Prepared by the National Program HIV/STI

Remarks by the Ministry of Health

As a nation, we are firmly committed to turning the tide on the 30-year-old fight against AIDS. To be clear, our country still faces enormous challenges. Far too many people are afraid of stigma and discrimination and thus are afraid to benefit of services of treatment, care and support.

We need to reach more people with both prevention and treatment services. But today, thanks to remarkable scientific discoveries and the work of countless individuals, organizations and governments, an AIDS-free generation is not just a rallying cry—it is a goal that is within our reach.

But creating an AIDS-free generation is too big a task for one government or one country. It requires the world to share in the responsibility. We call on partner countries, other donor nations, civil society, faithbased organizations, the private sector, foundations, multilateral institutions and people living with HIV to join us as we each do our part. Together, we can deliver a better future to millions across the globe. A future where children are not born with ()V... where teenagers and adults are at far lower risk of contracting the virus... where those who do have the virus get lifesaving treatment.

A future where every child has the chance to live up to his or her God-given potential.

On behalf of the Republic of Vanuatu, I am pleased to present the January – December 2015 Global AIDS Response Progress Reporting for Vanuatu.

REPUBLIC OF VANUATU
DIRECTOR GENERAL OF HEALTH
DIRECTEUR GENERAL DE LA SANTE
REPUBLIQUE DE VANUATU

George Taleo
Director General of Health

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
AusAID	Australian International Development Agency
BCC	Behaviour change communication
CBO	Community-based organization
CD4	Measure of HIV-caused reduction in immunity based on T-cell surface glycoprotein
CMS	Central Medical Supplies
CRIS	Country Response Information System
CSM	Corporate Social Marketing
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
FBO	Faith-based organization
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
IEC	Information, Education and Communication
ILO	International Labour Organisation
KPH	Wan Smol Bag clinic, Luganville
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Committee
NCM	National Coordinating Mechanism
NDH	Northern Districts Hospital
NGO	Non Government Organisation
NRL	National Serology Testing Laboratory, Melbourne, Australia
NSP	National Strategic Plan for HIV and Sexually Transmitted Infections
OI	Opportunistic Infections
OPD	Out-patients Department
OSSHHM	Oceania Society for Sexual Health and HIV Medicine
PAC	Provincial AIDS Committee
PCR	Polymerase chain reaction test (for HIV DNA)
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
PHD	Public Health Division
PIAF	Pacific Islands AIDS Foundation
PICAS	Pacific Islands Counselling and Social Services

PICTs	Pacific Islands Countries and Territories
PMTCT	Prevention of Mother To Child Transmission (of HIV)
PNG	Papua New Guinea
PRFC	Pacific Response Fund Committee
PRSIP	Pacific Islands Regional Strategy and Implementation Plan for HIV and STIs, 2009 – 2013
PWID	People Who Inject Drugs
RF	Response Fund
RH	Reproductive Health
RRRT	Regional Rights Resource Team
SHC	Strategic Health Communication
SGS	Second Generation Surveillance Survey
SPC	Secretariat of the Pacific Community
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms of Reference
ToT	Training of Trainers
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Childrenʒs Fund
UP	Universal Precautions
USD	US Dollar
VCCT	Voluntary Confidential Counselling and Testing
VFHA	Vanuatu Family Health Association
VNSO	Vanuatu National Statistics Office
VNTC	Vanuatu National Training Centre
VSO	Volunteer Service Overseas
WAD	World AIDS Day
WHO	World Health Organisation
WSB	Wan Smol Bag

Contents

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2. Indicator overview

Target		Indicators	Value 2014	Value 2015	Source	Comments
HIV PREVENTION AMONG GENERAL POPULATION	*Indicators for the general population*	1.1 Young People: Knowledge about HIV Prevention*	No Data	No new data	*2010. "Ino bin Gat Protection" UNICEF and Vanuatu Government*	
		1.2 Sex Before the Age of 15	No Data	No new data	*Second Generation Surveillance of Antenatal Woman, STI Clients and Youths, Vanuatu, 2008*	
		1.3 Multiple sexual partners	No data	No new data	*SGGS 2008*	
		1.4 Condom Use During Higher Risk-Sex	No Data	No new data	*2010. "Ino bin Gat Protection" UNICEF and Vanuatu Government*	
		1.5 People living HIV WHO know their status	85.7%	100%	*Every one living with HIV know their status*	
		1.6 HIV prevalence from antenatal	35%	40%	*ANC CLINICS*	
		1.20. HIV incidence rate -	No Data	No data		

KEY POPULATIONS						
		2.1 Size estimations for key populations	NO Data	No data		
		2.1 a). Sex workers - Vanuatu - 2015	No new Data	No new data		
		2.2 sex workers; Condom use	0%	No new data		
	Indicators for KEY	2.3 HIV Testing in SexWorkers	No Data	No Data		

	POPULATION	2.4 HIV Prevelance in Sex Workers	No Data	No data		

		2.1 b) Men who have sex with men	No Data	No Data		
		2.5 Men who have sex with men Condom use	No data	No data		
		2.6 HIV Testing in MSM	No data	No data		
		2.7 HIV Prevelance in MSM	No Data	No Data		

	People who inject drugs	2.1 C) People who inject Drugs	No Data	No Data		
	Inmates Indicator	2.8 People who inject drugs: Number of needles/IDU	No Data	No Data		
		2.9 People who use drugs: Condom use	No data	No data		
		2.10 People who use drugs, Safe injection practice	No Data	No data		
		2;11 HIV Testing in people who Inject Drugs	No data	No data		
		2.12 HIV Prevelance in people who inject Drugs	No Data	No new Data		
		2.13 Poid situation therapy coverage	No data	No new data		
		2. 1. d) Inmates/detainees	No Data	No new Data		
		2.14. HIV prevalence in inmates/detainees	No data	No data		

e) Transgender people	No data	No data		

• C. Prevention of mother-to-child transmission (PMTCT)						
		2.15. HIV prevalence in transgender people	No data	No data		
		3.1 Prevention of mother-to-child transmission	No data	No new data	National Office	We did not have any mothers preganant during the period
		3.2 Early infant diagnosis	No data	No data		
		3.3 Mother-to-child transmission of	No data	No data		
		3.4 PMTCT testing coverage	No data	No data		
		3.5 Testing coverage of pregnant	No data	No data		
		3.7 Coverage of infant ARV prophylaxis	No data	No data		
		3.9 Cotrimoxazole (CTX) prophylaxis coverage	No data	No data		
	D. Treatment	4.1 HIV treatment: antiretroviral therapy	100%	100%		
		4.2 Twelve-month retention on antiretroviral therapy	100%	100%		
		4.2a Twenty-four-month retention on antiretroviral	100%	100%		
		4.2b Sixty-month retention on antiretroviral therapy	100%	100%		
		4.3 HIV care coverage	4	4		
		4.4 Antiretroviral medicines (ARVs) stock-outs	No stock out	No Stock out		

		4.5 Late HIV diagnoses	No data	No data		
• I. HIV and other diseases	E. AIDS Spending F. Gender G. Stigma and discriminatio • H. Health systems integration a) Tuberculosis	4.6 Viral load suppression	No Data	No Data		
		4.7 AIDS-related deaths	1	1	*I Death during this reporting Priod*	
		6.1 AIDS spending	84,000,000 vatu	19,000.000vatu	*25,000,000vatu*	Source Ministry of Health, Vanuatu
		7.1 Prevalence of recent intimate partner	No Data	No New Data		
		8.1 Discriminatory attitudes towards people	No Data	No New Data		
		10.2 External economic support to the poorest	N/A	N/A		
		11.1. Co-management of tuberculosis and HIV treatment	no data	No data	HIV NATION UNIT	No patients with TB/HIV during this period
		11.2. Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis (TB)	0	0		*No cases*
		1.3. Proportion of people living with HIV newly enrolled in HIV care started on tuberculosis	0	0		*No cases*
	b) Hepatitis	11.4. Hepatitis B testing	No Data	No Data		*No cases*
		11.5. Proportion of HIV-HBV co-infected persons currently on	0	0		*No cases*
		11.6. Hepatitis C	0	0		No case

