I NO BIN GAT PROTECTION
Understanding HIV and AIDS Risk and Vulnerability Among Vanuatu Youth
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Understanding HIV and AIDS Risk and Vulnerability Among Vanuatu Youth.

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<td>ADB</td>
<td>Asian Development Bank</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AHD</td>
<td>Adolescent Health Development</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CRC</td>
<td>Commission on the Rights of the Child</td>
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<td>CSEC</td>
<td>Commercial and Sexual Exploitation of Children</td>
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<td>DILO</td>
<td>Day-in-the-Life-Of Qualitative Methodology</td>
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<td>DOS</td>
<td>Department of State</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FSP</td>
<td>Foundation for the Peoples of the South Pacific</td>
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<tr>
<td>EVA</td>
<td>Especially Vulnerable Adolescent</td>
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<tr>
<td>EVA/EVYP</td>
<td>Especially Vulnerable Adolescent or Young Person</td>
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<td>EVYP</td>
<td>Especially Vulnerable Young Person</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HIV</td>
<td>Human Immunodeficiency virus</td>
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<td>IATT</td>
<td>Inter-Agency Task Team on HIV and Young People</td>
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<td>IDU</td>
<td>Injecting Drug Use</td>
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<td>IV</td>
<td>Intravenous</td>
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<td>KAP</td>
<td>Knowledge Attitude and Practice</td>
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<td>Most-at-Risk Adolescent or Young Person</td>
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<td>MARYP</td>
<td>Most-at-Risk Young Person</td>
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<td>MARP</td>
<td>Most-at-Risk Population</td>
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<td>MILO</td>
<td>Moment-in-the-Life-Of Qualitative Methodology</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men Having Sex with Men</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>PAPE</td>
<td>Policy, Advocacy, Planning, and Evaluation</td>
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<td>PI</td>
<td>Pacific Island</td>
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<tr>
<td>PLWHA</td>
<td>Person Living With HIV or AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>SDA</td>
<td>Seventh Day Adventist</td>
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<tr>
<td>SPC</td>
<td>The Secretariat of the Pacific Commission</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually-Transmitted Infections</td>
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<td>TV</td>
<td>Television</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>The Joint UN Organisation on HIV/AIDS</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session HIV/AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>US</td>
<td>United States of America</td>
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<tr>
<td>VANGO</td>
<td>Vanuatu Association of Non-Governmental Organisations</td>
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<td>VFHA</td>
<td>Vanuatu Family Health Association</td>
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<tr>
<td>VTU</td>
<td>Vatu currency</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>WPRO</td>
<td>Western Pacific Regional Office (WHO)</td>
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While Vanuatu, like other Pacific Islands Countries (PICs), still experiences a low HIV prevalence of less than one percent in the general population, the country has some unique factors which increases vulnerabilities and risks to HIV infection. Vanuatu has a rapid growing population, with high internal and international migration of young people.

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

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

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

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

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

Dr. Isiye Ndombi,
UNICEF Country Representative
Background and Objectives

One of the goals of the Vanuatu Ministry of Health (MOH) and UNICEF Pacific’s Country Programme for 2008-2012 is to reduce vulnerability to and impact of HIV and AIDS among most at risk populations in selected Pacific Island countries, including Vanuatu. The programme has a special focus on women and children.

The first person was diagnosed with HIV in Vanuatu in 2002, the second by the end of 2003, and the first recorded death in 2006. By the end of 2009, the total number of confirmed HIV positive cases had risen to five. Two males had died and three persons were living with HIV. It is assumed that the actual number of new cases would be higher due to underreporting.

In the early stage HIV epidemic, HIV cases are mostly reported among most-at-risk populations with youth ages 15-24 representing about half of all new HIV infections. Thus, it is important to maintain careful surveillance of the rates of HIV among most-at-risk populations (including most-at-risk adolescents and most-at-risk young people) to understand the driving factors for the epidemic, including knowledge, attitude and practices of identified at-risk populations, and to use the information for strategic programming for HIV prevention. A desk review was undertaken in 2008 with the conclusion that the existing information from Vanuatu was insufficient for that purpose.

In this regard, UNICEF has partnered with MOH to gain a better understanding of risk and vulnerability related to HIV and AIDS among Most-At-Risk and Especially Vulnerable Adolescents (MARAs and EVAs) and Young People (MARYPs and EVYPs) and general population youth in Vanuatu. A study assessing Knowledge, Attitude and Practices on HIV and AIDS among adolescents and young people was conducted in three areas in Vanuatu — Port Vila area, Tanna (Tafea Province) and Malekula (Malampa Province) — from May 2008 to November 2009. Strategic information resulting from this study will be used to guide development of programme interventions as well as establish baseline measures for subsequent monitoring and evaluation on the impact of intervention.

The study aimed to address three formative research questions:

1) 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 Vanuatu?
2) What factors influence current behaviours and could influence future interventions for those Most-At-Risk, Especially Vulnerable and the general youth population?
3) How do these youth currently receive information and advice and what communication methods are likely to be most effective in reaching them?
This research was based on spatial and conceptual mapping that explored the existence of risks to HIV infection as globally defined by UNAIDS and co-sponsors, while assessing the existence of other factors increasing vulnerability among youth. It also facilitated stakeholders coming to a consensus of what constitutes “Vulnerability to HIV” among the youth of Vanuatu.

The significance of this survey is that findings will provide data for development of baseline indicators for tracking progress of HIV and AIDS programme interventions, reveal differences in risk and vulnerability between most-at-risk, especially vulnerable and general population adolescents and young people and facilitate development of more effective HIV and AIDS programmes to reduce risk and vulnerability for youth in Vanuatu. Furthermore, survey findings will be used in development and selection of policy options.

**Terminology**

This report uses “adolescent” to describe those of 15-19 years, “young people” to describe the 20-24 year old group, and “youth” for this sample of 15-24 years. The terms Most-At-Risk Adolescent (MARA), Most-At-Risk Young Person (MARYP), Especially Vulnerable Adolescent (EVA) and Especially Vulnerable Young Person (EVYP) are used in accordance with international standards. The term “increased risk” is utilised for the purpose of describing those who are not “most” at risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth.

