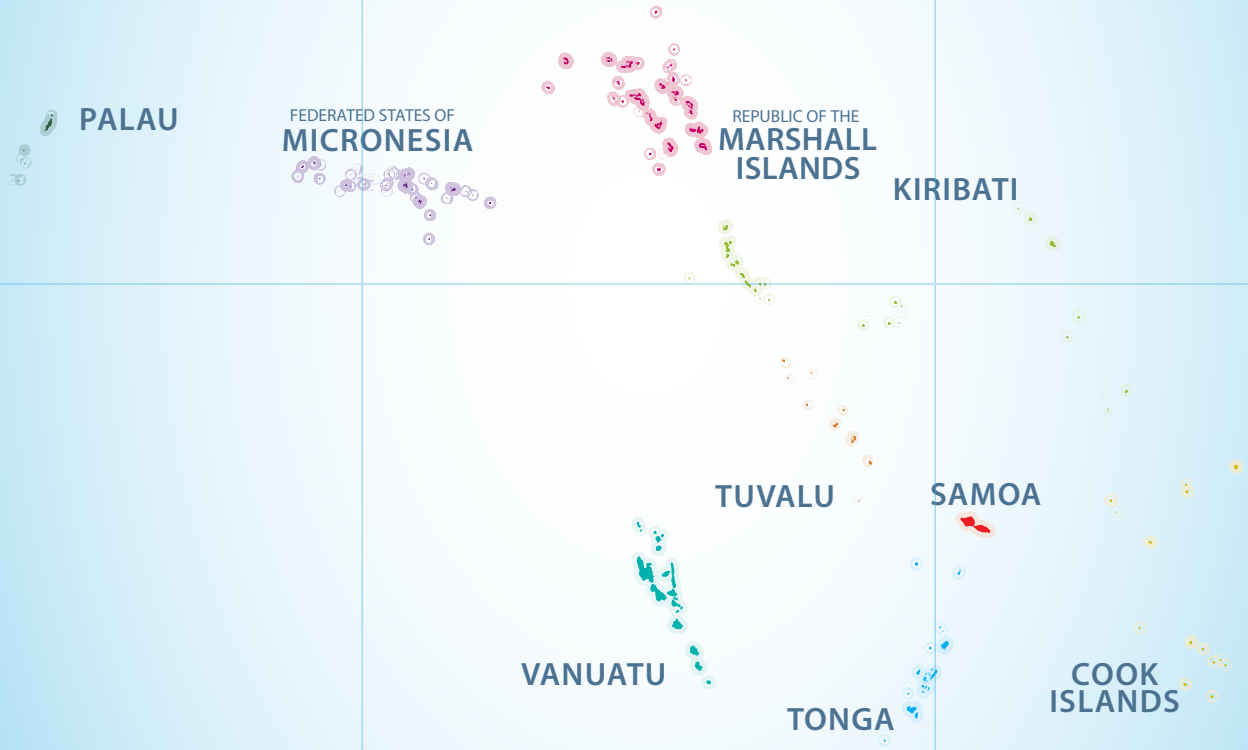
PACIFIC MULTI-COUNTRY MAPPING AND BEHAVIOURAL STUDY: HIV AND STI RISK VULNERABILITY AMONG KEY POPULATIONS

VANUATU



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Acknowledgements

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

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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.

Abbreviations

AIDS .....Acquired immune deficiency syndrome
FSW .....Female sex workers
HIV .....Human immunodeficiency virus
KPH ..... Kam Pusem Hed Clinic, Wan Smolbag Theatre
LGBTI ..... Lesbian, gay, bisexual, transgender and intersex people
MoH..... Ministry of Health
MSM ..... Men who have sex with men
NGO ..... Non-governmental organisation
SD .....Standard deviation
STI .....Sexually transmissible infection
TB .....Tuberculosis
VFHA.....Vanuatu Family Health Association
WSB …… .....Wan Smolbag

1 Executive summary

Vanuatu has a low HIV prevalence, with only nine cases recorded, but a high prevalence of STIs.

Through a stakeholder workshop, we estimated there are around 2,000 female sex workers (FSW) in Vanuatu. Most of these are casual and intermittent workers. There are around 600 men who have sex with men (MSM) and transgender people (TG). They tend to be a hidden group due to stigma.

Transgender and men who have sex with men

- We undertook a behavioural survey of 50 TG and MSM, and an in-depth interview with eight MSM/TG. Unlike in other Pacific states, few of the men surveyed identified as transgender (14%). There was a vibrant mix of sexual identities: gay, homosexual and straight.
- Sex between men is legal in Vanuatu; however, stigma in the form of homophobic verbal abuse is common, as are other stigma and discrimination.
- Most of the men interviewed were proud of their identity, although the survey indicated that 47% had feelings of shame regarding their sexual identity in the past 12 months, while 18% felt guilty.
- Mothers were important in the process of 'coming out' and generally families were supportive. Close circles of friends and the workplace were also important for social support.
- In total, 90% of the participants had ever had sexual intercourse. The mean age of sexual debut was 16. Twenty-seven participants had concurrent sexual partners in the previous six months.
- In the 12 months prior to the survey, over 50% had more than four male sexual partners.
- In the 12 months prior to the survey, 23% had been paid for sex by a man.
- Just fewer than 40% had anal intercourse (either receptive, insertive or both) on the last occasion that they had sex with a male partner.
- Condom use in the last 12 months was low. Over 80% reported no or occasional condom use with a casual partner.
- Reported condom use for anal intercourse with a casual partner at the last occasion was 62%.
- In the 12 months prior to the survey, 34% had also had sex with a female partner. Of these, around half had sex with a regular female partner and half with a casual female partner. Condom use was low, particularly with casual female partners, and none reported always using a condom in the past 12 months.
- Nine participants reported having had STI symptoms in the past 12 months.
- Correct knowledge about HIV was high in this group.
- Over 10% had been sexually assaulted in the past 12 months.
- Although a majority of participants knew how to access condoms and information, less than one-third knew how to access HIV and STI treatment and testing.

- Of those that had used a sexual health service in the past 12 months, the majority were satisfied with the service. Most of the interviewees spoke highly of Wan Smolbag.
- Eighteen participants reported ever having had an HIV test, and seven (14% of the sample) had a test in the past 12 months. All reported a negative result.

Female sex workers

- Eighty women took part in the behavioural survey and 10 were interviewed in-depth.
- Their mean age was 28. Most women reported not being married but having a boyfriend, and 76% had children. Most were not formally employed. Most sold sex because of limited employment opportunities and the high cost of living.
- Of these women, 88.8% had ever had sexual intercourse. The age at which they ever received money or goods in return for some type of sex was between 10 and 40 years old.
- Seventy-one women received goods or money for sex in the past 12 months, but the median number of clients was only two, indicating an intermittent type of sex work.
- Paid sex tends to take place at the client's place or in a hotel, and typically the clients decide the amount paid. Sex workers reported declining income from sex work, with the client paying between VT1,000 and VT75,000 (between about US$8 and US$40).
- Condom use for sex with clients was low for both vaginal and anal sex. Of these women, 70% and 85% respectively never or sometimes used a condom in the past 12 months. Condoms were provided by the sex worker on about half of the occasions.
- Of these women, 46% indicated only one client on the last day they had paid sex. On that occasion, 82% had vaginal intercourse and 64% had anal intercourse. Condom use on that occasion was reported by 31% of the women, although from the in-depth interviews it would appear that more sex workers are using condoms than in the past and that the use of condoms was being driven by the sex workers themselves.
- Regular condom use with regular and casual partners was also very low.
- Thirty-five (44%) sex workers reported STI symptoms in the last 12 months. Of these 35, 25 sought treatment and were diagnosed with an STI.
- Twenty-five (31%) women reported sexual assault in the last 12 months, committed by a range of men.
- About 50% of the women knew how to access sexual health services, and a larger proportion (69%) knew the names of a local organisation providing information and services related to condoms.
- Of the 24 women who had visited a sexual health clinic in the past 12 months, the overwhelming majority found the experience to be a positive one.
- Twenty-two women had ever been tested for HIV, and 11 of those had been tested in the past 12 months (14% of the total sample). None of those tested for HIV in the last 12 months had been diagnosed with HIV.

Capacity assessment of HIV organisations and services

- The Vanuatu Ministry of Health undertakes HIV and STI activities, but does not engage with MSM/TG or sex workers. WSB directly engages with these populations. Vanuatu Family Health Association provides sexual health services, but with no specific focus on key populations. VPride is an unfunded LBGTI network focusing on advocacy and peer support. WSB has extensive reach.
- The National AIDS Council is established, but is not currently functioning. The Ministry of Health takes on the national HIV and STI coordinating role.
- HIV testing is undertaken by several groups and condoms are distributed by a number of organisations.
- Strengths include agencies being guided by global, regional and domestic HIV policies and guidelines; large-scale coverage; partnerships between agencies; good monitoring and evaluation; and data collection.
- Needs include greater engagement with MSM/TG and sex workers by organisations other than WSB and VPride; training for staff and volunteers; funding for service delivery; attention to data collection gaps; and better government support for HIV and STI work with key populations.

2 Introduction

2.1 Background to the research

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

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

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

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

3 Vanuatu

The Republic of Vanuatu is an archipelago of 82 small islands of around 12,000 square kilometres with a population of over 270,000 people. The mainstays of the economy are farming, tourism and offshore financial services. Poverty is an issue for many ni-Vanuatu.

While the number of HIV cases in Vanuatu is low, the high prevalence of sexually transmitted infections and risky behaviour – in particular, unsafe sex among young people – creates a context in which HIV could spread. As at December 2013, there had been nine officially reported HIV cases – seven adults and two children aged 0–14 years. Of these nine cases, three people died and six are currently living with HIV (Ministry of Health Vanuatu 2013).

The key mode of HIV transmission is through sexual activity. Of the nine HIV cases, one was acquired overseas and two were acquired by transmission to women from their partners, who had acquired the infection outside the country. There have been two reported cases of mother-to-child transmission of HIV. The other four HIV cases were acquired through sexual intercourse. While MSM are present in most communities, there have been no reported cases of HIV among them. There have also been no *reported* cases of HIV among sex workers. There has been no transmission of HIV through unsafe blood products (Ministry of Health, Vanuatu 2013).

