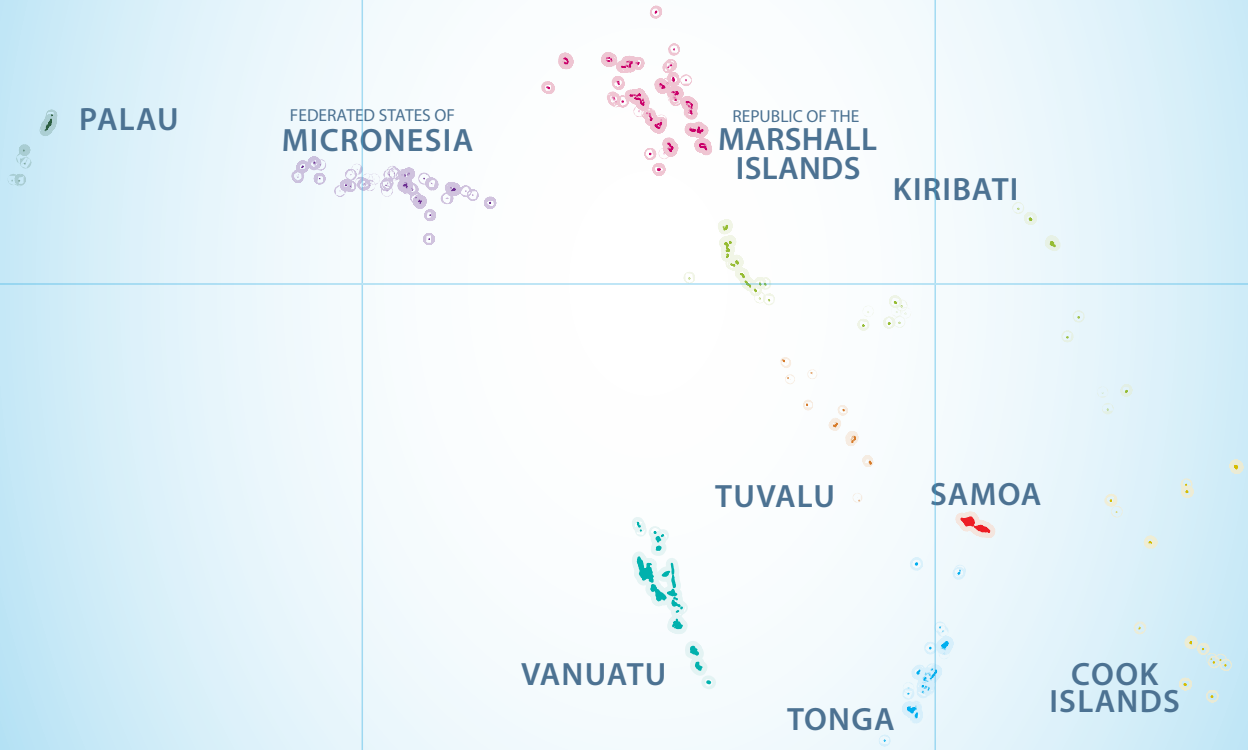
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

KIRIBATI



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Acknowledgements

The *Pacific Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Kiribati* was conducted in 2016 and examined the behaviour risk factors and social and structural determinants of risk that drive the epidemic among vulnerable groups, such as men who have sex with men, transgender people, sex workers and seafarers. The study was part of a larger research effort that covered nine Pacific countries.

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Abbreviations

AHD	Adolescent Health Service
AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral drugs
BIMBA	Boutoka Inaomataia ao Marurunga Binabinaine
CCM	Country Coordination Mechanism
DFAT	Australian Department of fForeign Affairs and Trade
FSW	Female sex workers
HIV	Human immunodeficiency virus
KFHA	Kiribati Family Health Association
IFRC	International Federation of Red Cross and Red Crescent Societies
IPPF	International Planned Parenthood Federation
MHMS	Ministry of Health and Medical Services
MSM	Men who have sex with men
MTC	Marine Training Centre
NGO	Non-governmental organisation
PLHIV	People living with HIV/AIDS
RA	Research assistant
SD	Standard deviation
SPMS	South Pacific Marine Services
SPC	Secretariat of (the Pacific Community)
STI	Sexually transmissible infection
TB	Tuberculosis
TG	Transgender
UNFPA	United Nations Population Fund
VCT	Voluntary counselling and testing

Inclusion criteria

Participant inclusion criteria

Female sex workers:

Any female aged 17 years and over who has exchanged sex (oral, anal and/or vaginal) for money or other items of value, over the past 12 months and is currently residing or working in the study area.

Transgender people and MSM:

Any male aged 17 years and over who has had any sexual contact (oral/anal sex, hand jobs, 'rimming', etc.) with a male or transgender person, regardless of his/her gender identity or sexual identity or orientation, over the past 12 months, and is currently residing in the study area.

Seafarers:

Any male aged 17 years and over who is engaged in working on a ship that is docked or based in the study area.

Definitions relevant to all participant groups

Regular partners:

Any sexual partner who the participant considers to be their main or regular non-paying partner. This person could be a spouse, boyfriend or girlfriend.

Casual partners:

Any sexual partner who is not a regular partner or a paying partner.

Commercial partner:

Any sexual partner who has paid the participant money or goods in exchange for sex.

The Joint UN Programme on AIDS defines sex workers to include "female, male and transgender adults aged over 18 years who sell consensual sexual services in return for cash or payment in kind, and who may sell sex formally or informally, regularly or occasionally". Sex work varies between and within countries and communities. Sex work may vary in the degree to which it is more or less "formal" or organized, and in the degree to which it is distinct from other social and sexual relationships and types of sexual-economic exchange. In accordance with article 34 of the Convention on the Rights of the Child which ensures the protection of all children from all forms of sexual exploitation and sexual abuse, reference is made to sexual exploitation of children for young people below the age of 18.

Executive summary

- Kiribati has low prevalence generalised epidemic. While numbers are low (31 people are currently living with HIV), Kiribati has one of the highest HIV infection rates in the Pacific. This study collected data from three populations considered to be particularly vulnerable to infection: seafarers, transgender/men who have sex with men, and female sex workers.
- In the absence of adequate service provider data, and with little provider engagement with vulnerable populations, representatives of the target populations themselves were considered the most reliable sources for population estimates. It was estimated that there are at least 118 people who identify as *binabinaine*,[1] transgender or men who have sex with men in Kiribati.
- The known female sex worker population was estimated at 114. Eighty women are known to be involved in sex work on Tarawa. Another 34 are known on Kiritimati Island, but roundtable participants expected that there would be other female sex workers on Kiritimati who they are unaware of.
- This study captured the first ever behavioural survey and interview data from men who have sex with men and transgender in Kiribati.

Seafarers

- A behavioural survey of 52 I-Kiribati seafarers was conducted. Of these, 38.4% had regular female sexual partners in the last 12 months, 23% had commercial sexual partners and 17% had casual sexual partners in that time.
- Consistent condom use on each occasion was low with regular partners (20%) and casual partners (22.2%), but was more likely with commercial partners (41.7%).
- Knowledge of HIV transmission was relatively high, with 45.8% answering all knowledge questions correctly.
- While a majority of seafarers knew where they could access health services, fewer knew where to access HIV and STI treatment and testing. Over 55% had accessed a health service in the past 12 months and the majority were satisfied with the service and would use it again.
- Fifty seafarers (96.2%) reported having had an HIV test, among whom 36 had an HIV test in the 12 months prior to the survey. None of the seafarers had tested positive for HIV.

Transgender and men who have sex with men

- Twenty-two transgender/men who have sex with men (TG/MSM) took part in a behavioural survey and five took part in in-depth interviews. In the surveys most participants identified as men who have sex with men (MSM) and a few as gay/homosexual. The interviews however revealed an ambivalence around gender identification, with the categories of MSM and transgender being inadequate to capture the experience of gender identity for most. The local term *binabinaine* was used by participants to include both MSM and transgender.

[1] The local term used by interview participants to refer to both MSM and transgender in Kiribati.

- The majority of survey participants reported feeling ashamed of their sexual identity. While interviewees said that their gender identity was understood and generally accepted by their family, it would not be possible to bring a male partner home or to live openly with a male partner.
- The mean age of sexual debut was 13.91 years for survey participants
- All of the TG/MSM in the survey had ever had sexual intercourse. Of these, 90.9% had receptive anal intercourse on the last occasion. Over 90% of participants had sex with at least four casual male partners during the previous 12 months, while about 15% had at least one paying partner during that period. Two (9.1%) of the 22 participants reported ever having had sexual intercourse (vaginal or anal) with a female partner.
- Overall knowledge about HIV was high in this group, and the participants all knew that condoms are a barrier to HIV infection. However, condom use was inconsistent. The barriers to condom use were that they were not available and partner objection. About 40% of participants reported that they never used condoms for anal intercourse with a regular male partner. With casual male partners, 75% 'sometimes' used condoms and 25% 'never' used condoms. Interview participants also elaborated on the role that alcohol played in hindering condom use
- Forced sex was a common experience among participants, and eight of 22 participants who responded to this question reported forced sex in the past 12 months. 'A stranger' was most frequently cited as the perpetrator.
- A majority of participants knew how to access health services for HIV and STI testing, and how to access condoms and health-related information, but only half of all respondents knew how to access HIV and STI treatment. About one-quarter knew how to access support.
- Ten of the 22 TG/MSM in the survey had been tested for HIV in the past 12 months. None reported being HIV positive.

Female sex workers

- Thirty-five women, who receive money and goods in exchange for sex took part in the survey and eight participated in in-depth interviews.
- Sex work on Tarawa is concentrated in Betio, the port district. FSW operate from bars in the area, and often board foreign fishing vessels. The women may stay on board the vessels for days or weeks at a time. Sex work with local clients also occurs.
- Both the average and mean age of the survey participants was 23 years.
- One participant had taken up sex work at 12 years of age, and the oldest age at which sex work had begun was 20.
- The median number of paying partners in the last 12 months was 3.67 (SD=3.96) partners. Of the 35 women surveyed, the majority were single (60%), another 26% had a boyfriend but were not married (26%). Only 2 survey participants (6%) were currently married.
- Condom use is sporadic. In the past 12 months 71% of women 'sometimes' used condoms and 15% 'never' used condoms with paying male partners. The most common reasons for not using a condom with a paying partner included partner objecting, condoms taking away pleasure, and my partner/s and I are faithful. Seven women

reported not using a condom because the paying partner paid extra money. Most women reported 'never' or 'sometimes' using condoms with their regular male partners.

- Alcohol is closely connected with sex work in Tarawa. 80% of the 34 women reported drinking alcohol in the preceding four weeks, of which the majority had drunk alcohol at least once a week (44%). Over 67% had used kava and 21% had used marijuana in the past 12 months. Eight women had sex in the last 4 weeks where they did not feel in control after drinking.
- FSW experience a variety of threats of physical and sexual violence. Local men sometimes prowl around their homes at night, Family members frequently beat sex workers. FSW also fear that the wives of their local clients may beat them. Police have coerced FSW into having sex, under threat of jail. Twenty-two of the 35 participants (64%) had been sexually assaulted in the last 12 months: most (15) had been sexually assaulted by a stranger, and six by a friend.
- Over 50% of women knew how to access health-related information and support, but a majority of women did not know where to access HIV and STI testing or treatment services, or services that provided condoms. Almost half of the women surveyed had an HIV test in the twelve months prior to the survey. All those who had received a HIV test result reported HIV-negative status, except one who did not know her result.

Capacity assessment

- The Kiribati Ministry of Health and Medical Services (MHMS) and the Kiribati Family Health Association (KFHA) are the key organisations providing HIV and STI services. KFHA and the MHMS HIV program both focus on general population services, however they do run one or two workshops annually that specifically target MSM/TG and FSWs. Both also partner with the Marine Training College (MTC) to deliver HIV and STI prevention courses to trainee and qualified seafarers. There is one emerging NGO that supports and advocates for I-Kiribati transgender and MSM (BIMBA).
- HIV and STI counselling and testing is provided by the MHMS through the hospital. The nurse at the MHMS HIV program unit delivers treatment to PLWHIV in their homes. KFHA provides HIV and STI counselling and Rapid Reactive tests both through a mobile clinic and at the main clinic. The MTC clinic provides counselling and rapid reactive testing to seafarers and trainees working on South Pacific Marine Services Ships. All confirmative tests are conducted through the hospital and the MHMS labs. There is a dedicated HIV doctor at the MHMS hospital.
- **Organisational strengths:** The MHMS HIV program and KFHA are already key providers of HIV and STI prevention and treatment services to the population of Kiribati. They are both supportive of, and appreciative of the need for, improving services for vulnerable groups. Country Coordination Mechanism (CCM) meetings facilitate communication with and between stakeholders, and ensure well established connections and ease of communication between relevant bodies. KFHA is a stable NGO with a range of funding sources, it is a part of larger international networks, has good staff continuity and has a reputation of being an approachable and non-judgemental service among participants in the research.
- **Capacity building needs**: Service provider staff from both key provider organisations say that they need updating on developments in knowledge around HIV prevention and care: this includes staff upskilling for clinical management, staff training on monitoring and evaluation including technical support, and development of targeted IEC

resources. There is also a need for training on vulnerable population issues (including consultation and engagement).

1 Introduction

1.1 Background to the research

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

1. Constitute an operational baseline for the implementation of the Integrated HIV/TB Multi-Country Grant in the Pacific and for the Pacific Regional Sexual and Reproductive Health Programme.
2. Provide quantitative and qualitative data to inform relevant interventions aiming at reducing the HIV and STI risk vulnerability of key populations.
3. Consolidate and generate specific evidence of barriers to prevention, improve effectiveness of prevention interventions, and develop a strong advocacy case for legal and social transformation.

The key specific aims that the *Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations* must achieve in order to fulfil the objectives in each country are to:

- Estimate population sizes of vulnerable groups: sex workers, transgender/men who have sex with men (and, in some countries, seafarers) through a variety of methodologies.
- Identify demographic and behavioural factors (for example, sexual behaviours, mobility, drug use, history of STIs, etc) that represent risk practices in each of these groups, as well as access to services and experiences of stigma, discrimination and violence through a quantitative survey design. This survey must include baseline values for quantitative indicators for reporting obligations.
- Identify in-depth social and structural determinants influencing these risk factors, including stigma, human rights violation, all forms of violence, discrimination, socio-economic marginalisation and exclusion, as well as community norms, expectations and subcultures that can be facilitators or barriers for the uptake of HIV and STI prevention, care and support services, and barriers to accessing services, through in-depth interviews.

2 Kiribati

The Republic of Kiribati is a Micronesian nation of 33 islands and is located in the central Pacific Ocean. Kiribati is a former British colony that gained independence in 1979. It has a population of 110,110, with over half living in urban South Tarawa, the capital of Kiribati (National Statistics Office & MFED, 2016). The country's main port is located in Betio, the largest township in South Tarawa.

The total land area of the islands of Kiribati is 726 square kilometres, excluding uninhabited islands (UNdata, 2016). There is a very high population density in South Tarawa, which is increasing as people migrate from outer islands in search of employment. Most of the population are dependent on subsistence activities, including fishing and the growing of food crops. Subsistence farming, copra and fishing are the primary economic activities. In 2015, fishing licence revenues as a share of GDP were 99% for Kiribati (ADB, 2016).

Kiribati has one of the highest rates of HIV/AIDs infection rates in the Pacific with 60 cases cumulatively from 1991 to 2015, of whom 29 have died (pers. comm Kiribati HIV Program, 2016). The first person was diagnosed with HIV in 1991 (UNICEF 2013). There are currently an estimated 30 people living with HIV in Kiribati (one has migrated). Of the 30 people in the country living with HIV, 7 are currently receiving HRT and the whereabouts of the remaining 2 are unknown (pers. comm Kiribati HIV Program, 2016). So far, the majority have been associated with heterosexual transmission, followed by perinatal transmission. Those identified as most at risk include seafarers, their intimate partners and children, and those involved in commercial or transactional sex (Ministry of Health and Medical Services, 2016).