**Methodology**

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

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

Consultative mapping workshop data was triangulated through a two-level approach at the community level and by most-at-risk and especially vulnerable youth. In Vanuatu, the Port Vila area, Tanna in Tafea Province, and Malekula in Malampa Province were sampled. Tafea Province and the Port Vila area were selected because they will be the focus of initial programme implementation by MOH and UNICEF, and Malampa Province because it will serve as a control area. One-third of this sample was school-based since about one-third of this target population is enrolled in school.

The targeted sample size for Vanuatu was 350 with a confidence level of 95% and confidence interval of 5.2 based on an estimated total population of 21,887 youth aged 15-24 years in the two provinces and Port Vila area being sampled. Based on a proportional coefficient, the targeted sample size by province was about 130 for the Port Vila area, 97 for Tafea Province, and 122 for Malampa Province. The targeted sample sizes were exceeded.
The chosen sampling strategy offers baseline data and indicators for measuring progress in Vanuatu, as well as spatial and contextual information concerning MARA/MARYP, EVA/EVYP, and general population youth. The sampling strategy does not produce statistically representative data which can be extrapolated to the entire country of Vanuatu. It is acknowledged that there are several confounding factors, including the inverse relationship between level of vulnerability and likelihood of being interviewed, invisibility of family vulnerability, and potential unwillingness for interviewees to discuss private information related to their vulnerability. The study population was small, not random and the total number of the study population was estimated, but not known. These study results, however, have the potential to make a substantial contribution to effectiveness of intervention efforts related to lowering risk and vulnerability of these target populations.

Findings
Research findings provided information on contexts of risk and vulnerability for these youth:

1. Demographic data revealed most youth were not married (87%), not employed (60%), not in school (80%), and not living on their home island (51%) where they had parental and community support.

2. Findings related to knowledge revealed a relatively low level (24%) of comprehensive knowledge of HIV and AIDS, lack of belief in their personal risk (65%), and lack of focus on changing unsafe behaviour despite a basic understanding of risks. Only 10% sexually active youth had been tested for HIV and received their results.

3. Data on attitudes of these youth elucidated problematic issues related to promoting safer sex. Less than 60% of respondents had used a condom, although 70% were sexually active. Forty-six percent said their parents talked with them about sexuality and prevention of HIV. Responses to a girl dropping a condom packet or boy seen leaving an STI clinic included embarrassment, fear, and suspicion.
Research areas included several practices that increase risk and vulnerability to HIV and AIDS, including:

1. Fourteen (8%) sexually active males reported having had MSM, 11/14 unprotected, with number of partners ranging from 1-6 and 12-16 per month as reported by a key informant. Forced sex of MSM was reported by 60% in Vanuatu.

2. Sixty-six respondents in the sample, including 22 males, engaged in commercial sex and 101 in transactional sex. Only 39% of them reported using a condom at last sex.

3. Forty-five percent of sexually active youth reported forced sex with ongoing vulnerability for 39%. First sex was forced for 36% of sexually active youth overall and 43% for Port Vila area interviewees.

4. Sexually active youth reported 42% condom use at last high-risk sex (with non-regular partner), indicating 58% were having unprotected high-risk sex. Condom use at last sex (46%) was similar.

5. Increased risk related to substance use was significant. Forty-three percent of the sample reported alcohol use, 34% kava, and 18% homebrew. The rate of frequent alcohol consumption (more than three times per week) was 7.3%. No interviewee reported IDU, but five reported sharing needles.

6. Those who had first sex before age 15 were 11.4% of all 15-19 year olds sampled: 8.5% for Port Vila, 11.8% Tanna, and 14.4% Malekula, with some youth reporting sex as young as 7 years old.

7. Data on healthcare utilisation indicated utilisation of health workers as sources of information on HIV and AIDS or as a source for condoms was higher for males than females. Utilisation of clinics as a source of condoms was 56% for males and 43% for females. Forty-eight percent of most-at-risk adolescents and 55% most-at-risk young people reported attending an HIV prevention workshop.

8. Communication findings indicated that 59% read the newspaper once a week. Fifty-five percent had access to a working radio; 45% had access to a working TV; and about 81% to a mobile phone. Sixty-two percent listened to the radio and 50% watched TV with listening and viewing patterns having largest numbers on weekends and lowest in mid-week. There was little difference between current, preferred, and trusted sources of information on HIV and AIDS. Fifty-nine percent had attended a program on preventing HIV; 63% had heard an AIDS programme on radio; 92% had seen a poster; and 81% had seen a video on HIV or AIDS.
Discussion of issues related to these findings is organised in three sections addressing issues of general population, or mainstream, youth who are not involved in high-risk behaviours; most-at-risk youth who are engaged in the highest risk behaviours; and vulnerable and increased risk youth who are more likely to start engaging in risk behaviours due to exposure to vulnerability factors or are engaging in less risky behaviours.

Areas of high risk for those most-at-risk in Vanuatu are commercial/transactional sex, and small numbers of MSM and IDU. Additional data on risk behaviours of those who have become infected will be required to elucidate the contribution of sex work, MSM and IDU to epidemic spread, but the most-at-risk populations are said to include commercial sex workers, MSM, IDU, and mobile workers. There are several factors contributing to the risk level of vulnerable and increased risk youth in Vanuatu including: substance use, forced sex, early onset sex, and unprotected sex.

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

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

I. HIV programme targeting Most-at-Risk Adolescents and Young People (MARA/YP) and Especially Vulnerable Adolescents and Young People (EVA/YP)
The KAP survey gives strong evidence that MARA/YP and EVA/YP groups are more at risk and vulnerable to HIV and AIDS among sampled adolescents and young people. The survey sample of 510 youth, of whom 326 were sexually active, included 66 respondents who engaged in commercial and/or transactional sex. Sixty-one of the 66 were also engaged in transactional sex plus an additional 39 who only had transactional sex for a total of 100. Sixty-six respondents who reported commercial sex constituted 20.2% of sexually active youth in this sample and by gender, 22 (13.4%) of males and 44 (27.2%) of females. In relation to their risk behaviours, 59% were having transactional sex in comparison to about 30% of those not having commercial or transactional sex. Findings also demonstrate a higher percentage of risk (MARA/MARYP) females (28.6%) than males (24.3%) and vulnerability for females (EVA/EVYP) (20.7%) than males (16.4%).

