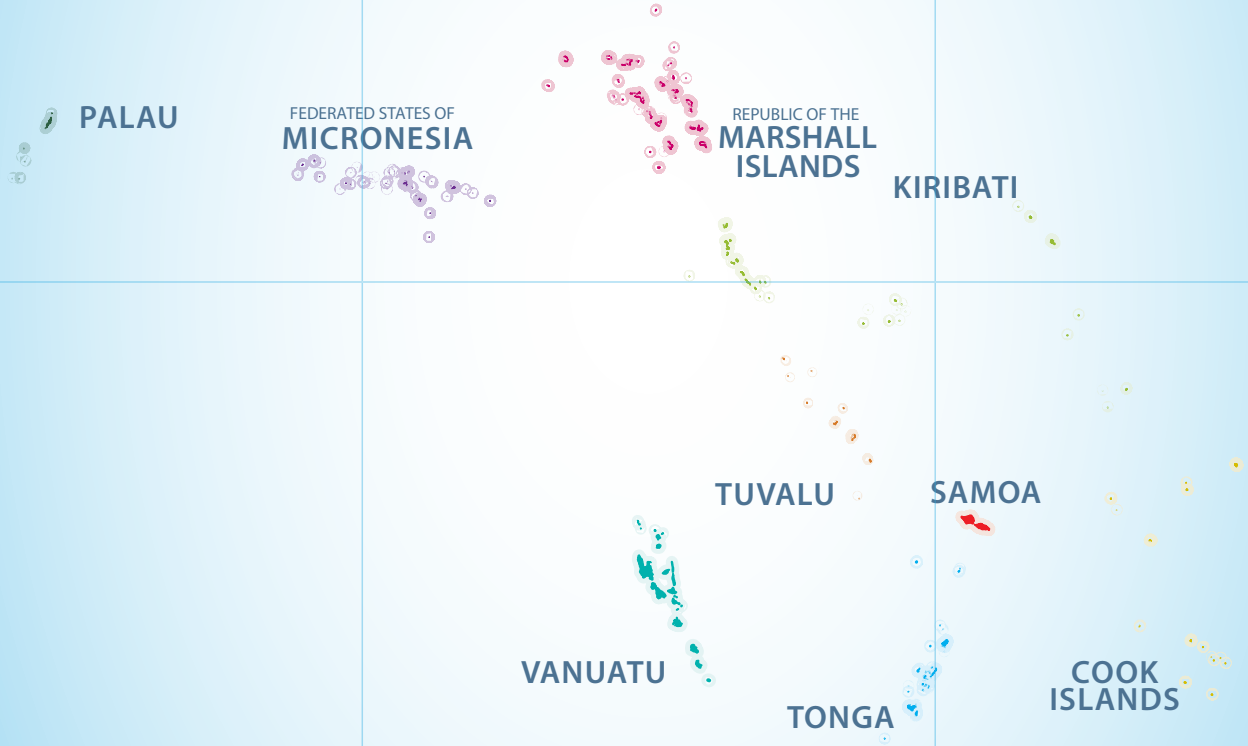
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

REPUBLIC OF THE MARSHALL ISLANDS



UNDP 50 YEARS
Empowered lives. Resilient nations.

UNSW AUSTRALIA

ashm

Acknowledgements

The *Pacific Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Republic of the Marshall Islands* 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.

This study was undertaken by the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF) and the University of New South Wales (UNSW). We gratefully acknowledge Heather Worth, Patrick Rawstorne, Michelle O'Connor, Karen McMillan, Robyn Drysdale, Hilary Gorman and Scott McGill from UNSW, who designed and implemented the study with the support of numerous local research assistants from the communities.

We would like to thank Women United Together Marshall Islands, particularly Kathryn Relang, for all their assistance and support with this project.

Thanks are extended to Youth to Youth in Health and the RMI Ministry of Health, and Marie Maddison for translation of the behavioural surveys.

We are grateful to research assistants Adelma Louis and Loreena Maio and to Kristy for the recruitment of female sex workers. Special thanks also to the research assistants from the men who have sex with men and transgender community who prefer not to be named.

We thank as well all of the participants who gave their time and shared their stories.

Thanks are also due to Maisoon Elbukhari Ibrahim, Programme Manager, Ferdinand Strobel, Policy Specialist, UNDP Pacific Office in Fiji, Sara Faletoese, UNDP Samoa, Russel Tamata, UNDP Vanuatu, Ian Mungall, Programme Analyst, UNDP Bangkok Regional Hub, Frances VuliVuli, HIV and AIDS Officer, UNICEF Pacific Office, Maria Vasileva-blazev, HIV and Youth Specialist, UNFPA Pacific Office, and Ken Moala, Advisor/Co-Founder, Pacific Sexual Diversity Network. Additional support was provided by the Technical Working Group of the Pacific Islands Regional Multi-Country Coordinating Mechanism.

The *Pacific Multi-Country Mapping and Behavioural Study* was supported by UNDP under the Global Fund through the Multi-Country Western Pacific Integrated HIV/Tuberculosis Programme.

Table of contents

List of tables

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

- There is a low prevalence generalised epidemic of HIV in the Republic of the Marshall Islands (RMI), with 28 people having been diagnosed to the end of 2015. This study collected data from two populations considered to be particularly vulnerable to infection: transgender/men who have sex with men, and female sex workers.
- Key stakeholders and representatives of target populations estimated that there are between 100 and 150 men who have sex with men (MSM) and transgender (TG) in the Marshall Islands, and around 200–250 female sex workers (FSW).

Transgender/Men who have sex with men

- The Marshall Islands decriminalised consensual male-to-male sex in 2005, but there are no laws that prohibit discrimination against a person based on their sexual orientation or gender identity.
- Ten men who have sex with men (MSM)/transgender (TG) took part in the behavioural survey and three MSM/TG participated in in-depth interviews. There was a range of sexual identities – gay/homosexual, bisexual and transgender/*kakkwol*[1]. The local term *Kakkwol* was used by participants to include both MSM and transgender.
- The majority were not employed, were single and lived with parents or siblings.
- While interviewees said that their gender identity was generally accepted by their family, it would not be possible to bring a male partner home or to live openly with a male partner.
- All participants reported having had sexual intercourse (anal and/or vaginal). The mean age of sexual debut of survey participants was 17.8 years old (SD=4.16).
- In the last 12 months, 90% of survey participants reported having at least one regular male partner, with whom they had anal intercourse. 80% had sex with at least one casual partner, and 20% with at least one paying partner.
- Condom use was low. In the last 12 months, 88.9% of survey participants 'sometimes' or 'never' used a condom with regular partners. All of the participants reported that they 'sometimes' or 'never' used condoms with casual partners. One man indicated that he 'sometimes' used condoms with a paying partner.
- In the last 12 months, 33.3% had female sexual partners. Two of these men had one regular partner and two had one casual partner. Most never used a condom.
- In the last 12 months, 30% of participants had sexually transmissible infection (STI) symptoms. The majority visited a hospital (66.6%) or talked to a friend (66.6%), and 33.3% had traditional treatment.
- Knowledge about HIV was moderate, with the majority answering at least five of 10 questions correctly.

[1] Local Marshallese term for 'girly man'

- Some participants had experienced stigmatising attitudes, particularly from employers, co-workers and people other than family who had gossiped about them. However, family members were generally less likely than co-workers and other people to know about the participants' sexual identity. In the last 12 months, 40% of participants reported feeling ashamed about their sexual identity, and 30% felt low self-esteem.
- A majority of participants knew how to access sexual health services, but only half (50%) knew of a local organisation providing information or services related to condoms, HIV and STIs, or sexual assault. Only half (50%) had accessed any of these services. Those who had used the services were generally satisfied with them.
- In the previous 12 months, 30% of survey participants had tested for HIV. All had received a negative result. The majority of interviewees had been tested for HIV due to six monthly employment health checks
- Alcohol was consumed at least once a week by the majority of participants, with four drinks the median number consumed on the last occasion. In the last 12 months, the most widely used drug was reported to be kava 60% (n=6), followed by marijuana 50% (n=5), freebase 20% (n=2) and cocaine 10% (n=1). Among all participants, 60% said that they had sex after taking alcohol and/or drugs in the last month, that 'left them feeling not in control'.

Female sex workers

- Sixteen women who sold sex in exchange for money or goods provided survey data and six women participated in in-depth interviews.
- In Majuro, FSW operate from bars or compounds where they rent a room. Sexual partners are predominantly seafarers who are regular clients and often viewed as boyfriends by the women. Sex with local men also occurs.
- 50% of the sixteen women reported being 'currently single' and 44% reported having a boyfriend but not married, while 6.2% were widowed, divorced or separated. The majority had children (81.2%).
- Fourteen (87.5%) of the women reported ever having had sex. The age at which they first had sex ranged from 14 to 21 years of age. The age at which the women first received money or goods in exchange for sex ranged between 19 and 30 years of age.
- In the last 12 months, the women had a mean of 6.5 male sex partners. Due to the low numbers, it is likely that each of the women had mostly regular paying partners.
- When asked how many paying partners they had on the last day that they were paid for sex, 87.5% reported two or more paying partners, while 19% reported 10 or more.
- 75% of participants reported that they always used a condom in the past 12 months with a paying partner. 44% of women reported not ever using a condom, as the partner paid more money for sex without a condom.
- 12.5% of the participants reported having sex with casual non-paying male partners in the preceding 12 months.

- All 16 women (100%) reported knowing where they could obtain condoms. When asked where they had previously obtained condoms, 31.3% indicated that they had obtained condoms from the health clinic, 25% from the hospital, 18.8% from a condom dispenser at a bar/nightclub/restaurant and 12.5% from a hotel front desk.
- 37.5% of the women reported having STI symptoms in the preceding 12 months. 31% reported ever having been diagnosed with an STI.
- HIV knowledge was reasonably high, but the majority of women answered the question 'can a person reduce the risk of HIV by using a condom every time they have sex' incorrectly.
- Participants were asked whether they had been raped or forced to have sex in the preceding 12 months, and 19% (n=3) said that they had been sexually assaulted in that period.
- 80% of the FSW participants knew where to access health-related information, but the majority reported that they did not know where to access support services, HIV and STI testing or treatment services, or services that provide condoms. When asked if they had used a sexual health service in the previous 12 months, 19% had not used a sexual and reproductive health service in the past 12 months, and 19% had. 62.5% said that this question was not applicable to them.
- 78.6% of the participants had an HIV test in the past 12 months, and all were tested at the hospital/government health service. Two of the 16 women reported that they were HIV positive and were taking antiretroviral treatment.

Capacity assessment

- There are three organisations working in HIV in RMI: The Ministry of Health (MoH) under the HIV and STD Program; Women United Together Marshall Islands (WUTMI); and Youth to Youth in Health (YTYIH).
- No organisation provides programs specifically targeted to the needs of MSM/TG or FSW. Some MSM/TG and FSW are reached through programs aimed at the general population.
- The MoH National HIV/STD Program is responsible for HIV and STI clinical services and prevention for the general population. The work of the program is guided by the HIV and STIs National Strategic Plan 2013–2017. The program currently has six staff members, including a program manager, one midwife and four nurses. The HIV/STD Program is also responsible for national data collection and reporting. It does not collect data on key populations, with the exception of seven people living with HIV/AIDS (PLHIV) who are currently on treatment.
- The National Advisory Committee on STDs, HIV & TB (NAC) co-ordinates HIV prevention activities, with WUTMI providing secretariat support. The NAC experiences some challenges with meeting regularly.
- Condoms are distributed by the MoH through health clinics. Condom distribution is also carried out by YTYIH as part of its peer-based outreach activities.

- **Overarching strengths** include being guided by the HIV and STIs National Strategic Plan 2013–2017. Activities are coordinated among the three key HIV prevention organisations and other stakeholders. Partnerships between the MoH, WUTMI, YTYIH and other relevant organisations are long-standing.
- **Overarching capacity needs** include greater and specific engagement of key populations in service delivery; staff refresher training and mentoring on HIV and STI clinical management; and technical support to assist with capacity building, particularly monitoring and evaluation.

1 Introduction

This research was carried out as a response to the need for greatly increased, contextualised information about the vulnerability to HIV of MSM/TG and sex workers and seafarers in many Pacific countries. The study provides:

1. 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. Quantitative and qualitative data to inform relevant interventions aimed at reducing the HIV and STI risk vulnerability of key populations.
3. Specific evidence of barriers to prevention, in order to improve the effectiveness of prevention interventions and to 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, MSM/TG 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, and so on) 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 through in-depth interviews the social and structural determinants influencing these risk factors, including stigma, human rights violation, all forms of violence, discrimination, and 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.