At present, there are nine accredited VCT sites in South Tarawa and Betio, and approximately 40 trained counsellors, but the sites are often unstaffed largely due to human resourcing constraints (Ministry of Health and Medical Services, 2016). Mobile testing services cover South Tarawa and some of the outer islands (Ministry of Health and Medical Services, 2016). The Marine Training Centre (MTC) in Betio has its own health clinic, which imposes compulsory HIV testing on seafarers who have travelled overseas. There are no centres designated for the provision of ARV treatments (Ministry of Health and Medical Services, 2016).

There is a high prevalence of STIs in Kiribati. Surveillance surveys conducted among selected groups have found that 6.7% of males and 4.5% of young people reported ever having an STI (2008); 20% of pregnant women attending antenatal clinics (in 2004-05) and 13% (in 2008) had chlamydia; and 17% of police and 22.7% of seafarers tested positive for hepatitis B infection (in 2008) (Kiribati Ministry of Health & SPC, 2010; WHO, MoH Republic of Kiribati, & UNSW, 2004). One survey of sex workers who board boats found 58% of the participants had one or more STI (Toatu, 2007). Data from the Ministry of Health and Medical Services (MHMS) laboratory and Health Information unit (2015) shows a higher level of STI compared to the previous year in the general population, particularly, syphilis and gonorrhoea (Ministry of Health and Medical Services, 2016). However, data on STIs is not systematically collected.

The Red Cross and the Kiribati Family Health Association (KFHA) distribute condoms to young people, MSM, sex workers and bus drivers in nightspots and stores primarily in Betio town and Bikenibeu (Ministry of Health and Medical Services, 2016). Condoms are not usually available in stores or are hidden, and supplies often run out or temporarily cease due to stock management issues (UNFPA, 2014).

As Kiribati's national response to HIV is almost entirely dependent on overseas donors, prevention programs in particular are extremely vulnerable to funding cuts. The planned adoption of a new model of funding by the Global Fund – a key donor – has led to uncertainty over future funding, and a decrease in funding is reportedly already having an impact on preventive service delivery (Ministry of Health and Medical Services, 2016) .

2.1 Seafarers

Kiribati is a nation of seafarers and fishers and these activities are central to everyday life. Seafaring is also critical to the economic livelihood of Kiribati, with approximately 20% of the total number of paid workers engaged in the fisheries sector (National Statistics Office & Ministry of Finance and Economic Planning, 2012). Men are employed to work on foreign merchant ships or tuna vessels, and are away from home for months at a time for their entire working careers (Karen McMillan & Worth, 2010). Due to casual and paid sexual encounters while in overseas ports, seafarers, their intimate partners and their children are considered the group most vulnerable to HIV (Ministry of Health and Medical Services, 2016), and indeed many of the first reported HIV infections in Kiribati were identified in seafarers and the spouses of seafarers (Oriente, 2006).

The 2008 Second Generation Surveillance Survey indicated that 58% of seafarers sampled had sex with someone other than their partner during their last overseas engagement, of which, over 56% had sex with multiple transactional sex partners. Only 9% reported using a condom every time they had sex in the last 12 months (Kiribati Ministry of Health & SPC, 2010). When most seafarers do not use condoms while at sea or with their regular sex partners at home, these high risk behaviours increase the vulnerability of their partners and children to HIV infection (Robate et al., 2010).

High levels of STIs have been reported among I-Kiribati seafarers; a 2002 survey found a 9.3% prevalence of chlamydia and 2.7% prevalence of syphilis (WHO et al., 2004). Of all the seafarers included in the survey, 28.2% had at least one STI. High rates of STIs, combined with low knowledge of HIV, low condom use and multiple partners indicate particular vulnerabilities to HIV infection. Many seafarers also report heavy use of alcohol and other intoxicants, heightening the risks of unsafe sex (WHO et al., 2004).

2.2 Transgender and men who have sex with men

Male to male sex is illegal in Kiribati (J. Godwin, 2010). In general, there has been a reluctance to acknowledge men who have sex with men in Kiribati and they remain a hidden and stigmatised population (McMillan and Worth, 2010). Anecdotal evidence suggests that there are men who board foreign boats in a similar manner to female sex workers. However, the stigma associated with MSM is likely to preclude any admission of having sex with male seafarers, whether or not it is a commercial exchange (Karen McMillan & Worth, 2010).

In an SGS survey of youth and seafarers in Kiribati, 8 young people and 4 seafarers indicated they were transgender (2008). Of the seafarers who reported that they had ever had sex, 3 indicated 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. No research has been done on STI and HIV prevalence in MSM and transgender populations in Kiribati, nor on their attitudes and risk behaviours.

2.3 Sex workers

On Tarawa, sex work takes place predominantly in Betio and on foreign fishing vessels. Crews of foreign fishing vessels interact with local I-Kiribati women in Betio bars and clubs to seek sexual services (Karen McMillan & Worth, 2010). These women, known as *ainen matawa*,[2] board fishing vessels moored off Betio and may stay with one client on board for up to months at a time (McMillian and Worth 2010). *Ainen matawa* receive money and goods in return for sex, and create a social life on board the boats. Alongside economic drivers, the relative luxury and safety of life on board are primary motivators for sex work with seafarers, given the shortage of employment options in Kiribati and subsequent hardship and boredom of life onshore (Karen McMillan & Worth, 2010; Sladden & Vulavou, 2008; Toatu, 2007). In 2010, it was estimated that there were about 80 young women on Tarawa who regularly boarded boats, and another 40 on the atoll of Kiritimati (K McMillan, 2013).

A 2007 study found no cases of HIV among the *ainen matawa* population (Toatu, 2007) However, they are considered vulnerable, particularly as HIV diagnoses in Kiribati to date have been predominantly among local seafarers. Additionally, surveys of *ainen matawa* consistently find high levels of other STI.

Although the act of sex work is not illegal, associated activities such as soliciting or living on the earnings of sex work are illegal (J. Godwin, 2012). Sex work is highly stigmatised in Kiribati and many *ainen matawa* have been disowned by or estranged from their families and are marginalised, in the wider community. They are vulnerable to sexual and physical abuse from many locals, some seafarers and sometimes also police (McMillan and Worth 2010). Fear of punishment and shame deter them from accessing sexual health services or seeking help when they are subject to violence and abuse. *Ainen matawa* reportedly use condoms with seafarer clients initially, but as they stay with the same client for extended periods use ceases as familiarity and trust grows (McMillian and Worth 2010). Additionally, the association of heavy use of alcohol use and intoxication with sex work has the potential to exacerbate further risk taking behaviour.

Concerns about underage girls selling sex to seafarers once led to a temporary ban on Korean fishing boats from entering Kiribati ports in 2003 (UNICEF, 2010). In 2006, 80 young women were reportedly selling sex to Korean fisherman and were brought before the courts before being released. After the ban was lifted in 2007, 24 sex workers were found to be selling sex to Korean seafarers, seven of whom were aged between 14-18 years, Reportedly, seafarers did not want to use condoms and a number of unintended pregnancies resulted (UNICEF, 2010). Sex was being exchanged for money, clothes, alcohol and fish. (UNICEF, 2006).

Although sex work on and off-shore is conducted primarily by females, there may also be a hidden population of young men also engaged in sex work (UNICEF 2010). Among 367 young people surveyed in South Tarawa and Abenama, 236 reported being sexually active, of which 30 indicated they were engaged in commercial sex work. Of these, 4 were male.

[2] In local parlance the term *ainen matawa* refers to women who board foreign fishing vessels and engage in sex for money and goods with foreign seafarers. Some of the female sex workers who were interviewed for this study expressed a preference for the term *uen Kiribati* (literally flowers of Kiribati).

Sex work also takes place on-shore: the UNICEF survey found that nearly half of paid sex occurred in houses, hotels, clubs and outdoor areas such as the beach (2010). This is consistent with claims by *ainen matawa* in 2010 that there were many more sex workers in Betio who do not board boats (McMillan and Worth 2010). In 2014, KFHA conducted counselling and testing among 30 FSW in Tarawa, all of who tested negative to HIV (RMI Ministry of Health and NAC, 2014). Paid sex is also apparent on Kiritimati Island near Hawaii, where clients are said to include United States (US) tourists, some local crew and foreign seafarers (Sladden & Vulavou, 2008).

3 Methodology

This study employed a variety of methods in a cross-sectional (snapshot) design. Survey participants for each of the three target groups were recruited through convenience snowball sampling. Fieldwork was undertaken between April and May 2016 in South Tarawa. Three local research assistants were hired and trained by the Team Leader to assist in the collection of data.

3.1 Population size estimation

A mapping exercise estimated the size of the MSM/TG and sex-worker populations. Population estimates were made by representatives from the target populations themselves. This was considered the most appropriate method as service data for target populations are inadequate for a multiplier method, and service providers currently have only minimal engagement with FSW, MSM and transgender. Moreover, women engaged in sex work recognise other sex workers from bars and are also aware of which other women are staying on board foreign fishing vessels. The process of recruitment of survey participants also revealed that female sex workers tend to live together in shared households. Similarly, MSM and transgender are themselves the most reliable sources of information on the MSM and transgender population.

Two round table meetings were held. The first meeting to estimate female sex worker population involved 5 female sex workers, each from different households and areas in Betio where sex work is concentrated.

A second roundtable meeting to estimate TG/MSM population in Kiribati was held with 6 MSM and TG from different villages across Tarawa Atoll.

3.2 Behavioural survey and interviews

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

This study captured the first behavioural survey and interview data from MSM and transgender in Kiribati.

Snowball recruitment was initially seeded by MSM, TG and sex workers who were known to the I-Kiribati research assistants (RAs). MSM and transgender recruitment was also supported by the Pacific Sexual Network, and a local representative in Tarawa. Potential participants were provided with information about the study and invited to take part in the survey. Participants who took part were asked to invite others who, if they were interested, could contact the RAs and arrange a suitable meeting. Most often, the survey participants chose to have an RA visit them at their homes.

Survey participants who were interested were also invited to take part in an in-depth face-to-face interview. Selection of FSW interviewees aimed at capturing the experiences of women from a range of ages and from a variety of different households. All FSW were interviewed in their own homes. All FSW interviews were conducted in I-Kiribati and translated, post interview, by the research assistant and the Team Leader.

MSM and transgender interviewees were interviewed in a private room at the hotel where the Team Leader was staying. The MSM and transgender interviewees all spoke English and chose to be interviewed by the Team Leader. The interviews took between 20 to 40 minutes and were digitally recorded.

Fifty seafarers undergoing a range of vocational or refresher courses at the Marine Training Centre (MTC) in Betio completed the survey. All participants were active seafarers and not trainees. Teachers at the MTC introduced the survey in class and invited the seafarers, on the Team Leader and researcher's behalf, to take part. Those wishing to participate came to the Medical Centre office at lunchtime. The surveys were held in the privacy of the nurse's room in the MTC medical clinic at lunchtime. Participants were assured that their involvement in the study was completely voluntary and would be kept confidential from the MTC. No names of participants or any other identifying feature was recorded. Surveys were self-administered using an electronic tablet and RAs were available to clarify any questions.

Surveys took 20 to 40 minutes to complete.

All participants received a $10 payment to thank them for their time.

3.3 Institutional capacity assessment

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

3.4 Ethics approval

Ethical approval for the project was obtained from the University of New South Wales Human Research Ethics Committee. Approvals to conduct the research were also obtained from the Ministry of Health and Medical Services, Kiribati and from the Ministry of Labour and Human Resource Development, Kiribati.

4 Results

4.1 Population size estimation

4.1.1 Methods

The hybrid method of estimating the population size of key affected communities in small countries involves asking a group of key informants about population numbers, requiring specificity about the whereabouts and numbers of people in different locations, and ensuring that any individuals identified have not been duplicated in the counting. Key informants in the population estimate process in Kiribati were all members of the target populations themselves: female sex workers, men who have sex with men and transgender I-Kiribati.

4.1.2 Transgender and men who have sex with men

A meeting was held that brought together MSM and transgender, from a variety of Tarawa villages, to estimate the size of the MSM and TG population in Kiribati. The participants ranged in age between 22 and 43 years old. An effort was made to ensure that meeting participants were not from the same social networks. The participants concluded that they knew of 118 different people in Kiribati who are TG or MSM.

The key informant group could identify 84 MSM or transgender living in Tarawa; of which 66 are aged between 18-39 years old, and another 18 are over 40 years of age.

In addition to the 84 people living on Tarawa, the roundtable group knew of another 34 MSM and TG living on Kiritimati Island and the outer islands. However, they pointed out that none of the discussion group had recently or regularly visited those islands and would not know all the MSM/TG there (Table 1).

4.1.3 Female sex workers

A population estimate was conducted that engaged FSW, to count the number of FSW in Tarawa, and on other islands, based on participants' knowledge.

A meeting was held bringing together FSW from 5 different households and areas of Betio. The participants ranged in age between 18 and 34 years old. Based on their personal knowledge, the FSW key informants together estimated that there were 80 women conducting sex work on Tarawa (Table 1).

The roundtable group also personally knew of 34 FSW on Kiritimati Island. However, they assumed that the actual number would be greater than this as there were likely to be many that they did not know.

FSW live and work in Betio, and often live in shared households with other sex workers. FSW on foreign fishing vessels often spend months at a stretch on board and they know which other women are on the boats. Socialising takes place between the different boats as well as on shore. For these reasons, sex workers know one another through the bars, and through time spent on the vessels, and are an accurate source of information about numbers.

According to this estimate, the numbers of FSW are the same as in 2009 (see McMillan and Worth, 2010) despite some women having moved in or out of sex work or married and settled in the villages. One change noted by participants however was that numbers of women boarding vessels had reduced in recent years as a result of stricter regulations and increased fines for vessels that allow local women to board. This has not reduced the number of sex workers but has altered the form of sex work; women who board boats now also engage in sex work on shore, and often have local as well as foreign clients. This was not the case in 2010 when women who boarded boats for sex said they did not have paid sex with local men (Karen McMillan & Worth, 2010).

The participants said that FSW in Tarawa are mostly 17 years or older. However, they all knew of one 12-year-old had boarded boats, and had sex with seafarers. They described her as an exception and unusual case.

Table 1: Population size estimation

Informants	Location	MSM/TG n	Sex workers n
FSW roundtable group	Total Tarawa	–	
TG/MSM roundtable group	Tarawa	84	80
	Kiritimati	34	34
	Total Kiribati	118	114

4.2 Behavioural survey

4.2.1 Seafarers

4.2.1.1 Description of the sample

Data were collected from 52 male seafarers. The age of the men ranged from 22 to 60, with a mean age of 34 (SD=8.71). The majority of seafarers had been educated to a pre-secondary or secondary level and all had completed their marine training between 1973 and 2015. Unlike their counterparts in Tuvalu, none of the men had been university educated (Table 2).

Table 2: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	1	1.9
Pre-primary/Primary	2	3.8
Pre-secondary/Secondary	46	88.4
Polytechnic/Diploma	1	1.9
University	0	–
Other (college, Maritime Training Centre)	2	3.8
Total	**52**	**100.0**

The majority of seafarers were married and living with their spouse (Table 3).

Table 3: Marital status and living situation

	Frequency	Percent (%)
Currently married and living with spouse	39	75.0
Not married and not living with sexual partner	8	15.4
Not married and living with sexual partner	4	7.7
Currently married and living with other sexual partner	1	1.9
Total	**52**	**100.0**

All but one seafarer reported living with at least one other person, most typically their wife and, to a lesser extent, children or siblings (Table 4).