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

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

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

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

The survey shows that only 10% of Vanuatu respondents were tested for HIV and received their results, highlighting the concern that MARA/YP and EVA/YP are not accessing SRH services to an acceptable level. Several reasons cited include services are not readily available, not accessible, or not friendly to young people. The study has also shown that many adolescents and young boys and girls are unaware of the existence of SRH services, while others do not feel the need to use SRH services. There is a need to scale up SRH services for adolescents and young people that meet the agreed national standards. As an initial step, the government needs to issue guidance on minimum standards for SRH that are youth-friendly, and address the needs of adolescents and young people as identified by adolescents and young people themselves.

Access to and the use of SRH services by adolescents and young people complement other prevention interventions. The SRH services should include information dissemination, STI management, family planning, HIV counselling and testing services, and other counselling services. The KAP study also shows that Vanuatu youth trust health facilities and health workers as their sources of information thus providing an opportunity to disseminate relevant and correct information to young people who are in contact with healthcare providers.
IV. Strengthen Communication for Development Programs for dissemination of HIV and AIDS prevention messages that are relevant to young girls and boys through suitable communication channels

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

V. Strengthen partnership and coordination among programme stakeholders

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

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

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

VII. Provide opportunities for livelihood

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

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HIV and AIDS in Vanuatu

The Government of Vanuatu and UNICEF Pacific had agreed on a five-year programme from 2008-2012 with HIV and AIDS as one of the five components. One goal of the HIV and AIDS programme component is to reduce vulnerability and risk to HIV and AIDS for the most-at-risk populations in Vanuatu, with a special focus on women and children.

Both the Government and UNICEF had agreed on expected outputs by 2012 that include change of risk behaviours among Most-At-Risk Adolescents, Most-At-Risk Youths and especially women in selected areas of Vanuatu; improved access to reproductive health and Preventing Mother To Child Transmission (PMTCT) services for women, children, PLWHA their families; and increased participation and ownerships of STI, HIV and AIDS prevention programme among targeted populations.

Vanuatu, formerly New Hebrides, is a group of about 80 islands in the South Pacific with a land area of 12,185 square kilometres. The population, estimated at 218,519 (July 2009 est.), comprise of 94% indigenous Melanesians. They speak 105 local languages that include Pidgin (known as Bislama) 23.1%, English 1.9%, French 1.4%, other 0.3%, and unspecified 0.7% (1999 Census). About 30,000 live in the capital, Port Vila; 9,600 in Luganville; and the remainder in rural areas. Natural hazards that occur in this country are tropical cyclones or typhoons, volcanic eruptions, earthquakes, and tsunamis. The economy is primarily based on small-scale agriculture, fishing, offshore financial services and tourism.

The first person was diagnosed with HIV in Vanuatu in 2002. By 2007, three cases had been confirmed, included two females and one male, one of whom died in 2006. The second female diagnosed was the child of the first diagnosed. It is assumed that the actual number of new cases is higher due to underreporting.

In 2005, HIV and AIDS cases were reported to MOH, but no systematic reporting of results was in place. Information was reported to be incomplete due to low reporting rates, underreporting and incorrect classification. The Pacific region was said to be a high probability that HIV was underreported and underestimated; VCCT was not accessible; blood screening varied; avoidance resulted from lack of faith in the healthcare system and fear of stigma.

An alarming rate of violence perpetrated by men against women and children was reported in 2002 in Vanuatu, where reported sexual offences had more than doubled since the late 1980s. Other forms of violence, such as urban-based gang crime, tribal disputes, and civil disturbances, also exposed women to the risks of contracting STIs and HIV. Most cases of violence against women nevertheless went unreported, under-recorded and under-prosecuted. It was common for police to refer domestic violence cases to local chiefs, with the result that many were incomplete or withdrawn.
Violence against women and children that were not reported nor prosecuted remains until today. In 2002, the Mavatmauri Chief’s Council tried to ban trousers for women, claiming that “trousers cause men to rape women”.15 The same claim was made in the Tanna mapping workshop. In 2002, as part of an enumeration of PICs risk factors, Vanuatu received special mention for youth STIs and pregnancy, transactional sex, low condom use, low status of women, depressed economy, and rapid urbanisation.

In 2005, the risk factors included low condom use, proximity to high prevalence HIV, international travel, tourism, multiple sex partners, transactional sex, low status of women, and cultural and religious attitudes discouraging condoms. Sexual abuse and incest were also said to be common, with female children from a previous relationship and adopted children were at risk of sexual abuse in the family especially by the stepfather or grandfather.17 Similar risks were found during this research.

In 2007, ethnic violence in Blacksands squatter camp on the outskirts of Port Vila claimed three fatalities and led to a state of emergency.18 The impact of that ethnic strife remains today in Blacksands which was one of the sampled areas for this research. In 2007, a chief called for MOH to publish names of people with HIV and AIDS and blamed MOH for epidemic spread.19 These belief, stigma and fear were also expressed in stakeholders Focus Group Discussions and mapping workshops during the research. Nonetheless, the passing of the passage of the Family Protection Act that provides women and children with strengthened protection from domestic violence is a significant accomplishment.

Definitions

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

The definition of adolescence as 15-19 years of age has been accepted by Vanuatu leader, stakeholders and youth for this purpose although some of them consider adolescence to last longer than 19 years of age. Likewise, 20-24 year olds are termed young people in this report. These terms refer to both males and females.

While UNICEF program interests are in adolescents aged 10-19 years of age, this study focuses on the 15-24 year age group because of ethical issues in collection of data for those under 15, and also because it made sense to include 20-24 year olds, rather than focus only on 15-19 year olds in relation to the study objectives.

