I FEEL I CAN
NEVER GET INFECTED!

Understanding HIV and AIDS Risk and Vulnerability Among
Kiribati Islands Youth
I FEEL I CAN NEVER GET INFECTED

Understanding HIV and AIDS Risk and Vulnerability Among Kiribati Youth.

UNICEF Pacific Offices and The Government of Kiribati
I. Executive Summary

10 Background and Objectives
11 Terminology
11 Methodology
13 Recommendations

I. HIV programme targeting Most-at-Risk Adolescents and Young People (MARA/YP) and Especially Vulnerable Adolescents and Young People (EVA/YP)

II. Selection of appropriate HIV prevention interventions for MARA/YP

III. Strengthen Sexual and Reproductive Health (SRH) Services for all Adolescents and Young People

IV. Strengthen Communication for Development Programs for dissemination of HIV and AIDS prevention messages that are relevant to young girls and boys through suitable communication channels

V. Strengthen partnership and coordination among programme stakeholders

VI. Strengthen adolescents and young people participation in HIV programming and information exchange

VII. Provide opportunities for livelihood

UNGASS Indicators

II. Introduction

17 HIV and AIDS in Kiribati

18 Definitions

19 Ethical Considerations

19 Methodology and Limitations

21 Processes and Tools used in the Mapping

21 KAP Data Collection

24 Quantitative Research Methods

24 Qualitative data collection

26 What the sampling strategy offers

26 What the sampling strategy does not offer

26 Limitations

III. Findings

27 Spatial and Contextual Mapping Results

27 Demographics

29 Residences

30 School Enrollment

31 Employment

32 Marital Status

35 Summary

37 Knowledge

38 Comprehensive Knowledge on HIV and AIDS

40 Knowledge and Belief in Their Own Risk

40 Risk Perception

42 Knowledge of their HIV Status

44 Summary

45 Attitudes

50 Summary
### III. Findings

- Practices and Contributing Factors Related to Risk and Vulnerability 51
- Men Having Sex with Men (MSM) 52
- Summary 54
- Commercial and Transactional Sex 55
- Summary 57
- Forced Sex 59
- Summary 62
- Substance Use 63
- Summary 67
- Condom Use 68
- Summary 71
- Age at First Sex 72
- Summary 73
- Health and Social Services Utilisation 74
- Summary 85
- Communication for Behaviour Change 87
- Newspaper 87
- Access 87
- Radio 88
- Source of Information 89
- Summary 68

### IV. Discussions

- General Population Youth and HIV 92
- Most-At-Risk Youth and HIV 93
- Men Having Sex with Men (MSM) 93
- Commercial and Transactional Sex 94
- Vulnerable and Increased Risk Youth 95
- Forced Sex 95
- Early Onset Sex 96
- Unprotected Sex 96
- Substance Use 97
- Settings of Vulnerability 98
- Health Service Utilisation 98
- Communication 99

### V. Review of Findings and Recommendations

- Knowledge of HIV and AIDS 100
- Attitudes 102
- Practices 104
- VI. Conclusions 110
- VII. The Way Forward 112
- Model for Next Steps 112
- List of Annexes 113
- Annex 1: Definitions, Acronyms used in this report 114
- Annex 2: References 115
- Annex 3: Overview of Baseline Survey Methodology 116
- Annex 4: CPAP Indicator for Kiribati 117
- Annex 5: Kiribati Tools 118
- Annex 6: Mapping Workshop Results 143
- Annex 7: Survey Sites Selection 148
- Annex 8: Kiribati Research Team 149
List of Tables

Table 1. Linking HIV and AIDS core objectives to sampling 20
Table 2. Mapping risks, vulnerability and contributing factors 28
Table 3. Reasons given for why they are personally at risk of HIV infection 40
Table 4. Whether they would live in the same house with PLWHA 46
Table 5. What they would do if invited by friend to take marijuana 46
Table 6. Reaction to girl dropping condom packet 47
Table 7. Reaction to seeing boy leaving STI clinic 48
Table 8. Age at first sex 73

List of Figures

Figure 1. Demographic of sample by gender and age group 29
Figure 2. Demographic of sample by gender and risk category 29
Figure 3. Residence by gender and age group 30
Figure 4. Whether lives with family, on home island or away from home island by risk category 31
Figure 5. School enrollment by gender and age group 31
Figure 6. School enrollment by risk category 31
Figure 7. School level by gender and age group 32
Figure 8. School level by risk category 32
Figure 9. Employment by gender and age, school-based sample 33
Figure 10. Employment by gender and age, community-based sample 33
Figure 11. Employment by risk category 33
Figure 12. Employment type by gender and age 34
Figure 13. Fortnightly earnings by gender 34
Figure 14. Fortnightly earnings by risk category 34
Figure 15. Marital status 35
Figure 16. Marital status by gender and age 36
Figure 17. Marital status by risk category 37
Figure 18. Knowledge of individual HIV and AIDS facts 38
Figure 19. Comprehensive knowledge by risk category 38
Figure 20. Comprehensive knowledge of HIV and AIDS by age, school or community 38
Figure 21. Knowledge of STI, HIV and AIDS by gender and age 39
Figure 22. Knowledge of STI, HIV and AIDS by risk category 39
Figure 23. Whether they think they are personally at risk of HIV infection by gender and age 41
Figure 24. Whether they think they are personally at risk of HIV infection by risk category 41
Figure 25. Knowledge of HIV test results by location 41
Figure 26. Knowledge of HIV test results by gender, age, school- or community-based 42
Figure 27. Whether they have been tested for HIV and received results by risk category 42
Figure 28. Why used a condom, if used, by age and gender 42
Figure 29. Why not used a condom, if not used, by age and gender 43
Figure 30. Why used a condom, if used, by risk category 44
Figure 31. Why not used a condom, if not used, by risk category 44
Figure 32. Whether want to use condom next time they have sex by gender and age 44
List of Figures

Figure 33. Whether want to use condom next time they have sex by risk category 45
Figure 34. Whether their parents talk to them about sexuality and prevention of STI and HIV by gender and age group 45
Figure 35. Whether their parents talk to them about sexuality and prevention of STI and HIV by risk category 45
Figure 36. Preferred source of help and advice on HIV prevention 49
Figure 37. Preferred source of help and advice on HIV prevention by risk category 49
Figure 38. MSM by location 52
Figure 39. MSM by age group, school- or community-based 52
Figure 40. Commercial sex by gender and age group 55
Figure 41. Commercial sex by school- or community-based 55
Figure 42. Commercial sex by location 55
Figure 43. Transactional sex by location 56
Figure 44. Transactional sex by gender, age, school- or community-based 56
Figure 45. Forced sex by location 59
Figure 46. Forced sex by gender, age, school- or community-based 59
Figure 47. Forced sex by risk category 60
Figure 48. First sex forced by risk category 60
Figure 49. First sex forced by gender and age group 61
Figure 50. First sex forced by age, school or community, location 61

