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Prioritizing HIV Services for Transgender Women and Men Who Have Sex With Men in Manila, Philippines: An Opportunity for HIV Provider Interventions

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Abstract

Transgender women (TW) and men who have sex with men (MSM) are highly affected by the rising HIV epidemic in the Philippines. HIV providers are essential to curbing the epidemic. Between July and August 2017, we conducted one-on-one qualitative interviews with 15 HIV providers in Manila, Philippines. Overall, providers reported tension between willingness to provide care versus actual competencies. Most discussed treating every patient equally regardless of gender or sexual identities. However, many expressed hesitations in providing HIV services due to (a) not knowing the health needs of TW and MSM, (b) having little to no training in HIV, and difficulty being sensitive to patient gender and sexuality. Although providers were unsure about how to prioritize HIV services for TW and MSM, some expressed interest in learning and engaging these populations in their practices. Our findings suggest the importance of provider-focused interventions to prioritize TW and MSM health needs.

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Keywords

HIV; men who have sex with men; Philippines; prevention; providers; transgender women

The HIV epidemic is a rapidly expanding public health problem in the Philippines. After the first report of HIV in the Philippines in 1984, the increase in HIV incidence remained relatively “low and slow” until recently, when the country experienced an exponential rise in the number of people diagnosed with HIV (Philippine Department of Health, 2017). The Joint United Nations Programme on HIV/AIDS (2017) estimated that there were 10,500 new HIV infections in 2016 in the Philippines or more than seven times the incidence in 2006. The rapid upsurge of HIV infections has led to the fastest growing HIV epidemic in the Asia–Pacific region. The country-specific epidemic stands in striking contrast to declining HIV rates in other Asia–Pacific countries (Joint United Nations Programme on HIV/AIDS, 2017).

Transgender women (TW) and men who have sex with men (MSM) have been at disproportionately greater risk for HIV infection in the Philippines due, in part, to behavioral factors such as inconsistent condom use and high levels of sexual risk-taking (Philippine Department of Health, 2017; Restar et al., 2018). Recent findings indicated that TW and men, specifically MSM, were key populations vulnerable to HIV and accounted for 83% of newly reported HIV infections in 2016 (Joint United Nations Programme on HIV/AIDS, 2017). The Philippine Department of Health (2017) also noted that in these groups, two thirds of new HIV infections were in youth and young adults aged 15–29 years.

Despite significant risk of HIV infection, a limited proportion of TW and MSM in the Philippines have been reached by HIV prevention and treatment programs. In the greater Manila area, which has a population of approximately 12.8 million, there were 14 HIV Counseling and Testing (HCT) facilities as of 2018, with only two nongovernmental organization–operated clinics and one private clinic targeting MSM (United Nations Development Programme, 2017). The HCT facilities included two social hygiene clinics (SHCs) run by local governments providing sexual health screening and treatment to MSM and other patients (Ross et al., 2013). However, no known HIV prevention and treatment sites in Manila have yet provided services designed to meet the needs of TW. HIV facilities have been characterized as insufficient in their infrastructure, including limited outreach strategies and provision of care for TW and MSM. Findings from Joint United Nations Programme on HIV/AIDS (2017) showed that only 27.9% of MSM and 27.1% of transgender (TG) people in the Philippines were covered by the HIV care program. A review of the Philippine health sector response to the HIV epidemic underscored that

... most programme activities remain focused on FSWs [female sex workers], mostly through the vast and busy network of SHCs [social hygiene clinics], while HIV continues to spread, unabated, among other key populations that have little or no access to services suited to their needs. (World Health Organization, 2015a; p. 8)

Given the emerging epidemic and the lack of HIV prevention and treatment coverage for TW and MSM, there is a clear and urgent need to enhance the delivery of HIV-related

services for these highly affected populations. Prioritizing HIV services to communities that are affected by the epidemic is not only a cost-efficient strategy (Beyrer et al., 2014; Schwartländer et al., 2011; Thomas et al., 2011), which is critical for low-resourced and poor health care system infrastructure settings such as the Philippines (World Health Organization, 2015a), but also an opportunity for the Philippine public health system, including its health care providers, to target services and prevent a currently concentrated epidemic from becoming generalized (Restar et al., 2018; Thomas et al., 2011). Furthermore, in the current era of “undetectable equals untransmittable,” or “U5U,” which recognizes that people living with HIV (PLWH) who “achieve and maintain an undetectable viral load...cannot sexually transmit the virus to others” (Eisinger, Dieffenbach, & Fauci, 2019, p. 451), prioritizing HIV services to identifying and linking PLWH to care is critical to disease control and prevention. However, little is known about health care providers’ willingness and readiness to prioritize HIV services for TW and MSM in the Philippines. A recent review of the Philippine HIV literature revealed that no studies had sampled health care providers (Restar et al., 2018). The competencies and skills of health care providers to deliver HIV-related services to key populations have been shown to influence service utilization and health-seeking behavior by TW and MSM (Beyrer et al., 2012; Sevelius, Patouhas, Keatley, & Johnson, 2013). Discriminatory attitudes and behaviors (e.g., making homophobic and transphobic comments and misgendering TW by not using appropriate pronouns) by providers have been noted as major barriers to HIV service access by TW and MSM (Beattie et al., 2012; Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011), and the Philippines is no exception. A World Health Organization (2015a) report revealed high levels of actual and perceived stigma in health care settings in the Philippines, which hindered MSM from using HIV services.

