

Appendix A

Country Profiles

The following country overviews are presented to provide a snapshot of HIV/AIDS data, programs, and policies in selected Pacific developing member countries. It must be noted that there are often discrepancies in the available data. To provide the greatest level of standardization, all data were first taken from a single source, if possible, and then supplemented with other data when available. The primary sources of data are:

- 1) Pacific Regional HIV/AIDS Project. Milestone 2. HIV/AIDS situation and responses in seven Pacific Island Countries. January 2005;
- 2) Secretariat of the Pacific Community (SPC) for epidemiology as of December 2004;
- 3) Specific studies conducted by SPC, United Nations (UN) bodies, and others;
- 4) Country strategic plans; and
- 5) ADB's country strategy documents.

Cook Islands

Background

The Cook Islands is small but relatively prosperous with a population of about 18,000 and a gross domestic product (GDP) per capita of US\$4,385, tourism. Pearl farming and agriculture sustain the economy. Foreign aid represents only 5-6% of the GDP with New Zealand supplying 62% of that. Thus far, there have been no detected cases of HIV. The government has nonetheless responded with attention to the issue. A situational assessment was completed and a National Strategic Plan drafted. The Ministry of Health has taken the lead and is significantly helped by the Cook Islands Red Cross whose project coordinator has been trained by the AIDS Task Force of Fiji. The Cook Islands Christian Church, Child Welfare Association, and National Council of Women have undertaken some community HIV education and could do more if given the resources. The leader of the House of Ariki attended the regional HIV meeting sponsored by The Joint United Nations Programme on HIV/AIDS (UNAIDS) at Vuda in March 2004. Inspired by the active role of the Fiji Great Council of Chiefs in the Fiji HIV response, he has become a champion and encourages the participation of the traditional leaders in the Cook Islands response to HIV.

The scope of activities has been limited, however, and capacity to carry out programs not developed. The National AIDS Council has no full-time permanent coordinator. A major constraint for HIV prevention activities in the Cook Islands is the cost of providing services outside the capital of Rarotonga. For example, it currently costs more to travel to the northern Cook Islands than it does to travel to New Zealand. There is a need to improve surveillance of HIV and other sexually transmitted infections (STI) and the risk behaviors of different population groups in the Cook Islands. Because the risk of HIV seems low at present in the Cook Islands, activities should be targeted at the most likely at-risk groups, such as youth, visiting seafarers, hotel workers, and others employed in the hospitality industry.

The National Strategic Plan and Responses

The Cook Islands national strategic plan has identified a number of factors that could make the country vulnerable to future infections including:

- Limited knowledge and awareness of HIV/AIDS in the population;
- Low condom usage;
- Cultural and religious barriers to open discussion about sex, sexual health, and sexuality;
- Excessive alcohol use among young people;
- Mobility of Cook Islanders within the islands and outside the country;

- Increasing number of tourists coming to the country and increased interaction between tourists and locals.

There are also concerns about the possibility of HIV spread through the planned fishing industry.

Facilities are not extensive. There is one voluntary testing site in the country, based at the hospital laboratory, although many persons have been tested over the years in unlinked surveys. Approximately five people request HIV tests annually. In Rarotonga, STI infections are confirmed through laboratory testing; on the other islands, STIs are managed through syndromic diagnosis and treatment. The true levels of STI in the community are unknown.

The first Short Term Plan for the prevention and control of AIDS in the Cook Islands was produced in 1987 and the first Medium Term Plan in 1989. After undertaking a situational analysis in 2000 informed by meetings with various sections of the society, a national strategic plan was produced. This was updated in 2003 to cover the period 2004–2008. The plan was developed at a workshop facilitated by the Division of Public Health in the Ministry of Health with participants from different sectors of society. The new national strategic plan has been endorsed by the Cabinet. The priority areas of the plan and a short summary of responses are presented below.

- Reduce vulnerability and promote safer sexual behavior within specific groups.

Safe sex practices including the use of condoms are promoted by the Ministry of Health and the Cook Islands Red Cross through a peer education program, funded by the International Federation of Red Cross and Red Crescent Societies regional project and supported by the Organization of the Petroleum Exporting Countries. The Red Cross also makes condoms available to hotels and guesthouses around Rarotonga. In addition, condoms are available through Ministry of Health clinics and hospitals and through private pharmacies. However, there still needs to be a shift in attitudes amongst politicians, community leaders, and the Church for condom use to be more accepted as a means of protection.

The New Zealand government is supporting the Ministry of Education in developing a curriculum on health and physical well-being, including sexual health education, to be taught to all school children from five years of age. Community consultations undertaken on each island to gauge attitudes to teaching about sexuality in schools found general support for the approach. A workshop to train teachers in sexual health education was undertaken in 2003.

- Provide safe blood.

All donated blood is tested for HIV, Hepatitis B, and syphilis. Those who have had a laboratory diagnosis of an STI are automatically rejected. The Cook Islands Red Cross provides pretest counselling and training sessions on HIV to potential blood donors.

- Prevent and control STIs.

Prevention and control of STIs consists of health education and awareness-raising workshops conducted by the Ministry of Health for various sections of the community. Cook Islands Red Cross also undertakes community peer education and condom promotion and distribution activities.

- Provide a support and caring service system for people living with and those affected by HIV/AIDS.

No activities have been reported in relation to this priority area because the two HIV positive individuals living in the Cook Islands are foreign nationals and receive most of their medical treatment outside the country. However, reported incidents of discrimination against one of the people living with HIV by employees in the health care system has highlighted an urgent need to provide further education and training to health care workers on care and support issues.

- Coordinate the HIV/STI multi-sectoral response.

The National AIDS Council is responsible for coordinating the national response and also serves as the country coordinating mechanism for the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) project in the Cook Islands. The Council is multi-sectoral, with representation from different government ministries, NGOs, traditional leaders, the police, and the Airport Authority. It meets every quarter to discuss HIV related issues and policy matters, including World AIDS Day events. The Health Educator in the Division of Public Health is the focal point for the national HIV response and the National AIDS Council.

- Promote awareness of human rights issues relating to HIV/STI.

Aside from one reported problem, no other human rights issues have been reported and no activities undertaken to directly address this priority area. Another issue that will have to be tackled in this priority area is the issue of confidentiality.

- Improve access to testing for HIV.

The Cook Islands does not have a voluntary counseling and testing (VCT) program in place to encourage voluntary testing. Currently the only people tested are blood donors and antenatal mothers.

Other HIV/AIDS Responses/Programs

As of December 2004, the Pacific Regional HIV/AIDS Project had granted the Cook Islands about A\$110,000, mostly for training opportunities. The GFATM Regional Project provides US\$10,000 annually for the national HIV response. This has been used to organize workshops for church and other leaders.

