Next chart presents the youth responses to whether their parents talked to them about their sexuality and prevention of HIV and other STIs. Figure 34 shows that 67.4% of parents overall were said to talk to their children about sexuality and preventing HIV and AIDS. The percentage of females who responded that their parents talked to them was almost one-third more than for males and the percentage of adolescents was 6% more than that of young people.

The most frequent reason youth gave to the question of why they thought their parents did not talk to them was that “it was not culturally acceptable” (15.2%), followed by their “parents did not know what to say” (14%), and they think “I’m too young” (2.2%). Their parents were their first choice as the best people to talk to them about their sexuality and issues of preventing HIV and AIDS.

As presented in Figure 35, the highest percentage reporting that their parents talked to them about their sexuality were EVAs at 75%, followed by mainstream youth at 72%, increased risk at 65.3%, EVYPs at 58.8%, MARAs at 53.5%, and MARYPs at 51.2%.
Of this sample, 36.5% of those asked said they would share a house with a person who they knew had HIV or AIDS as shown in the Table IV.

Table 4. Whether they would live in the same house with PLWHA

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>216</td>
<td>35.8</td>
<td>36.5</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>375</td>
<td>62.1</td>
<td>63.5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>591</td>
<td>97.8</td>
<td>100</td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>13</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>604</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

If their friends asked them to take marijuana with them, 2% said they would be shocked, 71.2% would refuse, 2% would tell their parents, 20.7% would agree to take marijuana, and 2.6% did not know as shown in Table V below.

Table 5. What they would do if invited by friend to take marijuana

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will be shocked</td>
<td>9</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Will refuse to take marijuana</td>
<td>430</td>
<td>71.2</td>
<td>74.7</td>
</tr>
<tr>
<td>Will inform their parents</td>
<td>12</td>
<td>2.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Will agree, they are my friends</td>
<td>125</td>
<td>20.7</td>
<td>97.4</td>
</tr>
<tr>
<td>Don’t know</td>
<td>16</td>
<td>2.6</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>604</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
As shown in Table VI below, among these respondents, if a girl they knew dropped a condom packet and they picked it up, 14.9% would be embarrassed and would not give it to her, 34.3% would be embarrassed but give it to her, 26.7% would figure what she does was none of their business and would give it to her, 12.1% would be impressed she used a condom, 8.8% shocked by her behaviour, and 2.3% would have an “other” response that ranged from being kind or offering advice to her to “hating” her, calling her a prostitute, laughing at her and injuring her.

Table 6. Reaction to girl dropping condom packet

<table>
<thead>
<tr>
<th>What they will feel and do if a girl they know and respect drops packet containing condom</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing</td>
<td>6</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Embarrassed and will not give it to her</td>
<td>90</td>
<td>14.9</td>
<td>14.9</td>
<td>15.9</td>
</tr>
<tr>
<td>Embarrassed but will give the packet to her</td>
<td>207</td>
<td>34.3</td>
<td>34.3</td>
<td>50.2</td>
</tr>
<tr>
<td>What she does is none of my business, so I will give it to her</td>
<td>161</td>
<td>26.7</td>
<td>26.7</td>
<td>76.8</td>
</tr>
<tr>
<td>Impressed that she uses a condom</td>
<td>73</td>
<td>12.1</td>
<td>12.1</td>
<td>88.9</td>
</tr>
<tr>
<td>Shocked by her behaviour</td>
<td>53</td>
<td>8.8</td>
<td>8.8</td>
<td>97.7</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>2.3</td>
<td>2.3</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>604</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Responses to the survey question about what respondents would do and feel if a girl they knew dropped a packet that contained a condom are enlightening in relation to those who were unwilling to use a condom. Almost half would be embarrassed but one-third would give it back to her. Twelve percent would be impressed she used a condom and 9% would be shocked, the rest would have an “other” reaction that ranged from asking her to use the condom with them to making jokes, thinking she had HIV or throwing it away. These attitudes must be considered in efforts to increase condom use.
Table 7. Reaction to seeing boy leaving STI clinic

<table>
<thead>
<tr>
<th>What they will do if they see a boy they know and respect leaving a clinic providing STI treatment</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet him and greet him as usual</td>
<td>384</td>
<td>64.3</td>
<td>64.3</td>
</tr>
<tr>
<td>Embarrassed: You walk away so that you do not meet him</td>
<td>169</td>
<td>28.3</td>
<td>92.6</td>
</tr>
<tr>
<td>Other</td>
<td>44</td>
<td>7.4</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>597</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

As is shown above, 64.3% would meet and greet him as usual, but 28.3% would be embarrassed and walk away so they did not meet him, with another 7.4% having “other” reaction. Those “other” reactions included: fear, hate, sympathy, curiosity, laughing at him, and assuming he had HIV. Those responses are similar to those elicited by the question about the girl dropping a condom packet. Their embarrassment, fear, and hatred must be taken into account in programming for issues related to preventing and treating STIs including HIV and condom use.

Their most frequent responses to preferred source of help and advice on HIV prevention were family, followed by friends, “other”, school, church and nowhere as their preferred source of advice. Their explanations for the “other” response revealed that over half were for parents, followed by friends and chief/community leaders.

The first choice for mainstream and increased risk youth, as well as EVAs, was family; while the first choice of MARYPs was friends; and of MARAs and EVYPs was “other” with the most frequent “other” choice being family. The responses of this sample to the advice they would give a girl they knew and respected about being pregnant would be to talk to her mother (33.9%), followed closely by talking to a nurse (32.8%). For a boy asking the same advice, the most frequent response would be to talk to his father (25.8%), also followed closely by talking to a nurse (23.3%). Some would also advise the girl to talk to the boy who made her pregnant and to advise the boy to marry her.
Figure 36. Preferred source of help and advice on HIV prevention

Figure 37. Preferred source of help and advice on HIV Prevention by risk category
Summary

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

1. The highest percentage using condoms to prevent pregnancy by risk category was for EVAs and to prevent STI/HIV was MARYPs with mainstream youth situated midway among the categories. The highest percentage not using condoms because their partner did not want to was for MARAs; because they themselves did not want to was for MARYPs; and because it was embarrassing was for MARAs.

2. The highest percentages 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 (78.7%).

3. There was no discernible pattern to the responses to whether their parents talked to them about their sexuality related to their risk categories. The highest percentage reporting that their parents talked to them about their sexuality was EVAs at 75%, followed by Mainstream youth at 72%, increased risk at 65.3%, EVYPs at 58.8%, MARAs at 53.5%, and MARYPs at 51.2%.

4. The first choice for mainstream and increased risk respondents, as well as EVAs and MARAs, for their preferred source of help and advice in preventing HIV was family, while the first choice of EVYPs and MARYPs was friends.

In summary, in the area of Attitudes for these Solomon Islands youth, both mainstream youth and those at high risk and vulnerability used condoms for the purpose of pregnancy prevention at a higher rate than for prevention of STIs including HIV. Little more than half had used a condom, although over three-quarters were sexually active. 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 that they did not feel good. It is significant that 84% 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 persons (88.1%) than adolescents (82%).

Over two-thirds of respondents said that their parents talked to them about their sexuality and preventing HIV and AIDS, and their parents were their first choice to talk to them about those issues. If they were advising a male or female friend facing an unplanned pregnancy, they would advise them to talk with their parents.

Over one-third of those asked said they would share a house with a person who they knew had HIV or AIDS. Their use of marijuana was relatively low and almost three-quarters of them said they would refuse to use marijuana if offered by their friends.

Almost half said they would be embarrassed by a girl dropping a condom packet, while others expressed shock, hatred, fear, and suspicion that she had HIV. Their feelings of embarrassment, hatred, fear, and suspicion were similar in the situation of a boy seen leaving a STI treatment clinic. These attitudes will be important factors in the potential for success of interventions to increase condom use and must be considered in programme planning.
Practices and Contributing Factors Related to Risk and Vulnerability

Although previous mapping exercises have been done, this is the first to focus on behaviours and contexts that increase risk and vulnerability to HIV and AIDS of youth in Solomon Islands with the intention of providing evidence upon which to base development of interventions and policies.

Examples of groups of adolescents considered to be at higher risk include: injecting drug users (IDU) who share injecting equipment, those who have unprotected sex with multiple partners, males having sex with males, those exchanging or selling sex, and migrants. In Solomon Islands, IDU was reported by only one adolescent male in Choiseul Province, however the potential exists that additional IDU could be brought in from outside, similar to HIV. MSM was reported by five respondents, two of whom were adolescents and three young people; three in Honiara and two in Western Province. Other youth, whose behaviours placed them at higher risk, were easily found, with that increased risk obviously significant both for the individuals and for potential spread of HIV and AIDS.

The usual context of higher vulnerability for adolescents includes: poverty, homelessness, sexual violence, incest, lack of community and family support, being away from home, being out of school, single mothers, pregnant teens, or having STIs. All those contexts were found in Solomon Islands. Only two of our respondents identified themselves as living on the street. Both were females interviewed in Malaita, one was an adolescent and another young person. Nonetheless, a breakdown of family structure and community safety nets has led to an unknown number of homeless youth and children in Honiara, most of whom have no support.19 Contexts that were found to be major factors in increased risk and vulnerability to HIV and AIDS in Solomon Islands were forced sex and intoxication due to frequent consumption of alcohol, homebrew or kwaso, kava and marijuana.

This section focuses on some of the most significant risk and vulnerability practices and contributing factors for Solomon Islands youth: commercial and transaction sex, forced sex, substance abuse and unprotected sex with multiple partners. MSM that was reported by five males within our sample of 233 sexually active males is also discussed.
Safe Sex on Taro Island

On Taro Island, the provincial centre for Choiseul Province, youth race the plane on foot or by bicycle as it lands on the rutted airstrip that resembles a football field. The small island's only vehicles are transporting petrol cylinders and heavy equipment. The only indication of any trouble is a sign on the footpath in front of the police station that warns veteran football players that it is a crime to play football on the airstrip.

Taro Island appears to be a very safe place in relation to risk and vulnerability to HIV and AIDS for island youth. Yet quantitative survey results revealed that the percentage of those youth experiencing forced sex at 68% was over twice as high as other Solomon Island survey sites at 33%. Likewise, those who still felt vulnerable were 93% in relation to 65% for other sites and those whose first sex was forced at 46% was almost three times higher than other sites.

A closer look at the data for Choiseul showed that 56% of male respondents and 77% of females had ever been forced and that first sex had been forced for 35% of the males and 54% of females. More than one-third of the females indicated that their uncles were the forcers and half of the males indicated males were forcers, including an uncle.

A young female key informant described how her mother had asked her to serve food to her uncle. She felt unsafe as she was aware he had been heavily drinking, but her mother insisted. When she was close to the table, he grabbed her but she was able to escape with great effort. Because he was her mother’s brother, she was culturally restricted from telling her mother, but she did tell her grandmother. So, her answer to the question about why she continued to feel vulnerable that there was "no one to tell" had an additional dimension than the usual lack of someone to provide advice.
Men Having Sex with Men (MSM)

During mapping workshops and a stakeholder focus group discussion, MSM practices were reported to be found rarely in Malaita Province, in the Munda area of Western Province, and in the Honiara area. Students in Auki and Kilusakwalo, Malaita Province, reported during focus group discussions that they had heard of MSM, including a young boy from Auki who went with an older, expatriate, white man with money, and MSM involving boys who looked like girls. They said that condoms were not used and were uncertain whether the practice was always by choice. MSM practice was reported to be rare (0.8%) in the 2008 SI SGS. During this survey, routine data collection in schools and communities included five male respondents in the sample of 233 sexually active Solomon Islands males, who reported having sex with males or 1.8%. Figure 38 below shows the distribution of the five reported MSM by location, age group, and school- or community-based.

As shown in Figure 38, males who reported having sex with males in the Honiara area comprised 5.6% of all males sampled there, while in Western Province, MSM comprised 2.1% of all males sampled. Two of these men practicing MSM were adolescents and three were young people. Of those reporting MSM practice, three said that they were male and curious, one that they preferred sex with men, while one said they engaged in this practice because of "other" undisclosed reasons. Four reported having sex in a hidden place and one reported having sex in an "other" place. Four out of the five reported having had MSM for money. One reported using a condom while four reported no condom use. Two reported only one partner, and one each reported two, four and six partners. In the Honiara area, one men was interviewed in Kolaridge and two in Kwa Hill. Two men were interviewed in the Gizo area of Western Province.

Figure 39 shows the percentage of MSM practice among adolescents (15-19) in the sample compared to the percentage among young people (20-24).
male adolescents sampled, while the percentage in the sample of young people (20-24) comprised 2.3%. The percentage of those reporting ever having sex with men comprised 0% of the males in the school-based sample and 2.6% of those in the community-based sample.

The percentage of those who experienced forced sex in this sample was higher for the small group of MSM at 60% than for men who do not have sex with men at 27.6%. One of the five was physically forced to have sex the first time and three were ever forced. One said they were forced by a female and one by a male. Two said they were still vulnerable because there was “no one to tell” and that he needed money.

Only 1 of the 5 males who reported having sex with males said that they or the other male used a condom, leaving four, or 80%, who are having unprotected sex with men. The number of sexual partners ranged from one to six.

The number of respondents (5) and percentage of MSM (1.8%) were small in this sample of 233 sexually active male youth within the overall sample of 604, as was the percentage (0.8%) reported in the 2007 SI SGS sample of 309 male youth within the overall sample of 592. However, it is probable that the actual numbers are higher due to the fear of stigma, discrimination, and embarrassment that was described by youth in Focus Group Discussions.

Although small in number, the number of MSM represented by these four out of five Solomon Islands MSM within this sample of 233 sexually active males that have unprotected sex with multiple partners is clearly a potential contributor to HIV and AIDS risk and vulnerability for Solomon Islands MSM, as well as a potential source of epidemic spread to the broader community, since the males who engaged in MSM practice may also have sex with females.

Forced sex is also a serious issue for the MSM group. As previously mentioned, one of the five was physically forced to have first sex and three were ever forced, one by a female and one by a male.

Support and awareness needs to be available to MSM from an early age. Among these five men reportedly having sex with men, the age of first sex was 13, 14 for two, 18 and 19. Other SI youth had first sex as young as 7. Promoting condom use, limiting partners, and controlling alcohol and other substance use are important to limiting risk and vulnerability due to MSM, and will require policy changes.
Summary

There were five or 1.8% males who reported ever having sex with males in the sample of 280 male youth, of whom 233 were sexually active. The three males who reported having sex with males in the Honiara area comprised 5.6% of all males sampled there, while the two men in Western Province comprised 2.1% of all males sampled. By age group, two were adolescents and three were young people.

Of those reporting MSM, three said that they were male and curious, one that they preferred sex with men, while one said he engaged in this practice because of “other” undisclosed reasons. Four reported having sex in a hidden place and one reported having sex in an “other” place. Four out of the five men reported having sex with men for money. One reported using a condom while four reported no condom use. Two reported only one partner, and one each reported 2, 4, and 6 partners. The sample did not include prisoners.

The percentage of those who experienced forced sex in this sample was over twice as high for the small group of MSM at 60% than for men who do not have sex with men at 27.6%. One of the five was physically forced to have sex the first time and three were ever forced. One said they were forced by a female and one by a male. Two said they were still vulnerable with the reason for one of them being there was no one to tell and for the other that he needs money. Clearly, unprotected MSM with multiple partners, even for this small number, has the potential to contribute to the spread of HIV beyond MSM in Solomon Islands.
Commercial and Transactional Sex

Within the sample of 604 interviewees of whom 450 were sexually active, there were 56 who reported commercial sex as shown below in Figure 40.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Whether had sex for money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
</tr>
<tr>
<td>Male (N=231)</td>
<td>93.5%</td>
</tr>
<tr>
<td>Female (N=219)</td>
<td>81.3%</td>
</tr>
<tr>
<td>Adolescent (N=238)</td>
<td>89.9%</td>
</tr>
<tr>
<td>Young Person (N=212)</td>
<td>84.9%</td>
</tr>
<tr>
<td>Total (N=450)</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Figure 40. Commercial sex by gender and age group

Figure 40 shows the breakdown by gender and age of those who engaged in commercial sex. There were 15 (6.5%) of sexually active males, and 41 (18.7%) of sexually active females in the sample, 24 (10.1%) of sexually active adolescents and 32 (15.1%) young people in this sample.

As presented in Figure 41, among the 56 (12.4%) youth in the sample who reported having commercial sex, only four or 3.9% of the sexually active school-based respondents were in the school-based sample and 52 or 15% of sexually active community-based respondents in the community-based portion of the sample.

<table>
<thead>
<tr>
<th>Location</th>
<th>Whether had sex for money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
</tr>
<tr>
<td>School (N=103)</td>
<td>96.1%</td>
</tr>
<tr>
<td>Community (N=347)</td>
<td>85.0%</td>
</tr>
<tr>
<td>Total (N=450)</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Figure 41. Commercial sex by school- or community-based

<table>
<thead>
<tr>
<th>Location</th>
<th>Whether had sex for money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
</tr>
<tr>
<td>Honiara</td>
<td>76.7%</td>
</tr>
<tr>
<td>Western</td>
<td>92.1%</td>
</tr>
<tr>
<td>Choiseul</td>
<td>86.9%</td>
</tr>
<tr>
<td>Malaita</td>
<td>89.9%</td>
</tr>
<tr>
<td>Total (N=450)</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Figure 42. Commercial sex by location
As shown in Figure 42, 21 or 23.3% of the sexually-active portion of the Honiara sample reported that they had sex for money, while among the Western Province sample of 140 sexually active youth, 11 or 7.9% reported having sex for money among the 56 or 12.4% for sexually active SI youth overall.

All but 15 of those who engaged in commercial sex also engaged in transactional sex (41) and seven only engaged in transactional sex. The breakdown by location is shown in the next chart.

As is shown in Figure 43, 23.3% of those sexually active youth interviewed in the Honiara area reported they had transactional sex, 4.4% of those in Malaita, and 48 or 10.7% of sexually active SI youth overall. Figure 44 below shows the breakdown of those having transactional sex by sex, age, and school or community-based location of the interview.

Figure 44 shows that there were over three times as many sexually active females as males having sex for gifts, food, or trade, as there was for commercial sex. The percentage of adolescents at 11% and young people at 10.5% was similar. The percentage of those who had transactional sex in the school-based portion of this sample (2.9%) was less than one-quarter of the percentage in the community-based subset (13.1%). Overall the percentage reporting transactional sex was 48, or 10.7%.

Only one-third (33.9%) of those engaging in commercial or transactional sex used a condom the last time they had sex and 66.1% did not, with about twice as many young persons as adolescents, females as males, and those in Honiara as in Choiseul. Those who had sex for money food or gifts did so because they need money (60%), need drugs or alcohol (3.2%), other reasons (15.9%), were forced (11%), and need food (7.9%). They had sex for money, food or gifts in bush or beach (65%), clubs (13%), and houses or wharf (22%).
Sex for sale or trade was identified in all SI mapping workshops as high-risk behaviour. Within the quantitative survey sample of 604 youth, 56 reported having sex for money and 44 having sex for food, gifts or trade. Commercial sex was usually linked to outside sources of cash such as to logging, and transactional sex to a need for food or desire for gifts.

Port Cruz wharf in Honiara area was identified by mapping participants as a place where it was easy to buy sex. This was confirmed when data collectors accompanied by the MOH focal person boarded a ship at night and interviewed girls selling sex. Another Honiara survey site was under a tree, where stones became the resting and meeting place for girls selling sex. Surveys were also done in other sites where youth sold and traded sex, including White River beach and Central Market, where youth gambled, had sex, and engaged in frequent violence; Mamana Watah where Malaitan settlers were said to gamble, hang out at the market, and sell sex for easy money; Fishing Village, the site of mother boats where girls could sell sex for fish; and Tuvaruhu a multicultural area and the site of frequent teen pregnancy and abortion, where newborn babies were said to be sometimes thrown into the river. Factors contributing to Honiara’s highest percentage of youth selling and trading sex were: fishing and mother boats, tourism, logging, clubs, and wharfs.

The Munda/ Noro and Gizo area survey sites of Western Province were also areas for selling and trading sex. Munda is an administrative centre where a market and transits brought outsiders to town. Several houses, transits, and sites, such as Lambete beaches, the bush near Goldie Hospital, and a Blue house, were identified as places for commercial sex. There were companies whose workers had money to buy sex; the logging industry; fishing boats; tourists; girls going out to ships to exchange sex for fish; foreigners; workers from overseas coming without wives and looking for girls; and so-called “naughty girls” from one school who robbed tourists to whom they sold sex.

Noro’s attractions for those engaged in commercial and transactional sex included a wharf, market, tuna cannery, and such risky sites as Backway, Black Town, BTM Beach club, Kokosu Beach, Cha Cha Back Yard, and hostels.

Gizo Town is a district centre with several hotels known for commercial sex, including one hotel bar where researchers interviewed several girls and a male selling sex to outsiders. The research team travelled by canoe and found sex for sale or trade on remote Vela la Vela Island and Barakoma village as well as in such rural Gizo areas as Lonely Village, Hilltop, Million Dollar View, Tsunami Beach, Water Pump, and Banana Valley. However, a severe storm prevented travel to Gizo area tsunami camps.
Factors supporting commercial sex in Choiseul Province included: proximity to the Bougainville border, logging camps, fishing boats, and mining camps. Sex was sold in Poro Poro, an isolated logging village where a “town crier” announced the researchers’ arrival, and in Choiseul Bay where locals and foreigners gave money to school girls for sex, who were reported to have at least two to three partners in one night.

In Malaita Province, youth gathered at the airport sporting grounds for the Malaita Day football tournament and for sale and exchange of sex by some. Other factors supporting commercial and transactional sex in Malaita Province were the passenger ship’s arrival every Friday night, drugs, the cannery, logging, and continued political turmoil and displacement following the “tensions”. Auki students told of friends who went to logging camps and sold sex to business men and rich men because their parents did not support them and they needed money. Boys were also reported to sell sex to married women.

Although only Honiara and Western Province quantitative survey respondents reported selling or trading sex, qualitative focus group and key informant data confirmed that the need for money and food, and desire for nice things, coupled with lack of parental support, fuelled the high-risk sale and trade of sex by youth in all areas surveyed.

Summary
The Solomon Islands survey sample of 604 youth included 56 (12.4% of those who were sexually active) who reported having commercial sex and 44 (10.7%) who reported transactional sex. Of the commercial sex workers, 15 (6.5%) were male and 41 (18.7%) female; 10.1% adolescents and 15.1% young people; 3.9% of the sexually active school-based sample and 15.0% community-based; 23.3% of the sexually active Honiara sample, 7.9% Western, 13.1% Choiseul, and 10.1% Malaita.

Most of those who had commercial sex also had transactional sex (10.7%). Two-thirds of those engaging in commercial or transactional sex did not use a condom the last time. Those who had sex for money food or gifts did so because: they need money (60%), need drugs or alcohol (3.2%), other reasons (15.9%), forced (11%), and need food (7.9%). Increased risk and vulnerability related to unprotected commercial and transactional sex is significant and can be expected to be difficult to reduce in relation to the extent of the SI youth’s need for money and food, as well as desire for good things.
Forced Sex

Forced sex is an unavoidable reality for too many Solomon Islands youth. Thirty-eight percent of sexually active youth reported that they had been forced to have sex when they did not want to with 71% saying they are still vulnerable. The percentage of those who report forced sex by location is shown in Figure 45.

The distribution of reported forced sex by province/area in Figure 45 shows that Choiseul Province has the highest level (68.3%) and Honiara the lowest (23.3%).

As in Figure 46 above, almost half the sexually active females in this sample experienced forced sex, as did over one-quarter of sexually active males. Adolescents had a slightly higher percentage at 39.7% than young people at 36.2% with the overall rate 38.1%. Those sampled in schools and communities were essentially the same.
The next chart presents the percentage of forced sex by risk category.
As shown in Figure 47, only 32 (17.3%) mainstream youth have experienced forced sex out of the sample of 449 sexually active youth. Those at increased risk were 33.1% and in ascending order: MARYP at 65.1%, MARAs at 70.5%, EVAs 78.8% and EVYPs 82.4%. Thus, compared to mainstream youth, those at increased risk reported two times the percentage of forced sex while EVYPs reported almost five times the forced sex at 82.4%.