In addition to having sufficient awareness and attitudes, health care providers must be culturally competent and equipped with the skills needed to interact with and deliver sensitive HIV-related services to TW and MSM (Beattie et al., 2012; Beyrer et al., 2012). Although efforts have been made to ensure the availability of HIV-related services, efforts to prioritize TW and MSM remain neglected in the Philippines. Services for TW are especially warranted because their needs are often conflated with services for MSM, despite the fact that their needs, risks, and prevention strategies are different from those of MSM (World Health Organization, 2015b).

In light of the increasing need for HIV prevention and treatment in TW and MSM, it is imperative to have an empirical examination of health care provider attitudes, perceived competence, and ability to prioritize HIV-related services to TW and MSM in the Philippines. We used a qualitative study to investigate these concerns. Findings from our analysis can provide a formative step toward enhancing the quality and effectiveness of health care services for these key populations in the context of the Philippine-concentrated HIV epidemic.

Methods

Study Design

We used a phenomenological approach (Brentano, 2012) to qualitatively investigate and deepen our understanding of the lived experiences of health care providers, including their attitudes, perceived competence, and ability to prioritize delivering HIV-related services to TW and MSM patients. Qualitative data were gathered using semi-structured, one-on-one interviews until data saturation (Saunders et al., 2018) was reached with regard to our primary aims.

Key Informants—Using a snowball sampling technique (Robinson, 2014), initial seed informants from HCT facilities were identified by our local study partners, which consisted of two HIV nonprofit organizations, and our local co-investigator (L.H.). We used seed informant referrals to identify other potential key informants, which was deemed an appropriate recruitment approach by our local study partners given that no existing public database of HIV providers had been produced in the Philippines.

Health care providers were eligible to participate if they were at least 18 years of age, had a history of serving TW and MSM, were willing to be audio-recorded and provide written informed consent, and were currently working in a health care facility that offered HIV prevention and treatment services, including local hospitals, community-based clinics or SHCs, nonprofit grassroots organizations, and state-sponsored organizations in Metro Manila, Philippines. The definition of providers was broad so as to include physicians, counselors, nurses, volunteers, and program or project care coordinators and managers. To build rapport with key informants and their organizations, members of the research team took tours of the HCT facilities, attended workshops (e.g., HIV testing workshops) given by the facilities, and collected materials (e.g., brochures, outreach materials), when possible.

Procedures—Interviews were conducted between July and August 2017. The purpose of the interview was to examine health care contextual factors that could affect HIV prevention and treatment services to TW and MSM. Interviews were conducted by two research assistants trained in qualitative interview methods by a lead investigator who was fluent in Tagalog. Initial communications with providers and staff were conducted in Tagalog; however, all interviews were conducted in English or “Taglish” (a hybrid of English and Tagalog). English is commonly spoken throughout the Philippines and was not an impediment to recruiting, creating rapport, or interviewing providers and staff. Key informants were encouraged to use Tagalog words or phrases to communicate their ideas; instances of transcribed Tagalog text were later translated into English by a linguistically competent team member. Interviews were conducted in a private space at the local offices of collaborating organizations and lasted between 60 and 90 minutes. After completing the interview, key informants were compensated 500 Philippine Pesos (about \$10 USD) for their time.

Ethics—All procedures were approved by the Brown University Ethics Review Board. Written informed consent documents were obtained from all key informants. Key informants were informed about the purpose of the study and their rights to confidentiality, withdrawal,

and refusal to answer any questions. Key informants were advised to use pseudonyms, and any mention of personally identifiable information was removed from the transcripts.

Analysis Strategy—We analyzed data from 15 qualitative interviews. All interviews were transcribed and translated, when necessary, into English. Completed transcripts and translations were checked for accuracy by an independent research team member, who was fluent in Tagalog and verified that the terms or phrases transcribed were correct and had retained their original meanings and sense of words. Once transcriptions and data quality checks were completed, the research team used Braun and Clarke's (2006) thematic analysis approach to analyzing qualitative data by immersing in the data for familiarity, generating and defining initial codes, identifying themes based on codes, and noting which themes were more useful than others in understanding the phenomenon. The team then developed a codebook based on the themes that emerged. All research team members were trained in the application of the codes. Any discrepancies in the application of codes were discussed using codebook definitions and rules until consensus was reached by all research team members. Specific for this analysis, we focused on questions, displayed in Table 1, that examined health care provider attitudes and willingness to prioritize HIV prevention and treatment for TW and MSM. All coding occurred from September to November 2017 using Dedoose (2015).

Results

Health Care Provider Characteristics

Table 2 displays key informant characteristics by role/title, type of facility they worked in, description of the facility, and target populations of the facility. The sample consisted of two physicians, four nurses, one volunteer, and five program/project officers. Seven key informants worked in nonprofit organizations, three at SHCs, two at public hospitals, and two at state-sponsored facilities. Eight facilities targeted general populations; four targeted PLWH, including TW, MSM, children, and people who used intravenous drugs; and three targeted either TW or MSM.

Themes

We identified three main themes: (a) test all, treat all; (b) hesitancy to prioritize HIV service delivery to TW and MSM; and (c) willingness to prioritize community-sensitive services for TW and MSM. Subthemes further elaborated on the main themes.

