

Youth Vulnerability to HIV in the Pacific

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Introduction

From 1984 to 2006, the number of young people with HIV infections has been increasing globally and in Pacific Island country and territories (PICT). The aim of this paper is to draw attention to the growing global and Pacific youth HIV epidemics, and to present details and insights into the risks and vulnerabilities of young people to HIV infection in the Pacific. In the process, this paper will highlight the need to address young people's behavioral risks, as well as the contexts of their lives and vulnerabilities, to alter the course of HIV epidemics in the Pacific. These pose both challenges and opportunities for change (Chambers *et al.*, 2006).

In Part 1, a summary of the 2005 global HIV statistics, Pacific surveillance, and other research are presented together to allow comparison of the levels of HIV and sexually transmitted infections (STI) among young people, as well as what is known about exposure, HIV knowledge and reported sexual behaviors, and youth involvement in highly vulnerable groups. The data show the large proportion of new HIV infections in young people, particularly female youth, and the lack of knowledge about HIV. Further, the information demonstrates how youth commonly can become involved in practices—globally and in the Pacific—that put them at high risk of exposure to HIV.

Like their global peers, young people in the Pacific encounter situations that are known to have a great impact on the course of HIV epidemics (United Nations Children's Fund [UNICEF] *et al.*, 2005; UNICEF and Joint United Nations Programme on HIV/AIDS [UNAIDS], 2006). In Part 2, the factors worldwide that heighten youth vulnerability, and

the conditions of young people's lives in the Pacific, underscore how the spread of HIV is not just about individual practices. It is multifaceted and contextual. Similarities and differences in the circumstances of young people's lives are analyzed. These include a poverty of opportunities in education, employment, and decision making, as well as sociocultural change, substance abuse, and gender and age inequalities.

In Part 3, a case study from Auki, Malaita in the Solomon Islands details sexual practices that increase risk of HIV infection for young people, and the contextual nature of their sexualities and vulnerabilities. This research illustrates the effect of rapid change and social conflict in young people's lives, and how globalization, culture, and political economies can influence young people's sexualities and sexual practices, sexual violence, and their ideologies and attitudes about these. The study demonstrates that religious and sociocultural factors can affect young people's access to information, condoms, and STI treatment services, which impact how health systems interact with youth.

The final discussion draws attention to HIV prevention, treatment, and care, as well as the need to tailor responses to young people in local contexts that support youth resilience, advocacy, and change (Dowsett and Aggleton, 1999; Cobram *et al.*, 2006).

PART 1: YOUTH KNOWLEDGE, PRACTICE, AND HIV EPIDEMICS

In the 21st century, the world has the largest youth generation in history, with close to half of the global population under the age of 25 (United Nations Population Fund [UNFPA], 2003). By the end of 2001, an estimated 11.8 million young people 15–24 years old were living with HIV (UNICEF *et al.*, 2002). HIV epidemics have spread worldwide over the past 25 years, with women and young people now being infected disproportionately. By 2002, about half of all infections worldwide were women and young girls (UNAIDS, 2004). In 2005, UNAIDS (2006) estimated that about half of the 4.1 million new HIV infections worldwide were in children and young people under 25 years old, with more female than male youth being infected.

UNAIDS does not report annual country and global estimates of young people (aged 15–24) living with HIV. Reported country estimates of HIV prevalence in young people have been limited. Gaps in country-level data make it difficult to compare statistics over time to gauge regional and global trends in HIV prevalence among young people, or the achievements of countries in their United Nations General Assembly on AIDS (UNGASS) commitments to reduce HIV prevalence by 25% among young people (aged 15–24) by 2005 (UNAIDS, 2004; UNAIDS and World Health Organization [WHO], 2005).¹

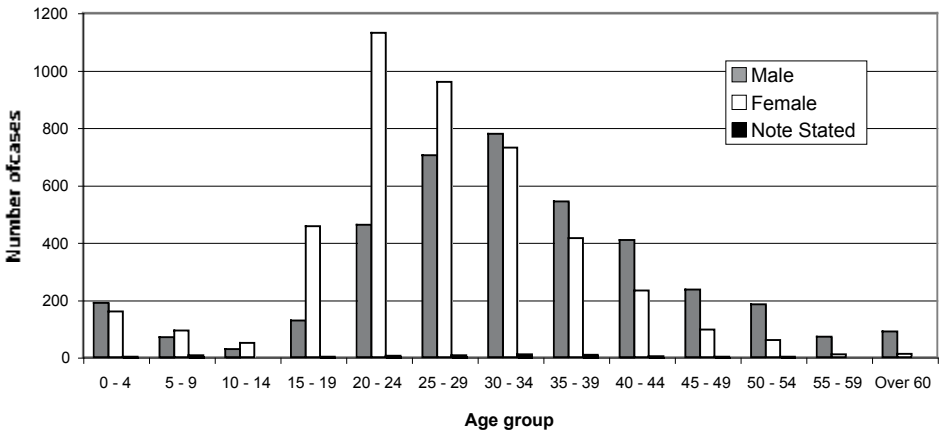
PACIFIC HIV EPIDEMIOLOGY AND YOUTH

UNAIDS did not report most HIV-related indicators for PICT in 2005 (UNAIDS and WHO, 2005). However, HIV surveillance data is available at the country and regional levels. Pacific Island youth are as affected by HIV

1 In 2001, 189 countries attending the United Nations General Assembly on AIDS (UNGASS) made a “Declaration of Commitment” to reduce HIV prevalence by 25% in male and female youth aged 15–24 by 2005. Of the countries reporting progress indicators to UNAIDS in 2005, 9% (11/126) provided data for 2000 and 2001 and 2004 and 2005 on HIV prevalence in young people. Of these 11 countries, six achieved a 25% or more decline in national youth HIV prevalence between 2001 and 2005, though limited to capital cities in three countries. Declining overall prevalence trends were reported in a number of countries. However, without a breakdown in age (15–24), the degree of change in youth HIV prevalence is not known (UNAIDS and WHO, 2005; UNAIDS, 2006).

infection as their peers around the world. The epidemiological data available where age was recorded shows that the majority of people diagnosed with HIV, and the majority of all new infections in the Pacific region, are young people (15–34).²

FIGURE 1: HIV/AIDS INFECTION DETECTED IN PAPUA NEW GUINEA, 1987–2005 (AGE GROUP AND SEX)



Source: NACS and DOH (2005b).

For Papua New Guinea (PNG), age is missing in 38% of HIV surveillance data. However, where age was recorded, 64% of those diagnosed with HIV infection between 1987 and 2005 (September) were 15–34 years old. The majority of these young people can be assumed to have been infected some years before their diagnosis (Pacific Regional HIV/AIDS Project [PRHP], 2004). Female youth 15–29 years old predominate, with young wom-

2 The UN and other organizations define youth as 15–24 years old for statistical purposes and ease of comparison. In the Pacific, however, the definitions of “youth” vary, ranging from age 12–13 to mid-30s in some countries. The Pacific region has 22 small island countries and territories that are grouped together as Melanesia, Polynesia, and Micronesia. Generalizations are not easy. Countries and territories cover vast areas of the Pacific Ocean with remote, dispersed islands that offer diverse geography, sociocultural traditions, languages and practices, subsistence and economic systems, traditional leaderships, and political contexts that differ within and between islands. This report refers to all areas, but focuses on the priority areas and issues where documentation is available.

en aged 20–24 most affected (National AIDS Council Secretariat [NACS] and Papua New Guinea Department of Health [PNG-DOH], 2005b).

In the first quarter of 2005, most newly diagnosed HIV infections in PNG were in the 20–24 and 25–29 age groups. In the 15–34 age group, 61% were female and 36% were male. In the third quarter of 2005, the majority of new HIV infections were in the 20–34 age group, again with more female than male young people being infected (NACS and PNG-DOH, 2005a; NACS and PNG-DOH, 2005b).

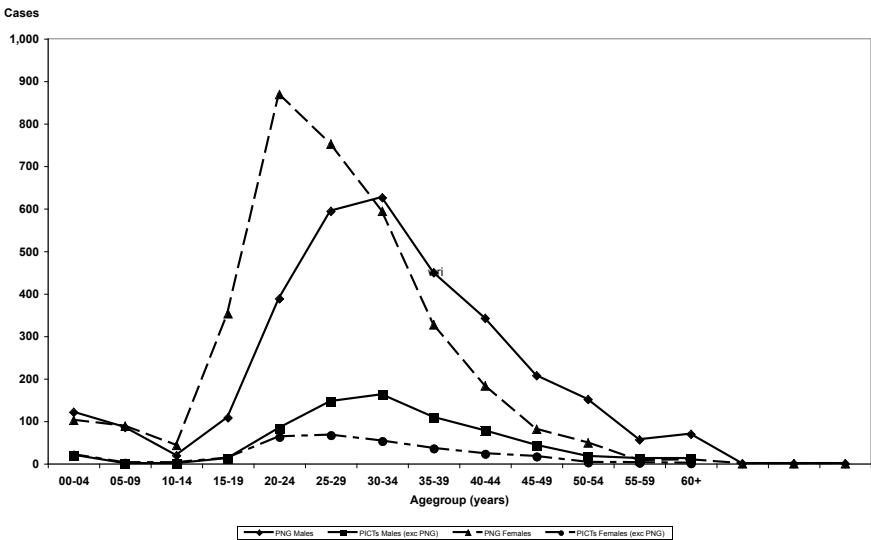
The concentration of HIV infections in particular age groups in other PICTs is somewhat similar to that in PNG, with higher numbers of people aged 15–34 being diagnosed (Figures 2 and 3). In PICT, 61% of those living with HIV were diagnosed between the ages of 15 and 34. However, the distribution of HIV infections varies between islands and between the three regions of Melanesia, Polynesia, and Micronesia. The majority of HIV infections among these three regions are in Melanesia (44%), with higher concentrations of infections in the 0–14 (48%), 15–24 (52%), and 30–34 (50%) age groups than in Polynesia and Micronesia. Polynesia has a higher concentration of infections in the 25–29 age group (46%) than in Melanesia and Micronesia, as well as a higher concentration of infections than Micronesia in the 0–14 (30%) and 15–24 (27%) age groups. Micronesia has had more people diagnosed with HIV than Polynesia in the 30–34 and over 35 age groups (Table 1).

TABLE 1: DISTRIBUTION OF HIV INFECTIONS BY AGE GROUPS (TO DECEMBER 2004)
(PICT, MELANESIA, MICRONESIA, AND POLYNESIA)

Age Group	PICT		Melanesia		Micronesia		Polynesia	
	# HIV Infections	% of PICT	# HIV	% of PICT	# HIV	% of PICT	# HIV	% of PICT
0-14	48	4.7	23	48	12	25	13	27
15-24	209	20.5	109	52	37	18	63	30
25-29	172	17	54	31	39	23	79	46
30-34	238	23.4	118	50	76	32	44	19
35+	321	31.5	134	42	104	32	83	26
Unknown	30	2.9	12	40	17	57	1	3
Total	1018	100	450	44	285	28	283	28

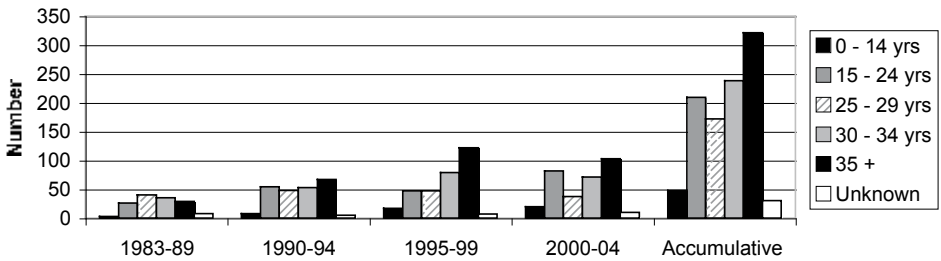
PICT = Pacific Island countries and territories.
Source: Secretariat of the Pacific Community, (2006). HIV STI Section, Public Health Programme.

FIGURE 2: CUMULATIVE HIV INFECTIONS BY AGE AND SEX IN PAPUA NEW GUINEA AND OTHER PICT (TO DECEMBER 2004)



PICT = Pacific Island countries and territories, PNG = Papua New Guinea.
Source: Sladden (2006).

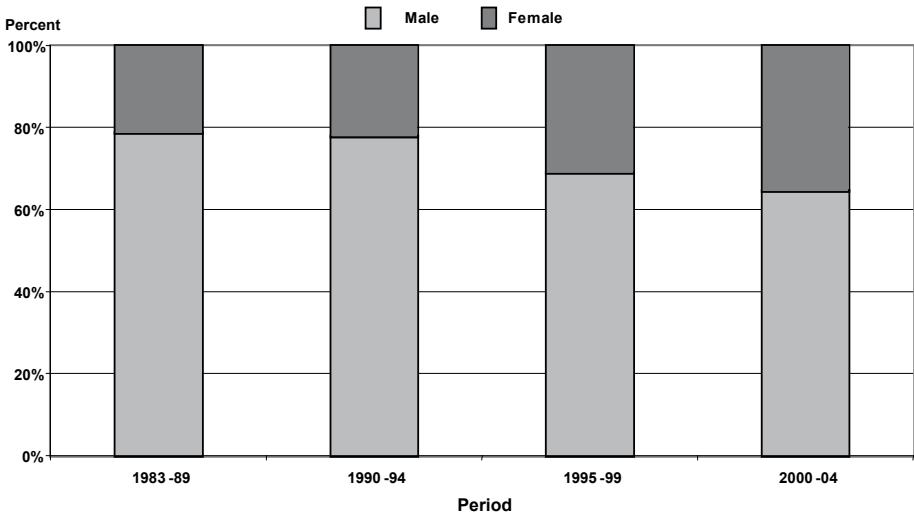
FIGURE 3: CUMULATIVE HIV INFECTIONS BY AGE AND YEAR (ALL PICT, EXCEPT PNG)



PICT = Pacific Island countries and territories, PNG = Papua New Guinea.
 Source: HIV and STI Section, Public Health Programme,
 Secretariat of the Pacific Community (2006).

