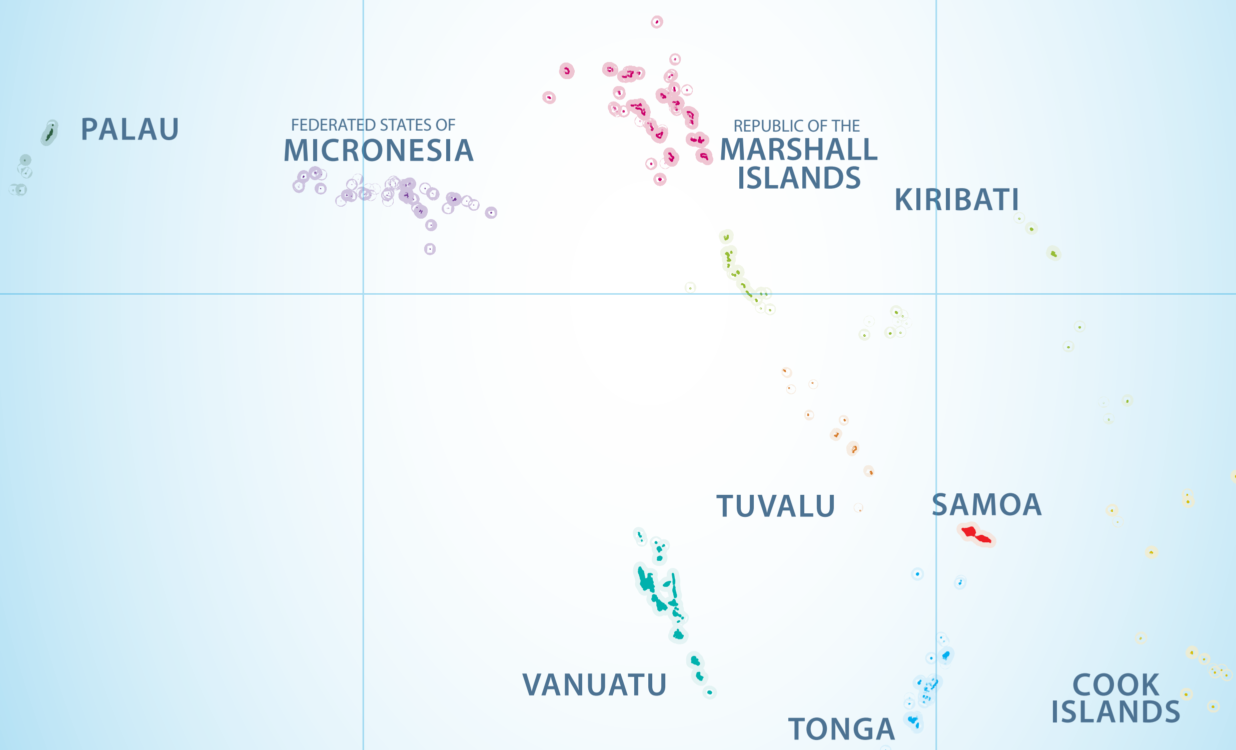
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

COOK ISLANDS



Acknowledgements

The *Pacific Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Cook Islands* was conducted in 2016 and examined the behaviour risk factors and social and structural determinants of risk that drive the epidemic among vulnerable groups, such as men who have sex with men, transgender people, sex workers and seafarers. The study was part of a larger research effort that covered nine Pacific countries.

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Inclusion criteria

Participant inclusion criteria
Female sex workers:
Any female aged 17 years and over who has exchanged sex (oral, anal and/or vaginal) for money or other items of value, over the past 12 months and is currently residing or working in the study area.
Transgender people and MSM:
Any male aged 17 years and over who has had any sexual contact (oral/anal sex, hand jobs, 'rimming', etc.) with a male or transgender person, regardless of his/her gender identity or sexual identity or orientation, over the past 12 months, and is currently residing in the study area.
Seafarers:
Any male aged 17 years and over who is engaged in working on a ship that is docked or based in the study area.

Definitions relevant to all participant groups
Regular partners:
Any sexual partner who the participant considers to be their main or regular non-paying partner. This person could be a spouse, boyfriend or girlfriend.
Casual partners:
Any sexual partner who is not a regular partner or a paying partner.
Commercial partner:
Any sexual partner who has paid the participant money or goods in exchange for sex.

The Joint UN Programme on AIDS defines sex workers to include "female, male and transgender adults aged over 18 years who sell consensual sexual services in return for cash or payment in kind, and who may sell sex formally or informally, regularly or occasionally". Sex work varies between and within countries and communities. Sex work may vary in the degree to which it is more or less "formal" or organized, and in the degree to which it is distinct from other social and sexual relationships and types of sexual-economic exchange. In accordance with article 34 of the Convention on the Rights of the Child which ensures the protection of all children from all forms of sexual exploitation and sexual abuse, reference is made to sexual exploitation of children for young people below the age of 18.

Executive summary

- The incidence of HIV is low, with only four people having been diagnosed to the end of 2015.
- We estimated that there are between 500 and 850 men who have sex with men (MSM) and transgender (TG) in the Cook Islands, and around 50 female sex workers (FSW) (some of whom are thought to be from Fiji and the Philippines).

Transgender/Men who have sex with men

- Homosexuality in the Cook Islands is illegal and homosexual men remain a hidden population.
- Sixty-seven MSM/TG took part in the behavioural survey and eight of them were interviewed in-depth. There was a range of sexual identities – mostly gay or transgender/*akava'ine.*
- Around half were employed full-time, most of them working in wholesale and retail work.
- All participants reported having had sexual intercourse (anal and/or vaginal). The mean age of sexual debut was 15 years old.
- In the last 12 months, 60% of participants reported anal intercourse with regular sexual partners, 76% with casual partners, and 12% with men who paid them for sex.
- Condom use was low. In the last 12 months, a condom never or sometimes being used was reported by participants to be 63% for regular partners, 68% for casual partners, and 80% for paying partners.
- On the last occasion of sex, 43% had insertive anal intercourse, while 68% had receptive anal intercourse. Condom use on the last occasion was 52% with regular partners, 56% with casual partners, and 40% with paying partners.
- In the last 12 months, 22% of men had female as well as male sexual partners. The majority were regular partners. Most never used a condom and only two men used a condom with either regular or casual female partners on the last occasion of sex.
- In the last 12 months, 22% of participants had sexually transmissible infection (STI) symptoms. The majority did not access any treatment, while around 30% visited a hospital or clinic.
- Knowledge about HIV was relatively high, apart from understanding around mother-to-child transmission.
- Employers and co-workers appear to be more supportive of the participants' sexual identity than are their families. A majority reported that their family members ignore them or refuse to talk to them. In the last 12 months, 40% reported feeling ashamed about their sexual identity, and 30% felt low self-esteem.
- A majority of participants knew how to access sexual health services and over 80% knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault. However, the majority of participants (85%) had not accessed any of the services. Those who had used the services were generally satisfied with them.

- In the previous 12 months, 22% of participants had tested for HIV. All had received a negative result.
- Alcohol was consumed at least once a week by 65% of participants, with a high median number of drinks (eight) being consumed on the last occasion. In the last 12 months, 43% had used marijuana. Among all participants, 35% said that they had engaged in anal or vaginal intercourse after taking alcohol and/or drugs in the last month which they reported 'left them feeling not in control'.

Female sex workers

- Four women who sold sex in exchange for money or goods provided survey data.
- All four women reported being 'single' and not married. One woman reported having one child.
- All four women reported ever having had sexual intercourse. The first time they had sexual intercourse ranged from 11 to 15 years of age. The age at which the women first received money or goods in exchange for sex was 16 (n=3) and 19 (n=1).
- In the last 12 months, each of the women had between 2 and 15 paying male partners. Due to the low numbers, it is likely that each of the women had mostly regular paying partners.
- When asked how many paying partners they had on the last day that they were paid for sex, two women reported one paying partner, while the other two women reported two paying partners.
- Two of the women reported using a condom on the last occasion of vaginal intercourse with a paying partner. One woman who had anal intercourse reported using a condom and lubricant on the last occasion with a client.
- Three women reported never using a condom with a paying partner, as the partner paid more money for intercourse without a condom.
- Three of the four women reported having had sex with a regular male partner (for example, a boyfriend or husband) in the previous 12 months. None of the women had used a condom for vaginal intercourse with their regular partner on the last occasion.
- Three of the four women reported having sex with casual male partners in the preceding 12 months.
- All four women reported knowing where they could obtain condoms. When asked where they had previously obtained condoms, all four women indicated that they had obtained condoms through a condom dispenser.
- None of the women reported having STI symptoms in the preceding 12 months. Two women reported ever having been diagnosed with an STI.
- HIV knowledge was generally high.
- Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Two of the four women answered in the affirmative that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, responses included man who paid for sex (n=2), family friend (n=1) and stranger (n=1).

- Although they knew of them, no sexual health services were used by the participants in the past 12 months, and they had never accessed sexual health information from any organisation. Two of the women indicated that the health worker they saw when they last accessed the health service was not friendly or easy to talk to.
- Three women reported having an HIV test in the past 12 months, all of which took place at the government health service. All three women received a negative result.

Capacity assessment

- Under the Cook Islands National Health Strategy 2012–2016, the Cook Islands Ministry of Health (MoH) provides national coverage of healthcare services.
- The MoH does not specifically engage MSM/TG or FSW in service delivery, but it works with and supports organisations that provide health and well-being promotion to key populations. The two organisations that carry out peer education and other services to MSM/TG are the Te Tiare Association (TTA) and the Cook Islands Family Welfare Association (CIFWA). No services are provided specifically for FSW.
- Planning and policy development related to HIV is conducted by the Cook Islands National HIV, STI and TB Committee, which last met in 2014 and is reportedly not currently functioning.
- Condoms are mainly distributed through condom dispensers that are stocked by CIFWA and the Red Cross; however, there were reports of dispensers sometimes being empty. TTA provides low numbers of condoms to key populations, but it refers key populations to the MoH and CIFWA for condoms.
- Overarching strengths include being guided by local, regional and global policies; good coverage for MSM/TG; well-connected organisations; data collection; and the successful delivery of services.
- Overarching capacity needs include greater and specific engagement of key populations in service delivery; training and professional development; changes in the attitudes of health workers towards key populations; and homosexuality law reform.