		11.7. Proportion of persons diagnosed with HIV-HCV infection started on HCV	0	No data		
	c). Sexually Transmitted Infections	11.8. Syphilis testing in pregnant women		3514	*MOH HIV UNIT*	
		11.9. Syphilis rates among antenatal care attendees		14.6%	MOH HIV UNIT	
		11.10. Syphilis treatment coverage among syphilis		514	MOH HIV UNIT	
		11.11. Congenital syphilis rate (live births and stillbirth)	No data	No data	MOH HIV UNIT	
		11.12. Men with urethral discharge		No data	*MOH*	
		11.13. Genital ulcer disease in	0	0		
		A HIV testing services	No data	No data		
	• II. Policy and Programmatic Questions	A HIV testing services	Yes	Yes		MOH
		4.7 Viral load suppression	No data	No data		

3. Status at a glance

Vanuatu consists of a Y-shaped chain of four main islands and 80 smaller islands, spanning a distance of 1,100 kms. Vanuatu is part of Melanesia, a grouping of islands ethnically and geographically distinct from Micronesia and Polynesia. Vanuatu has a highly-structured, hierarchical, village-based social organisation.)n ′□□,, Vanuatuʒs population was estimated at 264,700, with one-fifth of the population living in the capital Port Vila and the majority (76%) living in villages of less than 200 people. The population is predominantly young with □′% of the population below ′□. Vanuatuʒs human development index in 2012 was 0.626, positioning it at 124 out of 187 countries. The 2013 GDP per capita was USD 3,277 (World Bank).

3.1. HIV in Vanuatu

The first HIV case in Vanuatu was found in 2002. To date, the cumulative number of HIV cases is 10, with four of these detected in 2012 alone. Six people are still alive today, while FOUR have died. However, the number of officially reported HIV cases is based on passive testing through VCT centres, and actual HIV numbers are expected to be much higher. HIV testing is still very limited. . In 2013, only 27% (367/1344) of all pregnant women were tested for HIV. Currently, 4 people – all female – are enrolled in ART. Although the mode of transmission for these cases has not been reported, data from the wider Pacific region show that most transmission is through heterosexual contact. Important HIV-risk factors include high STI rates, early sexual debut and high teen-pregnancy rate, and a low condom-use rate. Results from a SGS study in 2008 among pregnant women (under 25) revealed that 9% had had two or more sex partners in the last 12 months; 3.6% had had sex for money or gifts; and 5% had had concurrent partners in the last 12 months. Preliminary results from the most recent DHS (2013) showed that a large majority (91% of females, 92% of males) aged 15–49 had heard of AIDS and 21-22% (male, female) had comprehensive HIV knowledge. Three percent (3%) of males aged 15-49 had paid for sex in the last year. Condom use at first sex was 45% in urban areas for both men and women, but only 31% for women and 36% of men in rural areas. Overall acceptance of people living with HIV (PLHIV) was very low. Just 10 percent of women and 19 percent of men aged 15–49 expressed overall tolerance and acceptance

3.2. Sexually transmitted infections

While HIV rates are still very low, high STI rates reveal a high level of risk behaviours and vulnerability to HIV. In the period 2011-2014, 21% of 14,037 men and women tested were infected with Chlamydia; 5.6% of 13,655 men and women tested were infected with Gonorrhoea; and 4.3% of 9,831 men and women with Syphilis. Similarly, STI testing among pregnant women in the same period showed infection rates of 23.5% (n=336/1431) with Chlamydia; no cases of Gonorrhoea (while 2008 SGS data revealed 3%); and 4.3% (n=19/1097) with Syphilis.

3.3. Sex work and transactional sex

While there appears to be no established commercial sex industry in Vanuatu and there are no known full-time brothels in Port Vila, transactional sex – the exchange of sex for money and/or goods – is common (Mitchell, 2001). Sex work is commonplace in urban nakamals (kava bars) and nightclubs and is primarily driven by a desire to have disposable cash to participate in Port Vilaž̧s nightlife and purchase consumer goods, while few women rely on sex work for daily food or shelter. A behavioural survey among sex workers in Vanuatu in 2006 reported that sex work in Vanuatu was largely informal (Gold et al, 2007), and another study among sex workers in Port Vila found that few women self-identified as sex workers, despite regularly exchanging sex for money (McMillan, 2011). The 2006 survey found low HIV-test rates and many HIV/STI risk behaviours, including inconsistent condom use with both paying and non-paying partners; use of alcohol and other drugs; tattooing; and non-consensual sex (Gold et al., 2007). Inconsistent condom use was associated with pressure and extra payment for unsafe sex by transactional sex partners. Sex workers were also less likely to carry condoms due to fear of arrest or harassment from police. In addition, sex workers were less likely to regularly test for HIV because of stigma, fear of confidentiality breaches, lack of transport and inconvenient clinic hours (McMillan et al, 2011).

A bio-behavioural study among sex workers in 2011 estimated the number of sex workers in Vanuatu to be 1,398, comprising 7-18% of the total female population in Port Vila aged 20-54 years (Van Gemert et al., 2013a). The study confirmed the predominantly transactional character of sex work in Vanuatu: 86% of the women received both goods and money in exchange for sex in the previous week. Nearly all (>90%) clients were Vanuatan, suggesting that sex work is not driven by tourism. Most women started transactional sex at a young age, with over one-third starting before 18 and within one year after sexual debut. While knowledge on HIV transmission routes was good, condom use with transactional sex partners was extremely low, with only 7.5% of women reporting always using a condom in the last month; similarly, condom use with non-transactional sex partners (regular and/or casual partners) was low (7.2% consistent condom use). Group sex and anal sex were common, with 28% of women reporting anal sex and 38% group sex in the last year, while condom use at last anal and group sex was low (40% and 44% respectively). Over two-thirds of sex workers (69.5%) reported ever being forced to have sex. Drug and alcohol use was high,

with three-quarters reporting recent kava use, and just over one-third recent cannabis use. HIV testing was very low: only 5.5% reported an HIV test in last 12 months. Three quarters of sex workers reported a genital symptom in the past 12 months and STI tests revealed high infection rates of chlamydia (36.7% overall; and 63% for sex workers under 19); Gonorrhoea (17.1%) and Syphilis (3.7%). No HIV cases were found. The majority of chlamydia-positive FSW were not aware they were infected.

Another common type of transactional sex occurs among bus and taxi drivers, who often offer free transport to young women and girls who do not have money to pay for the ride in return for sex. Few of them use condoms.