Fiji Islands

Background

About half of the 332 islands and coral atolls of Fiji are inhabited. In addition to a parliamentary system presided over by a Prime Minister, indigenous Fijian chiefs, the Bose Levu Vakaturaga (Great Council of Chiefs), meet several times a year to discuss matters of concern to the Fijian people. The Council appoints the President of Fiji.

The Fijian population of nearly 825,000 is composed of 51% indigenous Fijians, 44% Indo-Fijians, and the rest are a mixture of Pacific Islanders, Chinese, and Europeans. Fiji was once a major trade center for the Pacific and today is a major tourist destination, with tourism contributing around 20% of GDP. Sugar, manufacturing, and remittances from Fiji Islanders working overseas as soldiers, nurses, rugby players, and in other professions are the major earners. Remittances are now Fiji's fourth largest source of foreign exchange. Though prosperous overall, about 40-50% of the population is considered to be poor, a problem that has been made worse by the political instability of the past five years. Religion is important in the lives of Fijians. Most indigenous Fijians are practising Christians while Indo-Fijians are mostly Hindu with a minority of Muslims.

Epidemiology

Fiji appears to be experiencing a growing HIV epidemic. By April 2005, a cumulative total of 182 HIV infections had been recorded in the country, but surveillance is poor and all observers recognize that a great deal of underreporting is highly likely. Of the total number of infections detected to date, 85% are among indigenous Fijians, 13% are Indo-Fijian, and 2% are other ethnic groups. Over 50% of infections are among people aged 20 to 29 years. The proportions of men versus women infected are 60% and 40% respectively.

The World Health Organization (WHO)/UNAIDS estimates that there could be as many as 4,836 people infected with HIV in Fiji. Based on this estimate, it is projected that without effective prevention efforts over 200,000 Fijians could be HIV positive by 2015.

Transmission appears to be nearly totally sexual. STIs are also probably increasing but data are poor. Reports of the Suva STI Clinic show that more than 70% of the STI cases they see are young people aged 15–25 years. More than 90% of their patients have more than one sexual partner. Most women they see (70%) do not show any signs or symptoms of STI.¹

Little useful research has been carried out in Fiji to examine risk factors. The major at-risk

¹ Fiji HIV/AIDS Situation Analysis and Response Review, 1999.

groups appear to be the following:

- Brothel and non-brothel based sex workers, male, female, and transgender, plus Chinese sex workers;
- Seafarers, foreign and local fishermen and sailors;
- Street children;
- Men-who-have-sex-with-men (MSM);
- Migrating and mobile populations, including police and military; and
- Youth engaging in risk-taking activities, i.e., drug and alcohol use and casual sex.

The overall response by government, leaders, and other partners has increased significantly within the past few years, but the primary factors hindering effectiveness remain. Health workers and other service providers concerned are highly judgemental; sex is still a very taboo subject; homosexuality, while protected against discrimination in the constitution, remains illegal and is persecuted; there is no public health response to the growing sex trade; and the lack of technical knowledge and skills needed to manage the rising epidemic remains inadequately developed. Aside from Papua New Guinea, Fiji is likely to be affected by HIV/AIDS more than the other Pacific Islands.

The National Strategic Plan and Responses

A three-year HIV/AIDS National Strategic Plan (2004–2006) was developed in October 2003 that proceeds from the 2001–2003 National Strategic Plan. The plan has eight priority areas for action with a projected budget of F\$5 million. Government allocations for the work plan are F\$2,305,200 in 2004, F\$1,663,000 in 2005, and F\$998,500 in 2006.

- Preventing people from becoming infected with HIV.

All donated blood is tested for HIV and other blood borne diseases. Of the 17,000 HIV tests completed in 2002, 11,000 were of donated blood. Fiji Red Cross undertakes HIV education for blood donors, but has turned over all screening to the Ministry of Health.

A large number of community awareness events have taken place, but few behavioral change programs have been implemented. The AIDS Task Force of Fiji undertakes HIV prevention education and condom distribution for sex workers and MSM in the Suva area and run an STI clinic for sex workers and young people. A policy to address HIV/AIDS in prisons has been developed, but has not yet been endorsed. UNAIDS and United Nations Development Programme (UNDP), together with the Fiji Women's Crisis Centre, conduct HIV awareness workshops for policemen sent overseas for peacekeeping duties.

- Prevention of HIV/AIDS in young people.

Little prevention work has been directly developed for and with young people. SPC has funded an Adolescent Reproductive Health Project, but it has not emphasized how to prevent HIV infections. Marie Stopes International has developed a condom intended for young people, but advertising is limited. Condoms are available in many shops but there are no studies of the

ease with which young people can access them.

- Supporting people living with HIV and AIDS.

FJN+, a support group for people living with HIV, was established in 2003. Reports in the media and from FJN+ indicate that stigma and discrimination continue to impact negatively on people living with HIV and AIDS. FJN+ has worked with the Social Welfare department to provide housing for HIV+ people who were evicted from their homes because of their HIV status.

Recently, churches have become more involved with AIDS. A multi-denominational group of pastors have developed a manual to assist Christian leaders to address HIV/AIDS. The manual—“What Christian Leaders can do about HIV/AIDS”—was developed with support from the Ministry of Health and funded by UNICEF. It provides essential information, using quotations from the bible, to assist church leaders to raise awareness about HIV to prevent the spread of the virus. The manual also emphasizes the importance of not stigmatizing and discriminating against people living with HIV and AIDS.

- Providing voluntary counselling and HIV testing.

The Hub centre in Suva, the Reproductive Health Clinic of Lautoka Hospital, and the AIDS Task Force of Fiji STI clinic provide voluntary, confidential HIV testing and counselling to the public. Confidentiality remains problematic and uptake from the most at-risk groups is poor.

- Clinical management and treatment of HIV/AIDS.

In July 2004, the government HIV/AIDS Hub Centre, based at the government Reproductive Health Clinic in Suva, began an antiretroviral therapy program with a grant of F\$20,000 from the New Zealand government to the Pacific Islands AIDS Foundation. Following an adherence counselling process, 16 people living with HIV enrolled in the program. Three people have since dropped out.

- HIV/AIDS surveillance and research.

Surveillance has been carried out as a matter of routine (with unknown levels of counselling) for ANC patients, blood donors, and police and military personnel. The same groups are included in the newer second-generation surveillance efforts. Without surveillance of MSM, sex workers, and client groups such as fishermen (and developing effective prevention programs with them), what is probably now a concentrated epidemic will move smoothly into a generalized epidemic, as in Papua New Guinea.

Research on monitoring and evaluation for all interventions intent on behavior change is also needed.

- Human rights and HIV/AIDS.

