



**Save the Children**  
Australia

(SOLOMON ISLANDS)

# HIV – VULNERABLE GROUPS RESEARCH

## A PRE-INTERVENTION ASSESSMENT 2006



## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AusAID	Australian Development Assistance.....
BSS	Behavioural Sentinel Surveillance
FGD	Focus Group Discussion
HIV	Human Immuno-deficiency Virus
IDI	In-depth Individual Interview
IEC	Information Education Communication
ISWG	Inter Sectoral Working Group
MHMS	Ministry of Health and Medical Services
MSM	Men who have Sex with Men
NGO	Non Government Organization
PNG	Papua New Guinea
PRPH	Pacific Regional HIV Project
PSP	Porosap Project
SCA	Save the Children Australia
SIG	Solomon Islands Government
SINAC	Solomon Islands National AIDS Council
SIPPA	Solomon Islands Planned Parenthood Association
STI	Sexually Transmitted Infection
SW	Sex Worker
WHO	World Health Organization
VCCT	Voluntary Confidential Counselling and Testing

## Table of contents

<b>Acronyms</b> .....	ii
<b>Acknowledgement</b> .....	1
<b>Section 1: Introduction</b>	
1.1. Overview of HIV and AIDS Situation in Solomon Islands .....	1
1.2. Work of SCA (SI) regarding Reproductive Health including STI/HIV&AIDS .....	2
<b>Section 2: Purpose of Research</b>	
2.1. Primary Targeted Vulnerable Groups .....	3
2.1.1. Sex Workers .....	3
2.1.2. Men who have Sex with Men .....	3
2.1.3. Youth .....	4
<b>Section 3: Methodology</b>	
3.1. Research Method .....	4
3.2. Research Tools .....	5
3.3. Selection and Training of Interviewers .....	5
3.4. Locations .....	5
3.5. Ethics .....	6
3.6. Study Population and Sampling .....	6
3.7. Data Collection and Data Entry .....	7
3.8. Analysis .....	8
<b>Section 4: Research Findings</b>	
4.1. Multiple Sex Partners .....	8
4.2. Low and Inconsistent Condom Use .....	10
4.3. Health Seeking Practices .....	11
4.4. Drugs, Alcohol and Sexual Violence .....	12
4.5. Sexual Exploitation .....	13
4.6. Teenage Pregnancy .....	13
4.7. Low levels of HIV and AIDS and STI Knowledge .....	14
4.8. Stigma and Discrimination .....	14
4.9. Intervention suggested by Informants .....	15
<b>Section 5: Discussion</b> .....	17
<b>Section 6: Recommendations – Interventions</b> .....	18
<b>References</b> .....	20

## **ACKNOWLEDGEMENT**

We would like to acknowledge the participation of those interviewed who willingly gave us information and insight into their situations. We thank those who organized and made possible meetings in the different communities, especially health workers and the management of companies operating in the research sites. We extend our appreciation to the community leaders and elders for allowing the research team to conduct interviews in their communities, as well as staff volunteers who assisted in arranging interviewees.

We thank AusAID through the Pacific Regional HIV Project (PRHP) for the financial assistance provided. We also appreciate the technical assistance from the Poro Sapot Project (PSP) and the HIV program of Save the Children in PNG – Madeline Lemeki and Peter Raynes; tengkiu tru.

Cover page is designed by Jimmy Wale and Nelson Gwamani.

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## **1. INTRODUCTION**

### **1.1 Overview of HIV and AIDS Situation in Solomon Islands**

The concern over the issue of HIV and AIDS in Solomon Islands has been increasing since the first person was diagnosed with HIV in 1994; and particularly since 2004 when 4 people were diagnosed in one year, of whom two have died of AIDS (SIG 2005). HIV confirmed cases at the end of 2004 stands at five, however, the Ministry of Health warns that this number reflects under reporting of people living with HIV considering the degree of availability and capacity for HIV testing and diagnosis (SIG 2005; WHO 2006). Although there is a low HIV prevalence rate in the Solomon Islands, the full epidemiological picture of HIV infections and modes of transmission is not clear because of a lack of surveillance and accessible HIV voluntary confidential counseling and testing (VCCT), stigma and discrimination in society towards people living with HIV or AIDS, and a lack of confidentiality and judgmental attitudes within the health system (SIG, Oxfam 2004; Buchanan et al 2004; SIG 2005). At the same time, behavioral risks and contexts that create vulnerabilities to HIV transmission are present. Factors affecting young people's vulnerability and risk include: a poverty of opportunities in education and employment to increase living standards, attitudinal issues such as denial, cultural and religious beliefs that can create taboos about talking about sex and safe sex practices such as condom use, sexual violence and child sexual abuse and socio-cultural change (SIG, Oxfam 2004; Buchanan et al. 1999; SIG 2005)

Efforts have been made by the Government, donors and other stakeholders to ascertain the HIV situation, and behaviours and situations that contribute to risk of HIV transmission in the country. These include: situational analysis of STI and HIV in Solomon Islands (SIG, Oxfam 2004) baseline – Behavioural Sentinel Surveillance (BSS) done with in and out of school youth in Auki in 2000 (Buchanan-Aruwafu 2002); and in 2004, baseline BSS was done with in and out of school youth in Honiara, and STI and HIV testing and behavioural surveys were done with antenatal mothers in Honiara and Western Province, as part of 2<sup>nd</sup> Generation Surveillance (WHO 2006). These reports and other research have also indicated high levels of unprotected sex, especially among young people, resulting in a continuous increase in reported sexually transmitted infections (STI) and teenage pregnancy. Young people reported exchanging sex for cash or goods, with low condom usage, while a small number of male youth reported male to male sex and young people reporting intravenous drug use (Buchanan-Aruwafu et al. 2003; Burslem et al. 1997; Hall et al. 1998; WHO 2006). Some areas in the current National HIV Strategic Plan (SIG 2005) highlight the logging industry and put emphasis on sex workers (SW), men who have sex with men (MSM) and HIV and human rights.