There was a survey carried out this year on sex Workers and Men having sex with men. Reports will be available during the Next round of reporting

3.4 MSM and Transgender (TG) persons

A 2011 bio-behavioural study among 52 MSM and TG estimated the total MSM-TG population to be 327, 2-3% of the total male population (20-59 years) in Port Vila (van Gemert et al., 2013b). TG showed more risky behaviours than MSM, including lower age of sexual debut (16 years for MSM vs 12 years for TG) and lower rates of condom use at last anal sex (57.8% of MSM and 75% of TG); There was limited understanding among MSM and TG regarding transmission of HIV through anal sex. Sexual contact with women was common: one-third of TG (32%) and nearly all MSM (89%) reported ever having sex with a female partner. This highlights the interconnectedness of heterosexual and homosexual sexual networks in Vanuatu and the potential for rapid STI transmission in the face of low condom use. The level of forced sex was concerning; two thirds of TG (63%) and one-third of MSM (36%) reported ever being forced to have sex. 18% of TGs and 36% of MSM reported a genital symptom in the last year, but none of the TGs and 70% of MSM sought treatment. Fear was the main reason for not seeking STI treatment. The most common STI was Chlamydia (17.7% of MSM and 20.8% of TG), while infection with Gonorrhoea) 11% of MSM, 8% of TGs) and Syphilis (11% of MSM, 5% of TGs) was also common. No HIV was found.

4. National Strategic Plan

The Vanuatu NSP is currently being updated. The last NSP, which was valid till 2012, has 4 intervention areas: **Strategic Direction 1: Engage the Vanuatu population at large, using established local governance and civil society - to raise awareness and come to a nation-wide agreement on a strategy to address STIs and HIV.**

Strategic Direction 2: Provide support to High Risk Groups, in partnership with NGOs, to increase prevention and treatment for vulnerable population, and reduce human rights abuses.

Strategic Direction 3: Strengthen the Health System to improve testing, treatment and care services, as well as improve programme management.

The NSP has 3 main goals: 1) To reduce the prevalence of STI in the Vanuatu population; 2) To prevent and minimise the spread of HIV infection in Vanuatu population.

Intervention area 1: Reduced community vulnerability to HIV and STIs

Key output areas:

- Developed and implemented appropriate and effective BCC strategy
- Developed HIV and STI preventive strategic intervention for the youth
- Developed specific strategic intervention targeting to prevent HIV and STI in vulnerable groups
- Increased the availability, accessibility, and use of condom among sexually active population
- Ensured the quality and safety of blood products
- Strengthened the practice of universal precaution in health facilities and other settings if applicable
- Ensured availability and accessibility to post-exposure prophylaxis (PEP)
- Expanded, with quality, the services for counselling and testing with confidentiality
- Intervention area 2: Implemented a comprehensive programme of treatment, care and support for people infected and affected by HIV

Key output areas:

- Developed comprehensive national policy for treatment, care, and supports for people living with HIV
- Established core team for HIV care and treatment in the two main hospitals
- Provided adequate resources for the main facilities to enable care and treatment for HIV patients
- Initiated the community intervention for providing appropriate home- base support, care and treatment for HIV patients
- Strengthened the health services to effectively provide STI care and treatment
- Strengthened the quality of laboratory services in all hospitals to support HIV and STI diagnosis and case management
- Initiated the comprehensive strategic intervention on PMTCT
- Explored the practicality on male circumcision practices in country
- Established the link between TB and HIV programme on referral system

Intervention area 3: To create a policy and social environment in which an effective HIV response can flourish

- Commit support and HIV response from high levels
- Key output areas:
- Strategy for the reduction of stigma and discrimination of people infected and affected by HIV devised and implemented
- Policies, legislation and traditional laws that discriminate against vulnerable populations
- Monitor human rights violations against people living with HIV and their family members
- Intervention area 4: Efficient and effective management of the HIV National Strategic Plan

Key output areas:

- Effective multi-sectoral engagement in the NSP
- Improved coordination and management of the National response

- Comprehensive programme of HIV and STI surveillance and research implemented and annual figures disseminated
- One national monitoring and evaluation framework designed and implemented
- Evidence based planning undertaken on annual basis
- Vanuatuʒs national ()V response adequately resourced

5. The Health System in Vanuatu

The national vision of the Vanuatu Government under the Priorities and Action Agenda (PAA) 2006–′□□□ is Dz(ealthy Vanuatudz, with the mission of the Ministry of (ealth îMO(Ò as Dzprotection and promotion of the health of all people living in Vanuatu, with the vision of having an integrated and decentralised health system to promote effective, efficient and equitable development and services for the well being of all people across Vanuatu.dz Under a Primary (health Care approach, policy objectives are to:

1. Improve the health status of the people;

2. Improve access to services;

3. Improve the quality of services delivered;

4. Make more effective use of resources.

The MOH is responsible for the provision of curative and preventive health services. The Ministry formulates national health policies, coordinates the development and planning of public health sectors, and regulates health standards. The vision, broad objectives and strategies for development of Vanuatuʒs health sector are defined in the (ealth Sector Strategy 2010–2016.

Under this strategy, in line with the PAA, the MOH has committed to:

- Ensure that the whole population has access to a range of evidence based and affordable health promotion and preventive services

- Ensure universal equitable access to emergency, curative and rehabilitative services

- Ensure that quality Primary Health Care remains pre-eminent as the central strategic health priority for the country, and that this is reflected in the budget

- Ensure that the health systems necessary to provide such services, which are accountable to clients and are cost effective, are developed and strengthened in line with international best practices

- Actively engage in partnerships with donor agencies, private sectors, civil society groups and other development partners to assist in optimizing health service delivery
- Adopt a 3 year strategic planning framework (Corporate Plan), with rolling yearly implementation plans (Business Plans) that should drive the budgeting process
- Ensure that all significant external funding is in line with the priorities and directions of the MOH.

There are six public and one private hospitals in Vanuatu, which provide inpatient and specialist outpatient services. Of the six hospitals, there are two tertiary referral public hospitals, one located in Port Vila and one in Luganville. Specialized tertiary services are not available in Vanuatu and are referred for overseas treatment, mainly to Australia and New Zealand.

There are 32 health centres (also referred to as district/first-level referral hospitals), about six in each province. They provide outpatient and inpatient services (mostly deliveries), health promotion and preventive health services, such as immunization. Each of these health centres is staffed by a nurse practitioner (who is also the manager), a midwife and a general nurse. The health centres are the referral centres for dispensaries (PHC centres) and aid posts. There are 89 active dispensaries providing primary care. All the islands have at least one dispensary, which is usually staffed by a general nurse.

Aid posts have been established in most villages and are funded by the community, while the Ministry of Health provides basic medicine and training for the staff. There are about 180 aid posts in the country, each staffed by a village health worker. The support services for hospitals and primary health care programmes include pharmaceutical, blood transfusion and laboratory services.

6. Non-government Health Services

In addition to government health services, there are also clinics operated by NGOs, FBOs and the private sector. Wan Smol Bag (WSB) has health clinics in Port Vila and Luganville and also has a mobile clinic in Pentecost Island, which is visited once a month. WSB employs four registered nurses. Vanuatu Family Health Association (VFHA) on the other hand has health clinics in Port Vila and Luganville, and also runs a health hotline, which provides information on sexual and reproductive health, STIs, HIV and related issues.

The two major NGOs providing reproductive health services in Vanuatu which are Vanuatu Family Health Association have a total of 50-55 clients per day in Port Vila and 35-40 per day in Luganville. Both clinics are centrally located in their respective towns.

Most clients in Port Vila come for family planning, though some come primarily for symptomatic STIs. The family planning clients do not routinely get a genital examination for STIs, but an estimated 20-30% has symptoms such as discharge or abdominal pain, in which case they get a genital examination including speculum examination. Blood (for syphilis testing of symptomatic clients) and urine (for Chlamydia testing of all clients, when operational) are referred to Vila Central Hospital. In the Luganville clinic, there are few family planning clients; instead, the intake is split equally between those with STIs and general medical overflow from the provincial hospital.

