016) for coding and qualitative analysis.

COVID-19

Due to the global COVID-19 pandemic, in-person interviewing was suspended in late February 2020. As social distancing forced interviewing to an online format, interviews were

conducted via Zoom's web-based conferencing services. To maximize security, participants' were emailed a link and password to join the Zoom call and Zoom's waiting room feature was enabled allowing the researchers to moderate entry into the call. In addition, participants video settings were switched of for the interview and screennames were replaced with participant numbers by the researchers. All recordings were downloaded from Zoom and deleted from its database once downloaded.

Analysis

Due to COVID-19 related study delays, we were only able to complete 12 interviews. Inductive thematic saturation and data saturation, or the degree to which new themes and data appear in interviews (Saunders et al., 2018), was assessed upon the completion of the first 6 interviews once stay-at-home orders were implemented and at the completion of all 12 interviews. More interviews are needed to confirm saturation. A codebook was developed by the research team which drew on previous literature, our conceptual models, and recommendations from the CAC. We also read two initial transcripts to identify additional themes before coding began. All interviews were coded and analyzed using Dedoose's web-based qualitative analytic software. Interviews were coded for health experiences of QTPI; positive, non-preferred, and culturally responsive experiences of health information collection with providers; and culturally rooted health promotion mechanisms. Each transcript was coded by two research team members independently, then consolidated by all coders as a group to reconcile codes to ensure intercoder reliability. Once completed, all coded excerpts were reviewed for common and unique themes within each code category. The following section contains findings from this analysis.

Results

Demographics

Participants were CHamoru (*n=5)*, Sāmoan (*n=6)*, Filipinx (*n=1)*, and Tongan (*n=1)* in descent and ranged between 22 -42 years old. One participant identified as being of both Sāmoan and Tongan descent. One participant's gender was not quantified to protect their anonymity. Gender, sexuality, and other demographics can be found in **Table 1.**

Table 1. This table represents the demographics of the study's participants

Variable	n	%	$\bar{x}$
Ethnicity	12		
CHamoru	5	41.7%	n/a
Filipino	1	08.3%	n/a
Sāmoan	5	41.7%	n/a
Sāmoan-Tongan	1	08.3%	n/a
Sexuality	12		
Gay	2	16.7%	n/a
Gela'	3	25.0%	n/a
Queer	3	25.0%	n/a
Straight	4	33.3%	n/a
Gender	12		
Cisgender Female	2	16.7%	n/a
Cisgender Male	2	16.7%	n/a
Fa'afafine	5	41.7%	n/a
Gela'	1	8.3%	n/a

Pinalao'anan/Tinalao'an	1	8.3%	n/a
Not Quantifiable	1	8.3%	n/a

Qualitative Results:

Our analysis of the personal stories that QTPI shared, provided insight into the following: how they experience their health, best practices in collecting their health information, and aspects of Pacific Islander cultures that would best promote their health. Results were based on codes that captured health issues experienced by QTPI, interactions with providers when they discussed their health information, and culturally rooted health promotion mechanisms. QTPI ideas of health often included their ability to feel whole, such that their mind, body, and spirit[3] were in harmony. Their narratives also suggested that providers who were able to address their culturally specific needs as both Pacific Islanders and Queer and/or Transgender people impacted their ability to share their health information. Finally, QTPI suggested that the ways their cultures, communities and family practice alofa and agofli'e greatly impacted their spiritual, cultural, and mental health. Examples and thematic analysis from their stories are discussed in the following subsections. Excerpts were edited to improve their clarity and readability by removing pauses, repetitive speech, and grammatical errors.

Colonization's Impact on QTPI Health

QTPI identified they or others in the community experienced heart disease, diabetes, STDs, anxiety, suicide, depression, sexual and gender-based violence, imposter syndrome, and gender dysphoria. QTPI notions of health commonly involved how they felt their mind, body,

[3] Mind, body, and spirit is a holistic health concept integrating psychological, physiological, and spiritual health that has been identified by Māori healers as an important facilitator to indigenous health (Mark & Lyons, 2010).

and spirit were shaped by cultural and societal norms. These were often expressed in relation to internalized oppression, imposter syndrome, experiences of violence, and gender dysphoria. One Fa'afafine participant discussed how gender norms in Sāmoan communities have an impact the health of Fa'afafine:

> *"…The stories that I've been told over and over again is that women…were the heads of families... And we've transitioned to a society where….being feminine isn't a strength anymore... I can see the impacts of…the attack on femininity. And it doesn't just affect me…it also affects any person who is femme… And there's never any space for…men to explore what femininity is.... A lot of that internalized fa'afafine phobia that you carry with you, it follows you into adulthood. And for me, I sought validation and felt affirmed by men. And in some ways, I was being fetishized …. but it helped with my self-esteem... You go searching for what's missing from your own family, and sometimes it's in the wrong places, where you are met with more violence.*

QTPI expressed that Pacific Islander cultural norms around gender and sexuality disrupted the harmony between their mind, body, and spirit. Many of them identified homophobia, transphobia, transmisogyny, and heterosexism as engrained into their cultural belief systems and causes for these disruptions. A CHamoru Pinalao'anan participant discussed how homophobia and transphobia influenced their feelings of imposter syndrome, then linked this to their ability to feel connected to their cultural identity:

> *"With being Queer, Trans, and PI, you do get secluded ... pushed away in a box from PIs who are straight and cisgender… our community has been shamed…oppressed… because of our gender identities and sexual identities. …..We've had to search harder for people who identify similarly and accept us because we're not accepted by PIs as a*

> *whole. ...Homophobia, transphobia, and phobias are still very prominent within Pacific Islanders….Being excluded from your people because of your gender and sexual identity adds a lot more strain on the mental. It's like, "oh, aren't these my people, this is my culture too," you know?...*

Although QTPI identified oppression of their gender and sexuality by their families; communities; and cultures as causes disconnection between their mind; body; and spirit, they identified colonialism and colonization of their communities and land as root causes of health conditions. Some participants suggested that colonialism and colonization established gender and sexuality-based oppression that exist in their cultures today. Another Queer CHamoru participant illustrates this relationship between colonization and oppression below:

> *"I think about colonization as being the root of heterosexism, transmisogyny and transphobia… In our Indigenous world views….including many Pacific Islander world views, people who we call trans or queer, often hold and have held spiritually significant and important roles in the community. And I think that the erasure of that through colonization endangers our lives. But it also endangers the health of the entire community because ... what was once a resource to our community ... is now an excuse for disconnection and violence."*

Cultural responsiveness and respect from providers

QTPI suggested cultural responsiveness – the ability of a provider to adapt their standard questioning and conversational practice to specific Pacific Islander, Queer, or Transgender cultural norms – influenced QTPI's ability to share their health information with their providers. Cultural responsiveness influenced QTPI's ability to trust their providers. One Fa'afafine

participant noted she felt comfortable and respected by her provider when they asked her about her preferred pronouns and name:

> *I went to [a clinic] and I met with a female doctor. I wasn't sure how to feel about that, because I'm a male to female transwoman seeking… hormone replacement therapy. Part of me was like, how would a white woman know about… what I need as a trans woman? I mean, she sounded like she was pretty educated around trans care. And when I first sat down... Basically, she first asked me what my preferred name was and what my preferred pronouns were. So that explained a lot to me…like this person is trying to respect me for who I am. And is doing her best to make sure that she doesn't misgender me … I felt like it was a pretty pleasant experience.*

QTPI expressed discomfort with providers who did not take their Queer and Transgender identity into account when asking about their health concerns. Transgender participants suggested that providers would ask inappropriate questions about their gender that were unrelated to their health. A different Fa'afafine participant discussed this type experience with her provider:

> *"Questions…that reduced me down to my body parts and just my body in general…were…not appropriate for the relationship that I have with my medical provider. But also, not at all related to…what I was there for as far as my visit. I remember trying to find a primary care physician here when I first moved down… and I was referred to [a clinic]. They asked questions like, when was your last period? And I was like, "oh, I don't have a period, I'm a trans woman"…. And they were just creepy and asked, "do you have a vagina"… This was our first-time meeting; it was a*

> *consultation…And it just was a very uncomfortable experience. You know, I'm good at masking that. But yeah…that happens all the time."*

