Literature review

Pacific multi-country mapping and behavioural study: HIV and STI risk vulnerability among key populations

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1. Introduction

The Pacific Island countries and territories (PICTs) are a group of small island nations that are particularly diverse, with widely varying political regimes, cultural norms and languages. Excluding Papua New Guinea, the Pacific has a low prevalence of HIV and no evidence of either generalised or concentrated epidemics at this point. Most information on newly detected HIV cases in the Pacific has been obtained from routine HIV testing. Sexual transmission is established as the predominant mode of transmission (95%), with varying shares of heterosexual versus male-to-male transmission between sub-regions (for example, Micronesia, Melanesia, Polynesia) and countries within sub-regions. Available data for Micronesia shows that male-to-male transmission represents between 33% and 50% of total transmissions. This higher percentage of cases of male-to-male transmission in French Polynesia and Guam may mimic the epidemic in their metropolitan countries, and a number of these men may have contracted HIV outside of the country, but there is little documented evidence of this (pers. Com. Ferdinand Strobel January 13 2016).

The calculated prevalence from targeted surveys among key populations has also been low. Two countries recently conducted surveys among key populations at high risk of HIV infection. Fiji's survey showed a prevalence of 0.5% among men having sex with men, as well as a prevalence of 0.7% among all sex workers and 1.8% among transgender sex workers. In Vanuatu's survey, no HIV cases were detected among the two key population groups (female sex workers and men having sex with men) that were surveyed (Wanyeki 2013).

Nevertheless, the extent of male-to-male transmission is believed to be underreported outside the French and US territories due to intense stigmatisation and other factors, such as inadequate reporting. HIV surveillance is limited and mostly passive (mainly through antenatal clinics) and, as a result, the trends in the number of HIV cases detected may well reflect as much the changes in availability and uptake of HIV testing as the real spread of HIV within countries and sub-population groups.

However, there are structural, social and behavioural conditions in the region that place Pacific Islanders at high HIV vulnerability risk. The rapid pace of social, economic and cultural change in the region intensifies these vulnerabilities (McMillan and Worth 2014). In contemporary Pacific society grappling with the impacts of globalisation, social safety networks of extended family are being significantly weakened (UNAIDS 2009).

There are a number of vulnerable (and sometimes unacknowledged) populations – men who have sex with men, sex workers and seafarers. The prevalence of sexually transmissible infections, particularly chlamydia, is among the highest in the world (van Gemert et al 2013), and is often untreated. Migration and mobility are widespread within and beyond the region and pose significant vulnerability (UNAIDS 2009). The isolation of many islands, weak health systems and the migration of skilled personnel, as well as conservative and religious social milieus, add to the structural barriers and to stigmatisation and discrimination against those whose sexuality and gender are non-normative. Connections between alcohol, unsafe sex and HIV are evident across all countries (UNAIDS 2009).

There have also been correspondingly low levels of HIV education in the region, and very little attention paid to HIV prevention programs for those communities most vulnerable to HIV: sex workers and men who have sex with men/transgender (and, in some islands, seafarers) (Russell et al 2007). Lack of open discussion and attention to sexual health, and legal frameworks that criminalise sex work in all countries, and homosexuality in many, create significant barriers for effective prevention. The effects of these discriminatory laws on the ability of HIV and prevention services to reach key populations are increasingly clear globally, and there is anecdotal evidence that this is also the case in the Pacific Islands region.

This review will describe the extant literature on key populations vulnerable to HIV in order to inform a mapping and behavioural study that will provide a baseline for the implementation of the Integrated HIV/TB multi-country grant in the Pacific and for the Pacific Regional Sexual and Reproductive Health Programme, by providing quantitative and qualitative data to inform relevant interventions aiming at reducing the HIV and STI risk vulnerability of key populations, as well as consolidating and generating specific evidence to evaluate barriers to prevention, improve effectiveness of prevention interventions, and develop a strong advocacy case for legal and social transformation. In many Pacific countries, there is a dearth (or even a complete lack) of data about each of the key populations.

1.1 Men who have sex with men and transgender

In the Pacific, male-to-male sex occurs in all countries. However, defining sex between men or, indeed, defining gender, in Western terms – such as men who have sex with men (MSM) or transgender (TG) – can be problematic, due to the complex ways in the region in which gender and sexuality are expressed. The term 'transgender' does not do justice to groups such as *fa'afafine, fakaleiti* and *akava'ine,* who in the Pacific fulfil both traditional social roles and modern, more hybrid forms of sexual and gender identity. There are some claims that traditionally, young men's sexual activity with *fa'afafine* or *fakaleti* was sanctioned to ensure that girls remained vrgins until marriage (Besnier 1997, Tcherkezoff 2014).

The nomenclature 'MSM' does not readily equate to those men who have sex with men and do not identify as transgender. In the Pacific, some men who have sex with men identify as heterosexual and have sex with women (Buchanan-Aruwafu 2007), thus potentially increasing the risk of HIV infection to women (UNAIDS 2009).

Aside from definitional difficulties in adequately representing MSM and TG populations in the Pacific, most sex between men in the Pacific is hidden, illegal and denied, and it is not addressed appropriately in most national HIV plans (UNAIDS 2009). Discrimination, societal and religious stigma, physical and emotional abuse, and laws criminalising homosexuality or sodomy all play a role in preventing individuals from openly identifying as homosexual. Male-to-male sex is illegal in nine of the 22 PICT (including the Cook Islands, Samoa, Tonga, Tuvalu, Kiribati and Palau) and there appears to be even greater proscription towards – and greater secrecy among – this group (Godwin 2010). Despite dramatic increases in resources available for HIV services, there is estimated to be a low coverage of services for MSM and transgender – at only around 5% (UNAIDS 2009). In the Pacific region, there are very few strategic interventions that specifically address the needs of men who have sex with men and transgender. There is a lack of engagement of key populations in the response at national and regional levels, despite the fact that they are central to the fight against HIV among these communities (Moala 2014). There is also a lack of investment in MSM HIV prevention services throughout the Pacific (UNAIDS 2009).

At present, there is limited information on the prevalence of HIV and other STIs among MSM and TG communities in the region, and only New Caledonia, French Polynesia and Guam have reported cases (UNAIDS 2009). The recent integrated bio-behavioural survey (IBBS) among MSM and transgender in Fiji uncovered two cases (see Rawstorne et al 2009), but it is highly unlikely that these are the only countries where male-to-male transmission has occurred. Guam has the highest proportion in the Pacific of MSM who are known to be HIV-positive (UNAIDS 2009). Behavioural surveillance identifies male-to-male sex among youth in the Solomon Islands, Vanuatu and Samoa, as well as police and military in Fiji (15, 6.7%), STI clinic patients in Fiji and Samoa (5, 7%), and seafarers in Kiribati in 2002–2003 (19, 5.6%) (Buchanan-Aruwafu 2002; Solomon Islands Ministry of Health and Medical Services 2005; WHO 2006; WHO 2004, cited in Jenkins and Buchanan 2006, p 94). Of the few HIV studies that have been carried out in PICT specifically among MSM and TG populations, the majority have been behavioural surveillance surveys (BSS), which have been conducted in the Cook Islands in 2009 (Rawstorne et al 2009), Fiji in 2010 (Mossman et al 2013), Tonga in 2008 (Tonga Ministry of Health and Secretariat of the Pacific Community 2008), Guam in 2007 (Guam Department of Public Health and Social Services 2007), and Vanuatu in 2011/2012 (van Gemert et al 2013). These surveys revealed varying levels and types of risk behaviours engaged in by MSM and TG based on country. For example, reported condom use at last anal sex in Tonga was recorded at 21%, while in the Cook Islands it was reported at 55%, and in Vanuatu at 42.25% of MSM and 25% of TG – indicating both discrepancies created by cultural differences between PICTs and potential variances in HIV prevention efficacy. These studies also have differences in the way in which they define TG and MSM communities, with data not consistently presented separately for each group. For example, the BSS in Tonga (2008), the Cook Islands (2009) and Guam (2007) combined MSM and TG into one group for analysis. Detailed information about MSM and transgender people is not available, and it remains unclear if men who have sex with men and transgender have been disproportionately affected with HIV (UNAIDS 2009). Ethnographic studies confirm high rates of sex between men in the Pacific, though the practice is rarely open and even less often acknowledged (UNAIDS 2009).