Wan Smol bagʒs Kam Pusum (ed clinic on the other hand is in a discreet location on the outskirts of Port Vila. This clinic appears to attract a less settled clientele –the percentage living with their sexual partner is half that seen at the hospitalʒs ANC clinic (36% vs. 74%); and their condom use at last sex was several-fold lower than for ANC clients and youth. An estimated □□% of the clinicʒs clients come for family planning services and 30% because of symptomatic STIs. Those with STIs are mostly 17-25 years old, and include almost as many men as women. The clinic has small groups of FSW and MSM peer educators. Wan Smol bagʒs Northern Care Youth Clinic, sees both family planning and STI clients and has a comfortable and inviting reception area with couches and educational DVDs. At both sites, Wan Smol bag has extensive drama and public education initiatives.

Vanuatu Family Health Association and Wan Smol bag both supply condoms to RH services at these NGO clinics in Vanuatu and are well integrated and the clinics refer samples for testing to the hospital laboratory. However, relative to the hospital testing numbers, the testing volume is 4 times lower at the Northern Care Youth Clinic run by Wan Smol bag, and 12 times lower at the Vanuatu Family Health Association. Within the Northern Provincial Hospital itself, the ANC clients account for 80% of the serological testing volume for HIV, syphilis and hepatitis B.

The majority of services are focused on the general population such as ANC clients. It is of course important to reach key affected populations, which include young people, MSM and sex workers. Vanuatu is still at the inception phase of developing services for key populations.

Vanuatu benefits from the youth-friendly facilities and peer educators of Wan Smol bag. In part because of the small size, the country has implemented many cross-program initiatives. Clients diagnosed (either syndromically or etiologically) with an STI are tested for other STIs and offered HIV testing; ANC mothers are generally tested for HIV, syphilis and hepatitis B. During family planning sessions, testing for HIV and other STIs is offered in some facilities but not others.

7. HIV and AIDS Management

HIV and AIDS is recognized in the PAA (2006-2015) as an emerging threat, although acknowledging the lack of routine monitoring and evidence regarding the extent of HIV infection in Vanuatu. However, while the PAA includes reference to contraceptive prevalence, and other factors related to HIV and STI transmission, no mention is made of either MDG Indicator 6 (HIV and AIDS), or of the high prevalence of STIs in the country. Similarly, the Health Sector Strategy 2010–2016 makes no specific reference to HIV and AIDS or STIs.

8. Prevalence and incidence of HIV and STIs

Data on the number of diagnosed HIV cases is available from reports by government and NGOs clinics. Vanuatu officially reported its first HIV positive case in September 2002. The second case was reported at the end of 2003, and the first recorded death in 2006. By the end of 2011, the number of reported HIV positive cases had risen to six. As of September 2015 there have been twn officially reported HIV cases, six of whom are still living. One case was diagnosed through ANC, but has been lost to follow-up, and her child has not been tested. Reported cases appear to be evenly distributed across the country: of the six people currently living with HIV, two were diagnosed in Port Vila, two in Tanna and two in Santo. Of these cases, one was apparently acquired overseas, and two by transmission to women from partners who acquired the infection outside the country. While men who have sex with men (MSM) are present in most communities, to date there have been no reported cases among MSM. Very little injecting drug use has been reported in Vanuatu, and there are no known cases of HIV transmission among people who inject drugs (PWID).

Table 1: Reported HIV cases by province, 2015

	Number of reported cases by province						Total
	Torba	Penama	Sanma	Malampa	Shefa	Tafea	
Male adult	0	0	0	0	2	1	3
Female adult	0	0	2	0	1	2	5
Child	0	0	0	0	1	1	2
Total	0	0	2	0	4	4	10

Source: HIV and STI Unit, MOH

Current HIV surveillance is based on information derived from four main sources: ANC, STI, and TB clients, and blood donations. There is a specific reporting form for HIV.

Sexually transmitted infections (STIs) have long been highly prevalent in Vanuatu, and data from health facilities indicate high prevalence and incidence. Data on the number of STI cases is provided by reports from OPD, ANC and other clinics. Information on incidence and prevalence of STIs, including HIV, knowledge of HIV and STIs, and risk behavior for transmission is available from several sources. These include, primarily, Second Generation Surveillance Surveys, with additional data provided by Multiple Indicator Cluster Surveys (MICS), the last of which was conducted in 2007. Information on risk behavior of young people is available from a purposive survey of HIV and AIDS Risk and Vulnerability Among Vanuatu Youth undertaken in 2009 (UNICEF 2009).

Two Second Generation Surveillance Surveys (SGS) have been conducted in Vanuatu, in 2005 and 2008. Both surveys were conducted in Port Vila, with data collected from ANC clients, STI clinic attendees and youth surveys. In the 2008 survey, information on sexual behaviour and risk factors was collected from all participants through

interviewer-administered questionnaires. ANC clients were tested for HIV, hepatitis B virus, syphilis, chlamydia and gonorrhoea infections, and STI clinic attendees were tested for HIV, hepatitis B virus and syphilis infections. The survey found high rates of STIs among all groups tested. Among ANC clients, 3 percent tested positive for gonorrhea, 5 percent of women were found to have syphilis, 11.9 percent had a hepatitis B infection and 25 percent had chlamydia, a significant increase from 13.2 percent in the first round of SGS. No cases of HIV were detected. Over one quarter of youth reported that they had previously had an STI, with gonorrhoea the most commonly reported infection (21 percent). Two in five females (42 percent) and one in four males (28 percent) reported having at least one STI symptom in the last month. However only one third of females who reported having a symptom also reported that had sought treatment (32 percent) compared with 93 percent of males. Among STI clinic attendees, no participants were found to have the HIV virus. Hepatitis B surface antigen was detected in 19 percent of males and percent of females, while 7 percent of males and less than one percent of females were seropositive for syphilis.

Table 2: STI situation overview (SGS 2008)

Variable	Percentage
Prevalence ANC women over 25 years	18%
Prevalence ANC women under 25 years	29%
Ever diagnosed with an STI: male youth	37%
At least one symptom STI: female youth	42%
% female youth with symptom(s) who sought treatment	30%
STI client sexual partner(s) treated: male	38%
STI client sexual partner(s) treated: female	28%

Source: Adapted from Cave (2011)

From this data, it is clear that, based on the data from 2008, STIs are highly prevalent in Vanuatu, and widespread amongst all areas of the population, including young people and women. The rates of STIs are also amongst the highest in the Pacific region.

8.1 Knowledge and risk behaviour related to HIV and STIs

While there is high awareness amongst some youth and sex workers on ways to prevent the sexual transmission of HIV, in general levels of knowledge concerning HIV and STIs are generally low. There are high levels of risk behavior, in particular sexual behavior, amongst vulnerable population groups in Vanuatu. This especially evident among young people (see Table 4), There is little information available on key affected populations.

The main source of information is the survey on HIV and AIDS risk and vulnerability among youth, mentioned above. This survey found that 12.9 percent of young people (9 percent of males and 16.5 percent of females) had participated in sex work. It also found that 5.7 percent of males (8 percent of sexually active males) reported having had sex with men. The actual numbers are likely to be higher. The NGO WSB is currently in the data collection phase of research with sex workers and MSM populations.

In regard to drug use, there is also very limited information available. The 2009 youth survey found that no young person mentioned injecting drugs. However, substance use is a concern in relation to reducing HIV and AIDS vulnerability with 43.1 percent reporting using alcohol, 34.3 percent reporting using kava and 18.4 percent reporting using home brew. Anecdotal evidence suggests that marijuana use is high amongst young people in some areas.