While variations can be found at the country level, and between the three regions, infections overall are increasing in the 0-14 and 15-24 age groups. The numbers of infections in the 30-34 increased until 1999, and then remained steady until the end of 2004; the 25-29 age group has remained at relatively the same levels since 1990, with a slight decrease in 2000-2004. Trends in the gender distribution of people living with HIV (PLWH) indicate ongoing increases in the proportion of female youth and women being infected in the Pacific region (Figure 4). While the gender distribution has shifted over time, with more and more females being diagnosed, the percentage of male youth and adult men infected outside of PNG is still greater than women. In 2004, the ratio of male to female infections was 1.1 to 1 for the entire Pacific Island region, and 2.5 to 1 excluding PNG. While the changes in the ratio of male to female infections over time could be linked to changing modes of transmission outside of PNG (Sladden, 2006), discerning whether this increase in infection over time is primarily among younger than older women is not possible from available data.

FIGURE 4: MALE AND FEMALE DISTRIBUTION OF REPORTED HIV CASES IN ALL PICT, EXCEPT PNG (1980S THROUGH 2004)



PICT = Pacific Island countries and territories, PNG = Papua New Guinea.
 Source: Sladden (2006).

How HIV is being transmitted is less documented in the epidemiological data from PNG than for other PICT. In PNG, 75% of documented HIV infections do not indicate the mode of transmission. Of the remaining 25% that are known, about 85% were infected through heterosexual transmission, with the rest through male-to-male sex (0.4%), perinatal transmission (4.6%), and others (10%), which are not explained (NACS and DOH, 2005b).

Across other PICT, heterosexual transmission accounts for 49.5% and male-to-male sexual transmission accounts for 32.8%. The remainder of exposure is attributed to intravenous drug use (6.7%), perinatal transmission (4.7%), and blood exposure (2.9%), with 3.5% unknown. In the Pacific, HIV transmission through male-to-male sex has been highest in Guam (64.9%), Tonga (58.3%), French Polynesia (38.5%), and New Caledonia (37.1%). Male-to-male sex accounts for 43.6% of known exposure in Micronesia, 37.4% in Polynesia, and 22.8% in Melanesia, excluding PNG (Sladden, 2006). While UNAIDS has planned behavioral or surveillance studies in 2006 focusing on male-to-male sex in the Pacific, none has been done. This represents a gap in much-needed information.

HIV surveillance surveys have been done in some Pacific Island countries. In 2002–2003, for example, 383 seafarers in Kiribati were tested during HIV and STI prevalence surveys, and one tested positive (WHO, 2004). Between 2004 and 2005, 771 people considered to be at higher risk of HIV infection were recruited to participate in HIV prevalence surveys: (i) 100 antenatal mothers in Solomon Islands from areas that border PNG; (ii) 367 people attending STI clinics in Fiji Islands, Samoa, and Vanuatu; and (iii) 304 seafarers in Kiribati. Of those surveyed, 36.8% were under 25 years old. No HIV infections were found in the samples tested. In STI prevalence surveys in Fiji Islands, Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu, 1,618 antenatal mothers were tested for HIV. Of those surveyed, 42.6% were under 25 years old. No HIV infections were detected in these antenatal samples, though levels of other STIs were high (WHO, 2006).

High levels of HIV prevalence were reported during HIV surveillance in PNG of patients at STI clinics in Port Moresby (8% HIV positive), Goroka (1.59%), and Mt. Hagen (6.33%); and of antenatal mothers in Port Moresby (1.35%) and Lae (2.5%). This illustrates the generalized nature of the PNG epidemic, and the concentrations of infections in those with a history of other STIs. Unfortunately, the data reported was not disaggregated by age (NAC and DOH, 2004).

PACIFIC STI EPIDEMIOLOGY AND YOUTH

STIs are a sensitive marker of unprotected sexual behaviors that put people at risk of HIV infection and are cofactors that increase the probability of HIV infection. In the Pacific, as it is globally, precise documentation of treatment service coverage and data for STIs is scarce at the country level (UNAIDS, 2006). However, many HIV strategic plans and country situation analyses in the Pacific suggest high or increasing levels of STIs among the youth (Buchanan *et al.*, 1999: Kiribati HIV/AIDS/TB Task Force [KHATBTF], 2005; Government of the Republic of Marshall Islands [RMI] and UNICEF, 2003 and 2004; Ministry of Health [MOH]-Vanuatu, 2004; UNICEF, 2004b; Government of PNG and UNICEF, 1996).

Studies and STI surveillance in PNG involving STI clinic patients, sex workers, and women long have found that STI levels are high for young

people in urban and rural areas (Hudson *et al.*, 1994; Lemeki *et al.*, 1996; Mgone *et al.*, 1999; Mgone *et al.*, 2002; Passey *et al.*, 1998). In a study of rural women in the Highlands of PNG, having an STI was significantly associated with being younger and 45.2% of all young women tested who were less than 25 years old had chlamydia (Passey *et al.*, 1998).

STI surveillance studies conducted in other Pacific Island countries have focused only on antenatal mothers and seafarers, and not specifically youth. Surveillance data on antenatal mothers and seafarers, when disaggregated by age, shows that younger women were more likely to have STIs than older women while younger seafarers had high prevalence of STIs.

Between 1999 and 2000, an STI surveillance survey in Apia, Samoa involving 427 pregnant women aged 15–44 (mean age 26) found high levels of chlamydia (30.9%) and trichomoniasis (20.8%). While 42.7% of women had at least one STI, female youth under 25 years old were three times more likely to have an STI than older women. The number of female youth with STI peaked at the age of 21, while half of the 71 teenage mothers tested had an infection. Youth was associated significantly with increased risk of STI. Nearly all of those who had gonorrhoea were less than 25 years old, with 85.7% of these having multiple infections (Sullivan *et al.*, 2004).

In Vanuatu, 547 pregnant women and female youth were tested in an antenatal clinic STI survey between 1999 and 2000. The survey found that 39% had one or more STI, with high rates of chlamydia (22.4%) and trichomoniasis (27.5%). Of those surveyed, 75% were under the age of 30, 54% were 25 years old or younger, and the majority was unmarried. The survey found that younger single women were more likely to have an STI: 54% of females aged 20–24 and 58% of teenage girls had an infection, while more than 22% of teenage girls had more than one infection. Overall, those with STIs were significantly more likely to be unmarried and young, and single teenage mothers were at highest risk of having an STI (MOH Vanuatu and WHO, 2000; Sullivan *et al.*, 2003).

In 2004–2005, STI prevalence surveys of 1,618 antenatal mothers in Fiji Islands, Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu found 18% had chlamydia. Of those surveyed, 42.6% were under the age of 25, and the mean age was 26.6 years for all women aged 15–44. Younger women were more likely to have chlamydia than older women. While chlamydia

prevalence in female youth under 25 years old ranged from 7.3% in the Solomon Islands to 40.7% in Samoa, younger women from all six countries had higher levels of STIs in these studies.

In an STI prevalence survey of 357 male seafarers in Kiribati in 2003, about a third (34.3%) were younger than 25 and well over half (58.8%) were less than 30. The highest prevalence of chlamydia was found among seafarers aged 25–29 years (14.3%), and the highest prevalence of hepatitis B was found in seafarers 20–29 years old. Close to all seafarers (94.7%) tested positive for the herpes simplex virus, HSV-1 (WHO, 2005).

Available STI prevalence surveillance data clearly show that female youth more often have an STI than older women. Moreover, the prevalence of STIs among seafarers is high, increasing their chances of exposure to HIV considerably.

YOUTH KNOWLEDGE, PRACTICE, AND RISK

Young people are being exposed to HIV infection in different ways, and particular behaviors enhance the probability of transmission. Significant risk of infection for young people involves unprotected anal and vaginal sex, which can start at a young age and involve multiple partners (UNAIDS, 2006). Other factors that increase the probability of HIV and other STIs being spread during unprotected sex include sexual violence and forced sex, biological factors that make young women more physiologically susceptible, untreated STIs, and not being circumcised (UNAIDS and WHO, 2000). Further, penile inserts, which are common in some parts of the Pacific, and genital piercing can create tears and abrasions during sex; and inflammation and sores can occur after insertion, creating openings for HIV infection to be transmitted during unprotected sex. Inserts and piercing also create the potential for condom breakage during protected sex (Hull, 2000 and 2001). The reuse of razors, needles, or other sharp objects during scarification, circumcision, and tattooing poses the risk of transmission, while the reuse of needles and syringes during drug injecting creates a high risk for HIV transmission as the virus is introduced directly into the bloodstream (UNAIDS, 2004).

GLOBAL—YOUTH KNOWLEDGE, PRACTICE, AND HIGHLY VULNERABLE GROUPS

UNGASS progress indicator reports in 2005 highlighted the wide variation in young people's reported sexual behaviors, condom use, and knowledge about HIV at the country level (UNAIDS, 2006).³ Overall, limited knowledge of HIV, infrequent use of condoms, and multiple sexual partners place male and female youth (15–24 years old) at risk of exposure to HIV infection through unprotected sex within large sexual networks from a young age. The indicator data illustrate that young people's sexual practices and knowledge of HIV can be particularly gendered. While male and female youth were sexually active and could have multiple partners, more male than female youth reported having sex with nonregular partners. Moreover, while condom use was less than 50% across all countries, more male than female youth reported using a condom with their multiple sexual partners. Young people's knowledge of HIV was not comprehensive, with less than 50% of respondents having comprehensive knowledge as measured by progress indicators, and less so in rural areas. Female youth tended to have less knowledge that they are at risk of infection if they have unprotected sex (UNAIDS, 2006; Measure DHS, 2006). While this generation of young people has never lived in a world without HIV, the majority appears to have little knowledge about HIV transmission and their risk of exposure—and take minimal precautions. And gender disparities in practices and knowledge continue.

Youth, as an age-defined category (i.e., 15–24 years old), cuts across groups identified at higher HIV risk and vulnerability, such as (i) men who have sex with men (MSM), (ii) intravenous drug users (IDU), and (iii) sex

3 For example, the percentage of young people (aged 15–24) reporting condom usage at last sex varies widely between countries. While condom use increased in eight countries, overall condom usage was less than 50% across all of the 55 countries that reported this UNGASS indicator (UNAIDS, 2006). A sampling of young people's condom use with nonregular sexual partners: 5.0% of females and 12.0% of males in Madagascar; 75.0% of females and 88.0% of males in Botswana; 31.0% of females and 55.0% of males in the Czech Republic; 33.3% of females and 77.8% of males in Barbados; 65.0% of females and 75.0% of males in the Ukraine; and 19.0% of females and 34.0% of males in Benin.

workers and their clients.⁴ Male and female intravenous drug use, sex work, and male-to-male sex occur in a minority of the youth population. However, HIV prevalence can be higher in these groups than in the general population (Cáceres *et al.*, 2006; UNAIDS, 2006; Vandepitte *et al.*, 2006). Highly vulnerable groups are not mutually exclusive. Young people can move between different higher risk settings, and sexual and IDU networks, and have unprotected sex with youth and adults from other sexual networks, providing the conditions for HIV to spread more broadly (Aceijas *et al.*, 2006).

Research shows that sex workers can be female, male, or transgender; and young or old. However, they are more often female and young. Youth can begin sex work in their teens and early 20s; research from many regions confirms the youthfulness of sex workers and their clients. In Eastern Europe and Central Asia, for example, 80% of sex workers were under 25 years old. Meanwhile, in South Asia, South Africa, Europe, and Mexico, the trafficking of young girls in sex work was common, with some of these youth under 16 and as young as 10 years old (International Labour Organization/International Programme on the Elimination of Child Labour, 2002; UNAIDS, 2005 and 2006). Research in Sub-Saharan Africa, South and Southeast Asia, and Latin America shows that young men between the ages of 20 and 24 are the most frequent clients of sex workers. Further, paid sex can account for many of male youth's first sexual partners, while condom use is low and inconsistent (Carael *et al.*, 2006). Many youth also experience rape and sexual violence. Young female, male, and transgender sex workers are often the victims of sexual violence, including gang rape, increasing greatly their risk of HIV infection from unprotected forced sex with large numbers of men (Anang and Jenkins, 1998; Buchanan-Aruwafu, 2002a; UNAIDS, 2004; USAID, 2006).

Male-to-male sex and intravenous drug use are not well documented in many countries. Research is scant relative to HIV prevalence in these groups and the efficiency of HIV transmission through unprotected anal sex and the sharing of unclean syringes (Cáceres *et al.*, 2006; UNAIDS, 2006). MSM and IDU are social and behavioral categories, not groups of people who are all similar. These labels tend to create naïve understand-

4 Vulnerable populations also include people living in poverty, children and youth living on the streets, people in conflict and post-conflict situations, refugees and internally displaced persons, prisoners, migrant and mobile laborers, people living with HIV, and indigenous peoples (Fried, 2006; UNAIDS, 2006).

ings of sexual and drug-injecting cultures within epidemiological studies (Jenkins, 2004). While groups of MSM can be socially and self-defined, their identities and the complexity of their sexual cultures show much diversity globally (Dowsett *et al.*, 2006). Young men who have unprotected male-to-male sex also can have unprotected sex with female partners, including wives, girlfriends, and sex workers (Carael *et al.*, 2006). In a study of young men and women (aged 18–29) in Peru, 9% of young men reported that at least one of their last three sexual partners was a man, while condoms were used only with 30% of these partners (UNAIDS, 2004).

