BAD SICKNESS
RUBBISH SICKI

Understanding HIV and AIDS Risk and Vulnerability Among Solomon Islands Youth
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III. Findings

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AHD</td>
<td>Adolescent Health Development</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<tr>
<td>CRC</td>
<td>Commission on the Rights of the Child</td>
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<td>CSEC</td>
<td>Commercial and Sexual Exploitation of Children</td>
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<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>
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<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>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>MARA</td>
<td>Most-at-Risk Adolescent</td>
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<tr>
<td>MARA/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>
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<tr>
<td>MILO</td>
<td>Moment-in-the-Life-Of Qualitative Methodology</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Men Having Sex with Men</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>PAPE</td>
<td>Policy, Advocacy, Planning, and Evaluation</td>
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<tr>
<td>PI</td>
<td>Pacific Island</td>
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<tr>
<td>PLWHA</td>
<td>Person Living With HIV or AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>SDA</td>
<td>Seventh Day Adventist</td>
</tr>
<tr>
<td>SPC</td>
<td>The Secretariat of the Pacific Commission</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>STI</td>
<td>Sexually-Transmitted Infections</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>The Joint UN Organisation on HIV/AIDS</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session HIV/AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>US</td>
<td>United States of America</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WPRO</td>
<td>Western Pacific Regional Office (WHO)</td>
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While Solomon Islands, 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. Solomon Islands has a rapid growing population, with high internal and international migration of young people.

The people of Solomon Islands 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 Solomon Islands 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 practises of these groups, and that the information gathered will assist in developing interventions which are more relevant to Solomon Islands 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
Executive Summary
Background and Objectives
The Government of Solomon Islands (SI) and UNICEF Pacific had agreed on a five-year programme from 2008-2012 with HIV and AIDS as one of five components. One goal of the HIV and AIDS programme component is to reduce vulnerability and risk to HIV and AIDS for youth aged 15-24 in SI. The programme has a special focus on women and children.

The first person was diagnosed with HIV in Solomon Islands in 1994. In 2004, four more people were diagnosed in one year, bringing the total known cases to five. The main route of transmission was reported to be heterosexual contact. By 2008, 12 HIV cases had been confirmed. It is assumed that the actual number of new cases would be higher due to underreporting.

In an early stage HIV epidemic, HIV cases are mostly reported among most-at-risk populations with young people ages 15-24 representing about half of new HIV infections. Hence, it is important to maintain careful surveillance of rates of HIV among most-at-risk populations (including most-at-risk 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 programming for HIV prevention. A desk review was undertaken in 2008 with the conclusion that the existing information from Solomon Islands 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 Solomon Islands 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 Solomon Islands?
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 Solomon Islands.

The significance is that findings can inform programmes and policies; thus potentially help reduce HIV and AIDS spread among Solomon Islands 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 utilised 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 semistructured 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 Solomon Islands, the Honiara area, Western, Choiseul, and Malaita Provinces were sampled. Western and Choiseul Provinces and Honiara area were selected because they will be the focus of initial programme implementation by MOH and UNICEF, and Malaita Province because it will serve as a control area. One-third of this sample was school-based since about one-third of this target population is enrolled in school.

The targeted sample size in Solomon Islands was 550 with a confidence level of 95% and confidence interval of 4.16, based on an estimated total population of 66,257 youth aged 15-24 years in the three provinces and the Honiara area being sampled. Based on a proportional coefficient, the targeted sample size by province was about 120 for the Honiara area, 140 for Western Province, 50 for Choiseul Province, and 250 for Malaita Province. Two separate areas of Western Province were sampled – Munda/Noro and Gizo areas. The targeted sample sizes were exceeded.

The chosen sampling strategy offers baseline data and indicators for measuring progress in SI, 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 SI. It is acknowledged that there are several confounding factors, including the inverse relationship between level of vulnerability and likelihood of being interviewed, invisibility, and potential unwillingness for interviewees to discuss their private information related to their vulnerability of family 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.
Findings
Research findings provided information on contexts of risk and vulnerability for these youth:

1. Demographic data revealed most youth were not married (95%), not employed (78%), not in school (51%), and not living on their home island (36%) where they had community and family support.

2. Findings related to knowledge revealed a relatively low level (32%) of comprehensive knowledge of HIV and AIDS, a lack of belief in their personal risk for 48%, and lack of focus on changing unsafe behaviour despite a basic understanding of their risks. Only 5.8% of 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 half of the respondents had used a condom, although three-quarters were sexually active. Sixty-seven percent said their parents talked with them about their 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.

4. Five (2.1%) sexually active males reported having had MSM, four of whom were unprotected, with number of partners ranging from one to six. Forced sex of MSM was reported by three out of five MSM in Solomon Islands.

5. Fifty-six respondents in the sample, including 15 males, engaged in commercial and/ or transactional sex. Only 34% reported using a condom at last sex.

6. Thirty-eight percent of sexually active youth reported forced sex with ongoing vulnerability for 71%. First sex was forced for 20.4% of sexually active youth overall and 45.9% Choiseul Province respondents.

7. Sexually active youth reported 32.8% condom use at last high-risk sex (with non-regular partner), indicating 67.2% having unprotected high-risk sex. Condom use at last sex (37.3%) was similar.

Research areas included several practices that increase risk and vulnerability to HIV and AIDS, including:

1. Five (2.1%) sexually active males reported having had MSM, four of whom were unprotected, with number of partners ranging from one to six. Forced sex of MSM was reported by three out of five MSM in Solomon Islands.

2. Fifty-six respondents in the sample, including 15 males, engaged in commercial and/ or transactional sex. Only 34% reported using a condom at last sex.