The terms Most-at-Risk Adolescent (MARA), Most-at-Risk Young Person (MARYP), Especially Vulnerable Adolescent (EVA) and Especially Vulnerable Young Person (EVYP) are used in accordance with international standards. The term “increased risk” is utilised in this report for the purpose of describing those who are not “most” at risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth.
Ethical Considerations
This research put the utmost priority on ethical concerns. These include strict maintenance of confidentiality, informed consent, security of data, code of conduct for data collectors, respect for interviewees and community members, careful training of the team, a reference group of young people to assist in the research, and working with service providers to the target populations. Following data collection, confidentiality was maintained for all notes, recordings, and other records; with transportation of recorded questionnaires in secured boxes; and subsequent storage of recorded questionnaires in secure offices. Only those with a need to use the data for data checking, cleaning, entry, analysis and reporting had access to these files. Following completion of the research, records are being retained in a secure and locked place by UNICEF Pacific for seven years and will be destroyed prior to disposal or transferred to appropriate Vanuatu health officials.

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

1. Spatial and contextual nature of risk and vulnerability to HIV and AIDS among Most-at-Risk Adolescents (MARAs) and Young People (MARYPs), Especially Vulnerable Adolescents (EVAs) and Young People (EVYPs) in Vanuatu.
2. Factors influencing risk, vulnerability, and the potential of future interventions to reduce risk and vulnerability to HIV and AIDS in Vanuatu.
3. Current and desired communication patterns and factors potentially influencing future communication concerning information and advice on HIV and AIDS.
The following key research questions were designed to address objectives of the study:

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

The methods chosen to answer these key questions were:

1. Spatial and contextual mapping to locate MARA, MARYP, EVA, and EVYP groups
2. Knowledge Attitude and Practice (KAP) survey of sampled respondents from the above groups, as well as general population adolescents and young people, through: Quantitative structured questionnaire, Qualitative semistructured questionnaires (Focus Group Discussion and Key Informant Interviews/ KIs).

The core objectives of this study were directly linked to research questions which determined the survey methodology and sampling strategy. Samples were taken from Port Vila area, Tanna of Tafea Province, and Malekula of Malampa Province. One-third of this sample was school-based since about one-third of those in the target population were in school. These methods and sampling strategy, are illustrated in Table 1.
Table 1: Linking HIV and AIDS core objectives to sampling

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

To conduct mapping of MARA, EVA, MARYP, and EVYP, in relation to spatial and contextual issues related to risk and vulnerability to HIV and AIDS, three consultative mapping workshops were held at the MOH office in Port Vila; Lenakel Hospital in Tafea Province; and Norsup Hospital in Lakatoro, Malampa Province. In each case, mapping workshops preceded any data collection activities.

Workshop participants included representatives of all relevant stakeholders; including health and social service providers; staff members from MOH; civil service organisations working with MARPs, adolescents and youth; staff members from UNICEF Vanuatu, and selected young people. For mapping workshops outside Port Vila, workshop participants included relevant stakeholders in each area. Through participatory methods of facilitation, participants of each consultative workshop:

- Gained an understanding on how risk to HIV and AIDS and vulnerability is defined globally, sought and reached consensus for a local definition among stakeholders.
- Provided information on what were considered locally to be risk factors for HIV and AIDS; on factors increasing vulnerability among adolescents and youth, and underlying factors.
- Provided information on specific sites within areas identified by participants as places where most MARA/MARYPs and EVA/EVYPs were located in the Port Vila area; Tanna, Tafea Province; and Malekula, Malampa Province. Provided information on logistics for contacting data sources.

Throughout all the workshops, data was recorded on flip charts by Vanuatu Research Assistants.
KAP Data Collection
Data was collected from the sampled population through quantitative and qualitative research methods, as described below.

Quantitative Research Methods

A. Sampling method
Field research involved “purposive” sampling to select research locations within Vanuatu. Specifically, data collection was carried out within the areas of Port Vila and Tafea Province, where Vanuatu MOH and UNICEF Pacific will implement programming, and Malampa Province that will serve as a control area. A National Consultative Mapping Workshop in Port Vila and Provincial workshops in Tanna, Tafea Province and Malekula, Malampa Province provided data to guide choice of individual locations within each area.

The targeted sample size for KAP quantitative questionnaires in Vanuatu was 350, with a confidence level of 95% and confidence interval of 5.2 based on an estimated total population of 21,887 youth aged 15-24 years in the two provinces and Port Vila area being sampled. Based on a proportional coefficient, sample sizes by province were: 130 for the Port Vila area, 97 for Tafea Province, and 122 for Malampa Province. The actual sampled size for KAP questionnaires was 213 for Port Vila, 130 for Tafea Province, and 167 for Malampa Province for a total of 510, exceeding the 350 target.

Within each area, locations were purposively selected during the mapping workshop to include those areas with the most risk and vulnerability among adolescents and young people. This study did not target a cross-section of the population as a whole, but a cross-section of youth who were most-at-risk and especially vulnerable, as well as mainstream youth.

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

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

The quantitative KAP survey questionnaire was developed to address core objectives of the study. Thus, it addressed gaps that had been identified in a previous desk review of baseline indicators for HIV and AIDS programming, specifically in relation to: 1) risk behaviours and contexts of vulnerability for MARA/ MARYP, EVA/ EVYP, and general population youth; 2) factors influencing risk and vulnerability and potentially influencing potential future interventions intended to reduce risk and vulnerability; and 3) current and desired communication patterns and factors that might influence future communication and advice on HIV and AIDS. It was developed to collect data that would serve as baseline indicators and also guide subsequent programme and policy development. The development was through a collaborative and iterative process with the country involved. Methodology and tools were reviewed in Vanuatu with MOH staff to assure that specific local issues were addressed.