Efforts have been made to decrease the spread of HIV by the Ministry of Health, NGOs, community groups, Churches and several donors. The funding opportunities made available to community groups, church groups and NGOs by donors have seen an increase in HIV activities targeting communities. Activities carried out range from trainings, awareness raising, development of Information Education Communication (IEC) materials, training in behavior change and project management, condom distribution, peer education, to development of VCCT and other clinical services such as HIV counseling and testing and STI treatment. The active participation of stakeholders in networking meetings facilitated by the Ministry of Health and Oxfam Australia with assistance from the Regional HIV project (PRHP) has kept stakeholders informed of the different activities that are being carried out by other organizations. These meetings have enabled the input of the stakeholders in the development of Inter-sectoral Working Groups (ISWG) under the Solomon Islands National AIDS Council, hence contributing to the realization of multi-sectoral partnerships in addressing HIV and other related issues.

## **1.2 Work of SCA Solomon Islands regarding Reproductive Health including STIs/HIV and AIDS**

Save the Children's involvement in HIV related work has been in the areas of training peer educators, information dissemination, development of youth-focused IEC materials on HIV and AIDS, safe sex, marijuana and alcohol, and stigma and discrimination, and through active condom distribution. Under the Youth Outreach Project, community based volunteers (youth) were trained bi-annually to undertake awareness raising talks in their communities on youth issues including adolescent sexual and reproductive health and HIV and AIDS, and distribute condoms through youth volunteer network in five of the 9 provinces.

Prior to having the Youth Outreach Project, SCA has worked with the Ministry of Health on Maternal and Child Health care training programs.

SCA in the Solomon Island's strategic plan 2005 - 2010 has identified, through a consultative process, that SCA is well placed to implement a HIV program with a focus on reducing the impact of HIV in vulnerable and higher risk groups.

## **2. PURPOSE OF RESEARCH**

This research was conducted to assess the situations and sexual behaviours among youth, sex workers and men who have sex with men. The purpose of this research is to strengthen the evidence base to inform HIV interventions with sex workers (SW), MSM and young people. The information gathered will give SCA and other stakeholders, including the Solomon Islands National Aids Council (SINAC), a deeper insight into situations, issues and information/service needs of these groups to enable the designing of evidence-based HIV programs.

### **2.1. Primary targeted vulnerable groups**

Three vulnerable groups at higher risk were selected as the primary target groups of the project - Sex workers, Men who have Sex with Men and Youth. These target groups were identified in the National HIV Policy and Multi-sectoral Strategic Plan 2005 – 2010, as groups that HIV prevention and behaviour change programs need to target. In addition, no formal and continual HIV prevention work has been done with SW and MSM, except for some visitations done by some groups mainly in Honiara.

**2.1.1 SW** - There has been no evidence of highly organized sex work operations, however, sex in exchange for food, money, shelter and other resources occurs in an unorganized or sporadic manner. The recent Behavioural Surveillance Survey (BSS) of young people in Honiara done by the Ministry of Health highlighted the existence of both male and sex workers (WHO 2006; Solomon Islands MHMS 2005). Of the 600 in and out of school youth surveyed, 83 (27.7%) female youth had sold sex for money in the last 12 months, with the age of first sex for money ranging from 11 – 22 years of age. Another BSS research done in 2000 in Auki, Malaita also recorded SWs. Fourteen females out of the 150 surveyed, reported selling sex for money, and three received other resources apart from money (Buchanan-Aruwafu 2002). This study demonstrated that sex work is happening outside of Honiara; which had also been identified in 1999 (Buchanan et al. 1999). Media and anecdotes reports also highlighted the movement of sex workers to logging sites outside of Honiara. A study of the reproductive health of teenage girls in Honiara (Burslem et al., 1997) reported that money has been mentioned as one of the reasons for having sex while in another similar study (Hall et al., 1998) with boys; money is referred to as a means of getting sex.

There is an inadequate amount of qualitative and quantitative data to explain and give insight into the context of sex work in the country, and identify and differentiate the extent of sex worker. In the context of the Solomon Islands' current weak economy, rapid urbanization and high unemployment rates and the lack of rural development, the sex trade is an important means of survival and will likely continue to increase.

**2.1.2 MSM** – Male-male sex practice is a very sensitive issue in the Solomon Islands and it is prohibited culturally, religiously and legally, consequently attracting a lot of stigma, discrimination and shame and making it difficult to identify and access these male youth and men.

Information collected on MSM is minimal; however, from observations, this practice is becoming increasingly more evident, but in a very discrete manner because of the social stigma associated with male to male sex practices. The BSS done in 2004 with in and out of school youth in Honiara also found that male-to-male sex is happening; research done with boys in Honiara in 1998 also reported male to male sex and sex work (Solomon Islands MHMS 2005).

**2.1.3 Youth** – Youth represent a significant proportion of the Solomon Islands population. 20% of the total population are between the ages of 15 – 24. There are numerous definitions of youth by different sectors and organizations locally and internationally. Regardless of these definitions, young people are rated as a higher risk group due to social, economic and educational factors such as, high unemployment, low level of educational attainment, rapid social change, sexual violence and abuse and a general poverty of opportunity.