Sexual health issues, such as HIV and STDs, and mental health issues, such as suicide and depression, were identified by participants as common health conditions experienced by QTPI. QTPI noted that cultural taboo around sexuality and mental health impacted their ability to talk about their sexual health with their provider. A CHamoru Pinalao'anan discussed how taboo influenced their ability have a conversation with their provider about their sexual and reproductive health:

> *"…We started having talks about …reproductive organs, how to protect myself, how to be knowledgeable of their functions or what could happen. This was awkward…but the healthcare providers who were talking to me were very compassionate… They were really open and trying to make me feel comfortable, though I was like, "this is very awkward." Especially since sexual activity and sexuality, was still kind of taboo to talk about…"*

Cultural taboo and social norms around gender identity also influence QTPIs ability to share their health information with providers. Another Fa'afafine participant noted that her providers' inability to understand Sāmoan cultural taboo related to her gender impacted her ability to share her mental health experiences:

> *So, I went through counseling… I didn't like the way it was structured, mainly because I felt that I couldn't relate to some of the stuff that they were talking about….[I] was brought up in a culture that was very male-only. Everything was taboo. It was hard for me to share my feelings. But at the same time, it was also hard for me to tell him that I*

just want to be a woman like--I just want to dress up, go to work and just, grow my hair, wear makeup and, be happy like, is that too much to ask for?

This QTPI also noted her providers' inability to understand her gender and culture collectively created a challenge when trying to talk to them about her mental health. She simultaneously had to discuss her gender identity and teach her provider about her cultural heritage:

… I have to explain to…the health care provider the value of no matter what I've been through, that's still my family, still my mom, that I still love and hold dear to my heart, because that's the person that…cared for me and who …gave me all the knowledge that I have…When I talk about cultural values with providers and how I hold that dear to my heart, there's always some question about why do I continue to value something that has hurt me?… That's always a challenge….because…that's my identity….No matter where I go, no matter where I'll be in this world, I will always be a Sāmoan fa'afafine who is rooted in family values, my Sāmoan culture, and my Sāmoan traditions. And I would always have my respect for my country and my family.

The power of agofli'e, alofa, and culture in promoting QTPI health

QTPI noted many different cultural values and traditions had the potential to improve their communities' health. These ranged from tangible practices like language, storytelling, art, dance, food, and community gatherings like to'ona'i, to intangible values like inafa'maolek – the values of respect, reciprocity, relationality – forgiveness, kindness, and familial bonds. Among these traditions and practices, participants' shared stories of how agofli'e and alofa from their friends, chosen and given families, communities, and cultures improved their health. Alofa, defined by the CAC, is the many ways in which Sāmoan people express love for one another. It takes into account practices of relationality that Pasifika people have with one another. Agofli'e,

as defined by the CAC is a CHamoru word literally defined as loving one another, but also means to really see someone; not just physically, but to see deeper into someone's reality, lived experiences, and spirit. These dynamic and holistic views of visibility and love for QTPI were seen to improve their mental health and the ways in which they viewed their mind, body, and spirit as interconnected. A Fa'afafine participant noted how the perceptions of fa'afafine in her community impacted her mental health and her ability to feel liberated:

> *I think it's more of acceptance for my community…They still see [fa'afafine] as caretakers of families without rights to express ourselves, to love who we want to love, to be who we want to be, and to be accepted just for that… We fully come out and we're just affected mentally and then just have to serve, to respect our family and to seek acceptance. [These rights] have just been denied from us and it affects a lot of my community, my fa'afafine community, and myself mentally just from that denial of what is my right.*

Although many QTPI felt rejection from their communities and families, some identified that chosen family[4] provided them with agofli'e and alofa. QPTI with chosen family connected this to better overall health. Another fa'afafine participant shared how her chosen family provided agofli'e and alofa that influenced her emotional health and identity:

> *"…The kind of moral support that it took for me to be strong and confident as a trans woman that I am today, I would have never received in my family. And I know they love me dearly, but they would have never understood that because they're not trans, they're not fa'afafine...And as much as they want to understand and support me, they never truly do. And because I have that choice to create chosen family with other people that truly*

[4] Chosen family can be defined as nonbiological kinships that are formed as a source of social support for an individual (SAGE).