List of Figures

Figure 51. Kiribati substance use 63
Figure 52. Substance use by gender, age, and location 64
Figure 53. Substance use by risk category 65
Figure 54. Frequent alcohol use by gender, school or community, and MSM 66
Figure 55. Frequent alcohol use by risk category 66
Figure 56. Condom use at last high-risk sex by location 68
Figure 57. Condom use at last high-risk sex by risk category 68
Figure 58. Condom use at last high-risk sex by gender, age, school- or community-based 69
Figure 59. Condom use at last sex for sexually active adolescents by risk category 69
Figure 60. Condom use at last sex by interview location 69
Figure 61. Condom use at last sex by gender, age, school- or community-based 70
Figure 62. Whether delayed age of first sex 72
Figure 63. Early onset sex by gender, school- or community-based 72
Figure 64. Sex before 15 years of age by risk category (15-19 years) 72
Figure 65. Whether utilised health worker for HIV and AIDS information 74
Figure 66. Males who talked to health worker about HIV and AIDS by risk category 74
Figure 67. Females who talked to health worker about HIV and AIDS by risk category 75
Figure 68. Obtained and used condom from health clinic by gender and location 76
Figure 69. Males who obtained and used condom from health clinic by risk category 76

List of Figures

Figure 70. Females who obtained and used condom from health clinic by risk category 77
Figure 71. Males utilising health clinic for HIV and AIDS information by age 78
Figure 72. Males utilising health clinic for obtaining condom by age 78
Figure 73. Females utilising health clinic for HIV and AIDS information by age 78
Figure 74. Females utilising health clinic for obtaining condom by age 78
Figure 75. Males STIs in past year by location 79
Figure 76. Females STIs in past year by location 79
Figure 77. Male STI treatment by location 79
Figure 78. Female STI treatment by location 80
Figure 79. Male frequency of STI in past year by risk category 80
Figure 80. Male STI treatment utilisation by risk category 81
Figure 81. Female frequency of STI in past year by risk category 81
Figure 82. Female STI treatment utilisation by risk category 82
Figure 83. HIV and AIDS prevention workshop for most-at-risk coverage 83
Figure 84. Most-at-risk reached by HIV prevention programmes by risk category 84
Figure 85. Radio listeners by days of the week 85
Figure 86. Current and preferred source of information and advice on HIV and AIDS 88
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AHD</td>
<td>Adolescent Health Development</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>CPAP</td>
<td>Country Programme Action Plan</td>
</tr>
<tr>
<td>CRC</td>
<td>Commission on the Rights of the Child</td>
</tr>
<tr>
<td>CSEC</td>
<td>Commercial and Sexual Exploitation of Children</td>
</tr>
<tr>
<td>DILO</td>
<td>Day-in-the-Life-Of Qualitative Methodology</td>
</tr>
<tr>
<td>DOS</td>
<td>Department of State</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FSP</td>
<td>Foundation for the Peoples of the South Pacific</td>
</tr>
<tr>
<td>EVA</td>
<td>Especially Vulnerable Adolescent</td>
</tr>
<tr>
<td>EVA/EVYP</td>
<td>Especially Vulnerable Adolescent or Young Person</td>
</tr>
<tr>
<td>EVYP</td>
<td>Especially Vulnerable Young Person</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency virus</td>
</tr>
<tr>
<td>IATT</td>
<td>Inter-Agency Task Team on HIV and Young People</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug Use</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge Attitude and Practice</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>MARA</td>
<td>Most-at-Risk Adolescent</td>
</tr>
<tr>
<td>MARYP</td>
<td>Most-at-Risk Adolescent or Young Person</td>
</tr>
<tr>
<td>MARYP</td>
<td>Most-at-Risk Young Person</td>
</tr>
<tr>
<td>MARP</td>
<td>Most-at-Risk Population</td>
</tr>
<tr>
<td>MILO</td>
<td>Moment-in-the-Life-Of Qualitative Methodology</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Having Sex with Men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>PAPE</td>
<td>Policy, Advocacy, Planning, and Evaluation</td>
</tr>
<tr>
<td>PI</td>
<td>Pacific Island</td>
</tr>
<tr>
<td>PLWHA</td>
<td>Person Living With HIV or AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>SDA</td>
<td>Seventh Day Adventist</td>
</tr>
<tr>
<td>SPC</td>
<td>The Secretariat of the Pacific Commission</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually-Transmitted Infections</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint UN Organisation on HIV/AIDS</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
</tr>
<tr>
<td>US</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WPRO</td>
<td>Western Pacific Regional Office (WHO)</td>
</tr>
</tbody>
</table>
While Kiribati, like other Pacific Islands Countries (PICs), still experiences a low HIV prevalence of less than one percent in the general population, the country has some unique factors which increases vulnerabilities and risks to HIV infection. Kiribati has a rapid growing population, with high internal and international migration of young people.

The people of Kiribati are exposed to HIV at different rates of risks and vulnerabilities. In many situations those who are at high risk, or increased vulnerability, also are in unfortunate situations of having less access to services for prevention, care and treatment. Studies have shown that even their access to information is limited, hence increasing their vulnerability even further.

In such a setting, effective HIV prevention services should include mapping where such groups are, and designing relevant and appropriate interventions, with the participation of these high risk and vulnerable groups. This is the only way of ensuring that these groups are reached, and the transmission chain is interrupted. It is well known that even where national systems for service delivery are strong and well established, without well designed targeted HIV interventions, which are sensitive to the needs of the target groups, access to services can be seriously hampered. Targeting ensures equity and cost efficiency.

In East Asia and Pacific we are observing an increase in feminization of the HIV epidemic. Women and girls are accounting for a higher proportion of HIV infections. Furthermore HIV-related stigma, discrimination and punitive laws continue to operate in many countries, reducing the ability of vulnerable and most-at-risk populations, (including injecting drug users, sex workers and their clients, men who have sex with men, transgender people and prisoners), to access the necessary services. And where relevant information about these groups is not available, it is very easy to assume that these groups are equally served by existing systems when, in reality, the opposite could be true.

As a friend and partner of the Kiribati government, UNICEF has had the privilege to facilitate this study and generate this data, which attempts to address some of the existing information gaps. This was done with the participation of identified high risk and vulnerable groups, males and females, boys and girls, so that the intricacies of their relationships and what increases their risks and vulnerability could be understood. It is my hope that the study has brought more understanding to the practices of these groups, and that the information gathered will assist in developing interventions which are more relevant to Kiribati people.

UNICEF believes that equity-focused approaches will not only accelerate progress towards the millennium development goals, but are also cost–effective, and that equity in relation to HIV interventions, is not only about pro poor services, but targeting those who are most vulnerable and at high risk of infection.

Dr. Isiye Ndombi,
UNICEF Country Representative
Background and Objectives
The Government of Kiribati and UNICEF Pacific Offices agreed on HIV and AIDS as one of five components in their five-year programme from 2008-2012. One goal of the HIV and AIDS programme component is to reduce vulnerability and risk to HIV and AIDS for youth aged 15-24. The programme has a special focus on women and children.

