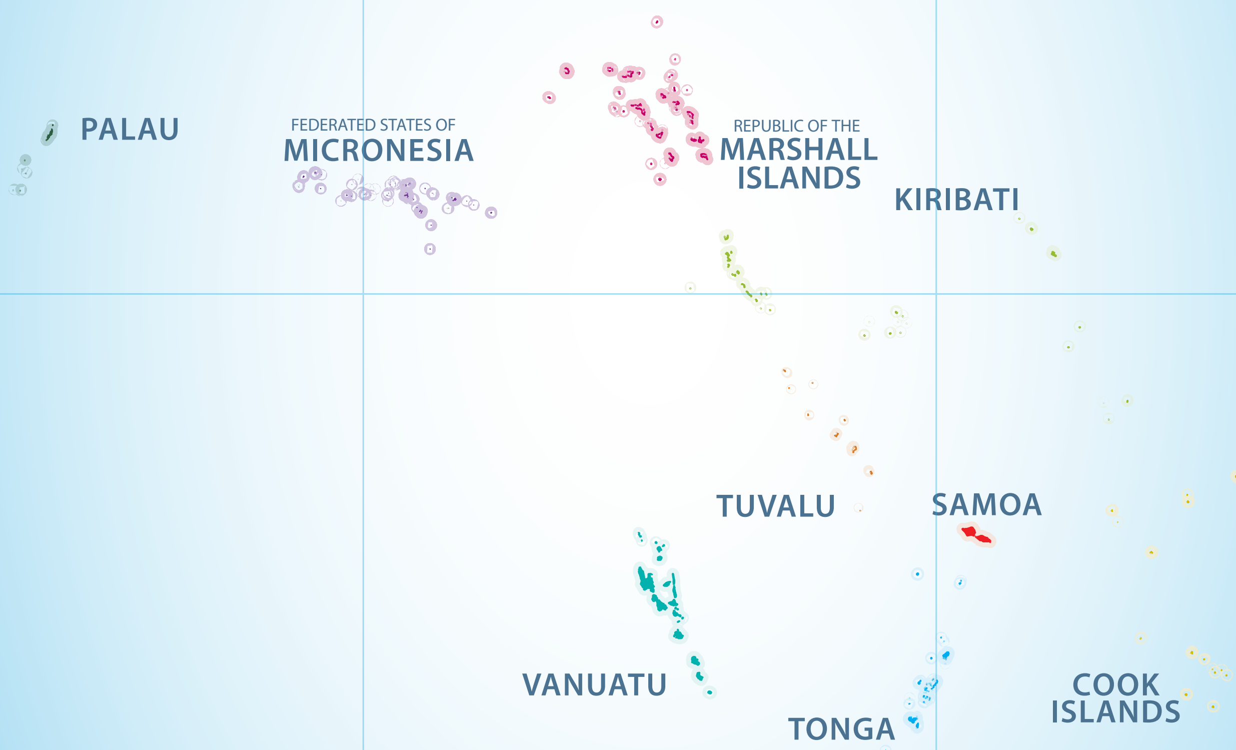
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

TONGA



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Acknowledgements

The *Pacific Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Tonga* 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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- **The TFHA and Talitha Project are both in a position to undertake a FSW peer education program. They must be careful to do so in a way that does not stigmatise or ‘out’ the women and builds real partnerships with the FSW. Both organisations are well networked and would be able to do this. 75**
- **A high population has mobile phones and communicate via text or Facebook. It could be worth considering using mhealth to reach hidden populations. 75**
- **TLA require technical support in facilitating a consultation with decision makers including government personnel, local council members and church leaders (through the Forum of Church Leaders) on LGBTI rights. 75**
- **Community and health care LGBTI sensitisation programs are recommended to reduce stigma and barriers to accessing services. 75**
- **Assist the government with finding funds for Chlamydia testing and treatment. 75**

- **The MoH would benefit from receiving technical support in integrating HIV and SRH as per their national strategy. 75**

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Abbreviations

AHD	Adolescent Health Service
AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral drugs
FAT	Australian Department of Foreign Affairs and Trade
FSW	Female sex workers
GDP	Gross domestic product
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IPPF	International Planned Parenthood Federation
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organisation
PLHIV	People living with HIV/AIDS
RA	Research assistant
SD	Standard deviation
SPC	Secretariat of (the Pacific Community)
STI	Sexually transmissible infection
TB	Tuberculosis
TFHA	Tonga Family Health Association
TLA	The Tonga Leitis Association
TG	Transgender
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCT	Voluntary counselling and testing

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

- Tonga has a low prevalence generalised HIV epidemic. This study collected data from two populations considered to be particularly vulnerable to infection: transgender/men who have sex with men (TG/MSM), and female sex workers (FSW).
- Key stakeholders and representatives of the target populations estimated that there are at least 100 people who identify as faka/leiti, transgender, or men who have sex with men in Tonga. There was no consensus for FSW but we roughly estimate there are 1000 FSW in Tonga

Transgender and men who have sex with men

- Seventy-three self-identifying transgender (TG) and men who have sex with men (MSM) provided survey data and eight took part in in-depth interviews. The local term f*akaleitis* or *leitis* was used by participants to include MSM, gay and transgender.
- In the surveys most participants identified their gender as transgender fa'afafine/fakaleiti/avakavaine (60.3%) or men (32.9%). The interviews revealed that some TG also gender identified as women.
- 36.6% claimed a sexual identity as transgender/fa'afafine/fakaleiti/avakavaine, 25.3% as MSM, and 15.5% as gay/homosexual
- 37.1% of respondents said their sexual identity was supported by their families, but 34.3% kept it hidden from their families. While interviewees said that their gender identity was generally accepted by their family, relationships with male partners were not.
- Long-term relationships tended to be with 'straight' men before these men married.
- Participants reported their first occasion of sexual intercourse occurring between the ages of 3 and 45, with a mean age of sexual debut being 15.9.
- All of the TG/MSM in the survey had ever had sexual intercourse.
- 77% of participants had sex with at least one casual male partner during the previous 12 months
- 58% had at least one paying partner in the last 12 months. All of the interviewees had participated in transactional sex or identified as sex workers. Some TG interviewees paid adolescent boys and men for sex.
- Overall knowledge about HIV was moderate with 73.7% correctly identifying that condoms are a barrier to HIV infection.
- Condom use was reasonably high, but inconsistent. With casual male partners, 10.7% 'never' used condoms, while 9.1% never used condoms with paying partners. Interviewees reported that lubricant was often not available.
- Almost 60% of participants who had anal intercourse with a regular male partner used condoms on the last occasion.
- 17 % of participants reported forced sex in the past 12 months. Interviewees disclosed child sexual assault by family members.
- 52% of participants had engaged in anal or vaginal intercourse after taking alcohol and/or drugs which left them feeling not in control.

- 58.9% had accessed a sexual health service in the last 12 months. Interviewees appreciated the support and advocacy efforts of the Tonga Leitis Association (TLA)
- 56% MSM/TG had an HIV test in the twelve months prior to the survey

Female sex workers

- Eighty-two women, who receive money and goods in exchange for sex took part in the survey and eight participated in in-depth interviews.
- Interviewees sold sex for financial support for themselves and their children. Some exchanged sex for food, gifts, lifts home, drugs or alcohol.
- The age of survey respondents ranged from 16 to 49, with a mean age of 26.9
- Paying partners tended to be Tongan men.
- 40.2% of women were not employed
- Age of sexual debut ranged from 13 to 24 years of age.
- The age at which they reported first receiving money or goods in exchange for sex ranged from 15 to 25 years of age.
- The mean number of paying partners in the last 12 months was 5.83
- Condom use was sporadic or not used at all with paying partners. In the past 12 months, 37.9% 'never' used condoms with paying partners (for vaginal intercourse). All except one interviewee reported that it was their male partner who decided on condom use.
- Almost 60% of participants who had anal intercourse with a regular male partner used condoms on the last occasion.
- 70.7% of the women reported having had sex with a casual non-paying male partner in the previous 12 months. 64.3% of respondents never used condoms with casual partners (for vaginal intercourse).
- 37.5% drank alcohol at least once a week. Half the respondents reported they had engaged in sexual intercourse after taking alcohol and/or drugs which left them feeling not in control in the previous 4 weeks.
- 26.8% reported having symptoms of an STI in the past 12 months.
- Overall knowledge of HIV was low.
- Only 7.1% had visited a health service for information or services related to condoms, family planning, HIV and STIs or sexual assault in the past 12 months
- 11% of women had an HIV test in the previous 12 months

Capacity assessment

- The National HIV Program sits within the Ministry of Health (MoH). HIV testing is carried out by the MoH. The Tonga Leitis Association (TLA) is the main organisation working in HIV prevention and advocacy for the rights for LGBTI in partnership with the MoH and Tonga Family Health Association (TFHA) when clinical support and services. The MOH through the Communicable Disease Section and Reproductive Health Section distribute condoms. Both TFHA and TLA distribute condoms and lubricants provided by the Ministry of Health which are procured from UNFPA.
- TFHA and the Talitha Project provide sexual and reproductive health education and support services to vulnerable women, through which they reported to reach some FSW.
  - **Organisational strengths:** The TLA was valued by participants for its actions in supporting and advocating for TG/MSM.
  - **Capacity building needs**: Identified needs by staff from key provider organisations include: clinical refresher training and mentorship, and guidance in program management, reporting, monitoring and evaluation. Support for the development of targeted IEC resources; provider training on vulnerable population issues; and strengthening of peer education programs. Funding support for Chlamydia testing reagents and increased availability of lubrication is needed.

1 Introduction

1.1 Background to the research

This research was carried out as a response to the need for greatly increased, contextualised information about the vulnerability to HIV of transgender/men who have sex with men, sex workers and seafarers in many Pacific countries. The study will:

1. Constitute 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. Provide quantitative and qualitative data to inform relevant interventions aiming at reducing the HIV and STI risk vulnerability of key populations.
3. Consolidate and generate specific evidence of barriers to prevention, improve 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, transgender/men who have sex with men (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, etc.) 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 in-depth social and structural determinants influencing these risk factors, including stigma, human rights violation, all forms of violence, discrimination, 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, and barriers to accessing services, through in-depth interviews.

2 Tonga

The kingdom of Tonga is a Polynesian sovereign state located in the southern Pacific Ocean, comprising of over 170 islands (36 of which are inhabited). The country consists of four main island groups, including Tongatapu, Vava'u, Hapa'ai and the more remote islands in the Niuas (Ministry of Finance and National Planning 2010). The population of Tonga is 103,252, with the majority living on Tongatapu (75,416), where the capital Nuku'alofa is located (Tonga Department of Statistics, 2016). The national government and the seat of monarchy is located in Nuku'alofa, along with the majority of the commercial and transport infrastructure. Tongans on the outer islands have higher rates of hardship and poorer access to health services, education and economic opportunities (WHO & Ministry of Health Tonga 2012).

Tonga is classified as a low middle income country by the World Bank (2016). The economy is dominated by subsistence agriculture and is heavily reliant on external income from development assistance and remittances of Tongans living abroad (Commonwealth Secretariat 2015). Remittances were 23.8% of GDP in 2013 and are growing at a faster rate than the domestic economy and development assistance. Public health expenditure was 4.7% of GDP in 2013 (UNDP 2015).

Government health services are provided free of charge for all Tongan citizens. However, the population is scattered across 700,000 square kilometres of ocean, providing challenges to deliver universal access to quality services (WHO & Ministry of Health Tonga 2012). Testing for HIV and other STIs is available for antenatal women, potential blood donors, people presenting at a clinic with STI symptoms or TB, persons seeking visas to emigrate overseas, and as an occupational requirement for employees, including seafarers attending the Tonga Maritime School. Tonga currently has 14 accredited Voluntary Confidential Counselling and Testing (VCCT) facilities at the four major hospitals in Nuku'alofa, Vava'u, Ha'apai and 'Eua, and at the Tonga Family Health Association (TFHA) in Tongatapu and outer islands (Ministry of Health Tonga 2016).

Tonga has low prevalence of HIV, with 19 cases cumulatively as of December 2015, 11 of which have resulted in death. There are currently only two people known to be living with HIV in Tonga, as five have returned to their country of origin and one has migrated overseas (Tonga Ministry of Health 2016). Neither of the two people living with HIV is currently receiving ARV treatment, although there are ongoing efforts aimed at getting them to resume. So far, the majority of cases have been associated with heterosexual transmission (Ministry of Health Tonga 2016).

Key populations considered vulnerable to HIV include youth, transgender (*fakaleitis*), men who have sex with men, sex workers, mobile groups such as seafarers, disabled people and those who abuse alcohol and/or inject drugs (Ministry of Health Tonga 2016). As in other Pacific Islands, condom use is reported as low and STI rates are high among sub-populations. The key risk groups are under-researched in Tonga, and little is known about their sexual health attitudes, understandings, status and needs (Ministry of Health Tonga 2016).

2.1 Transgender and men who have sex with men

The terms *fakafefine*,[1] *fakaleiti*[2] and *leiti* are commonly used to refer to people who are born male but, in terms of gender, behave 'in the manner or fashion of women'. However, this definition does not capture the complex and dynamic gender and sexual identity of *leitis*. For instance, some *leitis* may perceive themselves as women, dress as women, and be sexually attracted to heterosexual men, while others may be effeminate but view themselves as men and be sexually attracted to men and/or women (James 1994; Farren 2010). Few *leitis* are said to identify as homosexual, and *leitis* are usually not sexually attracted to other *leitis* (James 1994; Besiner 1994, 2002). As Farren (2010) argues, *leitis* do not fit into Western categories of male, female, heterosexual, homosexual, bisexual or transsexual, but are unique to Tonga.

Leitis are both integrated and marginalised in Tongan society. On the one hand, they may be valued for their role in the household (e.g. weaving and cooking) and in the community (e.g. performance and beauty pageants). They may also be found in professional employment or feature in performances with royal patronage. But, on the other hand, they may face marginalisation and abuse because they are now associated with male-to-male sex, which is generally deplored and illegal in Tonga (Besnier 1994; James 1994; Farren 2010; Godwin 2010). Homosexuality is now a part of the stereotype of *leiti*, as are showy 'Western' transvestite performances (James 1994). It is an offence to impersonate a female in Tonga, although this law is not enforced (Godwin 2010). Homosexuality is illegal in Tonga under the anti-sodomy law.

Heterosexual Tongan men have sex with *leitis*, and this is not considered male-to-male sex (Besnier, cited in Munro 2015). *Leitis* may be more sexually available than women and can satisfy men's sexual needs without the social need for repayment (as there is with women). Heterosexual men who have sexual relationships with women may be expected to expend financial and material resources to win women over. In contrast, *leitis* are often responsible for making sex attractive to straight men by their feminine appearance and enticements such as alcohol and entertainment. *Leitis* may pay 'straight' men and adolescents to have sex with them (Besnier 1997).

There have been very few studies of the sexual health attitudes, understandings and needs of MSM and *leitis* in Tonga. Like other MSM and TG groups in the Pacific, *leitis* engage in high risk sexual behaviour, putting them at risk of HIV or STI transmission (Ministry of Health Tonga 2016). The 2008 Tonga SGS survey found that 12% of MSM ages 15–24 years and 27% of MSM aged 25 years or older used a condom the last time they had sex with a male partner. Only about 2% of MSM had been tested for HIV in the 12 months prior to the survey. There is no information available on specific sexual modes of HIV transmission (Ministry of Health Tonga & SPC 2008).

[1] An older term, still used occasionally, that literally translates as 'in the manner of a woman' (Besnier 2004).

[2] A term in more common usage today. The word *leiti* is borrowed from the English word 'lady' and is applied only to transgendered males, whereas *faka-* is a polysemic prefix in Tongan. In this context, it means 'in the fashion of' (Besnier 2002).

2.2 Sex workers

There are no official reports, statistics or interview data for sex workers in Tonga. Although informal and formal sex work among women has been documented, restrictive legislation, stigma and cultural attitudes towards sex work have hindered official monitoring of the health of sex workers (Peteru 2002; Women & Children's Crisis Centre in Tonga 2010; Tonga Ministry of Health 2014, 2016). Many Tongan women are unlikely to identify as sex workers, and this may also complicate attempts to identify their health needs (Godwin 2012).