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4. Sexually active youth reported 32.8% condom use at last high-risk sex (with non-regular partner), indicating 67.2% having unprotected high-risk sex. Condom use at last sex (37.3%) was similar.
5. Increased risk related to substance use was significant. Forty-four percent of the sample reported alcohol use, 28% used homebrew or kwaso, and 4% used kava. The rate of frequent alcohol consumption (more than three times per week) was 5.2%. Only one interviewee reported IDU.

6. Those who had first sex before 15 years of age were 14.9% of all 15-19 year olds sampled, including 28.8% for Honiara, and 18.2% for Choiseul, with some youth reporting sex as young as age 7.

7. Data on healthcare utilisation indicated utilisation of health workers as sources of information on HIV and AIDS was higher for females than males, except in Malaita Province. Utilisation of clinics as a source of condoms was 8% higher for females than males overall. Seventy-two percent of most-at-risk adolescents and 77% of most-at-risk young people reported attending HIV prevention workshop.

8. Communication findings indicated that 59% read a newspaper once a week; 86% had access to a working radio; 37% had access to a working TV; and 22% to a mobile phone. Ninety-one percent said they listened to the radio and 59% watched TV with listening and viewing patterns following a curve with 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. Almost three-quarters (73%) had attended a program on preventing HIV; 89% had heard an AIDS programme on radio; 92% had seen a poster, and 83% had seen a video on HIV or AIDS.

The discussion of issues related to these findings is organised 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 especially 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.

The two areas of high-risk for those most-at-risk in Solomon Islands are commercial/transactional sex and small numbers of MSM. Injecting drug use was reported by one respondent. Additional data on the risk behaviours of those who have become infected will be required to elucidate the contribution of sex work, MSM, and IDU to epidemic spread, but most-at-risk populations were said to include mobile workers, commercial sex workers, students, and MSM. There are several factors contributing to the risk level of vulnerable and increased risk youth in SI, including substance use, forced sex, early onset sex, and unprotected sex.
Recommendations

Findings in the KAP survey show that there are specific groups among SI 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 marginalised 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 SI 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. SI survey sample of 604 youth, of whom 450 were sexually active, included 56 respondents who were engaged in commercial sex. Forty-one of the 56 were also engaged in transactional sex plus an additional seven who only had transactional sex for a total of 48. The 56 respondents who reported commercial sex constituted 12.4% of sexually active youth in this sample and by gender, 15 males (6.5%) and 41 females (18.7%). In relation to their risk behaviours, two-thirds were having unprotected sex in comparison to about one-half for those not having commercial or transactional sex. Findings also demonstrate a higher percentage of risk (MARA/MARYP) for females (19.9%) than males (8.2%) and vulnerability for females (EVA/EVYP) (11.2%) than males (5%).

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 Solomon Islands 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 SI 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 marginalised 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 healthcare 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 customised 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 marginalised 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 healthcare 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 only 9% of Solomon Islands respondents were tested for HIV while 5.8% 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 SI 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 healthcare 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 SI 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

Solomon Islands 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 SI 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 healthcare 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 Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<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>21 % 9</td>
<td>14 % 6.4</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>-38% -</td>
<td>-27% -</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>-12.9</td>
<td>-16.3</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>
</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>-42.3</td>
<td>-33.1</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>1 %20</td>
<td>- -</td>
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HIV and AIDS in Solomon Islands

One of the goals of the Solomon Islands Ministry of Health (MOH) 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 Solomon Islands. Thus, UNICEF has partnered with MOH 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 SI. The programmes are particularly focused on women and children.

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 Solomon Islands; 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 and youth and women; and increased participation and ownership of STI, HIV and AIDS prevention programme by targeted populations.

The population of SI was estimated to be 595,613 in July 2009, comprised of diverse cultures, languages, and customs: 93.3% Melanesian, 4% Polynesian, and 1.5% Micronesian speaking about 70 vernaculars in total. Most people reside in small settlements along the coasts, including 60% in localities with fewer than 200 persons and only 11% in urban areas. The SI form an archipelago of 922 islands, 347 of which are inhabited, with a land area of 28,900 square kilometres spreading over 1.3 million square kilometres. Significant social disturbances and a population increase in recent years have challenged economic and health improvements, increasing pressure on infrastructure, employment, and environment.

The first person was diagnosed with HIV and AIDS in SI in 1994. Ten years later in 2004, four more people were diagnosed in one year, bringing the total known cases to five, including two males and three females. Two of the five died of AIDS by 2006. The main route of transmission was reported to be sexual contact. In 2005, a surveillance survey of 241 pregnant women aged 15-44 years attending their first ANC at four clinics found none to be HIV positive. By 2008, the cumulative reports of HIV, AIDS, and AIDS-related deaths were twelve, including four males and eight females. It is assumed that the actual number of new cases is higher due to underreporting. The most-at-risk populations included mobile workers, commercial sex workers, students, and men who have sex with men.

3. The HIV Unit and SINAC were established in 2005 and MOH warned of underreporting due to inadequate HIV surveillance. The epidemiology of HIV spread in SI was said to be unclear due to lack of accessible VCCT, stigma and discrimination, lack of confidentiality, and judgmental attitudes within the healthcare system. HIV vulnerability was assessed as high due to behavioural risks and contexts, including poverty of opportunity for youth; taboos against talking about sex and safe sex practices; sexual violence; child sexual abuse, and socio-cultural change. Sexual violence, including group rape, and exploitation was found to occur under the influence of drugs and alcohol with condoms seldom used. Parents often encouraged or forced daughters to sell sex for cash, including in relation to logging. Sex was begun at an early age and many girls became pregnant the same year they had their menarches. Without support, young single mothers were often forced to turn to sex work.

