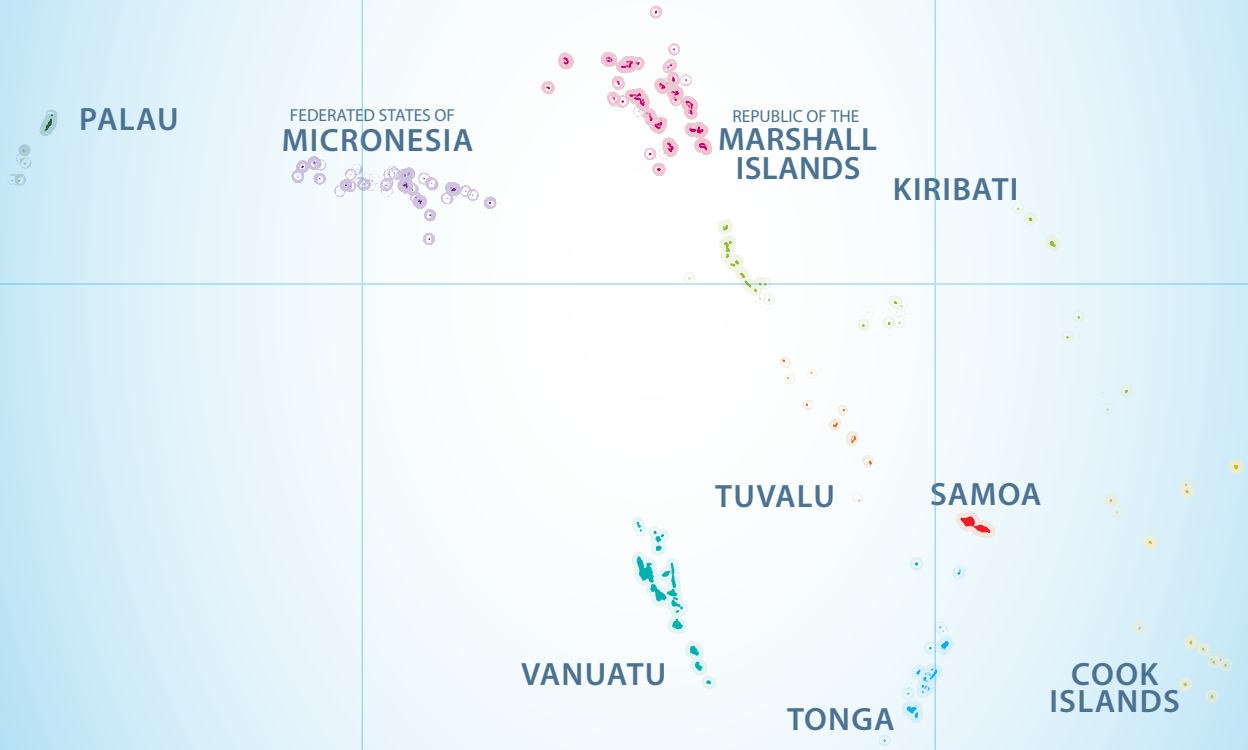
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

SAMOA



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Acknowledgements

The *Pacific Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Samoa* 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 in Samoa is low, with a cumulative total of 24 cases.
- We estimated that there are approximately 25,000–30,000 men who have sex with men (MSM) and transgender (TG) in Samoa and around 400 female sex workers (FSW).

Transgender/Men who have sex with men

- Both gender and sexual identity were complicated issues in this study. Some in the study identified as straight (both *fa'afafine* and male), and some as gay or homosexual.
- 112 TG and MSM took part in the behavioural survey.
- 80 participants had sexual intercourse, and the mean age of sexual debut was close to 16 years.
- In the interviews, *fa'afafine* talked about the problems of relationships with men. They said that they had often had their hearts broken as men moved into relationships with women.
- The most common number of sexual partners in the 12 months prior to the survey was between one and three, with 49% reporting concurrent sexual partners in the six months prior to the survey.
- 32.4% had been paid for sex in the last 12 months.
- Condom use was low, with 43.9% stating that they had never used a condom for sex with a regular partner in the last 12 months and 40% reported never using a condom with paying partners. In the interviews, many participants said that they did not use condoms because they felt safe from HIV.
- 41% of participants used a condom at last anal intercourse with a casual partner.
- 10 people reported having sex with a female partner in the last 12 months. 58.58% never used a condom for vaginal intercourse with a casual female partner in that period.
- 12 respondents reported having STI symptoms in the last 12 months, with three doing nothing about those symptoms.
- Knowledge about HIV was generally high. However, only 16.3% had an HIV test in the last 12 months.
- A small proportion of participants had experienced stigmatising attitudes from family and community. Only 8.7% felt ashamed about their sexual identity, although the interviews indicate that this is complicated, particularly when young.
- 11.9% of participants had been sexually assaulted in the previous 12 months.
- 57.4% of participants knew of a local organisation that provided access to information or services related to condoms, HIV and STIs, and sexual assault. 32.7% had accessed these services in the past 12 months.
- 35.9% of men had drunk alcohol in the last week.

Female sex workers

- 12 women took part in the behavioural survey. They work from public spaces around town, but are likely to also work via mobile phones, at tourist sites and in villages.
- Most women are doing sex work for economic reasons. Payment varied considerably from 50 to 200 tala.
- The women had a wide range of clients, including local and foreign men.
- The age of the women was between 18 and 46; 58.3% had children and the majority had no other employment.
- The age at which women began sex work ranged from 13 to 21 years old.
- The mean numbers of partners in the last 12 months was 10, of whom nine were clients (most likely many regular clients).
- Only 33% of the participants used a condom on the last occasion of vaginal intercourse with a client; a majority were inconsistent condom users with clients in the last 12 months.
- Condom use with casual non-paying partners was low; 50% used a condom on the last occasion.
- A minority of the women (18.2%) drank alcohol in the last week.
- HIV knowledge was moderate.
- None of the women had accessed a sexual health service in the last 12 months, although 60% had been given condoms in that period. None had been tested for HIV in the previous 12 months.

Capacity assessment

- While the National Health Service (NHS) delivers general population HIV and STI services, only the Samoan Fa'afafine Association (SFA) provides targeted services and programs for *fa'afafine*.
- Currently there are no services or programs specifically for FSW in Samoa.
- National HIV activities are overseen by the Country Coordinating Mechanism for Communicable Diseases, which includes a National AIDS Committee Working Group.
- HIV and STI testing is provided by the National Health Service and the National Laboratory is responsible for diagnostics. According to the Global AIDS Progress Report 2016, a total of 8,870 HIV tests were conducted in 2015, covering 4.6% of the population (mostly ANC testing). There is no targeted testing for MSM and TG.
- UNFPA supplies condoms and lubricant to the MoH. Condoms are distributed to clinics, public dispensers and to SFA.
- SFA provides peer support to members and Samoa Family Health Association also reaches some *fa'afafine*.
- SFA reaches a large number of *fa'afafine* and works in partnership with the MoH.

- MSM and FSW are a hidden population and are not presently reached in HIV prevention programs.
- Training in program management and the monitoring and evaluation of programs is needed.
- More funding is needed, but reporting templates and processes need simplification.
- Sensitisation and stigma training is needed for health workers and the community.

1 Introduction

This research was carried out as a response to the need for greatly increased, contextualised information about the vulnerability to HIV of men who have sex with men (MSM) and transgender (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 Samoa

Samoa is an independent state in the South Pacific consisting of two main islands, Upolu and Savai'i, and seven smaller islets. Upolu is home to nearly three-quarters of Samoa's population of 187,182 (2011 Census). Samoa gained independence in 1962. Agriculture employs two-thirds of the labour force and furnishes 90% of exports, featuring coconut cream, coconut oil and copra. Samoa is also dependent on development aid and private remittances from overseas.

HIV infection in Samoa remains very low, with only 24 cumulative cases of HIV since 1990. There are currently 11 people living with HIV, of whom one is a returned citizen from overseas. Two are cases of mother-to-child transmission, and the rest were transmitted through sexual intercourse. All of these people are on antiretroviral treatment (Government of Samoa 2016). In May 2016, there were two new cases that have recently been noted in the media. The Ministry of Health has recently become concerned with HIV transmission through traditional tattooing.

2.1 Men who have sex with men, *fa'afafine* and transgender

Definitions of sex and sexual preference in Samoa do not completely align with Western concepts of MSM and TG populations. F*a'afafine* (literally, 'the way of a woman'), fulfil both traditional social roles and modern, more hybrid forms of sexual and gender identity. Of all the Pacific countries apart from Hawaii, *fa'afafine* in Samoa have been the most studied ethnographically (although there have been few studies assessing their sexual health status and needs). *Fa'afafine* are a widely accepted community within Samoa, although within strictly bounded terms (see Tcherkézoff 2014).

While they are an integral part of the sexual division of labour (they do women's work), the term carries sexual connotations – although these are viewed within hetero-normative framings (sex can only be possible if one partner is 'female'). This leaves little room for homosexual men who do not identify as *fa'afafine* (see Wallace 1999). It

Although male-to-male sex remains illegal in Samoa, a Behavioural Surveillance Survey (BSS) of young people in 2005 reported that 21.8% of male participants had ever had sex with a man, with 14.7% having had male-to-male sex in the past 12 months (WHO 2006). Such statistics indicate that there is a significant community of MSM in Samoa, part of which may remain hidden in comparison to *fa'afafine*.

Conversely, a 2005 HIV surveillance survey indicated that only 4.2% of STI clinic attendees were men reporting sex with men in the past 12 months, while 7% of attendees had experienced sex with another male in their lifetime (WHO 2006). While the variance in rates of self-reported MSM between these two different demographics could be caused by a number of factors – location of the clinic, age groups involved, and so on – it is highly likely that there is an underreporting of STI symptoms among MSM communities, which corresponds to the low level of MSM attendance at the clinic. As homosexual sex still remains illegal in Samoa, there is potential that this underreporting is due to fear of exposure

There are high levels of STIs in Samoa, with SGS surveys indicating that infections such as chlamydia are particularly prevalent in the under-25 youth population (Samoa Ministry of

Health 2014). High levels of risk-taking behaviour and low condom use can be attributed to a lack of availability of condoms and low levels of sexual education, which is often hindered by religious and community leaders who do not support education programs – especially those geared towards young people. The Samoa Fa'afafine Association is one of the oldest supporters of HIV prevention and continues to act on behalf of the transgender community (Samoa Ministry of Health 2014).

2.2 Sex workers

Sex work is illegal in Samoa and takes place at the margins of society. Therefore, sex workers in Samoa are widely invisible and, up to the time of this report, there was no credible information related to them. Seafarers have reported that sex workers are easily available in Samoa (McMillan 2013), and anecdotal evidence suggests that there are hidden populations on the rise.

It is understood that sex in exchange for cash or goods has existed for a while, and often takes place in situations and places where alcohol is involved (Samoa Ministry of Health 2013). The 2013 Global Aids Progress Report indicates that sex work is prominent among unemployed young people, which may be a way to supplement their incomes when other work is not available.

Of persons who are tested for HIV or STIs, there are currently no records kept on occupations (Samoa Ministry of Health 2013). There is therefore no current way of drawing an understanding of the sexual health of sex workers and their testing habits by looking at existing data. Additionally, condom use is very low among the general population (less than 15%), indicating that there may be issues of access and education that need to be addressed (Samoa Ministry of Health 2013).

3 Methodology

The research in Samoa 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 Samoa Ministry of Health, Health Research Committee.

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

Five research assistants were selected and participated in a one-day training sessions focused on the basics of social research, research ethics, and practical discussion of recruitment of research participants. The research assistants were recommended by the Samoa Fa'afafine Association and approved by the team leader. There were five research assistants in total with varied networks from Apia neighbourhoods and one from a village a couple of hours from Apia.

MSM and *fa'afafine* participants were recruited through the research assistants' networks. They contacted potential participants by meeting with them face-to-face at home, at work or in social settings, or through mobile phone text messaging and social media. Potential participants were approached in these contexts by the research assistants and provided with

background information about the study. They were then invited to participate in the survey. Participants had the option of completing the survey in English or Samoan. The surveys were completed at locations selected by the participants, including their workplace, their home or a public meeting place in their neighbourhood, such as a shopfront or casual meeting area. The research assistants asked to be referred to other potential MSM and *fa'afafine* participants, They were able to expand the number of MSM and *fa'afafine* reached through a snowball sampling technique.

The majority of in-depth interview participants identified as *fa'afafine*, except for two who identified as straight men. The team leader conducted the interviews at her hotel to allow for privacy. The interview participants were recruited through the research assistants' networks and were selected to include varying backgrounds and experiences. One interview included a research assistant to translate some interview questions.