The first person was diagnosed with HIV and AIDS in 1991. By June 2009, 52 cases were confirmed living with HIV. Kiribati now has one of the highest HIV and AIDS infection rates in the Pacific. Most of those diagnosed have been seafarers, their wives and children with the main mode of transmission through heterosexual sex. It is assumed the actual number of new HIV cases would be higher due to under reporting. In an early stage HIV epidemic, cases are mostly reported among most-at-risk populations, with youth ages 15-24 representing about half all new HIV infections. Thus, it is important to maintain careful surveillance of HIV rates among most-at-risk populations (including adolescents and young people) to understand the driving factors for the epidemic, including knowledge, attitude and practices of identified at risk populations; and to use the information for strategic HIV prevention programming. A 2008 desk review concluded that existing information from Kiribati was insufficient for that purpose.

Therefore, an assessment of knowledge, attitude and practices on HIV and AIDS amongst adolescents and young people was undertaken in Kiribati between May 2008-November 2009 to address three formative research questions:

1) What is the spatial and contextual nature of risk and vulnerability to HIV and AIDS among youth aged 15-24 years in selected areas of Kiribati?
2) What factors influence current behaviours and could influence future interventions for those Most-at-Risk, Especially Vulnerable and the general youth population?
3) How do these youth currently receive information and advice and what communication methods are likely to be most effective in reaching them?

This research was based on spatial and conceptual mapping that explored risks to HIV infection as globally defined by UNAIDS and co-sponsors, while assessing existence of other factors increasing vulnerability among youth. It also facilitated stakeholders to reach consensus on what constitutes "Vulnerability to HIV" among youth of Kiribati. The significance is that findings can inform programmes and policies, and thus potentially help reduce HIV and AIDS spread among Kiribati youth.
**Terminology**
This report uses “adolescent” to describe those of 15-19 years, “young people” to describe the 20-24 year old group, and “youth” for this sample of 15-24 years. The terms Most-At-Risk Adolescent (MARA), Most-At-Risk Young Person (MARYP), Especially Vulnerable Adolescent (EVA) and Especially Vulnerable Young Person (EVYP) are used in accordance with international standards. The term “increased risk” is utilized for the purpose of describing those who are not “most”-at-risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth.

**Methodology**
The core objectives of this study were directly linked to research questions which determined the choice of survey methodology and sampling strategy. Two methods were chosen:

1) Spatial and contextual mapping to locate MARA, MARYP, EVA, and EVYP groups
2) Knowledge, Attitude and Practice (KAP) survey of sampled respondents from the above groups, as well as other adolescents and young people, through quantitative structured questionnaire and qualitative semi structured questionnaires (Focus Group Discussion and Key Informant Interviews).

Consultative mapping workshop data was triangulated through a two-level approach at the community level and by most-at-risk and especially vulnerable youth. In Kiribati, South Tarawa Atoll and Abemama Atoll were sampled. These areas were selected because they will be the focus of initial programme implementation by MHMS and UNICEF. No Control area has yet been identified for Kiribati. One-third of this sample was school-based, since about one-third of this target population is enrolled in school.

The targeted sample size for Kiribati was 325 with a confidence level of 95% and confidence interval of 5.4 based on the estimated population of 10,000 youth aged 15-24 years in South Tarawa and Abemama, the samples areas. Based on a proportional coefficient, the targeted sample size by area was 300 for South Tarawa and 25 for Abemama Island, but the Abemama target was increased to 50 due to its small size. These targeted sample sizes were exceeded.
The chosen sampling strategy offers baseline data and indicators for measuring progress in Kiribati, as well as spatial and contextual information concerning MARA/MARYP, EVA/EVYP, and general population youth. The sampling strategy does not produce statistically representative data which can be extrapolated to the entire country of Kiribati. It is acknowledged that there are several confounding factors, including the inverse relationship between level of vulnerability and likelihood of being interviewed, invisibility of family vulnerability, and potential unwillingness for interviewee to discuss private information related to their vulnerability. The study population was small, not random, and the total number of the study population was estimated, but not known. These study results, however, have the potential to make a substantial contribution to effectiveness of intervention efforts related to lowering risk and vulnerability of these target populations.

(1) Demographic data revealed most youth were not married (88.5%), not employed (87%), not in school (67%), and not living on their home island (67%) where they had community and support.

(2) Findings related to knowledge revealed a relatively low level (12.5%) of comprehensive knowledge of HIV and AIDS, lack of belief in their personal risk for 81% and lack of focus on changing unsafe behaviour despite a basic understanding of their risks. Only 19.3% sexually active youth had been tested for HIV and received their results.

(3) Data on attitudes of these youth elucidated problematic issues related to promoting safer sex. Only one-third of respondents had used a condom, although two-thirds were sexually active. Only one-third said their parents talked with them about sexuality and prevention of HIV. Responses to a girl dropping a condom packet or boy seen leaving an STI clinic included embarrassment, fear, and hatred.

(1) Thirty-five percent of sexually active males reported MSM, 83.4% unprotected, with number of partners ranging from 1-31. Forced sex of MSM was reported by 47.2% in Kiribati and 67% on Abemama.

(2) Thirty-six respondents in the sample engaged in commercial and/or transactional sex. Only 49% reported using a condom at last sex. The issues of Kiribati girls selling sex in bars and ships as well as Abemama youth's risk behaviour are important contributing factors to increased risk.

(3) Forty-three percent of sexually active youth reported forced sex with ongoing vulnerability for 79%. First sex was forced for 21.1% of sexually active youth overall and 36% of Abemama interviewee.

(4) Sexually active youth reported 42.9% condom use at last high-risk sex (non-regular partner) indicating 57.1% were having unprotected high-risk sex. Condom use at last sex was similar.
(5) Increased risk related to substance use was significant. Two-thirds of the sample reported alcohol use, over half used kaokio, and a quarter used kava. Their rate of frequent alcohol consumption (more than three times per week) was 12.2%. There were no IDUs reported in this sample.

(6) Those who had first sex before 15 years of age were 13.2% of all 15-19 year olds sampled – 9.7% on Tarawa and 28.6% on Abemama with some youth reporting sex as young as 9 years.

(7) Data on health care utilisation indicated utilisation of health workers as sources of information on HIV and AIDS or as a source for condoms was higher for males (33% and 44% respectively) than females (18% and 22% respectively). Sixty-seven percent of most-at-risk youth reported attending an HIV prevention workshop.

(8) Communication findings indicated 48% read the newspaper once a week; almost all had access to a working radio; about one-third to a working TV; and a quarter to a mobile phone. Eighty-five percent listened to the radio and 45% watched TV with listening and viewing patterns having largest numbers on weekends and lowest in mid-week. There was little difference between current, preferred, and trusted sources of information on HIV and AIDS. Two-thirds of respondents had attended a program on preventing HIV; 74% had heard an AIDS programme on radio; 72% had seen a poster; and 39% had seen a video on HIV or AIDS.

Findings
Research findings provided information on contexts of risk and vulnerability for these youth:
Research areas included several practices that increase risk and vulnerability to HIV and AIDS, including:
Discussion of issues related to findings is organized in three sections to address issues of general population, or mainstream, youth who are not involved in high-risk behaviours; most-at-risk youth who are engaged in the highest risk behaviours; and vulnerable and increased risk youth who are more likely to start engaging in risk behaviours due to exposure to vulnerability factors or are engaging in less risky behaviours.