3.1 Transgender and men who have sex with men

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

Due to their lack of recognition, there has only ever been one study centred on MSM and TG in Vanuatu. That study by Veronese et al (2015) notes low levels of treatment-seeking behaviour among MSM and TG in Vanuatu, with a large variance between those exhibiting STI symptoms and those who seek health advice and treatment. Testing as part of the 2011 integrated bio-behavioural surveillance of MSM and TG revealed an STI prevalence of one in five TG, and one in three MSM. In the 12 months prior, 17% of TG persons identified STI symptoms but none had an STI diagnosis history, while 36% of MSM also experienced STI symptoms but only five of 28 had ever had a positive diagnosis. This discrepancy between symptoms, diagnosis and treatment-seeking indicates that there are barriers between MSM and TG persons and health service accessibility. This may be due to a fear of disclosing sexual behaviours to a healthcare professional in a society where male-to-male sex is not widely accepted (Veronese et al 2015), as well as a lack of specific MSM/TG screening or treatment.

In terms of risk, it has been indicated that TG persons are likely to have riskier behaviours than MSM, with a lower age of sexual debut (12 years versus 16 years) and lower condom use. They are also more likely to experience forced sex (63.4%); however, this is also a

major concern for MSM, with 35.7% having experienced forced sex (Veronese et al 2015). The most prominent organisation with the ability to deal with MSM and TG issues and health promotion initiatives is Wan Smolbag (WSB), which is an NGO that is broadly aimed at youth but has created some initiatives geared towards MSM. WSB has opened up access to condoms in places such as kava bars. Clinics run by WSB have reduced the need for contact with staff and shopkeepers by having free condom distribution with open access.

3.2 Sex workers

While it is considered to be somewhat shameful and is practised covertly, selling sex is a common practice in Port Vila town, according to those who engage in it. Sex work is largely informal, taking place in the street, or in kava bars and clubs (Bulu et al 2007; McMillan and Worth 2011). Sex work in Vanuatu has been shaped by local and national experiences of social and economic change, which are closely tied to urban social life (McMillan 2011). Selling sex in Port Vila is closely linked with the concept of 'going to town', both literally and figuratively. In a study by McMillan (2011), many sex workers said that they started selling sex when they moved to the town of Port Vila, but they also described 'going to town' in search of clients when they needed money. In line with this change, sex work in the region has also seen an increase due to urbanisation, tourism, development, high unemployment, family violence, and kava and alcohol use (Bulu et al 2007; McMillan and Worth 2011; McMillan 2011). There is anecdotal evidence that the 2014 cyclone and the drought that followed were also factors in women taking up sex work.

An integrated bio-behavioural surveillance conducted in Port Vila in 2011 (van Gemert et al 2013) indicates that nearly all of those surveyed had received both goods and money in exchange for sex in the previous week. Over 90% of FSW reported that their most recent transactional sex partner was ni-Vanuatu, rather than a tourist. Sex workers started transactional sex at a young age; over one-third started transacting sex when they were aged younger than 18 years. Condom use by FSW with transactional sex partners was extremely low, with only 7.5% of FSW reporting always using a condom with transactional sex partners during the previous month. Multiple concurrent partners were likely and group sex and anal sex were commonly reported, with 28.2% of FSW reporting anal sex and 37.6% reporting group sex during the previous 12 months. Condom use by FSW during the last anal sex and group sex was low (40% and 44% respectively). Forced sex had occurred for over two-thirds of sex workers in their lifetime. STI testing and treatment were low: while three-quarters reported a genital symptom in the past 12 months, only one-third had been tested, and only 5.5% had been tested for HIV in the previous 12 months and knew their result. Sex workers either work alone, meeting clients on the streets during the day and making arrangements to rendezvous later, or operate with small groups of friends to find clients in nakamals, bars and nightclubs. In this latter style of sex work, social and monetary motivations tend to converge (McMillan and Worth 2011).

Clients in Port Vila comprise local men from all occupational classes, male tourists and ex-patriot businessmen, as well as older local and tourist women. Sex workers commonly adopt a sliding scale of charging according to income, and sometimes small offerings and inexpensive gifts are accepted from clients who have little means, but occasionally sex workers earn significant amounts from wealthy tourists (McMillan and Worth 2011). The payment received from sex work affords them a degree of independence and autonomy – a way to take control of their lives (McMillan 2011).

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

Due to the adverse societal association with sex work in Vanuatu, pressure has been placed on those in the sex worker community to give up their way of life and take on more traditional roles. Sex workers become less inclined to access services and condoms because it might expose their activities. This concern also makes sex workers harder to reach by peers, who may have been witnesses to their pledges to renounce sex work (McMillan 2011).

In terms of health and risk-taking behaviour, sex workers tend to be inconsistent in their use of condoms with clients, despite an overall preference for condom use (McMillan and Worth 2011). Concerns about privacy and accessibility have an impact on condom use. Sex workers also hold many misconceptions about condoms and have a poor understanding of the role they play in preventing STIs and HIV transmission (McMillan and Worth 2011).

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

4 Methodology

The research in Vanuatu employed a variety of methods in a cross-sectional (snapshot) design. Survey participants for each of the target groups were recruited through convenience snowball sampling.

4.1 Population size estimation

A mapping exercise estimated the size of the MSM/TG and FSW populations. This was done through a stakeholder meeting of those people working with each of the key populations.

4.2 Behavioural survey and interviews

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

FSW study participants were recruited through WSB peer educators, who have been working on the sex worker peer educator program for a number of years. Peer educators visited communities where they knew of women who were undertaking sexual exchange, as well as various sites and locations where sex work occurs, to talk about the study and extend invitations for participation. Following participation, respondents also referred their peers to the study.

MSM/TG participants were recruited through the local sexual diversity network/support group. The study trained and employed three members of this group as research assistants, who then promoted the study through the network and to their community. An older MSM/TG community member, who is well known due to his high-level government work, used email lists and Facebook to recruit an older and more ‘white collar’ cohort of participants.

The majority of the FSW surveys and interviews were undertaken at WSB, as many preferred to undertake the study away from their own communities. WSB is a well-known organisation and people come to the site for a range of programs and services. This allowed for anonymity for study participants. With a diversity of programs and buildings spread across the site (such as a theatre, youth centre, sports centre, clinic etc), research assistants were able to meet respondents in different areas and find a private space to undertake the survey. Further, FSW were very comfortable with the organisation, due to the longstanding peer education program and the well-known sexual health clinic site. In the case of some women with small children who could not leave their communities, surveys were undertaken in private spaces within homes. Interviews were undertaken at the WSB clinic site after clinic hours.

MSM/TG surveys were predominantly undertaken in communities (in private spaces), at respondent workplaces (during lunch hours) and meeting places, such as the seafront, and in cafes. Interviews were undertaken at both WSB and also at the team leader’s hotel.

4.3 Institutional capacity assessment

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

Ethical approval for the project was obtained from the University of New South Wales Human Research Ethics Committee and from the Vanuatu Ministry of Health.

5 Results

5.1 Population size estimation

The hybrid method of estimating the population size of key affected communities in small countries involves asking key informants about the populations and about the whereabouts and the numbers of people observed in different locations to identify how many people are uniquely observed and how many have been duplicated in the counting. Key informants include a range of people who have knowledge of the particular populations. They include primarily public and private clinicians and public health workers, NGO workers and – most importantly – members of the specific populations; they may also include others, such as taxi drivers and other government workers (for example, ambulance personnel). A stakeholder meeting was held to discuss and arrive at a consensus regarding the population size estimations for MSM/TG and FSW. Present at this meeting were representatives from the following five agencies:

- Ministry of Health
- Wan Smolbag
- VPride
- CARE International
- Youth Challenge Vanuatu.

(Note: Vanuatu Family Health, Save the Children, and the Vanuatu National Youth Council were also invited but were unable to attend.)

After considerable discussion there, was group consensus that in 2016 there are:

- at least 2,000 FSW in Vanuatu (and that due to the high cost of living in Vila, particularly, this number had increased in recent years)
- approximately 600 MSM/TG.

5.2 Behavioural survey

5.2.1 Transgender and men who have sex with men

5.2.1.1 Description of the sample

Fifty self-identifying TG and MSM provided survey data. In describing their gender, 36 participants described themselves as men while three identified as being transgender, two as transsexual, and two as transvestite. One participant answered 'other' and then indicated their gender as 'gay'. Two participants chose not to answer this question. Participants were also asked to describe their sexual identity (Table 1).

There was a range of categories provided to participants, in addition to the ones that they chose and which are shown in Table 1. The majority of participants described their sexual identity as gay/homosexual or as heterosexual/straight.

Table 1: Sexual identity

	Frequency	**Percent (%)**
Gay/Homosexual	24	49.0
Heterosexual/Straight	12	24.5
MSM	5	10.2
Bisexual	5	10.2
Pansexual	2	4.1
Other (chose not to elaborate)	1	2.0
Total	**49**[1]	**100.0**

[1] Missing data n=1.

The age of participants ranged from 18 to 50, with a mean age of 28 (SD=7.5) and a median age of 26.5. The majority of participants had been educated to a secondary level or higher (Table 2).

Table 2: Highest level of education

Level of education	Frequency	Percent (%)
Never been to school	2	4.1
Pre-primary/Primary	10	20.4
Pre-secondary	3	6.1
Secondary	26	53.1
Polytechnic/Diploma	2	4.1
University/College	5	10.2
Other (responded with 'peer educator')	1	2.0
Total	**49[1]**	**100.0**

[1] Missing data n=1.

In responding to the question about relationship status, a majority of participants reported being single or having a girlfriend (Table 3).

Table 3: Relationship status

	Frequency	Percent (%)
Currently single	31	63.3
Have a girlfriend	12	24.5
Have a boyfriend	5	10.2
Currently married	1	2.0
Total	**49[1]**	**100.0**

[1] Missing data n=1.

The majority of participants reported living with parents or with friends or other relatives (Table 4).

Table 4: Whom participants were living with (n=49)*

	Frequency	Percent (%)
Parents	32	65.3
Friends	7	14.3
Other relatives	5	10.2
Siblings	4	8.2
Live alone	4	8.2
Boyfriend/Husband	1	2.0
Other female partner	1	2.0
Children	1	2.0

* Multiple answers possible.

Just over half were employed, mostly in full-time work. Conversely, almost half were unemployed (Table 5).

Table 5: Employment status

	Frequency	Percent (%)
Not employed	23	46.9
Full-time employed	15	30.6
Self-employed	9	18.4
Part-time or casual employment	2	4.1
Total*	**49[1]**	**100.0**

[1] Missing data n=1.

When asked to indicate their main job, the 26 who reported being currently employed indicated a range of different types of work, as shown in Table 6.