1 Introduction

This research was carried out as a response to the need for greatly increased, contextualised information about the vulnerability to HIV of MSM/TG and sex workers and seafarers in many Pacific countries. The study provides:

1. An operational baseline for the implementation of the Integrated HIV/TB Multi-Country Grant in the Pacific and for the Pacific Regional Sexual and Reproductive Health Programme.
2. Quantitative and qualitative data to inform relevant interventions aimed at reducing the HIV and STI risk vulnerability of key populations.
3. Specific evidence of barriers to prevention, in order to improve the effectiveness of prevention interventions and develop a strong advocacy case for legal and social transformation.

The key specific aims that the *Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations* must achieve in order to fulfil the objectives in each country are to:

- Estimate population sizes of vulnerable groups – sex workers, MSM/TG and, in some countries, seafarers – through a variety of methodologies.
- Identify demographic and behavioural factors (for example, sexual behaviours, mobility, drug use, history of STIs, and so on) that represent risk practices in each of these groups, as well as access to services and experiences of stigma, discrimination and violence, through a quantitative survey design. This survey must include baseline values for quantitative indicators for reporting obligations.
- Identify through in-depth interviews the social and structural determinants influencing these risk factors, including stigma, human rights violation, all forms of violence, discrimination, and socio-economic marginalisation and exclusion, as well as community norms, expectations and subcultures that can be facilitators or barriers for the uptake of HIV and STI prevention, care and support services.

2 Cook Islands

The Cook Islands is a small island nation in the South Pacific. It is self-governing in free association with New Zealand, but is responsible for internal affairs. The Cook Islands is isolated from foreign markets. It has some inadequate infrastructure and lacks major natural resources. Tourism provides the economic base that makes up two-thirds of GDP. Since approximately 1989, the Cook Islands has become a tax haven. Additionally, the economy is supported by foreign aid, largely from New Zealand. The People's Republic of China has also contributed foreign aid.

HIV prevalence in the Cook Islands is low. HIV became a notifiable infection in the Cook Islands in 2004. As of 31 December 2015, the Cook Islands had reported a total of four HIV cases. These were recorded in 1997, 2003, 2010 and 2015. It is suspected that infection in all four cases occurred outside of the Cook Islands. The only cases that were diagnosed in the Cook Islands were in late 2010 and 2015. Transmission of these two cases is thought to be via sexual contact. None of these cases currently live in the Cook Islands. In 2010–11, 2,490 HIV tests were conducted, with only one positive case identified; in 2014, 824 HIV tests were conducted with no positive cases identified; in 2015, 883 tests were conducted, with one positive case (Cook Islands Ministry of Health 2014).

However, sexually transmitted infections (STIs) are common in the Cook Islands. The second generation surveillance conducted in 2006 showed a 22% prevalence rate of chlamydia; 46% of these cases were in people between the ages of 15 and 29 years. After a robust intervention campaign, a repeat survey in 2012 showed a 50% decrease in prevalence. The current challenge is to reduce further the prevalence of STIs in the Cook Islands, particularly in light of reduced donor funding for HIV/STI intervention (Cook Islands Ministry of Health 2014).

The national response to HIV and STI is guided by the Integrated National Strategic Plan for Sexual Reproductive Health 2014–2018. This strategy had been developed by the Ministry of Health and the National HIV, STI and TB Committee (NHSTC). Formerly the National AIDS Committee, this committee was formalised in 2010 and is the National Country Coordinating Mechanism. The NHSTC is made up of key stakeholder civil society organisations, government and affected populations that are involved in the HIV and STI response in the country.

2.1 Men who have sex with men and transgender

Homosexuality in the Cook Islands is illegal and homosexual men remain a hidden population. More open and accepted are transgender Cook Islanders, who have recently adopted the term *akava'ine* (literally, to be like a woman), based on the Samoan word *fa'afafine*, to describe their identity. The term *akava'ine* had previously been used pejoratively to refer to young women who were immodest (see Alexeyeff 2009).

In a 2009 behavioural surveillance survey conducted among those who identify as MSM or *akava'ine*, 76% of respondents reported ever having male-to-male sex, with about 32% ever having an *akava'ine* partner (Rawstorne et al 2009). Despite high levels of knowledge regarding HIV transmission and prevention, the results of the survey indicate high levels of risky sexual behaviour among MSM, as indicated by the early age of sexual debut, multiple *akava'ine* and male anal sex partners in the past six months, and the high incidence of concurrent partnerships and group sex. Fewer than half of respondents reported using a

condom the last time they had sex with any partner. Many respondents also experienced first sex at a young age, and 44% of participants under 25 indicated that they had been forced to have sex in the past six months. While there have been no known cases of HIV contracted through male-to-male sex in the Cook Islands, unprotected sex with multiple partners, and a number of other factors – such as high levels of alcohol, binge drinking and drug use – exacerbated by a lack of societal openness and acceptance of homosexuality, put MSM and *akava'ine* at risk of STI and HIV.

The 2009 second generation surveillance survey (Rawstorne et al 2009) found that 24% of MSM/*akava'ine* respondents had been diagnosed with an STI at some point, and almost one-fifth of those surveyed had experienced STI symptoms over the past month. However, only a small proportion of those people indicated that they had sought treatment. It is likely that the prevalence of STIs within the MSM community is higher than currently reported.

Awareness of prevention activities was very high, with almost all participants (99%) reporting that they were aware of at least one of the activities in the Cook Islands. Passive forms of communication – such as billboards (82%), newspapers (77%) and television (77%) – were the most common source of HIV information reported by participants. Just over half (52%) of respondents reported taking part in a peer education program, and 48% reported that they had been given condoms through an outreach service, health clinic or drop-in centre (Rawstorne et al 2009). However, 40% of respondents believed that it was not possible to obtain a confidential HIV test in the Cook Islands, with 85% of those respondents believing that people would find out (Rawstorne et al 2009). Under-reporting of symptoms, and lack of health-seeking behaviour, may be attributed to a lack of privacy in treatment-seeking, the stigma attached to MSM, and the potential for an HIV test to come back positive.

2.2 Female sex workers

Until this research, there have been no studies of sex work in the Cook Islands. In fact, the 2014 Global AIDS Progress Report for the Cook Islands indicated that there are no known sex workers or sex work networks in the Cook Islands (although this is clearly not supported by anecdotal evidence), and there are therefore no current interventions targeting sex workers (Cook Islands Ministry of Health 2014). Soliciting in the Cook Islands is a criminal offence, with a fine of NZ$20 or imprisonment for one month as punishment (Dalla et al 2011). The implications of the illegality of sex work make any population of sex workers particularly hidden.

While there are no statistics on sex work, paid sex still occurs in a quiet and hidden manner. A youth survey conducted in 2012 suggested that the levels of individuals who pay for sex are low at 8%, while slightly higher numbers of people had been paid to have sex (10%) (Cook Islands Ministry of Health 2013). It is possible that such numbers are higher in the adult population. As a vulnerable population with no open access to specialised health services, sex workers are particularly at risk.

3 Methodology

The research in the Cook Islands attempted a variety of methods of a cross-sectional (snapshot) design. Ethical approval for the project was obtained from the UNSW Human Research Ethics Committee and from the National Research Committee through the Office of the Prime Minister and the Cook Islands Ministry of Health Research Committee.

Fieldwork was undertaken between March and April 2016.

3.1 Population size estimation

A Roundtable Stakeholder Meeting was carried out with a range of organisations to estimate the size of the MSM and FSW populations in the Cook Islands. Those people and organisations present were:

- Edwina Tangaroa – HIV & TB Focal Point, Ministry of Health
- Marama Anguna – Acting Director of the Policy and Planning Division, Ministry of Health
- Valentino (Valery) Wichman – Policy Officer, Ministry of Health/Te Tiare Association/ Research Assistant
- Jim Nimerota – Statistics Officer, Statistics Division, Ministry of Finance and Economic Management
- Rongo File – Executive Director, Cook Islands Family Welfare Association
- Shaniqua Ngatoire – Te Tiare Association/Research Assistant
- Tuika Tini – Research Assistant
- Tamara File – CIFWA Youth Volunteer/Research Assistant
- Apologies were given for:
  - Dr Neti Hermann – Director of Public Health, Ministry of Health
  - Ruta Pokura – Director of Gender Division, Ministry of Internal Affairs
  - Silveria Wulf – CIFWA Youth Volunteer/Research Assistant
  - Polly Tongia – CIFWA Board Member

After a brief presentation by Hilary Gorman on the *Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations* and an update on data collected to date in the Cook Islands, the stakeholders discussed population size.

3.2 Behavioural survey and interviews

3.2.1 Behavioural survey of men who have sex with men and transgender

A behavioural survey captured quantitative information from MSM and TG about sexual behaviour, mobility, drugs and alcohol, STIs, and stigma and discrimination, as well as access to and assessment of services. In-depth interviews were conducted with members of key populations, collecting qualitatively rich data that described the circumstances and experiences of key populations over a range of issues.

Five research assistants (RAs) were selected. The RAs participated in a one-day training focused on the basics of social research, research ethics and practical discussion of the recruitment of research participants. The RAs included three MSM who are members of the Te Tiare Association (TTA), two of whom are *akava'ine*, and two young women who are youth volunteers with the Cook Islands Family Welfare Association (CIFWA). The RAs have networks of MSM and some were aware of a few young women whom they thought were having sex in exchange for cash.

MSM participants were initially recruited through the RAs' networks. They contacted potential participants using their networks via mobile phone text messaging, Facebook, visiting them at their homes and workplaces, and meeting them in social settings. MSM and TG were approached in these contexts by the RAs and were provided with background information about the study and then invited to complete the survey. If the initial contact was not face-to-face, they arranged a time and place to meet to complete the survey. The RAs asked to be referred to other potential MSM and TG participants and were able to expand the number of MSM and *akava'ine* reached through a snowball sampling technique.