### **3. METHODOLOGY**

#### **3.1 Research Method**

The research was a qualitative study. This is a formative research strategy, whereby qualitative data is gathered to obtain a deeper insight and understanding of the situations of the selected study groups. Qualitative methods were used to collect data and included Focus group discussions (FGD), Individual In-depth Interviews (IDI) with study subjects and Key Informant interviews (KIs).

*Focus group discussions* were carried initially conducted with male and female youth only. Due to the sensitive nature and the limited knowledge on how effective a group discussion would be with SW and MSM, FGD were not used with them. However, in three locations, opportunities to discuss with older women and men resulted in group discussions carried out with adults on issues surrounding sex work and young people.

*Key informants* about each researched group (Youth, Sex Workers and Men who have Sex with Men) were identified as those who had been living in the community for a more than a year, and were either part of any community group, whether formal or informal, or employees of companies operating in the area, or community chiefs, church leaders women's group leaders, or health workers, police officers or teachers. These people were interviewed individually.

*Individual interviews* were done with the three different target groups: sex workers (SW), men who have sex with men (MSM) and young people (14 – 25 years old).

*Observations* were done in all the sites, and interviewers observed the interactions of people living within these communities. Observations were used to verify stories collected from the interviews.

*Debriefings* were held in all sites by the team. The debriefing sessions were used to discuss other stories and observations captured outside of the formal interviews.

### 3.2 Research Tools

Nine sets of questions guides were developed with semi-structured questions for the focus group discussions, and the in-depth and key informant interviews for the 3 targeted groups (Youth, Sex Workers and Men who have Sex with Men). The question guides were further tailored to include questions to capture the characteristics of the research sites, such as logging, fishing vessels, border crossings, urban and rural areas, and to meet the objective of the research.

The question guides were pre-tested in Honiara except questions that related specifically to the other sites. Further adjustments were done to the question guides based on the feedback from the pre-testing of the tools.

Question guides developed for the different target groups are as follows:

<b>Focus Group Discussions (FGDs)</b>	<b>In-depth Interviews (IDIs)</b>	<b>Key Informants (KIs)</b>
Female Youth	Female Youth	Youth
Male Youth	Male Youth	SW
	SW	MSM
	MSM	

### 3.3 Selection and Training of Interviewers

Interviewers were recruited on the basis of previous experience in survey or similar research with young people, and experience in working with young people on sexual and reproductive health issues. Four interviewers were recruited during the first month of the research and training was done with a hands-on approach. The interviewers recruited had previous experience in conducting individual interviews (surveys – quantitative data collection); hence more emphasis was placed on getting them to understand the qualitative methodology through their involvement in the development of question guides and the pre-testing of the tools. Informal sessions were conducted with interviewers to familiarize them with the purpose and objectives of the research. This was done over a period of 2 weeks.

### 3.4 Locations

Research was done in both rural and urban areas. Fourteen communities in the Western province and six communities in Malaita were visited including both urban and rural communities, and research was also conducted in urban Honiara.

### 3.5 Ethics

The nature of this study required gathering particularly sensitive information, an ethics statement was read out and informants were asked for their consent to participate in the study before interviews were conducted. Care was taken in writing this report to not reveal the locations where information was gathered. Areas in which interviews were conducted will not be identified as assurances of confidentiality were given to those individuals interviewed.

Approval was gained as required by the government from the Research Ethics Committee of the Ministry of Health and Medical Services (MHMS).

### 3.6 Study Population and Sampling

The numbers of respondents interviewed are tabulated below. There were 306 individuals interviewed and 326 individuals interviewed in focus group discussions bringing the total of respondents to 632.

Table 2: Summary of Respondents recruited by Location and Study Groups

LOCATION	STUDY GROUPS							Total No. of Respondents
	Sex workers		MSM		Youth			
	KI	IDI	KI	IDI	KI	IDI	FGD	
Honiara	3	12	5	5	5	31 (13 male, 18 females)	6 (3 Female FGD - 19 participants, 3 Male FGD - 21 participants)	101 individuals interviewed
Western Prov. including Shortland Is.	17	23		1	23	96 (40 males, 56 females)	10 (7 Female FGD - 126 participants, 3 Male FGD - 70 participants)	356 individuals interviewed
Malaita	2	3			13	67 (31 males, 36 females)	8 (2 Female FGD - 14 participants, 6 Male FGD - 76 participants)	175 individuals interviewed
Total	22	38	5	6	41	194	24 FGDs (159 female participants, 167 male participants)	632 individuals interviewed

*Key: KI = Key Informants, IDI= In-depth Interviews, FGD= Focus Group Discussions, MSM= Men who have sex with men.*

*Note: 3 key informants for MSMs were also interviewed as MSM IDI*

The research planned to conduct a total of 400 individual interviews however, the final total of individuals interviewed was increased by 232.

The numbers of individuals in the study groups are unevenly distributed across locations for a number of reasons. Firstly, there were more interviews carried out in the Western Province because one of the aims of the study was to investigate sex work in areas where there was a lot of income generating activities. While in Western Province, the interview team spent a longer period (5 weeks) compared to the other two locations because of development such as logging, fishing and oil Palm plantations. The Western Province was also a location of interest because of its closeness to Bougainville, the North Solomons Province of Papua New Guinea (PNG). The study also wanted to find out if border crossing played a role in providing opportunities for risky sexual behaviours. The interview team divided itself into two teams, thus covering more areas while in the Western Province. Two interviewers interviewed in two locations in Western Province, while the other three interviewers visited Shortlands and another area of Western Province.