Several instances of job dismissal for being HIV positive have taken place. A draft HIV/AIDS Policy addressing discrimination against people living with HIV has been developed and endorsed by the National Advisory Council on AIDS. The policy, which also proposes criminalizing

willful transmission of HIV, has been submitted to the Attorney-General for review.

- Coordinating the multi-sectoral response.

The National Advisory Council on AIDS, with 28 members and chaired by the Minister of Health, is the main coordinating body of the HIV/AIDS response in Fiji and meets regularly every quarter. Many sectors of both society and government have, at times, been involved in some type of HIV/AIDS activity. In addition to the Ministry of Health and its many components, the Ministry of Education, Youth, Women, Fijian Affairs, Military and Prisons have also taken part. Several NGOs and training institutions also have HIV/AIDS activities. Most, however, do not go beyond raising awareness. Some remain highly judgemental.

Other HIV/AIDS Responses/Programs

The Pacific Regional HIV/AIDS Project has donated over A\$200,000 to Fiji for participation in meetings and trainings and to civil society organizations to develop programs. Fiji receives GFATM funds to upgrade Mataika House Laboratory in preparation for its role as a regional HIV testing facility for diagnosis and surveillance under the Pacific Public Health Surveillance Network. The GFATM Regional Project also provides funding to undertake the second generation surveillance described above and to purchase antiretroviral and STI drugs and HIV and STI test kits.

Kiribati

Background

The Republic of Kiribati has poor resources and is logistically-challenged country. It is composed of three main groups of islands—the Gilbert Islands in the West, which includes the capital, Tarawa; the Phoenix Islands; and the Line Islands—that together comprise 33 low-lying atolls (of which 23 are inhabited) scattered over 3.5 million square kilometers in the Pacific Ocean with a total land area of 811 square kilometers. Most of the population (estimated at 84,494 in 2003) live on the western islands of Kiribati, with over one third or 36,717 living on the crowded capital atoll of South Tarawa and the remaining 47,777 in the Outer Islands. Forty per cent of Kiribati's population is under 15 years of age. The economy is primarily based on copra, fish, and remittances from overseas workers. The GDP per capita was calculated at US\$482 in 2002.²

Epidemiology

At the end of 2004 there were 46 cumulative reported HIV infections in Kiribati and 28 reported deaths due to AIDS. The majority (72%) of the reported cases were male. Half of these were seafarers and most cases were reported in South Tarawa, the capital.

A situational analysis conducted in 1999 identified socioeconomic and demographic factors such as overcrowding, rapid social change, migration, mobility, and alcohol abuse as risk factors for vulnerability to HIV infection in Kiribati. Bars and nightclubs dominate the modern social scene; there are no sports facilities or other venues for other types of social activities. The majority of people infected with HIV have been Kiribati men who work overseas as merchant seamen who in turn passed on the infection to their wives and children. Over a thousand Kiribati seafarers are working on merchant ships at any point in time. While there is no organized sex industry in Kiribati, there is transactional sex between I-Kiribati women or girls and visiting fishermen.

The National Strategic Plan and Responses

The Kiribati STI and HIV/AIDS Strategic Plan was developed in 2000 with the support of AusAID through the Pacific Regional Strategic Planning Project (1998-2001). A multi-sectoral group led by the Kiribati Overseas Seamen's Union, with representation from government, NGOs, and the Church developed the plan. Kiribati established the Kiribati HIV/AIDS Task Force to coordinate

² Pacific Program Profiles, 2003–2004. AusAID.

activities addressing HIV/AIDS and STIs within the nation. The government neither has the capacity nor the resources to implement an effective and sustainable response to the epidemic. Considerable capacity building will be required by the Kiribati HIV/AIDS Task Force and local NGOs to improve the quality of their programs. Though a small number of individuals have been sent overseas to be trained, little capacity building has occurred in-country.

To date, the non-government sector has been the mainstay of the national response. Resources have been too limited to fully manage and implement the National Strategic Plan since its development in 2000 and capacity (including number of personnel) in both government and non-government sectors needs a great deal of investment. Nevertheless aspects of the plan, which covers five priority areas, have been implemented.

- Care and support for people living with HIV and AIDS and their families.

Stigma and confidentiality are difficult issues in small societies such as Kiribati. Thus, until 1 December 2004 none of Kiribati's 46 reported cases had declared their HIV status publicly. Direct care is currently provided through the government health service, the Catholic Church, and by families of HIV positive people. Other organizations, including the Red Cross, Foundation of the Peoples of the South Pacific International, Kiribati Family Health Association, Peace Corps, and the SPC through its Adolescent and Reproductive Health Program, do training on care but deliver no services. Antiretroviral medications are to become available when the GFATM Regional Project activities are set up.

- Reducing the vulnerability of specific groups.

There have been a variety of responses in this area. These include the following

- The Kiribati HIV/AIDS Task Force has begun a VCT program with a full time counsellor in South Tarawa.
- The Kiribati Maritime School continues to use the HIV/AIDS curriculum developed through the Seafarers Project of SPC and New Zealand's International Aid and Development Agency (NZAID), but the material needs to be updated. This training is supported by the Seafarers Union in the country.
- Foundation for the Peoples of the South Pacific, Kiribati employs a full time HIV/AIDS Project Officer to train peer educators. These peer educators were paid A\$5 per hour to undertake outreach activities and distribution of condoms in nightclubs and the port area of Tarawa. The program may be finished and no peer educators have been trained in the outer islands.
- The Red Cross has recently trained 20 peer educators (12 men and 8 women). All are based on Tarawa although there are plans to extend the training to the outer islands.
- The Adolescent Reproductive Health Program in Kiribati has established a drop-in center for youth on Tarawa. The drop in centre provides information on HIV/AIDS and utilizes instruction, education, and communication (IEC) materials developed by SPC. It also undertakes education programs with the Ministry of Education at schools in the capital.
- A gym supported by the Peace Corps has recently been established to improve recreational options for local youth.
- UNICEF implemented the Pacific Stars Lifeskills Program in Kiribati in 2003. The pro-

gram supported qualitative research by young people to capture issues of concern relating to HIV/AIDS and the youth on camera. The photographs were analyzed using a participatory approach and used as an advocacy tool in various national and international exhibitions. Twenty-five young people from selected youth and NGO groups were trained as trainers to implement the program.

- Preventing and controlling STIs and promoting safer blood supplies.

STIs are underreported in Kiribati, but the prevalence seems to be increasing. Data reported by the Pacific Regional HIV/AIDS Project indicates 180 cases of STI during the first nine months of 2002, compared to 110 for the whole of 2001 and 25 cases in 2000. The increase in reported cases of STIs indicates that the awareness and preventative education programs have not resulted in significant behavior change. Unsafe sex continues to be practiced and the risk of HIV continues to increase in Kiribati.

