



A report on MSM and the Pacific Region

Based on information collected during the 1st Pacific MSM network meeting, Apia, Samoa, August 28-31, 2007, which Aditya Bondhyopadhyay was present representing APCOM

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Background

APCOM follows the regional and sub-regional divisions that have been defined for the purpose of HIV and AIDS prevention activity by UNAIDS. Under this scheme the following Pacific Island Nations are relevant to APCOM:

<i>FROM THE POLYNESIAN GROUP OF ISLAND NATIONS</i>	
1	KINGDOM OF TONGA
2	NIUE
3	COOK ISLAND
4	TOKELAU
5	SAMOA
<i>FROM THE MELANESIAN GROUP OF ISLAND NATIONS</i>	
6	SOLOMON ISLANDS
7	VANUATU
8	PAPUA NEW GUINEA
<i>PART MELANESIAN AND PART POLYNESIAN</i>	
9	FIJI
<i>FROM THE MICRONESIAN GROUP OF ISLAND NATIONS</i>	
10	KIRIBATI
11	TUVALU
12	NAURU
13	REPUBLIC OF THE MARSHALL ISLANDS
14	PALAU
15	FEDERATED STATES OF MICRONESIA

It should be noted that there are 24 Island Nations / territories in all, but since the ones not included in the above list are either territories of metropolitan France, or sovereign territories of USA, they are not included in the classification of the “Asia and the Pacific” Region by UNAIDS.

The Fa'afa fini construct, MSM, violence, and implications for HIV and AIDS

The term 'Fa'a' means 'like this' or 'like that'. When prefixed to the term 'fini' or 'leite' both of which means woman, in Samoan and Tongan tongues respectively, it denotes 'like a woman'. The unstated understanding being that it is a reference to someone who is 'like a woman' but is not a woman. In other words to a male person who does not conform to the culturally accepted behaviours of men, and irrespective of biology, is feminine in action and demeanour.¹

At least in the Polynesian cultures, the fa'afa tradition of feminised males is well integrated into the social framework and they are accepted by society and by family, without any erosion of their respect or without any opprobrium or violence meted out to them.

It is a gendered construction much like the kothi construction in many parts of South Asia. The gender role-play that the fa'afa undertakes extends to the sexual act. While it is difficult to pinpoint the exact sexual activity that a fa'afa would perform in the sexual act, the common understanding is that being the 'woman' in the act, s/he would perform the role of the passive partner or 'bottom'. This understanding also extends to the common perception that a fa'afa would be penetrated in the sexual act.

The identity and the recognition of the fa'afa is both externally validated by society, and internalised by the fa'afa him/her self. However, the sexual partner of the fa'afa is a regular man and can be from any segment of society. They have no notion of identity based on sexual preference or sexuality and the only identity that they conform to or identify with is that of being 'men'. The fact of having sex with another male person [the fa'afa] does not affect their self-identification or self-perception of being 'men' in any way.

The consequence of this is that there is no developed 'gay' identity construct and the fact that two men can have sex is therefore frowned upon. If and when MSM is defined as 'men who have sex with men' it also therefore becomes problematic as the men do not identify as having sex with other men, since societal consciousness blocks them from considering fa'afa as men. The fa'afa too considers themselves as women [not men] and therefore they too have a problem identifying with the above definition of MSM.

In terms of MSM HIV Prevention approach, it is very important to keep this cultural reality in mind and seek a redefinition of MSM that avoids the usage of the gendered term 'men' and maybe replaces it some biologically relevant term like 'males'.

The fact that the fa'afa plays the role of women in the sexual act means they also attract the same degree of vulnerability to HIV infection as women do and need to be targeted as a specially vulnerable group. That their 'men' sex-partners are dissolved in the mainstream of society implies that they cannot be reached with regular intervention approaches designed for targeting 'gay' men or other men who have a perception or self-identification based on their sexuality and sexual preference. Therefore the best way to reach them with safer sex information and also with other services is by using the fa'afa themselves.

It therefore becomes vital for HIV prevention efforts that the fa'afa groups and networks be given adequate support and technical backing, so that they can become the backbone of the MSM HIV Prevention strategy of the region. This is the only approach that is feasible, practicable, and economically sustainable. The first step in this direction should be to support fa'afa groups and networks to form their own community-based organisations (CBOs) with available services, such as a drop-in centre (DiC) etc. They should also be given adequate training to enable them to take on HIV prevention work amongst

¹ Similarly, Aka'Venu or Tuku'Venu in the native tongue of Cook Island, meaning 'acts like a woman' or 'looks like a woman' respectively.

themselves and with their partners.

Pacific Societies are strictly structured, hierarchical, and clannish, with a very strong sense amongst the members of ties to their families, clans, tribes etc. In that respect it is not very different from most societies of the rest of the Asian region. As is usually found in such regimented societies, shame is a strong emotion, where any act that shames is met with strict opprobrium. Therefore, in the Pacific if a 'man' is found to have sex with another 'man', that is acting against the set rules of manliness, and it is societally opposed. However if the same man is found to have sex with a fa'afa then the same is acceptable. Pacific societies deviate from the societies of South Asia in this crucial respect, for in societies of South Asia, the very fact of femininity of a male person is considered a shaming matter, and therefore kothis are targeted by violence within families for just being themselves. In the Pacific however, the fa'afa are accepted and treasured as equal members of the family and therefore they are not subjected to familial violence on account of their gender construct.

In discussions with some senior fa'afa fini, the only area where violence against feminised gendered construction came to light within family setting is with the case of underage boys who start showing the gendered tendencies of being a fa'afa. Such boys are often targeted for sex by elder men within the extended family or the clan. This entails a high degree of CSA, but the shame based society keeps a lid on information about this aspect and does not allow news about it to spread out of the family setting, thus restricting redress and also help to the victims. It was strongly suggested by this senior fa'afa fini and President of the Samoa Fa'afa fini Association [Ms Roger] that this should be an area of research that should be conducted with schoolboys with fa'afa's themselves collecting the data and conducting the interviews.

Observations on Samoa

Samoa AIDS Foundation [SAF] is the leading agency in Samoa undertaking HIV prevention work. While the organisation leadership has a fair representation of MSM, their HIV work is not confined to just MSM. However MSM HIV Prevention forms a large focus of their activities, which they are promoting by encouraging and supporting the formation of the fa'afa fini CBO Samoa Fa'afa fini Foundation [SFF].

Funding is needed for the SFF to streamline its activities, including urgently for a Drop in Centre. SFF also needs technical assistance by way of training and organisational development support.

Observations on Vanuatu

In Vanuatu the KAM PUSUM HED CLINIC [KPH] undertakes MSM HIV prevention work. It is clear from interaction with **Jayline Malverus** of KPH, that the situation of MSM in Vanuatu is very different from Polynesia and that there is a lot of institutional violence and abuse of MSM. Most MSM are extremely closeted about their sexuality and therefore are hard to reach. There are no social spaces for same sex attracted persons to interact and intermingle. Public spaces that are accessed by MSM are often targeted by state agencies with violence. Violence is also high within family settings.

While KPH is a mainstream NGO, it's MSM intervention work is carried out mainly through employing a few MSM peer outreach workers. MSM do not have any effective say in the decision-making processes within the organisation. However it must be mentioned that it is very courageous of KPH to venture into undertaking MSM HIV prevention work in spite of all the societal odds that it is confronted with and in spite of the security risk it runs by doing MSM HIV prevention.

In Vanuatu, there appears to be a need to nurture MSM owned and MSM operated CBOs that take on community development work along with HIV interventions work. For this KPH can be encouraged to nurture and develop MSM CBOs, as also develop MSM leadership that can guide and lead such CBOs.

Interview with George Raubi of Papua New Guinea (PNG)

George has worked on MSM HIV prevention for the last 5 years. He started working with the NTPEP project of the PNG Institute of Medical Research as Volunteer peer educator. The project was given over to Save the Children (STC) in 2003.

While STC today manages the only significant MSM HIV intervention project in PNG, covering 2 cities, Port Moresby and Lae, George is of the opinion that STC having the project is not the ideal situation. He reports frequent clashes between the community and STC, and questions about why an organisation like STC should run a MSM and Sex Workers project is often raised. While admitting the fact that STC got to run this project because no other organisation at that time was willing to come forward to do this work, George also mentions that at the time STC had claimed that they have similar projects in many other parts of the world. This claim of STC remains unverified.

What is most rued is the fact that there has been no community development work initiated by STC. The project runs using peer workers simply to give information and condoms, but requests for funds for community based and community owned interventions and support work has not been respected. There is an effective Catch-22 situation where when the community members approach the National AIDS Council for support, they are told to go back to STC, since the entire AusAID Grant for MSM HIV Interventions given to NSA has been awarded to STC. He feels that APCOM can actually raise this issue with AusAID on behalf of the Community in PNG.

George is responsible for developing activity plans for MSM intervention work for the STC project and ensure its implementation. The plans that George comes up with are very tightly reviewed and it is mostly accepted, the scale at which activities need to happen is not happening under the project. George also mentions that there is a lack of transparency in what STC is actually receiving for doing MSM HIV intervention work.