Qualitative research conducted on sex workers, men having sex with men (MSM), and youth found that young males and females in urban and rural areas; especially logging sites, fishing boats and other cash generating projects; turned to sex work with multiple partners as a quick option to make good pay with little or no skills. The same study indicated that many youth had little or no understanding of how to obtain or use condoms. Rude attitudes of clinic staff toward youth and lack of confidentiality further limited access to condoms and STI treatment. Youth felt more comfortable using traditional (kastom) medicine and talking to NGO activists. The logging industry, sex workers, MSM, and human rights were emphasised as target areas of concern in National HIV Strategic Plan.

The Committee on Rights of the Child expressed concern over abuse of children, including significant sexual abuse within families and institutions; lack of information and services on adolescent health, including prevention and treatment of STIs and teen pregnancy; child prostitution and other sexual exploitation of children; the minimum age of criminal responsibility being 8 years old; and the number of street children.

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. Since this study includes three Pacific Island countries, the definition of adolescence as 15-19 years of age has been accepted by SI, Kiribati and Vanuatu leaders, stakeholders and youth for this purpose although some of them consider adolescence to last much longer than 19 years. 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 age 10-19 years of age, 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 utilised 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 was based on respect for all young people for whom results were intended, for those young people carrying out data collection, for members and leaders of communities and schools who hosted research activities in SI and for health, education, social service and government professionals who contributed to the work in accordance with the approval of the MOH Committee on Ethical Clearance and UNICEF Guidance on Research. These include strict maintenance of confidentiality, informed consent, security of data, code of conduct for data collectors, respect for interviewees 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 Solomon Islands 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 & AIDS among Most-at-Risk Adolescents (MARAs) and Young People (MARYPs), Especially Vulnerable Adolescents (EVAs) and Young People (EVYPs) in Solomon Islands.
2) Factors influencing risk, vulnerability and the potential of future interventions to reduce risk and vulnerability to HIV and AIDS in Solomon Islands.
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 Honiara area, Munda and Gizo areas of Western Province, Choiseul Province and Malaita Province?
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 semistructured 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 Solomon Islands, the Honiara area, Munda and Gizo areas of Western Province, Choiseul Province, and Malaita Province were sampled. One-third of this sample was school-based since about one-third of the samples 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>
</table>
| Determine spatial and contextual nature of risk and vulnerability to HIV and AIDS among MARAs, MARYPs, EVAs, EVYPs, and general population youth in the Honiara area, Western, Choiseul an Malaita Provinces in Solomon Islands. | • Where are MARAs and EVAs found?  
• What risk behaviours are involved?  
• What are the contexts of vulnerability?  
• What are the contributing factors? | • Mapping workshops  
• Structured interviews (questionnaires)  
• Semi-structured interviews (KII) | • Focus group discussions  
• Purposive selection stakeholders  
• Random in schools, non-random in communities  
• Purposive selection special informants  
• Quasi-random |
| Determine factors influencing risk and vulnerability, and potentially influencing future interventions to reduce risk and vulnerability to HIV and AIDS in Honiara, Western, Choiseul, Malaita Provinces. | • 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 & vulnerability to HIV & AIDS? | • Structured interviews (questionnaires)  
• Semi-structured interviews (KII)  
• Focus group discussions | • Non-random mapping participants  
• Random in schools, non-random in communities  
• Quasi-random |
| Determine current and desired communication patterns and factors that have potential for influencing future communication concerning information and advice on HIV and AIDS. | • 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? | • Structured interviews (questionnaires)  
• Semi-structured interviews  
• Focus group discussions | • Random in schools, non-random in communities  
• Purposive selection special informants  
• Quasi-random |
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, five consultative mapping workshops were held at the MOH office in Honiara; Helena Goldie Hospital in Munda settlement and Gizo Hospital in Gizo, Western Province; Taro Provincial Hospital in Choiseul Province; and the World Vision office in Auki, Malaita Province. In each case mapping workshops preceded any data collection activities.

Workshop participants included representatives of all relevant stakeholders, including health and social service providers; staff members from MOH; civil service organisations working with MARPs, adolescents and youth; staff members from UNICEF Solomon Islands, and selected young people. For mapping workshops outside Honiara, workshop participants included relevant stakeholders in each area. Through participatory methods of facilitation, participants of each 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 were located in the Honiara area, Munda and Gizo areas of Western Province, Taro Island of Choiseul Province, and Auki, Malaita Province.
- Provided information on logistics for contacting data sources.

Throughout all the workshops, data was recorded on flip charts by Solomon Islands research assistants (Agendas for the workshops are attached in Annex 5)
KAP Data Collection

Data was collected from the sampled population through quantitative and qualitative research methods as described below. A detailed list of sampled areas is attached in Annex 7.

Quantitative Research Methods

A. Sampling method

Field research involved “purposive” sampling to select research locations within SI. Specifically, data collection was carried out in SI within the areas of Honiara, Munda/Noro and Gizo areas of Western Province, and Choiseul Province, where SI MOH and UNICEF Pacific will implement programming; and Malaita Province that will serve as a control area. A National Consultative Mapping Workshop in Honiara and Provincial workshops in Munda and Gizo of Western Province, Taro Island of Choiseul, and Auki of Malaita Province provided data to guide choice of individual locations within each area.

