

HIV/AIDS in the Pacific

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Foreword

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Abbreviations

ADB	– Asian Development Bank
AIDS	– acquired immunodeficiency syndrome
AusAID	– Australian Agency for International Development
FSM	– Federated States of Micronesia
GFATM	– Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	– human immunodeficiency virus
HSV-2	– herpes simplex virus, type 2
IEC	– instruction, education, and communication
ILO	– International Labour Organization
MSM	– men-who-have-sex-with-men
NZAID	– New Zealand’s International Aid and Development Agency
NGO	– non-government organization
PICT	– Pacific Island countries and territories
PNG	Papua New Guinea
RMI	– Republic of the Marshall Islands
SPC	– Secretariat for the Pacific Community
STD	– sexually transmitted disease
STI	– sexually transmitted infection
TB	– tuberculosis
UNAIDS	– The Joint United Nations Programme on HIV/AIDS
UN	– United Nations
UNDP	– United Nations Development Programme
UNFPA	– United Nations Population Fund
UNICEF	– United Nations Children’s Fund
UNIFEM	– United Nations Development Fund for Women
US	– United States
USA	– United States of America
USAID	– United States Agency for International Development
VCCT	– voluntary confidential counseling and testing
VCT	– voluntary counseling and testing
WHO	– World Health Organization

Executive Summary

The Asian Development Bank (ADB) considers the threat of HIV/AIDS¹ in the Pacific Region to be real and is concerned about its potentially destructive effects on efforts to secure sustainable development for the region's peoples. Together with its regional development partners, ADB wishes to respond to this threat. Thus, this review attempts to summarize the situation in the Pacific Region—what is known about the epidemic and its contributing factors, the extent and speed of its spread, as well as an assessment of the responses to date—with the aim of delineating how ADB can provide the most useful contribution.

The Situation

The Pacific Island nations of the Cook Islands, Fiji, Kiribati, Republic of the Marshall Islands (RMI), Nauru, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu comprise the subset of particular interest. While these include some of the poorest as well as some of the more successful countries in the region, social and behavioral factors common throughout the Pacific place some people in all islands at risk of acquiring an HIV infection. Travel and migration for work, education, and other purposes are common and widespread. Several islands depend heavily on remittances from family members working abroad as well as on the salaries of international seafarers who are away from home for long periods of time. HIV has already begun to spread among them and to their partners.

Levels of sexually transmitted infections (STI), where examined, are relatively high and warrant investments in effective diagnosis and treatment. Considerable effort in improving the capacity of health systems to manage both STIs and HIV is required.

Injecting drug use is relatively rare throughout the Pacific but bears monitoring. Most substance-related behavioral issues are associated with alcohol. Marijuana is present and kava is widely drunk by young and old alike.

Young people in the Pacific, like young people in most of the world, experiment with drugs and sex without adequate correct information on the potential negative consequences as well as how to prevent them. Speaking about sex is taboo and information poor. Attitudinal issues—for example, toward coercive sex, domestic violence, and the rights of women—play a role in facilitating risky behavior. Sexuality is not treated scientifically in schools and conservative churches contribute to the prevailing stigma and vulnerability associated with it by discouraging advertising or other promotion of condoms, particularly to youth.

¹ Human immunodeficiency virus/acquired immunodeficiency syndrome.

Commercial sex is more common in larger urban areas, but a minority of young women and sometimes young men sell or exchange sex for cash, goods, or services. In addition, male-to-male sex, particularly involving transgendered people, is a form of sexuality with traditional roots (Murray 2002), but is highly condemned by influential religious leaders.

Stigma and fear are still highly associated with being HIV positive, though some progress has been made in supporting positive people. Advocacy to enable a rights-based approach to prevention, treatment, and care remains a high priority.

Responses

After a decade of very slow recognition of the problem, the overall response to HIV/AIDS throughout the region has intensified in the past few years. United Nations agencies, AusAID, and NZAID have taken the lead as donors and organizers in collaboration with regional agencies, particularly the Secretariat of the Pacific Community. A Regional Strategic Plan has been formulated and a regional grant has been obtained from the Global Fund to fight AIDS, Tuberculosis and Malaria, for which the Secretariat for the Pacific Community acts as the implementing body and is the principal recipient. Though coordination remains difficult across many agencies and programs, real efforts are being made to do so. Most countries now have developed a strategic plan and have a central AIDS body, such as a National AIDS Committee. The functioning of these bodies varies greatly. In general, human, technical, and financial resources are inadequate. With many islands spread over a vast distance, regional agencies also experience difficulty following-up on various activities.

A Role for ADB

ADB's contribution to the region's HIV prevention and care efforts can complement and intensify the efforts planned by the region's stakeholders. Given the existing situation, the principal aims should be to:

- Strengthen surveillance and research capacity;
- Develop technical capacity to design, implement, monitor and evaluate targeted behavior change interventions with and for vulnerable people ;
- Encourage the social marketing of condoms; and
- Support coordination and management.

Further delay in progress in these areas could seriously jeopardize the strategies and plans that have already been adopted and place the region at the threshold of the kind of rapid spread that began to be seen in Papua New Guinea around 1994 and has not yet relented.

Introduction

The Asian Development Bank (ADB) considers the threat of HIV/AIDS¹ in the Pacific Region to be real. Like other development partners in the region, ADB is concerned about its potentially destructive effects on economic and social development efforts. For this reason it wishes to ensure that adequate attention is paid to this threat by Pacific Island countries and territories (PICT) and that the necessary knowledge and skills are available to manage HIV/AIDS. Toward this end, ADB intends:

- to help countries in the region understand the nature of their epidemics by generating information through improved surveillance and other studies;
- enhance the decision-making skills of program managers through the improved use of information;
- build the skills of local government and civil society organizations to implement prevention and care programs;
- and develop useful and practical monitoring and evaluation systems.

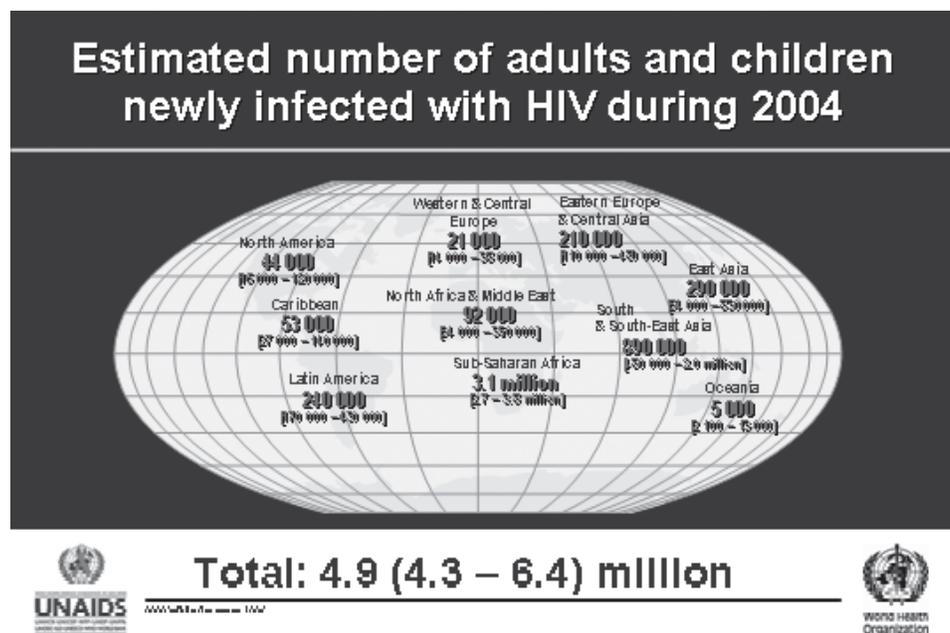
This report presents the state of the epidemic in the region, a description and assessment of the response to date, an assessment of the remaining gaps, and suggestions on the types of activities ADB may usefully support.

¹ Human immunodeficiency virus/acquired immunodeficiency syndrome.

Background

This section summarizes the most salient information on HIV/AIDS in the PICTs.² The widely diverse Pacific Islands are considered low HIV prevalence countries but it is not likely to remain that way. Globally, the distribution of people infected with HIV is markedly uneven. Yet, there is no region unaffected and prevalence levels, both high and low, hide considerable geographical variation within regions and within countries. Closer examination in each area reveals some of the social and economic factors that underlie such variation. These demand nuanced differences in approach to contain the epidemic in each case. Further, only in rare cases does the epidemic appear static. Change is inevitable and mistakes are made when these changes are not monitored and anticipated. The Pacific Islands are a case in point.