> *identify with the way I am, I get to get to benefit from that, because I get to bring in the support that I never had in my given family. Emotionally and mentally I find that it's therapeutic because normal conversations we have as a family are not normal conversations that I see in any other families…"*

Other QTPIs suggested that lack of agofli'e and alofa in their cultures impacted their ability to feel their mind, body, and spirit were connected and how this impacted their overall health. In CHamoru language, there isn't a commonly used word that identifies someone who is Queer or Transgender. Queer and Transgender CHamoru people have recently reclaimed old terms like Gela' and Pinalao'anan to describe their gender and sexuality. One Gela' CHamoru identified how having CHamoru workds to describe their identity expressed agofli'e and alofa from their culture and has impacted the ways their mind, body, and spirit feel interconnected:

> *"A lot of people are trying to figure out ways to articulate themselves and often times outside of their own cultural contexts. Therefore, I think there's always something that's lost in translation…Within, our culture, Western culture, and the Queer community at large…there's a lack of discussion around our experiences. And I think ... that leads to a lack of resources [to] recognize, build, and contribute to a healthy, intimate relationship…And so that definitely leads to…domestic and sexual violence…. Not having representation or feeling like you have a voice in your community…. takes a toll on how you see yourself. It's influenced [by] how the community and the world sees you… You're oftentimes stereotyped or pushed… You're not allowed to exist as a person, period. And so I think that further drives…toxicity, and all of us mad."*

Other QTPI suggested that feeling of agofli'e and alofa are dependent on environmental contexts. Several QTPI shared that they felt greater agofli'e and alofa in WA state and felt

healthier compared to living on their home islands. A female CHamoru Ge'la feared losing a sense of agofli'e and alofa when she moved back to Guåhan. She noted how this might have a negative impact on her mental, emotional, and spiritual health:

> *"I think our people's history points at ways in which we can extend our lineage. And I don't think that we're there yet, to realize that queer children can also be an extension of your lineage…[In WA] there's just this aura in the air and the energy that you feel that it's okay to be who you are and to be with the person that you choose to be with… that has contributed so much to my mental, emotional, and spiritual health…Back home, granted my and my partner's family have definitely come to terms with our relationship, it's still really hard. They're very focused on…having a son and a daughter in law…grandkids…So, they have only been exposed to that one view in life that then reinforces a lot of the history that we've talked about…I just felt like it was going to go back to being hush hush, you know?"*

Finally, most QTPI described religion as detractive to their ability to feel like their mind, body, and spirit were connected. Many QTPI had complex or poor relationships with Christianity and religion and noted that Christian religion was a source of trauma and mental distress. One CHamoru participant noted that indigenous spiritual practices improved their health. Generally, QTPI noted that a lack of alofa and agofli'i for their gender or sexuality from their community was dependent on religious views of their sexuality and gender. One fa'afafine exemplified this relationship when comparing and contrasting her experiences in her sisters and her own church:

> *"A very huge percentage of the Pacific Islander community are ongoing church members. When going to church they are instilled with ideas from the Bible, people's perspectives of it, of what's considered a norm… And I think when people are building a*

bond, these ideas, and principles affect a certain community because… according to them, LGBTQ is frowned upon and it's a sin. So that affects their decision of acceptance for the community. And I think it's just solely based off of not knowing. And then they are hit with this idea of religion, church and everything of what's a norm, and this is being considered taboo and unacceptable."

Discussion

The results of this study indicate three major themes related to how QTPI experience their health:

1. QTPI views of their health were related to harmonious relationships between their mind, body, and spirit; these relationships were shaped by societal and cultural norms.
2. Cultural responsiveness, and a simultaneous understanding a QTPI's culture; gender; and sexuality, creates comfort and greater ability to talk about their health with providers.
3. Agofli'e and alofa were identified as important cultural mechanisms to improve QTPI mental health and the relationship between their mind, body, and spirit.

These findings indicate that the ability of providers to respond to the specific cultural needs of QTPI and their ability to conceptualize QTPI identity in its entirety reduce barriers for QTPI to discuss their health experiences. They also inform that health promotion interventions that address colonialism should also facilitate the relationships between QTPI, their communities, and their families to support QTPI health. This section relates these findings back to established literature and discusses the limitations and future directions of this study.