Young men and young women inject drugs and, in some places, more male youth are known to be injecting than female youth. Research in 20 countries in Eastern Europe, Central Asia, and South and Southeast Asia identified young men under the age of 29 as the majority of those using intravenous drugs. In 11 of these countries, the largest percentage of IDU were young people 20–29 years old, with a number of countries reporting significant numbers of youth aged 15–19 who were injecting. In Indonesia, young people 18–24 years old represented the largest proportion of IDU. Young men and women who use intravenous drugs also can have unprotected sex with other partners—wives, husbands, boyfriends, and girlfriends, including sex workers. In some Eastern European countries, the sexual transmission of HIV has been linked to IDU and their sexual partners (Aceijas *et al.*, 2006; UNICEF *et al.*, 2002). Young people in groups at higher risk of HIV exposure are marginalized and stigmatized. Their practices are illegal in many countries, making these young people harder to reach, underreporting of their behaviors more probable, and their vulnerabilities and risks more complex.

The global statistics and behavioral data that have been outlined focus on the behavioral dimensions of risk, or the possibility that a young person might become infected with HIV because of certain practices that can create, enhance, and perpetuate risk of HIV transmission (Shaw and Aggleton, 2002). Globally, young people’s involvement in highly vulnerable groups, their multiple sexual partners and broad sexual networks, lack of condom use, and use of nonsterile needles would explain increasing HIV prevalence in youth, while suggesting the high probability for further expansion of HIV epidemics among young people.

PACIFIC—YOUTH KNOWLEDGE AND SEXUAL PRACTICE

In the 1990s, situation analyses and other research in PICT indicated that, like their global peers, young people were (i) sexually active; (ii) had unprotected sex with multiple partners; (iii) lacked information about reproduction, STIs, and HIV transmission and prevention; (iv) started having sex at a young age; (v) could experience sexual violence; and (vi) could become involved in “higher risk” practices and in highly vulnerable groups (UNICEF, 1998; Buchanan *et al.*, 1998; Burslem *et al.*, 1998; Chung, 2000; Hall *et al.*, 1998; Jenkins, 1997a and 1997b; Lemeki *et al.*, 1996; Mitchell, 1998; National Sex and Reproduction Research Team [NSRRT] and Jenkins, 1994; Singh *et al.*, 1995; United Nations, 1996). This makes PICT vulnerable to increasing epidemics in young people, particularly if the HIV virus becomes more present and concentrated in sexual networks. The research results that follow are sampled from young seafarers, young antenatal mothers, in-school and out-of-school youth, and youth who attended an STI clinic. Youth who exchange sex for money or other goods, and youth having male-to-male sex, and using intravenous drugs also are identified from these samples.

UNFPA conducted three surveys of adolescents in Cook Islands, Kiribati, and Samoa between 1998 and 2000, combining knowledge and sexual behavior questions. Data was collected in Samoa in 1998, with 1,077 adolescents (544 male, 533 female) aged 13–19, who were randomly sampled in a household survey. The data show that most young Samoans had little knowledge about the meaning of menstruation (2.1%), fertility cycle (5.8%), and STI and HIV. Overall, about half (51%) of the youth had heard of STIs. However, only one of the 1,077 adolescents had heard of syphilis, and only three had heard of gonorrhea. Knowledge of STI symptoms also was low. In assessing knowledge of prevention, only 20% mentioned that condoms could provide protection against STIs, 46% mentioned having one faithful partner, and 15% said avoiding MSM. None mentioned abstinence (Seniloli, 2003a).

The UNFPA studies in Cook Islands and Kiribati also indicated scant knowledge of HIV prevention, though with differences between the countries in how to increase protection from HIV through avoiding male-to-male sex, using contraception, and not sharing needles. Abstinence was not

mentioned in either country as a preventive measure. The UNFPA study in Cook Islands in 1999 included 237 adolescents (118 male, 119 female) aged 13–19. About half (54%) had heard of STIs, though only 22% could identify a symptom and just 13% was aware that condoms provided protection against STIs. Of the 41.8% who had heard of HIV, about 30% said that having one faithful, uninfected partner, or using condoms would prevent HIV infection, while only 2% knew not to share needles (Seniloli, 2003b). Data collected in Kiribati in 2000, in a survey of 404 adolescents (179 male, 225 female) aged 13–19, also indicated limited knowledge of prevention and transmission. Only 19% of those who had heard of STIs and 10% of those who had heard of HIV identified condom use as a way to avoid these infections. Further, 20% of male youth and 30% of female youth had no knowledge of STIs, and more than 95% had not heard of syphilis or gonorrhoea, while 30% had not heard of HIV or AIDS. Nearly a third (31%) thought that using contraception could protect against STIs during sex, but none mentioned abstinence (Seniloli, 2003c).

Behavioral surveillance surveys (BSS) in 2004 and 2005, involving 1,000 unmarried young people aged 15–24 in Samoa (300), Solomon Islands (374), and Vanuatu (326), found low levels of knowledge about HIV transmission and prevention in all samples. Moreover, few had accepting attitudes toward PLWH. Of the young people surveyed, 60% were less than 20 years old. More than half (53.8%) of the youth surveyed knew that using a condom, not having sex, and being faithful were preventive measures. Fewer young people (37.4%) knew that HIV was not transmitted by mosquitoes, or that a healthy-looking person could have an HIV infection. Even fewer (Samoa 12.7%, Solomon Islands 39.3%, and Vanuatu 21.2%) understood both prevention and transmission (WHO, 2006). About a third (32.5%) of the young people surveyed (Samoa 21.7%, Solomon Islands 28.3%, and Vanuatu 47.2%) expressed accepting attitudes toward PLWH, and would share a meal with them or buy food from them, and not want to keep it a secret if a family member was living with HIV. Only 2.7% had ever been tested for HIV and knew the results (WHO, 2006).

As this research shows, young people's knowledge about HIV transmission and prevention is generally weak. Thus, the lack of acceptance of PLWH and the lack of voluntary testing are not surprising. If young people believe that HIV can be transmitted through food and social contact, their

reasons for being fearful are more understandable. In those circumstances, their discrimination is an outcome of their self protection. Since they also believe that mosquitoes can transmit HIV, why would they want to use condoms, which they dislike and are not easily accessible? So few youth have ever been tested for HIV, perhaps increasing their knowledge about their risks and where to be tested, and decreasing community stigma and discrimination toward PLWH, would increase voluntary confidential counseling and testing (VCCT).

The UNFPA surveys of young people between 1998 and 2000 in Samoa, Cook Islands, and Kiribati reported relatively low levels of sexual activity with little condom use. However, the surveys also found high levels of pressure or force involved in first sexual experiences, or having unwanted sex when drunk or high on drugs (Seniloli, 2003a, 2003b, 2003c). UNICEF studies in Pohnpei State in the Federated States of Micronesia (FSM), Tonga, and Vanuatu in 2001, as well as BSS in Kiribati, Samoa, Solomon Islands, and Vanuatu in 2004–2005, found more young people reporting having sex, unprotected sex, more than one partner, and male-to-male sex. Large numbers from these studies also reported being pressured into having sex, or having unwanted sex when drunk or high on drugs (UNICEF, 2001a, 2001b, 2001c; WHO, 2006).

In the UNFPA study in Samoa in 1998, only 5% (58) of the adolescent sample reported having had sex, with a median age of 16 years for first sex for boys and girls. Of the sexually active adolescents, 12% had been forced or been raped for their first sexual experience (Seniloli, 2003a), most of whom were male youth (5 males, 2 females). More young people said that they had had their first sexual experience because they wanted to express love (21 males, 6 females) or be friends (12 male, 2 female), than to experiment and know how it felt (6 males, 1 female). The majority of first sexual experience occurred at home, or at a friend's or relative's house, with less occurring in bushes or at the beach (17.2%) or in cars (5%) (Seniloli, 2003a).

In a similar study in Cook Islands in 1999, 16.5% of the youth (39) reported having had sex, with a median age of 15 years for first sex for boys and girls. Significantly, 23% reported being raped or forced in their first sexual experience (6 males, 3 females), and 6% said that they had been

“cheated”(1 male, 1 female) into having sex. More male youth said that they tried sex to know how it felt (14 males, 1 female), while twice as many males as females wanted to show love. Like in Samoa, most had had sex at their parent’s or friend’s houses (62%), and some (17.9%) at the beach or in bushes (Seniloli, 2003b). The data collected in Kiribati in 2000 showed that about 10% (39), mostly male youth (29 males, 10 females), said that they had had sex before. In the previous 12 months, about half (49%) of the sexually active youth had had sex with more than one partner, and only a third of the male youth had ever used a condom. The median age at first sex for girls was 15 years, and for boys was 16 years. The majority (61.5%) had had their first sexual experience in the bushes and at the beach. Like in Samoa, significantly 23% of sexually active male and female adolescents reported being forced into their first sexual experiences, while 8% reported being deceived. Close to half (49%), primarily male youth, had their first sex because they wanted to experiment, though 18% wanted to express their love (Seniloli, 2003c).

A UNICEF survey in Pohnpei, FSM, included 1,699 youth who were in and out of school; 183 out-of-school youth were asked questions about sexual behavior. More than three quarters (77%) of out-of-school youth reported having sex in the past (85.8% male, 60.3% female). While both female and male youth reported having more than one partner (57.9% female, 73.7% male); more female than male youth reported having only one partner. More than three times as many male as female youth reported having sex with four or more partners. Only 9.0% of the sexually active out-of-school youth always used a condom, while 6.5% sometimes used a condom. About half of the male youth and a third of the female youth reported having unwanted sex when they were drunk or high on drugs; and 28.2% of out-of-school youth reported that they had been pressured to have sex within their relationships, from strangers, within the family, or from unknown people or groups of people. While detailed data was not given for the sexual behavior of in-school youth, a substantial number of students reportedly were sexually active. Students felt more pressured (45%) than out-of-school youth to have sex with their boyfriends and girlfriends, as well as with others whom they knew. The majority of sexually active students (60% female, 40% male) had never used a condom (UNICEF, 2001c).

The UNICEF study in Vanuatu involving 424 out-of-school youth found that 57.4% of male youth and 43.2% of female youth had had sex. As in Pohnpei, both female (45.3%) and male (74.1%) youth had more than one partner, with male youth particularly having four or more partners. More female than male youth had just one partner. Just over 50% of youth reported using protection against STIs, although “condom use” is not stated clearly in the data. Male (36.1%) and female (22.4%) youth reported having unwanted sex when drunk or high on drugs (UNICEF, 2001a).

The Tonga UNICEF study of 1,008 out-of-school youth found far less sexual activity for female youth (12.9%) than for male youth (47.2%). Of those who reported having sex, multiple partners were high for female (50%) and male (86%) youth, with a high percentage of both having four or more partners (38.6% males, 26.2% females). Nearly three quarters of female youth (73.4%) and two fifths of male youth did not use any measures to protect themselves from STIs. More male than female youth (21.7% male, 4.4% female) reported having unwanted sex when drunk or high on drugs (UNICEF, 2003b).

BSS were conducted on unmarried youth aged 15–24 in Vanuatu (326) and Samoa (300), and on unmarried in-school youth aged 15–24 in the Solomon Islands (374). Almost two thirds (64%) of male and female youth reported having sex, though considerably fewer young people in Samoa reported having sex. Overall, more male than female youth had had sex (72.2% male, 57.9% female), with male youth also reporting more partners. While some male youth (8.9%) reported having paid for sex in the previous year, more male (19.7%) and female youth (25.2%) reported receiving money or other goods in exchange for sex. The survey found that 40 male youth (7.6%) reported ever having male-to-male sex, with most (25) reporting having male-to-male sex in the previous year. Significantly more male-to-male sex was reported in Samoa, though more than a third in the Solomon Islands (37.4%) provided “no response” to this question. More young people in the Solomon Islands and Vanuatu had multiple partners, or had previously exchanged sex for money or goods. One fifth of students in the Solomon Islands and two fifths of out-of-school youth in Vanuatu reported having exchanged sex for money or goods in the previous year. Although the levels varied across the three countries, having sex, exchanging sex, and having multiple partners was very high. At the same time,

young people's condom use was very low, inconsistent, and variable at the country levels (WHO, 2006).

TABLE 2: REPORTED SEXUAL BEHAVIORS FROM BSS WITH YOUNG PEOPLE IN SAMOA, SOLOMON ISLANDS, AND VANUATU

Type of Sexual Behaviors Reported	Samoa (%) (n=300)	Solomon Islands (%) (n=374)	Vanuatu (%) (n=326)
Sex before	38.3	78.6	76.1
Male-to-male sex before	21.8 (M)	1.1 (M)	0.6 (M)
Condom use at first sex	24.3	14.6	16.9
More than 2 partners in previous year	12.7	21.9	43.3
Consistent condom use with casual partners in previous 12 months	5.2	7.6	15.7
Exchanged sex for cash or goods in previous year	8.7	20.3	39.9
Male youth paying for sex	8.2 (M)	9.5 (M)	8.9 (M)
Consistent condom use with commercial partners in previous 12 months	0	7.3	18.7

BSS = behavioral surveillance surveys, M = males, n = number of respondents.
Source: WHO (2006).

In HIV prevalence surveillance of male youth and men attending an STI clinic in Fiji Islands, behavioral data indicate higher-risk practices, such as (i) having unprotected sex with sex workers, (ii) exchanging sex without using condoms, (iii) having unprotected male-to-male sex, and (iv) intravenous drug use. The majority of the sample were unmarried, and more than half (59%) of the 157 surveyed were under 25 years old. Nearly everyone interviewed (98.1%) had had sex before and had more than one partner. However, they rarely (4%) used condoms consistently, and a fifth (20.4%) had paid for sex in the previous year. Some (8.9%) who were interviewed reported having had male-to-male sex. In the previous year, some exchanged sex for money or gifts, and only 20% had used a condom the last time they had male-to-male sex (WHO, 2006). The lack of disaggre-

gated data by age makes an assessment of the involvement of male youth from this sample in these higher-risk practices difficult. However, the male youth clearly were at higher risk of HIV infection, as almost the entire sample had had sex, had multiple partners, and rarely used condoms consistently. Since those being interviewed were attending an STI clinic, many might have had an STI or a history of STI, though prevalence data was not reported.