Table 6: Type of work

	Frequency	Percent (%)
Community, social and personal services	3	11.5
Financial and business services	3	11.5
Agriculture/Forestry/Fishing	2	7.7
Student	2	7.7
Wholesale and retail trade	1	3.8
Construction	1	3.8
Other (included air transport, hospitality, bus driver, hairdresser, mechanic, receptionist, spa, shopkeeper, baker, bar work)	14	53.8
Total*	**26[1]**	**100.0**

[1] Missing data n=2.

5.2.1.2 Sexual history and practice

Forty-five of 50 participants (90.0%) indicated that they had ever had sexual intercourse (anal or vaginal). Of these 45 people, their first occasion of sexual intercourse occurred between the ages of 7 and 28, with a mean age of sexual debut being 16 (SD=3.58). Twenty-seven participants reported being in more than one sexual relationship concurrently in the previous six months.

5.2.1.2.1 Sex with male partners

Participants were asked to report on the types of sexual activity that they had engaged in during the last occasion on which they had sex with a male partner (Table 7). Of the 46 participants who answered this question, close to a majority had engaged in oral sex and/or anal intercourse. Participants were generally as likely to be the receptive partner as the insertive partner for both oral and anal sex.

Table 7: Types of sexual activity on last occasion of sex with a male partner (n=46)*

	Frequency	Percent (%)
Handshake (you masturbated him)	11	23.9
Handshake (he masturbated you)	9	19.6
Oral sex (you sucked his penis)	19	41.3
Oral sex (he sucked your penis)	19	41.3
Intercrural sex (his penis between your thighs)	6	13.0
Intercrural sex (your penis between his thighs)	6	13.0
Anal intercourse (your penis inside his anus)	18	39.1
Anal intercourse (his penis inside your anus)	17	37.0

* Multiple answers possible. Missing data n=4.

5.2.1.2.2 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 number of male sex partners in the 12 months prior to the survey was between four and 10, whereas over the lifetime a majority of participants indicated having had more than four male partners, with 8% of participants reporting 50 or more male partners (Table 8). Six participants reported having no male partners in the previous 12 months.

Table 8: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
0	0	6 (12.2)
1 to 3	14 (29.2)	14 (28.6)
4 to 10	20 (41.6)	23 (46.9)
11 to 49	10 (20.9)	5 (10.2)
50+	4 (8.3)	1 (2.1)
Total*	**48 (100)[1]**	**49 (100.0)[2]**

[1] Missing data n=2. [2] Missing data n=1.

All 45 participants who reported ever having had sexual intercourse 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 9). Almost 75% of participants had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. Slightly fewer participants had anal intercourse with a casual male partner during the previous 12 months, and almost one-quarter of participants reported anal intercourse with male partners who paid them for sex.

Table 9: 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	11 (25.6)	13 (31.0)	33 (76.6)
1 to 3	22 (51.1)	16 (38.0)	5 (11.7)
4 +	10 (23.3)	13 (31.0)	5 (11.7)
Total	**43 (100.0)[1]**	**42 (100.0)[2]**	**43 (100.0)[1]**

[1] Missing data n=2. [2] Missing data n=3.

5.2.1.2.3 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 10. Condom use with regular partners was understandably low. Condom use with casual partners was also low, with over 80% of participants reporting no condom use or occasional condom use. Only five of the 10 participants who earlier reported sex with paying partners chose to answer questions about condom use with those partners, and none of these participants had used condoms on every occasion with a paying partner.

Reported condom use on the last occasion of anal intercourse with each of the partner types in Table 10 was at higher levels than for the last 12 months. Although not shown in Table 10, 15 (46.9%) of the 32 participants who had sex with a regular male partner reported using a condom on the last occasion with that partner. Eighteen (62.1%) of the 29 participants who had sex with casual male partners reported condom use on the last occasion of anal intercourse with a casual male partner. Four of the five participants who had a paying male partner and who responded to the questions about condom use reported condom use on the last occasion with that type of partner.

Table 10: 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	9 (28.1)	5 (17.2)	1 (20.0)
Sometimes	19 (59.4)	19 (65.5)	3 (60.0)
Almost every time	2 (6.3)	3 (10.3)	1 (20.0)
Every time	2 (6.3)	2 (6.9)	–
Total	**32 (100.0)**	**29 (100.0)**	**5 (100.0)[1]**

* Missing data n=5.

The use of lubrication for anal intercourse was relatively high. Twenty-one (65.6%) of the 32 people who had sex with a regular male partner in the preceding 12 months reported using lubrication the last time they had anal intercourse with a regular partner. Also, 20 (69.0%) of the 29 participants who had casual male partners reported using lubricant on the last occasion of anal intercourse with a casual male partner. And three of the five participants who had answered the question about lubricant use with paying partners used lubricant on the last occasion of anal intercourse with a paying partner.

All participants were asked whether they used lubricant the last time they used a condom, to which 35 (83.3%) of the 42 answered the question in the affirmative. When asked which type of lubricant they used on that occasion, 30 reported using water-based lubricant and three used hand lotion, while one person reported the use of Vaseline and another used baby oil. Participants obtained lubricant on that last occasion from various sources, including a health clinic (n=19), pharmacy (n=5), peer education worker (n=4), friend (n=4) and hospital (n=3).

5.2.1.2.4 Female partners

Twenty-three (48.9%) of 47 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 between one and 25 female partners in their lifetime. Sixteen (69.6%) of these 23 participants reported having sex with a female partner during the 12 months preceding the survey. The majority of these 16 participants had a regular female partner in the previous 12 months, and a majority also had at least one casual female partner in that period (Table 11).

Table 11: Number of regular and casual female partners in the last 12 months

Number of female partners	Regular partner n (%)	Casual partner n (%)
0	2 (13.3)	3 (20.0)
1 to 3	10 (66.7)	9 (60.0)
4 to 10	3 (20.0)	3 (20.0)
Total*	**15 (100)[1]**	**15 (100.0)[1]**

[1] Missing data n=1.

Of the 13 participants who had sex with a regular female partner in the 12 months preceding the survey, the majority used condoms 'sometimes' for vaginal intercourse with their regular female partner(s) (Table 12). Nine (69.2%) of the 13 participants reported using a condom on the last occasion of vaginal intercourse with their regular female partner. Of the 12 participants who had sex with a casual female partner in the 12 months preceding the survey, condom use was surprisingly less likely than for sex with regular partners – the majority reported using condoms 'sometimes' or 'never' with casual female partners. Six (50%) of the 12 participants did report condom use on the last occasion of vaginal intercourse with a casual female partner.

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

Regularity of condom use	Regular partners n (%)	Casual partners n (%)
Never	1 (7.7)	4 (33.3)
Sometimes	8 (61.5)	7 (58.3)
Almost every time	1 (7.7)	1 (8.3)
Every time	3 (23.1)	0
Total	**13 (100.0)**	**12 (100.0)**

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

Forty-four (91.7%) of the 48 participants who answered the question about condoms reported knowing what a condom was prior to the survey. Of these 44 participants, 40 participants knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them (Table 13). A large majority had last obtained condoms from a health clinic. The remainder of participants had last obtained condoms from a range of sources, including peer educators, friends and condom dispensers.

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

	Frequency	Percent (%)
Health clinic	26	61.9
Peer educator/outreach worker	6	14.3
Friend	4	9.5
Condom dispenser (bar/nightclub/restaurant/other venue)	3	7.1
Pharmacy	1	2.4
Hospital	1	2.4
Client	1	2.4
Total	**42**	**(100.0)**

The most commonly reported reasons for not using condoms were not identical for sex with male and female partners. For sex with male partners, the most common reasons reported for not using a condom for anal intercourse included objections from partner and condoms not being available. For vaginal or anal intercourse with female partners, there was an even spread of reasons, including not liking condoms, condoms taking away pleasure, condoms not being available, and faithfulness in the relationship (Table 14).

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

	Male partners n=42 (%)	Female partners n=14 (%)
Condoms take away pleasure	8 (19.0)	3 (21.4)
Do not like condoms	6 (14.3)	4 (28.6)
Condoms were not available	11 (26.2)	3 (21.4)
Difficulty obtaining condoms	2 (4.8)	0
My partner(s) and I are faithful	4 (9.5)	3 (21.4)
Partner objected	16 (38.1)	1 (6.3)
Not necessary	0	0
Condoms are too expensive	0	0
Used other prevention methods	0	0

* Multiple answers possible.

5.2.1.2.6 Sexually transmissible infections, including HIV

Thirty-one participants reported ever having heard of diseases that can be transmitted sexually. Of these 31 participants, nine reported having had symptoms of an STI in the past 12 months. Three participants reported genital discharge in the 12 months preceding the survey, two reported genital ulcers or sores, and eight reported ever having pain while urinating. These nine participants were asked what they did the last time they had any of these symptoms (Table 15). Participants generally visited a private clinic or an STI clinic the last time they had STI symptoms. Four participants reported ever having been diagnosed with an STI, which included gonorrhoea (n=3), syphilis (n=1) and chlamydia (n=1).

Table 15: What participants did the last time they had STI symptoms (n=9)*

	Frequency	Percent (%)
Visited a private clinic	4	44.4
Visited an STI clinic	3	33.3
Did nothing	2	22.2
Visited a healthcare worker	1	11.1
Talked to a friend	1	11.1
Visited a hospital	1	11.1
Got medicine from pharmacy	1	11.1
Received traditional treatment	0	–

* Multiple answers possible.

Thirty-nine (83.0%) participants reported having ever heard of HIV or the disease called AIDS prior to the survey. The most commonly reported sources of information about HIV and AIDS were friends or family, radio, television, school and pamphlets (Table 16). Twenty participants reported knowing someone who was infected with HIV.

Table 16: Sources of information about HIV and AIDS (n=39)*

	Frequency	Percent (%)
Friends or family	18	46.2
Radio	13	33.3
Television	13	33.3
School	13	33.3
Pamphlets/Leaflets	11	28.2
Newspapers/Magazines	10	25.6
NGO program	10	25.6
Posters/Billboards	9	23.1
Workplace	7	17.9

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

The 39 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 was high among this group, with 11 participants answering all 10 knowledge questions correctly, and 14 participants answering eight or more questions correctly. The lowest score recorded was three correct answers for the 10 questions.