Given its size and geographic dispersion, surveillance for HIV/STIs in Kiribati is a big challenge but is being conducted in 2005. All blood donated at the medical facilities in Kiribati is tested for HIV.

- Coordinating the responses to HIV/AIDS and STIs.

The Kiribati HIV/AIDS Task Force coordinates activities addressing HIV/AIDS and STIs within the nation. The Task Force is comprised of government and NGO representatives and has a full time coordinator. Despite the commitment shown, little capacity exists to implement the needed programs. The Pacific Regional HIV/AIDS Project will support an Australian Youth Ambassador to provide project management and administrative support for one year from March 2005.

Other HIV/AIDS Responses/Programs

The Pacific Regional HIV/AIDS Project has contributed A\$102,000 so far, largely for capacity building. Kiribati also receives funding for surveillance and care and treatment as a member of the GFATM regional group.

Republic of the Marshall Islands

Background

The Republic of the Marshall Islands (RMI) has a disturbed history, having been subjected to occupation and control by four different foreign powers. Modern Marshallese society has been profoundly affected by this history together with World War II and the legacy of nuclear testing (UNICEF 2004). RMI is made up of 29 coral atolls and five islands spread across approximately two million square kilometers of the central Pacific. Approximately 56,000 people live in RMI—70% of them in two densely populated urban areas (50% on Majuro and 20% on Ebeye). Ebeye, a logistical support centre for the United States (US) Department of Defense, has an extraordinary population density of 66,750 people per square mile. The population of RMI is very young, with 55% of Marshallese being less than 20 years of age. Fertility remains high and almost 20% of births are to teenagers.

RMI has been independent from the United States of America since 1986, but about 80% of government revenue is derived directly from US grants (including compensation for past nuclear testing and current use of Kwajalein Atoll for the US Army's missile testing range) under the Compact of Free Association. Other income comes from remittances and fishing. Unemployment is over 30% and increasing.

Epidemiology

To date there have been 10 cases of HIV infection officially recorded in RMI and only two are left living with HIV. Data on STIs are poor, but they seem to indicate a high level of infection among young women.

Behavioral risk factors have been established. For a variety of reasons, sex starts early in RMI, at around 13 or 14 years old. Severe overcrowding seems to be an exacerbating factor in domestic and sexual violence, high rates of suicide, STIs, alcohol abuse, and child abuse. Chinese and Korean sex workers in the night clubs and bars serve Asian and Marshallese men. Young women engage in unsafe sexual practices with visiting seafarers and other men who provide them with alcoholic beverages, cigarettes, and/or money. Marshallese women have been lured into false adoption schemes in the US, in which they go to Hawaii to have their children but do not get properly paid and resort to sex work in order to pay for their return airfare to RMI. In addition, “designer circumcision”—whereby males cut their foreskin to form shapes such as butterflies—may be gaining in popularity. There are also effeminate males (referred to as *geegle* or *goggle*) who are generally accepted socially. In Majuro, there is an all male *geegle* group called Girl Power that dances at special occasions in people's homes and in social settings. It can be assumed that male-to-male sex

may also be an area of risk. Overall, multiple-partnered sex between women and men is common among all ages regardless of marital status.

The National Strategic Plan and Responses

RMI does not have a National Strategic Plan for responding to HIV/AIDS and STIs. It has submitted annual plans to US Centers for Disease Control and Prevention for a number of years to access funding for HIV related activities and recently submitted a proposal valued at US \$216,000. Nearly all funds for HIV work continue to be US-derived. In recent years abstinence campaigns have become the primary message of behavior change.

The Bureau of Primary Health Care in the Ministry of Health has primary responsibility for the national HIV response. Currently the HIV Program in the Bureau has seven staff funded by the US, three health educators, three lab technicians, and one staff nurse. There are two site coordinators who handle the implementation of activities for both Majuro and Ebeye. The Ministry of Education includes HIV education in the high school curriculum, although the quality of this curriculum has not been reviewed.

In the non-government sector, one major NGO named Youth to Youth in Health undertakes outreach/awareness-raising in schools on a variety of topics with a rotating schedule, a weekly half hour radio program, counselling services, a clinic (with a nurse) which provides contraception including condoms, and a youth drop-in center. There is supposed to be greater representation from civil society through a Community Planning Group, but this has to date not been successful. Most importantly, condoms are not widely available in the Marshall Islands. Distribution is limited to Family Planning Clinics, the clinic nurse, Youth-to-Youth in Health, some schools, and some bars. Condoms are not available for purchase in local stores or pharmacies.

Other HIV/AIDS Responses/Programs

The Pacific Regional HIV/AIDS Project has funded improvement of HIV and STI surveillance, a situational analysis, and attendance at meetings for officials. RMI is not included in the GFATM regional group.

Unlike some other islands, RMI has several NGOs able to devote themselves to an AIDS response. The government has a relatively large number of health workers also involved. Resources, direction, and expertise need developing.

Nauru

Background

Nauru lies south of the RMI, 40 kilometers south of the Equator. Its population of approximately 12,000 people live on 21 square kilometers, which is one of the three great phosphate rocks in the Pacific Ocean. With only some 100 hectares of arable land, the island cannot produce the food it requires. It also has limited natural fresh water resources and depends on rainwater collection and an aging desalination plant.

The financial situation in Nauru has become extremely poor. The phosphate mine that was once the source of a remarkable income for islanders has closed. Other income is derived from fishing licenses issued to China, Japan, Korea, Taiwan, and the US. The government has nearly exhausted the phosphate trust funds. Infrastructure is collapsing and many people are hungry and poor.

Epidemiology

Only two reported cases of HIV have been recorded in Nauru and both involved foreigners. The first case was identified through the routine testing of contract workers for HIV that resulted in the deportation of an Air Nauru flight attendant from Guam who tested positive for HIV. The second case involved a Senegalese fisherman who was hospitalized and died on the island.

STIs may be on the increase in Nauru with 10 cases of syphilis reported monthly, but no accurate figures are available. The majority of people with STIs do not seek treatment from health services and instead resort to self treatment by buying drugs from pharmacies. Others are treated outside the health system by relatives who work as health workers. Alcohol abuse is a major factor contributing to social decay, and women have low access to education and family planning. Although there is no national data regarding the sexual behavior of young people, there is anecdotal evidence that the youth become sexually active at an early age. Frequent travel by Nauruans to and from the island could bring them in contact with HIV. Lack of awareness of HIV and knowledge of prevention places Nauruans at risk.