The only available data on sex workers is gleaned from SGS surveys of antenatal women. In 2005, 1.7% of antenatal women had engaged in commercial sex in the previous 12 months. In 2008, four women (1.1% of women surveyed) and four youth (0.7%) had received cash or goods in return for sex (WHO 2006; Ministry of Health Tonga & SPC 2008). The number of women sampled in these surveys was small, therefore the actual number of women engaging in sex work in Tonga may be higher.

Although there is no specific law prohibiting the exchange of sex for money (in private), it is an offence to keep a brothel, to solicit, or to live on the earning of sex workers (Godwin 2012). In 2010, a Chinese national was convicted of sex trafficking, running a brothel and trading in prostitution in Tongatapu. The trafficking involved two Chinese women – aged 29 and 33 years – who were told that they would work in a hotel, but when they arrived were forced into prostitution. One of the victims reported that there were 'many other' women in the same situation, but were too scared to come forward (Social Policy and Parliamentary Unit of the Salvation Army 2011).

In the absence of detailed data, sex workers are deemed to be at higher risk of exposure based on Pacific, regional and global experiences, as well as known socio-economic and cultural determinants (Tonga Ministry of Health 2014). These determinants in Pacific countries include poverty, unemployment and gender inequality, and key risks include low STI/HIV prevention knowledge, low condom use, and multiple partners among selected populations (Buchanan-Aruwafu 2007; McMillan 2013).

3 Methodology

This study employed a variety of methods in a cross-sectional (snapshot) design. FSW participants were recruited through convenience snowball sampling, and TG/MSM were recruited through respondent-driven sampling. Fieldwork was undertaken between 6 and 20 July 2016 in Nuku'alofa (TG/MSM/FSW) and villages in surrounding areas (FSW).

Four local Research Assistants (RAs) from the Tonga Leitis Association (TLA) and the Tonga Family Health Association (TFHA), were hired and trained by the Team Leader to assist in the collection of data. A fifth RA from TLA assisted with recruiting FSW through her network. RA training was held on 5 and 6 July 2016. Content of the training included the principles of social research, ethics, recruitment and data collection method for this study.

3.1 Population size estimation

Stakeholders from a range of Tongan health and welfare agencies and organisations were asked to provide an estimation of the number of the MSM/TG and FSW populations in Tonga. This provided a basis for the later population size estimation exercise undertaken during the roundtable meeting with key informants.

A roundtable meeting was held with key informants from a range of health and advocacy organisations. It included members of key affected organisations (MSM/TG). At this meeting, participants were asked to provide an estimation of the number of the MSM/TG and FSW populations in Tonga.

The organisations that were present at the roundtable meeting were:

- Ministry of Health (1 participant)
- Tonga Family Health Association (4 participants)
- Tonga Leitis Association (3 participants)
- Women and Children's Crisis Centre (1 participant)
- Talitha Project (1 participant).

Apologies were sent by:

- UNDP Focal Point
- Tonga National Children and Women's Centre.

After a brief presentation by Michelle O'Connor on the *Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations,* and an update on data collected to date in Tonga, the stakeholders were presented with the estimates of population size provided earlier by key informants and affected populations. The stakeholders then went on to discuss population size.

3.2 Behavioural survey and interviews

A behavioural survey captured 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 key populations' circumstances and experiences over a range of issues.

All surveys were translated into Tongan by the Ministry of Health and piloted among MSM/TG and other stakeholders to ensure that the wording was accurate and culturally appropriate. Despite this, some participants were confused or shocked by the directness of the survey questions, as sexual practices are usually covert. There are many words related to sexual practices and health that are not available in Tongan, or the literal translations are culturally inappropriate, so English words were used in some instances, or the concepts were described as practised in Tonga when talking about issues related to sex.

Snowball recruitment (FSW) and respondent-driven sampling (MSM/TG) were initially seeded by MSM/TG and FSWs who were known to the Tongan RAs. MSM and TG recruitment was supported by the Tonga Leitis Association (TLA), and FSW recruitment was supported by the Tonga Family Health Association (TFHA).

Potential participants were provided with information about the study, assured their involvement was completely voluntary, and invited to take part. Interviews were held in English or Tongan language, depending on interviewee preference, and were transcribed verbatim post-interview. Those interviews in Tongan were conducted by the RAs and translated for the Team Leader during the interview, and then clarified and checked for accuracy post-interview. Interviews took 30 minutes to one hour to complete. They were digitally recorded.

Surveys were self-administered using an electronic tablet and the Team Leader and/or RAs were available to clarify any questions. Respondents had a choice of completing surveys in Tongan or English. The surveys took approximately 30–40 minutes to complete.

All interviewees and survey respondents received T$10 to thank them for their time.

3.2.1 Men who have sex with men and transgender

MSM/TG were recruited by respondent-driven sampling. Potential MSM/TG 'seeds' were identified by the RAs, and seeds who completed the survey received three recruitment coupons to recruit other TG/MSM who are members of their network. The seeds' recruits redeemed the coupons to enrol in and complete the survey, and so on. TG were also encouraged to ask their sexual partners to complete the survey. The participants were all recruited in Nuku'alofa.

The surveys were completed at a place of choice convenient for participants. Most were completed in a private area at the TLA drop-in centre. The RAs promoted the survey through word of mouth and announcements on the TLA Facebook page, and contacted participants to follow up on potential referrals. The RAs also recruited participants at a netball trial. Each participant received T$10 for completing the survey and T$2 for each referred person who completed the survey.

Some MSM/TG who completed the survey were also invited to take part in an in-depth interview. For those who accepted, the interviews took place at the TLA office in a private room. An effort was made to ensure that participants were not from the same social networks. Participants included TG/MSM well connected to TLA and those with few links to TLA.

3.2.2 Female sex workers

The female Tongan RAs initially approached women they knew, or believed, to be involved in sex work, and snowball recruitment progressed through these initial contacts. The participants were recruited in Nuku'alofa and villages outside of the capital. Most of the surveys were conducted in a private area at the THFA office in Nuku'alofa (participants were provided with transport if requested), or in the participant's home, depending on preference. FSW who completed the survey were offered a free pap smear at the THFA clinic.

Some participants were also invited to take part in an in-depth interview. Those who agreed chose to be interviewed at the TFHA office (in a private room), or behind a canteen shop near their village outside of Nuku'alofa.

3.3 Institutional capacity assessment

In-depth interviews with key informants in services and other organisations, including government personnel, healthcare workers and NGOs, assessed the capacity of the existing institutions to undertake activities to reduce HIV-risk vulnerability among MSM, TG and sex workers.

There is very limited data on health service utilisation by MSM and TG and by FSW. Due to the legislative environment and the social and cultural context, FSW and MSM/TG may not willingly self-identify to health services. The Tonga Ministry of Health, TFHA and TLA are the identified organisations/agencies providing HIV and STI-related services and/or support for TG/MSM and FSWs in Tonga.

3.4 Ethics approval

Ethical approval for the project was obtained from the University of New South Wales Human Research Ethics Committee. Approvals to conduct the research were also obtained from the Tongan National Health Ethics and Research Committee (NHERC), Ministry of Health.

4 Results

4.1 Population size estimation

4.1.1 Methods

Stakeholders from health and welfare agencies and organisations were interviewed and asked to estimate FSW and TG/MSM populations. These estimations were presented to the key informants and stakeholders at a roundtable meeting for their consideration.

The hybrid method of estimating the population size of key affected communities in small countries involves asking a group of stakeholders and key informants about population numbers, requiring knowledge about the whereabouts and numbers of people in different locations. Participants in the population estimate process were representatives of organisations who provide services to affected populations, in addition to members of the target populations themselves (MSM/TG).

At the roundtable meeting, key informants from six Tongan agencies, including members of key affected populations, were asked to estimate the MSM/TG and FSW populations in Tonga. The group considered the numbers of FSW and MSM/TG in Tonga and came to some agreement.

4.1.2 Transgender and men who have sex with men

The participants at the roundtable meeting concluded they estimate there are approximately 1,000 MSM in Tonga including 400 Leitis/transgender (Table 1). This number was based in part on the number of MSM/TG who are reached in programs provided by the organisations present, and MSM/TG who were known in person or on social media sites to MSM/TG at the meeting as well as estimates by stakeholders.

Most of the informants felt that the MSM/TG population was likely concentrated on Tongatapu, but is also present in smaller numbers across the islands including Vava'u and Hap'apia. There was some agreement that there were 50 MSM/TG on each of these islands.

However, one MSM/TG participant estimated the number to be much higher and reported being personally aware of over 1,000 Tongan TG/MSM in Tonga on Grindr, a 'gay social network app'. Another MSM/TG knew of 200 Tongans on Grindr.

4.1.3 Female sex workers

A population estimate was conducted that engaged key informants to estimate the number of FSW in Tonga, based on participants' knowledge. The group was unable to reach consensus about the number of FSW in Tonga. As a rough estimate, the group believed that there were over 1,000 FSW in Tonga, but felt that this number reflects those women regularly engaging in sex work and not women who occasionally engage in sex work when there is a need for something (Table 1).

The number of FSW who are reached through TFHA is approximately 200 per year, and a fellowship established by the Secretariat of the Forum of Church Leaders had 65 FSW members at the time that the fellowship ended in 2012.

Table 1: Population size estimation

Informants	Location	TG/MSM	Sex workers n
Stakeholder and key affected population roundtable group	Tongatapu	300	
	Vava'u	50	
	Ha'apia	50	
Estimated number of 'hidden' straight identifying MSM		600	
	Tonga		1,000
Total		**1,000**	**1,000**

4.2 Behavioural survey

4.2.1 Transgender and men who have sex with men

4.2.1.1 Description of the sample

Seventy-three self-identifying transgender (TG) and men who have sex with men (MSM) provided survey data. In describing their gender, 24 (32.9%) participants described themselves as men, 44 (60.3%) as transgender, four (5.5%) as transsexual, and one (1.4%) as transvestite.

Participants were also asked to describe their sexual identity (Table 2). The majority of participants described their sexual identity as transgender/Fa'afafine/Fakaleiti/Avakavaine followed by MSM and gay/homosexual.

Table 2: Sexual identity

	Frequency	Percent (%)
Transgender/*Fa'afafine/Fakaleiti/Avakavaine*	26	36.6
MSM	18	25.3
Gay/Homosexual	11	15.5
Bisexual	7	9.9
Heterosexual/Straight	4	5.6
Asexual	3	4.2
Queer	1	1.4
Pansexual	1	1.4
Total	**71[1]**	**100.0**

[1] Missing data n=2.

The age of participants ranged from 16 to 49, with a mean age of 26.9 (SD=7.94) and a median age of 25.5. The sample was generally well educated, with a large majority of participants having been educated to a secondary level or higher (Table 3).

Table 3: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	2	2.8
Pre-primary/Primary	6	8.4
Pre-secondary	3	4.2
Secondary	33	45.8
Polytechnic/Diploma	19	26.4
University/College	9	12.5
Total	**72[1]**	**100.0**

[1] Missing data n=1.

In responding to the question about relationship status, almost three-quarters of the sample reported being single. About 16% reported having a boyfriend and only one person reported being married (Table 4).

Table 4: Relationship status

	Frequency	Percent (%)
Currently single	54	74.0
Have a boyfriend	12	16.4
Have a girlfriend	5	6.8
Widowed/divorced/separated	1	1.4
Currently married	1	1.4
Total	**73**	**100.0**

The majority of participants reported living with family members, mostly with parents or siblings (Table 5). Over one-quarter of the sample reported living with friends. It would appear that very few participants were living with their sexual partners.

Table 5: Who participants were living with

	Frequency	Percent (%)
Parents	33	45.2
Friends	19	26.0
Siblings	12	16.4
Other relatives	11	15.1
Live alone	2	2.7
Children	2	2.7
Other female partner	1	1.4
Boyfriend/Husband	1	1.4
Co-workers	1	1.4
Other (friend, Neighbours, Partner)	6	8.2

N=73. * Multiple answers possible.

A majority were not employed. Those who were employed were working in full-time, part-time or casual type positions (Table 5).

Table 5: Employment status

	Frequency	Percent (%)
Not employed	29	40.3
Full-time employed	22	30.6
Part-time or casual employment	16	22.2
Self-employed	5	6.9
Total*	**72[1]**	**100.0**

[1] Missing data n=1.

When asked to indicate their main job, there was a range of positions that participants reported on, including financial and business services, student, and various service and tourism-related roles. Of interest is that 31 participants responded to this question with not applicable which suggests that many of them may be involved in non-formalised areas of work (Table 7).

Table 6: Type of work

	Frequency	Percent (%)
Financial and business services	6	14.6
Student	6	14.6
Community, social and personal services	4	9.8
Transport and communication	3	7.3
Agriculture, forestry and fishing	2	4.9
Manufacturing	1	2.4
Electricity and water	1	2.4
Construction	1	2.4
Other (included airline, cleaner, counselor, first aid instructor, helpdesk, humanitarian, tourism, volunteer)	17	41.5
Total*	**41[1]**	**100.0**

[1] Missing data n=2

4.2.1.2 Sexual history and practice

All seventy-three participants reported ever having had sexual intercourse (anal or vaginal). Participants reported their first occasion of sexual intercourse occurring between the ages of three and 45, with a mean age of sexual debut being 15.921 (SD=6.69). While we cannot verify the validity of these lower ages, it is notable that 42% 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 is a robust and reliable finding.

Of the 59 participants who answered the question about having more than one sexual relationship during the same period in the previous six months (concurrent partnerships), 30 (50.8%) affirmed that they had.

4.2.1.2.1 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 8). The most common type of sexual activity that occurred on the last occasion was receptive anal intercourse, followed by masturbating one's partner, and then receptive oral sex. For most sexual practices, there was an even level of reciprocity between participants and their partners; the exception is anal intercourse, for which many more participants were receptive than insertive. This type of sexual positioning is generally more typical among transgender, which is consistent with how participants identified their gender as reported earlier.

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

	Frequency	Percent (%)
Handshake (you masturbated him)	24	33.3
Handshake (he masturbated you)	17	23.6
Oral sex (you sucked his penis)	23	31.9
Oral sex (he sucked your penis)	22	30.6
Intercrural sex (his penis between your thighs)	11	15.3
Intercrural sex (your penis between his thighs)	11	15.3
Anal intercourse (your penis inside his anus)	20	27.8
Anal intercourse (his penis inside your anus)	37	51.4

N=72. * Multiple answers possible. Missing data n=1.

4.2.1.2.1.1 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 four to 10 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	6 (10.0)	19 (29.7)
4 to 10	17 (28.3)	27 (42.2)
11 to 49	25 (41.7)	12 (18.7)
50+	12 (20.0)	6 (9.4)
Total*	**60 (100)[1]**	**64 (100.0)[2]**

[1] Missing data n=11. [2] Missing data n=9.

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 10). Almost 90% of participants who answered the question about numbers of regular male partners reported having had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. Over 85% of participants who answered the question about numbers of casual male partners had sex with at least one casual male partner during the previous 12 months, while over 70% of participants who answered the question about numbers of paying male partners 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	8 (12.9)	7 (11.1)	15 (26.3)
1 to 3	23 (37.1)	26 (41.3)	20 (35.1)
4 +	31 (50.0)	30 (47.6)	22 (38.6)
Total	**62[1] (100.0)**	**63[2] (100.0)**	**57[3] (100.0)[1]**

[1] Missing data n=11. [2] Missing data n=10. [3] Missing data n=16.

4.2.1.2.1.2 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 11. Condom use with regular partners was understandably low, though there were very few (n=4; 7.4%) who 'never' used condoms with their regular male partners. Condom use with casual partners was not noticeably different from condom use with regular male partners, which is unusual. Indeed, almost 11% of participants reported 'never' using condoms with casual male partners in the previous 12 months. Only 22 participants provided

data about condom use with paying male partners. Condom use was surprisingly low for sex with paying male partners. Almost three-quarters of the participants reporting using condoms 'sometimes'.