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

Utilising the quantitative KAP survey tool, most-at-risk, especially vulnerable, and general population youth were asked their demographic information; knowledge of STIs and AIDS; perception of personal risk; age at first sex and whether forced or intoxicated; their attitudes and practices relating to risk and vulnerability, including condom use and accessibility; community support; utilisation of health and social services; risk behaviours; context of vulnerability; where they obtained information about HIV, AIDS, and STIs; what information sources they preferred; and their recommendations for decreasing risk and vulnerability to HIV and AIDS for youth.

C. Field testing

Data collector training in asking questions in Bislama, Vanuatu language, utilising the English language questionnaire and field testing of the KAP Questionnaire (Annex 5) were held immediately after the mapping workshop following a structured curriculum and rehearsal of interview techniques. Data collectors in the Port Vila area, Tanna and Malekula read each question in English and Vanuatu Bislama, discussed what it meant in English and Bislama, and did practice interviews with each other as part of their training. Subsequently, the research team tested the questionnaire at local schools with immediate review of completed questionnaires, provision of answers to data collector questions, and guidance following each individual interview. Participatory input to survey tools was solicited from youth who acted as a reference group during field testing and data collection.
D. Data Collection

Subsequent data collection was based on mapping workshop recommendations, as those recommendations directly influenced interview site selection. Among other locations, Port Vila data was collected in markets, clubs, hotels, beaches, settlements and on the wharf; Tanna, Tafea Province data was collected in transits and clubs; Malekula, Malampa Province data was collected in hotels, beaches, wharfs, sports fields and markets. The team was unable to collect data from prisons. The research team met daily to review progress, make any revisions in plans, and assess what additional areas should be sampled.

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

The team adjusted the interview schedule and venues as was necessary to reach those most-at-risk and especially vulnerable, and sought to provide interview places where interviewees felt secure. Nonetheless, interviewees were extremely helpful and were interviewed in noisy transits, on the wharf, in markets, on the road, in schools, gardens, and at their homes.

The research team worked with individuals and such organisations as Wan Smol Bag, Save the Children, and Foundation for the Peoples of the South Pacific Vanuatu, and Vanuatu Red Cross to assist with contacts, locating interviewees, meeting space, and transportation. In addition to providing assistance with access, these organisations were in a position to provide short-term support as well as ongoing sustainable services, for those who might be in need following the interview to which the team was unable to provide.

Qualitative data collection

A. Selection of respondents/interviewees

During data collection, key informants were purposefully sought in relation to issues which arose during data collection, such as school students selling sex or getting raped while walking long distances to school, incest, MSM, and young girls who exchanged sex for money or gifts in clubs, houses, or the bush. Issues related to community support were studied through focus groups and key informant interviews, including with community members and stakeholders. Data collection focused on perceived support by respondents, actual support provided by communities and family members and attitude of community members towards most-at-risk and especially vulnerable youth, including their fear and prejudice. The study also explored the possible role of the communities in providing support to MARA/ MARYP, EVA/EVYP and general population youth.
The attitude and practices of health and social service providers, such as CBOs and NGOs dealing with HIV prevention issues for youth, was explored through their participation in focus group discussions and key informant interviews. Social service providers to youth included churches, NGOs, social service staff, and community organisations.

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

Mainstream adolescents and youth were non-randomly sampled for FGDs with the intention of illuminating the issues of risk and vulnerability for mainstream youth, obtaining their input on how to reduce risk and vulnerability, their views on issues related to receiving information and support, and as a basis for programme and policy development. Sample selection was purposeful in relation to both their place of residence and providing adequate and diverse samples of youth in Port Vila area; Tanna, Tafea Province; and Malekula, Malampa Province.

Sample Justification: The sampling strategy for mainstream youth and overall sample size was set to provide an adequate basis for examining a range of issues affecting these populations and to illuminate quantitative information obtained by the KAP questionnaire.

MARA/ MARYP and EVA/ EVYP were non-randomly sampled to participate in KIIs and FGDs with the aim of providing information-rich cases upon which to base programme and policy development. As in the quantitative component, the intention was to provide a balance in the nature of risks and vulnerabilities. To reach these populations, the research team utilised the knowledge and experience of a reference group of representatives, organisations providing services, and community members. Additionally, the team used a snowball technique to seek out additional respondents at high risk and vulnerability when appropriate.

Sample Justification: It was felt that 10-25 KIIs would provide an adequate sample of information-rich cases, but the team planned to interview to redundancy. Nineteen KIIs were completed. Likewise, up to 27 FGDs were expected to provide an adequate base for examining a range of issues affecting these populations and 33 FGDs were completed.

Members of Stakeholders, Health & Social Service Providers, and Community Members and Leaders were non-randomly and purposefully selected to provide special knowledge related to the issues of risk and vulnerability related to HIV and AIDS for the target populations of MARA/ MARYP, EVA/ EVYP, and general population youth.

Sample Justification: The sampling strategy of one FGD per sampling location intended to provide adequate information on populations providing information, services and support, including their special knowledge of target populations. The target was met.
B. Focus Group Discussions

Focus group discussions were held with general population youth in schools and villages; and with female sex workers in community sites, including bars, hotels and community sites. Each group of data collectors, who were part of the target age group, also participated in a focus group to provide their observations at the end of the data collection period. A focus group of stakeholders provided input to issues of community support, attitudes and perceptions of HIV and AIDS risk and vulnerability. Focus Group Discussions involved six to 20 persons led by the Lead Researcher and Research Assistants, who recorded in Vanuatu Bislama and English. An FGD script was utilised (see Annex 5), but was revised as appropriate. FGDs lasted about one to two hours. Data were transcribed and analysed for themes and relevant information.

Key Informant Interviews

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

What the sampling strategy offers

This formative research provides spatial and contextual information concerning MARA/ MARYP and EVA/ EVYP youth through findings from Port Vila area; Tanna, Tafea Province; and Malekula, Malampa Province mapping workshops and qualitative data on the nature of risk and vulnerability to inform HIV prevention programme interventions for MARA/ MARYP and EVA/ EVYP youth, including community support and communication strategies. This would not be possible through probability sampling.