Theme 1: Test all, treat all.—Overall, key informants displayed positive attitudes, welcoming all patients in their practices. Key informants believed in the importance of treating and providing services equally to all patients regardless of gender or sexual identity. This view emerged in several ways. Some key informants recited the goals and missions of their facilities, which aligned with a stated personal belief of “equal treatment for all.” Others asserted pride in their facility's “humanistic approach” to provide services to all patients by virtue of being human, and they expressed the belief that treating everyone the same was part of providing good service. As three key informants described: “The mission is to test all and treat all” (Key Informant 1, physician); “I’m so proud that [the hospital] don’t

care if you're transgender, they don't care what's your gender as long as you're human, they give, they support, they help.” (Key Informant 6, physician); and “Regardless of what is your gender, if you're cisgender male, or you're a straight male, or if you're cisgender female, or a straight female, what's important is that we can give the good service that the clinic have” (Key Informant 12, clinic coordinator).

For these informants, gender and sexual identities were not viewed as important to the provision of HIV-related services. Instead, they endorsed a “test all, treat all” approach that deemphasized patient characteristics. They noted that this view was embedded in institutional practices and professional training: “They train us to treat every individual with the same treatment as others” (Key Informant 6, physician).

Although these statements were inclusive, they supported institutional practices and training messages that could minimize the importance of population-specific knowledge, sensitivity, and skills for providing effective HIV and other health services to patients with special needs, including TW and MSM patients. This issue is discussed in Theme 2.

Theme 2: Hesitancy to prioritize HIV service delivery to TW and MSM.—

Although key informants generally endorsed viewing and treating patients equally without regard to gender and sexual identity, some expressed hesitancy providing HIV-related services specifically related to patient identification as either TW or MSM. The hesitancy was, in part, attributed by key informants to the following subthemes:

- Limited knowledge about TW and MSM
- Limited training to provide HIV services for TW and MSM
- Difficulty understanding the need for community-sensitive services.

Subtheme A focused on limited knowledge about TW and MSM. Some key informants described a lack of knowledge about the lived experiences of TW and MSM as a reason for their hesitancy to treat these patients. Specifically, many key informants mentioned not being aware of the specific health needs that TW and MSM might present to the clinic. Even when key informants were aware of the different health needs for these patients, such as hormone therapy for TW, they often lacked the expertise to provide effective treatment, as one informant noted:

What would be their issues? I don't know, I don't have much idea about the needs of TGs [transgender people]. I know—I heard from people have this support group here, TGs are taking medications for hormones. I do not know that. I just don't focus on what they are talking about, the pills they are taking, you know? ... That's my only idea on what are the needs. The pills they are taking to enhance their physical, you know. (Key Informant 10, program coordinator)

Key Informant 13 (a physician) also discussed this issue, “In terms of prevention ... again, even for the MSM community, it's not just TG but even for the MSM, it's so hard to define what the need really is in terms of HIV prevention.”

A few key informants expressed familiarity with TW and MSM medical issues and health needs, including HIV prevention services. One provider mentioned having a “superficial” awareness of the hormone-related treatment needs of TW and expressed uncertainty about the specific mechanisms of action by which hormones affected the body:

I am not aware...I'm really not aware. [Hormone] is a very popular thing to do—it's kinda expensive, the [hormone] medical management. That's my impression ... How, what happened and what are the physical changes and what medications—it's more a mystery thing. But there are also resources on the psychological impact of this kind of patient. More or less, we have superficial [knowledge], but the awareness is there. (Key Informant 3, nurse)

Although some key informants may have had a basic awareness of TW and MSM health, our informants indicated that they had inaccurate impressions of health needs and medical issues. Key informants mentioned that their conceptualization of TW and MSM health needs stemmed from what they heard from others, instead of from formal training.

Subtheme B addressed limited training to provide HIV services for TW and MSM. Some key informants stated that they had not been formally trained about how to provide HIV-related services specific to TW and MSM. One key informant said the facility did not have tailored trainings and lacked “sensitivity” toward TW and MSM:

HIV prevention trainings? I'm not sure if there are any. I hope there are prevention trainings. But I think this [health care facility] is still struggling to grasp the whole idea of HIV and how it affects the LGBT [lesbian, gay, bisexual, and trans-gender] community. I mean, medically speaking they understand how HIV works. But they...lack the sensitivity, I think to such [LGBT] issues... So yeah that's disappointing to me. (Key Informant 4, nurse)

Others echoed that their facilities did not offer tailored trainings about providing HIV-related services to TW and MSM, despite these being the highest risk groups for HIV, because their facilities catered more toward general populations: “Training for TGs [transgender people] no, we don't have that. It's general” (Key Informant 3, nurse); and “No, we don't have training programs specifically for transgender...We also don't have [a] program for MSM. Only general population” (Key Informant 11, program manager).

Other informants said the lack of tailored training for TW and MSM patients lead some health care providers to “shun away” and discriminate against patients in their practices:

I think the lack of training on a transgender and MSM health service delivery is the main problem because most doctors would assume or shun away patients because they are not sure on how to provide service for them...So, yes, there are health care providers who may be discriminating or stigmatizing, [and] doesn't want to deal with trans. (Key Informant 11, program manager)

Another informant, when asked if other organizations were welcoming of LGBT patients, said, “Not all. I think not all because as of now, we need to face the reality that there's discrimination, there's a bullying also, there's confusing, there's questioning, something like

that. I think not all organization already accept LGBT” (Key Informant 12, clinic coordinator).