1.2 Sex workers

The forms of sex work undertaken across the Pacific are as diverse as the social, economic and political contexts in which they are situated. Reliable information on sex work in PICTs is fragmented and incomplete. However, characteristic forms of sex work include paid sex with seafarers, women boarding boats, and the provision of sex to affluent locals, tourists, business travellers and migrant workers. Sex work typically occurs around ports and transit hubs, in development or construction enclaves, and near military installations. Most sex work is informally organised and sex workers operate independently, although in Guam and Palau sex work is managed from within other entertainment establishments. Significant levels of sex work have been documented in Port Moresby, Honiara, Suva, Guam and Saipan (Connell and Negin 2012, p 30), but various forms of sex work take place throughout the region.

In the Pacific many women exchanging sex infor money and goods do not identify as sex workers. However, sex work in the region is largely driven by economic need, but boredom, lack of opportunity, and a limited long-term outlook, along with alienation and marginalisation, are also factors (McMillan and Worth 2010; Sladden and Vulavou 2008; UNICEF 2010; Toatu 2007). Along with financial support, engagement in sex work may also supply a sense of community, a means of distraction, and a form of escape (McMillan and Worth 2010; Sladden and Vulavou 2008). Sex work is often coupled with alcohol or other intoxicants, heightening the risks of unsafe sex. Other documented motivations for sex work

include a desire for independence and an expression of resistance and revenge (Wardlow 2002; McMillan and Worth 2010; 2011).

Sex work undertaken in Pacific countries is mostly independent, with workers arranging their own business. However, in a few PICTs – mainly US-affiliated – sex work is more organised and based in karaoke bars, massage parlours and strip clubs, some of which provide for sex on the premises or arrange for escort services. A significant amount of informal, casual or opportunistic sex work also takes place across the Pacific. Sex exchanged for food, transport or other resources, though less visible, is assumed to be more widespread than sex for cash (UNAIDS 2009). In some countries, women engaged in paid sex do not necessarily identify themselves as sex workers, even when they support themselves and their children by selling sex (UNAIDS 2009; McMillan and Worth 2011; Chuuk Resource Centre 2011).

There are reports of a growing presence of migrant, mainly Asian, sex workers, but there is no specific behavioural or other data on Chinese and other Asian sex workers in the Pacific (Connell and Negin 2012). Chinese and Koreans have been brought in by Asian businesses to work from clubs in Majuro (Jenkins 2005), and the migration of sex workers is said to be of some significance in the Northern Marianas and Marshall Islands (Connell and Negin 2012). Asian sex workers are heavily stigmatised and subject to discriminatory attitudes from both officials and the wider local community. Migrant sex workers are at a particular disadvantage compared to local sex workers, as their access to services is restricted by their illegal migration status and language barriers, and other constraints may arise from conditions of employment (Cwikel et al 2006; McMillan et al 2015).

According to anecdotal evidence, the number of people engaging in sex work is increasing across the Pacific. Structural drivers of sex work in the region include pressures of unemployment, unequal distribution of resources, forces of development, and the transition to consumerist monetarist societies, along with the effects of integration into and reliance on a global economy. The continuance of these economic factors, along with the social and cultural underpinnings of gendered inequalities, will ensure that sex work continues to be undertaken by many as a means of participating in an increasingly consumption-oriented social life, creating opportunity, or simply putting food on the table.

While there are a number of qualitative studies of sex work in the Pacific (mainly the work of McMillan and Worth), there are few behavioural surveillance surveys of sex workers. Only Papua New Guinea, Fiji, Chuuk and Vanuatu have surveyed female sex workers.

In the Fiji IBBS (Mossman et al 2013), STI rates were high among sex workers, but only three sex workers were found to be infected with HIV. Overall condom use with clients was high (91% reporting use with their last client). Over one-third of sex workers reported being tested for HIV and receiving their results in the previous 12 months, but 40% of participants reported never having had a sexual health check. Over one-third of sex workers reported being physically assaulted by clients in the previous 12 months, with 13% reporting being raped by a client in the previous 12 months. Vanuatu and Chuuk data are reported in later sections of this review.

1.3 Seafarers

All Pacific countries have increasing numbers of people working abroad and remittances are an increasing – and important – source of income. The reliance on transnational seafaring, where

international certified seafarers are employed on vessels operating worldwide, with renewable one-year contracts, bring in remittances that are central to the economy of some countries, but they have a large social and human cost (Borovnik, 2003; ILO 2005; Peteru, 2002; Buchanan-Arawafu, 2007; McMillan and Worth 2014). Seafaring occupations involve separation of workers from their homes and families for long periods of time, up to a year. They work long hours in mostly all male, exhausting, stressful, and dangerous working environments. Seafarers have substantial access to income to spend on alcohol, drugs, and sex when in port Only some ships have alcohol aboard, creating situations of binge drinking occurring when seafarers dock into ports (Armstrong, 1998; Peteru, 2002). Peteru (2002) reports that seafarers can have between one to 20 partners in a year, including sex workers, with low condom use (Peteru, 2002). Socialization, alcohol and drug use and partying on shore and on ship creates increased vulnerability and risk of HIV infection through unprotected sex with multiple partners (both male and female), but primarily with sex workers. This increased risk is for seafarers and their sexual partners, including wives, casual partners and sex workers (Armstrong, 1998; Borovnik, 2003; Peteru, 2002). Many of the early HIV infections in Kiribati and Tuvalu occurred among seafarers and their wives (UNAIDS 2009).

2. The Cook Islands

The Cook Islands are a low HIV burden country with a total of only three HIV cases reported (in 1997, 2003 and 2010) as of 31 December 2014. Transmission of these three cases is thought to be via sexual contact. None of these cases currently live in the Cook Islands. In 2014 824 HIV tests were conducted with no positive cases identified (Cook Islands Ministry of Health 2014).

2.1 Men who have sex with men and transgender

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

In a 2009 BSS conducted among those who identify as MSM or *akava'ine*, 76% of respondents reported ever having male-to-male sex, with about 32% ever having an *akava'ine* partner (Rawstorne et al 2009). Despite high levels of knowledge regarding HIV transmission and prevention, the results of the survey indicate high levels of risky sexual behaviour among men who have sex with men, as indicated by early age of sexual debut, multiple *akava'ine* and male anal sex partners in the past six months, and high incidence of concurrent partnerships and group sex. Less than half of respondents reported using a condom the last time they had sex with any partner. Many respondents also experienced first sex at a young age, and 44% of participants under 25 indicated that they had been forced to have sex in the past six months. While there have been no cases of HIV contracted through male-to-male sex in the Cook Islands, unprotected sex with multiple partners, and a number of other factors – such as high levels of alcohol, binge drinking and drug use – exacerbated by a lack of societal openness and acceptance of homosexuality put MSM and *akava'ine* at risk of STI and HIV.

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

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

2.2 Sex Workers

The 2008 Global AIDS Progress Report for the Cook Islands indicated that there are no known sex workers or sex work networks in the Cook Islands (although this is clearly not supported by anecdotal evidence), and there are therefore no current interventions targeting sex workers (Cook Islands Ministry of Health 2014). Soliciting in the Cook Islands is a criminal offence, with a fine of NZ$20 or imprisonment for one month as punishment (Dalla et al 2011). The implications of the illegality of sex work make any population of sex workers particularly hidden.

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

3. Federated States of Micronesia

Since the beginning of the HIV epidemic in 1989 FSM has reported 46 cases of HIV, and is considered to have a low prevalence of HIV. There are approximately nine people living with HIV in FSM as at 31 December 2014. Sex beyween men and women is the predominantly reported mode of transmission although there are reported cases of male-to- male-sexual transmnission as well as vertical transmission. Routine case surveillance in 2014 reported 7 new diagnosed HIV cases and one was diagnosed off Island and moved to FSM which made a total of 8 new cases reported in 2014 (Federated States of Micronesia 2015).