George is convinced that for the scale of the problem in PNG, the fact that only 2 staff has been recruited for the entire work of MSM intervention in 2 cities of PNG is grossly inadequate. He mentions that other support staff that should have been recruited has not been recruited. They somehow are made to manage with volunteers who are paid a meagre allowance of only 50 Kina [US\$ 20] per month.

George mentions that the other organisations that work for MSM in some capacity is 'Alternate Visions' and 'Hope Worldwide'. AV is right now concentrating mostly on research. George feels this is preliminary work to by AV to stake out the scope of their prospective program. Some of the ex-staff of STC are now employed by AV. HW has a program that is same as STC and employs 1 person in port Moresby to undertake MSM HIV work. HW however is a better paymaster to its volunteers, paying them almost 240 Kinas per month. HW gets its funding via FHI.

World Vision, another organisation, sometimes gives support for specific events, but its more of a one off thing than a regular project.

George thinks that the fact that there is very little communication between STC, HW, and AV, implies that the possible synergies are not optimised.

He identifies the problem as the fact that everything is done under the rubric of prevention and safer sex, while the community needs are much broader than just that. Lately STC has begun to acknowledge that it is important to have self help group registered by the community. George feels that self help group when registered should take on the mantle of HIV prevention work as well as work on the broader community needs.

George mentions that he and few other community members have already formed a support group and

hope to register themselves soon in Lae as a CBO. He thinks that they should start work in Lae and then move on to Port Moresby and other cities. He identifies 5 other cities where informal networks of MSM already exists and where there is an urgent need to start work. These cities are Madang, Alatao, Rabaul, Hagen, and Gorokan. They are waiting because they need monetary support to process the registration.

Once registered George identifies the needs of the CBO as follows:

- A Drop in centre in Lae to begin with, but in all the cities eventually.
- Capacity building for the organisation itself, preferably a training of trainers programme so that the trainers can then train the staff at other cities.
- Support to run the DiC and the outreach and intervention work

Interview with William Tepaki of Cook Island

William is leading a group of fa'afa fini in Cook Island and they hope to register themselves as a CBO soon. This group has been involved with fundraising for other charities but have not raised nay funds for themselves yet. They hope that in future, once they are registered, they shall start fundraising by organising events for themselves as well. They hope to register the CBO with the name 'Te Tiare' which means 'the Flower'.

William identifies the need for such a CBO that undertakes MSM HIV work as regular men access fa'afa fini for sex. These men are impossible to reach with MSM HIV prevention messages as they are part of the mainstream. But Fafafini can reach them as they are their sex partners. This is the only way in which MSM HIV intervention can happen in Cook Islands as straight acting gay men, who prefer other gay me are non existent. Most out and proud and queer persons in Cook Islands are femme.

William mentions that the economy of Cook Island is very closely linked with the economy of New Zealand, and that is why it is very expensive there. Therefore while they can do some fund raising on their own, it shall not be enough to meet the expenses of an intervention project through a CBO.

William mentions that under the law, any one who tests positive for HIV has to register themselves with the ministry of health. Being a small place with low population, this means that confidentiality is often breached. Many people do not trust that their confidentiality would be respected and often get themselves tested in New Zealand. But this is a very expensive proposition.

That is why William feels that along with a DIC what the Fa'afa fini of Cook Island really need is a clinic. Most Fa'afa fini do not trust the regular clinic for privacy and confidentiality reasons and that is why they often do not get themselves treated for STIs. William feels that the only solution is for the Fa'afa Fini to set up their own clinic.

To run the clinic, William feels that some of the fa'afa fini themselves can be trained as paramedics, and a trusted local doctor can be hired on a part time basis. He also hopes that the clinic once set up would allow them to invite external testers, like from the South Auckland Sexual Health, to visit on a regular basis to conduct testing on the Fa'afa fini. This would be a big cost saver for the community,

The legal situation in the Pacific Islands

This paper is an edited version of the running notes on the presentation of the legal situation of MSM in the Pacific Island countries as presented by Matautia Phineas, lawyer, at the 1st Pacific MSM Network Meeting in Apia, Samoa, 28th August 2007.

In the South Pacific the influence of religion and the church is undeniable. Extending from the village to national level with church representatives who are commonly also our political representatives involved with law reform.

Each word within Legislation is significant.

A single word can mean the difference between a citizen being protected by the Law and another citizen being excluded from that protection.

That is the challenge with our current Laws in the South Pacific that deal with MSM.

Current legislation regarding MSM in the Pacific region: strategies for changes in current legislation and creation of new legislation

- We will look at a general summary of current Legislation around the South Pacific relating to MSM.
- We will also look at strategies that we can use to make Legislation more appropriate when dealing with MSM within the South Pacific region.
- One way is to look at the appropriateness of certain western terms found in our legislation in the context of our unique culture(s)
- We will also look at how we can effectively change, (amend) or repeal (remove) discriminatory provisions and legislation.

MSM defined

But firstly who are MSM?

The legal definition of MSM from the *International Guidelines on HIV/AIDS and Human Rights*, state that MSM are men who have sex with men.

It is significant to add the fact that MSM do not (necessarily) identify as being either homosexual, gay, bisexual, transvestite or transgender.

The MSM term challenges pre-conceived ideas of who might make up this group of people.

MSM could be *any man* which brings home the importance of the message of HIV AIDS prevention being A message for every man.

Fa'afafine, Fakaleiti and Rere issues are *also* significant in the South Pacific where *we* are automatically identified as being either transvestite or transgender. But not identified under our own terms.

It is therefore inappropriate to describe our Pacific uniqueness through the eyes of western medical terminology.

Also being the most visible and vulnerable Fa'afafine, Rere and, Fakaleiti are often targeted as being the predominant contingent of the MSM population and scapegoats linked to the spread of HIV and AIDS in

the Pacific.

We must ensure that even though we are males who have sex with males we are not the only “males” who do so and the focus should not be on our heads alone.

Current legislation: constitutional rights

Living in the South Pacific most of us enjoy the political and fundamental rights that emanate from a constitution.

Political rights (like the right to vote) and fundamental rights (like the right to equality).

A constitution is the law that sets out the basic values and structure of a country as an independent and democratic nation.

Sadly for citizens who are MSM or HIV positive, the guarantee of their human rights under the constitution has been heavily undermined by politically driven amendments or repeals of the most important provisions.

The result is a constitution that protects only some of its citizens.

Much of the legislation relating to MSM IS ARCHAIC heavily influenced by our colonial and religious past, which uses western terms that are not culturally appropriate. One example of current legislation hailing from our colonial history are the Sodomy Laws The table below relates specifically to sodomy legislation which exists in the South Pacific.

Country	Lesbian	Male	Maximum Penalty
American Samoa	Legal	Legal	
Cook Islands	Legal	Illegal	14 years
Fiji Islands	Legal	Illegal	14 years
French Polynesia/Tahiti	Legal	Legal	
Guam	Legal	Legal	
Kiribati	Legal	Illegal	14 years
Maldives	Legal	Illegal	Life
Marshall Islands	Legal	Illegal	10 years
Micronesia	Legal	Legal	
New Caledonia	Legal	Legal	
Niue	Legal	Illegal	10 years
Papua New Guinea	Legal	Illegal	14 years
Samoa	Illegal	Illegal	7 years
Solomon Islands	Legal	Illegal	14 years
Tokelau	Legal	Illegal	10 years
Tongo	Legal	Illegal	10 years
Tuvalu	Legal	Illegal	10 years
Vanuatu/New Hebrides	Legal	Illegal	14 years

Implications

Sodomy laws aligns our citizens with western terminology laden with negative assumptions and connotations

It incorrectly labels our people with western terms and stereotypes. It burdens our people with western ideologies of exclusion, which clash directly with our culture of inclusiveness.

Sodomy laws criminalize private, same sex intimacy between consenting adults. Sodomy laws justify discrimination through anti-homosexual interpretations of the law. It does not limit the actual sexual behaviour but serves to;

- Demonize and isolate.
- Promote fear and suspicion.
- Promote ignorance by limiting access to safe-sex education.

Because of this MSM are at increased risk due to

- Not receiving safe sex information
- Not included in sex education, treatment and testing
- Are being targeted for discrimination.

Fiji: Incorporation of human rights principles into domestic legislation, and conformity with international standards

The Fiji *Constitution* is exceptional in providing gender and sexual orientation as prohibited grounds of discrimination, and the freedom from scientific or medical treatment or procedures without informed consent.

It is also one of the very few Pacific Constitutions to enable its courts to look to international treaties for guidance, whether or not they have been incorporated into domestic law. Fiji is also the only Pacific country to have a Human Rights Commission.

However, much of Fiji's legislation pre-dates the *Constitution* in its present form, and fails to conform to constitutional and international human rights.

The most significant areas of non-conformity are to be found in —

- the *Penal Code*: vulnerable groups and activities such as sex work are still criminalised, rape is not gender-neutral, and abortion is illegal.
- the *Public Health Act* which contains inappropriate provisions for the management of HIV and AIDS.
- the mandatory testing provisions of the *Public Health Act*, the *Royal Fiji Military Forces Act*, the *Police Act* and the *Immigration Act* are all prima facie unconstitutional.

The *Penal Code* and the *Public Health Act* are currently under review.

Hopefully the reviews will produce modernised laws, which will truly conform to human rights principles and thereby assist in managing the growing HIV epidemic in Fiji.