Areas of high-risk for those most-at-risk in Kiribati are commercial/transactional sex and MSM. Little or no IDU was reported. Additional data on risk behaviours of those who have become infected are required to elucidate the contribution of sex work and MSM to epidemic spread, but it is thought to have been fuelled by heterosexual sex and subsequent spread to families of seafarers who became infected while out of the country. Several factors contribute to the risk level of vulnerable and increased risk youth in Kiribati including: substance use, forced sex, early onset sex, and unprotected sex.
**Recommendations**

Findings in the KAP survey show that there are specific groups among Kiribati adolescents and young boys and girls who carry higher risks and vulnerability to STIs, HIV and AIDS. There is an urgent need to design specific intervention targeting those who are marginalized and at higher risks and vulnerability. The risks are reduced with their increased ability to make informed decision on when they are ready for sex; and make choices on how to protect themselves from STIs, HIV and AIDS; and further enable them to live a healthy and productive life. The survey also reported practices that increase risk and vulnerability to HIV and AIDS for Kiribati adolescents, and young boys and girls.

In order to ensure that adolescents and young people (boys and girls), particularly those who are most at risk and vulnerable to infection, are protected and enjoy a life that is free from STI (including HIV), the following recommendations are made:

I. **HIV programme targeting Most-at-Risk Adolescents and Young People (MARA/YP) and Especially Vulnerable Adolescents and Young People (EVA/YP)**

The KAP survey gives strong evidence that MARA/YP and EVA/YP groups are more at risk and vulnerable to HIV and AIDS among sampled adolescents and young people. The Kiribati survey sample of 367 youth, of whom 236 were sexually active, included 36 respondents who engaged in commercial and/or transactional sex. Thirty respondents reported having commercial sex of whom four were male and 26 female. All but three of those who engaged in commercial sex also engaged in transactional sex (27) and six only engaged in transactional sex for a total of 33. In relation to their risk behaviours, 51% of those engaging in commercial or transactional sex did not use a condom the last time. Findings also demonstrate a higher percentage of risk (MARA/MARYP) for males (35.1%) than for females (16.9%) and higher vulnerability for females (13.2%) than males (9.1%).

The programme interventions for MARA/YP and EVA/YP should be carried out by defining MARA/YP, EVA/YP, and their geographical settings; and through needs identification. These work should involve mainstream adolescents and young people, and representatives from at-risk and vulnerable groups. The Government of Kiribati should also develop policy guidelines and standards for programming and interventions that address the needs of most-at-risk and vulnerable adolescents, young boys and girls; and build their protective factor; while ensuring that interventions do not violate human rights.

II. **Selection of appropriate HIV prevention interventions for MARA/YP**

Based on survey findings, the Government of Kiribati needs to identify the best way to accomplish its human rights obligations and promote public health that take into account the specific cultural contexts. This should particularly target the marginalized or disadvantaged adolescents and young girls, adolescents and young girls and boys engaging in commercial and transactional sex and adolescents and young men who have sex with men. Since their risky behaviours are often illegal, adolescents and young people engaging in these practices would unlikely access health care services which are viewed as unfriendly to their specific needs. Consequently, mainstream HIV prevention and treatment efforts failed to reach out to these groups.

The government should consider HIV prevention interventions that are customized for MARA/YP and EVA/YP. The first step should be engaging these groups in discussions to find out what HIV prevention interventions that work well with them, such as youth clinics with flexible opening hours, and counselling service that involves trained counsellors who understand the needs of marginalized youth. Public health messages to foster behaviour change should cater to the specific groups’ different needs. As such, public information message on the correct use of condom could be accompanied with skill building.
Other interventions such as peer education programs and the provision of youth-friendly health care services should be designed to meet the needs of MARA/YP and EVA/YP. Engaging these groups in developing an HIV prevention interventions programme ensures long-term, sustainable behaviour changes in adolescents and young people.

III. Strengthen Sexual and Reproductive Health (SRH) Services for all Adolescents and Young People
The survey shows that 23% of Kiribati respondents were tested for HIV while 19.3% received their results, highlighting the concern that MARA/YP and EVA/YP are not accessing SRH services to an acceptable level. Several reasons cited include services are not readily available, not accessible, or not friendly to young people. The study has also shown that many adolescents and young boys and girls are unaware of the existence of SRH services, while others did not feel the need to use SRH services. There is a need to scale up SRH services for adolescents and young people that meet the agreed national standards. As an initial step, the government needs to issue guidance on minimum standards for SRH that are youth-friendly, and address the needs of adolescents and young people as identified by adolescents and young people themselves. Access to and the use of SRH services by adolescents and young people complement other prevention interventions. The SRH services should include information dissemination, STI management, family planning, HIV counselling and testing services, and other counselling services. The KAP study also shows that Kiribati youth trust health facilities and health workers as their sources of information thus providing an opportunity to disseminate relevant and correct information to young people who are in contact with health care providers.

IV. Strengthen Communication for Development Programs for dissemination of HIV and AIDS prevention messages that are relevant to young girls and boys through suitable communication channels
The KAP findings show that radio and newspapers are the most preferred sources of information for Kiribati youth. According to the survey, there was an increased condom use among youth following an HIV prevention message that was broadcast on the radio. A message will have significant impact to the public if it is disseminated continuously for more than six months. The messages for the youth must be developed with their participation, or by youth themselves. However, technical assistance is needed during messages development to ensure that they produce the intended result. In addition, public information messages targeting MARA/YP and EVA/YP should be relevant to their needs and acceptable to other community members as well. All communication messages must be directed towards action for specific target groups.

V. Strengthen partnership and coordination among programme stakeholders
Partnership and coordination amongst programme stakeholders are extremely important, as reflected in the KAP study. This should include planning, implementing, monitoring and evaluating prevention efforts in consultation with national and regional agencies, as well as with community stakeholders.

VI. Strengthen adolescents and young people participation in HIV programming and information exchange
Kiribati youth recommended that programming involve young people in communities instead of the same volunteers to increase effectiveness in their respective areas and enhance reliability of HIV information. Therefore, youth engagement in designing and implementing programmes to promote active learning is crucial. At the same time, it is important to strengthen the capacities of adolescents and young people, including MARA/YP and EVA/YP, to ensure that they could deliver quality information to their peers and provide a vital link to access SRH services including services for HIV.
VII. Provide opportunities for livelihood

The study suggest that there are certain social determinants such as poverty and lack of job opportunities that increase the risk and vulnerability of Kiribati adolescents and young people to HIV and AIDS. For a significant proportion of adolescents and young people, poverty is a reality that hampers development and affects access to health care services. It is recommended that programmes for young people, including MARA/YP and EVA/YP, could provide the opportunities for building entrepreneurship to generate income and secure employment.