3.1 Men who have sex with men and transgender

MSM communities in the Federated States of Micronesia (FSM) are hidden populations, with a dearth of research about the sexual practices of this group and their knowledge regarding HIV and STIs. The size of the population of men who have sex with men in FSM is not known. At present, there is no information available on the transgender population of FSM.

Despite their hidden status, 6 of the 46 HIV cases (8%) reported in FSM between 1989 and 2014 have been identified in MSM, and 1 in a bisexual individual (Government of the Federated States of Micronesia 2015). An SGS survey of youth carried out in Pohnpei in 2008 indicated that 7 (3.6%) of those men surveyed reported ever having sexual contact with another man. Of these 7, 2 youth (28.6%) reported condom use at last sex with a male partner (Government of the Federated States of Micronesia 2015).

The 2014 GARP report indicated that discussions at the National Strategic Plan workshops in 2013 pointed to a growing recognition of the need to identify and address the 'hidden' population of men who have sex with men. However, they are aware that the community ignores this group and does not accept the existence of men who have sex with men (Government of the Federated States of Micronesia 2015). The Chuuk HIV & STI Program has initiated focus group discussions through the peer education network as a first step in considering the health needs of this group. As a result, services rarely provide for the specific needs of men who have sex with men. The National Strategic Plan workshops agreed on the need to identify and provide services for the relatively hidden population of men who have sex with men.

3.2 Sex Workers

Sex work in Chuuk is strongly driven by unemployment and poverty (Sladden and Vulavou 2008; Chuuk Resource Centre 2011). A behavioural survey in 2010 (Chuuk Resource Centre 2011) indicated that most women sell sex for economic reasons, with 66% of those surveyed indicating that they engage in sex work in order to make money, while only 23% did so because they enjoyed it. Due to low socio-economic status and poor employment opportunities in the region, very few women who sell sex have any other form of income or paid work (14.5%). In line with the young population of FSM, where 60% of the nation is aged less than 24 years, 80% of respondents to the Chuuk Resource Centre survey were aged between 15 and 24 years (total respondent ages ranged from 15 to 40 years), creating notable vulnerability among the sex worker population.

In FSM, there has been much conjecture about young women being taken out to visit fishing vessels on speedboats and offered to crew members in exchange for fish or money. However, a 2010 behavioural survey of 70 women who exchange sex for goods and services (Chuuk Resource Centre

2011) found that 40% of participant women involved in sex work met their most recent client on the street. A further 16% said that their most recent client came through a friend or other client, and 13% said it was at a private house. Additionally, the most common locations for paid sex were private houses (54%) and hotels (17.5%), giving little indication of sex work taking place on fishing vessels.

It is quite possible that, as in Tarawa, Kiribati (see McMillan and Worth 2010), sex workers who operate on shore are a distinct group from those who go out to boats. In general, onshore clients of sex workers are Micronesian, with about one-third (36.5%) being youth, followed by government workers (20.6%) and businessmen (14.3%). There is, however, also a possibility that sex taking place on boats is non-consensual, as older men commonly exploit 'nieces' or other young unrelated women for paid sex, and there have been instances of exchanging girls for money with non-Chuukese men visiting the island (Smith 2014). This is backed up by the fact that Chuukese sex workers have reported significant experience of forced sex, with 66% having had sex against their will during their life – most often perpetrated by neighbours or an intimate partner, rather than a client (Chuuk Resource Centre 2011).

Like other areas in the Pacific, Chuuk has good levels of HIV and condom knowledge, but paradoxically high levels of risky behaviour – such as anal sex, multiple sexual partners and low condom use – among sex workers, and low levels of testing and treatment for all STIs. In the 2011 Chuuk Resource Centre survey, 73.5% of sex workers knew where to go to get an HIV test, and just over half (58.5%) demonstrated correct knowledge of HIV prevention. Despite this, over two-thirds (71%) did not use a condom with their last client, and almost all of those (94.9%) did not use a condom because none was readily available.

A lack of condom availability and access, low levels of knowledge, poor support networks, and societal stigmatisation of sex workers all play a role in risk behaviours and vulnerability among sex workers. Criminalisation of sex work and organised premises for prostitution on Chuuk and Pohnpei (Godwin 2010) hinder the formation of community support and services, which is exacerbated by the independent nature of sex work. To combat risky behaviour, the Chuuk Resource Centre (2011) report recommended a reorientation of the peer educator training to a problem-solving approach, and more STI recognition and treatment information to promote HIV prevention.

4. Kiribati

Kiribati is experiencing a low level general HIV epidemic, with an estimated 57 cumulative cases of HIV as at 31 December 2014. The majority of those diagnosed with HIV are men but is increasing number of women being diagnosed in the last decade. Of those currently estimated living with HIV (27), only five are on antiretroviral treatment (ART). Difficulties with health systems mean that the remaining 22 have been lost to follow-up (Kiribati Country Coordination Mechanism, 2015)

4.1 Men who have sex with men and transgender

Transgender persons in the Kiribati community are gaining visibility, but there is a denial of the existence of men who have sex with men. Both publicly and privately, they very much remain a hidden and stigmatised community (McMillan and Worth 2010). Male-to-male sex is also illegal in Kiribati (Godwin 2010). Anecdotal evidence in the bars around Betio indicates the presence of men who have sex with men (McMillan and Worth 2010). Research has also indicated that young men board foreign boats in a similar manner to *ainen matawa* (female sex workers), but there is such a stigma and danger associated with identifying as MSM that these men are unlikely to admit to having sex with other male seafarers (McMillan and Worth 2010).

No research has been done on STI and HIV prevalence in this population, or on their attitudes and risk behaviours. An SGS survey of youth and seafarers determined that there is a population that self-identifies as transgender in Kiribati, with 8 young people and 4 seafarers indicating that they were transgender (SPC 2008b). Over one-third (26, 36%) of male youths who reported ever having sexual intercourse reported that they had ever had sexual contact with another man, while half of those (13, 17.8%) had anal sex with another man in the past 12 months. Of those who had anal sex in the last year, only 5 (38.5%) had used a condom for last anal sex (SPC 2008b). Of the seafarers, 3 (12%) who reported that they had ever had sex reported that they had ever had sexual contact with another man. Of these, 2 seafarers reported that they had sexual contact with another man in the last 12 months, and 1 man declined to answer this question (SPC 2008b).

Kiribati is the country with the highest HIV prevalence in the Pacific, apart from Papua New Guinea (cumulative total of 53 as of 2014), with the majority of cases having been transmitted through heterosexual contact (Global Fund 2014). Although MSM and TG populations have not been significant in the spread of HIV, it is likely that they experience similar challenges and risk factors to those of nearby countries, and have increased chances of a rapid spread through the community if there is an outbreak of HIV.

4.2 Sex Work

Sex work in Kiribati takes place both in local townships and out on foreign fishing vessels. In South Tarawa, the crews of foreign fishing vessels interact with local i-Kiribati women in bars and clubs to seek sexual services (Toatu 2007; McMillan and Worth 2010). These local women, originally called *KoreKoreas* due to the frequent engagement of their services by Korean seafarers, are currently referred to as a*inen matawa* (literally translated as 'easy to grab'). Quite possibly the largest and most researched group of sex workers in Kiribati, they go out to the boats docked off Tarawa, often in groups, and stay with one client on board for up to three months (McMillan and Worth 2010). *Ainen matawa* are motivated by the money and goods they receive in return for sex, as well as the social life, relatively luxurious conditions, and safety of on-board life. Such benefits allow the *ainen matawa* a

certain level of agency over their lives, as there are very few opportunities for i-Kiribati women to engage in stable well-paid work. Indeed, the primary drivers of sex work in Kiribati (both on and off boats) are a lack of paid jobs for young women, causing subsequent economic hardship and boredom, and the poor treatment of women by local men (Sladden and Vulavou 2008; Toatu 2007; McMillan and Worth 2010).