Due to training deficits, many providers “question,” “have no idea,” or “are not sure” how to provide services that respond to the needs of TW and MSM.

One key informant mentioned the need for education and sensitivity trainings regarding TW and MSM patients:

“Training, because I have no idea when it comes to being LGBT” (Key Informant 6, physician).

Subtheme C was related to the difficulty key informants had in understanding the need for community-sensitive services. Hesitancy providing care to TW and MSM patients stemmed from difficulties understanding the relevance of being sensitive to their patients’ sexual and gender identities. Often, this difficulty was shown when providers misgendered their TW patients by addressing TW with the wrong pronouns and conflated TW gender identity with MSM sexual identity (e.g., gay cisgender men). One key informant provided an example of the challenges of sensitivity to TW patients:

Actually, a lot of challenges. [Laughs] A lot. I can share one. One day, a transgender comes here in our clinic, he was actually, you know, he’s transgender because he knows that in her heart—in his heart, sorry, she loves opposite, she loves the same sex, like she’s a man, he loves a man... The challenge for that is, he wants to transition to be a girl, but that’s a challenge because if you’re physically a man and then you want to be transition immediately, or you want to be a woman immediately, that’s a challenge because if you want to be a woman you need to undergo transitioning. But transitioning is not totally one click, you will be a woman. (Key Informant 3, nurse)

Other key informants displayed similar difficulties understanding and referring to TW as women. Often, key informants addressed TW with pronouns that referred to their anatomy rather than their gender identity. As shown by Key Informant 3 (a nurse), persistent misgendering can be detrimental to the provision of gender-affirming care, such as gender transitioning. Other key informants further conflated TW gender identity with MSM sexual identity (e.g., gay cisgender men), as demonstrated in these excerpts: “It’s seldom that we have TG. But, of course, before they become TG, they were MSM, I suppose, that’s the bottom line” (Key Informant 11, program manager).

And then of course in terms of ways [of] assessment because they [health care counselors] need to be oriented on the different sexual orientation of the transgender because they might identify themselves as female, but in terms of sexual behavior, they would perform the role of the male. So those are things that we need to emphasize to our health care counselors. (Key Informant 14, program manager)

Key Informant 11 believed that TW were once MSM, which showed how that informant did not view TW as women and conflated gender identity with sexual identity and behavior. Key

Informant 14 questioned TW womanhood by describing their sexual behaviors in terms of male sexual roles instead of gender-neutral sexual behavior terminology (e.g., anal intercourse).

Theme 3: Willingness to prioritize community-sensitive services for TW and MSM.—Key informants expressed interest in prioritizing HIV-related services for TW and MSM patients and acknowledged the importance of delivering competent HIV services to TW and MSM in the subthemes of:

- Learning how to improve delivery of HIV services.
- Engaging TW and MSM in delivery of HIV services.

Subtheme A involved a need to learn how to improve delivery of HIV services for TW and MSM patients in their practices. These key informants were willing to undergo specialized trainings to enrich their knowledge of TW and MSM health needs, including HIV. As two key informants expressed: “I want to do some transgender-focused training, which is related to HIV and some transgender health problems, or something like that” (Key Informant 8, nurse); and “I think there are those who are very much keen to helping transgender people but just doesn’t know how to do so because they don’t, they didn’t undergo very specialized training” (Key Informant 11, program manager).

Some of the key informants with knowledge and sensitivity to serve TW and MSM expressed interest in training other providers. In efforts to get other providers on board with tailored trainings, one key informant expressed interest in finding ways to train and mentor other providers about the HIV epidemic while identifying infrastructure and structural challenges to training, such as turnover rates and lack of permanent working positions.

Our staff turnover is so fast, so it’s hard to mentor, it’s hard to train people ... Because, we don’t have permanent positions ... So, that’s the biggest challenge that we face...we don’t see any solution. We are trying to find ways how to speed up mentoring...I mean, try to understand it, how do you explain the whole epidemic in, like, a month? Like, so that by next month, this person is ready. It’s just not easy.... (Key Informant 13, physician) with TW and MSM to better understand how to improve services:

I think it would be unfair for us to try to recommend programs, I mean, improvement in programs and policies without us actually interacting with the community that needs the programs and services. So, we make it a point to actually always consult, spend time...we make sure that they are part of the process. (Key Informant 13, physician)

Another approach key informants addressed was to hire TW and MSM as staff members and providers. Employing staff who were TW and MSM would not only confer opportunities for members of these communities to be part of the health care system but would also help increase provider sensitivity. As described by this key informant, who later disclosed that she was a TW:

Key Informant: Yes, we have lots of soon-to-be staff, even transgender staff. I proposed that ... Because we need transgender staff. Because if a transgender client needs this service, the only person she will look [to] is a transgender also. So, I will talk with you all of your problems because we understand each other.

Interviewer: Do you think that transgender people and also transgender health is a priority in this clinic?