Table 3: Summary of key variables on youth HIV knowledge and behaviour

Variable	Percentage		
	Males	Females	All
Young people (15-24) who can correctly identify ways to prevent HIV infection and reject misconceptions about HIV transmission	29	20	24
Young people (15-24) who had sexual intercourse with more than one partner in the last 12 months	52.9	27.4	40.5
Young people (15-24) who reported condom use at last high-risk sex (i.e. with a non-regular partner).	49.5	34.6	41.7
Young people (15-24) who have been tested for HIV and know their results	-	-	10
Young people who engaged in commercial and/or transactional sex reporting use of a condom the last time they had sex.	34.5	43.5	39.1

Sources: I No Bin Gat Protection, UNICEF Pacific Office and Government of Vanuatu, 2010; Second Generation Surveillance Survey of Antenatal Women, STI Clinic Clients and Youth, 2008; and Government of Vanuatu (2012)

Several reasons have been given to explain the high rates of STIs in Vanuatu. These include the fact that, since an estimated 80 percent of cases are asymptomatic, people are unaware that they have an STI and continue to engage in risky behaviour. High-risk

behavior for STI infection is common, with multiple sexual partners and low condom use. Also the rate of partner treatment is very low, so that re-infection is likely to occur, and the transmission of STIs is not interrupted by treatment.

Given that HIV shares many of the same risk factors as other STIs then it may be asked why HIV rates are not high as well. In this regard, there is a line of reasoning, repeated in the NSP (2008-2012), that draws a comparison between the situation in Vanuatu and that in neighbouring PNG, where high rates of STIs, similar to those of Vanuatu, have been followed by the rapid spread of HIV. However, the comparison as it appears in the NSP and other sources is not necessarily valid. In PNG the proportion of the male population that is circumcised is relatively low, in contrast to Vanuatu where the rates of male circumcision are very high. Based on recent evidence from studies in Africa that show the significant effect of male circumcision on reducing HIV transmission, it is likely that this practice has played an important role in maintaining the low prevalence of HIV in Vanuatu to date.

Despite the possible mitigating factors, if the data presented still reflect an accurate picture of the situation, then the risk of increased HIV transmission remains high because of the high rate of STIs, low levels of knowledge, patterns of high-risk behavior, and the important gaps that exist in knowledge, especially in relation to key affected populations. However, given the time that has elapsed since the last survey, and the impact of the extensive programming that has been undertaken in the interim there remains considerable room for doubt. Current reports of high incidence of STIs may, for example, reflect increased reporting as a result of expansion of VCCT programmes and increased community awareness. For this reason there is an urgent need for a further survey to assess the current situation regarding HIV and AIDS and STIs, and the changes that have occurred since the commencement of the NSP, in 2008, when the last SGS was conducted. In addition this will provide baseline data for the new NSP (2013-2017).

Conduct of a further SGS was in fact considered by the Vanuatu Government, with support from UNICEF, in 2012, however this did not proceed, and it is uncertain whether it will be implemented in 2013. The Vanuatu Government, through the National Statistics Office and Ministry of Health, with support from UNICEF, is planning to conduct a Demographic and Health Survey (DHS) in 2013. This will provide some key information on knowledge, attitudes and behavior regarding HIV and AIDS and STIs, however it will not yield the specific information on STIs that will allow a comparison to be made with the previous SGS surveys. For this reason, consideration should be given to support to conduct of an SGS, in addition to the planned DHS.

9. Care and treatment

As of 2015 patients were in ART treatment, two on 3TC/TDF + EFV and 3 on 3TC/TDF/EFV. At present there is provision for ARVs to be made available for all

people living with HIV who need ART from the Global Fund funds, whether referred by government or NGO clinics. Diagnostic and monitoring services for CD4 and viral load counts are also available, as is treatment for OIs. The main challenges are adherence to treatment, which is likely to result from a number of factors, including stigma and discrimination, including attitudes and behavior of health personnel as well as self-stigmatization, as well as geographical location, making access to services difficult. There is a need for national guidelines to be developed on treatment, care and support. Core Teams should be established in additional locations together with a mechanism for effective communication among them to enable technical support, learning and sharing of information.

In regard to STIs, effective services for diagnosis and treatment are in place, their effectiveness is challenged mainly by a lack of partner involvement. Clients diagnosed with an STI, or receiving presumptive treatment through ANC VCCT/PMTCT centres, are also provided with doses of medicines for their partners. However the uptake is low, and the programme has shown little impact in reducing the prevalence of STIs among the population. More effort is required to increase public awareness of STIs and treatment services, and also to promote partner involvement.

In Vanuatu, access to treatment, care and support for people living with HIV is ensured through other broad national policies that support the rights of all citizens to receive health care, however it was considered important to develop a national policy specifically on HIV that also includes these areas of the response. For this reason, the NSP included, as a specific activity, the development of a national policy for treatment, care and support for people living with HIV. Vanuatu is in the process of developing HIV legislation, to be included within the revised 2013 public health act, but this activity has not yet been completed. In August 2011, the MOH developed a policy paper for proposed legislation on the management and monitoring of HIV and STIs, HIV prevention, care, treatment and support and to address stigma and discrimination. However, due to competing priorities, this policy paper and the associated Ministerial briefing papers necessary for the Minister of Health to present the paper to the Council of Ministers have not yet been finalized. The MOH finalized the policy and briefing papers in 2012, however the legislation is still awaiting ratification.

Until the legislation becomes law, there will remain some uncertainty concerning its exact content, scope and provisions. This is because the process by which the law was drafted lacked involvement of health care workers and provincial HIV focal points. In any event, even when the HIV policy is finalized, there will still be a need for a complementary set of guidelines that outline specific protocols for treatment, care and support. At present Vanuatu has no specific guidelines for treatment of HIV, and follows the WHO Antiretroviral Therapy Guidelines for Adults and Adolescents/Infants and Children and the second edition of the region specific OSS((M DzRecommendations for ()V Medicine and Sexual (ealth Care in Pacific small island Countries and Territoriesdz.

Following diagnosis, cases are managed on a case-by-case basis by the Core Teams, in consultation with the SPC HIV Unit, with technical support from UNDP/WHO

With increased numbers of people being tested for HIV, however, there is a need for country-specific guidelines that can be distributed to service providers who may need to manage treatment of HIV cases. Stakeholders, including NGO, CBO and health service providers outside the Core Teams, are strongly in favour of development of guidelines for Vanuatu that would include, among other information, details of the various first and second line ART regimens, CD4 and viral load testing, referral protocols and other procedures. With appropriate technical assistance from regional bodies such as OSSHHM, guidelines for treatment, care and support could be developed relatively easily, by adaptation of existing guidelines already developed for other countries in the Asia-Pacific region, and the regional OSSHHM guidelines.

In Vanuatu, as in other countries in the region, Core Teams have been established for the management of care and treatment of people living with HIV. The Core Team approach is intended to reduce stigma and discrimination, improve quality of life, promote ARV adherence and reduce delivery costs of care. Members consist of representatives from key hospital units, including physicians, pharmacists, laboratory technicians and VCCT counselors. As mentioned above, case management by the Core Teams is guided by the WHO and OSSHHM treatment guidelines.

Under support from SPC/UNDP, Three HIV Core Teams were established, one at Vila Central Hospital, Luganville Hospital, Sanma province and TAFEA province. These commenced in 2009 and 2012 respectively. Capacity development support for the Core Teams is provided by OSSHHM, under support from the RF, with six-monthly visits (the last was in January 2013). With the ending of RF and GFATM support, the Core Teams are now in need of funds to support their on-going activities, including provision of ART and case conferences meetings.