2 Marshall Islands

The Marshall Islands – officially the Republic of the Marshall Islands – is a small Micronesian nation located near the equator in the Pacific Ocean. In 2011, the population was 53,158. Over 73% live in urbanised areas on Majuro atoll (70.9%) and Kwajalein atoll (29.1%), where there is significant overcrowding. The remainder of the population is scattered over atolls and coral islands where infrastructure and services are limited. The capital is Majuro, located on Majuro atoll (Economic Policy Planning and Statistics Office RMI & SPC, 2012).

The Marshall Islands is self-governing in free association with the United States. The country has few natural resources and relies on its service economy and some fishing and agriculture for income. Agricultural production is primarily subsistence. The economy is largely reliant on US development assistance and other external aid (Australian Government AusAID, 2011).

HIV prevalence in the Marshall Islands has remained low since the first person was diagnosed in 1984. As of 2015, there were a total of 28 cumulative cases, two of which were reported in 2011 and 2013 (with TB co-infection) and two in 2014 (not with TB co-infection). Approximately half of the total cumulative number have since died, and a few have left the country, leaving eight people living with HIV in the Marshall Islands (three are male and five are female). All except one is receiving antiretroviral treatment (ART), and all live in Majuro (RMI Ministry of Health & NAC, 2016).

The dominant mode of transmission is heterosexual (23 of the 28 cases), followed by three cases of mother-to-child transmission. Those identified as most at risk by the Ministry of Health (MoH) are sex workers, MSM, prisoners, taxi drivers, seafarers and travellers. Youth are also identified as vulnerable due to risky sexual behaviours and high rates of injecting drug use compared with other Pacific Island countries (RMI Ministry of Health & NAC, 2016).

Although HIV prevalence is low, sexually transmitted infections (STIs) are common in the Marshall Islands. In the most recent survey, conducted in 2007, 10% of women and 3% of men reported that they had an STI or symptoms of an STI in the 12 months preceding the survey (Economic Policy Planning and Statistics Office (EPPSO), SPC, & Macro International Inc, 2007). Surveillance surveys have found that the prevalence of chlamydia in women attending antenatal clinics increased from 9.5% (1999) to 9.2% (2001) to 25.1% (2006). Detected syphilis rates in antenatal women have increased from 2.2% (1999) to 7.1% (2001) to 13% (2006) (Marshall Islands SGS Management Team, 2006).

The national response to HIV and STI is guided by the HIV and STIs National Strategic Plan 2013–2017, which was developed by the MoH and the National Advisory Committee (NAC). Membership of the NAC is made up of representative from MoH, state local agencies, NGOs and community representatives. The NAC is responsible for identifying needs and priorities and developing the national HIV, STI and TB plans.

2.1 Men who have sex with men and transgender

The Marshall Islands decriminalised consensual male-to-male sex in 2005, but there are no laws that prohibit discrimination against a person based on their sexual orientation or gender identity (Godwin, 2010; Kaleidoscope Australia Human Rights Foundation, 2014).

In Marshallese, the word *jera* ('best friends') refers to any close relationship between people of the same sex, although it does not necessarily imply romantic love or sexual intimacy. Such close relationships – or 'male bonding' – is valued by Marshallese, whereas MSM are a hidden and stigmatised community. There is no word in Marshallese that describes sexual preference, such as 'gay', 'homosexual' or 'lesbian'. Men who identify themselves using the Western term 'gay' do not fit into a Marshallese social category and their status is therefore ambiguous (Dvorak, 2014; Schwartz, 2015). Dvorak (2014) notes that same-sex relationships are often not subject to social disapproval as long as intimacy is not openly expressed or discussed. In other research, male-to-male sex in the Marshall Islands is described as culturally unacceptable and subject to a culture of silence (Schwartz, 2015).

The term *kakōļ* refers to men who 'assume women's roles' and carry their bodies in feminine ways or wear women' s clothing (Dvorak, 2014). Male friendships and intimate encounters with *kakōļ* are said to be perceived as relations with women rather than men. Although TG people are reportedly more accepted than MSM, US conservative evangelic values may have influenced views of homosexuality and non-normative expression of gender (Dvorak, 2014). Increasingly, less distinction is made between sexuality and gender and, as a consequence, both TG and MSM may be facing increasing social stigmatisation.

At present, there is no data available representing the sexual behaviours or STI trends of either MSM or TG populations in the Marshall Islands. A youth survey in 2006 indicated that 4.3% (n=6) of male youth surveyed (n=388) reported ever having sex with a man (Hills L, Zachraias Z, & Heine W, 2006). Of the 26 total cases of HIV identified in the Marshall Islands, none have been identified in MSM or TG persons (RMI Ministry of Health & NAC, 2014).

2.2 Female sex workers

Sex workers are a particularly hidden population in the Marshall Islands, largely owing to the illegality of such work and the harsh penalties enforced. The actions of both clients and sex workers are criminalised, and there is a fine of US$5000 or imprisonment of up to two years, or both, if caught (Dalla, 2011). The Marshall Islands also criminalises the aiding and abetting of prostitution and the operation of organised premises. Any person who promotes sex work faces a US$10,000 fine or five years' imprisonment, or both (Jivan & Forster, 2007). There is currently no data available on the sexual health of sex workers in the Marshall Islands, but the National Strategic Plan has identified sex workers as a key group at risk of HIV (RMI Ministry of Health & NAC, 2016).

Literature on sex work in the Marshall Islands mainly revolves around human trafficking. The US Department of State published a report in 2013 naming RMI as both a source and a destination country for the trafficking of RMI and East Asian women and girls for sex work. Girls from RMI are said to be recruited by foreign business owners to engage in sex work with crew members of foreign fishing and trans-shipping vessels that dock in Majuro. Foreign women are forced into sex work in establishments frequented by crew members of Chinese and other foreign fishing vessels. Chinese women are often recruited with the promise of legitimate work, but are forced into sex work on arrival (US Department of State, 2014). The Marshall Islands government has dismissed this report as 'totally baseless' (ABC Radio Australia, 2013).

At present, there is a program running entitled Youth to Youth in Health (YTYIH), which is funded by the Secretariat of the Pacific Community (SPC) and run in Majuro and Ebeye (RMI Ministry of Health and NAC, 2014). It provides clinic services and runs multiple education and awareness programs aimed at reaching people from taxi drivers to sex workers. It also provides condoms at the clinic and distributes them in nightclubs, bars and hotels. YTYIH reports have shown interactions with approximately 50 sex workers over a three-month period (RMI Ministry of Health and NAC, 2014). There is little other data available on sex workers in RMI.

3 Methodology

The research in the Marshall Islands attempted a variety of methods of a cross-sectional (snapshot) design. Ethical approval for the project was obtained from the UNSW Human Research Ethics Committee. Written approval was also gained from the Interim Secretary of Health, Ministry of Health, RMI.

Fieldwork was undertaken between 3 and 20 May 2016.

3.1 Population size estimation

Key informants and members of key affected populations (FSW and MSM/TG) were asked to provide an estimation of the number of the MSM/TG and FSW populations in RMI. This provided a basis for the later population size estimation exercise undertaken during the roundtable meeting with stakeholders.

A roundtable stakeholder meeting was carried out with a range of organisations to estimate the size of the MSM and FSW populations in the Marshall Islands. The organisations that were present were:

- The Ministry of Health
- The Department of Immigration
- The Police Domestic Violence Prevention Unit
- Women United Together Marshall Islands (WUTMI)
- Youth to Youth in Health (YTYIH).

Apologies were sent by:

- The International Organization for Migration's Human Trafficking Program
- The Ministry of Health HIV/STI Program.

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

3.2 Behavioural survey and interviews

A behavioural survey captured quantitative information from MSM and TG about sexual behaviour, mobility, drugs and alcohol, STIs, and stigma and discrimination, as well as access to and assessment of services. In-depth interviews were conducted with members of key populations, collecting qualitatively rich data that described the circumstances and experiences of key populations over a range of issues. Four local research assistants (RAs) and one recruiter were hired and trained to help in the collection of interview and survey data.

3.2.1 Men who have sex with men and transgender

MSM/TG participants were recruited through the RAs, two of whom were members of the TG/MSM community and were able to promote the study through their own networks. Most of the MSM/TG participants were recruited through these well-known MSM/TG community members, one of whom was connected to the regional Pacific Sexual Diversity Network. MSM and TG were approached by the RAs in their workplaces, homes or other community venues.

Potential participants were provided with background information about the study and then invited to complete the survey or be interviewed. If the initial contact was not face-to-face, they arranged a time and place to meet to complete the survey or interview. The RAs asked to be referred to other potential MSM and TG participants and were able to expand the number of MSM/TG reached through a snowball sampling technique. A barbeque gathering was undertaken with this group, but had a smaller turnout than anticipated – possibly due to participants being reluctant to be seen in a group together.

Two MSM/TG took part in an interview and one in both an interview and the survey. Surveys were undertaken in a private area at the barbeque venue and in participants' homes, and two were undertaken at the home of one of the RAs at a pre-arranged time. Interviews were undertaken in the privacy of the Team Leader's hotel. RAs negotiated the settings with individual respondents based on where they felt most comfortable.

3.2.2 Female sex workers

FSW study participants were initially recruited through an individual who had connections to a network of young women doing sex work. Through this contact, a group of young Marshallese FSW from one compound area was invited to attend a BBQ gathering at an outside venue. Attendees were provided with background information about the study and then invited to complete the survey or be interviewed. Based on information gained from these initial respondents, the RAs visited communities where they were told women were undertaking sexual exchange, as well as venues where sex work occurs, to recruit further study participants. Interviews were held in the participants' preferred location, either at the Team Leader's hotel, or in the participants' homes or workplaces. Some interviews or surveys were undertaken at the barbeque venue for those who preferred to take part in the study away from their own communities. The interviews were all carried out by the RAs in Marshallese as the FSWs' English was limited for the majority of respondents. It was also felt that the Team Leader's presence in workplaces or living compounds would attract too much attention.

The FSW were very difficult to recruit due to significant privacy concerns and trust issues among the population. The interviewees were all Marshallese women who lived in urban Majuro or in a village on Majuro atoll. The Marshallese sex workers reported that there were also Chinese FSW in urban Majuro. Attempts were made to engage with Chinese managers

of hotels and stores at known sex work venues to recruit Chinese FSW to the study, as well as Marshallese FSW. Although managers were willing to allow the team contact with Marshallese residents/staff, they were unwilling to allow access to any who were Chinese. Access was also difficult because the research team did not speak the relevant Chinese language. A recent focus over the past 18 months on human trafficking within RMI, with one female Chinese business owner charged and incarcerated, may explain their reluctance. Information about Chinese FSW was therefore gathered solely through Marshallese FSW respondents and through key informant interviews.

Of the FSW, three participants completed both a survey and an interview and three completed an in-depth interview only.

3.3 Institutional capacity assessment

There is very limited data on health service utilisation by MSM and TG and by FSW. Due to the legislative environment and the social and cultural context, FSW and MSM/TG will not willingly self-identify to health services in the Marshall Islands. There are no specific HIV interventions or outreach programs targeting either MSM/TG or sex workers in RMI, although there is anecdotal evidence that some FSW attend the 'After Dark' (out of hours) clinic at Youth to Youth in Health (YTYIH). The RMI Ministry of Health and YTYIH and Women United Together Marshall Islands (WUTMI) are the identified agencies providing HIV and STI-related services and/or support.

4 Results

4.1 Population size estimation

Key informants from five RMI agencies were asked to estimate the MSM/TG and FSW populations. These key informants estimated up to 100 Marshallese FSW and up to 30 Chinese FSW on Majuro atoll. They estimated more than 50 MSM/TG.

Key affected populations were also asked to estimate their numbers. Although estimations ranged from 100 to 1000, there was general consensus by MSM/TG participants that there are approximately 100 TG/MSM on Majuro atoll and 100 on Ebeye atoll. FSW were unable to estimate their number, and a typical response was “too many to count”.

At the completion of the data collection for this study, a stakeholder meeting was held with the representatives from five agencies (Ministry of Health, Department of Immigration, WUTMI, YTYIH and the police). At this meeting, the key informant and affected population estimates were presented to the stakeholders for discussion. The group considered the numbers of FSW and MSM/TG in the Marshall Islands and came to an agreement that there are at least 200–250 FSW and 100–150 MSM/TG. Most of the stakeholders felt that the MSM/TG population were likely concentrated on Majuro, however, are present across the islands, whereas the FSW population would mostly represent the two atolls of Majuro and Ebeye. All attendees felt that the FSW numbers for the outer islands would be very small or negligible. Chinese FSW were present on Majuro only.