Overall, research and behavioral surveillance illustrate that male and female youth in the Pacific are at risk of HIV infection, because of their lack of knowledge and higher-risk practices. While sexual violence and tattooing practices also are occurring, these areas are less explored.

HIGHER VULNERABILITY

Much more is known about sexual violence, group rape, and forced sex in PNG than in other Pacific Island countries. However, these practices are affecting young people in many other PICT (Booth, 1999; Bradley and Kesno, 2000; Buchanan-Aruwafu, 2002a; Buchanan *et al.*, 1999; Jenkins, 1997a; KHATBTF, 2005; Lukere, 2002; NSRRT and Jenkins, 1994; Tennant, 1998). These are important areas to be integrated into HIV-related surveillance and other research with youth, because of their contextual salience and the heightened risk of infections that these situations pose. Sexual violence causes physical trauma and mental health issues, and creates the potential for HIV transmission for youth who experience practices such as gang rape and “forced” sex. Child protection issues and the commercial sexual exploitation of children also require research. Some of the UNFPA and UNICEF research, discussed above, illustrates that young people have an inability to negotiate sex or safe sex when drunk or on drugs, leading to unwanted sex; while other younger adolescents feel pressured into having sex by their peers. The prevalence and experiences of young men and women involved in gender-based violence—and the gender ideologies, situations, and legal and policy issues that might be structuring young people’s higher vulnerability to HIV infection through sexual violence—clearly must be better understood.

Behavioral surveillance demonstrates that (i) young people are having male-to-male sex, (ii) school students and out-of-school youth exchange sex for money or goods, (iii) male youth pay sex workers to have sex, and (iv) a smaller number report injecting drugs. More than half of the 22 antenatal mothers surveyed from Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu, who also reported selling sex in the previous year, were less than 25 years old. Behavioral surveys of police, military, and STI patients in the Fiji Islands, as well as of seafarers in Kiribati, also show that these groups were engaging in intravenous drug use, male-to-male sex, the exchange of sex, and purchase of sex. However, little is known about highly vulnerable groups in the Pacific, such as (i) sex workers and their clients, (ii) children and youth who are being sexually exploited, (iii) seafarers and their partners, (iv) youth who have male-to-male sex, and (v) IDU. The illegal nature of intravenous drug use, sex work, and male-to-male sexual practices in most countries—combined with religious and societal stigma, discrimination, and violence—drives these groups underground. Because they are hidden, underreporting of these practices is more likely.

EXCHANGE OF SEX

For more than 15 years, many young people in PNG have been exchanging sex for money or other goods (Hammar, 1992 and 1998; Jenkins, 1995 and 1996; Mgone *et al.*, 2002; NAC, 2005; NSRRT and Jenkins, 1994; Wardlow, 2001b). Male and female youth sell sex, and the patterns of sexual networking and sexual exchange are complex (Decock *et al.*, 1997; Hammar, 1998; Jenkins, 1996; Wardlow, 2001a and 2001b). Further, young people involved in the exchange of sex do not necessarily identify themselves as “sex workers” (Sinclair, 1995). Increasing numbers of adolescent youth aged 13–19—and some as young as 11 years old—are becoming involved in the exchange of sex in areas in PNG with resource development, such as mining, logging, and fishing projects (UNICEF, 2003a; NAC, 2005). For example, Jenkins (1995) reported that girls as young as 12 years old were selling sex to men who had made money during the coffee season. Some studies show that 30% of sex workers in these development areas are in this younger age group (UNICEF, 2003b). The commercial sexual exploitation of children and child sexual abuse also are being reported from other Pacific

Island countries (UNICEF, 2003b; Christian Care Centre of the Church of Melanesia, 2004).

Studies in PNG illustrate that (i) sex workers are young; (ii) male youth participate in sex work, but to a lesser degree than female youth; (iii) sex workers can become the victims of sexual violence and gang rape; and (iv) condom use is inconsistent (Anang and Jenkins, 1998; Jenkins, 1995 and 1996; NAC, 2005; NSRRT and Jenkins, 1994). Male youth and MSM also can be bisexual, and have sex with female youth and women. Male and female sex workers and their clients also have other noncommercial partners. In the research by Mgone *et al.* (2002), the average age of female sex workers in Lae and Port Moresby was about 24–25 years old—though some were as young as 13—and condom use was inconsistent. This study found that sex workers were frequented more often by students than by seafarers. In a multisite study, 50% of young women between the ages of 15 and 24 accepted cash or resources in exchange for sex (Jenkins, 1997b). Meanwhile, a national study showed about two thirds (66%) of young women under 25 years old exchanged sex for cash or other gifts (NSRRT and Jenkins, 1994). Another study of urban unemployed young women found that 48% were partially supporting themselves through sex work (Levantis, 2000). Sex workers reported being forced to have sex and gang raped, and police and security guards were identified as using their positions of power to coerce sex workers into having “free” and group sex (Anang and Jenkins, 1998).

In Kiribati, increases in sex work have been attributed to a lack of employment, education, and training for young women. Sex workers, referred to as *Te Korekorea*, can work from Betio wharf and harbor areas (Secretariat of the Pacific Community [SPC], 2004; UNICEF, 2005a; Vunisea, 2006). They regularly go out with local men or seafarers to bars and nightclubs, and go to foreign fishing vessels and exchange sex for money or other goods. Female and male sex workers go onto foreign vessels for entertainment, alcohol, gifts, and money; and some seafarers have local boyfriends. *Te Korekorea* sometimes drink excessive amounts of alcohol and become victims of violence (KHATBTF, 2005; Vunisea, 2006). No surveillance, behavioral, or other research has been done with *Te Korekorea*. Thus, little is known about their lives and practices, and that of their seafarer partners.

Surveillance in Kiribati in 2004 and 2005 indicated that 28.8% of seafarers aged 20–29 had had sex with sex workers in the previous year, as well as other casual female partners. Consistent condom use was low. Younger seafarers in this study reported having more commercial sex than seafarers in the older age categories (WHO, 2006).

In the Fiji Islands, female, male, and transgender youth exchange sex with local Fijian and Indian men, as well as expatriate men. Different kinds of sex work occur in Suva, and the sale of sex is negotiated in nightclubs or from the streets. Female youth under 16 years old also are exchanging sex and can be referred to as *kalavo ni Viti*, or the Fiji rats (Kaitani, 2003).

MALE-TO-MALE SEX

Behavioral surveillance of male youth in Solomon Islands, Vanuatu, and Samoa found male-to-male sex. It also was noted among police and military in Fiji Islands (15, 6.7%), STI clinic patients in Fiji Islands and Samoa (5, 7%), and seafarers in Kiribati in 2002–2003 (19, 5.6%) and 2004–2005 (3, 1%) (Buchanan-Aruwafu, 2002a; Solomon Islands Ministry of Health and Medical Services [SI-MHMS], 2005; WHO, 2006; WHO and Kiribati Ministry of Health, 2004). Little research is available in the Pacific on young men who have male-to-male sex, transgenders, and their partners. As such, knowledge about their sexual practices, sexualities, identities, or their life circumstances is scant. Societal and religious stigma and discrimination, laws that criminalize homosexuality or sodomy, and physical violence and emotional abuse directed at sexual minorities not only violate their human rights, but make young men who have male-to-male sex and women who have sex with women difficult to identify in many Pacific Island countries (Buchanan et al., 1999; Kaitani, 2001; Women’s Action Committee for Change Sexual Minorities Project [WAC-SM], 2003).

Sexual Minorities Project conducted research in the Fiji Islands to identify the needs and experiences of sexual minorities. The sample interviewed were 10–19 (11%), 20–29 (74%), and 30–39 years old (15%). They participated in 48 survey interviews (12 female, 36 male) across four sites, focus groups with 26 participants, and four case studies. Those interviewed identified themselves as male, female, and as both male and female; and

as homosexual (75% gay or lesbian); bisexual (14%); transgendered (6%); heterosexual (4%); and others (1%). Most of those interviewed (58%) reported being abused because of their sexuality, including physical (26%), verbal (39%), emotional (14%), and sexual abuse (21%), such as forced sex and rape. In this sample, a wide range of substances were used, with alcohol, kava, and marijuana the most preferred. Awareness about STIs, including HIV, and about safer sex was lacking, and respondents reported having unsafe sex. The respondents also reported that in the Fiji Islands, youth who are attracted to the same sex increasingly are being forced to leave home after disclosing their sexual preference and can become involved in crime, part-time employment, and leave school early (WAC-SM, 2003).

In addition, culturally defined transgendered roles can be found in the Pacific Island countries, such as Fiji Islands, French Polynesia, PNG, Samoa, and Tonga. Transgenders can be referred to as *logohu*, *fa'afafine*, *fakaleita*, *mahu*, *rae rae*, or *aka vaine* within their different cultural contexts (Schmidt, 2001; WAC-SM, 2003; UN, 1996; Watts, 1992). In Samoan villages, for example, *fa'afafine* are identified at a young age because of their ability and affinity to do feminine labor. While their sexualities can be objected to, they are valued for their ability to do both male and female work. Shifts from subsistence livelihoods based on the products of labor to a cash economy, and migration to urban centers for employment and education away from the familial context, are decreasing this feminized labor role as a gender marker for *fa'afafine* identity. Younger urban *fa'afafine* are creating new identities that are more sexualized. Like in most parts of the Pacific, urbanization has created less constrained environments where youth can escape the watchful eyes of family, whose monitoring plays a role in the social control of sexual behaviors in village settings. In urban areas, *fa'afafine* pursue sexual relationships that they might deny themselves in their villages, as they would risk their social standing, and attract moral and familial disapproval (Schmidt, 2001). Transgenders can have sex with men who identify as heterosexual, and have sex with women (UN, 1996). Despite traditionally accepted roles, transgenders and other sexual minorities still face discrimination and marginalization in their societies (Moala and Perera, 2006; Schmidt, 2001; WAC-SM, 2003; Watts, 1992).

In PNG, MSM and transgenders are marginalized and vulnerable. They face cultural, social, and legal stigmatization; and the legal system crimi-

nalizes their sexual practices. They face harassment, verbal and physical abuse, discrimination, and rejection by their families. No formal research has been done on MSM. Thus, the sexual networking of these men, and their partners, is not always well understood, nor are the contexts of their lives. Young MSM reported that they can exchange sex with men for money or resources to survive, and alcohol, marijuana, or other drugs can be used. They also have relationships with men who are married, and can have girlfriends or other boyfriends. Some of their clients also have sex with female sex workers, and unsafe sex is reported. Some marry because of family, social, and religious pressures, and bisexuality is common (PNG National Strategic Planning Workshop, 2003).

The Samoa AIDS Foundation and Fiji Island's Equal Ground Pacific are developing the first MSM Pacific network, which will support the celebration of MSM traditions. It also will increase support, information, and sharing of resources to try to reduce HIV transmission among highly vulnerable groups of MSM (Moala and Perera, 2006).

INTRAVENOUS DRUG USE

Outside of PNG, 6.7% of all known HIV infections in the Pacific were reported to be transmitted through intravenous drug use. However, little is known about intravenous drug use in Pacific Island countries. Behavioral surveys of youth in Vanuatu and Solomon Islands reported extremely low levels of intravenous drug use (WHO, 2006). A BSS, focusing on students and out-of-school youth in Honiara in the Solomon Islands, found that 0.8% or five youth (3 female, 2 male) who had injected drugs in the previous year (SI-MHMS, 2005). In a BSS in Vanuatu, two youth (0.6%) reported injecting drugs, but not sharing needles (WHO, 2006), while surveillance surveys at an STI clinic in the Fiji Islands found three males (1.9%) who reported injecting drugs in the previous year. In other behavioral surveys—one involving police and military in the Fiji Islands, the other seafarers in Kiribati—two males from each sample (0.9% Fiji Islands, 0.7% Kiribati) reported injecting drugs in the previous year (WHO, 2006). Intravenous drug use was also reported (i) by young people in Honiara in 1999 (Buchanan *et al.*, 1999), (ii) in Tonga during research into substance abuse

by youth (Pacific Action for Health Project [PAHP], 2003), and (iii) in PNG (Aceijas *et al.*, 2004). Overall, intravenous drug use is being reported across six countries in the Pacific, albeit in small numbers. With what is known about global HIV trends and HIV transmission through IDU, alarm bells should be ringing. Too little is known.

Young people's behavioral risks are clear. However, vulnerability to HIV infection in the Pacific is not just about individual practices; young people's vulnerability is also contextual and multifaceted.

PART 2: YOUTH'S MULTIDIMENSIONAL VULNERABILITY TO HIV RISK

GLOBAL TO PACIFIC CONTEXTS

A combination of global and local contexts influence and affect young people's lives, their views, options, and well-being. Young people around the world can live in difficult situations, including some where they cannot control the power relations and other factors that put their lives at risk (Schoepf, 2001). These situations include economic instability and poverty, war and armed conflict, migration, disease, gender and age inequalities, marginalization and discrimination, and rapid sociocultural change. Young people are vulnerable to a range of consequences from these situations, including unemployment; drug and alcohol abuse; illiteracy and lack of skills to earn a living; increased involvement in crime; sexual and physical violence, sexual exploitation, and abuse; homelessness; intergenerational conflicts; low self-esteem, mental health issues, and suicide; and increased risk of HIV and other infections (Foster and Sherr, 2006; UN, 2004; UNAIDS, 2006). The situations experienced by youth are not necessarily predictive of certain difficulties. However, the influences that have the greatest impact on youth vulnerability to HIV infection risk rarely occur alone, nor are they one dimensional.