Furthermore, first sex was forced for 20.4% of sexually active youth in Solomon Islands. The percentage of first sex forced by risk category is shown in the following chart. Figure 48 shows that only 15 or 8.2% of the 31 sexually active mainstream youth in this sample reported being physically forced to have sex the first time. The reported percentage varied by category with the next lowest being 13% for increased risk youth and the highest being 51.5% for EVAs. The reported percentage of forced first sex differed between males and females as shown below in Figure 49. Figure 49 displays that the percentage of those reporting their first sex was forced was 16.2% for males and 24.8% for females; 22.7% for adolescents and 17.7% for young people. Figure 50 presents the percentages of forced first sex by location.

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA (N=44)</td>
<td>70.5%</td>
<td>29.5%</td>
</tr>
<tr>
<td>MARYP (N=43)</td>
<td>65.1%</td>
<td>34.9%</td>
</tr>
<tr>
<td>EVA (N=33)</td>
<td>78.8%</td>
<td>21.2%</td>
</tr>
<tr>
<td>EVYP (N=17)</td>
<td>82.4%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Inc. Risk (N=127)</td>
<td>33.1%</td>
<td>71.9%</td>
</tr>
<tr>
<td>Mainstream (N=185)</td>
<td>17.3%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Total (N=449)</td>
<td>38.1%</td>
<td>61.9%</td>
</tr>
</tbody>
</table>

Figure 47. Forced sex by risk category
As illustrated in Figure 50, forced first sex was reported with little difference between Honiara, Western, and Malaita, but at almost three times the percentage of the other provinces/areas for those in Choiseul. Twenty-seven percent of sexually active youth who were interviewed at schools had experienced forced first sex and 18.3% of the sexually active community-based sample.

Those who said they had been forced were asked if they still feel vulnerable to being forced again. There was little variation by gender or age group among the 71% who answered “yes”. However, by risk category, only 37% of mainstream youth answered still felt vulnerable, 58% of increased risk youth, 88% MARA and MARYPs, 96% EVAs and 100% EVYPs.

By location, those in Western Province were lowest with 52%, while those in Choiseul were highest at 93%. When asked why they still feel vulnerable, the highest percentage of males answered they lived in the house with the forcer and highest percentages of females that the forcer lived in their neighbourhood, as did adolescents and young people. By risk category, the highest percentage of all categories except increased risk youth answered that the forcer was in their neighbourhood, while the highest percentage for increased risk youth was that the person had power over them.
Summary
Thirty-eight of those who are sexually active in this sample reported they had been forced to have sex when they did not want to with variation between males at 28% and females at 49%. By risk category, the variation appeared to be related to risk ranging from 17% for mainstream youth to 82% for EVYPs.

By location, the variation ranged from 23% for those in the Honiara area to 68% for those in Choiseul. There was little variation between the school and community-based portions of the sample.

Seventy-one percent of those who reported being forced said that they still feel vulnerable to being forced, with the percentage varying by gender from 70% for males to 71% for females and by place from 52.2% in Western Province to 92.5% in Choiseul Province. There was little variation between age groups and school- or community-based. By risk category, the percentage varied from 37% for mainstream youth to 100% for EVYPs. Furthermore, first sex was forced for 20.4% of sexually active youth in Solomon Islands, ranging from 8.2% for mainstream to 67% for increased risk and by sex from 16.2% for males to 24.8% for females.

Clearly, the high percentages of forced sex, particularly for Choiseul, have implications for risk and vulnerability of SI youth to HIV and AIDS. Forced sex has implications for HIV risk and vulnerability in that it is rarely protected sex. In addition the IATT cites global research results indicating that sexual abuse is associated with low self-esteem and often precludes sex work, making it less likely that the young sex worker will insist on safe sex.21

"Young people are afraid to go to the clinic. They have to walk a long distance and are attacked on the road by rapists."
Substance Use

One issue of concern in relation to HIV and AIDS risk and vulnerability in Solomon Islands is substance use, including alcohol, homebrew and marijuana. The percentage of the sample using each substance is illustrated in Figure 51 below.

Includes cigarettes, marijuana and rice “vine”

Forty-four percent of the survey sample use alcohol and over one-quarter use homebrew, a beer-like fermented drink, or kwaso, an illegal homebrew. Almost three-quarters use betel and 40.5% smoke tobacco.

As shown in Figure 52, males consistently use substances at a higher rate than females, except “other”. A higher percentage of young people use alcohol, homebrew, betel and tobacco, but a higher percentage of adolescents use “other” substances. A higher percentage of those in Honiara use alcohol, homebrew, and kava.

The percentage of mainstream youth using these substances is consistently one of the lower percentages than for those at risk. The percentage of MARA and MARYP using these substances tends to be higher than EVA and EVYP with the exception of kava, betel and tobacco. The rate of frequent alcohol consumption (greater than three times per week) varies within groups as illustrated in the next chart. The overall rate of frequent alcohol consumption (more than three times per week) for this sample is 5.2%, but the percentage of males is more than twice as high as females and for young people is over twice as high as for adolescents, as illustrated in Figure 54.
MARYPs report the highest percentage of frequent alcohol use at 11.6%; increased risk youth are next at 9.8%, EVAs at 9.1%, EVYP at 5.9%, MARA at 4.5%, and mainstream at 2.85%, as displayed in Figure 55. Frequent kwaso or homebrew use of more than three times per week was reported for 25 youth, including 7.1% males and 1.5% of females.

<table>
<thead>
<tr>
<th>Category</th>
<th>Alcohol</th>
<th>Kwaso/ homebrew</th>
<th>Kava</th>
<th>Betel</th>
<th>Tobacco</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (N=37)</td>
<td>6.8%</td>
<td>48.6%</td>
<td>57.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (N=70)</td>
<td>13.2%</td>
<td>71.3%</td>
<td>75.7%</td>
<td>31.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent (N=71)</td>
<td>4.1%</td>
<td>34.5%</td>
<td>72.9%</td>
<td>34.3%</td>
<td>57.7%</td>
<td></td>
</tr>
<tr>
<td>Young Person (N=36)</td>
<td>3.8%</td>
<td>52.3%</td>
<td>74.1%</td>
<td>34.3%</td>
<td>57.7%</td>
<td></td>
</tr>
<tr>
<td>Honiara (N=23)</td>
<td>7.2%</td>
<td>39.2%</td>
<td>57.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western (N=9)</td>
<td>4.4%</td>
<td>38.9%</td>
<td>56.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choiseul (N=14)</td>
<td>3.6%</td>
<td>46.3%</td>
<td>82.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaita (N=61)</td>
<td>2.3%</td>
<td>33.6%</td>
<td>64.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (N=107)</td>
<td>3.8%</td>
<td>28.2%</td>
<td>43.9%</td>
<td></td>
<td>40.5%</td>
<td>73.6%</td>
</tr>
</tbody>
</table>

Figure 52. Substance use by gender, age and location

<table>
<thead>
<tr>
<th>Category</th>
<th>Alcohol</th>
<th>Kwaso/ homebrew</th>
<th>Kava</th>
<th>Betel</th>
<th>Tobacco</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA (N=11)</td>
<td>3.3%</td>
<td>29.5%</td>
<td></td>
<td>25%</td>
<td>55.8%</td>
<td></td>
</tr>
<tr>
<td>MARYP (N=11)</td>
<td>2.3%</td>
<td>20.9%</td>
<td>70%</td>
<td>42.4%</td>
<td>74.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>EVA (N=4)</td>
<td>3%</td>
<td>12.1%</td>
<td>75.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EVYP (N=8)</td>
<td>5.9%</td>
<td>24.2%</td>
<td>76.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inc. Risk (N=38)</td>
<td>5.3%</td>
<td>13.8%</td>
<td>56.8%</td>
<td></td>
<td>78.5%</td>
<td></td>
</tr>
<tr>
<td>Mainstream (N=39)</td>
<td>3.6%</td>
<td>17.7%</td>
<td>43.5%</td>
<td></td>
<td>71.8%</td>
<td></td>
</tr>
<tr>
<td>Total (N=111)</td>
<td>3.8%</td>
<td>17.8%</td>
<td>43.5%</td>
<td>40.4%</td>
<td>73.3%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 53. Substance use by risk category
Only one of the 604 respondents reported Injecting Drug Use, an adolescent male who was part of the community-based sample in Choiseul Province. Of those youth surveyed, 15.6% said they currently use drugs. The types of drugs they reported using were: marijuana, ecstasy, ice, speed, and prescription drugs.

Substance use is clearly of regional concern in relation to reducing HIV and AIDS risk and vulnerability in Solomon Islands with alcohol, homebrew and kava used by a higher percentage of youth in the Honiara area.
Summary

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

The percentage of mainstream youth using these substances is consistently one of the lower percentages than for those at higher risk. The percentage of MARA and MARYP using these substances tends to be higher than EVA and EVYP with the exception of kava, betel, and tobacco.

MARYPs report the highest percentage of frequent alcohol use at 11.6%; increased risk youth are next at 9.8%, EVAs at 9.1%, EVYP at 5.9%, MARA at 4.5%, and mainstream at 2.5%. Frequent kwaso or homebrew use of more than three times per week was reported for 25 youth, including 7.1% males and 1.5% of females.

In summary, almost half of the survey sample reported using alcohol and over one-quarter using kwaso or homebrew, three-quarters reported using betel nut and 40% smoking tobacco. However, there is variation by province/area with alcohol use ranging from 25% in Malaita Province to 58% in the Honiara area; homebrew or kwaso use from 21% in Malaita to 39% in Honiara; kava from 1.3% in Malaita to 4.4% Western; tobacco from 16% Honiara to 52% Choiseul and other substances from 5% Western to 27% Malaita.

When they had first sex, 15.3% of this sample had consumed alcohol and 5.6% had taken a drug which made them want to have sex. The overall rate of frequent alcohol consumption (more than three times per week) for this sample is 5.2%, but it varies between groups from 3.5% for females, 7.3% males, and 3.6% adolescents to 7.8% for young people. Variation by risk category ranges from 2.5% for mainstream youth to 11.6% for MARYPs. Four of the five MSM reported using alcohol, but only infrequently. The increased risk related to substance use in SI as a contributing factor to HIV and AIDS risk and vulnerability appears to be less problematic than in some other Pacific Island countries, but more so in the Honiara area and should be addressed in terms of decision making for safer sex by SI youth.
**Condom Use**

Sexually active youth reporting condom use at last high-risk sex (with a non-regular partner) were 32.8% of those who were sampled, including 27% in Western Province, 29.4% in Malaita Province, 30.3% in Honiara area, and 64.2% in Choiseul Province as shown in Figure 56 below.

![Figure 56. Condom use at last high-risk sex by location](image)

- **Honiara (N=119)**: 32.8% Yes, 37% No, 30.3% No high-risk sex
- **Western (N=178)**: 44.4% Yes, 28.7% No, 27% No high-risk sex
- **Choiseul (N=67)**: 16.4% Yes, 64.2% No, 28.5% No high-risk sex
- **Malaita (N=228)**: 42.1% Yes, 29.4% No, 29.2% No high-risk sex
- **Total (N=592)**: 38% Yes, 29% No, 32.8% No high-risk sex

**Figure 57. Condom use at last high-risk sex by risk category**

- **MARA (44)**: 39% Yes, 55% No, 7% No high-risk sex
- **MARYP (43)**: 51% Yes, 47% No, 2% No high-risk sex
- **EVA (33)**: 52% Yes, 33% No, 15% No high-risk sex
- **EVYP (17)**: 41% Yes, 41% No, 18% No high-risk sex
- **Inc. Risk (131)**: 35% Yes, 47% No, 47% No high-risk sex
- **Mainstream (324)**: 26% Yes, 15% No, 15% No high-risk sex
- **Total (N=592)**: 33% Yes, 29% No, 29% No high-risk sex
As shown in Figure 57, the highest percentage of respondents reporting condom use at last high-risk sex were those at higher risk and vulnerability: EVAs (52%) and MARYPs (51%), followed by EVYPs (41%) and MARAs (39%), increased risk (35%) and mainstream (26%) with the overall percentage of 33%. However, the percentage of respondents saying they had no high-risk sex was highest for increased risk youth (47%), followed by mainstream youth (15%), EVYPs (18%), EVAs (15%), MARAs (7%), and MARYPs (2%). Those who did not use a condom ranged from 15% mainstream youth to 55% MARAs, which are the patterns that matched expectations of risk for these groups.
The percentage of sexually active males reporting condom use at last high-risk sex was almost 10% higher (37.9%) than that of females (28.4%) as shown in Figure 58. The range was similar for young people at 40.9% and adolescents at 27.5%. The school-based sample reported 23.3% condom use at last high-risk sex, while those who were community based reported 37.3%.

Figure 59 shows the highest percentage of adolescents who reported using a condom at last sex by risk category were EVAs at 54.5%, followed by MARYPs 48.8%, EVYPs 41.2%, MARA 38.6%, increased risk 36.9% and mainstream 33.8%.

Figure 60 presents data on condom use at last sex by place. There was about 20% difference in reported condom use at last sex between Western Province at 30.9% and Choiseul at 50.7%.

Figure 61 shows the percentages of those who reported condom use at last sex. Males reported over 42.3%, while females reported slightly less than one-third. Adolescents were at slightly below one-third, while young persons were at 46.8%. The school-based portion was at slightly over one-quarter, while the community-based portion reported 43.2%, and the overall sample reported 37.3%.

Both mainstream youth and those at high risk and vulnerability used condoms for the purpose of pregnancy prevention at a higher rate than for prevention of STIs, including HIV. Little more than half had used a condom, although over three-quarters were sexually active. 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 that they did not feel good. Although 84% of these youth said that they wanted to use a condom the next time they had sex, only half of the three-quarters who are sexually active say they have used a condom. Thus, at least one-quarter of SI youth are having unprotected sex.

Responses to survey question about what the respondents would do and feel if a girl they knew dropped a packet that contained a condom are enlightening in relation to condom use. Almost half would be embarrassed as expressed in the quote here, but one-third would give it back to her. Twelve percent would be impressed she used a condom and 9% would be shocked, the rest would have “other” reactions that ranged from asking her to use the condom with them, to making jokes, thinking she had HIV, or throwing it away. These attitudes must be carefully considered in efforts to increase condom use.
Summary

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

1. The highest percentage reporting condom use at last high-risk sex were those at higher risk and vulnerability with the lowest percentage those at lowest risk and vulnerability, ranging from EVAs (52%) to mainstream (26%).

2. The highest percentage of adolescents who reported using a condom at last sex by risk category were EVAs at 54.5%, followed by MARYPs 48.8%, EVYPs 41.2%, MARA 38.6%, increased risk 36.9% and mainstream 33.8%. As above, those at lowest risk had lowest condom use.

In summary, overall reported condom use at last high-risk sex for sexually active youth was slightly lower at 33% than for last sex at 37%. EVAs reported the highest percentages of use at 52% for last high-risk sex and 54% for last sex. The lowest percentage of reported condom use was for mainstream youth at 26% for last high-risk sex and at 34% for last sex. Distribution was similar for condom use at last sex and last high risk sex, but last sex percentages were lower.

The combination of sporadic or no condom use with many partners – “more the better” with 6-7 partners in one night – contributes to risk and vulnerability for youth in SI. Many youth believe that sex with condoms is not as enjoyable as skin to skin. Attitudes toward condom use in SI, including embarrassment and suspicion, involve complicated and strong cultural beliefs which must be considered when programmes and policies are being developed for increasing the percentage of use for SI youth.

“Shy to ask (for a condom). If run out, don’t go to get. Chief won’t stop it, but no one distributes in village”
Age at First Sex

Fifteen percent of all 15-19 year olds sampled had first sex before 15 years of age, including 9.8% in Malaita Province, 10.8% in Western Province, 18.2% in Choiseul, and 28.8% in Honiara as shown in Figure 62. The percentage of those who had sex before 15 years was almost three times as high in Honiara as in Malaita.

<table>
<thead>
<tr>
<th>Location</th>
<th>Sex before age 15</th>
<th>No sex before age 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honiara (N=73)</td>
<td>28.8%</td>
<td>71.2%</td>
</tr>
<tr>
<td>Western (N=102)</td>
<td>10.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Choiseul (N=44)</td>
<td>18.2%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Malaita (N=143)</td>
<td>9.8%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Total (N=362)</td>
<td>14.9%</td>
<td>85.1%</td>
</tr>
</tbody>
</table>

Figure 62. Whether delayed age of first sex

Figure 63. Early onset sex by gender, school or community-based
Figure 63 shows the percentage of those who reported they had first sex before 15 years of age by gender and school- or community-based. Of the males, 12.9% had first sex before 15 years, while females had a higher percentage at 16.3%. Within the community-based sample, 20% had first sex before 15 years, compared to 9.6% of the school-based sample. Although first sex was delayed to 15 years or older for 85.1% of Solomon Islands youth, the remaining youth reported having sex as young as 7 years of age. Figure 64 shows the distribution of adolescents who had sex before 15 years of age by risk category.

As shown in Figure 64, the difference in percentage of those who had sex before 15 years of age varies from 4.5% for mainstream youth to 52.4% for MARAs. Even between those who are at increased risk (23%) and mainstream youth (4.5%), the difference in percentage is marked. Table VIII shows the difference in mean age, median age, and age range for age at first sex.
Table 8. Age at first sex

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Age</th>
<th>Median Age</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>16.1</td>
<td>16</td>
<td>7-24</td>
</tr>
<tr>
<td>Female</td>
<td>16.2</td>
<td>16</td>
<td>10-23</td>
</tr>
<tr>
<td>Adolescent</td>
<td>15.4</td>
<td>16</td>
<td>7-19</td>
</tr>
<tr>
<td>Young Person</td>
<td>17</td>
<td>17</td>
<td>10-24</td>
</tr>
<tr>
<td>School-based</td>
<td>15.8</td>
<td>16</td>
<td>7-19</td>
</tr>
<tr>
<td>Community-based</td>
<td>16.3</td>
<td>16</td>
<td>10-24</td>
</tr>
<tr>
<td>Honiara area</td>
<td>15.6</td>
<td>16</td>
<td>7-24</td>
</tr>
<tr>
<td>Western Province</td>
<td>16.3</td>
<td>16</td>
<td>10-24</td>
</tr>
<tr>
<td>Choiseul Province</td>
<td>15.9</td>
<td>16</td>
<td>10-21</td>
</tr>
<tr>
<td>Malaita Province</td>
<td>16.5</td>
<td>16</td>
<td>10-23</td>
</tr>
<tr>
<td>MARA</td>
<td>14.6</td>
<td>14</td>
<td>10-19</td>
</tr>
<tr>
<td>MARYP</td>
<td>16.3</td>
<td>16</td>
<td>13-20</td>
</tr>
<tr>
<td>EVA</td>
<td>15.3</td>
<td>15</td>
<td>11-19</td>
</tr>
<tr>
<td>EVYP</td>
<td>17.2</td>
<td>17</td>
<td>14-20</td>
</tr>
<tr>
<td>Increased Risk</td>
<td>16.2</td>
<td>16</td>
<td>7-24</td>
</tr>
<tr>
<td>Mainstream</td>
<td>16.6</td>
<td>16</td>
<td>13-18</td>
</tr>
</tbody>
</table>

Table 8 displays the mean age of first sex ranged from 14.6 for MARAs to 17.2 for EVYPs. Median age varied from 14 for MARAs to 17 for EVYPs. Increased risk youth had the youngest (7) and oldest (24) ages of first sex by risk.
Summary

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

1. The difference in percentage of those who had sex before 15 years of age was dramatic between mainstream youth and all those at higher levels of risk and vulnerability, varying from 4.5% for mainstream youth to 52.4% for MARAs. Even between those who were mainstream (23%) and increased risk youth (4.5%), the difference in percentage was marked.

2. The mean age of first sex ranged from 14.6 for MARAs to 17.2 for EVYPs. Median age varied from 14 for MARAs to 17 for EVYPs. The broadest age range was from 7-24 for increased risk youth.

In summary, the percentage of those who had sex before 15 years was almost three times as high in Honiara as in Malaita and Western Provinces. For females, the percentage was a quarter higher than for males; and over two times higher for community-based than for school-based youth.

As previously mentioned, the difference in the percentage of those who had sex before 15 between mainstream youth and those at greater risk and vulnerability was dramatic. Although the age of first sex was delayed to 15 years or older for 85.1% of Solomon Islands youth as a whole and for 90% of Malaita Province youth, the remaining youth reported having sex as young as 7 years of age. Clearly these findings indicate increased risk and vulnerability related to the number of those who have sex before 15 years of age and have implications for programme and policy development. There was obviously a relationship between these findings and those for forced first sex, which was reported by 20.4% of sexually active youth in Solomon Islands, 51.5% of EVAs, 25% of females, and 46% of youth in Choiseul Province.

“This is a period of sexual pressure among young people.”
The percentages by location of Solomon Islands males and females who ever talked to a health worker about HIV and AIDS are shown in Figure 65.

![Figure 65. Whether utilised health worker for HIV and AIDS information](image)

If male, whether they ever talked about HIV or AIDS with a health worker

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA (N=10)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>MARYP (N=12)</td>
<td>66.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>EVA (N=8)</td>
<td>62.5%</td>
<td>37.5%</td>
</tr>
<tr>
<td>EVYP (N=7)</td>
<td>57.1%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Inc. Risk (N=85)</td>
<td>50.6%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Mainstream (N=156)</td>
<td>54.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Total (N=278)</td>
<td>54%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Figure 66. Males who talked to health worker about HIV and AIDS by risk category
Females in three out of four provinces/areas utilised health workers for information at a higher rate than males. Only Malaita Province had a higher percentage of males than females who utilised health workers. A higher percentage of males and females in Western and Choiseul Provinces utilised health workers for HIV and AIDS information than in the other areas, with Malaita Province at the lowest level. The breakdown of males who talked with a health worker by risk is shown in the following chart.

As shown in Figure 66, the percentage of males who talked to a health worker about HIV and AIDS ranged from 50% for MARAs to 67% for MARYPs with no apparent pattern. These numbers were low and the percentages should be viewed in that context.

Figure 67 shows that the percentage of females utilising health workers for HIV and AIDS information ranged from 55.9% for MARAs to 80% for EVYPs, but numbers were low and there was no apparent pattern. The percentages of Solomon Islands males and females who have ever obtained and used a condom from a health clinic by location are shown in the next chart.

![Figure 67. Females who talked to health worker about HIV and AIDS by risk category](image)
As illustrated in Figure 68, females were more likely to obtain and use a condom than males, with the exception of Choiseul and Malaita Provinces. The variation by place was similar for males and females.

The breakdown of males who obtained and used a condom from a health clinic by gender and location is shown below in Figure 69.

The breakdown of males who obtained and used a condom from a health clinic by risk category is shown below in Figure 69.
As shown in Figure 69, the breakdown by risk category in percentages of males who utilised a clinic for obtaining condoms ranged from 25% for EVAs to 86% for EVYPs. The percentages of most-at-risk youth were higher than for EVAs, increased risk or mainstream youth. The breakdown of females who obtained and used a condom from a health clinic by risk category is shown below in the following chart.

Figure 70 shows the percentages of females who obtained and used a condom from a health clinic ranged from 38% for mainstream to 90% for EVYPs. As above, there was no apparent pattern, except that those at higher risk had a higher percentage of utilisation than for mainstream youth.

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA</td>
<td>44.1%</td>
<td>55.9%</td>
</tr>
<tr>
<td>MARYP</td>
<td>66.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>EVA</td>
<td>69.6%</td>
<td>30.4%</td>
</tr>
<tr>
<td>EVYP</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Inc. Risk</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Mainstream</td>
<td>37.6%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Total (N=313)</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Female utilisation of a health clinic as a source of information and advice about HIV and AIDS or to obtain condoms was higher than for males. Males reported 54% talked with a health worker about HIV and AIDS and females reported 60%. Males reported 52% obtained and used a condom from a health clinic while females reported 60%.
The percentage of males who reported utilising a health clinic for obtaining information and advice about HIV and AIDS or obtaining and using a condom is shown by age group in Figures 71 and 72. The two charts show the percentage of 20-24 year old males who reported talking about HIV and AIDS to a health worker in a clinic was about 16% higher than for 15-19 year olds and the percentage who reported obtaining and using a condom from a health clinic was about 35% higher for 20-24 year olds than for 15-19 year olds.