Table 1: Population size estimation

Informants	Location	MSM/TG	Sex workers
Key informants from MoH, Department of Immigration, WUTMI, YTYIH and Police	Majuro and Ebeye atolls		N=200–250
Key informants from MoH, Department of Immigration, WUTMI, YITIH and Police	All Islands, but concentrated in Majuro	N=100–150	

4.2 Behavioural survey

4.2.1 Transgender and men who have sex with men

4.2.1.1 Description of the sample

Ten self-identifying TG and MSM provided survey data. With regard to their gender, three participants described themselves as men, four as transgender, two as transsexual and one as a woman. Participants were also asked to describe their sexual identity (Table 2). The majority of participants described their sexual identity as gay/homosexual or as bisexual. No participants described their sexual identity as heterosexual/straight.

Table 2: Sexual identity

	Frequency	Percent (%)
Gay/Homosexual	6	60.0
Bisexual	3	30.0
Queer	1	10.0
Heterosexual/Straight	0	–
MSM	0	–
Pansexual	0	–
Total	**10**	**100.0**

The age of participants ranged from 19 to 52, with a mean age of 29.2 (SD=9.3) and a median age of 27. The majority of participants had been educated to a secondary level or higher (Table 3).

Table 3: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	0	–
Pre-primary/Primary	3	30.0
Pre-secondary	0	–
Secondary	1	10.0
Polytechnic/Diploma	3	30.0
University/College	0	–
Other (community college, junior college, don't know)	3	30.0
Total	**10**	**100.0**

In responding to the question about relationship status, a majority of participants reported being single. Of note, no participant reported having a boyfriend (Table 4).

Table 4: Relationship status

	Frequency	Percent (%)
Currently single	9	90.0
Have a girlfriend	1	10.0
Have a boyfriend	0	–
Currently married	0	–
Total	**10**	**100.0**

The majority of participants reported living with family members, mostly with parents or siblings (Table 5).

Table 5: Whom participants were living with (n=10)*

	Frequency	Percent (%)
Parents	6	60.0
Siblings	4	40.0
Other relatives	2	20.0

* Multiple answers possible.

A majority were not employed. Those who were employed were in full-time work (Table 6).

Table 6: Employment status

	Frequency	Percent (%)
Not employed	6	60.0
Full-time employed	4	40.0
Self-employed	0	–
Part-time or casual employment	0	–
Total	**10**	**100.0**

When asked to indicate their main job, the four people who were employed indicated different types of work (Table 7).

Table 7: Type of work

	Frequency	Percent (%)
Financial and business services	1	25.0
Professional	1	25.0
Other (included graphic designer, practical nurse)	2	50.0
Total	**4**	**100.0**

4.2.1.2 Sexual history and practice

All 10 participants (100.0%) indicated they had ever had sexual intercourse (anal or vaginal). They reported their first occasion of sexual intercourse occurring between the ages of 11 and 24, with a mean age of sexual debut being 17.80 (SD=4.16). Two participants reported being in more than one sexual relationship concurrently in the previous six months.

4.2.1.2.1 Sex with male partners

Participants were asked to report on the types of sexual activity they had engaged in during the last occasion they had sex with a male partner (Table 8). The most common type of sexual activity that occurred on the last occasion was receptive anal intercourse, followed by receptive oral sex. It is worth noting that none of the participants indicated insertive anal intercourse on the last occasion of sex, 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 8: Types of sexual activity on last occasion of sex with a male partner (n=10)*

	Frequency	Percent (%)
Handshake (you masturbated him)	1	10.0
Handshake (he masturbated you)	0	–
Oral sex (you sucked his penis)	3	30.0
Oral sex (he sucked your penis)	2	20.0
Intercrural sex (his penis between your thighs)	0	–
Intercrural sex (your penis between his thighs)	0	–
Anal intercourse (your penis inside his anus)	0	–
Anal intercourse (his penis inside your anus)	5	50.0

* Multiple answers possible.

4.2.1.2.1.1 Types and numbers of male partners

Participants were asked how many male sex partners they had in their lifetime and in the last 12 months. The most commonly reported numbers of male sex partners in the 12 months prior to the survey were one to three partners, or between four and 10 partners (Table 9). A majority of participants reported having had four or more male partners in their lifetime.

Table 9: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
0	0	0
1 to 3	1 (12.5)	3 (37.5)
4 to 10	3 (37.5)	3 (37.5)
11 to 49	3 (37.5)	2 (25.0)
50+	1 (12.5)	0
Total	**8 (100)[1]**	**8 (100.0)[1]**

[1] Missing data n=2.

All participants were asked how many of their male sex partners with whom they had anal intercourse in the preceding 12 months were regular partners, casual partners and paying partners (Table 10). Ninety per cent of participants reported having had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. Eighty per cent of participants had sex with at least one casual male partner during the previous 12 months, while about 20% had at least one paying partner during that period.

Table 10: 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	1 (10.0)	2 (20.0)	7 (77.8)
1 to 3	5 (50.0)	7 (70.0)	2 (22.2)
4 +	4 (40.0)	1 (10.0)	–
Total	**10 (100.0)**	**10 (100.0)**	**9 (100.0)[1]**

[1] Missing data n=1.

4.2.1.2.1.2 Condom and lubrication use for anal intercourse with male partners

Condom use with the three different types of male partners in the last 12 months is shown in Table 11. Condom use with regular partners was understandably low, with over 50% of participants reporting that they never used condoms for anal intercourse with a regular male partner. Condom use with casual partners was also low, with five of the eight participants who had anal intercourse with a casual male partner reporting never using a condom with such partners, while the remaining three participants reported using condoms 'sometimes'. Only one of the two participants who had sex with a paying male partner in the preceding 12 months responded to this question and indicated 'sometimes' using condoms with paying male partners.

Table 11: 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	5 (55.6)	5 (62.5)	–
Sometimes	3 (33.3)	3 (37.5)	1
Almost every time	–	–	–
Every time	1 (11.1)	–	–
Total	**9 (100.0)**	**8 (100.0)**	**1 (100.0)[1]**

[1] Missing data n=1.

Reported condom use on the last occasion of anal intercourse with each of the partner types in Table 10 was, remarkably, at lower levels than for the 12-month period, which is atypical but may simply be an artefact of having a small sample size. Only one participant indicated condom use with regular partners on the last occasion of anal intercourse, while no participants used condoms on the last occasion with casual partners or paying partners.

The use of lubrication, on the other hand, appeared to be at higher levels than condom use. Four of the nine participants who had anal intercourse with a regular male partner reported having used lubricant on the last occasion, while three of the eight participants who had anal intercourse with casual male partners used lubricant on the last occasion, and one of the two participants used lubricant with the last male paying partner.

All participants were asked whether they used lubricant the last time they used a condom, to which three of the nine (33.3%) who answered the question did so in the affirmative. When asked which type of lubricant they used on that occasion, only four responded to the question, each providing a different response: water-based lubricant (n=1), Vaseline (n=1), baby oil (n=1) and coconut oil (n=1). Three participants provided data on where they had obtained lubricant on that last occasion: health clinic (n=1), hospital (n=1) and home (n=1).

4.2.1.2.2 Sex with female partners

Four (44.4%) of the nine participants who answered the question about ever having had sexual intercourse (vaginal or anal) with a female partner reported that they had. These participants reported having had sex with between two and 20 female partners in their lifetime. Three of these four participants reported having sex with a female partner during the 12 months preceding the survey. Two of the three participants each had one regular female partner in the previous 12 months, and two participants had sex with one casual female partner in that period (Table 12).

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

Number of female partners	Regular partner n (%)	Casual partner n (%)
0	1	1
1 to 3	2	2
4 to 10	0	0
Total	**3 (100)**	**3 (100.0)**

Of the two participants who had sex with a regular female partner in the 12 months preceding the survey, one reported using a condom 'sometimes' for vaginal intercourse with their regular female partner(s) during that time, while the other participant indicated 'never' using a condom. Neither of these participants reported using a condom on the last occasion of vaginal intercourse with their regular female partner. One of these two participants reported having anal intercourse with their regular female partner, and that person 'never' used condoms for anal intercourse with that partner. Only one of the two participants who had sex with a casual female partner had vaginal intercourse, and that person 'never' used a condom with a casual female partner. The participant who reported having had anal intercourse with a casual female partner in the preceding 12 months also never used condoms.

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

All 10 participants (100.0%) reported knowing what a condom was prior to the survey. Among them, nine participants knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them A large majority had last obtained condoms from the hospital (Table 13).

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

	Frequency	Percent (%)
Never obtained condoms	2	20.0
Hospital	7	70.0
Peer educator/Outreach worker	1	10.0
Total	**10**	**(100.0)**

The most commonly reported reasons for not using condoms were similar for sex with male and female partners. These reasons included condoms taking away pleasure, not liking condoms, condoms not being available, and objections from partner (Table 14).

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

	Male partners n=10 (%)	Female partners n=9 (%)
Condoms take away pleasure	4	3
Do not like condoms	3	3
Condoms were not available	2	2
Difficulty obtaining condoms	0	0
My partner(s) and I are faithful	0	0
Partner objected	2	2
Not necessary	1	1
Condoms are too expensive	0	0
Used other prevention methods	1	1
Other (because I like him; no; were not available)	3	–
Other (don't use condoms with women because I don't like women; no)	–	2

* Multiple answers possible.

4.2.1.3 Sexually transmissible infections, including HIV

Eight of the 10 participants had ever heard of diseases that can be transmitted sexually. Three of these eight participants reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months. Two of these participants reported having had genital discharge in the 12 months preceding the survey, two reported genital ulcers or sores, and two reported ever having pain while urinating. The three participants were asked what they did the last time they had any of these symptoms (Table 15). The most common responses were talking to a friend and visiting a hospital. Three participants reported having ever been diagnosed with an STI, including gonorrhoea (n=2) and syphilis (n=1), and one person reported 'cancer'.

Table 15: What participants did the last time they had STI symptoms (n=3)*

	Frequency	Percent (%)
Talked to a friend	2	66.6
Visited a hospital	2	66.6
Received traditional treatment	1	33.3
Visited a private clinic	0	–
Visited an STI clinic	0	–
Did nothing	0	–
Visited a healthcare worker	0	–
Got medicine from pharmacy	0	–

* Multiple answers possible.

Nine of the 10 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 school, workplace, friends or family, and newspapers or magazines (Table 16).

Table 16: Sources of information about HIV and AIDS (n=9)*

	Frequency	Percent (%)
School	7	77.8
Workplace	4	44.4
Friends or family	3	33.3
Television	3	33.3
Newspapers/Magazines	3	33.3
Radio	2	22.2
Pamphlets/Leaflets	2	22.2
NGO program	2	22.2
Posters/Billboards	2	22.2

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

The nine participants who had previously heard of HIV or AIDS were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 17. Correct knowledge across the questions ranged from low (22.2%) to high (90%). One participant answered all 10 questions correctly, while the majority answered at least five of the 10 questions correctly. The lowest score recorded was a participant with only one correct answer.

Table 17: Knowledge about HIV and AIDS*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	5 (55.6)	3 (33.3)	1 (11.1)	9 (100)
Do people get HIV because of something they have done wrong?	5 (55.6)	1 (11.1)	3 (33.3)	9 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	3 (33.3)	5 (55.6)	1 (11.1)	9 (100)
Can a person get HIV by sharing food with someone who is infected?	9 (100)	0	0	8 (100)[1]
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	4 (44.4)	5 (55.6)	0	9 (100)[1]
Can a healthy-looking person have HIV?	2 (22.2)	4 (44.4)	3 (33.3)	9 (100)
Can people be cured from HIV by a traditional healer?	6 (66.7)	0	3 (33.3)	9 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1 (11.1)	6 (66.7)	2 (22.2)	9 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	4 (44.4)	3 (33.3)	2 (22.2)	9 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	4 (44.4)	2 (22.2)	3 (33.3)	9 (100)

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

4.2.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 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, with which a majority agreed (Table 18).

Table 18: Attitudes towards people living with HIV among participants (n=9)*

	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	9 (100)	0	9 (100)
If a member of your family had HIV, would you want it to remain secret?	2 (22.2)	7 (77.8)	0	9 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	3 (33.3)	6 (66.7)	0	9 (100)

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

4.2.1.5 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. No participants were aware of someone they knew being denied health services in the previous 12 months as a result of living with HIV or being suspected of living with HIV (Table 19).

Table 19: Evidence of stigma and discrimination observed in the community (n=9)*

	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?	7 (77.8)	0	2 (22.2)	9 (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?	7 (77.8)	0	2 (22.2)	9 (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?	7 (77.8)	0	2 (22.2)	9 (100)

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

Participants reported on the reactions of various people to their sexual identity (Table 20). Some participants had experienced stigmatising attitudes, particularly from employers, co-workers and people other than family who had gossiped about them. However, it is worth noting that family members were generally less likely than co-workers and other people to know about the participants' sexual identity.