Colonization impacts QTPI health through the mind, body, and spirit relationship

Generally, QTPI conceptualized their health within a context of being able to feel whole; such that their mind, body, and spirit are strongly connected. These feelings of wholeness are

shaped by societal norms that perpetuate QTPI experiences of oppression and were attributed to colonization's impact on Pacific Islander cultures. QTPI shared experiences where they did not feel complete because of the suppression of their identities by their cultures and communities. In a qualitative study done in Aotearoa (New Zealand), Māori healers emphasized the connectedness of Māori's mind, body, and sense of spirit was an essential part in creating holistic health for Māori people (Mark & Lyons, 2010). Smith (2016) suggests that heteropatriarchy - the normalization of heterosexuality and male gender in society that underlies the oppression of queer and transgender people - is upheld by colonialism and the erasure of indigenous identity. V. M. Diaz (2010) further suggests that the cultural taboo of Queer identities in Pacific Islander cultures is also a result of the indoctrination of Western religion and values into Pacific Islander communities. Most participants of the study discussed that colonialism was a root cause of many of the health issues experienced by the QTPI community. One Queer CHamoru even indicated that the erasure of Queer and Transgender indigenous people in Pacific Islander cultures took away their roles as healers, which inevitably impacts the health of all Pacific Islanders.

Culturally Responsiveness improves QTPI's comfort with providers

Cultural responsiveness created safe and welcoming environments for QTPI to share their health experiences with their providers. According to the 2015 U.S. Transgender Survey, a large proportion of Transgender people reported mistreatment or verbal harassment from providers (James et al., 2016). This was similar to the way one fa'afafine described her experiences in finding a Primary Care Provider. In addition, the 2017 Center for American Progress Survey noted that 8 percent of LGBT respondents said they delayed or avoided care because of discrimination they experienced from their providers (Krehely, 2009). Cultural taboo around

sexuality and mental health may also influence QTPIs ability to share their health information with providers (Mirza & Rooney, 2018). Previous studies suggested that mental health is stigmatized in Pacific Islander communities (Subica et al., 2019). The CDC also notes that sexuality, specifically homosexuality, is highly stigmatized in Native Hawaiian and Pacific Islander populations (HIV and NHPI) (Center for Disease Control and Prevention, 2019a). Providers ability to respond to these taboo and to the specific Queer and Transgender health needs of participants can improve their QTPI's comfort in discussing their health concerns. Finally, the inability of medical providers to simultaneously think about QTPI's identity as a Pacific Islander and Queer/Transgender served as a barrier to sharing mental health experiences. The ways providers ascertain QTPI health concerns needs to address the complex intersectional social issues that impact QTPI health.

Agofli'e and Alofa as mechanisms to promote QTPI Health

Although QTPI identified specific cultural practices and values as important to improving QTPI health, the ability of Pacific Islander communities and families to practice alofa and agofli'e for their Queer and Transgender members were seen to promote QTPI mental health and the connections between their mind, body, and spirit. In Aotearoa, Kerekere (2017), developed a suicide prevention resource for Takatāpui to help raise awareness and visibility of their identities and their experiences of mental health. QTPI suggested that being "seen" by their communities and cultures was critical to creating strong relationships between their mind, body, and spirit. QTPI who felt disconnections stemmed from their culture's erasure or devaluation of their identity. According to the SAGE encyclopedia of Psychology and Gender, ethnocide has erased language and historical evidence of non-heterosexual sexualities in Pacific Islander cultures (McCubbin & Marcus, 2017). Furthermore, many QTPI found agofli'e and alofa in their chosen

families in lieu of a lack of this visibility and love from their given families. This type of support from their chosen families were perceived as promotive to their health. As many of our participants live in diaspora, several of them suggested that they feel greater senses of agofli'e and alofa living in WA compared to their home islands. Many QTPI considered Christianity as harmful to their health as church and religion were sources of trauma and mental distress. However some suggested that a church's ability to practice values of agofli'e and alofa are promotive to their health. The Indigenest Stress Coping Model notes that spirituality is complex in how it can facilitate better health of Queer and Transgender indigenous people (Fieland et al., 2007). One participant who had a positive relationship with her church community suggested that a Pacific Islanders ability to express agofli'e and alofa for their QTPI community members was dependent on how religion viewed QTPI identity.