FIGURE 1. Global HIV Distribution, 2004



Source: AIDS Epidemic Update, December 2004, UNAIDS/WHO: Geneva

While the majority of highly affected countries have epidemics due mainly to sexual transmission, a large number of Asian (Central, South, South East, and East) and Eastern European countries have significant levels of HIV due to injecting drug use. Patterns of sexual behavior differ and these differences are reflected in the speed and breadth of the virus's spread. Of particular concern

² Unless stated otherwise, Papua New Guinea (PNG) is not included in this analysis.

are those countries that appear to have slow or barely existent epidemics, such as Mongolia, Laos, Sri Lanka, the Philippines, and most Pacific Islands. In such countries low prevalence often also means that HIV has had low priority for both national governments and international donors.

With regard to the Pacific, one observer wrote that by the year 2000 prevalence would reach about 0.2% or 15-20 infections per 100,000 people and then would stabilize due to expanded control programs for AIDS and other sexually transmitted diseases (STD) (Rakaseta 1995). Another expert more recently made a similar prediction, that HIV will not rise beyond a prevalence rate of .25% in these countries (Chin 2003). This prediction is based on the observation that HIV has to date reached relatively high levels in Asia only where significant proportions of men frequent sex workers, as in Thailand and Cambodia, or injecting drug use is common, as in Myanmar. On the other hand, this same expert predicts that Papua New Guinea (PNG) could reach HIV levels of 4-6% because its sexual behavior patterns are more like those in Africa. Such an argument rests heavily on social and behavioral research that reveals sexual cultures and patterns of practice. PNG is the most researched nation in the Pacific (Chung 1999). Without comparable research conducted in other Pacific Islands, it is not prudent or possible to make such optimistic predictions. The potential socioeconomic impact of even relatively small numbers of infections on small islands could present Pacific communities with serious consequences. It behooves all concerned about the future of the Pacific to attend to the HIV-related needs of low prevalence countries now, in order to implement needed programs, closely monitor behavioral patterns, and help avert the possible spread of HIV.

The Epidemiological Situation in the Pacific

The 22 countries and territories of the Pacific Islands Region are listed below in Table 1 with the latest published data on reported HIV and AIDS cases. The estimated total population in these countries as of 2004 was about 2.9 million with approximately 1.4 million in the 15-49 year old age group. As of 2004, about 84% of cumulative cases were reported from only four countries: Fiji, French Polynesia, Guam, and New Caledonia. More recently, Fiji, Kiribati, and Tuvalu have had sharp rises in reported HIV infections. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that cases in the region are underreported by at least a factor of 2 (Watson 2005). There is little reason to believe that the rate of reporting has increased in recent years, although many reasons for underreporting are recognized: lack of testing capacity, avoidance of testing, concerns over confidentiality, and alternative diagnoses recorded on medical records or death certificates among others. The AIDS to HIV ratio (1:1.8) may indicate a maturing epidemic and suggests a larger pool of asymptomatic infected people than reported.

The distribution of recorded infections may be viewed in different ways. The “cumulative incidence per 100,000” is a good indicator of the potential impact of HIV on the local population. Even small numbers of cases in small populations such as Tuvalu, particularly if found among young working men, can have a devastating impact at the local level. Further, the lack of good sampling procedures for surveillance leave the observer wondering what is missing. The cases

TABLE 1
Cumulative Reported HIV, AIDS & AIDS Death Cases and HIV Case Incidence Rates
per 100,000 Population in Pacific Islands Countries and Territories

Country	As At	HIV including AIDS	Mid Year Population As of June 2004
American Samoa	Dec 2004	3	62,600
Cook Islands ^a	Dec 2004	2	14,000
Federated States of Micronesia	Dec 2004	25	112,700
Fiji Islands ^a	Dec 2004	182	836,000
French Polynesia	Dec 2004	243	250,500
Guam	Dec 2004	168	166,100
Kiribati ^a	Dec 2004	46	93,100
RMI ^a	Dec 2004	10	55,400
Nauru ^a	Dec 2004	2	10,100
New Caledonia	Dec 2004	272	236,900
Niue	Dec 2004	0	1,600
Northern Mariana Islands	Dec 2004	25	78,000
Palau ^a	Dec 2004	8	20,700
Papua New Guinea	Sep 2004	10,184	5,695,300
Pitcairn Islands	Dec 2004	0	50
Samoa ^a	Dec 2004	12	182,700
Solomon Islands ^a	Dec 2004	5	460,100
Tokelau Islands	Dec 2004	0	1,500
Tonga ^a	Dec 2004	13	98,300
Tuvalu ^a	Dec 2004	9	9,600
Vanuatu ^a	Dec 2004	2	215,800
Wallis and Futuna	Dec 2004	1	14,900
All Melanesia	Dec 2004	10,645	7,444,100
All Micronesia	Dec 2004	284	536,100
All Polynesia	Dec 2004	283	635,750
All PICTs	Dec 2004	11,212	8,615,950
All PICTs (excluding PNG)	Dec 2004	1,028	2,920,650

^a Marks countries within ADB's HIV project plans. All data are supplied by official country reporting authorities. All data are subject to revision.

Note: Reported cases do not reflect total disease burden. Case numbers are influenced by access to testing, testing uptake, and notification rates.

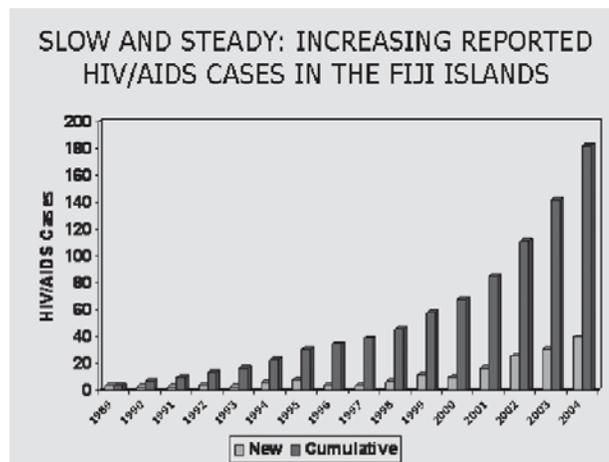
Source: AIDS Section, Public Health Programme, Secretariat of the Pacific Community (www.spc.int/aids) (7 June 2005).

Cumulative Incidence per 100,000 95% CIs		AIDS AIDS Deaths		Male HIV + AIDS	Female HIV + AIDS	Unknown HIV + AIDS
4.8	1.0 to 14.0	1	0	2	1	0
14.3	1.7 to 51.6	0	0	1	1	0
22.2	14.4 to 32.7	15	12	14	11	0
21.8	18.6 to 24.9	25 ^a	17 ^a	109	73	0
97.0	84.8 to 109.2	90	59	175	68	0
101.1	85.9 to 116.4	97	67	145	23	0
49.4	35.1 to 63.7	28	23	30	16	0
18.1	8.7 to 33.2	2	2	3	3	4
19.8	2.4 to 71.5	1	1	2	0	0
114.8	101.2 to 128.5	101	50	200	69	3
–	–	0	0	0	0	0
32.1	20.7 to 47.3	2	1	12	13	0
38.6	16.7 to 76.1	4	3	5	3	0
178.8	175.3 to 182.3	1,843	353	5,025	4,746	413
–	–	0	0	0	0	0
6.6	3.4 to 11.5	8	8	8	4	0
1.1	0.4 to 2.5	2	2	2	3	0
–	–	0	0	0	0	0
13.2	6.3 to 21.3	9	8	7	6	0
93.8	42.9 to 178.0	2	2	8	1	0
0.9	0.1 to 3.3	2	0	0	2	0
6.7	0.2 to 37.4	1	0	1	0	0
143.0	 140.3 to 145.7 	1,956	 422 	5,336	4,893	416
53.0	 46.8 to 59.1 	149	 109 	211	69	4
44.5	 39.2 to 49.5 	111	 77 	202	81	0
130.1	 127.7 to 132.5 	2,216	 608 	5,749	5,043	420
35.2	 33.0 to 37.3 	373	 255 	724	297	7

seen in Table 1 represent those who are subjected to mandatory testing by their governments (ANC attendees, STD patients, visa applicants, seafarers, military), those who voluntarily come to government services for testing (but not those who go to private doctors or laboratories), those cases detected where blood banks are capable of screening and reporting, and those who are tested under clinical suspicion of an attending physician. The intense stigma still experienced by persons living with HIV in most Pacific Islands forces people to hide their being tested, either by going overseas or by using private providers who are more trusted for confidentiality than government health providers. There is a general lack of anonymous or at least confidential voluntary counseling and testing (VCT) centers throughout the islands, hence the local use of the term “voluntary confidential counseling and testing” (VCCT) in order to emphasize confidentiality.