By contrast, the *Prisons and Corrections Act 2006* is fully compliant with international human rights standards regarding treatment of prisoners and HIV. This Act could well serve as a model for the rest of the Pacific.

The offences related to male-male sex and prostitution involving consenting adults in private, the gendered definition of rape, and the lack of provision for marital rape all contravene human rights.

Both the Human Rights Commission and the Ombudsman Commission have jurisdiction over human rights breaches and abuses. These provisions provide ample scope for the establishment of implementing provisions for HIV legislation.

Samoa: Incorporation of human rights principles into domestic legislation, and conformity with international standards

The declaration of HIV and AIDS as an infectious disease under the Public Health Ordinance 1929 is inappropriate for rights-based management of HIV. The World Health Organisation (WHO)² identified areas for legislative reform as:

- confidentiality
- transmission offences
- public health orders
- blood safety
- condom quality
- informed consent
- migration
- criminalisation of sex work, homosexuality and injecting drug use
- skin penetration regulations
- censorship of health promotion resources
- patents and compulsory licensing.

New health and other legislation should be prepared with these issues in mind.

The assault offences under the Crimes Ordinance 1961 are sufficient for prosecuting offences of wilful transmission.

The offences related to male-male sex and prostitution involving consenting adults in private, the gendered definition of rape, and the lack of provision for marital rape all contravene human rights. The offence of abortion contravenes the rights of women and girls to make their own reproductive choices as noted in the *International Guidelines*.

It is possible that Village *Fono* powers could still be exercised in banishing persons infected or affected by HIV for maintenance of village hygiene, on the grounds that banishment is a reasonable restriction on the right of freedom and movement and residence in the interests of public order and public health.

Tonga: Incorporation of human rights principles into domestic legislation, and conformity with international standards

The listing of HIV and AIDS in the *Public Health Act 1992* and the provisions of that Act relating to notifiable diseases generally, coupled with the absence of non-discrimination legislation and HIV legal protection, means that there are great implications to the human rights of PLWHA in particular and people generally (e.g. lack of confidentiality, mandatory testing, etc.)

Currently, the National Strategic Plan of 2001-2005 is the only national initiative incorporating both government and non-government organisation commitments to addressing HIV under a rights-based approach.

The guiding principles of the current National Strategic Plan 2001-2005 in its response to HIV in Tonga proposes HIV testing to be voluntary, confidential and consensual and also requires pre & post test counselling.

It also mentions the importance of respect for people living with HIV/AIDS (PLWHA), their families and their carers and the significance of sharing information and awareness on HIV particularly knowledge about human sexuality and relationships. It also provides for PLWHA having equal opportunity to

² Godwin, above, p.6

education and the need for a multi-sectoral approach in planning a national response against HIV.

The offences related to male-male sex and prostitution involving consenting adults in private, the gendered definition of rape, and the lack of provision for marital rape all contravene human rights.

Cook Island: Incorporation of human rights principles into domestic legislation, and conformity with international standards

The *Public Health Act 2004* has declared HIV and AIDS as transmissible notifiable conditions and dangerous conditions.

It has made provision for HIV issues to a large extent, but mandatory testing and screening on entry (requiring entrants to inform of infection) are still permissible.

Provision has been made for counselling, confidentiality, but not for exclusion from censorship of HIV awareness materials.

The offences related to male-male sex and prostitution involving consenting adults in private, the gendered definition of rape, and the lack of provision for marital rape all contravene human rights.

The offence of abortion contravenes the rights of women and girls to make their own reproductive choices as noted in the *International Guidelines*.

The offence of 'Infecting with Disease' under the *Crimes Act S.223* is sufficient to cover situations of intentional transmission.

It may however be necessary to provide specific defences of use of condom, informed partner's acquiescence etc., and provisions covering reckless and negligent transmission, and excluding mother-to-child transmission.

The limitations on the powers of the Ombudsman are quite stringent, but are capable of displacement by Act of Parliament.

PNG: Incorporation of human rights principles into domestic legislation, and conformity with international standards

The HAMP Act and the blood supply provisions of the *Public Health Act* were designed to take full account of the rights in the *Constitution*, human rights generally and the principles in the International Guidelines.

The following matters in the criminal law pertaining to vulnerable groups have not been addressed—

- the continued criminalisation of prostitution
- the continued criminalisation of abortion
- the sodomy law and the law on indecent dealings between males, which marginalises MSM

The offences related to male-male sex and prostitution involving consenting adults in private, contravene human rights.

Vanuatu: Incorporation of human rights principles into domestic legislation, and conformity with international standards

Vanuatu has included HIV/AIDS as a notifiable disease under Part 3 (Prevention and Suppression of Notifiable Disease) of the *Public Health Act 1994*.

Many of the powers of health officials under the Part contravene human rights principles generally and the specific rights set out in the *Constitution*. However, the relevant portions of this Act have not yet been commenced.

The *Penal Code* prohibition on discrimination at S.150 provides a good method of criminalising HIV discrimination, but does not provide for other remedies.

The offences related to prostitution involving consenting adults in private, the gendered definition of rape, the offence of abortion and the lack of provision for marital rape all contravene human rights and are likely to contribute to the spread of HIV.

The offences of intentional and unintentional harm causing permanent damage under the *Penal Code* are sufficient for prosecuting an offence of wilful transmission

All of these laws were written in the context of a South Pacific influenced by colonialism and in a time before HIV/AIDS and HIV/AIDS prevention. Therefore out of touch with the world of today.

So what strategies do we have to make positive changes to legislation?

International Guidelines on HIV/AIDS and Human Rights set up some guidelines. In regards to criminal law and correctional systems:

Guideline 4 states that: “States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted at vulnerable groups.” “Criminal law prohibiting sexual acts between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede the provision of HIV/AIDS prevention and care services.”

On anti-discrimination and protective laws, *Guideline 5* states in part that:

“States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors...”

The commentary provides that:

“Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men, including in the context of HIV/AIDS, in order, to reduce the vulnerability of men who have sex with men to infection by HIV and to the impact of HIV/AIDS.

So what strategies can we use in the South Pacific?

Clarification of our Constitution and provisions within our Human Rights and Anti-discrimination legislation.

The inclusion of MSM and HIV/AIDS as a prohibited ground for discrimination.

Redefining western terms to suit Pacific cultures with the inclusion of *Fa'afafine* and *Fakaleiti* and other uniquely Pacific minorities within our Constitution and Anti discriminatory and Human Rights

Legislation.

Contacting and gaining support from our Members of Parliament to amend and repeal archaic discriminatory legislation, and introduce new legislation.

Petition the wider community for political changes.

As individuals we can garner support from different church groups.

Inviting Church representatives and MP's to open debate understanding the close tie between the church and the state within the South Pacific.

Open discussion is one way in which we can challenge, address and allay fears and misconceptions about HIV/AIDS, MSM and how legislation can support the fight against the spread of the disease.

Conclusion

Legislation does not limit sexual activity between human beings.

Legislation can however provide an environment that protects its citizens by allowing access to education and through legislation can a country protect her most vulnerable against not only the disease but against fear and hatred.

As Martin Luther King, Jr, once said

“Judicial decrees may not change the heart, but they can restrain the heartless.”

The first step is up to us

Fiji country report

Legislation/HR abuses in regards to MSM & Sex workers

Fiji was the second country in the world to include sexual orientation in its Constitution after South Africa. Section 38 of the Bill of rights protects everyone regardless of their ethnicity, age, sex, sexual orientation, disabilities, gender ...etc.

Men Who have sex with men and sex work are liable to be charged with Penal Code under the *Offences Against Morality*

This part of the penal code includes offences for rape, defilement, indecent assault, prostitution, brothel keeping, abortion, incest, unnatural offences and gross male indecency. The impugned sections read:

Unnatural offences

175. *Any person who –*

(a) *has carnal knowledge of any person against the order of nature; or*

(b) *has carnal knowledge of an animal; or*

(c) *permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony, and is liable to imprisonment for fourteen years with or without corporal punishment.*

Indecent practices between males

177. *Any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony, and is liable to imprisonment for five years, with or without corporal punishment.*

Thomas McCosker, an Australian, visited Fiji, was arrested, tried and sentenced to 2 years jail for sodomy. An appeal was raised on the basis of Fiji's constitution outlawing discrimination on the basis of sexual orientation. On Friday August 26, 2005, his conviction, and that of Dhirendra Nadan, the other man involved, was overturned on constitutional grounds.

Anti-sodomy laws were found to incompatible with the country's 1997 Constitutional Bill of Rights. The debate over what is and isn't culturally acceptable was at the heart of the constitutional arguments which were presented during the McCosker High Court case (*Nadan & McCosker v State* also cited as *DPP v Nadan and McCosker*) and raised questions about the values enshrined in the country's Bill of Rights. The Constitution of Fiji was adopted in 1997 with a mandate to break the racially divisive legacy of the Fiji coups of 1987. Section 43, concerned the respect of traditional Fijian cultural values, in particular traditional titles, obligations, customs and ceremonies. It was designed to protect the specific interests of the indigenous Fijian communities. While the Methodist church in particular has always argued that homosexuality offends it on a cultural level, and it's not culturally appropriate for Fiji, the High Court disagreed with those arguments. The case is being seen as a victory for gay rights, in a country whose colonial legacy is dominated by strict Methodist values. (Most ethnic Fijians generally regard themselves as Christians, with approximately 65 per cent belonging to the Methodist faith.