After completing the survey, the participants were also asked if they would like to participate in an in-depth interview. The majority of MSM and TG who were asked to participate in the survey agreed, but some refused. It is estimated that 25–30 MSM did not participate, around half were willing but did not find the time, and others refused due to being uninterested or not wanting to disclose personal information. A small proportion of the survey participants were interested in doing an interview. The RAs speculated that people were interested in doing a tablet survey because they felt that it was more anonymous, but as Cook Islanders they were not interested in talking about what they viewed as sensitive issues – despite assurances of privacy and confidentiality.

The interviews were conducted by the Team Leader and took place at a private and mutually agreed location, either at the CIFWA office after office hours when no staff members were around or in a quiet and private outdoor area selected by the participant. The majority of interview participants were *akava'ine,* while some identified as gay or bisexual MSM. Although some hidden MSM (or 'straight' MSM, as referred to by the RAs) participated in surveys, none opted to do an interview.

3.2.2 Female sex workers

There are no women who openly identify as female sex workers in the Cook Islands and the context in which women exchange sex for money or goods is discrete and hidden. All five RAs sought to find women who exchange sex for money or goods within their networks. Two of the RAs made contact with a total of seven women who fit the survey criteria. Of the seven women, four agreed to complete the survey. All of the women were also invited to participate in an interview. All of them refused to meet with the Team Leader and none would consider doing an interview with the RAs or in any other context. The RAs cited that these women refused interviews as they did not want to discuss the terms and contexts in which they exchange sex for money.

3.3 Institutional capacity assessment

There is no data on health service utilisation by MSM and TG and by FSW. Due to the legislative environment and the social and cultural context, no FSW will willingly self-identify to health services in the Cook Islands. There are no HIV interventions or outreach programs targeting sex workers in the Cook Islands. The Cook Islands Ministry of Health and CIFWA are the only identified agencies providing HIV and STI-related services. TTA provides peer support and advocates for the human rights of LGBTFI.

3.4 Results

3.4.1 Population size estimation

The estimates of the MSM population provided by research participants ranged from 800–1,200 to 1,500. The estimates of the number of FSW provided by research participants ranged from 10 to 150 women. The meeting of stakeholders attempted an extrapolation of the male population in order to estimate the number of MSM/TG. The 2011 census states that there are 4,365 males between the ages of 15 and 59 years. The stakeholders estimated – based particularly on the information provided by the MSM themselves – that one in 10 MSM were *akava'ine*, two in 10 MSM were gay, and seven in 10 were straight-acting MSM. It was estimated that 90% of these men were sexually active (again substantiated by the MSM present), and therefore that there are approximately 100 *akava'ine,* of whom 90% are sexually active – equal to 90 *akava'ine*; 200 gay men, of whom 90% are sexually active – equal to 180 gay men; and 700 straight-acting MSM, of whom 90% are sexually active – equal to 630 men. The stakeholders then came to a consensus agreement that there are an estimated 900 MSM in the Cook Islands. It is possible that this is an overestimate of the number of MSM and that there may be approximately 3,600 sexually active men aged 15–59 years, which is equal to 520 MSM.

The discussion about the number of FSW was not as extensive. It was noted that through their work in conducting the survey, the research assistants had come in contact with approximately seven women who fit the criteria (of whom four agreed to be surveyed). It was stated that there were likely to be a few sub-populations of FSW, including the women surveyed; possibly women in Aitutaki who work in the tourism industry; and potentially a few groups of migrant worker women, including Filipino women and possibly Fijian women. It was noted that many of these women earn around the minimum wage, are away from their families, and have an obligation to send money home. The context in which sex work is thought to take place is through mobile phone communication via text or voice call to meet men who come to port on the boats (facilitated by a person working at the harbour), arrangements to meet men (both locals and tourists) at a motel in town, or meeting tourist men at the hotels and resorts. The stakeholders then came to a consensus agreement that there are an estimated 50 FSW in the Cook Islands.

3.4.2 Behavioural survey

3.4.2.1 Transgender and men who have sex with men

3.4.2.1.1 Description of the sample

Sixty-seven self-identifying transgender (TG) and men who have sex with men (MSM) provided survey data. In identifying their gender, 34 participants described themselves as men, while 22 described themselves as transgender, five as women, three as transsexual, and one as transvestite. Two participants answered ‘other’ and then indicated their gender as ‘homo’ and ‘Lele’, respectively.

Participants were also asked to describe their sexual identity (Table 1). There was a range of categories provided to participants. The majority of participants described their sexual identity as gay/homosexual or as transgender/*akava'ine*. Four men described their sexual identity as MSM.

Table 1: Sexual identity

	Frequency	Percent (%)
Gay/Homosexual	27	40.3
Transgender/*Akava'ine*	21	31.3
Heterosexual/Straight	8	11.9
Bisexual	5	7.5
MSM	4	6.0
Queer	1	1.5
Pansexual	1	1.5
Total	**67**	**100.0**

The age of participants ranged from 18 to 56, with a mean age of 29 (SD=8.95) and a median age of 28. All participants had attended school, with a majority having completed their education to a post-secondary level (that is, polytechnic/diploma or university) (Table 2).

Table 2: Highest level of education

Level of education	Frequency	Percent (%)
Pre-secondary	3	4.5
Secondary	31	46.3
Polytechnic/Diploma	12	17.9
University/College	21	31.3
Total	**67**	**100.0**

In responding to the question about relationship status, a majority of participants reported being single, with fewer participants reporting that they had a boyfriend or girlfriend (Table 3).

Table 3: Relationship status

	Frequency	Percent (%)
Currently single	48	71.6
Have a girlfriend	7	10.4
Have a boyfriend	9	13.4
Currently married	2	3.0
Widowed/Divorced/Separated	1	1.5
Total	**67**	**100.0**

The majority of participants reported living with parents, siblings, other relatives, friends or alone (Table 4).

Table 4: Whom participants were living with (n=67)*

	Frequency	Percent (%)
Parents	21	31.3
Siblings	17	25.4
Live alone	12	17.9
Other relatives	11	16.4
Friends	10	14.9
Boyfriend/Husband	4	6.0
Children	4	6.0
Co-workers	4	6.0
Wife	3	4.5
Other female partner	3	4.5
Other (girlfriend, grandmother)	2	3.0

* Multiple answers possible.

A majority were employed, mostly in full-time work. Six were unemployed (Table 5).

Table 5: Employment status

	Frequency	Percent (%)
Full-time employed	35	52.2
Part-time or casual employment	19	28.4
Self-employed	7	10.4
Not employed	6	9.0
Total	**67**	**100.0**

When asked to indicate their main job, the 61 participants who were employed indicated a range of different types of work, as shown in Table 6. Most participants were working in wholesale and retail work, while 24 participants chose the 'other' option. Ten of those 24 people reported working in hospitality.

Table 6: Type of work*

	Frequency	Percent (%)
Wholesale and retail trade	13	21.3
Professional	6	9.8
Transport and communication	4	6.6
Financial and business services	4	6.6
Construction	3	4.9
Community, social and personal services	3	4.9
Agriculture/Forestry/Fishing	2	3.3
Electricity and water	1	1.6
Student	1	1.6
Other (included hospitality, shop assistant, caregiver, chef, courier, health services, housekeeper, waitress)	24	39.3
Total	**61**	**100.0**

* Includes the 61 people who reported being employed.

3.4.2.1.2 Sexual history and practice

All 67 participants reported ever having had sexual intercourse (anal or vaginal). Their first occasion of sexual intercourse was reported to have occurred between the extremely young age of 6 and 21, with the mean age of sexual debut being 15 (SD=2.83). Forty-one participants (61.2%) reported being in more than one sexual relationship concurrently in the previous six months.

3.4.2.1.2.1 Sex with male partners

Participants were asked to report on the types of sexual activity that they had engaged in during the last occasion they had sex with a male partner (Table 7). Of the 65 participants who answered this question, giving oral sex and receptive anal intercourse were the most reported sexual practices engaged in by a majority. This pattern of reporting receptive more than insertive sexual practices is more typical among transgender than MSM.

Table 7: Types of sexual activity on last occasion of sex with a male partner (n=65)

	Frequency	Percent (%)
Handshake (you masturbated him)	32	49.2
Handshake (he masturbated you)	28	43.1
Oral sex (you sucked his penis)	44	67.7
Oral sex (he sucked your penis)	33	50.8
Intercrural sex (his penis between your thighs)	14	21.5
Intercrural sex (your penis between his thighs)	9	13.8
Anal intercourse (your penis inside his anus)	28	43.1
Anal intercourse (his penis inside your anus)	44	67.7

* Multiple answers possible.

3.4.2.1.2.2 Types and numbers of male partners

Participants were asked how many male sex partners they had in their lifetime and in the last 12 months. The most commonly reported number of male sex partners in the 12 months prior to the survey was between one and three, whereas over the lifetime a majority of participants indicated having had more than 10 male partners, with over one-third of participants reporting 50 or more male partners (Table 8). Two participants reported having no male partners in the previous 12 months and were therefore ineligible to proceed any further in the survey. As such, the remaining analyses are based on 65 participants.

Table 8: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
0	0	2 (3.0)
1 to 3	10 (14.9)	27 (40.3)
4 to 10	12 (17.9)	23 (34.3)
11 to 49	21 (31.4)	10 (14.9)
50+	24 (35.8)	5 (7.5)
Total	**67 (100)**	**67 (100.0)**

All 65 participants were asked how many of their male sex partners with whom they had anal intercourse in the preceding 12 months were regular partners, casual partners and paying partners (Table 9). Almost 60% of participants had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. A slightly higher proportion reported having had anal intercourse with casual male partners during the previous 12 months and comparatively fewer participants (about 12%) reported anal intercourse with male partners who paid them for sex.

Table 9: Number of regular, casual and paying male sexual partners with whom participants had anal intercourse in the 12 months prior to the survey

Number of partners	Regular partners frequency (%)	Casual partners frequency (%)	Paying partners frequency (%)
None	27 (41.5)	15 (23.1)	57 (87.7)
1 to 3	31 (47.7)	36 (55.4)	7 (10.8)
4+	7 (10.8)	14 (21.5)	1 (1.5)
Total	**65 (100.0)**	**65 (100.0)**	**65 (100.0)**

3.4.2.1.2.3 Condom and lubrication use for anal intercourse with male partners

Condom use with the three different types of male partners in the last 12 months is shown in Table 10. Condom use with regular partners was understandably low. Condom use with casual partners was also low, with about one-third reporting 'never' using condoms for anal intercourse with casual partners and a similar proportion reporting using condoms only 'sometimes'. The number of participants who had anal intercourse with a paying partner and who answered the question was too few to form any conclusions about condom use with these partners. However, among the five participants who provided data on condom use with paying partners, three of them reported 'never' using condoms with a paying partner.