Reliable estimates of HIV seroprevalence rates for Pacific Island nations do not exist, but the number of infections is growing steadily. For example, in Fiji the cumulative number rose from 4 in 1989 to 39 at the end of 1997, then to 68 in 2000, 142 at the end of 2003 and up to 182 at the end of 2004, a 28% increase in the last year. (See Figure 2.) It is difficult to know whether this represents a true rise in the proportion positive among those tested, as the denominators (number of those tested) are not available. However, the steep slope suggests an increasing rate of infection and should ring alarm bells. While the increase over time has not been as great in most of the Pacific Islands as it has been in Fiji, between 2003 and 2004 more than half of all the islands saw an increase, for an average rise of 8% in new cases. There is little room for complacency, given the limitations of surveillance data and the known risk factors present.

FIGURE 2. The Evolving HIV Epidemic of Fiji



Sources: Fiji Ministry of Health; Secretariat for the Pacific Community (SPC) Public Health Programme, June 7, 2005.

Risk Factors, Known and Suspected

Economic and Demographic Factors

The distribution of HIV cannot be simply explained by economic factors. Poverty *per se* is not closely associated with the spread of HIV, partly because knowledge and skills for preventing HIV are independent of income. In fact, HIV is often associated with higher incomes, particularly in the early stages of an epidemic, where these are used to access multiple sexual partners. Over time, however, HIV pools up among those with lower educational and income levels. And in turn, after being infected with HIV, the poor get poorer as family wealth is spent on medical care and continued earning is compromised by sickness.

Using 1997 data from 50 countries in Africa, Latin America, Asia, and the Middle East, Over (1997) showed that HIV prevalence levels increase as income per capita declines and inequality increases (as measured by the Gini coefficient). Unequal distribution of income contributes to greater vulnerability to an HIV epidemic through several mechanisms. The poor have less access to HIV prevention services, including treatment of sexually transmitted infections (STI), and therefore less knowledge about the risks of HIV and prevention methods. Poverty restricts options and can induce low-income women and men to engage in commercial or transactional sex, fueled by migration from rural to urban areas in expectation of income-earning opportunities. Poor men often must delay marriage, and where there is hardship spouses leave the household in search of jobs. Whatever the mechanism, international evidence suggests that sustainable growth and more equal distribution of income are factors that contribute to reducing the spread of HIV. In the Pacific, Fiji, Federated States of Micronesia (FSM), Kiribati, Republic of the Marshall Islands (RMI), Solomon Islands, Tuvalu, and Vanuatu all have 20% or more of their populations living on less than \$1 a day (Secretariat of the Pacific Community 2004). If calculated as basic needs poverty, the list extends to Tonga and Samoa. Available data on Gini coefficients for the Pacific shows that Fiji (0.46, 1990-91), FSM (0.41, 1998), and PNG (0.46, 1996) have the greatest inequality of income (Abbott and Pollock 2004).

HIV has a pernicious impact of women, particularly poor women. Where gender power disparities are great, sexual double standards, economic dependency, and greater female illiteracy as well as gender-based violence contribute to the increasing proportion of females infected. Over (1997) also demonstrated the correlation of HIV prevalence levels with several proxy indicators of women's equality in society, such as low female participation in the non-agricultural workforce (less than 30% is associated with high HIV levels), the gap between male and female literacy rates, or less education among women. In the Pacific, only PNG and the Solomon Islands have very low proportions of women in non-agricultural employment, 5% and 30% respectively, but the proportion does not rise to even just 40% in Fiji, FSM, Kiribati, RMI, and Tonga. In PNG, the Solomon Islands, and Vanuatu there are far fewer girls in tertiary education than boys.

The lack of sustainable livelihoods on many islands has led to high levels of out-migration, i.e., from Fiji, FSM, RMI, Samoa, and Tonga. Remittances from family members working abroad form

a major part of the national income on these islands, as do the remitted salaries of seafarers, especially on Kiribati and Tuvalu (Armstrong 1998; Dennis 2003). In most islands, overall economic growth has been stagnating and there is no clear indication that this will change over the medium-term. This poor outlook is coupled with and in part driven by high fertility on many islands as measured by the total fertility rate.³ PNG (4.6), Samoa (4.6), Vanuatu (4.8), Solomon Islands (4.8), Tokelau (4.9), and the RMI (5.7) had (as of 1999 to 2002) the highest rates of population growth in the region and the broadest bases in their population pyramids. The median age of all citizens in the RMI is 17.8 years and 43% of the population is under 20.

While most Pacific Islanders live in villages, this is rapidly changing. Overall urbanization is proceeding at an annual rate of 3-4% and already 11 out of 21 PICTs have more than 50% of their population living in urban centers. Both Honiara and Port Vila are expected to double in size in 16 years. Natural resources including water sources are under stress, pressure on land is great in many areas, housing has become more crowded, education systems have shown poor performance on almost all the islands, unemployment is increasing, and growth in the private sector is very slow. In addition, a variety of forces have whittled away at traditional kinship-based social support mechanisms. Under these conditions, it is difficult to envision what factors could protect Pacific Islanders from the further spread of HIV.

Sexual Behavior Patterns

The overwhelming handicap in any campaign against HIV/AIDS in the Pacific is the inability to speak about, discuss, or conduct research on human sexual behavior. At present, any public attempt to deal with it objectively is doomed to failure. Traditions that taboo such discussions between specific kinship relations have become thoroughly entwined with religious teachings and silence any truth-seeking about the nature of sex and sexuality in most Pacific populations. The tendency to claim that sex cannot be discussed is greatest among bureaucrats, church representatives, and other persons who feel it is their role to defend customs and traditions. However, the degree of denial, moral outrage, and prudishness has become quite damaging to the public health effort to reduce risks of acquiring HIV and other STIs, as well as teenage pregnancy rates. In one survey of Samoans, only 4-5% of people thought informing people about HIV could be preventive (Seniloli 2003). The reluctance to bring sexual issues into public view needs to be greatly reduced. Strong, scientifically-sound research is needed to counter the fear and misconceptions held by many in policy-making positions.

An audit of research on sex and sexuality conducted in 1999 found 724 studies that at least tangentially dealt with some aspect of sex in the Pacific (Chung 1999).⁴ There may have been more since

³ The total fertility rate refers to the average number of children a woman would give birth to during her lifetime if she were to pass through her childbearing years conforming to the fertility patterns prevailing in a given period.

⁴ By contrast, there is an enormous literature on gender in the Pacific, which is also of some use to planning HIV prevention programs.

then but perhaps with the exception of a few in French Polynesia and New Caledonia practically none have been formulated specifically as formative research for HIV behavior change interventions, baselines, or follow-up surveys. Overall, it seems fair to state that, while there is a great deal that has been learned about knowledge, cultural beliefs, and sexual practices in some of the Pacific Islands, there are others in which almost nothing has been investigated (e.g., Nauru, Niue, Tokelau, and Tuvalu) and much is outdated and inappropriate for use in planning programs.

More recent studies conducted by non-government organizations (NGO) have been qualitative and even simply anecdotal in nature. Domestic violence, sexual violence, and sexual abuse, particularly of children, have been studied among specific groups, such as Indo-Fijians, and more recently in other Pacific societies. The United Nations Children's Fund (UNICEF) has sponsored several studies on the lifestyles of youth, but only examined sexual behavior in a minimal way among out-of-school youth. These studies do not reveal the context or meaning of behaviors that might place young people at risk. Several other studies, however, conducted since the audit was done are of value and are mentioned below.

Among Young Men and Women

In a large non-probability sample of out-of-school youth in Tonga, mostly between 15 and 19 years old, 42% of boys and 13% of girls said they had had sex; 58.5% of boys had three or more different partners, while 33.3% of girls had done the same. Most never or rarely used condoms or other means of contraception (UNICEF 2001a). Similarly, in Pohnpei, Micronesia, of a large representative sample of school students (mostly 15-17 years old), 81% of boys and 42% of girls had begun having sex; 69% of boys and 29% of girls with three or more partners. Again the majority never or rarely used condoms. Among out-of-school Micronesians (mostly 17 to 20 years old), 86% of boys and 60% of girls had had sex; 61% of boys and 24% of girls with three or more partners, 73% of whom never or rarely used condoms (UNICEF 2001b).

A smaller study conducted in 1996 in Fiji, RMI, and Samoa, (Jenkins, 1996) found that among males 72% of Fijians, 64% Fijian Indians, 66% of Marshallese, and 64% of Samoans had begun having sex (mean ages 18-20). Further, 15.6% of the Fijians, 9.6% of Marshallese, and 2.3% of Samoans had paid for sex with cash. More interestingly, 12.2% of Fijians and 2.4% of Marshallese females had also paid men cash for sex. Selling sex for cash was reported by 4.9% of male and 13.3% of female Fijians, as well as 6% of males in RMI and 6% each of males and females in Samoa.