)n addition to these three official Core Teams, at least one province, Tafea, has established its own Core Team. This was in response to the feeling, expressed by stakeholders during the 2012 NSP review consultations, that effective case management faced challenges due to the difficulty in communication between the islands and Vila Central Hospital, which was at that time, the only Core Team. Stakeholders felt that active HIV Core Groups should also be established at hospitals on other islands, such as Santo, Lolowai, Lenakel, Norsup and Sola. A mechanism for communication between these teams should also be developed, to enable mutual technical support, learning and sharing of information..

Stakeholders also indicated that the role of Core Teams could be strengthened by the development and implementation of HIV case management guidelines. These would not only improve the effectiveness of the Core Teams themselves, but would also benefit other personnel involved in provision of treatment, care and support, including the expatriate staff working some hospitals, in the event that Core Teams did not function

effectively. At present, without specific HIV guidelines, there is nothing to specify who takes responsibility for case management, and which could, in a worst-case scenario, be left to nurses or untrained personnel, with little or no knowledge of HIV treatment protocols.

All main hospitals (Vila Central, Northern District, Norsup, Lolowai and Lenakel) provide general clinical services for care and treatment to all patients, including people living with HIV. However, there are only two public ART sites in Vanuatu, one in Port Villa and one in Luganville. Vanuatu uses World Health Organisation (WHO) guidelines for ART eligibility, with ARVs for the five people currently on ART supplied under funding support from the GFATM Round 7 grant. With the ending of GFATM support in mid-2013, if additional cases are identified then the MOH will need to find alternative resources to pay for ART. In the interim, an agreement has been made with the SPC and RF that they will continue to supply ARVs and laboratory consumables, from July 2013 until December 2015

ARVs are procured through the SPC regional pharmacist in Fiji. For new patients, the Core Teams consult the regional HIV specialist, who advises on different regimens. The medical staff in the Core Teams then liaise with patients to decide on the best regimen, after which a request is sent to the hospital pharmacist, who then places an order, together with a forecast, with the regional pharmacist using an SPC request form. The regional pharmacist screens the request to ensure it conforms with guidelines and finalizes it. Supplies are sent back via Central Medical Services (CMS), in Vila. When the request form is sent, the CMS manager is also advised on the order, by copying on emails, in order to help expedite delivery. According to pharmacists in the two hospitals, in practice the process usually works very smoothly, and they have never experienced stockouts or other problems. The SPC pharmacy in Fiji is apparently very proactive in asking about stocks, sending forms for completion regarding current stock and six month forecasts.

One issue that has arisen concerns the management of the stocks of ARVs that are ordered but remain unused owing to lack of adherence or loss to follow-up of people diagnosed with HIV for whom ARVs are prescribed. Hospital pharmacists are unsure how long to maintain stocks in such cases, and there is no clear guideline covering their return or transport to other centres for use by other clients.

Equipment is available to carry out CD4 tests at Vila Central Hospital serology laboratory, which also processes requests from Luganville Hospital, with a turnaround time of about one week. Recently a machine was acquired for DNA PCR, which was used in early 2013 in the case of a child who subsequently died. Viral load tests are currently sent to the NRL in Melbourne.

In terms of management of all supplies, including specimen tubes, reagents and test kits, as well as ARVs, provincial centres commented that the current system, where all supplies are procured through CMS in Vila, and funding is centrally managed, is

cumbersome and inefficient, leading to delays in supply and difficulties with forecasts. They suggested that a decentralized approach, with management of funds at the local level would be more effective.

10. PMTCT in Vanuatu

With support from UNICEF and other partners, Vanuatu has scaled up HIV testing and PMTCT services. Vanuatu has a maternal health working group, which has met regularly since May 2011. The country also has a Reproductive Health Policy 2008 and a Reproductive Health Strategy for 2008-2010. The Prevention of Mother to Child Transmission of HIV Policy and Guidelines were launched in January 2009. All six hospitals provide HIV testing and counselling services for pregnant women, through the VCCT centres located in ANC Units. In 2011, the last year for which data are available, 1,553 pregnant women were tested for HIV. During the 2010-2011 period, one pregnant woman was diagnosed with HIV, and was provided with ART prophylaxis. Delivery took place in January 2012, however the child has not yet been tested for HIV.

11. TB/HIV co-infection

Tuberculosis (TB) is a national concern in both urban and rural settings. From 2000 to 2007 the average yearly prevalence rate in Vanuatu was six cases per 10,000 inhabitants, which corresponds to around 120 TB cases per year. In 2011, a total of 112 cases were reported. The Ministry of Health has implemented the directly observed treatment, short-course îDOTSÕ strategy, and the case detection rate is ⍰′%. Vanuatuȝs national TB programme is supported under the Multi-Country Western Pacific Program to Fight Tuberculosis under GFATM Round 7, July 2008 - June 2013.

Vanuatu has a Tuberculosis TB/HIV co-infection policy, which was implemented from November 2011. According to this policy, all diagnosed TB patients are tested for HIV. There are also plans to test people living with HIV for TB, although to date little progress has been made in this area. To date there have been no people with advanced HIV infection who have received antiretroviral combination therapy and who started on TB treatment.

12. Stigma and discrimination

Vanuatuȝs laws are unclear in some areas relating to vulnerable populations. For example, the provisions of the Vanuatu Penal Code are unusual in the Pacific region, as most other Pacific Island nations criminalise homosexual sexual acts (Jowitt 2005), and while a provision in the penal code talks about homosexuality, it does not prohibit working with men who have sex with men. There are also inconsistencies in the law regarding the ages of consent between same-sex and heterosexual relationships.

Based on these and other reasons, a review of policies and laws, both modern and traditional, was planned in the NSP, with the aim of identifying any that discriminated against populations vulnerable to HIV and AIDS. In addition, the NSP aimed to revise

existing policies to include HIV issues. The support of members of parliament would be sought to help the passage of revised policies through parliament, and advocacy undertaken to ensure passing of human rights-based HIV policies.

Little progress appears to have been made in implementation of these activities. Issues related to the rights of vulnerable populations may, however, be addressed in the new HIV legislation. As mentioned above in Section 5.1, the HIV law has been drafted and is waiting for ratification, however because of the lack of involvement of health care workers and provincial HIV focal points, there are questions about the content and the process by which the law was drafted, so it is not known whether it will fully address the needs of vulnerable groups.

Human rights violation in the context of HIV was supported by a four-day training workshop in May 2009 on HIV, human rights and the law in partnership with the Regional Rights Resource Team (RRRT) from the SPC, which involved 20 participants, mainly health workers, from all six provinces. This was followed by a one-day follow-up Dzcrash coursedz in four provinces îShefa, Sanma, Penama and MalampaÒ, attended by a total of 54 people, including community leaders, chiefs, youth groups, women groups, church leaders and local police officers, with the goal of strengthening their capacity to respond effectively to human rights issues related to people living with HIV.

As a result of these activities stakeholder partners are very aware of human rights related issues and are making an effort to implement them. The main challenge is that there have not been many cases where a specific policy or law has been challenged on its application to a HIV situation.

Attitudes of the population in regards of PLHA were assessed through two studies, DHS 2007 and SGGS 2007.

Thus in the SGGS of 2007 nearly 60% of respondents reported that they would be willing to have casual contact with a shopkeeper or vendor in their community if they knew the person had HIV. However, less than half of respondents (48%) agreed that a female teacher who has HIV and is not sick should be allowed to continue teaching. Over third quarters of respondents reported that they would be willing to care for a family member who became sick with HIV in their own home (78%). Seven in ten respondents î,%Ò also indicated that they would not want their relativesž ()V status to remain a secret.