Key Informant: In this hospital and clinic, yes ... I believe so, because I am here. And it should be. (Key Informant 2, counselor)

By employing TW as staff, TW patients would have someone to “talk with” who could understand their problems. Moreover, TW and MSM as providers would make structural recommendations to the facility to prioritize TW and MSM patients. One key informant described the importance of integrating TW and MSM members into the governing board of the facility to ensure that the needs of these communities were represented and prioritized:

Because it was very clear in our vision mission statement that we are working into two key populations, which is MSM and transgender people, so we give them an opportunity to have equal representation in the governing board as well.” (Key Informant 10, program coordinator)

Thus, providers who received training about the HIV prevention and treatment needs of TW and MSM frequently left their positions, resulting in a continued need for well-trained and community-competent providers to take their places. Key informants here noted that the capacity to train providers about serving TW and MSM patients could not keep up with the demand.

Subtheme B addressed directly engaging TW and MSM in delivery of HIV services. One key informant mentioned the intention to “consult and spend time”

Discussion

Findings from our study provide insight into health care provider perspectives and practices regarding provision of HIV services to TW and MSM in Manila. The need for community-competent services is particularly urgent given the rapid rise and concentrated nature of the HIV epidemic in the Philippines (Joint United Nations Programme on HIV/AIDS, 2017; World Health Organization, 2016), which underscores the importance of sensitivity to gender and sexual identities when delivering HIV prevention, treatment, and related health services. Our findings highlight opportunities for health interventions to increase provider competency delivering HIV services and to improve provider–patient interpersonal relations and sensitivity with TW and MSM in Manila.

Our informants mostly used a “test all, treat all” approach to provide HIV services, which mainly catered to the general population instead of prioritizing populations that were highly affected by HIV. This view was observed to be embedded in health care facility culture and the mission to treat every patient equally and may have reflected the training providers received. A recent evaluation report on HIV education and training for health professionals

in the Philippines deemed that current medical, nursing, and public health curricula were adequate in responding to the HIV epidemic (Tawasil, Salvador, Juban, & Chan, 2012) but did not provide specific guidelines for HIV services provision for TW and MSM. Similarly, a recent national HIV strategic plan set forth by the Philippine Department of Health recommended interventions that would increase knowledge of HIV and HIV-related services for TW and MSM (Asuncion, Segarra, Samonte, Palaypayon, & Bermejo, 2017) but overlooked the vital role that health care providers had or the infrastructure in which they operated (e.g., lack of permanent work positions, lack of incentives for providers to become formally trained in HIV). In our study, key informants stated that they had limited understandings about TW and MSM health issues because they had received no training. The lack of competency and sensitivity often lead to discriminating behaviors toward TW and MSM patients. Therefore, we identified a gap in Philippine HIV research and strategic plans related to health care provider education and professional training. Specifically, we identified areas for improvement in the health care infrastructure that supported service reorientation by incentivizing providers to proactively and explicitly target TW and MSM in health services. Researchers should explore ways to promote provider HIV education for medical, nursing, and public health disciplines that specifically addresses the context of providing services to TW and MSM in the Philippines.

We also found that health care providers in Manila had limited familiarity of TW and MSM gender and sexual identities. Specifically, some key informants conflated Western-generated terminologies around behavioral risk category (e.g., MSM), sexual orientation (e.g., gay), and gender identities (e.g., transgender), suggesting that providers were unfamiliar with these terms and might not make distinctions when serving these populations, which can lead to negative health care experiences for TW and MSM. For example, some of our key informants undermined TW womanhood by misgendering or using wrong pronouns and pathologized TW bodies and sexual behaviors by equating them to MSM. Moreover, providers minimized the importance of gender-affirming health services, such as hormone therapy and gender confirmation surgeries, which might have implications for clinical and psychological outcomes for TW (Hidalgo et al., 2013). As such, to improve cultural competency and sensitivity for TW and MSM patients in Manila, it would be vital that training for providers bolster knowledge of the lived experiences and identities of TW and MWM to respond appropriately to their patients' HIV and other health needs (Hidalgo et al., 2013), including increasing provider understandings of the distinction between gender and sexual identities and behavioral risk categories, to inform care specific to these groups. Studies in clinical settings have shown improvements in provider competency and sensitivity toward TW and MSM by adapting patient-centered care and gender-affirming services and practices (e.g., use of correct pronouns and names, recognizing various gender and sexual identities in medical records, allowing use of restrooms consistent with patient gender identity, and establishing anti-discrimination policies; Reisner, Radix, & Deutsch, 2016; Restar & Reisner, 2017). Many TW and MSM, including those living with HIV, have been reluctant to seek health care due to fear of encountering prejudice and judgmental attitudes from their service providers (Adia et al., 2018; Ortega, Bicaldo, Sobritchea, & Tan, 2005; World Health Organization, 2015b). Improving sensitivity for these groups could not only enhance the quality of services but also reduce the stigma enacted and perceived in health

care settings, which could motivate HIV care engagement by these populations (Reisner et al., 2016). Research that explores ways to adapt patient-centered care and improve gender-affirming training practices by health care providers in the Philippines is warranted.