Reported condom use on the last occasion of anal intercourse with each of the partner types in Table 10 was at higher levels than for the last 12 months. Although not shown in Table 10, 20 (52.6%) of the 38 participants who had sex with a regular male partner reported using a condom on the last occasion with that partner. Twenty-three (46%) of the 50 participants who had sex with casual male partners reported condom use on the last occasion of anal intercourse with a casual male partner. And two of the five participants who had a paying male partner and who responded to the questions about condom use reported condom use on the last occasion with that type of partner.

Table 10: Consistency of condom use with different types of male partners in the last 12 months*

Regularity of condom use	Regular partners n (%)	Casual partners n (%)	Commercial partners n (%)
Never	10 (26.3)	16 (32.0)	3 (60.0)
Sometimes	14 (36.8)	17 (34.0)	1 (20.0)
Almost every time	7 (18.4)	5 (10.0)	0
Every time	7 (18.4)	12 (24.0)	1 (20.0)
Total	**38 (100.0)**	**50 (100.0)**	**5 (100.0)**[1]

* Includes only participants who had sex with the type of partner. [1] Missing data n=3.

The use of lubricant for anal intercourse was marginally higher than condom use with each partner type, which suggests that participants had been using lubricant on most occasions when they used condoms. Twenty-seven (71.1%) of the 38 people who had sex with a regular male partner in the preceding 12 months reported using lubricant the last time they had anal intercourse with a regular partner. Of the 50 participants who had casual male partners, 29 (58.8%) reported using lubricant on the last occasion of anal intercourse with a casual male partner. Three of the five participants who had answered the question about lubricant use with paying partners used lubricant on the last occasion of anal intercourse with a paying partner.

All 65 participants were asked whether they used lubricant the last time they used a condom, to which 41 (63.1%) answered in the affirmative. When asked which type of lubricant they used on that last occasion, 37 (90.2%) of the 41 reported using water-based lubricant, two used coconut oil, one used Vaseline and another used baby oil. Most participants had obtained lubricant on that last occasion from a condom dispenser in a bar, nightclub, restaurant or other venue (n=18) or from a pharmacy (n=12). Other sources included friend (n=4), 'home' (n=3), partner (n=1), health clinic (n=1) and peer educator (n=1).

3.4.2.1.2.4 Female partners

Twenty-six (40.0%) of the 65 participants reported having had sexual intercourse (vaginal or anal) with a female partner. They reported having had between one and 30 female partners in their lifetime. Fifteen (57.7%) of these 26 participants reported having sex with a female partner during the 12 months preceding the survey, ranging in number from one female partner to five during that time. The majority of these 15 participants had a regular female partner in the previous 12 months, and a majority also had at least one casual female partner in that period (Table 11).

Table 11: Number of regular and casual female partners in the last 12 months

Number of female partners	Regular partner n (%)	Casual partner n (%)
0	3 (20.0)	6 (40.0)
1 to 3	12 (80.0)	8 (53.3)
4 to 10	0	1 (6.7)
Total*	**15 (100)**	**15 (100.0)**

* Includes only participants who had sex with the type of partner.

Of the 12 participants who had sex with a regular female partner in the 12 months preceding the survey, the majority 'never' used condoms for vaginal intercourse with their regular female partner(s) (Table 12). Only two (16.7%) of the 12 participants reported using a condom on the last occasion of vaginal intercourse with their regular female partner and only one used condoms for anal intercourse on the last occasion. Of the nine participants who had sex with a casual female partner in the 12 months preceding the survey, condom use was also at very low rates – the majority reported 'never' using condoms for vaginal intercourse with casual female partners and only two (22.2%) of the nine participants reported using a condom on the last occasion, which was the same for anal intercourse.

Table 12: Consistency of condom use with different types of female partners in the last 12 months

Regularity of condom use	Regular partners n (%)	Casual partners n (%)
Never	8 (66.7)	6 (66.7)
Sometimes	3 (25.0)	1 (11.1)
Almost every time	1 (8.3)	1 (11.1)
Every time	0	1 (11.1)
Total	**12 (100.0)**	**9 (100.0)**

3.4.2.1.2.5 Obtaining condoms and reasons for not using them with male and female partners

All 65 participants reported knowing what a condom was prior to the survey, and 63 (96.9%) knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them (Table 13). A large majority had last obtained condoms from a condom dispenser, from a friend or from a pharmacy. The remainder of participants had last obtained condoms from a range of sources, including peer educators and health clinics.

Table 13: Where participants last obtained condoms for sex with male/female partners

	Frequency	**Percent (%)**
Condom dispenser (bar/nightclub/restaurant/other venue)	29	45.3
Friend	12	18.8
Pharmacy	9	14.1
Health clinic	3	4.7
Peer educator/Outreach worker	3	4.7
Hospital	2	3.1
Have never obtained condoms	2	3.1
Client	1	1.6
Other (reported: convenience store, partner, supermarket)	3	4.8
Total	**64[1]**	**100.0**

[1] Missing data n=1.

The most commonly reported reasons for not using condoms were similar for sex with male and female partners, but in a different order. For sex with male partners, the most common reasons reported for not using a condom for anal intercourse included condoms not being available followed by condoms taking away pleasure. For intercourse with female partners, the reasons given were condoms taking away pleasure, condoms not being available, and not liking condoms (Table 14).

Table 14: Reasons for not using condoms with male and female partners*

	Male partners n=59 (%)	**Female partners n=21 (%)**
Condoms take away pleasure	20 (33.9)	10 (48.0)
Do not like condoms	8 (13.6)	5 (23.8)
Condoms were not available	27 (45.8)	6 (28.6)
Difficulty obtaining condoms	4 (6.8)	1 (4.8)
My partner(s) and I are faithful	3 (5.1)	3 (14.3)
Partner objected	8 (13.6)	1 (4.8)
Not necessary	5 (8.5)	1 (4.8)
Condoms are too expensive	0	0
Used other prevention methods	3 (5.1)	1 (4.8)
Other (reported: could not be bothered, did not have it with me, heat of the moment)	5 (8.5)	0

* Multiple answers possible.

3.4.2.1.3 Sexually transmissible infections, including HIV

Fifty-nine participants reported ever having heard of sexually transmitted diseases, among whom 18 participants reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months or ever having had pain while urinating. Four participants reported genital discharge in the 12 months preceding the survey, six reported genital ulcers or sores, and 11 reported ever having pain while urinating. The 18 participants were asked what they did the last time they had any of these symptoms (Table 15). The majority of participants reported doing nothing, while some talked to a friend or visited a hospital. Six participants reported ever having been diagnosed with an STI. The majority of these six people had been diagnosed with chlamydia (n=5) and one person had been diagnosed with syphilis.

Table 15: What participants did the last time they had STI symptoms (n=17)*

	Frequency	Percent (%)
Did nothing	9	52.9
Talked to a friend	4	23.5
Visited a hospital	4	23.5
Got medicine from pharmacy	2	11.8
Visited an STI clinic	1	5.9
Visited a private clinic	0	–
Visited a healthcare worker	0	–
Received traditional treatment	0	–
Other (reported: consulted family member who is a nurse)	1	5.9

* Multiple answers possible. Missing data n=1.

Fifty-nine (90.8%) participants reported having ever heard of HIV or the disease called AIDS prior to the survey. There was quite a range of sources of information about HIV and AIDS from which many of the participants had acquired knowledge. The most commonly reported sources of information about HIV and AIDS were, in order, school, pamphlets, television and NGO program (Table 16). Ten participants knew someone who was infected with HIV.

Table 16: Sources of information about HIV and AIDS (n=58)*

	Frequency	Percent (%)
School	36	62.1
Pamphlets/Leaflets	30	51.7
Television	30	51.7
NGO program	28	48.3
Newspapers/Magazines	24	41.4
Posters/Billboards	23	39.7
Friends or family	22	37.9
Radio	18	31.0
Workplace	13	22.4
Other (reported: did my own research)	1	1.72

* Multiple answers possible. Includes only those respondents who reported having heard of HIV or AIDS. Missing data n=1.

The 59 participants who had previously heard of HIV or AIDS were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 17. Accurate knowledge was relatively high among this group for most questions – except those pertaining to mother-to-child transmission, for which only about half the participants knew the correct answers. Twelve participants answered all 10 questions correctly, and 42 participants (71.2%) answered seven or more questions correctly. The lowest score was for one person who recorded none of the answers correctly.

Table 17: Knowledge about HIV and AIDS (n=59)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	42 (71.2)	8 (13.6)	9 (15.3)	59 (100)
Do people get HIV because of something they have done wrong?	57 (96.6)	1 (1.7)	1 (1.7)	59 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	5 (8.5)	48 (81.4)	6 (10.2)	59 (100)
Can a person get HIV by sharing food with someone who is infected?	48 (81.4)	5 (8.5)	6 (10.2)	59 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	9 (15.3)	45 (76.3)	5 (8.5)	59 (100)
Can a healthy-looking person have HIV?	6 (10.2)	49 (83.1)	4 (6.8)	59 (100)
Can people be cured from HIV by a traditional healer?	47 (79.7)	8 (13.6)	4 (6.8)	59 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	9 (15.3)	41 (69.5)	9 (15.3)	59 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	18 (30.5)	31 (52.5)	10 (16.9)	59 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	17 (28.8)	32 (54.2)	10 (16.9)	59 (100)

* Includes only those respondents who reported having heard of HIV or AIDS.

3.4.2.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 59 participants who had heard of HIV had non-stigmatising attitudes towards people living with HIV across all three questions (Table 18), which is not always observed in other jurisdictions. For example, in some populations and countries, the question about wanting the HIV status of a family member to remain a secret is answered in the affirmative by a majority, even when respondents' answers to the other two questions show no evidence of stigmatising attitudes.