Like their global peers, youth in the Pacific experience situations that are known to have great impact on the course of HIV epidemics (UNICEF, 2003b; UNICEF *et al.*, 2005; UNICEF and Government of PNG, 2006; UNICEF and UNAIDS, 2006). Young people's vulnerabilities to HIV risk are found in the circumstances of their everyday lives, and in the dynamic nature of their practices within their sociocultural, economic, and political contexts (Farmer and Connors, 1996; Brummelhuis and Herdt, 1995).⁵

5 Contextual analysis had been missing in early HIV-related research and analysis. This change, from stressing "risk" behaviors to considering the situations of people's lives, reflected a philosophical refocusing and increased understanding of the importance of the wider contexts that structure people's vulnerability to HIV infection. The use of the term vulnerability by WHO and UNAIDS in the 1990s to emphasize contextual factors rather than a preoccupation with risk behavior in largely individualistic terms and in language that attributed blame to people, particularly highly vulnerable groups (UNAIDS, 1998; Parker, 2000; Schoepf, 2001).

BEING YOUNG IN THE PACIFIC ISLANDS

SPC, UNAIDS, UNICEF, and WHO define youth as people between 15 and 24 years old. This age cohort is used when collecting data, making analysis, and comparing indicators for young people, as well as for planning, policy, and programmatic processes. The age definitions for children (0–18 years) and adolescents (10–19 years) cut across each other and the age span that defines youth, highlighting the diversity of needs at the different life stages of “young people.”

The age definition for young people or youth varies across Pacific Island countries, depending on the context. A wide variety of local definitions across the Pacific can extend definitions of youth to include people as old as 34 and younger teenagers 13 and 14 years old (UNICEF, 1998, 2004a, 2004b; UNICEF *et al.*, 2005; PRHP, 2004; Government of PNG *et al.*, 2005). This report uses the narrower age definition of 15–24, though it also discusses what is known about younger teenagers (13–14) and older youth (under 35), depending on the availability of data, its relevance, and how youth are perceived within the local contexts being discussed.⁶

Transitions from childhood to youth, and from youth to adulthood, are marked not only by age in the Pacific, but also by a variety of initiation rituals or rites of passage. These can include menarche rituals for girls and puberty initiation rites for boys; or life course transitions and social markers, such as finishing school, finding employment, leaving home, marrying, having children, assuming a position of responsibility within the family, or gaining recognition and social status within a community (Government of PNG and UNICEF, 1996; NSRRT and Jenkins, 1994; UN, 2004). In the Solomon Islands, understandings of the categories of children and youth are quite fluid, and can be socially defined by markers highlighting the onset of puberty, marriage, creating a crop garden, finishing school, community and

6 The legal ages for drinking, driving, and voting in the Pacific are 18 or 21, and the minimum legal age when young people can marry (with parental consent) and take legal responsibility for their sexual behavior and crimes varies across countries, but is generally around 15 or 16 years old. In FSM, the age for sex with consent is 13 years old, and to marry without parental consent is 16 for girls and 18 for male youth. In Tonga, the age drops to 11 for criminal responsibility and in Cook Islands is between 10–14 for criminal responsibility, 12–16 years for sexual consent, and 15 for females and 18 for males to marry with parental consent (Buchanan *et al.*, 1999; UNICEF, 1998, 2004a, and 2004b).

religious participation, and social status in the community (Buchanan *et al.*, 1999; Hassal and Associates, 2003; Strocka, 2005).

PACIFIC ISLAND POPULATION AGE STRUCTURES

The majority of PICT (64% of the countries) has large youthful populations, with children and young people under the age of 25 accounting for more than half the population. While the 15–24 age group makes up only about one fifth of the total population of PICT, a much larger percentage of the population is younger than 15. In 41% of the countries, more than half of the population is less than 20 years old. In many countries in Melanesia and Micronesia, nearly two thirds (65%) of the population is under the age of 30; more than 70% of the population of RMI is less than 30. Table 3 illustrates the national age structures across PICT.

National age structures create a dynamic element to youth population growth. The present age structures of the populations and high fertility rates will continue to structure youthful populations (UNFPA and PRB 2005). As large numbers of children move into the 15–24 age groups, the numbers of young people will continue to grow, except perhaps in those countries in Micronesia and Polynesia where there is considerable international migration.⁷

The sheer magnitude of the numbers of young people and the growing numbers of children, youth, and young parents will sustain and increase already existing pressures on land and the environment, traditional social structures, and support networks, and increase demand for services and infrastructure, particularly in health and education, and for employment (Haberkom, 2004).

7 Extensive international migration is being seen particularly in FSM and Nauru in Micronesia; and in Tonga, Cook Islands, and Niue in Polynesia. Fiji Islands in Melanesia is experiencing some migration, though to a much smaller degree (Haberkom, 2004).

TABLE 3: POPULATION STATISTICS AND NATIONAL AGE STRUCTURES OF PICT

Area and Country	Population at Last Census	Population Estimate 2004	Median Age (years)	0-14 Years (%)	15-24 Years ^a (%)	< 25 Years (%)	< 30 Years (%)
Melanesia							
Fiji Islands	775,077	836,000	21.2	31.2	19.3	50.5	59.2
New Caledonia	196, 836	236,943	25.6	27.9	16.4	44.3	51.8
Papua New Guinea	5,190,786	5,695,301	19.7	39.2	19.9	59.1	69.1
Solomon Islands	409,042	460,104	18.8	40.5	20.3	60.8	69.2
Vanuatu	186,678	215,836	19.6	41.2	19.4	60.6	68.2
Micronesia							
Federated States of Micronesia	107,008	112,700	18.9	37.4	21.4	58.8	66.3
Guam	154,805	116,600	27.4	30.3	15.8	46.1	54.9
Kiribati	84,494	93,098	19.7	38.1	20.2	58.3	65.3
Marshall Islands	50,840	55,366	17.8	40.6	19.9	64.0	71.8
Nauru	10,065	10,100	20.7	38.5	19.8	58.3	66.2
Northern Marianas	69,221	78,034	28.7	26.9	14.3	41.2	53.8
Palau	19,129	20,703	30.8	23.9	14.2	38.1	48.1
Polynesia							
American Samoa	57,291	62,564	21.3	37.7	17.7	55.4	63.3
Cook Islands	18,027	14,000	25.3	34.1	15.6	49.7	56.3
French Polynesia	244,830	250,500	26.0	30.7	18.7	49.4	57.6
Niue	1,788	1,593	29.0	32.6	14.9	47.5	53.5
Pitcairn Islands	52	-	-	-	-	-	-
Samoa	176,710	182,750	19.7	40.6	17.6	58.2	64.5
Tokelau	1,537	1,519	19.9	41.7	14.8	56.5	63.4
Tonga	97,784	98,321	19.9	34.4	20.2	54.6	62.0

Area and Country	Population at Last Census	Population Estimate 2004	Median Age (years)	0-14 Years (%)	15-24 Years ^a (%)	< 25 Years (%)	< 30 Years (%)
Tuvalu	9,561	9,639	23.7	37.2	15.8	53.0	58.5
Wallis and Futuna	14,944	14,868	23.9	34.8	21.6	56.4	62.7

PICT = Pacific Island countries and territories.

^a Percentages of age groups are based on 2004 population estimates.

Source: Secretariat of the Pacific Communities, Demography Population Section. Pacific Island Populations (2004).

These large populations of young people are characterized by a higher concentration of HIV and other STIs, a dearth of information, and a lack of preference for and access to condoms. These characteristics increase young people's risk of exposure to HIV. Youth also experience difficult economic, educational, and sociopolitical circumstances, which can influence their choices and their well-being.

CIRCUMSTANCES AND YOUTH ISSUES

The interrelated situations that impact young people across the Pacific, and the difficulties that these youth experience, long have been identified (Buchanan *et al.*, 1999; Government of FSM and UNICEF, 1996; Government of Tuvalu and UNICEF, 1996; Government of PNG and UNICEF, 1996; Marshall, 1982 and 1993; O'Collins, 1986; Jenkins, 1995 and 1997a; UN, 1996; UNICEF, 1998 and 2003b; UNICEF *et al.*, 2005). The situations identified include (i) unemployment; (ii) lack of educational opportunities and gender disparities in education; (iii) mobility, migration, and urbanization; (iv) shift from subsistence to cash economies, and unequal development between rural and urban areas; (v) sociocultural change; (vi) gender and age inequalities; (vii) cultural taboos on open communication about sex and sexuality; and (viii) limited access to condoms and information about HIV.

While living in particular circumstances will not inevitably lead to difficult consequences, a range of highly interrelated issues for young people have been identified as significant across Pacific Island countries. These

include (i) poverty, homelessness, crime, and youth gangs; (ii) illiteracy and lack of skills to earn a living; (iii) exchange of sex for money or resources; (iv) conflict between tradition, religion, and the changing views of youth, and change in family and cultural structures; (v) young people's frustration from a lack of validation and participation; (vi) lack of sex education in schools, and poor knowledge of STI and HIV transmission and prevention; (vii) increasing teenage pregnancy and STIs, including HIV; (viii) drug and alcohol abuse; (ix) physical and sexual violence; (x) gossip, stigma, and discrimination; and (xi) suicide.

Some of these situations are the same as those identified globally that increase HIV vulnerability for youth. While some circumstances over the past 10 years have improved for young people, others have worsened. And new issues have emerged, such as (i) the volatility and involvement of youth in social and political upheavals; (ii) more visible poverty; (iii) increased HIV infections in young people, and human rights infringements against PLWH; (iv) the commercial sexual exploitation of children and youth; and (v) an increased urgency for youth involvement in decision making and political advocacy (Government of RMI and UNICEF, 2003; Kenny, 2005; UNICEF, 2003a and 2003b; UNICEF and Government of PNG, 2005). This paper presents similarities and differences in some young people's circumstances, particularly their economic contexts and educational opportunities and social change. Further, it illustrates the impact these have on young people, and how these link to vulnerability to HIV infection.

EMPLOYMENT AND EDUCATION—THE IMPACT OF A POVERTY OF OPPORTUNITIES

Some issues affecting young people in the Pacific are symptomatic of political economies and governance (Vete, 2006). The *Pacific 2020* report identified increased population growth, youth unemployment, and joblessness as pressing issues for Pacific Island countries (Government of Australia, 2006). These issues are leading to increased poverty, and the inability of government services to meet expectations and demand. Increasing frustration, particularly from young people, has created the potential for more social and political instability. During the consultations for the *Pacific 2020*

report, a consensus was reached that poverty was being experienced in the Pacific, particularly in terms of shelter; health care; and other basic needs, services, and infrastructure. In some countries, such as FSM, basic nutrition also is being affected by the lack of household income. In many countries, children and youth do not attend school because they do not have money for school fees. And in the Fiji Islands, an estimated 54% of the working population lives in poverty because of low wages (Narsey, 2006). Some countries, such as Cook Islands, Samoa, and Tuvalu, have experienced sustained economic growth since the 1990s. More recently, Fiji Islands, PNG, Solomon Islands, and Vanuatu have grown economically. However, economic growth has not been rapid enough to make a difference in youth unemployment (Government of Australia, 2006; Government of Solomon Islands and UNICEF, 2004; UNICEF, 2004b and 2005b).

The growth in labor markets in most Pacific countries is attributed to students leaving school, and unemployment is highest for young people 16–24 years old (McMurray, 2001). With the limited development of rural and private sectors and secondary industry, as well as the lack of skills development for young people, the increasing youth labor force is not being absorbed. At the same time, existing labor markets are experiencing shortages in skill levels (UNICEF *et al.*, 2005). In 2000, for example, Fiji Islands had five working aged people for every formal sector job, despite rapid job creation. In the Solomon Islands, which has the slowest pace of job creation, 7.9 people were available for every available job. FSM had 22% unemployment in 2004. While Palau has a lot of opportunities for unskilled labor, unemployment among high school dropouts is high because of their higher expectations and preference for white-collar work (McMurray, 2001; UNICEF, 2004b). In the Cook Islands, although out-migration of young people helps to lower unemployment, cash employment is still restricted and unemployment is rising. For the young people who leave high school, many do not have the skills for the formal work sector (UNICEF, 2004a). In RMI, where people under 30 comprise more than 70% of the population, unemployment has increased radically, with three times more young people unemployed now than a decade ago. Several hundred youth every year are unable to find work or self-employment, raising concerns about social stability on some atolls (Government of RMI and UNICEF, 2003). In South Tarawa in Kiribati, an estimated 70% of young people are underemployed or unemployed (UNICEF, 2005a). In Vanuatu, the economy needs to create

more than 4,000 jobs every year to provide jobs for young people who leave school—a demand that currently is not being met (UNICEF, 2005b).

While the employment needs of young people are not being met, education is not preparing youth adequately to compete for a limited number of jobs, which is limiting their economic and human potential. Most education systems in the Pacific have been geared toward developing skills for “white collar” employment, though the labor market does not match these skills. Curriculum reform, as well as vocational and other skills building, is needed to support more sustainable livelihoods for young people (McMurray, 2001).