Despite difficulty understanding health needs and identities, our findings suggested that health care providers were willing to prioritize TW and MSM patients in their practices, implying that there may already be considerable buy-in by providers to take part in provider-focused interventions to improve delivery of HIV and gender-affirming services to TW and MSM. Because key informants who were familiar with the context of the epidemic were willing to train other providers, research on provider-focused interventions delivered by providers (i.e., peer-delivered) might help to study and evaluate interventions (Medley, Kennedy, O'Reilly, & Sweat, 2009). Peer-delivered interventions have been shown to improve HIV knowledge and condom use (Medley et al., 2009; Shangani et al., 2017), but most of these studies sampled community participants, not providers. Understanding the role of peer-delivered interventions by providers could be an important intervention component that could improve provider competency and sensitivity.

Finally, we found that some health care facilities in Manila had structurally integrated TW and MSM community members into staff and provider positions to improve competency and sensitivity. One previous qualitative study found that having staff and providers who matched the demographics of patient populations could bolster responsiveness to prioritizing target population health needs (Grov, Restar, Gussmann, Schlemmer, & Rodríguez-Díaz, 2014). However, as indicated by key informants in our study, integration relies on having the structural support of facilities to train individuals. Changing the provider employment infrastructure to be more sustainable by including more permanent working positions could also bolster trainings for TW and MSM to become staff and providers.

Limitations

Several limitations to the study might have affected qualitative rigor. The transferability of study findings was limited due to the specific recruitment approach and participant characteristics, which might not reflect the range of diverse experiences among health care providers in Metro Manila and elsewhere in the Philippines. Further, because the conduct of interviews might have been prone to confirmation bias, future studies using triangulation approaches (e.g., involving patient subsamples) could provide greater analytic depth by confirming, disconfirming, or enhancing nuance to the findings. Although qualitative interviews provide rich contextualization of key informant experiences, it is possible that there could be other themes that were not identified in our analysis that could further explain the context and phenomena explored in our study, including themes from providers who opted out of the study. Reasons for not participating in the study would have provided useful information for future intervention designs for this population but were not available for our analysis. Similarly, other key informant characteristics (e.g., sex, age, length of time in his/her profession, experience working with TW and/or MSM, and experience working in HIV prevention/treatment) would have provided more nuanced descriptions that could have enriched the qualitative data but were not available for analysis.

The findings provided contextual insights about provider perspectives during a specific period when the HIV epidemic was in its early phase in the Philippines and might not reflect views that have emerged as the epidemic has matured. In-person, one-on-one interviews are prone to power dynamics between interviewee and interviewer and may give rise to socially desirable responses (Collins, Shattell, & Thomas, 2005), particularly when provider knowledge about health-related topics is being addressed. Finally, although English is widely spoken throughout the Philippines and was not a barrier to this study, we acknowledge that having had interviews in each key informants' native language could have generated more nuanced responses.

Implications for Research and Practice

Our findings provide insight for future research, which must further explore factors that affect provider competency and sensitivity related to HIV services for TW and MSM in Manila, and the association of provider competency and sensitivity to TW and MSM mental health and HIV risk behavior. In addition, research is needed to optimize provider familiarity with patient gender and sexual identities, which will inform specialized and tailored health care delivery for these populations. Finally, it remains unclear how identifying as TW or MSM when seeking HIV-related care could lead to stigma and discrimination in the health care setting.

Our results suggest programmatic implications that are relevant to prioritizing HIV services for TW and MSM. Multi-level programs to improve HIV services for TW and MSM in Manila could include: (a) delineating the role of health care providers in caring for TW and MSM as part of the national strategic plan; (b) incorporating specific topics related to HIV prevention, gender, and sexuality in health professions education; and (c) strengthening health care and HIV care systems by addressing the limited resource infrastructure and improving human resources employed in these facilities, with strategies such as incentive-based schemes for providers to receive HIV training and work positions, as well as training/hiring TW and MSM as health care staff and providers.

Conclusion

To our knowledge, this is the first study to qualitatively explore health care provider perspectives about prioritizing TW and MSM health needs in context of the rising HIV epidemic in the Philippines. We identified themes that described approaches providers used to provide HIV services and their willingness to prioritize such provision to TW and MSM. In doing so, we have informed future provider-focused interventions and HIV strategic plans and priorities in Manila. Although key informants were willing to provide HIV services to TW and MSM, many were unsure how to approach prioritization of service delivery.