Sex work both on and offshore is overridingly conducted by women; however, a 2009 survey of vulnerable youth found that some young men also engaged in sex work (UNICEF 2010). In 2010, it was estimated that there were about 80 young women on Tarawa who regularly boarded boats, and another 40 on Kiritimati (McMillan and Worth 2010). In Tarawa, the young women who board boats are typically aged between aged 18 and 25 years, although a few are as young as 16 years (McMillan and Worth 2010). There are no figures or other data on onshore sex workers or on male sex work.

I-Kiribati sex workers operate independently and make arrangements for themselves, rarely engaging with other sex workers except for small groups of friends. There is little practical distinction between cash and goods as payment for sex, as individuals who exchange sex for cash also exchange sex for non-cash goods (UNICEF 2010; McMillan and Worth 2010). While much paid sex in Kiribati takes place on-board ships, it also takes place ashore: one survey found that nearly half of paid sex occurred in houses, hotels, clubs and outdoor areas such as the bush or beach (UNICEF 2010). This is consistent with claims by *ainen matawa* that there are many more covert sex workers in Betio who do not board boats (McMillan and Worth 2010). Paid sex is also apparent on Kiritimati Island near Hawaii, where clients are said to include US tourists and some local crew, as well as foreign seafarers; while this sex work may exhibit similarities to that which is encountered on Tarawa, differences in population, conditions and dominant issues may occur (Sladden and Vulavou 2008).

Due to the comparatively high level of cumulative HIV cases in Kiribati to date (the highest of nine included PICTS, with 58 cases), the potential for an HIV epidemic among sex workers is of key concern. While a 2007 study by Toatu found no cases of HIV among the *ainen matawa* population, there are still worries about their HIV vulnerability – particularly as the HIV diagnoses that Kiribati has experienced to date have been predominantly among local seafarers and their families. This indicates that the foreign seafarers with whom the *ainen matawa* have sex may originate from, and also pass through, areas with significantly higher rates of HIV. Additionally, sexual health surveys of *ainen matawa* find consistently high levels of STIs among the women, indicating that an outbreak of HIV within either group (*ainen matawa* or seafarers) could potentially lead to an epidemic.

A qualitative investigation of the HIV prevention needs and capacities of i-Kiribati women who board foreign fishing vessels (McMillan and Worth 2010) showed that relationships between seafarers and i-Kiribati sex workers do not conform to typical models of sex worker–client relationships. Instead of a conventional single-transaction exchange, the engagement may last weeks or months and take the form of serial, rather than multiple concurrent, sexual relationships. This has ramifications on the way in which condom use is negotiated and decided, with a 2010 study showing that women who board boats use condoms with paying partners initially, but that condom use ceases with familiarity and trust (McMillan and Worth 2010). The level of familiarity with clients also plays into the identity of *ainen matawa* and others who exchange sex for money or goods in Kiribati, with most denouncing the label of sex worker and maintaining relationships with seafarers akin to those of wives and girlfriends by often referring to their clients as 'little husbands', thereby blurring the boundaries between intimacy and commerce (McMillan and Worth 2010).

Women who board boats are identifiable to the wider community as *ainen matawa* because of both their attire and the fact that they will inevitably be seen on-board or travelling to the vessels. Due to open identification and the negative outlook of Kiribati people on sex work, many women have been disowned by their families and placed in a marginalised position, leaving them vulnerable to discrimination and sexual and physical abuse from locals – including police (McMillan and Worth 2010). Fear of punishment, discriminatory treatment and shame deter them from accessing sexual health services or seeking help when they are subject to violence and abuse. Additionally, the association of heavy alcohol use and intoxication with sex work has the potential to put such females in vulnerable positions, or exacerbate further risk-taking behaviour.

Despite societal marginalisation, there have been growing levels of 'organisation' among *ainen matawa*. This has been met with tones of dismay by some organisations (see UNICEF 2010), yet it is not necessary to view this as a negative development. Socialising and spending extended periods of time together living on vessels, along with a shared experience of exclusion, generate a strong sense of group identity among the women, and the resultant community provides an excellent opportunity for the delivery of resources and information (McMillan and Worth 2010). Collectivisation is a necessary co-requisite of community mobilisation and is fundamental to effective HIV/STI prevention based on community empowerment. In Tarawa, *ainen matawa* have engaged enthusiastically in previous sex worker-specific HIV prevention projects, providing peer condom distribution, information and outreach services. It is the success of collective efforts such as this that holds hope for positive health outcomes among HIV- and STI-vulnerable communities in Kiribati.

4.3 Seafarers

Seafaring in Kiribati is a business ingrained into everyday life, and plays a very important role in the operation of the local economy of both the formal and informal sectors, particularly in a country where only 14% of adults are in paid employment (McMillan and Worth 2014). Many seafarers originating from Kiribati are employed by German or Korean fishing and shipping companies and become engaged in the 'seafaring lifestyle', part of the shipboard and port mateship culture that involves high levels of alcohol consumption, casual and paid sex while overseas, and infrequent condom use (McMillan and Worth 2014; WHO 2004). Such a lifestyle has become common among the seafaring population and impacts upon their health and the health of those with whom they engage in sexual relations.

With little to no STI or HIV surveillance in Kiribati, seafarers remain one of the key groups with a high risk level of contraction (WHO 2004). Their mobile state makes them more difficult to monitor than the rest of the population, and more likely to pass on any illness they contract to another sector of the local or international population if they engage in high risk behaviours. Seafarers are additionally associated with trends of buying sex due to long periods spent away from home and their families (McMillan and Worth 2010) – for example, a 2008 SGS survey indicated that 95% of seafarers had been away for longer than six months during their last overseas engagement, and 58% of those studied had sex with someone other than their partner while off-island (SPC 2008b). There are key concerns for the spouses and regular female sex partners of seafarers, as most do not use condoms due to the familiarity of their relationship – putting them at risk if their partner engaged in unsafe behaviours while working abroad (Apostolopoulos and Sonmez 2007).

Kiribati is a low prevalence HIV country but, as of June 2001, 20 of the 38 reported HIV infections (53%) were identified in seafarers, and 5 (13%) were found in the spouses of seafarers. With the majority of HIV diagnoses belonging to seafarers and their partners, it is indicated that they would be a particularly vulnerable population if there were an HIV epidemic in Kiribati, and they may be a bridge for infection to the rest of Kiribati society. They are also a group that experiences high levels of STIs in general. A 2002–2003 study by the WHO, the government of Kiribati and the University of New South Wales involving 386 seafarers showed that they had a 9.3% prevalence of chlamydia and a 2.7% prevalence of syphilis. The age group with the highest prevalence of chlamydia was those aged 25–29 years, indicating a possible higher level of risky activity among the younger population. Of all seafarers included in the study, 28.2% had at least one STI. In this particular study, there was also one case of HIV detected (0.3%), which – combined with the overall STI prevalence rates – suggests that seafarers do not regularly report symptoms or engage with STI testing, despite their vulnerability on the whole.

Seafarers also engage in or have experienced other high risk behaviours that increase their chances of contracting an STI. The WHO study (2004) indicated that seafarers reported an average of 2.8 sexual partners in the last 12 months, and 5.6% of those surveyed had sex with another male in the past 12 months. There is also a particularly low level of condom use among the seafaring population, with only 37.9% having used a condom at last sex (WHO 2004). Most commonly, seafarers chose not to use a condom at last sex because it was with a trusting partner (23%) or they didn't want to (20%), but there are also issues of availability, with 19% of seafarers in a 2008 SGS survey citing that they were not easily available (SPC 2008b). Additionally, 42.2% of respondents in the same survey indicated that they never used a condom in the past 12 months (SGS 2008).