The next figure shows female utilisation of health clinics to obtain information and advice about HIV and AIDS and obtain and use a condom. Figures 73 and 74 show that utilisation of females by age group was similar to that of males in that the percentage of 20-24 year olds who talked to a health worker about HIV and AIDS was 4% higher than for 15-19 year olds.

The difference in those who obtained and used a condom from a clinic was 11% higher for 20-24 year olds than 15-19 year olds. The number of times males and females reported having had STIs in the past year by place is shown in Figures 75 and 76. As can be seen from Figures 75 and 76, females in Choiseul reported the highest percentage (19%) of more than five STIs in the past year at almost three times higher than females in Honiara, the next highest. Choiseul males also reported the highest percentage (4%) of 1-5 STIs in the past year. Western and Malaita males (76%) and Western females (86%) reported the highest percentage of no STIs.
If female, whether talked about HIV and AIDS with health worker

If female, whether obtained and used a condom from health clinic

Figure 73. Females utilising health clinic for HIV and AIDS information by age

Figure 74. Females utilising health clinic for obtaining condom by age

Figure 75. Males STIs in past year by location

Figure 76. Females STIs in past year by location
Males who reported pain or infection in their genitals said they received treatment by location of interview as shown in Figure 77 below. Figure 77 illustrates that more males utilised clinical treatment for STIs (70%) than non-clinical or no treatment (11%) and that a higher percentage of Malaita (24%) and Honiara (23%) males reported no pain or infection than Western (17%) or Choiseul (4%) males.
Figure 78 illustrates that 47% to 87% of the females from the sampled locations got treatment from a clinic if they were symptomatic for STIs, while 0-7% chose no treatment.

As shown in Figure 79, there was only one male respondent who reported more than five STIs in the past year. Those experiencing 1-5 STIs ranged from 3.3% for mainstream youth to 80% for MARAs. Those who had no STIs ranged from 20% of MARAs to 96.7% of mainstream youth.
Figure 80 displays STI treatment utilisation for symptomatic males by risk category. As shown in Figure 78, about 70% of symptomatic male mainstream youth usually chose clinical treatment (clinic and youth clinic), as did about 75% increased risk, 57% EVYP, 63% EVA, 69% MARYP, and 44% MARA. Those who chose no treatment ranged from 6% for increased risk youth to 44% MARA.

The frequency of STIs by risk category for females in the past year is shown in the following chart.

Figure 81 shows that there were 10 female respondents, six of whom were MARAs, who reported more than five STIs in the past year as compared to one male. Those 31 females who experienced 1-5 STIs ranged from one for mainstream youth and EVYPs to 52.2% or 12 (52.2%) for the MARA sample. Those who had no STIs ranged from 22% of MARAs to 99% of mainstream youth.
As shown in Figure 82, about 55% of symptomatic female mainstream youth usually chose clinical treatment, as did about 93% increased risk, 86% EVYP, 76% EVA, 73% MARYP, and 56% MARA. Only 10 overall chose no treatment.

<table>
<thead>
<tr>
<th>Category</th>
<th>Clinic</th>
<th>Youth clinic</th>
<th>Other</th>
<th>No symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA</td>
<td>56.3%</td>
<td>15.6%</td>
<td>28.1%</td>
<td></td>
</tr>
<tr>
<td>MARYP</td>
<td>4.5%</td>
<td>4.5%</td>
<td>22.7%</td>
<td></td>
</tr>
<tr>
<td>EVA</td>
<td>0%</td>
<td>0%</td>
<td>23.8%</td>
<td></td>
</tr>
<tr>
<td>EVYP</td>
<td>0%</td>
<td></td>
<td>14.3%</td>
<td></td>
</tr>
<tr>
<td>Inc. Risk</td>
<td>6.9%</td>
<td>3.4%</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>Mainstream</td>
<td>2.2%</td>
<td>3.2%</td>
<td>41.9%</td>
<td></td>
</tr>
<tr>
<td>Total (N=204)</td>
<td>2.9%</td>
<td>4.9%</td>
<td>29.4%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 82: Female STI treatment utilisation by risk category
The following chart presents the HIV and AIDS Prevention Workshop Coverage for most-at-risk youth.

Figure 83 illustrates that 73.8% of those most-at-risk who were surveyed in Solomon Islands indicated they had attended an HIV prevention workshop with little variation by gender or age group. School-based interviewees reported 100% as compared to 71% community based. Attendance was highest in Honiara at 86%, 80% in Choiseul Province, 71% in Western Province, and 56% in Malaita Province.

Figure 84 displays the breakdown of those most-at-risk that have been reached by HIV prevention programmes by risk category. It shows that over 72% MARAs and 77% MARYPs have been reached by HIV Prevention Programmes.

![Chart showing HIV and AIDS Prevention Workshop Coverage](image-url)

**Figure 83. HIV and AIDS Prevention Workshop for most-at-risk coverage**

<table>
<thead>
<tr>
<th>Category</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>76.2%</td>
</tr>
<tr>
<td>Female</td>
<td>72.7%</td>
</tr>
<tr>
<td>Adolescent</td>
<td>73.3%</td>
</tr>
<tr>
<td>Young Person</td>
<td>74.3%</td>
</tr>
<tr>
<td>School</td>
<td>100%</td>
</tr>
<tr>
<td>Community</td>
<td>71.2%</td>
</tr>
<tr>
<td>Honiara</td>
<td>86.4%</td>
</tr>
<tr>
<td>Western</td>
<td>70.6%</td>
</tr>
<tr>
<td>Choiseul</td>
<td>80%</td>
</tr>
<tr>
<td>Malaita</td>
<td>56.3%</td>
</tr>
<tr>
<td>Total</td>
<td>73.8%</td>
</tr>
</tbody>
</table>

![Chart showing Most-at-risk reached by HIV prevention programme by category](image-url)

**Figure 84. Most-at-risk reached by HIV prevention programme by category**
Summary

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

1. The utilisation of healthcare workers as a source for HIV and AIDS information was about 50% for mainstream males and slightly higher for those at greater risk, lower for EVAs at 25% and much higher for EVYPs at 86%. For females, utilisation by mainstream females was about 60% with those at greater risk similar except for EVYPs who, as for males, were much higher at 80%.

2. The percentages of males utilising a clinic for obtaining condoms were about 50% for mainstream with similar percentages for greater risk youth, except that EVAs were lower at 25% and EVYPs were much higher at 86%. Mainstream females had a lower percentage (38%) obtaining and using condoms than those at greater risk and vulnerability with EVYPs highest at 90%.

3. Only one male respondent, as opposed to 10 females, experienced more than five STIs in the past year. Males experiencing 1-5 STIs ranged from 3.3% for mainstream youth to 80% for MARAs. Males who had no STIs ranged from 20% of MARAs to 96.7% of mainstream youth. The 31 females who experienced 1-5 STIs ranged from one for mainstream youth and EVYPs to 52.2% or 12 for the MARA sample. Females who had no STIs ranged from 22% of MARAs to 99% of mainstream youth.

4. About 70% of symptomatic male mainstream youth usually chose clinical treatment (clinic and youth clinic), with those at greater risk ranging from 44% MARA to 79% MARYP. Those who chose no treatment ranged from 6% for increased risk youth to 44% MARA. About 55% of symptomatic female mainstream youth chose clinical treatment; while those at higher risk and vulnerability ranged from 56% MARAs to 93% increased risk. Only 10 females overall chose no treatment.

5. Over 72% MARAs and 77% MARYPs had been reached by HIV Prevention Programmes.
In summary, males in three out of four Solomon Islands provinces/areas utilised health workers for information at a lower rate than females, but a higher percentage of males than females in Malaita Province utilised health workers for information. A higher percentage of males and females in Western and Choiseul Provinces utilised health workers for HIV and AIDS information than in the other areas, with Malaita Province at the lowest level.

Females were more likely to obtain and use a condom than males, with the exception of Choiseul and Malaita Provinces. The variation by place in using a health clinic for HIV and AIDS information or to obtain a condom was similar for males and females with Malaita at the lowest percentage and Choiseul the highest.

The percentage of 20-24 year old males who reported talking to a health worker in a clinic about HIV and AIDS was about 16% higher than those who were 15-19 years old and the percentage who reported obtaining and using a condom from a health clinic was about twice as high for 20-24 year olds as for 15-19 year olds. Females were more likely to obtain and use a condom than males, with the exception of Choiseul and Malaita Provinces. The 20-24 year old females in this sample were 5% more likely to have talked with a healthcare worker about HIV and AIDS and 11% more likely to have obtained and used a condom than 15-19 year old adolescents.

The findings also show that females in Choiseul reported the highest percentages (19%) of more than five STIs in the past year by almost three times higher than females in Honiara, the next highest. Choiseul males also reported the highest percentage (4%) of 1-5 STIs in the past year. Western and Malaita males (76%) and Western females (86%) reported the highest percentage of no STIs.

More males utilised clinical treatment for STIs (70%) than non-clinical or no treatment (11%) and a higher percentage of Malaita (24%) and Honiara (23%) males reported no pain or infection than Western (17%) or Choiseul (4%) males. Over half of symptomatic female mainstream youth would usually choose clinical treatment, with those at higher risk ranging from 56% MARA to 93% increased risk. Only 10 overall would choose no treatment.

Seventy-four percent of those most-at-risk who were surveyed in Solomon Islands indicated they had attended an HIV prevention workshop with little variation by gender or age group. One hundred of school-based interviewees attended in comparison to 71% community-based. Attendance varied by place from 56% in Malaita, 71% Western, 80% Choiseul to 86% Honiara. These findings indicate gaps in healthcare utilisation, especially for those youth who are especially vulnerable and at increased risk and, as in the other areas, have implications for programme and policy development.
Communication for Behaviour Change

Newspaper

Fifty-nine percent (598) of youth who took part in this part of the survey read the newspaper once a week, but they varied by location.

By gender, 59% of males read once a week, 12% every day, and the remaining 28% did not read the newspaper. The readership pattern for females was virtually the same with 58% who read once a week, 17% who read daily, and 25% who did not read newspapers. There was little variation in frequency of reading by age group.

By type of reading, 50% of the sample read news and 21% entertainment with little variation by gender, age, and risk category. By location, there were slightly higher percentages reading news in Choiseul and Malaita Provinces and slightly lower percentages reading entertainment. By risk, those who read once a week ranged from most-at-risk at 32-42%, to especially vulnerable at 64-65%, increased risk at 56% and mainstream at 65%, an apparent inverse relationship.

Access

- All but one interviewee had access to a working radio.
- Virtually all had access to a working TV.
- Likewise, virtually all had access to a working mobile phone.

Radio

Ninety-one percent of these interviewees listened to the radio with little variation by age, gender, risk, and location except that the listenership was 10% lower in Choiseul Province. Within the sample of 549 who responded, only 51 or 8.5% said they did not listen to the radio. The majority (53%) listened almost every day in the early evening (45%) with little variation by gender, age, location, or risk category except that Choiseul was lower at 27%, Honiara higher at 69%, and EVYPs lower at 31%.

Their favourite radio programmes were music for 70%, news for 19%, and other types, including sports and health, for 2%. Their favourite radio stations overall were National Radio for 32%, FM96.3 for 28%, FM97.7 for 20%, and FM99.5 for 16.6%. There was variation in favourite station by location with the Honiara favouring FM97.7 (46%), Western FM96.3 (80%), Choiseul (50%) and Malaita (53%) favouring National Radio. The listening pattern for all groups and risk levels followed a curve with the largest numbers listening on the weekends and the lowest in the middle of the week.
Television

Fifty-nine percent of interviewees watched TV with 22% watching almost daily, 37% weekly, and 41% not at all. By gender, 49% males and 68% of females watched TV, including 62% of those in Honiara, 65% Western, 69% Choiseul, and 50% Malaita. By risk category, the percentage of most-at-risk youth who watched was about 15% lower and for especially vulnerable youth was more than 20% higher.

The pattern of watching by days of the week was almost identical to that of listening to radio with the exception that there were one-third to one-half as many TV watchers. The highest percentage overall (27%) watched in early evening, but fewer males than females watched in early evening and more in late evening; fewer young people in early evening and more in late evening than adolescents. The largest numbers preferred to watch movies (205), followed by sports (133), and news (110).
Source of Information

Current and preferred sources of information and advice on HIV and AIDS for these youth are shown below in Figure 87.

Their top five current sources at that time were: Clinic/Health facility (78%), Radio (46%), Youth Centre (16%), Peer Educator (19%), and Friends (25%). Their top five preferred sources of information were: Clinic/health facility (78%), Radio (38%), Youth Centre (16%), Peer Educator (18%), and Friends (20%). Their most trusted sources of information were: Clinic/health facility (73%), Peer Educator (8%), and Radio (5%). Those at higher risk and vulnerability made essentially the same choices. There was little difference between their current and preferred sources. In terms of trust, they rated radio slightly lower and youth centres slightly higher than their preferred sources.

Almost three quarters had attended a program on preventing HIV. Of those who attended, 50% attended 1-4 sessions, 12% 5-10 and 6% greater than 10. The most frequent venues were schools (22%), youth programmes (20%) and clinics (14%). Eighty-nine percent had heard an AIDS programme on radio, 92% have seen a poster and 83% seen a video on HIV or AIDS. Percentages were similar for all interview locations and risk categories.

Figure 86. Television programme preference
Summary
Differences between the mainstream youth and those at higher levels of risk and vulnerability in relation to Communication were:

1. By risk categories, those who reported reading the newspaper once a week ranged from MARAs at 32% to mainstream and EVYPs twice as high at 65%.

2. About 22% of those at mainstream, 30% increased risk, 24% EVYP, 21% EVA, 44% MARYP, and 41% MARAs reported not reading newspapers at all. It appeared that the percentages of those who read the newspaper decreased with increased risk.

3. Almost all males and females in this sample reported they had access to a working radio, working TV and working mobile phone, including all risk levels.

4. Ninety-one percent listened to radio with little variation by risk category.

5. The majority (53%) listen to the radio almost every day in the early evening (45%) with little variation by risk except that EVYPs were lower at 31%.

6. The listening pattern for all risk levels followed a curve with the largest numbers listening on the weekends and the lowest in the middle of the week.

7. About 59% watched TV across all risk categories with the exception that 15% fewer most-at-risk youth watched and 20% more especially vulnerable youth.

8. Those at higher risk and vulnerability made essentially the same choices as mainstream youth for their current, preferred and most trusted sources of information about HIV and AIDS. There was little difference between their current and preferred sources with health facilities at 75-78%, radio 38-46%, and friends 20-25%.

10. Percentages of those who reported attending a program on preventing HIV, hearing an AIDS programme on radio, and seeing a video on HIV or AIDS, including number of programmes attended and venues were essentially the same across all risk categories.
In summary the youth have reported on:

1. Their current access to means of receiving information;
2. Their patterns and preferences of reading, listening, and viewing;
3. Their current, preferred, and most trusted sources of information and advice on HIV and AIDS;
4. Their attendance to HIV prevention programmes by frequency and venue;
5. and whether they have seen a video, heard a radio programme, and seen a poster on HIV and AIDS.

Communication findings indicated that 59% read the newspaper once a week. Virtually all had access to a working radio, working TV, and working mobile phone. Ninety-one percent listened to the radio and 59% watched TV with listening and viewing patterns following a curve with the largest numbers on weekends and the lowest during mid-week. There was little difference between current, preferred, and trusted sources of information on HIV and AIDS.

Almost three-quarters had attended a program on preventing HIV, 89% had heard an AIDS programme on radio, 92% had seen a poster, and 83% seen a video on HIV or AIDS. This information should provide the basis for development and fine-tuning of communication programmes aimed at preventing unsafe behaviour, decreasing vulnerability, and promoting protective factors.
Discussions
General Population Youth and HIV

This section will address findings and issues related to general population Solomon Islands youth who were at least risk and vulnerability for HIV and AIDS in the four areas surveyed, Honiara area, Western Province, Choiseul Province, and Malaita Province. These youth were not engaged in high-risk behaviours, such as unprotected MSM or commercial and transactional sex, although some engaged in lower risk unprotected sex and/or multiple partners. They were not involved in IDU, which was reported by only one respondent in this survey. Although one-third used alcohol, only 2.5% of mainstream youth were frequent drinkers. They were neither in vulnerable situations involving forced sex or frequent substance use, nor in vulnerable settings, such as in prison or living on the street. Clearly, their general population, or mainstream, status was fluid and could change in relation to changes in their behaviours, setting, support, or level of vulnerability.

Demographic data revealed that essentially the same percentage of SI males (56.1%) and females (54.7%) could be considered to be mainstream or general population. A significant percentage of SI youth in this sample were not married (94.4%), not employed (77.6%), not in school (50.6%), and not living on their home island (36%) where they might have had community and family support. These youth indicated that lack of meaningful activities and support was a key factor contributing to their involvement with multiple partners and sex at an early age. Mainstream youth were found to be more likely than youth at higher risk and vulnerability to be living with their families and enrolled in school and less likely to be employed, married, separated, or divorced. These demographic findings are significant in relation to planning to reduce risk and vulnerability to HIV for SI youth.

Findings related to Knowledge of HIV and AIDS revealed a moderate to low level (32%) of comprehensive knowledge on HIV for mainstream youth, a disbelief that they were personally at risk (44%) for HIV, and a seeming lack of motivation to change their unsafe behaviour. The level of comprehensive knowledge for females and adolescents was much lower than that for males and young people, the school-based portion lower than the community-based portion and those in the Honiara area lower than those in other locations of the SI sample. It is of concern that their lowest levels of knowledge were related to not knowing that correctly using a condom or abstaining from having sex at all could protect them from becoming infected with HIV.

It is of at least equal concern that although three-quarters of the youth surveyed could answer the question correctly about condom use, only 34% of mainstream youth who had sex used a condom the last time they had sex and an even lower percentage (26%) of those who had high-risk sex. General population youth had among the lower scores for comprehensive knowledge of HIV and AIDS and for belief in their personal risk of HIV infection. Interviewees described the reasons for their personal risk as including nightclubs, prostitutes at logging camps, untrustworthy sexual partners, and their youthful desire. The quote given in response to why they are at personal risk, “Because of carelessness in having sex with random people”, is a clear expression why influencing behaviour in relation to safer sex among mainstream youth will be difficult. An added difficulty is linked to their firmly-held belief that you cannot get pregnant or contract HIV if you only have sex once.

Findings related to Attitudes shed light on problematic issues related to promoting safer sex for mainstream youth. Only one-third of sexually active mainstream respondents reported using a condom at last sex and 45% ever using a condom. Both mainstream youth and those at high risk and vulnerability used condoms for the purpose of pregnancy prevention at a higher rate than for prevention of STIs, including HIV. One of their quotes, “Not looking after myself”, seemed to be an apt description of their attitude to condom use.
The lowest percentage who said they wanted to use a condom the next time they had sex were mainstream youth at 78.7%, while those at higher risk and vulnerability ranged from 86% to 96.9%. Nonetheless, the actions of mainstream youth did not support their stated desire to use a condom since only one-third used a condom at last sex and 26% at last high-risk sex. It is important to carefully consider the circumstances of their failure to use condoms. Seventy-nine percent of mainstream youth knew where to get a condom and 94% knew that condoms were free. Although 69% said they would obtain a condom from a health clinic, if they were going to get one, only 48% had ever obtained a condom.

The most frequent reasons they gave for not getting a condom were that it was embarrassing (55%), people might recognise you (17%), distance (15%), people might see you (5%), and staff were unfriendly (3%). Youth in FGDs said they were “shy to ask – if run out, don’t go to get”. They recommended having condoms available in the villages and distributed by youth. They also said that condoms did not feel good, were not available when they needed one, and might lead to people thinking they were having sex.

It was a positive finding that fully 72% of mainstream youth said that their parents talked with them about their sexuality and prevention of HIV, because their parents were their first choices to talk with them. The percentage of parents talking to youth at higher risk and vulnerability was lower than for mainstream youth, ranging from 54% to 65% with the exception of EVAs at 75%. Their current and preferred sources of help and advice about HIV prevention in order of preference were family, friends, and “other” including community leaders or chiefs.

The reported use of marijuana by SI youth is relatively low (15.2%) and almost three-quarters of them said they would refuse to use marijuana if offered by their friends. However, school-based youth reported in FGDs that their friends smoked or sniffed marijuana.

Although 36.5% would live in the same house with a PLWHA, some expressed strong feelings of embarrassment, fear, hatred, and suspicion concerning HIV status in relation to a girl dropping a condom or boy seen leaving an STI clinic. These attitudes appear to have cultural aspects and will be important factors in potential for success of interventions to lower risk and vulnerability to HIV AIDS.

Most-At-Risk Youth and HIV
This section will address findings and issues related to Solomon Islands youth who are most-at-risk for HIV and AIDS in the four areas surveyed, Honiara area, Western Province, Choiseul Province and Malaita Province. These youth are engaged in at least one of three high-risk behaviours driving spread of HIV and AIDS in Solomon Islands: a small number practicing unprotected MSM, male and female commercial and transactional sex, and unprotected sex with those having sex with sex workers. IDU was reported by only one interviewee in this sample and by one focus group discussion in which female students had heard of young people injecting drugs with their own needles in Malaita Province. This section will address briefly address the limited MSM, and commercial and transactional sex. The next section will address issues contributing to vulnerability and risk, including: forced sex, early onset sex, unprotected sex, frequent substance use, multiple partners, and vulnerable settings, such as living on the street or with someone who forces sex. As with mainstream youth, their most-at-risk status can change in relation to changes in their behaviour, setting, support, or vulnerability.
Men Having Sex with Men (MSM)

Although mapping workshop results indicated some men practicing MSM in each province surveyed in SI, mapping workshop attendees did not identify specific sites where the research team could purposefully find and interview them, such as in “gay houses or bars”. Nonetheless, KAP questionnaire survey results revealed five men who practiced MSM were included unintentionally in the questionnaire survey sample in schools and communities. Additionally, school-based FGDs indicated students were familiar with and had heard of MSM practice in Auki and Kilusakwalo of Malaita Province, including a young boy who “went with” an expatriate with money and those involving boys who looked like girls.

These findings are similar to those of the SI SGS, in which two males indicated having sex with males among 592 youth aged 15-24 years, including 263 sexually active males (0.8%). The SGS BSS involved a convenience sample of youth interviewed by trained youth volunteers in Honiara “hotspots”, Gizo, Munda and Noro in Western Province, and Auki in Malaita Province. Considering the fear of stigma, discrimination, and embarrassment related to MSM, it is highly likely that MSM was under-reported in both SI surveys.

These KAP survey questionnaire findings indicated that the following types of MSM occurred among these SI youth: MSM for curiosity (3 of 5), MSM for money or trade (4 of 5), unprotected MSM (4 out of 5), early onset MSM before 15 years of age (3 out of 5), MSM among men who prefer sex with men (1 of 5), and forced MSM (1 out of 5).

The five MSM constituted 2.1% of SI sexually active male interviewees. Their distribution among sexually active males was: by place, three of five in the Honiara area and two of the five in Western Province; by age group two of five adolescents and three of five young persons; and by interview site was zero school-based and five community-based. The research team was not able to interview prisoners in SI.

In relation to their risk behaviour: four of five men were having unprotected sex with men; their number of sexual partners ranged from 1-6; first sex for three of five men was younger than 15 years of age; and three of the five had experienced forced sex, one by a female and one by a male with the others unspecified, opposed to 27.6% ever forced for males who did not have sex with males.

Receptive anal sex is known to be up to 10 times more efficient than vaginal sex in transmitting HIV. Some men engaged in MSM practice reported also having sex with females, both forced and consensual. Based on their low rate of condom use (1 of 5), relatively high number of partners (1-6), and sex with females, unprotected MSM with multiple partners has the potential to contribute further to the spread of HIV among SI MSM youth and beyond to the broader Solomon Islands community. There were no data yet available on whether any HIV positive and/or AIDS case in SI was linked to MSM.

Although the number reporting MSM in this survey was relatively low, if the numbers are extrapolated to the entire population of 15-24 year old males in SI, the number would be roughly 925. Taking into account the likelihood of under-reporting, the contribution of unprotected MSM practice with multiple partners has the potential to contribute significantly to the spread of HIV beyond MSM and increasing risk and vulnerability to SI youth. Programme and policy development are critical to address this potential spread and increased risk and vulnerability.
Commercial and Transactional Sex

Solomon Islands participants in each mapping workshop indicated that the research team would find high-risk commercial and transactional sex in each site that was surveyed. The Solomon Islands 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. Community and school-based youth in FGDs indicated that they or their friends were having sex for money or gifts in all but one group of younger school-based girls. Likewise, only one school-based group indicated that they or their friends had sex for food.