One of the best recent studies is that of Kaitani (2004) on young Fijian men. Using both qualitative methods and a cluster survey of 822 men under 25 years old, mostly in educational institutions, the study amply demonstrated the poor quality of sexual and reproductive health education available to those attending school, the strong influence of Christian religious and moral beliefs on attitudes, but their relative lack of influence on practice. By the age of 19, 61% of these young men had had premarital sex (vaginal or anal intercourse). First sexual experiences were with other men (10%), female casual friends (39%), girlfriends (34%), sex workers (16%), and new acquaintances (2%). In the prior six months, about 31% had had three or more partners and 11% had gone to sex

workers. Further, the study showed that those professing greater religious commitment were significantly more likely to have had sexual intercourse and to have had multiple partners in the prior six months, a phenomenon interpreted to indicate that such young men had greater access to sexual partners through church socials than those who did not attend. While over 70% of these sexually active young men had ever used condoms, only about 24% claimed to be consistent users. Interestingly, those who considered themselves homosexual were four times more likely to have ever used condoms than the others. “Convoy” or group sex, in which many men line up for one woman, often by force or trickery (which makes it gang rape), was discussed in this study as a perceived normative practice for youth, but its frequency was not measured. In the study done in 1996 among youth in Fiji, Jenkins (1996) found 41% of males and 15% of females had participated in convoys.

Sexual behavior patterns in the Solomon Islands have been better documented than on most other islands. Buchanan-Aruwafu (2002) describes the context and meaning of “longline” (gang rape). Her quantitative study revealed that 21% of males and less than 1% of females in a sample of 300 admitted to having been involved. Aggressive coercive sex and passive shame are gendered roles in Malaita society. Most men said that longline occurred to teach women not to dress or act in a sexually provocative manner and not to be involved in sex work, as these went against their traditional moral values and were spoiling their family and community image. Punitive rape has been documented in other societies, including several in Melanesia (Salomon et al. 2003; National Sex and Reproduction Research Team and Jenkins 1994) and elsewhere.

Within the Commercial Sex Trade

Other than an early unpublished brief study of prostitution in Fiji by Plange (1990) and a brief article on sex workers from a clinician in Fiji (Sainath 1994), little has been published beyond anecdotes that would clarify the nature of the sex trade and the lives of sex workers on most islands or establish quantitative baselines against which progress could be measured. No population size estimations have been attempted. While the quality of much of the research is poor and often tainted with moral outrage, the nature of the observations and testimonies makes it clear that the selling of sex for cash and/or other commodities or services is widespread in the Pacific, by females and to a lesser extent by males and transgenders. There is, however, a continuing definitional problem with the term “sex worker” or “prostitute”, partly because the exchange of sex for commodities (fish, other food items, shell jewelry, trade goods) is an old pattern in many Pacific Islands and has been observed and documented many times (Mageo 1998; Snow and Waine 1979; Wallace 2003). The transformation from commodities to cash is a natural evolution given the rise of cash economies. In addition, marriage just post-menarche is a common feature of island societies. Girls of an age seen to be ready for marriage are seen to be ready for sexual intercourse. While the various churches and formal educational institutions have tried to alter the perceptions and practices of Pacific Islanders on these issues, the evidence suggests they persist and other approaches are necessary in the current era of AIDS.

Anecdotal evidence abounds of widespread formal and informal sex trading throughout the Pacific. In Fiji, Chinese sex workers have been brought in to service Asian sailors and fishermen and are apparently organized in brothels by Chinese managers. Fijian sex workers can be found in suburban residences, on streets and parks, in clubs, and, increasingly, on call through an organized cell phone network. In Majuro, Chinese and Koreans have been brought in by Asian business to work from clubs. Seafarers reported in one study that sex workers were easily available in Fiji, French Polynesia, Guam, Nauru, New Caledonia, PNG, Samoa, and Tonga (Peteru 2002). In the Solomon Islands, the term “*dugongs*” (Buchanan-Aruwafu, Maebiru and Aruwafu 2003) and in Kiribati the term “*korekoreas*” refer to young women who meet tuna fishermen and sailors at the docks as they take shore leave (Vunisea 2005). Earlier women could board the ships, but a new policy in 2004 has attempted to halt this practice. The ingenuity of all concerned can probably be counted on to make enforcement problematic.

Behavioral research (Buchanan-Aruwafu 2002) done in Auki, Solomon Islands in 2000 showed that 13% of 262 sexually active youth (both male and female) had exchanged sex for money or resources. Of the sexually active males, 18% reported buying sex in the previous year and only one had ever used a condom. In 1996, Jenkins found that selling sex for cash was reported by 4.9% of male and 13.3% of female Fijians, as well as 6% of males in RMI and 6% each of males and females in Samoa. Further, among males, 15.6% of Fijians, 9.6% of Marshallese, and 2.3% of Samoans had paid for sex with cash. More interestingly, 12.2% of Fijian and 2.4% of Marshallese but no Samoan females had also paid men cash for sex.

Sexual Abuse and Violence

The special problems of child sexual abuse and child prostitution also require better examination and documentation in order to deal with it properly, though considerable material has been gathered to document that it exists and appears widespread (Christian Care et al. 2005; Wan Smolbag Theater et al. 2004). A strategy is needed to manage the differences between prosecuting abusers, providing HIV harm reduction methods to older girls, removing very young girls or boys from exposure, and so on. Despite the definition of the United Nations (UN) of 18 as the age at which childhood ends, local cultural ideas of an age of personal agency will play a role in the ways in which the community responds to the challenges of managing the sexual adventurism and/or exploitation of some young people.

The Samoa Family Health and Safety Study, a recent effort organized by the Secretariat for the Pacific Community (SPC), using an adapted World Health Organization (WHO) protocol developed for multi-site studies of domestic violence and related issues, is an excellent example of thorough treatment of a difficult issue and should be repeated elsewhere in the Pacific. This study has shown that physical and sexual abuse is more common in rural areas among the less educated sectors of the population. Among both rural and urban women, 18% stated their husbands had affairs with other women while married to them, twice as many among women who reported having been abused than among others. A possible link with the number of attempted suicides is suggested. Similar findings were discussed in New Caledonia. While direct linkages with risk of

acquiring HIV were not highlighted in these studies, evidence from elsewhere indicates repeatedly that women who are physically and sexually abused by their partners, whether married or not, are at additional risk of acquiring HIV and other STIs (Dunkle et al. 2004; Johnson and Hellerstedt 2002; Martin et al. 1999; Raj et al. 2004). When HIV begins to spread from men to their wives or main partners, most of whom are not having multiple partners, the task of prevention becomes much more difficult than when it is confined in the traditional high risk groups—i.e., sex workers, their clients, and men who have sex with men (MSM). Screening for abused wives/partners at women’s health or family planning clinics could offer a way to target the women at greatest risk and offer them special training in prevention negotiation or other services. While there is considerable effort being made to conduct education about and provide services for abused women in several Pacific Islands, linkage with HIV prevention has yet to be well developed (Pacific Women’s Network against Violence against Women 2004).

Among Sexual Minorities

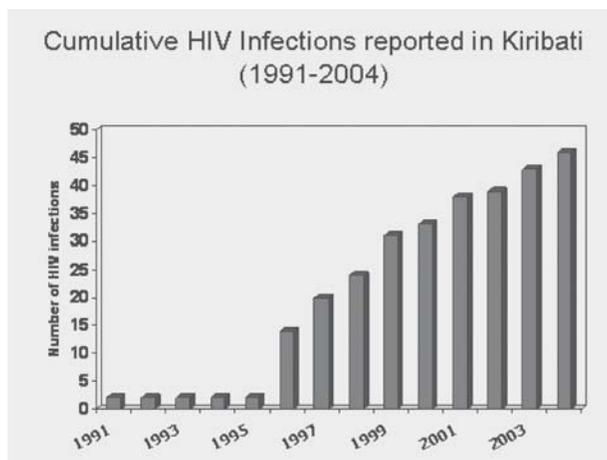
The Pacific Islands are well-endowed with traditional gender-variant roles for males, for example, the *fa’afafine* of Samoa, *fakaleiti* of Tonga, *laelae* in the Cook Islands, *mahu* in Tahiti and Hawaii, and others elsewhere. While there is little evidence that these roles have ever had a real sacred nature, it is well documented that these persons were accepted and respected in their communities, and some served as healers. Although it is generally understood that young males often had their first sex with *fa’afafine* (way of a woman), the sexual aspects of the role did not predominate in the traditional pattern. Some mothers deliberately raised a last-born son as a *fa’afafine* because they were seen as very helpful and valuable to the community. They took on the work roles of women and even today in Apia, Samoa, one can see *fa’afafine* serving as receptionists, bank tellers, or in other jobs in an unremarkable manner. However, over time, with outside influences, the *fa’afafine* has become more widely known as a flamboyant nightclub performer and sex worker. An exaggerated feminine sexuality has become dominant in the public eye. Many tourist areas make use of *fa’afafine* for beauty competitions and other shows. Today the role is becoming more and more stigmatized and as in Hawaii, where the term *mahu* has become pejorative, the standard western negativity about gender variance is taking hold.