Table 20: Reactions of family members and other people to participants' sexual identity*

	Reaction of family members n=10 (%)	Reaction of other people n=10 (%)	Reaction of employer or co-workers n=10 (%)
They don't know at all	5 (50.0)	3 (30.0)	3 (30.0)
They support my identity	1 (10.0)	4 (40.0)	3 (30.0)
They ignore me/refuse to talk to me	1 (10.0)	1 (10.0)	1 (10.0)
They criticised/blamed/verbally abused me	1 (10.0)	1 (10.0)	0
They conduct violence/physical abuse on me	0	0	0
They lock/restrict me	1 (10.0)	NA	NA
They kicked me out of the family/group	0	0	NA
They force me to work more	1 (10.0)	NA	NA
They gossip about me	NA	3 (30.0)	2 (20.0)
They fired me from work	NA	NA	0

* Multiple answers possible. NA=not applicable.

4.2.1.6 Emotional and physical well-being

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

Table 21: Participants' negative thoughts and feelings about their sexual identity in the last 12 months (n=10)*

	Frequency	Percent (%)
I feel ashamed	4	40.0
I have low self-esteem	3	30.0
I feel guilty	1	10.0
I blame myself	1	10.0
I feel suicidal	0	–
I feel I should be punished	0	–
I blame others	0	–

* Multiple answers possible.

Participants were asked to indicate whether they had engaged in or avoided certain events or activities because of their sexual identity (Table 22). There were generally few participants who had done or avoided doing certain events or activities. The only responses that were endorsed included deciding not to get married, and choosing not to attend a social gathering.

Table 22: Participants' actions as a result of their sexual identity in the last 12 months (n=10)*

	Frequency	Percent (%)
I decided not to get married	3	30.0
I have chosen not to attend social gathering	1	20.0
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 children	0	–
I decided not to have sex	0	–
I have isolated myself from my family and/or friends	0	–
I decided to stop working	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. Two of the 10 participants answered in the affirmative, that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, the responses included a stranger (n=2), casual partner (n=1), family member (n=1) and paying client (n=1).

4.2.1.7 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 support and health-related information, fewer knew how to access health services for HIV and STI testing and HIV and STI treatments, as well as condoms (Table 23).

Five of the 10 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: YTYIH (Youth to Youth in Health), YTYIH clinic, NGO, school, Ministry of Health.

Table 23: Knowledge about accessing health services*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Condoms	7 (70.0)	3 (30.0)	0	10 (100)
Health-related information	5 (50.0)	5 (50.0)	0	10 (100)
Support	3 (30.0)	7 (70.0)	0	10 (100)
HIV and STI testing	7 (70.0)	3 (30.0)	0	10 (100)
HIV and STI treatment	6 (60.0)	4 (40.0)	0	10 (100)

* Multiple answers possible.

For all of the services presented in Table 24, participants were more likely not to have used the service – with the exception of visiting a health service, for which 50% reported doing so in the preceding 12 months.

Table 24: Connection with HIV-related and other health services

	No n (%)	Yes n (%)	Not applicable/ Don't know n (%)	Total n (%)
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, HIV and STIs, or sexual assault?	3 (30.0)	1 (10.0)	6 (60.0)	10 (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?	5 (50.0)	5 (50.0)	–	10 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	0	2 (20.0)	8 (80.0)	10 (100)
Have you ever participated in an HIV peer education program?	7 (70.0)	3 (30.0)	–	10 (100)

The five participants who reported visiting a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault were asked for feedback on their experiences with the service (Table 25). The majority of participants who used the service were generally satisfied and would use it again. Eight participants reported that they would like to receive additional information about HIV, as well as contact details for any support services.

Table 25: Feedback about the health service (n=5)*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	0	0	5 (100.0)	0	5 (100.0)
The health worker I saw was friendly and easy to talk to	0	0	0	5 (100.0)	0	5 (100.0)
I felt uncomfortable and embarrassed	1 (20.0)	4 (80.0)	0	0	0	5 (100.0)
The service was confidential and I felt my privacy was respected	0	1 (20.0)	0	3 (60.0)	1 (20.0)	5 (100.0)
I could get what I needed, e.g. contraceptives, condoms, HIV and STI test, etc.	0	0	0	4 (80.0)	1 (20.0)	5 (100.0)
I would use the service again if I needed to	0	1 (20.0)	0	3 (60.0)	1 (20.0)	5 (100.0)

* Includes only those participants who reported using the service.

4.2.1.8 HIV testing

Nine of the 10 participants believed that it was possible for someone in their community to get a test to find out if they are infected with HIV, and all knew where to go to receive the test. Five participants reported having ever had an HIV test and three of these people had an HIV test in the 12 months prior to the survey. All three participants indicated that they had received their HIV test in the last 12 months at the government hospital health service. All five of the people who had ever had an HIV test reported receiving their HIV results and all reported that they were HIV-negative based on that result.

4.2.1.9 Alcohol and drug use

All 10 participants reported drinking alcohol in the preceding four weeks, with a majority indicating that they drank alcohol at least once a week (Table 26). Those who drank alcohol were asked how many drinks they had the last time they drank alcohol, with the number ranging from one drink to 18 drinks. Four drinks was the median number consumed on the last occasion of alcohol use.

Table 26: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	0
Never in the last 4 weeks	0
Less than once a week	1 (10.0)
At least once a week	6 (60.0)
Every day	3 (30.0)
Total	

Participants were asked whether they had taken a range of drugs during the preceding 12 months. The most widely used drug was reported to be kava (n=6), followed by marijuana (n=5), cocaine (n=1), and freebase (n=2). 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, six participants responded in the affirmative.

4.2.2 Female sex workers

4.2.2.1 Description of the sample

Sixteen women who sold sex in exchange for money or goods provided survey data. The age of the women ranged from 18 to 51, with a mean age of 30.81 (SD=10.01) and a median age of 28.5. Most of the women had been educated to a primary or secondary level (Table 27).

Table 27: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	1	6.2
Pre-primary/Primary	3	18.8
Pre-secondary/Secondary	11	68.8
Polytechnic/Diploma	1	6.2
University/College	0	–
Total	**16**	**100.0**

In responding to the question about relationship status, 50% of the women reported being 'single' while slightly less than 50% reported having a boyfriend and not being married (Table 28).

Table 28: Relationship status

	Frequency	Percent (%)
Currently single	8	50.0
Have a boyfriend but not married	7	43.8
Widowed/Divorced/Separated	1	6.2
Currently married	0	–
Have a girlfriend	0	–
Total	**16**	**100.0**

Thirteen women (81.2%) reported having children. Among these women, the majority had between one or three children. The remaining four women had between four and six children.

Women were most likely to live with relatives, including parents/in-laws, children or siblings. Fewer lived with friends, a husband or a boyfriend (Table 29).

Table 29: Whom participants were living with (n=16)*

	Frequency	Percent (%)
Parents/In-laws	10	62.5
Children	10	62.5
Siblings	10	62.5
Husband	3	18.8
Friends	3	18.8
Other relatives	2	12.5
Boyfriend	1	6.2
Live alone	1	6.2
Other male partner	0	–
Co-workers	0	–

* Multiple answers possible.

Women were asked whether they were employed, to which the majority reported that they were not (Table 30). When the seven women who were employed were asked what paid work they were involved in, they all reported hospitality.

Table 30: Employment status

	Frequency	Percent (%)
Not employed	9	56.3
Full-time employed	5	31.2
Part-time or casual employment	2	12.5
Self-employed	0	–
Total	**16**	**100.0**

4.2.2.2 Sexual history and practice

Fourteen women (87.5%) reported ever having had sexual intercourse. The age at which they first had sexual intercourse ranged from 14 to 21 years of age. The age at which they first received money or goods in exchange for sex ranged from 19 to 30 years of age, which indicates that all women were adults at the time they commenced sex work.

4.2.2.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses ranged from four to 36 male partners with a median of 17 partners and a mean of 18 partners. This is an unexpectedly low number for sex workers and it may be the case that many of the women do not consider male clients as sex partners. The number of male sex partners reported in the last 12 months ranged from two to 25, with a median of 4.5 and a mean of 6.5 partners. Only one woman reported having sexual partners concurrently (that is, more than one sexual partner during the same period) in the previous six months.

4.2.2.2.2 Condoms

Fifteen women answered the question about knowing what a condom is and all responded that they did. All 16 women who participated in the survey reported knowing where they could obtain condoms. When asked where they had last obtained condoms, the most common responses included health clinic, hospital, condom dispenser and hotel front desk (Table 31). Despite 15 of the 16 women having obtained condoms in the past, only 12 women reported ever using a condom.

Table 31: Where condoms were last obtained

	Frequency	Percent (%)
Health clinic	5	31.3
Hospital	4	25.0
Condom dispenser (bar/nightclub/restaurant/other venue)	3	18.8
Other (hotel front desk)	2	12.5
Friend	1	6.2
Never obtained condoms	1	6.2
NGO	0	–
Client	0	–
Pharmacy	0	–
Total	**16**	**100.0**

4.2.2.2.3 Sex with paying male partners

When asked how many paying partners they had in the 12 months preceding the survey, answers ranged from one to 250 partners with a mean of 39.13 (SD=70.2) and a median of five paying partners. Since these figures are considerably higher than the numbers reported for sexual partners in the preceding 12 months, it can be concluded that some of the women answered the earlier question without including their paying partners. Also, given that only five women reported having had 10 or more paying partners in that period, it is likely that some women underreported the actual number of paying partners they had sex with. Indeed, when asked how many paying partners they had on the last day that they had paid sex, 14 (87.5%) of the 16 women reported two or more paying partners, while three women reported 10 or more partners and one woman reported 35 paying partners – the latter appearing to be on the high side of plausibility.

4.2.2.2.3.1 Types of sexual practices with paying male partners

Women were asked what types of sexual contact they had with paying partners during the preceding 12 months (Table 32). The most common practice was vaginal intercourse, followed by masturbating the client and cunnilingus.

Table 32: Types of sexual activity on last occasion of sex with a paying male partner (n=15)*

	Frequency	Percent (%)
Vaginal intercourse	12	80.0
Handshake (you masturbated him)	5	33.3
Oral sex (he licked your vagina)	4	26.7
Handshake (he masturbated you)	3	20.0
Oral sex (you sucked his penis)	2	13.3
His penis between your thighs or breasts	1	6.7
Anal intercourse	1	6.7

* Multiple answers possible. Missing data n=1.

4.2.2.2.3.2 Where sex with paying male partners takes place

Women were asked where they had sex with their last paying client (Table 33). The most common response was at a hotel. Based on this response – as well as responses to the question of where women obtain condoms, as reported above (that is, hotel front desk) – it is apparent that hotels are a key site for sex work.

Table 33: Where sex occurred on the last occasion of paid sex (n=16)

	Frequency	Percent (%)
Hotel	13	81.3
My house	1	6.2
Other (Aunty's house, hotel, my house)	2	12.5

4.2.2.2.3.3 Who decides how much money she receives?

When asked who decides how much they get paid when having sex with a client (multiple answers were possible), the majority of women indicated that it is typically decided by themselves and, to a lesser extent, by their paying partner (Table 34).

Table 34: Who decides how much the woman gets paid for sex with a client (n=16)*

	Frequency	Percent (%)
I decide	12	75.0
Paying partner decides	7	43.8
Agent/Pimp decides	0	–
Manager of the business (eg madam in brothel)	0	–

* Multiple answers possible.

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

Condom use with paying clients was relatively high for vaginal and anal intercourse (Table 35). The majority of women reported using condoms every time for vaginal intercourse with paying partners, while the sole woman who reported anal sex with clients reported 100% condom use and use of lubricant on the last occasion. Two of the three women who did not use condoms 100% of the time responded to the question about condom use on the last occasion, with one of the women reporting the use of a condom on that last occasion.

Table 35: 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	1 (8.3%)	–
Sometimes	2 (16.7%)	–
Almost every time	–	–
Every time	9 (75.0%)	1 (100.0)
Total	**12[1] (100.0)**	**1[2] (100.0)**

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

There were only three women who had not used condoms in the preceding 12 months and who reported reasons for not using condoms with paying partners. The most common responses included partner objecting, condoms taking away pleasure, and a dislike of condoms (Table 36). Seven women reported not ever using a condom because the paying partner paid extra money.

Table 36: Reasons for not using condoms for vaginal and/or anal intercourse with paying partners*

	Paying male partners n=3 (%)
Partner objected	2
Condoms take away pleasure	1
Do not like condoms	1
My partner(s) and I are faithful	0
Condoms were not available	0
Difficulty obtaining condoms	0
Used other prevention methods	0
Used other protection methods	0
Never heard of condoms	0
Not necessary	0
Condoms are too expensive	0

* 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'. Three women responded that it was difficult 'all of the time' (Table 37).