Retention rates are low, and many students are being pushed out because of structural factors. Countries have increasingly large numbers of children to educate, not enough places for students in secondary schools, and many youth being pushed out after failing exams. Many who do reach high school perform poorly. RMI has compulsory education for all children aged 6–14, or until primary school is finished (8 years). While school enrollments have increased, retention rates for secondary school are low, and in many countries are less for female youth. The last census in RMI showed that 30.4% of females aged 14–18 and 69.8% aged 19–21 were not enrolled in school (Government of RMI and UNICEF, 2003). In Vanuatu, although compulsory and free education until year 8 is a Government policy, students are refused access if parents cannot pay high school contribution fees. Most youth do not go to secondary school after primary school due to their failure of exams, or because the costs of education are beyond the reach of most parents. The push-out rate after primary school in Vanuatu was about 50% in 1999–2000. Not enough spaces are available for students, and only 40% of students can continue to junior secondary school. In 2001, about 63% were pushed out after junior secondary school (UNICEF, 2005b). Likewise in Nauru, PNG, and Solomon Islands, a high number of students are unable to continue to secondary school because of inadequate space. In Kiribati, primary education is compulsory and free (grades 1–6), and junior secondary education (form 1–3) is compulsory (Kiribati National Advisory Committee on Children [KNACC], 2002). Enrollment rates, as well as the participation of female children and youth, have increased, with a ratio of 93 girls to 100 boys in primary school and 114 girls to 100 boys in secondary school. However, the costs of secondary school lower the retention

rates, with increasing numbers of students pushed out who lack the skills for the labor market (KNACC, 2002; UNICEF, 2005a). In FSM, though school enrollment is high, the quality of education is of concern due to the lack of trained teachers. High school students can perform poorly, and do not have enough skills to meet the demands of the economy (UNICEF, 2004b).

In many countries, student performance suggests low literacy and mathematical skills. Except for marine training schools, vocational training has been unable to reduce unemployment or help youth meet market demands. Fiji Islands, French Polynesia, FSM, Kiribati, PNG, Solomon Islands, Tuvalu, Tonga, Samoa, and Vanuatu have marine training schools for seafarers. The work of seafarers has increased employment and country incomes (Government of Australia, 2006). However, HIV could jeopardize this positive growth and inflict human costs. Seafarers are a highly vulnerable group, and large numbers of HIV infections in young male seafarers could decrease the remittances to countries such as Kiribati and Tuvalu, whose economies and household budgets depend on them. Further, this could create an additional burden on health systems to provide treatment, care, and support.

Youth unemployment and underemployment, as well as a lack of educational opportunities, skills, and literacy, are producing many idle youth. These young people, who are not being absorbed into the formal, informal, or subsistence economies, live in poverty. The inability of young people to meet their livelihood needs, or their social and familial expectations and obligations, is integrally linked to their lack of employment or education to equip them for the changing contexts in which they live. These structural challenges add a dynamic that is beyond young people's immediate control to change. Youth living in difficult economic circumstances in the Pacific are becoming involved in crime, as well as the exchange of sex—often unprotected—for money or things that they desire or need for their survival. As such, they can be more easily exploited. Substance abuse is also increasing. Sociocultural change is contributing to young people's increased vulnerability to HIV (Buchanan-Aruwafu, 2002a; Chevalier, 2000; KHATBTF, 2005; NAC, 2005; UNICEF, 1998; UNICEF *et al.*, 2005; UNICEF Pacific, 2003a; UN, 1996).

THE IMPACT OF SOCIOCULTURAL CHANGE—A BAROMETER OF VULNERABILITY

Young people in Pacific Island countries experience and interact with in political, economic, and sociocultural contexts that are much different than those of their parents' and grandparents' generations. Rapid urbanization, migration for education and work, shifts from subsistence to cash economies, changes in population and familial structures, travel, global influences through communication and media, and HIV epidemics have changed the dynamics of the world that young people live in. Urbanization and migration for employment and education have allowed young people more freedom away from the watchful eyes of their parents and extended family networks. This has changed mechanisms of social control over sexual activities, relationships, and drug and alcohol use. As a result, teenage pregnancies and STI levels have increased among the youth (Buchanan *et al.*, 1999; KHATBTF, 2005; NSRRT and Jenkins, 1994; Schmidt, 2001; UNICEF, 2005a) As illustrated in the case study from the Solomon Islands in the next part of this paper, the risk of HIV infection thrives in the contradictions and dilemmas between sociocultural expectations and ideals on the one hand and young people's changing worlds, identities, and practices, on the other.

In the context of social change in the Pacific, young people juggle a range of influences, which include (i) sociocultural traditions and norms; (ii) religion; (iii) parental authority and expectations; (iv) social mechanisms of control; (v) youth cultures; (vi) personal values and identities; (vii) changing lifestyles; and (viii) frustrations from economic, social, and political marginalization and lack of participation. Culture and cultural identity are important for young people, and they have a strong sense of the importance of familial expectations and their responsibility, and their own social obligations and status. These can cause shame, fear, misunderstandings, intergenerational conflicts, and despair for youth when they cannot meet the expectations of their parents, their social environments, or their own aspirations (Buchanan-Aruwafu, 2002a; UNICEF *et al.*, 2005). The context of socioeconomic and cultural change creates contradictions, confusion, and ambiguity for young people, and subsequent issues such as drug and alcohol abuse and suicide are evident (Lowe, 2003).

Social change and the use of alcohol and drugs are associated with suicide in some countries. Many young people are committing suicide in the Pacific—in Fiji Islands, Guam, Palau, Samoa, Solomon Islands, and RMI. Some Pacific countries report some of the highest prevalence of suicide in the world. Suicide is occurring in the context of social change when (i) young people cannot meet parental and societal expectations, and their own desires; (ii) they do not have the power, communication, or negotiation skills to reconcile differences when intergenerational conflict occurs; and (iii) young people do not have the ability to change the shifting contexts of their lives, and resolve the incongruity between the different identities that they create. While an in-depth discussion is outside the scope of this paper, suicide and attempted suicide are important barometers of the kinds and degree of stress that young people are experiencing in their employment and education, as well as from age, status and gender disparities, in the context of social change. While alcohol and drugs are used by youth to alleviate stress, they can create greater vulnerability to HIV infection (Booth, 1999; Lowe, 2003; Pinhey and Millman, 2004; Rubinstein, 2002; UNICEF *et al.*, 2005).

ALCOHOL AND DRUGS

Young people use and abuse a range of drugs and alcohol, which they can associate with being out of school, unemployed, uninvolved or unaccomplished, and stressed. Alcohol and drugs are used to (i) relax and relieve tension; (ii) experiment, have fun, and generate excitement; (iii) bond with peers (and because of peer pressure); and (iv) enhance personal image and confidence, and decrease young people's inhibitions in their pursuit of relationships and sex. The use of alcohol and drugs has been associated with unprotected sex. Binge drinking and excessive marijuana use also have been linked to poor health, accidents and violence, crime, gang rape, unwanted sex, teen pregnancies, STIs, and mental health problems across Pacific Island countries (Buchanan-Aruwafu, 2002a; Koops, 2002; PAHP, 2001a, 2001b, and 2003; UNICEF, 2003b; UNAIDS, 2006; Mielke, 1995). The following selected data illustrate young people's substance use, and how it is related to potential HIV transmission.

Box 1: Bottle Breaks

Do you think it is OK for girls to drink nowadays?

G1: I think that it is OK. Just a small amount for those girls who feel very shy to go in public (during dances). Enough to let them get over their shyness. But it is bad when you take too much. You do not know what you are supposed to be doing. It is too much. And in the end you would be surprised to see a long queue waiting to have their turn on you!

G2: Your bottle breaks (virginity is lost) and there is a long queue! (Female youth, PAHP, 2001a:30).

Box 2: Showing Off

In your observations why do you think the young generation drinks?

They are just showing off. They want to fight. Girls drinks maybe to want to go on a date. Others just want to get drunk to enjoy themselves and forget their worries. Most people when they drink they chase after women (Male youth, PAHP, 2001a:9).

In Kiribati, young people under the age of 21 cannot drink alcohol legally. However, alcohol abuse and drunkenness are common among young people. An increase in female youth drinking is being reported, underage drinkers can be found in bars, teenagers are being charged with drunk and disorderly conduct, and heavy drinking is common for tertiary students (KHATBTF, 2005; PAHP, 2001a; UNICEF, 2005a). A study in South Tarawa

found that youth use a range of substances, including imported beer and spirits, fermented toddy (*kaokioki*), and home brews. Youth also sniff benzene and drink methylated spirits, but marijuana smoking is rare in Kiribati (KHATBTF, 2005; PAHP, 2001a). Unwanted sex, unprotected sex, and pregnancy reported were some of the consequences of drinking alcohol (UNICEF, 2005a).

In Vanuatu, research found that young people use a range of substances, often in combination, including kava, beer, wine, hot stuff (liquor) and homebrews, betel nut, marijuana, bell flower (*Datura*), and methyl alcohol (PAHP, 2001b). Youth reported using substances frequently and in large quantities, which was linked to a lack of employment and alternate activities for young people. Most youth hid their substance use from their parents. Some others had greater freedom to use substances more frequently and in larger quantities, as their parents were living on outer islands while they were living in Port Vila (PAHP, 2001b). A UNICEF study (2001a) showed that substance use can start at a young age in Vanuatu—as young as 12—with consumption increasing with age as young people moved through their teenage years.

Box 3: No Jobs

I think young people's (lives) are getting low because there are no jobs so that (is) why we must get drugs to satisfy our basic needs. (Male youth, PAHP, 2001b:10).

Box 4: I Can't Stop

What has made me to drink is when I go with most of my friends they start to drink they would give me a glass. I would sit and drink with them and then from then on I start to drink and until now I've become addicted and I can't stop. I feel when I want a drink I have to. I can't hold it because I am use to

it. Also, another thing that causes me to drink is because of the problems I have at home, makes me worry a lot and thinking of it makes it hard for me to sleep. Problems that I have at work and in my studies since now that I am a student, it's hard for me so I have to drink to forget my problems to make me sleep and to stop thinking about them. (Male youth, PAHP, 2001b:26).

In Tonga, research with in-school and out-of-school youth indicates that substance use is common, although higher use and frequency of use was reported with out-of-school youth (PAHP, 2003; UNICEF, 2001b). Youth said unemployment and a lack of alternative activities were the reasons why they abused substances to pass the time. Substance use facilitated a form of peer bonding and social interaction, self-esteem, and self-worth. Substances used included tobacco, alcohol, solvents, marijuana, methylated spirits, cocaine, mushrooms, and *fafangu* (*Datura*). Familial conflict, violence, and crime were linked to drug and alcohol use. Severe punishment from parents over alcohol and drug use could cause it to become more hidden and more abused (PAHP, 2003.)

Box 5: Cruising

Yes when they were at school they start smoking and drinking alcohol these two things interfere with their studies and lead to a situation where they are expelled from school. If they don't have the opportunity for schooling this will lead them to unemployment so they just cruise around town (Male youth, PAHP, 2003:15).

I use drugs to solve my problem. If I'm angry with someone I can smoke a joint of marijuana and all of a sudden the feeling of anger goes away from me (Male youth, PAHP, 2003:39).

Box 6: Some People End Up Dead

Some guys when they drink mushroom they will drink alcohol afterwards and it's worse. Because they won't know how much alcohol they are drinking and when the alcohol has had an affect on them. Some people end up dead and that's it (Male youth, PAHP, 2003:50).

A high proportion of female and male youth drink alcohol in Cook Islands, particularly in the urban center of Rarotonga (UNICEF, 2004a). An ethnographic study in Cook Islands (Koops, 2002) found that young people favor drinking beer and spirits, though home brew is also available when funds are short or access to other alcohol is limited. Binge drinking is the general pattern of consumption, with youth drinking over long hours. Youth said they began drinking to experiment and feel cool, fit in with their peers, show off, and be like adults. After becoming familiar with alcohol, drinking gains social salience as a way to initiate and maintain relationships between friends, kin, and strangers. It is used to relax, decrease inhibitions for conversation, inspire one to sing and dance, or find a spouse or sexual partner. Drinking also could cause embarrassment, lead to violence and arguments, and accidents.

Box 7: Alcohol and Sex Drive

I had been drinking over at my friends', and there was this guy standing in front of me—I was so curious of what he would be like in bed, and that did happen—and yes, I was happy but inside I was scared, oh shit what did I have to do this for—yeah, you know, it was just the alcohol that gave me that drive (Female, 27, drinker) (Koops, 2002:192).

Box 8: Sweet Talk

So we're sitting in a group, having a drink and then, once we go out we're socializing through own and that. When we get to a certain place, and sort of like, when they see girls and that, they go up to them and start talking. Yeah, that's what they normally do (Male, 21, drinker) (Koops, 2002:187).

The men tend to be a bit more, like the guys I know, when they're around other people they tend to be a bit quiet—around other people they don't really know—but then when we all drink together, they'll just out of the blue say something, and they're real sleazy, trying to hit on you. That's what the guys are like over here—all they think about is their things down below [laugh]. And girls, when they're drunk they tend to get sucked in, what I've experienced. Like when I was drunk one time, and you just get sucked in by their sweet talk, blah, blah, blah, and wake up the next morning and realize what you've done, and you can't really go back and change it, too bad (Female, 19, drinker) (Koops, 2002:192).

Many young people in PNG use marijuana (spak brus) and alcohol, including out-of-school youth and young people at school and university (Johnson, 1998). Alcohol use leads to other problems, such as domestic and sexual violence, fighting and disruption in the community, crime, and alcohol-related accidents. Young people use alcohol and drugs for pleasure, and to escape and forget about their problems, such as poverty, domestic violence, sexual abuse, lack of money, and lack of communication with parents and other adults (Decock *et al.*, 1997). PNG marijuana is potent, widely used, illegal, easily accessible, and inexpensive (Marshall, 1993). Jenkins and Alpers (1996) found marijuana being used more than alcohol, and youth reported that it decreases their sexual inhibitions.

The degree of substance use by young people, combined with how alcohol and marijuana can decrease sexual inhibitions while reducing condom use, heightens the risk of HIV infection for youth. Drug and alcohol use by young people, the situations they live in, and their vulnerability to HIV cannot be considered or addressed meaningfully in isolation—they are intertwined.