The overall targeted sample size for KAP quantitative questionnaires in SI was 550, with a confidence level of 95% and confidence interval of 4.16 based on an estimated total population of 66,257 youth aged 15-24 years of age in the 3 provinces and the Honiara area being sampled. Based on a proportional coefficient, the sample sizes by province and area were: 120 for the Honiara area, 140 for Western Province, 50 for Choiseul Province, and 250 for Malaita Province. The actual sampled size for the KAP questionnaires was 125 for Honiara, 183 for Western, 67 for Choiseul, and 229 for Malaita Province for a total of 604, exceeding the 550 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, 20-24-year-olds male and 20-24-year-olds female 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 interviewees, 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 could not be generalised, both the sampling strategy for KAP questionnaire data collection from MARA/MARYP and EVA/EVYP youth and the overall sample size for SI 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 Pacific Island countries. Methodology and tools were also reviewed in SI with MOH staff to assure that specific local issues were addressed.

The questionnaire was not translated into Solomon Islands pidgin at the advice of MOH, in relation to the level of English proficiency of potential data collectors, who read the questions in English, asked the questions in pidgin or local language and recorded answers in English. Data collectors practiced translating questions from English, asking in SI pidgin or other appropriate language, and translating the answers back to English. Questions were fine tuned to assure accurate translation.

Utilising the quantitative KAP survey tool, the most-at-risk, especially vulnerable, and general population youth were asked about their demographic information, knowledge of STIs and AIDS, their perception of personal risk, their age at first sex and whether they were 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 get information about HIV, AIDS, and STIs; what they prefer as information sources and their recommendations for mitigating the risk and vulnerability to HIV and AIDS for youth.

C. Field testing

Training of data collector in posing questions in SI pidgin utilising the English language questionnaire and field testing of the KAP Questionnaire (Annex 5) were held immediately after the mapping workshop, following a structured curriculum and rehearsal of interview techniques. Data collectors in the Honiara area, Munda and Gizo areas of Western Province, Choiseul Province, and Malaita Province read each question in English and SI pidgin, discussed what it meant in English and pidgin, 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 their 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. Among other locations, Honiara data was collected in markets, clubs, hotels, beaches, on the wharf and onboard ship; Munda area data was collected in transits, on wharfs, in logging camps, and clubs; Gizo data was collected in hotels, outer islands, beaches, post-tsunami camps and markets; Choiseul Province data was collected in logging camps, transits, beaches, and outer islands; and Malaita data was collected at the airport sporting field, Malaita day celebration site, and nearby camps of displaced persons. The team was unable to collect data from prisons, from Gizo-area post-tsunami camps due to serious storms and from more remote Malaita Province areas due to political unrest. The research team met daily to review progress, make any 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 interviewees 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 or on shipboard, 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 to include considerable time at night in local bars in order to reach those most-at-risk and especially vulnerable, and sought to provide interview places where interviewees felt secure. Nonetheless, interviewees were extremely helpful and were interviewed in noisy bars, on the wharf, on shipboard, in markets, logging camps, on the road, in schools, and at their homes. The research team worked with individuals and some organisations including Save the Children Australia, SIPPA, Helena Goldie Hospital in Munda, Gizo Hospital, and World Vision in Malaita to assist with contacts, locating interviewees, meeting space, and transportation. 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 for which the team were unable to provide.

Qualitative data collection

A. Selection of respondents/interviewees

During data collection, key informants were purposefully sought in relation to issues which arose during data collection, such as school students selling sex or getting raped while walking long distances to school, incest, 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 and stakeholders. 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, in dealing with HIV prevention issues for youth was explored through their participation in focus groups 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 Group Discussions (FGD), 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 FGDs with the intention of illuminating 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 their place of residence and providing adequate and diverse samples of youth in the Honiara area, Munda and Gizo areas of Western Province, Choiseul and Malaita Provinces.

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 by the KAP questionnaire.

MARA/MARYP and EVA/EVYP were non-randomly sampled to participate in KIIs and FGDs 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 nature of risks and vulnerabilities. To reach these populations, the research team utilised 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 8-32 KIIs would provide an adequate sample of information rich cases, but the team planned to interview to the point of redundancy. Nine KIIs were completed. Likewise, up to 12 FGDs were expected to provide an adequate base for examining the range of issues affecting these populations and 19 FGDs were completed.

Members of Stakeholders, Health & 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 in community sites, including bars, hotels and 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. Focus Group Discussions involved 6–20 persons led by the consultant and research assistants, who recorded in Solomon Islands pidgin and English. An FGD script was utilised (see Annex 5), but revised as appropriate. The FGDs lasted about an hour. Data were transcribed and analysed for themes and relevant information.

C. Key Informant Interviews

Key Informant Interviewees were purposefully chosen on the basis of their special knowledge. As examples, school principals were interviewed in relation to teen pregnancy rates and school-based sex workers; health professionals and community leaders in relation to input on providing support; and youth in relation to their observations on such issues as incest. Scripts (see Annex 5) were utilised and adapted. Data entry and analysis proceeded as with FGDs.

What the sampling strategy offers

This formative research provides spatial and contextual information concerning MARA/MARYP and EVA/EVYP youth through findings of Honiara area, Munda/ Noro and Gizo areas of Western Province, Choiseul Province and Malaita Province 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 Solomon Islands.

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 interviewees 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 Solomon Islands. 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 Solomon Islands youth.

The reasons why they believe they are personally at risk of the infection include habitual visits to night clubs, forced sex, unprotected sex, commercial sex, youthful desire and uncertainty of their partners, which encouraged them to resort to sex with multiple partners.
Findings

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: whether things are better now or worse and why, what programmes were effective at mitigating risk and vulnerability, who else should have been at the table, what organisations needed to be more effective at reducing risks, and their recommendations for improving services. (See Annex 6). Their responses provided insight to issues impacting risk and vulnerability for the youth within these communities and their attitudes about HIV and AIDS. Among the issues they provided are: illiteracy, girls not supported by parents, parents more concerned with young children than youth, and that Correctional Services should have been at the table.