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References

- Adia AC, Bermudez ANC, Callahan MW, Hernandez LI, Imperial RH, & Operario D. (2018). "An evil lurking behind you": Drivers, experiences, and consequences of HIV-related stigma among men who have sex with men with HIV in Manila, Philippines. *AIDS Education and Prevention*, 30(4), 322–334. doi:10.1521/aeap.2018.30.4.322 [PubMed: 30148671]
- Asuncion IL, Segarra AB, Samonte GMJ, Palaypayon NS, & Bermejo MR (2017). The state of the Philippine HIV Epidemic 2016: Facing challenges, forging solutions. Retrieved from http://www.doh.gov.ph/sites/default/files/publications/publication__nonSerials_State%20of%20HIV%20Epidemic%20in%20the%20Philippines.pdf
- Beattie TS, Bhattacharjee P, Suresh M, Isac S, Ramesh B, & Moses S. (2012). Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. *Journal of Epidemiology and Community Health*, 66(suppl 2), ii42–ii48. doi:10.1136/jech-2011-200475
- Beyrer C, Baral SD, Weir BW, Curran JW, Chaisson RE, & Sullivan PS (2014). A call to action for concentrated HIV epidemics. *Current Opinion in HIV and AIDS*, 9(2), 95–100. doi:10.1097/coh.0000000000000043 [PubMed: 24499807]
- Beyrer C, Sullivan PS, Sanchez J, Dowdy D, Altman D, Trapence G, Collins C, ... Mayer KH (2012). A call to action for comprehensive HIV services for men who have sex with men. *Lancet*, 380(9839), 424–438. doi:10.1016/s0140-6736(12)61022-8 [PubMed: 22819663]
- Braun V, & Clarke V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa
- Brentano F. (2012). *Psychology from an empirical standpoint*. London, UK: Routledge. doi:10.4324/9780203202883
- Collins M, Shattell M, & Thomas SP (2005). Problematic interviewee behaviors in qualitative research. *Western Journal of Nursing Research*, 27(2), 188–199. doi:10.1177/0193945904268068 [PubMed: 15695576]
- Eisinger RW, Dieffenbach CW, & Fauci AS (2019). HIV viral load and transmissibility of HIV infection: Undetectable equals untransmittable. *JAMA*, 321(5), 451–452. doi:10.1001/jama.2018.21167 [PubMed: 30629090]
- Grov C, Restar A, Gussmann P, Schlemmer K, & Rodríguez-Díaz, C. E. (2014). Providers' perspectives on the best practices for HIV prevention for men who have sex with men in Berlin, Germany: Lessons for policy and prevention. *AIDS Education and Prevention*, 26(6), 485–499. doi:10.1521/aeap.2014.26.6.485 [PubMed: 25490731]
- Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, & Olson J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56(5), 285–290. doi:10.1159/000355235
- Joint United Nations Programme on HIV/AIDS. (2017). UNAIDS data 2017. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf
- Medley A, Kennedy C, O'Reilly K, & Sweat M. (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. *AIDS Education and Prevention*, 21(3), 181–206. doi:10.1521/aeap.2009.21.3.181 [PubMed: 19519235]
- Ortega NL, Bicaldo BF, Sobritchea C, & Tan ML (2005). Exploring the realities of HIV/AIDS-related discrimination in Manila, Philippines. *AIDS Care*, 17(2), S153–S164. doi:10.1080/09540120500119833 [PubMed: 16174626]
- Philippine Department of Health. (2017). HIV/AIDS & ART Registry of the Philippines (HARP) Report—October 2017. Retrieved from http://www.doh.gov.ph/sites/default/files/statistics/EB_HIV_Oct_AIDSreg2017.pdf

- Reisner SL, Radix A, & Deutsch MB (2016). Integrated and gender-affirming transgender clinical care and research. *Journal of Acquired Immune Deficiency Syndromes*, 72(3), S235–S242. doi:10.1097/qai.0000000000001088 [PubMed: 27429189]
- Restar A, Nguyen M, Nguyen K, Adia A, Nazareno J, Hernandez L, & Operario D. (2018). Trends and emerging directions in HIV risk and prevention research in the Philippines: A systematic review of the literature. *PLoS One*, 13(12), 1–21. doi:10.1371/journal.pone.0207663
- Restar AJ, & Reisner SL (2017). Protect trans people: Gender equality and equity in action. *Lancet*, 390(10106), 1933–1935. doi:10.1016/s0140-6736(17)31823-8 [PubMed: 29115217]
- Rispel LC, Metcalf CA, Cloete A, Moorman J, & Reddy V. (2011). You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities. *Journal of Public Health Policy*, 32(1), S137–S151. doi:10.1057/jphp.2011.29 [PubMed: 21730987]
- Robinson OC (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, 11(1), 25–41. doi:10.1080/14780887.2013.801543
- Ross AG, Ditangco RA, Belimac JG, Olveda RM, Mercado ES, Rogers GD, & Crowe SM (2013). HIV epidemic in men who have sex with men in Philippines. *The Lancet Infectious Diseases*, 13(6), 472–473. doi:10.1016/s1473-3099(13)70129-4 [PubMed: 23718916]
- Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, & Jinks C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, 52(4), 1893–1907. doi:10.1007/s11135-017-0574-8
- Schwartländer B, Stover J, Hallett T, Atun R, Avila C, Gouws E, & Barr D. (2011). Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 377(9782), 2031–2041. doi: 10.1016/s0140-6736(11)60702-2 [PubMed: 21641026]
- Sevelius JM, Patouhas E, Keatley JG, & Johnson MO (2013). Barriers and facilitators to engagement and retention in care among transgender women living with human immunodeficiency virus. *Annals of Behavioral Medicine*, 47(1), 5–16. doi:10.1007/s12160-013-9565-8
- Shangani S, Escudero D, Kirwa K, Harrison A, Marshall B, & Operario D. (2017). Effectiveness of peer-led interventions to increase HIV testing among men who have sex with men: a systematic review and meta-analysis. *AIDS Care*, 29(8), 1003–1013. doi:10.1080/09540121.2017.1282105 [PubMed: 28150501]
- Tawasil JR, Salvador VD, Juban NR, & Chan MB (2012). HIV/AIDS education in health professionals training in the Philippines. Washington, DC: World Bank.
- Thomas B, Mimiaga MJ, Kumar S, Swaminathan S, Safren SA, & Mayer KH (2011). HIV in Indian MSM: Reasons for a concentrated epidemic and strategies for prevention. *The Indian Journal of Medical Research*, 134(6), 920–929. doi:10.4103/0971-5916.92637 [PubMed: 22310824]
- United Nations Development Programme. (2017). Missing in action—loss of clients from HIV testing, treatment, care and support services: Case studies of gay men and other men who have sex with men in Manila. Retrieved from http://www.ph.undp.org/content/philippines/en/home/library/hiv_aids/MissingInAction.html
- World Health Organization. (2015a). External review of the national health sector response to HIV and sexually transmitted infections 2013: Republic of the Philippines. Retrieved from http://iris.wpro.who.int/bitstream/handle/10665.1/11217/9789290617068_eng.pdf
- World Health Organization. (2015b). Transgender people and HIV. Retrieved from <https://www.who.int/hiv/pub/transgender/transgender-hiv-policy/en/>
- World Health Organization. (2016). Country profiles on HIV: Philippines. Retrieved from <http://www.wpro.who.int/hiv/data/countries/phl/en/>