There have been three different SGS surveys of seafarers in Kiribati conducted since 2003 – one by the WHO in 2002–2003, another by the WHO in 2005, and one by the SPC in 2008 (2008b). Of these, all included trainees from the Marine Training College in Tarawa, while only the 2005 study included seafarers recruited from the Kiribati Islands Overseas Seafarers Union, the Seamen's Hostel, and the Fisheries Training Centre (WHO 2004; Robate et al 2010). Institutions such as these are useful in locating seafarers when they are onshore, as they can be difficult to recruit due to their highly mobile lifestyle. This, however, may create biases, as seafarers attending the Marine Training College may be younger and have spent less time working abroad than other seafarers. Nevertheless, these studies provide an essential starting point to establishing trends in the risk behaviour, and STI and HIV prevalence rates, among the seafaring community, which will assist in understanding behavioural changes over time and informing new initiatives for prevention and promotion.

While HIV transmission statistics improved between the two SGS studies conducted in 2005 and 2008, there has been very little change in risky behaviour (McMillan and Worth 2014). There are very few targeted prevention programs for seafarers, and the culture of their lifestyle is not conducive to minimising risky behaviour. STI levels remain elevated and the majority of seafarers engage in risk-taking activities, which is essential to address in order to avoid the further spread of HIV through the community and to prevent the potential for an epidemic in the future.

5. Marshall Islands

RMI is considered to be a low prevalence setting for HIV, with 26 cases as at 31 December 2013. Two new cases were identified during the 2011-2013; both clients presented as co-infection with TB. RMI currently has 8 people living with HIV on Majuro, of which seven are currently on ARV treatment. Three are male and five are female (Republic of the Marshall Islands (RMI) Ministry of Health 2014).

5.1 Men who have sex with men and transgender

Dvorak's (2014) research indicates that the word *kakōḷ* refers to men who have similar (but not identical) social and personal characteristics as *fa'afafine, fakaleiti* and so on. Another term used for close relationships between men is *jerã*, but this is not sexual or romantic and cannot be equated to the term 'gay'. In terms of homosexuality, Dvorak argues that there is little open discussion about same-sex relations in the Marshall Islands, and that the influence of American conservative, evangelic values may influence views of homosexuality or non-normative expression of gender. While his respondents stated that homosexuality was met with homophobia, they also agreed that same-sex relationships may simply just not be meant to be openly discussed.

At present, there is no data available representing the sexual behaviours or STI trends of either MSM or TG populations in the Marshall Islands. Youth surveys have indicated that male-to-male sex does occur in younger age groups, and therefore is likely to take place in wider society (Burnet Institute 2010). Of the 26 total cases of HIV identified in the Marshall Islands, none have been identified in MSM or TG persons (RMI Ministry of Health 2014).

5.2 Sex Workers

Sex workers are a particularly hidden population in the Marshall Islands, largely owing to the illegality of such work and the harsh penalties enforced. The actions of both clients and sex workers are criminalised, and there is a fine of US$5,000 or imprisonment of up to two years if caught (Dalla et al 2011). There is currently no data available on the sexual health of sex workers in the Marshall Islands, but the National Strategic Plan has identified sex workers as a key group at risk of HIV contraction (RMI Ministry of Health 2014). Literature on sex work in the Marshall Islands mainly revolves around human trafficking, of which there is very little information. Chinese women are often recruited with the promise of legitimate work, but are forced into sex work on arrival.

An article appearing in the *Marshall Islands Journal* indicated the hidden but common nature of sex work in Majuro, and implied that a large number of sex workers were Asian in origin (*Marshall Islands Journal* 2014). This was reiterated in a published interview with an anonymous Marshallese sex worker, who noted that most of her colleagues were Chinese. This same article also reported that many customers of sex workers in the area were foreign, with one bar excluding Marshallese men from entry, and that many sex workers catch on to the benefits of exchanging sex for favours from a young age.

At present, there is a program running entitled Youth to Youth in Health (YTYIH), which is funded by the Secretariat of the Pacific Community (SPC) and run in Majuro and Ebeye (RMI Ministry of Health 2014). While not directly aimed at sex workers, it provides clinic services and runs multiple education and awareness programs aimed at reaching people from taxi drivers to sex workers. It also provides condoms at the clinic and distributes them in nightclubs, bars and hotels. Furthermore, YTYIH reports

have shown interactions with approximately 50 sex workers over a three-month period, indicating that sex workers definitely exist in the Marshall Islands and do utilise sexual health facilities (RMI Ministry of Health 2014). Shortcomings exist in the sense that no evaluation data is available on sex workers from the YTYIH.

6. Palau

Since testing and surveillance were implemented in 1989, a total of twelve people have been identified as HIV-positive in the Republic of Palau. Five of the twelve people living with HIV (PLHIV) are currently alive and reside in Palau. Three are receiving ART and are linked to the care of Ministry physicians/clinicians (Republic of Palau, Ministry of Health 2015).

6.1 Men who have sex with men and transgender

Despite reports to the contrary (Republic of Palau Ministry of Health 2014), MSM populations have been identified in Palau. The 1991 Palau Health Survey reported that 4.3% of males identified as homosexual or bisexual (Gold et al 2007), and a 2006 SGS survey of young people recruited 12 MSM to take part in the survey; however, due to the small sample size recruited, they were excluded from the results (SPC 2008b). Voluntary HIV testing is uncommon among MSM in Palau, with only 3 reported tests of known MSM occurring in 2004 out of 1,084 tests overall (Gold et al 2007). Although male-to-male sex has been decriminalised in Palau, the MSM community is still faced with stigma and discrimination, and it remains mostly hidden (McMillan et al 2015). There are currently no community groups or health initiatives aimed at this population. Transgender persons also experience stigmatisation, and are a hidden community with no current research having been carried out on their sexual health status. Palau decriminalised homosexuality in 2014.

6.2 Sex Workers

There is one study of sex work in Palau (McMillan et al 2015). Results from this qualitative project indicate that sex work (known in Palau as 'Ladies in the Entertainment Business') undertaken by hostesses in the entertainment and hospitality industry is the main form of sex work in Palau. The majority of hostess workers in Koror, the capital of Palau, come from China or the Philippines, and the workplaces typically differ by the country of origin of the workers. The circumstances, concerns and needs of Chinese hostess workers with regard to paid sex and HIV and STI prevention differ in many respects from those of Filipino hostess workers. The report mostly details the experiences, needs and concerns of the Filipina interviewees. It indicates that hostesses in KTV bars serve drinks, dance, sing and/or talk with customers. Kissing, cuddling and being physically handled by male patrons who pay for drinks is standard practice in most hostess establishments. VIP and other private rooms afford in-house venues where sex can take place. Some establishments also provide call-out services. Clients frequently expect that hostesses and masseuses who are booked for callouts will also negotiate sexual services. Interviewees say that it is the worker's decision whether or not to provide sexual services.

Employment agents in the Philippines routinely mislead prospective hostess workers over the nature of the role and the salary, and charge high fees for placements. However, while some hostesses had been misled about the job that they were contracting to do, all the hostess workers had freely chosen to come to Palau, had entered the country legally, and had been granted valid work visas before entry. Similarly, while some hostesses were unhappy in their employment, financial considerations and visa conditions constituted a strong deterrent to terminating contracts. No hostesses were held against their will or prevented, by employers, from returning home. Few hostesses arrive in Palau intending to engage in sex work; however, a number of contextual factors create strong incentives to undertake paid sex. In addition to the hostess dress code, the behaviours necessary to hostess success sexualise hostess workers, and employment practices position them as employers' chattels – available to be

bought. While these factors, along with debt and low wages, created incentive and opportunity to undertake sex work, none of the hostesses had been coerced into selling sex. Due to stigma and fears of prosecution and deportation, hostesses are unwilling to identify as sex workers. HIV prevention programs for sex workers should be embedded first in hostess programs.

There are informal prevention interventions for sex workers that allow for interventions to take place without formally defining sex workers, as sex work is illegal in Palau (Republic of Palau, Ministry of Health 2014).