Table 4: Whom participants were living with (n=52)*

	Frequency	Percent (%)
Wife	36	69.2
Children	11	21.2
Siblings	8	15.4
Parents/In-laws	6	11.5
Other relatives	5	9.6
Friends	3	5.8
Live alone	1	1.9

* Multiple answers possible.

All but three of the men who answered the question about having ever worked on an overseas ship answered in the affirmative. The majority of seafarers reported that they were away from home for between seven and 12 months on the last occasion of being on an overseas ship. Almost one-quarter of the men reported being away for more than one year on their last trip (Table 5). A majority of the men (61.5%) reported being off-island in the previous 12 months.

Table 5: Period away from home on the last trip on an overseas ship

	Frequency	Percent (%)
Less than one month	3	6.1
One to six months	9	18.4
Seven to 12 months	25	51.0
One to two years	8	16.3
More than two years	4	8.2
Total	**49**	**100.0**

The majority of men reported their position of work as being an able-bodied seaman or an ordinary seaman. Over 20% said that they worked as a motorman, with fewer men reporting working as a bosun or cook (Table 6).

Table 6: Type of work (n=52)*

	Frequency	Percent (%)
Able-bodied seaman	12	23.1
Ordinary seaman	20	38.5
Motorman	15	28.8
Bosun	2	3.8
Cook	2	3.8
Qualified steward	0	–
Fitter	1	1.9
Engineer	2	3.8
MTC trainee/cadet	1	1.9
Other (officer, OSE/OSD)	2	3.8

* Multiple answers possible.

4.2.1.2 Sexual history and practice

A majority of the 52 men (73.1%) who answered the question about ever having had sexual intercourse responded in the affirmative. The age at which these 38 men had their first sexual intercourse ranged from 12 to 30, with a mean age of 19 (SD=3.5). Thirty-two (61.5%) of the 52 men reported having had sexual intercourse in the previous 12 months.

4.2.1.2.1 Types and numbers of partners

All men were asked how many female sexual partners (not restricted to sexual intercourse) they had in the previous 12 months who were regular partners, casual partners or commercial partners. Twenty men reported having had a regular sexual partner during the previous 12 months, nine men had sex with at least one casual partner in that period, and 12 men had sex with commercial partners (Table 7). For each partner type, a majority of the men had sex with one partner only. Three of the men who had casual partners and five of the men who had commercial partners in the preceding six months reported having these partners while off-island.

Table 7: Number of female sexual partners in the 12 months prior to survey

Number of partners	Regular partners n (%)	Casual partners n (%)	Commercial partners n (%)
None	32 (61.5)	43 (82.7)	40 (79.9)
One	13 (25.0)	6 (11.5)	6 (11.5)
Two	3 (5.8)	2 (3.8)	–
Three to five	4 (7.6)	–	4 (7.6)
Six +	0	1 (1.9)	2 (3.8)
Total	**52 (100.0)**	**52 (100.0)**	**52 (100.0)**

4.2.1.2.2 Condom use with women

Condom use was least likely with regular partners and more likely with casual and commercial partners (Table 8). Use of condoms on every occasion was most likely with commercial partners.

Table 8: Consistency of condom use with different types of female partners

Regularity of condom use	Regular partners n (%)	Casual partners n (%)	Commercial partners n (%)
Never	10 (50.0)	1 (11.1)	2 (16.7)
Sometimes	6 (30.0)	5 (55.6)	4 (33.3)
Almost every time	0	1 (11.1)	1 (8.3)
Every time	4 (20.0)	2 (22.2)	5 (41.7)
Total	**20 (100.0)**	**9* (100.0)**	**12 (100.0)**

* Missing data n=1.

With all partner types, seafarers were generally more likely than their partners to suggest condom use (Table 9).

Table 9: Who suggested condom use on last sexual occasion with different female partners?*

Who suggested condom use	Regular partners n (%)	Casual partners n (%)	Commercial partners n (%)
Myself	6 (60.0)	6 (100.0)	5 (62.5)
Partner	3 (30.0)	–	3 (37.5)
Joint suggestion/decision	1 (10.0)	–	–
Total	**10 (100.0)**	**6[1] (100.0)**	**8[1] (100.0)**

* Includes only those who reported condom use. [1] Missing data n=2.

The most commonly reported reason for not using condoms with regular female partners was perceiving one's partner as being faithful. This was also a prominent reason reported for not using condoms with casual and commercial female partners. Other main reasons for not using condoms were consistent for each partner type and included condoms taking away pleasure and condoms not being available (Table 10).

Table 10: Reasons for not using condoms with different types of female partners*

	Regular partners n=16 (%)	Casual partners n=7 (%)	Commercial partners n=7 (%)
My partner(s) are faithful	9 (56.3)	3 (42.9)	2 (28.6)
Condoms take away pleasure	3 (18.8)	3 (42.9)	2 (28.6)
Condoms were not available	3 (18.8)	2 (28.6)	3 (42.9)
Do not like condoms	1 (6.3)	0	0
Not necessary	1 (6.3)	0	0
Partner objected	0	1 (14.3)	0
Difficulty obtaining condoms	0	0	0
Condoms are too expensive	0	0	0
Used other prevention methods	0	0	0
Used other protection methods	0	0	0
Never heard of condoms	0	0	0
Other (wife only)	1 (6.3)	–	–
Other (too much drink)	–	–	1 (14.3)

* Multiple answers possible. Includes only those who reported some occasions of not using condoms.

4.2.1.2.3 Sex and condom use with men

Two (3.8%) of the 52 seafarers reported ever having had sex with another man in the 12 months prior to the survey. One of these men reported having no male partners with whom he had anal intercourse in the preceding 12 months, while the other man reported having anal sex with four men during that period. This latter man also reported 'sometimes' using condoms for anal intercourse with male partners in the preceding 12 months, and using a condom on the last occasion of anal intercourse.

4.2.1.3 Sexually transmissible infections, including HIV

Forty-six (88.5%) seafarers reported ever having heard of diseases that can be transmitted sexually. Six men (11.5%) reported having had symptoms of a sexually transmissible infection (STI), including four men (7.7%) who reported genital discharge in the previous 12 months, one man (1.9%) who reported having had a genital ulcer or sore, and three men (5.8%) who had ever experienced pain while urinating. Six men (11.5%) reported ever having been diagnosed with an STI, which included chlamydia (n=3), gonorrhoea (n=2), thrush (n=2), syphilis (n=1), trichomonas (n=1), genital herpes (n=1), genital warts (n=1) and hepatitis B (n=1). One man did not know the name of the infection. The most common response to having an STI symptom was to talk to a friend, visit a hospital, or do nothing (Table 11).

Table 11: What they did the last time they had genital discharge, genital ulcer or sore, or pain while urinating (n=6)*

	Frequency	Percent (%)
Talked to a friend	2	33.33
Visited a hospital	2	33.33
Did nothing	2	33.33
Visited an STI clinic	1	16.7
Visited a healthcare worker	1	16.7
Visited a private clinic	0	–
Got medicine from a pharmacy	0	–

* Multiple answers possible. Includes only those men who reported any of the STI symptoms.

Forty-eight men (92.3%) reported having ever heard of HIV or the disease called AIDS. The most commonly reported sources of information about HIV and AIDS were school, radio, newspapers/magazines and the workplace (Table 12). Twenty-five of the men who had previously heard of HIV or AIDS reported knowing someone who was infected with HIV.

Table 12: Sources of information about HIV and AIDS (n=48)*

	Frequency	Percent (%)
School	39	81.3
Radio	27	56.3
Newspapers/Magazines	23	47.9
Workplace	22	45.8
Posters/Billboards	19	39.6
Pamphlets/Leaflets	16	33.3
NGO program	13	27.1
Friends or family	13	27.1
Television	12	25.0
Other (posters, workshop)	5	10.4

* Multiple answers possible. Includes only those men who reported having heard of HIV or AIDS.

The 48 men who had previously heard of HIV or AIDS were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 13. Accurate knowledge was relatively high, with 22 (45.8%) of the 48 men answering all 10 knowledge questions correctly. Five questions were answered correctly by more than 90% of the men. The question that showed the most incorrect responses was still answered correctly by two-thirds of the men. Only one man answered fewer than half of the questions correctly and about 75% of the men answered nine or more questions correctly.

Table 13: Knowledge about HIV and AIDS (n=48)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	45 (93.8)	3 (6.3)	0	48 (100)
Do people get HIV because of something they have done wrong?	45 (93.8)	2 (4.2)	1 (2.1)	48 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	4 (8.3)	44 (91.7)	0	48 (100)
Can a person get HIV by sharing food with someone who is infected?	48 (100)	0	0	48 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	11 (22.9)	37 (77.1)	0	48 (100)
Can a healthy-looking person have HIV?	5 (10.4)	43 (89.6)	0	48 (100)
Can people be cured from HIV by a traditional healer?	41 (85.4)	4 (8.3)	3 (6.3)	48 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1 (2.1)	47 (97.9)	0	48 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	0	45 (93.8)	3 (6.3)	48 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	12 (25.0)	32 (66.7)	4 (8.3)	48 (100)

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

4.2.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 48 seafarers who had heard of HIV had non-stigmatising attitudes towards people living with HIV (Table 14). There were nonetheless about 20% of the men who showed evidence of stigmatising attitudes.

Table 14: Attitudes towards people living with HIV among participants (n=48)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	0	48 (100)	0	48 (100)
If a member of your family had HIV, would you want it to remain secret?	38 (79.2)	10 (20.8)	0	48 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	11 (22.9)	35 (72.9)	2 (3.8)	48 (100)

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

4.2.1.5 Stigma and discrimination observed in the community

Seafarers were also asked questions about evidence of stigma that they had observed in the community (Table 15). While the majority were not aware of anyone they knew having experienced stigma and discrimination, about 10–15% of the men were aware of each of the three types of stigma and discrimination shown in Table 14.

Table 15: Evidence of stigma and discrimination observed in the community (n=48)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	39 (81.3)	7 (14.6)	2 (4.2)	48 (100)
Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	40 (83.3)	6 (12.5)	2 (4.2)	48 (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	41 (85.4)	4 (8.3)	3 (6.3)	48 (100)

4.2.1.6 Access to health services

All seafarers were asked whether they knew where they could access a range of health services (Table 16). Health-related information was the service that the highest proportion of men knew how to access. The service with the fewest men knowing how to access it was HIV and STI treatment.

Forty-six men knew of a local organisation providing information or services related to condoms, family planning, HIV and STIs. When asked what the names of any of these organisations were, the following were reported: KFHA, Red Cross Society, hospital, KIFA Catholic missionaries, kava bars.

Table 16: Knowledge about accessing health services (n=47)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Support	16 (34.0)	31 (66.0)	0	47 (100)
Health-related information	7 (14.9)	40 (85.1)	0	47 (100)
HIV and STI testing	19 (40.4)	28 (59.6)	0	47 (100)
HIV and STI treatment	22 (46.8)	25 (53.2)	0	47 (100)
Condoms	18 (38.3)	29 (61.7)	0	47 (100)

* Missing data n=5.

For all of the services presented in Table 17, participants were more likely to report having used the service – with the exception of having ever participated in an HIV peer education program, for which 28% of participants had used the service. Many indicated that being given condoms through an outreach service was not applicable to them.

Table 17: Connection with HIV-related and other health services*

	No n (%)	Yes n (%)	Not applicable n (%)	Total n (%)
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, pregnancy, HIV and STIs, or sexual assault?	16 (34)	30 (65.2)	1 (2.1)	46[1] (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault?	21 (44.7)	26 (55.3)	0	47[2] (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	1 (2.1)	29 (61.7)	17 (36.2)	47[2] (100)
Have you ever participated in an HIV peer education program?	34 (72.3)	13 (27.7)	0	47[2] (100)

* Includes only those men who reported having heard of HIV or AIDS. [1] Missing data n=2. [2] Missing data n=1.

The 26 men who reported visiting a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault were asked for feedback on their experiences with the service. These are reported on in Table 18. The majority of men who used the service were generally satisfied and would use it again. Forty-eight men (92.3%) reported that they would like to receive additional information about HIV, as well as contact details of any support services.

Table 18: Feedback about the health service (n=26)*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	2 (7.7)	0	0	10 (38.5)	14 (53.8)	26 (100)
The health worker I saw was friendly and easy to talk to	1 (4.0)	0	0	12 (48.0)	12 (48.0)	25[1] (100)
I felt uncomfortable and embarrassed	7 (26.9)	9 (34.6)	1 (3.8)	4 (15.4)	5 (19.2)	26 (100)
The service was confidential and I felt my privacy was respected	0	0	1 (3.8)	12 (46.2)	13 (50.0)	26 (100)
I could get what I needed, e.g. contraceptives, condoms, HIV and STI test, etc.	0	0	2 (7.7)	14 (53.8)	10 (38.5)	26 (100)
I would use the service again if I needed to	0	0	0	17 (65.4)	9 (34.6)	26 (100)

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

4.2.1.7 HIV testing

The majority of men (75%) believed that it is possible for someone in their community to get a test to find out if they are infected with HIV, and they knew where to go to receive the test. Fifty men (96.2%) reported having had an HIV test, among whom 36 men had an HIV test in the 12 months prior to the survey. The most commonly reported place where they had an HIV test was at an NGO clinic and the government hospital health service (Table 19).

Table 19: Place where they had their HIV test in the last 12 months*

	No n (%)	Yes n (%)	Total n (%)
NGO clinic	31 (93.9)	2 (6.1)	33[1] (100)
Hospital/Government health service	16 (48.5)	17 (51.5)	33[1] (100)
Private doctor	32 (88.9)	4 (11.1)	36 (100)
Other (Austria, MTC clinic)	16 (44.4)	20 (55.6)	36 (100)

* Includes only those men who reported having had an HIV test. [1] Missing data n=3.

Forty-six of the 50 men who had ever been tested for HIV reported receiving their HIV results the last time they had an HIV test. All 46 men reported that they were HIV-negative based on that result.

4.2.2 Transgender and men who have sex with men

4.2.2.1 Description of the sample

Twenty-two self-identifying TG and MSM provided survey data. In describing their gender, nine participants described themselves as women, another nine as transgender, three as men, and one as transsexual.

Participants were also asked to describe their sexual identity (Table 20). Over 80% of participants described their sexual identity as MSM, and fewer as gay/homosexual. None described their sexual identity as heterosexual/straight, bisexual, queer or pansexual.

Table 20: Sexual identity

	Frequency	Percent (%)
MSM	18	81.8
Gay/Homosexual	4	18.2
Heterosexual/Straight	0	–
Bisexual	0	–
Queer	0	–
Pansexual	0	–
Total	**22**	**100.0**

The age of participants ranged from 19 to 39, with a mean age of 26.64 (SD=5.62) and a median age of 25. The majority of participants had been educated to a secondary level (Table 21).

Table 21: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	0	–
Pre-primary/Primary	1	4.5
Pre-secondary	0	–
Secondary	20	90.9
Polytechnic/Diploma	0	–
University/College	1	4.5
Other (community college, junior college, don't know)	0	–
Total	**22**	**100.0**

In responding to the question about relationship status, all participants reported being single. Of note, no participant reported having a boyfriend, girlfriend or being married (Table 22).

Table 22: Relationship status

	Frequency	Percent (%)
Currently single	22	100.0
Have a girlfriend	0	–
Have a boyfriend	0	–
Currently married	0	–
Total	**22**	**100.0**

The majority of participants reported living with family members, mostly with parents or siblings (Table 23).

Table 23: Whom participants were living with (n=22)*

	Frequency	Percent (%)
Parents	12	54.5
Siblings	9	40.9
Other relatives	4	18.2

* Multiple answers possible.

A majority were not employed. Those who were employed were more likely to be in full-time work (Table 24).