SHHH—TABOO

Issues affecting young people's vulnerability to HIV in the Pacific are also symptomatic of culture and social relations. For example, sex and sexuality are not easily discussed within families in the Pacific because of cultural taboos on discussions about sexual matters between specific kinship relations. There is a widespread belief and an unquestioning acceptance of the status quo—that talking about sex and other sensitive issues goes against Pacific cultures. Consequently, silence and inhibited communication about sex and sexuality in families, churches, educational curricula, and even health systems have contributed to young people's ignorance. This also has limited youth's access to services that reduce risk and vulnerability, including accurate information about reproductive and sexual health, STI and HIV transmission and prevention, STI treatment, and condoms. The impact, as noted above, is clear in young people's lack of knowledge, infrequent condom use, and levels of STI and HIV. In some studies, young people expressed shame and fear to broach these questions with adults.

The three UNFPA studies in Cook Islands, Kiribati, and Samoa indicated that many adolescents were told not to have sex and to value virginity. However, adolescents lacked guidance from parents, schools, and churches on sexuality, reproduction, HIV, and other STIs (Seniloli, 2003a, 2003b, and 2003c). To varying degrees in these three countries, young people reported not seeking information because of shame and embarrassment, fear of parents, religion, or the belief that information about contraception was only for adults. The case study on Auki, which follows, illustrates this dynamic. In the PAHP studies on drug and alcohol use in Tonga, Vanuatu, and Kiribati (PAHP, 2001a, 2001b, and 2003), young people said they hid their substance abuse from their parents because of fear of punishment.

Thus, the opportunities for adults to guide and support young people were reduced. When young people's substance use was discovered, they often were punished severely. This could isolate young people further, which can produce opposite the intended effect by increasing their substance abuse.

Across the Pacific, gender and age inequalities affect women—particularly female youth—and young people's participation in family, social, and political discussions and decision making. “Cultures of silence” and “cultures of violence” have been coined to illustrate many Pacific cultural practices and beliefs which oppress the status of young people, children and women (Carling 2004). Sociocultural norms promote the belief that children and youth should not question their elders, or express their opinions in adult conversations—that, in short, they should be “seen and not heard.” These norms are reinforced through socialization, authoritarian parenting approaches, and violence to ensure deference to adults, particularly male elders. Norms affect the ability of young people to (i) talk openly with adults; (ii) ask advice; (iii) question and express their opinions to their parents and other adults; and (iv) be open and honest about their sexual relationships, their youth cultures, or even their HIV status (Buchanan-Aruwafu, 2002a; PRHP, 2004; UNICEF, 2002; UNICEF *et al.*, 2005; UNICEF and Government of PNG, 2006). Age and gender inequalities contribute to discrimination, young people's resistance and intergenerational conflict, physical and sexual violence, and young people hiding and exerting their own agency through their practices (Buchanan-Aruwafu *et al.*, 2003; Bradley and Kesno, 2000; UNICEF, 1998; UNICEF *et al.*, 2005). The following case study from Auki Malaita in the Solomon Islands illustrates how culture and taboos regarding talking about sex, sociocultural change, age and gender inequalities, and social conflict impact young people's knowledge, practices and their experiences. The research data in this case study was collected with youth researchers, and illustrates the value of involving youth in researching issues that affect their lives.

PART 3: AUKI—A CASE STUDY

The Solomon Islands archipelago has an estimated population of 460,000, which is young and growing quickly. In 1999, the island of Malaita had the highest population of the country's nine provinces (122,620), with more than 64% of its people under the age of 25 and a high annual growth rate of 3.3%. Auki, the capital of Malaita, has developed rapidly and consistently over the past 50 years, with an estimated population of 4,421 (Government of Solomon Islands, 2000).

Young people from rural areas are highly mobile and migrate to Auki and other urbanizing centers for many reasons, including (i) employment; (ii) education; (iii) escape from the close surveillance of their families in rural areas; and (iv) curiosity, adventure, excitement, and attraction of urban life (Jourdan, 1995; Burslem and Larson, 1998; Buchanan-Aruwafu, 2002b). Young people experience high levels of unemployment, a lack of educational opportunities, a depressed economy, increased inflation, and political corruption (Chevalier, 2001; Fraenkel, 2004; Government of Solomon Islands and UNICEF, 2004). As has been seen in Fiji Islands and PNG, young people in the Solomon Islands can contribute to social and political instability, as well as become involved in crime, lawlessness, and armed conflict, when their disparities are not addressed. This, in turn, can undermine economic and social stability further (Buchanan-Aruwafu, 2002; Chevalier, 2000; NAC, 2005; UNICEF *et al.*, 2005).

Between 1998 and 2000, more than 20,000 people were displaced back to Malaita due to ethnic tension and armed conflict. An estimated 50% of those displaced were young people under the age of 21. The conflict was based on tensions between the indigenous Guadalcanal population and Malaitan migrants, and centered on land ownership on Guadalcanal, control of resources, and compensation for alleged murders (Kabutaulaka, 2000). In 2000, there was a political coup.

During the research for this study in 2000, male youth from Malaita who became involved in the armed conflict as “militants” were the victims and perpetrators of violence. Sociopolitical instability and armed conflict (i) displaced large numbers of young people to Auki, and interrupted their education and work; (ii) created insecurities, and broke down legal and

societal structures; (iii) disrupted health and other basic services, and increased the burden of disease; and (iv) increased the risk of acquiring STIs, including HIV, for militants and civilians. Sociopolitical instability constrained economic stability and development, increasing unemployment (Amnesty International, 2004; Buchanan-Aruwafu, 2002; Chevalier, 2000; Government of Solomon Islands and UNICEF, 2004).

Violence and inequality between men and women, and an imbalance in power, existed on Malaita before the ethnic conflict. Power imbalances were exacerbated and shifted during the conflict, with arms creating power for young men—they became above the law and *kastom* negotiations. (*Kastom* is broadly defined as cultural traditions and beliefs.) Acute ruptures in power relations and social norms occurred during this time between chiefs, community leaders, politicians, police, militants, and young people on Malaita, which undermined the maintenance of social and *kastom* norms for youth (Buchanan-Aruwafu, 2002a; Chevalier, 2001; Fraenkel, 2004). Power also was expressed through sexual activity. Militants were involved in rape, and sex with multiple partners, sex workers, and other transient young women. Physical and sexual violence against women, as well as child sexual abuse, occurred in the Solomon Islands before the ethnic conflict. During the conflict, sexual violence against women and young girls increased (Amnesty International, 2004; Buchanan-Aruwafu, 2002).

Women's status in the Solomon Islands society is low. Malaita is a patriarchal, male-dominated society, with gender and age inequalities, and power relations that do not support women and young people in leadership and political roles (Akin, 1993; Pollard, 1988). From a young age, girls are socialized to respect men, and their submission and obedience is reinforced. Girls are not supposed to be vocal and to question, and they must serve the men in their family and respect their brothers. Boys are taught not to be vocal and to question their male elders and they can use physical violence against their sisters, particularly regarding their obedience, respect, and sexual behavior. Youth are socialized about sexual behavior that stresses female virginity at marriage, while boys are told not to be promiscuous, creating double standards.

In 2000, sexual prohibitions and their consequences, brideprice,⁸ compensation, violence, religion, and gossip continued as contemporary forces that limited young people's behaviors. These are used to regulate premarital sex and boyfriend-girlfriend relationships, illustrating the continuity of practices despite changes in the variability and form of *kastom* on Malaita. When the community becomes aware that young people are having sex, the issue is addressed between families, including through violence or paying compensation, or trying to force the young people to marry.

Box 9: Red Money

When I go with a girl, it is to satisfy my desire. Yes I think of compensation. I think that when we went no one saw us, we were hidden, but to my surprise someone saw us. In *kastom* if you take their girl somewhere, and they see you with her, then only red (shell) money and money will solve the problem. From before until this time it is the same, that is how it works. Even if you hide and any of her brothers see you with her, then you are in trouble, and red money or money will go to them. These are to solve the problem. If you do not give it them 'ma nek aot na ia', they will cut off your head (they will beat you), from before till this time it is the same (Kusa, 2000).

If a young girl gets pregnant, her family will ask for compensation. After these negotiations, the young people may marry, but this does not always happen.

Box 10: Everything Changes

If it happens that she gets pregnant, then everything changes. They will tell you to marry her and if you don't want to marry her then you must give more. It is more than the time

⁸ Bride-price is an exchange made between families and is paid by the family of the bridegroom to the family of the bride. Bride-price creates ties between families and is also seen as a reimbursement to the girl's family for the loss of her labor.

they have seen you talking with her and walking around together. If you make her pregnant then the amount that they will ask will be more. If you pay for her and marry, then that is OK, but if you don't want to marry her then it will cost more money. Five red shell money would have to be given to the girl's father, with two or three thousand dollars (Kome, 2000).

Female and male youth fear violence and compensation. However, they resist by refusing to marry and continuing their sexual practices, while feeling guilt and shame for not meeting social and parental expectations.

While *kastom* varies between the ethnic groups on Malaita, the prohibition against premarital sex is linked to the bride-price expectation that a girl is a virgin when she marries, that her reproductive role is confined to marriage, and that she will bear children to continue her husband's kin group. When a girl is young, she is told that her family will not receive a high bride-price if she has had sex or has a bad reputation. Bride-price is embedded in systems of exchange, creating ties between families and social relations between kin groups. It reimburses the family for their daughter's value and the loss of her productive and reproductive labor, and helps to pay for the wives of her brothers. Female youth work hard to protect their reputations through secrecy and not bring shame on their families. Young people said that the shift to a cash economy is changing the significance of bride-price, leading to a commoditization of a girl's body and the further oppression of women. Bride-price was seen as a source of pride and obligation, and as a burden and restriction of freedom by female youth.

Box 11: Only Money

I have seen people paying brideprice and I have seen it change. They say that everyone should pay with money, only money. Before if you had a bag of money and it went to 50 or 100, then that was enough money, but now if you give five red money they will reject it unless there is also money. The way that I think that it has changed is that the amount of money

they sell her for is big, the amount of the bride-price is high. The church have put the limit to five red money when you marry, five red money or how much the boy has he gives, but this time it isn't like that (Ruki, 2000).

Box 12: Yes, I Break the Rules

When I stay with my uncle it is difficult to go out and meet my boyfriend. He stops me from going out so I do not go. I cannot go out with other people. If a person comes by and asks me to go, I cannot go and then I just stay. Once my uncle tells me something, tells me these things, I do them otherwise 'stiki na banga' (I get hit with a stick) ... Yes I break the rules... Yes I break them—sapos mi go wiki—(if I get sick of it) I will lie that I was in a different place, but it's not true. I have been with my boyfriend in some empty house, over there (points and laughs), until four o'clock and we have been there since one. We will talk; we will sit down and talk until four. When I go back, my uncle will ask, "Where did you come from? I have been to the market three times and they told me at the market that you were on your way up." Then I will tell him; "Oh, I went to visit with my uncle on the other side of town." My uncle lives there. Then he would say, "OK, it is all right if that is how it was." I feel really bad, (when I am restricted) I feel sad and I don't like to eat. From morning to evening, I cook and then I sleep. I turn on the stereo low and I sleep. When I don't eat during the day, I also don't talk... sit down quietly, just thinking; only thinking of my boyfriend. Thinking of the boy—Tinkim boe (thinking of the boy) (Nix, 2000).

Young people are conflicted over their obligations to their parents and their own desires. The refusal of parents and guardians to allow boyfriend-girlfriend relationships, and for female and male youth to marry whom they choose, causes intergenerational conflict and stress for young people.

Sometimes young people run away, increase their alcohol and marijuana use, and even commit suicide. Nix committed suicide a couple of years after this interview because of conflicts over a relationship.

Social gossip and criticism are used to ridicule young people publicly in attempts to control their relationships and desires. Gossip, particularly by women, and the practice of suspending young people from school or church if it becomes known that they are having a sexual relationship outside of marriage, is used to regulate sexuality through public humiliation. This creates further disadvantages for young people. A young girl and boy, seen together alone at an unusual place or time, also can arouse suspicion, and a clandestine relationship might be assumed. While young people fear compensation and violence, they greatly dislike criticism and the stigma placed on them by the wider community if their relationships are discovered. Stigma and humiliation are a major part of why young people are secretive about their sexual practices and relationships. Young people had a range of strategies to hide their boyfriend-girlfriend relationships.

Box 13: Sneak Out

I will wait until everyone is asleep, open the door, no one will hear me, open the door and sneak out. Go, sit down, have sex and then come back to the house not long before dawn (Lai-Sex, 2000).

Secrecy and clandestine meetings can make young women particularly vulnerable during negotiations over whether to have sex or have protected sex when they are in isolated areas. Coerced sex and rape, violence, unwanted pregnancies, and STIs could be consequences of their secrecy.

The majority of young people said that neither *kastom* nor religion stopped their sexual practices, though these affected how they felt (i.e., shame and fear) and the degree of secrecy that they used to hide their relationships. At the same time, the majority of young people condemned sex before marriage or sex with multiple partners, which conflicted with their own practice. Contradictions and personal conflicts are created for

youth when their allegiances to *kastom* and religion clash with their pursuit of pleasure.

The BSS surveyed 300 young people, with equal numbers of female and male youth. The majority of those surveyed were 15–24 years old. Young people were quite sexually active: 262 of the respondents had had sex. The median age at first sex was 15 years old; 86% of the young people had had sex by the age of 17. Only 77 (29%) of the sexually active young people had ever used a condom, and only 36 (14%) had used a condom at last sex. When asked why they did not use a condom, young people generally responded that they did not like condoms, or that they did not have or have access to a condom. Of all young people who were sexually active, 21% said that there were times that they had not used a condom even when they might have had one, because they were drunk or stoned. Alcohol and marijuana use is quite high in Malaita, and young people associate alcohol use, sexual desire, and having unprotected sex.