The Solomon Islands sites recommended by mapping workshop participants for sampling and their reasons for making the selections are attached in Annex 7.

Table II below summarises the risk, vulnerability, and contributing factors that were identified by workshop participants in Honiara for Solomon Islands National Consultative Workshop, Munda and Gizo of Western Province, Taro in Choiseul Province, and Auki in Malaita Province in relation to what the research team should expect to find during the research period. Research findings reflected their projections as reported in the subsequent sections of this report.
<table>
<thead>
<tr>
<th>Risk Behaviours</th>
<th>Contexts of Vulnerability</th>
<th>Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial sex – including child prostitution of both genders</td>
<td>Sexual violence and beatings of sex workers</td>
<td>Unreliable condom supplies</td>
</tr>
<tr>
<td>Transactional sex – alcohol, clothes, food, fish</td>
<td>Forced sex, including gang rape</td>
<td>Poverty</td>
</tr>
<tr>
<td>Males sex with males</td>
<td>Expulsion from school following rape</td>
<td>Stigma to sex workers</td>
</tr>
<tr>
<td>Unprotected sex</td>
<td>Sexual abuse within families and institutions, including adoptive homes</td>
<td>Discrimination to women and children</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>Extramarital sex of males and inability of females to negotiate safer sex</td>
<td>Adolescents lack information and services</td>
</tr>
<tr>
<td>Sharing traditional tattoo tools</td>
<td>Displaced populations</td>
<td>Unemployment</td>
</tr>
<tr>
<td></td>
<td>Teen pregnancy</td>
<td>International seafarers</td>
</tr>
<tr>
<td></td>
<td>Alcohol and substance use</td>
<td>High rates of STIs</td>
</tr>
<tr>
<td></td>
<td>Child sex tourism</td>
<td>Trafficking to and within SI</td>
</tr>
<tr>
<td></td>
<td>Lack of education, lack of information, illiteracy</td>
<td>Forced marriage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outside influences, including tourism, fishing, logging and wharfs, Bougainville border</td>
</tr>
</tbody>
</table>

Additional Issues – Western, Choiseul and Malaita Provinces

| Broken homes, parents not setting good examples, not home, unattended children  | Nightclubs                                                           |
| Early onset sex                                                                 | Peer pressure                                                        |
| Pornography                                                                     | Lack of activities                                                   |
| Too shy to get condoms                                                           | Creeping                                                             |

Table 2:
Demographics

As is illustrated in Figure 1, the sample of 604 who were surveyed by KAP quantitative questionnaire included slightly more females (54%) than males (46%). The sample also included more adolescents (60%) than young people (40%) by design due to the focus on adolescents for this survey; and one-third of respondents were randomly sampled from schools, since about one-third of this population attends school.

Figure 2 below shows the 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 utilised for those who are not "most"-at-risk or "exceptionally" vulnerable, but have more risk or vulnerability than most mainstream youth.

Figure 2 demonstrates a higher percentage of risk (MARA/ MARYP) for females (19.9%) than males (8.2%) in this sample and vulnerability for females (EVA/ EVYP) (11.2%) than males (5%), as well as a higher percentage of those at increased risk for males (30.7%) than females (14.3%).
Residences

As shown in Figure 3 below, 71% of those surveyed were living with their family, 16% with other relatives, and a lower percentage of young people than adolescents living with family and other relatives. Only two of the samples reported living on the street.

Figure 4 indicates that a higher percentage of youth who were EVA, EVYP, and increased risk were living with their families than MARA, MARYP, and mainstream. It also shows that one-third of these youth were living away from their home island, ranging from 18% of EVA to 41% MARYP.

Figure 3. Residence by gender and age group

<table>
<thead>
<tr>
<th>Gender and Age Group</th>
<th>With Family (N=428)</th>
<th>Friends’ House (N=15)</th>
<th>Relatives (N=96)</th>
<th>Street (N=2)</th>
<th>Elsewhere (N=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males (15-19 yo)</td>
<td>70%</td>
<td>2%</td>
<td>13%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Females (15-19 yo)</td>
<td>72%</td>
<td>2%</td>
<td>16%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Males (20-24 yo)</td>
<td>3%</td>
<td>6%</td>
<td>19%</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>Females (20-24 yo)</td>
<td>3%</td>
<td>6%</td>
<td>16%</td>
<td>1%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Figure 4. Whether lives with family, on home island or away from home island by risk category

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Lives with family (N=428)</th>
<th>Does not live with family (N=168)</th>
<th>Lives on home island (N=376)</th>
<th>Lives away from home island (N=215)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA</td>
<td>65.9%</td>
<td>34.1%</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>MARYP</td>
<td>62.8%</td>
<td>37.2%</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>EVA</td>
<td>72.7%</td>
<td>27.3%</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>EVYP</td>
<td>88.2%</td>
<td>11.8%</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>Inc. Risk</td>
<td>76%</td>
<td>27.3%</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Mainstream</td>
<td>71.5%</td>
<td>27%</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>71.1%</td>
<td>27.9%</td>
<td>64%</td>
<td>36%</td>
</tr>
</tbody>
</table>
School Enrollment

Almost half (49.4%) of the community-based portion of this sample reported being enrolled full-time in school as shown in Figure 5, with adolescents and females having the highest levels of enrollment at 65% and 53% respectively.