What the sampling strategy does not offer

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

Limitations

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

Spatial and Contextual Mapping Results

Spatial and Contextual mapping provided the following:

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

Table 2 below summarises the risk, vulnerability, and contributing factors that were identified by workshop participants in Port Vila for Vanuatu National Consultative Workshop; Tanna, Tafea Province and Malekula, Malampa Province in relation to what the research team should expect to find during the research period.
Table 2:

<table>
<thead>
<tr>
<th>Risk Behaviours</th>
<th>Contexts of Vulnerability</th>
<th>Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial sex – including child prostitution of both sexes</td>
<td>School dropouts – shame, hiding in bush</td>
<td>Socio-cultural events, e.g. death ceremonies, sex &amp; drugs</td>
</tr>
<tr>
<td>Transactional sex – alcohol, kava, marijuana, clothes, food, transport</td>
<td>Teen pregnancy – single mothers</td>
<td>Poverty, Unemployment</td>
</tr>
<tr>
<td>Males sex with males</td>
<td>Gender inequality – inability of females to negotiate safer sex or refuse sex</td>
<td>Little participation in decision-making, especially females</td>
</tr>
<tr>
<td>Unprotected sex</td>
<td>Forced sex, including gang rape, incest</td>
<td>School rules and religions ban contraceptive use</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>Drug use, including cultivation and marketing</td>
<td>Lack of support from community leader</td>
</tr>
<tr>
<td>Drug use, including cultivation and marketing, mainly marijuana</td>
<td>Displaced populations</td>
<td>High rates STIs</td>
</tr>
<tr>
<td></td>
<td>Teen prostitution</td>
<td>Lack of parental support</td>
</tr>
<tr>
<td></td>
<td>Lack of education, lack information, illiteracy</td>
<td>Adolescents living away from home – school, work, with relative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health – anxiety, depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of information</td>
</tr>
<tr>
<td>Additional Issues – Tafea and Malampa Provinces</td>
<td>Consumption methylated spirits (Coleman fuel)</td>
<td>Nightclubs</td>
</tr>
<tr>
<td></td>
<td>Early Onset Sex</td>
<td>Boarding School</td>
</tr>
<tr>
<td></td>
<td>Pornography</td>
<td>Market days, tourism, mobile populations especially Port Vila.</td>
</tr>
<tr>
<td></td>
<td>Arranged marriage at menarche</td>
<td>Logging</td>
</tr>
<tr>
<td></td>
<td>Abortions</td>
<td>Bell-shaped flower homebrew</td>
</tr>
<tr>
<td></td>
<td>Young boys having sex with widows, Tawian system – in-laws available sexually</td>
<td>Entamelen – closed, isolated custom village</td>
</tr>
</tbody>
</table>
The sample also included more adolescents (62%) than young people (38%) by design due to the focus on adolescents for this survey and one-third randomly sampled from schools, since about one-third of this population attends school.

Figure 2 shows the demographics of the sample by gender and risk category. The risk category is an informal classification based on globally accepted definitions for these groups with the exception of increased risk, which is utilised for those who are not “most” at risk or “exceptionally” vulnerable, but have more risk or vulnerability than most mainstream youth. The chart demonstrates a higher percentage of risk (MARA/MARYP) females (28.6%) than males (24.3%) in this sample and vulnerability for females (EVA/EVYP) (20.7%) than males (16.4%) as well as a higher percentage of those at increased risk (8.2%) for males than females (1.9%).
Residences
As shown in Figure 3, 71% of those surveyed were living with their family, 16% with other relatives, and a lower percentage of adolescent males living with family and other relatives than 20-24 year old males and for females essentially the same for adolescents and 20-24 year olds. No respondents of this sample reported living on the street.

Figure 4 indicates that a higher percentage of youth who were MARYP, EVA and increased risk were living with their families than MARA, EVYP, and mainstream. It shows that slightly over half these youth were living away from their home island, ranging from 46% EVAs and EVYPs to 63% MARYP.
School Enrollment

Almost one-fifth (19.7%) of the community-based portion of this sample reported being enrolled full time in school as shown in Figure 5, with males and adolescents having the highest levels of enrolment at 25.8% and 28.5% respectively.

As shown in Figure 6, the highest enrolment by risk was for mainstream youth at 56% with EVYPs the lowest at 13.5%. Figure 7 indicates that 83% of those enrolled were enrolled at secondary school level and 14% enrolled in college or university level with more males than females enrolled overall, except at secondary school level. Likewise, there were six times as many adolescents enrolled as young people.

A higher percentage of MARYPs were enrolled at primary school level than other risk categories, as shown in Figure 8. Mainstream youth had the

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![Figure 5. School enrollment by gender and age group](image5)

![Figure 6. School enrollment by risk category](image6)

![Figure 7. School level by gender and age group](image7)
highest number of college level students. The secondary school level had the highest level of enrollment at 83.2% with numbers too low to support conclusions related to the relationship between risk category and school level.

Figure 7. School level by gender and age group

Figure 8. School level by risk category
Employment

Figure 9 indicates that 40% percent of the community-based portion of the sample was in salaried jobs or self-employed at the time of the survey with a higher percentage of employed males (48%) than females (34%) and young people (51%) almost two times the percentage of adolescents (29%). Sixteen percent of the school-based population was employed.

In the entire sample, MARYPs (52.5%) and EVYPs (52%) had the highest percentages of employment with EVAs at the lowest percentage (27%), as shown in Figure 10.

Figure 11 shows that for the community-based portion of the sample, types of jobs differed by gender with 10% of males employed in professional jobs compared to 5% females, 42% females employed in service jobs compared to 33% males. Thirty-two percent of community-based employed portion of the sample were adolescents and 68% young people.

Of those 30 employed with children, 12 males and 18 females had caretakers for their children. Only three of those with caretakers were adolescents and the remaining 27 were young people. Eighteen out of 30 utilised family members to care for their children.