Table 17: Knowledge about HIV and AIDS (n=39)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	33 (89.2)	4 (10.8)	2 (5.1)	39 (100)
Do people get HIV because of something they have done wrong?	35 (89.7)	4 (10.3)	0	39 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	10 (26.3)	28 (73.7)	0	38[1] (100)
Can a person get HIV by sharing food with someone who is infected?	35 (89.7)	4 (10.3)		39 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	7 (17.9)	31 (79.5)	1 (2.6)	39 (100)
Can a healthy-looking person have HIV?	10 (25.6)	28 (71.8)	1 (2.6)	39 (100)
Can people be cured from HIV by a traditional healer?	27 (69.2)	9 (23.1)	3 (7.7)	39 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	7 (17.9)	31 (79.5)	1 (2.6)	39 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	6 (15.4)	29 (74.4)	4 (10.3)	39 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	9 (23.1)	25 (64.1)	5 (12.8)	39 (100)

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

5.2.1.2.7 Stigmatising attitudes towards people living with HIV

A majority of the 39 participants who had heard of HIV had non-stigmatising attitudes towards people living with HIV (Table 18). However, a majority indicated that if a family member had HIV they would want it to remain a secret.

Table 18: Attitudes towards people living with HIV among participants (n=39)*

	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?	2 (5.1)	36 (92.3)	1 (2.6)	39 (100)
If a member of your family had HIV, would you want it to remain secret?	8 (20.5)	29 (74.4)	2 (5.1)	39 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	6 (15.4)	32 (82.1)	1 (2.6)	39 (100)

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

5.2.1.2.8 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community. Several participants, albeit a minority, 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=39)*

	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?	31 (79.5)	6 (15.4)	2 (5.1)	39 (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?	34 (87.2)	4 (10.3)	1 (2.6)	39 (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?	33 (84.6)	5 (12.8)	1 (2.6)	39 (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). Perhaps surprisingly, employers and co-workers appear to have been more supportive of participants' sexual identities than family members and other people. Close to a majority of participants reported that family, other people, and employers and co-workers were unaware of their sexual identity. Gossiping about them was the most commonly reported reaction of other people.

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

	Reaction of family members n=47 (%)[1]	Reaction of other people n=46 (%)[2]	Reaction of employer or co-workers n=45 (%)[3]
They don't know at all	24 (51.1)	22 (47.8)	22 (48.9)
They support my identity	14 (29.8)	13 (28.3)	19 (42.2)
They ignore me/refuse to talk to me	4 (8.5)	1 (2.2)	1 (2.2)
They criticised/blamed/verbally abused me	2 (4.3)	7 (15.2)	1 (2.2)
They conduct violence/physical abuse on me	0	0	0
They lock/restrict me	1 (2.1)	NA	NA
They kicked me out of the family/group	1 (2.1)	0	NA
They force me to work more	1 (2.1)	NA	NA
They gossip about me	NA	11 (23.9)	2 (4.4)
They fired me from work	NA	NA	0

* Multiple answers possible. [1] Missing data n=3. [2] Missing data n=4. [3] Missing data n=5. NA=not applicable.

5.2.1.2.9 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. Forty-five participants answered these questions. The most commonly reported response was feeling ashamed. A minority of participants also reported that they felt guilty (Table 21).

Table 21: Participants negative thoughts and feelings about their sexual identity in the last 12 months (n=45)*

	Frequency	Percent (%)
I feel ashamed	21	46.7
I feel guilty	8	17.8
I have low self-esteem	6	13.3
I feel suicidal	5	11.1
I blame myself	4	8.9
I feel I should be punished	3	6.7
I blame others	1	2.2

* Multiple answers possible. Missing data n=5.

Participants were asked to indicate whether they had engaged in or avoided certain events or activities because of their sexual identity (Table 22). Forty-one participants chose to answer these questions. The most commonly reported responses included deciding not to get married, avoiding going to a hospital or clinic when needed, choosing not to attend a social gathering, and deciding not to have children.

Table 22: Participants' actions as a result of their sexual identity in the last 12 months (n=41)*

	Frequency	Percent (%)
I decided not to get married	7	17.1
I avoided going to a hospital when I needed to	7	17.1
I avoided going to a local clinic when I needed to	6	14.6
I have chosen not to attend social gathering	6	14.6
I decided not to have children	4	9.8
I decided not to have sex	3	7.3
I have isolated myself from my family and/or friends	3	7.3
I decided to stop working	1	2.4
I decided not to apply for a job or for a promotion	1	2.4
I withdrew from education/training	0	–

* Multiple answers possible. Missing data n=9.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Five of the 48 people who responded to this question reported in the affirmative, that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, only one respondent choose to answer, indicating that it had been a friend who was responsible for the assault.

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

Thirty-six 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 by the majority: WSB Clinic, Save the Children, Vila Central Hospital, and Vanuatu Family Health.

Table 23: Knowledge about accessing health services

	No n (%)	**Yes n (%)**	**Don't know n (%)**	**Total n (%)**
Condoms	18 (37.5)	28 (58.3)	2 (4.0)	48 (100)
Health-related information	19 (39.6)	27 (56.3)	2 (20.0)	48 (100)
Support	21 (43.8)	25 (52.1)	2 (4.2)	48 (100)
HIV and STI testing	33 (68.8)	13 (27.1)	2 (4.2)	48 (100)
HIV and STI treatment	37 (77.1)	9 (18.8)	2 (4.2)	48 (100)

For all the services presented in Table 24, participants were either more likely to report having used the service or equally likely to report having used the service as not having used the service. A slight majority reported that being given condoms through an outreach service was not applicable to them.

Table 24: 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, HIV and STIs, or sexual assault?	12 (24.0)	24 (48.0)	14 (28.0)	50 (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?	15 (30.0)	33 (66.0)	2 (4.0)	50 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	1 (2.0)	23 (46.0)	26 (52.0)	50 (100)
Have you ever participated in an HIV peer education program?	22 (22.0)	26 (52.0)	2 (4.0)	50 (100)

* Missing data n=1.

The 33 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. A minority of the participants indicated that they were uncomfortable and embarrassed by the service, while only one person indicated that they would not use the service again. Forty-five participants (90.0%) 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=20)*

	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**	**Total**
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
The service was easy to access or find	2 (6.1)	0	2 (6.1)	24 (72.7)	5 (15.2)	33 (100.0)
The health worker I saw was friendly and easy to talk to	1 (3.1)	0	0	25 (78.1)	6 (18.8)	32[1] (100.0)
I felt uncomfortable and embarrassed	5 (15.2)	11 (33.3)	1 (3.0)	14 (42.4)	2 (6.1)	33 (100.0)
The service was confidential and I felt my privacy was respected	2 (6.1)	0	1 (3.0)	23 (69.7)	7 (21.2)	33 (100.0)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	1 (3.0)	0	1 (3.0)	28 (84.8)	3 (9.1)	33 (100.0)
I would use the service again if I needed to	1 (3.0)	0	0	26 (78.8)	6 (18.2)	33 (100.0)

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

5.2.1.2.11 HIV testing

Of the 39 participants who had heard of HIV or AIDS before the survey, 34 (87.2%) believed that it was possible for someone in their community to get a test to find out if they are infected with HIV, and 34 participants knew where to go to receive the test. Eighteen participants reported having ever had an HIV test and seven of these people had an HIV test in the 12 months prior to the survey. The most commonly reported place where they had an HIV test was at a government hospital health service (n=5), NGO clinic (n=3), private doctor (n=1) and elsewhere (n=1). Fifteen of the 18 people (83.3%) who had ever been tested for HIV reported receiving their HIV results. Of these 15 people, all reported that they were HIV-negative based on that result.

5.2.1.2.12 Alcohol and drug use

Twenty-five of the 47 participants who responded to questions about alcohol use reported drinking alcohol in the preceding four weeks. Of those who reported drinking alcohol, a majority indicated 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 50 drinks, the latter being improbable unless drinks contained very low alcohol and were consumed over multiple days. 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	11 (23.4)
Never in the last 4 weeks	11 (23.4)
Less than once a week	10 (21.3)
At least once a week	13 (27.7)
Every day	2 (4.3)
Total	**47[1] (100.0)**

[1] Missing data n=3.

Participants were asked whether they had taken a range of drugs during the preceding 12 months. The most widely used drug reported was kava (n=36), followed by marijuana (n=8), cocaine (n=1), heroin (n=1) and freebase (n=1). 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, 12 participants responded in the affirmative.

5.2.2 Female sex workers

5.2.2.1 Description of the sample

Eighty women who sold sex in exchange for money or goods provided survey data. The age of the women ranged from 18 to 46, with a mean age of 28 (SD=6.86) and median age of 27. 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	1.3
Pre-primary/Primary	35	46.0
Pre-secondary/Secondary	35	46.0
Polytechnic/Diploma	1	1.3
University/College	3	3.9
Other (responded with 'peer educator')	1	1.3
Total	**76**[1]	**100.0**

[1] Missing data n=4.

In responding to the question about relationship status, a majority of women reported having a boyfriend and not being married (Table 28). About 16% of the women indicated that they were 'single', with a similar percentage being widowed, divorced or separated.

Table 28: Relationship status

	Frequency	Percent (%)
Have a boyfriend but not married	41	51.2
Currently single	13	16.3
Widowed/Divorced/Separated	11	13.8
Currently married	10	12.5
Have a girlfriend	1	1.3
Don't know	4	5.0
Total	**80**	**100.0**

Sixty-one women reported having children. Among these women, about 60% had either one, two or three children and the remaining 40% had between four and six children.

Women were most likely to live with parents/in-laws (n=31), more so than with a husband (n=13). Many lived with a boyfriend (n=18) or children (n=12) (Table 29).

Table 29: Who participants were living with (n=75)*

	Frequency	Percent (%)
Parents/In-laws	31	41.3
Boyfriend	18	24.0
Husband	13	17.3
Children	12	16.0
Siblings	5	6.7
Live alone	5	6.7
Parents	2	2.6
Other male partner	2	2.7
Friends	1	1.3
Co-workers	1	1.3

* Multiple answers possible. Missing data n=5.

Women were asked whether they were employed, to which the majority reported that they were not (Table 30). When the women who were employed were asked what paid work they did, there was a range of responses including 'house girl', bar work, peer educator, gardener, selling food, and ship work.

Table 30: Employment status

	Frequency	Percent (%)
Not employed	52	68.4
Full-time employed	11	14.5
Part-time or casual employment	11	14.5
Self-employed	2	2.6
Total*	**76[1]**	**100.0**

[1] Missing data n=4.

5.2.2.2 Sexual history and practice

Seventy-one women (88.8%) reported ever having had sexual intercourse. Their age at the first occasion of sexual intercourse ranged from 13 to 26 years old. The age at which they first received money or goods in exchange for sex ranged from 10 to 40 years old, which indicates that some women were exchanging sex at a very young age, albeit not sexual intercourse.

5.2.2.2.1 Numbers of male partners

When asked how many male sex partners they had in their lifetime, the responses ranged from five to 80 male partners with a median of five partners and a mean of 11 partners. About 75% of the women indicated that they had had 10 or fewer male sex partners in their lifetime. 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 one to 52, with a median of two and a mean of four partners. Twenty women (25.0%) reported having sexual partners concurrently (that is, more than one sexual partner during the same period) in the previous six months.