UNGASS Indicator

<table>
<thead>
<tr>
<th>UNGASS Indicator</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>7. Percentage of women and men aged 15-24 who received an HIV test in the last 12 months and who know their results.</td>
<td>28</td>
<td>18.2</td>
<td>43</td>
<td>20.2</td>
</tr>
<tr>
<td>13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</td>
<td>-</td>
<td>14</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>15. Percentage of young women and men aged 15-19 who have had sexual intercourse before the age of 15 years.</td>
<td>-</td>
<td>21.3</td>
<td>-</td>
<td>7.8</td>
</tr>
<tr>
<td>16. Percentage of women and men aged 15-24 who have had sexual intercourse with more than one sexual partner in the past 12 months.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17. Percentage of women and men aged 15-24 who have had sexual intercourse with more than one sexual partner in the past 12 months reporting the use of condom during their last sexual intercourse.</td>
<td>52</td>
<td>44.4</td>
<td>44</td>
<td>41.1</td>
</tr>
<tr>
<td>19. Percentage of men reporting the use of a condom the last time they had sex with a male partner.</td>
<td>-</td>
<td>35.2</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
HIV and AIDS in Kiribati

One of the goals of the Kiribati Ministry of Health and Medical Services (MHMS) and UNICEF Pacific’s Country Programme for 2008-2012 is to reduce vulnerability to and impact of HIV and AIDS among most at risk populations in selected Pacific island Countries, including Kiribati, with a special focus on women and children. Thus, UNICEF has partnered with MHMS to gain a better understanding of risk and vulnerability related to HIV and AIDS among most-at-risk and especially vulnerable adolescents (MARAs and EVAs) and young people (MARYPs and EVYPs) and general population youth in Kiribati.

Both the Government and UNICEF had agreed on expected outputs by 2012 that include change of risk behaviours among most-at-risk adolescents, most-at-risk youths and especially women in selected areas of Kiribati; improved access to reproductive health and Preventing Mother To Child Transmission (PMTCT) services for women, children, PLWHA and their families; development of emergency preparedness plan to support most-at-risk adolescents, youth and women; and increased participation and ownership of STI, HIV and AIDS prevention programme by targeted populations.

The population of Kiribati was 99,999 in the 2005 census, is estimated to be 110,000 today, and is projected to double within the next 20 years. The first case of HIV was diagnosed in Kiribati in 1991. By September 2001, 38 cases of HIV and AIDS had been reported while 17 people had died from AIDS. Most of those infected were seafarers, their wives and children. The Ministry of Health & Medical Services (MHMS) reported that in June 2009, 52 cases had been reported to be living with HIV, which included 32 men and 20 women.

Kiribati progress in relation to Millennium Development Goals (MDGs), including Goal 6, on reversing or halting the epidemic for HIV and AIDS has been considered weak compared to other small Pacific Island nations. However, Kiribati is relatively small, isolated, and vulnerable with a land mass of only 811 square kilometers and 33 islands over an exclusive economic zone of 3.5 million square kilometers. Kiribati suffers from profound threats from external economic and environmental factors, including climate change. Currently, questions about the country’s sustainability in relation to a rapidly growing population represent major long term concerns.

Because of few opportunities for employment on Kiribati outer islands, there is migration of residents to the capital, Teinainano United Council (TUC), Tarawa. As a result, about 43.5% of the population are concentrated in South Tarawa resulted in overcrowding, especially on the islet of Betio. Kiribati depends highly on fishing as a source of livelihood, with about 80% of Kiribati households sustained through fishing. Agricultural opportunities are extremely limited, because of crowded land base, and the fact that there is little arable land. Economic growth is limited by the small capacity of the economy, its remote and dispersed geography, lack of skilled workers, and weak infrastructure. Over 50% of Kiribati’s total population lives on its outer islands where transportation and communication are costly, there are few services including health, and opportunities for education and livelihood are limited.

Among social problems reported to face Kiribati population are excessive alcohol consumption, domestic violence, teenage pregnancy, and unemployment. Excessive alcohol consumption is recognized to have become a very severe problem both socially and health-wise, with domestic violence, linked to alcohol abuse, an increasing problem.
Trafficking underage girls for commercial sexual exploitation by crews of foreign and local fishing vessels has also been an issue of concern. In 2003, Kiribati banned Korean fishing boats from entering Kiribati ports after reports of 30-50, mostly underage, girls selling sex to Korean fishermen. In 2006, Kiribati police rounded up and then released 80 girls due to the reported lack of a law against prostitution. In 2007 and 2008, Kiribati was considered to be a special case due to trafficking in persons, coupled with a lack of reliable data. In 2007, the National Youth Commission reported that Korean fisherman resumed buying sex from young girls when the ban was lifted. They reported that seven of 24 prostitutes were between 14-18 years old, that the Koreans did not want to use condoms and several girls had children. In 2009, Kiribati was again discussing preventing fishing boats from entering Kiribati ports.

The CRC also expressed concerns about sexual violence, increasing prevalence of HIV among adolescents, lack of knowledge about HIV among youth, coupled with an absence of awareness raising and prevention programmes. Although HIV prevalence is low in Kiribati, ADB’s modelling approach projects great impacts of HIV on the Kiribati population, if no effective interventions are undertaken. Under a high-growth scenario on HIV and AIDS in Kiribati by 2020, these impacts are projected to include:

- HIV prevalence reaching 1.6%.
- 2.8 years decrease in life expectancy.
- USD0.3 million in costs for increased ART demand for 873 on treatment.

Definitions
The United Nations (UN) definition of youth is 15-24 years of age. This research involves risk and vulnerability for youth aged 15-24 years of age, who will be termed “youth” in this report, in concordance with the UN definition. In this study, the sampled population was divided into two groups aged 15-19 and 20-24 years of age. The younger group aged 15-19 years of age is termed “adolescent” for the purpose of this report. The older group aged 20-24 is termed “young people” for the purpose of this report. This use of the terms “adolescent” and “young people” does not adhere to the WHO definitions of “adolescent” lasting from 10-19 years and “young people” from 10-24 years.

Adolescence is considered to last much longer than 19 years of age in some Pacific Island countries, including Kiribati, where adolescence is considered by some to extend to 30 years of age, as was discussed during the National Consultative Mapping Workshop. Since this study includes three Pacific Island countries, the definition of adolescence as 15-19 years of age has been accepted by Kiribati leaders, stakeholders and youth for this purpose. Likewise, 20-24 year olds are termed young people in this report. These terms refer to both males and females. While UNICEF program interests are in adolescents 10-19, this study focuses on the 15-24 year age group because of ethical issues in collection of data for those under 15, and also because it was more relevant to include 20-24 year olds, rather than focus only on 15-19 year olds in relation to the objectives of the study.

The terms Most-at-Risk Adolescent (MARA), Most-at-Risk Young Person (MARYP), Especially Vulnerable Adolescent (EVA) and Especially Vulnerable Young Person (EVYP) are used in accordance with international standards. The term “increased risk” is utilized in this report for the purpose of describing those who are not “most” at risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth.
Ethical Considerations
This research put the utmost priority on ethical concerns. These include strict maintenance of confidentiality, informed consent, security of data, code of conduct for data collectors, respect for interviewee and community members, careful training of the team, a reference group of young people to assist in the research, and working with service providers to the target populations.