Secondly, political instability and the riots that occurred in Honiara during the data collection period resulted in the lower collection of interviews. In addition, there was minimum supervision provided for the interviewers while in Honiara because the Project Manager traveled out twice for other official commitments.

Thirdly, as shown in the Table above, it was easier getting interviews from the youth than from the other two study groups. This may have been the result of the biased recruitment of interviewers. All four interviewers were youth and not sex workers or MSM. They could relate and feel more comfortably with their own peers. The interview team only spent two weeks in Malaita and three weeks in Honiara respectively, giving the interviewers very limited time to build rapport before interviewing.

Non-probability sampling was used, thus recruiting of the study subjects are done based on a convenience sample of those who were available, who had been identified by key informants or by the research team from observations, and who gave consent to be interviewed.

### **3.7 Data Collection and Data Entry**

Data collection was done between April and August 2006 in 21 communities across 5 different locations.

Information gathered was either recorded using digital voice recorders or written as notes; hand written notes were further expanded immediately after the interviews. Interviews both recorded and handwritten were transcribed and typed into the computer using Microsoft Word. Some data was entered into the computer during the data collection period; but most data input was done in the two weeks before the analysis took place. Observations were written while others were recorded during the team's debriefing sessions.

Translation of the interviews was done during and after interviews hence the quotes are not direct but translated by interviewers to their closest meaning in English.

### **3.8 Analysis**

Due to time limitations, no software for qualitative data analysis was used. All transcribed data was laid out on the table under the categories of location, study groups and the type of interview done. Analysis was done by reading through the interviews and simple thematic analysis was conducted. Key themes were identified and significant examples were extracted from the data to form the basis of the findings. The information collected using the different methods of data collection were similar however, there were variations in magnitude and reasons for undertaking risk behaviours. The analysis took a week to complete.

As mentioned, this research was conducted with the intention of assessing the situation and sexual behaviours that increase risk of STI and HIV infections among youth, sex workers (both male and female) and men who have sex with men. It is hoped that the results of this study will generate further funding for effective HIV intervention programs among these study populations.

## **4. THE RESEARCH FINDINGS**

In all locations and among all study groups, evidence of one form or several forms of risk sexual behaviours were reported. In this report, risk sexual practices refer to any activity that contributes to a conducive environment for STI and HIV transmission. This section of the report discusses the findings of this qualitative study that investigated the sexual practices and views of three specific study populations. However, the findings do not isolate issues to specific study groups because the data showed that most issues were cross cutting or similar in all three study groups with variations.

### ***FACTORS LIKELY TO CONTRIBUTE TOWARDS HIV AND STI TRANSMISSION***

#### **4. 1: Multiple Sex Partners**

The gradual breakdown of traditional customs and fast pace transition into a more modern lifestyle with demands for cash and material items, have driven young people into quick money making options that require less or no skill, and that pay well. Among the sex workers and out of school youth in this study, levels of education are generally quite low. Some of them have low paying jobs. To complement the low wages, they sell sex which earns them more than what they receive from their regular paid jobs. Parents often encourage or force their daughters into selling sex in order to get cash.

Western province used to have so many cultural practices that have now been lost. People seem to be having a different attitude towards their way of life. They used to have skills in carving, making baskets and mats and even go fishing but nowadays these activities are gone. They need to revive these practices so that it can benefit young people who would spend their time producing these artifacts to sell for their extra income rather than spending their time in issues affecting them in a negative way (male, 36 years old, KI).

Individuals who were interviewed privately using the in-depth interview guides reported more than one sexual partner in a week. Among sex workers, the number of sexual partners in a week ranged between four to eight partners, among MSM it was 3 to 4 sexual partners and among male youth 4 to 5 and female youth 2 to 3 sexual partners in a week.

How many sexual partners did you have sex with in the last one week?

I had sex with five men (Female, 15 yrs old, married, IDI).

The main people who go around to have sex for money are young girls, and their parents are the worst ones who are involved in arranging them for men with money. We have a lot of young girls who do sex work. It's true that what you said that parents do support their daughters to do these things like this (sex work) (female, 19 years old, single parent, IDI).

What I can say is that I'm a girl that never cares about these waku (Asians), I play around with them, so for me I think I never miss a night, some day times I had job to do, so I miss it sometimes, even day time when they are back for lunch. The lowest I could get is \$50 and the highest I could get is \$1000 (female, 23 years old, IDI).

In the last couple of months, I had sex with three expatriate men aged 29, 36 and 40 years old – No condom use. - 1 expatriate tourist 30-36 years of age, no condom use. Another expatriate man who lives and works in Honiara aged 29 years of age. I didn't know because I was too drunk. - 1 Local man, aged 22, we used condoms. For the last 12 months I have sex with male only. I am too shy to collect condom at the youth centre. My friends do the negotiations and I would be the one selling sex to other men for money and especially alcohol (Male, 19 years old, IDI).

Sex life of young people is very risky. Nearly every night young people look for sex in the village. The activities happening in here initiates that we have a very high risk in contracting HIV (male youth, FGD).