In Choiseul near one of the logging camps, secondary school-based girls indicated their friends had sex for money with two to three local or foreign logging workers per night. A group of young mothers in a Choiseul logging camp village indicated that their friends had sex for money to buy cigarettes but not drink. School-based girls in Auki, Malaita Province, said some of their friends had sex for money in the logging camp or with business or rich men because of family problems and lack of family support.

Boys also had sex for money with married women. Auki school boys also said their friends had sex for money but that many boys and girls were forced in the villages or market. Kilusakwalo students, Malaita Province, told of both boys and girls having sex for money because they were unemployed and it was an easy way to get money in one night. Some had been chased from their houses and some just wanted to eat good food or buy clothes when they had no parental support.

Comparing these findings with those of the SI SGS 2008 indicates that the percentage of sexually active males having sex for money was similar for this survey (6.5%) as for the SGS (6.2%) but that the percentage of sexually active females was higher for this survey (18.7%) than for the SGS (5.3%). Concerning transactional sex, the percentage among males for this survey was 5.2% and for the SGS was 10.5%. For females, the percentage for this survey was 16.5% and for the SGS was 5.8%. The underlying reason for the higher percentage of females reporting both commercial and transactional sex is unclear but probably relates to differences in sampling and survey protocols. This survey included one-third who were randomly sampled from schools and the remainder being purposively recruited from places defined by mapping workshop participants as places where the research team could find higher risk youth as well as general population youth. This survey questionnaire took between 45 minutes to an hour to administer versus 20-25 minutes for the SGS. Although percentages of males and females by age group were relatively similar, the distribution of females by age for this survey included a slightly higher percentage of adolescents (67%) compared to the 2008 SGS (61%).

These KAP survey questionnaire and FGD findings indicate that the following types of commercial and transactional sex could be found in SI: sex for money (60%), drugs or alcohol (3.2%), survival/need food (7.9%), forced sex (11%), and other reasons (15.9%), including desire for luxuries, curiosity, and sex stimulated by pornography or substances. Only one-third (33.9%) reported using a condom at last sex and thus 66.1% were having unprotected sex with multiple partners.
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%). They were distributed as follows: 23.3% in the Honiara area, 7.9% in Western Province, 13.1% in Choiseul Province and 10.1% Malaita Province; by age group, 10.1% adolescents and 15.1% young persons; and by interview site was 3.9% school-based and 15% community-based. The distribution for those reporting transactional sex was almost the same.

In relation to their risk behaviour: two-thirds were having unprotected sex in comparison to about one-half for those not having commercial or transactional sex; first sex younger than 15 years of age for 70% versus 18%; forced sex for 59% versus 35%, and first sex forced for 24% versus 20%. Their reported number of sexual partners according to FGD was not exact, but often 2-3 or “several” per night. The distribution for those reporting transactional sex was almost the same.

The highest percentage of those engaging in commercial and transactional sex because they needed money (68%), followed by were forced (12.5%), needed food (8.9%), needed drugs or alcohol (3.6%), and other reasons. Two-thirds lived with their family and one-third lived with relatives, friends, or in an academic dorm or employer’s hostel. Those who lived away from their family had commercial sex because they needed money at twice the rate as those who lived with their family; were forced at 2.5 times the rate of those who lived with their families; needed food or drugs and alcohol, while none who lived with their families had that reason for engaging in commercial or transactional sex.

Those youth engaging in commercial and transactional sex were using condoms for both high-risk sex and last sex at a lower rate than other youth; the percentage who had initiated sex before 15 years of age was almost four times higher than for other youth; they had experienced forced sex at almost twice the percentage as other youth; and their first sex was forced for 4% more than for other youth. Increased risk and vulnerability related to unprotected commercial and transactional sex is significant and can be expected to be difficult to reduce in relation to the compelling reasons for youth engaging in it: needing money, food, drugs and alcohol, desire for nice things, and sometimes involving force or family pressure.

**Vulnerable and Increased Risk Youth**

This section will address the findings and issues of Solomon Islands youth who are in between those who are general population, or mainstream, and those who are most-at-risk. For this report, the terms EVA and EVYP have been used to indicate those who are especially vulnerable. The report also uses “Increased Risk” as a term for those who have more risk and/ or vulnerability than mainstream, but are not most-at-risk. This section will address issues that contribute to their risk and vulnerability, including: forced sex, early onset of sex, unprotected sex, and substance use. The youth in this category may be seen as not necessarily ready to initiate high-risk behaviours, such as MSM or sex work; however, these contributing factors may force or influence them to engage in behaviour that is unsafe, although not at the highest risk level. Thus, it includes youth who may have unprotected sex with numerous partners, may endure ongoing forced sex, may initiate sex at a very young age, and may not be able to make sound decisions while under the influence of substances. It also includes the young men and women in prison or partners of seafarers who may have unprotected sex that exposes them to HIV.
Forced Sex

Forced sex is a harsh reality for Solomon Islands youth. Thirty-eight percent of the sexually active youth in the survey sample reported forced sex with variation by place from 23.3% in the Honiara area to 68.3% in Choiseul Province; and by gender from 27.8% for males to 48.9% for females; and with little variation by age group or school or community-based location of the interview. Forced sex was at its lowest rate for mainstream youth (17.3%), and increased by level of risk to the highest rate (82.4%) for EVYPs at almost five times the rate for mainstream youth. Those 71% who said they were still vulnerable ranged from 37% for mainstream youth to 100% EVYPs and by place from 52% for Western Province to 93% for Choiseul.

First sex was forced for 20.4% of sexually active youth with variation by place from 13.5% in the Honiara area to 45.9% for Choiseul – about three times the rate of the Honiara area and the other sampled provinces that had little variation. As with forced sex, the variation by gender was from 16.2% for males to 24.8% for females; by age group was 17.7% for young people to 22.7% for adolescents; and by location of interview was 27% for school-based and 18.3% community-based. By risk category, 8.2% mainstream youth experienced first sex forced, increasing to 13% for increased risk youth to 51.5% for EVAs. Among the 71% who said they still felt vulnerable, the variation by risk category ranged from 37% for mainstream youth to 100% for EVYPs and by location from Western Province at 52% to Choiseul at 93%. Males most frequently reported they were still vulnerable because they were living in the same house with the forcer, while females most frequently reported that the forcer was living in their neighbourhood.

Over two-thirds of youth from Choiseul Province reported they had been forced to have sex when they did not want to – over twice as high as other sites. Furthermore, 93% still felt vulnerable compared to 65% for other sites. In Choiseul, first sex was forced for 46%, almost three times higher than other sites. The rate of forced sex for Choiseul females was 1.5 times higher than for males. More than one-third of females reported that their uncles were the forcers and half the males indicated that males were their forcers, including one who specified an uncle. Males also reported girlfriends and older women as forcers. Students reported in FGDs that rates of forced sex were higher when forcers used alcohol.

Forced sex has implications for HIV risk and vulnerability in that it is rarely protected sex. In addition, the IATT cites global research indicating that sexual abuse is associated with low self-esteem and often precludes sex work,25 making it less likely that young sex workers would insist on safe sex. Thus, SI youth who experience forced sex and forced first sex bear significant potential exposure to HIV, as well as a significant contributing factor to engaging in unsafe behaviour. Clearly, youth in Choiseul Province are at significantly higher risk and vulnerability than other SI youth due to forced sex and forced first sex.
**Early Onset Sex**

The percentage of those who had first sex before 15 years of age in Solomon Islands was 14.9% of sexually active 15-19 year olds sampled. However, a closer look at the data indicates that the percentage was almost three times higher in the Honiara area than in Malaita Province; 3% higher for females than for males; and over two times higher for community-based than for school-based youth.

The difference between mainstream youth and those at greater risk was dramatic, with mainstream youth at 2.7%, increased risk at 24%, and MARAs at 32.4%. Although first sex was delayed to 15 years or older for 85.1% of SI youth and 90% of those in Malaita Province, the remaining youth reported having sex as young as 7 years. Students in FGDs report that their classmates have first sex at 10-15 years of age.

There is obviously a relationship between these findings and those for forced first sex, which was reported by 20.4% of sexually active youth in Solomon Islands, 52% of EVAs, 25% of females, and 46% of youth in Choiseul Province. Their first sex was forced for 26% of those who had first sex before 15 years of age in Solomon Islands, compared to 22% of those who had sex at age 15 years or older. In Choiseul Province, first sex was forced for 38% of those who had early onset sex and 55% of those who had sex at age 15 or older.

Clearly these findings indicate that forced first sex is a significant contributor to early onset sex in SI, particularly in Choiseul Province, and to increased risk and vulnerability related to the number of those who have sex before 15 years of age. Furthermore, these findings have implications for programme and policy development.

**Unprotected Sex**

In Solomon Islands, attitudes toward condom use involve complicated and strong cultural beliefs. If a girl they know and respect dropped a packet that they realised was a condom after picking it up, 12% would be impressed that she uses a condom and 27% would feel it was not their business and would give it to her; but 15% would be embarrassed and not give it to her, another 34% would also be embarrassed but would give it to her, and 9% would be shocked by her behaviour.

The remaining respondents answered “other”. A review of the reasons they give indicates that the majority would have strongly negative feelings toward the girl, including fear, hatred, and suspicion. A lesser number would try to help her and slightly less would laugh at her. A few would assume she has HIV or is a prostitute and avoid her. Some of those with strongly negative reactions are themselves having sex but the dropped condom seems to be a public admission that makes it obvious and not culturally acceptable.

Overall reported condom use at last high-risk sex (with a non-regular partner) was lower at 32.8% than for last sex at 37.3%. The highest percentage of use at last high-risk sex was reported by EVAs at 52% with only 2% difference between the reported 52% for last high-risk sex and 54.5% for last sex. The lowest percentage reported condom use was for mainstream youth at 26% for last high-risk sex and 34% for last sex.
In addition to increased risk of HIV, teen pregnancy and other STIs can result from unprotected sex. Data from FGDs involving school-based youth and KII with school principals revealed that sometimes in the case of teen pregnancy, both the boy and girl had to leave school, but usually only the girl, who might also be chased from her home even if she was pregnant due to being raped. Key informant family members indicated that in some cases, families were angry in the beginning, but eventually accepted their pregnant daughter.

The combination of sporadic condom use with many partners – involving “more the better” lists with 6-7 partners in one night – contributes to risk and vulnerability for youth in Solomon Islands. Religious beliefs and school rules prevented some youth from having access or using condoms. FGDs indicated that youth were shy to ask for condoms and did not go to get if they ran out. They said that clinics were not youth-friendly, were frightening, and that staff did not talk kindly to them. Many youth also believed that sex with condoms was not as enjoyable or intimate as skin to skin sex.

Attitudes toward condom use in Solomon Islands involve complicated and strong cultural beliefs which must be considered when programmes and policies for increasing the percentage of youth practicing safer sex are being developed.

Substance Use
One issue of concern in relation to HIV and AIDS risk and vulnerability in Solomon Islands is substance use. Increased risk related to substance use is 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% with variation by risk category, from 2.5% for mainstream youth to 11.6% for MARYPs; by gender, from 3.5% for females to 7.3% for males; by age, from 3.6% for adolescents to 7.8% for young people; and by location of interview, from 4.2% for school-based to 5.8% community-based sample. Males consistently used substances at a higher rate than females; a higher percentage of young people used alcohol, homebrew/ kwaso, betel and tobacco than adolescents; and a higher percentage of those in the Honiara area used alcohol, homebrew or kwaso and kava.

Mapping workshop participants indicated that substance use contributed to risk and vulnerability for HIV and AIDS in all areas surveyed. Alcohol and kwaso use was specifically mentioned in all areas. Additionally, participants specified: homemade beer, homebrew, betel, marijuana, Angel’s flower, ecstasy, speed and ice. They said that bars did not enforce restrictions related to youth using alcohol and said when bars were closed, ad-hoc bars sprung up. In addition to intoxication of youth, they cited the need for money to buy drinks or cigarettes as leading to commercial and transactional sex by youth. They also indicated that parents’ drinking led to negligence of children, sending their children to have sex for money and incest.

Youth in FGDs indicated that they and their friends used substances that contributed to the likelihood of early onset sex, unprotected sex, and sex with multiple partners. They said that forced sex was more likely when the forcer(s) drank kwaso or other alcohol. In Auki, schoolgirls indicated their classmates drank kwaso and smoked marijuana in nightclubs or “other” places on weekends.

Only one of the 604 KAP survey respondents reported IDU, an adolescent male who was part of the community-based sample in Choiseul Province. Among this survey sample, 15.6% said they currently used drugs, including: marijuana, ecstasy, ice, speed, and prescription drugs.
Health Service Utilisation

Health and social services utilisation is relatively low for youth, especially since it is a major source of information for them on HIV and AIDS and condoms. Fifty-four percent of male interviewees and 60% females had talked to a health worker about HIV and AIDS. Malaita Province was the only area where males talked to health workers about HIV and AIDS at a higher percentage than females. The variation by risk category was similar for both males and females in that numbers were low and there was no apparent pattern.

Fifty-two percent of males and 60% females had obtained and used a condom from a health clinic, with Choiseul and Malaita Provinces the only areas where males had a higher percentage than females. The variation by place for youth utilising clinics for HIV and AIDS information and condoms was similar in that Choiseul Province had the highest percentages and Malaita Province the lowest. Young people had a higher percentage of utilisation than adolescents.

Seventy percent symptomatic males and 66% symptomatic females sought clinical treatment for STIs, ranging among males from 44% MARAs to 74% increased risk, and among females from 55% mainstream youth to 93% increased risk. By location, the lowest percentage seeking STI treatment from a clinic for males was 67% from Choiseul and Malaita to 74% in Western Province, and by location for females ranged from 49% of those in Malaita Province to 95% in the Honiara area. Over 72% MARAs and 77% MARYPs had been reached by HIV Prevention Programmes.

Females in Choiseul reported the highest percentages (19%) of more than five STIs in the past year by almost three times higher than females in Honiara, the next highest. Choiseul males also reported the highest percentage (4%) of 1-5 STIs in the past year.

These findings indicate gaps in health care utilisation, in particular for especially vulnerable and at increased risk youth, and have implications for programme and policy development. Youth provide their perspective on low levels of healthcare utilisation in data from FGDs. As far as obtaining condoms from a health worker at a clinic or hospital, the clinics are often at a distance and they are not able to reach them; they are shy to ask at the clinic and consider healthcare workers to be frightening, unkind and not friendly; sometimes condoms are not in supply; they worry about whether condoms are safe because they have been told in awareness sessions that condoms are not 100% safe; many do not know how to use condoms; they consider that sex with a condom does not feel good; and they do not have a condom because they do not plan to have sex and say that it comes as an accident.

They recommend that condoms be available locally in their villages, that condom dispensers be set up, and that youth be appointed to distribute condoms with a male distributor for males and female for females. They have similar problems with obtaining advice at a clinic, considering that the clinic or hospital is a place for sick people and that staff are too busy to advise them. They recommend youth-friendly clinics or centres; community-based awareness programmes including drama; church groups providing awareness and youth activities; island-wide activities for youth; sports; awareness provided to entire families; and families being assisted to learn how to talk with their children.
Communication

Lack of access limits the types of communication modes that would be most effective to reduce risk and vulnerability to HIV and AIDS for youth in SI. Communication findings indicated that 59% read the newspaper once a week. Virtually all had access to a working radio, working TV, and working mobile phone. Radio and newspapers provided the broadest coverage. Furthermore, radio was one of the most preferred sources of information for these youth.

Ninety-one percent listened to the radio and 59% watched TV, with listening and viewing patterns following a curve with the largest numbers on weekends and the lowest during mid-week. There was little difference between current, preferred, and trusted sources of information on HIV and AIDS. Almost three-quarters had attended a program on preventing HIV; 89% had heard an AIDS programme on radio; 92% had seen a poster; and 83% seen a video on HIV or AIDS. However, there is no data to assess the effectiveness of these awareness activities. In fact, it appeared that those youth who had attended a programme on preventing HIV, seen a poster, and listened to a programme on the radio had higher percentages of commercial and transactional sex and no condom use at last sex than those who did not. Those who had watched a video on HIV and AIDS appeared to have lower percentages of the same risk behaviours than whose who had not. Further research would be required to control for confounding factors.

Data provided by youth in focus group discussions provides important details to the above data. For those in more rural or remote locations, reading the newspaper is dependent on the papers arriving by plane, someone bringing a paper to the village, and youth being allowed to read an adult paper; radio listening is dependent on having enough batteries for the radio and TV viewing on having adequate fuel.
### Review of Findings and Recommendations

#### Knowledge of HIV and AIDS

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| 1. Knowledge of HIV and AIDS  
Youth had strong feelings about the issues of HIV prevention and awareness programmes and HIV testing. They expressed the need for more programmes that were coordinated rather than episodic, often once a year. They advocated for inclusion of PLWHA in presenting information to them, with even those on remote islands mentioning PLWHA who had spoken to them by name. And they advocated for better access to awareness programmes and HIV testing.  
Youth recommended ongoing HIV and AIDS awareness activities, rather than once or twice a year.  
Youth reported that awareness activities are most effectively presented by PLWHA.  
Knowledge does not appear to be translated to safe sex behaviour by youth.  
Survey results demonstrate that awareness activities are needed by all groups, as lack of comprehensive knowledge and unsafe behaviours are apparent within all groups.  
IATT advocated youth participation in planning and decision-making regarding HIV interventions. | 1.1 Assure that HIV and AIDS awareness is addressed in a comprehensive, rather than an episodic manner. Include presentations by PLWHA.  
1.2 Find ways to link awareness activities to behaviour change. Monitor improvements in knowledge level and safe behaviours.  
1.3 Be sure that activities are available in schools as well as communities, to females as well as males, to adolescents as well as young people, and to MSM as well as those not having MSM.  
1.4 Engage youth in designing and implementing programs to achieve active instead of passive learning. | Work with schools and communities to assure that ongoing comprehensive programmes are developed and implemented for all groups, including awareness activities and youth-friendly condom distribution.  
Develop activities for youth, including sports for all and volunteer work, to engage them in productive activities and build protective factors. |
| 2. HIV Testing  
Only 7.8% sexually active young people surveyed in SI had been tested and received results. | 2.1 Make a clear decision whether wide-spread population-based HIV testing is a priority at this level of HIV epidemic in SI. If the answer is "yes", plan and monitor how testing will be carried out, how the programme will assure delivery of results, and engage schools, communities, and health providers in the planning process. If the answer is "no", plan and monitor the same issues for the subsection of young people who feel they have reason to be tested. | Should a policy of HIV testing and delivery of results is to be followed, accountability, utilisation of results and adequate funding need to be allocated to follow this policy. |
### Review of Findings

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<th>2. HIV Testing</th>
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<td>Testing was reported to be relatively low for all sampled areas except for Western Province. Only 3% of adolescents compared to 13% young people, and only 4% school-based, compared to 9% community-based, were tested and had knowledge of their test results.</td>
<td>2.2 If HIV testing is to take place on a comprehensive basis, plan and monitor how services will be provided to those in remote provinces, for adolescents and school-based youth.</td>
<td>Planning need to involve all those who will be expected to contribute to carrying out testing activities as well as input by intended recipients.</td>
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<td>Of the 9% who reported to have been tested in SI, only 5.8% had received their results.</td>
<td>2.3 If HIV testing is to take place, plan and monitor whether those who have been tested receive their results and whether those who test positive are lost to follow-up.</td>
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### Review of Findings and Recommendations

#### Attitudes

1. **Attitudes**
   Youth strongly felt that parents were the best ones to talk to them about sexuality and preventing HIV, and recommended that there be programmes to teach parents to talk to their children. Although only one-third of them were willing to live with a PLWHA, they were not afraid of Stanley and Alice, PLWHA who had spoken with them about preventing HIV and AIDS. They recommended that programmes be initiated to help youth stop using alcohol and other substances. They also strongly recommended that church groups and other organisations initiate youth activities and that youth-friendly centres or clinics be established.

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<td><strong>1.1 Attitudes on condom and treatment of STIs, including HIV</strong></td>
<td>Meet with young people to gain a better understanding of why they would fear, hate, laughing at, and feel embarrassment about someone who uses a condom or gets treatment for STIs. Ask for their advice in overcoming these attitudes. Take these intense attitudes into account in developing programmes for increasing condom use or preventing and treating STIs, including HIV.</td>
<td>Impacting these strong attitudes and emotions will require deliberate programme planning and evaluation plus dedicated funding and accountability to develop and implement programmes that provide a safe, friendly place for youth to get advice, help and condoms; workshops to train parents to interact with their children; sessions with youth to get their input on dealing with negative attitudes toward condom use and STI, including HIV treatment; monitoring marijuana and other substance use; and effective awareness programmes to teach youth about relative risk of HIV and how to use condoms.</td>
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<td><strong>1.2 Attitudes on parents talking to children</strong></td>
<td>Plan activities and workshops for parents, or, if acceptable, for parents and their children together to share results of the survey. Teach parents how to talk to their children about their sexuality and prevention of STIs and have practice sessions. Have the youth speak to their parents about the importance of being able to talk with them.</td>
<td>Purposively strengthen protective factors for supporting vulnerable and at risk youth.</td>
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<td><strong>1.3 Attitudes on risk of living in the same house with PLWHA</strong></td>
<td>Include information in awareness activities about lack of risks involved in living in the same house with PLWHA and similar scenarios. Involving PLWHA and their housemates in these awareness activities would add to the impact.</td>
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Regarding the situation where a girl dropped a condom packet, several respondents said they would laugh at or fear her as she might have HIV. Similar responses were elicited by the question about the boy coming out of an STI clinic. Their embarrassment, fear, and hate must be taken into account in programming for issues related to preventing and treating STIs including HIV.

Two-thirds of these interviewees said that their parents talk to them about issues of their sexuality and prevention of STIs including HIV.

Their parents are their first choice to talk with them.