Reported condom use on the last occasion of anal intercourse with each of the partner types in Table 10 was at higher levels than for the 12-month period, which is to be expected. Almost 60% of participants who had anal intercourse with a regular male partner used condoms on the last occasion. Forty-four (84.6%) of the 52 men who answered the question about lubricant use on the last occasion of anal intercourse with their regular male partner reported using lube on that occasion. About 70% of participants (n=39) used a condom on the last occasion of anal intercourse with a casual male partner and 42 (75.0%) used lubrication on that last occasion. On the last occasion of anal intercourse with a paying male partner, 17 (77.3%) of the 22 participants confirmed use of condoms on that occasion and 16 (76.2%) of the 22 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	4 (7.4)	6 (10.7)	2 (9.1)
Sometimes	31 (57.4)	34 (60.7)	16 (72.7)
Almost every time	7 (13.0)	4 (7.1)	1 (4.5)
Every time	12 (22.2)	12 (21.4)	3 (13.6)
Total	**54 (100.0)**	**56 (100.0)**	**22 (100.0)[1]**

[1] Missing data n=20.

All participants were asked whether they used lubricant the last time they used a condom, to which 51 (73.9%) of the 69 who answered the question answered in the affirmative. When asked which type of lubricant they used on that occasion, the following responses were elicited: water-based lubricant (n=22; 43.1%); Vaseline (n=13; 25.5%); hand lotion (n=9; 17.6%); and baby oil (n=7; 13.7%). Fifty respondents provided data on where they had obtained lubrication on that last occasion, which included a range of sources: hospital (n=16; 32.0%), health clinic (n=8; 16.0%); client (n=8; 16.0%); friend (n=7; 14.0%); NGO (n=3; 6.0%); peer educator (n=2; 4.0%); condom dispenser (n=2; 4.0%); and pharmacy (n=2; 4.0%).

4.2.1.2.2 Sex with female partners

Twenty-four (32.9%) participants reported ever having had sexual intercourse (vagina or anal) with a female partner. These participants reported having had sex with between 1 and 100 female partners in their lifetime. Twenty (83.3%) 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 ranged from one to 55, 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	0	1 (5.9)
1 to 3	9 (52.9)	10 (58.9)
4 to 10	7 (41.2)	5 (29.5)
5+	1 (5.9)	1 (5.9)
Total*	**17[1] (100)**	**17[1] (100.0)**

[1] Missing data n=3.

Of the participants who had sex with a regular female partner in the 12 months preceding the survey, the vast majority reported using condoms 'sometimes' for vaginal intercourse and for anal intercourse. About half of the 19 and 18 respondents, respectively, reported using a condom on the last occasion of vaginal and anal intercourse with their regular partner (Table 12).

With casual female partners, about two-thirds reported using condoms 'sometimes' for vaginal and anal intercourse (Table 12). Of the 17 respondents who answered the questions about condom use on the last occasion with casual female partners, about two-thirds used a condom on the last occasion of vaginal intercourse and about half used a condom on the last occasion of 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	2 (10.5)	1 (5.6)	2 (11.8)	3 (16.7)
Sometimes	15 (79.0)	15 (83.3)	11 (64.7)	11 (61.1)
Almost every time	1 (5.3)	1 (5.6)	1 (5.9)	2 (11.1)
Every time	1 (5.3)	1 (5.6)	3 (17.6)	2 (11.1)
Total	**19[1] (100.0)**	**18[2] (100)**	**17[3] (100.0)**	**18[2] (100.0)**

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

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

Seventy participants (95.9%) reported knowing what a condom was prior to the survey, among whom 65 knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them. The places where condoms were most commonly reported to be located from included hospital, health clinic, NGO, and friends (Table 13).

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

	Frequency	Percent (%)
Hospital	14	20.3
Health clinic	13	18.8
NGO	11	15.9
Friend	6	8.7
Pharmacy	5	7.2
Never obtained condoms	5	7.2
Condom dispenser	2	2.9
Client	2	2.9
Peer educator/Outreach worker	3	4.3
Other (Family Health; Ofisipaea, TLA, Tonga Health, Tonga leitis)	8	11.6
Total	**69[1]**	**100.0**

[1] Missing data n=1.

The most commonly reported reasons for not using condoms with male partners included condoms taking away pleasure, partner objecting to the use of condoms, condoms not being available, and not liking condoms. The most reported reasons for not using condoms with female partners included condoms taking away pleasure, being in a monogamous relationship, and perceiving the use of condoms as unnecessary (Table 14).

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

	Male partners n=62 (%)	Female partners n=18 (%)
Condoms take away pleasure	21 (33.9)	4 (22.2)
Do not like condoms	9 (14.5)	2 (11.1)
Condoms were not available	10 (16.1)	2 (11.1)
Difficulty obtaining condoms	3 (4.8)	2 (11.1)
My partner(s) and I are faithful	7 (11.3)	4 (22.2)
Partner objected	13 (21.0)	2 (11.1)
Not necessary	9 (14.5)	4 (22.2)
Condoms are too expensive	0	0
Used other prevention methods	5 (8.1)	0
Other (‘because I like him’, ‘no’, ‘were not available’)	2 (3.2)	0

* Multiple answers possible.

4.2.1.3 Sexually transmissible infections including HIV

Fifty-five (75.3%) 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. Eight participants reported having had genital discharge in the 12 months preceding the survey, four reported genital ulcers or sores, and six 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 not noticing the symptoms, or visiting a clinic or hospital or a health care worker.

Five participants reported having ever been diagnosed with a sexually transmissible infection (STI), including gonorrhoea (n=1), genital herpes (n=1), genital warts (n=1) chlamydia (n=1), and one person reported ‘PELA’ (genital or vaginal discharge).

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

	Frequency	Percent (%)
Never noticed these symptoms	4	36.4
Visited a private clinic	2	18.2
Visited an STI clinic	2	18.2
Visited a hospital	2	18.2
Visited a health care worker	2	18.2
Talked to a friend	1	9.1
Did nothing	1	9.1
Received traditional treatment	0	–
Got medicine from pharmacy	0	–
Other (no text responses provided)	2	18.2

N=11. * Multiple answers possible. Missing data n=1.

Fifty-eight (79.5%) 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, and radio (Table 16).

Table 16: Sources of information about HIV and AIDS *

	Frequency	Percent (%)
Television	26	44.8
NGO program	23	39.7
Radio	17	29.3
Friends or family	13	22.4
School	12	20.7
Newspapers/Magazines	11	19.0
Pamphlets/Leaflets	11	19.0
Workplace	10	17.2
Posters/Billboards	7	12.1

N=58. * Multiple answers possible. Includes only those respondents who reported having heard of HIV or AIDS.

The 58 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 ranged from moderate (57.9%) to high (91.2%). Twelve (20.7%) of the 58 participants answered all 10 questions correctly, while 60% of respondents answered at least six of the 10 questions correctly. The lowest score recorded was for two participants with only three correct answers.

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?	42 (73.7)	12 (21.1)	3 (21.1)	57[1] (100)
Do people get HIV because of something they have done wrong?	52 (91.2)	3 (5.3)	2 (3.5)	57[1] (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	13 (22.8)	42 (73.7)	2 (3.5)	57[1] (100)
Can a person get HIV by sharing food with someone who is infected?	49 (86.0)	7 (12.3)	1 (1.8)	57[1] (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	17 (29.8)	38 (66.7)	2 (3.5)	57[1] (100)
Can a healthy-looking person have HIV?	18 (31.6)	38 (66.7)	1 (1.8)	57[1] (100)
Can people be cured from HIV by a traditional healer?	52 (91.2)	5 (8.8)	0	57[1] (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	7 (12.3)	49 (86.0)	1 (1.8)	57[1] (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	8 (14.0)	47 (82.5)	2 (3.5)	57[1] (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	21 (36.8)	33 (57.9)	3 (5.3)	57[1] (100)

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

4.2.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 58 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).

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?	7 (12.1)	50 (86.2)	1 (1.7)	58 (100)
If a member of your family had HIV, would you want it to remain secret?	35 (61.4)	22 (38.6)	0	57[1] (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	16 (28.1)	41 (71.9)	0	57[1] (100)

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

4.2.1.5 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. Almost 20% of participants were aware of someone they knew being denied health services in the previous 12 months as a result of living with HIV or being suspected of living with HIV (Table 19).

Table 19: Evidence of stigma and discrimination observed in the community*

	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?	44 (77.2)	11 (19.3)	2 (3.5)	57[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?	49 (84.5)	4 (6.9)	5 (8.6)	58 (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?	49 (86.0)	5 (8.8)	3 (5.3)	57[1] (100)

N=9. * Includes only those participants who reported having heard of HIV or AIDS. [1] Missing data n=1.

Participants reported on the reactions of various people to their sexual identity (Table 20). Some participants had experienced stigmatising attitudes, particularly from family members and from other people. About one-third of participants reported that each of these groups of people were unaware of their sexual identity. Around 40 to 50% of respondents indicated 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=70 (%)	Reaction of other people n=68 (%)	Reaction of employer or co-workers n=40 (%)
They don't know at all	24 (34.3)	27 (39.7)	9 (22.5)
They support my identity	26 (37.1)	27 (39.7)	21 (52.5)
They ignore me/refuse to talk to me	5 (7.1)	5 (7.4)	2 (5.0)
They criticized/blamed/verbally abused me	4 (5.7)	5 (7.4)	1 (2.5)
They conduct violence/physical abuse on me	2 (2.9)	4 (5.9)	1 (2.5)
They lock/restrict me	2 (2.9)	NA	NA
They kicked me out of the family/group	6 (8.6)	2 (2.9)	NA
They force me to work more	7 (10.0)	NA	NA
They gossip about me	NA	15 (22.1)	5 (12.5)
They fired me from work	NA	NA	3 (7.5)
Other	3 (4.3)	0	0

* Multiple answers possible. NA=not applicable.

4.2.1.6 Emotional and physical well-being

Participants were asked to indicate whether they had experienced any of a list of thoughts and feelings because of their sexual identity in the preceding 12 months. The most commonly reported responses included feeling ashamed, feeling guilty, blaming oneself and having low self-esteem (Table 21).

Table 21: Participants' negative thoughts and feelings about their sexual identity in the last 12 months

	Frequency	Percent (%)
I feel ashamed	33	55.0
I feel guilty	18	30.0
I blame myself	10	16.7
I have low self-esteem	7	11.7
I feel I should be punished	3	5.0
I feel suicidal	2	3.3
I blame others	1	1.7

N=60. * 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). There were generally around 2% to 20% 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, withdrawing from education/training, deciding to stop working, and isolating oneself from family and/or friends.

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

	Frequency	Percent (%)
I decided not to get married	11	21.2
I withdrew from education/training	8	15.4
I decided to stop working	7	13.5
I have isolated myself from my family and/or friends	6	11.5
I have chosen not to attend social gathering	5	9.6
I decided not to have children	5	9.6
I decided not to apply for a job or for a promotion	5	9.6
I decided not to have sex	4	7.7
I avoided going to a hospital when I needed to	3	5.8
I avoided going to a local clinic when I needed to	1	1.9

N=52. * Multiple answers possible.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Twelve (17.4%) of 69 participants 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 a stranger (n=6), casual partner (n=4), boyfriend/husband (n=3), friend (n=3), paying partner (n=1), police (n=1), casual partner (n=1) and family member (n=1). Note that multiple answers were possible which accounts for some participants being sexually assaulted on more than one occasion.

4.2.1.7 Access to health services

All participants were asked whether they knew where they could access a range of health services. Only a minority of respondents knew how to access the services shown in Table 23. The service for which almost 50% knew where to access was HIV and STI testing.

Table 23: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Condoms	53 (73.6)	16 (22.2)	3 (4.2)	72 (100.0)
Health-related information	42 (58.3)	27 (37.5)	3 (4.2)	72 (100.0)
Support	52 (72.2)	17 (23.6)	3 (4.2)	72 (100.0)
HIV and STI testing	35 (48.6)	34 (47.2)	3 (4.2)	72 (100.0)
HIV and STI treatment	52 (72.2)	17 (23.6)	3 (4.2)	72 (100.0)

Forty-five (61.6%) 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: Family Health Association, Family Planning (TFHA), Fili Tonu (TFHA drama group), Ikai keu ilo eau ha feituu pehe, Koe kau neesi fkkolo, Ofahepaea, Ofisi kau leiti (TLA office), Seno, Talitha Project, Tonga Leities (TLA office), village clinic.

For all of the services presented in Table 24, participants were more likely to have used the service than not to have used the service. Participation in an HIV peer education program has been particularly well attended, with 71.2% 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?	10 (13.7)	34 (46.6)	29 (39.8)	73 (100.0)
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?	25 (34.2)	43 (58.9)	5 (6.8)	73 (100.0)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	21 (28.8)	41 (56.2)	11 (15.1)	73 (100.0)
Have you ever participated in an HIV peer education program?	19 (26.0)	52 (71.2)	2 (2.7)	73 (100.0)

The 43 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). Almost all respondents were generally satisfied and would use the service again. A high proportion indicated feeling uncomfortable or embarrassed, which may not be a criticism of the service but rather a reflection of community

taboos about sex and sexuality. Eight participants reported that they would like to receive additional information about HIV as well as contact details for any support services.

Table 25: Feedback about the health service*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total
The service was easy to access or find	2 (4.8)	1 (2.4)	1 (2.4)	33 (78.6)	5 (11.9)	42[1] (100.0)
The health worker I saw was friendly and easy to talk to	1 (2.3)	1 (2.3)	2 (4.7)	30 (69.8)	9 (20.9)	43 (100.0)
I felt uncomfortable and embarrassed	2 (4.9)	10 (24.4)	2 (4.9)	19 (46.3)	8 (19.5)	41[2] (100.0)
The service was confidential and I felt my privacy was respected	1 (2.3)	1 (2.3)	3 (7.0)	27 (62.8)	11 (25.6)	43 (100.0)
I could get what I needed eg condoms, contraceptives, HIV and STI test, etc	1 (2.3)	1 (2.3)	2 (4.7)	30 (69.8)	9 (20.9)	43 (100.0)
I would use the service again if I needed to	0	0	3 (7.0)	25 (58.1)	15 (34.9)	43 (100.0)

* Includes only those participants who reported using the service. [1] Missing data n=1. [2] Missing data n=2.

4.2.1.8 HIV testing

Forty-six (63.0%) 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. Forty-three participants reported having ever had an HIV test and 41 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=10); hospital/government health service (n=6); NGO clinic (n=19); and Tonga Family Health Association (n=7). The Tonga Family Health clinics in Nuku'alofa and Vava'u are the only NGO clinics in Tonga, therefore the latter two are likely to be referring to the same clinics. Thirty-nine of the 43 participants who had an HIV test in the previous 12 months reported receiving their results. Of these, 40 chose to answer the question about their HIV status, which they reported to be HIV-negative (n=32), HIV-positive (n=1) or don't know result (n=7). The person with HIV chose not to report the year in which the HIV diagnosis occurred and did report not being on antiretroviral treatments.

4.2.1.9 Alcohol and drug use

Fifty-seven respondents reported drinking alcohol in the preceding four weeks, with a majority 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 drink to 58 drinks, the latter appearing to be improbable unless drinks contained very low alcohol or were consumed over multiple days which may have occurred with an event. Twelve drinks was the median number consumed on the last occasion of alcohol use, which appears to be very high.

Table 26: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	9 (12.5)
Never in the last 4 weeks	6 (8.3)
Less than once a week	21 (29.2)
At least once a week	35 (48.6)
Every day	1 (1.4)
Total	**72[1] (100.0)**

[1] Missing data n=1.

Participants were asked whether they had taken a range of drugs during the preceding 12 months. The most widely used drugs were reported to be kava (n=6), freebase (n=6), marijuana (n=10), heroin (n=4), amphetamine (n=4), crystal (n=4), ecstasy (MDMA) (n=3), inhalants (n=3) and cocaine (n=3). 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, 38 participants responded in the affirmative.

4.2.1.10 Visited the United States

Seven participants reported ever having visited the United States. The reported reason for these visits was predominantly for a holiday (n=5); other responses were visiting relatives (n=1) and visiting friends (n=1). The length of stay during these visits ranged from less than four weeks to between one and six months. In response to the question about ever having been deported from the United States, all seven of the participants reported that they had not.