Sex in exchange for goods and money occurs mainly in the big villages, it is reduced now because of lack of income generating activities such as logging and bech-de-mer, we are currently experiencing economic difficulties however, sex work is happening but is low now, and the payment is low too. Regardless of money, sex work is happening. (Adult Male, KI)

Males as well as females bought and sold sex. This is not only an urban phenomena but it is happening in rural communities as well. However, sex work is more evident in urban centers than in rural areas. Though exact numbers of sex workers is not known estimated number of sex workers in urban centers is around 250. This figure is only an estimate.

The girl I had a child with gave me money when ever we had sex (male, 18 years old, IDI)

The findings of the study discovered risky sexual behaviours among young females forced into selling sex by their parents and relatives for cash, material wealth, alcohol and gifts especially at logging sites, on fishing boats and at cash generating projects such as the oil palm plantations. Negotiations for sex are either done by the girls themselves or by young men. The young men act as pimps by negotiating sex for girls with foreign men. The pimps get a reward in the form of cash or usually alcohol. Partners of sex workers were foreign men, local business men who were usually married, as well as the pimps. Condoms were seldom used.

Although there were occurrences of sexual relationships between border crossers, the sale of sex was not common.

Not only are young people having multiple partners, but are beginning sex at a very young age and having several sexual partners simultaneously after their first sexual encounter. Their first sexual experience usually takes place without the use of condoms. Many young people mentioned that they did not know about condoms and did not know where to get them. Both young men and women reported having had their first sexual experience at ages 13 to 14 years old.

I had my first girlfriend when I was 14 years of age. My girl friend was not a stable girlfriend; she had sex with me and other boys in the community as well. She was 11 years old at that time (male, 22 years old, IDI).

I was fourteen years old when I first had sex with my boy friend. No, we did not use condoms (female, 15 years old, student, IDI).

I was fifteen years old when I first had sex. We agree together to have sex. At first time we didn't use any condom because we knew nothing about condoms (female, 21 years old, IDI).

I have sex with three girls in the last month. We didn't use condoms because they were not available. I don't know where to get condom and don't know how to use it (male, 24 years old, IDI).

A few young people resisted peer pressure to have sex if the consequences would be severe if their parents or guardian found out; consequences such as non payment of school fees.

#### **4. 2: Low and Inconsistent Use of Condoms**

The findings show a very low and inconsistent use of condoms. As shown above, most young people begin to practice sexual intercourse without knowing anything about condoms. Apart from their lack of condom knowledge, there is also great resistance to use condoms as young people prefer “naked wire” or “meat to meat”; meaning having sex flesh to flesh.

I was nineteen years old when I started selling sex for money and beer. In the last one week I had sex with three men. Only two of them used condoms. I did not use condoms with the other one. The other guy didn't want to use a condom because he wanted naked wire (Female, 21 yrs old, IDI).

Respondents who gave accounts of being involved in ‘line ups’ (rape), admitted no use of condoms by any of the men who participated in the rape.

I first had sex at the age of 14. The girl and I agree to have sex. I was involved once in long line up. We all got drunk and she was also drinking with us. She was terrified the next day when she found out. We all didn't use condoms (male, 19 years old, IDI)

Accessibility of condoms is another problem that individuals from the three study groups reported. One of the major obstacles has been staff attitudes at clinics. In certain clinics in the

respective provinces where the study was conducted, staff refused to give condoms to single people saying it was for family planning only and therefore condoms were given to married couples only. Moreover, many young people were hesitant to get condoms from their local clinics because they felt there was no confidentiality.

#### **4. 3 Health Seeking Practices for Sexually Transmitted Infections**

Respondents were asked where they would go to get treatment if they had an STI. Many said they preferred “kastom” (traditional) medicine because it was quick and confidential.

We have custom medicine for STI's. It's a big deal going to the clinic for exposure; custom medicine is much quicker and confidential. I prefer custom medicine because it's free, confidential, it heals in just three days and I don't have to bother going to the clinic. (Male teacher, FGD)

I would go to the custom doctor for treatment because who wants to go the place where the nurses are very rude to us even when we are not sick but go to ask for condom they will get angry and say sex every time. My girl friend last month had gonorrhoea. I told her to go the clinic but she did not want to go there because of the attitude of the nurses at the clinic. Are the nurses there at the clinic to help every one or for those good people only? I think the ministry of health should look at this and take this seriously. If I have any sick like gonorrhoea or syphilis we don't want to go the clinic we would look for custom medicines (female, 21 yrs old, IDI)

If I have STI again I will seek custom doctor for medicine because I don't want the same nurse to see me again. Custom medicine is good because it is very confidential and only one treatment and it's done. And no one will know (male, 19 years old, IDI)

And there are those that experience signs and symptoms of STIs and do not know what it is, indicating the need for more knowledge about STI among young people.

I have a problem with my private part, when passing water it feels so painful. I don't know what causes the pain (Male, 17 yrs old, IDI)

Interviews were conducted with clinic staff at locations where the study took place. One of the key informants mentioned the difficulty in having group discussions with the local people as well as conducting health awareness in schools. In addition, she elaborated on the cases of STIs reported at the clinic.

Problems we face when doing our programs are; shyness when it comes to asking question, hard to ask question in community talks, no knowledge at all in the community. We found out that from the age of 10 to 13 we have less case in STI's recorded, and at age 14 to 18 we have higher records of STI's. From the age of 18 and 35 that's where active sexual activities happen because of much higher records of STI cases is reported from the other clinics and also in this clinic (female nurse, key informant).

Informants stated that they felt more comfortable getting condoms from Non Government Organizations (NGOs) such as the Solomon Island Planned Parenthood Association (SIPPA) and Save the Children as staff attitudes were friendlier. The following quotes are from

interviewees who lived closer to where they could access services from the mentioned organizations.