Table 24: Employment status

	Frequency	Percent (%)
Not employed	12	54.5
Full-time employed	6	27.3
Part-time or casual employment	4	18.2
Self-employed	0	–
Total	**22**	**100.0**

When asked to indicate their main job, the 10 people who were employed indicated a range of different types of work, as shown in Table 25. Housekeeping was the most commonly reported type of work.

Table 25: Type of work

	Frequency	Percent (%)
Wholesale and retail trade	2	20.0
Agriculture, forestry and fishing	1	10.0
Student	1	10.0
Financial and business services	0	–
Professional	0	–
Other (included housekeeping (n=3), nursing aid, seafarer, security)	6	60.0
Total	**10**	**100.0**

4.2.2.2 Sexual history and practice

All 22 participants (100.0%) indicated that they had ever had sexual intercourse (anal or vaginal). They reported their first occasion of sexual intercourse occurring between the ages of 10 and 23, with a mean age of sexual debut being 13.91 (SD=3.13). Six participants reported being in more than one sexual relationship concurrently in the previous six months.

4.2.2.2.1 Sex with male partners

Participants were asked to report on the types of sexual activity they had engaged in during the last occasion they had sex with a male partner (Table 26). The most common type of sexual activity that occurred on the last occasion was receptive anal intercourse, which 20 of the participants had engaged in on the last occasion. Receptive oral sex was also commonly reported, as was masturbating one's partner. It is worth noting that none of the participants indicated insertive anal intercourse on the last occasion, which may indicate a preference for being receptive. This type of sexual positioning is generally more typical among transgender and is consistent with how participants identified their gender, as reported earlier.

Table 26: Types of sexual activity on last occasion of sex with a male partner (n=22)*

	Frequency	Percent (%)
Handshake (you masturbated him)	7	31.8
Handshake (he masturbated you)	2	9.1
Oral sex (you sucked his penis)	19	86.4
Oral sex (he sucked your penis)	3	13.6
Intercrural sex (his penis between your thighs)	1	4.5
Intercrural sex (your penis between his thighs)	0	–
Anal intercourse (your penis inside his anus)	0	–
Anal intercourse (his penis inside your anus)	20	90.9

* Multiple answers possible.

4.2.2.2.1.1 Types and numbers of male partners

Participants were asked how many male sex partners they had in their lifetime and in the last 12 months. All participants reported having had between three and 50 male sex partners in the 12 months prior to the survey (Table 27). Across their lifetime, almost all participants reported having had more than 50 male partners. No participants had fewer than 20 male partners in their lifetime.

Table 27: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
0	0	0
3 to 19	0	12 (54.5)
20 to 50	3 (13.6)	10 (45.5)
51 to 99	12 (54.56)	0
100 to 199	4 (18.2)	0
200+	3 (13.6)	0
Total	**22 (100)**	**22 (100.0)**

All participants were asked how many of their male sex partners with whom they had anal intercourse in the preceding 12 months were regular partners, casual partners and paying partners (Table 28). About 85% of participants reported having had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. Over 90% of participants had sex with at least four casual male partners during the previous 12 months, while about 15% had at least one paying partner during that period.

Table 28: Number of regular, casual and paying male sexual partners with whom participants had anal intercourse in the 12 months prior to the survey

Number of partners	Regular partners Frequency (%)	Casual partners Frequency (%)	Paying partners Frequency (%)
None	3 (14.3)	2 (9.0)	19 (86.4)
1 to 3	16 (76.1)	0	2 (9.0)
4 to 6	2 (9.6)	3 (13.6)	0
7 to 19	0	8 (36.4)	1 (4.5)
20+	0	9 (40.9)	0
Total	**21[1] (100.0)**	**22 (100.0)**	**22 (100.0)**

[1] Missing data n=1.

4.2.2.2.1.2 Condom and lubrication use for anal intercourse with male partners

Condom use with the three different types of male partners in the last 12 months is shown in Table 29. Only those who reported having such partners were asked questions about condom use with those partners.

Condom use with regular partners was understandably low, with about 40% of participants reporting that they never used condoms for anal intercourse with a regular male partner. The remaining participants reported using condoms 'sometimes' with such partners. Condom use with casual partners was also relatively low, with the majority of participants reporting using condoms 'sometimes' and no participant using condoms almost every time or every time with casual male partners. The two participants who answered questions about condom use with paying partners indicated never and sometimes using condoms, respectively.

Table 29: Consistency of condom use with different types of male partners in the last 12 months

Regularity of condom use	Regular partners n (%)	Casual partners n (%)	Commercial partners* n (%)
Never	6 (35.3)	5 (25.0)	1 (50.0)
Sometimes	11 (64.7)	15 (75.0)	1 (50.0)
Almost every time	0	0	0
Every time	0	0	0
Total	**17[1] 19 (100.0)**	**20 (100.0)**	**2[1] (100.0)**

* Missing data n=1.

Reported condom use on the last occasion of anal intercourse with each of the partner types in Table 28 was similarly low. Four participants used a condom on the last occasion with a regular male partner, two used a condom with their last casual male partner, and none of the three participants who had sex with a paying partner reported condom use on the last occasion.

The use of lubrication for anal intercourse was more common than condom use. Eleven (57.9%) participants used lube on the last occasion of anal intercourse with a regular male partner, 12 (63.2%) used lube with their last casual male partner, and two (100%) used lube with their last paying male partner.

All participants were asked whether they used lubricant the last time they used a condom, to which 11 (50%) of the 22 participants answered in the affirmative. When asked which type of lubricant they used on that occasion, five reported using water-based lubricant, two reported using baby oil, and four reported using coconut oil. Those same participants were asked where they had obtained lubricant on that last occasion. Responses included NGO (n=3), health clinic (n=2), store (n=2), peer educator/outreach worker (n=1), condom dispenser (n=1), friend (n=1) and shop (n=1).

4.2.2.2.2 Sex with female partners

Two (9.1%) of the 22 participants reported ever having had sexual intercourse (vagina or anal) with a female partner. One of these participants reported having had sex with five female partners and the other with nine female partners in their lifetime. One of the participants reported having no female partners during the 12 months preceding the survey. The other participant indicated having three female partners in that period, all of whom were regular female partners (Table 30).

Table 30: Number of regular and casual female partners in the last 12 months

Number of female partners	Regular partner n (%)	Casual partner n (%)
0	0	0
1 to 3	1	0
4 to 10	0	0
Total	**1 (100)**	**0**

The participant who had sex with three regular female partners in the 12 months preceding the survey reported never using a condom for vaginal and anal intercourse with those partners.

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

All 22 participants (100.0%) reported knowing what a condom was prior to the survey, and each knew where to obtain condoms. All 22 participants were asked where they had last obtained condoms. The most commonly reported place for obtaining condoms was from a condom dispenser (Table 31).

Table 31: Where participants last obtained condoms for sex with male or female partners

	Frequency	Percent (%)
Health clinic	7	31.8
Condom dispenser	6	27.3
NGO	6	27.3
Hospital	1	4.5
Never obtained condoms	0	–
Peer educator/Outreach worker	0	–
Other (bar, kava bar, store, partner)	2	9.1
Total	**22**	**(100.0)**

The most commonly reported reasons for not using condoms were similar for sex with male and female partners. The most commonly reported reasons for not using a condom with male partners included condoms not being available and partner objecting. The one participant who had sex with a female partner in the preceding 12 months attributed the lack of condom use to condoms taking away pleasure (Table 32).

Table 32: Reasons for not using condoms with male and female partners*

	Male partners n=22 (%)	Female partners n=1 (%)
Condoms take away pleasure	2 (9.1)	1 (100.0)
Do not like condoms	0	0
Condoms were not available	12 (54.5)	0
Difficulty obtaining condoms	0	0
My partner(s) and I are faithful	1 (4.5)	0
Partner objected	10 (45.5)	0
Not necessary	0	0
Condoms are too expensive	0	0
Used other prevention methods	0	0
Other (no further response provided)	2 (9.1)	0

* Multiple answers possible.

4.2.2.3 Sexually transmissible infections, including HIV

Twenty-one participants had ever heard of diseases that can be transmitted sexually, among whom only one participant reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months, that being pain while urinating. That participant (who had earlier identified as a woman) was asked whether she took any action in response to these symptoms, to which she responded that she talked to a friend and visited a hospital. Two participants indicated ever having been diagnosed with a sexually transmissible infection (STI), to which only one of the participants responded by reporting that they were diagnosed with gonorrhoea.

All 22 participants confirmed having heard of HIV or the disease called AIDS prior to the survey. The most commonly reported sources of information about HIV and AIDS were radio, pamphlets/leaflets, an NGO program, posters/billboards and school (Table 33).

Table 33: Sources of information about HIV and AIDS (n=22)*

	Frequency	Percent (%)
Radio	21	95.5
Pamphlets/Leaflets	18	81.8
NGO program	16	72.7
Posters/Billboards	16	72.7
School	15	68.2
Newspapers/Magazines	10	45.5
Friends or family	4	18.2
Television	3	13.6
Workplace	1	4.5
Other (KFHA, workshop)	2	9.0

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

The 22 participants were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 34. Correct knowledge across the questions ranged from medium (31.8%) to high (100%). Two participants answered all 10 questions correctly, while the majority answered nine or more correctly. The lowest scores recorded were for three participants who nonetheless answered seven out of the 10 questions correctly.

Table 34: Knowledge about HIV and AIDS

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	20 (90.9)	0	2 (9.1)	22 (100)
Do people get HIV because of something they have done wrong?	22 (100)	0	0	22 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	0	22 (100)	0	22 (100)
Can a person get HIV by sharing food with someone who is infected?	22 (100)	0	0	22 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	8 (36.4)	14 (63.6)	0	22 (100)
Can a healthy-looking person have HIV?	5 (22.7)	17 (77.3)	0	22 (100)
Can people be cured from HIV by a traditional healer?	22 (100)	0	0	22 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	0	21 (95.5)	1 (4.5)	22 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	0	20 (90.9)	2 (9.1)	22 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	14 (63.6)	7 (31.8)	1 (4.5)	22 (100)

4.2.2.4 Stigmatising attitudes towards people living with HIV

A majority of the nine participants who had heard of HIV had non-stigmatising attitudes towards people living with HIV, with the exception of wanting a family member with HIV to remain a secret – for which a majority agreed (Table 35).

Table 35: Attitudes towards people living with HIV among participants (n=22)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	4 (18.2)	18 (81.8)	0	22 (100)
If a member of your family had HIV, would you want it to remain secret?	6 (27.3)	15 (68.2)	1 (4.5)	22 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	6 (27.3)	16 (72.7)	0	22 (100)

4.2.2.5 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. Only one participant reported being aware of each of the three types of stigma and discrimination shown in Table 36.

Table 36: Evidence of stigma and discrimination observed in the community (n=22)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	21 (95.5)	1 (4.5)	0	22 (100)
Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	21 (95.5)	1 (4.5)	0	22 (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	21 (95.5)	1 (4.5)	0	22 (100)

Participants reported on the reactions of various people to their sexual identity (Table 37). Some participants had experienced stigmatising attitudes, which was most likely from 'other' people. The reaction of employers and co-workers appears to be generally supportive. There was mixed support from family members. It is worth noting that all three groups of people depicted in Table 36 knew the identity of participants, with the exception of one participant whose identity was not known at work.

Table 37: Reactions of family members and other people to participants' sexual identity*

	Reaction of family members n=22 (%)	Reaction of other people n=22 (%)	Reaction of employer or co-workers n=14 (%)
They don't know at all	0	0	1 (7.1)
They support my identity	13 (59.1)	11 (50.0)	12 (86.0)
They ignore me/refuse to talk to me	4 (18.2)	5 (22.7)	1 (7.1)
They criticised/blamed/verbally abused me	1 (4.5)	1 (4.5)	0
They conduct violence/physical abuse on me	0	1 (4.5)	0
They lock/restrict me	1 (4.5)	NA	NA
They kicked me out of the family/group	0	1 (4.5)	NA
They force me to work more	1 (4.5)	NA	0
They gossip about me	NA	4 (18.2)	0
They fired me from work	NA	NA	0
Other (siblings and mother supportive, but father is not; surprised but accepting; they leave me alone; parents okay and some relatives)	7 (31.8)	-	-
Other (make fun of me; make fun of me for being a lady; not supportive)	-	7 (31.8)	-
Other	-	-	0

* Multiple answers possible. NA=not applicable.

4.2.2.6 Emotional and physical well-being

Participants were asked to indicate whether they had experienced any of a list of thoughts and feelings because of their sexual identity in the preceding 12 months. Three participants chose not to answer these questions. The most commonly reported responses included feeling ashamed, blaming oneself, and feeling guilty (Table 38).

Table 38: Participants' negative thoughts and feelings about their sexual identity in the last 12 months (n=19)*

	Frequency	Percent (%)
I feel ashamed	17	89.5
I blame myself	5	26.3
I feel guilty	3	15.8
I feel I should be punished	2	10.5
I have low self-esteem	1	5.3
I feel suicidal	1	5.3
I blame others	0	–

* Multiple answers possible. Missing data n=3.

Participants were asked to indicate whether they had engaged in or avoided certain events or activities because of their sexual identity (Table 39). Once again, there were three participants who chose not to answer these questions. The most commonly reported response was deciding not to get married and isolating oneself from family and/or friends.

Table 39: Participants' actions as a result of their sexual identity in the last 12 months (n=19)*

	Frequency	Percent (%)
I decided not to get married	12	63.2
I have isolated myself from my family and/or friends	3	15.8
I have chosen not to attend social gathering	2	10.5
I decided not to have children	1	5.3
I decided to stop working	1	5.3
I avoided going to a hospital when I needed to	0	–
I avoided going to a local clinic when I needed to	0	–
I decided not to have sex	0	–
I decided not to apply for a job or for a promotion	0	–
I withdrew from education/training	0	–

* Multiple answers possible.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Eight of the 22 participants answered in the affirmative, that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, the most common response was a stranger (n=7), followed by boyfriend/husband (n=1) and casual partner (n=1).

4.2.2.7 Access to health services

All participants were asked whether they knew where they could access a range of health services. Although a majority of respondents knew how to access HIV and STI testing, condoms and health-related information, half of the respondents knew how to access HIV and STI treatment and about one-quarter knew how to access support (Table 40).

Table 40: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Condoms	9 (40.9)	13 (59.1)	0	22 (100)
Health-related information	10 (45.5)	12 (54.5)	0	22 (100)
Support	16 (72.7)	6 (27.3)	0	22 (100)
HIV and STI testing	5 (22.7)	17 (77.3)	0	22 (100)
HIV and STI treatment	11 (50.0)	11 (50.0)	0	22 (100)

Twenty (90.9%) participants knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault. When asked what the names of any of these organisations were, the following names were reported: Clinic KFPA, KFHA, KFHA HIV/AIDS taskforce, KFHA Kiribati Family Health Association, Women's organisation.

For all of the services presented in Table 41, participants were more likely not to have used the service – with the exception of having been contacted by a volunteer or outreach worker, for which 50% had experienced that type of service in the preceding 12 months.

Table 41: Connection with HIV-related and other health services

	No n (%)	Yes n (%)	Not applicable/ Don't know n (%)	Total n (%)
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, HIV and STIs, or sexual assault?	9 (40.9)	11 (50.0)	2 (9.1)	22 (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault?	19 (86.4)	3 (13.6)	0	22 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	10 (45.5)	1 (4.5)	11 (50.0)	22 (100)
Have you ever participated in an HIV peer education program?	14 (63.6)	8 (36.4)	0	22 (100)

The three participants who reported visiting a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault were asked for feedback on their experiences with the service (Table 42). All three participants who used the service were generally satisfied and would use it again. Twenty-one participants reported that they would like to receive additional information about HIV, as well as contact details for any support services.