Thirty-seven percent of those surveyed were willing to live in the same house with PLWHA.
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| If they were out with friends who offered them marijuana, 71% would refuse, 21% would accept, 3% did not know, 2% would inform their parents, and 2% would be shocked. | **1.4 Attitudes on marijuana use**  
Although marijuana use appears to be low at this time, it is important to continually monitor what substances youth are using in relation to the outside influences that can introduce new substances and to assure that youth are aware of the potential negative impacts of marijuana use. | |
| Their responses to the advice they would give a girl they know and respect about being pregnant, would overwhelmingly be to talk to her mother. For a boy asking for the same advice, the most frequent response would be to talk to his father. Focus group discussions revealed that parents’ attitudes about talking to their children about sex are so strong that they do not do so even when they understand clearly that they should. Likewise, youth are very threatened about getting help or advice or a condom that they do not do so even when they would like to use a condom the next time they have sex. | **1.5 Attitudes on who they would prefer to talk to**  
During meetings with parents, let them know that their children want and need to be able talk with them. Provide assistance to parents to learn how to talk to their children.  
Set up a safe place where youth can talk to someone for those cases where parents cannot overcome their avoidance of talking to their children about sex. The place should be friendly, unthreatening and safe. | |
### Review of Findings and Recommendations

#### Practices

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<td><strong>1. MSM</strong>&lt;br&gt;All mapping workshop participants indicated that MSM took place in their area. During FGDs, youth indicated that they were aware of MSM, although only five respondents reported practicing MSM. They were aware that MSM would hide due to fear of stigma and discrimination.</td>
<td><strong>1.1 Bring together a small group of mixed age MSM to participate in developing programmes to serve their needs for support and awareness and facilitate their participation in existing programmes.</strong></td>
<td>Seriously address the problem of forced sex for all persons in Solomon Islands, including youth and MSM. Develop and enforce a system that provides meaningful consequences to those who harm others.</td>
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<td>MSM in other Pacific Island Countries (PICs) have indicated a lack of service programmes available to meet their needs for information pertaining to safe sex and HIV prevention. It is likely that initiation of MSM and youth friendly services will gradually overcome their fear and bring MSM into contact with health and social service providers.</td>
<td><strong>1.2 As part of support provided to young MSM, establish a safe place where both in- and out-of-school youth, including MSM, can report forced sex, get a condom, or have their questions answered.</strong></td>
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<td>Young people, including MSM, have cited “no one to tell” as the reason they are unable to end their vulnerability to forced sex.</td>
<td><strong>1.3 Ensure that MSM can participate in other activities developed to serve youth without bullying.</strong></td>
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<td>Young MSM in other PICs have indicated that they are bullied by other youth.</td>
<td><strong>1.4 Ensure that condoms and information about HIV and AIDS are available in prisons.</strong></td>
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<td>The research team was unable to interview SI prisoners, but evidence from other PICs indicates that MSM among youth is taking place in prisons.</td>
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<td><strong>2. Commercial and transactional sex</strong>&lt;br&gt;Youth said that although some “naughty” boys and girls do commercial and transactional sex because they want to buy drinks and cigarettes, others need money for school fees or food if their parents will not or cannot support them.</td>
<td><strong>2.1 Convene broad group to discuss issues of commercial and transactional sex in their communities. Include all those who would need to be involved in developing interventions to reduce commercial and transactional sex and to practice harm reduction by promoting safer sex. Include traditional leaders, churches, educators, women and youth.</strong></td>
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<td>Among those 604 who participated in questionnaire, 56 youth reported having commercial sex and 48 transactional sex (41 of whom also practiced commercial sex).</td>
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**Review of Findings**

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<td>At least 8% of those selling sex did so for survival and an additional 11% were forced. Condom use for those practicing sex for money or trade was lower, at one-third than for those who were not. Forced sex was twice as high and early onset sex (before age 15) was 70% versus 18% for those who were not having sex for money or trade; forced sex at 59% versus 35%, and first sex forced for 24% versus 20%.</td>
<td>2.2 Initiate a support group involving church and community organisations that will address needs of those selling and trading sex, as well as those of the broader community. Include condom distribution.</td>
<td>Legislation must be developed to deal with those who are forcing youth to have sex when they do not want to. Developing services for a “safe place” will require dedicated budget, accountability, planning, and evaluation to address this serious problem. Cultural taboos on reporting crimes of rape and police attitudes encouraging reconciliation over prosecution lead to infrequent prosecution. (DOS Country Report)</td>
</tr>
</tbody>
</table>

3. **Forced sex**  
Youth do not easily talk about their forced sex, but the main reason they give for their ongoing vulnerability is “no one to tell”. It is important to note that they did tell the young data collectors. They also expressed their desire for a place where they can get help.

In SI culture, it is extremely difficult for youth to tell if the forcer is one of their family or someone who has power over them. They could not tell what happened due to tradition and respect. Additionally, they were scared to report to police, but would deal in a custom way so the case would not come out into the open. They were clear that boys were also being forced, by older women and girlfriends.

| Youth do not feel they have any option to escape their forced sex. | 3.1 Develop a safe place where youth can go to talk with someone and receive help in dealing with their forced sex – with sensitivity to prevent others from knowing. | Legislation must be developed to deal with those who are forcing youth to have sex when they do not want to. |
| The extent of forced sex and first sex forced is extreme, especially for Choiseul Province. Thirty-eight percent of sexually active youth reported that they had been forced to have sex when they did not want to with variation by gender from 27.8% for males to 48.9% for females, and with 68.3% forced in Choiseul Province, most of whom said they are still vulnerable (93%). | 3.2 Seriously address the alarming extent of forced sex by treating it as the urgent issue that it is for the wellbeing of Solomon Islands youth. Develop protective factors for vulnerable youth. | Developing services for a “safe place” will require dedicated budget, accountability, planning, and evaluation to address this serious problem. Cultural taboos on reporting crimes of rape and police attitudes encouraging reconciliation over prosecution lead to infrequent prosecution. (DOS Country Report) |
### 4. Substance Use

Young data collectors in Solomon Islands who contributed to this research were disturbed about the extent of drinking and smoking marijuana among the very young in SI. Not only did the adolescents lose control when drinking or smoking, but they also developed a need for money to support their substance use that led to commercial and transactional sex. Some said they had sex for money to obtain alcohol or drugs or for a drink or drugs. They felt that age restrictions for bars should be enforced and that drug and alcohol treatment programmes should be provided for youth.

Almost half of the survey sample reported using alcohol and over one quarter used kwaso or homebrew, three-quarters reported using betel nut and 40% smoked tobacco, with alcohol use ranging from 25% in Malaita Province to 58% in the Honiara area.

When they had first sex, 15.3% of this sample had consumed alcohol and 5.6% had taken a drug which made them want to have sex.

The overall rate of frequent alcohol consumption (more than three times per week) for this sample is 5.2%, varying between groups from 3.5% for females to 7.3% for males.

- **Recommendations:**
  - 4.1 Address the serious needs of youth related to frequent alcohol and other substance abuse by developing and enforcing policies and legislation that prevent supply of alcohol and other substances and access to drinking establishments to underage youth and provide meaningful penalties to those who do not adhere to these policies.

### 5. Condom Use

Youth had strong feelings about issues of obtaining condoms and condom use. They were discouraged at going to a hospital or clinic to obtain condoms, especially if the atmosphere was unfriendly. They were not able to travel long distances, especially when they sometimes found that the condom supply depleted. They wanted youth and shops to distribute condoms in their villages. In terms of using condoms, they preferred skin to skin and were easily dissuaded by partners.

Many chose not to get condoms due to embarrassment. The most frequent reasons were they were “embarrassed to ask”, “someone might know you”, or “someone might see you”.

As for not using a condom, among the reasons they gave are that: their partner did not want, they had sex with a regular partner, they were embarrassed to use, they did not know how to use, condoms were boring, they forgot, and condom use conflicted with their religious belief.

- **Recommendations:**
  - 5.1 Convene a youth advisory group to make recommendations to lower risk of unprotected sex by increasing condom use. Convene a group of health, education, and religious stakeholders to review youth recommendations and work with them to develop policies and programmes.

- **Policy Implications:**
  - Ask the group of health, education, and religious stakeholders to find acceptable solutions to issues of condoms not being allowed in schools and young people having unprotected sex due to religion.
<table>
<thead>
<tr>
<th>Review of Findings</th>
<th>Recommendations</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth and their partners also say they do not use condoms because they do not like the lack of feeling they relate to condom use and that condoms are boring. Eighty-four percent of those asked whether they wanted to use a condom at next sex said yes.</td>
<td>5.2 Explore the possibilities of obtaining condoms that can be marketed as being more pleasurable with consideration given to colour, texture, and scent. Actively involve youth in the planning.</td>
<td></td>
</tr>
<tr>
<td>When asked for their recommendations for lowering risk in the qualitative questionnaires, youth consistently suggest that youth be appointed to distribute condoms and that condoms be available in the villages in a youth-friendly model as opposed to a hospital or clinic.</td>
<td>5.3 Consider the recommendations by many youth in this research that youth be appointed to distribute condoms and that condoms be available in the community.</td>
<td></td>
</tr>
<tr>
<td>Many of those who did not use a condom said that they did not know how, they were unable to get, they do not want to use and that condoms are boring.</td>
<td>5.4 Address the issues of young males and females who do not know how to use a condom. Find a way to show them what a condom looks like, have someone tell them where to get it.</td>
<td></td>
</tr>
</tbody>
</table>
### 6. Early onset sex

Young data collectors were shocked at the extremely young ages the interviewees had their first sex. They also noted that youth were drinking, using drugs and engaging in unprotected sex at a very young age. They felt that it was critical for parents to take responsibility for teaching their children in order that they could mature to be the leaders of the future.

<table>
<thead>
<tr>
<th>Review of Findings</th>
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<tbody>
<tr>
<td>The percentage of those who had first sex before 15 years of age in SI was 14.9% of sexually active 15-19 year olds sampled. However, the percentage was almost three times higher in the Honiara area than in Malaita Province; 3% higher for females than for males; and over two times higher for community-based than for school-based youth.</td>
<td>6.1 Ensure that coverage of programmes to address early onset of first sex covers all subgroups, especially youth in remote areas.</td>
<td>Implementation of these recommendations will require a dedicated budget, accountability, programme development and monitoring of implementation. Development of programming for very young children at risk will require involvement of schools and communities, churches and all who can build support.</td>
</tr>
<tr>
<td>Age at first sex for this sample ranged from 7 years of age to 24 years old while that of their partners ranged from aged 10 to 50. For those whose first sex was before age 15, fully 26% were forced and the early onset was not by their choice. The percentage was highest in Choiseul Province at 46%.</td>
<td>6.2 Develop programmes to prevent forced sex of youth and to address perpetrators.</td>
<td></td>
</tr>
<tr>
<td>Programmes that begin at adolescence would be too late for 15% of those in this sample and in Honiara would be too late for 29%.</td>
<td>6.3 Develop educational programmes for young children that teach them the type of touching that must be avoided, that they have the right to say “No” to se and where they can go for help when needed.</td>
<td></td>
</tr>
</tbody>
</table>
### 7. Health & Social Services Utilisation
Youth have been clear about being embarrassed to utilise clinic-based services to discuss HIV and AIDS information or to obtain condoms. They are worried that they might be seen or that someone in the clinic will know them or that the staff will be unfriendly. They tend to ignore the risk of HIV and AIDS and that decreases further the likelihood that they will access information or condoms at the clinic.

<table>
<thead>
<tr>
<th>Review of Findings</th>
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<th>Policy Implications</th>
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<tbody>
<tr>
<td>Youth have been quite clear in their responses that although they trust clinical services they find most of them to be threatening or embarrassing to access, with some exceptions involving mostly individual nurses who have been helpful in providing them information or condoms without embarrassment.</td>
<td>7.1 Engage youth from all surveyed areas, adolescents and young people, school and community-based to provide advice to leaders in designing services that will be youth-friendly, village- and school-based and easy and unthreatening to access.</td>
<td>Provision of youth-friendly and appropriate services will require dedicated funding, a planning process involving youth, accountability and ongoing monitoring.</td>
</tr>
<tr>
<td>Even when individual providers have been friendly, most services are difficult for youth to access due to distance and waiting time. A youth-friendly clinic or drop-in centre provides the opportunity to build protective factors for youth who are vulnerable and at risk.</td>
<td>7.2 Decide if and when Solomon Islands can develop youth-friendly and accessible clinical services.</td>
<td>Successful implementation would require involvement of all sectors, including church, education, health, NGOs, and especially youth themselves.</td>
</tr>
</tbody>
</table>

### 8. HIV and AIDS Prevention Workshop Coverage for MAR
Youth perceive awareness programmes to be episodic and ask that they be systematic.

<table>
<thead>
<tr>
<th>Review of Findings</th>
<th>Recommendations</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth perceive awareness programmes to be episodic and ask that they be systematic.</td>
<td>8.1 Ensure that awareness workshops are carefully planned to be an ongoing part of a systematic HIV and AIDS education programme.</td>
<td>Successful implementation of these recommendations will require dedicated budget, accountability, comprehensive planning and monitoring of results to build protective factors for those at risk.</td>
</tr>
<tr>
<td>Current practices, such as condom use data, as reported in this survey, do not necessarily match the level of knowledge.</td>
<td>8.2 Monitor the effectiveness of workshops in changing reported behaviour as well as the level of knowledge about HIV and AIDS.</td>
<td></td>
</tr>
<tr>
<td>There is not a large difference in coverage by age or gender, but community-based coverage is higher than school-based and Honiara and Choiseul coverage is higher than the other provinces, especially Malaita.</td>
<td>8.3 Ensure that all groups are covered, whether in Honiara or more remote Provinces, male or female, school or community-based and adolescent or young people.</td>
<td></td>
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</tbody>
</table>
### Review of Findings and Recommendations

#### Practices

<table>
<thead>
<tr>
<th>Review of Findings</th>
<th>Recommendations</th>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote providers note that programmes from outside are not well coordinated with ongoing local programmes.</td>
<td>8.4 Ensure that the programme is implemented by an organisation that can provide ongoing coordination or that such an organisation partners.</td>
<td></td>
</tr>
</tbody>
</table>

#### 9. Communication

Youth consistently asked for more awareness. The impact of drama and stories by PLWHA was most vivid for them and seemed to have more potential for changing their behaviour. They liked technology but did not have much access. Almost all reported they had access to a working radio, TV and mobile phone, but those in remote areas could not always keep up with the information. Youth and service providers did not like having awareness available to them only at rare intervals. They wanted ongoing communication.

Youth have expressed shyness to approach health facilities despite trusting the information. Involvement of youth may increase the potential for knowledge leading to behaviour change for both those who are presenting and those who are the audience.

Youth have not always had access to reliable technology to keep up with the information. They did not have batteries for radio, or fuel for the TV that showed videos.

9.1 Engage youth in each area and province to help develop a programme for communicating to youth.

9.2 Ensure that awareness and communication programmes are not episodic.

9.3 Involve youth in presentations, whether workshops, radio programmes, print media, or any other communication. Train youth to be sources for other youth at youth-friendly clinics or drop-in centres.
This study set out to address three formative research questions:

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Conclusions</th>
</tr>
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<tbody>
<tr>
<td>What is the spatial and contextual nature of risk and vulnerability to HIV and AIDS among young people aged 15-24 years in selected areas of Solomon Islands?</td>
<td>Findings from mapping workshops, KAP survey questionnaires, FGDs, and KIIs demonstrated that 15-24 year olds in all survey locations were at increased risk and vulnerability in SI, but that the level of the risk and vulnerability varied by place, gender, age, and school or community-base of interview as described in the Findings and Discussion sections of this report. The major risk behaviours were commercial and transactional sex, and limited MSM. Little IDU was noted but there was enough to contribute to the level of risk and vulnerability. Those contexts increasing vulnerability in SI included: displaced populations, outside influences, poverty, forced sex, and substance use.</td>
</tr>
<tr>
<td>What factors influence current behaviours and could influence future interventions for those most-at-risk, especially vulnerable and the general youth population?</td>
<td>Factors influencing current behaviours and potentially influencing future interventions included: substance use, vulnerability to forcers, lack of family and community support, and youth activities. Condom use is currently influenced by unreliable supplies, inaccessibility of sources for youth, unfriendly providers, lack of confidentiality, religious and traditional beliefs, and embarrassment. These problems will continue to influence future interventions unless solutions are found. Possession of a condom is considered proof that the youth is having sex. Poverty coupled with money coming from the outside via loggers, seafarers, and tourists favours commercial and transactional sex. Lack of response to perpetrators of forced sex coupled with families and communities blaming the victim favour continuation of forced sex.</td>
</tr>
<tr>
<td>How do these youth currently receive information and advice and what communication methods are likely to be most effective in reaching them?</td>
<td>Youth consistently asked for more awareness, especially presentations by PLWHA, which have potential for changing their behaviours. They trusted health facilities and personnel as sources of information, but did not always find them friendly. They liked technology but their access was limited. Youth in remote villages were dependent on batteries for radios, fuel for generators to operate televisions or video players, and someone bringing newspapers from outside. Those villages were less likely to host awareness activities.</td>
</tr>
</tbody>
</table>
Among the most critical issues related to risk and vulnerability of youth in SI were the following:

- Exposure to outside influences and poverty leading youth and/or their parents to perceive an increased need for money that leads to sex for money or trade.

- A dramatic level of forced sex of children in Choiseul Province, as well as three times the percentages of more than five STIs for Choiseul females than any other area in 2009.

- CSEC, including child sex tourism, was often linked to logging, mining, and fishing in remote areas. High levels of child sex tourism, prostitution, and trafficking in Honiara, where it was reported there were at least 30 boys and 100 girls under 15 practicing prostitution.26

- Populations that were still displaced from the “tensions” and also from recent tsunamis. Most of these youth were not married, not employed, and not enrolled in school. Youth cited lack of activity and support as contributing factors for their involvement with multiple partners and commercial and transactional sex at an early age.

- Their level of comprehensive knowledge of HIV and AIDS was low (32%) and should be of concern. Moreover, their level of knowledge was not linked to their behaviours.

- Eighty-four percent said they wanted to use a condom “next time” but only 37% did use a condom the “last time”. The percentage of sexually active females practicing commercial sex (27%) was twice as high as for males. The percentage of those practicing transactional sex by sex was about the same.

- Nineteen percent females practiced commercial sex and 7% males with transactional sex about the same. Thirty-eight percent of sexually active youth overall had been forced to have sex, with 71% still vulnerable, and the rate for females almost twice that of males. Sixty-eight percent in Choiseul Province reported forced sex. The rate of forced first sex was 20% overall, but 46% for Choiseul Province.

- Substance use was common with 44% using alcohol and 28% using kwaso or homebrew and over 5% reporting they used alcohol more than three times per week. Youth also reported using ecstasy, ice, speed, and prescription drugs.

- Fifteen percent of sexually active youth reported early onset of sex of less than 15 years with some having sex as young as 7 years of age.
Observations of local youth data collectors have been woven into this report, but some are included in this conclusion due to their unique perspective based on their interviews with survey respondents. They observed that youth gained awareness of their risk through the interview survey process. However, they observed that high-risk youth thought they were safe and continued their behaviours. They said that despite the fact that youth could repeat HIV prevention slogans, they did not really understand such issues as how HIV was transmitted or how to put on a condom, and did not change their behaviours.

Some facts that surprised the data collectors were: the young age their respondents initiated sex and utilised substances such as kwaso and marijuana; the high rates of young teen pregnancy and abortions; that parents did not talk to their children even if they knew they were engaging in high-risk behaviours; and that boys were forced too. They observed that youth in Honiara were freer to move around than youth in rural areas where they could be raped on the road while walking to school. They recommended that families and communities work together to lower risk and vulnerability of their youth to HIV and AIDS.
This study has assessed knowledge, attitudes, utilisation of health and social services, family and community support, risk behaviours, preferences for receiving information, and what Solomon Islands youth recommend as most effective interventions to help them reduce their risk and vulnerability to HIV and AIDS. The needs and their recommendations are clear. The next steps must register an active involvement of all youth in planning and implementing services, accountability and monitoring of evidence-based services, and action by those who have the authority to reduce the context of vulnerability over which youth have no control. This report has no potential to contribute to reduction of risk and vulnerability for HIV and AIDS among Solomon Islands youth unless this evidence leads to action and those next steps are taken.
Annex 1: Definitions and Acronyms Used in This Report

Annex 2: References

Annex 3: Overview of Baseline Survey Methodology

Annex 4: CPAP Indicators for Solomon Islands
- Comprehensive Knowledge of HIV and AIDS
- HIV Test and Result Distribution
- Condom Use at Last High-Risk Sex
- Condom Use at Last Sex (15-19 years old)
- Age at First Sex
- HIV and AIDS Prevention Workshop Coverage

Annex 5: Solomon Islands Tools
- National Mapping Workshop Agenda (Separate workshops were also held in Munda and Gizo of Western Province, Taro Island of Choiseul Province, and Auki of Malaita Province)
- KAP Survey Questionnaire (English)
- Focus Group Discussion Prompts (Stakeholders and Youth)

Annex 6: Mapping Workshop Results
- Solomon Islands National Consultative Mapping Workshop Results
- Munda area, Western Province Mapping Workshop Results
- Gizo area, Western Province Mapping Workshop Results
- Choiseul Province Mapping Workshop Results
- Malaita Province Mapping Workshop Results

Annex 7: Survey Sites Selection
- Selected Honiara area survey site and reasons for selection
- Munda area, Western Province survey site and reasons for selection
- Gizo area, Western Province survey site and reasons for selection
- Selected Choiseul Province survey site and reasons for selection
- Selected Malaita Province survey site and reasons for selection

Annex 8: SOLOMON ISLANDS Research Team
Annex 1: Definitions, Acronyms used in this report

<table>
<thead>
<tr>
<th>Terms</th>
<th>Definitions</th>
</tr>
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<tbody>
<tr>
<td>Adolescent</td>
<td>15-19 years of age</td>
</tr>
<tr>
<td>Young Person</td>
<td>20-24 years of age</td>
</tr>
<tr>
<td>Youth</td>
<td>15-24 years of age</td>
</tr>
<tr>
<td>MARA</td>
<td>Most at Risk Adolescent</td>
</tr>
<tr>
<td>MARYP</td>
<td>Most at Risk Young Person</td>
</tr>
<tr>
<td>EVA</td>
<td>Especially Vulnerable Person</td>
</tr>
<tr>
<td>EVYP</td>
<td>Especially Vulnerable Young Person</td>
</tr>
<tr>
<td>Increased Risk</td>
<td>At more risk or vulnerability than most mainstream youth.</td>
</tr>
</tbody>
</table>

Most-at-risk young people are defined* as those who are:
- IDUs who use non-sterile injecting equipment
- Males who have unprotected anal sex with other males
- Females and males who are involved in sex work, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex
- Males who have unprotected sex with sex workers.

Especially Vulnerable Young People are defined* as those who are “one step away from engaging in high-risk behaviour”, because of such factors as:
- Displacement;
- Ethnicity and social exclusion;
- Having parents, siblings, or peers who inject drugs;
- Migration (internal and external);
- Family breakdown and abuse;
- Harmful cultural practices; and
- Poverty.

They also describe settings such as:
- Juvenile detention facilities and prisons; as well as situations such as living without parental care or on the street that cause young people to be Especially Vulnerable.

* Inter-Agency Task Team (IATT) on HIV and Young People


Annex 3: Overview of Baseline Survey Methodology

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Youth 15-24 years&lt;br&gt;Honiara area, Western, Choiseul and Malaita Provinces</td>
</tr>
<tr>
<td>Survey type</td>
<td>KAP Quantitative Questionnaire&lt;br&gt;Qualitative Focus Group Discussions (FGD) &amp; Key Informant Interviews (KII)</td>
</tr>
<tr>
<td>Sampling method</td>
<td>Community-based KAP quantitative questionnaire interviewees – non-random purposive selection&lt;br&gt;School-based KAP quantitative questionnaire and FGD student interviewees – random selection from non-random purposive school site selection&lt;br&gt;FGD, KII – non-random purposive selection interviewees</td>
</tr>
<tr>
<td>Inclusion criteria</td>
<td>Youth 15-24 - KAP quantitative questionnaires, FGD, KII&lt;br&gt;Stakeholders – FGD, KII&lt;br&gt;Key Informants – specialised knowledge of youth risk &amp; vulnerability</td>
</tr>
<tr>
<td>Interview locations</td>
<td>Schools- and community-based sites&lt;br&gt;Honiara area, Munda and Gizo areas of Western Province, Choiseul Province, Malaita Province</td>
</tr>
<tr>
<td>Administrators of questionnaire</td>
<td>KAP Questionnaire – Young Data Collectors&lt;br&gt;FGDs and KIs – Young Data Collectors, Field Research Assistants, International consultant.</td>
</tr>
<tr>
<td>Consent</td>
<td>Verbal with interviewee mark and interviewer signature</td>
</tr>
<tr>
<td>Time required</td>
<td>Average 45 minutes</td>
</tr>
<tr>
<td>Data collection period</td>
<td>July 10 – August 18, 2009&lt;--&gt;</td>
</tr>
</tbody>
</table>
**Annex 4: CPAP Indicator for Solomon Islands**

<table>
<thead>
<tr>
<th>CPAP Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Young people (15-24) who correctly identify ways of preventing sexual transmission of HIV – including delaying sexual debut, reducing partners, and use of condoms and reject major misconceptions.</td>
</tr>
<tr>
<td>1.2</td>
<td>Young people (15-24) who have been tested and know their HIV status.</td>
</tr>
<tr>
<td>1.3</td>
<td>Young people (15-19) who had first sex before age 15 and percent who delay age of sexual initiation.</td>
</tr>
<tr>
<td>1.5</td>
<td>Condom use at last high-risk sex for males and females 15-24 (at risk groups).</td>
</tr>
<tr>
<td>1.6</td>
<td>Condom use at last sex for sexually active adolescents (15-19).</td>
</tr>
<tr>
<td>2.2</td>
<td>Most-at-risk population reached by HIV Prevention Programmes</td>
</tr>
</tbody>
</table>
National Mapping Workshop Agenda (Separate workshops were also held in Munda and Gizo of Western Province, Taro Island of Choiseul Province, and Auki of Malaita Province)

KAP Survey Questionnaire (English)
Focus Group Discussion Prompts

Stakeholders
Youth
MINISTRY OF HEALTH NATIONAL CONSULTATIVE WORKSHOP
MAPPING HIV/AIDS AMONG SOLOMON ISLANDS YOUNG PEOPLE
July 6, 2009 – Honiara, SCA Conference Room – 10am – 3pm

I. Welcome and Introductions – Solomon Islands MOH and UNICEF

II. Purpose of Workshop

III. Background – Prior Mapping Results for Solomon Islands

IV. Focus on Most-at Risk (MARA) and Especially Vulnerable Adolescents (EVA) – definitions and rationale
   - What risk behaviours will we find in Solomon Islands?
   - What factors contribute to vulnerability in Solomon Islands?