Strengths and Limitations of the Study

One major strength of this study is that it utilized CBPR principles to engage community members to take part in the research development. The inclusion of the CAC's guidance greatly improved the validity of our analysis and helped us to ethically and effectively collect data from the WA QTPI community. Although QTPI community members were not active in the data collection, bringing in Pacific Islander epistemologies and praxis improved the quality of the research. Futhermore, Queer, Trasngender, and Pacific Islander researchers were used to collect data which helped to improve ability to capture accurate and high quality data. Including practices of storytelling and conversation as well as the introduction of values into our coding scheme helped to structure the data collection process in a way that would best reflect QTPI experiences and capture nuances that would not be understood using non-community centered approaches to research. This thesis project serves to help build trust with the community in hopes

to expand upon this study's findings and collectively create better health research and health promotion for QTPI.

Although CBPR was useful in collecting accurate information about QTPI's experiences of health, several limitations to the study's findings still exist. One limitation is that the study's sample was strongly biased towards the experiences of Sāmoan and CHamoru respondents. Future studies of QTPI health should look at a greater diversity of Pacific Islander populations to get a stronger understanding of unique and common health experiences. Another limitation to this study is that COVID-19 influenced data collection practices and recruitment of participants. During digital interviews, being unable to have face to face conversations with participants and to share food while talking may have impacted the ability of participants to share their stories and parts of their life as well as consistency of data collection. The study was also limited in that participants were not asked to discuss specific barriers to disclosing health information with their providers. Although some participants shared their experiences with providers and how it impacted their ability to share health information with them, other research suggests that barriers such as non-provider discrimination could impact Queer and Transgender populations' ability to disclose health information(Krehely, 2009). Finally, the current research questions do not adequately address common themes of sexual violence, gender-based violence, and sex work, which were discussed by QTPI and were beyond the scope of the study. Future studies should seek to examine these health issues further.

Conclusion

In conclusion, providers should consider the ways they practice cultural responsiveness to create safer environments for QTPI to share their health experiences with them. Furthermore, practices of agofli'e and alofa should be included in models and culturally-rooted health

interventions that seek to improve QTPI health. Culture is a critical determinant to consider when seeking to understand and improve QTPI health. QTPI's ability to understand the complex ways that colonialism impacts their health and culture may hold the key to reducing health disparities impacting their community more. This project demonstrates that Pacific Islander researchers and allies who are passionate about these small underrepresented and vital communities are necessary to continue building collaborations with this community in support of their health and wellness.

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Appendix

Appendix A:

Contains questions asked during the interview. Participants were encouraged to use indigenous language and storytelling to answer the questions.

General Health Questions:

- *Does your cultural identity, gender identity, or sexuality influence your health?*
  - *If so, in what ways do they influence your health?*
  - *How do others' reactions to your sexuality impact your health?*
  - *How do others' reactions to your gender impact your health?*
  - *Are there any other key aspects of your identity that affect your health?*
- *What are key aspects of your people's history that affect your health as a QTPI person?*
- *Do you have a chosen family? In what ways do they support your health?*
  - if asked what a chosen family is, say close friends, community, etc
- *What are the ways that you practice relationships, (intimate, casual, or otherwise)?*
  - *How does this impact your health?*

Health Information Collection Questions:

- *Can you tell me a story of when a healthcare professional asked about your health concerns?*
  - if no, ask *if a health provider were to ask you about your health concerns, how should they ask it? Why?*
- *Can you tell me a story of when a healthcare professional asked about your sexual health?*
  - if no, ask *if a health provider were to ask you about your sexual health, how should they ask it? Why?*

- *Can you tell me a story of when a healthcare professional asked about your substance use?*
    - if no, ask *if a health provider were to ask you about your substance use, how should they ask it? Why?*
- *Can you tell me a story of when about a time when a healthcare professional asked about your mental health?*
    - if no, ask *if a health provider were to ask you about your mental health, how should they ask it? Why?*
- *If you can change how your healthcare providers ask you about your health concerns, your sexual health, your substance use, and your mental health, what are some things you would change?*
- *Which of the following would you prefer or not prefer in a program or treatment aimed at improving your health?*
    - *Western medical practices*
    - *Western medical practitioners* (i.e. nurses, doctors)
    - *Traditional medical practices*
    - *Traditional medical practitioners* (i.e. traditional healers, people who use traditional medicine when people are sick).
- *Why did you choose (insert choices)?*

Culturally Rooted Health Programs and Interventions:

This coconut tree represents community health. The left side of the page represents the Pacific Islander community broadly, the right side represents the QTPI community specifically.