5.2.2.2.2 Condoms

Sixty-nine (90.8%) of the 76 women who answered the question about knowing what a condom is responded by indicating that they did. Of these women, 66 (95.7%) reported knowing where they could obtain condoms. When asked where they had last obtained condoms, the most common responses included health clinic and NGO (Table 31). Sixty (87%) of the 69 women who had heard of a condom reported ever using a condom.

Table 31: Where condoms were last obtained

	Frequency	Percent (%)
Health clinic	24	34.8
NGO	16	23.2
Other – KPH Clinic	9	13.0
Condom dispenser (bar/nightclub/restaurant/other venue)	7	10.1
Friend	5	7.2
Hospital	4	5.8
Never obtained condoms	2	2.9
Client	1	1.4
Pharmacy	1	1.4
Total	**69**	**100.0**

5.2.2.2.3 Sex with paying male partners

Nine women reported that they had not received money or goods in exchange for sex in the previous 12 months, contrary to their earlier assertion when being recruited that they had. As such, the remaining analyses contain data for the 71 women who acknowledged in the survey that they had received money or goods in exchange for sex.

When asked how many paying partners they had in the 12 months preceding the survey, answers ranged from one to 30 partners with a median of two partners only. Given that only 10% of the women reported having had five or more paying partners in that period, it is expected that women underreported the actual number of partners. Indeed, when asked how many paying partners they had on the last day that they had paid sex, close to a majority (46.3%) reported one paying partner, 31.3% reported two paying partners, 19.4% had three paying partners and the remaining two women (3%) had 9 and 15 paying partners respectively.

5.2.2.2.4 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 anal intercourse, then oral sex.

Table 32: Types of sexual activity on last occasion of sex with a paying male partner (n=67)*

	Frequency	Percent (%)
Handshake (you masturbated him)	15	22.4
Handshake (he masturbated you)	7	10.4
Oral sex (you sucked his penis)	17	25.4
Oral sex (he licked your vagina)	15	22.4
His penis between your thighs or breasts	3	4.5
Vaginal intercourse	55	82.1
Anal intercourse	43	64.1

* Multiple answers possible. Missing data n=4.

5.2.2.2.5 Where sex with paying male partners takes place

Women were asked where they had sex with their paying clients the last time they had sex with a paying partner (Table 33). The most common response was at the client's house or at a guesthouse.

Table 33: Where sex occurred on the last occasion of paid sex (n=67)*

	Frequency	Percent (%)
His house	23	34.3
Hotel/Guesthouse	23	34.3
Outside (eg bushes, beach, etc)	11	16.4
My house	6	9.0
Car	4	6.0

* Missing data n=4.

5.2.2.2.6 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 the paying partner. A smaller proportion of women indicated that it was their own decision (Table 34).

Table 34: Who decides how much the woman gets paid for sex with a client (n=66)*

	Frequency	Percent (%)
Paying partner decides	44	66.7
I decide	23	34.8
Agent/Pimp decides	1	1.5
Manager of the business (eg madam in brothel)	0	–

* Multiple answers possible. Missing data n=5.

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

Condom use with paying clients was low for both vaginal and anal intercourse (Table 35). Over 70% and 85% of women respectively indicated 'never' or only 'sometimes' using condoms for vaginal and anal intercourse with paying male clients. A surprisingly high 42% of women reported never using a condom for anal intercourse in the previous 12 months. This may suggest that they and/or their paying partners are using condoms as a contraceptive tool more than for HIV and STI prevention. Among the 34 women who had used a condom sometimes or almost every time for vaginal intercourse, and among the 23 women who had used a condom sometimes or almost every time for anal intercourse, 31.5% and 44.2% respectively reported using a condom on the last occasion of vaginal intercourse and anal intercourse. On the last occasion of anal intercourse with a client, only about 26% of the women reported using lubricant.

Table 35: Consistency of condom use for vaginal and anal intercourse with paying male in the previous 12 months

Regularity of condom use	Vaginal intercourse n (%)	Anal intercourse n (%)
Never	11 (20.4)	18 (41.9)
Sometimes	30 (55.6)	20 (46.5)
Almost every time	4 (7.4)	3 (7.0)
Every time	9 (16.7)	2 (4.7)
Total	**54[1] (100.0)**	**43[2] (100.0)**

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

The most commonly reported reasons for not using condoms with paying partners included partner objecting, condoms taking away pleasure, partner being faithful and a dislike for condoms (Table 36).

Eighteen women reported not using a condom because the paying partner paid extra money for that to happen.

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

	Paying male partners n=65[1] (%)
Partner objected	26 (40.0)
Condoms take away pleasure	13 (20.0)
My partner(s) and I are faithful	10 (15.4)
Do not like condoms	7 (10.8)
Condoms were not available	4 (6.2)
Difficulty obtaining condoms	4 (6.2)
Used other prevention methods	3 (4.2)
Used other protection methods	3 (4.2)
Never heard of condoms	2 (3.1)
Not necessary	1 (1.5)
Condoms are too expensive	0
Other (included he gave me more money, masturbated him, we trust each other, did not have condoms as did not expect to have sex, forgot to get condoms, maybe he wants me to get pregnant, partner scared, unexpected, did not think about it)	12 (18.5)

* Multiple answers possible. [1] Missing data n=6.

In response to the question about how often it was difficult to get clients to use condoms, most women reported ‘a little of the time’ or ‘some 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	13 (19.7)
A little of the time	21 (31.8)
Some of the time	16 (24.2)
A lot of the time	8 (12.1)
All of the time	3 (4.25)
I did not try and get my clients to use a condom	5 (7.6)
Total	**66[1] (100.0)**

[1] Missing data n=6.

When asked who supplies the condom, the majority of women reported that they provide the condom while about one-third indicated that the client provides the condom (Table 38).

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

	Paying male partners n= (%)
I never use a condom	6 (8.8)
I provide the condom	37 (54.4)
Client provides the condom	23 (33.8)
Other (included none, none of us – *presumably someone else*)	2 (2.9)
Total	**68[1] (100.0)**

[1] Missing data n=3.

5.2.2.2.8 Sex with regular male partners

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

5.2.2.2.9 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 generally low, which is typically the case with regular partners, and to be expected. However, given the low rates of condom use with clients, there is a clear risk of transmitting HIV and other STIs to regular partners.

Among the 30 women who had used a condom sometimes or almost every time for vaginal intercourse with their regular partner(s) and among the 18 women who had used a condom sometimes or almost every time for anal intercourse, 53.3% and 77.8% respectively reported using a condom on the last occasion of vaginal intercourse and anal intercourse. On the last occasion of anal intercourse with a regular male partner, 42.1% of the 38 women who had anal intercourse reported using lubricant.

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 n (%)**	**Anal intercourse n (%)**
Never	23 (37.7)	17 (44.7)
Sometimes	25 (41.0)	16 (42.1)
Almost every time	5 (8.2)	2 (5.3)
Every time	8 (13.1)	3 (7.9)
Total	**61[1] (100.0)**	**38[2] (100.0)**

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

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

Table 40: Reasons for not using condoms for vaginal and/or anal intercourse with regular male partner(s)*

	Regular male partners n=53[1] (%)
Partner objected	20 (37.7)
My partner(s) and I are faithful	16 (30.2)
Condoms take away pleasure	12 (22.6)
Do not like condoms	7 (13.2)
Condoms were not available	4 (7.5)
Not necessary	4 (7.5)
Used other protection methods	3 (5.7)
Difficulty obtaining condoms	2 (3.8)
Used other prevention methods	1 (1.9)
Never heard of condoms	–
Condoms are too expensive	–
Other (included because he is my husband, my partner said if I use condom it means I have seen another guy, did not think about it, only use during monthly period, I trust him, want to have another child)	7 (13.2)

* Multiple answers possible. [1] Missing data n=9.

5.2.2.2.10 Sex with casual male partners

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

5.2.2.2.11 Condom use with casual non-paying male partners

Participants were asked how often they had used condoms for vaginal intercourse and anal intercourse with their casual male partners in the last 12 months (Table 41). Condom use for both types of intercourse was similar, with about one-third of women reporting 'never' using a condom for vaginal and anal intercourse with casual male partners. About 50% of women reported 'sometimes' using condoms with casual male partners.

Among the 20 women who had used a condom sometimes or almost every time for vaginal intercourse with their casual partners, and among the 13 women who had used a condom sometimes or almost every time for anal intercourse, 70% and 76.9% respectively reported using a condom on the last occasion of vaginal intercourse and anal intercourse. On the last occasion of anal intercourse with a casual male partner, 37.5% of the 24 women who had anal intercourse reported using lubricant.

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	14 (35.9)	8 (33.3)
Sometimes	18 (46.2)	12 (50.0)
Almost every time	2 (5.1)	1 (4.2)
Every time	5 (12.8)	3 (12.5)
Total	**39[1] (100.0)**	**24[2] (100.0)**

* Missing data n=1. [1] Includes only women who reported having vaginal intercourse. [2] Includes only women who reported having anal intercourse.

Women were asked for their reasons for not using condoms with casual male partners. The most common responses included partner objecting, perceived faithfulness, condoms taking away pleasure, and not liking condoms (Table 42). It is worth noting that the same reasons for not using condoms emerged for each of the three different partner types.

Table 42: Reasons for not using condoms for vaginal and/or anal intercourse with casual male partner(s)*

	Casual male partners n=35[1] (%)
Partner objected	15 (42.9)
My partner(s) and I are faithful	8 (22.9)
Condoms take away pleasure	6 (17.1)
Do not like condoms	6 (17.1)
Condoms were not available	5 (14.3)
Not necessary	1 (2.9)
Used other protection methods	1 (2.9)
Difficulty obtaining condoms	1 (2.9)
Used other prevention methods	0
Never heard of condoms	0
Condoms are too expensive	0
Other (included because I masturbated them, did not think about it, I forgot to get condoms)	4 (11.4)

* Multiple answers possible. [1] Missing data n=5.

5.2.2.3 Alcohol and drug use

Thirty-four of the 69 participants who responded to questions about alcohol use reported drinking alcohol in the preceding four weeks (Table 43). Of those who reported drinking alcohol in that period, they were equally likely to have drunk alcohol less than once a week or at least once a week. None of the women reported drinking alcohol every day.