EGP response to GLBT related Human Rights Issues in Fiji.

In the years since the beginning of the Project EGP has recorded/documented numerous human rights abuses that has occurred in Fiji, and also how at times a majority of these abuses are not reported to the authorities, namely the Human Rights Commission in Fiji. During the December takeover of Fijis Government by the Fiji Military Forces the sex worker community had reports abuse and harassment being inflicted on them by military and police officers. Some reported being stripped naked, others had

their hair shaven off, while some were subjected to physical abuse and all reports alleged that they were also verbally abused by their captors. Many of these abuses have been documented and EGP with the support and assistance of the ATFF had initiated dialogue with the military to address the issue of abuse and harassment against male and female sex workers on the streets. This initiative had allowed us to voice our concerns with the Military spokesperson regarding the mistreatment of sex workers on the streets of Suva. As a result of this there was a decrease in the number of reports lodged by the Sex Workers regarding abuse on the streets. Since then has been isolated incidents being reported by sex workers in regards to continued abuse and harassments from police officers. There was an incident in which a female sex worker reported that a group of police officers approached her and took her handbag, rummaged through and took her condoms that she had earlier collected from our Drop In Center. The young woman, because of the fact that she had to earn money that night she had continued servicing her clients until a friend of hers gave her some condoms. Clearly this sort of behavior put these sex workers at risk of being exposed to HIV or STI's.

- **History of the MSM community**

Throughout the Melanesian countries, homosexuality has been a practise for generations and Fiji unlike other Melanesian countries, has little to no documented evidence of this. After much debate with several researchers professors at the University of the South Pacific, they alleged that the homosexual rituals wasn't a homosexual act at all but an initiation process. What!

- **Access to services and information**

Over the years there has been word on the ground regarding the treatment inflicted on Men who have Sex with men and Sex Workers when trying to access Fijis mainstream health system. Many have told of stories of victimization, verbal abuse and being shunned by some health care providers.

Equal Ground Pasifik was founded as a sub project of Women's Action for Change in 1998. Then it was called the Sexual Minorities Project. Through collaboration with other CSOs and the Health arm of the Government we have been able to actively participate in the addressing of Sexual and Reproductive Health Issues of the minority groups in Fiji.

EGP Participation in National response to HIV/AIDS.

After being registered as an NGO in 2005, EGP has undertaken numerous activities to facilitate behavior change in the community and to creating an enabling environment. Our partnership with other NGO's has strengthened our capacity in terms of service and information delivery. Through such collaboration EGP was able to participate in the Melanesian Arts Festival held in Suva Fiji. Our Peer Educators were part of the Ministry of Health and S.P.C Peer Education Programmes initiative that focused on Behavior Change. We are also a member of the national body comprising of both government and non government organizations that work in the field of HIV/AIDS. (National Advisory Committee on AIDS).

Our Peer Education Program has been greatly received by the Sex worker community and through our Key Contacts around the country most of whom are former Sex Workers themselves, we have been able to map out a wider network of sex workers and at the same time have been able to distribute condoms through these networks and also introduce new sex workers to our Peer Education Program. Through the ATFF Clinic that we refer our target population to, we have been able to gauge the effectiveness of our Peer Education Programme by the number of Sex Workers, MSM, WSW that use the service and access our Drop In Centre at the same time. Our Peer Education programme has become the vital link between the organization and the Community that we serve, as this is the first point of contact between Equal Ground Pasifik and the GLBT community in Fiji. Through our Peer Ed programme we have been able to assist in conducting follow-ups for the ATFF clinic, we have been able to make condoms easily available to sex workers while they are working on the streets and also provide referral services to the community. This concept was born out of the fact and accounts of sex workers that when they are providing service to their clients, the hotel's, motel's or apartments that they go to would sell condoms at very high prices, and these would create a lot of expenses for the sex worker, thus he/she would loose money.

Since the implementation of our Health Programmes we have been able to broaden our scope of services and this included conducting continuous peer education work and also referral to the VCCT clinic of one of our partner organizations the AIDS Task Force of Fiji. This partnership, forged on the fact that both organizations work with vulnerable groups has allowed us to work together and create an enabling environment whereby men who have sex with Men, Women who have sex with Women, Sex Workers, street Kids, and unemployed young people are able to access clinical services including treatment free of charge. Our partnership with the AIDS Task Force of Fiji also saw our opening of a Drop In Centre that is attached to the clinic. One of the main reasons of the implementation of such an activity is the fact that in all of the similar health Programmes run in Fiji, none has efficiently addressed sexual and reproductive health issues of Men who have sex with men, Women who have sex with women, and Bisexual people. Though these issues are sometimes mentioned, no program has ever dared talked about anal sex, oral sex, masturbation, an HIV/AIDS in the glbt perspective. There has never been any involvement of the glbt community in the putting together of these sorts of activities nor the existence of a policy that would ensure the inclusion of such issues in mainstream health education. Being the only glbt organization in Fiji, it has been a challenge to addressing these issues, and we sincerely hope that our activities continue to be supported and it is hoped that in the future the issues of the glbt community is addressed in mainstream health education. Through the PRHP, EGP, has been able to implement Empowerment Workshops around the country, and also organize and facilitate support group sessions for the GLBT community around the country. Our library and Drop In Centre with the support of Sexual Health and Family Planning Australia has continuously undergone change and development and with the continued support of our donors we hope to provide efficient, accurate and relevant information and services to our target community.

Women who have sex with women (WSW)

Generally, lesbians are at low risk of HIV infection, unplanned pregnancy and becoming infected with STDs. However, even though sex between women has a reduced likelihood of transmitting HIV, transmission can still occur. Sex between women is not always safe, and therefore women need to know the risks and how to protect themselves. HIV and AIDS Lesbians/bisexual women are not at high risk of becoming infected with HIV through woman-to-woman sex.

However, like many women:

- Some lesbians have unsafe sex with men
- In some parts of the world, lesbians inject drugs and share needles
- Some lesbian sexual practices are risky (with the use of sex toys)
- Lesbians wanting to get pregnant face decisions about semen donors

In Fiji to date the invisibility of the lesbians is also a common issue just like any other country around the world. With the awareness on HIV and AIDS many WSW (Women who have sex with women) are beginning to come out in the respective pocket groups and voice their opinions on sexuality in a subtle manner. This is due to culture and religion that cause's society to turn blind eyes when the issue of sexual diversity is challenged.

The outreach programme that we operate at EGP is mostly centred around safe houses and on the streets via through the distribution of condoms to sex workers who are LWSWB. In a recent outreach that was conducted in June this year at a home or safe space of a LWSW couple who paid a weekly rent of \$45 a day at a motel.

This was a safe space for LWSW and transgender men too. The discussion was centred on the struggles that their face on a daily basis.

- Sex work
- Domestic violence
- Accessing health services
- Lack of condoms distribution
- Possible self employment opportunities

- Adequate housing

During the discussion a very important point that was constantly mentioned was the lack of condoms in the area. EGP recognized the need for a point of connection for the community there. We also identified the person to be our PC there (Nadi/Lautoka) she is a local person there and has connections to other LWSWB women who live as partners, sex workers or women in the working field. The eagerness in her to do the work there directed us to the many reasons of the need to have a person there to help EGP with the contributions off condoms (that is a great need) and materials to disseminate to other members of the community therein.

The question of funding possible business was discussed at great length. It was obvious from the discussion that this group of people wanted to create diversion within they lifestyle. They requested that EGP write a letter of recommendation to support an application for Hawke's license. The party involved had previously formed a business initiative but was later approached by the council (Nadi town) for inconvenience to the hotel business within the area. Thus the party involved has put their business initiative on hold and hope to find constructive aid to help them with this initiative. This plan led us to go to the Nadi town council and enquire about the hawk's license for them.

The issue centred on condom use and distribution came out strongly from the GLBT people that were present. It was obvious that they were familiar with the importance of using condoms. They were knowledgeable regarding sexual and reproductive health, they main concern was the lack of condoms and the money that they have to spend to buy them. We identified this situation and acquired a volunteer for the distribution EGP felt that this concern needed attention ASAP, thus we established LWSWB connection regarding this matter.

Domestic violence was a sensitive topic that did not create much attention but led to other domestic violence topic that was centred on other WSWLB people in these areas (Nadi/Lautoka).

Accessing health services for STI's and other sexual disease prompt them to speak about some personal experiences. Homophobia is still is a common problem regarding the use of this service. Some one said that she would rather come to Suva (ATFF) for a blood test rather than the Health services in Nadi.

They life style as sex workers was a struggle in terms of competition with the community there. They concern regarding family obligations and personal needs and wants geared them to function in this profession. There were times when trouble brewed between them (SW) and certain people involved to mediate between the two parties. The SW business is on a roll, there are certain people that we spoke to, that hope to divert from this field and seek constructive assistance to divert the mindset to something permissible.

Lesbians face a level of social marginalization and disadvantage thus making life more difficult for them. From the moment they are aware of their sexual minority status, they are also aware of the challengers to their lives. Lesbians must negotiate the sexism that all women face. If they are members of cultural minority groups they must negotiate racism. If they have a physical or perceptual disability, they must negotiate ableism. Of course, if they are old they must negotiate ageism as well. These social disadvantages are a pile on for lesbians, who face the additional and ever-present challengers that are purpose of their sexual minority status.