The team leader and two research assistants recruited female sex workers by visiting locations where they were known to work. When visiting these locations, they met with the sex workers and discussed the study with them and extended an invitation to participate. Most, but not all, of the women were interested in taking part in the survey and some were also interested in participating in an interview. Participants had the option of completing the survey in English or Samoan. The surveys were completed in a private area at the location where the women worked. In-depth interviews with FSW were conducted at a mutually agreed location, including a private area at the location where they work from or at the team leader's hotel. A research assistant supported translation during two of the interviews.

3.1 Population size estimation

Due to the significant time involved in getting final approval to conduct the research in Samoa through the signing of the MOU, we were unable to hold a stakeholder meeting for the size estimation of the key populations. Instead, organisations were asked to estimate the size of the MSM/TG and FSW populations during the capacity assessment interviews. Some organisations did so, but others were very unsure of the size of the populations and did not provide estimates.

This estimate of female sex workers was based on head counts of visible FSW and asking organisations and the FSW themselves. From these various sources, we estimate that there are between 200 and 400 sex workers in the country (excluding those who occasionally exchange sex for goods such as alcohol). In the Apia urban area, approximately 30–50 women operate from public areas and possibly 100 women operate in a more hidden manner. There may be up to 250 women in other areas of the country.

The estimates for the number of MSM in Samoa varied enormously, with there being a view from the Samoa Fa'afafine Association that, due to the more fluid nature of gender and sexuality in Samoa compare to other parts of the world, 70–80% of the male population has sex with another man or a *fa'afafine* in their lifetime. Sex between men may be underreported in surveys. For example, in the 2006 BSS of young people, 21.8% of those surveyed had sex with another man in their lifetime, and 14.7% in the last 12 months (WHO 2006). Data from the same report of STI clinic attendees indicated that 7.0% of men had sex with another man in their lifetime, with 4.2% in the last 12 months (WHO 2006). Sex with *fa'afafine* may be underreported, as it carries greater stigma.

We would conservatively estimate that around approximately 25–30% of adult men have had sex with another man in their lifetime – in total, around 25,000 men (2011 census). This does not mean that these men regularly have sex with men; this may occur only in their youth.

There is considerable agreement among groups of the size of the *fa'afafine* population, which is estimated to be 7–9% of the adult male population 15 years and over – a total of around 9,000 (2011 Census).

3.2 Behavioural survey and interviews

3.2.1 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 this group, collecting qualitatively rich data that described their circumstances and experiences over a range of issues.

3.2.2 Female sex workers

A behavioural survey captured quantitative information from FSW 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 collecting qualitatively rich data that described their circumstances and experiences over a range of issues.

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 Samoa. There are no HIV interventions or outreach programs targeting sex workers in Samoa. The Ministry of Health coordinates HIV and STI activities within the country, including surveillance, policy and awareness programs. It works closely with the National Health Service, which provides HIV and STI-related health services. The Samoa Family Health Association also conducts awareness programs and provides HIV and STI-related health services. The Samoa Fa'afafine Association provides peer support and advocates for the human rights of LGBQTI.

4 Results

4.1 Behavioural survey

4.1.1 Transgender and men who have sex with men

4.1.1.1 Description of the sample

One hundred and twelve self-identifying transgender (TG) and men who have sex with men (MSM) provided survey data. Of these participants, eight denied having any sex with male partners in the preceding 12 months and were therefore ineligible to answer any further questions beyond the demographic questions. As such, data only from the 104 participants who reported having sex with another male in the past 12 months will be included in the report from this point onwards.

In describing their gender, 22 (21.2%) participants described themselves as men while four (3.8%) described themselves as women. There were 55 (51.0%) who described themselves as transgender, four (5.5%) as transsexual, 11 (10.6%) as transvestite, and 11 as 'other' (which included *tama lelei* (n=10) and *musu e tali* (n=1)). Participants were also asked to describe their sexual identity (Table 1). The majority of participants described their sexual identity as transgender, heterosexual/straight or bisexual.

Table 1: Sexual identity

	Frequency	Percent (%)
Transgender/*Fa'afafine/Fakaleiti/Avakavaine*	55	57.9
Heterosexual/Straight	13	13.7
Bisexual	12	12.6
Gay/Homosexual	8	8.4
Pansexual	4	4.3
MSM	3	3.1
Asexual	0	–
Queer	0	–
Total	**95**	**100.0**

The age of participants ranged from 18 to 58, with a mean age of 28.79 (SD=8.22) and a median age of 27.0. The sample was generally well educated, with a large majority of participants having been educated to a secondary level or higher (Table 2).

Table 2: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	4	3.6
Pre-primary/Primary	13	11.6
Pre-secondary	8	7.1
Secondary	32	31.1
Polytechnic/Diploma	10	8.9
University/College	45	40.1
Total	**112**	**100.0**

*multiple answers possible

In responding to the question about relationship status, about two-thirds of the sample reported being single. There was a relatively even split in the numbers of those reporting having a boyfriend or girlfriend. Four respondents reported currently being married (Table 3).

Table 3: Relationship status

	Frequency	Percent (%)
Currently single	69	66.9
Have a girlfriend	18	17.5
Have a boyfriend	12	11.7
Currently married	4	3.9
Total	**103**	**100.0**

The majority of participants reported living with family members, mostly with parents or siblings (Table 4). Over one-quarter of the sample reported living with friends. It would appear that very few participants were living with their sexual partners.

Table 4: Whom participants were living with

	Frequency	Percent (%)
Parents	59	56.7
Siblings	44	42.3
Other relatives	42	40.4
Friends	11	10.6
Children	9	8.7
Wife	6	5.8
Boyfriend/Husband	5	4.8
Live alone	4	3.8
Other female partner	4	3.8
Co-workers	3	2.9
Other (*aiga*, grandmother, *matuafaaleagaga, musu e tali*)	7	6.7

N=104. * Multiple answers possible.

A majority were employed full-time. There was also a sizeable proportion who reported not being employed (Table 5).

Table 5: Employment status

	Frequency	Percent (%)
Full-time employed	52	50.0
Not employed	39	37.5
Self-employed	9	8.7
Part-time or casual employment	4	3.8
Total	**104**	**100.0**

When asked to indicate their main job, there was a range of positions that participants reported. The most commonly reported job sectors included community, social and personal services; financial and business services; and professional positions (Table 6).

Table 6: Type of work

	Frequency	Percent (%)
Community, social and personal services	13	20.0
Financial and business services	11	16.9
Professional	7	10.8
Wholesale and retail trade	6	9.2
Transport and communication	4	6.2
Manufacturing	4	6.2
Agriculture, forestry and fishing	2	3.1
Student	0	–
Electricity and water	0	–
Construction	0	–
Other (included: designer; elei; environment conservation; Faatauoloa; Faiaoga; Fiji Airways; hairdresser; hotel work; house girl; Kuka; laundry assistant; policy analyst; salesperson; suisui; swa; teacher; tourism hospitality)	18	27.6
Total	**65**[1]	**100.0**

[1] Missing data n=39. Those who answered 'not employed' (see Table 5) were not asked this question.

4.1.1.2 Sexual history and practice

Eighty (76.9%) of the 104 participants reported ever having had sexual intercourse (anal or vaginal). The 24 people who did not report intercourse have been kept in the analysis as they all reported having other types of sex.

Among the 80 participants who reported sexual intercourse, they reported their first occasion of sexual intercourse occurring between the ages of two and 28, with a mean age of sexual debut being 15.77 (SD=4.4). While we cannot verify the validity of these lower ages, it is notable that 28% of participants reported their age of sexual debut for intercourse as less than 15 years. That such a large proportion of the sample indicated early sexual debut suggests that it may be a robust and reliable finding, more so than the specific ages that have been provided.

Of the 90 participants who answered the question about having more than one sexual relationship during the same period in the previous six months (concurrent partnerships), 44 (48.9%) affirmed that they had.

4.1.1.2.1 Sex with male partners

Participants were asked to report on the types of sexual activity they had engaged in during the last occasion they had sex with a male partner (Table 7). The most commonly reported type of sexual activity that occurred on the last occasion was insertive oral sex (fellatio) and receptive oral sex, with fewer people engaging in other practices such as anal intercourse.

Table 7: Types of sexual activity on last occasion of sex with a male partner

	Frequency	Percent (%)
Handshake (you masturbated him)	33	32.0
Handshake (he masturbated you)	29	28.2
Oral sex (you sucked his penis)	47	45.6
Oral sex (he sucked your penis)	64	62.1
Intercrural sex (his penis between your thighs)	30	29.1
Intercrural sex (your penis between his thighs)	25	24.3
Anal intercourse (your penis inside his anus)	35	34.0
Anal intercourse (his penis inside your anus)	36	35.0

N=103* Multiple answers possible. Missing data n=1.

4.1.1.2.2 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 one to three partners (Table 8). A majority of participants reported having had 11 or more male partners in their lifetime.

Table 8: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
1 to 3	24 (24.5)	38 (37.6)
4 to 10	19 (19.4)	32 (31.7)
11 to 49	30 (30.6)	27 (26.7)
50+	25 (25.5)	4 (4.0)
Total	**98 (100)[1]**	**101 (100.0)[2]**

[1] Missing data n=6. [2] Missing data n=3.

All 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). About two-thirds of participants reported having had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. A similar proportion had sex with at least one casual male partner during the previous 12 months, while about one-third had at least one paying partner during that period.

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	35 (34.3)	37 (37.0)	69 (67.6)
1 to 3	48 (47.1)	29 (29.0)	22 (21.6)
4+	19 (18.6)	34 (34.0)	11 (10.8)
Total	**102[1] (100.0)**	**100[2] (100.0)**	**102[1] (100.0)**

[1] Missing data n=2. [2] Missing data n=4.

4.1.1.2.3 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, with almost half of participants reporting that they 'never' used condoms with their regular male partners. Condom use with casual partners was only marginally higher than for condom use with regular male partners, with about three-quarters of the participants indicating that they had 'never' or 'sometimes' used condoms. Only 10 participants provided data about condom use with paying male partners. Condom use was surprisingly low for sex with paying male partners, with about 70% reporting use of condoms 'sometimes' or 'never'.

Reported condom use on the last occasion of anal intercourse with each of the partner types (Table 10) was at higher levels than for the 12-month period, which is to be expected. Forty-four percent of participants who had anal intercourse with a regular male partner reported using condoms on the last occasion. The same proportion (44%) used lubricant on the last occasion of anal intercourse with their regular male partner. A surprisingly similar proportion (41%) used a condom on the last occasion of anal intercourse with a casual male partner, with a higher proportion (47%) reporting the use of lubrication on that last occasion. On the last occasion of anal intercourse with a paying male partner, four (40%) of the 10 participants confirmed the use of condoms on that occasion and six (60%) of the 10 used lubricant.

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	32 (46.4)	29 (43.9)	4 (40.0)
Sometimes	25 (36.2)	21 (31.8)	3 (30.0)
Almost every time	6 (8.7)	4 (6.1)	1 (10.0)
Every time	6 (8.7)	12 (18.2)	2 (20.0)
Total	**69 (100.0)**	**66[1] (100.0)**	**10[2] (100.0)[1]**

* Includes only participants who had sex with that type of partner. [1] Missing data n=1. [2] Missing data n=25.

All participants were asked whether they used lubricant the last time they used a condom, to which 50 (55.6%) of the 90 who answered the question indicated that they had. When asked which type of lubricant they used on that occasion, the following responses were elicited: water-based lubricant (n=26; 51.0%); Vaseline (n=9; 17.6%); hand lotion (n=5; 9.8%); baby oil (n=9; 17.6%); and coconut oil (n=2; 3.9%). Forty-nine respondents provided data on where they had obtained lubrication on that last occasion, which included hospital (n=6; 12.2%), health clinic (n=3; 6.1%); client (n=3; 6.1%); friend (n=12; 24.5%); NGO (n=3; 6.1%); peer educator (n=1; 2.0%); condom dispenser (n=3; 6.1%); and pharmacy (n=11; 22.4%); never obtained lube (n=2; 4.1%); and other (n=5; 10.2%), which included Faatau Mai E Faleoloa, Falmai, home, and Red Cross.

4.1.1.2.4 Female partners

Twenty-four (23.1%) participants reported ever having had sexual intercourse (vagina or anal) with a female partner. These participants reported having had sex with between one and 26 female partners in their lifetime. Twenty of the 24 participants reported having had sex with a female partner during the 12 months preceding the survey. Numbers of female partners in that period also ranged from one to 26, with the majority reporting one to three regular female partners and one to three casual female partners (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	2 (10.0)	7 (36.8)
1 to 3	14 (70.0%)	9 (47.5)
4 to 10	3 (15.0%)	2 (10.6)
11+	1 (5.0%)	1 (5.3)
Total	**20 (100)**	**19 (100.0)**

Of the participants who had sex with a regular female partner in the 12 months preceding the survey, the majority reported ‘never’ using condoms for vaginal intercourse and for anal intercourse, with only one person using condoms every time (Table 12). There were also few participants who reported condom use on the last occasion of vaginal intercourse (23.5%) and anal intercourse (37.5%) with a regular female partner.