Table 42: Feedback about the health service (n=5)*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
The service was easy to access or find	0	0	0	2 (66.7)	1 (33.3)	3 (100.0)
The health worker I saw was friendly and easy to talk to	0	0	0	2 (66.7)	1 (33.3)	3 (100.0)
I felt uncomfortable and embarrassed	0	3 (100.0)	0	0	0	3 (100.0)
The service was confidential and I felt my privacy was respected	0	0	0	2 (66.7)	1 (33.3)	3 (100.0)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	0	0	0	3 (100.0)	0	3 (100.0)
I would use the service again if I needed to	0	0	0	2 (66.7)	1 (33.3)	3 (100.0)

* Includes only those participants who reported using the service.

4.2.2.8 HIV testing

Six participants believed it was possible for someone in their community to get a test to find out if they are infected with HIV; oddly, 21 participants knew where to go to receive the test. Indeed, 15 participants reported having ever had an HIV test, and 10 had an HIV test in the 12 months prior to the survey. Five participants indicated that they had received their HIV test in the last 12 months at the government hospital health service, two at an NGO clinic, one from a private doctor, one from a village meeting house, and another reported ‘working place’. Of the 15 participants who had ever had an HIV test, 13 reported that they received their results the last time they were tested and all 13 reported being HIV negative based on that result.

4.2.2.9 Alcohol and drug use

Eighteen participants reported drinking alcohol in the preceding four weeks, with a majority indicating that they drank alcohol at least once a week (Table 43). Those who drank alcohol were asked how many drinks they had the last time they drank alcohol, with the number ranging from three drinks to 27 drinks, the latter appearing to be somewhat improbable unless drinks contain very low alcohol or standard drinks are of less quantity. The median number of drinks on that last occasion was 18, which again sounds improbable.

Table 43: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	3 (13.6)
Never in the last 4 weeks	1 (4.5)
Less than once a week	3 (13.6)
At least once a week	15 (68.2)
Every day	0
Total	**22 (100.0)**

Participants were asked whether they had taken a range of drugs during the preceding 12 months. Drug use was uncommon. Participants reported inhalants (n=1), kava (n=1) and kouben (n=1).

When asked whether in the previous four weeks they had engaged in anal or vaginal intercourse after taking alcohol and/or drugs which left them feeling not in control, six participants responded in the affirmative.

4.2.3 Female sex workers

4.2.3.1 Description of the sample

Thirty-five women who sold sex in exchange for money or goods provided survey data. The age of the women ranged from 17 to 34, with a mean age of 23.43 (SD=5.06) and a median age of 23. Almost all of the women had been educated to a secondary level (Table 44).

Table 44: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	0	–
Pre-primary/Primary	3	8.6
Pre-secondary/Secondary	32	91.4
Polytechnic/Diploma	0	–
University/College	0	–
Total	**35**	**100.0**

In responding to the question about relationship status, a majority of women reported being 'single' or having a boyfriend but not married (Table 45).

Table 45: Relationship status

	Frequency	Percent (%)
Currently single	21	60.0
Have a boyfriend but not married	10	28.6
Widowed/Divorced/Separated	1	2.9
Currently married	2	5.7
Have a girlfriend	1	2.9
Total	**35**	**100.0**

Eighteen women (51.4%) reported having children – among whom the majority had one child. Eight women had two or more children. Women were most likely to live with siblings, friends or other relatives (Table 46).

Table 46: Whom participants were living with (n=35)*

	Frequency	Percent (%)
Siblings	15	42.9
Friends	13	37.1
Other relatives	10	28.6
Parents/In-laws	5	14.3
Children	4	11.4
Boyfriend	2	5.7
Husband	1	2.9
Live alone	0	–
Other male partner	0	–
Co-workers	0	–

* Multiple answers possible.

Women were asked whether they were employed, to which almost all (94.3%) reported that they were not (Table 47). When the two women who were employed were asked what paid work they were involved in, only one of them responded. That woman reported working as a bus conductor.

Table 47: Employment status

	Frequency	Percent (%)
Not employed	33	94.3
Full-time employed	0	–
Part-time or casual employment	2	5.7
Self-employed	0	–
Total	**35**	**100.0**

4.2.3.2 Sexual history and practice

All 35 women reported ever having had sexual intercourse. The age at which they first had sexual intercourse ranged from 12 to 20 years of age. The age at which they first received money or goods in exchange for sex ranged from 13 to 35 years of age, which indicates that some women were involved in commercial sex at a young age.

4.2.3.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses ranged from two to 150 partners with a median of 30 partners and a mean of 42.7 partners. The number of male sex partners reported in the last 12 months ranged from 1 to 30, with a median and mean of eight partners. Seven woman reported having had sexual partners concurrently (that is, more than one sexual partner during the same period) in the previous six months.

4.2.3.2.2 Condoms

Thirty-four (97.1%) women had previously heard of a condom and all knew where to obtain condoms. When asked where they had last obtained condoms, the most common response was a condom dispenser, followed by peer educator/outreach worker (Table 48). Thirty-one women reported ever using a condom with any partner.

Table 48: Where condoms were last obtained

	Frequency	Percent (%)
Condom dispenser (bar/nightclub/restaurant/other venue)	24	70.6
Peer educator/Outreach worker	3	8.8
Health clinic	2	5.9
Hospital	1	2.9
Friend	1	2.9
NGO	1	2.9
Client	1	2.9
Pharmacy	0	–
Other (KFHA)	1	2.9
Total	**34**	**100.0**

4.2.3.2.3 Sex with paying male partners

One woman reported not having had any paying partners in the previous 12 months, despite earlier having said that she had in order to be eligible for the study. The questionnaire automatically prompted a further question to make sure that she had not entered the information incorrectly. On the second occasion of being asked, she again claimed to have had no paying partners in that period. As such, she was automatically routed to the end of the questionnaire and no further data is available for this woman. The remaining analyses are based on the 34 women who had paying partners in the 12 months preceding the survey.

When asked how many paying partners they had in the 12 months, answers ranged from one to 20 partners with a mean of 3.67 (SD=3.96) partners, which appears to be low but in keeping with the number of overall partners they reported for the previous 12 months. When asked how many paying partners they had on the last day that they had paid sex, the numbers ranged from one to 20, with a distribution that was not dissimilar to the number of paying partners they reported for the previous 12 months. It would seem that the figure provided for number of paying partners on the last day they had paid sex is more realistic and accurate than the figures for the previous 12 months. It is possible that the women read the question on paying partners over the last 12 months as an average of the number of paying partners in a day.

4.2.3.2.3.1 Types of sexual practices with paying male partners

Women were asked what types of sexual contact they had with paying partners during the preceding 12 months (Table 49). The most common practice was vaginal intercourse, followed by cunnilingus and being masturbated by the client. Only two women reported anal intercourse with paying male partners.

Table 49: Types of sexual activity on last occasion of sex with a paying male partner (n=33)*

	Frequency	Percent (%)
Vaginal intercourse	32	97.0
Oral sex (he licked your vagina)	20	60.6
Handshake (he masturbated you)	19	57.6
His penis between your thighs or breasts	17	51.5
Oral sex (you sucked his penis)	14	42.4
Handshake (you masturbated him)	13	39.4
Anal intercourse	2	6.1

* Multiple answers possible. Missing data n=1.

4.2.3.2.3.2 Where sex with paying male partners takes place

Women were asked where they had sex with their last paying client (Table 50). The most common response was at a hotel, which was reported by almost 50% of the women.

Table 50: Where sex occurred on the last occasion of paid sex

	Frequency	Percent (%)
Hotel	15	45.5
Car	5	15.2
Outside (eg bushes, beach)	4	12.1
My house	4	12.1
His house	3	9.1
Workplace	1	3.0
Other (ship)	1	3.0
Total	**33[1]**	**100.0**

[1] Missing data n=1.

4.2.3.2.3.3 Who decides how much money she receives?

When asked who decides how much they get paid when having sex with a client (multiple answers were possible), the majority of women indicated that it is typically decided by their paying partner and to a lesser extent themselves (Table 51).

Table 51: Who decides how much the woman gets paid for sex with a client (n=33)*

	Frequency	Percent (%)
Paying partner decides	24	72.7
I decide	16	48.5
Agent/Pimp decides	0	–
Manager of the business (eg madam in brothel)	0	–
Other (mother, friend, husband)	6	18.2

* Multiple answers possible. Missing data n=1.

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

Condom use with paying clients was high for vaginal and anal intercourse (Table 52). The majority of women reported using condoms 'sometimes' for vaginal intercourse with paying partners, while the two women who reported anal sex with clients reported 'sometimes' or 'never' using condoms. Neither of these two women reported using lubricant on the last occasion of anal intercourse with a paying partner.

On the last occasion of vaginal intercourse with a paying partner, 10 women reported using a condom. The one woman who had 'sometimes' used condoms for anal intercourse with a paying partner had not used a condom on the last occasion.

Table 52: Consistency of condom use for vaginal and anal intercourse with paying male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	5 (14.7)	1 (50.0)
Sometimes	24 (70.6)	1 (50.0)
Almost every time	1 (2.9)	0
Every time	4 (11.8)	0
Total	**34[1] (100.0)**	**2[2] (100.0)**

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

Twenty-nine of the women who had not always used a condom in the 12 months preceding the survey provided their reasons for not using condoms with paying partners. The most common responses included partner objecting and condoms taking away pleasure (Table 53). Seven women reported ever not using a condom because the paying partner paid extra money.

Table 53: Reasons for not using condoms for vaginal and/or anal intercourse with paying partners*

	Paying male partners n=29 (%)
Partner objected	13 (44.8)
Condoms take away pleasure	13 (44.8)
My partner(s) and I are faithful	12 (41.4)
Condoms were not available	7 (24.1)
Do not like condoms	2 (6.9)
Used other protection methods	2 (6.9)
Not necessary	2 (6.9)
Difficulty obtaining condoms	0
Used other prevention methods	0
Condoms are too expensive	0
Other (we have children; he wants a child with me; he wants to marry me)	7 (24.1)

* Multiple answers possible.

In response to the question about how often it was difficult to get clients to use condoms, most women reported 'none of the time', though three women responded that it was difficult 'a lot of the time' or 'all of the time' (Table 54).

Fifteen women reported that they had ever had sex without a condom because the paying partner paid extra money for no condom to be used.

Table 54: Level of difficulty in getting clients to use a condom

	Paying male partners n (%)
None of the time	17 (51.5)
A little of the time	6 (18.2)
Some of the time	6 (18.2)
A lot of the time	2 (6.1)
All of the time	1 (3.0)
I did not try and get my clients to use a condom	1 (3.0)
Total	**33[1] (100.0)**

[1] Missing data n=1.

When asked who usually supplies the condom for sex with paying partners, the majority of women reported that they do (Table 55).

Table 55: Who usually supplies the condom with paying partners?

	Paying male partners n (%)
I provide the condom	24 (72.7)
I never use a condom	6 (18.2)
Client provides the condom	2 (6.1)
Owner/Manager of the place	0
Other (hotel supplies/provides)	1 (3.0)
Total	**33[1] (100.0)**

[1] Missing data n=1.

4.2.3.2.4 Sex with regular male partners

Thirty-three (97.1%) women reported having had sex with a husband or boyfriend in the previous 12 months.

4.2.3.2.4.1 Condom use with regular male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their regular male partners in the last 12 months (Table 56). Condom use was understandably low, given that condom use in many jurisdictions is not commonly practised among long-term, heterosexual couples. Most women reported 'never' or 'sometimes' using condoms with their regular male partners. Condom use was also low for anal intercourse with regular male partners.

Table 56: Consistency of condom use for vaginal and anal intercourse with regular male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse[1] n (%)	Anal intercourse[2] n (%)
Never	16 (48.5)	4 (66.7)
Sometimes	13 (39.4)	2 (33.3)
Almost every time	1 (3.0)	0
Every time	3 (9.1)	0
Total	**33 (100.0)**	**6 (100.0)**

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

Among the 14 women who had used a condom sometimes or almost every time for vaginal intercourse with their regular partner(s), six of them used a condom on the last occasion with such a partner. And among the two women who had used a condom sometimes for anal intercourse, neither reported using a condom for anal intercourse on the last occasion with a regular male partner. On the last occasion of anal intercourse with a regular male partner, five women reported that they had used lubricant. As such, women were more likely to use lubricant than condoms for anal intercourse with their regular male partners.

Women were asked for their reasons for not using condoms with regular male partners. The most common responses included perceived faithfulness in the relationship; condoms taking away pleasure; and partner objecting (Table 57).

Table 57: Reasons for not using condoms for vaginal and/or anal intercourse with regular male partner(s)*

	Regular male partners n=30 (%)
My partner(s) and I are faithful	22 (73.3)
Condoms take away pleasure	15 (50.0)
Partner objected	12 (40.0)
Condoms were not available	3 (10.0)
Not necessary	3 (10.0)
Do not like condoms	2 (6.7)
Difficulty obtaining condoms	0
Used other protection methods	0
Used other prevention methods	0
Never heard of condoms	0
Condoms are too expensive	0

* Multiple answers possible.

4.2.3.2.5 Sex with casual male partners

Fourteen women reported having had sex with a casual non-paying male partner in the previous 12 months.

4.2.3.2.5.1 Condom use with casual non-paying male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their casual male partners in the last 12 months (Table 58). Of the 14 women who had sex with casual male partners, the majority reported 'never' or 'sometimes' using a condom with those partners. Four women did report using condoms every time with casual male partners. None of the women reported having anal intercourse with casual male partners.

Table 58: Consistency of condom use for vaginal and anal intercourse with casual male partners in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	6 (42.9)	–
Sometimes	4 (28.6)	–
Almost every time	0	–
Every time	4 (28.6)	–
Total	**14 (100.0)[1]**	**0 (100.0)[2]**

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

The 10 women who had some unprotected vaginal intercourse with casual male partners reported their reasons for not always using condoms (Table 59). The most commonly reported reasons for not using condoms with casual male partners included partner objecting, and condoms taking away pleasure.

Table 59: Reasons for not using condoms for vaginal and/or anal intercourse with casual male partner(s)*

	Regular male partners n=10 (%)
Partner objected	5 (50.0)
Condoms take away pleasure	4 (40.0)
Condoms were not available	2 (20.0)
My partner(s) and I are faithful	1 (10.0)
Not necessary	0
Do not like condoms	0
Difficulty obtaining condoms	0
Used other protection methods	0
Used other prevention methods	0
Never heard of condoms	0
Condoms are too expensive	0

* Multiple answers possible.

4.2.3.3 Alcohol and drug use

Twenty-seven (79.4%) of the 34 women reported drinking alcohol in the preceding four weeks (Table 60). Of those who reported drinking alcohol in that period, the majority had drunk alcohol at least once a week or every day. In responding to the question about the number of drinks they consumed on the last occasion that they drank alcohol, the number of drinks ranged from four to 40. with a median of 12 drinks. Six women reported drinking 20 or more drinks the last time they drank alcohol, which appears to be implausible unless drinks were highly diluted with water or soft drink.

Table 60: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	7 (20.6)
Never in the last 4 weeks	0
Less than once a week	7 (20.6)
At least once a week	15 (44.1)
Every day	5 (14.7)
Total	**34 (100.0)**

Participants were asked whether they had taken a range of drugs during the preceding 12 months (Table 61). The most widely used drugs included kava and marijuana. When asked whether in the previous four weeks they had engaged in anal or vaginal intercourse after taking alcohol and/or drugs that left them feeling not in control, eight women responded in the affirmative.

Table 61: Use of recreational and illicit drugs in the past 12 months*

	n=34 (%)
Kava (sakau/ava/awa)	23 (67.6)
Marijuana	7 (20.6)
Inhalants (eg sniffing glue, paint, petrol, spray can)	2 (5.9)
Heroin	0
Freebase	0
Cocaine	0
Amphetamine (speed)	0
Crystal/Ice (methamphetamine)	0
Ecstasy/MDMA	0
Other (kouben, tobacco, smoke local cigarettes)	4 (11.6)

* Multiple answers possible. [1] Missing data n=2.