Table 37: Level of difficulty in getting clients to use a condom

	Paying male partners n= (%)
None of the time	10 (62.5)
A little of the time	0
Some of the time	2 (12.5)
A lot of the time	0
All of the time	3 (18.8)
I did not try and get my clients to use a condom	1 (6.2)
Total	**16 (100.0)**

When asked who usually supplies the condom for sex with paying partners, the majority of women reported that they do (Table 38).

Table 38: Who usually supplies the condom with paying partners?

	Paying male partners n= (%)
I provide the condom	12 (75.0)
Client provides the condom	2 (12.6)
I never use a condom	1 (6.2)
Owner/manager of the place	1 (6.2)
Total	**16 (100.0)**

4.2.2.2.4 Sex with regular male partners

Fourteen women reported having had sex with a husband or boyfriend in the previous 12 months.

4.2.2.2.4.1 Condom use with regular male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their regular male partners in the last 12 months (Table 39). Condom use was varied, as expected for sex with regular partners. Some women reported never using condoms with their regular male partners, while others used condoms every time with such partners.

Table 39: 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	6 (42.9)	3 (42.8)
Sometimes	5 (35.7)	2 (28.6)
Almost every time	0	
Every time	3 (21.4)	2 (28.6)
Total	**14 (100.0)**	**7 (100.0)**

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

Among the five women who had sometimes used a condom for vaginal intercourse with their regular partner(s), two of them used a condom on the last occasion with these partners. Among the two women who had sometimes used a condom for anal intercourse, both 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, four of the seven women reported that they had used lubricant.

Women were asked for their reasons for not using condoms with regular male partners. The most common responses included perceived faithfulness in the relationship, not liking condoms, condoms taking away pleasure, and partner objecting (Table 40).

Table 40: Reasons for not using condoms for vaginal and/or anal intercourse with regular male partners*

	Regular male partners n=10[1] (%)
My partner(s) and I are faithful	6 (60.0)
Do not like condoms	5 (50.0)
Condoms take away pleasure	4 (40.0)
Partner objected	2 (20.0)
Condoms were not available	1 (10.0)
Not necessary	1 (10.0)
Difficulty obtaining condoms	1 (10.0)
Used other protection methods	0
Used other prevention methods	0
Never heard of condoms	0
Condoms are too expensive	0

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

4.2.2.2.5 Sex with casual male partners

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

4.2.2.2.5.1 Condom use with casual non-paying male partners

Participants were asked how often they had used condoms for vaginal and anal intercourse with their casual male partners in the last 12 months (Table 41). Of the two women who had sex with casual male partners, one had used a condom on every occasion of vaginal intercourse while another reported never using a condom with casual male partners. The only woman to report having had anal intercourse with a casual male partner reported sometimes using a condom in the previous 12 months, and using a condom as well as lubricant on the last occasion of anal intercourse with a casual male partner.

Table 41: 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	1	0
Sometimes	0	1
Almost every time	0	0
Every time	1	0
Total	**2 (100.0)[1]**	**1 (100.0)[2]**

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

The only women who had sex with casual male partner(s) in the preceding 12 months and did not use condoms on every occasion reported that the reason for not always using condoms was that she did not like condoms.

4.2.2.3 Alcohol and drug use

Nine of the 16 (56.2%) women reported drinking alcohol in the preceding four weeks (Table 42). 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, there was quite high consumption. A majority of women reported six drinks or more. Four women reported drinking 24 or 25 drinks on that last occasion, which seems implausible unless drinks were highly diluted with water or soft drink.

Table 42: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	4 (25.0)
Never in the last 4 weeks	3 (18.8)
Less than once a week	2 (12.5)
At least once a week	2 (12.5)
Every day	5 (31.3)
Total	**16 (100.0)**

Participants were asked whether they had taken a range of drugs during the preceding 12 months (Table 43). The most widely used drugs included marijuana and kava. Aside from one woman reporting the use of heroin, no participants reported using any other recreational or illicit drug in the preceding 12 months. 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, four women responded in the affirmative.

Table 43: Use of recreational and illicit drugs in the past 12 months*

	n=16 (%)
Marijuana	8 (50.0)
Kava (sakau/ava/awa)	5 (31.3)
Heroin	1 (6.2)
Freebase	0
Cocaine	0
Inhalants (eg sniffing glue, paint, petrol, spray can)	0
Amphetamine (speed)	0
Crystal/Ice (methamphetamine)	0
Ecstasy/MDMA	0
Other	0

* Multiple answers possible.

4.2.2.4 Sexually transmissible infections, including HIV

Fifteen of the 16 women reported ever having heard of diseases that can be transmitted sexually, among whom six reported having had symptoms of a sexually transmissible infection (STI) in the past 12 months. Six women reported genital discharge in the 12 months preceding the survey, five of whom reported genital ulcers or sores and five of whom reported ever having had pain while urinating. These six women were asked what they did the last time they had any of these symptoms (Table 44). The women generally visited a hospital or received traditional treatment the last time they had STI symptoms.

Table 44: What participants did the last time they had STI symptoms (n=6)*

	Frequency	Percent (%)
Visited a hospital	4	66.7
Received traditional treatment	2	33.3
Never noticed any of these symptoms	1	16.7
Visited an STI clinic	0	–
Did nothing	0	–
Talked to a friend	0	–
Visited a private clinic	0	–
Got medicine from pharmacy	0	–
Visited a healthcare worker	0	–

* Multiple answers possible.

Five women reported ever having been diagnosed with a sexually transmissible infection (STI), which included syphilis (n=4) only. One of the women did not identify an STI that she had been diagnosed with and perhaps she was unsure of which STI it was.

Fifteen women (93.8%) 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 sources being radio, friends or family, school, newspapers and magazines, television and the workplace (Table 45). None of the women reported knowing someone who was infected with HIV.

Table 45: Sources of information about HIV and AIDS (n=15)*

	Frequency	Percent (%)
Radio	10	66.7
Friends or family	9	60.0
School	9	60.0
Newspapers/Magazines	8	53.3
Television	6	40.0
Workplace	6	40.0
Posters/Billboards	2	13.3
Pamphlets/Leaflets	1	6.7
NGO program	1	6.7

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

4.2.2.5 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 27. Correct knowledge was reasonably high; however, there are some concerning signs. For example, the question about reducing risk of HIV by using condoms was answered incorrectly by a majority. Also, none of the women answered all 10 questions correctly and 69% of the women answered five or fewer questions correctly. There is clearly scope for improved knowledge.

Table 46: Knowledge about HIV and AIDS (n=15)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	11 (73.3)	4 (26.7)	0	15 (100)
Do people get HIV because of something they have done wrong?	15 (100.0)	–	0	15 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	11 (73.3)	4 (26.7)	0	15 (100)
Can a person get HIV by sharing food with someone who is infected?	10 (66.7)	5 (31.3)	0	15 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	8 (53.3)	7 (46.7)	0	15 (100)
Can a healthy-looking person have HIV?	5 (33.3)	10 (66.7)	0	15 (100)
Can people be cured from HIV by a traditional healer?	13 (86.8)	2 (13.3)	0	15 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	0	15 (100.0)	0	15 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	0	15 (100.0)	0	15 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	1 (6.7)	14 (93.3)	0	15 (100)

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

4.2.2.6 Stigmatising attitudes towards people living with HIV

A majority of the women had non-stigmatising attitudes towards people living with HIV (Table 47). However, about one-third of the women indicated stigmatising attitudes based on their responses to these three questions, and a majority reported that they would want a family member's HIV infection to remain a secret.

Table 47: 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?	4 (26.7)	11 (73.3)	0	15 (100)
If a member of your family had HIV, would you want it to remain secret?	6 (40.0)	9 (60.0)	0	15 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	6 (40.0)	9 (60.0)	0	15 (100)

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

4.2.2.7 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 48). Based on their responses, there is evidence of stigma and discrimination in the community, particularly in the context of knowing someone who has been verbally abused or teased because he or she has HIV or is suspected of having HIV.

Table 48: 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?	14 (93.3)	1 (6.7)	0	15 (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?	11 (73.3)	4 (26.7)	0	15 (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?	3 (20.0)	12 (80.0)	0	15 (100)

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

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Three 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 casual partner (n=1) or stranger (n=1). One woman chose not to report who had sexually assaulted her.

4.2.2.8 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 49). Aside from knowing where to access health-related information, which 80% of women knew about, an overwhelming majority of women did not know where to access support services, 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 49: Knowledge about accessing health services

	No n (%)	Yes n (%)	Refuse to answer n (%)	Total n (%)
Support	15 (100.0)	0	0	15 (100)
Health-related information	3 (20.0)	12 (80.0)	0	15 (100)
HIV and STI testing	14 (93.3)	1 (6.7)	0	15 (100)
HIV and STI treatment	14 (93.3)	1 (6.7)	0	15 (100)
Condoms	14 (93.3)	1 (6.7)	0	15 (100)

Twelve women (75%) 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, one name was mentioned by all: Youth to Youth in Health (YTYIH). Women United Together Marshall Islands (WUTMI) was also mentioned.

A minority of women reported using each of the services in Table 50, with the exception of having been contacted by a volunteer or outreach worker, for which 50% reported using. Many of the women reported that these services were not applicable to them.

Table 50: 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?	6 (37.5)	6 (37.5)	4 (25.0)	16 (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?	3 (18.8)	3 (18.8)	10 (62.5)	16 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	5 (31.3)	1 (6.3)	10 (62.5)	16 (100)
Have you ever participated in an HIV peer education program?	10 (62.5)	1 (6.3)	5 (31.3)	16 (100)

Of the three 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 fair or slightly positive. Two of the women indicated that they would use the service again (Table 51). 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 per se.

Table 51: Feedback about the health service*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	0	1	1	1	3 (100)
The health worker I saw was friendly and easy to talk to	0	0	1	2	0	3 (100)
I felt uncomfortable and embarrassed	0	1	1	1	0	3 (100)
The service was confidential and I felt my privacy was respected	0	0	1	2	0	3 (100)
I could get what I needed, e.g. contraceptives, condoms, HIV and STI test, etc.	0	0	1	2	0	3 (100)
I would use the service again if I needed to	0	0	1	1	1	3 (100)

* Includes only those women who reported using the service.

4.2.2.9 HIV testing

Fifteen women (93.8%) believed that it was possible for someone in their community to get a test to find out if they were infected with HIV and somewhat surprisingly all 16 women knew where to go to receive such a test. Fourteen women reported having had an HIV test, among whom 11 (78.6%) had an HIV test in the 12 months prior to the survey. All 11 women reported that their test was carried out through the hospital/government health service. Of the 14 women who had ever been tested for HIV, all 14 reported receiving their results. Based on these results, 12 women reported being HIV-negative while two women reported being HIV-positive. The two women who reported being HIV-positive had been diagnosed in 2010 and 2015, respectively, and both reported that they were currently taking antiretroviral treatment which they had commenced in the same year that they were diagnosed.

4.3 In-depth Interviews

4.3.1 Transgender and men who have sex with men

Three RMI men were interviewed in-depth, one of whom identified as 'bisexual' and the other two as 'gay'. Interviewees also referred to themselves or other TG as *kakkwol* ('girly-boys'). Interviewees were living at home with their extended families. Alik[2] supports his younger brothers – including one who has a disability. The other two interviewees are employed full-time; Makson contributes to the household finances and Junior is the sole earner in his household of three male cousins. One of these cousins also identifies as 'gay', with the other two identifying as 'straight'.

Although interviewees are open about their TG identity, their sexuality is kept hidden and is not discussed. Sexual behaviour tends to be casual and their sexual partners are often considered 'straight' by the interviewees. Having a long-term boyfriend is very difficult because of stigma and the need to keep relationships clandestine. Condoms are easy to access, but use is often sporadic and 'heterosexual' partners are usually resistant to using them. Interviewees have experienced sexual violence and discrimination.

Although the interviewees have regular contact with health services as part of employment health checks, they do not disclose that they are MSM/TG primarily because of concerns about the confidentiality of the local health service.

4.3.1.1 Identity

The interviewees noted that there are no local terms for MSM and described themselves as 'gay-boy'/homosexual or did not like to use labels. Makson, for example, said that he just "goes about being himself". When describing themselves or other MSM/TG, the interviewees preferred to use the term *kakkwol*, which was considered less demeaning than other local terms.