With casual female partners, over three-quarters of participants reported using condoms ‘sometimes’ or ‘never’ for vaginal and anal intercourse (Table 12). Of the 13 respondents who answered the questions about condom use on the last occasion with casual female partners, about one-third used a condom on the last occasion of vaginal intercourse and anal intercourse with a casual female partner.

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

Regularity of condom use	Regular partners Vaginal intercourse n (%)	Regular partners Anal intercourse n (%)	Casual partners Vaginal intercourse n (%)	Casual partners Anal intercourse n (%)
Never	10 (58.8)	12 (75.0)	8 (61.5)	8 (61.5)
Sometimes	3 (17.6)	2 (12.5)	3 (23.1)	2 (15.4)
Almost every time	3 (17.6)	1 (6.3)	0	2 (15.4)
Every time	1 (5.9)	1 (6.3)	2 (15.4)	1 (7.7)
Total	**17 (100.0)**	**16 (100)**	**13 (100.0)**	**13 (100.0)**

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

Ninety participants (87.4%) reported knowing what a condom was prior to the survey, among whom 71 knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them. The places from where condoms were most commonly reported to be sourced included health clinic, friends, hospital, pharmacy and condom dispenser (Table 13).

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

	Frequency	Percent (%)
Health clinic	14	16.1
Friend	13	14.9
Hospital	12	13.8
Pharmacy	11	12.6
Condom dispenser	11	12.6
Never obtained condoms	10	11.5
Client	6	6.9
Peer educator/Outreach worker	4	4.6
NGO	2	2.3
Other (bar, nightclub, Red Cross, Ua fai si leva. Lesi au uo)	4	4.6
Total	**87[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 and included condoms taking away pleasure, condoms not being available, not liking condoms, and perceived monogamy (Table 14).

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

	Male partners n=75 (%)	Female partners n=18 (%)
Condoms take away pleasure	29 (38.7)	10 (55.6)
Condoms were not available	27 (36.0)	8 (44.4)
Do not like condoms	14 (18.7)	2 (11.1)
My partner(s) and I are faithful	13 (17.3)	2 (11.1)
Partner objected	8 (10.7)	1 (5.6)
Difficulty obtaining condoms	4 (5.3)	2 (11.1)
Not necessary	5 (6.7)	0
Used other prevention methods	2 (2.7)	1 (5.6)
Condoms are too expensive	0	0
Other (responses: ‘because I like him; ‘no’; ‘were not available’)	6 (8.0)	0

* Multiple answers possible.

4.1.1.3 Sexually transmissible infections including HIV

Eighty-four (80.8%) participants had ever heard of diseases that can be transmitted sexually, among whom 12 participants reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months. Five participants reported having had genital discharge in the 12 months preceding the survey, eight reported genital ulcers or sores, and 10 reported ever having had pain while urinating. These 12 participants were asked what they did the last time they had any of these symptoms (Table 15). The most common responses were talking to a friend, visiting a clinic or hospital, or doing nothing.

Ten respondents reported having ever been diagnosed with STI, which included syphilis (n=2), gonorrhoea (n=1), thrush (n=1), genital warts (n=1) and chlamydia (n=1). Four people reported ‘other’, which include ‘Es’, Leai Se Mea, and Pepe Tino.

Table 15: What participants did the last time they had STI symptoms

	Frequency	Percent (%)
Talked to a friend	8	66.7
Visited a hospital	4	33.3
Visited a private clinic	3	25.0
Did nothing	3	25.0
Visited an STI clinic	2	16.7
Visited a health care worker	1	8.3
Received traditional treatment	1	8.3
Got medicine from pharmacy	1	8.3
Never noticed these symptoms	0	–
Other (no text responses provided)	0	–

* Multiple answers possible.

Eighty-eight (84.6%) participants confirmed having heard of HIV or the disease called AIDS prior to the survey. The most commonly reported sources of information about HIV and AIDS were television, NGO program, school and radio (Table 16).

Table 16: Sources of information about HIV and AIDS

	Frequency	Percent (%)
Television	62	70.5
NGO program	48	54.5
School	41	46.6
Radio	40	45.5
Newspapers/Magazines	35	39.8
Friends or family	27	30.7
Workplace	28	31.8
Posters/Billboards	28	31.8
Pamphlets/Leaflets	23	26.1

N=88. * Multiple answers possible. Includes only those respondents who reported having heard of HIV or AIDS.

The 88 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. Correct knowledge across the questions was generally high, exceeding 63.6% correct for each question. Ten (11.4%) of the 88 participants answered all 10 questions correctly, while about two-thirds of respondents answered six or more questions correctly. The lowest score recorded was for two participants who answered none of the questions correctly.

Table 17: Knowledge about HIV and AIDS

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	53 (67.1)	26 (32.9)	9 (10.2)	88 (100)
Do people get HIV because of something they have done wrong?	67 (76.1)	11 (12.5)	10 (11.4)	88 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	15 (17.0)	70 (79.5)	3 (3.4)	88 (100)
Can a person get HIV by sharing food with someone who is infected?	56 (63.6)	24 (27.3)	8 (9.1)	88 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	15 (17.0)	71 (80.7)	2 (2.3)	88 (100)
Can a healthy-looking person have HIV?	18 (20.5)	63 (71.6)	7 (8.0)	88 (100)
Can people be cured from HIV by a traditional healer?	76 (86.4)	9 (10.2)	3 (3.4)	88 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	9 (10.3)	68 (78.2)	10 (11.5)	87[1] (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	16 (18.2)	59 (67.0)	13 (14.8)	88 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	9 (10.3)	68 (78.2)	10 (11.5)	87 (100)

* Includes only those respondents who reported having heard of HIV or AIDS. [1] Missing data n=1.

4.1.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 88 participants who had heard of HIV had non-stigmatising attitudes towards people living with HIV. On all three questions, a majority endorsed the non-stigmatising attitude (Table 18). Thirty (34.1%) of the 88 respondents reported knowing someone with HIV.

Table 18: 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?	17 (19.3)	68 (77.3)	3 (3.4)	88 (100)
If a member of your family had HIV, would you want it to remain secret?	62 (70.5)	24 (27.3)	2 (2.3)	88 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	38 (43.2)	45 (51.1)	5 (5.7)	88 (100)

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

4.1.1.5 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. Just over a tenth of participants were aware of someone who had been verbally abused or teased in the previous 12 months as a result of being assumed to have HIV (Table 19). Fewer participants had observed discrimination in the other two areas shown in Table 19.

Table 19: 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?	81 (92.0)	5 (5.7)	2 (2.3)	88 (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?	80 (90.9)	7 (8.0)	1 (1.1)	88 (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?	77 (87.5)	10 (11.4)	1 (1.1)	88 (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). A minority of participants had experienced stigmatising attitudes, particularly from family members and from other people. A majority reported that each of the respective groups of people shown in Table 20 (that is, family, others, and co-workers) were supportive of their sexual identity.

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

	Reaction of family members n=99 (%)	Reaction of other people n=97 (%)	Reaction of employer or co-workers n=63[1] (%)
They don't know at all	9 (9.1)	6 (6.2)	3 (4.8)
They support my identity	62 (62.6)	57 (58.8)	47 (74.6)
They ignore me/refuse to talk to me	0	8 (8.2)	2 (3.2)
They criticized/blamed/verbally abused me	6 (6.1)	11 (11.3)	1 (1.6)
They conduct violence/physical abuse on me	3 (3.0)	3 (3.1)	0
They lock/restrict me	3 (3.0)	NA	NA
They kicked me out of the family/group	5 (5.1)	1 (8.2)	NA
They force me to work more	0	NA	–
They gossip about me	NA	12 (12.4)	3 (4.8)
They fired me from work	NA	NA	0
Other (lagolago, latou te le iloa, le iloa, leai, my family accepted me for who i am, not too supportive, ofu tene e fai, ote)	9 (9.1)		
Other (le fia talano mai, le manaomia, leai se mea, mocked, tauemu)		5 (5.2)	
Other (discrimination, fainana ou ala, joked about it, le iloa, leai se mea)			3 (4.8)

* Multiple answers possible. NA=not applicable. [1] Includes only those who were employed.

4.1.1.6 Emotional and physical well-being

Participants were asked to indicate their experiences in a list of thoughts and feelings because of their sexual identity in the preceding 12 months. The most commonly reported responses included having low self-esteem and feeling guilt or shame (Table 21).

Table 21: Participants' negative feelings about their sexual identity (last 12 months)

	Frequency	Percent (%)
I have low self-esteem	20	29.0
I feel guilty	9	13.0
I feel ashamed	6	8.7
I feel suicidal	3	4.3
I blame myself	3	4.3
I blame others	3	4.3
I feel I should be punished	2	2.9

N=69. * Multiple answers possible.

Participants were asked to indicate whether they had engaged in or avoided certain events or activities because of their sexual identity (Table 22). Between 4% to 13% of participants who had taken certain actions or avoided certain events or activities. The most commonly reported actions taken included deciding not to get married, choosing not to attend social gatherings, not applying for a job or promotion, and deciding not to have children.

Table 22: Participants' actions as a result of their sexual identity in the last 12 months

	Frequency	Percent (%)
I decided not to get married	9	12.7
I have chosen not to attend social gathering	9	12.7
I decided not to apply for a job or for a promotion	6	8.5
I decided not to have children	5	7.0
I decided not to have sex	4	5.6
I avoided going to a hospital when I needed to	4	5.6
I avoided going to a local clinic when I needed to	4	5.6
I withdrew from education/training	3	4.2
I decided to stop working	3	4.2
I have isolated myself from my family and/or friends	3	4.2

N=71. * Multiple answers possible.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Twelve (11.9%) of the 101 participants who responded to this question answered in the affirmative, that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, the responses included stranger (n=6), casual partner (n=3), boyfriend/husband (n=3), friend (n=1), paying partner (n=1), work colleague (n=1), family friend (n=1) and family member (n=1).

4.1.1.7 Access to health services

All participants were asked whether they knew where they could access a range of health services. A small majority of respondents reported knowing how to access the services shown in Table 23.

Table 23: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Condoms	38 (37.3)	55 (53.9)	9 (8.8)	102 (100)
Health-related information	30 (29.4)	63 (61.8)	9 (8.8)	102 (100)
Support	29 (28.4)	64 (62.7)	9 (8.8)	102 (100)
HIV and STI testing	41 (40.2)	52 (51.0)	9 (8.8)	102 (100)
HIV and STI treatment	39 (38.2)	54 (52.9)	9 (8.8)	102 (100)

N=102

Fifty-eight (57.4%) 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: *aiga fuafuaina*, *falemai*, family health, family planning, hospital, *le iloa*, *le manaomia*, Ministry of Health, National Health Service, Red Cross, Samoa AIDS Foundation, Samoa Fa'afafine Association, Soifua Maloloina.

For the services presented in Table 24, there were about equal proportions of participants who had and had not been contacted by a volunteer or outreach worker; had visited a health service for sexual health-related purposes; or had been given condoms through an outreach service, health clinic or drop-in centre. Participation in an HIV peer education program had been particularly well attended, with 62.5% reporting participation in the preceding 12 months.

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

	No n (%)	Yes n (%)	Not applicable/ Don't know 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?	31 (29.8)	26 (25.0)	47 (45.2)	104 (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?	68 (65.4)	34 (32.7)	2 (2.0)	104 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	34 (32.7)	36 (34.6)	34 (32.7)	104 (100)
Have you ever participated in an HIV peer education program?	37 (35.6)	65 (62.5)	2 (2.0)	104 (100)

The 34 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). Most respondents were generally satisfied and would use the service again. However, approximately 10% were not satisfied with each of the services, with most concerns being about feeling uncomfortable, perceiving the service not to be confidential, and not getting what they wanted. Sixty-nine (66.3%) participants reported that they would like to receive additional information about HIV and contact details for any support services.

Table 25: Feedback about the health service

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Tota n (%)
The service was easy to access or find	3 (8.8)	1 (2.9)	3 (8.8)	13 (38.2)	14 (41.2)	34 (100)
The health worker I saw was friendly and easy to talk to	5 (14.7)	0	3 (8.8)	10 (29.4)	16 (47.1)	34 (100)
I felt uncomfortable and embarrassed	4 (11.8)	9 (26.5)	9 (26.5)	6 (17.6)	6 (17.6)	34 (100)
The service was confidential and I felt my privacy was respected	4 (11.8)	1 (2.9)	4 (11.8)	13 (38.2)	12 (35.2)	34 (100)
I could get what I needed, eg condoms, contraceptives, HIV and STI test, etc	3 (8.8)	2 (5.9)	2 (5.9)	14 (41.2)	13 (38.2)	34 (100)
I would use the service again if I needed to	3 (8.6)	0	4 (11.4)	15 (42.9)	13 (37.1)	34 (100)

* Includes only those participants who reported using the service.