4.2.3.4 Sexually transmissible infections, including HIV

All 34 women reported ever having heard of diseases that can be transmitted sexually. Among these women, 13 reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months or ever having had pain while urinating: seven women reported genital discharge in the 12 months preceding the survey, four reported genital ulcers or sores, and 10 reported ever having had pain while urinating.

The 13 women who reported having had STI symptoms were asked what they did the last time they had any of these symptoms (Table 62). These women generally did nothing, talked to a friend, or visited a hospital.

Table 62: What participants did the last time they had STI symptoms (n=13)*

	Frequency	Percent (%)
Did nothing	4	30.8
Talked to a friend	4	30.8
Visited a hospital	2	15.4
Never noticed any of these symptoms	1	7.7
Visited an STI clinic	1	7.7
Visited a healthcare worker	1	7.7
Received traditional treatment	0	–
Visited a private clinic	0	–
Got medicine from pharmacy	0	–
Other (clinic hospital, KFHA, local medicine, symptoms disappeared on their own, drank sweet tea)	5	38.5

* Multiple answers possible.

Four women reported ever having been diagnosed with an STI, which included a range of infections: HIV (n=3), hepatitis b (n=2), gonorrhoea (n=2), syphilis (n=2), genital warts (n=2), chlamydia (n=2), thrush (n=1), trichomonas (n=1) and genital herpes (n=1).

All 34 women reported having ever heard of HIV or the disease called AIDS prior to the survey. There was a range of reported sources of information about HIV and AIDS, the most commonly reported were radio, friends or family, an NGO program, and school (Table 63). Thirty of the women reported knowing someone who was infected with HIV.

Table 63: Sources of information about HIV and AIDS (n=34)*

	Frequency	Percent (%)
Radio	26	76.5
Friends or family	24	70.6
NGO program	17	50.0
School	15	44.1
Pamphlets/Leaflets	9	26.5
Newspapers/Magazines	8	23.5
Posters/Billboards	4	11.8
Television	0	–
Workplace	0	–

* Multiple answers possible.

4.2.3.5 Knowledge about HIV and AIDS

The women were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 64. Correct knowledge was reasonably high, with four women answering all 10 questions correctly and 20 women answering nine questions correctly. Also, each question was answered correctly by a majority, except for the question about reducing the risk of transmission by having one monogamous uninfected partner and the question about treatments for pregnant women – both of which were answered correctly by close to 50% of the women.

Table 64: Knowledge about HIV and AIDS

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	32 (94.1)	1 (2.9)	1 (2.9)	34 (100)
Do people get HIV because of something they have done wrong?	34 (100)	0	0	34 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	2 (5.9)	32 (94.1)	0	34 (100)
Can a person get HIV by sharing food with someone who is infected?	33 (97.1)	0	1 (2.9)	34 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	18 (52.9)	16 (47.1)	0	34 (100)
Can a healthy-looking person have HIV?	0	34 (100)	0	34 (100)
Can people be cured from HIV by a traditional healer?	33 (97.1)	0	1 (2.9)	34 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	0	32 (94.1)	2 (5.9)	34 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	0	32 (94.1)	2 (5.9)	34 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	9 (26.5)	16 (47.1)	9 (26.5)	34 (100)

4.2.3.6 Stigmatising attitudes towards people living with HIV

A majority of the women had non-stigmatising attitudes towards people living with HIV, which applied to all three questions (Table 65).

Table 65: Attitudes towards people living with HIV among participants

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	5 (14.7)	29 (85.3)	0	34 (100)
If a member of your family had HIV, would you want it to remain secret?	20 (58.8)	13 (38.2)	1 (2.9)	34 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	6 (17.6)	28 (82.4)	0	34 (100)

4.2.3.7 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 66). Based on their responses, there is evidence of stigma and discrimination in the community, particularly in the context of knowing someone who has been denied health services because he or she is suspected of having HIV.

Table 66: Evidence of stigma and discrimination observed in the community

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	20 (58.8)	11 (32.4)	3 (8.8)	34 (100)
Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	26 (76.5)	5 (14.7)	3 (8.8)	34 (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	31 (91.2)	0	3 (8.8)	34 (100)

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Twenty-two women answered in the affirmative that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, while multiple answers were possible, the women indicated that it was a stranger (n=15), friend (n=6), casual partner (n=4), boyfriend/husband (n=3), police (n=2) or family friend (n=1).

4.2.3.8 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 67). Aside from knowing where to access health-related information and support, both of which more than 50% of women knew how to access, a majority of women

otherwise did not know where to access HIV and STI testing or treatment services, or services that provided condoms. There is clearly scope to improve knowledge about accessing these health services for this group of women.

Table 67: Knowledge about accessing health services

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Support	15 (44.1)	18 (52.9)	1 (2.9)	34 (100)
Health-related information	8 (23.5)	25 (73.5)	1 (2.9)	34 (100)
HIV and STI testing	18 (52.9)	15 (44.1)	1 (2.9)	34 (100)
HIV and STI treatment	23 (67.6)	10 (29.4)	1 (2.9)	34 (100)
Condoms	19 (55.9)	14 (41.2)	1 (2.9)	34 (100)

Aside from being contacted by a volunteer or outreach worker, which the majority had experienced, the other services had not been used by a majority of the women. Many of the women reported that these services were not applicable to them (Table 68).

Twenty-nine women (85.3%) knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault. When asked what the names of any of these organisations were, the following names were mentioned: AHD, Catholic women's association (Focalare), and KFHA Clinic.

Table 68: Connection with HIV-related and other health services

	No n (%)	Yes n (%)	Not applicable n (%)	Total n (%)
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, pregnancy, HIV and STIs, or sexual assault?	9 (26.5)	20 (58.8)	5 (14.7)	34 (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs or sexual assault?	11 (32.4)	2 (5.9)	21 (61.8)	34 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	11 (32.4)	9 (26.5)	14 (41.2)	34 (100)
Have you ever participated in an HIV peer education program?	21 (61.8)	2 (5.9)	11 (32.4)	34 (100)

Of the two women who had visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault, they generally rated their experience as positive and would use the service again. The aspect of their experience which they rated least favourably was in relation to feeling uncomfortable and embarrassed, which

may or may not have had more to do with their own levels of comfort with the subject matter than with the service offered.

4.2.3.9 HIV testing

Thirteen women (38.2%) believed that it was possible for someone in their community to get a test to find out if they were infected with HIV. Surprisingly, all 34 women knew where to go to receive such a test. Twenty-seven (79.4%) women reported having had an HIV test, among whom 17 had an HIV test in the 12 months prior to the survey. The women reported that their test was carried out through a private doctor (n=3), hospital/government health service (n=5), NGO clinic (n=7) or KFHA clinic (n=2). Of the 27 women who had ever been tested for HIV, 22 got the results from their last HIV test. Based on these results, 21 women reported being HIV-negative and one woman did not know her HIV status. These results are slightly in contrast to the earlier mentioned reference of having been diagnosed with HIV.

4.3 In-depth interviews

4.3.1 Transgender and men who have sex with men

In-depth interviews were conducted with 5 participants who were born male and had sex with men. One identified clearly as male, and another as transgender, the other four participants were more ambivalent about their gender identity and the MSM /transgender categories were not completely appropriate for them. Participants themselves used the I-Kiribati word *Binabinaine* to refer to both TG and MSM. The interviews took place in hotel rooms, during the month of May, 2016. They were conducted in English.

Although sex between men is highly stigmatised in Kiribati, most of the interviewees said they were well accepted by their families, with the exception of the unemployed participant. Generally, men who are employed and contribute to the household income and fulfil traditional masculine roles at home and in the community, are accepted by family. However, none of the interviewees felt that they could bring their partners home or introduce a boyfriend to their families, as that would be too confronting for family members. Committed long term relationships were difficult and rare and no interviewees currently had a 'public' boyfriend.

Openly transgender women are often the butt of unpleasant jokes. A transgendered self-identification is not always evidenced by dress. Some transgender limit gender expression to household roles and activities such as sewing and cooking, while others express themselves more visually and physically, ranging from eyebrow plucking and feminine grooming, to fully feminine attire.

The interviewees stated that condoms were readily available but lubricant was not. Access to health services was considered adequate for those employed, particularly as they have regular health check-ups as part of their employment conditions. For unemployed MSM/TG contact with health services was limited and more difficult to access.

4.3.1.1 Gender and sexual identity

For most participants, the terms TG and MSM were inadequate to represent their gender identities. Most say they are both male and female:

> In my head I am both. What is the name for that? [Mikey*, 35 years]

Allan at first described himself as a male, but later went on to say that he is female also, and has been both since he was a child:

> When I was a child my elder sisters used to beautify me. Maybe it affected me… Me, I know for sure that I'm not a girl – I'm just a male – but I really want to be that [a girl]. I played with girls, I enjoyed dancing with them… I know I'm a boy, but I'm both sexes… that's the way I was born. [Allan, 43 years]

Although he feels he is both a male and a female, Allan dresses and presents himself as a male. He keeps his feelings secret, but his sense of himself and his desires remain feminine:

> I'm a man, but I feel that my heart is a woman…In my heart I still have that feeling, I really love the boys. But I cannot tell [anyone] that I am a woman inside. [Allan, 43 years]

Interviewee Glen identified as MSM, but then went on to say that "I am really a transgender" who prefers to wear women's clothes. In Kiribati, Glen felt that she must wear men's clothes because it would bring shame on her family to dress as a female. Although her family has come to accept her sexuality, public visibility of her transgender identity would not be tolerated. However, she feels free to express her identity and dress as a female while on board an international vessel where she works as a steward.

Kerry, who lives at home with her mother and siblings, identifies strongly as a woman:

> I can see that I'm a man, but I feel that I'm a woman. I was born this way. I'm acting 100 percent as a woman. [Kerry 34 years]

Kerry would love to have a long term relationship with a man, but feels that this is not possible as long as she lives at home (in Tarawa). She feels that she would have to go and live on an outer island to have a long term relationship. Her current sexual encounters are all casual and the men she has sex with all identify as heterosexual and have girlfriends or wives. She stated that she has no trouble finding these men to sleep with, and that while they would not be seen with her publicly, they often tell their friends that they have had sex with her:

> The men are not like us [*binabinaine*], most of the men I slept with are married…some of them tell others that they do something with me. [Kerry, 34 years]

Another interviewee Pete is unequivocal that his gender is male. Pete, has a boyfriend who he describes as 'straight'. He would eventually like to get married (to a man). Only a few close friends know of his relationship with his boyfriend. He believes that Kiribati society is less open to sexual diversity than other parts of the Pacific, partly because of cultural expectations of masculine roles and partly because "the church says it's wrong" [Pete, 27 years].

4.3.1.2 Sexual behaviour

Most of the interviewees tend to have casual sexual encounters with other men, although some have had longer term relationships with men in secret or outside of their country. Some also had sex with women. Allan for example, has sex with women, but says that he is lured by the women who pay for his drinks:

> I don't feel happy with them, but it seems that they trap me. [Allan, 43 years]

Allan has had no long term relationships aside from one relationship with an older man who has since died. All his male sex partners have been older men:

> I don't like [men] my age. I like old ones…I think maybe they know something, maybe they know how to touch me when they come in the night time…I only fight with ones my own age [who approach me]. I'm a sportsman so I chase them [away]. [Allan, 43 years]

Mikey also once had a boyfriend – a young man who was a friend of the family and lived nearby. The relationship lasted in secret for over a year his boyfriend got drunk and told everyone he was in love with Mikey. As a result, his boyfriend's brother kicked the boyfriend out of the house, telling him he was no longer welcome and not to ever return. His boyfriend went back to an outer island to live with family, and although he asked Mikey to go with him, Mikey wouldn't go:

> I did love him, but you know in the bible it's wrong and I feel guilty. I am wrong. That's why I dress like this [in men's clothing]. I am trying to be good. [Mikey, 35 years]

Mikey's ex-boyfriend is still living on an outer Island and is now married to a woman.

Glen was in a relationship with a fellow seafarer, and they lived together on board until Glen's contract came to an end. Glen's lover, a European, is still on contract. They keep in touch, and have talked about making a life together and perhaps getting married somewhere where same sex marriage is possible. But Glen points out that maintaining a relationship between seafarers is difficult, as they never know where their next contract will be, or if they will ever be on a ship together again. This is only Glen's second long term relationship, the first was when she was aged in her 20s and lasted about 5 years. Their families did not know that they were in a relationship.

All of the interviewees felt that it was almost impossible to have a long term boyfriend because of family and community disapproval. Kerry describes having brief and casual encounters with other men instead:

> If I want a man to sleep with I can. I've had a lot of men to sleep with – but not a boyfriend, because of what my family can do to me. [Kerry, 34 years]

These encounters take place in secret, and away from home and family:

> I have never had a boyfriend. I only sleep with men for a night, that's all. And I only sleep with men from another village, far away from my family. [Kerry, 34 years]

Interviewees identified their casual sexual partners as heterosexual or "straight" and said that they were usually married. As well as fear of family reaction another reason for maintaining secrecy was because they were fearful of their sexual partner's wives and wanted to avoid the repercussions if caught:

> For me I feel comfortable that way [meeting in secret] because I don't want to be seen. If they've got a partner, they might come and quarrel. [Allan, 43 years]

Interviewees first had sex when they were adolescents with other boys their own age. Allan was the exception, as he had only had sexual encounters with older men, in keeping with his preference. Kerry started with thigh sex at age 12 – with boys at school rubbing their penis between her thighs. At age 18 she had oral sex and 23 years she engaged in penetrative anal sex. Kerry described her first experience of anal sex as "moving into the next stage of my being", a phrase that I-Kiribati people use when a girl first menstruates to signify that she has now moved into a new stage of being as a woman.

Alcohol and sex seem are often associated in the interview narratives. Kerry for example, once went to a friend's house to borrow $20 to continue drinking. Her friends were not at home but an older man from the household said that he would give her money if she lay on the bed with him for half an hour. She agreed and gave him oral sex. Kerry lost her job after too many absences from work as a result of heavy drinking. She has not had alcohol now for over 18 months and hopes to get her job back in the future.

Allan said that he has reluctantly had sex with women he meets in bars when they pay for his drinks. Allan's casual encounters with men occur after drinking kava, although he says that he goes out to drink, not to have sex:

> It happens [sex with men] when I'm with friends going for kava, but I don't invite them to my house. [Allan, 43 years]

Allan explained that alcohol has been a determining factor in his life and decisions. Although a promising student, he left school at age 15 to go partying with older MSM friends in his village.

Years later, he attended the University of the South Pacific but dropped out because of heavy drinking. He still acknowledges drinking as something he needs to control and tries to minimise his beer drinking now by drinking kava instead.

4.3.1.3 Condom use

Condom use is described as being inconsistent. The interviewees said that they usually use condoms - unless they are drunk, in a relationship, or if their partner does not want to use them. Kerry said that she always asks her male partners to use condoms for anal sex, but that ultimately it is up to them, and sometimes they don't want to:

> I always ask them – but they decide …some of my partners are very bad, they don't want to use the condom… I want to have sex with them so I have to accept what they want. [Kerry, 43 years]

Kerry knows a lot about condoms and HIV and STIs because of her previous work a health service. She likes to use condoms and usually carries some around in case she meets a man. She is confident with engaging with health services workers and it is easy for her to access condoms from service providers and from nightclubs.

Both Glen and Pete use condoms sometimes, but do not use them when they are drunk and consequently forget or just do not bother to use them. Glen assesses the risks associated with each partner before deciding whether to use a condom. She knows that men who are training on Maritime courses have to get blood tests that check for HIV and is less likely to use a condom with these partners. Glen likes that condoms offer protection from HIV and STIs, but prefers sex without them.