7. Samoa

HIV infection in Samoa remains very low with only 23 cumulative cases of HIV since 1990. There are currently 12 people living with HIV, of whom one is a returned citizen from overseas, two cases of mother to child transmission, and the rest is through sexual intercourse of whom all are on antiretroviral treatment. The main mode of transmission is through sexual activities. (government of Samoa 2015).

7.1 Men who have sex with men and transgender

Definitions of sex and sexual preference in Samoa do not completely align with Western concepts of MSM and TG populations. Of all the Pacific countries apart from Hawaii, *fa'afafine* (literally, 'the way of a woman') in Samoa have been the most studied ethnographically and there is a culture acceptance of this group (although there have been few studies assessing their sexual health status and needs). *Fa'afafine* are a widely accepted community within Samoa, although within strictly bounded terms (see Tcherkézoff 2014). While they are an integral part of the sexual division of labour (they do women's work), the term carries with it sexual connotations – although these are viewed within heteronormative framings (sex can only be possible if one partner is 'female'). This leaves little room for homosexual men who do not identify as *fa'afafine* (see Wallace 1999).

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

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

Samoa is a low HIV-prevalence country. As of 2013, there had been 23 cumulative cases of HIV in Samoa, with 90% of infections having been transmitted through heterosexual sex (Samoa Ministry of Health 2014). There are, however, high levels of STIs, with SGS surveys indicating that infections such as chlamydia are particularly prevalent in the under-25 youth population (Samoa Ministry of Health 2014). High levels of risk-taking behaviour and low condom use can be attributed to a lack of availability of condoms and low levels of sexual education, which is often hindered by religious and community leaders who do not support education programs – especially those geared towards young people. The Samoa Fa'afafine Association is one of the oldest supporters of HIV prevention and continues to do so behalf of the transgender community (Samoa Ministry of Health 2014).

7.2 Sex workers

Sex workers in Samoa are widely invisible, and there is currently no information related to them. This is largely due to the illegal nature of sex work in the community. Seafarers have reported that sex

workers are easily available in Samoa (McMillan 2013), and anecdotal evidence suggests that there are hidden populations on the rise. Many informal accounts suggest that key clients are Chinese builders and other international workers, and that sex workers operate out of hidden places such as empty buildings.

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

In terms of HIV and STIs, as of 2013 there have been 23 cumulative cases of HIV and a high prevalence of chlamydia – similar to other Pacific countries (Samoa Ministry of Health 2013). Of persons who are tested for HIV or STIs, there are currently no records kept on occupation (Samoa Ministry of Health 2013), so there is no current way of drawing an understanding of the sexual health of sex workers and their testing habits by looking at existing data. Additionally, condom use is very low among the general population (less than 15%), indicating that there may be issues of access and education that need to be addressed (Samoa Ministry of Health 2013).

8. Tonga

The cumulative number of HIV cases in Tonga is low with only 19 people ever having been diagnosed with HIV as of December 2014. Twelve of those are male and 7 female. The predominant known mode of transmission of HIV in Tonga remains heterosexual contact. Of the 19 reported HIV cases, 11 had died, 5 had returned to their countries of origin, 1 migrated overseas, and 2 remained in Tonga (Kingdom of Tonga 2015).

8.1 Men who have sex with men and transgender

Fakaleiti, or more commonly *leiti*, is the Tongan term most often used in referring to male-to-female transgender individuals, but it can also encompass MSM, gay and bisexual men, and non-identifying MSM (Apcom 2013). The *leiti* of Tonga live in a world of paradox. On the one hand, they are a widely accepted population, able to openly express their gender identity in a way that is accepted by wider society (largely through dress, societal roles, and highly popular beauty pageants). However, on the other hand, they face stigma associated with their sexual practice (as male-to-male sex is not widely accepted), and potential familial rejection due to their femininity – particularly on the paternal side (Besnier 1997). Many men are also attracted to sex with *leiti,* as there is no social need for 'repayment' as there is with women. To engage in heterosexual intercourse with a woman, men are socially expected to expend financial and material resources to win her over. However, on the other end of the spectrum, it is the *leiti* who are responsible for making sex attractive to straight men by providing enticements such as alcohol and entertainment (Besnier 1997). There is community support available to both MSM and TG *leiti* through organisations such as the Tonga Leiti Association (TLA). In the first half of 2013, the TLA dispensed a total of 2,134 condoms throughout Tonga. However, there are still varying levels of access to sexual health information and support, depending on the level of acceptance an individual receives through their own networks.

Tonga is a low HIV prevalence country, with only 19 cumulative cases having been reported as of 2012 (Tukia et al 2014) – although there is no information available on specific sexual modes of transmission. Although there is a dearth of information surrounding HIV and STI diagnosis in *leiti*, other studies have shown that overall STI rates are relatively high in Tonga (Cliffe et al 2008), indicating a need for further data collection on a national level, and among specific communities.

Despite the general acceptance and longstanding status of *leiti* within Tongan society, there have been very few studies into the sexual health attitudes, understandings, status and needs of the sub-population. Like other MSM and TG groups in the Pacific region, *leiti* engage in high risk sexual behaviour, putting them at risk of HIV or STI transmission. The 2008 Tonga MSM SGS survey indicated that 12% of MSM between ages 15 and 24 years, and 27% of MSM ages 25 years or older, used a condom the last time they had anal intercourse with a male partner. However, only around 2% of MSM had been tested for HIV in the previous 12 months (Tonga Ministry of Health 2008).

8.2 Sex workers

As with a number of other countries in the Pacific region, there are no official health reports of sex work in Tonga, nor are there any statistics or in-depth information available on the sexual health of people who engage in paid sex. Stigma and cultural attitudes towards sex have limited the capacity of the community to engage in conversations about sex work, and have also hindered the actions of the department of health and other institutions in monitoring the health situation of sex workers. Despite

being hidden, sex work does occur in Tonga, with the 2008 SGS survey of antenatal women reporting that 4 women (1.1% of those surveyed) had received cash or goods in return for sex, while another 4 youth (0.7%) experienced the same (Tonga Ministry of Health 2008). Considering the small subsection of the population included in the survey, actual numbers of women who have engaged in paid sex may vary significantly. The SGS survey recognised that sex workers were a vulnerable group for potential HIV contraction, indicating an understanding of the challenges faced by this group, but at present prevalence remains low and stable, and there have been no studies conducted surrounding HIV, STIs or sexual behaviours to date (Tonga Ministry of Health 2008).

Previous surveys have indicated that although there is a low in-country HIV prevalence (as of 2008, there had been 17 cases of HIV), there are high levels of other STIs (Tonga Ministry of Health 2008).

9. Tuvalu

The cumulative number of HIV cases in Tivalu to 31 Deceber 2014 is 11, two of whom have died. In 2011 three new HIV cases were identified and two in 2012. Of the 9 people with HIV still alive, none are currently enrolled in ART. In 2013, a total of 791 persons were tested for HIV, which represents 7.5% of the total population; no HIV cases were found (Ministry of Health of Tuvalu 2015).

9.1 Men who have sex with men and transgender

MSM are very much a hidden population in Tuvalu. The country's 2010 UNGASS report failed to identify MSM as a risk population for HIV/AIDS. While anecdotal evidence suggested increasing prevalence of HIV in MSM, recognition of the risks that the MSM population of Tuvalu faces only began to come about in 2012 (Tuvalu National AIDS Committee 2012). It is only recently that MSM have begun to openly speak to health practitioners about their health status and concerns. While the government cites this as a starting point for tailored health initiatives, it is unlikely that much will come about if other measures are not taken to make the population less hidden. The 2015 GARP report for Tuvalu indicates that transgender populations – called *Pinapinaaine* (borrowed from Gilbertese) or *fa'afafine* (derived from the Samoan) (Besnier 1994) – are often seen in Tuvalu, but there have so far been no studies conducted on their sexual behaviours and risks.

Among the youth population, a 2005–2006 IBBS revealed that nearly 14% of young men surveyed had engaged in sexual acts with a male partner in their lifetime, with 8% having had encounters in the past 12 months (Government of Tuvalu 2009). Despite these numbers, laws that criminalise homosexuality, societal and religious stigma, and physical and emotional abuse mean that this group remains hidden overall, and there have been no other studies concerning HIV and STI risk in MSM, either in youth or at other ages.