4.1.1.8 HIV testing

Fifty-seven (55.3%) participants believed that it was possible for someone in their community to get a test to find out if they are infected with HIV, and all knew where to go to receive the test. Twenty-nine participants reported having ever had an HIV test and 17 of these people had an HIV test in the 12 months prior to the survey.

Participants received their test from a range of places, including private doctor (n=4); hospital/government health service (n=12); and NGO clinic (n=4). Nineteen of the 29 participants who had ever had an HIV test reported receiving their results. Of these, 20 chose to answer the question about their HIV status, which they reported to be HIV-negative (n=18) or don't know result (n=2).

4.1.1.9 Alcohol and drug use

Seventy-five (72.9%) respondents reported drinking alcohol in the preceding four weeks, with about one-third of the sample indicating 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 one to 40 drinks. The latter appears to be improbable unless drinks contained very low alcohol or were consumed over multiple days, which may have occurred with an event. Eight drinks was the median number consumed on the last occasion of alcohol use, which seems to be very high.

Table 26: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	19 (18.4)
Never in the last 4 weeks	9 (8.7)
Less than once a week	38 (36.9)
At least once a week	27 (26.2)
Every day	10 (9.7)
Total	**1031 (100.0)**

[1] Missing data n=1.

Participants were asked whether they had taken a range of drugs during the preceding 12 months. Drugs reported were kava (n=6), freebase (n=4), marijuana (n=7), heroin (n=2), amphetamine (n=3), crystal (n=3), ecstasy (MDMA) (n=2), inhalants (n=3), cocaine (n=2) and other (n=4), which included *Le iloa, Le manaomania, Leai ni vailaau ou faaaogaina, Leai se ma, Musu e tali, Sikaleki,* smoke. 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, 33 participants responded in the affirmative.

4.1.1.10 Visited the United States

Twelve participants reported ever having visited the United States. The reported reason for these visits was predominantly for work, but also for a holiday: working (n=6), holidaying (n=1), visiting relatives (n=2) and visiting friends (n=3). The length of stay during these visits ranged from less than four weeks (33.3%) to greater than two years (25%). In response to the question about ever having been deported from the United States, one person reported that they had been deported.

4.1.1.11 Willingness to take part in studies involving the collection and testing of blood, urine and saliva samples

Seventy-six (73.8%) participants indicated their willingness to participate in a study such as the current one if the study collected and tested samples of blood, urine and saliva for HIV and other sexually transmissible infections (STIs).

4.1.2 Female sex workers

The data collected in this report found that there is a small group of women and a few *fa'afafine* who work from public spaces along the seawall that runs along the main area of town, in the park areas and fringes of the market and bus stop. Most of them live and sleep in and around those areas, working from evening to dawn. Women may be working from other public areas, such as around the harbour and hospital. There are also *fa'afafine* street-based sex workers in Apia. Sex work may also take place in other contexts that are more hidden than the women working from the streets. These contexts include:

- through networks using mobile phones, social media or a third party (likely taxi drivers) – these workers are likely to be younger women
- at tourism sites by hotel workers
- in village contexts more as an exchange of sex for favours, such as providing food or money for cultural obligations or school fees
- transactional sex between young people.

4.1.2.1 Description of the sample

Twelve women who sold sex in exchange for money or goods provided survey data. These small numbers mean that we must be careful that we do not assume that the women that took part are representative of all sex workers in Samoa.

The age of the women ranged from 18 to 46, with a mean age of 27.75 (SD=7.74) and median age of 25. Most of the women had been educated to a secondary level (Table 27).

Table 27: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	0	–
Pre-primary	0	–
Primary	1	8.3
Pre-secondary/Secondary	9	75.0
Polytechnic/Diploma	0	–
University/College	2	16.7
Total	**12**	**100.0**

In responding to the question about relationship status, the majority of women reported being 'single' or currently married (Table 28).

Table 28: Relationship status

	Frequency	Percent (%)
Currently single	5	41.7
Currently married	4	33.3
Have a boyfriend but not married	2	16.7
Widowed/Divorced/Separated	1	8.3
Have a girlfriend	0	–
Total	**12**	**100.0**

Seven women (58.3%) reported having children. Among these women, the majority had either one (n=2) or two (n=2) children. One woman reported having seven children.

Women were most likely to live with parents/in-laws, children, other male partner and other relatives. None of the women reported living with their husbands (Table 29).

Table 29: Whom participants were living with

	Frequency	Percent (%)
Parents/In-laws	6	50.0
Children	5	41.7
Other male partner	3	25.0
Other relatives	3	25.0
Boyfriend	1	8.3
Friends	1	8.3
Siblings	0	–
Husband	0	–
Live alone	0	–
Co-workers	0	–
Other (no text provided)	0	–

* Multiple answers possible.

Women were asked whether they were employed, to which the majority reported that they were not. This is not surprising, as they are likely to perceive that their sex work is not legitimate work (Table 30).

Table 30: Employment status

	Frequency	Percent (%)
Not employed	8	66.7
Full-time employed	2	16.7
Part-time or casual employment	1	8.3
Self-employed	1	8.3
Total	**12**	**100.0**

The four women who reported being employed were asked what paid work they were involved in. Three reported sewing and two reported other areas of work, which included *fai teu mo falesa* and *leai*.

4.1.2.2 Sexual history and practice

All 12 women reported ever having had sexual intercourse. The age reported at which they first had sexual intercourse ranged from 12 to 20 years. One of the 12 women denied receiving money or goods in exchange for sex in the previous 12 months. As such, she was omitted from the questionnaire and is therefore excluded from further analyses. The remaining analyses are therefore based on data from 11 women.

The age at which the 11 women reported first receiving money or goods in exchange for sex ranged from 13 to 21 years, which indicates that some of the women were not adults at the time they commenced sex work. The median age for commencement of sex work was 18.5 years.

4.1.2.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses ranged from one to 100 male partners, with a median of 25 and mean of 31 partners (Table 31). It may be the case that many of the women do not consider male clients as sex partners, or that some of them are very new to sex work. The number of male sex partners reported in the last 12 months ranged from one to 40, with a median of seven and mean of 10 partners.

Two of the eight women who responded to the question about multiple concurrent partners (MCPs) (that is, more than one sexual partner during the same period) confirmed that they had MCPs in the previous six months.

Table 31: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
1 to 3	1 (9.1)	4 (36.4)
4 to 10	1 (18.2)	4 (36.4)
11 to 49	7 (63.6)	3 (27.3)
50+	2 (18.2)	0
Total	**11 (100)**	**11 (100.0)**

4.1.2.3 Condoms

All 11 women had ever heard of a condom, among whom eight women had ever used a condom. Seven women reported knowing where they could obtain condoms. When asked where they had last obtained condoms, the most common responses included friend and hospital (Table 32).

Table 32: Where condoms were last obtained

	Frequency	Percent (%)
Friend	3	42.9
Hospital	2	28.6
NGO	1	14.3
Condom dispenser (bar/nightclub/restaurant/other venue)	1	14.3
Total	**7**	**100.0**

* Includes only those who knew where to obtain condoms.

4.1.2.3.1 Sex with paying male partners

When asked how many paying partners they had in the 12 months preceding the survey, answers ranged from one to 30 partners with a mean of nine (SD=9.08) and a median of four paying partners. Slightly over half of the women reported having fewer than 10 paying partners in the preceding six months, which suggests that they are either seeing a lot of repeat customers (that is, much of their work is with regular paying partners) or underreporting the number of paying partners. The latter has more validity, given that women reported between one and 30 paying partners on the last day that they had paid sex. While 30 partners appear to be on the high side of plausibility, a more robust finding was that the majority of women reported between two and 15 paying partners on the last day of paid sex.

4.1.2.3.2 Types of sexual practices with paying male partners

Women were asked what types of sexual contact they had with paying partners during the preceding 12 months (Table 33). The most common practice was vaginal intercourse, followed by cunnilingus and the client's penis between her thighs.

Table 33: Types of sexual activity with paying male partners over the previous 12 months

	Frequency	Percent (%)
Vaginal intercourse	6	54.5
Handshake (he masturbated you)	6	54.5
His penis between your thighs or breasts	6	54.5
Oral sex (you sucked his penis)	5	45.5
Handshake (you masturbated him)	4	36.4
Oral sex (he licked your vagina)	4	36.4
Anal intercourse	2	18.2

N=11. * Multiple answers possible.

4.1.2.3.3 Where sex with paying male partners takes place

Women were asked where they had sex with their last paying client (Table 34). The most common response was at a hotel.

Table 34: Where sex occurred on the last occasion of paid sex

	Frequency	Percent (%)
Hotel	6	54.5
Car	2	18.2
His house	1	9.1
Outside (eg bushes, beach, etc)	1	9.1
My house	1	9.1
Workplace	0	–
Total	**11**	**100.0**

4.1.2.3.4 Who decides how much money she receives?

When asked who decides how much they get paid when having sex with a client (multiple answers were possible), the majority of women indicated that it is typically decided themselves and to a lesser extent by their clients, which suggests that the amount is often negotiated (Table 35).

Table 35: Who decides how much the woman gets paid for sex with a client

	Frequency	Percent (%)
I decide	8	72.7
Paying partner decides	4	36.4

* Multiple answers possible..

4.1.2.3.5 Condom use and lubrication for vaginal intercourse with paying male partners

Condom use with paying clients was relatively mixed for vaginal and anal intercourse (Table 36). A majority of women reported using condoms ‘almost every time’ or ‘every time’, while two women had ‘never’ used condoms for vaginal intercourse with paying partners in the past 12 months. On the last occasion of vaginal intercourse with a paying partner, only one of the three women who answered this question reported using a condom. Among the two women who reported having anal intercourse with a paying partner, condom use was low, reported as ‘never’ or ‘sometimes’. The woman who used condoms ‘sometimes’ reported not using a condom on the last occasion of anal intercourse with a paying partner. Only one of the two women who had anal intercourse with a client responded to the question about using lubricant on the last occasion, which she confirmed she had not.

Table 36: Consistency of condom use for vaginal and anal intercourse with paying male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	2 (33.3)	1 (50.0)
Sometimes	0	1 (50.0)
Almost every time	3 (50.0)	0
Every time	1 (16.7)	0
Total	**6[1] (100.0)**	**2[2] (100.0)**

[1] Includes only women who reported having vaginal intercourse with clients. [2] Includes only women who reported having anal intercourse.

Eight women responded to the questions about why they had not used condoms all of the time in the preceding 12 months. The most common responses included condoms not being available, condoms taking away pleasure, partner objecting, and difficulty obtaining condoms (Table 37). Two women reported having had sex without a condom because the paying partner paid extra money for no condom to be used.

Table 37: Reasons for not using condoms for vaginal and/or anal intercourse with paying partners

	Paying male partners n=8 (%)
Condoms were not available	4 (50.0)
Condoms take away pleasure	2 (25.0)
Partner objected	2 (25.0)
Difficulty obtaining condoms	2 (25.0)
Do not like condoms	1 (12.5)
Used other prevention methods	0
Never heard of condoms	0
Not necessary	0
Used other protection methods	0
My partner(s) and I are faithful	0
Condoms are too expensive	0

* Multiple answers possible.

In response to the question about how often it was difficult to get paying partners to use condoms, there was a fairly even spread across the options, indicating that some women may have been more skilled at negotiating condom use than others (Table 38).

Table 38: Level of difficulty in getting clients to use a condom

	Paying male partners n (%)
None of the time	4 (40.0)
A little of the time	0
Some of the time	2 (20.0)
A lot of the time	3 (30.0)
All of the time	3 (30.0)
I did not try and get my clients to use a condom	1 (10.0)
Total	**13 (100.0)**

*multiple answers given

Supplying of the condom with clients appears to occur mostly by the paying partner and to a lesser extent the woman herself (Table 39).

Table 39: Who usually supplies the condom with paying partners?

	Paying male partners n (%)
Client provides the condom	5 (45.5)
I provide the condom	4 (36.4)
I never use a condom	2 (18.2)
Owner/Manager of the place	0
Total	**11 (100.0)**

4.1.2.4 Sex with regular male partners

Ten (90.9%) women reported having had sex with a boyfriend or husband in the previous 12 months.

4.1.2.4.1 Condom use with regular male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their regular male partners in the last 12 months (Table 40). Condom use was low, as generally expected for sex with regular partners. For vaginal intercourse, 8 of the 10 women reported using condoms 'never' or 'sometimes' with their regular male partner. Four women confirmed using a condom on the last occasion of vaginal intercourse with their regular partner.