Following data collection, confidentiality was maintained for all notes, recordings, and other records; with transportation of recorded questionnaires in secured boxes; and subsequent storage of recorded questionnaires in secure offices. Only those with a need to use the data for data checking, cleaning, entry, analysis and reporting had access to these files. Following completion of the research, records are being retained in a secure and locked place by UNICEF Pacific for seven years and will be destroyed prior to disposal or transferred to appropriate Kiribati health officials.

Methodology and Limitations
The core objectives of this study were to determine:

1. Spatial and contextual nature of risk and vulnerability to HIV and AIDS among Most-at-Risk Adolescents (MARAs) and Young People (MARYPs), Especially Vulnerable Adolescents (EVAs) and Young People (EVYPs) in Kiribati.
2. Factors influencing risk, vulnerability and the potential of future interventions to reduce risk and vulnerability to HIV and AIDS in Kiribati.
3. Current and desired communication patterns and factors potentially influencing future communication concerning information and advice on HIV and AIDS.

The following key research questions were designed to address objectives of the study:

1) Where are MARAs, EVAs, MARYPs, and EVYPs found in South Tarawa and Abemama Island?
2) What risk behaviours are involved?
3) What are the contexts of vulnerability?
4) What factors contribute to risk and vulnerability?
5) What are their attitudes about issues related to their sexuality?
6) What health and social services do youth utilise?
7) What channels of communication do youth currently access and use?
8) What programming and channels of communication would they prefer?
9) What types of HIV and AIDS information do youth currently receive?
10) How would they prefer to be informed about HIV and AIDS advice and information?
11) What sources do they trust the most for HIV and AIDS advice and information?

The methods chosen to answer these key questions were:

1) Spatial and contextual mapping to locate MARA, MARYP, EVA, and EVYP groups
2) Knowledge, Attitude and Practice (KAP) survey of sampled respondents from the above groups, as well as general population adolescents and young people, through: quantitative structured questionnaire and qualitative semi structured questionnaires (Focus Group Discussion and Key Informant Interviews/ KIIs).
The core objectives of this study were directly linked to research questions which determined the survey methodology and sampling strategy. In Kiribati, South Tarawa atoll and Abemama Atoll were sampled. One-third of this sample was school-based since about one-third of those in this target population are in school. These methods and sampling strategy, are illustrated in Table I below:

Table 1: Linking HIV and AIDS core objectives to sampling

<table>
<thead>
<tr>
<th>Core Objectives</th>
<th>Key Questions</th>
<th>Methods</th>
<th>Samplings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine spatial and contextual nature of risk and vulnerability to HIV and AIDS among MARAs, MARYPs, EVAs, EVYPs, and general population youth in South Tarawa and Abemama, Kiribati.</td>
<td>Where are MARAs and EVAs found? What risk behaviours are involved? What are the contexts of vulnerability? What are the contributing factors?</td>
<td>Mapping workshops, Structured interviews (questionnaires), Semi-structured interviews (KII), Focus group discussions</td>
<td>Purposive selection stakeholders Random in schools, non-random in communities Purposive selection special informants Quasi-random</td>
</tr>
<tr>
<td>Determine factors influencing risk and vulnerability, and potentially influencing future interventions to reduce risk and vulnerability to HIV and AIDS in S. Tarawa and Abemama, Kiribati</td>
<td>What health and social services do youth utilise? What are their attitudes about issues related to their sexuality? What do youth say they need to lower risk and vulnerability to HIV and AIDS?</td>
<td>Structured interviews (questionnaires), Semi-structured interviews (KII), Focus group discussions</td>
<td>Non-random mapping participants Random in schools, non-random in communities Quasi-random</td>
</tr>
<tr>
<td>Determine current and desired communication patterns and factors that have potential for influencing future communication concerning information and advice on HIV and AIDS.</td>
<td>What channels of communication do youth currently use and would they prefer? What types of HIV and AIDS advice and information do youth receive? What types of HIV and AIDS communication would they prefer?</td>
<td>Structured interviews (questionnaires), Semi-structured interviews, Focus group discussions</td>
<td>Random in schools, non-random in communities Purposive selection special informants Quasi-random</td>
</tr>
</tbody>
</table>
Processes and Tools used in the Mapping

To conduct mapping of MARA, EVA, MARYP, and EVYP, in relation to spatial and contextual issues related to risk and vulnerability to HIV and AIDS, two consultative workshops were held at Tungaru Central Hospital, Nawerere, Tarawa; and at a Council Mwaneaba, or traditional community hall in Abemama Island. Both preceded any data collection activities.

Workshop participants included representatives of all relevant stakeholders; including health and social service providers; staff members from MHMS; civil service organisations working with MARPs, adolescents and young people; staff members from UNICEF; and selected youth. For Abemama, workshop participants included relevant stakeholders in Abemama Island. Through participatory methods of facilitation, participants of the consultative workshop:

- Gained an understanding on how risk to HIV and AIDS and vulnerability is defined globally, and sought consensus for local definition among stakeholders.
- Provided information on what were considered locally to be risk factors for HIV and AIDS; on factors increasing vulnerability among adolescents and youth; and underlying factors.
- Provided information on specific sites within areas identified by participants as places where most MARA/ MARYPs and EVA/EVYPs could be located in S. Tarawa and Abemama.

- Provided information on logistics for contacting data sources.

Throughout all the workshops, data was recorded on flip charts in Kiribati language and English by Kiribati Research Assistants. (Annex 6)

KAP Data Collection

Data was collected from the sampled population through quantitative and qualitative research methods, as described below.

Quantitative Research Methods

A. Sampling method

Field research involved “purposive” sampling to select research locations within Kiribati. Specifically, data collection was carried out in within the area of South Tarawa Atoll, including Betio Islet, and within Abemama Island where MHMS and UNICEF Pacific will implement programming. A National Consultative Mapping Workshop in South Tarawa Atoll and Provincial Workshop in Abemama Island provided data to guide choice of individual locations in each area.

The targeted sample size for KAP quantitative questionnaires in Kiribati was 325 with a confidence level of 95% and confidence interval of 5.4 based on an estimated total population of 10,000 youth aged 15-24 years of age in Abemama Island and the S. Tarawa area. Based on a proportional coefficient, sample sizes by area were: 300 for South Tarawa and 25 for Abemama. Due to small size, up to 50 questionnaires were targeted for Abemama. The actual sampled size for KAP questionnaires was 306 on South Tarawa and 57 on Abemama Island for a total of 363, exceeding the 325 target.
Within each area, locations were purposively selected during the mapping workshop to include those areas with the most risk and vulnerability among adolescents and young people. This study did not target a cross-section of the population as a whole, but a cross-section of youth who were most-at-risk and especially vulnerable as well as mainstream youth.

In each non-school setting the research team non-randomly selected male adolescents, female adolescents, male 20-24 year olds, and female 20-24 year olds from a non-random selection of households and settings where adolescents and young people gathered, but which had been identified as areas where most-at-risk and especially vulnerable youth would also be found.