Figure 6 shows that the highest enrollment by risk was for EVAs at 61% and mainstream at 60% with MARYPs and EVYPs at the lowest level (29%). As in Figure 7 below, 82% of those enrolled were enrolled at the secondary school level with a slightly higher percentage of females (57%) than males (43%) and a higher percentage of adolescents enrolled (79%) than young people (21%).
Figure 8 shows a higher percentage of MARAs than other risk categories were enrolled at the primary school level, at twice the percentage of mainstream youth but numbers are too small to support conclusions.

Figure 7. School level by gender and age group

Figure 8. School level by risk category
Employment
Twenty-two percent of the community-based sample were in salaried jobs or self-employed at the time of the survey with a higher percentage of employed males (26%) than females (19%) and young people almost three times the percentage of adolescents as in Figure 9. Distribution by risk is shown in Figure 10.

As shown in Figure 10, MARYPs (33%) and EVYPs (29%) had the highest percentages of employment with MARAs at the lowest percentage (6%), but numbers are small.

Figure 11 indicates the types of jobs by gender differed with 21% of females employed in professional jobs compared to 14% males, 16% males compared to 11% females employed in “other” jobs which included carpentry, driver, farming, construction, security, mechanic, and shopkeeper. Twenty-four percent of community-based adolescents were employed and 76% of community-based young people.

Of those 79 employed, seven males and 10 females had caretakers for their children. Only three of those with caretakers were adolescents and the remaining 14 were young people. Fifteen respondents utilised family members to care for their children and two made “other” arrangements. By risk category, of those 79 employed, 4 MARYPs, 7 increased risk, and 6 mainstream youth had caretakers for their children.
Figure 12 displays fortnightly earnings by gender. Of those 89 employed, only 24% (21) earned more than SBD500, with over 25% more females than males earning SBD200-500, an estimated average fortnightly wage, more than twice as many males as females earning less than SBD200 and over half more males than females earning more than SBD500. Wage distribution by age group was almost equal. Figure 13 displays fortnightly earnings by risk category. It shows that one MARA, one MARYP, one EVYP, six increased risk and 12 mainstream respondents, 24% in all, made more than SBD500 per fortnight.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Less than SBD200</th>
<th>SBD200-500</th>
<th>More than SBD500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>38%</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Female</td>
<td>17.9%</td>
<td>61.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Adolescent</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>Young Person</td>
<td>29%</td>
<td>46.4%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Total (N=89)</td>
<td>29.2%</td>
<td>47.2%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Less than SBD200</th>
<th>SBD200-500</th>
<th>More than SBD500</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA</td>
<td>50%</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>MARYP</td>
<td>35.7%</td>
<td>57.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>EVA</td>
<td></td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>EVYP</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Inc. Risk</td>
<td>39.1%</td>
<td>34.8%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Mainstream</td>
<td>17.9%</td>
<td>51.3%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Total (N=89)</td>
<td>29.2%</td>
<td>47.2%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>
Marital Status

Ninety-four percent of this sample of 15-24 year olds had never been married as shown in Figure 14 with 4.7% having been married or living with a partner, and 0.9% separated or divorced. The distribution by age group and gender is shown in Figure 15 below.

As could be expected, Figure 15 shows the percentage of adolescents who had never been married (97.8%) was higher than young people (89.4%); the percentage of those who were married or living with a partner was higher for young people (8.4%) than for adolescents (2.2%); as was the percentage of young people who had been separated or divorced (2.1%) higher than for adolescents (0).

All EVAs in this sample had never been married; the percentages of never married for MARAs, mainstream youth and the overall sample were between 90-100%; and MARYPs, EVYPs, and increased risk youth were between 80-90%. Eighteen percent of those who were EVYP had been married or living with a partner; less than 10% for those at increased risk; and 12 mainstream respondents, 24% in all, made more than SBD500 per fortnight.
Summary
Most of these youth were not married, not employed, and not in school. In their recommendations, youth cited lack of activity and support as contributing factors for them to be involved with multiple partners and sex at an early age. Unemployment and employment at low pay were factors that may have contribute to risk behaviours such as commercial and transactional sex.

![Figure 16. Marital status by risk category.](image)

Differences between the mainstream youth and those at higher levels of risk and vulnerability in relation to Demographics are:

1. A higher percentage of females than males were MARA (10.6% compared to 3.6%), MARYP (9.3% compared to 4.6%), EVA (8.1% compared to 2.5%), and EVYP (3.1% compared to 2.5%). A higher percentage of males than females were increased risk (30.7% compared to 14.3%) and mainstream (56.1% compared to 54.7%). Thus, 31.1% of females were most-at-risk and especially vulnerable versus 13.2% males.

2. The highest percentage of youth who lived with their families were EVYPs at 88%, followed by increased risk at 76%, EVA at 73%, mainstream at 72%, and the lowest were MARA at 66% and MARYP at 63%

There was no apparent association by risk to this pattern.
3. MARYPs (41%) and increased risk youth (40%) had the highest percentages living away from their home islands. The rest were 35-36% with the exception of EVA at 18%.

4. EVAs and mainstream youth had significantly higher percentages enrolled in school at 61% and 60%, than the others, ranging from MARYP at 29% to MARA at 49%.

5. A higher percentage of MARAs at 20% were enrolled at the primary school level than other risk categories, at more than twice the percentage of mainstream youth. Those enrolled in the secondary school level ranged from 73% to 100% with no apparent pattern by risk level. At the college or university level the highest percentage enrolled was increased risk and MARYP at 16%, followed by MARA and mainstream at 6% and EVA/EVYP at 0%.