Table 43: Alcohol use in the past four weeks

	n (%)
I never drink alcohol	20 (29.0)
Never in the last 4 weeks	15 (21.7)
Less than once a week	18 (26.1)
At least once a week	16 (23.2)
Every day	0
Total	**69[1] (100.0)**

[1] Missing data n=2.

Participants were asked whether they had taken a range of drugs during the preceding 12 months (Table 44). The most widely used drugs included kava, marijuana, heroin and freebase. 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, 23 (46.9%) of the 49 participants who answered the question responded in the affirmative.

Table 44: Use of recreational and illicit drugs in the past 12 months*

	n=69[1] (%)
Kava (sakau/ava/awa)	56 (81.2)
Marijuana	21 (30.4)
Heroin	10 (14.5)
Freebase	8 (11.6)
Cocaine	3 (4.3)
Inhalants (eg sniffing glue, paint, petrol, spray can)	3 (4.3)
Amphetamine (Speed)	3 (4.3)
Crystal/Ice (methamphetamine)	2 (2.9)
Ecstasy/MDMA	2 (2.9)
Other (included cigarettes, white powder, cocaine – *presumably some respondents did not see that cocaine was an option in the list*)	7 (10.1)

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

5.2.2.4 Sexually transmissible infections, including HIV

Fifty-two participants reported ever having heard of diseases that can be transmitted sexually. Among these participants, 35 reported having had symptoms of an STI in the past 12 months. Thirty-three participants reported genital discharge in the 12 months preceding the survey, 11 reported genital ulcers or sores, and 33 reported ever having pain while urinating. These 35 participants were asked what they did the last time they had any of these symptoms (Table 45). Participants generally visited an STI clinic or hospital, or did nothing the last time they had STI symptoms. Twenty-five participants reported ever having been diagnosed with an STI, which included gonorrhoea (n=18), syphilis (n=4), trichomonas (n=2), genital herpes (n=1), genital warts (n=1), chlamydia (n=1) and other (n=7). Given that one person manually typed 'AIDS' – see immediately above – it is unclear whether this means that they were diagnosed with HIV or whether they were provided with information about HIV and AIDS. It ought to be noted that further on in the analyses, under 'HIV testing', none of the women reported receiving an HIV positive diagnosis.

Table 45: What participants did the last time they had STI symptoms (n=35)*

	Frequency	Percent (%)
Visited an STI clinic	15	32.6
Did nothing	12	26.1
Visited a hospital	8	17.4
Received traditional treatment	4	8.7
Talked to a friend	3	6.5
Visited a private clinic	3	6.5
Got medicine from a pharmacy	2	4.3
Visited a healthcare worker	1	2.2
Other (included went to KPH Clinic [WSB], just had a shower, poured boiling water into a big dish and sat on it, took Panadol)	5	10.8

* Multiple answers possible.

Sixty-one (85.9%) participants reported having ever heard of HIV or the disease called AIDS prior to the survey. The most commonly reported sources of information about HIV and AIDS were radio, friends or family, an NGO and school (Table 46). Twenty-six participants reported knowing someone who was infected with HIV.

Table 46: Sources of information about HIV and AIDS (n=61)*

	Frequency	Percent (%)
Radio	18	29.5
Friends or family	15	24.6
NGO program	15	24.6
School	10	16.4
Pamphlets/Leaflets	8	13.1
Television	7	11.5
Newspapers/Magazines	3	4.9
Posters/Billboards	3	4.9
Workplace	0	–
Other (included awareness in KPH, be faithful to one partner, HIV transmission)	16	26.2

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

5.2.2.5 Knowledge about HIV and AIDS

The 61 women were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 47. Correct knowledge was neither low nor high in this group. There is clearly scope for improved knowledge.

Table 47: Knowledge about HIV and AIDS (n=4)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	24 (39.3)	26 (42.6)	11 (18.0)	61 (100)
Do people get HIV because of something they have done wrong?	42 (68.9)	15 (24.6)	4 (6.6)	61 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	16 (26.2)	41 (67.2)	4 (6.6)	61 (100)
Can a person get HIV by sharing food with someone who is infected?	41 (67.2)	16 (26.2)	4 (6.6)	61 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	13 (21.3)	43 (70.5)	5 (8.2)	61 (100)
Can a healthy-looking person have HIV?	20 (32.8)	38 (62.3)	3 (4.9)	61 (100)
Can people be cured from HIV by a traditional healer?	47 (77.0)	10 (16.4)	4 (6.6)	61 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1 (1.6)	57 (93.4)	3 (4.9)	61 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	12 (19.7)	40 (65.6)	9 (14.8)	61 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	25 (41.0)	28 (45.9)	8 (13.1)	61 (100)

5.2.2.6 Stigmatising attitudes towards people living with HIV

A majority of the women had non-stigmatising attitudes towards people living with HIV (Table 48). However, 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 48: 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?	16 (26.2)	41 (67.2)	4 (6.6)	61 (100)
If a member of your family had HIV, would you want it to remain secret?	23 (37.7)	37 (60.7)	1 (1.6)	61 (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	20 (32.8)	41 (67.2)	–	61 (100)

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

5.2.2.7 Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 49). 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 49: 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?	46 (75.4)	12 (19.7)	3 (4.9)	61 (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?	46 (75.4)	11 (18.0)	4 (6.6)	61 (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?	39 (63.9)	21 (34.4)	1 (1.6)	61 (100)

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

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. Twenty-five 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 their boyfriend or husband (n=4), family friend (n=2), casual partner (n=4), friend (n=6), stranger (n=5), work colleague (n=2) and other (ex-boyfriend) (n=1).

5.2.2.8 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 50). About 50% of the women knew where and how to access these services, while the remainder did not. There is clearly scope to improve knowledge about accessing these health services for this group of women.

Fifty-five women 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 by the majority: WSB Clinic, health dispensary, Vila Central Hospital, and Vanuatu Family Health Association.

Table 50: Knowledge about accessing health services

	No n (%)	**Yes n (%)**	**Refuse to answer n (%)**	**Total n (%)**
Support	44 (62.0)	25 (35.2)	2 (2.8)	71 (100)
Health-related information	38 (53.5)	31 (43.7)	2 (2.8)	71 (100)
HIV and STI testing	39 (54.9)	30 (42.3)	2 (2.8)	71 (100)
HIV and STI treatment	43 (47.9)	26 (36.6)	2 (2.8)	71 (100)
Condoms	34 (47.9)	35 (49.3)	2 (2.8)	71 (100)

For all the services presented in Table 51, a minority reported using the service. A majority reported that being given condoms was a service that was not applicable to them.

Table 51: 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?	31 (43.7)	25 (35.2)	15 (21.1)	71 (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault?	11 (15.5)	24 (33.8)	36 (50.7)	71 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	6 (8.6)	19 (26.8)	46 (63.4)	71 (100)
Have you ever participated in an HIV peer education program?	35 (49.3)	29 (40.8)	7 (9.9)	71 (100)

The 24 women who had visited a health service for information or services related to condoms, family planning, HIV and STIs, or sexual assault overwhelmingly rated their experience as positive and all would use the service again (Table 52). The aspect of their experience that 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 52: 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	1 (4.2)	0	10 (41.7)	13 (54.2)	24 (100)
The health worker I saw was friendly and easy to talk to	0	0	0	12 (50.0)	12 (50.0)	24 (100)
I felt uncomfortable and embarrassed	2 (8.3)	14 (58.3)	0	7 (29.2)	1 (4.2)	24 (100)
The service was confidential and I felt my privacy was respected	0	1 (4.2)	0	10 (41.7)	13 (54.2)	24 (100)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	0	1 (4.2)	0	12 (50.0)	11 (45.8)	24 (100)
I would use the service again if I needed to	0	0	0	12 (50.0)	12 (50.0	24 (100)

* Includes only those women who reported using the service.

5.2.2.9 HIV testing

Forty-eight (78.7%) of the 61 women believed that it is 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. Twenty-two women had ever had an HIV test, of whom 11 (13.8% of those surveyed) had an HIV test in the 12 months prior to the survey. These women reported that they had their tests carried out through a private doctor (n=1), government hospital health service (n=5) and NGO clinic (n=5). Of the 22 women who had ever been tested for HIV, 13 (59.1%) reported receiving their results and all were informed that they were HIV negative based on that result.

5.3 In-depth interviews

5.3.1 Female sex workers

The 10 FSW interviewed were all from Vanuatu. A number of them came to Port Vila from other islands; two had lived all their life in Port Vila; and one was living on Tanna Island. Those interviewed were aged between 19 and 48. They lived with their extended family, mostly, or with their boyfriends and various relatives. One woman lived with her children. Most clients are locals, foreign businessmen, government officials, or education or health professionals.

5.3.1.1 Social and structural factors

While sex work is legal in Vanuatu, soliciting is not and neither are brothels. Vanuatu's *National Strategic Plan on HIV and STIs* has as a component the building of an enabling environment and the review and revision of national policies, legislation and traditional laws that discriminate against vulnerable populations (Godwin 2010).

5.3.1.2 Reasons for sex work

Most of the participants worked as FSW due to limited employment opportunities in Vanuatu. The opportunities for employment that existed paid poorly when compared with sex work. Interviewee 7 said that the reason she does sex work is that 'I got good money from this so I never thought about applying for a job'.

Interviewee 8 said:

> There's no job, no money, so that's the only way we find money … so when we get to the nakamal and come back, in the morning we can buy breakfast – but if we don't go to the nakamal then we don't get money to get breakfast.

The work that was mentioned in the interviews could be categorised as 'small business': making copra, making and selling kava. There was occasional part-time work, such as when the cruise ships docked, and there was work in coffee shops or hotels.

There was an element of satisfaction in being your own boss and there was also immediacy of payment when you were performing sex work:

> When I work at the coffee shop, I have a boss … and I have to wait to get paid – with this I can get whatever I want, when I want it. Like If I'm in town and I want to eat chips but I don't have any money, I just go stand on the road and someone will pick me up and then after I will have my chips.

5.3.1.3 Sex work earnings

Earnings had declined recently (possibly mostly to do with Vanuatu's cyclone and drought), but most men paid anywhere between VT1,000 and VT5,000 (roughly between US$8 and US$40). There were instances where the FSW were paid greater amounts. These were generally payments from foreigners or government employees who kept the women solely for themselves. Interviewee 6 had an ongoing relationship with a well-off local man, but she had no freedom:

> That man he paid for everything, house, food, pocket money, car, anything I want to buy … he gave me everything in exchange for his pleasure – for about three years like this … [He also] had a wife and so many girlfriends plus me and every girlfriend has got everything like me, he pays the home for them too … [but] I had no freedom – I can't go out, can't go with other men …

She has since ended this arrangement, and said:

> I think now it's better, I have little money but I have freedom, I go with who I want.