My girl friend who works for Save the Children in Gizo gave me condom (Female, 21 years old, IDI)

If I had an STI, I would go to SIPPA. They have the right medicine and proper treatment towards young people like me (male, 20 years old, IDI)

Although many respondents said that the clinics were the best places to go for STI treatment, many of them actually went to a non government health facility.

The clinic is the best place to get treatment for STIs. I use to experience pain in my private part after having sex. I got treated at SIPPA and it's gone. (male, 27 years old, KI)

Some respondents did attend government health services to get treatment for STIs.

Yes, I had gonorrhoea when I was in Malaita. I went to Kilufi hospital and got treatment (female, 17 years old, IDI)

Yes, I had gonorrhoea before. My mother took me to the hospital and I got injection for five days and got healed (female, 14 yrs old, IDI).

If the clinic staff is male, it is difficult for females to go and report reproductive health problems that they might be experiencing and vice versa.

It's the boys who will come out first, the boys are good. If you ask them they will tell you who the last girl they met. But it's difficult for the girls, especially to tell a male nurse. [You don't have any female nurse?] No (male nurse, 40 years old, KI)

#### **4. 4 Drugs, Alcohol, and Sexual Violence**

According to informants of the study, most cases of rape occurred under the influence of drugs and alcohol. Under this condition, condoms are rarely used.

When alcohol is bought for the woman, the man takes control from there. He has spent money on alcohol so she goes along with what he wants. That means he may not want to pay her cash or use condoms either. Most times, both men and woman are so drunk there is no negotiation for the use of condoms.

When I was nineteen years old I started selling sex. The first time I had sex we didn't use any condoms because that time we were drinking too much beer and I was so drunk (female, 21 years old, IDI)

Drug and alcohol is a major problem for our young people in the camp, especially during paydays or when logging ships come in to load the logs. Sailors would provide alcohol for the boys and the boys would act as pimps. The boys would get the girls and have sex with them before taking them to the ships for sex selling to the seafarers (Male, 22 years old, KI)

Marijuana is another problem for our young boys. They get it from the passenger boats coming from Honiara, they don't grow it here (male, 36 years old, KI)

Drug is one of the major health hazards for our young people. We had three boys affected by marijuana problem and ended up with mental problems, but still this does not seem to bother our young people (Male, 29 years old, Key Informant)

Alcohol is also a problem in the border islands of Solomon Islands. It is the men who go over to Bougainville to sell fish and other items. The money they get from their sales is frequently spent on alcohol.

Men get JJ (homebrew) from the other side [Bouganville] (male, FGD)

Alcohol has been reported as a major problem on the border of Solomon Islands and PNG (Bougainville). Though there has been no clear linkages alcohol and sexual violence, informants expressed that sex under the influence of alcohol exist.

#### **4.5 Sexual Exploitation**

There were many narratives gathered about parents and relatives forcing girls to sell sex or become wives to older men in anticipation for cash and material wealth, such as electronic items and gifts such as jewelry, to be given to the girl's family.

Some of the girls were sent by their parents to the camp to marry the Asians so that they can get extra support from them. One of the parents sold her 13 year old daughter for just a bottle of spirit to the Asian and now she is living with him as a temporary wife (male, 22 years old, KI).

Young men negotiate with foreign men or other local men for the exchange of sex with women. They bring in women and girls to exchange sex. The women may or may not get any payment while the person who negotiated the meeting is rewarded. Time and again this can happen without the consent of the young women leaving her powerless to make decisions about safer sex practices.

Everyone here is involved in negotiating sex, married men and women too, young boys who just hang around in this village doing nothing. When they want to drink beer they would make arrangements with those people. After they would come back take the girls to those men and those people would give them money or beer (female, 21 years old, IDI).

#### **4.6 Teenage Pregnancy**

Although specific questions on reproductive health were not asked, informants in all locations visited mentioned teenage pregnancy as a social and health problem. Many girls got pregnant in the same year they first had their menstrual period, often between the ages of thirteen and sixteen. More girls are pregnant to older men who have had more sexual exposure compared to the young girls, making these girls particularly vulnerable to HIV because of their physical biology and their higher risk partners.

I started my period a few months before I fell pregnant. I was 16 years old when I first had sex with a boy and straight after that I got pregnant with my first child (female, 18 years old, IDI)

Teenage pregnancy is one of the main problems too. Some girls from other villages living with the wakus (Asians) are already pregnant at the age of 13- 15 years old (female, 19 years old, KI)

Teenage pregnancy is also an issue for young people in this camp, Young girls are having babies with no fathers and that's another issue that triggers sex work for our girls and single mothers (male, 22 years old, KI)

#### **4.7 Low Levels of HIV and AIDS and STI knowledge**

Many respondents had heard of HIV and AIDS. They described the common modes of transmission and prevention, however answers given were also either vague or had misconceptions, and there are still those who have heard the name but do not know exactly what HIV or AIDS are.

HIV can be passed on through blood contact and by sharing clothes. To protect yourself from catching this sickness, you have to stay away from those who have HIV. Their hairs fall off, their faces will change and they lose a lot of weight (female 23 years old, IDI).

HIV is a sickness that scientists developed the virus that causes HIV, because the population of the Africa is very high so they made it to decrease the population. And the other thing I heard about is that the virus is made by God because of the sinful world (male, 16 years old, IDI)

I didn't hear about any of those sicknesses so I don't use condoms (male, 19 years old, IDI).