Condom use for anal intercourse with regular male partners was similarly low, with all but one woman reporting 'never' or 'sometimes' using condoms for anal intercourse with their main partner. However, four women reported using a condom on the last occasion of anal intercourse with that partner.

Table 40: Consistency of condom use for vaginal and anal intercourse with regular male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	4 (40.0)	4 (50.0)
Sometimes	4 (40.0)	3 (37.5)
Almost every time	1 (10.0)	1 (12.5)
Every time	1 (10.0)	0
Total	**10[1] (100.0)**	**8[2] (100.0)**

[1] Includes only women who reported having vaginal intercourse. [2] Includes only women who reported having anal intercourse.

Among the women who had a regular male partner and who did not use a condom on every occasion of vaginal or anal intercourse with their regular partner(s), they were asked why they had not used condoms. A range of responses were endorsed, including partner objecting (n=2), condoms taking away pleasure (n=1), not liking condoms (n=1), condoms not being available (n=1), difficulty obtaining condoms (n=1) and not necessary (n=1).

4.1.2.5 Sex with casual male partners

Four (36.5%) of the women reported having had sex with a casual non-paying male partner in the previous 12 months.

4.1.2.5.1 Condom use with casual non-paying male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their casual male partners in the last 12 months (Table 41). Condom use was particularly low for vaginal intercourse with casual male partners. Two of the four women reported using a condom on the last occasion of vaginal intercourse with a casual male partner.

Condom use for anal intercourse with casual partners was identical to condom use for vaginal intercourse for both the last 12 months and on the last occasion. Two of the four women confirmed using lubrication on the last occasion of anal intercourse with a casual male partner, the same rate for condom use on that occasion.

Table 41: Consistency of condom use for vaginal and anal intercourse with casual male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	2 (50.0)	2 (50.0)
Sometimes	1 (25.0)	1 (25.0)
Almost every time	1 (25.0)	1 (25.0)
Every time	0	0
Total	**4 (100.0)[1]**	**4 (100.0)[2]**

[1] Includes only women who reported having vaginal intercourse. [2] Includes only women who reported having anal intercourse.

4.1.2.6 Alcohol and drug use

Six women reported drinking alcohol in the preceding four weeks (Table 42). Of those who reported drinking alcohol in that period, the majority had drunk alcohol less frequently than once a week. In responding to the question about the number of drinks they consumed on the last occasion that they drank alcohol, the number ranged from three to 10.

Table 42: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	5 (45.5)
Never in the last 4 weeks	0
Less than once a week	4 (36.4)
At least once a week	1 (9.1)
Every day	1 (9.1)
Total	**11 (100.0)**

Participants were asked whether they had taken a range of drugs during the preceding 12 months (Table 43). The most widely used drugs included kava and marijuana. 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, four women (40.0%) responded in the affirmative.

Table 43: Use of recreational and illicit drugs in the past 12 months

	n (%)
Kava (sakau/ava/awa)	5 (45.5)
Marijuana	3 (27.3)
Inhalants (eg sniffing glue, paint, petrol, spray can)	1 (9.1)
Cocaine	1 (9.1)
Heroin	1 (9.1)
Freebase	1 (9.1)
Ecstasy/MDMA	1 (9.1)
Crystal/Ice (methamphetamine)	0
Amphetamine (Speed)	0
Other ('Spili')	1 (9.1)

N=11. * Multiple answers possible.

4.1.2.7 Sexually transmissible infections including HIV

Eight (72.7%) women reported ever having heard of diseases that can be transmitted sexually, among whom two women reported having ever had symptoms of a sexually transmissible infection (STI), which they reported to be pain while urinating. These two women were asked what they did the last time they had any of these symptoms. Only one of the women responded that she visited a private clinic. One of the women reported ever having been diagnosed with a sexually transmissible infection (STI), yet chose not to say what it was that she had been diagnosed with.

Nine women (81.8%) reported having ever heard of HIV or the disease called AIDS prior to the survey. As this number is one fewer than the eight women who had heard about STIs, it may be the case that one or more women do not consider HIV as an STI. There was a range of reported sources of information about HIV and AIDS, the most common being an NGO program, radio, school or television (Table 44). One woman reported knowing someone who was infected with HIV.

Table 44: Sources of information about HIV and AIDS

	Frequency	Percent (%)
NGO program	5	55.6
Radio	3	33.3
School	3	33.3
Television	3	33.3
Friends or family	2	22.2
Newspapers/Magazines	2	22.2
Posters/Billboards	1	11.1
Workplace	0	–
Pamphlets/Leaflets	0	–
Other (‘FOMAI’)	1	11.1

N=9. * Multiple answers possible. Includes those women who reported having heard of HIV or AIDS.

4.1.2.8 Knowledge about HIV and AIDS

The women who had previously heard about HIV (n=9) were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 45. Correct knowledge was varied across the questions, with most questions answered accurately by a majority. A couple of questions were answered inaccurately by a majority, including whether people get HIV because of something they have done wrong and whether a person can get HIV by sharing food with someone who has HIV. None of the women answered all 10 questions correctly.

Table 45: Knowledge about HIV and AIDS

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	4 (44.4)	4 (44.4)	1 (11.1)	9 (100)
Do people get HIV because of something they have done wrong?	3 (33.3)	5 (55.6)	1 (11.1)	9 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	2 (22.2)	7 (77.8)	0	9 (100)
Can a person get HIV by sharing food with someone who is infected?	2 (22.2)	6 (66.7)	1 (11.1)	9 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	3 (33.3)	6 (66.7)	0	9 (100)
Can a healthy-looking person have HIV?	5 (55.6)	4 (44.4)	0	9 (100)
Can people be cured from HIV by a traditional healer?	5 (55.6)	3 (33.3)	1 (11.1)	9 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1 (11.1)	7 (77.8)	1 (11.1)	9 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	1 (11.1)	7 (77.8)	1 (11.1)	9 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	4 (44.4)	3 (33.3)	2 (22.2)	9 (100)

N=9. * Includes those women who reported having heard of HIV or AIDS.

4.1.2.9 Stigmatising attitudes towards people living with HIV

There was a range of attitudes indicated by the way women responded to the three questions. While a majority reported that they would be willing to care for a relative who was ill with HIV, and a majority would also buy fresh vegetables from someone with HIV, less than half would want a family member's HIV status to remain a secret (Table 46).

Table 46: 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?	3 (33.3)	6 (66.7)	0	9 (100)
If a member of your family had HIV, would you want it to remain secret?	7 (77.8)	2 (22.2)	0	9 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	4 (44.4)	5 (55.6)	0	9 (100)

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

4.1.2.10 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 47). Based on their responses, and although endorsed by a minority of the women, there is some evidence of stigma and discrimination in the community across all aspects covered by these three questions.

Table 47: 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?	6 (75.0)	2 (25.0)	0	8[1] (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?	8 (88.9)	1 (11.1)	0	9 (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?	8 (88.9)	1 (11.1)	0	9 (100)

* Includes only those women who reported having heard of HIV or AIDS. [1] Missing data n=1.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Three (27.3%) of eight women answered in the affirmative, that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, multiple answers were possible. The women indicated that it was a casual partner (n=3) or stranger (n=1).

4.1.2.11 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 48). With the exception of support services, which a majority knew where to access, for each of the other services a majority did not know where to access the service. There is clearly scope for improving knowledge about accessing these health services for this group of women.

Table 48: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Support	2 (25.0)	5 (62.5)	1 (12.5)	8[1] (100)
Health-related information	4 (50.0)	3 (37.5)	1 (12.5)	8[1] (100)
HIV and STI testing	5 (62.5)	2 (25.0)	1 (12.5)	8[1] (100)
HIV and STI treatment	6 (75.0)	1 (25.0)	1 (12.5)	8[1] (100)
Condoms	5 (62.5)	2 (25.0)	1 (12.5)	8[1] (100)

* Multiple answers possible. [1] Missing data n=1.

Five women (45.5%) 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 mentioned: Falemai, National Health and Soifua Maloloina. These five women were asked about their experience with each of the services shown in Table 49. For two of the services presented in Table 49, a majority had been accessed in the previous 12 months, whereas the other two had not been accessed by a majority.

Table 49: 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?	2 (40.0)	3 (60.0)	0	5 (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?	1 (20.0)	0	4 (80.0)	5 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	0	3 (60.0)	2 (20.0)	5 (100)
Have you ever participated in an HIV peer education program?	4 (80.0)	1 (20.0)	0	5 (100)

Since none of the five women reported visiting a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault, there are no experiences to report back about.

4.1.2.12 HIV testing

Only one woman (9.1%) believed that it was possible for someone in their community to get a test to find out if they were infected with HIV. However, three women reported knowing where to go to receive such a test. Only one woman reported ever having had an HIV test, which did not occur in the last 12 months. That woman reported not getting her test results.

4.1.2.13 Visited the United States

One woman reported ever having visited the United States, which was for a holiday, where she stayed for between one and six months. In response to the question about ever having been deported from the United States, she confirmed that she had not been deported.

4.1.2.14 Willingness to take part in studies involving the collection and testing of blood, urine and saliva samples

Seven (70%) of the women indicated their willingness to participate in a study such as the current one if the study collected and tested samples of blood, urine, and saliva for HIV and other sexually transmissible infections (STIs).

4.2 Interviews

4.2.1 Transgender and men who have sex with men

In-depth interviews were carried out with six *fa'afafine* and two straight-identifying men who have sex with men.

4.2.1.1 Social and structural factors

Fa'afafine have traditionally played important gendered roles in Samoan society. However, these roles are changing through migration and the inculcation of the Pacific into a globalised world. Men who have sex with men who do not identify as *fa'afafine* are less accepted and are more stigmatised.

Male-to-male sex between consenting adults is criminalised in Samoa. (Godwin 2010). Crimes Ordinance 1961 s 58D prohibits indecent acts between males, regardless of consent. Section 58E prohibits sodomy. Consent is not a defence. The penalty for sodomy of a male is imprisonment for a term not exceeding five years. Section 58J prohibits keeping any premises used as a place of resort for the commission of indecent acts between males. (Godwin 2010).

4.2.1.2 Identity

Both gender and sexual identity were complicated issues in the interviews. Some in the study identified as straight (both *fa'afafine* and male) and some as gay or homosexual. Interviewee 2 summed up the identity of the more feminine *fa'afafine* participants:

> I look at myself as a woman because everything I do, only the women do. I see myself as more of a woman than as a man, more of a feminine *fa'afafine.* (Interviewee 2)

All *fa'afafine* were open (their families, friends, colleagues and communities knew) regarding their sexual orientation:

> When I first came out I felt good about myself and I felt pretty now that I felt confident. I always had these feelings towards guys but I never knew how to express it until now, now that I have dressed up and put on make-up. Now it's easier for me to approach men. So with the people, I think the ladies I get to connect more with my community. I am more confident now, before I used to be like a closed book, people used to have to guess what I was like and what I would want, but now I am more open. (Interviewee 2)

One of the two straight-identifying men stated:

> I am straight but I also like *fa'afafines* … There are many parties, with many *fa'afafines*, at clubs you can go there and enjoy with the *fa'afafines*. (Interviewee 6)

Both of the straight-identifying men were not out to their families.