The National Strategic Plan and Responses

In December 1999 a multi-sectoral AIDS Task Force of four people with a number of advisers was formed, under the instruction of the President, to address the rising concerns about HIV/AIDS on Nauru. The Government ministries, the churches, and civil society participated in a workshop

held in December 1999 that formulated the National Strategic Plan to Respond to HIV/AIDS and STIs.

The Plan covers six priority areas:

- Coordinating the response to HIV/AIDS in Nauru;
- Safe blood supply;
- Infection control;
- Testing for HIV;
- Reduced vulnerability to HIV/STIs in the community; and
- Care and support for people living with HIV and AIDS, their families and caregivers.

The Plan has remained by and large a plan. It has yet to receive any endorsement at a national political level and is not even widely known to exist. There are very few persons capable of handling the priorities identified. There is no infrastructure for testing nor condom promotion. There is no civil society ready to deal with HIV/AIDS. Many of the current activities revolve around World AIDS Day when the Ministry of Health highlights the issues of HIV risk and HIV prevention.

Samoa

Background

Samoa, consisting of the two main islands of Savaii and Upolu and several smaller islands and uninhabited islets, was the first Polynesian nation to reestablish independence in the 20th century. After being a German Protectorate, it was occupied by New Zealand in 1914 until 1962. Although a parliamentary democracy with universal voting rights, Samoa's Constitution reserves all but two seats in the 49 member Parliament for *matai*, or chiefly titleholders under customary law. Samoa is an ethnically homogenous nation, with an economy dependent on agriculture, fishing, remittances, and development aid. Tourism is expanding and accounts for 25% of GDP.

Epidemiology

The first AIDS case in Samoa was diagnosed in 1990. From 1990 to 2001, a cumulative total of 12 HIV cases were reported in the country, including four persons who had been living overseas and two infants. Eight AIDS-related deaths have been recorded and there are four people currently living with HIV/AIDS. Eight of the infections were transmitted heterosexually, two by homosexual intercourse, and two from an infected mother to her child.

Risk factors include the diaspora of Samoans living in New Zealand and the USA and their frequent visiting of each other, the increased number of tourists, and men working in town who can bring infections back to the rural areas. In Apia, a study by WHO and the Ministry of Health has shown that STI levels in pregnant women are high, with 31% having either chlamydia or gonorrhoea.

Contemporary Samoan society has few culturally institutionalized means of transmitting information about sex and sexuality to its young people and open discussions about sex are generally taboo. Gender roles are strict and females are expected to be submissive to males. Many people, including many women, consider it acceptable for men to physically discipline their wives and to expect sex on demand. A study of partner violence has shown that physical and sexual abuse is more common in rural areas among the less educated sectors of the population. In this study of both rural and urban women, 18% stated their husbands had affairs with other women while married to them, twice as many among women who reported having been abused than among others. An earlier small study of youth in Apia revealed that over half of young males had sexual intercourse by the age of about 18, had slightly over two partners the past year, and 12% had engaged in group sex.

A traditional alternative gender role, the *fa'a'afafine*, has general public acceptability and is associated with male-to-male sex. Early sex among males is not uncommon. Sex work in night

clubs, hotels, and brothels is reported. Growing unemployment among youth and problems with alcohol and substance abuse contribute to a risky profile.

Condoms are not easily available, particularly in rural areas.

The National Strategic Plan and Responses

Samoa does not have a national HIV/AIDS strategic plan. A National HIV/AIDS Policy was developed in 2001 and accepted by the Cabinet, and a draft national Plan of Action for HIV/AIDS/STI (2003 to 2005) was developed in April 2003 by the Technical AIDS Committee of the National AIDS Coordinating Committee and remains unendorsed. The Plan of Action has three priorities.

- Strengthen national coordination for the planning and implementation of HIV/AIDS programs and activities.

The National AIDS Coordinating Committee was formed in 1987 with a variety of government departments and NGOs represented. It will undertake the functions of the country coordinating mechanism for the GFATM Regional Project, though it has not met frequently. Most decision making on the national HIV response is done by the Technical AIDS Committee made up mainly of health personnel.

- Strengthen national health promotion and prevention programs for HIV/AIDS/STIs in Samoa.

HIV education and awareness-raising activities were carried out by the Health Education and Promotional Services, the Ministry of Women's Affairs and Community Development, and some NGOs mostly before 2000. Efforts to continue and develop prevention programs need to be intensified.

- Strengthen the management, treatment, and surveillance of HIV/AIDS/STI cases in Samoa.

The government of Samoa committed itself in 1996 to provide lifelong antiretroviral treatment for eligible HIV positive persons living in the country. The regimen set up in 2000 is composed of expensive brand name drugs and, though the number of persons in need is very small, funding and supply are uncertain, leaving some without medications for a time. Samoa will participate in the GFATM Regional Project's antiretroviral treatment program and will need to manage the drug regimen transition. Plans have been developed to initiate a prevention of mother to child transmission program.

Surveillance has been passive to date. To improve information on HIV infection and individual risk behaviors, second generation surveillance, implemented by the SPC, is underway.

Other HIV/AIDS Responses/Programs

As a participant of the GFATM Regional Project, Samoa receives US\$10,000 per year to support the activities of the county coordinating mechanism.

Responses by other government sectors besides the Ministry of Health have mainly consisted of HIV awareness-raising for those employed in those sectors. Several NGOs have become active. A *fa'a'afine* group called My Girls Association reacted to stigmatizing public perceptions and provided HIV education for members of the group and promoted prevention to the community through float parades and Drag Queen contests. The Samoa Family Health Association, the Samoa Red Cross Society, Sautimai—a Catholic social service agency, and the Samoa YMCA utilize their specific agendas and target groups to incorporate HIV education. One person openly living with HIV has also played an important role in community education. The National AIDS Coordinating Committee has designated the Samoa Umbrella of NGOs (SUNGO) as the community development organization (CDO) for Samoa and as such will receive Pacific Regional HIV/AIDS Project funds for serving as a focal training agency for smaller local organizations.

Solomon Islands

Background

The Solomon Islands is one of the least developed nations in the Pacific. After achieving independence from Britain in 1978, a combination of poor governance and ethnic antagonism culminated in violence and total economic collapse between 1999 and 2002. In 2003 a regional peace-keeping force under Australian leadership was requested and the nation has begun to rebuild. With an estimated population of about 538,000 in mid-2005, its high levels of population growth and unemployment are not encouraging. Literacy is estimated at 30% and most young people are not in school. Over 80% of people are farmers and fishermen, while the nation's income is derived from timber, mining, tuna fisheries, copra, and other agricultural products. Its land area of 28,369 square kilometers of rugged mountains and coral atolls is dwarfed by its sea resource area of 1.6 million square kilometers. Most of its people live along the coastline or within access of the sea.