I heard about HIV but I don't know anything about it. I don't know how it can transmit and how to prevent myself from getting it. I have no idea about STIs. (female, 17 years old, IDI).

It's a sickness. I heard it from my girl friends. I don't know how it transmits to another person (female, 16 years old, IDI).

I don't know what HIV is. I have heard of the name HIV but still don't know what it is. I don't know any single information about it. I don't know how to protect myself. I don't know what VCCT is. I don't know how to identify those who have AIDS (male, 18 years old, IDI).

#### **4.8 Stigma and Discrimination**

Stigma and discrimination were often faced by members of the study groups mainly because of their sexual practices. Members of the community, family and even service providers were cited as people who discriminated against groups such as sex workers, men who have sex with men and young people. Discrimination hampers safer sex practices.

Sex workers are treated unkindly when they are in town. People shout at them, discriminate them with bad words. If a woman suspects that a sex worker is going around with her husband, she can go directly and beat that girl. So now you hardly see them during the day. They move around at night times when nobody can recognize them (male, 24 years old, KI)

I have experienced discrimination from the public especially in town. That contributes to my lack of involvement in sport and church activities. It also affects the way I try to access health services, especially getting condoms (male, MSM, 27 years old, IDI).

Occasionally, the stigma is so bad that it leads to constant threats, and physical or sexual violence towards the victims.

Some of the MSMs hook up with the local boys and sometimes get threatened badly when they are drunk. One of my gay friends went out with some of his old high school mates for a drink at the beach. He was forced to blow job (have oral sex) with all of them and he did. After that they embarrassed him by making fun of him so he ran away from them to the club. He caught up with them later and they asked him to go out again but he refused (male, 29 years old, KI).

Within health service delivery facilities, discrimination is evident when it comes to providing treatment. Young people have complained that they were refused treatment for STIs and also discriminated against when they asked for condoms.

In a previous situation that happened in the clinic, one young man was infected with STI and was discriminated by the nurse. Now young people don't access the clinic anymore (male, 22 years old, KI).

The clinic is under the company and the priority of services goes to the Asians working in the camp. Young people don't see the clinic as accessible for health support or services for them. The only time they access the clinic is when they are sick with malaria or flu. There is no HIV & AIDS prevention program organized by the company for the clinic to the community. Condoms were provided in the clinic but it depended on the availability. The nurse sometimes doesn't give condom to young people when they ask for it (male, 22 years old, KI)

### ***INTERVENTION PROGRAMS REQUIRED AS SUGGESTED BY INFORMANTS***

In light of the factors discussed in the above section, informants were then asked to identify solutions to these challenges or the problems facing them. Below are some of their suggestions.

Clinic is very far from us. We have to get a truck or canoe to get to the clinic. We need more health programs for our young people especially for those once in the village who are not educated. House visit is one of the needs for our young people so that it's easy to reach them. They can also tell you what health issues are affecting them. We need a STI clinic nearby for treatment and counseling young people in reproductive health issue. Services provided should be friendly so that it's accessible by young people. Mix the sex of nurses in clinic, that is, have male and female nurses in one clinic. (Male, Shortland Islands, FGD)

Here we should have an office of Save the Children to make programs for our young people here to educate them more on the issues like teenage pregnancies and other sexual transmitted disease and to make it easy for us to get condoms to protect us from STIs (female, 21 years old, Western Province, IDI).

Young people here in the oil palm nursery need to have access to condom, we heard the clinic has condom but it's only for the bosses and Asians. We need access to Reproductive health treatment and more on condom distribution. We need some one who is youth friendly to work in the clinics, I have STI once and the nurse told my aunt about it and my aunt told me to go over the next day to get my treatment so my aunt knew about it and told my dad and he beats me up. Young people in the plantation need sport activity to spent time in after working in the plantation so that young people don't think about sex all the time (male, 19 yrs old, IDI).

There is a drama group established in the community and they raise awareness through drama on some of the issues affecting young people in the community. Beside that there is no other health support in the community. I think drama is a good way of raising awareness of issues such as HIV and AIDS (female, 25 years old, KI)

We need awareness talks on sexual and reproductive health. Counseling for young people on sexual and reproductive health so that young people can understand the function of their reproductive systems. Young people need somewhere that is youth friendly so that they can easily access the right information. Young people will know and be able to make the right decision when it comes to sex negotiation. Condom must be accessible to all young people. More awareness is needed on health related issues (male, 29 yrs old, KI)

We need some educational programs that would really help us to change some of our attitudes and behavior in sexual practices, and also we need condom to be available to us here not in the clinics but just any where around here that we can go and get at any time we need it (female, 21 years old, IDI).

At the moment there is nothing protecting young people in the area, but only if we have program such as awareness talks on social and health issues or if the company would provide youth centre that can cater for counseling and treatment just for young people in the community and provide contraceptives for young people then I think our youths will be safe (male, 22 years old, KI).

In summarizing the quotations above, it is clear that there is definitely a need for peer education interventions for sex workers, MSM and the youth. There is acceptance of condoms among the study groups as they request the accessibility to a consistent supply of condoms. They are also calling for intervention programs that will provide awareness of HIV, sexually transmitted infections and reproductive health, because without adequate knowledge they will not be able to make sound decisions and right choices for safer sex practices. Furthermore, informants have suggested user-friendly health facilities where they can visit without fear of being humiliated by the staff. STI clinics and HIV testing and counselling services were also among the list of services required.