Both of the gay/*kakkwol* interviewees liked to express their feminine sides publicly: Alik has been wearing dresses since elementary (primary) school and Makson used to perform in a popular 'girl-band' in high school and college. However, both consider themselves male and do not want to be women:

> Although I identify with women, I don't want to turn into one, I'm comfortable with this [male] anatomy. [Makson, 32 years]

When Alik was a child, his father would buy him dresses or a Barbie doll for Christmas when he asked for them, but his mother was less accepting:

> My dad always treated me like a little princess … but my mum … she's the one who always treat me like a boy … She would get angry and tell my dad not to treat me as a girl because it's against the culture … [Alik, 33 years]

Although interviewees were open about their *kakkwol* identity, their sexuality and any sexual behaviour was kept clandestine. Although interviewees believed that their families were aware of their sexuality, it is never discussed and they believed that their families would not accept

[2] Participants' real names are not used in this report.

it. Makson said that he would never directly talk about his sexuality with his mother because he did not want to upset her and ruin their relationship:

> I just respect her [his mother] so much, that I don't want to ruin that relationship so I just let things be. [Makson, 32 years]

Makson said that despite his family knowing that he is MSM, they still apply pressure on him to marry (a woman):

> I'm the only male in the family and my mum tells me all the time that she wants a daughter-in-law [and grandchildren], I just ignore it. [Makson, 32 years]

Friends, siblings, co-workers and other community members were aware that they were MSM, but any relationship was kept hidden and only known by 'other *kakkwol*' or a close and trusted confidant.

Both Alik and Makson realised that they were 'gay' while they were in primary school:

> Ever since I was little, I was attracted to men. [Makson, 32 years]

Junior considers himself bisexual. As a young man, he had married a local woman and had continued to have sexual encounters with other males:

> I'm into both boys and girls – but as I'm getting older I'm getting more interested in boys. [Junior, 52 years]

4.3.1.2 Sexual behaviour

The interviewees were all single and tended to have casual sexual encounters with men, whom they referred to as "fuck buddies", "one night stands" or "friends with benefits'" Makson said that most of his fuck buddies were heterosexual and have their own girlfriends, but also went with 'men like him'. Although they do not pretend to be 'straight', interviewees' sexual behaviours/relationships were hidden:

> It's really on the down-low, it's like score and go. [Makson, 32 years]

Alik also described his casual male sexual partners as "heterosexual" and he "likes the manly ones". In contrast, Junior had girlfriends and boyfriends and was married to a woman for 15 years. During his marriage, he continued to have boyfriends (but not girlfriends). Currently, he prefers young men, whom he says come and visit him for sex. He was recently seeing a teenage boy whom he was:

> Crazy in love with and I know he liked me too – he was always questioning me about other boys, checking if I was seeing anyone else. [Junior, 52 years]

Neither Makson nor Alik are interested in having a sexual relationship with a woman. They have never had any sexual contact with a woman:

> Although a lot of women approach me, I'm just not into it … I never wanted to be sexual with any female at all. [Makson, 32 years]

All three participants had serious long-term relationships with other boys in high school and after they left school, Makson and Alik have had serious boyfriends. Alik had a Marshallese partner for three or four years who left for the United States about two years ago. Makson had boyfriends when he lived for a few years 'off-island', but he found it difficult as he was so used to hiding his relationships. He felt uncomfortable when a boyfriend wanted to show any affection and hold his hand in public:

> I felt they were too clingy or something. [Makson, 32 years]

Both Alik and Junior now prefer to have casual sexual encounters because they say possessiveness and jealousy within relationships lead to arguments:

> Once you've been in a long-term relationship for a while, you always fight. [Alik, 33 years]

Although Makson would like to have a long-term relationship with another man in RMI, he thinks it is too hard and feels that "friends with benefits" is more realistic for life on the Island. If his boyfriend was Marshallese, he thinks that he would feel more 'comfortable' but would still want to keep it on the "down low".

With the exception of Junior, the interviewees had not been involved in transactional sex. Junior had bought food and drinks for his young sexual partners because "they expect it" or 'ask him to buy for them'.

As in other Pacific countries, alcohol and sex seem to go hand in hand. Makson noted that alcohol was not involved in his encounters with other boys in high school, but drinking and socialising are now used as a cover to hide that he and other MSM are seeking sex:

> It's like when you grow older, you want to hide how you score, so most of the time its drinking – it's kind of hard for me and other boys like me to score without alcohol involved … I don't remember any straight men coming to me when I'm sober. [Makson, 32 years]

4.3.1.3 Stigma and discrimination

The interviewees reported some form of discrimination, both subtle and direct. Makson said that stigma mainly takes the form of verbal abuse and demeaning words, which clearly communicate to him that "the world is not meant for people like you". He has also heard of family members beating their young sons to "make them stop acting that way". He says that he cannot live the way he wants to:

> I don't get to live how I want to live, how I wish to live – like all other 'normal' people. [Makson, 32 years]

Junior had been physically and verbally abused and this convinced him to keep his identity hidden:

> Some guys they don't like *kakkwol*, they say bad things, or in a taxi they will give you bad looks or bad attitude. [Junior, 52 years]

Over two years ago, Junior was raped, but because sexual behaviour between men is so hidden he had no recourse. He was fooling around with a man in the back seat of a van and the man wanted to have anal sex. He did not want to (he had never had anal sex as a receptive partner), but the man forced him.

An interviewee saw RMI as less open to sexual diversity than other countries in the Pacific. Makson had gone to Suva, Fiji in 2015 as the first gay representative for the Marshall Islands. He was astonished by how open the Fijians were about sexual diversity, and the recognition given to the advocacy organisation, MenFiji[3]:

> Even their President was acknowledging their [MenFiji work. [Makson, 32 years]

[3] Now 'Rainbow Pride Foundation'

He explained how he had gone back to his hotel and cried:

> I wish my country could be the same, but I know it's going to take some time. [Makson, 32 years]

Makson feels that maybe he could be the first Marshallese gay activist, but he believes that things have to move very slowly to protect people's safety.

Alik reported that he has never been abused and generally everybody accepts him (as long as his sexuality is kept hidden). Aside from the problems he had with his mother over wanting to wear a dress as a child, he has good familial support.

4.3.1.4 Condom use

One interviewee used condoms regularly and the others only occasionally. Junior only used condoms if his partner wanted to use them, and Alik only used them if he does not trust the other person. He preferred not to use condoms and goes without if his partner has had a recent negative STI/HIV test. Some of his partners are surprised by his demand for test results:

> They say 'girl you're crazy', and I say 'nuh uh, I'm smart! [Alik, 33 years]

Makson, the only regular condom user, started using condoms in high school (but not when he first started having sex) and now carries condoms with him whenever he goes out. He is usually the one who decides to use condoms:

> Boys like us, we're usually the recipients, we're never the 'givers' … I like doing both, but when you meet straight men, it's hard to find ones who are prepared to [be the recipient]. [Makson, 32 years]

Makson is motivated to use condoms after learning about the risk of STI/HIV transmission:

> I've been scared of the risks, so I try to be as careful as I can. [Makson, 32 years]

All of the interviewees stated that they receive resistance from their partners if they suggest using condoms. Junior noted that when he gives a condom to the younger boys he has sex with, they 'want to go without it'. For Makson, his 'straight' partners mostly prefer "bareback" and he often has to convince them, for him condom use is essential:

> Sometimes they say 'oh that's a total waste of time' and I say 'well you want to have it [sex]?' [Makson, 32 years]

Alik is usually the one who decides to use a condom and he makes it clear that condom use is non-negotiable. Sometimes sexual partners abuse him for his insistence:

> He goes 'you know what? You're a fucking drama queen' and I say nuh ah, I just want to protect myself, sorry. [Alik, 33 years]

If Junior attempts to negotiate using condoms with his young partners, he usually tells them that they have no idea what diseases he may have and they should be careful. Although he doesn't always wear a condom, he worries about his safety. He "doesn't have so many partners", but he believes that the young men he has sex with have multiple partners and "you gotta be safe".

No interviewee had any trouble in accessing male condoms. They got them from the hospital clinic, which has a basket of them on the counter, or from bars and restaurants. YTYIH was also mentioned as a place where condoms were easily accessible and was thought of as a 'safe' place for MSM/TG to get condoms. In the past, Makson had helped a nurse at a local

high school to distribute condoms. None of the interviewees were familiar with female condoms and were not aware that they could be used for anal intercourse.

Lubricant was also seen as easily accessible and either came in condom packs or was obtained from the hospital. Both Alik and Makson used lubricant, but Junior was less likely to use lubricant now that he is less sexually active. One interviewee said that if he ran out of lube, he used saliva.

Two of the interviewees (Alik and Makson) learnt about condoms in high school (about Grade 10), when they were learning about STIs. However, they did not use condoms for much of their high school years, when they were sexually active.

4.3.1.5 Access to services

Two of the interviewees regularly go to the hospital for employment health checks and an HIV test is one of the tests which must be undertaken. Junior and Makson are required to have a health check every six months as a condition of their employment. Alik is not required to have an employment health check for his job, but he chooses to visit the clinic every four months:

> I just want to go and check everything, not only blood but TB … everything. [Alik, 33 years]

Alik goes to the hospital to be tested and he feels very comfortable going there because he has a nurse friend (who is also MSM) who works at the hospital. Both Makson and Junior are more reluctant to attend sexual health services. For Makson this was because of concerns about safety with respect to local health workers. For Junior this was because he was "ashamed" and "embarrassed" and felt unable to tell the local health staff about his same-sex activity. During their regular health checks, they reported that the health worker had not asked questions about sexual behaviours. On one occasion, Junior went to the HIV/STI clinic, as he had STI symptoms, and was diagnosed and treated for gonorrhoea. The health worker carried out contact tracing and asked Junior for the names of all the girls whom he had sex with. He did not disclose to the health worker that he also had sex with men:

> No, I did not … I cannot tell; I cannot talk about all that [to them] … I'm ashamed … [Junior, 52 years]

All the interviewees were concerned that the health service would not be confidential and that details about their private life would leak out. However, two of the interviewees felt that they would be able to be open about their sexual behaviour with a foreign health worker:

> I would only talk to a foreigner [health worker] because it's never safe [confidential] to talk to a Marshallese physician or a nurse because gossiping is kind of part of the culture, so it's hard to trust, even though they have sworn in their workplace, words are going to leak out somehow. [Alik, 33 years]

Junior knows of situations where people's confidentiality has been breached by the hospital clinic and he sees this as a key reason why people do not seek treatment:

> It was on Facebook last week, the gossip in the hospital is so much … last week a sick person went and got treatment, not only the doctor knew about it, they spread it around … if you go, not only you will know that you have this, but the rest of the community is gonna know. [Junior, 52 years]

One interviewee believed that sexual health services are offered only in the hospital:

> I don't know anywhere on island where they do HIV or STI testing apart from the hospital. [Makson, 32 years]

Another interviewee was aware of other MSM/TG going to YTYIH and believed this service to be more appropriate for MSM/TG:

> It's more confidential there [YTYIH] than at the hospital. [Junior, 52 years]

4.3.2 Female sex workers

Six women who sold sex were interviewed in depth. The interviewees were all Marshallese and lived in urban Majuro or in a village on Majuro atoll. Their ages ranged from 18 to 51. Most of the women sold sex so that they could buy the things they needed to support themselves and their children, such as rent, food and clothes. Some of the interviewees also had full-time waitress and bar work jobs, but they did not earn enough from this work to support themselves or their families:

> I get paid much less [as a waitress] than doing this [sex work] … I need more money, it's not enough. [Dorothy, 51 years]

Although Justina occasionally sent money for her children and relatives who lived on an outer island, she said that she mainly spent the money she earnt on herself:

> Most of the money I spend with my friends, going out and buying drinks; buying clothes and food for myself. [Justina, 28 years]

A number of interviewees lived with other women selling sex in a compound; a few lived with their families. A compound is a few rooms in a building or converted shipping containers which a manager or owner (often Chinese) rented out. Compounds usually had a fence and locked gate to 'contain' the residents and prevent easy access by non-residents. There were reportedly a number of compounds housing women who sold sex; frequently the managers or owners facilitated this.

The interviewees said their families accepted them, but the majority of their families did not know that they were selling sex. They usually tried to hide this work from everyone but close friends who were also sex workers. Two of the interviewees whose family members had discovered that they were selling sex did not have a good relationship with their families. Marsha's family was unhappy with her because of rumours she was doing sex work. Marsha has one child whose father is an Indonesian seafarer and the child lives with her family. When she visits her son and gives her family money from the child's father, her family just accepted the money and told her to go away. Marsha was living with other FSWs in the compound, but now lives with relatives.

Emi lived with her family away from urban Majuro but had a volatile relationship with them, and when fights occur (sometimes over her sex work), she goes to live with other FSWs in a compound in Majuro. Another interviewee, Justina, also lives in a compound with another FSW. She is a single mother with four children, each with different fathers. The children lived with relatives on an outer island.

Three of the interviewees were married, although Daisy was separated from her husband. Dorothy and Loretta's husbands were aware of their work and accepted it and both women had a good relationship with their extended families. However, their extended families and communities are not aware they did sex work, except for Daisy's brother who found out and 'got mad about it'. Dorothy, who lived with her husband and five children, worked at a well-known bar as a waitress and was able to hide her sex work from everyone but co-workers and

men who drank at the bar. Whereas Loretta, who also had children, lived with another FSW so that her sex work could remain hidden from her extended family.