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

Fifty-eight (80.6%) 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).

4.2.2 Female sex workers

4.2.2.1 Description of the sample

Eighty-two women who sold sex in exchange for money or goods provided survey data. The age of the women ranged from 17 to 49, with a mean age of 26.65 (SD=7.23) and a 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	3	3.7
Pre-primary/Primary	7	8.6
Pre-secondary/Secondary	57	69.5
Polytechnic/Diploma	6	7.3
University/College	7	8.5
Other	2	2.4
Total	**82**	**100.0**

In responding to the question about relationship status, the majority of women reported being ‘single’ or having a boyfriend (Table 28). About one-quarter of the women indicated that they were widowed or divorced or separated.

Table 28: Relationship status

	Frequency	Percent (%)
Currently single	27	32.9
Have a boyfriend but not married	22	26.8
Widowed/Divorced/Separated	20	24.4
Currently married	11	13.4
Have a girlfriend	2	2.4
Total	**82**	**100.0**

Fifty-five women (67%) reported having children, among whom the majority had either one (n=18) or two (n=18) children. Six women had five or more children, with one woman reporting having nine.

Women were most likely to live with relatives, including children, parents/in-laws and other relatives. About-one third of the women lived with their boyfriend or husband (Table 29).

Table 29: Whom participants were living with

	Frequency	Percent (%)
Children	27	34.2
Parents/In-laws	24	30.4
Other relatives	18	22.8
Boyfriend	18	22.8
Friends	15	19.0
Siblings	13	16.5
Husband	9	11.4
Other male partner	6	7.6
Live alone	3	3.8
Co-workers	2	2.5
Other (no text provided)	7	8.9

N=79. * Multiple answers possible. Missing data n=3.

Women were asked whether they were employed, to which the majority reported that they were (Table 30). A sizeable proportion of women reported not being employed.

Table 30: Employment status

	Frequency	Percent (%)
Not employed	33	40.2
Full-time employed	20	24.4
Part-time or casual employment	19	23.2
Self-employed	10	12.2
Total	**82**	**100.0**

The 49 women who were employed were asked what paid work they were involved in. Multiple answers were possible and some women reported more than one of the categories of work shown in Table 31. The majority of women reported being involved in retail or hospitality.

Table 31: Type of paid work*

	Frequency	Percent (%)
Retail	17	34.7
Hospitality	17	34.7
Sewing	9	18.4
Government	6	12.2
Other	12	24.5

N=49. * Multiple answers possible. [1] Missing data n=1.

4.2.2.2 Sexual history and practice

Seventy-nine women (96.3%) reported ever having had sexual intercourse. The age at which they first had sexual intercourse ranged from 13 to 24 years. All of the women acknowledged receiving money or goods in exchange for sex. The age at which they reported first receiving money or goods in exchange for sex ranged from 15 to 25 years, which indicates that some of the women were not adults at the time they commenced sex work.

4.2.2.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses ranged from two to 900 male partners, with a median of seven and a mean of 36 partners (Table 35). It may be the case that many of the women do not consider male clients as sex partners. The number of male sex partners reported in the last 12 months ranged from one to 500, with a median of three and a mean of 10 partners. Thirty eight (67.9%) of the 56 women who answered 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 32: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
1 to 3	14 (17.3)	43 (53.1)
4 to 10	37 (45.7)	30 (37.0)
11 to 49	20 (24.7)	7 (8.7)
50+	10 (12.3)	1 (1.2)
Total	**81[1] (100)**	**81[1] (100.0)**

[1] Missing data n=1.

4.2.2.2.2 Condoms

Fifty-six (68.3%) of the 82 women had ever heard of a condom. Among these 56 women, 43 had ever used a condom. Forty-seven women reported knowing where they could obtain condoms. When asked where they had last obtained condoms, the most common responses included friend, client and health clinic (Table 33). These responses indicate that women are heavily reliant on other people to provide condoms, which is clearly not an ideal situation.

Table 33: Where condoms were last obtained

	Frequency	Percent (%)
Friend	13	28.9
Client	8	17.8
Health clinic	7	15.6
NGO	5	11.1
Hospital	4	8.9
Pharmacy	3	6.7
Condom dispenser (bar/nightclub/restaurant/other venue)	2	4.4
Peer education	1	2.2
Workplace	1	2.2
Other	1	2.2
Total	**45**	**100.0**

4.2.2.2.3 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 200 partners with a mean of 5.83 (SD=21.98) and a median of three paying partners. About three-quarters of the women reported having five or fewer paying partners in the preceding six months, which suggests that they are seeing a lot of repeat customers (that is, much of their work is with regular paying partners). There may also be some underreporting of the actual number of paying partners they had sex with. Indeed, when asked how many paying partners they had on the last day that they had paid sex, a majority (81.6%) of the 76 women who answered this question reported two or more paying partners, while three women reported 10 or more partners.

4.2.2.2.3.1 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 34). The most common practice was vaginal intercourse, followed by masturbating the client and fellatio.

Table 34: Types of sexual activity on last occasion of sex with a paying male partner (n=81)*

	Frequency	Percent (%)
Vaginal intercourse	67	82.7
Handshake (you masturbated him)	61	75.3
Oral sex (you sucked his penis)	61	75.3
Handshake (he masturbated you)	52	64.2
Oral sex (he licked your vagina)	50	61.7
His penis between your thighs or breasts	34	42.0
Anal intercourse	19	23.5

* Multiple answers possible. Missing data n=1.

4.2.2.2.3.2 Where sex with paying male partners takes place

Women were asked where they had sex with their last paying client (Table 35). The most common response was at the homes of their clients, as well as outside, in the car or at a hotel.

Table 35: Where sex occurred on the last occasion of paid sex

	Frequency	Percent (%)
His house	21	25.9
Outside (eg bushes, beach, etc)	20	24.7
Car	13	16.0
Hotel	12	14.8
My house	8	9.9
Workplace	3	3.7
Other (reported: Ikai koe fai pe he lotolelei)	4	4.9
Total	**81[1]**	**100.0**

[1] Missing data n=1.

4.2.2.2.3.3 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 by their clients or themselves, which appears to suggest that the amount is often negotiated (Table 36).

Table 36: Who decides how much the woman gets paid for sex with a client (n=79)*

	Frequency	Percent (%)
Paying partner decides	51	64.6
I decide	47	59.5
Agent/Pimp decides	5	6.3
Manager of the business (eg Madam in brothel)	1	1.3

* Multiple answers possible. Missing data n=1.

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

Condom use with paying clients was relatively low for vaginal and anal intercourse (Table 37). A majority of women reported using condoms ‘never’ or ‘sometimes’ for vaginal intercourse with paying partners in the past 12 months. On the last occasion of vaginal intercourse with a paying partner, 12 women reported using a condom. Condom use was also low for anal intercourse with paying partners. Only two (10.6%) of the 19 women reported using condoms ‘almost every time’ or ‘every time’ for anal intercourse with paying partners. Three women reported using a condom on the last occasion of anal intercourse with a paying partner. Eleven of the 19 women who had anal intercourse with paying partners answered the question about use of lubricant on the last occasion of anal

intercourse. Five (45.5%) of the 11 women confirmed that they had used lubrication on that occasion, which is a higher number (n=3) than used condoms on that same occasion.

Table 37: 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	25 (37.9)	8 (42.1)
Sometimes	30 (45.5)	9 (47.4)
Almost every time	3 (4.5)	1 (5.3)
Every time	8 (12.1)	1 (5.3)
Total	**66[1] (100.0)**	**19[2] (100.0)**

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

Sixty-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 using other prevention methods (Table 38). Nineteen women reported having had sex without a condom because the paying partner paid extra money for no condom to be used.

Table 38: Reasons for not using condoms for vaginal and/or anal intercourse with paying partners*

	Paying male partners n=68 (%)
Condoms were not available	23 (33.8)
Condoms take away pleasure	22 (32.4)
Partner objected	16 (23.5)
Used other prevention methods	14 (20.6)
Never heard of condoms	8 (11.8)
Do not like condoms	7 (10.3)
Not necessary	7 (10.3)
Difficulty obtaining condoms	6 (8.8)
Used other protection methods	6 (8.8)
My partner(s) and I are faithful	1 (1.5)
Condoms are too expensive	1 (1.5)

* 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. Almost 15% of the

women did not even try to get their clients to use condoms and it is not entirely clear why that was the case (Table 39).

Table 39: Level of difficulty in getting clients to use a condom

	Paying male partners n (%)
None of the time	27 (39.1)
A little of the time	5 (7.2)
Some of the time	12 (17.4)
A lot of the time	11 (15.9)
All of the time	4 (5.8)
I did not try and get my clients to use a condom	10 (14.5)
Total	**69 (100.0)**

When asked who usually supplies the condom for sex with paying partners, 14 women chose not to answer this question. The majority of women who answered the question reported that they never used a condom. Supplying the condom appears to occur mostly by the woman and to a lesser extent by the paying partner (Table 40).

Table 40: Who usually supplies the condom with paying partners?

	Paying male partners n (%)
I never use a condom	31 (45.6)
I provide the condom	21 (30.9)
Client provides the condom	14 (20.6)
Owner/Manager of the place	2 (2.9)
Total	**68[1] (100.0)**

[1] Missing data n=14.

4.2.2.2.4 Sex with regular male partners

Sixty-eight (82.9%) women reported having had sex with a boyfriend or husband in the previous 12 months.

4.2.2.2.4.1 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 41). Condom use was low, as generally expected for sex with regular partners. The patterns of condom use appear remarkably similar to condom use with paying partners, which suggests a habit in their condom use and perhaps not being entirely clear on why they are using condoms. A majority of women reported ‘never’ or ‘sometimes’ using a condom for vaginal intercourse with their regular male partner. On the last occasion of vaginal intercourse with that partner, 14 women reported using a condom.

Condom use for anal intercourse with regular male partners showed a similar pattern as for vaginal intercourse. A majority of women had 'never' or 'sometimes' used condoms for anal intercourse with their main partner and only seven women used a condom on the last occasion of anal intercourse with that partner.

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

Regularity of condom use	Vaginal intercourse[1] n (%)	Anal intercourse[2] n (%)
Never	27 (41.5)	21 (46.7)
Sometimes	29 (44.6)	18 (40.0)
Almost every time	6 (9.2)	4 (8.9)
Every time	3 (4.6)	2 (4.4)
Total	**65[1] (100.0)**	**45[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 (Table 43). A range of responses was endorsed, with the most common being condoms not being available, condoms taking away pleasure, and partner objecting. Other responses – including not necessary, used prevention and protection methods, and faithfulness in the relationship – indicate that some women do not perceive any need to use condoms with their regular male partner. One woman indicated that she did not use condoms because of her Catholic faith.

Table 42: Reasons for not using condoms for vaginal and/or anal intercourse with regular male partner(s)*

	Regular male partners n=54[1] (%)
Condoms were not available	29 (53.7)
Condoms take away pleasure	14 (25.9)
Partner objected	13 (24.1)
Used other prevention methods	9 (16.7)
Not necessary	8 (14.8)
Never heard of condoms	7 (13.0)
Used other protection methods	6 (11.1)
Difficulty obtaining condoms	6 (11.1)
Do not like condoms	5 (9.3)
My partner(s) and I are faithful	4 (7.4)
Condoms are too expensive	0
Other (*Fepaki mo eku tui fakalotu*; I am catholic)	2 (3.7)

* Multiple answers possible. [1] Includes only those women who had a regular male partner and did not use condoms all the time.

4.2.2.2.5 Sex with casual male partners

Fifty-eight (70.7%) of the women reported having had sex with a casual non-paying male partner in the previous 12 months.

4.2.2.2.5.1 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 43). Condom use was particularly low for vaginal intercourse with casual male partners, with almost two-thirds of the women reporting ‘never’ using a condom. Only three 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 also low, with 75% reporting they ‘never’ used condoms in the last 12 months. Only one woman indicated that she had used a condom on the last occasion of anal intercourse with a casual male partner. Seven women confirmed that they had used lubrication on the last occasion of anal intercourse with a casual male partner, a higher rate than for condom use.

Table 43: 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	36 (64.3)	27 (75.0)
Sometimes	13 (23.2)	5 (13.9)
Almost every time	3 (5.4)	2 (5.6)
Every time	4 (7.1)	2 (5.6)
Total	**56 (100.0)[1]**	**36 (100.0)[2]**

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

4.2.2.3 Alcohol and drug use

Fifty-nine (73.7%) women reported drinking alcohol in the preceding four weeks (Table 44). Of those who reported drinking alcohol in that period, a majority had drunk alcohol at least once a week. In responding to the question about the number of drinks they consumed on the last occasion that they drank alcohol, there was apparently very high consumption with a majority of women reporting 10 drinks or more. Eight women reported drinking 20 drinks or more on that last occasion, which seems implausible unless drinks were highly diluted with water or soft drink or that the last occasion was spread out over several days.

Table 44: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	8 (10.0)
Never in the last 4 weeks	13 (16.3)
Less than once a week	25 (31.3)
At least once a week	30 (37.5)
Every day	4 (5.0)
Total	**80[1] (100.0)**

[1] Missing data n=2.

Participants were asked whether they had taken a range of drugs during the preceding 12 months (Table 45). The most widely used drugs included marijuana, inhalants, kava and crystal.

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, 41 women (50.0%) responded in the affirmative.

Table 45: Use of recreational and illicit drugs in the past 12 months*

	n (%)
Marijuana	42 (51.2)
Inhalants (eg sniffing glue, paint, petrol, spray can)	23[4] (28.4)
Kava (sakau/ava/awa)	21[5] (26.3)
Crystal/Ice (methamphetamine)	17[2] (21.8)
Cocaine	4[1] (5.2)
Heroin	2[1] (2.6)
Freebase	2[3] (2.6)
Ecstasy/MDMA	3[3] (3.9)
Amphetamine (speed)	0
Other (‘Ikai mahino’)	3[3] (3.9)

N=82. * Multiple answers possible. [1] Missing data n=5. [2] Missing data n=4. [3] Missing data n=6. [4] Missing data n=1. [5] Missing data n=2.

4.2.2.4 Sexually transmissible infections including HIV

Fifty-three women reported ever having heard of diseases that can be transmitted sexually. Twenty-two (26.8%) reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months. Four women reported genital discharge in the 12 months preceding the survey, three reported genital ulcers or sores, and 22 reported ever having had pain while urinating. These 22 women were asked what they did the last time they had any of these symptoms (Table 46). These women generally talked to a friend or visited a hospital or an STI clinic. Three women did nothing. Fifteen women reported ever having been diagnosed with a sexually transmissible infection (STI), which included gonorrhoea (n=10), thrush (n=3) and chlamydia (n=7).

Table 46: What participants did the last time they had STI symptoms (n=20)*

	Frequency	Percent (%)
Talked to a friend	12	60
Visited a hospital	8	40
Visited an STI clinic	4	20
Did nothing	3	15
Visited a health care worker	3	15
Visited a private clinic	1	5
Got medicine from pharmacy	1	5
Received traditional treatment	0	–
Never noticed any of these symptoms	0	–

* Multiple answers possible. Missing data n=2.

Forty-six women (56.8%) reported having ever heard of HIV or the disease called AIDS prior to the survey, which is surprisingly low. There was a range of reported sources of information about HIV and AIDS. The most commonly reported were radio, friends or family, school, television, and newspapers and magazines (Table 47). Four women reported knowing someone who was infected with HIV.

Table 47: Sources of information about HIV and AIDS (n=45)*

	Frequency	Percent (%)
Radio	32	71.1
Friends or family	27	60.0
School	19	42.2
Television	19	42.2
Newspapers/Magazines	18	40.0
Workplace	15	33.3
Posters/Billboards	16	35.6
Pamphlets/Leaflets	13	28.9
NGO program	19	42.2

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

4.2.2.5 Knowledge about HIV and AIDS

The women who had previously heard about HIV (n=46) were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 48. Correct knowledge was reasonably low, with a majority answering less than half of the questions correctly. Four women answered all 10 questions incorrectly and only three women answered all 10 questions correctly. There is clearly scope for improved knowledge in addition to HIV awareness.