Most FSW were supporting themselves, their children, their elderly parents and sometimes ill husbands and unemployed or 'lazy' boyfriends. If there were other ways they could achieve a standard of living to which they were used or aspired, then they would not be active as FSW.

5.3.1.4 Condom use

Those participants who used condoms provided the condoms themselves. They either sourced them from Kam Pusem Hed Clinic (KPH) or the clinic at WSB, where they were free, or occasionally bought them. Condoms cost approximately VT50 (approximately A$0.60) for a three-pack. Interviewee 6 said:

> I take condoms only from here [KPH] and sometimes I take a big box and put in the nakamal [kava bar in her community]. And some they laugh at me, but I say, 'in Vila we have no distributor [of condoms] so put [the box] on top of your counter and leave it there'.

Condom use appeared to be on the increase and is also, increasingly, being driven by the FSW. One respondent explained how she takes condoms with her and before sex she takes out the condom and explains to the client that they must use it:

> I tell them I'm afraid of getting the sick [STI], I don't know your life, how many partners you have and if you go with other women you can get STI and bring it to me.

However, for it to be truly effective, the FSW has to walk away if the client refuses to use the condom. In many instances, though, it is still a case of the need for the payment being greater than the fear of turning down the client and annoying them. Further, as sex work is frequently opportunistic, an FSW may not be carrying condoms at the time a sexual exchange occurs. Interviewee 7 said:

> Sometimes I don't have condoms with me but if I don't go ahead and have sex then I don't get money.

Some of the interviewees viewed condoms primarily as contraceptives, but most were aware that condoms were a useful protection against contracting an STI or worse.

Interviewee 5 knew little of condom use, but she was in the minority: 'I don't know anything of condoms or how to use them but I've seen them.'

5.3.1.5 Sex worker support and services

There are no FSW-specific networks in Vanuatu. They are largely reliant on WSB, its clinic (KPH), the hospital and the Vanuatu Family Health Association.

FSW are reliant on their own resources and rely heavily on the clinic for their source of condom protection, treatments for STI symptoms, and information and advice. One woman mentioned being 'ruined' because she had contracted an STI.

Interviewee 1 had been asked to be a peer educator after attending KPH:

> The KPH clinic wanted me to be a peer educator because I've been here coming to the clinic a lot and I've participated in workshops, so they trained me and I've been going around with the youths – they know that I'm one who has been going around so they trained me to be a part time peer educator, and through this I'm coming to understand [about prevention, condoms] …

There was specific mention by one interviewee that they did not see peer educators any longer and they wondered what had happened to them. In fact, the funding for the FSW program ceased and WSB had to halt the peer education program

5.3.2 Transgender and men who have sex with men

Eight in-depth interviews were conducted, with only one self-identifying TG but seven men who identified as homosexual or 'gay' – MSM.

5.3.2.1 Social and structural factors

Vanuatu does not have any legal prohibition of same-sex behaviour and does not selectively enforce criminal laws against MSM and transgender people. However, strong traditional and Christian views against homosexuality still exist.

5.3.2.2 Stigma

Those who took part in the in-depth interviews argued that TG and homosexual or 'gay' men are not highly stigmatised in Port Vila. It is, however, different in the islands. Interviewee 3, who lives on a small island, reported that when he was in town (Port Vila) he would dress up and use make-up when he went out, but 'in the island we can't, we have to act normal'.

However, there was still some verbal abuse, although none reported any physical violence in the community. Interviewee 1 suggested:

> … physical violence [towards gay men] is less in recent years, more limited to experience verbal abuse/name calling now.

Public attitudes are said to be more accepting as more individuals 'come out' – possibly being more accepting than their families, who feel there is some shame. Therefore, MSM and TG generally feel more safe and comfortable among intimate friends rather than family groups. Interviewee 3 also talked of respect and that notions of respect remain strong. This participant is a teacher and enjoys the respect he is shown:

> When I walk to school, people greet me, when I walk through the village the kids call out 'teacher, teacher!'

There are often one or two people within the family who are aware of or suspect the sexuality of the MSM or TG, but outside these one or two relatives they feel vulnerable. Mothers were very important in the process and most accepted and were supportive of their sons in the end. Interviewee 3 felt confident that his parents know that he is gay, although he hasn't had a conversation with them about it: 'they know, but they just leave me alone'.

The close circles of friends and workplace are integral to social support. Interviewee 5 said:

> Close friends and close work colleagues know that I'm gay and also knew about my boyfriend [relationship with work colleague].

The church was not described as being accepting. It does not banish MSM or TG; however, it is experienced as being judgmental. Interviewee 1 has stopped going to church 'because they only preach against being gay, so why should I go?'

Despite being proud of their sexuality, and public attitudes broadening to some acceptance, on the whole this cohort tended to keep their relationships relatively private and among their intimates. Interviewee 5 said:

> When I'm in a relationship I like to show affection – hold hands; hug; kiss. But local boys usually want to hide it.

5.3.2.3 Identity

Although this group has experienced homophobia and gossip, all are proud of their identity as either transgender or gay. Some were active in the community, one worked in a nightclub, one as a teacher (including Sunday School) and another acted in the WSB Theatre group. They were proud of their sexual identity and were not particularly secretive about it, although they did not flaunt it. Interviewee 1 said:

> People invite you to lots of parties, picnics, functions … people want you to go because you're going to be the life of the party.

Some MSM preferred 'straight men' (masculine looking) as opposed to overtly feminine men and some men were more masculine than feminine themselves. For instance, Interviewee 1 said: 'With men, I go for my own type – the straight gays.'

5.3.2.4 Work

Those interviewed in this group worked in the arts, education and service industries. The teaching profession was represented, along with acting and bartending.

5.3.2.5 Sexual relationships

Most of the MSM/TG we spoke to had begun having sex with men while in high school. Interviewee 2, who identifies as TG, said that she began having sex with men while in high school (Year 11, 16 years old): 'boys approached me because I was so feminine.' Interviewee 2 seems to have had what might be considered a particularly difficult time as a boarder at school:

> I was placed in a dorm with other 'fairies' … One particular boy kept asking for sexual favours; one night he came into the dorm and lay on top of me and started kissing me …

> From this time, many of the boys [at the school] would come seeking sexual pleasure, we [the gay/feminine boys] were like sex toys to them; but during the day these same boys would verbally abuse us around school …

Some had relationships with girls, but most ultimately did not progress to sex. All the men interviewed preferred a long-term relationship and a number of them had had successful long-term relationships, albeit often hidden. Often distance became a problem when one of them moved away to work or study.

5.3.2.6 Condom use

While all believed in condom use, some were more adamant than others. It is still a problem enforcing their requests with their partner, and only one of the participants would insist that a condom be used every time. Interviewee 1 was prepared to walk away from the partner, even a one night stand, if they declined his request to use a condom: 'if the guy doesn't want to use then I won't go (have sex) with him.'

In one instance, the request was made of Interviewee 2, whose boyfriend asked him to use a condom. He hadn't thought about it until that point, but agreed:

> [I] was seeing a young man [18 years] who raised the issue of condom use – so it was he who negotiated it … when he raised it, I said 'no I don't use condoms' but then I realised that yes I should and so I agreed.

Condom use is quite opportunistic. If the participant had condoms, they were likely to ask the sexual partner to use them. Interviewee 3 said: 'Sometimes I use them, if I have them, or the boy has a condom.'

It was unlikely that they will go to very much trouble to find condoms. Therefore, easy access to condoms – including condom availability in more (and more private) locations, particularly for free – is absolutely essential in increasing the use of condoms, and taking condom use from occasional to regular use. Interviewee 3 said that the biggest change to his condom use is that now that he's living on the island, he finds it hard to get them: 'When I come to town I take a box back with me and share them with the other [gay] boys.'

Of course, attitudes among their sexual partners also need to be altered.

In most instances, too, the subject used their judgement as to whether a sexual partner was safe to go without the protection of a condom.

It was more common to ask for a condom to be used with a one-night stand, but not with their regular partner. According to Interviewee 3, 'when I'm with a [long-term] partner I don't use condoms, but if it's just one night, I usually use them'. Expats and mobile men are also perceived as being higher risk: 'If I'm with an expat or someone who I know is travelling, I will always use a condom.'

About half of the interviewees were not aware of lubricant. Those who were aware of lubricant had difficulty obtaining it. This seems to be something that is common throughout the islands. One participant used condoms that had lubricant, because it made anal sex easier to perform.

5.3.2.7 Outreach

Most of the participants spoke very highly of WSB and considered WSB and its clinic to be the preferred source of information and advice. For some, their interaction with WSB was their introduction to the use of condoms and being aware of HIV and STI infections. Interviewee 2 felt strongly that her life was significantly changed (in a positive way) by becoming involved with WSB Theatre: 'my involvement led to me using condoms and accessing the clinic as well.'

Interviewee 2 said that involvement with WSB 'also led to involvement with MSM program at WSB [VPride, previously Solidarity]'. Interviewee 1 said:

> I joined VPride [Solidarity, as it was called then] in 2012 or 2013. I heard about it from my cousin who is also gay … There was a lot of programs about awareness and also protection; I learnt a lot there.

Peer educators were noted as not being as visible as they were in the past.

5.3.2.8 Services/HIV testing

Most of those interviewed had had an HIV test. The test was not always a stand-alone test but, rather, in conjunction with another purpose – for example, giving blood or employment screening (such as for seasonal work in New Zealand or Australia).

If a test was needed, most interviewees said that they would choose to seek treatment and advice from KPH because it was seen as being more confidential, more understanding of the client's need, and less judgemental. Interviewee 4 said:

> If I ever had symptoms [of an STI] or was worried, I think I would come to Vila to a clinic.
>
> *[Why?]*
>
> Some [people on the island] understand, some don't understand so to make it easier I think I would come to Port Vila.

There is also a view that there are a lot of MSM/TG who do not undergo testing as they have a mistrust of those employed in the services. Interviewee 2 said:

> Even those who are 'high class' [in good jobs, well educated, well off] because they try to hide their sexual relationships.

5.4 Capacity assessment of HIV organisations and services

5.4.1 Vanuatu – HIV organisations and services

5.4.1.1 Organisational mapping

Under the country's Public Health and HIV National Strategic Plan, the HIV/STI department of the Vanuatu Ministry of Health (MoH) undertakes prevention, testing and treatment activities and coordinates the country's HIV-related activities. The MoH does not specifically engage MSM/TG, FSW or seafarers in its service delivery, but it gives non-financial support to organisations providing health and well-being promotion to key populations, such as Wan Smolbag and VPride.