Table 18: Attitudes towards people living with HIV among participants (n=59)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	9 (15.3)	50 (84.7)	0	59 (100)
If a member of your family had HIV, would you want it to remain secret?	22 (37.3)	36 (61.0)	1 (1.7)	59 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	15 (25.4)	38 (64.4)	6 (10.2)	59 (100)

* Includes only those participants who reported having heard of HIV or AIDS.

3.4.2.1.5 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. The majority of participants had not observed any stigma and discrimination of the types asked in the three questions in Table 19. A small proportion of participants were aware of someone they knew being denied health services or denied involvement in social or other events, or of being verbally abused in the previous 12 months as a result of living with HIV or being suspected of living with HIV (Table 19).

Table 19: Evidence of stigma and discrimination observed in the community (n=59)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	56 (94.9)	3 (5.1)	0	59 (100)
Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	56 (94.9)	3 (5.1)	0	59 (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	57 (96.6)	2 (3.4)	0	59 (100)

* Includes only those participants who reported having heard of HIV or AIDS.

Participants reported on the reactions of various people to their sexual identity (Table 20). Employers and co-workers appear to have been more supportive of participants' sexual identities than were family members. This occurrence cannot be explained by more family members than employees knowing about the participants' status, as there was no difference across the three groups on the option 'they don't know at all'. A majority reported that their family members ignore or refuse to talk with them. However, there was more gossip reported in the context of other people and employers and co-workers compared with family members.

Table 20: Reactions of family members and other people to participants' sexual identity*

	Reaction of family members n=63 (%)[1]	**Reaction of other people n=65 (%)**	**Reaction of employer or co-workers n=64 (%)[2]**
They don't know at all	13 (20.6)	13 (20.0)	14 (21.5)
They support my identity	35 (55.6)	46 (70.8)	46 (70.8)
They ignore me/refuse to talk to me	35 (55.6)	7 (10.8)	0
They criticized/blamed/verbally abused me	7 (11.1)	8 (12.3)	0
They conduct violence/physical abuse on me	1 (1.6)	6 (9.2)	0
They lock/restrict me	0	NA	NA
They kicked me out of the family/group	1 (1.6)	1 (1.5)	NA
They force me to work more	4 (6.3)	NA	NA
They gossip about me	NA	18 (27.7)	9 (13.8)
They fired me from work	NA	NA	0
Other (reported: accept my preference; over time they have learnt to accept me; hasn't been discussed; not spoken – they pretend it is not real; it's tolerated but not discussed; they don't accept me as I am; they love me for who I am)	9 (14.3)		
Other (reported: hiding; ok; they don't accept me; they treat me like normal)		4 (6.2)	
Other (reported: ok; they love me; they support me)			3 (4.6)

* Multiple answers possible. [1] Missing data n=2. [2] Missing data n=1. NA=not applicable.

3.4.2.1.6 Emotional and physical well-being

Participants were asked to indicate whether they had experienced any of a list of thoughts and feelings because of their sexual identity in the preceding 12 months. Only 44 of the 65 participants responded to these questions, most likely because of the negative slant of the questions. The most commonly reported responses included feeling ashamed and having low self-esteem (Table 21).

Table 21: Participants' negative thoughts and feelings about their sexual identity in the last 12 months (n=44)*

	Frequency	Percent (%)
I feel ashamed	18	40.9
I have low self-esteem	13	29.5
I feel guilty	9	20.5
I blame myself	8	18.2
I feel I should be punished	4	9.1
I feel suicidal	3	6.8
I blame others	1	2.3

* Multiple answers possible. Missing data n=21.

Participants were asked to indicate whether they had engaged in or avoided certain events or activities because of their sexual identity (Table 22). Only 40 of the 65 participants chose to answer these questions, most likely for the same reasons mentioned in the context of the questions about emotional well-being. The most commonly reported responses included choosing not to attend a social gathering and deciding to isolate oneself from family and/or friends.

Table 22: Participants' actions as a result of their sexual identity in the last 12 months (n=40)*

	Frequency	Percent (%)
I have chosen not to attend social gathering	15	37.5
I have isolated myself from my family and/or friends	8	20.0
I decided not to apply for a job or for a promotion	5	12.5
I decided not to have children	4	10.0
I decided not to get married	3	7.5
I withdrew from education/training	3	7.5
I decided to stop working	2	5.0
I avoided going to a hospital when I needed to	2	5.0
I avoided going to a local clinic when I needed to	2	5.0
I decided not to have sex	1	2.5

* Multiple answers possible. Missing data n=25.

All participants were asked whether they had been raped or forced to have sex in the preceding 12 months, to which seven people (10.5%) responded in the affirmative. When asked who was responsible for the sexual assault, responses included casual partner (n=3), stranger (n=2), boyfriend/husband (n=1), friend (n=1), family member (n=1), work colleague (n=1) and tourist (n=1).

3.4.2.1.7 Access to health services

All participants were asked whether they knew where they could access a range of health services. A majority of respondents knew how to access all of the services reported on in Table 23, particularly condoms, health-related information, and HIV and STI testing. Fewer participants – though still a majority – reported knowing how to access support as well as HIV and STI treatments (Table 23).

Fifty-four participants knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault. When asked what the names of any of these organisations were, the following were reported by the majority: AIDS Task Force, Ministry of Health, Cook Islands Family Welfare Association (CIFAW), Red Cross, Hospital, Police, Te Tiare Association (TTA), Tupapa Clinic and New Zealand Helpline.

Table 23: Knowledge about accessing health services

	No n (%)	**Yes n (%)**	**Don't know n (%)**	**Total n (%)**
Condoms	7 (10.8)	55 (84.6)	3 (4.6)	65 (100)
Health-related information	11 (16.9)	51 (78.5)	3 (4.6)	65 (100)
Support	22 (33.8)	40 (61.5)	3 (4.6)	65 (100)
HIV and STI testing	11 (16.9)	51 (78.5)	3 (4.6)	65 (100)
HIV and STI treatment	18 (27.7)	44 (67.7)	3 (4.6)	65 (100)

For all of the services presented in Table 24, a majority reported not having used the service. The most commonly reported use of a service was for participating in an HIV peer education program.

Table 24: Connection with HIV-related and other health services

	No n (%)	**Yes n (%)**	**Not applicable n (%)**	**Total n (%)**
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, HIV and STIs, or sexual assault?	33 (55.9)	17 (28.8)	9 (15.3)	59 (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault?	44 (74.6)	15 (25.4)	0	59 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	6 (10.2)	11 (18.6)	42 (71.2)	59 (100)
Have you ever participated in an HIV peer education program?	36 (61.0)	23 (39.0)	0	59 (100)

The 15 participants who reported visiting a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault were asked for feedback on their experiences with the service (Table 25). The majority of participants who used the service were generally satisfied and would use it again. A minority of the participants indicated that they were uncomfortable with and embarrassed by the service.

Thirty-nine participants (60%) reported that they would like to receive additional information about HIV, as well as contact details for any support services.

Table 25: Feedback about the health service (n=15)*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	0	3 (20.0)	7 (46.7)	5 (33.3)	15 (100.0)
The health worker I saw was friendly and easy to talk to	0	1 (6.7)	3 (20.0)	6 (40.0)	5 (33.3)	15 (100.0)
I felt uncomfortable and embarrassed	5 (33.3)	3 (20.0)	5 (33.3)	1 (6.7)	1 (6.7)	15 (100.0)
The service was confidential and I felt my privacy was respected	1 (6.7)	0	4 (26.7)	3 (20.0)	7 (46.7)	15 (100.0)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	0	0	2 (13.3)	7 (46.7)	6 (40.0)	15 (100.0)
I would use the service again if I needed to	0	0	3 (20.0)	5 (33.3)	7 (46.7)	15 (100.0)

* Includes only those participants who reported using the service.

3.4.2.1.8 HIV testing

Of the 59 participants who had heard of HIV or AIDS before the survey, 50 (84.7%) believed that it was possible for someone in their community to get a test to find out if they are infected with HIV, and 48 participants knew where to go to receive the test. Twenty-five participants reported having ever had an HIV test and 15 (60%) of these same people had an HIV test in the 12 months prior to the survey. The places where they reported having had an HIV test included at a government hospital health service (n=14), private doctor's clinic (n=3) and NGO clinic (n=3). Of the 25 people who had ever had an HIV test, 22 (88%) reported receiving their HIV results. Of these 22 people, all reported that they were HIV-negative based on that result.

3.4.2.1.9 Alcohol and drug use

All but 10 participants reported drinking alcohol in the preceding four weeks. Of the 55 people who reported drinking alcohol in that time, a majority indicated that they drank alcohol at least once a week (Table 26).

Those who drank alcohol were asked how many drinks they had the last time they drank alcohol, with the number ranging from two drinks to 55 drinks – the latter being improbable, unless drinks contained very low alcohol and were consumed over multiple days. Nonetheless, there was a high median number of drinks – being eight – consumed on the last occasion of alcohol use.

Table 26: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	5 (7.7)
Never in the last 4 weeks	5 (7.7)
Less than once a week	13 (20.0)
At least once a week	41 (63.1)
Every day	1 (1.5)
Total	**65 (100.0)**

Participants were asked whether they had taken a range of drugs during the preceding 12 months. The most widely used drug was reported to be marijuana (n=29), followed by kava (n=9), freebase (n=5), crystal methamphetamine (n=4), inhalants (n=3), amphetamine (speed) (n=2), ecstasy (MDMA) (n=2) and other (reported to be 'don't know', fluoxetine and tramadol). When asked whether in the previous four weeks they had engaged in anal or vaginal intercourse after taking alcohol and/or drugs which left them feeling not in control, 24 participants responded in the affirmative.

3.4.2.2 Female sex workers

3.4.2.2.1 Description of the sample

Four women who sold sex in exchange for money or goods provided survey data. Given the small sample size, percentages will be avoided where possible and data will be only minimally presented in tables, with most results being reported within the text.

The age of the women ranged from 22 to 28, with a mean age of 24.25 (SD=2.63) and a median age of 23.50. Three of the women reported being educated to a secondary level and one woman to a polytechnic/diploma level. Three women reported being employed full-time while one woman indicated that she worked part-time or casually.