Table 48: Knowledge about HIV and AIDS (n=46)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	17 (37.0)	13 (28.3)	16 (34.8)	46 (100)
Do people get HIV because of something they have done wrong?	29 (63.0)	3 (6.5)	14 (30.4)	46 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	9 (19.6)	25 (54.3)	12 (26.1)	46 (100)
Can a person get HIV by sharing food with someone who is infected?	16 (34.8)	11 (23.9)	19 (41.3)	46 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	9 (19.6)	25 (54.3)	12 (26.1)	46 (100)
Can a healthy-looking person have HIV?	14 (30.4)	20 (43.5)	12 (26.1)	46 (100)
Can people be cured from HIV by a traditional healer?	19 (41.3)	6 (13.0)	21 (45.7)	46 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	4 (8.7)	27 (58.7)	15 (32.6)	46 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	7 (15.2)	15 (32.6)	24 (52.2)	46 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	10 (21.7)	13 (28.3)	23 (50.0)	46 (100)

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

4.2.2.6 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, a majority would not buy fresh vegetables from someone they knew had HIV. These somewhat stigmatising attitudes towards people living with HIV may be related to low levels of knowledge about HIV in this group (Table 49).

Table 49: 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?	18 (40.0)	26 (57.8)	1 (2.2)	45[1] (100)
If a member of your family had HIV, would you want it to remain secret?	20 (47.6)	20 (47.6)	2 (4.8)	45[1] (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	24 (54.4)	11 (24.4)	10 (22.2)	45[1] (100)

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

4.2.2.7 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 50). 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 50: 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?	34 (73.9)	4 (8.7)	8 (17.4)	46 (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?	34 (75.6)	4 (8.9)	7 (15.6)	45[1] (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?	32 (69.6)	5 (10.9)	9 (19.6)	46 (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. Seventeen (20.7%) of the 82 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 boyfriend or husband (n=11), man who paid for sex (n=7), casual partner (n=7), family friend (n=3), family member (n=3), stranger (n=1), employer (n=1) or police (n=1).

4.2.2.8 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 51). About one-third of the women did not know where to access any of the services shown in Table 51. The service that most participants knew where to access was support. Fewer than 20% of the women knew where to access HIV and STI testing or treatment services, which is problematic. There is clearly scope to improve knowledge about accessing these health services for this group of women.

Table 51: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Support	22 (28.6)	31 (40.3)	24 (31.2)	77[1] (100)
Health-related information	12 (15.6)	41 (53.2)	24 (31.2)	77[1] (100)
HIV and STI testing	40 (51.9)	13 (16.9)	24 (31.2)	77[1] (100)
HIV and STI treatment	38 (49.4)	15 (19.5)	24 (31.2)	77[1] (100)
Condoms	35 (45.5)	18 (23.4)	24 (31.2)	77[1] (100)

[1] Missing data n=5.

Twenty-eight women (34.1%) 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 names were mentioned: Tonga Family Health, Health Center at Vaiola Motua, Family Planning (different names for TFHA), Clinic Houma, Falemahaki (hospital), Health Center at Vaiola Motua, Private Clinic and Pharmacy, and Hospital.

The 28 women who knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault were asked about their experience with each of the services shown in Table 52. Two of the services presented in Table 52 were utilised by about three-quarters of these women. Fewer women had experienced peer education programs.

Table 52: 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?	15 (53.6)	13 (46.4)	0	28 (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?	2 (7.1)	22 (78.6)	4 (14.3)	28 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	4 (14.3)	20 (71.4)	4 (14.3)	28 (100)
Have you ever participated in an HIV peer education program?	17 (60.7)	7 (25.0)	4 (14.3)	28 (100)

Of the 22 women who had visited a health service for information or services related to condoms, family planning, HIV and STIs or sexual assault, they generally rated their experience as positive and all but one of these women would use the service again (Table 53). The aspect of their experience which they rated least favourably was in relation to feeling uncomfortable and embarrassed, with which 10 women agreed. This may or may not

have had more to do with their own levels of comfort with the subject matter than with the service per se.

Table 53: Feedback about the health service

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	1 (4.5)	0	12 (54.5)	9 (40.9)	22 (100)
The health worker I saw was friendly and easy to talk to	0	1 (4.5)	0	12 (54.5)	9 (40.9)	22 (100)
I felt uncomfortable and embarrassed	7 (31.8)	5 (22.7)	0	10 (45.5)	0	22 (100)
The service was confidential and I felt my privacy was respected	0	1 (4.5)	0	11 (50.0)	10 (45.5)	22 (100)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	0	1 (4.5)	0	10 (45.5)	11 (50.0)	22 (100)
I would use the service again if I needed to	0	1 (4.5)	0	10 (45.5)	11 (50.0)	22 (100)

* Includes only those women who reported using the service.

4.2.2.9 HIV testing

Twenty-six women (56.5%) believed it was possible for someone in their community to get a test to find out if they were infected with HIV and all 25 of these women knew where to go to receive such a test. Twelve women reported having had an HIV test, among whom nine had an HIV test in the 12 months prior to the survey. These nine women reported that their test was carried out through an NGO clinic (n=7) or the hospital/government health service (n=3), with one woman answered yes to both NGO and hospital. Eleven of the 12 women who had ever had a test confirmed that they had received their test results. Based on these results, all 11 women reported being HIV-negative.

4.2.2.10 Visited the United States

Twelve women reported ever having visited the United States. The reported reasons for these visits was predominantly for a holiday and to visit relatives: visit relatives (n=8), holidaying (n=6) and visiting friends (n=1). The length of stay during these visits ranged from less than four weeks to between six and 12 months, with all but one woman staying less than six months. In response to the question about ever having been deported from the United States, one woman confirmed that she had been deported.

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

Fifty-seven (69.5%) 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).

4.3 In-depth interviews

4.3.1 Transgender and men who have sex with men

In-depth interviews were conducted with eight participants who were born male and had sex with men and/or women. One identified as a male and gay, and another as a male and bisexual. The other six participants identified as transgender/*leiti* women. TG interviewees used the Tongan terms *fakaleitis* or *leitis* to refer to TG, MSM and gay people. Interviews took place in a private space at the Tongan Leitis Association (TLA) office in July 2016.

Sex between men is highly stigmatised (and illegal) in Tonga. The first diagnosed case of HIV in Tonga was reportedly a transgender person. As a result, there is said to be a perception among some in the community that TG people introduced HIV to Tonga. However, many of the TG interviewees said that they were accepted by their families. They felt useful and often valued for their involvement in female roles in the household and community, including childcare, cooking, catering and flower arranging at church. Some of the interviewees had respected jobs in the community. However, interviewees had all experienced sexual violence or abuse from community members and, in some cases, from family. Interviewees drew support from other TG people and a well-organised TG advocacy group (TLA).

Committed long-term relationships were hidden and tended to be with heterosexual 'straight' men before (or after) their heterosexual partner married. No interviewees currently had a 'public' boyfriend, although they often longed for a stable relationship or preferred casual relationships to avoid heartache from failed long-term relationships. All of the interviewees had participated in transactional sex and/or identified as commercial sex workers. Sexual partners were usually local 'straight' males and, occasionally, foreigners. Two interviewees had also worked as sex workers in New Zealand, but had returned to Tonga.

TG interviewees often paid local men or adolescent boys for sex, unless they were perceived to have a particularly feminine appearance – in which case, they were paid by locals for sex. Sex was exchanged for money, alcohol, cigarettes or lifts home. In New Zealand, one interviewee also exchanged sex for services with other Tongan men (such as getting a computer fixed).

The interviewees stated that condoms were readily available, but lubricant was not. Despite the availability of condoms, their use was sporadic. Access to health services was adequate in Tongatapu, as interviewees had identified a non-judgemental health service where they felt comfortable. At other locations, interviewees were apprehensive about being judged or were concerned about privacy. Resource constraints could prevent the provision of appropriate STI screening and appropriate tests were sometimes not available.

4.3.1.1 Gender and sexual identity

One interviewee described himself as a bisexual man; another described himself as a gay/*leiti*/man; and six interviewees described their gender as *fakaleiti*, *leiti* or transgender women. The TG interviewees used the female pronoun to describe themselves and used the term 'girl' or 'ladies' when referring to themselves or other *leitis*. One interviewee expressed a desire to undergo gender reassignment, and noted that some *leitis* she knew had been taking hormones prescribed by a doctor in Nuku'alofa.

Lee[1] described herself as a woman in a man's body:

> I identify myself as a *leitis* because I'm in a man's body, but 95% of my whole life is a woman. I feel that I am a woman, like I can talk like a woman, move like a woman, it's my gender identity. [Lee]

Interviewees often used the term *leiti* to refer to both TG and MSM, and they noted that community members also did not make the distinction. But for Ofa, *leiti* was a term that other Tongans labelled him with because of his "voice, the tone, my preferences in sexuality". He at first described his sexual orientation as "gay" and his gender as *leiti*, but then went on to say that it is other people who identify him as *faka/leiti* and that he would like others to view him as a man:

> People identify me, 'oh he is a *fakaleitis*' [but] I don't cross-dress, I never wear anything, it is just their perspective, just their perceptions because I am not acting [like] a normal boy … I would like my community to see I am a man. [Ofa]

Ofa defined TG as men who identify themselves as a woman, who cross-dress who and put on make-up. He believed that people viewed him as TG because of his effeminate nature, although, like TG people, he did not know if he was a "man or a girl". Although he would like to be viewed by others as a man, he felt that this would never happen because he is same-sex attracted:

> [W]hen I look at men, from my perspective [they are] straight, is a man, a man, a man 100%, the voice, the build, the figure and when it comes to sexuality I find myself, I have never been interested or attracted to my opposite sex, I always attracted to my sex. [Ofa]

All interviewees had relationships with other men, but this was generally "kept hidden in the closet" and not tolerated by their family. Jessie's family had found out she was living with another man and did not accept it. Community members were also very judgmental

> … the people are watching us in Tonga and they know we are going with men … this is the cause of people discriminating us. [Jessie]

Jessie felt her sexuality could not be expressed because it was against the law to have sexual relationships with other men. This legislation helped to reinforce people's negative and discriminatory attitudes towards TG/MSM:

> … it's the most important part here, it's the law. If the law says about us then people might fully understand, they might accept us. People here in Tonga are against us, they labelling us bad because of the law. [Jessie]

On the other hand, interviewees felt open to express their TG/*leiti* identity by wearing women's clothes, and they generally felt accepted by their families in doing so. One interviewee had dressed as a woman from a very young age and enjoyed this:

> At about 8, I decided that I wanted to be a *fakaleiti*. Because my parents let me do what I wanted to do. They didn't stop me. I used to wear dresses, and heels since I was in primary school. My cousins supported me too. They were calling me sister. [Lindsey]

Vali described himself as male and bisexual, as he "sleeps with both men and women". His previous sexual encounters had been casual, but his current relationship with his *leiti* partner was viewed as a long-term partnership, and they had chosen to be faithful to one another:

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[1] Real names are not used.

> My partner is very helpful to me, because before I used to go with different partners, my life before usually to go with different partners every night. But when we met up she was helpful to me. I have chosen in my life to stick to one another, to be faithful to one another. [Vali]

Interviewees who identified as gay or *leiti* had worked alongside their mothers and other female family members for much of their lives, doing 'female' household tasks. Female and male gender roles were clearly defined. Boys went hunting with other boys to make sure that there was sufficient food supply, whereas MSM and TG interviewees did chores in the home with other women. Vali helped to look after his disabled sister and assisted her with intimate tasks that his brothers would not be allowed to do:

> … in our culture we are not allowed as a brother to [do] something very private … with our sisters but since I was grown my mum left the country many times going overseas, and I was looking after my sisters so I bath them when they young whereas my other brothers can't, never do that. Up to now I still do this with my older sister … 'oh your bath time, shower time now', so I choose all these girls belongings, dry her up, so all this, do that. [Vali]

Charly had also stayed at home helping her mother as a child:

> [I] help[ed] my mum do women work like cleaning, washing, helping my aunty with weaving, preparing the pandanas for weaving. [Charly]

As they got older, many of the *leitis* had clearly defined 'female' roles in the community. Lee noted that *leitis* have a "good connection to the royal family" and their skills in flower arranging and cooking were valued:

> … all the royal event functions and all the royal things they [leave] it to *leiti*s to do the decorations, and all those things. Even the churches, they use *leitis* to do the decorations, the flower arrangements for churches. Like I do every Saturday … for our church, and most of the *leitis*, yes. And some of the *leitis*, they cook, they have talent most of them they have multi-talent, everything they can do. [Lee]

4.3.1.2 Sexual behaviour

TG interviewees had all had long-term relationships in the past with a "straight"' man. These men were referred to as their "partners" and they generally lived together at some point. All of these long-term relationships had ended when their partner left to get married (to a woman). Current sexual encounters tended to be casual, and partners were usually "straight", and occasionally, "gay", Tongan men whom they met in bars or picked up on the street. Only Vali, the bisexual-identified interviewee, was in a long-term relationship (with a *leiti* person). Two of the interviewees said they were sex workers had both Tongan and foreign clients, and others had sex with men for money, alcohol, cigarettes or to get a lift home. Some *leitis* paid adolescent boys to have sex with them. Sex usually occurred outside in the bushes.

Many of the interviewees longed for stable relationships and they expressed sadness that their previous relationships had ended (due to their partner getting married). Engaging in casual sex was viewed as protective – a way of avoiding any "heartbreak" that inevitability occurred when long-term relationships with straight men ended. But casual relationships were also seen as fun.

Long-term relationships were always kept hidden. Lee had been in a 10-year relationship with a Tongan man whom she met at school, but only other *leitis*, her closest friends, knew

about them. The relationship ended when her partner got married, although the marriage was very brief. Lee believed that the marriage had ended because of the shame her ex-partner felt in having a relationship with a *leiti*:

> … he was still in school [form 3] but I had already finished school … and then we met, and we had, you know like, sex, and all of those things. And since from form three up 'til the university, I still had the relationship. So, and then he got married … and they divorced … they were married for only two months. And then he came to me and tell me what … it's because of a shame and, of having an affair with a *leitis*. But he … support me doing this work. [Lee]

Ofa had a four-month relationship with a young man, but this had ended when his partner had been recruited in to the army. This partner was now married, but had tried to resume their sexual relationship:

> He is married. One time he tried to come and I said no. I don't want to be blamed for this. [Ofa]

Dressing as a woman was seen to attract local men. 'Straight' boys' were usually the most desirable sexual partners:

> You dress up like a girl and the men will take you, they're gonna like you. If you're not dressing like a girl, it is hard to get a man. For us in Tonga we just like boys, we don't like other *fakaleiti* or bisexual just straight boys. [Lindsey]

Lee noted that most *leitis* (including herself) pay 'boys' to have sex – this payment is usually alcoholic drinks or cash. But if the *leiti* is very "feminine", they usually do not have to pay:

> Seventy percent of *leitis* are paying the boys to have sex. Not just cash, but like buying drinks in the park … [and] thirty percent, they are *leitis* that are, you know, like, so feminine, and they don't really have to pay, to pay the boys. The boys are attracted to them. [Lee]

More than one interviewee noted that straight men "went down" on *leitis* (sucked their penis), with one interviewee expressing surprise at this, as it is seen as an action of females:

> This is quite shocking, one night I was walking back from here …, this guy stopping he … he goes down on me. You know, is this how straight men do? Went down on *leitis*? I say how confusing?! I was thinking he expected that I go down on him, not him go down on me … normally happens. Maybe that's how I see it, maybe different for other *leiti*s. [Ofa]

TG participants had both receptive and insertive anal sex, sometimes on the same occasion. Lee said that it is "play fair" to let the *leiti* have receptive anal sex first and then it's the "straight boy's" turn to have receptive anal sex.