When asked what they enjoyed about their sexual identity, some said that it made them feel happy to be themselves. Another participant stated:

> Because I see the challenges of, for example, working with clients who I don't even know their backgrounds, they may be transphobic or homophobic but it is amazing the results that I give them and amazing how they see through me, not necessarily me being a *fa'afafine* but they see me not as a *fa'afafine* but the work that I do and present to them. Also, another fact I enjoy is giving hope to my *fa'afafine* community, I have overcome a lot of challenges, because general perception is that *fa'afafines* are caretakers, the highest

> number of *fa'afafine* in professions is teachers or nurses, I enjoy giving back to the *fa'afafine* community. (Interviewee 5)

A number of participants had insights on men having sex with *fa'afafine* from a cultural perspective, including the difference between these sexual relationships in the rural villages and in urban Apia:

> There is a little gay in every man in Samoa. I think that's true, it's a way for guys, it's what they see if they like what they see then they want that, they wouldn't really care what identity are you, even you are *fa'afafine*, if you are gorgeous then they will probably want to get with you … I don't think they will identify themselves as gay … I am surprised myself sometimes with the guys I know that I wouldn't think would get with *fa'afafine*. So probably every guy has been with a *fa'afafine* before they have been with a girl … (Interviewee 2)

4.2.1.3 Stigma

Many *fa'afafine* participants noted that they felt generally but not fully accepted within society. Some noted that acceptance had to start from within the family and generally they were accepted by their families:

> Now I want to be called *fa'afafine*, it's a stage three … It's a third gender. So I am so proud of it but we are trying to because half of Samoa, no a quarter of Samoa don't understand and they don't like it, but the majority of people they know us, they love us because we do a lot of charity work for Samoa community. (Interviewee 1)

> My family feels ok because at school, I was always good at school … they teased me when I am too much, like when the song comes on the radio and I sing so loud … but they always feel happy about it and they didn't feel like stopping me from being a *fa'afafine*. But they always give me advice, go to school, get a job, because I was raised by my Grandpa and I grew up in a family with only boys, my Grandpa, two uncles and one cousins one uncle and cousin we were all the same age … I did the washing, dishes, picking up the rubbish and things like that. (Interviewee 3)

> I never experienced any struggles in my life because it starts from the family and if the family really cares for you and respects you, you know that is the beginning of your life, then to the community and then to the country. As I say I am a well-respected person in the society everybody knows me. I did a lot of good work for the country and for our communities at large. (Interviewee 8)

When one participant was asked if they felt accepted in their community, she responded:

> I see myself as ok, in my village in Savaii, some of my families in the town, I think its ok for me because I don't even care about the people who talk behind my back. Somebody making stories about *fa'afas*, but I don't care. (Interviewee 3)

Participants who were well known in the community tended to feel they were accepted as being a *fa'afafine*:

> In my community I feel tolerated … But there was one time in the village, where the pastor's son had to cut his hair it was long. [The *matai*] made up a rule that all of the guys had to cut their hair, so I had to cut mine too … I was about 20, I always felt feminine but I never really dressed up because I always figured that people would judge me, and stuff like that, until I got older and comfortable with myself. I thought it was an excuse so that they could get to me also, but I really didn't mind because I think that I kind of expected it so then I cut my hair short and then grew my hair. But when my mom came she got so pissed off and she said what does my hair have to do with the village? How is it affecting everyone

> else? None of them has ever bothered with my hair again, so I just cut it because I feel like cutting it now, I used to have really long hair also. (Interviewee 2)
>
> [I am] well, very well respected and accepted as well. People are so friendly and also as part of my work I deal with communities, committees I go out every week and work with village councils, I take the lead. I am so proud of how acceptance is also a feeling of recognition that it is coming from a *fa'afafine*. I am so proud of how people feel about myself. (Interviewee 8)
>
> No, it is not [a problem], no risks, I feel comfortable when I am dressing up. But in my own point of view I prefer dressing up like a girl or a woman, but in my workplace I respect my colleagues so that is why I always dress up like a man. But that doesn't mean that I showcase myself to them as a man, no I always showcase to them as a woman. (Interviewee 4)

While some of the participants said there were no risks or struggles as a result of their gender identity, others noted some specific examples:

> At the beginning with my family it has been a real struggle, I kept it very secret, I kept it to myself, and I know that when I was at high school. I grew up in a culture where it is a norm that a man has to marries a woman and a boyfriend and a girlfriend. So it was a real struggle to understand the kind of person that I was. I also grew up in a family that was very religious so issues such as homosexuality, I heard about it in the Bible and taught at Sunday school so when I felt these feelings that I was more attracted to the same sex I was very worried. I had these thinking that this was all evil spirits and I was possessed by the devil and all this when I was very young …The struggle was indeed a struggle and until when I realised that this is not something to be afraid of or shy away from.
>
> Then I had issues with my boyfriends, I didn't have the courage to bring them at home … So when I brought my boyfriend home my older sister and my mother were really against it, my mother was on the verge of disowning me and my sister cursed me from a religious point of view. It was really hard, I had to move out from my family, I rented an accommodation with my boyfriend until they realised they were making a big mistake and they welcomed me back with my boyfriend. (Interviewee 5)

4.2.1.4 Sexual relationships

Fa'afafine spoke about the difficulties of relationships with men. Some *fa'afafine* preferred long-term relationships, although this had caused them pain in the past:

> I have always preferred long-term relationships, I have this habit always see the goodness in people. I have been giving up my heart too soon and openly and then it gets broken from there, but I never give up. I always believe and hope that there will be that person who will love me no matter what. (Interviewee 5)

They felt that they had a greater emotional attachment to their male partners than their partners had to them:

> As *fa'afafines* we were more attached then they were, they were just in and out. We were more emotionally involved, just being wanted and being fucked you get your emotions attached to the whole thing, at first it did and then after a while you just get used to it. (Interviewee 2)
>
> I am afraid that he might leave me, I have my own insecurities about him. He is Samoan and brought up in the same system I was brought in, it is just a girl and a boy, especially in a culture that there is a ban on same sex relationships, it doesn't have a standing in Samoa or recognition so I scared of that upbringing that will continue to demonise him and

> me too … His father is trying, who is a matai title holder, is thinking of bestowing a titled on him, because he is the eldest, there is a proper ceremony his father is working on that. He is saying that if he gets that title that will be the end of us and that really hurts me, there goes our plans, we have a mutual understanding that we would work towards, so I am a bit heartbroken. (Interviewee 5)

One of the major issues for our interviewees was that many of the men with whom they had relationships 'moved on' to steady relationships with girls and to marriage:

> When the guys after they have been with a *fa'afafine* and after they have been with a girl they ignore you, they just don't look at you its funny … I think that is problem with me, get involved and then he moves on with another girl and I get hurt and I don't want to do this anymore so now I just want to be in and out, just have sex with you. No more I think that I like you kind of thing. (Interviewee 2)

> I don't think that I will fit in a relationship; I have my own reasons. It won't last so what's the point in doing it and all the guys they will end up married. (Interviewee 8)

> I have experienced it before with a boyfriend that I had for almost four years, now he is a church minister, the relationship was hidden and I was school in year 10… he broke up with me cause he started seeing a girl in the village. After he broke up with me I didn't sit three exams and dropped from third in the class to 108, and asked to be transferred to another school and then I started afresh. (Interviewee 5)

So a number of the *fa'afafine* moved to short-term or one-night stands in order to avoid the hurt:

> I used to do the long term, but when I grew up and think deeply about my gender as a *fa'afafine* so it is better for me to change it to short term. You know the reason why? The reason why is at the end of the day there is no ending. So I only do the hit and run, not the hit and continue because at the end of the day the guy finds a girl to live with. You as a *fa'afafine* you just enjoy the single life. (Interviewee 1)

> Because here in Samoa it is illegal to go out and marry a man with a man. So that is why I don't like long-term relationships. It hurts me so much when it breaks up when we are in a close relationship; that is why I prefer short term. (Interviewee 4)

> Some of my *fa'afafine* friends they have had the same experience and there come back is different from mine, because they had that bad experience they are now more sexually active as in being promiscuous. (Interviewee 5)

> I do one-night stands, I never had a relationships. I do sex but that's it, there is no talk about relationships. Just with men. I never had regular ones, just hit and run, I do that … In the car, the bushes, I don't have a place to go, I can't take them home. But sometimes I take my one-night stands to my friend's house, I use that as a venue for some men whose preference is a proper bed … I never experienced a sleepover; my timeframe is 5–10 minutes that's it, bang and go, no story or nothing, no lovey lovey … straight to the point and then that is the end. (Interviewee 8)

The straight men were at pains to say that they were the insertive partner in sexual relationships, in accord with a dominant view of masculinity:

> Usually, I would get blown but sometimes I would return the favour and blow a *fa'afafine*. But I am usually the top and never a bottom. (Interviewee 6)

One of the straight men talked about being paid for sex by *fa'afafine*:

> Anytime I go with girls or especially *fa'afafine* then I receive from them about 50 tala … The girls give like 10 tala or something. (Interviewee 7)

It was not clear whether this was seen as a straight cash transaction or a present, for example, one man noted that one time he received 200 tala to buy a new pair of rugby boots that he had wanted to buy:

> I never give them any money, but they usually give me money after sex … Like one hundred plus [tala]. The most I have gotten is more almost 200, but most of them just give me like 20 tala … I like it because I get money out of it and good sex. (Interviewee 6)

Two of the *fa'afafine* commented on this:

> I can give one dollar or one smoke, if he wants a dollar or a smoke then I give, if he doesn't ask then I say 'thank you, come again'. Some of them I meet on the road and some I know them … In town and also in the area where I stay … It depends on the cash, because when the boy only wants the cash, that's all. I only give one dollar or one smoke if he wants and I have it … I give it after we have sex. (Interviewee 3)

> When I go with some of the cute ones, they always ask for money and that's why I hate it. It's the first time to meet and they ask you for money, it's a bit off for me, that's not a genuine relationship from my thinking. (Interviewee 8)

4.2.1.5 Condom use

As the survey data indicates, many participants said that they never used condoms. The reasons they give are varied. The major reason was not liking condoms, but there was also the belief that they were 'safe' from HIV:

> I never use condoms, I don't know why. Why? It doesn't feel comfortable to me … I don't like the way they feel … And when you get someone at the last minute so you are not even prepared for the safety and everything like that … In Samoa the majority of the time it is with the Samoan people. I don't use them because I have trust that they are not infected. (Interviewee 1)

This interviewee went on to say that when he was in New Zealand he did use them, which shows an understanding of the relative risk of infection in Samoa and elsewhere:

> I never really used condoms, I never felt that it was necessary most times and plus it's never there. We never really have condoms … you know what I mean, they are never there when you are in the moment of having sex and you don't want to stop just so you can go and get one from your car. (Interviewee 2)

> I think only *palangi* people do that, have a conversation 'do you have a condom?' But in Samoan people, just bang. (Interviewee 1)

On the other hand, one of the straight men interviewed argued that he doesn't use a condom with his girlfriend, 'But when I go to *fa'afafine* I did use it to protect me'.

There were some *fa'afafine* that did prefer to use condoms:

> Usually [with one-night stands] I am the one who proposed or come up with the idea and I would usually be the one to determine the terms of using it. I would say 'no condom, no sex'. (Interviewee 5)

However, they also had difficulties convincing their partners to use condoms:

> Because it is always my preference, sometimes my partner is not willing, most of the time our sex is between the legs but there are some times very minimal times when I do anal sex, but I usually prefer between the thighs. There are times when you feel you want to do

> anal, but it is not very common for me, sometimes I don't like it, it can be painful, oh my god! (Interviewee 8)

Participants also did not use lubricant. Most used either lotion or saliva instead:

> Not really, just lotion: bath and body or perfume lotion, and besides most of the guys use saliva. (Interviewee 2)

They did not feel that lubricant was widely available or accessible, and it was viewed as expensive.

In essence there does not seem to be a condom culture in Samoa:

> There are so many forums we do, and *fa'afafine*'s understanding is very high at the general level, during the pageants, but still I am not sure of the application of that general or high understanding into the practical when it comes to sex. (Interviewee 8)

As the interviewee above noted, most *fa'afafine* and MSM know about safe sex, and participants first learned about condoms when they were in school:

> In school when we were talking about safe sex when they were bringing the AIDS programs to school. I was probably in grade 8, around 13 … I was well aware of the diseases but it never really convinced me to use condoms. (Interviewee 2)

> When I was at school, the Samoa AIDS Foundation did outreach programs at school, in college around the age of 15 or 16. (Interviewee 5)

Condoms seemed to be generally accessible, but one participant who did use condoms said:

> I think it's about accessibility. I buy them off the chemist [condoms and lube] but they are not easily accessible, I always carry condoms in my wallet so I always have three there. I am very conscientious about it now … I always buy [lubricant] from the pharmacy … before I was never confident about it, when I went and it was full I would back off and do some other shopping and then come back and come and get it from the shelf and pay for it. I make sure that it is just me and the counter server, before, but now I don't care … It is limited selection and it is quite expensive, about 23 tala, the condoms are about 15–20 tala. (Interviewee 8)

4.2.1.6 Support services

4.2.1.6.1 Sexual health and support services

Most participants (five of eight) had never had a sexual health check. The reasons included lack of time, fear, and feeling that it was not necessary.

> No I haven't and I don't think that I ever will … because I have never used condoms … and if I was to have HIV I wouldn't want to know because I have got too much on my mind already and the last thing that I need is for someone to tell me that I have a virus. (Interviewee 2)

> I don't know why I am not going. Maybe I don't have time, but I should have a test, we don't know if I am affected or something … I heard about it from my other friends, you don't have to be ashamed to have a test. (Interviewee 4)

> No I have never been to any clinic … I just never thought about going to get checked up. (Interviewee 6)

There were varying views on the work and type of support provided by the Samoa Fa'afafine Association. Some participants thought that the organisation did a good job at providing a support network and running events.

Other people felt that there was a need for a drive to get new members, do new activities, have an office space and a drop-in space, and have new materials and be more focused in their advocacy work. In addition, some participants felt that there was a need to do more practical activities, such as making lubricant and quality condoms more accessible; providing information; having LGBQTI-friendly trained pharmacies; improving access to hormone treatments; and engaging in dialogue with health workers and leaders.