Epidemiology

From 1995 to December 2004, only five persons have been detected with HIV in the Solomon Islands, the last four during 2004. WHO has estimated there will be 350 cases by 2010.

Risk factors have not been well documented in all sectors. Health statistics report rising levels of detection of both genital discharges and genital ulcers. Some evidence suggests that teenage pregnancies are also increasing. Emphasis has been directed toward young people with surveys showing very low levels of condom use and high levels of sexual activity. One study found a median age at first sex of 15. Cultural prohibitions on premarital sex for females drives a great deal of hiding and shame and females are generally disadvantaged in all aspects of social life. Both church and tradition combine as forces inhibiting improved knowledge of sexual and reproductive health for young people. Condoms are not promoted or made easily available, especially to youth. Poverty facilitates sex work as elsewhere, and both young women and young men are known to exchange sex for cash, goods, and services. "Longline" or gang rape is also present, though under-reported. Seafarers and fishermen, businessmen, and a sizable proportion of youth are known to be clients of sex workers. Little is known about the levels of extramarital sex or other aspects of sexual transmission dynamics. Male-to-male sex does occur but is not discussed or well-documented. Alcohol and marijuana are mentioned as substance use issues. Overall, the societies of the Solomon Islands are in a negative state, with environmental losses, poor economic forecasts, and inadequate public sector services.

The National Strategic Plan and Responses

The National HIV Policy and Multisectoral Strategic Plan was updated in 2005 for the years 2005–2010. For the first time, in 2005 the Solomon Islands Government allocated US\$70,000 for HIV/AIDS activities to the Ministry of Health. Although the government had begun considering the threat of HIV as early as the late 1980s, a coordinated response was not forthcoming. More recently, with external aid from WHO, AusAID, and the GFATM, structures are beginning to be set up and activities begun.

The strategic plan lists as priorities what it terms “policies”:

- Reduce risk-behavior and vulnerability to HIV and STIs.
- Enhance confidentiality of VCT for HIV as an entry point toward prevention and treatment of STIs and AIDS and blood safety.
- Enhance HIV/STIs surveillance, treatment, and care.
- Enhance capacity building for the national HIV response at both the community and institutional level.
- Ensure sustainable development to create an enabling environment for behavioral change, destigmatization, and elimination of discrimination that will promote prevention and care.

Numerous strategies and activities are listed under each point above, but a recent update on the overall response points out the following:

- STIs continue to rise but statistical data are very poor. Attempts are underway to improve the Health Information System.
- Although 17 VCT counsellors were trained in Papua New Guinea, no VCT service is presently available. Laboratory capacity is constrained by a number of factors, including confirmations sent overseas and lack of space and privacy. Papua New Guinea.
- The lack of training as well as testing kits and refrigerators has affected the universal screening of the blood supply.
- Lack of confidentiality, privacy, STI treatment kits, and a moralistic attitude among health workers deters young people, including sex workers, from seeking STI treatment in the public sector. Apparently government does not permit NGOs to develop youth-friendly clinics.
- While numerous trainings of health workers and NGO workers have taken place, there does not appear to be a single well-designed targeted intervention in place for any at-risk groups.
- In 2005, the Ministry of Health, with support from GFATM, conducted behavioral surveys with youth and sex workers and HIV surveillance among antenatal mothers.
- An HIV/AIDS Unit in the Ministry of Health has been developed, but remains understaffed and needs considerable capacity building.

- Health services remain weak and understaffed; health workers remain uninformed about HIV and STIs and lack needed drugs and infrastructure.
- Numerous NGOs are ready to engage in HIV activities but lack funding, technical skills, and a facilitated collaboration with government.
- While a little progress has been made in the areas of rights advocacy for people living with HIV and AIDS and for condom promotion, both continue to be highly difficult to actualize due to fear and lack of understanding among the populace.

Other HIV/AIDS Responses/Programs

Oxfam has been selected to receive support from the Pacific Regional HIV/AIDS Project to become a training resource for others. Several community grants have been awarded. Adventist Development & Relief Agency, Save the Children Australia, the Solomon Islands Planned Parenthood Association, UNICEF, World Vision, and numerous other NGOs are active in the Solomon Islands but in most cases are in need of considerable input in order to have effective programs.

Tonga

Background

The archipelago of Tonga, once known as the Friendly Islands, is the only constitutional monarchy in the Pacific. Tonga became independent of Britain in 1970 and remains a member of the Commonwealth of Nations. With a population of about 100,000, its primary income is derived from remittances, tourism, and some agricultural exports. New Zealand is an important trade partner and source of aid.

Tonga has high literacy rates and good school enrollment ratios. Its health indicators have generally improved but obesity and diabetes are modern problems. Economic growth is slow and some services have deteriorated. The government has made a commitment to improve conditions in the social sector.

Epidemiology

To date Tonga has recorded 13 cases of HIV, eight of whom had died of AIDS as of the end of December 2004.

Risk factors are assumed to be largely associated with youth and migrants. While out-migration remains high, increasing unemployment among young people threatens to create social problems. Tonga reports rising rates of teenage pregnancies and increasing substance abuse (tobacco, kava, alcohol, marijuana, and solvents). Tonga's Strategic Plan on HIV/AIDS and STIs lists the following as risk factors:

- the rise in teenage pregnancies, low use of condoms despite high awareness of the condom's benefits in relation to STIs and pregnancies and where they can be obtained;
- rising and fluctuating levels of STIs/HIV/AIDS;
- high mobility of people especially returning residents;
- increased availability and use of alcohol and drugs, especially marijuana; and
- increasing number of vulnerable groups like youths, seafarers, sex workers, recipients of blood donations, staffs of Defense services, and health workers.

One study conducted by UNICEF in 2001 showed that among out-of-school youth between 15 and 19 years old about half of the boys had initiated sex as had about 13% of the girls. Multiple partners, low condom and other contraceptive use, and having sex, sometimes unwanted, when drunk, were noted risk factors.

As in other Polynesian societies, an alternate gender, the *fakaleiti* or *fakafefine*, is traditional and members may occupy various positions in society, e.g., a Mormon bishop. Some have been sex workers both in Tonga and abroad, and some have acquired HIV elsewhere and died in Tonga.

The National Strategic Plan and Responses

Tonga developed a Strategic Plan for Responding to HIV/AIDS and STIs for the years 2000–2005 in 2000. Its priorities were listed as:

- Prevention and control of sexually transmitted infections.

Health workers have been trained in syndromic management of STIs on several occasions. HIV testing is said to be widely available, but the quality of laboratory performance and counselling has not been assessed.

- Reducing the vulnerability of specific groups and promotion of safer sexual behavior.