> … the *leiti* goes first and then the boys come second. It's because *leitis* don't really trust the boys that they're having sex with because they just met … most of their clients … that's their first time to meet – so the *leiti*s don't trust the boys, because the boys if they fuck first, they will just stand up and leave. [Lee]

Straight sexual partners could be as young as 13 years old. Lee said that they approached her on the street, and were alone or in groups (in both Tonga and in New Zealand). Boys asked him for money (T$10–$50) or alcohol, and in return she would have receptive anal sex or give them a blow job (one by one, not as a group). Sometimes she would be paid:

> All I have to do is just blow him, or he [will] fuck me. Most of time I pay them, and I fucked them. Ten dollars, twenty, fifty. In Auckland … we used to stand there at night time waiting for pickups and meeting with boys that walk around. We pay them, and some they

> pay us. The majority is we pay is the boys. But the most thing we do is invite them to the bar and pay them drinks and after the bar we came back and continue on drinking and that person knows have to pay the tab, you know, like, by having sex with me. [Lee]

For Vali, the only interviewee who identified as bisexual, casual encounters occurred with both men and women who approached him on the street. The number of female sexual partners were 'too many to count', and with men numbered about 10. Prior to meeting his *leiti* partner, he had never had sex with a TG person.

4.3.1.2.1 Sexual debut and forced sex

The sexual debut of all interviewees was at a young age, usually around 10 or 11 years old, and with older males. Charly was aged 10 when she first had sex with an older neighbour, and Lindsey was also aged 10 when she first engaged in sexual activity (with her cousin's friend):

> They just came back from school, so I used to call him in the shower and we would do things like that in the shower – like sucking. [Lindsey]

Ariel was also aged 10 when she first began to be picked up by local boys on the street to give "blow jobs". She was paid with food items, which she took back to her family. She was proud that she was able to work and contribute to her family:

> When I was 10 years old. Would be coming up pick me up from our street. I stand on the street with my little hair. They thought I am a little girl, and I was the prettiest. And then they come and take me and have sex. Give me corn beef, and … breadfruit. [Ariel]

Ariel had continued to sell sex as an adult. She had made trips to New Zealand, where her sister lived, to earn some money as a sex worker. She picked up men on Facebook, in bars, in restaurants and on the street, where she was sometimes paid up to NZ$1,000 per night (five clients at $200 each) for "full service". She referred to full service as receptive or passive anal sex and/or blow jobs. Sometimes she was paid in cigarettes or the drug 'ice'. In Tonga, her clients were foreigners or "rich Tongans" and they usually paid $80 to $100, and sometimes "only 50 bucks". Clients were described as regulars or young boys.

Ariel worried about the dangers of sex work and had been seriously assaulted when the client refused to pay the agreed price for 'full service'. She, like other TG interviewees, longed for a stable relationship (with a man):

> Maybe last year I was say to myself that's the last moment that I was doing that so I could be settled down and look for a partner. Settle down so I can get out from the street. But it's [a very big] struggle so you need money. [Ariel]

Lee had also lived for a time in New Zealand, where she had casual sexual encounters with other Tongans. She wasn't paid in cash, but instead was "paid by exchange":

> Sometimes I used to fuck boys, like, my age. They are electronical workers, IT, and … I [had] asked them to come and fix my computer, fix the electricity. In return I have to fuck, suck them. I haven't been paid by cash. We only, you know, paid by exchange. [Lee]

Max was aged 11 when she first had sex with a man, who was nearly 10 years older than her. She describes her first sexual encounter with this man as violent and forced

> … he tied my body inside in the luggage except this part [points to anus] and then fuck me in the bum. All my body was inside the suitcase. [Max]

Max had told her family about being raped and the man was charged and brought before the courts. But Max felt at this time that she was in love with this man, and the charge was eventually dropped. The man sent him to another island, where they lived as a couple for four years before her partner got married.

Jessie also said that her first sexual encounter was forced. At seven years old, her stepfather raped her. He continued to do so until she was 17 years old. She believed that he did this to stop her being transgender:

> I went with my stepdad to … fish[ing] areas and … he fucked me … I know he is trying for me not to be a transgender. He is forcing me and abusing me … I think because he sees me as transgender and he doesn't like me that way, I think from what I know of the past he did it to me because he didn't like me being a transgender. [Jessie]

Although Jessie told her mother about the rape, she was unable to do anything "because he's her husband … and she's quite weak". Her father started isolating her from her family and she ended up leaving her family home at age 18 and began to work as a sex worker. Her clients were older Tongan men who gave her money (around $100) or brought her "precious things like mobile phones" She also described her sexual encounters with clients as abusive:

> They wanted to use finger, anal sex … They want to put bottles in your anus. They say I am not going to pay you much. I will pay you more if you accept whatever I want … it's painful. [Jessie]

Ofa also first had non-consensual sex at 10 years old. His cousin, who was about 20 years older than him, used to come into his room at night and sexually abuse him. He never told anyone because he believed that he, and not the perpetrator, would be blamed:

> Very older, maybe 20 years older than me but he wasn't married at that time. So he just live next door to my house and it was only me and my mum that time and the younger kids … and I was sleeping in my room and he used to come late at night because we have TV and they don't have TV … I never talk because they would blame it on me, 'because of you being a *leiti* that's why you inviting him to come in'. [Ofa]

His next sexual encounter at age 13 or 14 had also not been consensual. It involved a boy creeping into his room at night. It wasn't until his last year of high school that he felt that he first had consensual sex.

4.3.1.2.2 Condom use

Condoms were seen as easy to obtain (and usually free) from TLA, clinics, hospital clinic, nightclubs and hotels. However, interviewees did not use condoms except for rare occasions – with the exception of Ofa and Lee, who often used condoms "for safety". For the others, it was generally "worth the risk" to not use condoms with long-term and casual partners. Condoms were seen by one interviewee as primarily for married couples to prevent unwanted pregnancies rather than STIs.

Condoms were disliked because they reduced feeling and were "not natural". Jessie almost never used condoms with clients or partners, despite multiple casual and paying partners locally and overseas, and a previous peer support role promoting condom use. Lee sometimes used condoms if she didn't know her partner, but use ceased with a few weeks of familiarity:

> I don't use condoms every time. For example, if I sleep with him 5 weeks, we can use three condoms, and the two other nights we don't use condoms. [Lee]

At some point, most of the interviewees had suggested to their partners that they use a condom. Across the board, interviewees reported that their partners were reluctant and questioned why the interviewees would want to do so:

> They say 'condom for what? You not safe enough? I am not safe enough?'.You know what their perceptions is. One day I used condom that night and he say this is the first time for me to use condom and he say please we don't use it next time. Why? It doesn't feel good. [Ofa]

More than one TG interviewee said they choose whether or not to use condoms based on the perceived trustworthiness of that person. For example, Jessie sensed whether her casual and paying sexual partners were "safe" or not before deciding on condom use:

> I sense that persons is safe … I use my conversation with that person. I am pretty sure it is unsafe not using condoms but as I see with my sensing it to other persons, oh you are alright I can have sex with you. But I know and understand condoms – it's important to use if having sex with anyone because you have no idea of that person but with my thoughts and my thinking for that person, oh you are ok, you are alright. [Jessie]

Age was also an important consideration for Jessie, Ariel and Charly, with younger partners considered 'safer' than older partners. Condoms were usually perceived to be more necessary with foreigners but not with young Tongan men:

> I used a condom every time I have sex with foreigners, tourists and Palangi and everyone. Here in Tonga it's still safe but you don't know, I still use it sometimes, but I like the young kids. The 21-year-olds. It's nice. They're still fresh. [Ariel]

However, Jessie worried about STI/HIV and if she perceived partners to be unsafe, she would sometimes change to less risky sexual activities:

> I do worry about that [STI/HIV] because it affecting our life. Like having sex, sometimes I use hand job. If I am not trusting that person I just use my hand, do hand jobs and stuff like that without using anal sex and stuff like that. [Jessie]

Alcohol contributed to risky behaviour. For instance, Lee said that she slept with multiple partners without condoms when she was drunk. She was trying to change her behaviour and only have sex when she was sober so that she would not forget to use a condom. She said that she has hepatitis B and was worried about infecting her partners. However, even when she told her sexual partners that she was infected, they were apparently not concerned and still wanted unprotected sex:

> … when we are … planning to do the thing, I can tell them that I am having the hepatitis B. But most of the boys when they came in they don't really care about hepatitis B because they just wanted to have the sex with me. [Lee]

Maxi protects herself from STIs by cleaning her body after unprotected sex. She preferred that her male partners did not wear a condom during anal sex so that she could get pregnant:

> I tell them not to pull out but just to come inside me because I always dream about getting pregnant like women … I can be pregnant if I want to. [Maxi]

Obtaining condoms was seen as "easy". Condoms were usually obtained through the hospital clinic, TLA, nightclubs and hotels and less occasionally through the Red Cross. One

interviewee noted that they are free at many places except local clinics where they cost approximately T$1 each but usually come with lubricant (lubricant is supplied less often at other places).

Pharmacies also supplied condoms, but staff could be judgemental:

> … in the local chemists when I walk around the stores 'oh you have condoms, rough riders and everything where do you get it?' … and they looking 'why is he talking about [a] condom, is he a prostitute?' [Ofa]

Lubricant was obtained from local clinics and TLA. Some interviewees said that they could easily obtain it, while others said that it was impossible to find. The Ministry of Health (MoH) clinic reportedly does not currently stock lubricant. Saliva was used often and oil occasionally.

4.3.1.2.3 HIV and STI testing

Interviewees who were connected to the Tonga Leitis Association (TLA) were checked for HIV and STIs at the Tonga Family Health Association (TFHA). The TLA reportedly organises one or two annual trips to the clinic to get *leitis* tested as a group. Results are given by the nurse to two TLA coordinators, who in turn inform the *leitis*.

Interviewees all said that if they had STI symptoms, they would visit the TLA office for advice, or visit the TFHA clinic where they felt safe. However, one interviewee believed that TFHA charged for health checks whereas the hospital did not. There were some reports that TFHA ran out of STI tests or did not always have the resources to supply all the necessary tests. TFHA reportedly relied on the hospital for their supplies:

> The HIV testing last week [at the TFHA clinic] … usually we have the specimen of the urine but this time they say oh sorry *leitis* [they] are running out of those equipment in the hospital. [Ofa]

Some interviewees were apprehensive about visiting the hospital clinic because staff were perceived as reluctant to see *leitis:*

> … they don't want serve you because you are the *leiti*. [Charly]

Maxi preferred to take a support person to the hospital with her because she felt unsafe and judged without them. The hospital offered little privacy and interviewees worried that everyone would know what they were there for:

> I am feeling safe to go with someone, it is very true, when a *leiti* go by herself to the hospital everyone there in the hospital 'she is a *leitis*', they thinking and seeing us with different eyes. They already labelling and thinking what are we doing. It makes me feel down and I want to put myself in a hole, go down there. [Maxi]

They felt safe at TFHA because they were seen to be working in partnership with TLA and were welcoming, non-judgemental and private:

> … we are working together with them, we know each other, we are friends and when I go there they accept me and [are] great to me, and do something like she feel in here.

A *leiti* interviewee said that the MoH clinic had called the police and forced *leitis* to comply with treatment (for HIV and other conditions) in the past. The MoH was not seen to have an understanding of *leiti*s and their needs:

> The Ministry of Health to me, with my understanding and experience, it's not really a connection with us … if a person from Tonga Leitis Association has been affected then they start bad labelling. But not in Tonga Family Health. We are more trusting of Tonga Family Health than the Ministry of Health. They [the hospital] don't know much about us, how we feel and how we want it …They do counselling, ok you have to do this, but not with the heart. [Jessie]

Vali, the man who identified as bisexual, had also gone to the TFHA clinic for an STI check when he experienced symptoms. He felt that he had been treated with respect and was given good treatment and advice.

4.3.1.3 Stigma

Family or community members often accepted a non-traditional gender identity, but actual evidence of sex between men is unacceptable (such as having a relationship with another man). Homosexuality is highly stigmatised in Tonga, and *leitis* felt that they were highly visible to the community as MSM. One interviewee said that the term *fakaleiti* was used by others in a very derogatory way, and because of this it was no longer acceptable to use the term (except by other *leitis*).

All interviewees had experienced discriminatory attitudes and verbal abuse from others:

> Other people, because they don't know us and they keep swearing at us when we walk on the road. But on the other side, on my family side, the people accept. [Lindsey]

The interviewees had faced bullying, violence and sexual assault. Two interviewees had been raped as a child by family members. Interviewees felt that they had little recourse, as they felt they, and not the perpetrator, would be blamed. The police were not considered helpful and were avoided.

Interviewees believed that they were marginalised in the community and felt strongly that discriminatory legislation only compounded their isolation. Interviewees called for change in laws which currently make sex between men and cross-dressing a crime. Prostitution legislation was also seen as discriminatory.

> … we are not trying to do the same sex marriage, that's … not our priority. There are some laws, [that put us] at risk, the cross-dressing law and the prostitute law. Because in some of that law it says if you intentionally tried to solicit in public you will be taken into court without [charge]. [Ofa]

Two interviewees had dropped out of school because of the bullying by students and teachers. Ariel felt very isolated from her community as a result:

> … when I go to school they mocking me … and the teacher separate me – 'just [go] aside from the others … You go to the back, those girls first, and then the boys, you are the last one'. Ok, just take me to the group, the bad group … It makes you feel like, that you're sad, like that you're left behind from the world. That you do not belong to Tonga. While that you don't belong in that school, I drop out, I walk away. [Ariel]

Charly had been beaten by her teacher and had dropped out. She felt that many *leitis* were forced to leave school early, and this created longer-term problems for *leitis* and their community:

> When they [*leitis*] drop out of school they try to run away from home, they go to different home and stay there; when they stay there they are not satisfied … so they try to go and

> do [things] like going around and stealing. They are trying to satisfied themselves, their needs and wants from wrong things. [Charly]

Interviewees were not permitted to 'cross-dress' at work, and this could limit employment opportunities. Charly had studied tourism and hospitality and was required to complete a work experience placement in a hotel. The first day she went to work, she wore heels, make up and the girl's uniform.

> After one week the manager … call[ed] and [said] come to see me in the office. He said no more dressing like a girl, dress like a boy … And I quit!

However, Charly's next work practical was a more positive experience:

> … my next practical I go to [another tourist organisation] and nothing happened there. I wear heels and a mini skirt and everybody liked it. [Charly]

Ofa felt that Tongan society was becoming more conservative and worried about the repercussions for *leiti*s:

> It's quite shocking for us because now … no more bread [is allowed to be sold] on Sunday so now the next move maybe the *leitis*. Maybe their next move is the minorities, the sexual minorities because they are against … us, especially our church leaders. [Ofa]

Vali kept his bisexuality a secret because he feared the repercussions from others:

> I don't want to hear anybody talking about me [if] I admit that I am bisexual. All the gossiping and talking. They are going to say I am a yukky person and not good. [Vali]

All interviewees had found comfort and support from other *leitis* through the *leitis* advocacy group, TLA. The Tonga Family Health Association was also viewed as a valuable advocate for *leiti* health. One interviewee felt that there was also a great need for a sex worker support group.

4.3.2 Female sex workers

Seven interviews were conducted with women who had exchanged sex for money or goods in the past five years. One interview was conducted with a woman, Anna,[1] who disclosed during the interview that it had been 20 years since she had transactional sex, but she was included for comparison. The eight interviewees were aged between 18 and 42 years. Four FSW were interviewed at the TFHA office in Nuku'alofa and four in a village outside of Nuku'alofa

The interviewees were single, married, separated or divorced. They lived with their husbands and children or with other family members and children. All except one interviewee had children. Their husbands and families were not aware that they were involved in sex work/transactional sex. Two of the interviewees self-identified as sex workers and exchanged sex for cash and other resources, and the remainder had short-term or longer-term relationships in which cash or goods were exchanged for sex.

Women engaging in transactional sex tended to use the term 'boyfriend' to describe their partners – possibly to distance their actions from sex work, which is very stigmatised. Interviewees had sought out sexual encounters with men, in exchange for cash and goods, so that they could provide for their own and their children's needs. Or, they had been

[1] Real names are not used.

motivated by the excitement of (illicit) sexual relationships as well as material and financial rewards from male partners.

Most interviewees were unsure where they could obtain condoms; did not ask their partners to use them, and some had never seen them. The women did not have any say about whether condoms were used and accepted this (with one exception). Financial rewards appeared to take precedence over fears of pregnancy or infection with STI/HIV. Condoms were also associated with infidelity or were perceived as being primarily for use as contraception for married women. No interviewees had HIV or STI checks (although one woman had sought help for STI symptoms). Most women said that they would seek help at the hospital if they had STI symptoms.