Of those 129 employed, 41% (53) earned more than 10,000 Vatu, with twice the percentage males as females earning that amount. There was little difference in variation by gender for those earning 5,000-

![Figure 9. Employment by gender and age](image)

![Figure 10. Employment by risk category](image)

![Figure 11. Employment type by gender and age](image)
10,000 Vatu, and more than three times the percentage females as males earning less than 5,000 Vatu. There were more than twice the percentage young people as adolescents earning more than 10,000 Vatu and almost twice the percentage adolescents earning less than 5,000 Vatu and 1.5 times earning 5,000-10,000 Vatu.

As is shown in Figure 13, four MARA, 18 MARYP, 14 EVYP, one increased risk and 16 mainstream youth, 41% of those employed, made more than 10,000 Vatu per fortnight. In 2008, minimum wage in Vanuatu was raised to USD244 per month, or 11620 Vatu per fortnight.22

<table>
<thead>
<tr>
<th>Category</th>
<th>Less than SBD200</th>
<th>SBD200-500</th>
<th>More than SBD500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>37.5%</td>
<td>42.5%</td>
<td>20%</td>
</tr>
<tr>
<td>Young Person</td>
<td>20.2%</td>
<td>29.2%</td>
<td>50.6%</td>
</tr>
<tr>
<td>Male</td>
<td>12.9%</td>
<td>34.3%</td>
<td>52.9%</td>
</tr>
<tr>
<td>Female</td>
<td>40.7%</td>
<td>32.2%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Total (N=129)</td>
<td>25.6%</td>
<td>33.3%</td>
<td>41.1%</td>
</tr>
</tbody>
</table>

Figure 12. Forthnightly earnings by gender and age

<table>
<thead>
<tr>
<th>Category</th>
<th>Less than SBD200</th>
<th>SBD200-500</th>
<th>More than SBD500</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA</td>
<td>35.7%</td>
<td>35.7%</td>
<td>28.6%</td>
</tr>
<tr>
<td>MARYP</td>
<td>9.7%</td>
<td>32.3%</td>
<td>58.1%</td>
</tr>
<tr>
<td>EVA</td>
<td></td>
<td>57.1%</td>
<td>42.9%</td>
</tr>
<tr>
<td>EVYP</td>
<td>23.1%</td>
<td>53.8%</td>
<td></td>
</tr>
<tr>
<td>Inc. Risk</td>
<td>33.3%</td>
<td>33.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Mainstream</td>
<td>29.8%</td>
<td>36.2%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Total (N=128)</td>
<td>25.8%</td>
<td>32.8%</td>
<td>41.4%</td>
</tr>
</tbody>
</table>

Figure 13. Forthnightly earnings by risk category
Marital Status

Eighty-five percent of this sample of 15-24 year olds had never been married as shown in Figure 14, with 13% having been married or living with a partner, and 2% separated or divorced.

As depicted in Figure 15, the percentage of adolescents who had never been married (95.5%) was higher than young people (66.5%); the percentage of those who were married or living with a partner was higher for young people (28.8%) than for adolescents (3.8%); as was the percentage of young people who had been separated or divorced (4.2%) higher than for adolescents (0.6%).

Figure 14 Marital Status
Those who had never been married in this sample ranged from EVYP at 53% to MARA at 92%; the percentages of those who had been married or living with a partner ranged from 7% for MARA to 43% for EVYP; and those who had been divorced or separated ranged from none for EVA to 6% for MARYP. The percentages for the overall sample were: 85% never married, 13% married or living with a partner, and 2% divorced or separated.
Knowledge

Comprehensive Knowledge on HIV and AIDS

Twenty-four percent of the respondents could correctly answer all five standard UNGASS standard indicator questions on three ways to prevent HIV infection and reject two common misconceptions. The percentage correctly answering each single question is shown in Figure 17 below. The percentage of interviewees correctly answering the question about sharing a meal was 19% higher than those correctly answering about not getting infected with HIV by mosquito bite.

As shown in Figure 18, increased risk youth had the lowest comprehensive knowledge at 13%, and EVYPs the highest at 30%.

Knowledge of Individual HIV and AIDS facts

Figure 17. Knowledge of Individual HIV and AIDS facts

Figure 18. Comprehensive knowledge by risk category
Comparison of respondents answering correctly by gender, age, and school- or community-based interview shows that the percentages of those who correctly answer all five questions varies by gender, age and school- or community-base as shown in Figure 19 below. It shows that males demonstrated comprehensive knowledge (29%) almost 1.5 times the percentage of females (20%); young people (27%) 4% higher than adolescents (23%); and community-based respondents (24%) the same as school-based respondents (24%).

Figure 19. Comprehensive knowledge of HIV and AIDS by gender, age, school or community

Figure 20 shows the area with the highest percentage of youth demonstrating comprehensive knowledge of HIV was in the Port Vila area (34%), followed by Malekula, Malampa Province (19%), and Tanna, Tafea Province (14%).

Figure 20. Comprehensive knowledge of HIV and AIDS by province
As shown in Figure 21, there was 2-9% difference in knowledge between males and females, with males having the higher level, except that a 2% higher percentage of females knew that a healthy looking person could be HIV positive. Likewise, there was 2-7% difference by age, with young people having the higher level than adolescents.

Knowledge on these topics as in Figure 22 was uneven, with highest scores on whether they heard of sexually transmitted diseases and lowest on knowing that a healthy-looking person can be infected with HIV. The lowest overall score for that question was by MARAs (54%). The highest overall score was 95% for those at increased risk on whether they knew about ways to avoid HIV infection.

Knowledge and Belief in Their Own Risk

When asked if they thought they were personally at risk of HIV, 35% of the sample answered yes with a higher percentage of males (50%) than females (22%), and young people (38%) than adolescents (33%), as shown in Figure 23. Forty-seven percent overall said they did not think they were personally at risk and 24% of females and 11% of males said they did not know if they were personally at risk.
The responses to the question on personal risk by risk category almost reflected the risks they are assumed to have had. Those who were classified as mainstream had the lowest percentage of thinking they were personally at risk with those classified as especially vulnerable and at increased risk next. Those who were MARA and MARYP had the highest percentage thinking they were personally at risk, as displayed in Figure 24.
Risk Perception
When the 35% of this sample who answered that they were personally at risk were asked for the reasons, their answers reflected the actual data on risk and vulnerability.