All four women reported being 'single' and not married. One woman reported having one child, while the remaining three women reported having no children. People with whom the women lived (multiple answers possible) included parents/in-laws (n=1), siblings (n=1), children (n=1) and other relatives (n=1).

3.4.2.2.2 Sexual history and practice

All four women reported ever having had sexual intercourse. The first time they had sexual intercourse ranged from 11 to 15 years of age. The age at which these women first received money or goods in exchange for sex included 16 (n=3) and 19 (n=1).

3.4.2.2.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses for all but one of the women appeared to be realistic. Responses included 11, 89, 90 and 200 male sex partners, with a median of 89.5. The number of male sex partners reported in the last 12 months appeared to be an underestimate and included 4, 10, 12 and 50, with a median of 11. However when asked how many male partners in the previous 12 months were paying partners, the numbers aligned as expected with overall male partners for the last 12 months, and included 3, 6, 10 and 15 paying male partners. Taken together, these figures suggest that most of the partners for these women were paying partners and that, due to the low numbers, it is likely that each of the women has regular paying partners rather than many new paying partners, which may indicate local rather than tourist clients.

3.4.2.2.3 Sex with paying male partners

When asked how many paying partners they had on the last day that they were paid for sex, two women reported one paying partner, while the other two women reported two paying partners.

3.4.2.2.3.1 Types of sexual practice with paying male partners

Women were asked what types of sexual contact they had with paying partners during the preceding 12 months. These included masturbating the partner (n=2), being masturbated by the partner (n=1), sucking his penis (n=3), he licking her vagina (n=4), his penis between her thighs or breasts (n=1), his penis inside her vagina (n=4) and his penis inside her anus (n=1).

3.4.2.2.3.2 Condom use and lubrication for anal intercourse with paying male partners

Two of the four women reported using a condom ‘almost every time’ for vaginal intercourse with a paying partner in the previous 12 months, while one women reported ‘sometimes’ using a condom and the other woman reported never using condoms with paying clients for vaginal intercourse. The same woman reported not using a condom on the last occasion of vaginal intercourse with a client. Two of the women reported using a condom on the last occasion of vaginal intercourse with a paying partner. The one woman who had anal intercourse with paying partners reported using condoms almost every time in the last 12 months for anal intercourse with clients. The same woman reported using a condom and lubricant the last time she had anal intercourse with a client.

Three women reported ever not using a condom because the paying partner paid extra money for that to happen. In response to the question about how often it was difficult to get clients to use condoms, women reported ‘a little of the time’ (n=1), ‘some of the time’ (n=1), ‘a lot of the time’ (n=1) and ‘all of the time’ (n=1). When asked who usually supplies the condom, three women reported that they do while one woman reported never using a condom.

When asked why they did not use condoms with paying partners, women reported the following reasons with multiple answers possible: condoms take away pleasure (n=1) and don’t like condoms (n=1).

3.4.2.2.3.3 Where sex with paying male partners takes place and who decides how much money she receives

Women were asked where they had sex with their paying clients the last time they had sex with a paying partner. Responses included at a hotel (n=2), at his house (n=1) and outside (n=1) (for example, bushes, beach, etc). Women were also asked who decides on how much money she gets paid by clients. Responses included the woman decides (n=3) and other – reported as we both decide (n=1).

3.4.2.2.4 Sex with regular male partners

Three of the four women reported having had sex with a regular male partner (for example, a boyfriend or husband) in the previous 12 months.

3.4.2.2.4.1 Condom use with regular male partners

Participants were asked how often they had used condoms for vaginal intercourse with their regular male partners in the last 12 months. Two women reported never using condoms, while one woman reported sometimes using condoms. None of the women had used a condom for vaginal intercourse with their regular partner on the last occasion. Two women reported having had anal intercourse with their regular partner during the previous 12 months. One woman reported never using a condom, while the other reported ‘sometimes’ using a condom for anal intercourse with their regular partner in the previous 12 months. Neither woman used a condom on the last occasion of anal intercourse with their regular male partner. One woman reported using lubricant on the last occasion of anal intercourse with a regular male partner.

Women were asked for their reasons for not using condoms with their regular partners. Responses were identical to those they provided for not using condoms with paying partners with one exception, and included condoms take away pleasure (n=1), don’t like condoms (n=1) and believing it’s not necessary (n=1).

3.4.2.2.5 Sex with casual male partners

Three of the four women reported having sex with casual male partners in the preceding 12 months.

3.4.2.2.5.1 Condom use with casual male partners

Two of the women reported ‘sometimes’ using condoms for vaginal intercourse with their casual male partners, with one woman reporting never using a condom with a casual male partner. One woman reported condom use on the last occasion of vaginal intercourse with a casual male partner.

Three women reported anal intercourse with casual male partners in the preceding 12 months. One of these women reported using a condom almost every time for anal intercourse with casual male partners, while another woman reported using a condom sometimes and the other woman reported never using a condom for anal intercourse with such partners in the preceding 12 months. One woman reported using lubricant on the last occasion of anal intercourse with a casual male partner.

Reasons provided for not using condoms with casual male partners included condoms take away pleasure (n=1), don’t like condoms (n=1), condoms were not available (n=1) and believing it’s not necessary (n=1).

3.4.2.2.6 Obtaining condoms

All four women reported knowing where they could obtain condoms. When asked where they had previously obtained condoms, all four women indicated that they obtained condoms through a condom dispenser (n=4).

3.4.2.2.7 Alcohol and drug use

Three of the four women reported drinking alcohol in the past four weeks and all three indicated that they had drunk alcohol at least once a week in that period. When asked how many drinks they had consumed the last time they drank alcohol, all four women gave responses ranging from five to an improbable 40 drinks. The latter may be possible if the drinks contained very low alcohol and were consumed over multiple days. All three women who had drunk alcohol in the past four weeks reported having had sex during the time they were taking alcohol or drugs and not feeling in control. The women were also asked what drugs, if any, they had taken in the last 12 months. Marijuana was the only drug in the list that one woman reported having taken in the preceding 12 months. Another of the women chose the ‘other’ option and then reported the drug she had taken as being Panadol.

3.4.2.2.8 Sexually transmissible infections, including HIV

All four women reported ever having heard of diseases that can be transmitted sexually, and two reported having ever had pain while urinating. However, none of the women reported genital discharge or having had a genital ulcer or sore in the preceding 12 months. Two women reported ever having been diagnosed with a sexually transmissible infection (STI), which included chlamydia (n=2) and gonorrhoea (n=1). The responses of the two women who had ever had an STI symptom included doing nothing (n=1) and visiting a hospital (n=1).

All four women had heard of HIV or the disease called AIDS prior to the survey. Their sources of information about HIV and AIDS (with multiple answers possible) included school (n=4), friends/family (n=2), television (n=2), newspaper/magazine (n=2), NGO program (n=1), pamphlets/leaflets (n=1) and radio (n=1). None of the women reported knowing someone who was infected with HIV.

3.4.2.2.9 Knowledge about HIV and AIDS

The four women were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 27. Knowledge was generally accurate with one notable exception: three women reported being unaware that the risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners. It is noted that for sex workers this piece of knowledge may be seen as somewhat redundant and irrelevant in their circumstances. Also, two of the women reported believing that HIV can be cured by a traditional healer.

Table 27: Knowledge about HIV and AIDS (n=4)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	4 (100)	0	0	4 (100)
Do people get HIV because of something they have done wrong?	4 (100)	0	0	4 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	1 (25)	3 (75)	0	4 (100)
Can a person get HIV by sharing food with someone who is infected?	3 (75)	1 (25)	0	4 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	3 (75)	1 (25)	0	4 (100)
Can a healthy-looking person have HIV?	0	4 (100)	0	4 (100)
Can people be cured from HIV by a traditional healer?	2 (50)	2 (50)	0	4 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	0	4 (100)	0	4 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	1 (25)	3 (75)	0	4 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	1 (25)	3 (75)	0	4 (100)

3.4.2.2.10 Stigmatising attitudes towards people living with HIV

Responses to the three attitudinal questions indicated that there was some evidence of stigmatising attitudes. While all four women reported being willing to care for a relative with HIV, three of the women indicated that they would prefer that a family member's HIV infection remained a secret, and two of the women reported that they would not buy fresh vegetables from someone they knew had HIV (Table 28)

Table 28: Attitudes towards people living with HIV among participants

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	0	4 (100)	0	4 (100)
If a member of your family had HIV, would you want it to remain secret?	1 (25)	3 (75)	0	4 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	2 (50)	2 (50)	0	4 (100)

3.4.2.2.11 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 29). No participant was aware of anyone being denied health services in the previous 12 months as a result of living with HIV or being suspected of living with HIV. However, one woman reported knowing someone who had been denied involvement in social, religious or community events in the preceding 12 months. One woman also indicated knowing someone who had been verbally abused in that period because they were thought to have HIV.

Table 29: Evidence of stigma and discrimination observed in the community

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	4 (100)	0	0	4 (100)
Do you personally know someone who has been denied involvement in social events, religious services or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	3 (75)	1 (25)	0	4 (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	3 (75)	1 (25)	0	4 (100)

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Two of the four women answered in the affirmative that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, responses included man who paid for sex (n=2), family friend (n=1) and stranger (n=1).

3.4.2.2.12 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 30). A majority of the women knew how to access all the services reported on in the table below with the exception of support, for which only two women had knowledge about how to access that service.

Table 30: Knowledge about accessing health services

	No n (%)	**Yes n (%)**	**Total n (%)**
Support	2 (50)	2 (50)	4 (100)
Health-related information	0	4 (100)	4 (100)
HIV and STI testing	0	4 (100)	4 (100)
HIV and STI treatment	1 (25)	3 (75)	4 (100)
Condoms	0	4 (100)	4 (100)

Of all the services presented in Table 31, none were utilised by the participants in the time periods mentioned in the questions, which was the last 12 months for three of the questions and 'ever' in the context of having participated in an HIV peer education program.