6. Employment for 15-24 year olds was highest at 33% for MARYPs, followed by 29% for EVYPs, 25% for increased risk, 24% EVA, 21% mainstream and 6% MARA with no apparent pattern except that young people were employed at a higher percentage than adolescents.

7. Of the 79 employed within the community-based portion of the sample, four MARYPs, seven increased risk and six mainstream youth had caretakers for their children. Fifteen utilised family members to care for their children and 2 made “other” arrangements.

8. Only one MARA, one MARYP, one EVYP, six increased risk and 12 mainstream respondents, 24% in all, made more than SBD200 per fortnight.

9. No EVAs in this sample had ever been married. The percentages for MARAs and mainstream youth were between 90-100%; and MARYPs, EVYPs, and increased risk youth were between 80-90%, with EVYP the lowest at 82.4%. Eighteen percent of those who were EVYP had been married or living with a partner; less than 10% for those at increased risk and less than 5% for the rest. The group that had experienced divorce or separation was MARYPs at 11.6%. Mainstream youth had the highest percentage of those who had never been married and the lowest percentage of those who had been separated or divorced at one out of 158.
Comprehensive Knowledge on HIV and AIDS

Thirty-two percent of the respondents could correctly answer all five standard UNGASS indicator questions on three ways to prevent HIV infection and reject two common misconceptions. The percentage correctly answering each single question is shown in Figure 17 below. The percentage of interviewees correctly answering the question about sharing a meal (93%) was 21% higher than those correctly answering about not having sex at all (72%).
As shown in Figure 18, MARAs had the lowest comprehensive knowledge at 25% and MARYPs the highest at 35%.
As shown in Figure 19, males demonstrated comprehensive knowledge (38%) almost 1.5 times the percentage of females (27%); young people (41%) about 1.5 times the percentage of adolescents (27%); and community-based respondents (37%) over 1.5 times the percentage of school-based respondents (23%).

![Figure 19. Comprehensive knowledge of HIV and AIDS by gender, age, school or community](image)

As shown in Figure 20, the province with the highest percentage of youth demonstrating comprehensive knowledge of HIV was in Malaita (38%), followed closely by Choiseul (36%), Western (31%), and the lowest in Honiara (22%).

As shown in Figure 21, there was little difference in knowledge between males and females, except that a 5% higher percentage of females had heard of STDs. Likewise, there was little difference by age, except that 7% more young persons knew that a healthy-looking person could be HIV positive.
Knowledge on these topics as presented in Figure 22 was uneven, with highest scores on whether they heard of HIV or AIDS and lowest on knowing that a healthy-looking person can be infected with HIV. The lowest overall score for that question was by MARAs (75%). The highest overall score with the greatest number was 100% for those at increased risk on whether they had heard of HIV or AIDS.

Figure 21. Knowledge of STI, HIV and AIDS by gender and age

Figure 22. Knowledge of STI, HIV and AIDS by risk category
**Knowledge and Belief in Their Own Risk**

Figure 23 presents the responses to whether these youth think they are personally at risk of HIV infection. When asked if they thought they were personally at risk of HIV, 52% of this sample answered yes with a higher percentage of females and young people than males or adolescents as shown in Figure 23 above. Thirty-five percent overall said they did not think they were personally at risk and 9.9% of females and 16.7% of males said they did not know if they were personally at risk.

The responses to the question on personal risk by risk category almost reflect the risks they are assumed to have. Those who are classified as mainstream had the lowest percentage of thinking they were personally at risk with those classified as increased risk next. Those who are EVAs are next, followed by MARYP, MARA, and EVYP with the highest percentage thinking they are personally at risk.

![Figure 23](image1)

**Figure 23. Whether they think they are personally at risk of HIV infection by gender and age**

<table>
<thead>
<tr>
<th></th>
<th>Yes %</th>
<th>No %</th>
<th>Don’t Know %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>16.7%</td>
<td>33%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Female</td>
<td>9.9%</td>
<td>36%</td>
<td>54%</td>
</tr>
<tr>
<td>Adolescent</td>
<td>10.8%</td>
<td>39.5%</td>
<td>49.7%</td>
</tr>
<tr>
<td>Young Person</td>
<td>16.5%</td>
<td>27.1%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Total (N=598)</td>
<td>13%</td>
<td>34.6%</td>
<td>52.3%</td>
</tr>
</tbody>
</table>

![Figure 24](image2)

**Figure 24. Whether they think they are personally at risk of HIV infection by risk Category**
Risk Perception
When the 52% of this sample who answered that they were personally at risk were asked for the reasons, their answers reflected the actual data on risk and vulnerability.

Table 3. Reasons given for why they are personally at risk of HIV infection

<table>
<thead>
<tr>
<th>Risk</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night clubs</td>
<td>“Night activities – night clubs.”</td>
</tr>
<tr>
<td>Forced sex</td>
<td>“Because I was forced to have sex.”</td>
</tr>
<tr>
<td>Unprotected sex with multiple partner</td>
<td>“Because of carelessness of having unprotected sex with random people.”</td>
</tr>
<tr>
<td>Commercial Sex</td>
<td>“Many girls at logging camp.”</td>
</tr>
<tr>
<td>Youthful desire</td>
<td>“I’m always thinking of sex when I see ladies.”</td>
</tr>
<tr>
<td>Uncertain of partner</td>
<td>“I didn’t trust my boyfriend.”</td>
</tr>
</tbody>
</table>

In addition to using a condom and staying with one trusted partner, those who answered that they were not at risk expressed their right to protect themselves and the importance of being responsible.

- **Being Responsible**
  - “It’s up to you to think about it.”