The key NGOs currently providing HIV and STI services are:

- the Vanuatu Family Health Association (VFHA), which works in a number of provinces to provide sexual and reproductive health services (no specific focus on key populations)
- Wan Smolbag (WSB), an NGO based in Port Vila (with clinics/drop-in centres in two other provinces), which focuses on HIV and STI prevention and the promotion of rights for youth, LGBT and sex workers.

VPride is an unfunded LGBTI network focusing on advocacy and peer support for LGBTI ni-Vanuatu.

A statutory body called the Vanuatu National Youth Council (VNYC) works with youth aged 12 to 30 years in advocacy, policy advice and representation, with some focus on HIV, reproductive health and human rights. CARE International, an international development NGO, undertakes a life skills program for young women aged 10 to 20 years in Tafea province, which covers HIV, STIs, reproductive health, and sexual orientation and gender identity issues.

The development NGO Save the Children Australia – Vanuatu conducts child protection, disaster risk reduction, and climate change awareness programs. It also had an antenatal care and reproductive health project until 2014.

A national organisation called Youth Challenge Vanuatu provides training and development programs for young people, but without a specific focus on health or HIV.

5.4.2 HIV and STI prevention activities in Vanuatu

5.4.2.1 National oversight, coordination and funding

A National AIDS Council is established but is reportedly not currently functioning. The MoH reported providing a coordinating role for the country's HIV/STI response. HIV/STI funding primarily comes from the Global Fund and the MoH.

5.4.2.2 HIV and STI testing, counselling and treatment

HIV/STI testing is conducted through the MoH (in hospital and clinics), VFHA (clinics in Port Vila, Santo and Tanna) and WSB (clinics in Port Vila, Luganville (Santo) and Pentecost).

5.4.2.3 Condom distribution

Condoms are distributed by a number of organisations, including VFHA, WSB and VPride. WSB and VPride distribute condoms directly to members of key populations.

5.4.2.4 Peer education

Peer education activities among MSM, TG and FSW populations are conducted by WSB and VPride. WSB's program has extensive reach with peer educators reported to have talked to 8,349 people (including non-MSM/TG/FSW) in Efate, Santo and Pentecost in 2015. VPride was born out of the work of WSB's peer education program. VPride members who are trained peer educators carry out peer education with LGBTI in the community, including on HIV prevention; provide condoms and social support; carry out skills building; and promote STI and HIV testing. VPride peer educators are also utilised by the MoH.

5.4.2.5 Strategic health communication

In the last 12 months, WSB reported holding five behaviour change and communication workshops with 63 women, of whom 18 were known FSW, and weekly meetings with 26 MSM/TG members of VPride.

5.4.2.6 Advocacy and legislation

WSB undertakes advocacy on equal treatment regardless of sexual orientation. VPride reported an advocacy remit and identified a need for capacity building in advocacy.

International NGOs CARE International and Save the Children Vanuatu reported being involved in advocacy on various issues, including women's empowerment, child protection and reproductive health. VNYC reported conducting youth-related advocacy work.

5.4.2.7 Other support services

VPride provides social support to its MSM/TG constituents.

Cross-cutting organisational strengths

- **Policies:** Many agencies reported being guided by global, regional and/or domestic policies and guidelines related to their sector of work.
- **Coverage:** Organisations including VFHA, Save the Children Australia – Vanuatu, CARE International and VNYC reported good coverage levels across the country.
- **Partnerships:** Organisations appear to be well-connected to other agencies working in their sector areas.
- **Monitoring and evaluation:** A number of service delivery organisations, including MoH, WSB, VFHA and CARE International, reported strong data collection and monitoring and evaluation systems/processes.

Cross-cutting organisational capacity-building needs

- **Greater/specific engagement of key populations in service delivery:** Many organisations (with the exception of WSB and VPride) acknowledged a need to directly engage key populations in relevant prevention/education activities and treatment services.
- **Training and professional development:** Most organisations sought training and professional development for staff and/or volunteers in either technical or organisational management areas.
- **Funding:** A greater need for HIV/sexual health-specific funding was identified, particularly for service delivery.
- **Data collection/Monitoring and evaluation:** Some data collection gaps were identified – for example, there is a need to collect data disaggregated by population type (MSM, FSW, etc).
- **Governmental barriers to advocacy and activities:** One organisation advised of a denial of sexual activity among young people, specifically multiple-concurrent partner behaviour and sex work. As well, the centralised government structure reportedly provides little support at the provincial level, with village health workers in some areas rarely or never being paid or incentivised by the government.

Identified capacity-building resources

The MoH receives technical support from the United Nations Development Programme, the Secretariat of the Pacific Community, and the World Health Organization, which could be increased to assist with capacity building. VFHA has existing support from the International Planned Parenthood Foundation. Some organisations have medium/long-term volunteers sourced through the Department of Foreign Affairs and Trade-funded Australian Volunteers for International Development program.

5.5 Suggestions for further support to key populations

1. Wan Smolbag is an excellent resource with extensive experience in peer education with key populations and the provision of accessible clinical services. Due to funding reductions over the past few years, the peer education program has 'shrunk' and related activities been limited. Yet the peer to peer approach within communities has clearly been a major source of education, condom distribution and service promotion amongst key populations within Vanuatu. We strongly recommend funding provided to reinstate their extensive peer outreach program & enable it to expand within all locations (islands) where WSB has a presence (given the large numbers of women opportunistically doing sex work in and around Port Vila and beyond) and consider how it could be expanded to other islands (perhaps in partnership with other agencies working in those settings - eg. Tanna through working with CARE International). Recommend also supporting WSB to act as a resource for other agencies who are willing and interested in engaging with key populations.

2. We recommend that UNDP & other regional agencies consider how they can facilitate the direct provision of commodities to non-government agencies. WSB and other NGOs continue to experience problems with accessing sufficient commodities through the Central Medical Store (at the Hospital). This leads to NGOs having stock outs of important commodities, and sometimes having to purchase from overseas retailers at significant expense.

3. We recommend direct funding to VPride to assist the group to become an established and registered organisation established independently of WSB with the structures and resources in place to carry out peer support, advocacy and sensitization training/workshops with health workers and community members to reduce stigma. Ideally they would then be able to employ one or more members of the community, even part-time to be a contact point and focus on organising meetings, communications (within Vanuatu & regionally), representation etc. I would strongly recommend that UNDP also facilitate the provision of technical support to assist with this.

4. UNDP & other regional agencies (including PSDN) ensure that invitations to VPride for attendance at regional meetings, consultations, capacity development opportunities etc. go to the president or vice president (as per the org. capacity assessment information), so these can be communicated to all members and allow equal opportunity for participation & capacity development.

5. Advocacy is needed t=for more SOGI-supportive policy, legislation and protection against discrimination for MSM/TG

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Annex 1: UNAIDS GARP data needs

DATA - VANUATU

Indicator relevance: Topic relevant, indicator relevant, data available

Data measurement Tool:

Please specify data measurement tool:

Data collection period:

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

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

Sample Size:

Number of Survey Respondents: 71

Sex Workers

	All	Males	Females	>25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	**23.9**		**23.9**	**19.0 %**	**26.0**
Numerator Number of sex workers who answered "Yes" to both questions	**17**		**17**	**4**	**13**
Denominator Total number of sex workers surveyed	**71**		**71**	**21**	**50**
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?"	**80.3**		**80.3**	**85.7 %**	**78.0 %**
Numerator Number of sex workers who replied "yes" to question 1	**57**		**57**	**18**	**39**
Denominator Total number of sex workers surveyed	**71**		**71**	**21**	**50**
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?	**26.8**		**26.8**	**19.0 %**	**30.0**
Numerator Number of sex workers who answered "Yes" to question 2	**19**		**19**	**4**	**15**
Denominator Total number of sex workers surveyed	**71**		**71**	**21**	**50**

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	**32.4 %**		**32.4 %**	**38.1 %**	**30.0 %**
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	**23**		**23**	**8**	**15**
Denominator Number of sex workers who reported having commercial sex in the last 12 months	**71**		**71**	**21**	**50**

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	**12.7 %**		**12.7 %**	**4.8 %**	**16.0 %**
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	**9**		**9**	**1**	**8**
Denominator Number of sex workers who responded to the questions	**71**		**71**	**21**	**50**

1.11 PERCENTAGE OF MSM REACHED WITH PREVENTION PROGRAMS

	All	>25	25+
Percentage (%) Percentage of MSM who answered "Yes" to both questions	**43.6 %**	**46.7 %**	**41.7 %**
Numerator Number of MSM who answered "Yes" to both questions	**17**	**7**	**10**
Denominator Total number of MSM surveyed	**39**	**15**	**24**
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?"	**84.6**	**86.7 %**	**83.3 %**
Numerator Number of MSM who replied "yes" to question 1	**33**	**13**	**20**
Denominator Total number of MSM surveyed	**39**	**15**	**24**
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**43.6 %**	**46.7 %**	**41.7 %**
Numerator Number of MSM who answered "Yes" to question 2	**17**	**7**	**10**
Denominator Total number of MSM surveyed	**39**	**15**	**24**

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	**43.6 %**	**53.3 %**	**37.5 %**
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner	**17**	**8**	**9**
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**39**	**15**	**24**

5.6 ?.?? 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	**20.5 %**	**33.3 %**	**12.5 %**
Numerator Number of MSM who have been tested for HIV during the last 12 months and who know their results	**8**	**5**	**3**
Denominator Number of MSM who responded to the questions	**39**	**15**	**24**

1.13 PERCENTAGE OF TRANSGENDER REACHED WITH PREVENTION PROGRAMS

	All	>25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions	**54.5 %**	**50.0 %**	**57.1 %**
Numerator Number of TG who answered "Yes" to both questions	**6**	**2**	**4**
Denominator Total number of TG surveyed	**11**	**4**	**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?"	**90.9 %**	**75.0 %**	**100.0 %**
Numerator Number of TG who replied "yes" to question 1	**10**	**3**	**7**
Denominator Total number of TG surveyed	**11**	**4**	**7**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**54.5 %**	**50.0 %**	**57.1 %**
Numerator Number of TG who answered "Yes" to question 2	**6**	**2**	**4**
Denominator Total number of TG surveyed	**11**	**4**	**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	**63.6 %**	**50.0 %**	**71.4 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**7**	**2**	**5**
Denominator Number of respondents who reported having had sex in the last 12 months	**11**	**4**	**7**

5.7 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	**9.1 %**	**0 %**	**14.3 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**1**	**0**	**1**
Denominator Number of TG who responded to the questions	**11**	**4**	**7**

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