To date the EGP women's project has been getting recognition about the importance of they exclusivity from other women's organisation such as WAC (Women's Action for change), FWRM (Fiji women's Rights Movement), FemLink, etc. The recognition that EGP receives has enabled us to reshape our interventions in expanding our options in getting support and empowerment. Through the personal stories and documentation of the LWSWB women this has enabled EGP to create visions in guiding our work and moving with experiences thus evaluating results to changing environments.

PNG Country Report

Tok out Tok Stret

Talk out Talk Direct (be direct and frank)

Introduction

Papua New Guinea is the large island nation located north of Australia it shares its border with Indonesia to the left and Solomon Island to the right.

Papua New Guinea boast a rich culture with more than 900 + language and traditional values and practices which range from cannibalism, tribal fights, art, subsistence farming, music, traditional dress, with colourful face decoration to sexual rituals and initiation rights which include men to men sexual behaviour.

Legislation Human Rights Abuses in Regards to MSM Sex worker in PNG

Papua New Guinea was a colony of the British to the south and German to the north of New Guinea before World War I & after World War II it became a territory of Australia until PNG gained independence on September 16th 1975. Most of Papua New Guinea's legislation has been influenced a lot by the British colonial laws and religious influence by the early missionaries who brought with them their values and culture plus ideology about sexuality and men to men sexual behaviour.

PNG constitution and laws was adopted around 1973 from the Australian and British legislation and put together in preparation for independence in 1975.

Sodomy is illegal in PNG with a 14 years imprisonment as penalty; Sodomy is defined as anal penetration or act of unnatural sex whether it be male/female.

Sex work is illegal and one has to prove that you are living off the earning of prostitution. Penalty is not exceeding K400.00 and 1 year in prison.

Human Rights Abuses in PNG

MSM have always faced high stigma and discrimination in from the community in PNG if their behavior or sexual preference is known especially with feminine men. Most feminine men are abused by their own close relative in their homes than to the community and the nation. Abuse begins with verbal (E.g.: why can't you be a men) to physical abuse hitting and finally sexual abuse. Most feminine men are survivors of sexual abuse from an early age with emotional and mental scars that repeats itself in life finding an answer is not easy.

Example: 1. Annalisa is a feminine man who live in Goroka in the highlands of Papua New Guinea she loves wearing her make up and high heel boots with tight jeans and T/shirt she works for a four star hotel in Goroka. Annalisa was stabbed twice in the stomach and physically beaten up a number of times because of her appearance and feminine characteristics.

Example: 2. Josephine is a male sex worker and wears full women's clothing whenever he feels like. Josephine was deserted by her parents at an early age when they separated they left her to aunties who soled sex on the street he grew up on the street and had to survive by selling sex. His father and mother deserted him because he was not a man or a woman. Josephine has always been through a lot of abuses in her life from knives wounds, fist, stone, gun butts being used to hit her abuse from police and rape.

Both Annalisa and Josephine now have support and friends from Poro Sapot Project who educates the community to understand male sexuality (Transgender/MSM) to accept us for who we are and to advocate plus protect us from abuse from our families and everyone else in the community.

History of MSM community in PNG

There are certain tribal rituals in certain parts of PNG and initiation rights that involves men to men sexual behaviour.

Example: when reaching puberty young men and women in PNG must go through their tribal initiation rights and ceremonies. This is the time when they are taught knowledge of hunting, fishing, land boundaries, magic, and most importantly how to have sex each belief is distinct from each other.

Example 1 Northern Niugini

Torture pain from tattooing, circumcision and anal sex with less food is what makes you strong to become a man and to learn how to survive

Example 2 Highlands of Papua New Guinea

Oral sex initiation (drinking semen/sperm from uncle will give you strength, life and the semen is believed to start the process of reproducing sperm in the young males body to continue the generation to have children when he marries.

The ceremonies are completed with pig killing and feasting to acknowledge the spirit of the land who protects the clan or tribe.

The arrival of missionaries during the early 1900's has forced most of our traditional practices to be hidden. Sex is now a taboo subject because it's a sin to talk openly about it.

Access to services and information

Access to service and information is still limited to province with project office only in Port Moresby and Lae.

Stigma and discrimination prevents sister girls and in the closet MSM to access the services and information available in the community.

Most information is not specific to MSM needs and issues Peer Education has proven to be successful to bring information to MSM peer who don't access services and thus encourage and empower them to be confident to access services available.

Relationship with stakeholders

Building relationship with service provider is very vital to educate them on issues affecting MSM that make MSM vulnerable to HIV/AIDS.

Regular visits and sensitization meeting builds better working relationships knowledge and understanding about MSM to the service provider to help them respond positively towards providing to our needs.

Being open and direct with issues around MSM issues to your community can make a big difference

Promoting the 3Rs

- Respect
- Recognised
- Rely

Respect MSM/SW

Recognize MSM/SW for who they are their decision and choice

Rely Rely on MSM and SW knowledge and understanding to find solutions to Issues affecting MSM/SW and empower us to take the lead in fighting stigma and discrimination.

Don't speak on behalf of me, because you might say the wrong thing.

Don't tell me what to do, because you don't know me. Just ask me and I'll show you.

Stand beside me and let me lead the way.

Cook Islands Country Report MSM in the Cook Islands

The term sex worker has been removed from the above statement as there is no evidence anecdotally or formally of sex workers in the Community (Sex worker as defined as exchanging sex for money or goods)

The Cook Islands constitution guarantees all people the fundamental right to life, liberty, freedom and security within the law, yet past and present administrations have enacted laws contrary to this.

The crimes act of 1969 specifically refers to acts of indecency between males, regardless if they are of mature age, and consenting. This law only refers to males yet not to women, a double blow to MSMs, who are not allowed by law to engage sexually but is alright if women partake in lesbian activity. This in turn criminalises all MSMs for engaging in acts deemed indecent and further pushing MSMs underground.

New legislation amending the previous Cook Islands Marriage Act of 1973 in regards to marriages has been passed, the amendment article no.7 15a stipulates that 'Marriage between persons of same gender prohibited.' The authorities don't seem to view the MSM community as being worthy of representation in the general public with the recent amendments, in terms of MSMs not being able to formalise these relationships. This piece of legislation denies all MSMs the right to marry their male partner should they choose to do so which is in direct contravention to the Bill of Rights in the constitution. The Minister who submitted the amendment to the Cook Islands Marriage Act acknowledges that this could have some implications against the constitution should it be taken to the courts for interpretation. This amendment was raised in reaction to the civil marriages act approved in NZ two years ago and also based on the lucrative wedding packages sold in Rarotonga and to prevent members of the same sex coming to the Cook Islands to get married.

Legislation/human rights abuses that are currently suffered by MSM are based on Western perceptions of law and order yet culturally we suffer no such prejudices or abuses, in fact we are highly regarded by our people culturally for our artistic skills and hard working attitudes.

Cook Islands history of MSM

Cook Islands history in relation to the MSM community are recent additions to literature and common knowledge as the Cook Islands has no historical written evidence of MSM society going back 100 years.

There has been hearsay on the topic but no actual written facts to support MSM being established in this country before that, yet we share common cultural similarities with our neighbours e.g. Samoa and Tahiti who did have MSMs or what was commonly known as the Fa'afafine and Rara in their community.

The advent of Christianity in the country would have been a contributing factor to the lack of written evidence or the avoidance of speaking about this topic, where even today, speaking about it let alone writing about it still considered taboo.

There is still general "acceptance" in society of MSM, however, these are limited to women based activities in which the MSM prefer to participate in, however in positions of leadership and government with public profiles the fact that MSM display feminine qualities, is an impediment to their progress e.g. (gave the example of Tangee standing for parliament and the doughnut comment).

The present history of the community in the Cook Islands is assured for the future reference with the continual rise of MSM in society through education, sports, health, government, business, community groups, religious organisations and entertainment.

Access to services and information

Access to services for MSM could be considered as average, where we have access to all public infrastructure facilities. In terms of health services in relation to HIV/AIDS and STI's the services are geared towards mainstream public and don't cater to the sensitiveness of MSM.

MSM find using certain health services problematic due to the fact there is no confidentiality e.g. testing for STIs, where your business is every ones. While it is acknowledged that this may be a problem for the general population, this is exacerbated for MSM.

Gaining access to information is time consuming, at times prohibited by cost and the poor level of statistics and data collection. We have major health stakeholders in the community apart from our localised agencies, such as the International Red Cross and the Pacific Islands AIDS Foundation, but none specifically to deal with the needs of MSM, who like the general population require anonymity, unless they have health or welfare issues that require disclosure to the appropriate authorities.

Relationship with stakeholders

At this moment in time there is no established agreement between possible stakeholders such as PIAF, Redcross, Punanga Tauturu (human rights based organisation), Te Kainga (Mental Health) and Cook Islands Ministry of Health because in the past there has been no interest by the MSM community to establish themselves formally an association or incorporated group.

The MSM community has an open dialogue of understanding with certain possible stakeholders such as Punanga Tauturu and sport based groups, but nothing that clearly formalises or represents the views of MSM community into general society.