Several NGOs, including one specifically for *fakaleiti*, have conducted awareness programs that had peer education components. However, most of the activity took place in earlier years, around 1999–2000, and has decreased. Behavior change communication training is planned. UNICEF has begun implementing its Pacific Stars Life Skills program for young people.

- Safe blood supply.

The Tongan Red Cross has been tasked with improving the mode of recruiting blood donors and has been assisted by the Pacific Regional Red Cross branch.

- Care and support for people living with HIV/AIDS and their families.
- Human Rights and HIV/AIDS.

Ethical principles to protect persons with HIV and their families are listed in the Strategic Plan. These include the endorsement of caring and supporting people living with HIV and AIDS according to Christian and Tongan traditional community values. HIV testing is not approved unless it is voluntary and includes pre- and post-test counselling.

- Coordinating the multi-sectoral response.

There is a great need to raise the level of political commitment and leadership. Inclusion of Tongan traditional leaders in various regional meetings has recently taken place

Other HIV/AIDS Responses/Programs

The progress made towards working on the above issues is not well documented. Various NGOs are available to supplement government agencies. The inclusion of Tonga in the GFATM program should improve Tonga's response. For example, during 2005 second-generation surveillance has been supported by the GFATM for a number of population groups on Tonga.

Tuvalu

Background

Tuvalu—with a land area of 26 square kilometers made up of nine inhabited coral atolls over a distance of around 560 kilometers—is one of the world's smallest and most isolated independent nations. Poor soil and droughts inhibit agriculture and its population of about 10,000 persons depend mainly on remittances from seafarers working overseas, fishing fees, and copra sales.

Epidemiology

Nine cases of HIV infection, including two deaths, have been recorded in Tuvalu up to December 2004. Six of the cases involved seafarers. All HIV infections in Tuvalu are due to sexual transmission except for one mother-to-child transmission.

Many Tuvaluans travel a great deal—for education, work, to attend conferences, and other activities. At any time about 400-500 seafarers are working abroad, although 42% of Tuvaluan men are trained and registered as seafarers. In addition to seafarers and their sexual partners, young people are considered to be at-risk for several reasons: 1) there is little sex education; 2) alcohol use among young people is increasing; 3) negative attitudes of health service providers drives young people away; and 4) sexually active youth barely use condoms and do not consider themselves to be at risk.

Implementation of needed programs in Tuvalu is seriously hampered by the difficulty of travel to the outer islands and the shortage of trained persons.

The National Strategic Plan and Responses

A National Strategic Plan (2001–2005) was developed by the Tuvalu National AIDS Committee during a multi-sectoral workshop in the capital, Funafuti, in May 2000. The plan was endorsed by the national Cabinet towards the end of 2001. With external support, several NGOs have begun to take action according to the plan's priorities.

- Support and care for people living with HIV/AIDS and their families.

Training on general and HIV counselling has been conducted for health workers and teachers. All pregnant mothers are now routinely tested, though there is no prevention of mother to child transmission program and pretest counselling is doubtful. Specific counselling for people living with HIV is available through doctors only and is restricted because of difficulties expe-

rienced in maintaining confidentiality. Antiretroviral treatment is not available for people living with HIV, but the GFATM Regional Project will probably make some antiretroviral medication available for Tuvalu. The Government of Tuvalu has recently included funding for the national response in 2004, primarily to purchase antiretroviral drugs.

- Prevention and control of STIs.

There is no testing available for any STI except syphilis on Tuvalu. The Tuvalu Family Health Association can syndromically diagnose but not treat STIs. Patients are referred to the hospital for treatment. Seafarers are tested for Hepatitis B at the request of the German shipping company that recruits them. As a positive result is associated with job discrimination and confidentiality is poor, this practice seems questionable.

- Reducing vulnerability and promoting safer behaviors among specific groups.

The Tuvalu Overseas Seamen's Union conducts a two week training program for seafarers leading to a certificate regularly through the year. This program covers a number of areas of behavior management, including HIV and STIs, and has had positive appraisals. UNICEF has been implementing the Pacific Stars Lifeskills Program in Tuvalu since 2003 in collaboration with the Ministry of Youth. The Tuvalu Family Health Association also targets youth.

- Safe blood and blood products.

All blood transfusions at Princess Margaret Hospital are now screened.

- Coordinating the multi-sectoral response.

While political leadership has vacillated, action has been largely driven by specific individuals. The Ministry of Health included HIV in the annual meetings of church leaders and has good relations with the active NGOs.

Other HIV/AIDS Responses/Programs

The Tuvalu Association of Non Governmental Organisations (TANGO) is the coordinating body for the 30 registered NGOs in the country and provides training. It is funded by the New Zealand and Canadian governments and the Commonwealth Foundation.

The Tuvalu Seaman's Union is actively involved in HIV prevention activities in the country. The Tuvalu Family Health Association, a member of the International Planned Parenthood Federation, receives support from the international partnership for a Youth Centre that was constructed with funding from the Japan International Cooperation Agency. The Tuvalu Red Cross Society may be reviving its involvement with HIV prevention and care.

Tuvalu participates in the GFATM Regional Project and receives US\$10,000 per year to support the activities of the county coordinating mechanism. Tuvalu will also benefit from the HIV/STI Surveillance enhancement project implemented by SPC.

Vanuatu

Background

Vanuatu is comprised of about 80 islands stretching over 1,100 kilometers. Its land mass is small (12,189 square kilometers) but its sea area is extensive. With a population of about 200,000 and an annual growth rate of 3%, it is one of the fastest growing populations in the Pacific. Earlier known as the New Hebrides and jointly ruled by Britain and France, Vanuatu gained independence in 1980. Its people are basically subsistence farmers and fishermen, while agriculture, cattle-raising, and forestry bring income into the country.

Literacy, school enrollments, and health indicators are generally poor. Overall there is a great deal of poverty, with 51% of the population living on less than US\$1 per day. Women, especially rural women, are seriously disadvantaged socially, politically, and economically.

Epidemiology

Vanuatu has only recorded two cases of HIV infection to date. With no HIV services available, this level of detection seems likely to be under-reported.

A study by UNICEF among out-of-school youth (13–19 years old) showed that 57% of boys and 43% of girls had begun to have sex, many with multiple partners. A third of sexually active boys and a quarter of the girls used no condoms or other contraceptives.

A WHO study of STIs among antenatal women found 2.4% with syphilis, 6% with gonorrhoea, 22% with chlamydia, and 28% with trichomonas.