- **Desire to have safe sex**
  - “I can take good care of myself.”

“Families and communities should work together to keep youth safe from HIV.”
Knowledge of their HIV Status
In this sample, 5.8% of 15-24-year-old youth had HIV testing and received their results. Information on age of consent for testing was not available. Figure 25 below compares percentages of interviewees from Honiara area, Western, Choiseul, and Malaita Provinces who were tested and received results.

Nine percent of those surveyed in Solomon Islands have been tested for HIV and 5.8% have also received their results (CPAP Indicator 1.2). The distribution by location was reported to be 3.3% in Honiara area, 18.8% in Western Province, 3% in Choiseul Province, and 1.8% in Malaita Province. The differences in knowledge of HIV test results by gender, age, school-based or community-based sample, and risk category are shown below in Figure 26 for those who are sexually active (as opposed to CPAP indicator 1.2 above).

![Figure 25: Knowledge of HIV test results by location](image)

![Figure 26: Knowledge of HIV Test results by gender and age group, school- or community-based](image)
As shown in Figure 26, 9% of sexually active males in the sample, 6.4% of females, 3.4% of adolescents and 12.7% of young people have been tested for HIV and know their results within the overall rate of 7.8% for sexually active youth in this sample. The chart also shows that 3.8% of sexually active youth who were sampled in schools and 9% of those who were sampled in the community reported they were tested for HIV and knew their result.

As shown in Figure 27, the range in percentage of sexually active youth who have been tested and received results is from 4.5% for MARAs to 17.6% EVYPs.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA (2/44)</td>
<td>4.5%</td>
</tr>
<tr>
<td>MARYP (3/43)</td>
<td>7%</td>
</tr>
<tr>
<td>EVA (3/33)</td>
<td>9.1%</td>
</tr>
<tr>
<td>EVYP (3/17)</td>
<td>17.6%</td>
</tr>
<tr>
<td>Inc. Risk (9/130)</td>
<td>6.9%</td>
</tr>
<tr>
<td>Mainstream (11/184)</td>
<td>6%</td>
</tr>
<tr>
<td>Total (31/451)</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

Figure 27. Whether they have been tested for HIV and received results by risk category.
Summary

Differences between mainstream youth and those at higher levels of risk and vulnerability in relation to Knowledge are:

1. For comprehensive knowledge of HIV, as measured by UNGASS standard indicator questions, mainstream youth scored 32%. MARAs had the lowest comprehensive knowledge at 25% and MARYPs the highest at 35%. EVYPs scored 29%, EVAs 33%, and those at increased risk 34%.

2. The scores for other knowledge questions were mixed, with the highest scores on whether they had heard of HIV or AIDS and the lowest on knowing that a healthy-looking person can be infected with HIV. The lowest overall score for that question was by MARAs (75%). The highest overall score with the greatest number was 100% for those at increased risk on whether they had heard of HIV or AIDS.

3. The responses to the question on personal risk by risk category almost reflect the risks these youth are assumed to have. Those who are classified as mainstream have the lowest percentage of thinking they are personally at risk with those classed as increased risk next. Those who are EVAs are next, followed by MARYPs and MARAs, with EVYPs having the highest percentage of perceiving their personal risk.

4. The reasons given for why they thought they were at risk reflected risk behaviours and contexts of vulnerability presented in the data, including commercial sex, unprotected sex, multiple partners, and forced sex. The percentage of those who have been tested for HIV and received their results ranged from 4.5% for MARAs to 17.6% for especially vulnerable young persons.

In summary, in the area of Knowledge for these Solomon Islands youth, comprehensive understanding of HIV and AIDS is relatively low at 32% and should be of concern, particularly since the areas of greatest misconception are being able to avoid HIV infection by always using a condom correctly or not having sex at all.

Fifty-two percent of the samples felt that they were at personal risk of HIV infection but they did not seem motivated to change their behaviours. Those who judged themselves at risk had a basic understanding of the risks they were taking, such as unprotected sex, multiple partners and commercial sex; but may not have truly believed that they could become infected. The reported 6.9% rate of sexually active youth who have been tested and received their results is low and may reflect lack of access.
As presented in Figures 28 and 29, it is important to note that more than twice as many respondents said they chose to use a condom to prevent pregnancy than to prevent STIs, including HIV, and that little more than half had used a condom, although over three-quarters were sexually active.
attitudes

For programming purposes, it is also important to note that many of those who did not use a condom said that they did not know how, were unable to obtain a condom, condoms were not safe, and they did not feel good. The next chart shows the distribution of reasons for using or not using condoms by risk with more than one answer possible.

Figures 30 and 31 show that the highest percentage using condoms to prevent pregnancy by risk category were EVA and to prevent STI/HIV were MARYP. The highest percentage not using condoms because they had sex with their regular partner was for EVYP; because their partner did not want to was for MARA; because they did not want to was for MARYP; and because of embarrassment was for MARA.
Figure 31 shows the responses to whether these youth wanted to use a condom the next time they had sex by respondent sex and age. Eighty-four percent of these youth said that they wanted to use a condom the next time they had sex with a higher percentage of males (92%) than females (77.8%) and young people (88.1%) than adolescents (82%).

As shown in Figure 33, the highest percentages of those wanting to use a condom the next time they had sex were for EVAs (96.9%) and EVYPs (94.1%). The next highest groups were increased risk (92.7%), MARAs (86.4%), and MARYPs (86%) with mainstream youth having the lowest percentage at 78.7%. 

![Figure 32: Whether want to use condom next time they have sex by gender and age](image1)

![Figure 33: Whether want to use condom next time they have sex by risk category](image2)