There is an understanding among out MSM to commit to establishing an organisation that would work alongside other human rights groups to enhance and gain access and services as well as to seek fair representation in government on issues that affect MSM.

Acknowledgments:

To all the 'Sisters in Rarotonga' Kairangi J. Samuela, Legal Rights Training Officer – Punanga Tauturu Incorporated, Cook Islands Women's Counselling Centre

Status Report of GLBT in Tonga

1. Introduction – This report on the current status of the GLBT community will focus more specifically on the gay or leiti populations in Tonga, consisting of males who are considered as gay, transgender, or Bisexual. This report is primarily to bring light on the social, economic, health and spiritual status of this population along with some of the challenges, obstacles and future aspirations of this group collectively and individually.

With the installation of programs, activities and partnerships with private groups, government agencies and community organisations, we have fortunately been able to share some of the basic and crucial needs and challenges; we are often confronted by the lack of access, opportunity and equality to information and activities that should involve us in the forefront of planning. We are usually an afterthought. They are 138 members and 3 lesbians who are open about their sexuality.

2. Social – the leiti's in Tonga strive to be very involved in their community by participating in social activities when they are needed to assist in execution of certain task which may involve cooking, decorating, entertaining and cleaning. Their social acceptance among their community is still disenfranchising because they are allowed to participate in some activities and yet they are not allowed to take on roles that might be seen as male dominant roles.

With the annual Miss Galaxy Pageant we have provided a nationwide and international venue for leiti's to present their talents and views to the public. It's the one time during the year we come together to present the best of what we can offer our community as far as talents, entertainment and public awareness about who we are thanks to the ending support of our Princess Her Royal Highness Princess Salote Pilolevu Tuita and our Patron who is Her Highness Eldest daughter Hon. Lupepau'u Tuita. Unfortunately, even though we have made strides with the Miss Galaxy, we are often challenged by public misconceptions and the lack of financial support to help those who would like to participate in this pageant. We are hoping that in the future we can provide educational opportunities to create programs to provide the public with a broader look into our specific realities and give them better a sense of which we are and how we can be more positive contributor to the society in which they live.

3. Economic – There is an increasing of leiti's striving to become self-sufficient and create a unique niche in the economy. There is an increase of leiti's involved in the opening up their own little boutique salon offering beauty services to the public. Fortunately, they have been trained by other leitis mentors in this industry. There are others also involved in the public health arena as nurses, doctors, medical; practitioners and also teaches in schools but who have no strong association with the majority of leitis. I think these few educate don't realise the impact they can have on these leitis who are not as fortunate to access opportunities as they have.

There is a huge population of leitis that are basically “homeless” and have no family or economic support. This is a major challenge for us to try and find out opportunities to provide economic assistance to them in trying to find employment and education, especially for those that have exited early from school.

4. Health – the status of health among leitis in Tonga is very dismal with the lack of consistent monitoring and reporting of health status for this population. We are lucky that we are not at a stage of emergency in any specific health crisis in our country but the lack of information and consistent monitoring of the health status of GLBT and leitis in Tonga can become a major obstacle if not realised now.

We have participated in several HIV educational workshops and activities thanks for the help of Tonga Family Health, but there have not been any attempts by any particular government agency or community group to organise a consistent monitoring assessment of the general health issues and status of GLBT individuals in Tonga.

5. Spiritual – It is not uncommon to see leitis participating in church services in Tonga among the different religious groups. They provide a very unique role in that they are a great support system when there are tasks in social activities planning and implementation. There are some that are involved in choirs and youth groups assisting in whatever programs and activities they can be involved in and often can make a positive impact on the image of leitis.

However, there is still a huge population of leitis not involved in any religious groups due to fear of rejection and bringing shame to their families. There is also a lack of outreach by religious groups to leitis which could really make a difference in their acceptance within their religious organisations.

6. Challenges, Obstacles and Future for leitis - The challenges and obstacles by leitis can all be summed up in one word “lack of public education and support” of who what and how they can contribute to the social, spiritual, health and economic vitality of the community. This is probably one of the major obstacles facing them, which also contributes to their lack of access to employment, educational opportunities and acceptance in Tonga.

Cultural and health issues relating to being

Pacific MSM in NZ from a counselling perspective

By Silipa Take

Introduction

Fa'atalofa atu i le paia ma le mamalu o le tatou aofia i leni taeao. I tupu ma e'e ma paia lasilasi o Samoa. O paia lava ia mai le vavau se'i o'o i le fa'avavau. O paia fo'i ia o Samoa ua uma ona tofi o le a ou le tautala i ai. Fa'atalofa atu i malo vala'ulia mai isi motu o le pasefika ae maise uso ma tuafafine i Samoa nei. Fa'afetai mo le vala'aulia ma le amanaiaina o lo'u nei tagata e fai sina fa'amatalaga i leni fonotaga alo'aia.

Kia ora, and warm Pacific greetings from the land of The Long White Cloud, Aotearoa New Zealand. Special greetings from the New Zealand AIDS Foundation and the Pacific People's Project for the Fono.

My name is Silipa Take. I am a Counsellor with the Positive Health Programme and a Pacific Island Health Promoter with the Pacific People's Project of the New Zealand AIDS Foundation. And I am based at the Awhina Centre in Wellington.

Half of my job I do pretest and post-test counselling, ongoing support for HIV positive clients and sexuality counselling for men who have sex with men (msm). The other half I do the Pacific Island Health Promotion on HIV and AIDS, nationally. I travel the length of New Zealand, from Hawkes Bay and Taranaki to the bottom of the South Island to do workshops, and education sessions with PI health professionals, and communities. My colleague, Phylesha-Acton-Brown looks after Auckland and Northland. I'd like to take this opportunity to thank the organizers for the invitation to speak at this special gathering of our Pacific MSM's. Fa'etai tele lava.

What is Counselling?

Counselling is a word that is unfamiliar to our Pacific people. When people hear the word "Counselling", they immediately think something must be wrong with you mentally in order for you to be doing or going to counselling.

This is not the case. People confuse counselling and psychotherapy. Counselling is having a skilled and trained person there to reflect, offer support, offer different options and mirror things back to you, so you be able to make informed and rational decisions for yourself. The Counsellor is there to guide you and walk along side you on your journey of discovering yourself.

Confidentiality and professionalism are paramount in counselling. People go to Counselling for all sorts of reasons. They might present with one issue and discover that that is not what is causing their anxiety or worries at that time. The Counsellor have the skills to be able to reflect things to you so that you can see the parallels of what is causing the worry in the first place and things that have happened in your life, so you can move on and live your life the way you want.

"This is your journey of discovery."

There are ethics, boundaries and professional standards that you have to observe as a Counsellor in your work with the client. The process can take weeks, months or years to achieve the outcomes. The process had to be client centred or client focused. It is also has to be conducted at a pace where both the client and the counsellor are more comfortable with. Each individual is different and it takes a different amount of time to sort things out individually. A good Counsellor will not rush the client to achieve results.

At times during the process, there will be a few light bulb moments, and some people mistaken these as that they are ok to carry on by themselves. These will cause setbacks. But, like most things in life, we learn from our mistakes and mishaps. So the counsellor's job is to monitor this process and clients progress so the client doesn't get stuck. When a client is stuck and not sure which way to go or which way they are heading, the role of the counsellor is to guide the client in the right direction. Sometimes people get stuck because they do not want to revisit painful moments and events in their past. Or they are too comfortable with their present life, no matter how difficult and confusing it can be, and they are afraid of new changes.

As a counsellor, you should be able to challenge the client in a manner that is neither offensive nor harmful. You should maintain absolute professionalism with the client right throughout your contracted time in consultation. In New Zealand, the National Association of Counsellors (NZAC) has a Code of Ethics and guidelines that their members abide by. It is also recommended that, as a counsellor, you need to be doing ongoing personal developments and up-skilling every year. These include workshops, conferences and any other training and studies related to the counselling field. We need to understand that sometimes, sharing an issue with someone other than ourselves and loved ones can bring different perspectives, different approaches, and other options. When you are so wrapped up in the problem, you cannot see things clearly and you cannot critique what is going on with you or around you. As the saying goes, "*a problem shared is a problem solved.*"

The Pacific approach

As Pacific Islanders, we are not brought up with this concept. Our Counsellors are our grandparents, aunties, uncles and for some, the Church Minister and his wife. From the cultural point of view, this is the accepted norm.

Seeing someone who is not a family member to talk about your issues or problems is not ok. From what I have learned and observed in New Zealand, most people tackle these issues either from a religious or cultural approach. And I believe it is very similar right across most of the Pacific nations, according to conversations I had with other friends and colleagues from other PI nations.

I will not get into the religious approach. This is an issue that needs a whole conference of it's own to discuss. I will only touch on, and share my understanding of the cultural approach, which I mostly use in my work at the moment.

When we have issues or problems, we get directed to our elders. And if the family doesn't want to deal or not know how to deal with these issues, the Church Minister will be the next port of call. We do tend to rely on the wisdom of our elders and divine guidance of our Church Ministers to help with our day to day lives. This is the preferred way and the norm that most of us are used to here in the islands. We also try and keep these issues within the family or with the exception of the Church Minister and his wife. Sometimes it works sometimes it does not. Because most of the parents who are now residing in NZ were brought up in the islands with this process, they still stick to these ways. So when an incident happens or issues arises within the family or with a family member, protecting loved ones and the family pride or honour can take precedent rather than dealing with the source of the matter.