A. MARA
   - Who are the MARA in Solomon Islands?
   - Where will we find the most serious MARA in Solomon Islands?

B. EVA
   - What groups are Especially Vulnerable in Solomon Islands?
   - Where are they located?

V. What are the underlying reasons for Solomon Islands risk and vulnerability?

VI. What are your recommendations for our research?

VII. Why did you choose these communities?

VIII. What do you believe needs to change to reduce risk?

IX. Summary of Workshop Results

THANK YOU!

KAP Survey for Ministry of Health & UNICEF Pacific HIV/AIDS Data Collection
Interview Guide Questionnaire for MARA/EVAs & General Youth

Please fill in blanks

Introductions: Hello, my name is ____________ and I am here as a Field Research Asst. for a study on young people in Solomon Islands for the Ministry of Health and UNICEF.

Purpose: We are trying to find out how to best protect young people in Solomon Islands from HIV. We would really appreciate any help you can give us in finding out about young people here.

Procedure: We would like to ask you some questions, in an interview which will take about 30-45 minutes. We would like to talk to you alone, but if you like, you can ask for a parent or guardian to be present at any time.

Assurance of Confidentiality: If you agree to take part in this interview, the things you tell me will be confidential. That means they will be private between you and me. We'll be asking young people from different places in the country the same questions. Afterward, we will keep your answers safe. I am not going to write down your name, but you can give me your first name if you wish.

Right to Say No: If any of the questions make you feel uncomfortable or you don't want to answer them, remember you do not have to talk about anything you don't want to. Do you have any questions?

Informed Consent: Are you willing to participate in this interview? If you agree, you can indicate your agreement verbally and I will sign here to say that I have witnessed your agreement. Do you have any questions about any of the things I have just said?

_________________________________________  ________________________________
Signature of Field Researcher (witness)          Date

Location of Interview:________________________ Interviewer Code #________
   Port Vila – 1  Choiseul 6
   Tafea 2  Malaita 7
   Malekula 3  Tarawa 8
   Honiara 4  Abemama 9
   Western 5

Specific site: __________________________ (specify)
   School 1
   Non-school site 2

Any other relevant info: ________________________________

_________________________________________
Interview ID # ____________________________
   (to be entered by Research Assistant)

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### Demographic Information

#### Question No. | Questions and filters | Coding categories | Skip to
--- | --- | --- | ---
1.1 | Circle sex of the respondent | Male 1 |  
Female 2 |  
1.2 | How many years old were you at your last birthday? | Age in years |  
--- |  
1.3 | Do you live with your family? Probe if no | Yes 1 | If Yes, skip to 1.5  
No 2 |  
--- |  
1.4 | If not, where do you sleep now? | Own or rented house? 1 |  
Relative's house? 2 |  
Friend's house? 3 |  
Academic dormitory? 4 |  
Employer's hostel? 5 |  
On the street? 6 |  
Somewhere else (probe) 7 |  
--- |  
1.5 | Are you presently living away from your home island? | Yes 1 | If No, skip to 1.7  
No 2 |  
--- |  
1.6 | What is your home island? |  | (to be coded afterward) |  
--- |  
1.7 | Are you presently attending school or college/university full time? Explanation if no | Yes 1 | If No, skip to 1.9  
No 2 |  
--- |  
1.8 | If yes, which level are you attending? | Primary School? 1 |  
Secondary School? 2 |  
1st or 2nd year? 3 |  
Beyond 2nd year? 4 |  
--- |  
1.9 | What is your marital status? | Never married, living alone? 1 |  
Never married living with family or friends? 2 |  
Living with partner? 3 |  
Married? 4 |  
Separated? 5 |  
Divorced? 6 |  
---

### Knowledge of HIV/AIDS
Now I'd like to talk to you about sexually transmitted diseases including AIDS.

#### Question No. | Questions and filters | Coding categories | Skip to
--- | --- | --- | ---
2.1 | Have you ever heard of diseases that are transmitted by having sex with someone who is infected? | YES 1 | If 2, 2.3  
NO 2 |  
DK 98 |  
--- |  
2.2 | Can you tell me the symptoms of sexually transmitted diseases? (Don't tell interviewee, tick those they mention) | Pain on urination 1 |  
Unusual discharge from your genitals? 2 |  
Sores on your genitals? 3 |  
Lower abdominal pain? 4 |  
Don't Know (DK) 98 |  
--- |  
2.3 | Have you ever heard of the virus HIV or an illness called AIDS? | YES 1 | If 2, 2.6  
NO 2 |  
DK 98 |  
--- |  
2.4 | Is there anything a person can do to avoid getting infected with HIV, the virus that causes AIDS? | YES 1 |  
NO 2 |  
DK 98 |  
---
### Knowledge of HIV/AIDS (continued)

<table>
<thead>
<tr>
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<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>What ways can people protect themselves from getting infected with HIV?</td>
<td>USE CONDOMS</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CONSISTENTLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HAVE ONE FAITHFUL STUDENT</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UNINFECTED PARTNER</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO SEX AT ALL</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABSTAIN FROM SEX</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AVOID SHARING</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NEEDLES OR OTHER INJECTING EQUIPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AVOID TRANSFUSION OF BLOOD NOT TESTED FOR HIV</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OTHER</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(SPECIFY)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DON’T KNOW ANY</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CIRCLE ALL MENTIONED.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MORE THAN ONE ANSWER POSSIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DO NOT READ OUT THE WAYS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DO NOT PROBE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If partially correct, explain.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Now I’m going to read out some questions about HIV, the virus that causes AIDS. Some of the questions have accurate information and others incorrect information. Don’t worry about getting the right answer, just say what you think.

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<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>Can a person who looks healthy be infected with the AIDS virus (HIV)?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.7</td>
<td>Can people protect themselves from the AIDS virus by using a condom correctly all time they have sex?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.8</td>
<td>“Do you think that a person can get infected with the AIDS virus through mosquito bites?” (Local misconception)</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.9</td>
<td>Can people protect themselves from getting infected with the AIDS virus by having one uninfected sex partner who also has no other partners?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
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<tbody>
<tr>
<td>2.10</td>
<td>Can people protect themselves from getting infected with the AIDS virus by not having sex at all?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.11</td>
<td>Can a person get infected with the AIDS virus by getting injections with a clean, sterile needle?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.12</td>
<td>Can a person get infected with the AIDS virus by sharing a meal with a person who has HIV or AIDS?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.13</td>
<td>Do you think you can get HIV by kissing, hugging, or sneezing? (Local misconception)</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.14</td>
<td>Do you think you are personally at risk of HIV infection?</td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DK</td>
<td>98</td>
</tr>
<tr>
<td>2.15</td>
<td>If you think you are not at risk, why do you think you are not? (Do Not Probe)</td>
<td></td>
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### Practices

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<tbody>
<tr>
<td>3.1</td>
<td>Are you sexually active, I mean have you had sex? By having sex, I mean vaginal, anal or oral sex between a man and woman, a woman and woman, or between a man and a man.</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td>If No, go to 3.20</td>
</tr>
<tr>
<td>3.2</td>
<td>Now I'm going to ask you about your experience of first sex? How many years old were you the first time you had sex?</td>
<td>Age in years ___ ___</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Did you want to have sex?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Were you physically forced to have sex?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Were you coerced by your friends or another person to have sex? (By coerced I mean convinced.)</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.6</td>
<td>When you first had sex, had you taken alcohol or kava?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>When you first had sex, had you taken any drugs which made you want to have sex?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.8</td>
<td>How old was the person you first had sex with? (If you don’t know exactly, can you estimate?)</td>
<td>Age in years ___ ___</td>
<td></td>
</tr>
<tr>
<td>3.9</td>
<td>If male - Some men have sex with other men. Have you ever had sex with a man?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td>If No, go to 3.11</td>
</tr>
<tr>
<td>3.10</td>
<td>For male only - Different men have different reasons to have sex with a man. In your experience, why did you have sex with a man?</td>
<td>Curious 1&lt;br&gt;Forced 2&lt;br&gt;Prefer sex with men 3&lt;br&gt;Other 4</td>
<td></td>
</tr>
<tr>
<td>3.11</td>
<td>Did you ever have sex for money?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.12</td>
<td>Have you ever been given food or a gift in exchange for sex?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td>If No for 3.11 &amp; 3.12, go to 3.17</td>
</tr>
</tbody>
</table>

### Practices (continued)

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</thead>
<tbody>
<tr>
<td>3.13</td>
<td>The last time you had sex for money, food, or a gift, did you or the person you had sex with use a condom?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td></td>
</tr>
<tr>
<td>3.14</td>
<td>Why do you have sex for money, food or gifts?</td>
<td>Need money 1&lt;br&gt;Need food 2&lt;br&gt;Forced by other people (pimps) 3&lt;br&gt;Need drugs 4&lt;br&gt;Other 5</td>
<td></td>
</tr>
<tr>
<td>3.15</td>
<td>Where do you have sex for money?</td>
<td>Bushes 1&lt;br&gt;Clubs 2&lt;br&gt;Kava bar 3&lt;br&gt;Other 4</td>
<td></td>
</tr>
<tr>
<td>3.16</td>
<td>Where do you have sex for food or gifts?</td>
<td>Bushes 1&lt;br&gt;Clubs 2&lt;br&gt;Kava bar 3&lt;br&gt;Market 4&lt;br&gt;Wharf 5&lt;br&gt;Other 6</td>
<td></td>
</tr>
<tr>
<td>3.17</td>
<td>Have you ever been forced to have sex when you didn’t want to?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td>If No, go to 3.20</td>
</tr>
<tr>
<td>3.18</td>
<td>Do you feel vulnerable to having the same thing happen again?</td>
<td>YES 1&lt;br&gt;NO 2</td>
<td>If No, go to 3.20</td>
</tr>
<tr>
<td>3.19</td>
<td>Why do you feel vulnerable?</td>
<td>Living in house with one who forced me 1&lt;br&gt;In neighbourhood with one who forced me 2&lt;br&gt;Person has power over me (teacher, boss, older relative) 3&lt;br&gt;Noone to tell 4&lt;br&gt;Nowhere to report 5&lt;br&gt;Other 6&lt;br&gt;Don't know 98</td>
<td></td>
</tr>
</tbody>
</table>
### Practices (continued)

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</thead>
<tbody>
<tr>
<td>3.20</td>
<td>If you are going to have sex and want to protect yourself from sexually transmitted illnesses, what can you use?</td>
<td>CONDOM 1</td>
<td>NO ANSWER 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DON'T KNOW 98</td>
<td></td>
</tr>
<tr>
<td>3.21</td>
<td>Did you ever use a condom?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.22</td>
<td>If you choose to use a condom, do you know where you can get it?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WON'T USE CONDOM 3</td>
<td>If No or won't use, go to 3.25</td>
</tr>
<tr>
<td>3.23</td>
<td>Where do you get them?</td>
<td>Clinic/Health Facility 1</td>
<td>Peer Educators 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dispensers 3</td>
<td>Other 4</td>
</tr>
<tr>
<td>3.24</td>
<td>For the place you would get the condom, do you know what would the cost be?</td>
<td>Free 1</td>
<td>Affordable for You 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Too Expensive 3</td>
<td>Don't Know 98</td>
</tr>
<tr>
<td>3.25</td>
<td>Are there factors that prevent you from getting a condom?</td>
<td>Distance 1</td>
<td>Embarrassed to Ask 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People Might See You 3</td>
<td>People Know You 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unfriendly 5</td>
<td>Too Expensive 6</td>
</tr>
<tr>
<td>3.26</td>
<td>Did you use a condom the last time you had high risk sex (sex with a non-regular partner)?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.27</td>
<td>Did you use a condom the last time you had sex?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.28</td>
<td>Can you put on a condom on yourself in the dark?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.29</td>
<td>If someone is infected with HIV, how can they tell?</td>
<td>No Way 1</td>
<td>Having a Blood Test 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 3</td>
<td>Don't Know 98</td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td>3.30</td>
<td>Have you ever been tested for HIV?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If No, go to 3.33</td>
<td></td>
</tr>
<tr>
<td>3.31</td>
<td>If yes, did you receive the result?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.32</td>
<td>Where were you tested?</td>
<td>Clinic/Health Facility 1</td>
<td>VCCT Center 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Youth Friendly Clinic 3</td>
<td>Other 4</td>
</tr>
<tr>
<td>3.33</td>
<td>Do you use the following substances (Read and circle all mentioned)</td>
<td>Kava? 1</td>
<td>Betelnut? 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol? 3</td>
<td>Tobacco? 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home brew 5</td>
<td>Other 6</td>
</tr>
<tr>
<td>3.34</td>
<td>If you use Kava, how often do you use Kava? (Read)</td>
<td>Don't use 1</td>
<td>Occasionally 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Less than 3/week 3</td>
<td>More than 3/week 4</td>
</tr>
<tr>
<td>3.35</td>
<td>If you use alcohol, how often do you use alcohol? (Read)</td>
<td>Don't use 1</td>
<td>Occasionally 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Less than 3/week 3</td>
<td>More than 3/week 4</td>
</tr>
<tr>
<td>3.36</td>
<td>Did you ever use other drugs?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td></td>
<td>Probe if yes</td>
<td>If No, go to 3.42</td>
<td></td>
</tr>
<tr>
<td>3.37</td>
<td>Do you currently use drugs?</td>
<td>YES 1</td>
<td>NO 2</td>
</tr>
<tr>
<td>3.38</td>
<td>What types of drugs do you use? (circle all mentioned)</td>
<td>Marijuana 1</td>
<td>Ecstasy/speed 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heroin/methadone 3</td>
<td>Mandrax 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prescription drugs 5</td>
<td>Glue/gasoline 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 7</td>
<td></td>
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</table>


**Practices (continued)**

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<tbody>
<tr>
<td>3.39</td>
<td>With whom do you usually use drugs? READ LIST</td>
<td>Individually 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usually with Same Group 2</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>With Different Groups 3</td>
<td></td>
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<td></td>
<td></td>
<td>Depends on Circumstances 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable 9</td>
<td></td>
</tr>
<tr>
<td>3.40</td>
<td>How do you use drugs?</td>
<td>Smoking 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sniffing 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injecting 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 4</td>
<td></td>
</tr>
<tr>
<td>3.41</td>
<td>Did you share a syringe and needle the last time you injected drugs? (IF NEVER INJECTED, CODE 9)</td>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Never injected drugs 9</td>
<td></td>
</tr>
<tr>
<td>3.42</td>
<td>Women: Have you ever been pregnant? Men: Have you caused someone to be pregnant?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
</tr>
<tr>
<td>3.43</td>
<td>Women: Have you had an abortion, or miscarriage?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
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**Health and Social Services Utilization – Questions for Males only**

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<tbody>
<tr>
<td>4.1</td>
<td>Have you ever had pain in your genitals when you urinate?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td>Male only</td>
</tr>
<tr>
<td>4.2</td>
<td>Have you ever had unusual discharge from your genitals?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Have you ever had sores on your genitals? (Circle all that apply)</td>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>None/NA 0</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Where do you get treated if you have pain or infection in your genitals? More than 5</td>
<td>Clinic 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Youth clinic 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No treatment 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No pain/infection 5</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>How often have you had these problems or sexually transmitted diseases in the past year?</td>
<td>None 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 1</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Some men have sex with men. How many men have you ever had sex with?</td>
<td>None 0</td>
<td>If, 0 Skip to 4.10</td>
</tr>
<tr>
<td>4.7</td>
<td>Did you or the other man use a condom?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Do you have sex in exchange for money or gifts?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
</tr>
<tr>
<td>4.9</td>
<td>Where do you have sex with men?</td>
<td>Hidden place 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Street 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Business 3</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Have you ever talked about HIV or AIDS with a health worker?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
</tr>
<tr>
<td>4.11</td>
<td>Have you ever obtained and used a condom from a health clinic?</td>
<td>YES 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO 2</td>
<td></td>
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</tbody>
</table>
### Health and Social Services Utilization – Questions for Females only

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<tbody>
<tr>
<td>5.1</td>
<td>Some women have problems that affect their genitals. They might have unusual discharge, sores, or lower abdominal pain. In the past 4 weeks have you had lower abdominal pain?</td>
<td>YES 1 NO 2</td>
<td>Female only</td>
</tr>
<tr>
<td>5.2</td>
<td>In the past 4 weeks have you had unusual discharge?</td>
<td>YES 1 NO 2</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>In the past 4 weeks have you had sores?</td>
<td>YES 1 NO 2</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>If you had any symptoms, what did you do for treatment?</td>
<td>Clinic 1 Youth clinic 2 Other 3 No treatment 4 No symptoms 5</td>
<td>If no for 5.1, 5.2, &amp; 5.3, skip to next section</td>
</tr>
<tr>
<td>5.5</td>
<td>How often have you had these problems or sexually transmitted diseases in the past year?</td>
<td>None 0 1-5 1 More than 5 2</td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>Have you ever talked about HIV or AIDS with a health worker?</td>
<td>YES 1 NO 2</td>
<td></td>
</tr>
<tr>
<td>5.7</td>
<td>Have you ever obtained and used a condom from a health clinic?</td>
<td>YES 1 NO 2</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes

<table>
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<tr>
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<tbody>
<tr>
<td>6.1</td>
<td>In case you have used a condom, what were the reasons you used a condom? (Select all that apply)</td>
<td>Prevent pregnancy 1 Prevent STD/HIV 2 Partner insisted 3 Other (specify) 4 I have not used a condom before 5</td>
<td>If 1-4, go to 6.3</td>
</tr>
<tr>
<td>6.2</td>
<td>What were the reasons you did not use a condom? (Select all that apply)</td>
<td>Embarrassing to use condom Unable to get condoms 2 Had sex with partner who was sex worker 3 Had sex with my regular partner 4 Partner did not want to 5 I did not want to 6 Other (specify) 7 DK 98</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Do you want to use a condom the next time you have sex?</td>
<td>YES 1 NO 2</td>
<td></td>
</tr>
<tr>
<td>6.4</td>
<td>Do your parents talk to you on matters relating to your sexuality, and prevention of STI, or HIV?</td>
<td>YES 1 NO 2</td>
<td>If no, go to 6.6</td>
</tr>
<tr>
<td>6.5</td>
<td>If not, what do you think makes it difficult for your parents to talk to you?</td>
<td>Not culturally acceptable 1 They think I’m too young 2 They probably do not know what to say 3</td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>Who in the family and community will be the best person to talk to you on issues of sexuality, growing up, and STI and HIV prevention?</td>
<td>Brother 1 Sister 2 Aunt 3 Uncle 4 Grandmother 5 Grandfather 6 Nurse or health care provider 7 Teacher 8 Other (mention) 9</td>
<td></td>
</tr>
</tbody>
</table>
### Attitudes (continued)

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>6.7</td>
<td>What is your preferred source of help and advice in preventing HIV?</td>
<td>Family 1, Friends 2, School 3, Church 4, Other 5, Nowhere 6</td>
<td></td>
</tr>
<tr>
<td>6.8</td>
<td>If you knew that someone had HIV or AIDS, would you agree to live in the same house with him or her?</td>
<td>YES 1, NO 2</td>
<td></td>
</tr>
<tr>
<td>6.9</td>
<td>You have been out with your friends, now they invite you to take marijuana with them, what will you do?</td>
<td>Will be shocked 1, Will refuse to take marijuana 2, Will inform their parents 3, Will agree, because they are my friends 4, DK 98</td>
<td></td>
</tr>
<tr>
<td>6.10</td>
<td>A girl you know and respect has accidentally dropped a packet. You pick it up and realize it is a condom. What will you feel and do?</td>
<td>Embarrassed, and will not give it to her 1, Embarrassed, but will give the packet to her 2, What she does is none of my business, so I will give it to her 3, Impressed that she uses a condom 4, Shocked by her behavior 5, Other 6</td>
<td></td>
</tr>
<tr>
<td>6.11</td>
<td>You see a boy you know and respect coming from a clinic, where people are treated for STIs, what will you do?</td>
<td>Meet him and greet him as usual 1, Embarrassed, so you walk away so that you do not meet him 2, Other 3</td>
<td></td>
</tr>
<tr>
<td>6.12</td>
<td>A girl you know and respect has told you that she is pregnant. She does not know who to talk to, and has asked for your advice. Who will you suggest that she talks to?</td>
<td>Her mother 1, Her aunt 2, Grandmother 3, School teacher 4, Nurse 5, Older Close friend 6, Other 7</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes (continued)

<table>
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</thead>
<tbody>
<tr>
<td>6.13</td>
<td>A boy you know and respect has told you that he has made someone pregnant. He doesn’t know who to talk to and seeks your advice. Who will you suggest that he talks to?</td>
<td>His father 1, His uncle 2, Grandfather 3, School teacher 4, Nurse 5, Other 6</td>
<td></td>
</tr>
</tbody>
</table>

### Communication

I would like to find out how you get information

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<tbody>
<tr>
<td>7.1</td>
<td>How often do you read newspapers?</td>
<td>Every day 1, Once a week 2, Not at all 3</td>
<td>If not at all, go to 7.3</td>
</tr>
<tr>
<td>7.2</td>
<td>What type of news paper or magazine do you read?</td>
<td>News 1, Entertainment 2, Other 3</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Do you access and use the following? (ask each)</td>
<td>Working radio 1, Working TV 2, Working mobile phone 3</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Do you listen to radio?</td>
<td>YES 1, NO 2</td>
<td></td>
</tr>
<tr>
<td>7.5</td>
<td>What day would you say you almost always listen to radio?</td>
<td>Almost every day 1, Around once in 2 weeks 2, Not at all 3, Mostly Saturday and Sunday 4</td>
<td></td>
</tr>
</tbody>
</table>
### Communication (continued)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>7.6</td>
<td>Listening by day of the week (circle all that apply)</td>
<td>Monday 1, Tuesday 2, Wednesday 3, Thursday 4, Friday 5, Saturday 6, Sunday 7, No specific day 8, Any day 9, Do not listen to radio 10</td>
<td></td>
</tr>
<tr>
<td>7.7</td>
<td>What time would you say you almost always listen to radio?</td>
<td>Morning 1, Mid-day 2, Early evening 3, Late evening 4</td>
<td></td>
</tr>
<tr>
<td>7.8</td>
<td>What are your favourite radio programmes?</td>
<td>Music 1, News 2, Others ------- 3 (describe)</td>
<td></td>
</tr>
<tr>
<td>7.9</td>
<td>What is your favorite radio station?</td>
<td>National Radio Station 1, FM 99.5 2, FM 97.7 3, FM 96.3 4, Other ________ 5</td>
<td></td>
</tr>
<tr>
<td>7.10.1</td>
<td>How often do you watch television?</td>
<td>Almost every day 1, About once a week 2, Not at all 3</td>
<td>If not at all, go to 7.13</td>
</tr>
</tbody>
</table>

### Communication (continued)

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>7.10</td>
<td>What day would you say you almost always watch TV? (Circle all that apply)</td>
<td>Monday 1, Tuesday 2, Wednesday 3, Thursday 4, Friday 5, Saturday 6, Sunday 7, No specific day 8, Any day 9, Don't watch TV 10</td>
<td>If don't watch, go to 7.13</td>
</tr>
<tr>
<td>7.11</td>
<td>What time would you say you almost always watch TV?</td>
<td>Morning 1, Mid-day 2, Early evening 3, Late evening 4</td>
<td></td>
</tr>
<tr>
<td>7.12</td>
<td>What programmes do you prefer to watch?</td>
<td>Movies 1, News 2, Teledrama 3, Comedy shows 4, Quiz shows 5, Cooking program 6, Sports 7, Others 8</td>
<td></td>
</tr>
</tbody>
</table>
### Communication (continued)

<table>
<thead>
<tr>
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<th>Coding categories</th>
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</tr>
</thead>
<tbody>
<tr>
<td>7.13</td>
<td>Can you tell me some sources that you might use to get informed about HIV/AIDS and then I’ll ask you some questions? Where do you get information about HIV/AIDS? (Select all that apply. Do not probe)</td>
<td>Clinic/health facility 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Youth /drop in centre</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer educators</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radio</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TV</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internet</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD/DVD</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Church</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family/clan elders</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Friends</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School /teacher</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobile phone</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Theater/ drama in the community</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other________</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nowhere</td>
<td>15</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.14</td>
<td>How would you prefer to get informed about HIV and AIDS? (Select all that apply. Do not probe)</td>
<td>Clinic/health facility 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Youth /drop in centre</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer educators</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radio</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TV</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internet</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD/DVD</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Church</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family/clan elders</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Friends</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School /teacher</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobile phone</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Theater/ drama in the community</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other________</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nowhere</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Newspaper</td>
<td>16</td>
</tr>
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</thead>
</table>
| 7.18         | If yes, where were the programs held? | Clinic 1  
Youth program 2  
Church 3  
School (NGO) 4  
Other 5 |         |
| 7.19         | Have you ever seen a video on HIV/AIDS? | YES 1  
NO 2 |         |
| 7.20         | Have you ever heard an AIDS program on the radio? | YES 1  
NO 2 |         |
| 7.21         | Have you ever seen a poster on HIV or AIDS? | YES 1  
NO 2 |         |

Your input is very important for helping us to understand how we can help young people protect themselves from HIV. Thank you!