> I have been to the Samoa AIDS Foundation clinic and to the Samoa Family Health Association clinic, but I have never been to the Ministry of Health clinic. It was very friendly [at those clinics], but a bit not professional … [There were] some side comments that show their judgmental understanding, things like when I ask for lubricant they say 'only woman use them'. They were saying only pregnant women use those [lubricant]. It may be a one off, but it was really weird. (Interviewee 5)

4.2.2 Female sex workers

4.2.2.1 Personal background

Three female sex workers were interviewed in depth. The situations of the women varied, and they each illustrate the differing contexts and experiences of sex work in Samoa. Interviewee 1, who is 20 years old, lives with her parents and recently started having sex with foreign men for large sums of money (100–300 tala). Her husband recently left her and she started hanging around with her friend who hangs out in the area where sex workers are based at night in Apia. She buys clothes and things with the money she earns for herself and does not seem to do it out of economic necessity. Interviewee 2 is 24 years old and now lives in the village with her family. While living in American Samoa, she started casually receiving goods and money from men and, in return, had sex with them. Her involvement in sex work/sexual exchange seemed more opportunistic and casual. Interviewee 3, who is 29 years old, sometimes lives in the area where sex workers are based and sometimes stays with her aunty. She describes having an unsupportive family situation. She only goes with locals and her rate is 50 tala or less. She says she is tired of doing it. The workers had this to say about other women engaged in sex work:

> I see many girls just come and get a taxi and then go, taxi go, taxi go and they just get 10 tala. They go with local Samoan, they go to the seawall or the mountain. (Interviewee 1)

> There are more than 20 that work from where I work and I know there are other girls and locations, around the hospital. One time we had a kind of disagreement (among the girls working there) so some went and set up near the hospital. For some of the girls that do the same work, on Friday and Saturday nights are busy and some women only come out then, it is good working nights, but for us we come out every day. (Interviewee 3)

One young woman in her early 20s began hanging around with her friend in the area where a number of sex workers are based. She said this about the first time she went with a client:

> I was just relaxing and then I came the next night and the taxi driver picked me up and to hotel, where he [client] stays, he is Indonesian, the taxi driver come and pick me up to meet this man. I spent the whole night and he gave me 200 tala. (Interviewee 1)

Another young woman described how she started having sex for money or goods on a casual basis and said:

> I started [having sex for money] when I was in American Samoa … I was getting things from these guys so in return then I would have sex with them. They were different guys that my boyfriend didn't know about. (Interviewee 2)

One woman started having sex for money to buy clothes and other things while she was attending high school in American Samoa. Later, when she returned to Apia, she got involved in sex work. She said:

> When I was 18, I met the group, I didn't know who they were at the time. Then I started to get to know them and heard them talking about sex work and the way they look and the clothes they wear … I started to observe how they dress up, how they call out to the guys on the road, both locals and foreigners, that is how it started. Sometimes my family members passed by and they were calling my name to come back home. But I just realised from there, the girls are getting money out of it, and I see and I wanted to join. If I go home I don't know what to do. So I drank with them and that is how it all started with party life …

> Now I feel this is it, I don't want to go back home. This is a way for me to get some income. (Interviewee 3)

4.2.2.2 Economics/Role of sex work

For two of the women we interviewed, sex work provides them with money:

> For this money it is only to support me. I don't want to use this money for my family because I know that it is dirty money and I don't want to feed my family with the food that I buy with this money … I am about to quit, I am tired of this life and I see there is no ending and I am bit tired and getting old. So I started to feel it is about time to quit doing this kind of work, but the only reason is to earn income. With this money I can use to buy my clothes, for food, it's really for food and for smokes. (Interviewee 3)

> I was happy doing it, I was getting money out of it and it was helping me and my family out. (Interviewee 2)

The other woman, whose husband left her shortly after they were married, said that she started having sex for money:

> Because this happened [he left her and moved overseas] with my husband, and just many friends tell me 'hey just go relax' and 'never mind' you know that girl here, she is my best friend, she told me 'go and join together and enjoy your life, you know its ok'. (Interviewee 1)

4.2.2.3 Clients

The women interviewed had a wide range of clients. One young woman met her clients through taxi drivers:

> I only go with [men from] overseas … China, American, Solomon, Indonesian, not locals. (Interviewee 1)

> Locals, I don't want to go with the palangi ones cause I am not comfortable with my English. I am more comfortable with the local ones … I go with them to the budget hotels around town, but they also take me to the bush spots and in the car as well. (Interviewee 3)

4.2.2.4 Payment

As well as a range of clients, there was a range of payment for their services. A young woman who was casually having sex for money while she was in American Samoa away from her family in the village said 'It's really up to them, how much they want to give' (Interviewee 2). On the other hand, a young woman who had only recently started doing sex work charged considerable amounts for sex:

> Oh, I don't know about other girl but with me they pay 150 or 200 [tala] … 300 [tala] … Someone asked me to go fuck for the 50 tala, but I don't like it. I tell him give me first the big money and then let me show you, but only 50 tala I don't like it, go talk to the other girl. (Interviewee 1)

On the other hand, the older woman, who had been involved in sex work for a number of years and only had local clients, said:

> I have a rate of 50 tala minimum, then goes up. But some of my clients do negotiate the price, but it is also a negotiation for me and I always ask for the price before we have sex. So it is my call to do it or not do it. Some of my clients negotiate 20 or 30, if it is the only clients available then I will have to take it cause it's better than nothing. (Interviewee 3)

4.2.2.5 Condom use

Condom use is always an issue for sex workers, although – compared to the men in this study who have sex with men – they seemed more aware of the risks of not using condoms. The women were insistent that they almost always used condoms with their clients and said that they did not face many problems in negotiating condom use. The young woman who only had sex with foreigners and received high rates of pay said this about using condoms:

> Yeah, I use it. With many men I use it, I don't want to fuck without a condom, I use it. (Interviewee 1)

> For me with all the partners I go with it is always a wake-up call to use condoms. I always bring them with me and whether he like it or not, if he uses it can we can proceed but if not I always put a stop because I don't want to take a risk … Also, the fear of sexually transmitted diseases and all that, I know it is really a risk for us because we are accessing lots of different partners, even though they are locals, but still they also do have their wives and other many partners. (Interviewee 3)

One young woman commented on condom negotiation and use and said:

> Yeah, I come to the hotel and ask the guy 'do you have a condom?' [He answers] 'Yeah I have a condom' because I just come to relax here. I have it in my pocket and I use it for go to the hotel [with men]. Many night, many people [potential clients] come to me I ask them 'do you have a condom?' they answer 'no'. I said 'I don't like it' because you have a condom then its ok. (Interviewee 1)

One woman described how her condom use habits changed over time:

> In the beginning I never really used, but as time went by I was worried about the illnesses and also I didn't want to get pregnant so that is why I started using them. (Interviewee 2)

However, there are considerable challenges in negotiation of condom use, as many clients do not want to use them.

> Well my call is always to use a condom, but if he insists not to use it then I don't take him … A bit of minor arguments in the beginning to negotiate the use of condoms, I also try and explain the risk and the need and in the end we both agreed despite some misunderstanding. (Interviewee 3)

Alcohol and drug use can make sex workers less able to negotiate the use of condoms. One interviewee told us:

> Last Saturday a guy came and said 'hey come' so I went to the hotel with him and he said I have a room we can go sleep and I drive you … I came we got drunk and he smoke ice and marijuana. I got so drunk, I had a shower and fell asleep on the bed. He came and I don't know what he did to me and at 5 in the morning he woke me and said 'hey, wake up let me drop you off'. He gave me a 50. He said this Saturday I will come and pick you up? I said no only one time … He is a *afakasi* [half Samoan and half white] guy. (Interviewee 3)

4.2.2.6 Condom access

Accessing condoms is another issue that sex workers face. It is particularly difficult if there is no outreach work or programs specifically designed for sex workers:

> Recently, we don't have any supply there anymore so we tend to go to RSA and get it from the toilets. When I go to National Health Services I usually get big boxes and then I bring it back and share it with the girls to use. The feeling is we understand the importance but somehow we are shy to go and get it, we don't really know the people working at the STI clinic and we are a bit shy to ask for condoms. (Interviewee 3)

One of the best ways to promote access to and use of condoms is to involve peers. Sex workers are often the best educators of other sex workers. The women described how they learned about condoms from their friends. As one woman said:

> The first night I met with that woman at the seawall she gave me a condom and I asked her, cause I thought it was a lolly. She told me that it was something to give to a man to protect you from being pregnant. (Interviewee 3)

4.2.2.7 Sexual health services

None of the woman had accessed sexual health services at the National Health Service or services provided by NGOs such as the Samoa Family Health Association. Only one woman mentioned contact with a Red Cross volunteer one time, although the others said, 'No, we never got information, my friend just went and got condoms from the hospital'. As well, none of them had been tested for HIV or other STIs. One young woman engaged in sex work said she did not go to get tested:

> Because I don't have HIV/AIDS because I use the condoms for safety. (Interviewee 1)

4.2.2.8 The future

After noting the risks of sex work, the woman who had been doing sex work for about 10 years described her aspirations for the future:

> But I have a plan to have beautiful kids in the future and I am also looking forward to find someone who loves me so that I can quit this kind of work and have children in life, I need to nurture some beautiful kids in life. (Interviewee 3)

4.3 Institutional capacity assessment

4.3.1 Organisational mapping

The Ministry of Health (MoH), National Health Service, the Samoa Fa'afafine Association (SFA) and the Samoa Family Health Association (SFHA) deliver HIV and STI services and programs which they report are available to the general public including key populations. However, only the SFA provide targeted services and programs for *fa'afafine* and currently there are no services or programs specifically for FSW in Samoa.

The National Health Service is responsible for HIV and STI services and the MoH is responsible for surveillance, policy and health promotion. The HIV and STI Unit is located within the Health Sector Monitoring and Resourcing Division of the MoH and has two staff members allocated to lead the coordination of the National Program for HIV, AIDS, STI and TB. It also serves as the primary coordinator for resourcing activities for STIs and HIV. As stated in the National HIV & AIDS Policy 2011–2016, the mission statement of the HIV section is defined as*: 'To provide strategic leadership for a national multi-sectoral response to HIV/AIDS leading to the reduction of further infections associated diseases and the adverse socio-economic effect of the epidemic.'*

The SFA was established and registered as a non-government organisation in 2006. The majority of the members of the organisation are *fa'afafine* (male-to-female transgender) but also a minority are *fa'afatama* (female-to-male transgender). Members are recruited via the newspaper, TV, Facebook and word of mouth. The organsation has over 100 members, of whom 52 are financial members. They reported last year reaching over 200 MSM/*fa'afafine*, 20 *fa'afatama*, 10 sex workers and 200 members of the general public. The four focus areas of the organisation, as stated in the SFA strategic plan, are health and safety, capacity building, advocacy and legal.

The SFHA was established and registered as an NGO in 1982. The organisation has an association agreement with IPPF. Its work aims to provide services to PMSEU (poor, marginalised, socially excluded and underserved), which includes MSM, transgender, PLHIV, young people in and out of school, and vulnerable communities (defined as certain geographically hard-to-reach villages). In 2015, SFHA reported reaching 14,234 clients through outreach and clinical services, of whom 12,000 were PMSEU. The organisation's work is guided by IPPF's 5 A's policy: (1) adolescents and young people; (2) access to services; (3) AIDS and HIV; (4) abortion services; and (5) advocacy.

4.3.2 HIV and STI prevention and management for MSM/TG and FSW

4.3.2.1 National oversight, coordination and funding

National HIV activities are overseen by the Country Coordinating Mechanism for Communicable Diseases Control Committee (CDCC), which includes a National AIDS Committee Working Group. The last meeting was reportedly held in early 2015. Activities are guided by the National HIV & AIDS Policy 2011–2016 and by WHO, UNDP and UNFPA policies. The MoH receives HIV funding from the Global Fund as well as WHO and UNFPA and allocated government funds. Medical volunteers are provided to the MoH through

organisations such as the Fulbright volunteer program. SFA and SFHA are members of the National AIDS Council.

SFA is guided by an organisational strategic plan 2014–2020 developed by executive members and is governed by a board of directors. It was reported that decisions are generally made collectively via email or at monthly meetings.

SFHA is guided by a constitution and mission statement which states that it aims to *'lead the provision of quality Comprehensive Sexual Reproductive Health services in Samoa, and champions Sexual Reproductive Health Rights for all Samoans, especially the underserved'.* Decision-making and strategic planning are reported to take place in a collaborative approach between the board, staff and stakeholders.