Key Considerations

- Health care providers must acknowledge the unique health needs of TW and MSM patients and prioritize HIV services delivery accordingly, in response to the Philippine concentrated HIV epidemic.
- Health care providers lack familiarity with and competency about TW and MSM gender and sexual identities, which leads to negative health care experiences, including discrimination and misgendering.
- Integrating TW and MSM community members as part of the health care workforce could improve provider competency and sensitivity, and bolster prioritization of TW and MSM patient health needs.

Table 1.

Interview Question Items

Questions Related To:	Example Question Items
Relationship with TW and MSM communities	<ul style="list-style-type: none"> • What was your relationship with TW and MSM patients when you took on this role? • What is your relationship with TW and MSM patients now?
Motivation to provide services for TW and MSM patients	<ul style="list-style-type: none"> • What inspired you to get into servicing TW and MSM patients? • How is being connected with TW and MSM communities an important piece in what you do?
Organization focus on TW and MSM health services	<ul style="list-style-type: none"> • What goals does your organization have with respect to providing health services for TW and MSM communities? • What are some of the things that you feel this organization does really effectively in helping to achieve its mission? • Would you say that TW and MSM patients are a priority in this organization?
HIV service delivery challenges	<ul style="list-style-type: none"> • What are some of the biggest challenges that you face in achieving the organization's mission? • How do you overcome these challenges? • What resources are available to you to overcome these challenges? • Any other challenges in delivering health care services to TW and MSM patients?

Note. MSM 5 men who have sex with men; TW 5 transgender woman/women.

Table 2.

Characteristics of Key Informants and Facilities (N = 15)

Key Informant ID #	Role/Title	Type of Facility	Brief Description of Facility	Facility Target Population
1	Physician	Public hospital	Part of the national public hospital system that provides primary and specialty health care services. This public hospital also provides training and research experiences to health care providers, nurses, and other public health professionals about delivering HIV services.	General population
2	Counselor	SHC	Part of the HCT system that provides HIV and STI services to all populations, but with specific focus on community outreach to MSM and TW community members. Facility is run by transgender and MSM staff.	MSM and TW (main focus), general population
3	Nurse	SHC	Provides primary health care services as well as HIV and STI services to local community members.	General population
4	Nurse	Nonprofit organization	Provides primary health care services to general populations. Provides information about HIV and STI prevention and treatment.	General population
5	Project Coordinator	Nonprofit organization	Provides HIV services to promote the health and lives of all PLWH, including TW, MSM, children, and intravenous drug users.	PLWH who are TW, MSM, children, and intravenous drug users
6	Physician	Public hospital	Part of the national public hospital system that provides general and specialty health care services to all populations, particularly those who are from low-income backgrounds.	General population
7	Nurse	Nonprofit organization	Provides social support services (e.g., housing, legal advice) to all PLWH, including TW, MSM, children, and intravenous drug users.	TW, MSM, PLWH, children, and intravenous drug users
8	Nurse	Nonprofit organization	Provides outreach to TW in community gatherings with the goal of disseminating health information about HIV and STI prevention, and genderaffirming services.	TW
9	Counselor	Nonprofit organization	Offers education services about HIV prevention and care for PLWH and their friends and families. Facility is run by PLWH.	PLWH
10	Program Coordinator	Nonprofit organization	Provides HIV prevention and treatment services to TW and MSM who are living with HIV.	TW and MSM who are living with HIV
11	Program Manager	Nonprofit organization	Offers primary health care including HIV/STI prevention and treatment services to all community members.	General population
12	Clinic Coordinator	SHC	Provides primary health care and counseling for community members from low-income backgrounds.	General population
13	Physician	State-sponsored organization	Part of a national agency that promotes the health of populations, including those who are poor and marginalized.	General population (main focus), MSM and TW
14	Program Manager	State-sponsored organization	Part of a national agency that provides HIV prevention and treatment services to those who are poor and marginalized.	General population (main focus), MSM and TW
15	Volunteer	Nonprofit organization	Assist TW and MSM members by providing information and support for social (e.g., stigma) and health issues (e.g., insurance).	TW and MSM

Note. HCT 5HIV Counseling and Testing facilities; MSM 5men who have sex with men; PLWH 5people living with HIV; STI 5sexually transmitted infection; TW 5 transgender women.