4.3.2.1 Sexual behaviour

The women had sex for money so that they could buy food, supplies for their children (nappies, clothes, school activities) or cigarettes, drugs and alcohol. They had sex with local Tongan men whom they met on the streets, in bars, in shops and at their own homes. These men were regular clients, one-off clients and/or boyfriends. Sex occurred at home or outside at the beach, under trees, or in 'boy's huts' (informal brothels) and involved vaginal and oral sex. One woman had anal sex, while others viewed it with disgust. Two interviewees identified as sex workers, one of whom was the only interviewee who had sex with foreign clients.

Elle had been married for 13 years to a government worker. She was 33 years old and has six children, with another one on the way. She said that her husband's wage was too low and did not meet the family's needs. Consequently, she felt that she had little alternative but to walk around town and ask for money for sex. She gets T$30 to T$50 for vaginal or oral sex and has had about five clients, who are usually older than her. Elle's husband is not aware that she is doing this and the work makes her feel very sad:

> I don't want to go and sex around … But that's why I gonna do that, because I just wanna do this [for] my kids … for what they need and they want. They all go to school … They have something activity at school, I got nothing. I just made up my mind. I just go around and [have] sex for money, find some money. [Elle]

Louisa recently separated from her husband because he was abusive towards her. She has two children and currently lives with 11 adults and children, including her sister and a friend. She had group sex with Tongan "street boys", involving other women. She was motivated to do this so that she could pay for the drugs (ice and marijuana) that she uses. These drugs are given to her by one of the group sex participants after she has vaginal, anal and oral sex with the street boys. She also has sex with foreigners and is paid about T$200, which she said she uses to buy food for her children. Louisa thinks that she has had up to 50 clients in total. She was the only interviewee who agreed on a price with men before proceeding. She states that she enjoyed doing this, but she also said that she took drugs to give her confidence:

> I just use it [ice and marijuana] because of the confidence for me to use it to play with other people … I'm just very happy to get the money and at the same time stay high … [I prefer] Indian [men] because they have a big one and also good pay. [Louisa]

Some of the interviewees did not actively solicit sex. Instead, they had boyfriends, or short-term relationships with married or unmarried men, whom they asked for cash in

exchange for sex. This exchange of cash for sex appeared to be very direct and determined. Interviewees felt that they were making a pragmatic choice to do this so that they could provide for their needs and those of their children. This was described by one interviewee as “the Tongan way”.

Tania was separated from her husband and is concerned about the welfare of her children, who live with their father. She met a married Tongan man in a shop whom she had sex with and then asked him for money:

> I was trying to get something, to get someone that could give me everything that my kids want. That’s why. And one day I went to the shop and I met that guy. He was asking me out and then, I go with him in the night time and we go to the bar. First night, nothing happened, second night nothing, third night yes we did. We have sex. I was kind of thinking that I can control that guy to give me everything I want because I have sex with him. [Tania]

Tania received about T$600 from this man to buy food, things for her children, and alcohol. She was very direct with him in asking for money:

> I call him in the morning: I need some shopping for my kids … I went there. He gave me $200. And then, when it’s lunchtime I call him and tell him that I’m hungry and then he said ‘Ok, come and get this money’. He gave me $100. And then in the afternoon when he back from work he come for go for training and stop by the house that I was staying at and gave me $100. He call after training and come and pick me up for a drink. He gave me $200 to spend something at the bar, to get anything to drink. But he was already married, and he was so scared if the wife come find us at the bar. [Tania]

Sometimes interviewees sought regular payments from men in return for (regular) sex, and there was not a clear boundary between a transactional or romantic relationship:

> He was giving me money [T$200 a week], cigarettes, marijuana. I’m not sure whether he was giving it to me because of the sex or because he loved me. We were having sex because it was like we were married. Everything I ask him for things he always gives. Every time he wants me for sexual needs I always says yes. [Susie]

The gift itself may also indicate a man’s romantic intentions, thus blurring the interviewees’ motivations for engaging in sex. For example, Marisa met her ex-husband in high school where he paid her for sex, and they eventually married and had two children. However, he began to abuse alcohol and beat her and they divorced. She now has a boyfriend whom she met in a bar who pays her T$50–T$100, as well as alcohol and cigarettes, for vaginal and oral sex. Marisa had another two boyfriends, prior to her current relationship, but she did not ask them for money:

> For free … because the two [boyfriends] were cute, beautiful. [Marisa]

The interviewee who had engaged in transaction sex over 20 years ago believed that women who do this now on Tongatapu are not local to Tongatapu, and neither are their sexual partners:

> The problem is they are not people from here, they come from other places and stay here, they do things like that but not with men from here but from outside. They come from other islands. [Anna]

Alcohol and drugs were associated with risky behaviours and assault. For instance, Hone had gone drinking with two men whom she knew. She had sex with one of them. He had

taken her for a ride in his car and had forced her to have sex with his friend. He had said that if she refused, he was going to leave her on the side of the road:

> [He said] 'Like, do you want to sleep with him, or you gonna walk by yourself home?' I asked them to bring me home but then they didn't … because he, he has sex with me and then forced me to have sex with his friend and I felt very disgusted.

When Susie smoked marijuana, she often lost control:

> [If they] want to have sex with me, sometimes when I am really, really high I can't control myself, I can't say no but then at the same time I want it also because of the effect of the marijuana. [Susie]

4.3.2.1.1 Condom use

Condoms were not used by six of the women interviewed. The remaining two, Louisa and Hone, 'sometimes' used condoms. Aside from Louisa, the interviewees said that it was men who made the decision whether or not to use condoms and this was an accepted way of doing things. Louisa was also the only interviewee who obtained condoms for use. Condoms were associated with infidelity and therefore deemed inappropriate for those in relationships, whether they were short or long term. Young single women were also inhibited in obtaining or using condoms because this would indicate to health workers and their parents (if disclosed or discovered) that they were having sex before marriage.

There was some awareness that condoms protect against STIs and HIV. However, condoms were often perceived to be primarily for contraception among married women. For example, Avoca had heard that condoms can prevent STI infection and unwanted pregnancies, but she did not use them because she is not married, and her parents would not permit her to use contraception. She had one child and had unprotected sex with her boyfriend:

> … the only thing I do is … self-control, to stop myself having sexual activity with my boyfriend. My boyfriend gets mad and then he says that you don't love me because you're not having sex with me. He gets angry but I explain to him that it's more important for me to protect myself from getting pregnant again because if my parents find out about it, they'll beat me and get really mad. [Avoca]

Louisa was the only interviewee who insisted that her partners wear condoms to protect her from HIV and STIs, although she sometimes ran out. She said that she refused to have sex with them if they did not wear a condom.

> Before they we are having the job I ask they must wear the condom, they need to play clean, if not, the job is not going to happen. [Louisa]

Hone said that her boyfriend (or other partners) decided whether they used condoms. As with the remaining interviewees, she never had a part in this decision-making. Condoms were used occasionally and she didn't know where they were obtained from, although she would like to know where she could obtain them 'secretly'. Sometimes they also ran out of condoms:

> Sometimes we didn't have a condom, but we need it! [Hone]

In general, condom self-efficacy and knowledge was woeful. One woman did not know what a condom was. Others had never seen a condom, did not know how they were used, or how to obtain them, and had never been counselled about their use:

> I heard about it [condoms] from some friends but I never used it before, I never touched it before. [Elle]

The first time Elle had heard of condoms was from a nurse after the birth of one of her six (soon to be seven) children. Condoms were mentioned to Elle by the nurse as a method of preventing unwanted pregnancies and not for the prevention of STIs. She wasn't sure where she could get condoms, but thought perhaps at the hospital clinic. Susie got her information about condoms from gossip.

Tania said that if she asked her husband to wear a condom, he would suspect that she was seeing someone else and she did not want any suspicion of infidelity. Her views on condom negotiation were typical:

> If my husband wants to try it, or if that guy wants to try it, yes I can try. But they just want it normal. [Tania]

Avoca had heard that they were good for protection (from sex education at school) but never used them and thought they were distasteful:

> I heard from other people that condoms have chemicals, when you touch it, it's oily and stuff like that. [Avoca]

4.3.2.2 HIV and STI testing

Of the eight interviewees, not one had ever been routinely tested for HIV or STIs. One interviewee (Louisa) had been tested and treated for chlamydia at her local clinic after she experienced symptoms.

Most of the women had heard of HIV and some knew basic details:

> … it's a virus that go through you when you do that [sexual activity]. [Louisa]

Tania had heard about HIV when she had an antenatal check-up and had been given, or remembered, some erroneous advice:

> When I go there for my baby's scan … the nurse was talking about how we always have to protect ourselves to always take a bath and not to go out with so many men. [Tania]

There was less awareness of STIs and risk behaviours.

When STI symptoms were outlined to interviewees, they generally said that they would seek help at the hospital if they experienced these symptoms. Some interviewees were not aware of local clinics that offered testing.

Avoca said that she would tell her partner and mother if she experienced any symptoms despite the repercussions:

> I'd talk with him [boyfriend] first and, I'd tell my mum, even though I'd get beaten up, but then mum will take me to the hospital to get treated.

Susie had not been tested for STI/HIV because she said she didn't know enough about them to worry about it. One interviewee said that she was too shy to attend the hospital because she was worried about what people may think

> Scared of seeing people. They think why did I go and … do this. [Hone]

Louisa, who worked as a sex worker, had never been tested for HIV because she never had any time to get to the clinic. The closest clinic that provided HIV testing was quite far away and she had no transportation. Her local clinic did not provide HIV tests, but obtaining

condoms from this clinic was "easy" and the staff were "welcoming" to her when she was treated for chlamydia.

4.3.2.3 Stigma

Sex work is hidden in Tonga, and interviewees were very secretive because of the shame associated with it. Few had sought support from others because they were afraid of judgemental attitudes:

> … because of the people talking that you are … are [a] whore. [Avoca]

> I don't want anyone else to know because of mocking and talking about me. [Louisa]

Only Elle mentioned that she sought help from a few friends, but felt helpless about her situation:

> I just talk [to] my friends, how can I stop that? How can I get help? For what I'm just go around and sex for money. But I just go around to look after my family. But I don't want to do it. [Elle]

4.4 Capacity assessment of HIV organisations and services

4.4.1 National oversight, coordination and funding

4.4.2 Organisational mapping

The Tonga Ministry of Health (MoH) is responsible for research and health information, health promotion, and delivery of HIV and STI prevention, treatment and management in Tonga. A National HIV Coordinator sits within the MoH. The HIV program office is located in Nuku'alofa, at Vaiola Hospital and the coordinator has easy access to relevant organisations, such as the Tonga Leitis Association (TLA) and Tonga Family Health Association (TFHA). The MoH does not undertake specific activities targeting MSM/TG or FSW; however, it supports non-government organisations to do so.

The TLA is the main organisation working in HIV prevention and advocacy for the rights of LGBTI. It partners with TFHA and the MoH when clinical support and services are required. TLA also distributes condoms on behalf of the MoH. TLA is a community-based organisation with 182 LGBTI registered members (the majority of members are *leitis* or transgender). TLA has an office and drop-in centre in Nuku'alofa, where the majority of members reside. Members also live on Vava'u, a popular island for tourists, which offers employment opportunities in tourism and hospitality. TLA, a registered NGO in Tonga, was established in 1992 to educate LGBTI and the general community about HIV and to advocate for the rights of LGBTI. It is a member of the Pacific Sexual Diversity Network (PSDN), as well as a number of international LGBTI networks, from which the organisation receives technical support and advice. TLA currently has no core funding and relies on project funding from multiple donors. It is staffed by a pool of committed volunteers.

There are no programs specifically targeting FSW in Tonga. However, TFHA and the Talitha Project provide sexual and reproductive health education and services to vulnerable women, through which they reported reaching some FSW. TFHA was the first NGO to be established in Tonga in 1970. In 2009, it became a full member of IPPF. TFHA's core activities include the delivery of sexual and reproductive clinical services, health promotion, peer education, condom distribution, advocacy, and input into national policy and strategy development. The TFHA office, which includes a clinic and training room, is located close to the MoH and the centre of Nuku'alofa. Therefore, it is easily accessible. Clinical services are available to all though some are at a cost; however, reduced cost or complementary services are available for members, who are required to pay a one-off fee of T$5. TFHA currently has 325 paid members. The organisation also provides a weekly free youth-friendly health clinic and HIV and STI clinic. Two satellite clinics exist on the islands of Vava'u and Ha'apai. TFHA has been contracted by the MoH to be the capacity development organisation on its behalf. As such, TFHA offers training in project design, management, advocacy and education in sexual and reproductive to FBOs, NGOs and CBOs. TFHA has a close relationship with TLA and the Talitha Project, as well as other social services. It was reported that through its activities it reached approximately 100–200 FSW and 75–90 TG/MSM last year.

The Talitha Project is a grassroots NGO that focuses on the empowerment of young women (10–25 year olds) and offers a safe space for women. The organisation focuses on five thematic areas: sexual and reproductive health and rights; gender-based violence; leadership and political participation; economic empowerment; and climate change. It was reported that since the organisation was established in 2009, it has reached approximately 3,000 women.

There are also a number of other organisations that provide support to marginalised or vulnerable populations and may also be able to play a role in supporting LBGTI or FSW in the future. These organisations are summarised here. The Tonga National Centre for Women and Children (TNCWC) and the Women and Children's Crisis Centre (WCCC) provide a safe house, counselling and legal, health and social support to women and children who have experienced domestic violence. In addition, The Tonga National Youth Congress previously ran a peer to peer program for 14–35-year-old Tongans, funded by the Response Fund which ended in 2014. Sexual and reproductive health and rights (SRHR) is included in one of the 10 priorities of the Youth Congress; however, other than condom distribution, it does not currently carry out SRHR activities due to a lack of funding. The different organisations have a strong referral system with each other and appear generally to have clearly designated roles.

The National Forum of Church Leaders was previously engaged in HIV prevention activities. It signed an agreement in 2004 to promote abstinence and being faithful and agreed not to oppose other organisations promoting condoms. The Secretariat of the Forum, Reverend Filo Lilo, is passionate about HIV prevention and established a fellowship in 2003 for FSW to educate them about sexual health, which he did with the support of the MoH, and to connect the members to their local churches. When the fellowship was disbanded in 2012 due to time constraints, it had 64 FSW members.

4.4.3 HIV and STI prevention activities in Tonga

Governance of HIV activities is provided by the Country Coordinating Mechanism (CCM), which oversees the HIV component of the implementation of the Sexual and Reproductive Health National Strategic Plan 2014–2018. The CCM is chaired by the Minister of Health. TFHA, TLA and the Talitha Project are governed by boards and have strategic plans (Talitha Project aims to update its plan this year). All three organisations are also members of the CCM (however, it was reported that CCM meetings have not been held recently). There are no MSM/TG or FSW representatives on the board of TFHA or Talitha Project at present, in part due to the hidden nature of FSW.

The main source of HIV funding is reported to come from the Global Fund which funds diagnostics and treatment for HIV and other STIs, some community outreach activities, surveillance and the HIV Program coordinator position at the MoH. The MoH National budget funds human resources, facilities and equipment. There has been a reported deficit in funding following the end of the Response Fund. Funding is predominantly program based and does not always cover staff costs, or results in small allowances for staff, leaving the organisations relying on volunteers. It was reported that this has led to high staff turnover and difficulty in recruiting qualified staff. TFHA reported receiving funds from IPPF, UNFPA, Australian DFAT and the Canadian Fund. TLA receives some funds from the New Zealand AIDS Foundation and last year received some from the Australian DFAT for an income generation program. The Talitha Project is funded by UNWOMEN.