Overall, there have been 11 cumulative cases of HIV reported as of 2008, but only 7 confirmed (SPC 2008a). So far, none of these have been associated with homosexual transmission. At present, there is only one facility capable of undertaking HIV tests in Tuvalu, which is at the Princess Margaret Hospital on Funafuti. As such, there are no appropriate facilities for diagnosing and treating HIV on the outer islands, and lack of access to facilities has the potential for issues associated with underreporting (Ministry of Health of Tuvalu 2015). Like other nations of the Pacific, there is a high rate of STIs in Tuvalu (Homasi 2007).

9.2 Sex workers

In Tuvalu there are no recognised sex workers, but there are anecdotal reports of sexual transactions taking place in an informal manner (Tuvalu National AIDS Committee 2008). In this sense, those who engage in sex work remain a widely hidden population. It is likely that some local women turn to sex work or engage in sexual activity in exchange for cash or goods due to the limited economic capacity of Tuvalu, a country that relies on foreign aid, fishing and subsistence farming as its main economic activities (Homasi 2007). Sex work has the potential to increase the agency of women by enabling them to support themselves, despite its poor recognition by wider society. There have been no official reports of healthcare professionals being made aware that their patients engage in paid sex, and therefore no statistics on the health status and attitudes of sex workers. However, the 2008 UNGASS Country Progress Report recognises that sex workers are a high risk population for HIV due to conventional understandings of transmission, indicating that there is potential for risk prevention

programs to be set in place once a population is identified and their sexual health status reported. Information currently available also suggests that sex work in Tuvalu is stigmatised by the general population, with no current non-discrimination laws surrounding sex workers (Tuvalu National AIDS Committee 2008).

Despite the dearth of information about sex workers, we can learn a little about the way in which sex in Tuvalu occurs, and the way that others engage in sexual transactions, in surveys through data collected on other at-risk population groups. The first round of SGS that occurred in-country reported that 20.7% of seafaring respondents had engaged in sex with a sex worker, with 83.3% having used a condom during their last sex with a sex worker, which suggests that the engagement of sex workers may be slightly lower than in other nations in the Pacific, and that slightly higher levels of condom use may exist (Homasi 2007). With women being recognised as a high risk population, sex workers are particularly vulnerable to STIs and the contraction of HIV if there is an outbreak in the future.

9.3 Seafarers

Seafaring is a key part of life in Tuvalu, and there are large numbers of seafarers from Tuvalu working abroad (Power et al 2015). Working in the merchant navy is the second-most common occupation after working for the government, and many young men join so they can travel while they work (Homasi 2007). As of 2012, there were approximately 1,200 individuals registered as seafarers or fishers, making up 10% of the population (Connell and Negin 2012). While this is great for the local economy, it is not so great for the sexual health of the local population. As of 2012, there had been 11 cases of HIV in Tuvalu, 8 of which were identified in seafarers, and another 2 in the wife of a seafarer and her child (Tuvalu National AIDS Committee 2012; Homasi 2007). This means that, in all, 10 out of 11 cases of HIV in Tuvalu had a connection to seafaring. Of the 7 seafarers who had contacted HIV by 2009, all had become infected while working on overseas ships (Government of Tuvalu 2009). It is due to this that seafarers and their wives are considered to be the groups most at risk of HIV infection in Tuvalu (Government of Tuvalu 2009).

Part of this risk comes from low levels of condom use between seafarers and their regular partners. Due to long periods overseas, averaging approximately 12 months, many seafarers engage in sexual activity with sex workers or casual partners, which often goes hand-in-hand with unsafe sex (Homasi 2007). The 2005–2006 SGS survey indicated that 57% of seafarers with STIs report using condoms with sex workers, but if engaging with casual sex partners this drops to 16.6% (Government of Tuvalu 2009). Sex with regular partners on return rarely sees condom use, putting partners left at home at a significantly increased risk of HIV and STI contraction. The actions of seafarers having unprotected sex with multiple partners both overseas and at home has made them a high risk population, who in the case of an HIV outbreak may act as a bridge between international and local communities. Many seafarers cite ‘drinking too much alcohol’ – a key part of the mateship culture – as the main proponent of unsafe sex (Connell and Negin 2012), but low levels of condom use are also connected to low levels of knowledge about HIV and how it is spread.

A total of 209 seafarers were surveyed for the only SGS survey that has been carried out among the seafarer population of Tuvalu, of which only 28% had correct knowledge of HIV prevention. The majority of men surveyed had incorrect beliefs about the transmission of HIV or chose not to practise safe sex (Government of Tuvalu 2009). The seafaring population also had high levels of STIs, with 8.1% having chlamydia, 13.4% exhibiting the hepatitis B surface antigen, and 5.2% presenting with syphilis

(Government of Tuvalu 2009). Age was positively associated with increased STI contraction, with a higher prevalence among seafarers younger than 25 years (Tuvalu National AIDS Committee 2008).

Tuvalu also lacks screening processes for HIV and STIs. For the women married to seafarers, STI screening was only available during pregnancy until 2009, and has only recently been introduced in a cervical screening program. Meanwhile, men usually get tested overseas or on the ship rather than at home, particularly because health services are sparse in Tuvalu – especially in the outer islands (Government of Tuvalu 2009). This is a major issue in a country where levels of STIs have been increasing, and where there is one of the highest per capita incidences of HIV in the Pacific (UNICEF 2010).

10. Vanuatu

As at 31 December 2014 the cumulative number of HIV cases in Vanuatu was 9, with four new diagnoses in 2012. The mode of transmission for these cases has not been reported Six people are still alive today, while three have died. HIV testing is still very limited, with only 2,068 HIV tests in 2014. Currently, 4 people – all female – are enrolled in ART (Ministry of Health, Vanuatu 2015).

10.1 Men who have sex with men and transgender

Studies have indicated that MSM and TG persons are present in Vanuatu, but – unlike Samoa with *fa'afafine* and Tonga with *fakaleiti* – there is no specific term of identification for these groups, and such populations remain hidden due to stigma and fear of discrimination (van Gemert et al 2013; Moala 2014). A 2008 SGS survey undertaken with youth (15–24 years old) revealed that 13% of young males had ever had anal intercourse with another male, while another survey by UNICEF indicated that 8% of sexually active males had participated in sexual intercourse with a male (van Gemert et al 2013), indicating that, despite being hidden, MSM populations definitely occur in Vanuatu.

Due to their hidden status, there has only ever been one study centred on MSM and TG in Vanuatu. That study by Veronese et al (2015) notes low levels of treatment-seeking behaviour among MSM and TG in Vanuatu, with a large variance between those exhibiting STI symptoms and those who seek health advice and treatment. Testing as part of the 2011 IBBS of MSM and TG revealed an STI prevalence of 1 in 5 TG, and 1 in 3 MSM. In the 12 months prior, 17% of TG persons identified STI symptoms but 0 had an STI diagnosis history, while 36% of MSM also experienced STI symptoms but only 5 of 28 had ever had a positive diagnosis. This discrepancy between symptoms, diagnosis and treatment-seeking indicates that there are barriers between MSM and TG persons and health service accessibility. This may be due to a fear of disclosing sexual behaviours to a healthcare professional in a society where male-to-male sex is not widely accepted (Veronese et al 2015).

In terms of risk, it has been indicated that TG persons are likely to have riskier behaviours than MSM, with a lower age of sexual debut (12 years vs 16 years), and lower condom use. They are also more likely to experience forced sex (63.4%); however, this is also a major concern for MSM, with 35.7% having experienced forced sex (Veronese et al 2015).

Due to the hidden nature of MSM and TG populations in Vanuatu, there are no community-led organisations specifically aimed at their health concerns. The most prominent organisation with the ability to deal with MSM and TG issues and health promotion initiatives is Wan Smolbag, which is an NGO that is broadly aimed at youth but has created some initiatives geared towards MSM.