For our New Zealand born PI's, there are protocols, laws and policies within the health systems of NZ that we must adhere to. Most issues and especially those of the sexual nature, the authorities need to be involved. In any culture and setting, talking about sexual matters is a subject that most people are not comfortable with. My experience with our PI clientele, like anyone else, they too are not very comfortable talking about sexual matters, particularly to a PI Counsellor, or Health Promoter. People fear that it's a small community and that we all know each other and might tell others and/or their families about their presenting issues. What our people need to understand is that as trained professionals, we are bound by confidentiality contracts and code of ethics, both by the organization that we work for, and/or the Association of Counsellors that most Counsellors belong to. So whatever is discussed at a session stays there with the Counsellor. Every session have to have notes and should be recorded by the Counsellor to

assess the progress of the client. We are to contract each client so that it will help them commit to the sessions. It is also our responsibility to our funders so they know where we are spending their money. Depending on what issues a PI client brings to a session, as a PI Counsellor, I have to adjust my approach, attitude, behaviour, and mannerism towards the client. Most of the ones accessing our services are the NZ born PI's. Their issues are somewhat different from the island borne. Regulations and policies of the health system in NZ requires us to conduct the sessions in a certain model and way. But as a PI Counsellor, I have to weave some of the PI cultural influence and ways to make sure that my PI clientele are well looked after and be culturally appropriate to their presenting issues. I also check with the client whether the family needs to be involved in their care and progress. I work with the client to be in touch with their particular island nation's culture and protocols. I learn sometimes, the family approach does work well with most of our people and that the respect they give their elders and family will have a more beneficial outcome. That PI pride and way of doing things like in the fa`a Samoa, fa`aaloalo (respect), loto maualalo (being humble), loto fa`amagalo (forgiveness), agamalu (being gentle) and alofa (love), also help to guide the session to a more appropriate outcome. I rely on my other PI health professionals and allies to give me advice and the right protocols of their different island nations in order for me to work effectively with clients from various Pacific ethnicities.

Presenting Issues

Each person brings in different issues. What might seem like a problem at the time can be a smoke screen for a whole raft of underlying issues. We tend to get embarrassed to admit that we can't cope and that there is a problem. Our pride gets in the way and we put up barriers. It's a human trait and our defense mechanism being best at work. Added to that is the attitude in NZ of, "she'll be right mate." That does not help at all.

Sometimes we don't tell all the truth if we are talking to our families or the Minister and/or his wife. We tend to edit the stories to protect our families or ourselves. So the recovery work can take a different approach, and missed the root of the matter that should be dealt with or discussed. And even if and when the truth is told, some of these issues are too extreme to our people that the process of recovery for the client takes longer or completely missed the mark. The family, (more than often) do protect its name or save the embarrassment from the community, (especially our PI pride) than to protect the family member that has been hard done by or is in need of the help. If the client issues are of a sexual nature, most of our people will not be comfortable discussing or dealing with it. As in any culture and family, issues of the sexual nature or sexuality do not get discussed and brought to the open. Some people sweep these under the carpet and it festers until it is a major drama. These can escalate to a point where families get split up and people hating each other and all sorts of dilemmas. We know very well as PI's how gossip and ualesi moso`oi (wireless whispers) can ruin reputations and one's honour. No matter where you live, it's the same practice. The trouble is, as island borne, we are used to it and know exactly what is going on. But to our NZ born youngsters, most of them do not understand these practices and that can sometimes turn them against their communities. They have the NZ way of doing things, rules and laws and yet when they are at home and around our own people they don't feel they belong. Especially when it comes to gossip and how to not shame the family and/or talking to someone about their issues. Things are much more relaxed the island way. I had incidences of PI parents having a go at me for not telling them that their sons or daughters have seek counselling help from our services. They don't even understand when you try to explain the confidentiality side of things and human rights of the young person. To them, it doesn't matter how old the child is, they still have the right to know everything. They also expect me to tell them and it's my responsibility to them to say something. I just gently explain where I stand and apply the policy that I am working under to safeguard my client and myself. I do make sure that it is all culturally appropriate and respectful to my client first and then to the parents.

If a young person coming out as a fa`afafine, fakaleiti, akavaine, gay, lesbian, transgender, intersex or MSM, how would this be dealt with in our Cultural or Christian ways? From my experience growing up here in Samoa as a young fa`afafine in the 60's and 70's before migrating to NZ in the 80's, being a fa`afafine was not an issue. Our families and communities do know and it was a subject that was not discussed openly but we are loved and treated just like any other member of the family and community.

Sure there were the name calling and being teased by the other kids of the village and at school, but it wasn't malicious or hurtful. For me, my siblings and elders were very supportive and loving. I have my place in the family and I am always valued. That's not to say that every fa'afafine growing up here in those days have the same experience. But my observation was that it was very much similar for all of us then. Now living in NZ and being on the other side where some of our NZ born Islanders come to for advice and counselling, their presenting issues are so varied and complicated. They are very much alone and they are scared to ask for support. Also the influence of religious teachings and beliefs for some of the young ones make them confuse, and scared to come out to their parents or peers. They know they are different and are attracted to the same sex, but they don't want to come out. This is an issue that a lot of the new MSM and young ones find it hard to understand. Partly because of the perception that the PI non heterosexuals are all drag queens and only those who dress up can be identified as PI fa'afafine. There is also the fact that most of the PI parents were born and raised here in the islands and then migrated to NZ, so their thinking and attitudes are very much in the island way of doing things and yet these youngsters are born in NZ and are educated and brought up with laws and rules of their adopted country. This is one of the confusion that a lot of our young people growing up in NZ bring to counselling. There is a very good percentage of our NZ born PI MSM who are only comfortable as being gay and/or closeted, as in the palagi concept. I have worked with quite a few of them who detested our PI terms like fa'afafine, fakaleiti, akavaine and so forth. By identifying as just gay, they don't feel a sense of belonging to any group in particular. Some will only act on their homosexual tendencies when they are under the influence of drugs and alcohol. And by doing so they put themselves at risk of being blackmailed, gossip, HIV and other sexually transmissible diseases. At times I do wonder how many young PI msm's that committed suicide because of the fear of coming out to family, friends and peers.

Most people who come in for testing, we encourage them to come back for on going counselling; especially the high-risk promiscuous groups. Part of my job is to ask them the questions that will make them reflect on their actions and what has caused them to behave in a certain way and ended up putting themselves in harms way. One of the themes that come through very clearly is the fear of the moral judgement. Most have a Christian upbringing and they fear their parents will ostracise them from the family, because, God does not agree with their choice of lifestyle and who they become. I work with them to try and accept who they are. To understand that being gay and being attracted to the same sex is not a choice and it is not a lifestyle. They are born this way and this is whom they are. Learn to embrace their gayness and uniqueness.

Coming Out

I never heard of this term until I lived in NZ for a few years. My first experience of this is when one of the restaurant staff where I worked in the early 80's, said to me after learning that I am a fa'afafine, "so when did you come out" and why didn't you tell us that you are a fa'afafine? In which I replied, "Come out from where? I was never in a closet and I am always out", besides my sexual preference is a private matter.

I took it for granted the comfortable life I had here in Samoa. I never thought twice about telling people of my sexuality. I suppose when you grew up in a supportive environment and don't know any different, it was a shock to me when this guy asked. I grew up thinking that my sexual preference was no big deal and that it was a private affair, no one else's business. The teasing I had here and name-calling was nothing compared to this new experience. But because of the way I was brought up and the confidence that was installed in me that, I am someone and that I am special by my family, it carried me through in those early days and up till the present. Also, the support and confidence that was installed in me by some of the older fa'afafine, that took me under their wings and watchful eyes and guidance. It is part of this pride and respect that I use in my work to help others that are coming through. I still remember when I was eight going to church with my grandmother, and one old lady said to her, you are so lucky you have a fa'afafine son. I never knew what that meant until I was a bit older that I am seen by my family as like all the other siblings and that we are seen by our family and communities as valued members of the family. We're the ones that were doing most of the family chores and look after everyone. I was always encouraged as a youngster by my grandfather to do well in school and be independent. He said to me, you are different and you need to do things for yourself and not rely on anyone else. Even though he didn't say the word

“fa`afafine”, I knew what he meant. This helps me in my journey right throughout life. I very much believe in nature and nurture with love and support for a healthier prosperous future. It is imperative that our young ones and new MSM coming-out, get the support and understanding in order for them to be confident and have the self-esteem to be able to deal with bullying, prejudice, stigmatization and being ostracized out there in the community. For those new MSM coming out, they need to give their families and loved ones time and space to come to terms with their sexual identity. It is important to empower them to be proud of who they are and where they come from. They have to be a proud member of their family and a proud citizen of their island nation before their sexual identity. Be respectful of yourself and others and you will get respect back. Mentoring and ongoing encouragement and advice are always good strategies. We, Pacific Islanders, are a resilient bunch. I am sure that all of us that are gathered here at this conference have done this for our families and communities, and have offered this support to young ones in the past and are continuing doing so. Here, I applaud and give credit to those who are involved in the organizing of this Fono. This has shown your commitment and care for our MSM in the Pacific. Keep up the good work. Fa`amalo galue.