<table>
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</thead>
</table>
| 7.15         | Who do you trust the most for information about HIV? (Do not probe) | Clinic/health facility 1  
Youth /drop in centre 2  
Peer educators 3  
Radio 4  
TV 5  
Internet 6  
CD/DVD 7  
Church 8  
Family/clan elders 9  
Friends 10  
School /teacher 11  
Mobile phone 12  
Theater/ drama in the community 13  
Other 14  
Nowhere 15 |         |
| 7.16         | Have you ever attended programs that explained how to prevent HIV? | YES 1  
NO 2 |         |
|              | If No, go to 7.19     |                   |         |
| 7.17         | If yes, how many programs have you attended? | 1 to 4 1  
5 to 10 2  
More than ten 3 |         |
Stake Holders - Health/Social Service Providers, Media, Community members/leaders
– Focus Group Discussion

Script for consultant or research assistant

UNICEF Pacific HIV/AIDS Data Collection

Location________________________ Date__________

Interviewer Code_____________________

Participants/Roles_________________________________________________________

________________________________________________________________________

Context____________________________________________________________________

________________________________________________________________________

Introductions

Explanation of purpose of study and definitions MARA & EVA

Informed consent ______________________

Signature of Field Data Collector (witness)

Questions (selected in relation to participants and number in group)

• Role
  What is your most important role in the community? What service do you provide?
  What do you do to fulfill this role?

  What is your role in relation to youth and risk of HIV and AIDS?

HIV/AIDS Risk for Adolescents

Do you think HIV/AIDS is a problem that affects youth in your community?

What are the risks that they face in relation to HIV/AIDS?

• Most at Risk & Especially Vulnerable Adolescents (MARA & EVAs)
  Are some youth in this community more vulnerable than others?

  What can you tell me about them?

  Do you believe that your community has any role in helping young people to protect themselves from HIV infection or to assist MARAs and EVAs to avoid HIV/AIDS, sexual violence, and vulnerability?

• Services
  Do MARAs & EVAs receive services from your clinic / programme/ school/community?

  Do you believe your services can assist them to avoid HIV/AIDS, sexual violence, and vulnerability?

    If not, how could they be improved?

• Support
  Do you feel you have what you need to provide services? If not, what would help?

    Education about HIV/AIDS?

    Equipment?

    Training?

    What do you need to do this work effectively with adolescents?
**Attitudes toward MARAs & EVAs**
How do you feel about supporting or providing services to MARAs & EVAs?

Do you think they should be able to get condoms, information about HIV/AIDS, treatment if they have Sexually Transmitted Diseases?

**Strengthening Support**
Do you think these services are effective?

If not, what would strengthen these services?

Does this community support MARAs & EVAs?

If not, why?

What would help your community in this role?

**Recommendations**
What recommendations do you have to keeping these adolescents safe from HIV/AIDS?

Thank you for your valuable input and for doing this important work!

---

**MARAs, EVAs, MARYPs, EVYPs, Mainstream– Focus Group Discussions**

**Script for consultant or research assistant**

**UNICEF Pacific HIV/AIDS Data Collection**

Location____________________ Date__________

Interviewer____________________

Description & context of group

____________________________________

Context related to risk/vulnerability______________________________

______________________________

Introductions

Explanation of purpose of study and definitions MARA & EVA

Informed consent

Questions

**Knowledge of HIV/AIDS**

Do you know about HIV/AIDS? If yes, what do you know?

Do you think you are personally at risk? If yes, how?

Do you think you are more vulnerable to getting HIV/AIDS than other young people? Why?

Where do you get information about HIV/AIDS? (Add locally specific sources)

Is it easy for you to get the information you need?

If not, what would need to change to make it easy for you?

What would be the best information sources for you?
• **Age at first sex**
  Have most of your friends had sex?
  About how old were they when they first had sex?
  Why did they have sex?
  Did they want to have sex? Were they forced?
  Were they intoxicated? Using drugs?
  How old was the person with whom they had sex?
  How many partners do they have sex with in one month?

• **Condom use**
  How do you and your friends protect yourself from getting HIV/AIDS?
  Do most of your friends (or their partners) use a condom when they have sex?
    - If not, why don’t they use a condom?
  Are you able to get condoms if you want them?
  Where do you get them?
  Are the people there helpful to young people?
  What could they change to make it easier for you all to get protection?

• **Community support**
  Are there any programmes or groups that can assist you all to avoid HIV/AIDS?
  (Add local programmes/groups)
    - If you don’t use these programmes, why not? Do they treat young people well?
  What other programmes would be helpful to young people?
  What kind of programmes would you recommend be started to help young people?

• **Testing**
  What do you or your friends do when they think they might have a STI (pain and disease in your private parts) or HIV/AIDS?
    - Have they ever been tested for HIV?
      - If so, do they know the result?
    - Where were they tested? Do the providers treat them well?
    - Are they friendly and helpful toward young people?
    - How could testing be accessible for you and your friends if you needed it?

• **Teen pregnancy**
  Have you, your sexual partners, or friends been pregnant?
    - Was the sex forced or by choice?
    - Was protection available?
      - If not how could it be accessible?
    - Did you (or they) have adequate sex education about pregnancy prevention?
      - If not how could it be more accessible to you and your friends?
• **Communications**
  Do you all read any newspapers or magazines? Which ones? How often?

  Do you get information from newspapers or magazines that help protect you from getting infected with HIV? If yes, which ones? What did you learn?

  Do most of your families own a working TV? Working radio?
  - About how many hours per week do you all watch TV?
  - What kind of programmes do you watch? (Vanuatu – do you watch Love Patrol?)
  - How many hours per week do you all listen to the radio?
  - What kind of programmes do you listen to?
  Do you get any information on the radio or TV that helps protect you from getting infected with HIV? If yes, which ones? What did you learn?


• **Transactional or commercial sex**
  Have any of your friends ever been given money, food or a gift in exchange for sex?

  Did they agree and why?

  Do they still exchange sex for money, food or a gift? If yes, do you think they be willing to talk with us? You can talk to me afterwards to let me know.

  Have your group of friends ever been forced to have sex when you didn’t want to? If yes, what happened?

  Do you feel vulnerable to having the same thing happen again? Why? In what situations? In what places?

• **Injection drug use**
  Have you or your friends ever used injection drugs and shared a needle?

  Do you or they still use injection drugs? How often?
  How do they get the money to buy the drugs?
  If yes, would they be willing to talk with us?

• **Men having Sex with Men**
  For male only - Have you or your friends ever had sex with a man?

  Was it by choice?
  Were you or they experimenting?
  Did you or they continue to have sex with men?
  Do you or they use a condom for sex with men? Always? Often? Never?
  Would they be willing to talk with us?

• **Recommendations**
  What do you recommend that would help you be less at risk for HIV?

  Do you have any questions for me/us?

  Your input is very important for helping us to understand how we can help young people protect themselves from HIV.

  Thank you very much!
ANNEX 6

annex 6: Mapping Workshop Results

Solomon Islands National Consultative Mapping Workshop Results

Munda area, Western Province Mapping Workshop Results

Gizo area, Western Province Mapping Workshop Results

Choiseul Province Mapping Workshop Results

Malaita Province Mapping Workshop Results
SOLOMON ISLANDS NATIONAL CONSULTATIVE MAPPING WORKSHOP
SUMMARY RESULTS
SCA Conference Room
Honiara – Monday July 6, 2009 – 10am – 3pm

Participants:
- Japhet Honima – STI/HIV Community & Research Facilitator, Solomon Islands (SI) Ministry of Health (MOH)
- Hellen Tomasai – HIV/STI Facilitator, VCCT & PMTCT Coordinator, SI MOH
- Kennedy Falasi, Save the Children Australia (SCA)
- Alfred Ngire Hendy – AHD Clinic, SI Planned Parenthood Association (SIPPA)
- Samantha Tome – World Vision
- Yaxley Tadokata – World Vision
- Isaac Muliloa – STI/HIV Coordinator, SI MOH
- Carol Murry – UNICEF Pacific Consultant, HIV/AIDS Baseline Study
- Stephen Maltani – UNICEF SI HIV/AIDS Program Officer

Explanation of Purpose: Solomon Islands Ministry of Health, with support of UNICEF Pacific, is implementing HIV/AIDS Baseline data collection with a focus on most-at-risk and especially vulnerable adolescents (MARAs and EVAs) in response to specific recommendations for primary data collection. The national consultative mapping workshop involving representatives of several organizations serving this target population and MOH and UNICEF representatives was held to map the contextual and spatial issues of MARAs and EVAs and provide input to the study.

Definition and Rationale for Focus on Most at Risk Adolescents (MARAs) and Especially Vulnerable Adolescents (EVAs): Those adolescents whose behaviour places them most-at-risk are termed MARAs and include: sex workers, injection drug users sharing non-sterile equipment, males having unprotected sex with males and sex workers, females and males involved in sex work and having unprotected transactional sex. Those adolescents at greatest vulnerability relating to the HIV and AIDS are termed EVAs. Examples of factors increasing adolescent vulnerability to HIV and AIDS include: living away from family, juvenile detention or prisons, being an impoverished teen parent, and living in the vicinity of forces of forced sex. Their vulnerability is not directly related to their personal behaviour. Solomon Islands is a low prevalence country for HIV/AIDS with high risk and vulnerability for its adolescents. A focus on MARAs and EVAs will provide the most effective intervention to prevent transmission.

FactorsReported as Contributing to High Risk Behaviours and Vulnerability of Solomon Islands MARAs and EVAs:
Dislike and unreliable supply of condoms, Unprotected sex – multiple partners, Selling and Exchange of Sex, Poverty leading to child prostitution of both sexes, Sex workers subjected to beatings and sexual violence due to stigma, Violence and coerced sex including rape and gang rape, Expulsion from school following rape, Significant sexual abuse within family and institutions, Vulnerability to abuse in adoptive homes, Discrimination to women and children, Extramarital sex of males and inability to negotiate safer sex of females, Adolescents lack information and services, Clinics focusing on FP rather than youth needs, Rising unemployment,

Factors Contributing to Risk and Vulnerability in Solomon Islands:
- Tourism, Outside Influences
- Fishing Boats – Mother boat
- Logging - Makira, Malaita, Western, Choiseul, Ysabel, All logging sites
- Wharfs – Malaita, Western
- Unemployment

Locations of Honiara Area MARAs and EVAs (bold indicates emphasis):

<table>
<thead>
<tr>
<th>Sites</th>
<th>Communities</th>
<th>Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market – White River</td>
<td>Childrens’ Park, Botanical Garden</td>
<td>*Panatina Community High School</td>
</tr>
<tr>
<td>Beach fronts-Lela, Hammock, Blue Flag</td>
<td>Vara Creek</td>
<td>*White River</td>
</tr>
<tr>
<td>Koa Hill, YWCA, Kukum Hostel</td>
<td>Kaiba</td>
<td>King George</td>
</tr>
<tr>
<td>Point Cruz Wharf</td>
<td>Borderline</td>
<td>*Honira High</td>
</tr>
<tr>
<td>Burns Creek</td>
<td>Green Valley</td>
<td>Burns Creek</td>
</tr>
<tr>
<td>Kukum Dump Site</td>
<td>Mataniko</td>
<td>Vara CHS</td>
</tr>
</tbody>
</table>

Locations MARAs
- Kukum
- Fishing Village
- Tandai
- Burns Creek
- Manama Wota

Locations EVAs
- Corrections
- Mission Schools – SDA, Catholic, SICHE
- Displaced Populations
- Street Kids
- Port Cruz
- Market
- Chinatown
Locations Recommended for Data Collection in Honiara Area:

- White River
- Lordhowe
- Fishing Village
- Ranadi Dump Site
- Tuvaruhu
- Night clubs – Friday and Saturday nights

Schedule:
Friday – Pilot test in Chinatown, Lordhowe, Vare Creek, Port Cruz, Burns Creek area
Saturday – Interview MARAs Save the Children Australia (SCA) by Kennedy
Sunday – Market, Port Vila, White River, Tuvaruhu
Monday – White River, Mamana Wotah – Monday night – wharf
Tuesday – Sex workers Focus Group Discussion at SCA

Wednesday morning – Additional interviews as necessary
Schools - Penatina Community High School, White River Community High School, Honiara High School – to be scheduled in relation to which schools in session

Reasons for Site Selection:
The 3 schools were selected for geographic representation:

- Honiara High School is in the center of Honiara,
- White River is in the Western end
- Penatina is in the Eastern area, inland from the main road.

Several communities were suggested and selected for the following selected:
- White River is known for having the most young people in Guadalcanal, as the site where sexual activity is negotiated, and for its weekly violence.
- Fishing Village is a site of "mother boats" and where youth get fish for sex and sell them at the market.
- Lordhowe is the site where Polynesian Lao people have settled. The settlement is overcrowded and the site of strong cultural practices as well as criminal activity. Youth centers are being erected to counteract problems.
- Ranadi dump area is the site of Malaitan settlers who are in survival mode.
- Tuvaruhu - is a multi-ethnic multi-cultural area. It is known for many cases of teen pregnancy, abortions and babies thrown in the river.
- Mamana Wotah – settlement of Malaitans who gamble and go to the market at night. They don’t want to work in the garden, preferring “easy” money, sell sex.
- Night Clubs – are the places where young people go to look for sexual partners.
- Wharf – is the site where foreign vessels are at anchorage. There are many males and it is easy to buy sex with girls.

Are Things Better Now or Worse? Worse Why?
Outside influences
Girls don’t get enough support from their parents.
More and more young girls and boys are smokers and need money.
Youth like to keep up-to-date with the latest fashions
Influence from expatriates
Youth living away from their parents to live in town and unable to meet the costs
In town there are too many ethics and cultures. It’s hard to follow cultures or custom.
Parents working whole day. Children left alone to learn from neighbours or house girl
Parents are more concerned about young children than youth

Specific Programme Activities Effective at Mitigating Risk and Vulnerability in Solomon Islands:
Sports, activities, church activities, studying, good teaching and parenting, Awareness, Rules, Condoms.

Organizations and Individuals Offering Services to Adolescents and Youth:
- World Vision – condom dispensers, sports, awareness, small business development, substance abuse services, working with church leaders, taxi networking, TV news - One News, on HIV - Stepping Stones.
- Save the Children Australia (SCA) – work with MSM and sex workers, business houses awareness programmes, condom distribution (IEC), networking with sex workers, youth friendly approach, TV programming waiting pre-testing, quiz nights, peer to peer education at night clubs for 2 hours on Fridays, sea-farers HIV prevention, work with other stakeholders.
- Solomon Islands Planned Parenthood Association – Radio programming, awareness, VCCT, Family Planning, youth friendly services, training volunteers, Stepping Stones, distribution of condoms (IEC), training for community leaders, school awareness, music awareness, STI counseling and treatment, condom marketing.
- Ministry of Health – training, VCCT, distribution of condoms (IEC), Stepping Stones, Surveillance, testing, and treatment for STI and HIV, Awareness, monitoring PLWHA, policy and guidelines development, planning.

Who Else should be at the Table?
- Correctional Services
- Church of Melanesia
- Adventist Development Relief Agency (ADRA)
- OXFAM
- Ministry of Education – Curriculum
- Ministry of Women and Youth
- Universal Peace Federation
- SSEC
SOLOMON ISLANDS WESTERN PROVINCIAL MUNDA AREA
CONSULTATIVE MAPPING WORKSHOP

SUMMARY RESULTS
Helena Goldie Hospital (GHG)
Munda – Thursday July 16, 2009 – 9am – 2pm

Participants:
- Japhet Honimae – STI/HIV Community & Research Facilitator, Solomon Islands (SI) Ministry of Health (MOH)
- Thelma Panda, Registered Nurse SI Government - 61354/66950
- Veronica Malva, Project Officer, SCA - 61358/66369, nicakivah27@gmail.com
- John Sisilo, Health Secretary United Church SI - 62125/62137
- Binet Muvo, Senior Education Officer – 71453
- Joyce Gumi, Registered Nurse SI Government (GHG)
- Moses Wickham, Youth Rep – 68051
- Rachel L. Tagi, Police Officer Munda – 62114
- Prima Kuku, Teacher, Dunde Community High School – P.O.Box 95, Munda
- Solomon Soakai, Med. Laboratory/SI Red Cross, Munda – 62112, solmnz@solomail.com.sb
- Marco Piani, Kindu Community – Kindu Community
- Chris Leve, Director of Nursing, GHG, 62112
- Jenny Longbottom, Medical Doctor, GHG
- Graham Longbottom, Medical Doctor, GHG
- Salise Barakan, Rep. Women’s Roviana Circuit – 71160
- Rev. Aaron Bea, Bible Class Children – 62137
- Hetty Bea, GHG Health Promotion – 62112 (GHG) Ext. 205
- Hilda Kii, UNICEF Pacific Research Assistant, HIV/AIDS Baseline Study
- Carol Muny – UNICEF Pacific Consultant, HIV/AIDS Baseline Study

Explanation of Purpose: Solomon Islands Ministry of Health, with support of UNICEF Pacific, is implementing HIV/AIDS Baseline data collection with a focus on most-at-risk and especially vulnerable adolescents (MARAs and EVAs) in response to specific recommendations for primary data collection. The Munda area, Western Province consultative mapping workshop involving representatives of several organizations serving this target population and MOH and UNICEF representatives was held to map the contextual and spatial issues of MARAs and EVAs for the Munda and Noro areas and provide input to the study.

Definition and Rationale for Focus on Most at Risk Adolescents (MARAs) and Especially Vulnerable Adolescents (EVA): Those adolescents whose behaviour places them most-at-risk are termed MARAs and include: sex workers, injection drug users sharing non-sterile equipment, males having unprotected sex with males and sex workers, females and males involved in sex work and having unprotected transactional sex. Those adolescents at greatest vulnerability relating to the HIV and AIDS are termed EVAs. Examples of factors increasing adolescent vulnerability to HIV and AIDS include: living away from family, juvenile detention or prisons, being an impoverished teen parent, and living in the vicinity of forcer of forced sex. Their vulnerability is not directly related to their personal behaviour. Solomon Islands is a low prevalence country for HIV/AIDS with high risk and vulnerability for its adolescents. A focus on MARAs and EVAs will provide the most effective intervention to prevent transmission.

High Risk Behaviours of Munda and Noro areas of Western Province Solomon Islands MARAs and EVAs:

Vulnerability in Munda and Noro areas, Western Province, SI
- Drinking
- Smoking tobacco and marijuana – can lead to incest and rape
- Housegirls – clean and act like a wife and have kids, are usually left behind but sometimes supported.
- Churches sometimes provide support
- Gang rapes don’t happen in this area, but nearby. Often the girl is blamed.
- Lack of education.
- Poverty.

Factors Reported as Contributing to High Risk Behaviours and Vulnerability of Solomon Islands MARAs and EVAs (continued):
- Competition with other young people.

Changes Contributing to High Risk Behaviours and Vulnerability Nowadays
- Companies where workers have money buy sex – logging industry, fishing boats, girls going out to ships exchanging fish for sex, foreigners, workers from overseas coming without wive and looking for girls, tourists.
- Cell phones and internet allow young people to agree to get together for sex or for men to contact girls to buy sex.
- Night clubs are held on an ad hoc basis.
- Movies include pornographic materials.
- Parents are not providing time and attention to their youth because they may be busy with work or drinking or they don’t care. Some sell their young daughters to get things they want, such as a house, or because they don’t want to work. Incest is increasing. Girls who are forced to have sex are pressured not to tell. Close relatives such as cousins or brothers and sisters may be having sex.
- Poverty of families or of their daughters who may be sent away if they are pregnant, even if it was forced sex.
- Unemployment.
- Increased tourism and outside influences.
Locations where MARAs and EVAs may be Found

Communities
Kekehe
Kindu
1. Likohoana
2. Lambete – Beaches – Airfield, Japanese, Blue House, Utilities shop, Old Fisheries House, Court House
3. Noro – STC office for base, Main port, (Kitano wharf, Soltau port, Backway, Black Town, BTM Beach (clubs)), (Kokosu Beach, Cha Cha Back Yard, hostels)
4. Munda transit e.g. Agnes Lodge
5. HGH Bush area
6. Lola Resort (island)
7. Logging Camp – Bahoro
8. Outer Islands
9. Rawaki – Gilbertese settlement
10. Canaan

Locations Recommended for Data Collection in Munda and Noro Area

Communities
- Dunde Village
- Noro Town
- Kindu
- Lambete

Schools
- Kokegolo Community High School
- Dunde Community High School
- Noro Community High School

Best time to survey schools is 1:30pm

What the Organizations need to Reduce Risks

1. HGH
   Provides information, counseling, condoms
   Need support of other NGOs and a Youth Friendly Center

2. Women
   Need MOH to teach them to provide awareness and support on provision of information, such as pamphlets.

3. Church Minister
   Needs support on teaching that sex is for marriage, such as pamphlets.

4. Education
   Develop curriculum for HIV and AIDS in schools

5. Community Representative
   Needs community awareness programs and financing.

6. Church Health Secretary (UC)
   Needs to be taught to teach life skills
   Needs involvement of church leaders and associates in HIV awareness at the community level

7. SCA
   Developed community policies on children and youth in conflict with the law.
   Presents education awareness.

8. Red Cross
   Awareness for youth on HIV

9. Noro Health Representative
   Needs to establish a youth clinic.

10. Education Representative
    Needs curriculum for HIV and training for teaching it, pamphlets and community training.

11. Police
    Preparation for making awareness presentations
    Community Policing guidelines

12. Youth Representative
    Youth need training and need to work together with community. Need band instruments to keep youth busy. House to house involvement of volunteers.

13. Health Promotion HGH
    Funds for HGH. She is responsible for 35-36,000 people, but doesn’t have transport for outreach activities and portable generator for showing videos.
SOLOMON ISLANDS WESTERN PROVINCIAL GIZO AREA
CONSULTATIVE MAPPING WORKSHOP
SUMMARY RESULTS
Gizo Hospital Leaf Hut
Gizo – Wednesday July 22, 2009 – 9am – 2pm

Participants:
- Japhet Honiame – STI/HIV Community & Research Facilitator, Solomon Islands (SI) Ministry of Health (MOH)
- Glenda Lapo - HIV Program Office, Gizo Hospital
- Br. Rudolph Tesc – Religious Community of Church of Melanesia
- Ian Rikado – Youth Organization
- Rellysdom A. Mala – Education for Life and Media, Diocese of Gizo
- Rendy Lamu Solomon – President, Western Province Council of Women
- Livingston Tura – Save the Children Program Officer
- Ricky Eddy – Medical Laboratory, Gizo Hospital
- Moana Moata – SIPPA Gizo
- Hilida Kii, UNICEF Pacific Research Assistant, HIV/AIDS Baseline Study
- Carol Murry – UNICEF Pacific Consultant, HIV/AIDS Baseline Study

Explanation of Purpose: Solomon Islands Ministry of Health, with support of UNICEF Pacific, is implementing HIV/AIDS Baseline data collection with a focus on most-at-risk and especially vulnerable adolescents (MARAs and EVAs) in response to specific recommendations for primary data collection. The Gizo area, Western Province consultative mapping workshop involving representatives of several organizations serving this target population and MOH and UNICEF representatives was held to map the contextual and spatial issues of MARAs and EVAs for the Gizo area and provide input to the study.