Wan Smolbag has also assisted in opening up access to condoms, alongside hospitals, kava bars and youth centres. Clinics run by Wan Smolbag have reduced the need for contact with staff and shopkeepers by having free condom distribution with open access. A 2008 study of young people, however, showed that while such places enhance distribution, there is very little access outside the main cities of Port Vila and Luganville (McMillan 2008). Even in areas where access is high, there may still be barriers such as fear of identification in health centres, or accusations of promiscuity. Additionally, regularity of condom use may be patchy due to availability and relationship type – individuals with a regular sexual partner were far less likely to use a condom during every sexual encounter (McMillan 2008). While most STI studies in Vanuatu have mainly been aimed at youth, the

results such as those above reflect societal attitudes to sex, and are likely to be mirrored to some extent in the MSM and TG communities.

10.2 Sex Workers

Sex work in Vanuatu has been shaped by local and national experiences of social and economic change, which are closely tied to urban social life (McMillan 2011). Vanuatu has experienced a rapid period of urbanisation and integration into the global economy that has dramatically affected the shape of Ni-Van social life, on Efate in particular. The restriction of Ni-Vanuatu to rural village life before independence (1980) and their subsequent exclusion from Port Vila has now, years later, triggered a response to social and economic exclusion through sex work, which enables such populations an opportunity to participate in town life and take advantage of changing gender relations in the area. Indeed, selling sex in Port Vila is closely linked with the concept of 'going to town' both literally and figuratively – in a study by McMillan (2011), many sex workers said that they started selling sex when they moved to the town of Port Vila, but they also described 'going to town' in search of clients when they needed money. In line with this change, sex work in the region has also seen an increase due to urbanisation, tourism, development, high unemployment, family violence, kava and alcohol use (Bulu et al 2007; McMillan and Worth 2011; McMillan 2011, see also Servy 2014).

While it is considered to be somewhat shameful and is practised covertly, selling sex is a common practice in Port Vila town, according to those who engage in it. Sex work is largely informal, taking place in the street, or in kava bars and clubs (Bulu et al 2007; McMillan and Worth 2011).

An IBBS conducted in Port Vila in 2011 (van Gemert et al 2013) indicates that nearly all of those surveyed had received both goods and money in exchange for sex in the previous week. Over 90% of female sex workers reported that their most recent transactional sex partner was ni-Vanuatu rather than a tourist. Sex workers started transactional sex at a young age; over one-third started transacting sex when aged younger than 18 years. Condom use by female sex workers with transactional sex partners was extremely low, with only 7.5% of female sex workers reporting always using a condom with transactional sex partners during the previous month. Multiple concurrent partners were likely and group sex and anal sex were commonly reported, with 28.2% of female sex workers reporting anal sex and 37.6% reporting group sex during the previous 12 months. Condom use during the female sex workers' last anal sex and group sex was low (40% and 44% respectively). Forced sex had occurred for over two-thirds of sex workers in their lifetime and STI testing and treatment were low: while three-quarters reporting a genital symptom in the past 12 months, only one-third had been tested, and only 5.5% had been tested for HIV in the previous 12 months and knew their result.

Sex workers either work alone, meeting clients on the streets during the day and making arrangements to rendezvous later, or operate with small groups of friends to find clients in nakamals, bars and nightclubs. In this latter style of sex work, social and monetary motivations tend to converge (McMillan and Worth 2011).

Another survey on youth also found that young males were involved in sex work and that they, like their older counterparts, may have sexual relations with both female and male partners (UNICEF 2010). Of key concern, there are very low rates of condom use among youth involved in sex work, with

usage rates being lower among young people who had paid sex than those who did not (UNICEF 2010).

Clients in Port Vila comprise local men from all occupational classes, male tourists and ex-patriot businessmen, as well as older local and tourist women. Sex workers commonly adopt a sliding scale of charging according to income, and sometimes small offerings and inexpensive gifts are accepted from clients who have little means. On the other end of the spectrum, however, women may receive the equivalent of a month's salary for spending the night with a wealthy tourist (McMillan and Worth 2011). The payment received from sex work affords the workers a degree of independence and autonomy – a way to take control of their lives (McMillan 2011). Sex workers in Vanuatu have often experienced issues such as inadequate employment, and unsatisfactory or abusive relationships with an intimate partner or family member, and thus this money provides an interim solution to adverse circumstances and a way to create other opportunities (McMillan and Worth 2011; McMillan 2011). In less adverse situations, the workers spend their earnings on non-essential items, creating a sense of independence (McMillan 2011).

As is common in many of the Pacific Islands, few of those who sell sex in Port Vila identify as sex workers, which has implications for the targeting of HIV prevention programs and services. While organic networks of sex workers do exist, they are informal and are loose arrangements of friends that may sometimes work together. Such networks are not extensive, as most sex workers are reluctant to let more than a small number of friends know of their engagement in paid sex (McMillan and Worth 2011).

Due to the adverse societal association with sex work in Vanuatu, pressure has been placed on those in the sex worker community to give up their way of life and take on more traditional roles. Pledges to renounce sex work given by sex workers to church or health service providers, however, often just result in a more covert approach to sex work. Sex workers become less inclined to access services and condoms because it might expose their activities. It also makes them harder to reach by peers, who may have been witness to the pledge (McMillan 2011). Because of this, HIV prevention programs that appeal to sex workers' desires to look after themselves and take control in their lives offer a more effective HIV prevention strategy than do attempts to discourage them from sex work, which merely increase risk-taking behaviours in the community (McMillan 2011).

In terms of health and risk-taking behaviour, sex workers tend to be inconsistent in their use of condoms with clients, despite an overall preference for condom use (McMillan and Worth 2011). For uptake to be maximised, condoms need to be free and at hand for both sex workers and their clients, as most sex workers spoken with in research said that they would not pay for condoms. If condoms were provided free of charge, concerns of privacy and confidentiality come into play – which are very important factors in determining whether or not sex workers would pick up free condoms. Concerns of privacy are not only connected to shame, but also have very strong implications for the personal safety of sex workers in a society that is not very open to their way of life (McMillan and Worth 2011).

Aside from privacy and accessibility impacting on condom use, sex workers also hold many misconceptions about condoms and have a poor understanding of the role they play in preventing STIs and HIV transmission. Some sex workers, and some clients, do not know how to put a condom on a man. Clients' wishes usually determine whether or not condoms are utilised, with local clients being particularly averse to their use. Sex workers in the 2011 study by McMillan and Worth were not confident or competent enough negotiators to convince a reluctant client to use a condom. However,

those sex workers who have accurate information about the role and efficacy of condoms in preventing HIV and STI transmission do actively encourage clients to use condoms (McMillan and Worth 2011).

A frequent combination of alcohol, kava and sex work may also exacerbate HIV/STI transmission risk, as intoxication compromises intentions to use condoms. Drinking alcohol is reported to be associated with lowered inhibitions and more adventurous sex than usual, and as kava and alcohol drinking and sex work are often intertwined (McMillan and Worth 2010; see also Bulu et al 2007), intoxication has to be taken into account when designing any HIV prevention programs and strategies for sex workers.

Little is known about sex work outside of Port Vila. Sex work does occur in Luganville and is assumed to be similar but on a smaller scale than in Port Vila. Nothing is known about the outer islands, but youth transactional sex is known to take place on numerous islands.

Conclusion

This literature review supports the need for better evidence about key population groups. It is clear that, apart from Fiji and Vanuatu, there is a dearth of information on the size of sex worker and MSM/TG populations. In some countries, there is a complete lack of any data on key populations, while in others data on behavioural risk factors and social and structural determinants of risk are either lacking or not recent. There is almost a complete lack of data on health service provision for these groups or on the facilitators or barriers for the uptake of HIV and STIs prevention, care and support services within countries. This data is necessary to support countries in their regional and global reporting obligations, such as the Global AIDS Response Progress Reporting (GARPR), and to inform national and regional planning, as well as to empower vulnerable groups to mount strong advocacy cases for change.

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