Models of health

With most government departments and health providers in New Zealand, they work in collaboration with each other in order to get the most appropriate trained professionals to deal with each individual's presenting issues. The medical model of health that we use at the New Zealand AIDS Foundation is based on the Ottawa Charter. This was developed at the first World Health Organisation (WHO), international Conference on Health promotion meeting in Ottawa, Canada in 1986. It defines as, *“the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health and well being.”*

We also have the Treaty of Waitangi, which is the founding document for New Zealand to assist us in our work. The Treaty is about partnership and fair treatment of all people. These are the documents we use to work with our clients and communities both in health promotion and HIV prevention to empower them to take control of their own lives and well being by making healthy choices. Most of the New Zealand AIDS Foundation Counsellors and Health Promoters use the Whale Tapa Wha model. It is a Maori model by Professor Mason Durie, which is very similar to the one that I use in both my counselling, and health promotion work with PI communities.

Fonofale Model

I use the “Fonofale model of health” by Fuimaono Karl Pulotu-Endermann. (One of our own proud Samoan fa`afafine in Wellington).

In Samoan culture, the falefono or meeting house is where everything gets sorted out for a family, village, district and the country. It's where all the decisions are made and where the matais (leaders) discuss and sort the families, village and district issues.

Even though we are only funded to do PI MSM health promotion, the Pacific way is through the family, we go out doing the workshops and educations to the whole family and communities. So we at the Pacific Peoples Project use this model for our health promotion work. We do not separate the community at large and MSM. We are also promoting the message that we, as MSM, are family members and that we are valued by our families. It also helps break down barriers and stereotypes out there that HIV affects everyone and it's not just a gay disease. It also helps to try and get the family to discuss these issues of the sexual nature openly.

The foundation (fa`avae) of the falefono, is the family, which is where we all belong and come from. These are our roots. But I also refer here to another family, which is your fa`afafine, akavaine, fakaleiti, mahu, msm, (glbti) queer families. The ones you created with your new circle of friends and role models. Some of our non-heterosexual people coming in for counselling and advice have already been ostracized by their families, or they have ostracized themselves from families due to the clash between their beliefs, morals,

culture and sexual identity. I encourage them to embrace and rebuild relationships with their families of origin or their new adopted families. It is vital to their journey to have that backing and support from people that do care and love them. It can be a very long process if the family is resistant. I focus mainly on the client so that they are safe and that they are at a place where they can manage to get on with their life with whatever outside support system that is available to them. But if the family is willing to work together and work through the issues with the client, it makes for a very happy and positive outcome for everyone. When this gets in a safe place and a more comfortable stage for the client, then I move on to the next phase.

The four main posts (pou tu) are, about their *physical, spiritual, mental well being and the others*, include sexuality, gender, age, socio-economics status. All of these are link to each other. In order to have a healthy and uplifting spiritual being, you have to be of sound mind and be stable mentally, and physically. All the other elements included on the “other post” have to be in order as well to be a together and well-adjusted person. This is the most difficult area to work with due to stigma about mental health issues. As in the past, and up until the 1970’s in NZ, any issues about homosexuality were diagnosed as a mental illness. Some people coming out have suicidal ideations and were treated with shock treatments in mental institutions. So we will never know the seriousness and the number of non-heterosexuals who committed suicide due to sexuality issues in those days. Common themes coming through at a counselling session is, internalized homophobia and homophobia phobia. *Internalized homophobia*, is about being gay and having a fear of anyone around that is acting gay. It is also a perception of what a gay person should behave and act like, especially in public. It can be insecurities about being gay and having to project it on to the other gay person. It is also the messages that are given when growing up from significant others. i.e. parents, siblings, peers, church and other people. *Homophobia-phobia*, is the fear of being labelled a homophobe and being associated with gay communities. As an example this is very common with individuals who are in search of their identity, and especially individuals who has spend most of their formative years in institutions like the armed forces, police, to some extend boys schools to name a few. But also it’s a societal expectation of how men should behave and act. It’s that macho image syndrome.

The posts connect us to the roof, which represents culture. Our cultures distinguished us from other ethnicities. It’s our identities and encompassing protector and our pride. In this we have positives and negatives. The culture can protect us but also exposed us. Sometimes in a counselling session, culture can be used by some people as an excuse for their objections and non-acceptance of their sexuality. Having talked to some of our elders and prominent leaders, fa`afafine had a positive role in the Samoan culture pre Christianity. It was also noted that the term fa`afafine, had no sexual connotations back then. It was only after the arrival of Christianity that it was deemed immoral and wrong. Sexuality is part of who you are and your identity.

Surrounding the falefono is the environment, time and context. This is our everyday lives and what we do in order to survive. This is where we relate to the outside world and everyone else. This is also where a lot of the outside influences come in and shape the way we do things. It’s this part as well that has the most negative effect on our daily lives but also forms a lot of the opinions about us as the sexual minorities. People’s perceptions affect us both negatively and positively whether we like it or not. What other people think and say does influence us, and the way we relate to others. Some of the negativity such as stigmatization, discrimination, ostracism, alienation and so forth, have stem from outside perceptions. We, as sexual minority groups, have been brought up in the Pacific amongst the Christian faiths and by heterosexual parents. So our up bringing was in heterosexual lifestyles and Christian beliefs. We grow up with our parents as role models. Whatever they learned growing up is what they teach to us to form our beliefs and morals in life. As non-heterosexuals, we find these messages confusing at most times. In a counselling session, the majority of the issues are about outside influences on the client and their mental state. I try and engage the client in revisiting their childhood and their upbringing to get a sense of where the issues stem from. It is also important to relate the client’s experiences from the past and what is going on in the present. Our past shapes our future.

Support Services

In New Zealand, there are support networks like Youthline, Rainbow Youth, Uni Q groups at most Universities, Gay Mens Welfare groups around the country, Social and Gay Sports groups, Schools Out for secondary schools, and some local groups in the regions. For our PI's, there are groups like AFA in Auckland and Mafutaga Uso Fa`afafine ma Aiga in Wellington, and many others in different island groups that nurture and support our young ones and new MSM coming out. These support networks are for young and old to be around their own peers, to share information, support for each other and create safe environments to be who they are. The Out There Programme of the New Zealand AIDS Foundation just held a national hui/fono last month for young queers in Wellington. The word queer has been reclaimed by young people who are non-heterosexuals as an inclusive term, rather than trying to go through the list of all the different sectors of the gay, lesbian, bisexual, transgender, intersex communities (glbti). There is always a debate amongst the young and old glbti communities in NZ about this word. Some of the older generations do not like this term because of the negative connotations while they were growing up. For us PI's, none of these words describe us here in the Pacific. So we stick to our terms.

About 120 young people from all around the country attended and it was a forum for youth leaders to get together to look at strategies for future development of these support networks. Some of our young Pacific MSM attended this gathering and most of them NZ born, can relate to these support groups well. A trend that is becoming clearer with young queer people accessing our services is that they do not want to be put in boxes or being labelled. To them, they are sexual beings. Their sexuality is fluid and that it depends where they are, mentally and psychologically. This means, in their teenage years they might come out as homosexual and in their mid twenties they click with a girl so they be comfortable as heterosexuals or bisexuals. They coined a new term called, poly-sexual. It's to do with their multi sexual partners. But as health workers, we see this non-defining of boundaries as an issue with sexual promiscuity, and a high rise in sexually transmitted diseases. The young non heterosexual people in NZ do come out much younger now then it was in the 70's, 80's and the 90's. The rates of sexually transmitted diseases are very high in NZ amongst non-heterosexual young people. At the NZAF, we endeavour to try and do as much work together with the Public Health and Family Planning Association (FPA) to educate and do some sexual reproductive and sexually transmitted disease prevention workshops with youth groups. We also try to get into the church groups in order for us to get our message across. Attitudes have changed in the past 20 years in NZ about sexuality and sexual behaviours. In general, people talk more openly about sexual matters.

The Homosexual Law Reform in 1986, also the De Facto relationship legislation and Civil Union legislation of the last few years in NZ contribute to these new and more confident attitudes. People are talking more about it and the media does play a very important part in this as well. Issues and programmes about homosexuality and sexual minority groups are all over the media now a-days. Also, most of the parents of young queer people were born in the baby boom of the 60's and grew up in the era of sex and rock and roll in the late 60's and 70's where most of these issues have been publicized and discussed openly, so their attitudes are very open and supportive. Young people do come out much younger now. While travelling with my work throughout the main centres in NZ and talking with our PI communities, there is still stigma and shame associated with the subjects of sex and sexuality. Our people know it exists but the attitude is out of sight out of mind. Some parents fear that their child will have a hard life and that they are sexually promiscuous and putting themselves at risk of HIV.

When I do talks and workshops in the communities I make sure that the message about HIV is clear. HIV has no boundaries and does not discriminate on your ethnicity, gender or sexual preference. Everyone is at risk of contracting the virus and not all homosexuals are sexually active and promiscuous.

In conclusion, I believe that having forums like these and peer support networks in each of our island nations to nurture and support our young MSM coming out is vital in making sure that we all have a more prominent and respectful presence in the Pacific.

Fa`afetai tele lava ma ia manuia la`asaga o totoa o le fonotaga.