Vanuatu's Strategic Plan on HIV/AIDS and STIs lists the following as risk factors:

- Low condom use in Port Vila (indicated by the high level of STIs);
- A high proportion of young people who are sexually active;
- Vanuatu's proximity to other Pacific countries with higher prevalence of HIV;
- Social change and transition which manifests in the flow of people from rural areas to town, increasing travel abroad, a tourist industry, increasing teenage pregnancy rates, multiple sexual partners, and transactional sex (to gain money or favors);
- The low status of women which generally makes it hard for them to assert themselves with men in issues relating to reproductive health; and
- Cultural and religious attitudes that discourage the use of condoms.

The National Strategic Plan and Responses

Vanuatu has developed a National Policy and Strategic Plan for HIV/AIDS and STIs (2003–2007). It is a document with ambitious goals considered in some detail. These goals include:

- Prevention of sexually transmitted HIV—
 - a) widespread distribution, including social marketing, of condoms; b) systematic general public awareness campaign about STIs and HIV; c) encouragement of safe sex behavior change in the following target groups: youth, Ni-Vanuatu who travel overseas, people using STI clinics, people who exchange sex for money or status, and seafarers.
- Safe blood supply—
 - a) screening all blood transfusions; b) Safe Blood Committee for oversight.
- Early intervention, care and treatment of people with HIV/STIs—
 - a) improve services; b) VCT; c) prevention of mother to child transmission; d) antiretroviral therapy.
- Program management—
 - a) revitalize the National AIDS Committee; b) monitoring and evaluation;
- Surveillance of STIs/HIV—
 - a) make HIV a reportable disease; b) develop second generation surveillance.
- Staff competence—
 - a) training on STI management and VCT; b) care and support for people living with HIV and AIDS;

While the Ministry of Health has been designated in the strategy as a major actor, Vanuatu has a number of NGOs devoted to various development goals. These have a role in the HIV response as well, including the Vanuatu Family Health Association, the National Youth Council, the National Council of Women, the Vanuatu Christian Council, the National Council of Chiefs, and a few other NGOs. Wan Smol Bag Theatre, a competent and experienced social development NGO, operates a clinic for youth (Kam Pusim Hed) and is developing a program for sex workers, in addition to its radio programs and numerous other activities. Wan Smol Bag is a resource for training other groups elsewhere in the Pacific and has been selected by the Pacific Regional HIV/AIDS Project as a community development organization and is thereby eligible to receive funding and compete for grants.

Other HIV/AIDS Responses/Programs

AusAID, the European Union, NZAID, and UNAIDS have invested in helping Vanuatu actualize these plans. As part of the GFATM group, Vanuatu is conducting surveillance surveys, participating in the Pacific Stars Life Skills program of UNICEF, and exerts efforts to engage traditional leaders.

Appendix B

Funding the Pacific's HIV/AIDS Prevention and Care Activities**TABLE B1a**
Resource Allocation per Country for HIV/AIDS and STI Related Initiatives , 2005–

Country	----- Pacific Regional HIV/AIDS Project (In A\$) -----						SPC ^a Surveillance	NZAID ^b
	NAC Grant	CDO Grant	Competitive Grant	Capacity Building	Technical Assistance	Total		
American Samoa							26,000	
Cook Islands	15,000	50,000	21,000	17,650	20,000	123,650		
Fiji	60,000	50,000	87,000	24,050	0	221,050		
FSM	0	0	58,000	50,000	20,000	128,000		
French Polynesia							26,000	
Guam							26,000	
Kiribati	50,000	50,000	7,000	35,450	15,500	157,950		
Marshall Islands	0	0	0	40,000	15,000	55,000	26,000	
Nauru	0	0	0	10,000	0	10,000	10,000	
New Caledonia							26,000	
Northern Marianas							26,000	
Niue	0	0	0	10,000	0	10,000		
Palau	0	0	0	25,000	0	25,000		
Samoa	40,000	50,000	0	21,810	7,524	119,334		
Solomon Islands	50,000	50,000	107,000	17,650	0	224,650		
Tokelau	0	0	0	10,000	0	10,000	10,000	
Tonga	30,000	50,000	7,000	20,450	24,200	131,650		
Tuvalu	30,000	50,000	33,000	26,550	0	139,550		
Vanuatu	50,000	50,000	143,000	17,650	0	260,650		
Wallis and Futuna							26,000	
Total	325,000	400,000	463,000	326,260	102,224	1,616,484	202,000	2,000,000

Abbreviations: AusAID = Australian Agency for International Development, CDO = community development organization, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, NAC = National AIDS Council or its country equivalent, NZAID = New Zealand's International Aid and Development Agency, SPC = Secretariat for the Pacific Community, STI = sexually transmitted infection.

^a Pacific Regional HIV/AIDS Project funds administered by the Secretariat for the Pacific Community. Amounts are in A\$.

^b Funds (in NZ\$) are coursed through UNICEF, part of which goes to support prevention of mother to child infection and youth-oriented projects.

TABLE B1b
Resource Allocation per Country for HIV/AIDS and STI Related Initiatives , 2005– , In US\$

Country	GFATM ^a 2005–2008	UNAIDS ^b	----- UN Agencies in the Pacific -----					ILO	WHO
			UNICEF	UNFPA	UNDP	UNIFEM			
Country									(US\$)
American Samoa			85,000						
Cook Islands		7,000							26,554
Fiji	36,300	75,000							12,500
FSM	248,750	15,000							27,800
French Polynesia	66,100								0
Guam			69,000						0
Kiribati		25,000	7,000						
Marshall Islands	105,250	15,000	34,000						0
Nauru									0
New Caledonia									0
Northern Marianas			23,000						0
Niue		5,000							
Palau	19,550	20,000	34,000						0
Samoa	43,950	35,000	80,000						35,600
Solomon Islands	84,100	30,000							0
Tokelau	110,650		9,000						1,000
Tonga		15,000	50,000						
Tuvalu	65,800	15,000	67,000						0
Vanuatu	46,000	20,000							
Wallis and Futuna	69,450								0
Total	895,900	277,000	458,000	312,204	400,000	23,000	20,000	293,938	^c

Abbreviations: GFATM = Global Fund to fight AIDS, Tuberculosis and Malaria, ILO = International Labour Organization, UN = United Nations, UNAIDS = The Joint United Nations Programme on HIV/AIDS, UNDP = United Nations Development Programme, UNFPA = United Nations Population Fund, UNICEF = United Nations Children's Fund, UNIFEM = United Nations Development Fund for Women, WHO = World Health Organization

^a There is, in addition, an allocation for expenditures through regional organizations of US\$1,604,450 and operating costs for the principal recipient, the Secretariat for the Pacific Community, of \$710,550 for the same time period. The GFATM R2P2 funding also excludes funds to regional organizations to support activities in countries of US\$573,150.

^b These are UNAIDS allocations only and do not include resources from other UN agencies in the Pacific.

^c The total amount includes \$190,484 for regional expenditures.

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