While condom use was low, the number of young people with multiple partners was high. Of those who had had sex, 150 (57%) had more than one regular sexual partner. More than half of these had had 1–4 sexual partners in the previous 12 months, and nearly 10% reported having more than 10 sexual partners. While 84% of the females reported that their last sex was with their regular partner, only 25% of the male youth had their last sex with a regular partner. The cultural double standards plays out in the data—the vast majority of female youth (83%) expect to have sex only with their regular partners, while only 17% of male youth shared this expectation. Only 15% of young men who were involved in relationships believed that having an affair when in a committed relationship was wrong, while 70% of young women who were involved in relationships believed that having an affair when in a committed relationship was wrong.

Of the sexually active young males, 18 (13%) had paid for sex in the previous year, and eight of these had contact with sex workers weekly or monthly. Further, 32 youth (53% females, 47% males) had exchanged sex for money or resources; 24 of these were 15–24 years old. The age when they had first been paid for sex ranged between 15 and 29. Of those who reported exchanging sex for cash or resources in the previous year, only one female youth said that she used condoms with her regular clients.

Young people's sexual practices indicate a high level of risk for HIV and other STIs.

Similar to data from other parts of the Pacific, young people in Auki also experienced sexual violence. Of youth surveyed, 96% had heard of others who had been raped, and 40% (103 male and 17 female) had seen a *long laen* rape (gang or group rape) happening. Sixty-three male youth and two female youth between the ages of 15 and 30 reported that they had been involved in a gang rape. The number of men involved during each gang rape ranged from two to 14. Of the 63 male youth who had been the perpetrators of long laen rape, only 12 reported ever using a condom in their lives. Youth said that alcohol abuse created opportunities for long laen rape to occur and young men took advantage of the situation. Female youth who had refused to have sex or insulted a young man could be later gang raped. Rape also was being used as a way to control female promiscuity so that bride-price payments would not be effected and to teach young girls a lesson so they would protect their reputations. Long laen rape was being used as a strategy to control young women and their sexuality, and is rooted in attitudes towards women. The contradictions that young people face in relation to their sexual practice and the status of women are at the root of sexual violence.

Fifteen male youth who participated in long laen rapes said that they previously had been the victims of sexual coercion by women when they were young. Thirty-nine (28 male, 11 female) youth said that they felt coerced or intimidated to have sex when they did not want to. Male youth said that their relationships to the women who forced them to have sex varied, but they were mostly women that they knew: their friends, their neighbors, house girls, and relatives, or some others they did not know. Female youth said that men they did not know had forced them to have sex, as did their neighbors, relatives, and friends. Shame and stigma affected the ability of both female and male youth to discuss or report when they have felt that they were victims of sexual violence.

Young people attributed the lack of reporting of cases of long laen rape to the shame and stigma a girl would feel if she reported the rape, that she could not protect her reputation if she went to the police, to her feeling that she may have deserved what happened, and the obstacles

faced within the health and legal systems. If a young girl chose to report the rape to her family, she feared reprisal from her family in the form of further violence and shame. If the rape is reported to the family, they might not report it to the police and choose instead to settle the issue through compensation. If a rape is settled through compensation, the young woman does not receive any share of the compensation payment, and the physical and emotional consequences of the sexual violence are not addressed.

Young people had other sexual and tattooing practices that heightened risk of HIV transmission. Young people reported the use of penile inserts (mabol) that can cause abrasion or inflammation, increasing the risk of HIV transmission (Hull and Budiharsana, 2001). Of the 150 males surveyed in Auki, 5% (8) had mabol. Meanwhile, 6% of sexually active female youth reported that they had had sex with a man with mabol. Tattooing practices also indicated risk of HIV and other infections. The survey found that 40% (119) of young people interviewed had been tattooed; and of these, 83 had more than one tattoo. Further, 25% (74) reported that others had had tattoos done before or after them, and 50% had been tattooed in their home villages. Data from Auki indicated that needles are not cleaned nor ink pots changed between tattoos, posing a risk of transmission of HIV and hepatitis. Meanwhile, their ability to gain information about their tattooing and sexual health risks, and condoms to protect themselves, was limited.

In Malaita, as in other places in the Solomon Islands, the knowledge of sexual and reproductive health within the community is poor. Discussions about reproductive and sexual health with young people in the family, educational, and health systems are limited due to cultural and religious barriers regarding discussions about sex. Primary and high schools do not have a formal curriculum for sex education, and continuing training for health workers in the areas of STI, HIV infection, and AIDS has been lacking. In addition, access to free or affordable condoms and youth-friendly sexual health services, particularly in rural areas, has been lacking. Health workers have negative attitudes toward condom distribution to young people and display moralistic negative attitudes when dealing with young people's sexual health issues. Further, access to antibiotics in clinics for STI treatment can be inconsistent (Buchanan *et al.*, 1999; SIG *et al.*, 2005).

While youth are told that they cannot have sex—and this was reinforced through violence, compensation, and gossip—they receive little guidance from their parents about sex. Adults maintain that talking about sex is *tabu* or prohibited. *Kastom* does not promote free conversations about sexuality and sexual health between men and women, including sisters and brothers. Parents identified religion, *kastom*, and a lack of knowledge as barriers in their ability to communicate about sex with their children. This study found that the ease with which young people talked about sex was contingent on the context, their gender and age, and the relationships of the people involved in the conversation. Young people were afraid, ashamed, or concerned that they might be criticized if they raised issues about sex with their parents. Only 10 (7 female, 3 male) of 300 young people surveyed in Auki had ever spoken to their parents about sexual or reproductive health issues. The primary reasons for not talking to parents were fear (51%; 93 female, 55 male), possible criticism (21%; 22 female, 42 male), and shame (14%; 28 female, 20 male). *Kastom* and religion were at the heart of these reasons.

Young people's sources of information about sex were their peers, relatives, and school, but not health workers. Health workers were not always open to discussing sexual health issues, and they identified religion, *kastom*, and a lack of training and educational materials as barriers to talking about sexuality. Young people identified criticism from health workers as a deterrent to seeking services, and felt that confidentiality was lacking. Health workers could exhibit negative attitudes when young unmarried people come to them with STIs. Condoms were not given routinely to unmarried youth when they requested them, even when they had an STI.

This study explored the knowledge about STIs and HIV among the youth. When young people were asked about STI symptoms, 54% said that a man could have an STI without symptoms; 46% said a man could not or were unsure. Most youth were unsure, or said that a woman had no obvious symptoms when she had an STI. While virtually all youth had heard of HIV and AIDS, the beliefs about HIV transmission were significantly different between male and female youth. While 162 young people thought that a healthy-looking person could have HIV (39 female, 123 male), more than two thirds of female youth (70%) believed that a healthy-looking person could not be infected with HIV. Female youth had more misconceptions about HIV transmission through social contact, such as hugging, cough-

ing, and sneezing, while male youth had more misconceptions about HIV transmission through mosquito bites. HIV transmission through mosquito bites, sneezing, and coughing were the most common local misconceptions of HIV transmission. Only 25% knew that a healthy person could be HIV positive and also reject the two most common misconceptions about transmission. That HIV/AIDS could be prevented by avoiding mosquito bites, not touching someone with HIV, or not using a public toilet were the three most common misconceptions about prevention. Only 16% knew a healthy person could be HIV positive and also reject the two most common misconceptions about prevention: avoid being bitten by mosquito bites and avoid touching someone with HIV. While the majority of young people thought that they could do something to protect themselves from HIV transmission, only 55 (18%) identified using condoms, 44 (15%) having one partner, 74 (25%) avoiding multiple partners, and 49 (16%) abstaining from sex.

When young people were asked if they would still be friends with someone with HIV, only 14% said yes, 1% was unsure, and 85% said no. The vast majority of young people (91%) said that a student with HIV should not go to school, and 67% felt that an HIV-infected student posed a risk of transmission to other students. The majority of young people rationalized their potential alienation of PLWH based on (i) a perceived risk that they could be infected through social contact, (ii) a belief that the person has “AIDS”, and (iii) fear. The data suggest why PLWH would be reluctant to disclose their status because of the alienation and associated stigma and discrimination they could face. Young people’s fear of HIV can contribute to misconceptions about HIV transmission, a lack of accurate information generally, and community attitudes regarding stigma and discrimination heard in the context of gossip and shame (Buchanan-Aruwafu, 2002).

Young people in Malaita live and participate in an environment of rapid sociocultural change, influenced by structural and global forces. Sociocultural traditions, religion, and family allegiances clash with the influences of modernity, young people’s subculture, and their desires for pleasure through sexual relationships, generating conflicts (Kwa’ioloa and Burt, 1997; Buchanan-Aruwafu, 2002a and 2002b). Young people resist—and feel conflict over—parental and societal rules. However, youth create new possibilities to express their sexualities, and use strategies

and their own agency to negotiate their desires within restrictive social conventions. Extramarital and premarital unprotected sex occurs in Auki and youth have a rich sexual subculture. Young people talk about and satisfy personal sexual urges and desires regardless of social and sexual norms (Buchanan-Aruwafu *et al.*, 2003). Meanwhile, the silence surrounding accurate information about HIV prevention and transmission, and young people's secrecy, makes them vulnerable to HIV infection.

Conclusion: Vulnerability, Power, Agency, and Resilience

The HIV epidemiological situation in the Pacific is very uncertain. Sentinel surveillance data is insufficient to be sure of the levels of HIV infection, particularly with more vulnerable groups. However, the concentration of STIs and HIV infections with young people is evident. The available research and behavioral surveillance data shows that the risks are elevated for young people through unprotected sex with multiple partners from a young age. Young people also are involved in highly vulnerable groups and can experience sexual violence. Alcohol and drug use increases unprotected sex. While reported intravenous drug use is low, it should be an area of serious concern. Youth lack knowledge and understanding of the risks that they are facing. At the same time, the contexts of their lives, including a poverty of opportunities, gender and age inequities, social change, and the continuity of norms that impede open conversation and participation, enhance young people's vulnerability to HIV infection.

From what is known about young people and their lives, the potential for an increase in the number of young PLWH in the Pacific—in this youth generation—is real. In 1997, Jenkins (1997a) predicted that in PNG “the people most likely to become infected in the next decade are the youth of today.” Nearly 10 years later, unfortunately, this prediction has come true. Infections continue to grow in this age group in PNG and across the Pacific. There cannot be a more urgent time to increase the focus on young people, particularly highly vulnerable youth, and their needs and priorities. To prevent an increase in HIV prevalence in the Pacific, the circumstances and structural vulnerabilities that influence young people's lifestyles and risk of HIV infection, including cultural norms, must be addressed. Further, the rights of highly vulnerable minority groups, including young people living with HIV, need to be protected, and real change created in young people's lives through advocacy and action (Vete, 2006). Young people's participation in changing the course of HIV epidemics in the Pacific must not be underestimated.

However, young people's meaningful and sustained participation is limited by the lack of (i) inclusive structures for national consultative, policy, and political processes; (ii) mainstreaming of youth participation in all sectors; (iii) power and resources allocated to support and

implement regional youth policies and plans at the country level; and (iv) strategies to increase youth participation in decision making within communities and in response to HIV. Political leaders and policy makers need to understand the increasing implications that youth disenfranchisement and discontentment have on economic and political stability and national security, and on youth substance abuse, suicide, and HIV infections (Carling, 2004; Rose Maebiru, personal communication, 2006). To decrease young people's cynicism, disillusionment, frustration, and vulnerability, a radical shift in attitude, practice, policy, and resource allocation is needed to create a culture in which adults listen and allow youth decision making and involvement at all levels (Carling 2004).

To decrease the poverty of opportunities that young people live in, and by extension youth vulnerability to HIV infection, faster economic growth is needed to change employment and educational challenges. These underlying factors and their impacts are driving HIV epidemics. Economic reform strategies, improved law and order, and good governance could counteract unemployment and reduce poverty. In turn, this could increase budgets in the public and private sector to improve health, education, and other pressing service issues for youth. Moreover, youth human capital needs to be strengthened through improved livelihoods, health, and education, as well as by changing attitudes and reducing barriers to female youth and women's involvement in the formal work force (Government of Australia, 2006), as well as the creation of policies to increase youth participation and the amendment of legislation to ensure that these policies are implemented (Rose Maebiru, personal communication, 2006). While easier said than done, solutions must come from within as leaders, communities, and young people articulate and nurture governance and the response to HIV in their own Pacific contexts.

Young people's participation in decision making at the community and political levels desperately needs to be nurtured, allowing them opportunities to articulate and create solutions within their own Pacific contexts. Further, this would give them the chance to reduce their economic, social, and political marginalization, as well as the gender and age inequities that they face. This generation's young people are the leaders of today, as well as the human, social, and financial capital for the present and the future. Young people whose reproductive and productive years increas-

ingly are affected by HIV infection can impact the overall development and economic stability of Pacific Island countries through a loss of their labor, skills, and productivity; increased medical services and costs to accommodate their care within health budgets; and increased burden on household budgets, families, and communities to meet their needs (UN, 1996). Young people presently living with HIV also have critical needs. The large numbers of young PLWH draws attention to existing treatment, support and care needs, including antiretroviral drugs, supportive care and treatment, counseling and accepting environments and protection from human rights abuses, stigma, and discrimination.

As outlined in this paper, research and experience from the Pacific and the HIV pandemic have shown that young people's practices and knowledge, their risk of HIV infection, and the impact of living with HIV cannot be separated from the circumstances in which they live. Nor can these be detached from their sexualities, desires, and human rights (UNAIDS, 1998; Aggleton and Dowsett, 1999; Dowsett, 2003; Schoepf, 2001). The impact of sociocultural influences, change, and political economies poses many challenges for young people, parents, leaders, and policy makers in the Pacific. Meanwhile, positive protective factors—such as youth resilience in the face of adversity; young people's ability to create change; the pivotal role of youth and young PLWH in the response to HIV epidemics in the Pacific; and the support that can be provided by families, peers, communities, leaders, and governments—should not be missed (Carling, 2004; Foster and Sherr, 2006; Schoepf, 2001; Shaw and Aggleton, 2002; UNICEF, 2003b).