Most Pacific Islanders who live gender-variant roles resist the terms transgender, gay, transsexual, homosexual, and so on because they feel these terms are centered on sexuality and sexual preference. Traditionally, the indigenous terms were more centered on aspects of the person that were more appreciated within the family and community; sexuality was more private and not central to identity. In a manner similar to Native Americans, in some places, such as Hawaii and Samoa, transgendered people have begun activities intended to rebuild their respectable place in society (Schmidt 2001). Nonetheless, under the constant influence of western models of sexuality, economic pressures, tourism, and, to some extent, the models that grow in HIV/AIDS programs, these Pacific formulations are being altered. These groups were among the first to have become infected with HIV in the Pacific (Sapiegal 1991).

More recently, influences largely from Australia, Guam, and New Zealand have fostered the development of a gay identity on several islands by developing gay organizations, using websites and other ways of communicating with others in the Pacific. As these men gain a voice, make their preferences known, and demand greater rights, they often suffer as individuals within families that are unable to accept their sexual preferences. Their risk level has never been well documented, but in French Polynesia, where data on transmission are better collected and managed than elsewhere, the evidence shows that among all cases detected before 1990 (n=90), 42% were homo/bisexual and only 27% heterosexual. Since 1995 the levels have shifted a bit, with 43% attributed to heterosexual transmission and 34% to homo/bisexual transmission as of 2002 (Soubiran 2003). One report (Hecklinger 2001) states that in Fiji 71% of 400 males who have sex with males interviewed by an NGO (probably Fiji AIDS Task Force) reported their male partners' self-identify as heterosexual and are perceived by society as heterosexual and yet regularly have sex with men. As this pattern is increasingly being revealed elsewhere as well, the scant data available on MSM, including transgenders, in the Pacific indicates a great need to devote more effort in documenting their levels of STIs and HIV and developing prevention and care services specifically for the identified men and their non-identified, largely bisexually active partners, who can easily serve as a bridge to the general population of females.

Seafarers

In Kiribati and Tuvalu, a spate of HIV infections has occurred among seafarers, engendering a great deal of concern. While the Pacific as a whole has only about 5,000 registered long-distance seafarers, most hail from those two islands. Although many of these men have been tested for HIV before they left on a voyage (though it was later recognized as not required), they are not tested upon their return and there apparently has been some transmission to partners. Seafarers worldwide are well known to "have a woman in every port" and Pacific Island seafarers are no different. One study found that about 50% of those on board would seek women at each port of call (Peteru 2002), many staying with the same woman for days. Male-to-male sex also occurs as do convoys. HIV/AIDS education appears to be given only to new recruits in maritime training schools and is moralistic and punitive in nature, according to one review. Peteru found, despite having had HIV training through the Department of Health, NGOs, and shipping companies, only 23% of the 78 men interviewed always used condoms and only 43% could answer correctly how HIV was spread. The frequent visits of *korekoreas*, the local variety of sex worker, to ships docked in Kiribati have now been dampened by new laws, although enforcement remains a problem (Regional Rights Resource Team 2004). Figure 3 shows the rising numbers of infections in Kiribati, half of which are among seafarers and about 13% among their spouses.

FIGURE 3. Rising Numbers of HIV Infections in Kiribati

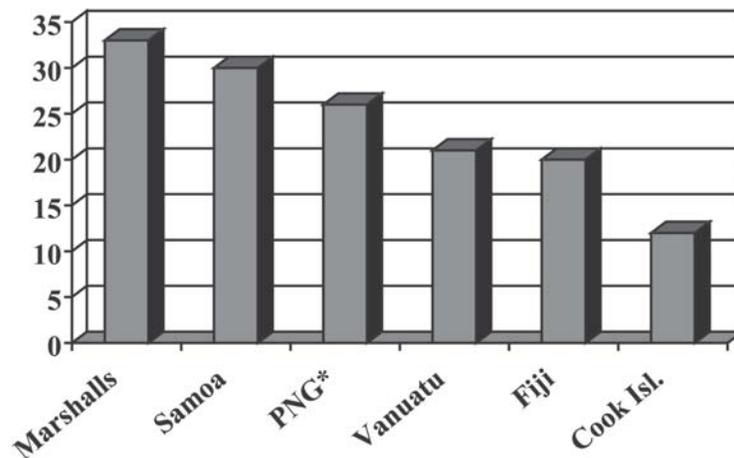
Source:

Sexually Transmitted Infections

Studies of STIs have recently been conducted in several island nations among antenatal women. On Samoa a survey of 427 pregnant women found high levels of chlamydia (30.9%) and trichomoniasis (20.8%). Although gonorrhoea and syphilis levels were much lower and no HIV infections were found, overall 42.7% of the women had at least one STI. Those under 25 years old were three times more likely to have an STI than older women (Sullivan et al. 2004). Similarly, in Vanuatu, 547 pregnant women were tested and 39% had one or more STI. The most common infection was trichomoniasis (27.4%), followed by chlamydia (21.4%), and gonorrhoea (5.9%); 2.4% had syphilis and none had HIV (Sullivan et al. 2003). In one clinic in Fiji, over 70% of all STIs were among young people between 15 and 25 years old. Figure 4 shows the prevalence of chlamydia among low-risk women in selected Pacific countries.

More recently, a study on Kiribati of antenatal women and seafarers reported 20.2% HSV-2, 9.3% chlamydia, 2.7% syphilis, and 0.3% HIV among the seafarers (many of whom were trainees) and no HIV and 1.4% syphilis among the women (WHO-WPRO and Ministry of Health, Kiribati 2005).⁵ Collectively, these STI prevalence data indicate widespread unprotected sex and the likelihood that men also have high levels of untreated STIs, thus heightening the risk of HIV transmission in the community.

⁵ For some unexplained reason no gonorrhoea was found among the seafarers and no HSV-2 among the women. Women were not tested for chlamydia or gonorrhoea.

FIGURE 4. Prevalence of Chlamydia Infection among Antenatal Women in Selected Pacific Countries

Source: World Health Organization 2001

Substance Abuse

Although some injecting drug use is known in French Polynesia, Guam, and Palau and sporadically elsewhere, only a few cases of HIV among injecting drug users have been recorded in the Pacific and it is not clear if these were transmitted while traveling elsewhere, i.e., France or the United States of America (USA). However, non-injectable drug use is often associated with careless sexual behavior. Reports of heroin, methamphetamines, and crack cocaine in the RMI, especially Ebeye, as well as sporadic reports from the Solomon Islands and elsewhere are cues for concern and monitoring. However, for most people excessive alcohol consumption may be the most common substance associated with high risk behavior.

Other Risks

Body piercing and tattooing, as well as the use of penis inserts (Hull 2002) are practices that can increase the likelihood of acquiring an HIV infection. These risks have often been noted in prison populations and among sailors and fishermen. Other risks for transmission of HIV in the Pacific, such as through blood transfusions, do exist, though the extent of such potential transmission is unclear. The blood safety program is under WHO oversight and is expected to be strengthened with support from the Global Fund Against AIDS, TB and Malaria (GFATM). Different approaches for different islands seems necessary, as some are simply too small to have a standard blood banking system. At present Red Cross reports that the Cook Islands and Fiji have the best systems for blood safety.

In sum, at least some Pacific Islands appear to have the sexual risk-taking conditions, particularly low condom use and relatively high STI levels, to sustain an HIV epidemic. The extent and speed of spread is dependent on patterns and sizes of sexual networks. Little solid information is available on either the extent of various sexual behaviors, degrees of condom usage, or networking. Practices associated with blood-related transmission are even less well documented. All of these types of data are necessary for effective project planning.

The Response

At the Regional Level

Pacific Regional Strategy

The SPC, formerly the Pacific Islands Commission, is one of the oldest regional organizations in the world. It is made up of 22 island countries and territories, plus the four remaining founding countries—Australia, France, New Zealand, and the USA. It is a non-political, technical assistance, and research body that fills a largely consultative and advisory role. SPC has constantly evolved, both reflecting and shaping the island regionalism that has built today's Pacific. The capacity to adapt to the changing needs of both territories and independent island countries that has enabled SPC to survive for more than half a century ensures its continuing role in the social and economic development of the Pacific Island region.