Figure 2. HIV/AIDS Knowledge, Attitudes and Beliefs, STI Clinic Clients, Vanuatu, SGGS 2008

	Male		Female		Total	
	N	%	N	%	N	%
Would buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV	49	66.3	71	54.2	120	58.5
In your opinion, if a female teacher has HIV and is not sick, should she be allowed to continue teaching in the school?						
Should be allowed	34	46.6	60	46.2	94	46.3
Should not be allowed	21	28.8	38	29.2	59	29.1
Don't know / not sure / depends	18	24.7	32	24.6	50	24.6
Would be willing to take care in their own household of a member their family who is sick with HIV	62	83.8	97	74.0	159	77.6
If a member of your family became ill with HIV, would want it to remain secret	25	33.8	51	38.9	76	37.1
A person should be able to keep his/her HIV status private						
Strongly agree	15	20.3	27	20.6	42	20.5
Agree	7	9.5	10	7.6	17	8.3
Disagree	44	59.5	68	51.9	112	54.6
Strongly disagree	1	1.4	4	3.1	5	2.4
Don't know	7	9.5	22	16.8	29	14.2

14. Gender inequalities

The population of Vanuatu shows of proportion of □.□, men X □ women îVanuatu National Census, 2009)1. Vanuatuȝs Population ′,□,□′, with a growth rate of ′.′ percent per year.

Male to female ratio: 104 Males to 100 Females per province.

14.1 MSM and TG in Vanuatu

When the Europeans first explored the South Seas they found large, thriving settlements along many of the islands coastlines. Some of the more inhabited islands such as Tahiti and Hawaii, had populations of up to two hundred thousand and were comparable in size with many European and American towns of the same period. Within these communities, homosexual and transgender natives were well documented by early French and British explorers such as Louis de Bougainville, James Cook, William Bligh and others. Third gender natives were evident in all major Polynesian islands including Tonga, Tahiti, Fiji, New Zeeland, Hawaii, Tonga, Samoa, Tuvalu, Vanuatu and to a lesser degree among dark-skinned aborigines that formed smaller tribes along the coasts of Australia and New Guinea. In Polynesia, European Exploders were surprised to encounter societies that had long regarded bisexual, homosexual and transgender conduct as normative. Third-gender natives were common on all of the islands and known by different names. In Tahiti, for instance, male-to-male transgenders that lived and behaved as women were called mahu. In Hawaii Islands, whose inhabitants are believed to have originated from Tahiti, the mahu were also present along with the aikane – sexually related or Dzfriendlydz men that were essentially masculine-type homosexuals and bisexuals. In Tuvalu, the word pinapinaaine substitutes for mahu, as does the word faȝafafine îlike a womanÕ in Samoa and fakafefine in Tonga. All these various terms refefred to the different types of transgender and homosexual men found among the South Sea natives. Polynesian mahu lived and worked alongside the women and excelled in traditionally female tasks such as basket weaving. They did not perform castration but instead tied their genitals up tightly against the groin. Both mahu and aikane were known for their talent in the elaborate dance ceremonies performed throughout the islands. Bisexuality was quite common in Polynesia and many islands kings kept both male and female partners in their royal huts for intimate relations. Lesbians were less reported in the South Sea although early British ethnographers observed such women in several of the western islands such as Vanuatu2.

Male-to-male sex occurs in all countries of PICT, however the term MSM is problematic in PICT as it does not reflect the complex way in which gender and sexuality is

[1] 2009 National Census of Population and Housing.

[2] https://books.google.com.fj/books?id=iZ5RAAAAQBAJ&pg=PA198&lpg=PA198&dq=third+gender+in+Tuvalu&source=bl&ots=PJEyqYxG8P&sig=KAiphQFRm3KoRH0I3bY3zy0QuJ0&hl=en&sa=X&ei=aD0rVbDKLtbeaqD9gfgK&redir_esc=y#v=onepage&q=third%20gender%20in%20Tuvalu&f=false

expressed. Buchanan-Aruwafu notes that culturally defined transgender roles for men are found in Fiji Islands, French Polynesia, PNG, Samoa, Marshall Islands and Tonga, however male-to-male sex also occurs with men who do not identify as transgender or as ǯhomosexualǯ, and who identify as heterosexual and have sex with women. Buchanan-Aruwafu also notes that identification of MSM is also problematic in PICT due to societal and religious stigma, discrimination, laws that criminalize homosexuality or sodomy, and physical violence and emotional abuse directed at sexual minorities. Male-to-male sex between adults is illegal in nine of the 22 PICT (Cook Islands, Samoa, Tonga, Tuvalu, PNG, Solomon Islands, Kiribati, Nauru, Palau) 3

)n a survey DzVanuatu)ntegrated Bio-Behavioral Survey and Population Size who have sex with men and transgender People, ′□□□dz, found out that out of the sample, □,% reported that they had anal sex with another male. In comparison, UNICEFs Knowledge, Attitude and Practices study looking at HIV and AIDS among adolescents and young people between 2008-2009 reported that 8% of sexually active male participants have had male-to-male sex. These data suggest that male-to-male sex is not uncommon in Vanuatu4.

Another report by International HIV Research Group also found that not only there are male sex workers selling sex to males, there are also males who sell sex to females, who are usually foreigners5.

14.2 Female Sex workers

A report by Secretariat of Pacific Societies found out that the most common places for commercial sex was at sex workers house 43.7%, guesthouse 36.5%, bushes 27.8%, clients house 23% and the beaches 22.2%. In exchange for sex, female sex workers were commonly given goods like clothing (62.7%) or drugs (16.5%) in exchange for sex. The most common reason for sex was to support themselves. The use of alcohol and drugs by the female sex workers was reported6.

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[3] McMillan, K., and Worth, H. (2011) Risky Business Vanuatu: Selling sex in Port Villa. International HIV Research Group, UNSW, Sydney.

[4] Van Gemert, C., Kwarteng, T., Bulu, S., Bergeri, I., Malverus, J., Wanyeki, I., Badman, S., Tarivonda, L., Vella, A.M, and Stoove, M. (2013). Vanuatu Integrated Bio-Behavioural Survey and Population Size Estimation with Men Who Have Sex With Men and Transgender People in Vanuatu, 2011. Melbourne, Burnet Institute.

[5] McMillan, K., and Worth, H. (2011) Risky Business Vanuatu: Selling sex in Port Villa. International HIV Research Group, UNSW, Sydney.

[6] Bulu, S., Gold, J., & Sladden, T. (2007) “Vanuatu Female Sex Workers Survey”.

In the report by International HIV Research Group, 2011, it was found out that most female sex workers enter the sex industry by their own will. Some of the reasons for entering the sex work reported in the study were due to long term relationships breakdown, movement to urban areas and shift to urban life, to earn money, unemployment, unstable relationships or violent partner and lastly to support their family7.

14.3 Forced sex

)n the survey Vanuatu integrated Bio-Behavioral Survey and Population Size who have sex with men and transgender People, ′□□□dz, it was found out that two thirds of TG and one-third of MSM report ever being forced to have sex. The relationship to the person that last forced sex differed between MSM and TG. Among MSM that reported ever being forced to have sex, one in ten reported last being forced to have sex by a client and the same number reported being forced to have sex by a neighbour. Among MSM, just one in ten reported last being forced to have sex with a client and one-fifth each reported last being forced to have sex by a partner, other relative or family friend8.

In the report by International HIV Research Group, it was also reported that forced sex and violence against women are wider societal issues that affect condom use and on sex work.