4.4.3.1 HIV and STI testing, counselling and treatment

HIV testing and counselling are available at 14 accredited sites in Tonga, 10 of which are on Tongatapu and the other four are on outer islands. Twelve are government-run health facilities and the remaining two are NGO facilities (Ministry of Health Tonga 2015). Blood samples are sent to the nearest Ministry of Health laboratory. There are no reported difficulties with the availability of HIV testing; however, the MoH did report a recent stock out of chlamydia testing reagents due to a lack of funding. While the MoH reported that there is a regional move towards the elimination of congenital syphilis, Tonga's number of syphilis cases is considered low and it was felt that efforts would be better placed focusing on chlamydia. One TG participant reported that treatment for chlamydia costs T$30, which can pose a barrier to people accessing treatment. However, free treatment is reported to be provided by the MoH. In addition, the need to send samples for CD4 and viral load testing to New Zealand within 24 hours of collection was identified as a challenge to HIV viral monitoring.

While HIV and STI testing appear to be fairly widely available, socio-cultural norms, a reluctance to seek medical assistance and the asymptomatic nature of some STIs were reported as barriers to accessing testing and treatment. Furthermore, it was noted that FSW are unlikely to have the means (car or bus fare) to reach the clinics.

TFHA offers HIV and STI testing and counselling for free within its clinic in Nuku'alofa and satellite services on the islands of Vava'u and Ha'apai. It also provides some outreach clinical services, such as collecting samples for testing. Participants reported that they generally felt they could access services from TFHA as confidentiality and privacy is maintained.

TLA members undertake voluntary group HIV and STI testing annually. The testing is carried out by either the MoH or TFHA. Results are received by TLA within two weeks of testing. The most recent was in July this year. STI testing did not take place, as testing reagents were not available.

4.4.3.2 Condom distribution

Condoms are provided to the MoH and TFHA by UNFPA and are then distributed to the other organisations. The MoH partners with TLA to distribute condoms at bars, hotels, resorts and nightclubs, as the community is more accepting of condom distribution by *leitis* than the MoH. TLA reported distributing up to 2,000 condoms per month. Lubricant was reported as not available. Condoms are also available at the other services and within clinics. TFHA, TLA and Talitha Project distribute condoms during outreach and education activities. However, Talitha reported that it experienced some young women being offended by being given a condom due to the associated connotations.

4.4.3.3 Peer education

TLA currently has 13 active peer educators, 12 of whom are located in Tongatapu and one in Vava'u. The peer educators were trained by the MoH. They conduct HIV education to *leitis* and MSM. TFHA has a strong peer education program, including both national peer educators and community peer-based educators. Peer educators are often out-of-school youth. TFHA also offers an accredited course for people to train as community health nurses. In rural areas, TFHA has community-based distribution centres, which are hubs for peer educators to access information and condoms for distribution. The peer education program does not specifically target MSM/TG or FSW, though some are believed to be reached

through peer education activities. Organisations expressed an impetus to establish an FSW program.

4.4.3.4 Strategic health communication

TLA annually hosts the Miss Galaxy beauty pageant, which is reported to have been successful in raising awareness of HIV, distributing condoms, promoting the rights of LGBTI, and fundraising to support the organisation’s work. TLA also holds education workshops for its members, the most recent one at the time of the visit was about Tongan law. TLA also recently started carrying out an anti-bullying of LGBTI campaign in schools. However, it was reported that while *leitis* have been invited into schools, they have experienced barriers in talking about sexual health. TLA previously provided print material on LGBTI rights and sexual health; however, it does not have the funding to reprint these materials.

TFHA carries out sexual and reproductive health education workshops that target marginalised youth. The organisation has a popular youth drama group called Fili Tonu (The Right Choice) which provides edutainment to schools and communities. Members of the drama group include some transgender members of TLA, who also work with the group to make costumes. In addition, TFHA conducts gender-sensitive life skills training for young vulnerable women. The training includes sexual health, family planning, baby care, first aid and nutrition for young girls who have dropped out of school, teenage mothers and other young women considered vulnerable. As part of its work with vulnerable populations TFHA carries out education activities with young people who are referred to in Tonga as ‘hut dwellers’ and are believed to engage in sex work. TFHA does this by engaging with the group leader and working with him or her to reach other group members. The leader is also encouraged to refer members to the clinic for HIV and STI testing. Print material on STIs in Tonga was available in the clinic at the time of this assessment.

The Talitha Project includes sexual and reproductive health education in their workshops and programs for young vulnerable women. It does not specifically target FSW, but feels there is a need for this to ensure FSW are reached.

4.4.3.5 Advocacy and legislation

TLA is active in advocacy and lobbying for the rights of LGBTI with the government. The first Pacific Conference on LGBTI was held in Tonga in 2015, hosted by PSDN with support from TLA. TLA also played a role in advocating for CEDAW recently, as did the WCCC and TFHA. Tonga is one of two countries in the Pacific that have not signed CEDAW (Ministry of Health Tonga 2015). TFHA also identifies advocacy as one of its core areas of business and provides input into national policy development

4.4.3.6 Other support services

TLA provides social support for LGBTI, with some members able to offer basic counselling. The organisation also provides a safe space for LGBTI to support one another. A core area of TLA’s work is to provide scholarships for studies and income-generating activities for LGBTI who, it was reported in some cases, have left school early due to homophobic or transphobic bullying. TLA played a large role in this study and in the 2008 MSM Second Generational Surveillance Survey.

The Talitha Project will be opening a drop-in centre for young women this year. The centre will include a resident counsellor, a computer with internet connectivity to access information, and a safe space to hang out.

4.4.4 Cross-cutting organisational strengths

- TLA is successful in delivery targeted sexual and reproductive health and rights education and social and economic support to LBGTI. The organisation is also a strong advocate for the rights of LGBTI.
- While there is no specific FSW program, some FSW are believed to be reached with community outreach and peer education activities and by TFHA and Talitha Project, which are well networked with FSW.
- Strong partnerships and referral mechanisms exist between the different organisations.
- TFHA is reported to be easily accessible by MSM/TG.
- There is a National HIV Coordinator, who is able to drive HIV activities.
- The work of the MoH and other stakeholders is guided by the integrated Sexual and Reproductive Health Strategic Plan 2014–2018 (unable to obtain a copy at time of visit).
- HIV and STI testing is available on the majority of islands in Tonga.
- While there are funding gaps, multiple donors are contributing to funding SRH programs, meaning that SRH is not reliant on one donor.

4.4.5 Cross-cutting organisational capacity-building needs

- Stigmatising attitudes towards MSM/TG and FSW, prohibitive laws and conservative attitudes regarding sex significantly hinder health promotion activities, condom distribution and people's ability to access sexual and reproductive health services.
- Funding gaps for staff result in a high turnover of staff or difficulty in finding qualified staff.
- Funding for reagents for chlamydia testing is not available.
- Lubrication is not available for free, other than through TFHA.
- Technical support in clinical management of HIV and STIs was previously provided by SPC, which ceased in 2014 due to the end of the response fund grant. It was reported that technical support is still required.
- Regular clinical refresher training and mentorship are required due to high clinical staff turnover.
- The peer education program could be strengthened by recruiting educators to replace those who have moved on and through refresher training.
- Funding is required for reprinting of sexual health and MSM/TG/LGBTI-friendly print material
- Capacity-building in program management, M&E and using the Global Fund proposal and reporting templates was identified as a need by NGOs.
- LGBTI sensitisation training for HCW and community members.
- Organisations may wish to consider establishing a Tongan glossary of words that can be used for sexual and reproductive-related issues and are not stigmatising.

4.4.6 Identified capacity-building resources

Tonga has access to a number of volunteer programs, including the Australian and Japanese programs. TLA is able to partner with international and regional LGBTI networks. For programs targeting FSW, organisations may wish to consider partnering with international FSW networks such as SAN Fiji and the Scarlett Alliance, as well as piggybacking on the work of gender programs where appropriate.

5 Recommendations

- The TFHA and Talitha Project are both in a position to undertake a FSW peer education program. They must be careful to do so in a way that does not stigmatise or 'out' the women and builds real partnerships with the FSW. Both organisations are well networked and would be able to do this.

- A high population has mobile phones and communicate via text or Facebook. It could be worth considering using mhealth to reach hidden populations.

- TLA require technical support in facilitating a consultation with decision makers including government personnel, local council members and church leaders (through the Forum of Church Leaders) on LGBTI rights.

- Community and health care LGBTI sensitisation programs are recommended to reduce stigma and barriers to accessing services.

- Assist the government with finding funds for Chlamydia testing and treatment.

- The MoH would benefit from receiving technical support in integrating HIV and SRH as per their national strategy.

References

Besnier N. (1994). Polynesian gender liminality. In Herdt G (Ed.), *Third sex, third gender, beyond sexual dimorphism in culture and history*. New York: Zone Books.

Besnier N. (1997). Sluts and superwomen: the politics of gender liminality in urban Tonga. *Ethnos, 62*(1–2), 5–31.

Besnier, Niko (2002). "Transgenderism, locality, and the miss galaxy beauty pageant in Tonga". *American Ethnologist*. 29, 534–566.

Buchanan-Aruwafu, H. (2007*). An integrated picture: HIV risk and vulnerability in the Pacific – research gaps, priorities and approaches*. New Caledonia: Secretariat of the Pacific Community.

Commonwealth Secretariat. (2015) The commonwealth yearbook: Tonga. London, UK. Commonwealth Secretariat. Retrieved from http://www.commonwealthofnations.org/wp-content/uploads/2013/12/yb15-0-prelims.pdf

Department of Statistics Tonga (2016). *Tonga – National population and housing Census 2011.* Tonga Government. Retrieved from http://tonga.prism.spc.int/census-population/census-of-population-and-housing#census-2011

Farran, S. (2010). Pacific Perspectives: Fa'afafine and fakaleiti in Samoa and Tonga: People between worlds. *Liverpool Law Review, 31*(1), 13-28. doi:10.1007/s10991-010-9070-0

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*. Retrieved from http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-Legal_Environment-FullReport.pdf

Godwin, J. (2012). *Sex work and the Law in Asia and the Pacific: Laws, HIV and human rights in the context of sex work*. Retrieved from http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf

James, K. E. (1994). Effeminate males and changes in the construction of gender in Tonga. *Pacific Studies, 17*(2), 39.

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.

Munro P. (2015, August 20). Transgendered Tongan 'leitis' finding their way in the conservative country. *The Sydney Morning Herald*. Retrieved from http://www.smh.com.au/world/transgendered-tongan-leitis-finding-their-way-in-the-conservative-country-20150820-gj48qw.html

Peteru A. (2002). *Pacific Island Seafarers: A study on HIV/AIDS and STI risk-related behaviour.* Noumea: SPC.

Social Policy and Parliamentary Unit of the Salvation Army. (2011). *Pacific Trafficking in Persons Forum Report.* Retrieved from Auckland: http://acrath.org.au/wp-content/uploads/2012/01/2011PPTConferenceReport.pdf

Ministry of Health and National Planning Tonga. (2010). *2nd National Millennium Development Goals Report: Tonga*. The Government of Tonga.

Ministry of Health Tonga. (2014). *Kingdom of Tonga National Integrated Sexual and Reproductive Health Strategic Plan (2014-2018)*. Retrieved from

http://www.aidsdatahub.org/sites/default/files/publication/2014-2018_Tonga_National_Integrated_Sexual_and_Reproductive_Health_Strategic_Plan.pdf

Ministry of Health Tonga. (2016). *Kingdom of Tonga Global AIDS Response Progress Report: 2015*. Retrieved from http://www.unaids.org/sites/default/files/country/documents/TON_narrative_report_2016.pdf

Ministry of Health Tonga & SPC. (2008). *Second Generation Surveillance Survey of MSM in Tonga 2008*. Retrieved from http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=210&Itemid=148

UNDP (2015). *Human Development Report.* New York: United Nations Development Programme. Retrieved from http://hdr.undp.org/sites/default/files/2015_human_development_report_1.pdf

World Bank. (2016). *Tonga Databank.* Retrieved from http://data.worldbank.org/country/tonga

WHO. (2006). *Second Generation Surveillance surveys of HIV, other STIs and risk behaviours in six Pacific Island Countries* Retrieved from Manila: http://tonga.prism.spc.int/tonga-documents?view=download&fileId=1167

WHO, & Ministry of Health Tonga. (2012). *Health Service Delivery Profile Kingdom of Tonga 2012* Retrieved from http://www.wpro.who.int/health_services/service_delivery_profile_tonga.pdf

Women & Children's Crisis Centre in Tonga. (2010). Response needed to sex industry in Tonga. Retrieved from http://tongawccc.org/blog/response-needed-to-sex-industry-in-tonga/

ANNEX1: UNAIDS GARP data needs

Data – Tonga

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: 82

Table for data input:

	All	Males	Females	<25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	**23.2 %**		**23.2 %**	**28.9 %**	**18.2 %**
Numerator Number of sex workers who answered "Yes" to both questions	**19**		**19**	**11**	**8**
Denominator Total number of sex workers surveyed	**82**		**82**	**38**	**44**
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?"	**40.2 %**		**40.2 %**	**42.1 %**	**38.6 %**
Numerator Number of sex workers who replied "yes" to question 1	**33**		**33**	**16**	**17**
Denominator Total number of sex workers surveyed	**82**		**82**	**38**	**44**
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?	**25.6 %**		**25.6 %**	**31.6 %**	**20.5 %**
Numerator Number of sex workers who answered "Yes" to question 2	**21**		**21**	**12**	**9**
Denominator Total number of sex workers surveyed	**82**		**82**	**38**	**44**

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

Table for data input:

	All	Males	Females	<25	25+
Percentage (%) Percentage of female and male sex workers reporting the use of a condom with their most recent client	**15.9 %**		**15.9 %**	**15.8 %**	**15.9 %**
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	**13**		**13**	**6**	**7**
Denominator Number of sex workers who reported having commercial sex in the last 12 months	**82**		**82**	**38**	**44**

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	**9.8 %**		**9.8 %**	**5.3 %**	**13.6 %**
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**8**		**8**	**2**	**6**
Denominator Number of sex workers who responded to the questions	**82**		**82**	**38**	**44**

1.11 Percentage of MSM reached with prevention programs

	All	**<25**	**25+**
Percentage (%) Percentage of MSM who answered "Yes" to both questions	**41.7 %**	**33.3 %**	**55.6 %**
Numerator Number of MSM who answered "Yes" to both questions	**10**	**5**	**5**
Denominator Total number of MSM surveyed	**24**	**15**	**9**
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?"	**58.3 %**	**46.7 %**	**77.8 %**
Numerator Number of MSM who replied "yes" to question 1	**14**	**7**	**7**
Denominator Total number of MSM surveyed	**24**	**15**	**9**
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**41.7 %**	**33.3 %**	**55.6 %**
Numerator Number of MSM who answered "Yes" to question 2	**10**	**5**	**5**
Denominator Total number of MSM surveyed	**24**	**15**	**9**

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	**62.5 %**	**66.6 %**	**55.6 %**
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner	**15**	**10**	**5**
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**24**	**15**	**9**

6 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	**25.0 %**	**20.0 %**	**33.3 %**
Numerator Number of MSM who have been tested for HIV during the last 12 months and who know their results	**6**	**3**	**3**
Denominator Number of MSM who responded to the questions	**24**	**15**	**9**

1.13 Percentage of TRANSGENDER reached with prevention programs

	All	**<25**	**25+**
Percentage (%) Percentage of TG who answered "Yes" to both questions	**87.8 %**	**33.3 %**	**71.0 %**
Numerator Number of TG who answered "Yes" to both questions	**43**	**6**	**22**
Denominator Total number of TG surveyed	**49**	**18**	**31**
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?"	**81.6 %**	**72.2 %**	**87.1 %**
Numerator Number of TG who replied "yes" to question 1	**40**	**13**	**27**
Denominator Total number of TG surveyed	**49**	**18**	**31**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**63.3 %**	**50.0 %**	**71.0 %**
Numerator Number of TG who answered "Yes" to question 2	**31**	**9**	**22**
Denominator Total number of TG surveyed	**49**	**18**	**31**

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	**77.6 %**	**77.7 %**	**77.4 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**38**	**14**	**24**
Denominator Number of respondents who reported having had sex in the last 12 months	**49**	**18**	**31**

7 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	**61.2 %**	**55.6 %**	**64.5 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**30**	**10**	**20**
Denominator Number of TG who responded to the questions	**49**	**18**	**31**

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