SPC has for many years taken a lead role in hosting and encouraging funded HIV activities. In the 1990s efforts were made, particularly by several UN agencies and the SPC, to alert Pacific Island countries to the threat of HIV. A regional strategy was developed in 1997 but was never fully funded or implemented. At the Pacific Islands Forum meeting in 2002 leaders discussed HIV/AIDS for the first time and in 2003 requested an updated regional strategy to be developed. The Pacific Regional Strategy (2004-2008) was developed and finalized in 2004.

The goal of the Pacific Regional Strategy is to reduce the spread and impact of HIV/AIDS, while embracing people infected and affected by the virus in Pacific communities. To achieve this it proposes:

- to increase the capacity of PICTs to achieve and sustain an effective response to HIV/AIDS;
- to strengthen coordination of the regional-level response and mobilize resources and expertise to assist countries to achieve their targets; and
- to help PICTs to achieve and report on their national and international targets in response to HIV/AIDS.

The strategy addresses four major areas and sets four corresponding objectives:

- **Leadership and governance:** To strengthen PICT leadership and governance on HIV/AIDS;
- **Access to quality services:** To strengthen the capacity of PICTs to deliver a continuum of care services for people living with HIV or AIDS;

- **Regional coordination:** To intensify regional cooperation and coordination on HIV/AIDS; and
- **Program management:** To effectively and efficiently manage the implementation of the Pacific Regional Strategy.

The strategy also identifies 11 major challenges.

- Inadequate surveillance and monitoring capacity at all levels;
- Long distances and communication difficulties;
- Providing sustained leadership at all levels;
- Lack of resources;
- Culture as a barrier to understanding and prevention initiatives;
- Lack of capacity in all aspects of HIV response and at all levels;
- Difficulty in sustaining comprehensive national responses;
- The need for coordination at national and regional levels;
- The need to deal with vulnerable groups and promote gender training and awareness;
- The need to address stigma and discrimination; and
- The need to build capacity to provide treatment to those with AIDS.

The Pacific Regional Strategy provides a framework to support action and an implementation plan has been developed with emphasis on holding workshops, developing networks, developing guidelines, establishing interagency groups, and training health workers, mostly for the encouragement of political commitment and instituting treatment programs for HIV and STI. However, while “vulnerable groups” are mentioned, they are not emphasized. Sex workers, their clients, and MSM are rarely cited as important at all. Youth are mentioned but are considered generically, without subdivisions. Women’s issues and sexual violence are omitted. Thus, the workplan calls for generic behavioral change communication for all vulnerable groups, presumably meaning that the same messages are applicable to each such group across all the Pacific cultures, urban and rural. This clearly contradicts all theory and practice in professional communication for behavior change. While it is uncertain why such an approach has been adopted, it seems likely that continuing embarrassment and ignorance about the sex trade (formal and informal) and MSM (gay, transgender, and other) may be at the root of these gaps and misdirected approaches. In addition, even as the strategy focuses on leaders and politicians, most other activities are related to the medical profession. While much needs to be accomplished in the medical field, a much wider range of skills and actions are needed to bring about normative changes in attitudes and behavior. The workplan appears to lack serious input from professionals in the social and behavioral sciences and reflects little understanding of the international best practice in these fields.

Global Fund to Fight AIDS, TB and Malaria

In 2002, 11 small Pacific island countries (Cook Islands, FSM, Fiji, Kiribati, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu) grouped together and applied for the second round of the Global Fund to Fight AIDS, TB and Malaria. Their request was approved for a multi-country HIV/AIDS grant of US\$5.2 million to be implemented and coordinated by SPC. The 5-year program seeks to:

- strengthen STI, HIV, and behavioral surveillance, blood safety, and laboratory capacity;
- improve STI/HIV services by 2007 and develop a comprehensive HIV care system in countries with an increasing number of cases; and
- reduce the risk of HIV and other STIs through targeted interventions that include—
 - reducing STI/HIV risk behavior through peer education and outreach programs focusing on condom promotion (including social marketing) among vulnerable groups measured by achieving 70-80% consistent condom use among sex workers and seafarers by 2007;
 - raising STI/HIV awareness among young people; and
 - enhancing a multisectoral response to the HIV epidemic to complement targeted interventions, including workplace interventions, national and regional planning, building NGO capacity, and advocacy based on ethics, law, and human rights.

Activities associated with the GFATM package include:

- conducting HIV surveys in six sites (Fiji, Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu) with workshops and planning meetings;
- strengthening regional and local laboratories;
- improving STI/HIV services by developing curricula, training health staff and traditional healers, holding workshops, and providing drugs;
- determining what is required to develop a comprehensive HIV care, treatment, and support system;
- reducing risk of spread of HIV/STI with targeted interventions for youth (no other high risk groups are mentioned in the workplan) by developing instruction, education, and communication (IEC) materials, distributing condoms, and conducting trainer of trainer programs for peer educators;
- developing advocacy programs through producing IEC materials for important events, funding HIV/AIDS Ambassadors, producing a video, having Wan Smolbag teach the use of drama and then funding the trained theatre groups to do national tours;
- establishing country coordinating mechanisms by strengthening NGOs and bringing them to-

gether with government representatives to establish a secretariat that will coordinate the overall effort in each country to formulate and implement a monitoring and evaluation plan, produce legal literacy materials, develop training modules, produce country reports on human rights issues, and other similar activities.

While the GFATM proposal includes the aim to reduce chlamydia to less than 10% in low risk women, it is neither well qualified nor is a clear strategy discussed. In most countries, strategies to reduce chlamydia in the general population require a screening program as most cases are asymptomatic. This is a relatively expensive proposition. The finding of 20% HSV-2 in seafarers is important, as HSV-2 is well-known as a strong facilitator of HIV infection. However, both testing and treatment for HSV-2 are very expensive activities and it is not likely that the laboratory or clinical facilities would be able to meet the challenge without a great deal of investment. Similarly, the aim of achieving 70-80% consistent condom use among sex workers and seafarers by 2007 seems remote given that there are few properly designed and implemented programs for these groups as of mid-2005. Condoms are not widely available or accessible to those who need them, and the work plan summarized above does not include the type of activities needed for designing targeted interventions for high risk groups. Further, considerable funding and time are likely to be wasted by targeting youth in general instead of specifically finding the high risk youth and designing programs, including condom promotion, for and with them.

Until recently, surveillance has been based solely on passive detection and occasional mandated testing. An effort at “second generation surveillance” has been directed by WHO with a contracted researcher from the University of New South Wales. A full-time person has been placed with SPC in Noumea to coordinate the work and funding from the French government is available for their dependent islands. Efforts have been made to strengthen laboratory capacity, particularly Maitani House in Suva that should serve eventually as a confirmatory laboratory. The surveyed populations were selected by the government in each island. Both HIV/STI and behavioral surveys have been carried out in 2005. While results are not available as of this writing, these surveys should yield somewhat better data on the extent of spread in most islands, though sample sizes are small among those expected to be higher risk. Moreover, the general denial of the presence of sex workers and MSM means very little attention has been paid to placing them in the surveillance program. While youth are frequently included, there is no evidence that these will be those at high risk. The majority of youth, even in high prevalence countries, are not at risk of acquiring an HIV infection. The general lack of targeted behavioral change interventions or services for high risk groups—such as MSM, sex workers and a subgroup of high risk youth, perhaps drug-using or club-going youth—means that they are not yet accessible for surveillance. As this is a new effort with inadequate investment in developing probability sampling frames, the selection and training of interviewers in sexuality research skills, and on-the-ground supervision by experienced persons, the results are likely to be compromised. Future improvement of the technical aspects of second generation surveillance will be necessary.

As of April 2005, the first phase of the GFATM grant (US\$3.04 million) was under-spent due to delays in getting activities started and the GFATM board has decided to reduce the second phase

funding by about US\$0.8 million. The same group, now expanded to 13 countries, has undertaken a new application for funding in the fifth round of the GFATM grants.