Leaves:

- *The leaves of the picture represent common health conditions for a community.*
- *What are some health conditions of the Pacific Islander community that you would add as leaves to the tree? Please go ahead and list them on the diagram?*
    - Follow up
        - *What would you add or take away for the QTPI community?*

Roots:

- *Imagine the roots of the tree are the root causes of the health conditions for a community.*
- *Given the health conditions you stated about the Pacific Islander community, what do you see as the root causes of these health conditions? Please go ahead and list them on the diagram? Feel free to go back in between sections if anything new comes up for you as well.*
    - **If the participant does not identify structural issues in their commentary generally, probe cautiously.**
    - *What would add or take away for the QTPI community?*

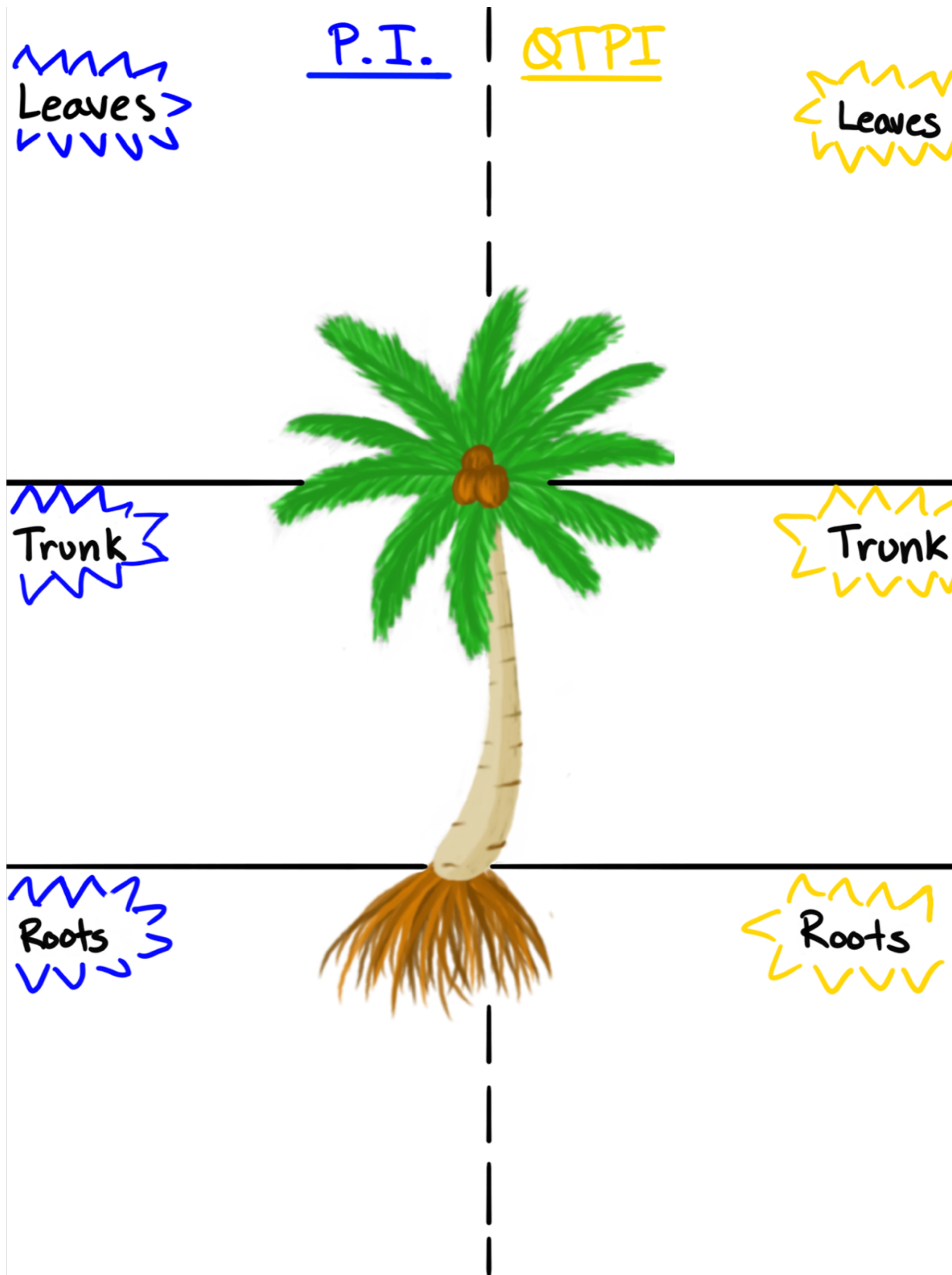
Trunk:

- *For the trunk of the tree please list traditions or practices from your culture and/or values that you have.*
    - *Which of the following do you see improving the health of the Pacific Islander community? Please underline them on the diagram.*

-
  - *How would these answers be different for the QTPI community? Would you add or take anything away?*
  - If the participant says culturally specific practices or values, ask: *Can you say out loud the practices or values that you feel are the most indigenous to your island's people?*
- *What are the ways in which the aspects you underlined on the trunk, improve your health?*
  - *Can you draw a star by the cultural practices or values you find most valuable to include when creating a program designed to improve the QTPI community's health on the paper?*
    - *Why are these more important than others?*
    - *How are they important in relation to your health?*

Appendix B

The following is the tree diagram used in the *Culturally Rooted Health Programs and Interventions* part of the interview.



Appendix C

The following is the codebook used to code transcripts of participant interviews.

1 Health Concerns/Issues related to QTPI identity	This code will be used to identify different types of health issues that participants identify as being related to their QT/PI identities.
1.1 QTPI Physical Health	Participant identifies Physical Health issues (Diabetes, HIV, STD, CVD, etc) related to their QTPI identity.
1.2 QTPI Mental Health	Participant identifies an experience of mental health issues related to their QTPI identity.
1.3 QTPI Spiritual/Cultural Health	Participant identifies a disconnect between mind, body, and spirit. Participant may identify that societal norms or systemic issues are the cause of trauma, certain mental health issues (PTSD, Gender Dysphoria), or issues in their overall holistic health. Health issues arising from conflicts between one's culture, sexuality, and spirituality should be coded with this code. Examples include Gender Dysphoria in relation to a community's spiritual norms, anxiety about being out in community because of religion, or internalized conflicts that arise from interactions

	between societies norms of gender, culture or spirituality.
2 Health Information Collection Practices	This set of codes is used to identify experiences that have come up when providers have collected health information from them.
2.1 Non-Preferred experiences or ways providers collected health information	Participant identifies a particularly negative experience of discussing health information with provider OR participant identifies a non-preferred method of collecting health information.
2.2 Cultural Responsiveness	Participant identifies a culturally responsive mode of collecting health information that was not practiced by their provider. This can include disclosure of sexual identity, or specific cultural norms that were not responded to by the provider.
2.3 Positive Health Info Collection Experiences.	Participant identifies a particularly positive experience of discussing health information with a provider OR participant identifies a preferred method of collecting health information.
3 Health Promotion Mechanisms	This set of codes will be used to identify practices or mechanisms by which their culture could work to improve QTPI health.

3.1 Visibility and Love of Sexual or Gender Identity	Participant identifies that agofli'e (deep CHamoru understanding of visibility, understanding and love) or alofa (the many ways in which Pasifika people express love) of their Queer or Trans identity by their family (chosen or given), communities (Pacific Islander, queer, trans, etc.), or culture as critical to promoting their health.
3.2 Cultural Resilience	Participant identifies their personal connections to indigenous identity, race, and ability to participate in their culture or community as important to promoting their health. For example, if a participant says when they don't feel in touch with culture or feel like they can participate in cultural or community activities as being detractive from their health or visa versa.
3.3 Spirituality	Participant identifies promotive or harmful ways that spirituality impacts QTPI health.
3.4 Values and Tangible Culture	This code will be used when the participant identifies a cultural practice that is rooted in values or cultural values or tangible experiences of culture being related to health promotion (having a meal with your family, preference for use of traditional; can be negative to, if they

	identify practices that are detractive from health like SPAM having strong cultural significance).