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

<table>
<thead>
<tr>
<th>Risk</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night clubs</td>
<td>“Yes (at risk) if I go to night club.”</td>
</tr>
<tr>
<td>Forced Sex</td>
<td>“Yes – I had 10 boys gang raped me.”</td>
</tr>
<tr>
<td>Unprotected Sex, multiple partners</td>
<td>“Excited to have activity and forget protection – 5 partners per month.”</td>
</tr>
<tr>
<td>Commercial Sex</td>
<td>“I agree (to sell sex) coz it’s one way I know how to live in this town.”</td>
</tr>
<tr>
<td>Substance Use</td>
<td>“Yes (vulnerable to forced sex) if I drink kava or alcohol.”</td>
</tr>
<tr>
<td>Uncertain of partner</td>
<td>“I don’t know if (my) partner (is) infected or not.”</td>
</tr>
</tbody>
</table>

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

- **Being Responsible**
  “No cure and you die – can destroy your family home, even affect your children.”

- **Desire to have safe sex**
  “Thank you for including me in this survey. I realise all the wrong things I do. I really learned something useful today.”
Knowledge of their HIV Status

In this sample, 10% of 15-24 year old youth had HIV testing and received their results. Information on age of consent for testing was not available. Figure 25 compares percentages of interviewees from Port Vila area, Tanna, and Malekula who were tested and received results.

Fifteen percent of those surveyed in Vanuatu have been tested for HIV and 10% have been tested and received their results (CPAP Indicator 1.2). The distribution by location was reported to be 9% in Port Vila area; 12% in Tanna, Tafea Province; and 10% in Malekula, Malampa Province.

“Families and communities should work together to keep youth safe from HIV”
The differences in knowledge of HIV test results by gender, age, school-based or community-based sample, and risk category are shown in Figures 26 and 27, for those who are sexually active (as opposed to CPAP indicator 1.2 above) which includes the entire sample whether active or not. Figure 26 shows that 10% of sexually active males in the sample had been tested and received results, 16% of sexually active females, 11% of sexually active adolescents, and 16% young people within the overall rate of 13% for sexually active youth. It also indicates that 12% of sexually active youth who were sampled in schools and 14% of those who were sampled in the community reported they were tested for HIV and knew their results.

As shown in Figure 27, the range in percentage of sexually active youth who have been tested and received results is from 6% for MARAs to 29% of increased risk youth.

![Figure 27. Whether they have been tested for HIV and received result by risk category](image)
Summary

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

1. Twenty-four percent of respondents could correctly answer all five standard UNGASS indicator questions on three ways to prevent HIV infection and reject two common misconceptions. Increased risk youth had the lowest comprehensive knowledge at 13% and EVYPs the highest at 30%. Mainstream youth had the same percentage of comprehensive knowledge (24%) as the sample as a whole.

2. The percentages of respondents answering the other knowledge questions correctly was uneven, with the highest scores on whether they heard of sexually transmitted diseases and lowest on knowing that a healthy-looking person can be infected with HIV. The lowest overall score for the question on a healthy-looking person was by MARAs (54%). The highest overall score was 95% for those at increased risk on whether they knew about ways to avoid HIV infection. As above the percentages for mainstream youth were similar to those for the group as a whole.

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

4. The reasons given for why they thought they were at risk reflected risk behaviours and contexts of vulnerability presented in the data, including: night clubs, forced sex, unprotected sex, multiple partners, commercial and transactional sex, substance use, and lack of trust in their partner.

5. The percentage of sexually active youth who had been tested for HIV and received their results ranged from 6% for MARAs to 29% for increased risk youth. The percentage for mainstream youth was 11% within the overall rate of 13%.

In summary, in the area of Knowledge for these Vanuatu youth, comprehensive understanding of HIV and AIDS is relatively low at 24% and should be of concern, particularly since among the areas of greatest misconception are being able to avoid HIV infection by having one faithful uninfected partner or not having sex at all. Thirty-five percent of this sample felt that they were at personal risk of HIV infection but several did not seem motivated to change their behaviours. Those who judged themselves at risk had a basic understanding of the risks they were taking, such as unprotected sex, multiple partners and commercial sex; but may not have truly believed that they could become infected. The reported 13% rate of sexually active youth who have been tested and received their results is rather low and may reflect lack of access.
As presented in Figures 28 and 29, it is important to note that almost twice as many respondents said they would choose to use a condom to prevent pregnancy as STIs, including HIV, and that less than 60% had used a condom, although almost 70% were sexually active. For programming purposes, it is also important that many of those who did not use a condom said that they did not know how, were unable to obtain a condom, condoms were not safe, and they did not feel good.
Figures 30 and 31 show that the highest percentage using condoms to prevent pregnancy by risk category were MARYP (84%) and to prevent STI/HIV were MARA (43%). The highest percentage not using condoms because they had sex with their regular partner was for MARYP (13%); because their partner did not want to was for MARYP (15%); because they did not want to was for MARA (14%); and because of embarrassment was for MARA (7%).
As shown in Figure 32, 81% of these youth said that they wanted to use a condom the next time they had sex with a higher percentage of males (88%) than females (74%) and adolescents (81%) slightly more than young people (80%).

In Figure 33, the highest percentages of those wanting to use a condom the next time they had sex were for MARYPs (89%) and increased risk (86%), MARAs (85%), EVAs (83%), EVYPs (79%), with mainstream youth having the lowest percentage at 78%.

As shown in Figure 34, 46% 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 2% more than for males and the percentage of adolescents was 5% more than that of young people – essentially the same by gender and age. 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” (20%), followed by their “parents did not know what to say” (11%), and “they think I’m too young” (8%). Their grandfather was their first choice as the best person 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 61%, followed by increased risk youth at 52%, mainstream youth at 48%, MARAs at 46%, EVYPs at 39%, and MARYPs at 27%. Of this sample, 37% of those asked said they would share a house with a person who they knew had HIV or AIDS as shown below in Table III.