Definition and Rationale for Focus on Most at Risk Adolescents (MARAs) and Especially Vulnerable Adolescents (EVAs): Those adolescents whose behaviour places them most-at-risk are termed MARAs and include: sex workers, injection drug users sharing non-sterile equipment, males having unprotected sex with males, females and males involved in sex work and having unprotected transactional sex. Those adolescents at greatest vulnerability relating to the HIV and AIDS are termed EVAs. Examples of factors increasing adolescent vulnerability to HIV and AIDS include: living away from family, juvenile detention or prisons, being an impoverished teen parent, and living in the vicinity of the former of forced sex. Their vulnerability is not directly related to their personal behaviour. Solomon Islands is a low prevalence country for HIV/AIDS with high risk and vulnerability for its adolescents. A focus on MARAs and EVAs will provide the most effective intervention to prevent transmission.

High Risk Behaviours of Gizo area of Western Province Solomon Islands
MARAs and EVAs:
- unprotected sex
- multiple partners
- sex for money, food or favors e.g. school fees, transportation
- MSM – little
- IDU – no

Vulnerability in Gizo, Western Province, SI:
- Drinking alcohol, home-made beer, kwaso, home brew
- Substance abuse – marijuana
- Incest
- Rape – few,
- Gang rape - rare

Factors Reported as contributing to High Risk Behaviours and Vulnerability of Solomon Islands MARAs and EVAs:
- Night clubs
- Unemployment
- Peer pressure
- Lack of information
- Ignorance
- Broken homes
- Parents setting bad examples
- Lack of recreational activities
- Mothers not staying home with children because need to earn money
- Parents leaving to go to Gizo to earn money while children left on home island
- Father spending most of his time away from home drinking
- Outside influence leading young people wanting new things for themselves, e.g. MP3 and MP4 players, mobile phones
- Fishing boats, log ponds, camps
- House-girls problem with father of family
- Parents encouraging children to steal for survival

Locations where MARAs and EVAs may be Found

Schools
Gizo Community High School (CHS)
Ngari CHS
Bilua CHS
Vonunu Provincial Secondary School

Communities
Gizo Town District area
Green Motel, New Georgia Motel
Rural Gizo area
Vela Island
Barakoma Village
**Camp Sites – Post-Tsunami**
- Titiana 1 and 2 (Gilbertese)
- Nusa Baruku (Gilbertese)
- Paeloge – Melanesian camp formed after the tsunami.

**Gizo area Sites**
- Million Dollar View
- Tsunami Beach
- Water Pump

**Locations Recommended for Data Collection in Gizo Area**

**Schools**
- Gizo CHS - High risk
  - Green and New Georgia Motels – contact through receptionists through Glenda
- Bilua CHS (Vela)

**Communities**
- Gizo Town
- Barakoma Village (Vela) – if weather allows and canoe available, approach through Clinic Nurse, Council Chairman, Chief, or church

**Camps**
- Contact through camp managers. 10-15 minutes travel time by truck or 5 minutes paddle.
- Titiana 1 and 2 (Gilbertese) - Young People using alcohol, marijuana, and sex as diversions in camp. Displaced people who have no land for subsistence and no income. Education level is low. Gilbertese are very social.
- Nusa Baruku (Gilbertese)
- Paeloge – Melanesian camp formed after the tsunami. People moved up from the coast and those from Simbo Island. They bring coconuts to the Gizo market.

**Services Being Provided and Recommendations**

**Hospital – Health promotion**
- Awareness to targeted groups
- VCCT
- Treatment
- IEC Condom distribution
- Prior project – SHARP Project involved Speech and drama competitions, awareness-funded by OXFAM, Peer to Peer Education
- Recommend continuation, strengthening and expansion of services
- Treatment and referral of specimens to lab should be strengthened
- No treatment for trichomonas or candidiasis – common problems

**Save the Children Australia – Engage youth through information centers, involvement in youth activities, generate activities.**
- Recommend strengthening youth programs and increased funding

**Catholic Church – capacity building**
- Training for communities
- Recommend expansion of programs and increased funding

**Church of Melanesia – awareness of HIV to provinces and schools**
- ABC – be faithful
- Seafarers’ program
- Recommend link health promotion in schools with hospital staff

**Council of Women – Provide resource center and facilities**
- Life skills training
- Income-generating activities
- Recommend listening to youth
- Involving youth in decision making
- Training youth to be self reliant
- Listening to their children
- Providing facilities for youth

**SIPPS – Youth services, health promotion, reproductive health, treatment, VCCT**
- Information on HIV and STIs
- Distribution of IEC materials and condoms
- Recommend more resources for Youth Friendly Clinic
SOLOMON ISLANDS CHOISEUL PROVINCIAL
CONSULTATIVE MAPPING WORKSHOP
SUMMARY RESULTS
Choiseul Hospital – SIPPA Conference Room
Taro – Monday July 27, 2009 – 8:30am – 1pm

Participants:
- Japhet Honimae – STI/HIV Community & Research Facilitator, SI Ministry of Health (MOH)
- Timothy Piziki – Health Promotion Assistant, 63190/63121
- Christina Biliki – SIPPA Staff, 63149, 57601
- Lorraine Ottoga – Taro School Teacher
- Christopher Makoni – Clerk to Assembly, SDA, 63132
- Tauora Sibwere – Police Officer, Office 63100/Mobile 57775
- Ismael Seka – UN Employeee, 57514
- Richard Maegerea – Nursing Officer, 69543, 63190
- Deborah Davo – STI/HIV/AIDS Program Office, 57589/63190
- Hilda Kii, UNICEF Pacific Research Assistant,
- Carol Murry – UNICEF Pacific Consultant,

Explanation of Purpose: Solomon Islands Ministry of Health, with support of UNICEF Pacific, is implementing HIV/AIDS Baseline data collection with a focus on most-at-risk and especially vulnerable adolescents (MARAs and EVAs) in response to specific recommendations for primary data collection. The Choiseul Province consultative mapping workshop involving representatives of several organizations serving this target population and MOH and UNICEF representatives was held to map the contextual and spatial issues of MARAs and EVAs for Choiseul Province and provide input to the study.

Definition and Rationale for Focus on Most at Risk Adolescents (MARAs) and Especially Vulnerable Adolescents (EVAs): Those adolescents whose behaviour places them most-at-risk are termed MARAs and include: sex workers, injection drug users sharing non-sterile equipment, males having unprotected sex with males, females and males involved in sex work and having unprotected transactional sex. Those adolescents at greatest vulnerability relating to the HIV and AIDS are termed EVAs. Examples of factors increasing adolescent vulnerability to HIV and AIDS include: living away from family, juvenile detention or prisons, being an impoverished teen parent, and living in the vicinity of the forcer of forced sex. Their vulnerability is not directly related to their personal behaviour, Solomon Islands is a low prevalence country for HIV/AIDS with high risk and vulnerability for its adolescents. A focus on MARAs and EVAs will provide the most effective intervention to prevent transmission.

High Risk Behaviours of Choiseul Province Solomon Islands MARAs and EVAs:
- Sex for money
- Sex for food or material goods
- Sex for alcohol, kwaso, or smoke
- Sex with multiple partners
- Sex at a young age
- Condom use rare (too shy to get condoms)
- MSM – no
- IDU – no

Factors Reported as Contributing to High Risk Behaviours and Vulnerability in Choiseul Province
- Incest
- Rape
- Creeping
- Exposure to outside influences, material goods
- Proximity to Bougainville border
- Logging camps
- Fishing boats
- Mining camps
- Working parents leaving girls with housegirls
- Illiteracy of parents who are unable to help children
- Parents too lazy to work and expecting handouts – leads to sex for money by children
- Custom of boys sleeping at home no longer followed
- Custom of respect between brother-sister and brother-sister avoidance no longer practiced
- Pornography
- Parents don’t counsel children on sexual customs
- Substance and alcohol use
- Gang rape - rare

Locations where MARAs and EVAs may be Found
- **Schools**
  - Sasamuga Community High School (CHS)
  - Choiseul Bay Provincial Secondary School
- **Communities**
  - Banganoa/Nabusasa
  - Poroporo
  - Taro Station
  - Choiseul Bay Camp
  - Sagaga Logging Camp
  - Sasamuga Community
  - Pangoe Community

Reasons for Choosing Locations Recommended for Data Collection in Choiseul Province
1. Banganoa/Nabusasa
   - Illiteracy
   - Alcohol use, smoking
   - Gambling
   - Ignorance of parents
   - Many sexual activities
   - More youth in populace
   - Sex for money risk area

2. Poroporo
   - Alcohol
   - Criminal activities
   - Sex for money or smoke
   - Smoking
   - High level sex activities
   - Fashions
3. Choiseul Bay Camp/PSS
   Close to town
   Logging camp station
   Creeping
   Young population – students
   Peer pressures
   More social activities (bobo night)
   Alcohol, smoking

4. Sasamuga
   Day students walk long distances
   People still displaced after tsunami
   Overcrowding
   Alcohol, kwaso
   Smoking, marijuana
   Increased STI rates
   Transportation – access to Gizo and Noro
   Access to information
   Adolescent population high
   Criminal activities high
   High level sexual activity

5. Taro Station
   Free border access
   Bars, alcohol

Recommendations for Reducing Risk Behaviours/Activities
1. Awareness to entire community
2. Regular follow-up
3. Introduction of STI/HIV/AIDS to school curriculum
4. Teaching sex education should begin at home
5. IEC materials should be translated to local languages
6. Monitoring and evaluation of activities
7. Stakeholders working in partnership
   Government – provincial NGOs
   Churches
   Community Chiefs and leaders
8. Provide testing site services in taro
9. Condom distribution
10. Churches should be involved in teaching issues related to STI/HIV/AIDS to their congregations
11. Logistic support
12. Training of health/clinic/community members

SOLOMON ISLANDS MALAITA PROVINCIAL
CONSULTATIVE MAPPING WORKSHOP
SUMMARY RESULTS
Auki World Vision Office Conference Room
Monday August 3, 2009, 8:30am - 1:30pm

Participants:
- Japhet Honimae – STI/HIV Community & Research Facilitator, HIV/AIDS Baseline Study Focal Person, Solomon Islands (SI) Ministry of Health (MOH)
- Ben Oli, Pastor SICA, c/o Eric Sogote’e World Vision
- Nemu Laeua, Community Chief, Kilusakwalo VGE
- Catherine Atu, RN Kiliuji Hospital
- Georgina Awa’ahu Project Officer, Save the Children
- Andrew Dau, Auki Police, 40132/87338
- Peter Baru, Businessman’s Representative, Auki, 40228/7478450
- Kemuel Iro, Health Promotion Officer, 40272/80426
- Dickson Manai, Health Field Facilitator for World Vision HIV/AIDS Prevention Project, 40133
- Eric Sogote’e, HIV Project Manager, World Vision SI, 40133
- Rebecca Tahosanau, HIV Project Facilitator, World Vision SI, 40133
- Charles Maebiru Sango, Malae Peace Building, World Vision SI, 40133
- Martha Rorai, Mothers’ Union Trainer, Diocese of Malaita, 40136
- Nixon Panda, UNICEF Pacific Research Assistant, HIV/AIDS Baseline Study
- Hilda Kii, UNICEF Pacific Research Assistant, HIV/AIDS Baseline Study
- Carol Murry – UNICEF Pacific Consultant, HIV/AIDS Baseline Study

Explanation of Purpose: SI Ministry of Health, with support of UNICEF Pacific, is implementing HIV/AIDS Baseline data collection with a focus on most-at-risk and especially vulnerable adolescents (MARAs and EVAs) in response to specific recommendations for primary data collection. The Malaita Province consultative mapping workshop, involving representatives of several organizations serving this target population, MOH and UNICEF representatives, was held to map contextual and spatial issues of MARAs and EVAs for Malaita Province and provide input to the study.

Definition and Rationale for Focus on Most at Risk Adolescents (MARAs) and Especially Vulnerable Adolescents (EVAs): Adolescents whose behaviour places them most-at-risk are termed MARAs and include: sex workers, injection drug users sharing non-sterile equipment, males having unprotected sex with males and sex workers, females and males involved in sex work and having unprotected transactional sex. Those adolescents at greatest vulnerability relating to the HIV and AIDS are termed EVAs. Examples of factors increasing adolescent vulnerability to HIV and AIDS include: living away from family, being in juvenile detention or prisons, being an impoverished teen parent, and living in the vicinity of forcer of forced sex. Their vulnerability is not directly related to their personal behaviour. Solomon Islands is a low prevalence country for HIV/AIDS with high risk and vulnerability for its adolescents. A focus on MARAs and EVAs will provide the most effective intervention to prevent transmission.
High Risk Behaviours of Malaita Province MARAs & EVAs:
Sex for money, food and gifts.
Males having sex with males
Unprotected sex – multiple partners
Rape and gang rape
Sharing Tattoo and ear piercing tools

Vulnerability in Malaita Province
• Congregation of youth, such as sports gatherings and community fundraising,
• Passenger ship arrivals in Auki Friday night
• Sexually Transmitted Infections
• Pregnant teen or rape victims pushed out of family
• Drinking alcohol or kwaso
• Chewing Betel nuts
• Youth residing away from family
• Broken families due to O or O²
• No family bond with new spouse or partner
• Illiteracy
• Poverty.

Factors Contributing to High Risk Behaviours and Vulnerability of Malaita Province MARAs and EVAs:
• Need school fees and transport,
• Peer pressure
• Outside influence, Teens copying outsiders
• Logging camps
• Releasing stress
• Working parents leaving children unattended
• Day students attacked while walking to school
• Unemployment
• Youth coming together in school
• Youth wanting new fashions or things, such as MP3s MP4s, mobile phones

Locations where MARAs and EVAs may be Found:

**Schools**
- Auki CHS
- Tawaimare CHS
- Aligegeo
- Su’u NSS
- Kliusakwalo
- Kiu CHS
- Waidigale
- Adaua PSS

**Communities**
- Auki Town, Market and Games Village
- Wairaha
- Lalisiana
- Kiu Village
- Ambu
- Kokomu Kwai & Ngogosila
- Ngalisigore
- Tuni
- Kwainaketo Village
- Aligegeo
- Fa’arau
- Alimea
- Malu’u Sub-Station
- Kliusakwalo
- Taliva
- Maoa Village
- Gounatolo
- S1 Beach
- Foi
- Radaekoa
- Dala, Hauhui

Selected Sites*
1. Ambu/Kwaiketo
2. Lalisiana
3. Auki Town
4. Airport (Games, Malaita Day)
5. Kiu SSEC Station, logging
6. Malu’u Sub-Station, interaction
7. Dala (South/North) – 1st HIV case

What the Organizations Recommend to Reduce Risks and Vulnerability

14. Kilufi Hospital
   Reproductive health training for adolescents, church leaders, and chiefs

15. Mothers’ Union Centre – Diocese of Malaita
   Parental Skills - Mother-Daughter, Father-Son pairs
   Health workers talk about HIV/AIDS to parents

16. Churches
   Churches take care of victims of sexual abuse, are struggling to address issues of HIV and need funds

17. SCA
   Training for Mothers and Fathers
   Life skills training is being delivered to the community for selected areas only

18. World Vision
   The issue of HIV and Reproductive Health is a big issue that needs to be delivered well to parents and children.
   Illiteracy is a problem for disadvantaged communities.

*Political unrest during data collection limited travel.
Annex 7: Survey Sites Selection
Selected Honiara area survey site and reasons for selection
**Selected Honiara area survey site and reasons for selection**

<table>
<thead>
<tr>
<th>COMMUNITY SITES</th>
<th>REASONS FOR SELECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>White River</td>
<td>Known for having the most young people in Guadalcanal</td>
</tr>
<tr>
<td></td>
<td>Site where sexual activity is negotiated and weekly violence.</td>
</tr>
<tr>
<td>Fishing Village</td>
<td>Site of “mother boats” and where youth get fish for sex and sell them at the market.</td>
</tr>
<tr>
<td>Lordhowe</td>
<td>Site where Polynesian Lao people have settled.</td>
</tr>
<tr>
<td></td>
<td>Overcrowded, strong cultural practices, criminal activity.</td>
</tr>
<tr>
<td>Ranadi dump area</td>
<td>Site of Malaitan settlers who are in survival mode</td>
</tr>
<tr>
<td>Tuvaruhi</td>
<td>Multi-ethnic multi-cultural area, known for many cases of teen pregnancy, abortions and babies thrown in the river.</td>
</tr>
<tr>
<td>Mamana Wotah –</td>
<td>Settlement of Malaitans who gamble at the market at night.</td>
</tr>
<tr>
<td></td>
<td>Don’t want to work in the garden, preferring “easy” money, sell sex.</td>
</tr>
<tr>
<td>Chinatown</td>
<td>Area burned during “tensions”</td>
</tr>
<tr>
<td>Night Clubs</td>
<td>Places where young people go to look for sexual partners</td>
</tr>
<tr>
<td>Wharf</td>
<td>Port Cruz. Site where foreign vessels are at anchorage. Many males and it is easy to buy sex with girls.</td>
</tr>
</tbody>
</table>

**SCHOOL SITES**

<table>
<thead>
<tr>
<th>REASONS FOR SELECTION (GEOG. REPRESENTATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honiara High School</td>
</tr>
<tr>
<td>White River</td>
</tr>
<tr>
<td>Panatina</td>
</tr>
</tbody>
</table>

**Munda area, Western Province survey site and reasons for selection**

<table>
<thead>
<tr>
<th>COMMUNITY SITES</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Dundee Village</td>
<td>Village in Munda area of about 800, headed by chief, traditional culture impacted by economy of logging and fishing</td>
</tr>
<tr>
<td></td>
<td>Neighbouring Lola resort (island)</td>
</tr>
<tr>
<td>Noro Town</td>
<td>Largest industrial and fisheries town</td>
</tr>
<tr>
<td></td>
<td>Market, STC office for base</td>
</tr>
<tr>
<td></td>
<td>Main port - Kitano wharf, Soltaai port, High Risk areas - Backway, Black Town, Cha Cha, Back Yard Beaches - Kokosu Beach, BTM Beach Clubs Hostels</td>
</tr>
<tr>
<td>Kindu</td>
<td>Small village of over 200 on Southern New Georgia coast on road connecting to Lambete, Helena Goldie Hospital and secondary school</td>
</tr>
<tr>
<td>Lambete</td>
<td>Largest village in Munda – market, shops, Bank, post office, telecommunications centre, airstrip with flights to Honiara and Gizo, and small port</td>
</tr>
<tr>
<td></td>
<td>Agnes Lodge on seafront - only tourist accommodation in Munda. Site of local bar and dive shop</td>
</tr>
<tr>
<td></td>
<td>Houses - Japanese House, Blue House, Old Fisheries House, Utilities shop Beaches</td>
</tr>
</tbody>
</table>

**SCHOOL SITES**

<table>
<thead>
<tr>
<th>REASONS FOR SELECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dundee Community High School</td>
</tr>
<tr>
<td>Noro Community High School</td>
</tr>
<tr>
<td>Kokeqolo Community High School</td>
</tr>
</tbody>
</table>
### Gizo area, Western Province survey site and reasons for selection

<table>
<thead>
<tr>
<th>COMMUNITY SITES</th>
<th>REASONS FOR SELECTION</th>
</tr>
</thead>
</table>
| Gizo Town                | District area, Market  
Gizo Hotel  
Green and New Georgia Motels – contact receptionists  
IsP Restaurant                                                                                                                                      |
| Rural Gizo areas         | Million Dollar View  
Tsunami Beach  
Water Pump  
Banana Valley, Hill Top, Lonely Village                                                                                                                                 |
| Vela Island              | Barakoma Village - if weather allows and canoe available, approach through Clinic Nurse, Council Chairman, Chief, or church  
Bilua CHS                                                                                                                                               |
| Tsunami Camps (travel had to be cancelled due to weather) | Titiana 1 and 2 (Gilbertese) - Young People using alcohol, marijuana, and sex as diversions in camp. Displaced people who have no land for subsistence and no income. Education level is low. Gilbertese are very social.  
Nusa Baruku (Gilbertese)  
Paeloge – Melanesian camp formed after the tsunami. People moved up from the coast and those from Simbo Island. They bring coconuts to the Gizo market. |  

### SCHOOL SITES REASONS FOR SELECTION

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<tbody>
<tr>
<td>Gizo Community High School</td>
<td>Gizo industrial centre – High risk</td>
</tr>
<tr>
<td>Ngari Community High School</td>
<td>Constructed as part of the Project to rebuild schools in the Western and Choiseul provinces destroyed or damaged by the effects of the earthquake and tsunami.</td>
</tr>
<tr>
<td>Bilua Community High School</td>
<td>Vela la Vela Island</td>
</tr>
<tr>
<td>Vonunu Provincial Secondary School</td>
<td>Site of high risk behaviour for youth</td>
</tr>
</tbody>
</table>

### Selected Choiseul Province survey site and reasons for selection

<table>
<thead>
<tr>
<th>COMMUNITY SITES</th>
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</tr>
</thead>
</table>
| Taro Station                                 | Airport, tourists  
Transit, restaurants  
Free border access  
Bars, alcohol                                                                                                                                     |
| PoroPoro                                      | Sex for money or smoke  
High level sex activities  
Alcohol, smoking  
Criminal activities  
Fashions                                                                                                                                           |
| Banganoe/Nabusasa                            | Sex for money risk area, many sexual activities  
Illiteracy, Ignorance of parents  
Alcohol use, smoking, gambling  
More youth in populace                                                                          |
| Sasamuga                                     | People still displaced after tsunami, overcrowding  
Alcohol, kwaso, smoking, marijuana  
Increased STI rates  
Transportation – access to Gizo and Noro  
Criminal activities high                                                                       |

### SCHOOL SITES REASONS FOR SELECTION

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</table>
| Choiseul Bay Provincial Secondary School          | Close to town and logging camp station (not operating)  
Young population – students, peer pressures  
Creeping, social activities (bobo night)  
Alcohol, smoking                                                                                   |
| Sasamuga Community High School (CHS)             | Day students walk long distances  
Adolescent population high  
High level sexual activity  
Access to information                                                                             |
## Selected Malaita Province survey site and reasons for selection

<table>
<thead>
<tr>
<th>COMMUNITY SITES</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Auki Town</td>
<td>Town market, wharf, Malaita Day parade, celebrations, showground, tourists, Friday arrival travellers from Honiara, Provincial headquarters</td>
</tr>
<tr>
<td>Gwaunaruu Games Village, Airport (Games, Malaita Day)</td>
<td>Congregation of youth and supporters from throughout province, including those selling sex, due to week long Malaita Day soccer tournament</td>
</tr>
<tr>
<td>Dala (sampled), Ambu/Kwaiketo, Liilisiana, Kiiu, Maluu, (not sampled due to political unrest)</td>
<td>Dala – 1st HIV case  Kiiu – SSEC Station, logging, Liilisiana – poverty, poor health, lack water and food  Maluu - Substation, interaction</td>
</tr>
<tr>
<td>Kware, Fauabu Clinic, Ana'asa soccer field, Boiboilangi, Gwai Dahi, Kwainamoro Garden, Fiu village and market, Klufi, Kwalo, Fote village, Aisalinga, Maoro, Foungwari, Dau Dau, Kwaimela, Kwaisulinu, Molou</td>
<td>These alternate sites sampled due to political unrest</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Auki Community High School</td>
<td>Administrative centre, market, tourism, intense activity</td>
</tr>
<tr>
<td>Aligegeo Provincial Secondary School</td>
<td>Provincial school</td>
</tr>
<tr>
<td>Adaua Provincial Secondary School</td>
<td>Drugs (site not sampled due to political unrest)</td>
</tr>
<tr>
<td>Kilusakwalo Community High School</td>
<td>Christian School</td>
</tr>
</tbody>
</table>
Annex 8: Solomon Islands Research Team

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Understanding HIV and AIDS Risk and Vulnerability Among Solomon Islands Youth