The Franco-Australian Pacific Regional HIV/AIDS Project

The Franco-Australian Pacific Regional HIV/AIDS and STI Initiative is an effort by the Australian and French governments to combine support in order to cover the majority of islands. In 2003, the Australian Agency for International Development (AusAID) committed A\$12.5 million over five years to the Pacific Regional HIV/AIDS Project that is jointly implemented by the Burnet Institute—Australia’s largest virology and communicable disease research institute, International Development Support Services, and SPC. To date, this project has helped 12 out of 14 participating countries (Cook Islands, Fiji, FSM, Kiribati, RMI, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, and Vanuatu) to develop national strategic plans.⁶ At least two have gone on to create work plans. The overall aim is to provide funding for the implementation of national plans. Eight national AIDS commissions have been given grants, and agencies designated as community development organizations (CDO) are given funds to become focal training agencies for smaller local organizations. These CDOs can compete for multi-year grants to implement programs. There is also a small grants component for funding meetings and other small efforts.

Despite these accomplishments, there remain numerous challenges for this project. Only one of the CDOs—Wan Smol Bag in Vanuatu—has a mature HIV-related program. Also, the technical assistance available does not seem sufficient. Presumably the funds given the CDOs can be spent to bring in short-term consultants to fill the gap, but the overall experience with short-term consultancies is poor. Provisions need to be made for longer term positions for experts willing to live and work in the region as they usually have more to offer and can mentor and train local persons far more effectively. Finally, activities, such as exposure to others with experience in Asia through visits or attendance at Asia-Pacific regional HIV conferences, are rarely funded. These should be encouraged to widen perspectives and promote cross-fertilization of Asian and Pacific experiences.

UNAIDS and the UN

The UN agencies present in the Pacific—the International Labour Organization (ILO), the United Nations Development Fund for Women (UNIFEM), the United Nations Population Fund (UNFPA), UNICEF, the United Nations Development Programme (UNDP), WHO—are collectively working with UNAIDS to carry out work on HIV/AIDS from the perspectives of their different mandates. They frequently receive GFATM funds in order to execute specific tasks required within their work plans. In addition, these agencies seek and obtain funds from other sources. Collectively, their

⁶ The French government added funds to this project to support improved second generation surveillance in the French-affiliated territories. Six US-affiliated islands, such as Guam and the Northern Marianas, are included through funding from the USA.

investment is considerable. Their efforts have included reviews of sexual abuse and exploitation of children, the development of school curricula, and life skills programs (UNICEF), support for local condom social marketing (UNFPA), reviews of HIV-related legal issues (UNDP), laboratory support, training in the treatment and care of HIV infected patients, training in STI management, VCT training, and workshops on second-generation surveillance (WHO), and meetings with police, military, and other occupational groups with regard to workplace policies (ILO, UNAIDS). UNAIDS has utilized its project acceleration funds for a variety of small projects, including research, support of groups of people living with HIV or AIDS, and advocacy.

Condom distribution by UNFPA as of April 2005 was 1.6 million to Fiji, FSM, Niue, Samoa, Solomon Islands, Tokelau, Tonga, and Tuvalu. Other Pacific Island countries had not ordered and it was assumed they did not need more. Condom sales resulting from the social marketing efforts of Marie Stopes International, funded by UNFPA, are not available. In general, however, most people still state that condoms are not available where they are needed, and on some islands permitted only to married couples or available through the health services but the name and number are taken and written down. During 2005, generic condom commercials placed on TV by the Fiji Department of Health had to be removed almost immediately due to public criticism. Clearly, HIV prevention in the Pacific cannot be successful unless condoms are made widely available, inexpensive, and promoted openly. A great deal more investment must be made for this purpose.

UNICEF has begun to implement its Pacific Stars Life Skills program, aimed at reaching 20% of youth in the region, in Fiji, FSM, Kiribati, RMI, Solomon Islands, Tonga, Tuvalu, and Vanuatu. Evaluations in a few countries elsewhere have shown some positive effects of life skills programs on behavior. These, however, have more often resulted in improved knowledge with little overall effect on long-term behavior. Long-term behavior change is difficult to measure, but similar school-based programs implemented by other agencies in the USA have shown little impact (Robin et al. 2004). It is likely that the failure of these programs is due to their generic nature, inasmuch as those that are more specifically tailored to the needs of various ethnic or class-delineated subgroups are more often successful (DiClemente et al. 2004; Jemmott, Jemmott and Fong 1998). Critics are urging UNICEF to invest more in targeted interventions for high risk youth that are based on the principles of communication and practice emphasizing full design and “ownership” by the affected youth themselves.

Another important UNICEF effort has been the documentation of the situation of sexually exploited children and young people in numerous countries. It is unclear how these problems will be approached, especially when the youth involved are near adulthood and are voluntarily selling/exchanging sex for material goods. These issues need further delineation and clarification in ways that bring representatives of at-risk young people into the discussions as equals.

UNDP has contracted local agencies to review the legal issues surrounding HIV in the Cook Islands, RMI, Samoa, Solomon Islands, and Vanuatu. The results to date have been fairly poor. This aspect of UNDP’s work will probably need a great deal more investment.

UNDP has also supported the Greater Involvement of People living with HIV and AIDS through workshops, trainings, and support of emerging positive support groups. This is a very important component of any HIV/AIDS response and much more emphasis on it is needed. Studies have shown that there is no more effective way to reduce stigma and discrimination than by facilitating face-to-face contact between positive people and others. Hence, helping positive people to develop communication skills would be highly valuable.

The ILO has taken the lead in facilitating the development of Codes of Practice for unions and employers and workplace policies for a wide variety of workplaces in Fiji, Kiribati, Samoa, Solomon Islands, and Vanuatu. These are important efforts that need to be coordinated with proper workplace prevention and care programs.

WHO has played a major role in providing training in STI management and VCT, laboratory support and improvement, and preparing countries for managing antiretroviral therapy. Its principal role has been to improve the capacity of health care workers. The provision of antiretroviral medications for patients, including prevention of mother-to-child transmission, will be a challenge, given the state of health services in several countries.

The Asia-Pacific Leadership Forum is a program associated with UNAIDS and funded largely by AusAID. It aims to improve knowledge and advocacy skills among leaders, from parliamentarians down to village headmen. Large workshops have been held to bring people together and to inform and inspire them. Critics point out that the effort lacks funding and capacity for follow-up, e.g., when a local leader becomes committed to engage with HIV issues, there are no funds or technical support to enable such an effort.

Secretariat of the Pacific Community

SPC has the lead role in the campaign against HIV/AIDS in the Pacific. Its main location in Noumea presents a slight handicap as that places it out of the more common travel routes and on an expensive westernized island. Recently, however, more functions of the SPC have been shifted to Suva where some facilities, particularly for training and meetings, are available. At present, it coordinates GFATM activities with other regional efforts within the framework of the Pacific Regional Strategy and hosts the persons responsible for surveillance and behavioral change communication funded by AusAID. SPC could take a far larger role in coordinating and executing components of the overall regional effort but will need investment and personnel.

In the past SPC hosted a Seafarers HIV/AIDS initiative. The project was well integrated with its Fisheries Division and the Regional Maritime Program, providing HIV/AIDS training and awareness materials in maritime schools. But this and other project activities ceased when the funding support from the NZAID seafarers project ended in 2001. It is clearly desirable to sustain it in some form, and update the training materials, improve the condom supply and distribution, and provide support for behavioral change among seafarers and their local partners.

National Governments

Most countries in the Pacific have a National AIDS Committee or the equivalent that have representatives from a variety of sectors, i.e., government, churches, NGOs, and academic institutions. Private sector participation has been limited. Collaborative relationships with NGOs vary in quality and intensity, but overall these committees are seldom functional. With the exception of Fiji and Kiribati, they do not regularly meet or carry out activities. There are several reasons why many are nonfunctional, and these include the lack of priority given to HIV/AIDS, the lack of a clear plan of action and role assignments, the lack of finances, and the lack of knowledge and skills. Only a few persons in any country are able or willing to work full-time on HIV issues. Further, without a sound evidence base that would convince those in denial or doubt where the risks lie and what needs to be done to diminish them, decision-making remains difficult and even contentious. In addition, where financial resources are scant, considerable competition exists for every dollar. A far clearer and more informed mode of operation is required in most countries. Annex 1 reviews the HIV situation and responses by country.

Indeed, national AIDS committees vary widely in their levels of activity and commitment. In all countries, health departments are the locus of whatever response has been made with little involvement of other sectors. In a few nations, such as the Solomon Islands, budgetary allocations to HIV/AIDS have recently been made for positions in an HIV/AIDS unit that, so far, have been difficult to fill. In the RMI, the USA donates US\$1 million per year for reproductive health and HIV/AIDS work. Overall, both government and civil society sectors have been relatively slow to respond and depend greatly on whatever support various regional actors and donors can give them.