In sites where a roster of attendees was available, such as a school, a random number method was used for selection of interviewee, but the selection of the school was not random. Schools were identified by mapping workshop participants in relation to the likelihood of finding most-at-risk and especially vulnerable youth. The selected non-school areas were purposefully sampled for most-at-risk and especially vulnerable youth. Based on previous studies and consultative mapping workshop findings, most-at-risk and especially vulnerable youth were expected to be at higher concentration in urban and peri-urban slum areas among multicultural settlements; among those who were poor; from unstable populations with higher migration and flux; and living away from family or traditional support. They were selected to reflect as much balance as possible in risk behaviours and vulnerability. Although the sample was non-random and not generalisable, both the sampling strategy for KAP questionnaire data collection from MARA/MARYP and EVA/EVYP youth and the overall sample size for Kiribati data collection was set with the purpose of providing the basis for possible re-measurement.

B. Quantitative Tool development

The quantitative KAP survey questionnaire was developed to address core objectives of the study. Thus, it addressed gaps that had been identified in a previous desk review of baseline indicators for HIV and AIDS programming, specifically in relation to: 1) risk behaviours and contexts of vulnerability for MARA/MARYP, EVA/EVYP, and general population youth; 2) factors influencing risk and vulnerability and potentially influencing potential future interventions intended to reduce risk and vulnerability; and 3) current and desired communication patterns and factors that might influence future communication and advice on HIV and AIDS.

It was developed to collect data that would serve as baseline indicators and also guide subsequent programme and policy development. The development was through a collaborative and iterative process with each of the three countries involved (Kiribati, Vanuatu, and Solomon Islands). Methodology and tools were reviewed in Kiribati with MOH and UNICEF Kiribati staff to assure that local issues were addressed. The questionnaire was translated into Kiribati language at the advice of MHMS in relation to the level of English proficiency of potential data collectors. The questionnaire was translated into Kiribati language, back translated to English, and each question was carefully reviewed and fine-tuned to assure accurate translation.
Utilising the quantitative KAP survey tool, the most-at-risk, especially vulnerable, and general population youth were asked their demographic information; knowledge of STIs and AIDS; perception of personal risk; age at first sex and whether forced or intoxicated; their attitudes and practices relating to risk and vulnerability including condom use and accessibility; community support; utilisation of health and social services; risk behaviours; context of vulnerability; where they obtained information about HIV, AIDS, and STIs; what information sources they preferred and their recommendations for decreasing risk and vulnerability to HIV and AIDS for youth.

C. Field testing
Data collector training and field testing of the KAP Questionnaire (Annex 5) that had been translated to Kiribati language was held immediately after the mapping workshop following a structured curriculum and rehearsal of interview techniques. Data collectors in South Tarawa and Abemama read each question in Kiribati, explained to the group what it meant in English, and did practice interviews with each other as part of their training. Subsequently, the research team tested the questionnaire at local schools with immediate review of completed questionnaires, provision of answers to data collector questions, and guidance following each individual interview. Participatory input to survey tools was solicited from youth who acted as a reference group during field testing and data collection.

D. Data Collection
Subsequent data collection was based on mapping workshop recommendations, as those recommendations directly influenced interview site selection. In South Tarawa, data was collected in Betio and Tarawa Union Council area bars, schools, prisons, villages, markets, houses, sports fields, bars, the wharf, and other places where youth congregate. In Abemama, data was also collected from bars, schools, villages, and other places where Abemama youth congregate. The research team met daily to review progress, make revisions in plans, and assess what additional areas should be sampled.

Reaching youth who are most-at-risk and especially vulnerable is known to be challenging due to their fear of authorities, focus on daily survival, mobility, long-term abuse and exploitation, and mental health issues. Additionally, they are often in acute need of ongoing sustainable services. Thus, the research team worked with the reference group of youth to obtain their input on how to best reach those who might otherwise not be reached. Letting interviewee know about the purpose and potential benefit of the study, coupled with the knowledge that their names would not be taken, led to almost total agreement by all who were asked, even in busy nightclubs while they were working. Most-at-risk and especially vulnerable youth were approached through a combination of techniques based on the specific situation with a focus on working with individuals and groups, such as service providers, who already had a long term trusted relationship with them, other youth who were most-at-risk and especially vulnerable, and respondent driven techniques as appropriate.

The team adjusted the interview schedule and venues as was necessary to include considerable time at night in local bars, as was necessary to reach those most-at-risk and especially vulnerable, and sought to provide interview places where interviewee felt secure. Nonetheless, interviewee were extremely helpful and were interviewed by flashlight on dark doorsteps and entryways, in noisy bars, on the wharf, in prison, by flashlight after class at the Fisheries Training Centre, in schools, on the street, and at their homes.
The research team worked with individuals and several organisations like Kiribati Family Health Association (KFHA) and Adolescent Health Development (AHD) to assist with contacts and locating interviewee, meeting space and transportation. In Abemama, researchers were assisted by the Island Council, school principals and the MHMS nurse. In addition to providing assistance with access, these organisations were in a position to provide short-term support as well as ongoing sustainable services, for those who might be in need following the interview to which the team was unable to provide.

Qualitative data collection
A. Selection of respondents/interviewee
During data collection, key informants were purposefully sought in relation to issues which arose during data collection, such as those involving men having sex with men (MSM) and young girls who exchanged sex for money or gifts in local bars or on ships. Issues related to community support were studied through focus groups and key informant interviews, including with community members. Data collection focused on perceived support by respondents, actual support provided by communities and family members, and attitude of community members towards most-at-risk and especially vulnerable youth, including their fear and prejudice. The study also explored the possible role of the communities in providing support to MARA/MARYP, EVA/EVYP and general population youth.

The attitude and practices of health and social service providers, such as CBOs and NGOs, dealing with HIV prevention issues for youth, was explored through their participation in focus group discussions and key informant interviews. Social service providers to youth included churches, NGOs, social service staff, and community organisations.

Choices of secondary target groups for data collection were informed by results of interviews with MARA/ MARYP and EVA/EVYP youth. Key informant interviews, focus groups and KAP surveys were carried out by the research consultant, research assistants, and youth data collectors.

Mainstream adolescents and youth were non-randomly sampled for Focus Group Discussions (FGDs) with the intention of illuminating the issues of risk and vulnerability for mainstream youth, obtaining their input on how to reduce risk and vulnerability, their views on issues related to receiving information and support, and as a basis for programme and policy development. Sample selection was purposeful in relation to both their place of residence and to provide adequate and diverse samples of male and female adolescents in South Tarawa and Abemama.
Sample Justification: The sampling strategy for mainstream youth and overall sample size was set to provide an adequate basis for examining a range of issues affecting these populations and to illuminate quantitative information obtained in the KAP questionnaire. MARA/ MARYP and EVA/ EVYP were non-randomly sampled to participate in KII and FGD with the aim of providing information-rich cases upon which to base programme and policy development. As in the quantitative component the intention was to provide a balance in the nature of risks and vulnerabilities. To reach these populations, the research team utilized the knowledge and experience of a reference group of representatives, organisations providing services, and community members. Additionally, the team used a snowball technique to seek out additional respondents at high-risk and vulnerability when appropriate.