Table 31: Connection with HIV-related and other health services

	No n (%)	**Yes n (%)**	**Not applicable n (%)**	**Total n (%)**
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, pregnancy, HIV and STIs, or sexual assault?	4 (100)	0	0	4 (100)
In the past 12 months, have you visited a health service for information or services on condoms, HIV and STIs, family planning, or sexual assault?	0	0	4 (100)	4 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	0	0	4 (100)	4 (100)
Have you ever participated in an HIV peer education program?	4 (100)	0	0	4 (100)

All four women reported knowing of local organisations providing information or services about condoms, HIV and STIs, family planning, and sexual assault, even though none had used any of these services in the previous 12 months. These women have presumably used these services at some stage in the past. When asked what the names of any local organisations were that provided these services, the responses included the Cook Islands Family and Welfare Association and the Ministry of Health. The four women responded to questions about their experiences with this type of health service (Table 32).

A majority of the women were neither flattering nor critical of the service and all seemed open to using the service again. The least endorsed aspect of the service was the health workers at the service, with two women indicating that the health worker they saw was not friendly and easy to talk to. This aspect of the service may provide an indication as to why the service was not well utilised by these four women in the past 12 months. Only one of the four women reported that she would like to receive additional information about HIV, as well as contact details of any support services.

Table 32: Feedback about the health service

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	1 (25)	1 (25)	2 (50)	0	4 (100.0)
The health worker I saw was friendly and easy to talk to	0	2 (50)	1 (25)	1 (25)	0	4 (100.0)
I felt uncomfortable and embarrassed	0	1 (25)	1 (25)	2 (50)	0	4 (100.0)
The service was confidential and I felt my privacy was respected	0	0	3 (75)	1 (25)	0	4 (100.0)
I could get what I needed eg contraceptives, condoms, HIV and STI tests, etc	0	1 (25)	3 (75)	0	0	4 (100.0)
I would use the service again if I needed to	0	0	3 (75)	1 (25)	0	4 (100.0)

3.4.2.2.13 HIV testing

All four women believed that it is possible for someone in their community to get a test to find out if they are infected with HIV and three of the four knew where to go to receive the test. Three women reported having ever had an HIV test. Although they indicated, as shown in the table above, that they did not utilise a service for HIV and STIs, all three women reported having had an HIV test in the 12 months prior to the survey. When asked where the test was conducted, all three women reported that their test took place at the government hospital health service. All three reported receiving their HIV test results and being informed that they were HIV negative based on that result.

3.4.3 Interviews

3.4.3.1 Transgender and men who have sex with men

Eight men were interviewed in-depth. The majority were transgender rather than men who have sex with men.

3.4.3.1.1 Identity

Most participants felt generally but not fully accepted by their families and communities, although many had never discussed their sexual orientation or gender identity with their family:

> Socially I feel accepted you know when we do things I feel that we are generally accepted. But then of course when the circles become smaller that is when I notice obvious animosity. So I guess what I am trying to say is that I feel accepted just not fully accepted. I feel like the difference in being a Cook Islander in the Cook Islands community, and being out in the world. In New Zealand when I identify as a woman generally I am viewed as one, but here I am viewed as a drag queen or a gay man in women's clothing. [Interviewee 4.]

A number of participants felt that times were changing and acceptance was increasing:

> I feel accepted, I haven't seen any rejection or [mean] people you know? I think that back in the days in the 1990s there was more rejection, telling you 'don't do that' or being forced to do things you don't want to do, like I remember I was forced to play rugby but I always ran away. I would rather play with the girls. But now it is more like … I don't have any issues. [Interviewee 1.]

3.4.3.1.2 Stigma and discrimination

Interviewees noted subtle discrimination, teasing and verbal abuse (which they seemed used to). A few also noted discrimination in employment and felt that they were viewed as unsuitable for both typically male and female jobs. They also noted that employers would, if they accepted a job, force them to wear the male uniform and cut their hair – with the exception of one transgender woman working in hospitality, who got to wear dresses:

> When you go for job interviews you can still feel the discrimination … you are capable it's just when people see you and the way you are then they have second thoughts on what you can do. If you apply for a warehouse job but [you don't get it] because they look at you and they see you are trans they automatically think that you can't pick a box up, they think that you are not fit for it – even though I am stronger than half of them … [In Rarotonga] some resorts you can't have long hair [as a transgender] you have to cut it, even some companies, you have to cut it … And I am not going to cut my hair. [Interviewee 8.]

3.4.3.2 Sexual relationships and practices

Most of the men who have sex with men and *akava'ine* had had only short-term hidden relationships with other men. The men would like longer-term relationships, but either they or their sexual partners have not made the transition to 'out' and/or steady partnerships:

> All my relationships have been with men, I have never been with a woman … I have only had maybe four or five relationships that I have tried to carry on, but to me it just felt … because they always tell you what to do. They are willing to be in a relationship with you but to go out in the open they are more of the 12 midnight type texts. I just can't be bothered. They enjoy your company and everything but when it comes to going out they are like no I don't want to be seen with you. [Interviewee 3.]

> I have had relationships with males … My relationships have been short term and hidden, I prefer it to be that way. I don't think the world or perhaps the Cook Islands really understands that we have gay guys together and we all know they are in relationships but you can't have a transgender and a straight guy in the Cook Islands and just walk around as if they are together. I prefer all my fuck buddies, my sexual relationships to be in my house behind closed doors and it is more or less like for those who want to explore. Most of the time it is drunk and just quick blow jobs and then like ok you have to go, because I like my own bed … More or less it's one-night stands, because the male in the Cook Islands, I've had a few come around to my house on a regular basis but I get tired of them. I have come this far and not had a relationship, as much as I would love to have one perhaps not in this country maybe in New Zealand. [Interviewee 5.]

> For me, I think that I have been with straight guys, and also some guys who are G-A-Y they dress up in men's clothes but are gay … I make it clear that if I need it I will call you, if you need it call me these are straight guys and it's for fun … I want it to be hidden, these are guys or men who might have partners and then I might get into trouble so I just want to keep it quiet. I don't want it getting out and people twisting stories. [Interviewee 6.]

> I've had lots of relations with supposedly straight men, and some gay as well. But the majority of my past relationships are with masculine men who could be seen as straight if you asked them. I have some open and a lot of hidden because I don't like to personally broadcast my relationships and be judged by society based on who I am seeing, a lot of my relationships I have kept on the 'down low' which often leads to arguments. [Interviewee 2.]

Some had been paid for sex in varying contexts: from having sugar daddies to regularly receiving gifts and goods by arrangement, to working the streets in Auckland with transgender friends:

> When I was living in Auckland I decided to go and work the streets … I thought it was fun while it lasted. But here [in Rarotonga] it's the older ones that pay … [In Auckland] some of the girls I knew there were doing it so I would follow them a couple of nights a week, if I drove them and felt like it … Older men here they got the money, you have a few young ones who have money … To me it means pleasure, [I get a] good time out of it, money and you can choose which ones you go with. [Interviewee 4.]

3.4.3.3 Condom use

Only one interviewee always used condoms for anal sex, and most of those who were interviewed used a condom occasionally:

> I use condoms occasionally, not all the time to be honest around half of the time … Depends on what mood I am in, if I am going to have sex I like to just get straight into it. The only time that I have taken condoms (and used them) really is just when the mood strikes me. [Interviewee 5.]

A couple of interviewees hated condoms:

> I have only tried it with a condom once, that was my first time [I had sex], two years ago that was the last time I ever used a condom. I just don't like the feeling, I don't like that rubber feeling it feels weird … Some guys asked if I wanted to use a condom and I have said no. I have them around, I carry it but I don't use it. But if it was with a full-on stranger to stranger I would use it. [Interviewee 6.]

> I don't like using condoms at all … because when guys use condoms it sort of delays when they ejaculate because the sensitivity goes down. I don't like it really quick but I don't want

> to go for like an hour if I am drunk or tired. And I trust the men that I sleep with so I don't use a condom with them, because word of mouth travels really fast so you kind of know who they have slept with. [Interviewee 3.]

One interviewee said 'I don't have a problem using it, it's almost the same with condom and lube and its much cleaner after you had sex and its safer', although he depended on the situation to decide whether or not to use a condom.

A few noted that condoms are promoted and generally around less than they used to be, but they are still available. Reasons for not using them included not comfortable, ruins the mood, being inconvenient, being drunk, and viewing them as unnecessary. Many participants felt that they trusted or knew their partners in a small community such as Rarotonga.

3.4.3.4 Access to services

In relation to accessing sexual health services, four of the eight interviewees had never been tested:

> [No] I don't use them [sexual health services]. The gossip here is terrible on the island … So it's really a privacy and confidentiality thing … it's really just gossiping here on the island and I fear that if I do have an STI it is just going to spread like wildfire, it does happen, it's sad to say but it does happen here on the island. [Interviewee 7.]

Three had been tested in the last two years. A number of participants noted that they had not been tested since the voluntary confidential counselling and testing (VCCT) program had ceased in 2014. Only one participant had been tested in the past year:

> I usually do my tests every six months, I used to go for VCCT now I just ring up the doctor. I miss the counsellors because you could talk first before doing a test, you know they will help you to keep you feeling positive … Now I feel scared and have put off getting tested. [Interviewee 5.]

3.4.4 Institutional capacity assessment: Cook Islands – HIV organisations and services

3.4.4.1 Organisational mapping

Under the Cook Islands National Health Strategy 2012–2016, the Cook Islands Ministry of Health (MoH) provides national coverage of healthcare services. The MoH has provided prevention activities, awareness programs, condom distribution, and voluntary confidential counselling and testing (VCCT) services, including mobile testing, antenatal testing and sexually transmissible infection (STI) treatment. Since HIV funding was greatly reduced in 2014, the MoH is less engaged in providing prevention activities, and awareness programs and VCCT services have been significantly reduced. The Integrated National Strategic Plan for Sexual and Reproductive Health 2014–2018 has not been utilised due to limited HIV and SRH funding. The MoH does not specifically engage MSM/TG or FSW in its service delivery, but it does partner with organisations that provide health and well-being promotion to key populations such as the Te Tiare Association (TTA).