Allan said that he knows where to get condoms but he doesn't carry them with him when he goes to kava bars because he is never planning to have sex. And while he noted that condoms are available at kava bars he will not pick them up there because he is worried that people will then know that he is going to have sex with whichever man he has met:

> It's not that we think about to do it, so we are not prepared to do it…because I don't want people to know what we do... [to think] oh, he picked a condom because he wants to go out with that one. [Allan, 43 years]

Mikey mostly uses condoms for casual encounters but did not use them with his boyfriend. He has had sex with three young women and, based on his own assessment of how sexually active they were, he used condoms with the two he describes as "the naughty ones". The third who he describes as "not naughty" he did not use a condom with. He learnt about condoms while working as a peer volunteer on an HIV/STI prevention project about 10 years ago. Before that he didn't know about condoms.

Although the interviewees agreed that condoms were readily available, packs of lubricant were definitely not. Coconut oil, which can be found in every household, and spit were used for lubrication during sex.

4.3.1.4 HIV and STI testing

Most of the interviewees had HIV and STI tests as a part of their employment conditions. Routine health checks are offered to employees and this includes HIV and STI testing. Glen has been regularly tested at the Marine Training Centre (MTC) and has never been to any other clinic. Pete has tested at both the hospital and the MTC while employed. Allan has been tested at the KFHA mobile clinic, which visits work places.

Access to health services for the unemployed is reportedly more difficult and they are not offered regular testing or care.

4.3.1.5 Stigma

Highly traditional gender roles are experienced as powerful constraints on the lives of most of the interviewees. Yet, even where family and community have accepted a non-traditional gender identity, actual evidence of sex between men is unacceptable to the family. Homosexuality is highly stigmatised in Kiribati.

Most of our interviewees were accepted to a large extent by their families, and their experiences also indicate that where a man's financial contribution to his household is significant, then his sexuality or gender identity is likely to be tacitly accepted. However, while most of the interviewees felt accepted by their families and friends, they all said that they could never bring a same-sex partner home to introduce to their families. For some, the discovery of youthful MSM relationships by family members had led to significant punishments, including being sent away to another island or being forced to drop out of school.

Pete is the main income earner in his household and he said that his close friends and family know that he is gay and are comfortable with that. However, only a few close friends know of his relationship with his boyfriend which is "on the quiet". Like Glen, he would like to get married to a man but doesn't think this will be possible in Kiribati, a country which he believes is less open to sexual diversity than other parts of the Pacific. He attributes negative attitudes to culture and cites "cultural expectations of masculine roles" and also to religion as "the church says it's wrong".

Glen also had a long term boyfriend that he kept a secret from his family. When Glen's boyfriend fell very ill and was hospitalised, he told his family that he needed Glen by his side, and asked them to bring Glen to look after him. The family then understood the nature of the relationship and were angry and refused to contact Glen. As the boyfriend's condition deteriorated, his mother relented and let Glen go to her son. The relationship continued for a while, but the boyfriend's stepfather wouldn't accept it and sent his step-son to Fiji, to a seminary school, to train to be a priest. Likewise, Mikey was also prevented from having a relationship with his boyfriend once it was discovered by his family. His boyfriend was sent to live on an outer island where he is now married to a woman. Mikey also cites the church's teachings as influencing his views:

> I did love him, but you know in the bible it's wrong and I feel guilty. I am wrong. That's why I dress like this [in men's clothing]. I am trying to be good. [Mikey 35 years]

Mikey, who is unemployed said that his family accepts him, except for his father.

> My father hates me. It makes me sad. [Mikey, 35 years]

Although they live in the same household, his father doesn't talk to Mikey, and if he does say something it is nasty. But his father allows Mikey to stay because he contributes the most of the household labour, he also fishes and by rolling pandanus cigarettes brings in the little money that the household has to live on. At age 16, Mikey was forced to drop out of school when his father found out he was having sex with other boys and refused to pay his school fees.

Allan, who identifies as both TG and MSM, tries to avoid judgemental attitudes by only expressing his femininity in the security of his household (e.g. cooking and sewing). Outside

of the home he presents as a male as a way of protecting himself. He describes having been a great runner and sportsperson in his youth, and how that saved him from bullying and physical abuse: his sporting prowess gave his status, and when that was not enough he could run fast – or fight and scare off potential attackers.

Kerry feels that she is accepted by her family and in her community as long as she does not take a boyfriend home. However, she says that the 'straight' men she has sex with talk about her and others laugh and make jokes:

> They make fun of me, but they don't mean to hurt me. It's not like they hate me - they really love me. They always laugh about what I'm doing. [TG, 34 years]

4.3.2 Female sex workers

Ten interviews were conducted who had been identified by others as sex workers, however 2 were deemed invalid. In one case the interviewee was living in a household with other FSWs but said that she herself did not receive money or goods for sex. In the second case, the interviewee was in a relationship with a foreign seafarer and had stayed on board the boat with him and had also regularly received money from him. However, she stated she had not had sex with anyone else, and upon further questioning the relationship appeared to be a de facto marriage. The interviewee lived at home with her parents, the couple stayed together there when her partner's boat was in Betio, and the parents accepted him as her partner.

The remaining 8 interviewees were aged between 16-29 years and all lived in Betio. They were interviewed by an I-Kiribati female research assistant (RA) in the local language. Interviews were translated immediately post interview by the RA and the Team Leader.

The repetition of similar narratives among the 8 eligible interviews indicated that saturation had been achieved: the women live in large shared households where no one has regular employment and sex work was the main source of income. The households are comprised largely of female sex workers and their children and usually one unemployed male. The women share childcare and household labour and use income from sex work to buy food and household supplies. Interviewees all feel vulnerable to physical and sexual abuse, especially on shore. The women are reluctant to seek sexual health services from providers who they are unfamiliar with or when they are unsure of confidentiality. All interviewees expressed positive attitudes to condoms.

The FSWs interviewed are all estranged from their families to varying degrees. They have all made new households with other FSWs and their children. As in other I-Kiribati households, food and resources are shared and those earning money support the others. Some of the women also try other ways of supplementing their income, such as selling small food items in bars, but potential earnings from these ventures are poor. FSWs interviewed variously provide financial support to parents or other family members, pay for sibling's school fees, and supply food for their neighbours when they have enough.

Interviewees' households generally include one or two men who provide passive protection as the women are less vulnerable if others know that there are men in the household. These men are often an unemployed member of one of the women's families and tend to contribute little to the household aside from their presence. FSW feel very vulnerable in every aspect of their lives, except perhaps when they are on board a boat. In their homes, they need protection from prowling local men, family members might beat them when they see them on the street, and

they are also frightened of the wives of their local clients, who they fear will also beat them. FSW have been coerced by police into having sex.

All the interviewees board boats in Betio port where they have paid sex with seafarers. FSWs often stay for extended periods on board the ships and say they feel "cared for" by seafarers. Nearly all these FSWs also have paid sex with local men, as recent regulations and higher fines for shipping companies have made it harder to get on board foreign vessels. Sexual relations with local clients are more clandestine than those with seafarers, as the local men are often married and the women are scared of repercussions from their wives. Those FSWs who have children to seafarers are entitled to go on board.

FSW usually move out of Betio and into new family households, when they marry or cease engaging in paid sex.

4.3.2.1 Sexual behaviour

Sexual partners are both local I-Kiribati and foreign seafarers. Korean seafarers are particularly valued as clients by the FSWs because they treat the women well and also provide them with food, gifts and money. I-Kiribati clients tend to be married, they won't pay until after sex and then they decide how much money they will give the women. The women pointed out that they are often only paid a small amount by the local men:

> Sometimes they will just give me $5 but at least then I can take some money home to buy food and we can eat. [Pauline, 22 years]

The youngest interviewee, Marta, also has local clients - including government workers who she says pay better than other locals. She sometimes goes to their offices after working hours for sex:

> The government men are good too, because I won't go with them until they have promised to give me a $50 note. They always use condoms too [Marta, 16 years]

The interviewees have sex with local clients in the bars near the wharf or in parks.

The FSW interviewed all board foreign fishing vessels and stay for several days and often weeks at a time. Sarah has three children aged 8, 9 and 10 who each have different Korean fathers. She keeps in touch with the fathers but they don't send her money until their boats come in to Tarawa, and then they will give her KID$2000 to $5000. The boats return regularly and when one of the fathers come in to port she will board with his child and they will all stay together on the boat. Her friends, or her mother, will look after the other children. If it happens that all three fathers are in port at the same time she will go with the eldest son to his father, who is her favourite. Sarah, like the other interviewees, says she enjoys her time on the boats because there is good food, free drinks and no housework to do. The women always leave the boats with money and goods:

> When we leave they give us money and presents: jewellery and lots of fish… We don't sell the fish we share it share with our neighbours. [Sarah, 29 years]

Life on board the boats is very much an ongoing party atmosphere with heavy drinking and luxury foods which are unavailable on shore, and is attractive to bored young women. For all our interviewees, first sex with seafarers occurred the first time they boarded a fishing vessel to party. Among our interviewees this occurred between the ages of 12 and 18.

Marta first had sex at age 12 with a Korean seafarer and now at age 16 continues to board boats as a sex worker, where she often stays for several days. She finds the seafarers kind

and caring. She has an 8-month old baby, and the father is a married local man who does not want to know her, and who does not provide child support. Marta originally came to Betio from an outer island to stay with relatives and attend school. Because Marta has a child and has taken up sex work she feels she is unable to make contact with her relatives:

> I was happy because I felt secure on the boat and the Koreans were kind and the man cared for me… I never went back to school... I don't go back to my relatives, I'm scared because they might send me home [to an outer island], they don't know that I've had a baby. [FSW, 16 years]

The first time Lily had sex was with a seafarer at age 13. Lily also prefers seafarer clients rather than local men and she likes it on the boats where she feels supported by her friends who also board the boats. Unlike most of the older FSW who prefer to stay with one client, Lily sometimes has up to 4 partners on the same boat so that she can get more money and says she gets $150 from each seafarer she has sex with. She also has local male clients when the ships are not in port:

> I get about $40 a day from local men. I give $20 to the household for meals and the rest I mostly spend on drinks. [Lily, 19 years]

The interviewees are mostly heavy drinkers, they spend time on the boats drinking alcohol and socialising and often seek local clients or seafarers in bars. Some of the scheduled interviews had to be cancelled, or rescheduled, because the interviewee was too drunk for the interview to take place. Alcohol and sex work are strongly connected in the lives of the interviewees, and alcohol use is likely to contribute to risk behaviour. Sarah, for example, first had sex at age 18 when she went on to a boat after meeting a group of Korean seafarers drinking with friends at a bar:

> I didn't realise when I woke up that I was on the boat because I was too drunk, I didn't remember getting there. [Sarah, 19 years]

Lily admitted that although she is aware of sexual diseases she forgets to asks her clients to wear condoms when she is drunk. This is a concern for her:

> I worry that they [the seafarers] might have infections. I worry about it when I'm sober. [Lily, 19 years]

4.3.2.2 Condom use

The FSWs are motivated to use condoms and they usually initiate condom use with clients. However, they tend not to use condoms with seafarers if they stay together for more than one night. As Sarah explains, the women stop using condoms when they become familiar with their seafarer client:

> Because they know each other and they trust each other and he can see that I'm not going with anyone else. [Sarah, 19 years]

Although the women say they usually initiate condom use, sometimes the clients refuse, mainly because they prefer the feeling without condoms:

> They are not pleasurable and they prefer skin to skin – that's what they always say. [Meg, 22 years].

In general, local clients were said to be more reluctant than seafarers to use condoms. Sometimes the women agreed to this because they "need the money" (Pauline, 22 years). One interviewee also said that men can refuse to wear condoms as they want to have children.

According to Meg, some of her local clients want babies because their wives are "barren". She has two sons to a local man and the children stay with his elder brother. But on the whole, the FSWs said they were firm about using condoms with local clients because they worry about STIs and also repercussions from the men's wives if they got pregnant. Sarah has a strict rule:

> It's a must. I don't trust them and often they are married. I don't want to get in trouble with their wives… If they don't want to use a condom I say 'Sorry no sex'. I'll go and look for someone else. [Sarah, 19 years]

Interviewees also promote condom use to other sex workers. For example, Sarah collects condoms from the bars to give her younger friends:

> I give condoms to them when they're drinking because the young ones are too embarrassed to pick them up themselves. [Sarah, 19 years]

Condoms are usually available on board the boats and can also be picked up free from bars and nightclubs. KFHA and the Ministry of Health and Medical Services (MHMS) have, on occasion, dropped off boxes directly to FSW households. The interviewees all said that condoms were easy to obtain, and if they ran out they would just go to another nightclub to get them.

Most of the women interviewed had learnt about condoms from KFHA MHMS or FSW education workshops, or from volunteering for KFHA as peer educators.

4.3.2.3 HIV and STI testing

Of the 8 FSW interviewees, 6 had been tested for HIV and STIs and 2 had not.

The reasons that were given for not being tested were either that they had missed the opportunity to be tested after a KFHA workshop (KFHA did not have capacity to test everyone) or because there were no appropriate local sexual health services in Betio:

> I'm not sure if they have the services that I need. [Meg, 22 years]

The women who had tested all preferred to go to the KFHA clinic because they knew the health workers there and this made them feel more comfortable. KFHA staff were perceived as non-judgemental and the women trusted the staff to keep their information confidential. But often they could not afford the bus fare to get there:

> We go to KFHA if we have bus fare. But often KFHA is too far away to get contraceptives or tests if we think we are sick. [Pauline, 22 years]

Many of the women would only attend health clinics if they "were sick". Even when they suspected infection, they would not go to the local Betio clinic but instead would wait until they had the bus fare or found someone to take them to KFHA:

> I felt embarrassed, and I don't trust that they [Betio clinic staff] would be confidential. I know them at KFHA. I know they are good. [Marta,16 years]

Local services in Betio were generally only used if they knew that a trusted relative or friend was working there, and had not been rostered to another clinic. Interviewees worried about the negative attitudes of staff and doubted the confidentiality of the service:

> We'll only go if [the relative] is working. We won't go if we don't know anyone because we're embarrassed, we're frightened of being treated badly and they will talk about us. [Pauline, 22 years]

Sarah noted that, despite it being within walking distance, she would only use the Betio clinic if she was pregnant, because:

> There is no shame in being pregnant…I can walk to the Betio clinic, and don't have to pay bus fare. [Sarah 19 years]

Two of the women had also accessed the KFHA mobile testing clinic when it came to Betio and had been pleased with the service. The remaining interviewees had either not heard of the mobile clinic, or had never seen it in Betio.

4.3.2.4 Stigma

Sex work is highly stigmatised in Kiribati, and women engaging in it not only marginalised but also vulnerable to physical assault. In their homes the women are fearful of prowling local men and usually have an unemployed male living with them to offer protection. FSW tend to be estranged from their families, who have often physically beaten them. They are also frightened of the wives of local clients who they fear would also beat them. Some of the women interviewed had also been coerced in to having sex by local police.

The women are particularly vulnerable to attack or coercion because they feel that they cannot turn to their families or authorities for support. Although some of the women financially contribute to family members through sex work earnings., they are "not accepted". Many, like Meg, avoid family because of beatings:

> When I didn't come home my parents looked for me and heard that I was on the boat and was hanging around with ainen matawa. One day we came ashore to buy a few things and I ran into my brother on the road. He gave me a beating. I never went home again. Now I live with my friends. [Meg, 22 years]

Some of the interviewees also hide that they have had children from their families, which in turn compounds their isolation. Those who have children to local men are abandoned and disavowed by the fathers, and in some cases their children have been removed from them. Without child support from their children's fathers, they are reliant on income from sex work, and on sharing resources with other sex workers.