## 5. DISCUSSION

The findings among the youth population reported in this study are consistent with previous studies among young men (Hall et al., 1998) and teenage girls in Honiara (Burslem et al., 1997). The situation has not changed much in Honiara, perhaps worsened, and this was also found to be similar in other provinces of the Solomon Islands (SIG, Oxfam 2004). Yet very few intervention programs are in place to respond to these problems with highly vulnerable youth, and no specific programs are available for groups such as sex workers and MSM who can engage in practices that increase their risk of HIV infection.

Although the issues were similar among the study populations, interventions need to be sensitive to the needs of the specific groups. For instance, in a peer education approach, a sex worker will reach out more effectively to another sex worker, thus programs for sex workers should be separate from a general youth project.

Multiple sex partnering coupled with low and inconsistent use of condoms has been shown around the world as a perfect recipe for HIV and STI transmission. Poor health seeking behaviours for STI treatment only make the spread of HIV easier because STIs are important co-factors in HIV transmission. Claims that traditional medicine heals STIs is yet to be proven scientifically. Meanwhile the negative attitudes of health workers only contribute to STI infections remaining untreated.

The increasing abuse of alcohol and drugs such as marijuana fuels sexual violence such as group rape – several men to one woman. This activity has legal implications and at the same time is a health concern, especially in the transmission of HIV and in the physical and mental trauma involved for the victim. Most young men do not realize that in such circumstances, they can contract HIV from another man who has gone in line before him during the group rape. In addition, when under the influence of alcohol and drugs, condom negotiation hardly ever takes place. Sexual exploitation is sexual violence as it involves coerced sexual intercourse. Young girls and MSM who are been forced into having sex without their consent are disempowered from making decisions as to whether or not sex occurs and for safe sex practices. With increasing desire for material wealth including cash, young girls are being pushed by family members to sell sex. Sexual exploitation sometimes results in teenage pregnancy, a reproductive health problem faced by many young girls in the Solomon Islands.

Girls are having sex soon after menarche or even before. With early exposure to sexual intercourse, their chances of contracting HIV and STIs increase as they can have a larger sexual network. As well, teenage girls' reproductive organs are not fully developed and early sexual debut makes them more vulnerable to HIV transmission.

Finally, discriminating against certain groups of the community will only drive them into hiding and they will not willingly come forward to access services and the information they need for HIV and STI prevention.

## **RECOMENDATIONS - INTERVENTIONS**

The following recommendations are made for possible HIV interventions from the suggestions of respondents and analysis of other influencing factors. These recommendations can be used to guide interventions, but consideration must be given to the continuous changes that occur within the lives of the intended beneficiaries and the contexts they live in.

Given the sensitivity of the legal and socio-cultural issues about sex work and male-to-male sex, inventions must be guided by the principles of:

- non-judgmental attitudes and confidentiality,
- involvement of target group in program development where appropriate, and addressing other parties involved i.e. clients, spouses and third party (pimps)

### **1. Peer Education**

It has been evident in other countries that peer education is an effective strategy to disseminate information and contribute to positive (safer) behaviour change. A peer network can be effective in driving condom distribution and promoting health care amongst peers.

Peer education can also facilitate the involvement of the target group, giving an avenue for meaningful participation and contribution from the beneficiaries.

### **2. Condom Distribution**

It is evident that condoms are not readily available especially in areas outside of the urban centers. Time and again this has come up from young people and is found to be the same with SWs and MSMs. Knowledge of how to properly use a condom needs to be promoted along with the distribution of condoms. It is also vital to dismiss some of the myths that surround condom use.

It is also important to address other preventative measures such as abstinence and fidelity but in light of the risky sexual practices taking place, promotion of condoms needs to be done as a priority.

### **3. STI/HIV services including VCCT**

An overwhelming resistance to seek medical treatment by the study group calls for a rigorous change of attitude not only by health workers but by young people, SWs and MSMs. Health workers are becoming conscious of the fact that moral judgments and personal beliefs can hinder effective delivery of health services, especially in addressing sexual and reproductive health. The negative experiences of some people when accessing sexual health services can hold back others who want to seek medical assistance thus pushing people to take other alternatives.

Hence, there is a need to work with health workers to enable them to be comfortable providing services for the sexually active population, for example by exposing them to work

settings established to provide services to this target group. In parallel, getting the vulnerable groups to attend the services must also be done to promote positive health seeking behaviour.

#### **4. Outreach**

Support towards the above mentioned strategies is vital. Outreach entails regular visits, mentoring and support in maintaining behaviour change. Outreach activities should aim to provide a conducive environment for the prevention of HIV. Raising people's awareness about HIV needs to be continued and intensified as most people in the rural areas do not fully understand what HIV is about and how it affects them. Awareness talks should go beyond the basic facts of HIV, to point out risk behaviours and attitudes that exist in communities and get people to make links between the risk activities that they are involved in and HIV transmission.

It is also imperative that dialogue with the beneficiaries need to occur regularly to include where appropriate other issues that will contribute to the effectiveness of the programs.

#### **5. Collaboration with Gate Keepers (Private Sector)**

Involving the private sector can greatly assist in carrying out HIV prevention activities amongst employees and families. As experienced during the research, the assistance provided by the certain companies has enabled the research team to access employees and their families. Companies employing itinerant workers and/or who operate in areas that attract employment seekers are essential to include in HIV research and interventions to also capture the clients of SWs and MSMs. These companies can also be an avenue for condom distribution, promotion of safe behaviours amongst employees and where possible programs can be co-facilitated by the company to encourage sustainability.

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