14.4 Alcohol consumption

In the reports it was found that most TG and MSM reported drinking alcohol. It was also found that more than half of the sample size reported drinking alcohol at binge levels (more than six drinks on one occasion). The use of Kava was also reported with both TG and MSM. When looking at illicit drugs, it was reported that approximately half of MSM and TG reported ever using illicit drugs. The most common illicit drug ever used was cannabis, by MSM and TG. Approximately one quarter of MSM and one in ten TG reported recent use of illicit drugs. Cannabis was the only illicit drug used. There was no injecting drug use reported by MSM or TG9.

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[7] McMillan, K., and Worth, H. (2011) Risky Business Vanuatu: Selling sex in Port Villa. International HIV Research Group, UNSW, Sydney.

[8] Van Gemert, C., Kwarteng, T., Bulu, S., Bergeri, I., Malverus, J., Wanyeki, I., Badman, S., Tarivonda, L., Vella, A.M, and Stoove, M. (2013). Vanuatu Integrated Bio-Behavioural Survey and Population Size Estimation with Men Who Have Sex With Men and Transgender People in Vanuatu, 2011. Melbourne, Burnet Institute.

[9] Bulu, S., Gold, J., & Sladden, T. (2007) "Vanuatu Female Sex Workers Survey".

The report by International HIV Research Group reported that excessive alcohol and kava consumption were commonly associated with sex10.

14.5 Violence Against Women By Husbands or Intimate Partners

Vanuatu has alarmingly high rates of violence against women by husbands/partners. Among women who have ever been married, lived with a man, or had an intimate sexual relationship with a partner, 3 in 5 (60%) experienced physical and/or sexual violence in their lifetime; more than 2 in 3 (68%) experienced emotional violence; more than 1 in 4 (28%) was subjected to several forms of control by their husband or partner, more than 2 in 3 (69%) experienced at least one form of coercive control, and most of these were living with physical and sexual violence. Most women who are subjected to violence by husbands/partners experience multiple forms of violence11.

Community Concerns the household questionnaire – which was answered by about 58% women and 42% men – asked a series of questions to gauge levels of community concern about other forms of violence. This provides an important context for the analysis of community responses and attitudes to domestic violence. The findings show that 44% of respondents were very concerned about levels of crime, 37% about violence due to land disputes, and 49% about violence due to sorcery. The vast majority of respondents were either a little or very concerned about all these problems12.

Issue	Not concerned		A little concerned		Very concerned		Total
	Number	%	Number	%	Number	%	Number
Concerned about levels of crime (robbery, assault, murder)	202	9%	1104	47%	1020	44%	2326
Concerned about violence due to land disputes	505	22%	963	41%	858	37%	2326
Concerned about violence due to sorcery	332	14%	844	36%	1149	49%	2326

[10] McMillan, K., and Worth, H. (2011) Risky Business Vanuatu: Selling sex in Port Villa. International HIV Research Group, UNSW, Sydney.

[11] Vanuatu National Survey on Women's Lives and Family Relationships, 2011

[12] Vanuatu National Survey on Women's Lives and Family Relationships, 2011

[13] Vanuatu National Survey on Women's Lives and Family Relationships, 2011

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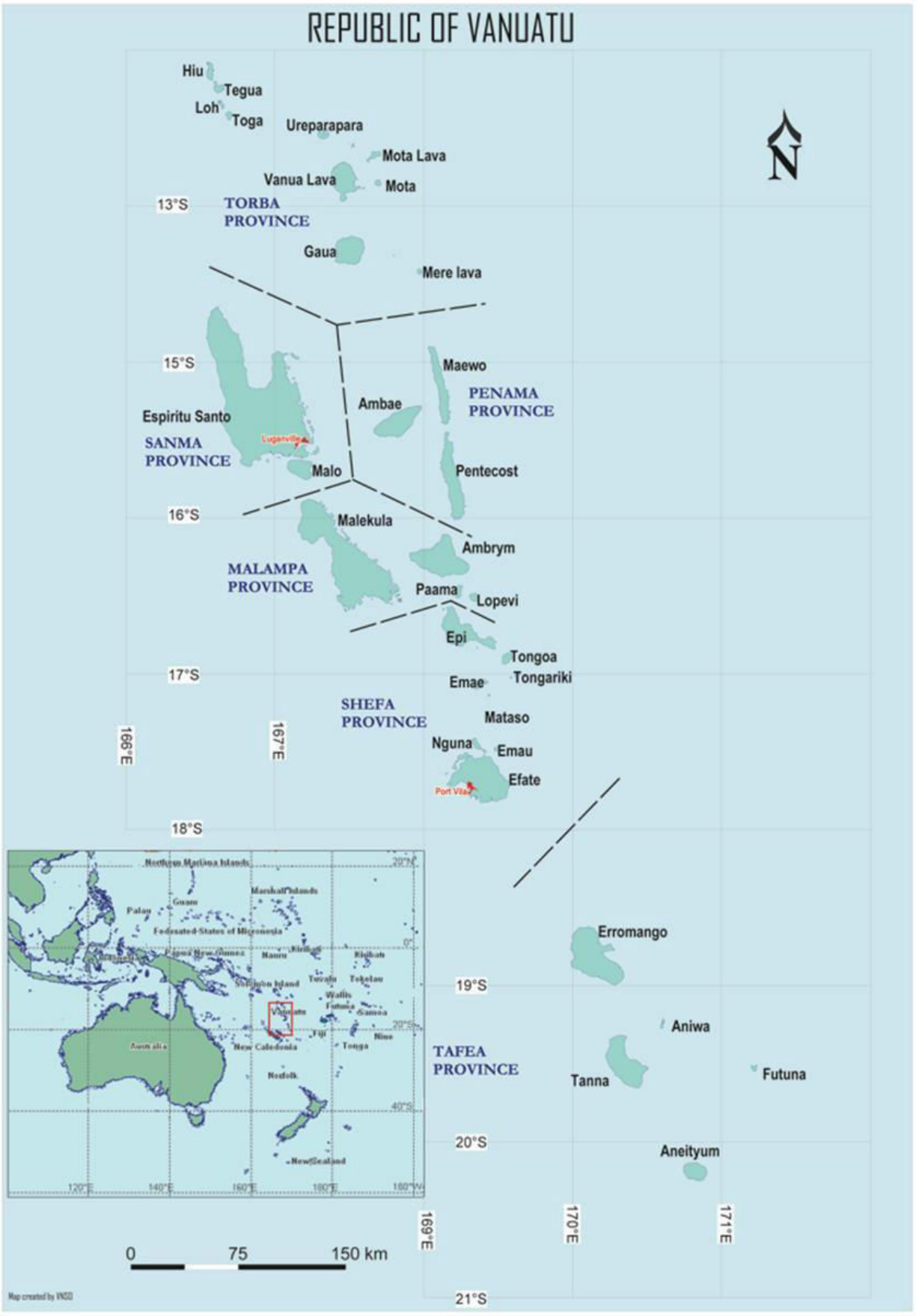
REPUBLIC OF VANUATU
Hiu
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Mota Lava
Vanua Lava
Mota
13°S
TORBA PROVINCE
Gaua
Mere lava
15°S
Maewo
PENAMA PROVINCE
Ambae
Espiritu Santo
SANMA PROVINCE
Malo
Pentecost
16°S
Malekula
Ambrym
MALAMPA PROVINCE
Paama
Lopevi
Epi
Tongoa
17°S
Tongariki
Emae
SHEFA PROVINCE
Mataso
166°E
167°E
Nguna
Emau
Efate
Port Vila
18°S
Erromango
19°S
Aniwa
TAFEA PROVINCE
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