Although most interviewees have been physically assaulted and night time prowlers are sometimes a problem - "some local men try to come sneaking in" - the interviewees do not seek help from the police. On occasion the police themselves are also the perpetrators of sexual assault. Marta and a friend were once taken in by the police and were told they would go to jail because they were underage drinkers. Marta was told that if she had sex with the policeman she could go:

> The policeman said "If I have sex with you, you are free to go". I did because I didn't want to go to jail. [Marta, 16 years]

Fear of the judgemental attitudes of health workers also keeps FSW from accessing local sexual health services.

One of the few places where women feel safe and happy is on board the foreign vessels, where they say they are treated well. The seafarers cook and clean for them and provide gifts and money.

> He cooks for me, he washed for me. [Leanne, 20 years]

The presence of other FSWs creates a supportive and enjoyable social environment. At home, according to the interviewees, neighbours know that they are sex workers and are generally kind to them. The FSWs tend to reciprocate that kindness by giving gifts of fish to their neighbours on their return from the vessels.

4.4 Capacity assessment of HIV organisations and services

4.4.1 Organisational mapping

There are currently two organisations engaged in HIV prevention and management with MSM/TG and FSW in Kiribati: The Ministry of Health and Medical Services (MHMS) HIV Program and Kiribati Family Health Association (KFHA). The MTC provides HIV and STI education and testing to seafarers. A third organisation, BIMBA, is an emergent MSM/TG network that aims to provide health and human rights advocacy for MSM/TG in Kiribati. All three organisations are based on South Tarawa.

The MHMS HIV Program has three staff members; a doctor, nurse and coordinator. The doctor is based at the main hospital and, unlike the other two positions, his position is not dependent on external funding. The main hospital is the only site that conducts confirmative HIV tests for Kiribati. The HIV program coordinator is responsible for the co-coordination of the CCM and for program monitoring. The nurse delivers treatment services to PLHIV. The HIV program is dependent on external funding, and in the past, gaps in funding have led to a cycle of staff turnover, gaps in implementation, and hindered any ongoing program development. Within the past year the program has carried out one workshop on HIV prevention for MSM/TG and one for FSW, both were reported to be a successful and enjoyed by participants. The HIV Program office is situated near the hospital at the opposite end of the island from where the target populations mostly live. Participants from the vulnerable communities claimed that this poses a barrier to access.

The Kiribati Family Health Association (KFHA) is a full International Planned Parenthood Federation (IPPF) member and is a registered NGO in Kiribati. The core activities of KFHA are: delivering sexual health and family planning services and information; HIV and STI prevention, peer to peer programs; condom distribution; and advocacy for reproductive rights. Their work includes conducting awareness and education programs on sexual and reproductive health with communities, schools, out of school youth, seafarers FSW and MSM/TG. KFHA also operates a mobile clinic which includes rapid testing facilities. KFHA has Memorandums of Understanding with the MHMS and with outer islands' counsellors and traditional leaders on 6 outer islands in 2015. KFHA is located part way between Betio and Birkenibeu and is reported to be popular with FSW and MSM/TG. KFHA's program focuses on eight islands which represent approximately 70% of the total population of Kiribati. Within the past year KFHA has conducted two workshops for FSW and one also for MSM/TG.

Boutoka Inaomataia ao Marurungia Binabinaine (BIMBA) is a new organisation established to support the health and rights of MSM/TG. It is currently working towards registration as an NGO. BIMBA has fifty MSM/TG members. The organization, although new, is well connected to international and regional sexual diversity organisations and is a member of the Kiribati CCM and AIDS Task Force. At the time this data was collected (May 2016) the organization did not have an office.

The Maritime Training Centre (MTC) located in Betio provides HIV and STI prevention training to trainee seafarers as part of the seafarer training curriculum and refresher training for qualified seafarers (required every five years). The MTC partners with the MHMS and KFHA

to deliver the trainings. MTC also has a clinic which offers sexual health services including HIV screening.

4.4.2 HIV and STI prevention activities in Kiribati

4.4.2.1 National oversight, coordination and funding

The HIV Program staff reported that they are unaware of a National HIV strategic plan (although one exists) or monitoring and evaluation framework to guide, coordinate and monitor HIV program implementation in Kiribati. There is however, a CCM and an HIV/AIDS Taskforce which provides oversight of HIV activities. The CCM includes an MSM/TG and a FSW representative.

The HIV Program at the Ministry of Health is completely funded through the Global Fund. KFHA currently receives funding from IPPF, Family Planning New Zealand, Department of Foreign Affairs and Trade (DFAT) and local income generated by clinical charges. In 2013, under the support of The Pacific Community (SPC), AUD$50,000 was allocated for community grants, which were managed by KFHA. The purpose of the community grant was to enhance active participation and the engagement of the community in HIV and STI prevention. This grant expired at the end of the funding round. It was reported that there is a need for further funding to continue HIV prevention activities with vulnerable populations.

4.4.2.2 HIV and STI testing, counselling and treatment

The Ministry of Health HIV program is responsible for national HIV and STI testing, counselling and treatment. A nurse and doctor are employed to oversee and deliver treatment to PLWHIV. The doctor is based at the hospital and the nurse is located at the HIV program office.

KFHA (at the KFHA clinic and through mobile outreach) and the MTC also provide HIV and STI counselling and rapid testing. All confirmative tests are conducted at the hospital and are analysed at the National Laboratory. The results are confidential and as such not shared with the MTC. The MTC clinic primarily provides medical services to its own trainees and to seafarers working on South Pacific Marine Services ships (SPMS). SPMS is the main, but not the only, agent for seafarers in Kiribati.

4.4.2.3 Condom distribution

Condoms are supplied to the Ministry of Health by UNFPA. The HIV program is responsible for condom distribution and distributes condoms to shops, clinics and other organisations. It was reported that female condoms are generally not available and, due to supply chain issues, male condoms were unavailable to the HIV program for some months from December 2015. Lubricant packs were also not available.

Condoms are also distributed by KFHA from their clinic, through the peer program, to shops, to FSW houses and to bars and nightclubs near the wharf. Seafarers can pick up condoms at the MTC. The staff of the HIV Program have also conducted condom distribution to Betio sex workers.

4.4.2.4 Peer education

KFHA has a peer to peer program in South Tarawa and on 6 outer islands. The peer program includes the distribution of condoms and HIV and STI information. KFHA have tried unsuccessfully to recruit FSW as peer educators within a general youth program. The value in having a sex worker only program has been identified but KFHA would need further support and resources to undertake this effectively. BIMBA have expressed a desire to be active partners in peer education and condom distribution programs

The BIMBA network is a grassroots group that has emerged from a shared understanding of the need for social support and the value of collectivisation to advocate for health and other rights for MSM and transgender.

4.4.2.5 Strategic health communication

The Ministry of Health provide HIV prevention messaging through TV, radio and the newspaper but this is aimed at the general population. KFHA makes print material on HIV or STI available to the public in Kiribati. KFHA also conduct awareness and training program on sexual and reproductive health with communities, schools, out of school youth FSW and MSM/TG. Both the HIV Program and KFHA have conducted educational workshops on sexual health with MSM/TG and FSW, however they have delivered the same program as that developed for the general population. Target population specific issues have not been identified or broached.

The Health Promotion department of the MHMS and KFHA also contribute sexual health education including HIV and STI information to the seafarer training curriculum at the MTC. KFHA reported reaching over 200 seafarers last year.

4.4.2.6 Advocacy and legislation

KFHA is active in advocacy for sexual and reproductive rights and have been successful in engaging with church leaders over these, sometimes contentious, issues. KFHA have developed numerous sexual and reproductive right factsheets aimed at the general population. BIMBA exists specifically to advocate for human rights, health and social support services for MSM and transgender in Kiribati. BIMBA's existence is itself a social support for MSM and TG in the community.

4.4.2.7 Other support services

BIMBA provides informal social support for MSM/TG through its membership and meeting with members. KHFA refers sexual assault and gender based violence cases to the Kiribati Crisis Centre.

4.4.3 Cross-cutting organisational strengths

The HIV program, KFHA and BIMBA are all working towards reaching and addressing the needs of vulnerable populations, including MSM/TG, FSW and, to a lesser extent, seafarers.

1. The BIMBA group is an MSM/TG network and is well connected to international and regional MSM/TG networks.
2. KFHA has satellite sites which provide STI testing, rapid HIV tests, and HIV and STI prevention and education activities on the outer islands, as well as in South Tarawa.

3. KFHA already works with MTC to contribute to HIV and STI awareness components of seafarer training.
4. The CCM and HIV taskforce now includes MSM/TG and FSW representatives.
5. There are opportunities for coordination and sharing of expertise between the organisations, which is likely to increase the cost effectiveness, reach and quality of activities.
6. When BIMBA gains registration it will be a valuable partner, especially for condom distribution and peer education activities.

4.4.4 Cross-cutting organisational capacity-building needs

1. Limited funding and resources to reach and support key populations, particularly the Ministry of Health, which is reliant on one donor.
2. Opportunities for increased engagement with, and service provision to FSW through an FSW peer-to-peer program require active support and resourcing.
3. Greater understanding and advocacy of MSM/TG/FSW needs and involvement of MSM/TG/FSW in the design and delivery of services and programs. In the case of MSM and TG, this could be facilitated through BIMBA.
4. Accessibility of services would be improved by locating services to, and conducting outreach in Betio, and improving communication to target populations about the scheduling of mobile services in Betio.
5. Seafarer awareness of services could be raised by ensuring that print materials and posters are available at the MTC clinic.
6. Upskilling and clinical training in HIV and STI management for service providers is required.
7. Mentoring and training in program management, financial reporting, and monitoring and evaluation for program coordinators is required.
8. Seafarers who are not trainees at MTC or work for the Pacific Marine Service may have less access to HIV and STI education and information about available clinical services, than MTC trainees.

4.4.5 Identified capacity-building resources

There are a number of regional partners, such as UN agencies, SPC and the Pacific Sexual Diversity Network, as well as other international affiliated organisations (IPPF/IFRC), that currently provide support, or may be able to provide support in capacity building.

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Annex 1: UNAIDS GARP data needs

DATA – KIRIBATI

Indicator relevance: Topic relevant, indicator relevant, data available

Data measurement Tool:

Please specify data measurement tool:

Data collection period:

Additional information related to entered data. e.g. reference to primary data source (please send data to My Documents if possible), methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to My Documents if possible:

Sample Size:

Number of Survey Respondents: 35

Sex Workers

	All	Males	Females	<25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	**25.7 %**		**25.7 %**	**29.2 %**	**18.2 %**
Numerator Number of sex workers who answered "Yes" to both questions	**9**		**9**	**7**	**2**
Denominator Total number of sex workers surveyed	**35**		**35**	**24**	**11**
Percentage (%) Percentage of sex workers who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**97.1 %**		**97.1 %**	**95.8 %**	**100.0 %**
Numerator Number of sex workers who replied "yes" to question 1	**34**		**34**	**23**	**11**
Denominator Total number of sex workers surveyed	**35**		**35**	**24**	**11**
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?	**25.7 %**		**25.7 %**	**29.2 %**	**18.2 %**
Numerator Number of sex workers who answered "Yes" to question 2	**9**		**9**	**7**	**2**
Denominator Total number of sex workers surveyed	**35**		**35**	**24**	**11**

1.8 PERCENTAGE OF FEMALE AND MALE SEX WORKERS REPORTING THE USE OF A CONDOM WITH THEIR MOST RECENT CLIENT

	All	Males	Females	<25	25+
Percentage (%) Percentage of sex workers who received an HIV test in the last 12 months and who know their results	**45.7 %**		**45.7 %**	**41.7 %**	**54.5 %**
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**16**		**16**	**10**	**6**
Denominator Number of sex workers who responded to the questions	**35**		**35**	**24**	**11**

1.11 PERCENTAGE OF MSM REACHED WITH PREVENTION PROGRAMS

	All	<25	25+
Percentage (%) Percentage of MSM who answered "Yes" to both questions	**0 %**		
Numerator Number of MSM who answered "Yes" to both questions	**0**		
Denominator Total number of MSM surveyed	**3**		
Percentage (%) Percentage of MSM who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**100.0 %**		
Numerator Number of MSM who replied "yes" to question 1	**3**		
Denominator Total number of MSM surveyed	**3**		
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**0 %**		
Numerator Number of MSM who answered "Yes" to question 2	**0**		
Denominator Total number of MSM surveyed	**3**		

1.12 PERCENTAGE OF MSM REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD ANAL SEX WITH A MALE PARTNER

	All	<25	25+
Percentage (%) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**33.3 %**		
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner	**1**		
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**3**		

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

	All	<25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions	**5.3 %**	**0 %**	**10.0 %**
Numerator Number of TG who answered "Yes" to both questions	**1**	**0**	**1**
Denominator Total number of TG surveyed	**19**	**9**	**10**
Percentage (%) Percentage of TG who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**94.7 %**	**100.0 %**	**90.0 %**
Numerator Number of TG who replied "yes" to question 1	**18**	**9**	**9**
Denominator Total number of TG surveyed	**19**	**9**	**10**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**5.3 %**	**0 %**	**10.0 %**
Numerator Number of TG who answered "Yes" to question 2	**1**	**0**	**1**
Denominator Total number of TG surveyed	**19**	**9**	**10**

1.14 PERCENTAGE OF TRANSGENDER REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD SEX

	All	<25	25+
Percentage (%) Percentage of TG reporting the use of a condom the last time they had sex	**15.8 %**	**11.1 %**	**20.0 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**3**	**1**	**2**
Denominator Number of respondents who reported having had sex in the last 12 months	**19**	**9**	10

4.6 1.15 PERCENTAGE OF TRANSGENDER WHO RECEIVED AN HIV TEST IN THE LAST 12 MONTHS AND WHO KNOW THEIR RESULTS

	All	<25	25+
Percentage (%) Percentage of TG who received an HIV test in the last 12 months and who know their results	**47.4 %**	**55.6 %**	**40.0 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**9**	**5**	**4**
Denominator Number of TG who responded to the questions	**19**	**9**	**10**

?.?? PERCENTAGE OF SEAFARERS REACHED WITH PREVENTION PROGRAMS

	All	<25	25+
Percentage (%) Percentage of SEAFARERS who answered "Yes" to both questions	**55.8 %**	**75.0 %**	**54.2 %**
Numerator Number of SEAFARERS who answered "Yes" to both questions	**29**	**3**	**26**
Denominator Total number of SEAFARERS surveyed	**52**	**4**	**48**
Percentage (%) Percentage of SEAFARERS who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**98.1 %**	**100.0 %**	**97.9 %**
Numerator Number of SEAFARERS who replied "yes" to question 1	**51**	**4**	**47**
Denominator Total number of SEAFARERS surveyed	**52**	**4**	**48**
Percentage (%) Percentage of SEAFARERS who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**55.8 %**	**75.0 %**	**54.2 %**
Numerator Number of SEAFARERS who answered "Yes" to question 2	**29**	**3**	**26**
Denominator Total number of SEAFARERS surveyed	**52**	**4**	**48**

?.?? PERCENTAGE OF SEAFARERS REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD SEX

	All	<25	25+
Percentage (%) Percentage of SEAFARERS reporting the use of a condom the last time they had sex	**15.4 %**	**25.0 %**	**14.6 %**
Numerator Number of SEAFARERS reporting the use of a condom the last time they had sex	**8**	**1**	**7**
Denominator Number of respondents who reported having had sex in the last 12 months	**52**	**4**	**48**

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

	All	<25	25+
Percentage (%) Percentage of SEAFARERS who received an HIV test in the last 12 months and who know their results	**63.5 %**	**50.0 %**	**64.6 %**
Numerator Number of SEAFARERS who have been tested for HIV during the last 12 months and who know their results	**33**	**2**	**31**
Denominator Number of SEAFARERS who responded to the questions	**52**	**4**	**48**

Empowered lives. Resilient nations.

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