Civil Society

International NGOs

There are only a few international NGOs working on HIV-related issues in the Pacific. The International Planned Parenthood Association, Pacific Regional International Federation of the Red Cross and Red Crescent Societies, Marie Stopes International, Oxfam, World Vision, World Council of Churches, and a few others are represented either as a regional office with local branches and/or at a country level. The Red Cross Society has until recently managed the blood supplies for Fiji, but this has been turned over to the Fiji Ministry of Health. On smaller islands, the Red Cross assists with recruitment strategies and promotion of safe blood supplies. Most of the other international NGOs have reputations for capacity in non-HIV related areas, particularly in their Pacific operations. While possessing the potential to mount programs, they will need considerable human and financial resources to be effective. Most of the small programs these international NGOs have carried out in the Pacific have been aided by persons in their organizations whose experience was garnered elsewhere. These represent resources of value but the financial and technical support for such efforts has not been great enough to show success.

National NGOs and Churches

Most island nations have at least a few local NGOs, many of which are associated with churches. The churches vary in their responses to the threat of HIV. It is recognized that the churches have an advantageous position from which to teach their members about HIV in a manner that would diminish stigma and encourage more accepting and caring attitudes; their positions on homosexuality and non-marital sex, however, remain fundamentalist and conservative.

The Pacific Office of the World Council of Churches, which includes most of the mainline older Protestant churches, is attempting to address the cultural issues in an educational program for church leaders. Financial support, however, for such work has yet to be identified. Some church NGOs, for example, ADRA in the Solomon Islands, are not averse to distributing condoms and carrying out clear HIV education for youth. More common, however, throughout the Pacific, is the conjunction of conservative Christian attitudes and cultural taboos that, together, chill any open discussions of sex and sexuality. This has negatively influenced the development of curricula for schools, the showing of condom commercials on TV, the targeting of interventions, and many other aspects of the response. From a range of researchers, it is clear that a great deal of risk behavior remains hidden. Few champions have emerged who will challenge these attitudes with evidence-based approaches.

Several locally developed NGOs have acquired considerable experience in HIV work, for example Wan Smol Bag Theatre in Vanuatu, Youth-to-Youth in Health in RMI, and the Fiji AIDS Task Force. As these and other local NGOs are supported to grow, their roles in the national and regional response can be expanded.

The Donor Community

At present AusAID and the GFATM represent the major donors for HIV/AIDS in the Pacific. UN agencies and UNAIDS funds collectively represent a major investment as well. NZAID and funding directly from the home offices of international NGOs, e.g., the International Red Cross and Marie Stopes International, are present but smaller. The United States Agency for International Development (USAID) has been approached but to date is only contributing to PNG and, other than France, additional bilaterals have not become involved. France contributes directly to its territories and the United States Centers for Disease Control and Prevention is contributing in the US-affiliated islands. Annex 2 lists the planned contributions from UN agencies, the GFATM Phase 2, and the Pacific Regional HIV/AIDS Project of AusAID.

Gaps and Challenges

What's Needed

This review of regional and country-level efforts reveals several major problems that are hindering the accomplishment of their goals. The nature of the Pacific region itself, composed of widely separated small populations, fosters investment at a regional level by donors, yet having three or four large complex programs with bases on different islands requires considerable effort at coordination. Electronic communications are not well developed on some islands and very slow and expensive on those that have commercial servers. Travel is hampered by high priced and infrequent flights. The state of the epidemic is largely unknown. It does not seem to be increasing rapidly, though such an impression may be simply due to poor surveillance. Nonetheless, political commitment is difficult to achieve as few governments are seeing their people dying of AIDS. Most importantly, for a low prevalence region the behavioral data needed, i.e., representative samples of high and medium risk groups that could clarify the potential for an epidemic are not yet available. While much progress in planning, coordination, and financial resource acquisition has been made in the past few years, the actual implementation of properly designed and prioritized prevention or care and treatment projects has been slow, infrequent, and transitory.

While many plans and strategies have been developed, they are seldom able to prioritize components of an overall response. Hence, decisions on how best to utilize funds are based on assumptions without evidence. In only a few cases have studies been conducted that reveal the nature of sexual risk behaviors in any detail. In most countries, the level of information does not extend beyond situational assessments that make a large number of assumptions with little more than anecdotes to support them. In Kiribati, studies of seafarers reveal considerable risk behaviors when overseas and upon return, but these studies do not have representative samples and are subject to biases. Without adequately sampled behavioral surveillance surveys among at-risk populations to serve as baselines, country programs will not be able to assess any possible future impact.

It is widely recognized that the knowledge and skills needed to design, manage, monitor, and evaluate HIV prevention and care activities are extremely scant in the region. To date, many workshops have been held in an attempt to develop those skills in Pacific Islanders, but building capacity for complex tasks requires more than workshops. There are several clear reasons for this problem: first and foremost is the severe lack of experienced personnel at all levels. Both civil society, including international NGOs, local NGOs, the private business sector, and community-based organizations, and government agencies have very few persons in paid posts with experience and knowledge to manage HIV prevention or care programs. Even at the level of regional organizations such as SPC, a few persons with advanced technical knowledge are expected to accomplish a broad

range of complex activities in a dozen or more islands. There are simply too few trained people on the ground in Pacific nations to mount the responses needed.

While there are plans to develop handbooks and guides to prevention “best practices” and for monitoring and evaluation that would presumably be conveyed through workshops, these methods of training cannot adequately meet the needs of numerous people with different levels of education and exposure on the many islands.

In addition, the region remains handicapped in dealing with the HIV/AIDS epidemic due to cultural, legal, religious, and political barriers that restrict the rights of women and socially marginalized groups, such as MSM including the relatively common transgendered males of Polynesia. Denial and reluctance to deal with socially shameful behaviors, such as sexual and other violence against women or young people, is widespread. Similarly, these restrictions do not allow unmarried young people easy access to information on their bodies, sex, condoms, or STI services. In much of the rural Pacific, custom rarely permits women or young people to participate in community decision-making, so it is impossible for them to make their needs known. In most islands, there are no legal protections for HIV positive persons. Social stigma is therefore a serious challenge that diminishes the ability of HIV positive persons, as well as those who are most vulnerable, to make their needs known, or to work with the appropriate agencies to help develop and implement effective responses. While culturally-competent persons are necessary to adapt the principles of behavior change programming to local settings and to implement programs, cultural norms themselves are often impediments to HIV prevention or access to care in that they privilege one component of society over another. It has long been recognized that particular aspects of traditional cultures have to be challenged in order to mount an effective rights-based response to HIV/AIDS.

Further, the necessary collaboration of government and civil society in a coordinated effort to develop prevention and care services for both marginalized high risk key populations as well as the wider general public, specifically youth and women married to at-risk men, has not yet knitted together in most islands. Those most likely to be infected and affected have not yet found their voice or been given a place at the planning table. In all countries, it is fair to say that both government and non-government agencies require considerable help to develop the necessary skills, knowledge, and openness in order to creatively and effectively address the issues in their countries. GFATM's requirement of having an active country coordinating mechanism made up of about 50% government and 50% civil society representatives provides an incentive for better collaboration among all sectors, but few countries have much experience in managing this without unproductive competition for scarce resources. Further, in none of the countries are the most at-risk populations or people living with HIV/AIDS represented on any national advisory committee.

Such an effort to improve skills and knowledge, research and monitoring, policy and rights to services, and the capacity to carry out interventions in a collaborative manner between government and civil society will require additional funds and at least five years of focused training and application.

A Framework for Strategic Action

With the recent addition of HIV/AIDS-designated grant monies, ADB will be able to constructively help its Pacific Island developing country members to reach their goals and avert a more serious epidemic. The proposed project aims at helping countries actualize the strategies and plans developed collaboratively by the GFATM partners, the AusAID-funded Pacific Regional HIV/AIDS Project partners, and the Pacific Regional Strategy partners. These projects generally overlap and do not represent drastically different approaches. What they lack repeatedly is evidence with which to prioritize actions to be taken and implementation plans, make decisions, and evaluate the effectiveness of what is being carried out at the local level. In addition, greater sophistication in social marketing and community-based and community-driven interventions are greatly needed.

ADB's contribution could help supply that evidence and train local partners in the skills needed to continue to generate such evidence, to conduct HIV-related policy research and advocacy, and to design, implement, monitor, and evaluate both targeted and holistic HIV prevention programs. Further delay in doing so could seriously jeopardize the strategies and plans that have already been adopted and place the region at the threshold of the kind of rapid spread that began to be seen in Papua New Guinea around 1994 and has not yet relented.

Based on the foregoing analysis, the principal aims of ADB's engagement should be to:

- Strengthen surveillance and research capacity;
- Develop technical capacity to design, implement, monitor, and evaluate targeted behavior change interventions with and for vulnerable people;
- Encourage social marketing of condoms; and
- Support coordination and management.