Sample Justification: It was felt that eight KII s would provide an adequate sample of information rich cases, but the team planned to interview to the point of redundancy. Twelve key KII s were completed. Likewise, up to eight FGDs were expected to provide an adequate base for examining a range of issues affecting these populations, and eight FGDs were completed. Members of Stakeholders, Health and Social Service Providers, and Community Members and Leaders were non-randomly and purposefully selected to provide special knowledge related to the issues of risk and vulnerability related to HIV and AIDS for the target populations of MARA/MARYP, EVA/EVYP, and general population youth.

Sample Justification: The sampling strategy of one FGD per sampling location had the intention of providing adequate information on populations providing information, services and support, including their special knowledge of target populations. The target was met.

B. Focus Group Discussions
Focus group discussions were held with general population youth in schools and villages and with female sex workers and MSM in community sites, including bars, houses, and other community sites. Each group of data collectors who were part of the target age group also participated in a focus group to provide their observations at the end of their data collection period. A focus group of stakeholders provided input to issues of community support, attitudes and perceptions of HIV and AIDS risk and vulnerability. FGDs involved 6-20 persons led by the consultant and research assistants, who recorded in Kiribati and English. An FGD script was utilized (see Annex 5), but revised as appropriate. FGDs lasted from one to two hours. Data were transcribed and analysed for themes and relevant information.

C. Key Informant Interviews
Key Informant Interviewee were purposefully chosen on the basis of their special knowledge. As examples, the research team interviewed family members of one of the female sex workers, as well as the manager of one of the bars where they worked, the organiser of the girls’ movements, and Abemama informants about its reputation as a “sexy island” and high risks. Scripts were usually developed for the specific information that was sought with some of the same questions asked as in the script for FGDs (Annex 5). Data entry and analysis proceeded as with the FGDs.
What the sampling strategy offers
This formative research provides spatial and contextual information concerning MARA/ MARYP and EVA/ EVYP youth through findings of South Tarawa and Abemama consultative workshops and qualitative data on the nature of risk and vulnerability to inform HIV prevention programme interventions for MARA/MARYP and EVA/EVYP youth, including community support and communication strategies. This would not be possible through probability sampling.

What the sampling strategy does not offer
The sampling strategy does not produce statistically representative data which can be extrapolated to the entire country of Kiribati.

Limitations
The potential for several confounding factors is acknowledged, including that those at most vulnerability would be less likely to be interviewed; vulnerability within the family would usually be invisible; and interviewee might not be willing or able to fully discuss the issues of their vulnerability. Further, the study population was relatively small, the sample was not random, and the total number of most at risk and especially vulnerable youth was not known, only estimated. The sample did not produce statistically representative data which can be extrapolated to the entire country of Kiribati. Thus, these research findings must be considered as formative and cannot be generalised to MARA/ MARYP, EVA/ EVYP and general population youth as a whole. Nonetheless, these results have the potential to contribute significantly to increasing effectiveness of intervention efforts related to HIV and AIDS for Kiribati youth.
Spatial and Contextual Mapping Results

Spatial and Contextual mapping provided the following:

1. Facilitated understanding on how risk and vulnerability to HIV and AIDS and Vulnerability is defined globally, and sought consensus among stakeholders.
2. Explored local understanding on factors increasing risk and vulnerability among youth.
3. Provided information on specific sites within areas identified by participants as places where most MARA/MARYPs and EVA/EVYPs could be located.
4. Specification of risks, vulnerability and underlying factors as understood by participants.
5. Participant recommendations and basis for recommendations for accessing MARA/ MARYP and EVA/ EVYP individuals.
6. Recommendations for individuals and organisations to be contacted for assistance during the survey.

Mapping workshop participants were also asked to state what they hoped to learn from survey results. Some of their responses provided insight to issues impacting risk and vulnerability for the youth within these communities and their attitudes about HIV and AIDS.

On South Tarawa, they hoped to learn about: the role of church leaders and attitude of families toward sex education policies on AIDS (attitudes) and young girls copying parents' drinking behaviour (alcohol use).

On Abemama, one attendee wanted to bring HIV and AIDS cases that were “discovered” during the survey to court (community attitude), one wanted information to advocate kava regulation (kava use), and one wanted to demonstrate that condom use encourages sex (condom use). The team explained the confidential anonymous nature of the study and MHMS policies on condom use.
Table II below summarises the risk, vulnerability and contributing factors that were identified by Kiribati National and Abemama Island Consultative workshop participants in relation to what the research team should expect to find during the research period. Our findings reflected their projections as reported in the subsequent sections of this report.

Table 2: Mapping risks, vulnerability, and contributing factors

<table>
<thead>
<tr>
<th>Risk Behaviours</th>
<th>Contexts of Vulnerability</th>
<th>Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial sex – cash, school fee</td>
<td>Forced sex, gang rape</td>
<td>Broken homes</td>
</tr>
<tr>
<td>Transactional sex – alcohol, clothes, food, fish</td>
<td>Frequent use – alcohol, kaokio, kava, yeast</td>
<td>Poverty</td>
</tr>
<tr>
<td>Males sex with males</td>
<td>Use of betel nut, marijuana, ecstas</td>
<td>Boarding</td>
</tr>
<tr>
<td>Unprotected sex</td>
<td>Seafarers giving neglected girls money, good treatment</td>
<td>Lack of employment</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>Incest when left with relatives</td>
<td>Lack of activities</td>
</tr>
<tr>
<td>Additional Issues – Abemama Island</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational sex – older females with young males</td>
<td>Pornography</td>
<td>Changing lifestyles, sexy clothing</td>
</tr>
</tbody>
</table>
As illustrated in Figure 1 below, the sample of 367 who were surveyed by KAP quantitative questionnaire included slightly more females (58%) than males (42%) due to the need to clarify risk and vulnerability of young female sex workers working on ships and in bars. The sample also included more adolescents (53%) than young people (47%) by design due to the focus on adolescents for this survey and 1/3 randomly sampled from schools, since about 1/3 of this population attends school.

Figure 2 shows demographics of the sample by gender and risk category. The risk category is an informal classification based on globally accepted definitions for these groups with the exception of increased risk, which is utilized for those who are not “most”-at risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth. The chart demonstrates a higher percentage of risk (MARA/ MARYP) for males (35.1%) than for females (16.9%) in this sample and higher vulnerability for females (13.2%) than males (9.1%), as well as a higher percentage of increased risk for males (22.7%) than females (19.2%).
Residences

As shown in Figure 3, 78% of those surveyed are living with family and 10% with other relatives with a lower percentage of young people than adolescents living with family and other relatives than 20-24 year old males and for females essentially the same for adolescents and 20-24 year olds. Only one of the sample reported living on the street. The only “homeless” person observed during data collection was a seriously mentally-ill girl wearing filthy clothes falling off her body, who was repeatedly driven away from a local bar. Key informants reported it would be a shame to the family for their youth to be on the street, except due to mental illness. Instead youth would leave home and go to a relative, who would usually give them money for drinks, cigarettes, kava and other substances, if they asked.

Figure 4 indicates that a higher percentage of youth who are increased risk and mainstream are living with their families than MARA/MARYP or EVA/EVYP. Almost two-thirds of these youth were living away from their home island, ranging from 50% of MARA to 69.8% mainstream.