4.3.2.2 HIV and STI testing, counselling and treatment

HIV and STI testing is provided by the National Health Service and the National Laboratory is responsible for diagnostics. According to the Global AIDS Progress Report 2016, a total of 8,870 HIV tests were conducted in 2015, covering 4.6% of the population. HIV testing took place within the following categories: antenatal clinic (32%), blood donors (17%), SFHA (13%), private clinic patients (13%), hospital patients (Upolu) (11%), hospital patients Savaii (6%), immigration (6%), STI clinic (1%), unknown (1%) and kidney foundation patients (0%). There is no targeted testing and counselling for MSM/TG or FSW. However, SFA refers members to the National Health Services STI clinic, SFHA and private doctors for clinical services. The MoH also has a group of trained community volunteers, some of whom are *fa'afafine*. The volunteers facilitate linkages between the community and health services.

4.3.2.3 Condom distribution

UNFPA and UNDP supply condoms and lubricants to the MoH and National Health Service. Condoms are distributed through clinics, public condom dispensers in bars, nightclubs and other locations, and through NGOs such as SFA. SFA distributes condoms to its members and the general public through events such as its annual beauty pageant. SFHA distributes condoms through outreach activities and its clinic. In 2015, SFHA reported distributing 7,000 male condoms. In the Global AIDS Progress Report 2016, MOH indicated that there was no clear data on condom distribution and lubricant distribution is not mentioned (p 23).

4.3.2.4 Peer education

SFA provides peer support to its members, which includes sexual health education. SFHA also undertakes sexual and reproductive health peer education and likely reaches some MSM, including *fa'afafine*, through its initiatives that target the general population. The culture of silence in Samoa regarding sexuality was reported as a challenge to carrying out peer education. SFHA reported that it would like to strengthen its peer education program by increasing the number of peer educators and by fostering a sense of ownership of the program among educators.

4.3.2.5 Strategic health communication

The MoH partners with SFA in the provision of sexual health education to *fa'afafine*. The Ministry also supports SFA with some small grants, which go towards HIV and sexual health education including promotion of safe sex through events such as the annual beauty pageant.

The *fa'afafine* pageant is hosted by SFA as a way to raise awareness in the community about human rights and sexual health. SFA reports having conducted sexual health education for its members and other *fa'afafine* through participating in regular awareness-raising events, such as the candlelight vigil and World AIDS Day, and carrying out sports events which attract its members. SFA currently does not have the capacity to monitor and evaluate the activities that it undertakes.

SFHA does not conduct programs specifically for MSM/TG or FSW, but reports that these are included within general outreach programs. It reported challenges in engaging with both populations as they are hidden and sex work is viewed as 'not suitable for public discussion'. SFHA reported that it is able to engage with MSM/TG through SFA and invite SFA members to outreach activities and education workshops.

4.3.2.6 Advocacy and legislation

SFA advocates for the rights of *fa'afafine*. For example, it played an integral role in the amendment of the 2012 Crimes Act, which in 2013 led to the impersonation of females being decriminalised. It also provides input into national policies as and when invited to do so by the government and other organisations.

4.3.2.7 Other support services

SFA aims to build the capacity of *fa'afafine* so that they are able to obtain employment. As such, SFA partners with Samoa National University and the Asia Pacific Technical College to provide vocational training for SFA members.

4.3.2.8 Cross-cutting organisational strengths

- SFA reaches a large population of *fa'afafine* and maintains a focus on advocating for the rights of *fa'afafine*. The organisation provides a network and social support for *fa'afafine* and offers opportunities for *fa'afafine* to obtain education and employment.
- There is an established link between the MoH and *fa'afafine* through *fa'afafine* community volunteers. SFA also refers members for clinical services to the MoH clinics and SFHA.
- The MoH is in the process of revising the National HIV Policy (which expires this year), with a plan to include targeted health promotion for MSM/TG.
- MoH plays an integral role in coordinating HIV programs and activities, as well as providing treatment to PLHIV and monitoring and collecting HIV data.

4.3.2.9 Cross-cutting organisational capacity-building needs

- MSM and FSW are viewed as hidden populations that are difficult to reach with health education and services.
- Financial challenges create difficulties in reaching people with clinical and social services in remote areas such as Savaii.
- It was reported across organisations that staff would benefit from capacity building in program management, monitoring and evaluation, and in resource mobilisation.
- SFA staff members are volunteers and therefore have competing demands on their time.

- Funding and training are required to support advocacy activities for MSM/TG and *fa'afafine*.
- It was reported that it would be easier to report to donors if templates and processes were simplified and there was training on UNDP reporting processes.
- Funding is required to increase the number of community volunteers and peer educators so as to strengthen and expand linkages between the communities and health services.
- Technical assistance is requested to keep up-to-date with the latest developments in sexual health clinical management and technologies.
- Sensitisation and stigma-reducing programs with health workers and communities would likely improve the ability to connect MSM/TG and FSW to health services.

4.3.2.10 Identified capacity-building resources

SFA partners with a number of LGBTI organisations and may wish to partner with other international organisations in order to access technical support and funding. At present, the majority of support received is through attending international meetings and conferences. SFHA may also be able to work with IPPF to strengthen the delivery of services to MSM/TG and FSW. There are also some volunteer programs that Samoa currently receives support from, including the Fulbright program. These organisations may be able to provide further support.

5 Recommendations

5.1 MSM Engagement and Support

- To strengthen the work of SFA, a Coordinator should be recruited and set up a desk within an existing office. The Coordinator should work with the executive members to progress the activities set out in the strategic plan as well as the activities noted below.
- Work with the Ministry of Health to promote condoms and lubricant and use of sexual health services within the MSM community.
    - Continue and improve upon condom distribution through the condom dispensary program.
    - Improving access to lubricant by sourcing lubricant and including in condom dispensary program.
    - Work with selected pharmacies to train staff to be LGBQTI-friendly and stock quality condoms and lubricants.
    - Develop social marketing of condoms and lubricant in Samoan language with local designs.
    - Work with National Health Services STI Clinic and Samoa Family Health Association to increase the capacity of their staff to provide MSM-friendly information, testing and treatment services and provide targeted services to MSM (for example a monthly clinic for fa'afafine).

5.2 FSW Engagement and Support

- Identify an appropriate support organisation to work with sex workers to improve their access to condoms, lubricant and sexual health services.
- Work with a few key members of the community of sex workers to develop a peer education program to supply condoms and lubricant, information on sexual health and support, encouragement and information on where to access sexual health services.

References

Farran, S. (2010). Pacific perspectives: Fa'afafine and fakaleiti in Samoa and Tonga: People between worlds. *Liverpool Law Review,* 31(1): 13–28.

Farran, S. and Su'a, A. (2005). Discriminating on the grounds of status: Criminal law and fa'afafine and fakaleiti in the South Pacific*. Journal of South Pacific Law,* 9(1): 1–14.

Godwin, J. (2010). Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: an agenda for action. Bangkok: UNDP.

Government of Samoa (2015). Global AIDS response progress report 2014. UNAIDS. Retrieved from http://www.unaids.org/sites/default/files/country/documents/Samoa_narrative_report_2015.pdf.

Government of Samoa (2016). Global AIDS response progress report 2015. UNAIDS. Retrieved from http://www.unaids.org/sites/default/files/country/documents/Samoa_narrative_report_2016.pdf.

Jenkins, C. (2005). HIV/AIDS in the Pacific. Manila: Asian Development Bank.

Jenkins, C. and Buchanan, H. (2006). Cultures and contexts matter: Understanding and preventing HIV in the Pacific. Manila: Asian Development Bank. Retrieved from http://www.hivpolicy.org/Library/HPP001294.pdf.

McMillan, K. (2013). Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programs in four selected countries. Suva: Secretariat of the Pacific Community.

Samoa Ministry of Health (2013). Global AIDS country progress report 2010–11. Retrieved from http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/WSM_narrative_report_2014.pdf.

Sladden, T. and Vulavou, I. (2008). UNFPA supported sex worker initiatives in six Pacific Island countries 2007–2008. UNFPA Pacific Sub-Regional Office.

Tcherkézoff, S. (2014). Transgender in Samoa: The cultural production of gender inequality. In N. Besnier and K. Alexeyeff (eds.), *Gender on the edge: Transgender, gay and other Pacific Islanders.* Honolulu: University of Hawaii Press.

UNAIDS (2009). Turning the tide: An OPEN strategy for a response to AIDS in the Pacific: Report of the Commission on AIDS in the Pacific. Suva: UNAIDS Pacific Region. Retrieved from http://data.unaids.org/pub/Report/2009/20091202_pacificcommission_en.pdf.

Wallace, L. (1999). Fa'afafine: Queens of Samoa and the elision of homosexuality. *Gay and Lesbian Quarterly,* 5(1): 25–39.

World Health Organisation (2006). Second generation surveillance surveys of HIV, other STIs and risk behaviours in six Pacific Island countries (2004–2005). Manila: World Health Organization Regional Office for the Western Pacific.

Annex 1: UNAIDS GARP data needs

DATA – SAMOA

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:

Sample Size: n/a

Number of Survey Respondents: 11

Sex Workers

	All	Males	Females	>25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	**9.1 %**		**9.1 %**	**0 %**	**20.0 %**
Numerator Number of sex workers who answered "Yes" to both questions	**1**		**1**	**0**	**1**
Denominator Total number of sex workers surveyed	**11**		**11**	**6**	**5**
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?"	**27.3 %**		**27.3 %**	**16.7 %**	**40.0 %**
Numerator Number of sex workers who replied "yes" to question 1	**3**		**3**	**1**	**2**
Denominator Total number of sex workers surveyed	**11**		**11**	**6**	**5**
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?	**27.3 %**		**27.3 %**	**16.7 %**	**40.0 %**
Numerator Number of sex workers who answered "Yes" to question 2	**3**		**3**	**1**	**2**
Denominator Total number of sex workers surveyed	**11**		**11**	**6**	**5**

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	**27.3 %**		**27.3 %**	**0 %**	**60.0 %**
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	**3**		**3**	**0**	**3**
Denominator Number of sex workers who reported having commercial sex in the last 12 months	**11**		**11**	**6**	**5**

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	**0 %**		**0 %**	**0 %**	**0 %**
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**0**		**0**	**0**	**0**
Denominator Number of sex workers who responded to the questions	**11**		**11**	**6**	**5**

1.11 Percentage of MSM reached with prevention programs

	All	>25	25+
Percentage (%) Percentage of MSM who answered "Yes" to both questions	**65.7 %**	**47.1 %**	**77.7 %**
Numerator Number of MSM who answered "Yes" to both questions	**23**	**1**	**14**
Denominator Total number of MSM surveyed	**35**	**17**	**18**
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?"	**62.9 %**	**47.1 %**	**77.8 %**
Numerator Number of MSM who replied "yes" to question 1	**22**	**8**	**14**
Denominator Total number of MSM surveyed	**35**	**17**	**18**
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**28.6 %**	**11.8 %**	**44.4 %**
Numerator Number of MSM who answered "Yes" to question 2	**10**	**2**	**8**
Denominator Total number of MSM surveyed	**35**	**17**	**18**

1.12 Percentage of MSM 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	**20.0 %**	**17.7 %**	**22.2 %**
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner	**7**	**3**	**1**
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**35**	**17**	**18**

5.3 ?.?? PERCENTAGE OF MSM WHO RECEIVED AN HIV TEST IN THE LAST 12 MONTHS AND WHO KNOW THEIR RESULTS

	All	>25	25+
Percentage (%) Percentage of MSM who received an HIV test in the last 12 months and who know their results	**5.7 %**	**0 %**	**11.1 %**
Numerator Number of MSM who have been tested for HIV during the last 12 months and who know their results	**2**	**0**	**2**
Denominator Number of MSM who responded to the questions	**35**	**17**	**18**

1.13 PERCENTAGE OF TRANSGENDER REACHED WITH PREVENTION PROGRAMS

	All	>25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions	**34.8 %**	**25.0 %**	**38.8 %**
Numerator Number of TG who answered "Yes" to both questions	**24**	**5**	**19**
Denominator Total number of TG surveyed	**69**	**20**	**49**
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?"	**81.2 %**	**70.0 %**	**85.7 %**
Numerator Number of TG who replied "yes" to question 1	**56**	**14**	**42**
Denominator Total number of TG surveyed	**69**	**20**	**49**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**37.7 %**	**25.0 %**	**42.9 %**
Numerator Number of TG who answered "Yes" to question 2	**26**	**5**	**21**
Denominator Total number of TG surveyed	**69**	**20**	**49**

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	**39.1 %**	**40.0 %**	**38.8 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**27**	**8**	**19**
Denominator Number of respondents who reported having had sex in the last 12 months	**69**	**20**	**49**

5.4 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	**18.8 %**	**10.0 %**	**22.4 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**13**	**2**	**11**
Denominator Number of TG who responded to the questions	**69**	**20**	**49**

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