The interviewees usually had only a few clients that they saw on a regular basis. Their clients tended to be foreign seafarers and less occasionally they engaged in transactional sex with local men. The women preferred to use condoms, unless they were familiar with the client or the client paid extra not to. Condoms were reported to be easy to access from Youth to Youth Health, the hospital clinic or from bars and stores. Interviewees regularly attended the hospital either for health checks as part of their employment health certification or to obtain long acting contraception. However, during their clinic consultations they were not asked about their sexual behaviours (and no sexual history taken) and did not disclose that they undertook sex work.

According to interviewees, the number of women undertaking sex work in Majuro was decreasing. They reported that some women were migrating to the United States, and others had been thrown out compounds (where sex work took place) for some transgression:

> There were seven girls there before [2 months ago] now there's only three; they [those remaining] will get a lot of clients. (Daisy, 28 years)

Less women selling sex through organized means such as by those living in the 'compounds' may mean those remaining were likely to earn more money due to increasing numbers of ships (foreign fishing vessels) in port and reportedly more men coming onshore looking for sex. However, it may also drive an increase the demand for casual sex work by those in other employment, such as bar/waitress staff selling sex to supplement their low incomes.

4.3.2.1 Sexual behaviour

Sexual partners of the FSW were predominantly seafarers who came in to port every month on international vessels and stayed for approximately two weeks. These seafarers were from Indonesia, United States, Taiwan, China, the Philippines, Pohnpei, Fiji and Papua New Guinea (PNG) and tended to be regular clients, often viewed as 'boyfriends' particularly by those young women who lived in the compounds.

> Every month they come, they have two weeks here [Majuro] then go back. [Emi, 19 years]

Sex with the seafarers usually occurred in a room at a hotel ('Chinese hotels' or backpacker bars/hotels) or at the compound where the women rented a room. They visited the women in their compound or met them in bars. Daisy had a regular seafarer client from Pohnpei who took her to a resort where they would stay for two weeks whilst he was in port: "He pays for food, drinks, everything".

Sexual partners also included local Marshallese men or Chinese local residents. Sex with local Marshallese often took place outside, in between shipping containers, or in the bushes. Clients who were Chinese local residents or visiting businessmen visited the women in their compound and sex took place in their rooms.

Women who rented a room in one compound reported having their movements restricted by the manager who locked them in:

> He has the keys and we have to wait for him to come and let us out. [Marsha, 18 years].

Women who rent a room in the compound have their movements restricted by the manager. He locks the compound and the women have to wait for him to come and let them out. Daisy was recently kicked out of the compound because she and her friends went out without permission. They climbed the gate and went drinking:

> We're not supposed to go out without telling the other girl or the manager, we're supposed to wait there for the clients to come. [Daisy, 28 years]

Daisy was trying to get back in to the "Chinese place" because she wanted to be with her friends (who were still there) and earn money. She reported that the compound manager would bring Chinese men from the ships to the women, but only some of the women would accept them as clients:

> He brings in Chinese men [clients] but only to two of the ladies because the rest of us don't want Chinese men … We don't know how to get along with them because they don't speak English, also the Chinese don't want to use condoms – they refuse. [Daisy, 28 years]

The women who had Chinese clients earned more money from them compared to having sex with clients of other nationalities. This was reported as US$500 or even up to US$1000; double or triple what other clients were charged. These clients paid extra to forgo condoms. Marsha accepted these clients but had recently left the compound because she did not like the restrictions. She explained how she had left her phone number with another girl at the compound:

> So if my regular clients came or called, they can call me and we can meet somewhere else. [Marsha, FSW, 18 years]

Payment for sex depended on who the client was. For foreign seafarers, the women described their payment as US$100 plus or US$150-300, however, some women described only charging US$30 to $40 if the seafarers were out of money. Daisy was paid "$200 plus" by an American ship captain every time he visited and Emi's seafarer "boyfriend" from Pohnpei gave her $400 every two weeks when he visited. Local men usually paid less than US$100 for sex.

The interviewees were generally unwilling to discuss their sexual practices. Only Marsha talked about it, saying that she was unwilling to do certain sexual acts:

> I don't like it when they force me to do other things I don't like [e.g. anal sex]. [Marsha,18 years]

Only one of the interviewees started sex work at a young age. Marsha started when she was 16 and still in high school. She eventually had to drop out of school when she became pregnant. The remaining women started when they were in their late teens or in their 20s – except for Dorothy, who started sex work when she was 48 years old. Nearly all of the women had only been doing sex work for the past few years. They had either followed their peers into the work – "my friends were doing it [sex work] and I went with them" – or had started doing sex work after they began working at a well-known bar as a waitress. All of the wait/bar staff working at this bar were reportedly also doing sex work.

4.3.2.2 Condom use

On the whole, interviewees preferred to use condoms to avoid 'sickness' and unwanted pregnancies. One of the woman had not used condoms with her boyfriends before she started sex work and had experienced four unintended pregnancies. She had also been infected and treated for syphilis on four separate occasions (diagnosed during antenatal screening):

> I thought they were faithful to me, and then I get pregnant and I find out I have syphilis … I'm happy that I haven't had syphilis again and I'll keep using condoms. [Justina, 28 years]

The interviewees stated that they usually insisted that their clients use condoms:

> I tell the client that if they don't use condom then I won't do anything with them, even those Chinese ones. [Marsha,18 years]

However, they often did not use condoms with their husbands or with regular sexual partners. As regular clients were frequently referred to as 'boyfriends', for a number of women this constituted the majority of their sexual partners. Daisy had been having sex with an Indonesian seafarer for about two years and did not use condoms with him:

> I don't use them with the Indonesian guy because he is like my boyfriend, I think he is very faithful … maybe he'll be my husband one day – he told me that every time he comes. [Daisy, 28 years]

As a result of foregoing condoms, a few of the women have also had children whose fathers were clients.

Condoms may also not be used if the man offered to pay more. Loretta asked both of her two regular clients to use condoms, but the PNG man often refused, so she agreed if he pays her double. Justina however refused to have sex without a condom even if the men offered to pay extra:

> All the time they don't want to use condoms, they even ask me not to use condom and they'll pay me more … I say no, I want to use condom for prevention. [Justina, 28 years]

If the women refused to have sex without a condom, the client sometimes ignored them and forced them:

> The times they want sex without a condom and offer to pay extra money – if I refuse, they force me. [Daisy, 28 years]

Condoms were considered easy to access by all the women and most of the interviewees obtained them from Youth to Youth in Health (YTYIH) or from bars where they worked (which YTYIH supplies). Some women got them from the hospital and one women said that she also bought them from stores.

> Youth to Youth is the place I get condoms every time me. [Daisy, 28 years]

YTYIH is also where most of the women interviewed reported learning about using condoms, although a few had learnt about them at school. Emi also said that she learnt about condoms from reading about them in the newspaper.

4.3.2.3 HIV and STI testing

The women who worked as waitresses/bar staff were required to have a health certificate, which involved a three monthly health check at the hospital. Interviewees relied on this health check to ensure they did not have STIs, but according to the MoH, health certification includes screening for TB, Hepatitis A, HIV and Syphilis, but no other STIs. The women did not disclose to the health workers at the hospital that they were doing sex work and the health workers did not take a sexual history or ask about sexual behaviours.

All of the other interviewees, except Emi, also regularly accessed health services. The women tended to go to the Family Planning clinic at the hospital every three months for Depo Provera,

or they go to the FPA clinic or YTYIH for pregnancy tests. One interviewee reported the (Chinese) compound manager telling the women to get tested every year:

> All of the girls at the compound get HIV and STI tests – every 12 months they go and check me. [Daisy, 28 years]

According to Marsha, the compound manager only wanted the girls to go to the YTYIH clinic:

> I'm not sure why … maybe because it's close to the compound. [Marsha, 18 years]

YTYIH clinic was also preferred by a number of the interviewees because they were familiar with the staff 'the nurse at the clinic knows us', and because the clinic was open late they felt able to maintain privacy:

> We go at 6pm when no-one else is there. [Marsha, 18 years]

Only one interviewee said that she had a past STI. Justina had syphilis detected and treated during antenatal appointments, prior to becoming a sex worker.

No women had attended a workshop on HIV/STIs but would be interested in doing so. They felt motivated to check for HIV/STIs and were aware of HIV risk. Emi, the only interviewee who had not been to a sexual health clinic for testing, said she had difficulties in accessing the clinic:

> I don't have any time to go there [to the clinic]. [Emi, FSW, 19 years]

Most of the sexual health information the women currently received was from YTYIH which provided counselling/education sessions to clients who attended for HIV/STI tests.

4.3.2.4 Stigma

Interviewees mostly felt accepted by their families and their wider community but only if they were unaware that they were doing sex work. If efforts to keep their work a secret had been unsuccessful the women faced estrangement from their families and sanctions from the wider community. As both sex work itself as well as activities associated with sex work were illegal they faced significant penalties if discovered. Although no Chinese FSWs were able to be interviewed for this research, they were said to be heavily stigmatised and subject to discriminatory attitudes from the community. Interviewees reported that they are brought to RMI to provide sexual services for Chinese seafarers and businessmen and kept hidden in compounds in Majuro. Local FSW were largely reluctant to have sex with Chinese clients as they are unable to communicate with them and are said to be unwilling to wear condoms.

4.4 Institutional capacity assessment: HIV organisations and services

4.4.1 Organisational mapping

There are three organisations working in HIV prevention in the Republic of Marshall Islands: The Ministry of Health (MoH) under the HIV and STD Program; Women United Together Marshall Islands (WUTMI); and Youth to Youth in Health (YTYIH). No organisation provides programs specifically targeted to the needs of MSM/TG or FSW. However, it was reported that some MSM/TG and FSW are reached through programs aimed at the general population. Furthermore, all three organisations expressed a need to better serve these populations and some steps have been taken towards this.

The Ministry of Health (MoH) National HIV/STD Program is responsible for HIV and STI clinical services and prevention for the general population. The work of the program is guided by the HIV and STI National Strategic Plan 2013-2017. The Program currently has six staff including a program manager, one midwife and four nurses. The HIV/STD Program is also responsible for national data collection and reporting. It does not collect data on key populations with the exception of seven PLHIV who are currently on treatment.

WUTMI is a national member based NGO which aims to *'provide a voice to Marshallese women and promote the empowerment and advancement of women through protection of cultural knowledge and human rights and safeguarding our island's environment and inherent resources'*. WUTMI's membership includes 22 Chapters of outer island women's groups and women's clubs which enables WUTMI to have good reach to the outer islands and remote areas. WUTMI currently has 15 staff members including two international volunteers. WUTMI works in the areas of HIV/STI, GBV, human rights, substance abuse, gender equality and leadership both nationally with the following target populations: seafarers, sex workers, MSM, TG, PLHIV, women, young girls, children and people with disabilities. WUTMI's core activities are awareness raising, legislation and policy reform, vocational training and service delivery e.g. supporting vulnerable women and children such as those who have experienced violence and human trafficking. HIV and TB education are integrated into all WUTMI programs.

In 2014–15, WUTMI carried out two consultations, one with MSM/TG and the other with FSW, to gain further understanding of their needs. The consultation with FSW was held in regards to gender-based violence This data was combined with data from other consultations to apply for funding to establish a support service for women experiencing violence. A consultation was also held with MSM through Facebook and individual contacts (participants in the consultation were not willing to meet for a group consultation, as they did not wish to be seen in a group). Stigma, religious attitudes and restrictive laws were identified during the consultation process as barriers to engaging with FSW and MSM/TG. WUTMI was also able to support one MSM/TG community representative to attend a regional Pacific Sexual Diversity Network meeting held in Nadi in 2015. WUTMI is keen to engage with FSW and MSM/TG, particularly through the provision of social support and advocacy for inclusive legislation, though it currently lacks the funding to do so.

YTYIH was founded in 1986 as an auxiliary wing of the Family Planning and Adolescent Reproductive Health Division of the Ministry of Health. In 1989, YTYIH became an independent, chartered NGO, forming a completely separate program in partnership with the

MOH. YTYIH works in the areas of gender-based violence, reproductive health, adolescent pregnancy, substance abuse prevention, HIV and STI prevention including through the delivery of HIV and STI testing and treatment in the YTYIH clinic in Majuro. YTYIH has 35 staff. No specific activities are carried out with MSM/TG and FSW, however FSW are believed to be utilising clinic services. A significant upcoming CDC-funded Teen Pregnancy Prevention project has an LGBTQI inclusivity component. There is also one employee who identifies as gay.

4.4.2 HIV and STI prevention activities in the Marshall Islands

4.4.2.1 National oversight, coordination and funding

Ongoing HIV activities are designed as per donor funding and implementation of HIV National Strategic Plan 2013 – 2017. Activities are coordinated by the National Advisory Committee on STDs, HIV & TB (NAC) for which WUTMI provides secretariat support. It was reported that the NAC experience some challenges with meeting regularly.