The key NGOs currently providing HIV and STI services are as follows:

- The Cook Islands Family and Welfare Association (CIFWA) provides national family planning, sexual and reproductive health and rights (SRHR) awareness, and advocacy to young people, antenatal women, women, men and TG.
- The Te Tiare Association (TTA) represents and works with the LGBTIQ community, specifically the MSM/TG community, and advocates on their behalf with government and the general public. TTA conducts peer support, distributes condoms, and refers members to the MoH for testing.

3.4.4.2 HIV and STI prevention activities in the Cook Islands

3.4.4.2.1 National oversight, coordination and funding

Planning and policy development related to HIV planning is conducted by the Cook Islands National HIV, STI and TB Committee, which last met in 2014 and is reportedly not currently functioning. MoH funding for HIV/STI was previously provided by the Response Fund (RF) and Global Fund, with minimal HIV funding remaining. TTA fundraises to provide activities and CIFWA funding is provided by the International Planned Parenthood Federation and the Australian Department of Foreign Affairs and Trade. CIFWA previously received funds from the United Nations Population Fund.

3.4.4.2.2 HIV and STI testing, counselling and treatment

A collaborative VCCT program was successful but is no longer functioning. HIV/STI testing occurs through antenatal testing and for those who request testing services. STI treatment has focused on mass chlamydia treatment. A mass treatment program in 2011–12 led to a significant reduction in the incidence of chlamydia.

3.4.4.2.3 Condom distribution

Condoms are mainly distributed through condom dispensers that are stocked by CIFWA and the Red Cross; however, there were reports of dispensers often being empty. TTA provides a low number of condoms to MSM/TG; however, it generally refers people to dispensers and to the MoH and CIFWA for condoms.

3.4.4.2.4 Peer education

Peer support for MSM/TG is primarily provided by TTA. For example, the Stepping Stones program, which aimed to improve sexual and reproductive health (SRH) and gender equality, was provided to *akava'ine* people and co-delivered by an *akava'ine* person and the former HIV Coordinator employed by the MoH. SRH sessions on comprehensive sexuality education for young people were provided to the general youth population by youth volunteers.

3.4.4.2.5 Strategic health communication

SRH awareness programs previously held were reported to result in increased levels of knowledge. The MoH has previously delivered specific awareness sessions with MSM, such as hosting an HIV night and offering HIV testing and counselling to *akava'ine*. SRH education is included in the national school curriculum, which may reach young people identifying with key populations. CIFWA delivered youth awareness activities in 2013–14 with the MoH and a VCCT program funded by Global Fund and the Pacific Response Fund. In 2015, CIFWA conducted 65 outreach HIV education sessions. The Stepping Stones program aimed to improve SRH and gender equality and was provided to *akava'ine* people and delivered by an *akava'ine* person in 2013.

3.4.4.2.6 Advocacy and legislation

CIFWA undertakes SRHR advocacy – for example, including comprehensive sexuality education as part of the national education curriculum that is compulsory in all schools. TTA's main advocacy activities are focused on the decriminalisation of homosexuality, reforming the Family Law Bill and promoting inclusivity.

3.4.4.2.7 Other support services

TTA provides social support to its members.

3.4.4.3 Cross-cutting organisational strengths

- **Policies:** Many agencies reported being guided by global, regional and/or domestic policies and guidelines related to their sector of work.
- **Coverage:** Organisations reported good coverage levels of services within Rarotonga and efforts having been made to provide services in the outer islands when funding allows for it.
- **Partnerships:** Organisations appear to be well connected to other agencies working in their sector area(s).
- **Monitoring and evaluation (M&E):** The MoH reported the use of M&E processes and the collection of communicable disease data. CIFWA uses MoH data to support advocacy efforts.

- **Programmatic outcomes:** Organisations reported successful delivery of services and programs, including STI testing and VCCT, and successes through the inclusion of SRH education in the national education curriculum.

3.4.4.4 Cross-cutting organisational capacity-building needs

- **Greater/Specific engagement of key populations in service delivery:** Many organisations (with the exception of TTA) acknowledged a need to access and directly engage key populations in relevant prevention/education activities and services. Organisations reported lacking the appropriate skills to engage key populations. There are also issues with TTA's capacity as it has no actual staff and relies on volunteers.
- **Training and professional development:** Most organisations reported requiring training and professional development for staff and/or volunteers in:
  - organisational management areas, such as IT, finance and accounting training;
  - how to work with MSM and TG and engage with marginalised groups, such as people with disabilities or MSM, more effectively; and
  - working with parents.
- **Funding:** Greater need for HIV/sexual health-specific funding was identified, particularly for service delivery, commodity provision, the implementation of the Integrated National Strategic Plan for Sexual and Reproductive Health 2014–2018, and the resumption of the National HIV, STI and TB Committee.
- **Data collection/M&E:** Some data collection gaps were identified – for example, data disaggregated by population type (MSM/TG) is currently not being collected. It is likely that this would not be possible for FSW due to their hidden nature. Furthermore, M&E appears ad hoc and informal for some organisations.
- **Governmental barriers to advocacy and activities:** Social attitudes – that is, the attitudes and religious views of health workers – were identified as barriers to advocacy and engaging with key populations.

3.4.4.5 Identified capacity-building resources

The MoH receives technical support from the Global Fund, which could be increased to assist with capacity building. CIFWA has existing support from the International Planned Parenthood Federation and has had a Volunteer Service Abroad worker from New Zealand for the last 12 months.

3.5 Further steps to assist key populations

- The condom dispensers provide good access to condoms, but better quality (that is, Durex or another brand and larger sized) condoms should be provided – along with quality lubricant, which currently is often not available. A few more condom dispensers and a new condom social marketing campaign and the production of condom and lube packs promoting safer sex could further support condom promotion.
- Outreach to FSW is not appropriate due to the quiet and hidden nature of sex work in Rarotonga. Outreach to the general community should be very broad and should aim to reach FSW, including in migrant worker communities. CIFWA and MoH can jointly undertake activities related to this and should be allocated funding to do so.
- A joint activity between TTA, CIFWA and MoH could help to improve engagement with MSM and also to build the capacity of TTA.
- TTA has already stated that it would like technical assistance to have MSM-specific sexual health awareness training. A workshop on MSM sexual health should be conducted for TTA members, CIFWA staff and volunteers, and relevant MoH staff.
- Another activity could be to jointly revive the MSM-targeted VCCT drive. Very few of the trained VCCT counsellors are still employed, so they may need a refresher course and funds to pay the counsellors.
- To strengthen the work of TTA, a Coordinator should be recruited and set up at a desk within an existing office. The Coordinator should contribute to condom promotion and distribution along with the other organisations.
- An activity under this role could be a stigma and discrimination awareness campaign leading up to the Pacific Human Rights (Pacific Sexual Diversity Network-coordinated) conference scheduled to take place in Rarotonga in September 2017.
- To support this work, the National HIV, STI and TB Committee should be revived. The secretariat role previously sat under the MoH.

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ANNEX1: UNAIDS GARP data needs

COOK ISLANDS

1.7 PERCENTAGE OF SEX WORKERS REACHED WITH PREVENTION PROGRAMMES

Indicator relevance: Topic relevant, indicator relevant, data available

Data measurement Tool:

Please specify data measurement tool:

Data collection period:

Additional information related to entered data. e.g. reference to primary data source (please send data to My Documents if possible), methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to My Documents if possible:

	All	Males	Females	>25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions					
Numerator Number of sex workers who answered "Yes" to both questions				**2**	**2**
Denominator Total number of sex workers surveyed	**4**		**4**		
Percentage (%) Percentage of sex workers who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"			**4**		
Numerator Number of sex workers who replied "yes" to question 1	**4**		**4**		
Denominator Total number of sex workers surveyed	**4**		**4**		
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?					
Numerator Number of sex workers who answered "Yes" to question 2	**0**		**0**		
Denominator Total number of sex workers surveyed	**4**		**4**		

1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client

	All	Males	Females	>25	25+
Percentage (%) Percentage of female and male sex workers reporting the use of a condom with their most recent client					
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	**3**		**3**		
Denominator Number of sex workers who reported having commercial sex in the last 12 months	**4**		**4**		

1.9 Percentage of sex workers who received an HIV test in the last 12 months and who know their results

	All	Males	Females	>25	25+
Percentage (%) Percentage of sex workers who received an HIV test in the last 12 months and who know their results					
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**3**		**3**		
Denominator Number of sex workers who responded to the questions	**4**		**4**		

1.11 Percentage of MSM reached with prevention programs

	All	>25	25+
Percentage (%) Percentage of MSM who answered "Yes" to both questions			
Numerator Number of MSM who answered "Yes" to both questions			
Denominator Total number of MSM surveyed	67		
Percentage (%) Percentage of MSM who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	78.5		
Numerator Number of MSM who replied "yes" to question 1	51		
Denominator Total number of MSM surveyed	67		
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	18.6		
Numerator Number of MSM who answered "Yes" to question 2	11		
Denominator Total number of MSM surveyed	67		

1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

	All	>25	25+
Percentage (%) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner			
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**65**		

1.13 Percentage of TRANSGENDER reached with prevention programs

	All	>25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions			
Numerator Number of TG who answered "Yes" to both questions			
Denominator Total number of TG surveyed			
Percentage (%) Percentage of TG who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"			
Numerator Number of TG who replied "yes" to question 1			
Denominator Total number of TG surveyed			
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "			
Numerator Number of TG who answered "Yes" to question 2			
Denominator Total number of TG surveyed			

1.14 PERCENTAGE OF TRANSGENDER REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD SEX

	All	>25	25+
Percentage (%) Percentage of TG reporting the use of a condom the last time they had sex			
Numerator Number of TG reporting the use of a condom the last time they had sex			
Denominator Number of respondents who reported having had sex in the last 12 months			

1.15 Percentage of transgender who received an HIV test in the last 12 months and who know their results

	All	>25	25+

Percentage (%) Percentage of TG who received an HIV test in the last 12 months and who know their results			
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results			
Denominator Number of TG who responded to the questions			

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United Nations Development Programme
Pacific Office in Fiji
Level 8, Kadavu House, 414 Victoria Parade
Private Mail Bag, Suva, Fiji
Tel : 679 331 2500
Fax : 679 330 1718
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www.pacific.undp.org