The MoH receives funding for HIV activities from: the CDC Program Collaboration Service Integration (PCSI) (fund HIV prevention activities, STI testing of pregnant mothers and HIV surveillance), the Global Fund (for counselling and condom distribution) and the Ryan White HIV/AIDS program (funding for PLHIV). WUTMI has received funding from the MoH through the CDC Partner Collaboration and Service Integration (PCSI) grant for activities with PLHIV, young people, pregnant women, MSM, TG and FSW.

YTYIH sources of funding include UNFPA (Adolescent Health and Development program), US Single State Agency (SSA) for Substance Abuse Services, the RMI National Training Council (funding leadership skills training) and small grants from the MoH. The YTYIH art project brings in minimal funds when artworks are sold and minimal donations are received from embassies. Challenges in funding include: short term grants resulting in year by year planning and uncertainty, difficulties in grant writing and data collection and reporting to donors.

4.4.2.2 HIV and STI testing, counselling and treatment

The HIV/STD program provides clinical services, including HIV and STI testing, and counselling, which predominantly takes the form of voluntary testing and counselling. Outer islands are reached through mobile clinics, which take place two to three times a year. YTYIH provides HIV and STI testing and treatment in the clinic in Majuro. YTYIH also has offices on Ebeye (Kwajalein Atoll) and in the satellite community of Laura on Majuro which provide HIV testing and counselling. In partnership with MoH, the organisation also conducts outreach to outer islands. YTYIH reaches more than 200 people per year through its services. Data is collected on age, sex and the service obtained.

4.4.2.3 Condom distribution

Condoms are supplied by the UNFPA to the MoH. It was reported that approximately six boxes (144 per box) of condoms were distributed over the last 12 months by the MoH. This low number is due to condom boxes being placed in the clinics, as opposed to being distributed to the communities at other venues. The family planning program reportedly also distributes female as well as male condoms. Condom distribution is also carried out by YTYIH as part of their peer-based outreach activities.

4.4.2.4 Peer education and outreach

YTYIH carries out peer-based outreach education activities to youth, including to outer islands through inter-organisation collaboration with the Ministry of Internal Affairs and the MoH. Peer support occurs in the form of: disseminating sexual and reproductive health information and education, training and skill building, and the provision of condoms.

4.4.2.5 Strategic health communication

The MoH engages WUTMI to deliver education to seafarers as part of the orientation for the fisheries observer program, which includes a mini course on HIV and STIs. During this course, WUTMI discuss its services and human rights and also promotes condom use.

4.4.2.6 Advocacy and legislation

WUTMI has to date played a key role in the review of HIV-related legislation and policies with the Attorney-General's office, specifically the Communicable Disease Act and public service rules and regulations. WUTMI also engages in activities that advocate for the rights of marginalised groups, particularly vulnerable women and children. However, there is still a great need for advocacy for the rights of LGBTI and FSW.

4.4.2.7 Other support services

WUTMI is currently in the process of setting up a support service for women who experience gender-based violence.

4.4.3 Cross-cutting organisational strengths

- **Policy:** The HIV and STIs National Strategic Plan 2013–2017 is reported to be utilised to guide and coordinate activities among the three organisations and other stakeholders.
- **Partnerships:** There are long-standing partnerships between the MoH, WUTMI and YTYIH, as well as other relevant organisations such as the Ministry of Internal Affairs (gender, child rights, youth bureau) and the Minister of Justice (police department), the Marshall Island Epidemiology and Prevention Initiative (MIEPI) and Waan Alelon in Majol (WAM) [Canoes of the Marshall Island].

4.4.4 Cross-cutting organisational capacity-building needs

- Increased advocacy and sensitisation for the rights of MSM/TG and FSW is required among the community, churches and services so as to break down stigmatising barriers to reaching these populations.
- Greater involvement of MSM/TG and FSW is needed in HIV and STI planning and decision-making activities, such as the NAC.
- Greater understanding and advocacy of MSM/TG/FSW needs and involvement of MSM/TG/FSW in the design and delivery of services and programs.
- Greater incorporation of MSM/TG and FSW into core activities of the MoH, WUTMI and YTYIH is needed.
- A peer education approach for FSW could be considered.
- Support (including technical support) in developing a MSM/TG support network through contact with community members should be considered.
- There is a need to take a more proactive approach to condom distribution, health promotion, and HIV/STI testing and counselling, especially targeting vulnerable populations.
- Refresher training and mentoring on HIV and STI clinical management is reportedly needed. This was previously provided by SPC under the Response Fund.
- Funding is received from a number of public and private donors, but is limited to specific activities with minimal inclusion of MSM/TG and FSW.
- Capacity development is needed in program management, proposal writing and response mobilisation and monitoring and evaluation.

4.4.5 Identified capacity-building resources

WUTMI and YTYIH has had a volunteer from Australian Volunteers International working with them (shared across three organisations) who provides technical assistance on program management and grants development. Other volunteer opportunities could be explored. The Regional Pacific Women Support Unit has provided WUTMI with capacity building support, particularly through the Ending Violence Against Women program, which could be harnessed to strengthen work with FSW.

References

ABC Radio Australia. (2013). Sex trafficking report on Marshall Islands 'totally baseless': government [Press release]. Retrieved from http://www.radioaustralia.net.au/international/2013-07-22/sex-trafficking-report-on-marshall-islands-totally-baseless-government/1164736

Australian Government AusAID. (2011). Republic of the Marshall Islands Annual Program Performance Report 2011. Retrieved from https://dfat.gov.au/about-us/publications/Documents/marshall-islands-appr-2011.pdf

Dalla, R. L., Baker, L. M., Defrain, J. D. and Williamson, C. . (2011). *Global perspectives on prostitution and sex trafficking: Africa, Asia, Middle East, and Oceania.* Lanham, Maryland: Lexington Books.

Dvorak, G. (2014). Two Turtles: Intimacy between men in the Marshall Islands In Besnier N & Alexeyeff K (Eds.). Honolulu: University of Hawaii Press.

Economic Policy Planning and Statistics Office (EPPSO), SPC, & Macro International Inc. (2007). *Republic of the Marshall Islands Demographic and Health Survey 2007*. Retrieved from Noumea: file:///C:/Users/Rachel/Downloads/MHL_2007_DHS_Final_Report.pdf

Economic Policy Planning and Statistics Office RMI, & SPC. (2012). Republic of the Marshall Islands 2011 Census Report. Retrieved from http://prism.spc.int/images/census_reports/Marshall_Islands_Census_2011-Full.pdf

Godwin, J. (2010). *Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action*. Retrieved from Bangkok:

Hills L, Zachraias Z, & Heine W. (2006). Second Generation Surveillance Survey of Sexual and Risk Behaviour Among Youth in the Republic of the Marshall Islands. Retrieved from http://www.aidsdatahub.org/sites/default/files/documents/SGS_youth_marshall_islands.pdf

Jivan, V., & Forster, C. (2007). Translating CEDAW into Law: CEDAW Legislative Compliance in Nine Pacific Island Countries. Retrieved from http://iknowpolitics.org/sites/default/files/tcl_executive_summary.pdf

Kaleidoscope Australia Human Rights Foundation. (2014). Submission to the UN Universal Periodic Review regarding the protection of the rights of LGBTI persons in the Republic of the Marshall Islands. Retrieved from http://www.kaleidoscopeaustralia.com/wp-content/uploads/2014/08/Marshall-Islands-Report-Final-14-August-2014.pdf

Marshall Islands SGS Management Team. (2006). Second Generation HIV Surveillance Survey of Women at the Majuro Hospital Prenatal Clinic, Republic of the Marshall Islands – 2006. Retrieved from http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=400&Itemid=1

RMI Ministry of Health, & NAC. (2014). Global AIDS Progress Report 2014. Retrieved from http://www.aidsdatahub.org/sites/default/files/publication/Marshall_Islands_narrative_report_2014.pdf

RMI Ministry of Health, & NAC. (2016). Global AIDS Progress Report 2015: Republic of the Marshall Islands. Retrieved from http://www.unaids.org/sites/default/files/country/documents/MHL_narrative_report_2016.pdf

Schwartz, J. (2015). "The Young Ladies Are Here": Marshallese Transgender Performance and Processes of Transformation. *Women and Music: A Journal of Gender and Culture, 19*, 95-107.

US Department of State. (2014). Marshall Islands 2014 Trafficking in Persons Report. Retrieved from http://www.state.gov/documents/organization/226844.pdf

Annex 1: UNAIDS GARP data needs

DATA – MARSHALL ISLANDS

Indicator relevance: Topic relevant, indicator relevant, data available

Data measurement Tool:

Please specify data measurement tool:

Data collection period:

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

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

Sample Size: n/a

Number of Survey Respondents: 16

Sex Workers

	All	Males	Females	<25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	**6.3 %**		**6.3 %**	**0 %**	**8.3 %**
Numerator Number of sex workers who answered "Yes" to both questions	**1**		**1**	**0**	**1**
Denominator Total number of sex workers surveyed	**16**		**16**	**4**	**12**
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?"	**100.0 %**		**100.0 %**	**100.0 %**	**100.0 %**
Numerator Number of sex workers who replied "yes" to question 1	**16**		**16**	**4**	**12**
Denominator Total number of sex workers surveyed	**16**		**16**	**4**	**12**
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?	**6.3 %**		**6.3 %**	**0 %**	**8.3 %**
Numerator Number of sex workers who answered "Yes" to question 2	**1**		**1**	**0**	**1**
Denominator Total number of sex workers surveyed	**16**		**16**	**4**	**12**

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 female and male sex workers reporting the use of a condom with their most recent client	**18.9 %**		**18.9 %**	**75.0 %**	**0 %**
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	**3**		**3**	**3**	**0**
Denominator Number of sex workers who reported having commercial sex in the last 12 months	**16**		**16**	**4**	**12**

1.9 Percentage of sex workers who received an HIV test in the last 12 months and who know their results

	All	Males	Females	<25	25+
Percentage (%) Percentage of sex workers who received an HIV test in the last 12 months and who know their results	**68.8 %**		**68.8 %**	**25.0 %**	**83.3 %**
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**11**		**11**	**1**	**10**
Denominator Number of sex workers who responded to the questions	**16**		**16**	**4**	**12**

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?"	**66.7 %**		
Numerator Number of MSM who replied "yes" to question 1	**2**		
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 MSM who received an HIV test in the last 12 months and who know their results	**0 %**		
Numerator Number of MSM who have been tested for HIV during the last 12 months and who know their results	**0**		
Denominator Number of MSM who responded to the questions	**3**		

1.13 PERCENTAGE OF TRANSGENDER REACHED WITH PREVENTION PROGRAMS

	All	<25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions	**28.6 %**		**28.6 %**
Numerator Number of TG who answered "Yes" to both questions	**2**		**2**
Denominator Total number of TG surveyed	**7**		**7**
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?"	**100.0 %**		**100.0 %**
Numerator Number of TG who replied "yes" to question 1	**7**		**7**
Denominator Total number of TG surveyed	**7**		**7**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**28.6 %**		**28.6 %**
Numerator Number of TG who answered "Yes" to question 2	**2**		**2**
Denominator Total number of TG surveyed	**7**		**7**

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	**0 %**		**0 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**0**		**0**
Denominator Number of respondents who reported having had sex in the last 12 months	**7**		**7**

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	**42.9 %**		**42.9 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**3**		**3**
Denominator Number of TG who responded to the questions	**7**		**7**

?.?? PERCENTAGE OF SEAFARERS REACHED WITH PREVENTION PROGRAMS

	All	<25	25+
Percentage (%) Percentage of SEAFARERS who answered "Yes" to both questions			
Numerator Number of SEAFARERS who answered "Yes" to both questions			
Denominator Total number of SEAFARERS surveyed			
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?"			
Numerator Number of SEAFARERS who replied "yes" to question 1			
Denominator Total number of SEAFARERS surveyed			
Percentage (%) Percentage of SEAFARERS who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "			
Numerator Number of SEAFARERS who answered "Yes" to question 2			
Denominator Total number of SEAFARERS surveyed			

?.?? 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			
Numerator Number of SEAFARERS reporting the use of a condom the last time they had sex			
Denominator Number of respondents who reported having had sex in the last 12 months			

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			
Numerator Number of SEAFARERS who have been tested for HIV during the last 12 months and who know their results			
Denominator Number of SEAFARERS who responded to the questions			

Empowered lives. Resilient nations.

United Nations Development Programme
Pacific Office in Fiji
Level 8, Kadavu House, 414 Victoria Parade
Private Mail Bag, Suva, Fiji
Tel : 679 331 2500
Fax : 679 330 1718
Email: registry.fj@undp.org
www.pacific.undp.org